

**The Implications of Drug Treatment Practitioner
Favourable Bias towards Illicit Drug Users, on Client
Treatment Outcomes**

A Thesis submitted for the degree of Doctor of Philosophy

by

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Abstract

This thesis is based around eight inter-related studies examining drug treatment practitioners' (DTP) actual and perceived favourability towards illicit drugs and illicit drug users (IDU), and the impact it may have on clients' drug treatment outcomes. Furthermore, the extent to which individual differences moderate levels of favourability are explored. It is impossible to study aspects of treatment success, without recognising the importance of the dyadic therapeutic alliance (TA) between DTP and IDU client. Consequently, this thesis draws upon the theory of symbolic interactionism (SI), which purports that social interactions shape, modify and develop the self, by aligning ones identity with the interpretations and performances with others. Thus, the TA can potentially be a fundamental aspect of recovery success. SI pertains to the notion that a blend of both quantitative and qualitative research brings strength to theoretical development, and provides an understanding of the connection between meanings and behaviour. Thus a mixed-method technique was employed to quantitatively develop and validate an 'attitudes towards illicit drugs and drug users scale' (ATIDDUS), so as to explore the association between actual and perceived favourability (in a number of different population samples), on clients' drug treatment outcomes. Then, to qualitatively evaluate aspects of treatment that were considered to influence recovery success. The findings support the view that there is an association between TA rapport and clients' treatment outcomes; particularly that DTPs do exhibit favourable bias towards IDUs, and that perception of DTP favourability was potentially associated to certain treatment outcomes (i.e. employment and no longer requiring aftercare). Further, aspects of the TA, such as continuity, trust and support were considered by current clients as aiding their treatment outcomes. The clinical implications of this research are, (1) on the recruitment of new DTPs; as individual differences in the general public were found to influence levels of favourability (e.g. personal/direct, and vicarious/non-direct experience with illicit drugs and IDUs improved favourability), (2) on the training and education of DTPs; DTPs were found to exhibit higher levels of favourability (when compared to the general public), yet it was significantly underestimated by clients. Thus indicating a requirement to address and enhance the disparity between actual and perceived favourability, so that clients can be positively influenced by DTPs' favourable bias.

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A special acknowledgment goes to the mothers that I have lost and the children that I have gained, along the pathway of this PhD.

This thesis is dedicated to Shirley June Murray: 1948 - 2011

Author's declaration

I declare that the work in this thesis is my own. The jointly authored posters presented at various British Psychological Society conferences were based on studies 1, 4, 5, 6, 7 and 8. The experiments were devised and conducted by myself.

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Abbreviations

ATIDDUS – Attitudes towards Illicit Drugs and Drug Users Scale

CJS – Criminal Justice System

DTP – Drug Treatment Practitioner

IDU – Illicit Drug User

NDTMS – National Drug Treatment Monitoring System

NTA – National Treatment Agency

SI – Symbolic Interactionism

SIT – Social Identity Theory

TA – Therapeutic Alliance

TOP – Treatment Outcomes Profile

1 CHAPTER ONE: Drug Treatment Effectiveness, the Therapeutic Alliance, and the Measurement of Attitudes

1.1 Framing the Research Question

The beginning of 2011 heralded the piloting of a 'Payment by Results' government scheme, in drug treatment. This was in an attempt to improve drug treatment effectiveness. The policy incentivised treatment results, whereby, treatment providers would be paid a percentage of money at the intake process of treatment, with the remainder being paid after completion (if clients were abstinent). However, it is questionable as to whether this scheme does in fact have the welfare of the client in mind. Quite often, a common criticism of treatment providers is the over-management by central government, regardless of whether it leads to effective treatment outcomes (Schorr, 1997); as research in the past has demonstrated that governmental proposals have not also translated into improving efficiency (Wachter, Flanders, Free and Pronovost, 2008).

Thus, suggestions of ways to improve treatment, informed by government policies, are not always best suited for improving effectiveness. This was exemplified in the US, where a national system was adopted in healthcare administration (the Veterans Health Administration) for measuring and incentivising particular clinical practices (Eisen and Francis, 2010; Jha, Perlin, Kizer and Dudley, 2003). It was reported that systems such as these, consequently produced league table competitions, whereby treatment providers exert more effort into becoming the best at a range of clinical practices (Oliver, 2007, 2008). Furthermore, providers potentially concealed poor performance, or over emphasised adequate or good performance, to make themselves appear to be more effective (Bevan and Hamblin, 2009). This was reflected in research conducted by Commons, McGuire and Riordan (1997) reporting that although performance appeared to have improved, later analysis showed that programmes began treating fewer problematic clients, after the contract was in place.

Humphreys and McLellan (2011) purported that new credentialing policies are weak when it comes to improving treatment outcomes. This is proposed for the reason that 'payment by results'

schemes in the US, may achieve process-of care targets, such as treatment programmes that have reduced the number of clients exiting programmes early (McLellan, Kemp, Brooks, and Carise 2008). Yet, target achieving has been shown to bear a weak relationship to client treatment outcomes (Harris, Humphreys, Bowe, Kivlahan and Finney, 2009; Harris, 2010).

It could be argued that the follow up is too late after commencement of treatment. Thus treatment may have initially been effective, yet an unknown variable, post-completion and prior to the follow up assessment, caused a relapse. Consequently, long-term outcomes cannot simply be equated to the quality of treatment services (Boyd, Humphrey and McCellan, 2011). This is exemplified by the fact that the chronic conditions associated to substance abuse are not solely associated with addiction, but with behavioural and environmental components that are deeply influenced by life context (Moos and Finney, 1983). Therefore, high quality treatment may be marred by returning to an environment of being homeless, unemployed and associating with other IDUs.

In accordance with the 'payments by results' scheme, clients not shown to be dependency-free at follow up, result in non-payment to the treatment provider, by the commissioner. This could have further negative consequences to treatment staff, in terms of feeling demoralised by a lack of success. Thus, potentially leading to a lack effort in the future, as they have been held accountable for something they have little control of. Consequently, this can further lead to learned helplessness behaviour, and burnout (Seligman and Maier, 1967; Kirk-Brown and Wallace, 2004). Subsequently, clients may be 'cherry-picked' by treatment providers, based on their perceived potential to succeed in treatment. Those that are considered too chaotic, would not be of cost-benefit to treatment providers, and thus would not be accepted for treatment.

However, Humphreys et al. (2011) proposed that 'payment by results' is potentially one of the most effective approaches to improve treatment effectiveness and success. This is perhaps for the reason that the scheme aims to integrate the client in the development and undertaking of their treatment journey. Hence, care programmes are individually tailor-made to suit the individual needs of the client; supporting dependency-free living, as well as factors of social reintegration (such as housing and employment issues). Yet, more research is required to establish the relationship between

treatment outcomes that immediately follow a treatment episode, and long-term success. It is for this reason that a different approach to drug treatment is necessary, whereby measures of success are determined by other successful aspects of treatment. For example, increasing the proportion of clients who have achieved various outcomes by the end of their programme; being abstinent for 30 days after the completion of treatment, or having a significant reduction in substance use since treatment intake. Ultimately, policies that drive decision-making in the commissioning, and improvements of drug treatment should be evidenced-based, rather than merely a political process.

Consequently, success in treatment should no longer be represented by simply increasing numbers of clients in treatment, but by a marked improvement in clients' treatment outcomes. This change in policy identifies the need to investigate ways in which clients' treatment outcomes may be improved. One such way to achieve this, draws upon Engel's (1977) 'biopsychosocial concept of illness', which argued that the holistic health experiences of the patient is far more important to their overall treatment outcomes, than simply focusing on their biological factors. Thus, suggesting that in order to improve clients' treatment outcomes, it is also necessary to investigate their personal experiences of drug treatment. This concept was further supported by findings from previous studies by Greenfield, Kaplan and Ware (1985), Smith, Garko, Bennett, Irwin and Schofield (1994) and Smith and Pettegrew (1986), reporting that personal experience had a considerable impact on clients' treatment outcomes.

A theoretical concept that places great importance on the client's own experience of treatment, in terms of their recovery, is that of patient centred care (PCC). Although this is a concept that has been more widely used in generic healthcare, it can also be applied to the treatment of substance misuse. The Institute of Medicine (2006) reported that PCC should be respectful of, and responsive to, the patients individual needs and values, as well as ensuring that patients' values should guide all clinical decisions. Thus firstly promoting the pivotal role that the client has on their own treatment, and secondly, the influence that communication between client and DTP has on their treatment outcomes (Gerteis, Edgman-Levitan, Daley and Delbanco, 1993). This is for the reason that involvement and mutual participation of decision-making in treatment, as well as the interpersonal relationships between DTP and client (such as the feeling of trust within this relationship), have all

been exemplified as having considerable impact on treatment success in PCC (Lambert, Street, Cegala, Smith, Kurtz and Schofield, 1997).

Not only is the importance of the therapeutic alliance (TA) between DTP and client indicated as having an influence on improving treatment goals, but also, the importance of research that focuses on the structure and content of the TA, and ways in which it actually impacts on treatment outcomes. Moreover, according to Burlison, Albrecht, Goldsmith and Sarason (1994) and House, Landais and Umberson (1988), research that takes this focus, takes precedence over research that has in the past simply investigated the presence or absence of any social relationships between DTP and client. This was for the reason that they did little to inform of the impact that favourable or unfavourable relationships may have on clients' outcomes.

Historically, a vast amount of literature has highlighted the importance of the dyadic relationship between practitioner and client, within the therapeutic setting. Studies such as Lowenberg (2003) and Shattell (2004) demonstrated that favourable and unfavourable attitudes displayed within the TA had a considerable impact on a client's recovery. Not only has the link between favourability and treatment outcomes been repeatedly found, but it has also been considered to be so accurate, that it was capable of predicting clients' compliance, retention and outcomes in treatment (Orlinsky, Ronnestad and Willutski, 2004).

More specifically, according to Puschner, Bauer, Horowitz and Kordy (2005), the presence of favourable attitudes within the TA results in enhanced treatment outcomes, whereas less favourable attitudes produced poorer treatment outcomes. Their study on the effects of the TA on treatment outcomes in psychotherapy reported that those patients described as being 'too hostile' in the therapeutic relationship were found to have a relatively poor helping alliance, whereas, those that were described as being 'too friendly' were reported to having a more favourable therapeutic relationship with their practitioner. Such findings imply that the more enhanced the rapport between DTP and client, the more improved the treatment outcomes. Thus, one potential way of improving treatment outcomes in drug treatment, is to investigate the role of favourable and unfavourable bias within the TA, and the impact that it has on clients' treatment outcomes.

Since this notion is not a new concept, the relationship between DTP and client is already of particular interest to the National Treatment Agency (NTA). Consequently, the TA has been highlighted as an aspect of treatment that can improve a client's likelihood of success in treatment, through the effect that the relationship has on clients' retention in treatment and subsequent improvements in outcomes. Comparatively, inflexible treatment packages and disciplinary responses to continued illicit drug-use is also recognised as influential factors that dissuade clients from remaining in treatment. Thus, drug treatment services are already aware that the TA needs to be positive in order to be effective. This supports PCC's contention that the key to attaining success within any care-giving therapeutic environment, is to allow the client to take an active role in their own treatment. Furthermore, that good quality TA's, relationships within the whole treatment team, and high expectations for personal growth, were all found to improve client engagement (Orford, 2008).

From a PCC perspective, Lambert et al. (1997) argued that the DTP and client have concomitant roles on treatment outcomes, with the DTP having greatest potential impact on the client's well-being and health. However, this notion elicits concern as to where the direction of ownership of recovery is placed, as it implies that ownership of recovery can be deflected from the client. Thus, although the DTP has been indicated as having considerable influence on the recovery of the client, so to, should the client. Subsequently, a social psychological theory that may be more adept at exploring the dyadic relationship between DTP and client is that of symbolic interactionism. This theory defines health in terms of the client's effort to align their own identity with the interpretations and performances of others, as a fundamental aspect of their own recovery.

This concept suggests that, in terms of having an impact on treatment, the way in which clients understand their treatment environment, is equally as important to the way in which they perceive and understand others in this environment. Consequently, perception and interpretation are important concepts to consider, for the reason that PCC should not only be viewed in terms of how the DTP relates to the client, but also the significance of the client's interpretation of the DTP. Not only do positive attitudes influence a favourable outcome, but perceptions of positive attitudes also influence favourable outcomes, as was demonstrated by Fiorentine, Nakashima and Anglin (1999). They found that client perception of the usefulness of drug treatment was reported to be a predictor

of their level of engagement with the service. Constructionists would argue that this was because perception of health, and health behaviour, is mediated and motivated by who the individual is, and what it means to be that individual. Thus, an IDUs' perception of, and behaviour to, drug treatment, is likely to be negative for the reason that they are probably still using drugs. Consequently, any previous experience with drug treatment services is unlikely to have been successful, thus negating a client's judgement on the usefulness of treatment.

Furthermore, the clients' identity is a prime motivator in their health cognition and behaviour towards treatment. Link, Elmer, Struening, Phelan and Nuttbrock (1997) maintain that a client will have been affected by years of stigmatisation for being an IDU. This will not only have a detrimental impact on their confidence, but will disrupt their social interactions and impair their social and occupational functioning. Subsequently, they will have a lower opinion of themselves, which according to Goffman (1963) and Richmond, Mason and Padgett (1972) produces a less favourable perception of the self. This links to theories of both self-esteem and social identity theory (SIT) purporting that parts of an individual's concept of the self is derived from perceptions of others; in terms of self-esteem, many years of stigmatisation will have a detrimental effect on the individuals' overall evaluation of his/her own self-worth (Tajfel and Turner, 1986).

These findings support Oskamp's (1962) delineation that the accuracy of peoples' opinions of others is completely unrelated to the confidence with which they are held. It is therefore not possible to say that individuals can accurately perceive favourability from others, particularly if the alliance is one in which one person is subordinate to another. This is highlighted by leader-membership exchange studies demonstrating that superiors and subordinates do not agree on the quality of their relationship (Campbell, White, and Johnson, 2003; Schriesheim, Neider, and Scandura, 1998; Xin, 2004).

This current project will employ the symbolic interactionist view that the dyadic relationship between DTP and client should be investigated in conjunction with one another. There is a general dearth of research on DTPs' levels of favourableness towards IDUs, and a comparison of clients' perceptions of DTPs favourability. Furthermore, there is limited research identifying the

consequential 'treatment effect' of favourable bias and the perceptions of favourability. A study such as this would identify whether DTPs do indeed exhibit favourable bias towards IDUs, and importantly, whether clients are capable of identifying this. Findings would thus have considerable significance to the importance of Cooley's (1909) concept of 'significant others' and 'the looking glass theory' in symbolic interactionism, and how these concepts shape the identity of the individual. Furthermore, findings from this project may indicate associated similar relationships between DTPs' interactions and clients' perceptions on treatment outcomes, thus not placing all the responsibility of treatment success in the hands of the DTP, as was implied by Lambert et al. (1997).

Previous research is indicative of the fact that the TA has significant bearing on clients' drug treatment outcomes. However, this is still a relatively under-researched area, particularly in terms of how perception in the TA impacts on treatment outcomes. Thus, for favourable and/or unfavourable bias within the TA to be confirmed as a causative factor in clients' treatment outcomes, one or more of the following assumptions must be identified; a) it must be shown that DTPs exhibit a significantly different level of favourability towards IDUs, in comparison to the general public, b) that clients can identify this favourable or unfavourable bias in DTPs, c) that measures of treatment success, such as social reintegration, can be influenced by favourable or unfavourable bias within the TA.

The purpose of this thesis is to advance knowledge and understanding, both theoretically and at practice-level, of the effect that favourable and unfavourable attitudes' within the TA can have on drug treatment outcomes. With this in mind, the ambition of this current project is to aid in the improvement of drug treatment effectiveness. It is for this reason that the focus of this thesis is to investigate each of the assumptions mentioned above. Firstly, by the development and validation of a new and effective tool for the measurement of both actual and perceived attitudes towards illicit drugs and drug users, demonstrating the range of favourable and unfavourable attitudes that IDUs encounter. This mixed-methods tool will be seen as one means of assessing the likely favourableness within the TA. Then, the tool will be used to explore a number of sample populations; the general public, DTPs, current clients, and previous clients, with the intention to investigate actual levels of favourableness and perceived levels of favourableness. In addition the tool will be used to explore the possible moderating effects of individuals' characteristics and their

experiences with illicit drugs and drug users, on their levels of favourableness. From the previous research reviewed in the literature search, it is proposed that actual and perceived unfavourable attitudes towards illicit drugs and drugs users, exhibited in the TA, will be reflected in clients' less successful treatment outcomes, and vice versa. Thus, the impact of attitudes within the TA will be explored in terms of clients' self-reported drug treatment outcomes, such as measures of social reintegration (for example, securing accommodation, employment, relationships, and reduction in drug use). Treatment effects will be examined in the web-based survey, and will be explored in more depth in the interview study.

The theoretical background to this thesis takes account of a combination of disciplines and theoretical perspectives, ranging from the effectiveness of drug treatment in clinical and treatment studies, to the sociology of illicit drug-using behaviour, through to the psychology of attitude, and the social psychology of symbolic interactions between DTP and client.

The development of a theory that adequately explains the complexity of human behaviour within a healthcare environment is a challenge facing researchers; natural-science research models favour that of a quantitative nature, yet, those who seek a more holistic explanation, prefer more qualitative methods. Subsequently there has been much debate in health research as to which method is more applicable; qualitative or quantitative (Duffy, 1985), and of the perceived incongruence between quantitative and qualitative designs.

However, symbolic interactionism argues that a blend of both quantitative and qualitative research brings strengths and weaknesses to theoretical development (Carr, 1994). Any theoretical method that adopts a mixed methods approach will be of benefit to the researcher, by offsetting the biases inherent in each method. For example, concerns over the influence that a researchers' presence can have on influencing participants, or how findings can be interpreted by the researchers' *a priori* assumptions, can be dissipated by varying the research techniques used.

Furthermore, as human behaviour can be dynamic, it is necessary to be flexible when researching. Mixed-methods thus allow for the most appropriate methodologies to be applied, dependent on the research population, and the context with which the research is being carried out (for example, current IDUs and previous IDUs in the current project). Moreover, there is always a moral responsibility to ensure sensitivity to the lives of those being researched. In relation to the current research project, some of the participants were considered to be from a marginalised group of society, thus an acknowledgment of cultural differences is also necessary.

According to symbolic interactionism, this can be achieved by applying Cooley's notion of 'sympathetic introspection' to the research being undertaken. Mead, and later, Blumer (1969) implemented mixed method techniques to intimately understand the individuals' world. Sympathetic introspection warranted the use of life histories, case studies, interviews and focus groups, to produce theories grounded in empirical data (Blumer 1969). This was concomitant to Kuhn (1964), who felt that human behaviour could be defined by stable attitudes, and thus 'the self' could be understood by testable events. Consequently, human behaviour could be predicted with empirical techniques such as questionnaires, tests and laboratory procedures.

In addition, Cooley purported that in order to gain sufficient understanding of meaning, observation of external behaviour was not enough; quantitatively asking someone their opinion on a subject (i.e. by way of a questionnaire), will only gather information as to what they report to thinking. Whereas, combining qualitative research (i.e. by way of interviews), will draw-out deeper interpretations and identify recurrent thematic phenomena. Thus, investigations of both overt and covert behaviour, provides enrichment and a fuller understanding of the meaning of interactions and perceptions. This in-depth focus on 'meaning' is what defines symbolic interactionism as being apart from that of other social psychological theories.

Consequently, mixed method design allows for concurrent formation and validation of theories, in an ever changing, dynamic social environment (for example, semi-structured interviews can be used to validate hypotheses and to suggest alternative hypotheses previously derived by questionnaires on behaviour and attitude). Subsequently, symbolic interactionism embraces a mixed-method

design in order to assist in the organisation and interpretation of theory. Regardless of the type of data collated, the overarching objective of symbolic interactionism is to understand the connection between the shared meanings and behaviour.

The research element of this thesis consists of seven interrelated quantitative studies, and one more in-depth, exploratory qualitative study: study 1) the development of a Thurstones scale for measuring attitudes towards illicit drugs and drug users; studies 2, 3 and 4) a series of validation tests on the developed scale, to include a test-retest correlation study, and vignette study investigating the scales predictive quality, and to measure the general publics' levels of favourability towards IDUs and moderators that effect this favourability; study 5) the use of the scale to measure DTPs' levels of favourability towards IDUs and moderators that effect this favourability; study 6) the use of the scale to investigate whether clients can comparably perceive DTPs' levels of favourability towards IDUs, and moderators that effect this favourability; study 7) the use of the scale to retrospectively investigate the treatment effect of previous clients' perception of DTPs' levels of favourability towards IDUs; study 8) an in-depth exploration of the aspects of treatment (particularly in terms of favourability displayed within the TA), that are perceived by current and previous clients', to have an impact on treatment. The following studies in this thesis are designed to address these research objectives.

1.2 Introduction to the Literature Review

The premise for this research is that positive interactions within the TA, between DTP and client, will influence behaviour and consequently clients' drug treatment outcomes. It is for this reason that the focal theory implemented in this research adopts a symbolic interactionism theoretical standpoint. This is for the reason that, a fundamental feature of this project is that social interactions, manifested as actual and perceived levels of favourability towards clients, will impact on the clients' drug treatment outcomes.

The thesis' overarching theory of symbolic interactionism suggests that; (1) human beings act towards things on the basis of the meanings that these things have for them. Thus, relationships are important as individuals will act towards another, dependent on their associated meaning. (2) Meaning is derived from social interactions with others. IDUs, who are a stigmatised group, will have a lower opinion of others, borne out of their lower opinion of themselves. This occurs as, according to SIT, part of an individual's concept of the self, derives from their perception of others. Subsequently, little meaning is likely to be placed on the TA. (3) Meaning is handled and modified through an interpretive process, thus there is possibility for change within the TA, and so, the therapeutic relationship can improve over time with exposure.

The literature review will examine whether attitudes towards illicit drugs and drug users within the TA will have an influence on clients' drug treatment outcomes. This is for the reason that there are a variety of psychological and sociological explanations for the relationship between attitude, the TA and clients' drug treatment outcomes. In view of this, a number of objectives must be met in order to explore this relationship with clarity. With this in mind, the literature review will address three aspects;

1. How treatment effectiveness may be improved
2. The influential role of the TA, and how it contributes to clients' drug treatment outcomes
3. The measures of attitudes

The first objective of the literature review is to highlight ways in which treatment effectiveness might be improved, particularly in terms of retention in treatment. Thus, an exploration of

moderators of improving engagement will be discussed, as well as a look at current policy, and how it has changed in recent times, and the subsequent impact it has had on treatment effectiveness.

The second objective is to illustrate how attitudes can contribute to the effectiveness of drug treatment, by establishing its role within the TA. How a client responds to treatment, as reflected by their drug treatment outcomes, is regarded as a response to the interactions with their DTP. Therefore, it has been proposed that both actual and perceived, and, favourable and unfavourable appraisals of an IDU client, within the TA, will have corresponding positive and negative effects on their treatment outcomes. Moreover, to investigate DTPs individual differences (for example, demographic differences, and levels of contact and experience); firstly, to see if individual differences impacted on levels of favourability. Secondly, to investigate whether individuals with a personal (direct) history of substance misuse or vicarious (in-direct) experience of illicit drug use, via friends and family members, may be particularly drawn into the profession of working with IDUs. In addition, the possibility of whether certain individual differences can identify DTPs, that would make more effective workers, subsequently having implications on employability in drug treatment services.

The third objective is to determine the very nature of the human response of attitude. Furthermore, the meaning of attitude, and measurements of attitude, that have previously been utilised by way of a methodological review. This will be performed so as to build up a reasonable explanation for why the scaling methodology used in the current project was selected.

1.3 Improving the effectiveness of drug treatment

1.3.1 Measuring treatment effectiveness

The National Drug Treatment Monitoring System (NDTMS) statistics reported that between 1 April 2010 and 31 March 2011 there were 204,473 adults actively engaged in treatment services (NTA for Substance Misuse, Oct 2011). The majority of these clients were either engaging in structured

community-based, residential and/or inpatient drug treatment services (approximately 64%). The demographic characteristics of these clients was reported as being that the majority of adults coming into treatment for the first time had a median age of 34 years, were male (73%), and were of White British ethnic origin (83%). Demographic information, such as this, support Kandel and Yamaguchi's (1993) proposal that certain individuals can be identified as being at greater risk of becoming addicts (the study proposed young males from deprived areas). Most clients reported to using either opiates and/or crack cocaine as their main drug of choice, and were most likely to self-refer into treatment, closely followed by coercive referrals from the Criminal Justice System (CJS) (approximately one third). (All above reported figures were published on the NTA website, accessed on 26 May 2012).

The NTA's reported figures also indicate that, of those clients in drug treatment, only 13.7% were reported to having exited from treatment having overcome their dependency (n=27,969). In terms of treatment success, when this figure is compared with alternative addictions such as smoking and alcoholism, the treatment on offer in the UK for illicit drug addiction does not appear to be as effective at producing dependence-free living (the NHS report a 55% smoking cessation success rate, following engagement with NHS Stop Smoking Services in England, and a 27% success rate of adults who were in contact with structured treatment for alcohol as a problematic substance). Thus, it would appear that monitoring the effectiveness of drug treatment in the UK is a necessity, so that outcomes from drug treatment are improved.

The National Drug treatment Monitoring System (NDTMS) is already in existence in the UK, and drug treatment often comes under scrutiny for the great financial emphasis and resources that the government invest in treating such a small, but growing, representation of society. For example, the General Household Survey (2007) report that whilst 37% of adults regularly exceed the maximum alcohol guidelines, the British Crime Statistics 2009/10 report that it is only 3.3% of adults who are defined as being frequent IDUs; using any illicit drug more than once a month on average, during the past year. However, problematic drug users are reported to having the biggest financial impact in the UK, spending an estimated £13.5 billion in England and Wales, for the role that drug abuse plays on drug-related crime (UKDPC, 2008). Similarly, this is reflected in the fact that between a third and a half of all new receptions to prison, are estimated to having problematic drug use (UKDPC, 2008).

Comparatively, the cost of alcohol on the NHS was recorded in the year 2006-07 as being £2.7 billion (House of Commons, 2009; NHS National Statistics on Alcohol, 2011). These figures illustrate the fact that a disproportionately small amount of society has a disproportionately huge financial impact on society. Consequently, there is a necessity to focus finances and resources on those IDUs who are most likely to commit acquisitive crimes to fund drug habits.

Hence, drug treatment services are continually monitored in terms of their effectiveness, but, it is also essential to look at ways in which drug treatment effectiveness can be improved, especially in view of the fact that dependency-free rates for IDUs leaving treatment falls short of comparable treatment addictions. Prior to May 2010 and the implementation of the latest drug strategy, the way in which drug treatment effectiveness was monitored, was by the increasing numbers of clients into treatment. This was possibly as a result of the knowledge that the published figures for problematic drug users engaging in drug treatment in the UK, only represented the 'tip of the iceberg' of the amount of IDUs there actually were. This was exemplified in study of the economic and social cost of class a drug use, by Godfrey, Eaton, McDougall and Culyer (2002), who implemented three methods of estimating populations, because of the uncertainty in estimating class a drug users. The study reported that the lowest estimate of drug users in England and Wales was actually 1,771,000, with the highest estimate being that of 3,486,000, and thus identifying a need to try and engage more individuals into treatment.

However, whilst increasing numbers in treatment may be able to claim quantity in treatment, this measure cannot claim quality of the treatment being delivered. The National Drug Treatment Monitoring System (NDTMS) prior to 2009/10 included successful completions for those who were occasional users of class a drugs. The 2010 revision of the NDTMS Core Data Set changed planned exits to being drug free or occasional user (not class a drugs). The Drug Strategy in 2010 heralded a change to treatment policy; no longer was treatment success measured by numbers in treatment, but by the achievement of clients' treatment goals, as set out at the commencement of their treatment journey. Subsequently, 'Payment by Results' pilot schemes (NTA, 2011) currently running countrywide, incentivise treatment services to attain clients' treatment goals, in terms of factors of social reintegration, for example, improving housing, employment, and a reduction in crime and in drug use. Consequently, there is a move towards focusing on treating the client in a holistic

approach to achieve dependence-free and social reintegration, rather than simply their drug use. Dependence-free alone is the only measure of treatment success, whereas in the past drug users may set out to achieve a secure home and employment, whilst continuing on a long term methadone maintenance programme.

Throughout the duration of this thesis the term 'substance misuse' will be adhered to; this was decided upon in accordance with the regularity in which the term is used in associated literature on drug treatment. However, this term may be considered as having negative connotations on the use of illicit drugs, and hence deemed to prolong the stigma associated with IDUs. Yet, there will always be terminology used within drug treatment, which can be considered to have implied negativity. For example, using the term 'substance use' invariably labels the IDU in a negative manner, by differentiating them from those that do not 'use substances', and therefore the stigma associated to IDUs will still be present, with whatever terminology is decided upon.

1.3.2 The importance of treatment retention

When clients come to leave drug treatment, it is very important that they do so in a 'planned' way, having met the goals initially proposed in care-plans at the beginning of treatment episodes. However, even though figures reported by the NTA for year 2008/09 demonstrate, a very high number of clients (n = 92%) had either stayed in treatment for a 12-week period, hence receiving 'effective' treatment, or had left drug-free beforehand, does not necessary follow that clients remained in treatment until planned discharge. Clients who have not yet reached their treatment goals are retained in treatment until they either do so, or they leave unplanned, before the goal has been achieved. Unplanned discharges encompass a range of causal factors for leaving treatment; clients simply 'drop out', go to prison, treatment is withdrawn for reasons such as continued use of drugs or alcohol (although this is not deemed to be good practice by the NTA), or treatment is declined by the client if the care plan isn't accepted, client moves away or loses contact with the treatment agency. Therefore a vast number of clients, who have undergone 12-weeks of effective treatment, will still leave treatment in an unplanned way, and will subsequently still use illicit drugs.

In light of this, the NTA's aim to increase retention, completion and planned discharge figures, should subsequently improve positive treatment outcomes in clients across a range of domains such as drug-related harm and dependency. The incentive for this is that planned exits, equate clients accruing the benefits of treatment, and subsequently achieving their treatment goals. With this in mind, the NTA published a good practice guide 'Towards successful treatment completion' (2009), to aid drug treatment services in improving completion and retention rates in their programmes. Furthermore, to enhance the delivery of services, and focus on those who are failing to benefit from treatment, which as the figures previously imply, could be argued as being the 87% of clients who are not dependency-free at the end of effective treatment.

The NTA's 'Towards successful treatment completion – a good practice guide' (2009), reports that there is a dearth of UK research into the identification of factors that enhance retention rates. They do however propose a number of factors that might influence the high drop-out rate in treatment. Firstly, that treatment has a long-term cumulative effect, and so, each treatment episode is a part of the clients' treatment journey. The process could take months or even years, for the client to accumulate enough of the benefits of treatment, to reach their overall goal. This view is further supported in the NTA's (2010) 'A Long-term Study of the Outcomes of Drug Users Leaving Treatment.' The NTA (2009) cited that clients' failing to reach mid-treatment goals, is also cited as a factor that influences high drop-out rates. Inflexible treatment packages and disciplinary responses to continued drug-use are said to be influential factors in whether a client chooses to stay in treatment, as demonstrated in Stevens, Radcliffe, Sanders and Hunt's (2008) study reporting that clients felt that agency workers were not responsive to their needs, particularly for those clients who worked or whose daily activity patterns did not coincide with 9 to 5 opening times. This research prompts investigation of current treatment plans and processes.

1.3.3 The negativity that IDUs experience

Since illicit drug using behaviour is present and persistent in most societies, it can be argued to be a normal entity in society that serves to maintain social order. This is for the reason that, according to Durkheim, certain behaviours, such as illicit drug use, do not exist unless they serve some positive social function. Consequently, the purpose that illicit drug use has is to separate the 'them' from the

'us' (Tajfel and Turner, 1986), whereby the definitions of boundaries between normal behaviour and deviant behaviour, identifies those that fall into a drug using group, and those that fall into the rest of society. According to Tajfel and Turner's (1986) Social Identity Theory (SIT), the societal majority thus creates an in-group, in order to favour themselves, at the expense of those who encompass the out-group. Since SIT states that a portion of an individual's self-concept is achieved through their perception with others, then being a part of the out-group will have a detrimental effect on their self-esteem as they will negatively appraise their own self-worth. Consequently, IDUs are not considered to be socially acceptable to the rest of society as they fail to live up to society's expectations because they go against the daily strive for employment, education, accommodation, relationships and family. Thus, IDUs can be considered by society to have 'opted out' of societal morals and values.

In similar respect to that of Tajfel and Turner's SIT, Becker (1953) stated that labelling is socially constructed by the majority, who decide which behaviour is abnormal, and is subsequently only carried out by the minority. This behaviour is then considered to be deviant, and becomes anomalous from the norm. Subsequently, IDUs have to cope with the stigmatisation that being labelled by society as deviant and different to the norm incurs, as well as the associated negative stereotypical images that are often associated with being an IDU. Negative labels are exemplified in the terminology often associated with IDUs, such as describing a drug user as a 'junkie', or by regarding dependence-free as being 'clean', which conversely implies that continued drug use is considered as 'dirty' (Davies and Huxley, 1997). Thus, the way in which they are perceived by others, in such a negative way, will have a detriment impact on their self-concept.

Associated labels to deviant acts thus shape the individual's social identity and behaviour, if they are viewed in a negative manner by the rest of society. Deviant roles are then formed on the basis of negative stereotypes, exacerbated by the media, which in relation to a drug user will emphasise all the negative aspects of the drug user and their behaviour, in order to further support societal disapproval of illicit drug use. This idea was supported by Thoits (1999) who claimed that individuals, who were labelled as deviant, were treated as deviant and thus became deviant. Subsequently, according to Davies' (1996) theory of attribution, the IDU will then learn to become

that stereotype of a drug addict, by adjusting their behaviour accordingly, thus a self-fulfilling prophecy emerges.

Therefore, it is conceivable that IDUs entering into drug treatment services do so, having endured a number of preconceived negative beliefs and attitudes towards them. Thus, not only might DTPs in drug treatment services also be influenced by negative labels towards IDUs, but, IDUs may enter into treatment with a negative preconception of society, having experienced years of stigmatisation, which according to Goffman (1963) and Richmond et al. (1972) will result in them having low self-esteem, this view is endorsed by their perspective of what others believe.

1.3.4 The link between attitude and behaviour

A DTP's attitude towards IDUs may be associated to how they behave towards the client. It is for this reason that researchers such as Wickler (1973) state that attitude predicts behaviour, thus DTPs' negative attitudes towards IDUs would associate to poor treatment outcomes in clients. Wickler's claims had such an impact in the world of social psychology, that it promoted further research on gaining a better understanding of the link between attitude and behaviour. Thus, the main problem identified with the link between attitude and behaviour, is that measures of attitude are fairly general, whereas measures for behaviour, can be more focused on a specific behaviour.

Furthermore, the view from cognitive social psychologists that attitude has both affective and belief components suggest that attitudes and behaviour should be consistent, for example, people with positive attitudes should behave positively toward the attitude object. In support of this view, Fishbein and Ajzen's (1975) Reasoned Action Theory purports that attitude predicts behaviour and therefore an individual with a positive attitude toward an object should behave positively toward that object. With this in mind, attitude is reflected in behaviour, and Rokeach (1968) states that attitude causes an individual to respond either favourably or unfavourably to an object or situation. Thus, Fishbein and Ajzen's (1980) reasoned action theory can be implemented to encapsulate the factors that influence behaviour, as behaviour is the consequence of intention to behave. Whereby, intention to behave is determined by (1) the individuals' attitude and (2) their perception of how others will view behaviour, which is also known as 'social desirability'. This theory was later

developed to Ajzen's (1991) theory of planned behaviour because of the addition of 'perceived behavioural control'. Similar to self-efficacy, perceived control affects intention to behave and actual behaviour. Thus, it is related to the theory of symbolic interactionism as it places emphasis on the importance of meaning and social interaction influencing behaviour.

Thus, whether actual appraisals and perceptions of appraisals are the same is an important concept, and this was demonstrated by Moodley-Kunnie (1988) who investigated attitudes and perceptions of health care professionals towards illicit drugs and drug users. The lack of consensus between practitioners' reported positive attitudes, and the negativity that they were perceived to display, suggests either that, perception is not always accurate, or that belief is not a precursor to behaviour, as argued by Fishbein and Ajzen (1975, 1980), for the reason that practitioners' reported to believing in a positive manner, but then behaved in a negative manner.

The way in which one person behaves, and is perceived to behave to another, draws upon the theory of symbolic interactionism, and this is for the reason that it views the self, identities and relationships as symbolic entities which are developed and changed through interactions with others, such as those that occur in the TA. Furthermore, symbolic interactionist theorists believe that the concept of health and well-being are both aspects of the self and personal identity. Thus symbolic interactionism is a central theory as it maintains that identities are created and sustained through interaction, and that health is an aspect of identity, therefore health is created and sustained in interaction. Furthermore, interpretation and meanings are interactional creations, and health behaviour is mediated by meanings and interpretations, thus health behaviour is a consequence of symbolic interaction between DTP and client.

1.3.5 Factors of treatment that promote change in the client

If IDUs are entering into treatment with a negative preconception of their self and of their treatment DTP, then, aspects of treatment that will facilitate change in clients' perspectives needs to be considered, so as to have an impact on their treatment outcomes. One factor that has already been identified at promoting change is a client's retention and compliance with treatment. This improves

treatment outcomes and risk of harm to the individual is reduced, whilst the client is actively engaging with treatment services (NTA, 2007).

Furthermore, for treatment outcomes to be improved, clients need to be retained in drug treatment for as long as is necessary to achieve treatment goals (National Institute for Clinical Excellence, 2007). This idea was supported by White (2008) who indicated that, although the TA is very important for 'in treatment' outcomes, once the client leaves treatment, internal and external resources that can be drawn upon to initiate and sustain recovery (known as 'recovery capital') become more important, thus the longer the client can stay in treatment, the more influenced by the treatment they can become.

However, the 2007/08 NTA treatment report suggests that there is a vast disparity in the best and worst performing treatment agencies in relation to retaining a client in treatment for a 12-week period (some agencies recorded as much as 91% retention, whereas some recorded as few as a 49% retention rate). This fluctuation between services implies that there are indeed other factors within the services that must have an effect on clients' retention. For example, research by Kleinman, Woody, Todd, Millman, Kang, Kemp, and Lipton (1990), Barber, Luborsky, Gallop, Crits-Christoph, et al. (2001) and Meier, Donmall, McElduff, Barrowclough, et al. (2006) all support the view that, even when controlled for, clients' retention in drug treatment varies widely between DTPs, indicating that the TA is an essential part of retaining a client in treatment. Whereas, Stevens, Radcliffe, Sanders and Hunt (2008) suggests that it is characteristics of the client that influence the likelihood of their retention in treatment; predictors of early exit were, being younger, being homeless and not being a current injector.

1.3.5.1 The impact of clients' individual differences on promoting change

Cross-culturally, studies by Stevens et al (2008), conducted in the UK, and White (2008), conducted in the US both reported that there were characteristics of the client that could predict engagement and retention. For example, Stevens et al. purported that those most at risk of unplanned exits from treatment were, being younger, being homeless, and non-injectors. Furthermore, White identified that some clients were more likely to leave treatment unplanned; those who had lower levels of education, were more likely to have greater alcohol and drug severity, were cigarette smokers, had psychiatric co-morbidity, had a high-risk family environment, had lower levels of motivation to recover, had a weaker TA, and had proposed worse long-term goals.

However, research conducted by both Millar (2004) and Meier (2005) state that clients' characteristics play only a small role in influencing treatment engagement and retention, which is an important concept to take into consideration, as, in the past, clients have been matched to appropriate drug treatment services, based on their appropriate needs. Thus, these contradictory findings therefore indicate that policies which focus on clients' characteristics' might become exclusionary, by their selection of only those believed to benefit most from the programme, which may not necessarily be the most effective initiative for treatment. Although it does, on the other hand, offer a fiscally-neutral alternative for improving compliance, retention and clients' treatment outcomes across the board.

1.3.5.2 The impact of clients' readiness for treatment on promoting change

The notion that an individual's readiness to address their problematic drug use will be reflected in their level of engagement, thus potentially explains the disparity between reported success rates in addiction treatments. This is for the reason that approximately one third of all drug users entering into drug treatment services in the UK, do so as a consequence of the CJS, and have thus been coerced into treatment, rather than a personal decision to address their drug use (NTA website report that the commonest routes into treatment in 2010/11 were 38% of self-referrals, 30% referred through the CJS and 14% were onward referrals from other drug services, website accessed Nov 2011). Therefore, those who have been coerced into engaging with drug treatment services will approach treatment with a lower motivation to recover than those who have voluntarily self-referred, which according to White (2008) was found to be related to long term treatment goals. These findings indicate that lower dependency-free rates are likely to be found in drug treatment because IDUs are entering into treatment without the readiness for treatment that self-referred individuals would display.

However, contrary to this point, is that any engagement, whether it be coerced or self-referred, will have a positive effect on the IDU, as according to the NTA (2007) whilst a client is actively engaging in drug treatment, they are at a reduced risk of harm to themselves, through improvements to health, drug use and criminality. Thus, whether the route into treatment is through self-referral, or through coercion, once the individual is in treatment, then it is important that they receive as effective a treatment as possible, in order for it to have an impact on their drug use.

Thus measures of readiness have in the past been utilised in an attempt to predict a client's likelihood of engaging in treatment, and this is for the reason that, in the past, clients' readiness for treatment has been highlighted as a predictor of short-term treatment outcome success (Handelsman, Stein and Grella, 2005). Furthermore, predictive models have been used to identify moderators of readiness for change, which have focused on clients' motivational aspects or their external contextual incentives. Models have identified individual differences as predictors for change, such as Handelsman et al. secondary review of studies on drug abuse treatment outcome (DATOS) and DATOS for adolescents', which identified cross-dependency as the strongest predictor of readiness for treatment, and health problems and deviant family and/or peers also found to be predictors.

Similarly, DeLeon and Jainchill's (1986) Circumstances Motivation Readiness Suitability (CMRS) scale also identified individual differences that predicted readiness for treatment. The scale utilised a number of Likert-type sub-scales to predict therapeutic community retention, by exploring client perception of their external and intrinsic pressures, as well as their readiness and suitability for treatment. Scores from the scale have in the past been found to be the largest and most consistent predictors of short term success, across all age groups (Melnick, DeLeon, Hawke, Jainchill and Kresell, 1997). Furthermore, the scale has also identified ethnic group differences at predicting retention, such as DeLeon, Melnick, Schoket, and Jainchill's (1993) study identifying clients that were of black ethnic origin, stayed in treatment for either 30 days or for one year, in comparison to those of Hispanic origin. Similarly, age, drug severity, legal referral, and social problems were all identified by the scale as moderators for predicting retention by Soyez, DeLeon, Rosseel, Broekaert (2006).

In addition to individual differences, the CMRS scale has also been able to identify that client' perceptions of treatment strongly correlates to 30-day retention in treatment, with the scale indicating that initial motivation and readiness scores continued to be the most persistent significant predictors of short-term retention in treatment across most groups. However, this was not found to be the case for one year retention (DeLeon et al. 1993 and DeLeon, Melnick and Kressel, 1997). This may be as a result of changing relationships and perception that occur within the therapy setting that might have an impact on changing the client's initial perception of treatment. Conversely, when the scale was carried out in Holland, it was capable of identifying longer term retention (Soyez,

DeLeon, Rosseel, Broekaert, 2006), as the predictive power of the scale was strong enough to identify services users' retention in treatment at one year. Thus implying that there are either cross-culturally differences between studies, or that the time periods with which they were carried out had an impact on findings. For example, that there are noticeable differences between the impact that the therapeutic setting had on clients perception had changed, either between the years, or between the cultures.

1.3.5.3 The impact of clients' perception in treatment on promoting change

According to Fiorentine, Nakashima and Anglin (1999) a further predictor of engagement was the client's perceived usefulness of the treatment on offer, as well as the supplementary services available such as housing and employment assistance, thus suggesting the importance of the practical side of treatment at influencing perception. This was further supported by the Audit Commission Report, Drug Misuse (2004) who stated that a client's perception of treatment impacts on whether they engage, as clients must perceive that the service has a useful and/or helpful aspect to it, in order to want to attend. This was reflected in Stevens et al. (2008) findings that clients reported that one of the main causal factors for leaving treatment early, was not through a lack of motivation, or that they were chaotic in their use of drugs, but that the treatment agencies were inflexible to their needs, particularly when they had work or daily activity patterns, and so could not readily access treatment services open between the times of 9 to 5pm. Similarly, the audit commission report identifies features such as, poor service delivery environments, such as a lack of wheelchair accessibility. Furthermore, no discreet places, being untidy, poorly maintained and having cramped rooms were also found to dissuade engagement. These environmental factors subsequently influenced clients' perceptions of the treatment service. Similarly, Broome et al. (2007) found that engagement with a service was found to improve in those programmes that had a better organisational climate and smaller organisational size. Thus, issues of availability and accessibility of services have in the past been found to be important.

However, the audit report also identified that not only was the perception of treatment service influenced by the practical elements of treatment, but also that the relational aspect with others has a significant impact on perception, and therefore willingness to attend. Furthermore, perceived negative attitudes in treatment, was reported as being a barrier to treatment (Rasool, 2006). This

was exemplified in findings that there was a need for services to be welcoming and non-judgemental, as the attitudes of treatment staff had been cited by clients', as a major reason for not continuing treatment. Furthermore, that it is crucial for front line staff, including reception, to be fully aware and have skills to respond effectively to the client's fear, uncertainty and low self-esteem. Thus, there is a need to provide a combination of both positive environmental, and relational features of a treatment service for services users to perceive it in a positive light, resulting in improved retention, such as those identified by Orford (2008) as a good quality therapeutic relationships and treatment team, high expectations for personal growth, moderate organisation structure, referral and treatment entry procedures, initial assessment producers and treatment environment.

This evidence suggests that perception is important within the TA for the reason that perceived appraisals have an influence on client's retention in treatment (White, 2008). If the DTP exhibits a positive attitude towards the client, then, according to a number of studies that have purported the causal effect that positive attitudes have on positive treatment outcomes (Horvath and Symonds, 1991; Horvath and Luborsky, 1993; Horvath and Greenberg, 1994; Krupnick, Sotsky, Simmens, Moyer, Elkin et al. (1996); Martin, Garske and Davis, 2000; Gaston, 2004), the client will respond positively to that treatment, of which retention is one example. On the other hand, if the client perceives a negative attitude from their DTP, then this will be reflected in their treatment outcomes accordingly. This is for the reason that, according to Athens (1998), behaviour and identity are defined by the on-going, real-life experiences, encountered on a day-to-day basis, that occur within the TA. How a client behaves in treatment can be regarded as a response to the interactions with their DTP, thus emphasising the importance of this relationship.

1.3.5.4 The impact of the TA on promoting change in clients

Taking a symbolic interactionist perspective, the way in which individuals behave in certain situations, such as in a drug treatment setting, is principally dependent on the meaning in which that individual places on the situation (Blumer, 1969). Thus, a client that places significant meaning on their TA within a treatment setting will behave in a more favourable way towards their treatment, than a client that places minimal meaning on this alliance. Blumer's suggested significance of meaning was supported by Anderson and Mott (1998), who indicated that simply having an

association to treatment was not enough for a client to present a positive behaviour in treatment (as demonstrated by a clients' compliance, retention and success in treatment outcomes). Accordingly, for treatment to have an impact, the client must first place meaning on the relational aspect of their therapeutic relationship with their DTP, which is acquired through social interactions. This meaning can be of a favourable persuasion, if the client develops a positive attitude towards treatment from this relationship, equally, it can also be of an unfavourable persuasion, should the client associate a negative meaning to their TA and treatment. Consequently, associated meanings that are both positive and negative can have a symptomatic effect on the way in which the client incurs their drug treatment.

Not only does this therapeutic relationship allow for the meaning of treatment to develop, but, also, according to symbolic interactionism, it can have considerable influence on the development and formation of the clients' self, through the social interactions with significant others (Athens, 1998). Cooley (1909) identified significant others to be those with whom an individual has intimate face-to-face associations, and are thus considered as being part of the individuals 'primary group'. Thus, Cooley termed these to be an individual's close friends and family to the individual. However, IDUs are quite often disassociated from their friends and families, and within a treatment setting, often spend much of their time with their DTP. Consequently, it can justifiably be argued that for many individuals, the DTP becomes a replacement for their primary network (instead of being in the individuals secondary group, as termed by Cooley), and can thus be considered as a significant other to the client. With this in mind, the DTP can then have considerable influence on the formation of the clients' concept of self.

Furthermore, another way that social interactions within this group allow for the individual to grow as a social being (Ritzer, 1996) is achieved through Cooley's concept of 'the looking glass self'. Cooley proposed that there is a believed reflection of the self that the individual sees in significant others. Subsequently, according to Kornblum (1997), and similar to Merton's (1968) theory of the self-fulfilling prophecy, the individual will assume this reflection. Thus, the perception of DTPs' attitudes towards illicit drugs and drug users, whether they are of a favourable or unfavourable nature, will be reflected onto the client, and clients' subsequent perceptions of their DTPs' attitude towards them may pertain to their subsequent drug treatment outcomes. For example, in terms of

believing that they are capable of being rehabilitated, should they perceive this attitude from their client, or conversely, that they are unable to be rehabilitated if this is the attitude that they perceive from their DTP. Subsequently, attitudes that are displayed and perceived within the TA are highly influential in terms of clients' treatment outcomes. The looking glass theory thus proposes a plausible explanation of how a client can absorb a positive identity from their DTP, and a reduction in their drug use, through long-term socialisation with a DTP that expresses a favourable attitude towards them. This therefore raises the question of whether drug treatment services are failing to produce large quantities of clients leaving drug treatment, drug free, because either DTPs exhibit unfavourable bias, or, that clients perceive unfavourable bias, whether it is accurate or not; thus implying, that DTPs need to be equipped with good interpersonal skills, in addition to having a sympathetic and professional approach.

The DTP attitude within the relationship is argued as essential in the success of the therapy and Molnos (1998) argues that it is as equally important as the techniques used in the delivery of the treatment. The DTP's role is to maintain awareness and thus, treatment should be in the clients' best interest, the DTP must have belief in the effectiveness of what they are doing, thus a positive attitude towards the rehabilitation of drug users is essential. According to Hongyi and Wei (2011), negative attitudes are of detriment to an IDUs recovery. Molnos also specifically delineates that this belief must be accurately portrayed to the client. Molnos reported that although new DTPs may not have the experience to adequately do this, they do excel over longer term DTPs in their enthusiasm and eagerness to help, and as such are likely to display a more positive attitude. Subsequently, according to Molnos, a positive attitude will result in improved rapport between DTP and client. The best way of improving rapport according to Molnos, is for the DTP to get close to the feelings and true self of the client, and not to be too detached and passive. Thus, a good rapport results in a TA, which is the client and DTPs' ability to understand one another and to be able to relate to each other at a deeper level. Most importantly, this is not something that can be achieved through specifically discussing the alliance as this will diminish the alliances power, but has to be developed on an unconscious level between DTP and client, as a relationship builds. Thus according to Molnos, the TA is the unconscious cooperation between DTP and client.

Molnos states that there is a demarcation between the terms therapeutic alliance and the working alliance. According to Molnos, the working alliance is the product of a DTP and clients' ability to work together on aspects of the client's internal world, their relationships with others and aspects of the client's life. In order for any therapy to take place, a working alliance is needed. However, a good working alliance requires that the client can look at themselves objectively with the DTP. In order for this to be achieved, there must be sufficient trust between DTP and client. Thus, aspects of good rapport, trust and belief are required, to allow for openness and respect to develop. Subsequently, the distinction between TA and working alliance demonstrates that although both parties, DTP and client, wish to work well together in treatment, the clients unconscious refuses to engage at a deeper level with the DTP, thus their working alliance may be good, but the TA is not strong enough to have such a dramatic impact on their treatment outcomes, arguably by ensuring both the working alliance and TA are based on trust, then too can the client make progress.

1.4 The influence of the TA on clients' drug treatment outcomes

A review of the literature has demonstrated a link between therapeutic attitude and client treatment outcomes (Lowenburg, 2003; Shattell, 2004). In particular, the importance of the TA between client and DTP, has been highlighted extensively in previous research as a predictor of clients' compliance, retention and treatment outcomes, with Orlinsky et al. (2004) reporting that this was found in over one-thousand findings of psychotherapy research, investigating process-outcomes. Furthermore, that favourable and unfavourable attitudes demonstrated within this alliance can have an effect on a client's outcomes. This was exemplified in a study by Puschner et al. (2005) who investigated the effects of the therapeutic relationship, on clients' treatment outcomes in psychotherapy. It was found that those patients described as being 'too hostile', were found to have a relatively poor helping alliance, whereas, patients who were described as being 'too friendly', were reported to having a more favourable therapeutic relationship with their DTP. Such findings imply that the more enhanced the rapport between DTP and client, the more effective the TA.

The role of the TA as an influence on clients' drug treatment outcomes can be most effectively described through the social psychological theory of symbolic interactionism, as the majority of symbolic interactionist research is on the micro-level of the relationship between DTP and client. The

theory was initially developed through pragmatism by Mead (1863 - 1931), and later formulated into symbolic interactionism by Cooley (1909) and Blumer (1969), with influences from Goffman (1959, 1963).

The fundamental premise of symbolic interactionism, is that the world is a social construction, of which there are two main components; the self and social interactions. According to Mead, and later, by Blumer, an individual's 'self' takes a proactive role in the construction of the individuals' social world. This process occurs through the interactions with others, and the undertaking of social experiences. This idea was further supported by Athens (1998) who proposed that behaviour was not simply defined in separate entities such as by biological or psychological explanations, as had been the case in many previous sociological and psychological theories, but, according to Athens, in the real-life, on-going experiences that individuals encounter on a day-to-day basis. These experiences thus shape the individual's social identity, such as the groups that individuals belong.

Subsequently, in accordance with Blumer's (1969) argument, that if social experiences were to be split into variables in order to translate them into numbers for statistical analysis, they may appear to gain the appearance of precision, but, they will have lost the meaning of the social experiences, which, according to symbolic interactionism, is most valuable to understanding human behaviour. This notion was further supported by Athens (1998), who argued that dividing behaviour into variables, such as the individuals' biology, psychology and social environment, would lose the basic integrity of social experience.

Thus, symbolic interactionism investigates behaviour in terms of a holistic event, encompassing a multidisciplinary of theories and can be argued to be an important conceptual theory in the relationship and interaction between DTP and client, particularly in its employment of the dramaturgical model to explain the impact that the TA has on treatment success. This was particularly highlighted in a study by Shattell (2004) who concluded from a review of the literature of symbolic interactionism and the nurse and client relationship, that the interactions within the relationship was an essential part of the nursing practice, which can therefore be argued to also be concomitant to the TA with the drug treatment field between DTP and client.

The theory of symbolic interactionism is pertinent to this current project as it juxtaposes theoretical analysis with research carried out in real-world settings (Forte, 2003). The very nature of this current research is to investigate human behaviour in real-life situations, looking at both DTPs and clients, who are currently involved with drug treatment services. The beneficial implications for this dyadic relationship between theory and practice is proposed by symbolic interactionists for the reason that theory and clinical practice can work effectively side by side; theory can govern practice, and practice can assist in the development of theory (Forte, 2003). Thus, according to symbolic interactionism, the study of human behaviour is best placed within a therapeutic setting, especially within a drug therapeutic setting, because it has for a long time been suggested as a helpful tool for dealing with social problems. This is also supported by patient-centred care which proposes that experience-based investigations of the role that the DTP has on the patient, was most effective when investigating patient-centred health communication (Lambert, Street, Cegala, Smith, Kurtz and Schofield, 1997).

Moreover, the theory has had a reciprocal relationship with clinical practice in the past, as on the one hand, theory has been utilised by social workers to develop more sophisticated concepts of practice, and on the other hand, symbolic interactionist theories have been carried out in social work settings.

Furthermore, symbolic interactionism can be argued as being particularly relevant in the field of illicit drug addiction for the reason that its ideas and concepts have often been used by DTPs in working with social problems (Zurcher, 1986). In fact, symbolic interactionism was used in practice by Falck (1988) who proposed that social work was united by the professional mission of understanding and helping others in order to improve social experience, and the understanding of meaning in relation to human behaviour. Thus, social interactions with one another endorse this meaning, therefore to apply the theory of symbolic interactionism to that of clinical practice helps to give an insight into the understanding of human behaviour, as demonstrated by Strauss' quote;

“the complete therapist (i.e. the DTP), were he[she] to have a sociological orientation, would have a deep understanding of the patient (the client) as a member of a variety of interacting groups”. (1987:p296)

Subsequently, Dunn and Cardwell (1986) called for the acknowledgment of the meaningful contributions that symbolic interactionism could have on the real world, in clinical practice.

However, this idea was not a new concept of its time, the proposition that practice and theory were concomitant was foremost to the forerunners of symbolic interactionism. Dewey (1929) rejected the idea of dualist thinking, which separated ideas from practice as he found that his own engagement with social problems actually stimulated theory development. In support, George H. Mead (Silva, 2011) believed that philosophical and psychological theory should have a direct or indirect bearing on social, political, economic, industrial and moral problems (Miller, 1973). A further proponent for the notion that there should be no split between theory and practice was William I. Thomas (Young, 1948) who believed that sociological knowledge should contribute to social problem solving. Similarly, Addams (1902) tied social theory to specific practical situations and Burgess (1921) worked alongside social workers collecting data on community-based problems, and using his theoretical knowledge to help individuals cope with membership challenges.

These theorists present a strong argument for the reason why the dyadic relationship between client and practitioner is so important, for the reason that DTPs can alert theorists of public problems (Deegan 1988a). On the other hand, theorists can assist DTPs in problem-solving real-life events. Thus, part of the rationale for this current project is to carry out theoretically-based research in real-life clinical settings. Then, to alert DTPs of any potential problems or occurrences that are unearthed, in relation to the impact that favourable and unfavourable bias might have on clients' drug treatment outcomes.

In the past, there has however been a general lack of pre-existing research, specifically investigating the impact that favourable bias, within a specialised drug treatment field, has on clients' outcomes. The preponderance of research in this area has predominantly related to that of generic health care staff, and how their attitudes may influence the patient in a therapeutic setting. A possible reason for this is that prior to 1998, the majority of care for opiate-using patients was predominantly carried out by general healthcare staff, such as general practitioners. Comparatively, the care delivery from drug treatment services has been far more of a recent occurrence. Therefore, the majority of

research pre-dating 1998 possibly focuses on the treatment of illicit drug use by general healthcare because this is where the care was directed.

Moreover, an increase of research on specialist services over the past fifteen years is perhaps as a result of the transfer of care to this area. This proposition is derived from the findings of Martin (1987) and Davies and Huxley (1997), and can also be related to the guidelines for the treatment of drug misuse proposed in the latest Models of Care (2002). Martin (1987) reported that the Government's published Guidelines of Good Clinical Practice in the Treatment of Drug Misuse, Department of Health (1984) had proposed that long-term maintenance in general practice was strongly discouraged, advising that IDUs should primarily be dealt with by general practitioners (GPs) who should assist in their achieving of dependence-free, from the injecting of opiates, within a two week to six month period. As such, GPs were advised that long-term maintenance use was strongly discouraged for opiate users, yet the classification of what was meant by 'long-term' was not made clear in the guidelines. Only those opiate users who were long-term users and therefore required more expertise in dealing with their illicit drug use should be cared for by specialist drug service, however, there were very few reported cases of long term opiate users at this time. Davies and Huxley (1997) went on to summarise that the intentions of the guidelines was to propose a shift in the care given to opiate users, from specialist drug treatment clinics, to the treatment provided in primary care by general practitioners.

More recently, in the last 15 years, generic health care of IDUs has changed to that of more specialist drug treatment services. However, this is carried out alongside general practitioner prescribing, and is known as 'shared care', whereby general practitioners are encouraged to prescribe substitute opioid medication, in conjunction with therapeutic treatment offered by DTPs, who can focus on the factors that contribute towards illicit drug use (Models of Care, 2002). Yet, this extra support has not been found to improve attitudes towards IDUs in treatment, with negativity being reported as prevalent in both nursing and medicine (Bate, 2005 and Landy et al. 2005). Further, that nurses report to disliking and fearing IDUs, as they felt the work was unrewarding and unpleasant (Peckover and Chidlaw, 2007).

Subsequently, the purpose of this thesis is to investigate the role that the TA, between DTP and their client, has on influencing the clients' drug treatment outcomes, as demonstrated in changes to their socio-economic status, health, criminality and illicit drug use. This premise is derived from a number of previous studies, more specifically, Martin, Garske and Davis (2000) who reported that the quality of the TA accounted for 22% of the variance in the rate of therapeutic success. Therefore, this thesis will delineate that it is the DTPs' favourable and unfavourable attitudes towards illicit drugs and drug users, displayed within the TA that can strongly influence a clients' drug treatment outcomes. Essentially, it is predicted that the TA can contribute to therapeutic change in the client.

However, in order that attitudinal favourability within the TA can be implicated as a contributing factor to clients' drug treatment outcomes, a number of proposed objectives will be raised and discussed, drawing on a myriad of sociological, psychological and social psychological theories, with supporting studies to demonstrate why the TA is believed to influence clients' treatment outcomes, demonstrated in changes to their health, use of illicit drugs, criminality and social reintegration.

Therefore, in order to explore the TA-treatment outcomes link with clarity, three defining questions will be addressed;

1. **What** is the TA?
2. **How** does the TA influence clients' treatment outcomes?
3. **When** do moderators of DTP attitudes impact on client outcomes?

The first objective is to clarify what is meant by the concept of the TA. A number of studies use different language to describe this relationship, which at times can be interchangeable. Furthermore, some propose a number of multifaceted names for the various areas of the relationship between DTP and client. With this in mind, definitions and concepts of the TA will be explored, so as to provide a coherent terminology to be used throughout the thesis.

The second objective is to illustrate how the TA can have an influential impact on the clients' treatment outcomes, as demonstrated by their response to treatment. This will be conducted by examining relevant previous studies, and sociological and psychological theories in relation to how an individual's behaviour can be affected by others, and by the proposal of a theoretical association between the TA and treatment outcomes.

When this has been established, the third objective is to investigate when the TA can contribute to positive drug treatment outcomes for clients. This will be performed by first exploring the favourability of DTPs' attitudes towards illicit drugs and drug users, leading to an examination of individual differences, in terms of demographic characteristics and levels of experience with illicit drugs, and their association to levels of favourability towards illicit drugs and drug users. These findings will thus potentially reveal when it is that a client may be at risk of receiving ineffectual drug treatment as a result of unfavourable attitudes from their DTP.

1.4.1 What is meant by the Therapeutic Alliance?

The need for clarification derives from the disagreement of terminology used in previous studies investigating the relationship between DTP and client. In addition, there are a number of studies that use a myriad of interchangeable synonyms to describe the professional working relationship between DTP and client. For example, Dziopa and Ahern (2009) employ the term 'therapeutic relationship', psychotherapy often refers to it as the 'helping alliance' (Puschner, Wolf and Kraft, 2008), and Knaevelsrud and Maercker (2006) adopt the term 'working alliance'. Within the field of drug treatment, the 'Therapeutic Alliance' has been more widely used (Meier, Barrowclough, and Donmall, 2005). Furthermore, it can be argued that these definitions are not interchangeable, as the meanings of these concepts differ, and as such, they can be distinguishable from one another, because they relate to different aspects of the dyadic relationship between DTP and client.

Within the field of psychotherapy, according to Gelso and Carter (1994), the therapeutic relationship refers to the association between DTP and client, and consists of three components; firstly, the therapeutic or working alliance, which is a combination of the DTP's beliefs of their ability to work

with the client, and the client's proactive role working with the DTP. This can be further explained by Bordin (1979) who had subdivided the alliance into three further divisions; the goals that the client hopes to achieve through treatment, the tasks that the DTP and client set in order to fulfil the tasks, and the bond between the DTP and client, consisting of the trust and confidence between one another that the tasks will aid the client reaching their goals. Furthermore, according to Molnos (1998) the TA differentiates from the working alliance, in that the TA relates more specifically to the unconscious aspect of the co-operation between DTP and client, whereas the working alliance relates to the conscious determination and ability for a DTP and client to work together.

According to Gelso and Carter (1994), the second component of the therapeutic relationship, is the transference and counter transference that exists between DTP and client, whereby an unconscious redirection of feelings occurs between DTP and client. The final component is the real relationship or rapport that occurs between DTP and client, being that of the DTP and client's ability to understand each other, and to relate to one another on a deeper level. However, it should be noted that this fails to develop in many cases, as some clients can be deterred from treatment if met with negative views, or perceived hostility.

More specific to the field of substance misuse and the treatment for IDUs, the conclusions drawn from Meier, Barrowclough, and Donmall's (2005) comprehensive critical review of studies carried out over the past twenty years on the relationship between DTP and client, acknowledged the term 'TA' as the most effective means of describing such a relationship. Furthermore, they concluded that it was an essential component of all psychotherapy and counselling, probably because of the beneficial properties that face-to-face contact, the sharing of the same physical space, talking and real-time interactions within this alliance has on treatment outcomes (Skarderud, 2003).

Although there is divergence in the definitions used between the various areas of therapy, each concept contributes to our overall understanding of the DTP/client relationship-outcomes link. However, in order to fully explicate the relationship within the field of drug treatment, it is proposed that the concept of the 'TA' will be more proficient, because of its pre-existing status. It is for this reason that this thesis will utilise the term 'TA' for the collaborative aspect of the relationship

between DTP and client, within the context of drug treatment, in line with past work (for example, Ilgen, McKellar, Moos, Finney, 2006).

1.4.2 How the TA influences clients' drug treatment outcomes

Existing research, has consistently reported a positive relationship between the quality of the TA and treatment outcomes (Horvath and Symonds, 1991; Horvath and Luborsky, 1993; Horvath and Greenberg, 1994; Krupnick et al. 1996; Martin, Garske and Davis, 2000; Gaston, 2004). It can therefore be argued that a client's drug treatment outcomes are demonstrative of how the client has responded to treatment, in response to interactions with their DTP. Furthermore, it has been proposed that both real and perceived and, favourable and unfavourable appraisals of an illicit drug using client, within the TA, have corresponding positive and negative effects on clients' treatment outcomes (McLaughlin, McKenna, Leslie, Moore and Robinson, 2006). It is therefore important to investigate the relationship between DTP and client, in order to see how the TA can influence a client's drug treatment outcome. This thesis will argue that a clients' drug treatment outcomes are influenced by the DTPs' favourable or unfavourable attitudes towards illicit drugs and drug users, and concurrent to the theory of symbolic interactionism, that not only do real opinions displayed within this alliance have an impact on outcomes, but also, clients' perceptions of their DTP.

In order to establish how and why attitudinal favourability within the TA can be implicated as a contributing factor to clients' drug treatment outcomes, a number of objectives first need to be met. According to Tajfel et al. (1986), an individuals' identity is heavily influenced both positively and negatively through the socialisation with others, and therefore with whom a client socialises is arguably an important aspect of treatment. Social identity can have an impact on treatment outcomes, therefore, this section will look firstly at how social identities are formed, particularly in relation to the role of a clients' DTP and illicit drug-using peers' on the formation of a positive or negative identity for the client.

Since illicit drug use is considered to be a deviant behaviour in current western society, IDUs are negatively perceived by the societal majority. Thus, the manner in which this marginalised group is treated, both in society and within the treatment setting can also be argued to have an effect on their treatment outcomes, in terms of engagement, retention and completion. Therefore, this section will then examine the impact that being a part of a stigmatised group has on IDUs, within society and the treatment setting. In addition, a fundamental concept of the symbolic interactionist theory is that an individual is influenced by whom they associate; therefore an essential part of this section is to look at how the client can be influenced by their treatment service, and their DTP. For example, improvements to clients' self-esteem and efficacy levels have a resultant effect on their treatment outcomes. Thus, such associations with the DTP can consequently influence the client, either in a positive manner, demonstrated by successful treatment outcomes, or in a negative manner as demonstrated by unsuccessful treatment outcomes. Therefore, this section will examine the influence that DTPs have on a clients' efficacy, which will hence, have a subsequent impact on their treatment outcomes.

1.4.3 The formation of social identities

The hypothesis that a clients' drug treatment outcomes are influenced by their DTPs' level of favourableness towards illicit drugs and drug users, relates to the theory of symbolic interactionism, which not only delineates that an individuals' identity is heavily influenced by the socialisation with others, particularly so, of the perception and peer pressure of those considered to be significant to the individual, but also that human ontology is made in meaningful relationships with other people. For example, a number of studies have supported the view that the peer relationship is important in identity formation because of the social approval the individual acquires from their peers (Ennett and Bauman, 1991; Harton and Latane, 1997). Similarly, the notion that social appraisals from significant others could not only negatively influence the construction of an individuals' identity in drug addiction, as proposed by Anderson (1994), but also by positively influencing identity by improving a client's self-esteem and efficacy, which can affect clients' success in treatment. This is for the reason that an IDUs' DTP, as well as their illicit drug-using peers, can be considered to be significant others as it is often the case that an IDU will have disassociated themselves from close friends and families. As a result, it is quite often the case that the DTPs and drug-using peers become the only people with which the IDU associates, and so they become their 'significant others'.

Although, this often depends on length of time of drug use, as families may be supportive to begin with. Similarly, to Cooley's (1909) concept of the primary groups, these individuals with which the drug user has face-to-face associations, have an influential role in the development of the individuals' social identity into a social being, through interactions with this group (Ritzer, 1996).

Individuals with whom a client associates in an intimate face-to-face capacity can be deemed to be highly influential to the social development of the client, through the assistance with their social ideas and nature (Cooley, 1909). Therefore, an individual will identify most with those with who they associate regularly, and this was exemplified in Anderson's (1995) proposal that drug abuse escalates with increased identification to illicit drug using groups. However, Lange, Schrieken and Smit (2003) disagreed with the notion that only face-to-face methods can assist in social development. They investigated internet-based treatment for work-related 'burnout', and found that face-to-face contact was not reported as having been missed by participants in the majority their sample (70%). This finding indicates that approaches which utilise treatment therapies whereby the client can remain anonymous can be just as effective, as they allow for clients to disclose without fear of judgement. In addition, the absence of social cues stops the formation of stereotypes that might have an influence on the TA (Whitty and Gavin, 2001).

Further support of methods of therapy utilising anonymity came from studies by Utz (2000) and Suler (2004), who promoted the importance of the absence of face-to-face approaches, as clients were considered to be more likely to self-disclose and be open and honest when there was visual anonymity. This is particularly so in males, as Herring (1993) reported that there were gender differences apparent in the use of internet communications, with men preferring to focus on one personal issue at a time, and were more prone to give or obtain information, ask questions, and discuss personal matters, in comparison to women who were more likely to ask questions to solicit information, and give or garner information. Thus implying that men would prefer on-line counselling, which, in view of the fact that three-quarters of adults in drug treatment are male (NTA's Women in Treatment Report, 2010). Thus suggesting that online methods would perhaps be better suited to drug using males, as a form of drug treatment therapy.

It is potentially for this reason that clinical trials of efficacy in treatment therapies have in the past indicated that online approaches are effective. With this in mind, Knaevelsrud et al. (2006) considered how it was possible for the alliance between DTP and client to evolve over the internet, with the absence of the face-to-face communication that Cooley deemed as crucial for the development of social identity, and thus, still resulting in the delivery of effective treatment. Although Knaevelsrud et al. predominantly investigated post-traumatic stress reactions; the key feature of this study was the effect that the TA had on treatment outcomes. However, numerous studies have indicated that the relationship between the TA and treatment outcome, are congruent in a range of different types of treatment, from cognitive-behavioural therapy (Stiles, Agnew-Davies, Hardy, Barkham and Shapiro, 1998), interpersonal therapy [Martin, Garske and Davis, 2000] and psychodynamic therapy [Horvath and Greenberg, 1994; Stiles et al., 1998]. Furthermore, according to Horvath and Symonds (1991) and Krupnick et al. (1996), the relationship between the TA and treatment outcomes does not differ significantly within these varying treatment approaches. Therefore, Knaevelsrud et al.'s findings are concomitant to the field of drug treatment.

However, Knaevelsrud et al.'s findings showed that although it was plausible to establish a working relationship online, the relationship was not found to be a predictor of clients' treatment outcomes. Hence, this finding suggests that there is a demarcation between face-to-face approaches, which have been shown to influence outcomes, and online methods that do not influence outcomes. Consequently, this indicates to the notion that it is the physical rapport present between therapist and client that has an impact on treatment. This finding supports Cooley's (1909) proposal that it is the face-to-face aspect of the TA that has an influence on a client's social development.

Accordingly, the importance of associations with significant others, supports the notion that favourable and unfavourable bias within the TA, has considerable impact on the shaping of a clients' identity, either positively or negatively. Within the alliance, if the DTP has a favourable attitude towards the client, then it can be hypothesised that the clients' self-esteem and efficacy will improve, which will in turn have an improvement on the clients' treatment outcomes. On the other hand, unfavourable attitudes towards the client will lead to stigma, self-fulfilling prophecy and labelling, and will subsequently have a detrimental effect on the clients' treatment outcomes.

Yet, simply by associating with an illicit drug-using peer group, or conversely, with a DTP, is not enough to initiate identity change (Anderson and Mott, 1998). A client's motivation to change was part of a set of subjective forces that drive and shape behaviour, whereby when the individual is motivated to find and create an identity, the more the illicit drug sub-culture offers an identity, the more likely they are to want to become part of it (Anderson et al., 1998). As such, the more an IDU can associate with the positive influence of DTP displaying a favourable attitude towards them, the more likely it is that they will have a more successful treatment outcome, in terms of a reduction of their drug use, criminality or improvement in their socio-economic status.

Furthermore, it is not only through the association with others that will influence social identity, but through the meaning that an individual associates to a person or group, that will have considerable influence on their social identity (Blumer, 1969). This concept was been demonstrated in a number of symbolic interactionist studies of real situations, for example, Goffman's (1969) 'Asylum' study, and Frank's (2000) acute care model. These studies showed that it was not the roles and systems of therapeutic institutions that had an impact on a clients' therapeutic change, but it was the clients' associated meanings, intentions and actions to treatment, that had influence on their treatment outcomes. Hence, for a DTP to have any influence over the therapeutic change of a client, then the client first needs to associate a meaning to their TA. Consequently, this is particularly important to address, but will require a more qualitative approach to investigate associated meanings in the TA and how they potentially impact on treatment outcomes. It is proposed that in the current project, this will be explored by semi-structured interviews with IDUs.

In addition, it can be argued that IDUs will adopt the stereotypical social constructs of a drug addict, in order to develop a sense of identity. This concept emanates from Booth-Davies' (1992) examination of IDUs from the perspective of Weiner's (1995) attribution theory. The theory argues that individuals seek to explain their own and others' behaviours, by focusing on the consequences of these explanations. Therefore, IDUs will attribute their own behaviours to that of a drug addict, and as such will absorb the behaviours of other drug addicts. Typically, these are negative stereotypes of an addict, such as that they are lazy, deceitful, untrustworthy, and are at fault for their condition (Hartney, 2009). This results in a negative sense of identity for the self. This concept can be related to the TA, as the IDU can not only adopt the negative constructs from other drug

users, but can also absorb more positive social constructs from their associations with the DTP. With this in mind, the relationship with their DTP must be of a positive influence in order to be effective. This is for the reason that unfavourable attitudes in the TA are delineated to have harmful effects on a clients' success in treatment, because clients who experience unfavourable attitudes from their DTP are argued to be more likely to absorb these attitudes, and as such, act accordingly. Whereas, a client that experiences a more favourable attitude from their DTP is more likely to establish a positive relationship with them, and as such, are comparatively more likely to display successful treatment outcomes.

This argument is therefore similar to that of Becker's (1963) self-fulfilling prophecy theory which purported that predictions from others, either directly or indirectly cause the prediction to become true for the individual. Consequently, the client will then absorb the predicted attributes of an IDU. However, it can also be argued that the opposite effect may occur. Known as a self-defeating prophecy, if the client feels strongly against allowing the prediction of negativity to come true, then they may try hard to falsify this prophecy.

In support of the view that increased socialisation with their DTP can relate to a reduction in clients' drug use, Cooley's (1909) theory of the 'looking-glass self', similarly to that of the self-fulfilling prophecy, explicates that a positive attitude towards the client will be reflected onto the client, by the DTP, and subsequently, the client will absorb that positivity (Kornblum, 1997). This is, the way in which an individual views his/her self, is actually a reflection of another peoples' appraisals. Therefore, Cooley's concept of the looking-glass self can be argued to have relevance in the drug treatment process because it explicates why it is that a client forms a positive association with their DTP. Whilst a client is regularly meeting with their DTP, they will absorb the DTPs' positive identity by modelling their self on the DTP (for example, by believing that they can successfully become dependency-free). Consequently, these meetings will have a considerable positive effect on the clients' drug treatment outcomes. However, as Anderson (1994) previously stated, once the client returns to the illicit drug using sub-culture, they are at risk of reverting back to the sub-cultures ideas and behaviour. Therefore, the effect that a positive appraisal can have on an individual needs to extend beyond the clinical setting and into the clients' social environment. Subsequently, in order to assist with being dependence-free of illicit drugs, the client will need to cease associations with the

drug-using sub culture, as they reflect a negative drug-using identity onto the client. Similarly to that of SIT, as formulated by Tajfel and Turner (1979), if the individual seeks to identify with peers from mainstream society, rather than peers from the drug sub-culture, then a consequential change in the individual's identity can be seen, which could have the effect of continuing and reinforcing the positive appraisal from the DTP on the client.

1.4.4 The impact of stigmatisation on facilitating therapeutic change

Illicit drug use is still considered as deviant behaviour in current western society, with IDUs being negatively perceived by the societal majority (Morris, 2010). Thus, the way in which this marginalised group is treated in society and within the treatment setting can be argued to have an effect on their treatment. Goffman (1963), and more recently, Lloyd (2010) proposed that the social phenomenon of stigma can be used to explain why it is that illicit drug use remains so negatively perceived in current western society, and how there may be pre-existing negativity towards illicit drug use, within specialist drug treatment services, that implicates treatment success.

Stigma was defined by Goffman as an "attribute that is deeply discrediting" and that reduces the bearer of the stigma "from a whole and usual person to a tainted, discounted one" (Goffman 1963, p. 3). Stigma has been argued to be a social construction because it is the societal majority that labels certain attributes as negative and discrediting. According to sociologist Durkheim (1895), in a perfect society where there is no crime and deviancy, society creates its own scandal over an individual's faults, however minor they may appear to be. Moreover, should this perfect society be able to judge and punish such faults, the faults would subsequently become deviant and criminal, and would be treated negatively by the societal majority. Therefore, illicit drug use as a stigma is socially constructed because it has been classified as a deviant behaviour, which opposes the behaviour of the societal majority.

The fact that stigma is socially constructed, particularly the stigmatisation of illicit drug use, is demonstrated in cross-cultural studies. Studies carried out cross-culturally of drug use have shown divergent attitudes towards the use of drugs, which are displayed in current western society. For example, this can be illustrated in tribal communities such as the Samena tribe from Venezuela

whose highly regarded Shamans' use psychoactive entheogens, such as the hallucinogenic drug 'Sakona', in religious and ritualistic contexts to develop spirituality, for the purposes of healing and for meditation. Comparatively, it is in these cultures that the more widely-regarded of society use drugs, whereas, in current western society it is the less respected members of society that use drugs (Walter and Fridman, 2004). Thus, behaviours that are labelled as criminal and deviant are cultural-specific, which supports both Durkheim and Goffman's assumption that stigma along with deviant behaviour, is a social construct.

Moreover, in current Western society, not only is stigma evident in illicit drug use, but it is also evident in a myriad of areas in society that include marginalised groups of society, such as those with psychiatric illness, disability, criminality, sexual orientation and ethnicity. This is potentially for the reason that stigma is associated to any factors that are perceived by the societal majority to demarcate from societal norm. According to Goffman, these differences can be compartmented into three main types, encompassing external differences such as a physical disability, or personality trait differences such as psychiatric illness, or tribal differences such as ethnicity groups. The latter was exemplified by Campbell and Deacon (2006) who proposed that those individuals who were of Arab descent, living in the United States post the nine-eleven attacks on the World Trade Centre, were stigmatised by society. Thus, stigma is related to the using of individual differences to segregate those from the majority in-group, from those in the minority out-group, who are considered to be noticeably different.

Consequently, illicit drug use can be argued to encompass two of these distinctions; firstly because the use of illicit drugs can be physically evident, such as the portrayal of before-and-after photographs encapsulating the physical changes to a methamphetamine addict in the US media (PBS, Frontline, 2006). Secondly, because IDUs demonstrate certain personality traits that are indicative of a drug user, such as criminal activity, or by being selfish, demanding, passive aggressive or demonstrating manipulative behaviour (Weiss, Mirin, and Bartell, 2002). In addition, the classification of addiction as a psychiatric illness in the most recent Diagnostic and Statistical Manual of Mental Disorders, fourth edition revised text (2000), evidences illicit drug use as a physical distinction. Therefore, by virtue of its classification, it controversially stigmatises those that seek medical assistance for illicit drug use, and shapes the norms for health and fitness in everyday life,

thus causing moral disgrace to those who fail to comply with their prescribed alternative opiate medication (Glassner, 1988, Brisset and Edgley, 1990). Thus, treatment non-compliance or the failure to overcome the addiction/habit further increases societal stigma towards IDUs.

The severe social disapproval and reaction to an individuals' attributes, behaviours, beliefs and/or characteristics as perceived by others to be against the social norms, leads to negative mental classifications by others, and results in the ruination of an individuals' social identity. This is where Goffman (1963) added to Durkheim's original concept of stigma being a social construction. Thus, the concept of social stigma can therefore explain how it is that society has classified illicit drug use in a negative way, and as such, treats IDUs negatively. Subsequently, IDUs acquire a negative identity within society, because their behaviour has been deemed to be immoral and deviant in modern Western society, despite the fact that illicit drug use is a commonly occurring cross-cultural phenomenon. In support, Falk (2001) argued that deviant behaviours, such as illicit drug use, becomes stigmatised within society because they go against the norms and social expectations of the group majority. Furthermore, stigmatism has a negative effect on behaviour, for the reason that the stigmatised individuals will entice prejudice attitude from others, and subsequently discriminatory behaviour, because of the associated negative stereotypes that the stigma will achieve, resulting in a disempowering effect on the stigmatised individual (Jacoby, 1994, Jacoby, Snape and Baker, 2005). Therefore, stigmatised individuals often experience feelings of psychological distress, and subsequently view themselves contemptuously (Heathertone, Kleck, Hebl and Hull, 2002). If the stigma of illicit drug use (prevalent in current Western society) is also reflected in drug treatment services, then it will have a harmful effect on the client and their subsequent treatment outcome.

Conversely, it can be argued that stigma does not always result in a negative effect on the individual. Heathertone et al. (2002) also proposed that those individuals in stigmatised groups could display higher levels of self-esteem, perform at a higher level, and were generally happier in comparison to individuals without a stigmatism. Then again, these findings possibly emanate from the ability of those in the stigmatised group to become resilient to the negativity that they have experienced over a long period of time. Therefore, what would appear to be constructive factors of the stigmatism could be argued to be simply a coping mechanism created from living amongst society with the

stigma. Thus, it cannot be inferred from Heathertone et al.'s delineations that stigma results in a positive effect on individuals. These findings imply that clients in treatment may display levels of self-esteem, however this may be as a consequence of living with the long-term stigma of drug use, and this must be taken into consideration by the DTP when the client and DTP are working at improving a clients' levels of self-esteem in order to improve treatment outcomes.

There is also a demarcation among IDUs within society, which can have an impact on a clients' treatment success. There are those IDUs that have yet to reveal their stigma to others, which Goffman termed as the 'discreditable', and those that had already revealed their stigma, either intentionally or by a means beyond their control, which Goffman termed as the 'discredited'. How these stigmatised individuals deal with situations such as the processes of concealing and revealing their identities to others was of most interest to Goffman, because he purported that whether an individual is discreditable or discredited will not only have an effect on their behaviour, but also on the behaviour of others around them. For example, discreditable IDUs have yet to reveal their drug use, and as such, manage to live what would appear to be a stigma-free existence within society. However, the accessing of a drug treatment service subsequently reveals the stigma to society, and therefore, the effect that the transition from discreditable to discredited on the individual, would conceivably be moderated by the manner in which the DTP manages the client's transition. Thus, emphasising the significant role the DTP has on managing each individual.

There may be a reluctance of discreditable IDUs accessing drug treatment services because of the threat that social stigma entails, and this was demonstrated in a study by Reece, Tanner, Karpiak and Coffey (2007). This can be argued to be exemplified in Asian communities where there is an unwillingness to reveal a drug problem, possibly as a result of illicit drug use being even more stigmatised within this cultural group in comparison to the societal majority (Fountain, 2009). Therefore, through fear of 'shame' on the self, the family and the community, illicit drug use is concealed, and so remains hidden and untreated (Reach-Out Project, 2010). In this instance, treatment methods that allow for anonymity, such as online therapies may increase the number of Asian drug users in treatment.

This may explain the paucity of research in the area of ethnicity and illicit drug use, and may be partly explained by the lower tendency for some ethnic groups to present for drug treatment, thus they are therefore not recorded or investigated. For example, Muslim males are not as willing to access treatment for alcohol abuse because Islam does not allow use of alcohol, or any other intoxicating food or drink (Ott, Al-Khadhuri and Al-Junaibi, 2003). People from Muslim communities would be unwilling to admit to using alcohol, and are therefore less likely to present for treatment. Consequently, stigmatisation in general might be an explanation for why there are such low rates of problem drug users in treatment (Kelly and Westerhoff, 2010).

Hence, a potential method of therapy to counteract this problem can be seen in the recent influx of online treatment therapies, such as those discussed in the study by Knaevelsrud et al. (2006). Such treatment provisions mean that those individuals who continue to withhold their illicit drug use from society can access drug treatment anonymously whilst maintaining what would appear to the rest of society as a 'normal' existence and thus, being able to conceal their stigma. Furthermore, these methods of online therapy are especially useful to individuals who manage to balance an addiction, with, for example, a working life, or a family life, particularly in cases of addiction in women. This method of treatment allows for flexibility, thus a client can access help at a convenient time. Whereas, this is not always possible in drug treatment services where times are fixed, and there is limited flexibility; a barrier to treatment that is often highlighted as an issue in drug treatment by clients (Broome et al. 2007; Stevens et al. 2008).

According to Goffman's hypothesis, it is these IDUs who can continue to control the revealing of their stigma, that differentiate from those IDUs who perhaps do not have the opportunity to access treatment online, and therefore have little control in revealing their stigma if they wish to access drug treatment. The issue of control is an important aspect of identity; the perception of having little control over situations in life resulting in learned helplessness (Comer, 2004). Thus, individuals become less willing to attempt tasks, for their perception of failure and control from others.

Alternatively, the revealing off illicit drug use to another, does not necessarily equate to a negative outcome. This is for the reason that by choosing who to reveal the need for help to will result in

different outcomes, as in Goffman's model of stigmatised (1963) there are two categories of individuals that the 'stigmatised' individual could reveal their stigma to; the 'normal' and the 'wise'. This model delineates that the general public would be categorised as the normal, and would therefore be most likely to treat the stigma of illicit drug use in a negative manner, because it is a behaviour that goes against that of the societal majority. Whereas, on the other hand, a DTP would be categorised as the wise, because they possess professional knowledge and experience at dealing with IDUs, and as such, should potentially be more sympathetic. Having said this, Lloyd (2010) reported that the stigma of drug use keeps IDUs away from treatment.

However, regardless of whether social stigma has a detrimental or beneficial effect on the individual, it is the labelling process that is associated to the stigma that can have considerable impact on the individual. The labels that society place on the stigmatised group can, according to Becker (1963), result in a self-fulfilling prophecy. Thus, the stigma can have an effect on the behaviour of those who have been stigmatised, in that they start to behave in a way that the stigmatiser expects them. In terms of a drug user, they will absorb the predicted attributes projected on them by another, of an IDU. Stigma not only changes behaviour but it has an effect on an individual's emotions and beliefs, thus affecting their belief as to whether they can achieve their treatment goals (Major and O'Brien, 2005). Thus, if stigma plays such an influential part of drug treatment, then aspects of stigma should be addressed in clients' treatment plans in order to assist in dealing with stigma, in association with successful reintegration into society.

1.4.5 The impact of the treatment service and DTP

The dramaturgical model of social life can be implemented to explain the impact that the TA has on treatment success. The model was brought to the social sciences in the 1960s and 1970s by Goffman, with his seminal work entitled 'the presentation of self in everyday life' (1959), and employed a theatrical metaphor that life is a stage whereby clients and DTPs act and react to one another, and the meaning that these roles have on one another influence human behaviour. The model can be used to explain human behaviour and explanations for that behaviour, because it not only explains what people are doing, but why they are doing it too (Burke, 1945). Therefore it examines how individuals accomplish meaning to their lives through socialisation with others,

because, according to the model, meaning is a behavioural, socially emergent variable of social interactions. This is for the reason that the model purports that our very being, is formed in the meaningful relationships with others. Thus, dramaturgy studies how individuals accomplish meaningful lives (Brisset et al. 1990).

The importance of associated meaning within the TA can thus be exemplified in clients' and DTPs' first impression of drug treatment services, as this is a particularly important time to engage clients into treatment. According to Goffman, when a client first enters into treatment and meets their DTP, the DTP will make certain judgments of the client based on their own preconceived attributions of an IDU. Consequently, the concept of stigma is important in the client's first presentation into drug treatment because it can impact on first impressions, and first impressions can subsequently effect whether a client decides to engage. Therefore the meaning and experience associated with how individuals deal with associated perceived stigmas from others poses the question as to how such a stigmatised group of IDUs responds to drug treatment, in terms of the meaning and experience they associate with such treatment.

Moreover, at the initial meeting, the DTP will categorise their client, based on their preconceptions of IDUs. Goffman described this as the clients' virtual social identity, because it is only based on the perception of the client, rather than their real identity. Goffman delineated that this process occurs because all members of society categorise individuals into social groups, by assigning them with attributes that are deemed normal for each categorisation. Thus, generalisations often occur because individuals are placed into groups regardless of how well they actually fit. Consequently, when a new client is met, the type of client they are likely to be (i.e. responsive to treatment or a non-engager) will be anticipated by the DTP, and the client will therefore be categorised as such. Subsequently, it can be argued that clients are categorised from the first stages of treatment, and that this classification process is influenced by the method of presentation to drug treatment (for example, as a self-referral or through the criminal justice system).

However, once the DTP establishes a degree of rapport with their client, Goffman purported that the DTP will possibly reclassify the client into another group, based on what the DTP perceives of the

client's real social identity. This was demonstrated in a study by Puschner et al. (2005) who reported that clients' interpersonal problems, found at the beginning of treatment, did not predict the dynamics of the TA one-and-a-half years into treatment. This finding implies that assumptions and relationships made in the initial stages of treatment are not static and can be changed over time with the establishment of a relationship between DTP and client. However, this can only occur if there is a continued relationship between DTP and client.

First impressions are therefore, not only most likely to be wrong, and will be changed with time, but can also have a negative effect on a client's engagement, if the client perceives their self to have been viewed in a negative manner by the DTP and/or service. How this can impact on treatment is that in those cases where a new client's attributes are deemed by the DTP to be of a less desirable quality, then, the client will be regarded as tainted and discounted, and as such, a stigma will be attached to the client by the DTP. Should this occur at the point of first encounter, stigmatisation may lead to the DTP having a wrongly placed negative opinion of the client, based on the virtual social identity they have been associated, which indeed would be damaging to the clients progress with treatment, because of a self-fulfilling prophecy.

In addition, Puschner et al.'s (2005) study concluded that a poor initial helping alliance between DTP and client is changeable during the course of treatment, as a relationship between client and DTP is established, which has important implications on the effect that on-going drug treatment can have on the TA. Goffman's assumption that first impressions are not static can be linked to Blumer's (1969) theory of meaning which proposed that meaning is developed through the social interactions with others. Furthermore, it is adaptive and can be changed by interpretation and self-reflection from the individual, whereby a client will react to the meaning they have placed on the relationship with their DTP. Furthermore, behaviour is continually adjusted and adapted because, according to Blumer, the interpretation of another persons' actions is a continual process, therefore the influence of the TA can alter depending on the meaning the client has currently associated with it. However, if the relationship is negative and is not salvageable, then a change in DTP may be more beneficial.

One possible explanation for why the process of reclassification occurs comes from Goffman's (1955) face work theory which purports that in one-to-one settings, such as that of the TA, a client will strive to avoid a loss of autonomy and self-esteem, termed by Goffman as a 'loss of face'. In addition, the client will also desire to be liked by the other person, in order to 'save face'. Consequently, the individual will attempt to interpret the other, and act in such a way as to maintain their 'face' in the presence of the other. One way of doing this is to use flattery, even if the client does not feel this way about the DTP. Hence, Goffman's (1955) face work theory can be employed to explain why a discrepancy between a clients' virtual identity and social identity may occur. In addition, Goffman's theory can be employed to explain why disparity between real and perceived identities within the TA, occurred in previous studies, such as those by Plaas (2002) and Shattell (2002). These studies reported finding discrepancies between the general beliefs that nurses were regarded by patients in a positive manner, and the negative manner in which nurses were actually described by their patients. Thus supporting the notion that clients perceive negativity from others, whether they are true or not, as a result of the years of stigma they have endured (Goffman, 1963).

Although reclassifications can occur once a relationship has been established, the discrepancy could have considerable repercussions on the client's initial experience of drug treatment. This is not only important to consider on the first meeting with a long term client, but also with clients met through brief interventions, such as at needle exchange facilities, as this is the time when potential clients can be engaged into treatment service and is an extremely effective means of initiating behavioural change in addiction, according to Bernstein, Bernstein, Tassiopoulos, Heeren, Levenson and Hingson (2005). Subsequently, first impressions can have an influential impact on a client's engagement with drug treatment services because clients regarded as less desirable, and treated accordingly, would be less likely to want to engage in treatment. Therefore the experience for a client should be that of a positive one, so as to facilitate engagement, and retention in treatment. Thus, further supporting the claim that, favourable attitudes towards IDUs is an important aspect of the dyadic relationship between DTP and client, in terms of its potential effect on engagement, retention and clients' drug treatment outcomes. However, how a client comes in to contact with a treatment service will also impact on the way that they view treatment. It is likely that clients' that have self-referred into treatment will approach treatment with a more favourable outlook, than those clients who have been coerced into treatment through the Criminal Justice System.

However, contrary to symbolic interactionist claims that social appraisal, perception and social experience can highly influence human behaviour and subsequently a client's drug treatment outcomes, Frank (2000) proposed that treatment institutions actually 'routinise' the human experience, suggesting that 'meaning' is often lost in treatment settings. When this occurs, the DTP has little chance of positively or negatively influencing the client, on the contrary, according to Goffman's seminal work of "Asylums" (1961), it is the treatment institutions itself that then has a significant effect on the client. Goffman purported that on entering into a treatment institution, the individual leaves their normal self behind, which he described as the 'mortification of their prior selves', and accepts and internalises the institution's new conceptions. This has implications for drug treatment carried out within an institutional setting, such as prison or residential rehabilitation centres.

Furthermore, according to Frank (2000), the dehumanisation of clients in treatment is most evident at times when clients have reached crisis situation, similarly to that of acute cases of drug addiction often found in drug treatment services. When this occurs, Frank purported that the meaning of treatment became objectified purely by DTPs' observations within clinical practice, rather than by the patients' subjective realities. Thus, resulting in the patient's loss of autonomy due to the fact that their care has become commodified and consequently they become 'caught-up' in the throes of the treatment system. Frank described this concept as a patients 'ride' through the treatment system, and was borne out of Max Weber's disenchantment with the world, which asserted that priority was given to scientific understanding and goal orientation, over the care givers own personal beliefs, as a result of the modernisation, bureaucratisation and secularisation of the treatment system in Western society (Weber, 1905).

Frank's delineations therefore propose that in current westernised treatment, there is little room for influential interactions between client and DTP. This is perhaps why those individuals with more severe problems in treatment are less likely to have a positive TA, as demonstrated in studies by Taft, Murphy, Musser and Remington (2004) and Knaevelsrud et al. (2006) who reported an inverse relationship between those patients with most severe problems, having less of a positive therapeutic relationship.

However, the dramaturgical model purports that individuals can never be construed as simply passive vehicles, through which forces play themselves out, therefore individuals do not take a submissive role in treatment, and as such the proposal that clients' ride through the treatment system with little meaningful interactions with DTPs is not static. Consequently, Frank (2000) maintained that as some DTPs are more charismatic in their interactions with patients, then, their clients will have a more personable experience in treatment, with a less problematic route through the treatment system. This type of relationship between DTP and client encourages the client to take individual action in their treatment, and will subsequently change the dynamics of 'the ride', to that which Frank described as 'the story'. Thus, according to Frank, the client will be enabled by the DTP to develop a voice, and have autonomy within the treatment system. Anderson (1994) purported that it was the influence of others that was fundamental to therapeutic change, which supports Frank's (2000) proposition that it is the people within the service that have most influence on clients.

Moreover, this was demonstrated in a study by Charmaz and Olesen (2003) of terminally ill patients who were argued to follow 'the ride' through treatment, pursuing treatment protocol until such time came when patients' illness progressed to a stage whereby the patient made the decision to go against generic treatment protocol, at their own will. It is at these times when clients can be most positively influenced by their DTPs, because the DTP is enabled to 'reach out' to the client as another individual. These studies exemplify why it is the case that symbolic interactionist theorists explore alternative organisations and ideas of influencing human experience, through the socialisations with others, rather than those that simply provide a traditional 'ride' through conventional systems. The drug treatment field is an example of this, and is demonstrative in the formation and increased use of IDU-groups as an alternative method of drug treatment, both in the assistance with developing policy and as drug treatment groups.

Hence, the way in which a patient feels about their treatment can subsequently impact on the influence it has on the patient. Thus, supporting Blumer's (1969) prior claim that it is the meaning an individual associates to an object or person that will affect the way in which they are influenced by the object or person. For example, if the client holds the treatment service in high regard, then they will be more likely to take notice of the treatment on offer. Whereas in comparison, a

treatment service held in lower regard by clients, will ultimately yield lower treatment outcomes. With this in mind, it can therefore be purported that it is the meaning that an individual places on treatment, which can impact on the influence the treatment has on the individual.

Due to the fact that studies by Frank (2000), and Charmaz and Olsen (2003), have been carried out in generic healthcare settings, whether their findings are comparable to that of the field of drug treatment can be questioned. This is for the reason that IDUs are a far more marginalised group of society than that of generic patients in the health system. Thus, delineations that care-givers' and institutions' influence therapeutic change may not necessarily be juxtaposed to drug treatment settings. In addition, although illicit drug use is a fairly commonly occurring phenomenon worldwide, it still elicits a considerable amount of negativity in current Western society, which could potentially seep into specialist drug treatment settings and have a subsequent impact on the way drug treatment is delivered.

The effect that such negativity can have within treatment settings has been demonstrated in a number of previous studies, and is exemplified in the detrimental effect that a psychiatric problem can have on patients' overall well-being and treatment-goal achievement, as shown in the five-year SAPPHIRE Programme (2010). In addition, an ethnographic study by Johnson and Webb (1995) of social judgements and social processes of care, experienced from the perspectives of both nurses and patients, found that patients attempted to avoid being labelled as difficult because they knew through previous experience, the negative implications that this would have on them in treatment. This was additionally supported in several studies by Carveth (1995), Finlay (1997) and Breeze and Repper (1998) who all reported that patients labelled as 'difficult' by nurses, subsequently received lower levels of care, since nurses would often distance themselves, and attempt to avoid those patients. These studies clearly demonstrate that either there is negativity in existence within treatment settings and that patients are capable of accurately perceiving such negativity, or, that IDUs only ever perceive a negativity due to a lifelong stigma attached to their drug use. For this reason, patients can deliberately manipulate their behaviour in order to acquire the best treatment possible.

Implications of these findings applied to drug treatment practice, are therefore likely to suggest that clients will not be as open and honest with their DTPs, for fear of being labelled as difficult, which subsequently impinges on the care and treatment provided by the DTP. This is perhaps evident in drug treatment interventions whereby the DTP is perceived by the client to have power over whether the client continues to receive their prescribed opiate-substitute medication. Thus, a client will not be as honest about their level of drug use for fear of having the prescription withdrawn or reduced. Furthermore, this example supports the argument that there is little equality in the TA, because power is given to the DTP by the client, as they are deemed to be the 'expert' (Parson, 1951; 1975). This situation hence results in the DTP experiencing feelings of empowerment, whilst the client experiences feelings of disempowerment. An unequal balance of power within the TA will have a consequential negative effect on the TA, and thus impact on the effectiveness of the drug treatment provision on offer to the client. Although there is this inequality, it is common place in clinical treatment settings, and should therefore be taken into consideration when assessing the clients' progress.

Conversely, one of the most fundamental factors highlighted in previous research of the TA, is the impact on effective communication, and particularly the role positivity within the alliance, has on clients' treatment outcomes. A number of studies have identified that a nurses' ability to demonstrate empathy was deemed to be a key helping component in the alliance, eliciting positive outcomes in clients (Ancel, 2006; Morse, Bortorf, Anderson, O'Brien and Soldberg, 2006; Crawford, Aubeeluck, Brown, Cotrel-Gibbons, Porock and Baker, 2009). Furthermore, a study carried out by Edwards, Peterson and Davies (2006) demonstrated further that it was the quality of the TA, in relation to good communication skills, which positively associated with improved treatment outcomes for clients'. Previously identified in a cross-cultural study between Scotland and Canada, Forchuk and Reynolds (2001) reported that the interpersonal relationship between nurse and client, from the clients' perspective, was congruent cross-culturally because participants commonly reported that the nursing practice was considered to be highly important. However the study also identified a need for further research in the area of perceived helping relationships between nurse and patient, and the relevance the relationship has on positive treatment outcomes, as they felt that this was an area where research was lacking. Furthermore, there is a need to inform DTPs of the important role that perception, within the TA, has on the client. Thus, DTPs' need to be made aware that there is a need to boost clients' perceptions in a positive manner.

In addition, similar findings have been demonstrated in other treatment therapies, aside from those in general healthcare treatment provisions, thus indicating that the findings from general healthcare treatments that positivity within the TA impacts favourably on treatment outcomes, is concomitant cross-therapies. For example, Lowenberg (2003) conducted a small scale study of the practitioner-client relationship in a stress management centre and concluded that the key element in the relationship was trust, demonstrating that regardless of the context of the treatment, it was the positive aspects within the TA that remained fundamental to the effective provision of treatment. These studies conclude that, although previous research investigating aspects of the TA have predominantly focused on the relationship between general health care staff, and their patients, the concept that the TA strongly influences treatment outcomes is transferable to other variations of treatment, such as the treatment of illicit drug use.

However, it can also be argued that DTPs cannot always appreciate the full power of their interactions upon their clients' well-being, and this proposition was demonstrated in a study by Altschul (1971) who reported divergent perceptions between nurses and patients on the impact of the therapeutic relationship, whereby patients deemed the nurse-patient relationship to be of therapeutic value in the treatment they received, whereas, nurses expressed doubt over the value of the nurse-patient relationship in the provision of effective treatment. Therefore, client's perception do not always tally with DTP, as this study showed, and although the therapeutic relationship may have therapeutic value, DTPs can at times, be argued to be unappreciative of the power of their interactions on the clients treatment outcomes. It is for this reason that issues such as power, the social and cultural context, and interpersonal competence are considered to be important factors within the TA. Nevertheless, as DTPs cannot always appreciate the full power of their interactions upon their clients' well-being, they must become more aware of the fact that such factors within the TA do have sufficient impact on their clients' treatment outcomes.

In order to empower the client in their treatment journey and improve their experience of treatment, Lambert et al's (1997) theory of Patient Centred Care (PCC) proposed seven dimensions, most of which are already evident in drug treatment services. Firstly, the dimension of co-ordination and the integration of care; exemplified by clients being encouraged to take a proactive role in the development and progression of their own care plans, in the systematic assessments and reviews that are carried out between the DTP and client throughout the course of their drug treatment.

Furthermore, that a client is more likely to be successful in treatment, if they are physically comfortable, thus exemplified by the provision of alternative opiate prescribing clinics, as well as the provision of alternative therapies.

In addition, the involvement of family and friends in a clients' treatment, with family support groups being common place among most drug treatment centres. Moreover, that transition and continuity can also already be seen to exist in drug treatment services, whereby emphasis is placed on the provision of long-term aftercare support for clients leaving treatment. Finally, that there is provision of one-to-one counselling sessions, group work facilities and drop-in services that offer brief interventions are already in place in drug treatment services, meet the PCCs proposed dimension of providing information, communication and education to clients, in order to assist in their treatment success.

Although drug treatment services are already delivering a number of PCCs proposed dimensions of treatment, the governments reported figures of clients leaving drug treatment after a period of effective treatment (which the NTA proposes as being twelve weeks), indicates that the majority of clients are leaving treatment still using illicit drugs. For example, in the year that the 2008 ten-year drug strategy plan commenced, the National Treatment Agencies published figures for 2008/09 demonstrated that only 12.8% of adults leaving effective treatment were reported to being completely dependency-free from all substances. These figures pose uncertainty as to whether current drug treatment services are fully achieving all seven of the PCC dimensions to achieve successful treatment. Thus, the final dimension of treatment that focuses specifically on the relationship between DTP and client, and the impact that it subsequently has on clients' drug treatment outcomes, should be explored in more detail. These were outlined by PCC as 'respect for patients' values, preferences and needs', and 'emotional support and alleviation of anxiety'.

1.4.6 The DTPs' impact on a clients' self- efficacy

The dyadic relationship between DTP and client can have considerable influence on the clients' beliefs that they are capable of successfully achieving their treatment goals, which in turn will subsequently impact on the clients treatment outcomes. This again can be attributed to the levels

of favourability displayed within the TA, because the DTP can have considerable positive influence on improving their clients' beliefs that they can successfully achieve the drug treatment goals set out in initial care plans at the commencement of treatment episodes if they approach the TA with a favourable attitude. Therefore, the DTP must promote the belief and/or assumption that the client can achieve their treatment goals, in order to be able to assist the client in believing this too. It is for this reason that, the concept of self-efficacy has had an instrumental role in the effectiveness of drug treatment, and as such has been incorporated into drug treatment programmes such as Marlatt and Gordon's (1985) Relapse Prevention Therapy. This was the reason that self-efficacy has been identified as a determining factor as to whether an IDU successfully achieved and maintained dependence-free or lapsed back into drug taking behaviour (Marlatt et al. 1985; Annis and Davis, 1989; and Parks and Marlatt, 1989).

This concept is known as the clients' self-efficacy, as it is the belief, perception and impression that the client is capable of reaching a desired goal, by following a course of action to get to that goal (Omrod, 2006). Self-efficacy is a central feature to Bandura's (1997) social cognitive theory, and is highly influential to human activity. According to the theory, individuals with a higher level of self-efficacy are more likely to feel motivated to reach their goals, and are thus more likely to take on tasks they believe they can achieve. This can not only help clients to get through treatment, but also in starting treatment in the first place. Moreover, if treatment has already commenced, then having a high level of self-efficacy throughout treatment, will reduce the risk of them failing to engage. This is for the reason that clients with a low self-efficacy will find tasks harder than they actually are, because of their lack of belief in their own ability to reach that particular goal. Furthermore, individuals with high self-efficacy tend to blame external reasons for failure, which can aid in the determination to find alternative routes to get through failures. Comparatively, individuals with lower self-efficacy blame themselves for failure, and therefore find it impossible to find alternative routes through failure. As a result, according to Bandura (1997) those individuals with higher levels of self-efficacy felt more in control of their life, whereas individuals with lower levels believed their lives were out of their hands. In addition, the higher the levels of self-efficacy an individual possesses, the more likely they were to make changes to their behaviour and to achieve goals such as dependence-free.

There are several factors that affect a clients' level of self-efficacy; firstly, previous experience of a task can either increase or decrease levels, which will inform whether the individual is capable of

achieving the task at hand. Therefore, in drug treatment, a client's previous experiences of drug treatment will have an impact on the level of self-efficacy they bring to the new treatment episode. For example, if they have attended a drug treatment service in the past and it has been deemed as successful, then, the client will associate a positive experience with treatment and are subsequently more likely to approach the notion of drug treatment with a higher level of self-efficacy. Secondly, a clients' level of self-efficacy can be influenced by a process of comparison to others, whereby an individual will adjust their self-efficacy accordingly to the comparison made of themselves to the ability of others around them to achieve the task. This is exemplified in a client's comparisons of length of dependence-free with others in the treatment service, with a greater amount of time improving efficacy levels (Heathertone et al. 2002).

Thirdly, social persuasions, which can be either encouraging or discouraging, can have an effect on levels of self-efficacy, and this was proposed by Bandura (1997). Again, one of the key features of the importance of the TA on treatment outcomes is the influence that a favourable attitude from the DTP can have on the clients' treatment outcomes. Thus, exemplified by the fact that most people can remember times when someone else has said something positive to them that has improved their confidence. It is for this reason that the relationship between DTP and client is so important, as positive encouragement, particularly from a significant other as previously proposed by Cooley (1909) and Goffman (1959), can have a positive effect on improving levels of self-efficacy, whereas, conversely, discouragement can have a negative effect on decreasing levels of self-efficacy.

Furthermore, it is easier to decrease a client's level of self-efficacy, than it is to increase it, and as such, this proposal supports the argument for prolonged drug treatment interventions. The National Treatment Agency (2007) are proponents for the fact that the longer a client is in treatment, the more improved the treatment, and as such propose that effective treatment be a period of at least twelve weeks. This is for the reason that a client is at reduced risk of harm to themselves, through improvements to health, drug use and criminality, whilst actively engaging in drug treatment. This was clearly demonstrated in a NTA Harm Reduction 2006 Survey (2007) reporting that ninety percent of their sample population claimed that their drug use had reduced as a result of the drug treatment they were attending, and so, the risk of harm, from the use of illicit drugs, was reduced in IDUs who are actively attending drug treatment service. This implies that the longer time the client is in treatment, the more time there is to improve a client's level of self-efficacy, and for a positive

TA to develop, which subsequently results in the client receiving effective drug treatment and delivering successful treatment outcomes.

1.4.7 Conclusion

There are a number of conclusions that can be drawn from the examination of the literature related to how the TA influences clients' drug treatment outcomes. Firstly, as an individual will seek to identify with those who they regard as significant, and who have important meaning, then the DTP can be considered to be an influential factor of identity formation and change, if they are held in such esteem by the client. This is for the reason that positive appraisals from the DTP to the client can aid the development of a positive identity, whereby, in comparison, identifying with peers from the drug sub-culture will have a negative impact on identity formation. Therefore, with whom a client associates plays an important role in the development of their self-identity. Yet, SIT would purport that the client would have a higher self-esteem when amongst in-group members, who are considered to be more accepting and non-judgemental, in comparison to DTPs.

Secondly, IDUs are a marginalised group in society, and as such, are routinely disparaged by the negative stereotypes and labels associated to the stigma of being an IDU. Therefore, the role that the DTP plays in assisting the client to manage such negativities, has important implications on the rehabilitation of the client, in terms of engagement, retention and successful completion of treatment. This will invariably be influenced by the DTP's ability to sympathetically deal with the negativity surrounding the stigma, and in particular, the client's transition from concealing to revealing their stigma to society.

Thirdly, negative labels and stereotypes have a negative impact on a client's treatment outcomes, in terms of the affect that they have on the client's self-esteem and efficacy levels. It is for this reason that the relationship between DTP and client is so important, as positive encouragement, particularly from a significant other, can have a positive effect on levels of self-efficacy, whereas, conversely, discouragement can have a negative effect on treatment outcomes. Although the majority of previous literature of the TA has focused on the generic healthcare service, the fact that the relationship between the TA and a client's treatment outcomes does not differ significantly

within varying treatment approaches, suggests that the concept of the TA strongly influencing treatment outcomes, can be transferable to other variations of treatment, such as the treatment of illicit drug use. Therefore, it can now be categorically delineated that both favourable and unfavourable attitudes within the TA has a therapeutic effect on client's treatment outcomes, as favourable attitudes within the TA have been shown to have a positively influence on client's drug treatment outcomes, and vice versa.

Finally, it has been shown that DTPs do not always appreciate the power that the TA has on the client's treatment outcomes, and as such, they must become more aware of the key factors within the alliance, relating to power, the social and cultural context, and interpersonal competence, that are considered to have sufficient impact on their clients' treatment outcomes. Furthermore, whilst it is possible to say that the favourability within the TA can influence clients' treatment outcomes, it cannot be said at this stage of the literature review that DTPs will actually display more favourable attitudes towards IDUs, and whether levels of favourability are influenced by individual differences, thus the next section will address these issues.

1.5 Moderators of DTP attitudes and client outcomes

The UK drugs policy commission in 2010 reported that there is still a significant gap in our understanding of the attitudes towards IDUs (Lloyd, 2010). More specifically, the majority of research reviewed on attitudes in treatment services has primarily focused on generic healthcare staff, and subsequently, there has been limited research investigating the attitudes of DTPs. Thus, the literature reviewed will examine what existing research there is that identifies levels of favourability of DTPs' attitudes in drug treatment system, to see if they infer that DTPs have a more or less favourable attitude towards IDUs than the general public. Furthermore, the literature reviewed will also explore whether levels of favourability are influenced by individual differences such as age, gender or experience with illicit drugs. However, this dearth of specialist research identifies a requirement for further exploratory research looking at DTPs' attitudes within the treatment system, and how they affect treatment outcomes.

Therefore, before it can be hypothesised that DTPs do have more favourable attitudes towards drug users than the general public, which leads to positive therapeutic change in the client, DTPs' levels of favourability towards IDUs first needs to be established. Previous research has indicated that positivity within the TA contributes to positive therapeutic change, although it cannot be inferred at this stage the definitive impact that favourable and unfavourable attitudes have on a clients' treatment outcomes, even if DTPs were found to have a more favourable attitude towards IDUs than the societal majority. Thus, levels of favourability within therapeutic settings need to be explored, to investigate the effects that they have on treatment engagement, retention, completion and outcomes in terms of improvements to clients' socio-economic status, drug use and criminality. Then, it will be possible to state whether favourable attitudes do actually equate to improvements in therapeutic change, and non-favourable attitudes equate to a reduction in a clients' therapeutic change.

Therefore, this section will explore DTPs' favourability towards illicit drugs and drug users, as well as the significance of individual differences in relation to psychological and physiological factors that may impact on attitude, which either improve or reduce favourability towards IDUs. Factors investigated include DTPs' personal experience with illicit drugs and working with IDUs, as well as demographic characteristics such as gender, age and ethnicity.

The concept of social stigma has been purported as an explanation for why IDUs are generally regarded in the general public as being dangerous, deceitful, unreliable, unpredictable, hard to talk to and to blame for their drug use, (Lloyd, 2010). However, according to the kernel of truth hypothesis, there is core accuracy to the heart of these cultural stereotypes. Furthermore, those that have personally experienced illicit drug use may continue to uphold these stereotypes, based on their past experiences.

Recent UK surveys have demonstrated that one-fifth to one-quarter of the samples had personal knowledge of someone with drug addiction (Roberts, 2009; Crisp, Gelder, Goddard, and Meltzer, 2005). Therefore, it cannot be argued that public opinion of IDUs is based simply on negative media portrayal, or a lack of knowledge and experience. Thus, it is questionable as to whether personal experience equates to more favourable attitudes or less favourable attitudes in individuals. In 2000,

the MORI survey of 'Attitudes to Illicit Drugs' demonstrated that the general public had a fairly negative attitude towards illicit drugs and illicit drug use. This was exemplified in majority disagreement to statements such as 'taking drugs is a matter of personal choice and should not be against the law' (69%) and furthermore, by respondents rating heroin dealing as a priority crime for policing. In addition, Luty and Grewal (2002) undertook a postal survey of the British public's attitude towards people with drug dependence and treatment policies for users. In support of the MORI surveys' findings, they also reported negativity in public opinion; drug addicts were not regarded as suffering from mental illness and were regarded as untrustworthy, deceitful and unreliable, thus supporting the notion that IDUs are socially stigmatised.

However, Reis, Duggan, Adgar and DeAngelis' (1994) earlier study of anti-drug advertising found that only half of respondents reported to having negative attitudes towards IDUs (52%), indicating that perhaps illicit drug use is not as stigmatised as initially thought, and this may be due to the fact that illicit drug use is a commonly occurring phenomenon, and that many respondents from Reis et al.'s study had factors that influenced their levels of favourability towards drug users, for example, their own personal experience with illicit drugs. This notion can be further supported by the findings from the Economic and Social Research Council (2005), study measuring the changing attitudes towards illegal drugs in Britain. The study reported that there had been a shift in support of the legalisation of drugs over the past two decades (12% in 1983 supported legalisation, compared to 41% in 2005). Thus suggesting that the increased support is as a consequence of the 'normalisation' of some illicit drugs, and as such, personal experience of illicit drug use does have an impact on levels of favourability towards illicit drugs and drug use. Therefore the use of recreational illicit drug use among young people is becoming more acceptable and as common place as cigarette smoking and excessive drinking, and as such, becoming increasingly accommodated into the social lives of conventional young adults (Parker, Aldridge and Measham, 1998). Furthermore, the ESRC (2005) study reported that this acceptance of illicit drug use is observable cross-generational, with the suggestion that it is the public perception of drugs' harmfulness that is causing the relaxation of public opinion; in particular, the research reported that cannabis is now believed to be less addictive and harmful, and a cause of crime and violence, than was previously believed by the public.

In comparison to the general public, the attitudes of DTPs are important to consider because their levels of favourability can be debatable. On the one hand, it would be expected that they would

display more favourable attitudes towards illicit drug use and users because of their regular interactions with IDUs. Conversely, DTPs, similar to that of the general public, can also be influenced by society's beliefs and assumptions that IDUs are perceived negatively. Thus, simply having expertise, knowledge and training does not necessarily make DTPs immune from social influence. This relates to Allport's (1954) social contact hypothesis, that contact can exacerbate and perpetuate prejudices in some cases. For example, DTPs may be threatened, or subjected to other abusive interactions that would reduce their levels of favourability.

Thus, it is for this reason that the attitudes of DTPs in the treatment setting are an important area to investigate because negative attitudes can be considered as having a barrier effect in terms of the DTPs' failing to carry out treatment effectively, and in the client's approach to treatment. Whereas, on the other hand, positive attitudes in treatment are important because IDUs crave care and treatment, and respond positively to treatment from staff members who are knowledgeable, understanding, caring and skilled (McLaughlin, McKenna and Leslie, 2000). Therefore, Phillips and Bourne (2007) claimed that a good relationship between the DTP and their client improved positive outcomes from the client, and also ensured that they were retained in treatment for longer. Furthermore, a literature review by Lloyd (2010) indicated those staff who had elected to work with IDUs demonstrated more compassion to their clients, therefore suggesting that DTP may thus be found to demonstrate a more favourable attitude towards illicit drugs and drug users.

Reviews of previous research indicate that negative attitudes exist in generic health care, towards IDUs (Romney and Bynner, 1972; Cohen, Schamroth, Nazareth, Johnson, Graham and Thomson 1992; Melby, Boore and Murray, 1992; Blank and Nelles, 1993; McLaughlin and Long, 1996; Carroll, 1996, McLaughlin et al., 2000; Mistral and Velleman, 2001; Saitz, Friedmann, Sullivan, Winter, Lloyd-Travaglini et al. 2002; Tang, Wiste, Mao and Hou, 2005, McLaughlin et al. 2006). However, this has not been found to be the case in specialist drug treatment staff. McLaughlin, et al. (2006) reported that most general healthcare professionals actually displayed a desire for specialist drug services to take over the care of IDUs, as this is where they would be better placed. Although it is possible to hypothesise that DTPs may have a more favourable attitude. It can also be argued that there are a number of factors that may actually lower levels of favourability in DTPs, for example, staff working with IDUs were found to demonstrate lower job satisfaction, compared with any other health care provision (Saitz et al. 2002). Research by Miller, Sheppard, Colenda and Magen (2001) showed that physicians' did not find that working with this group of patients was rewarding, suggest a reason

why low job satisfaction was found. Perhaps job satisfaction is also related to the physicians received ability to help the client. Saitz et al. (2002) reported that perceived responsibility for addressing substance problems was associated to greater job satisfaction, which implies that a feeling of helplessness was consequential to lower job satisfaction.

In addition, a limited amount of role models within the drug treatment field due to a lack of experienced and knowledgeable DTPs was found by Miller et al. (2001), therefore new DTPs have limited colleagues on which to model themselves. This may occur as a result of DTPs suffering from 'burnout' more frequently than generic healthcare staff, thus resulting in them either leaving the specialist teams earlier, hence the reason why a deficit in experienced workers was found by Miller et al. (2001). Where the DTP remains in service, the consequence of burnout may be of less favourable attitude towards illicit drugs and drug users, suggesting the notion that experience within the specialist drug treatment field actually decreases DTPs' levels of favourability. It is likely that DTPs are more prone to 'burnout', which according to Buunk (1990) is caused by the strain endured from an unbalanced relationship in the TA.

Consequently, at this stage, it cannot be argued with clarity that DTPs demonstrate a more, or less, favourable attitude towards illicit drugs and drug users than that of generic healthcare staff, which has already been shown. In addition, if their levels of favourability are affected by individual differences, such as DTPs' age, gender, ethnicity, along with their experience with illicit drugs and drug users.

1.5.1 The effect of demographic characteristic moderators on favourability

DTPs' demographic characteristics can also be considered as an important aspect of the TA. This has been demonstrated in the dramaturgical importance placed on the impact that a DTPs' non-discursive expressive apparatus can have on their client, particularly in terms of, what may appear to be unimportant factors, such as the DTPs clothing or hairstyle (Stone, 1962). This is for the reason that, the more a client can identify with their DTP, the more likely they are to associate a positive meaning to the alliance with that DTP, thus resulting in more successful outcomes. Since the majority of clients currently in drug treatment in the UK are young, white males, then, from the dramaturgical model it can thus be hypothesised that young, white, male DTPs would make the most effective DTPs because they are so closely identifiable with for the majority of clients. Thus it would

be interesting to survey the characteristics of DTPs to assess demographic features and see if this is reflected in their population.

However, a number of pre-existing studies have found conflicting levels of favourability towards illicit drugs and drug use in relation to individuals' demographic characteristics thus suggesting that it is perhaps not so easy to identify the 'ideal' DTP. Firstly, there has been disagreement in the studies of gender differences and attitude towards illicit drugs. Atha, Blanchard and Davis (1999) investigated regular marijuana users and reported that males aged between twenty and thirty years were heavier users of most types of illicit drugs in comparison to females, and in addition, expressed positive attitudes towards marijuana, LSD, magic mushrooms and ecstasy. However, the fact that males in this study have demonstrated more favourability towards illicit drugs may not be associated to the fact that they are male, but to the fact that they have personally used these drugs, in accordance with both Parker et al. (1998) and Martins et al.'s (2005) claims that personal use of illicit drugs was found to associate with improved levels of favourability.

In contrast, Ortiz, Soriano, Meza, Martinez and Galván (2006) claimed that there were differences between males and females in association with illicit drugs, reporting that males were more open about their drug use, whilst females conducted their use in privacy, as a result of illicit drug use being more widespread and socially acceptable in males than females. Although, the findings from Ortiz's study displayed gender differences in the use of illicit drugs, as opposed to gender differences affecting attitudes towards illicit drugs, such as Kauffman, Silver and Poulin (1996) who reported that gender affected attitudes towards drugs in relation to attributing causality to biological or environmental factors, perceiving drugs as more powerful, perceiving a higher incidence of substance abuse, and believing that prevention and treatment were more effective.

A possible explanation for why Ortiz found gender differences in drug taking is that males are more prone to risk-taking behaviour, and also have less of a concern for childcare issues than females might have. Conversely, Albers, Santangelo, McKinlay, Cavote and Rock (2002) reported that there were no associated differences in students' attitudes and perceptions of harm towards substance misuse in males and females. Thus, again the divergence of findings in the studies reviewed suggests being male or female does not necessarily equate to a more or less favourable attitude towards illicit drugs and drug users.

In relation to the effect that age has on levels of favourability to illicit drugs and drug use, there have been a number of proponents for the view that younger aged people actually display a less favourable attitude towards illicit drugs and drug users, than older people, as supported by the Royal College of Psychiatrists' survey delineating that young people expressed more negative views about most mental disorders, including drug addiction, than older people (Crisp, 2000). Power, Power and Gibson (1996) interviewed twenty-three recreational drug users aged between 16 and 19 years in London, asking about their views on heroin use. Twenty-one said that they would never try the drug, describing it as 'dirty', 'evil' and 'disgusting'. Although this finding fails to support that of Parker et al.'s (1998) previous claims that those individuals who use illicit drugs had a more favourable attitude towards drugs. A plausible reason for this lack of consensus is that the young people in Power et al.'s study wanted to differentiate themselves from the most negatively stigmatised group of heroin addicts, by trivialising their drug use as recreational and as such, widely divergent from that of the stereotypical portrayal of 'junkies'.

A further study that reported that young people have a less favourable attitude towards illicit drugs is that of Ormston et al. (2010) who reported that although young people were more likely than older age groups to recognise the difficult backgrounds of heroin users, those in employment were less comfortable than older people with the idea of working with an ex-heroin user. Thus, the changing attitude seen across age from less favourable, in the young to more favourable in the old, may be as a consequence of the accumulation of experience and education over time. This notion was supported by a study conducted in Canada investigating the impact of age and personal drug use on attitudes of 4,078 school students aged 12 to 19 years by Adlaf, Hamilton, Wu, and Noh (2009). Their findings indicated a clear decline in the negativity towards illicit drug use across age, with individual experience of drug use and close association with drug-using friends again being found to be influential factors of this decline. These findings thus imply that personal experience with illicit drugs is likely to have an impact on levels of favourability in treatment.

Although it was first thought that young people may have a better TA with clients because of the dramaturgical importance of identification, the reviewed studies actually indicates that young people do not necessarily make more effective DTPs. This potentially demonstrates that younger workers have less favourable attitudes towards illicit drugs and drug users, which can have a negative consequential effect on outcomes. Furthermore, a potential problem with the

dramaturgical approach is that the client's identification with the DTPs may have a negative consequence on their treatment because the client may acknowledge how far removed they are from that of the DTPs, thus believing that to reach that stage is unachievable, hence resulting in the client putting up another potential blocker in treatment.

1.5.2 The effect of working with IDUs, on favourability

Research heretofore has pointed towards the fact that DTPs' working experience with IDUs might also impact upon favourability of attitudes. It is debated as to whether long-term working within the drug field actually improves levels of favourableness towards illicit drugs and drug users, or whether, over time, favourability diminishes in DTPs. There are a number of possible reasons for this challenge. Firstly, it can be proposed that the more experience a DTP has in working with IDUs, the more favourable their attitude towards illicit drugs and drug users' may be. Potentiating factors for this assumption are that DTPs develop an empathy with the drug user, coming to understand the sometimes physiological and psychological motivations why some individuals turn to a lifestyle of illicit drug use. In support of this view, a study conducted by Carroll (1996) on attitudes within general healthcare staff working with IDUs, reported different levels of favourableness towards IDUs, depending on clinical grade, whereby more senior staff members demonstrated more favourable attitudes towards IDUs' than their lower grade counterparts. These findings imply that the longer an individual had worked within a service and hence the more experience, the more favourable their attitude, which is denoted by the assumption that they have senior positions, they are more likely to have been working with IDUs for a longer period of time.

Conversely, on the other side of the debate is that experience equates to less favourable attitudes towards illicit drugs and drug users. A study by Davies and Huxley (1997) conducting a postal questionnaire of the attitudes of general practitioners, found that positive attitudes to opiate users did occur within the service but only among younger general practitioners. These findings may imply that older DTPs have a less favourable attitude because they have spent more time working with IDUs, and there are a number of probable reasons why this has been found. Firstly, that an experienced DTP who has worked in drug treatment for a number of years could become

desensitised and less sympathetic to the plight of the drug user and their physiological and psychological factors that have led them into a lifestyle of illicit drug use.

Secondly, the overall successes of 'dependence-free' for clients can be few and far between, and in the majority of cases, a DTP will only work with a client for a very short time of the clients' drug-using career (proposed as an average of eight and a half years by Davids, Reinhold, Rosinger and Gastpar, 2003), thus leading to lowered job satisfaction in DTPs, which has been found to be more common place in the helping professions (Bingham, Valenstein, Blow, and Alexander, 2002; Malach-Pines and Yafe-Yanai, 2001).

Thirdly, as previously mentioned, that DTPs suffer 'burnout' more frequently than generic staff, thus longer-term workers are more likely to experience burnout resulting in less favourable attitude towards illicit drug use and users. After many years working within a service, directly with people who have experienced great trauma, according to Kirk-Brown et al. (2004), DTPs are more prone to experiencing long-term exhaustion and diminished interest in the work they are undertaking. Paton and Goddard (2003) posited that those in helping professions, such as DTPs, were more at risk of experiencing burnout. In addition, they may experience learned helplessness, whereby the DTP may feel powerless to change their self or situation in their role as drug workers, which is primarily caused by the individual attributing negative associations to such things as the clients they are working with, and the belief that the client is incapable of changing. These findings suggest that those DTPs who have worked within the drug treatment field for a longer period of time are more at risk of experiencing feelings of disinterest and negativity in their working roles.

Finally, an additional factor to consider is the type of drug treatment service that the DTPs' are employed in, as this may have an impact on the varying degrees of favourableness. This factor is two-fold, as attitudes can be affected, firstly, by the DTP, and secondly, by the client. In relation to the client affecting attitudinal levels, DTPs' working in first point of contact treatment services will be more likely to encounter far more chaotic drug users, and therefore the longer a DTP works with such clients, the more likely they are to experience feelings of reduced job satisfaction for the reason that they will rarely see any therapeutic change in clients. Conversely, in relation to the DTP

having an impact on attitude, it can be argued that the attitudes of staff members within a service are acquired from other staff members, therefore, if the service has a low team morale, then any potential negative attitudes will be shared around the members of staff, and this was demonstrated in a study by Petersen and McBride (2002).

In addition, the demarcation found between Carroll's (1996) and Davies et al.'s (1997) studies, that more experience indicated a more favourable attitude (Carroll, 1996), whereas Davies et al. (1997) reported that less experience indicated a more favourable attitude, may occur as a result of the different sample populations used. Carroll's study was carried out on frontline nursing staff, which may have more opportunity to develop a level of rapport with the client than those participants from Davies' study. Thus, more experience and higher levels of favourability may have occurred, as a result of nurses having more time and exposure to clients, than GPs will (i.e. from Davies et al.' study). Thus, exposure allows for a rapport to build between DTP and client, which promotes more favourable bias. Conversely, Davies et al.'s study of general practitioners, would have much less time with a client, to build up any kind of rapport, thus would not have such favourable bias. Furthermore, the fact that GPs with more experience, demonstrated less favourable bias, may be as a result of the lack of rapport, in combination with the despondency felt from the on-going appointments with clients that continue to require methadone prescribing. Whereas, in comparison, more recently qualified GPs were found to have a higher favourable bias, possibly as a result of their recent position and enthusiasm in the role.

1.5.3 The influence of a clients' perception on treatment outcomes

The clients' perception of treatment can also affect the impact that the treatment has on positive outcomes. As discussed previously in the clients' preconceptions of treatment, particularly at the first meeting where Goffman (1959) purported that the DTP forms their virtual social identity of the client, the clients' attitude and behaviour towards the drug treatment service and DTP, which will subsequently influence the DTPs' level of favourability towards the client. For example, if an IDU has been coerced into drug treatment through the criminal justice system, against their own personal choice to give up illicit drug use, then it is likely that they will have a less favourable attitude towards treatment in comparison to an IDU who has voluntarily sought drug treatment. This group of clients

makes up a large part of the treatment population in the UK, as according to the NTA statistics, published on the website, for referrals into treatment in 2010-11, 30% of clients were through the Criminal Justice System, and could thus be considered to be coerced into treatment.

Moreover, if an IDU has a positive attitude to a specialist drug treatment service, then they would be more likely to want to access the service. Whereas, an IDU who is dissatisfied with a treatment service, through reputation, previous experience, or 'hearsay', will be less likely to want to access that service. Indeed, a drug treatment services' reputation is important because it gives potential clients preconceived attitudes towards the service, before they have even engaged with the service. This idea is supported by the theory of social cognition proposed by Miller and Dollard (1941), which delineates that individuals acquire their knowledge of something through the observation of others within their social context. Therefore, the reputation of a treatment service is highly influential among that illicit drug using community, as to whether potential clients will access that service with favourable or unfavourable attitudes towards treatment.

Since favourable attitudes within treatment can be influenced by a clients' attitude towards treatment, then it is not only important to investigate the treatment service DTPs' attitudes towards illicit drugs and drug users, but it is important to explore clients' perceptions of treatment services and whether clients are capable of accurately perceiving the attitudes that exist. Treatment services and DTPs with favourable attitudes towards IDUs will be ineffective, if a client is unable to accurately identify this favourability. Consequently, a clients' perception of negativity will simply result in the client having a negative experience in treatment, and will be reflected in their treatment outcomes.

Previous studies have indicated a mixed response to perceived attitudes within treatment. McLaughlin et al. (1996) found that negative attitudes towards IDUs were projected by the healthcare practitioner, and were subsequently reported to be perceived by clients, in terms of the sense of 'loathing' towards them (McLaughlin et al. 2000). However, a study conducted by Neale et al. (2008) of IDUs' experiences of generic health and social services found generally positive experiences. Yet, there are two potential reasons why a lack of negativity in generic healthcare may have been reported. Firstly, that some of the sample had not frequently accessed healthcare

services, because they tended to avoid seeing a general practitioner through embarrassment, or for fear of having their children taken into care. Subsequently, it is conceivable that they had limited exposure to any negativity within generic healthcare services through lack of contact.

Secondly, those that did attend generic services reported that they did not have to wait very long to see a general practitioner, and as such, would have a more favourable perception of the service, in comparison to clients having to wait a number of weeks before seeing a DTP. Of those participants who did report to perceiving negativity, this was in the guise of experiencing feelings of hostility and unhelpful attitudes, but felt that they had no choice but to 'put up' with them because there was nowhere else for them to be treated. These perceptions were found mainly in hospitals where clients felt that they were perceived as wasting valuable resources and were treated differently to others, probably as a result of the self-blame nature of illicit drug use. This finding thus supports Landy et al.'s (2005) claims, that some medical school students felt that substance misusers were less deserving of treatment than other patients. Thus, it is perhaps the case that more positive attitudes towards IDUs as perceived by clients, come from the specialist treatment services in comparison to generic healthcare treatment, and this was reported by McLaughlin et al. (2000) who found that clients reported to have perceived poorer care from general practitioners in comparison to that of specialist drug treatment services.

Moreover, not only have treatment staff members been found to have a lack of knowledge in working with IDUs (Soverow, Rosenberg and Ferneau, 1972; Beauvais, Spooner and Oetting, 1991; Gorman and Morris, 1991; King, 1997; King et al. 1998 and McLaughlin et al. 2000), but a number of studies have also demonstrated that clients are able to accurately perceive this lack of knowledge, and as such, have used it to their own advantage. McLaughlin et al. (2000) reported that three-quarters of their illicit drug using population sample claimed that they were able to identify a lack of knowledge and understanding in their DTP, and often used it to manipulate situations to their advantage. Thus, implying that clients are capable of accurately perceiving their DTPs' knowledge, even though DTPs are unaware of how they are perceived by their client (McLaughlin et al. 2006). This supports the earlier conclusions from Altschul's (1971) study that DTPs cannot always appreciate the full power of their interactions upon their clients' well-being, and so they must become more aware of the fact that their attitude within treatment can have sufficient impact on

their clients' treatment outcomes. This was exemplified in McLaughlin et al.'s (1996) review that showed that healthcare staff did not knowingly or willingly set out to have a negative effect on clients' treatment, but that any negative attitudes were found to make the client feel negative about themselves and the drug treatment were receiving. In addition, the fact that clients can accurately perceive gaps in knowledge can suggest that they might also be able to accurately perceiving DTPs' positive or negative attitudes towards IDUs.

1.5.4 The recovered IDU as a DTP

According to Doukas and Cullen (2010), the 1940s saw an emergence of the recovered alcohol addict entering into the field of addiction treatment, as a paraprofessional, due to shortages of professional counsellors and as a part of the process of rehabilitation for the addict. Later, in the 1970s a large number of DTPs were required to work with the ever increasing number of IDUs. Since specific credentials for working within the field of substance abuse treatment had not yet been established, recovered IDUs were sought for employment as a good source of DTPs (Doukas and Cullen, 2011). In view of the notion that experience improves attitudes, recovered IDUs can be argued to be the most effective of DTPs because of their personal experience of illicit drug use.

However, this proposition is debatable, as on the one hand it could be argued that recovered addicts are more effective at working with current IDUs because they have first-hand knowledge of illicit drug use, and have personally experienced the harsh realities and problems that illicit drug use entails, and are thus more effective workers than DTPs who have never used illicit drugs, and experienced the social categorisation related to drug use. This suggestion is borne out of research that has indicated that non-heroin users demonstrate a different perception of heroin users, than heroin users do of non-heroin users, for that reason, it can be argued that attitudes will differ subject to DTPs own personal experiences with illicit drugs (Finnigan, 1996). With Petersen and McBride (2002) claiming that the recovered addict as DTP, would display a more favourable approach to IDUs as they have the ability to be able to empathise with the client. Hence, the first-hand knowledge of drug use from a recovered drug user, can help to gain trust and respect from clients, as they provide a positive role model and someone the client can confide in.

Therefore the notion that recovered addicts would make effective DTPs has already been put into clinical practice, and has subsequently been supported by the Home Office, the NTA, and the Health Care Commission in strategies on improving drug treatment effectiveness for illicit drug use. Furthermore, the head of the drug strategy directorate stated in 2006 that he was a strong supporter for recovered addicts working within the drug treatment field. Subsequently, the Health Care Commission and the NTA partnership programme believe that recovered addicts as DTPs are a beneficial resource to drug treatment, as they have been utilised in user-forums, as peer reviewers and advisors in the development of new treatment services, and as frontline staff working directly with IDUs in treatment.

However, it can be controversially argued that recovered addicts as DTPs may not necessarily make the most effective DTPs, and there are several reasons that can be proposed for this. Firstly, that recovered addicts might not necessarily display a more favourable attitude towards current IDUs because of their first-hand knowledge and experience of the manipulation that IDUs use, particularly within the TA. Furthermore, that recovered addicts can be argued to be more desensitised to illicit drug use, and as a result have a more 'matter of fact' approach to working with a current IDU, and not as protective and sympathetic as someone who had not been through the same situation themselves. Furthermore, that by the client knowing that the DTP was a recovered-addict, and seeing how far-removed they now were to them, might make the client believe that to be a recovered addict was unobtainable to them. This idea was demonstrated in the following extract from a book of a recovered heroin addict, whilst they were undergoing specialist drug treatment;

"Many of the staff... had been junkies themselves in the past, but this fact in itself was quite hard to deal with, because they just seemed so straight and normal compared to the rest of us, bruised and (emotionally) naked as we were. Don't get me wrong, they were really good people – I suppose they'd just calmed down a lot – but at first I found the whole process quite difficult to get to grips with" Brand (2007, p.291).

Therefore, being a recovered addict does not necessarily equate to a qualification for good practice. Experiences of illicit drug use and the treatment for illicit drug use are subjective, and thus differ between individuals. A recovered addict who is unable to separate their own personal experiences from that of the client is not demonstrating accurate empathy. Therefore suggesting that perhaps it

is objective experience, such as that acquired through training, education and working experience that equates to more favourable attitudes towards IDUs, instead of subjective experiences, such as displaying the attitudes that 'if I can do it then why can't you', or, 'this is the way that I did it, so it should work for you too', potentially demonstrated by some recovered addicts.

1.5.5 The impact of DTPs' individual differences on favourability

In addition to a DTP's level of experience with illicit drugs and/or drug users in relation to the effect it has on favourability towards illicit drugs and drug users, the literature reviewed will also explore whether levels of favourability are influenced by individual differences such as age, gender or experience with illicit drugs, thus potentially being able to predict how favourable a DTP may be towards an IDU within the TA, hence having implications in terms of employment and identifying when a client might be at risk of receiving ineffective drug treatment from their DTP.

Conflicting attitudes in public opinion of illicit drug use has been noted in previous studies (Ormston, Bradshaw and Anderson, 2010) and potential reasons for this can be delineated as emanating from a lack of knowledge and personal experience. For example, respondents to Ormston et al.'s study reported less favourable attitudes to illicit drugs, had no friends or family members who had used drugs, and in addition, had fewer qualifications. Thus supporting the notion that training and education improves attitudes, as well as indicating that by having a friend or family member that had used illicit drugs will actually improve favourability towards illicit drugs and drug users. It can be argued that this increases empathy towards IDUs and demonstrates the widespread nature of addiction in friends or family members.

The hypothesis that individuals have more favourable attitudes towards illicit drugs if their friends used drugs was supported in the findings of the Drugs, Young People and Service Provision DfES (2004) report, that young people were more tolerant of illicit drug use among their peers. Furthermore, studies by Parker et al. (1998) and Martins et al. (2005) also claimed that individuals were more likely to approve of an illicit drug, if their friends used them. Parker et al. (1998) examined adolescences' attitudes towards illicit drugs, finding that two-thirds of the sample who abstained from illicit drug use held approving attitudes towards illicit drugs users, and half of the

abstainers had friends who had used marijuana. These findings therefore suggest that the abstainers had a positive attitude because of their friends' use. Furthermore, those that personally used illicit drugs were also found to have more favourable attitudes towards illicit drugs (Parker et al. 1998; Martins et al. 2005). This research suggests that adolescents' acceptance of illicit drug use, was influenced by the normalisation of drugs amongst that peer group.

In addition to friends drug use having an influence on attitudes towards illicit drugs, in accordance with Ormston et al.'s (2010) claims, so to, does family members. If individuals have family members that use or have used illicit drugs, then their attitudes have been found to be more favourable. However, there is a clear distinction between favourable attitudes towards drug that increase acceptance, and, the likelihood of illicit drug taking and favourable attitudes that do not stigmatise those who engage in substance misuse at some point.

A Spanish study by Secades-Villa, Fernandez-Hermida and Vallejo-Seco (2005) of family factors associated with adolescent substance abuse, found that lenient parenting styles and attitudes towards illicit drugs in the family, particularly parental drug consumption, were identified as risk factors for illicit drugs use in adolescents. The findings from this study therefore suggest that there is an association between having a member of the family using illicit drugs and having more favourable attitudes towards illicit drugs, therefore indicating that it is aspects of the socialisation process that has an effect on levels of favourability towards illicit drugs and drug users.

However, a contra claim to that of family's drug use increasing favourability is that family's drug use can actually decrease favourability in the individual for the reason that the family members of an IDU can be considered to have been devalued in society by their use of illicit drugs. This was demonstrated by Corrigan and Shapiro (2006) who reported that the stigma of an IDU can extend to that of the family members, because they are often viewed as responsible for illicit drug use, and that drug dependence was often thought to have come from a family member. Therefore, it can be argued that having a family member having used illicit drugs does not necessarily equate to a more favourable attitude towards drugs, in fact it could arguably have the opposite effect. For example,

family members are often involved in the drug users' quest to obtain drugs through stealing from family members.

1.5.6 The necessity for DTP training and education

McCormick, Bryant, Sheridan and Gonzalez (2006) undertook a postal survey in New Zealand of 898 randomly selected community pharmacists to investigate levels of training and attitudes towards providing services for drug users. The survey asked about respondents' demographic characteristics, levels of training and included a 20-question attitude scale. The study explored the main attitude factors towards IDUs, and four principal factors explained 57% of the variance; these were attitudes towards: the general results of dispensing methadone to opioid misuser; the effect of opioid-dependent clients on a pharmacy; reducing harm associated with drug use; and engaging with drug users. Furthermore, training (having it or wanting to have it) was positively associated with the four attitude factors, with 26% reporting to having had previously undertaken training about the management of opiate-misuse. Thus suggesting that attitudes towards various aspects of service provision for IDUs, may not be as simple as previously perceived.

Thus, contra to the notion that more experience working with IDUs has an effect on positive or negative attitudes towards IDUs, there have also been studies that have indicated that a lack of working experience also has an impact on levels of favourability towards illicit drugs and drug users. This can be in particular exemplified in Roberts and Sims (1995) study reporting that a lack of contact with IDUs was found to be associated to more negative attitudes. Individuals supplement what they see with beliefs and assumption based on stereotypes, and then act according to their perceptions of the stigma, in a negative manner (Sampson and Raudenbush, 2005). Thus, increased contact can increase attitudes and negative perceptions by reducing stereotypical images. Furthermore, according to Cartwright (1980), increased training in healthcare staff would also improve attitudes, where there is a lack of experience working with IDUs.

This was demonstrated in a study of attitudes towards substance misusers in two separate years of two medical school students from the UK (Landy, Hynes, Checinski and Crome, 2005). Findings proposed that new students demonstrated a less favourable attitude towards IDUs in comparison to

students who were more advanced in their studies; in so far as 66% of first year students felt that substance misusers were not less deserving of treatment than other patients, whereas, 72% of fourth year students thought they were no less deserving. Furthermore, 17% of first year students disagreed that substance misusers posed no less of a threat to other patients and staff, in comparison to 26% of fourth year students. These findings implicate that the additional two years of training and education had improved students' favourability towards substance misusers, thus supporting the view that training and education are essential in improving attitudes in treatment. However, the study can be critiqued for being cross-sectional, as it was carried out over two schools, therefore findings may have been based on differences between the two samples of students.

In comparison, in the US, Miller, Sheppard, Colenda and Magen (2001) identified predominantly negative attitudes towards drug addiction in medical schools. Contra to Landy et al.'s (2005) findings that education improved attitudes, Miller et al. reported that the more training medical students received, the less favourable their attitudes towards drug addiction was. However the possible reason for this, was that Miller et al. also reported to there being limited addiction-related subjects in medical schools, so even though students may be in education for a longer period of time, their attitudes towards IDUs did not improve because of a lack of addiction-specific related training, thus further supporting the notion that it is the actually training and education, specific to addiction, that improves favourability towards IDUs.

These findings therefore support the argument that there is a need for the training and education of DTPs who wish to work with IDUs. This is relevant to DTPs who have less favourable attitudes because of their lack of time working with IDUs, as proposed by Carroll (1996), as training and education can assist in improving their attitudes, where they have yet to have the working time to do so. On the other hand, training and education can also be an essential part of improving the attitudes of more experienced DTPs who may demonstrate less favourable attitudes, as proposed by Davies and Huxley (1997) because they have reached burnout or disenchantment with drug treatment and clients. Therefore, training and education at this stage can help in reengaging with the purpose of treatment, and hence assist in improving favourability.

Therefore, in support of the claim that training and education improves attitudes, similarly to that reported by Miller et al. (2001), there have been studies which have reported that limited training causes negative attitudes in DTPs, such as McLaughlin et al.'s (2006) study of healthcare professionals working directly with IDUs, and found entrenched negative attitudes in DTPs, as a result of a lack of education and training in illicit drugs and working with IDUs. Furthermore, that relevant training, knowledge and experience were believed to successfully improve healthcare professionals' attitudes towards illicit drugs and users. However, the study also found that healthcare professionals were unwilling to undertake more in-depth drug training, as they felt that they would then be considered as 'expert' at working with IDUs, and would subsequently attract more IDUs to their services. This may be the reason why the need for training and education had been put into clinical practice in the early 1990s by the Advisory Council on the Misuse of Drugs (1990) who proposed that attitudes should be addressed at the basic level of training for all staff working with IDUs.

Additionally, this was later reinforced by the Drug Misuse and Dependency Guidelines on Clinical Management (1998) who called for the need to improve training for all staff who worked directly with IDUs. Subsequently, in 2002, the NTA improved the delivery of drug treatment training for practitioners specialising in working with IDUs, expressing a desire for all DTPs to have undergone accredited training programmes by 2005. This, however was a difficult target to reach, and as such, training levels in current DTPs are still questionable (McLaughlin et al. 2000; Mistral and Velleman, 2001; Grove, Heuston, Gerada, Gossop and Strang, 2002, Tang, Wiste, Mao and Hou, 2005), with a fundamental flaw in the lack of knowledge and skill in specialist teams to deal with IDUs (Soverow, Rosenberg and Ferneau, 1972; Beauvais, Spooner and Oetting, 1991; Gorman and Morris, 1991; King, 1997; King et al. 1998; and McLaughlin et al. 2000).

1.5.7 Conclusion

From the literature reviewed, it would appear that DTPs are likely to exhibit favourable attitudes towards illicit drugs and IDUs and that this can be argued to be as a result of objective experience, through working experience with IDUs and training and education. Conversely, other more subjective factors of experience, such as being a DTP that is a recovered addict, having friends or

family that have used illicit drugs, might improve levels of favourability but on the basis of opinion rather than fact, and as such, can be considered to be biased.

The divergent findings in studies of demographic characteristics imply that it is not possible to easily identify DTPs who will have more favourable attitude or less favourable attitudes, simply by their age, gender or experience with illicit drugs because there are so many variables that have been found to effect levels off favourability. The importance of training and education in improving attitudes has been proposed as an essential to the development of the DTPs, and this can be at separate times in the working life; when they are newly into working with IDUs, and training can improve attitudes, where a lack of work experience has improved attitudes. Conversely, for longer term workers, who may have developed negative attitudes over time for a number of reasons, training and education delivered at this time will refresh and promote more favourable attitudes.

Clients' perception in drug treatment is also highly influential in terms of its effect on their treatment outcomes. In order for a client to be successful in treatment, they not only have to receive favourable attitudes from their DTP, but they must be able to perceive this favourability, for it to have an effect. In addition, all too often, DTPs are unaware of the impact that their levels of favourability has on clients outcomes, as well as a lack of appreciation of the full power that the interactions within the TA have upon their clients' well-being. Therefore, DTPs must become more aware of the fact that their attitude within treatment can have sufficient impact on their clients' treatment outcomes.

A considerable amount of research in this area has focused on generic health services, and as it has been claimed that IDUs require more specialist 'wrap around' services to assist in the holistic problem of drug addiction, then more focused research needs to be conducted on the attitudes towards illicit drugs and drugs users within specialist treatment services. Conversely, by sending an IDU to a specialist drug treatment facilities, rather than generic healthcare, it continues the stigmatisation process by differentiating IDUs from the rest of society. It is therefore questionable whether IDUs will receive more effective treatment in generic services, as opposed to specialist drug treatment services. However, the majority of previous research investigating effectiveness of IDUs

has predominantly focused on provision of health care via generic services. Thus, the dearth of research of specialist drug treatment services calls for a need to investigate this area.

1.6 The measurement of attitudes in a therapeutic setting

Favourable attitudes displayed within the TA, between client and DTP, have been shown to have a positive influence on clients' treatment behaviour, in terms of improving compliance and retention (Orlinsky et al. 2004), which are indicative that the client is taking a proactive role in their drug treatment programme by attending regular therapeutic sessions, engaging in discussion with their DTP, thus developing a relationship with their DTP (De Weert-Van Oene et al, 2001; Fiorentine and Anglin, 1997; Joe, 2001; Simpson, 2001). Such engagement with drug treatment services can thus impact on a clients' drug treatment outcomes in a number of ways, such as by helping to reduce the adverse health consequences of illicit drug use to the client, or by assisting in their achievement of 'dependence-free' from illicit drug use, by improving socioeconomic factors such as housing and employment, or by improving relationships, which in turn will aid the clients successful reintegration into society. Therefore, the quality of the TA between DTP and client positively associates with improved treatment outcomes for clients' (Edwards, Peterson and Davies, 2006).

Conversely, numerous studies have identified that unfavourable attitudes within generic healthcare services between care-giver and patient, have an unhelpful impact on treatment outcomes, as patients were often found to receive lower levels of care (Breeze and Repper, 1998; Carveth, 1995; Finlay, 1997). Moreover, these findings are not exclusive to generic healthcare, as Puschner et al. (2005) discovered that unfavourable attitudes between DTP and client within the expertise of drug treatment services, had a negative effect on clients' levels of success in treatment by impacting on clients engagement with treatment, having an influence on their leaving treatment unplanned and early, and by influencing levels of trust, and thus not having a positive rapport with their DTP. Such negative behaviours to drug treatment subsequently impact on clients' drug treatment outcomes as clients that retain in treatment for at least as long as a one-year period have most benefit from treatment, whereas, clients that leave treatment early and unplanned are at higher risk of returning to illicit drug use, which was exemplified in a study focusing predominately on methadone

maintenance by the English National Treatment Outcomes Research study (Keen, Oliver, Rowse and Mathers, 2003).

Similarly, this discovery is concomitant to that of clients' negative treatment behaviours in the US, as early drug treatment leavers were also found to have worse outcomes than those who continued in treatment (US Drug Abuse Treatment Outcome Studies, 1991-1994). Thus, in order to improve clients' drug treatment success rates, Ashton and Witton (2004) proposed that drug treatment services in Britain must focus on ways to improve clients' engaging and retention in treatment, for the reason that on-going drug treatment assists in reducing the harmful behaviours associated with problematic drug use (DTORS, 2009). One possible way of doing this would be to investigate aspects of favourable and unfavourable attitudes within the TA on clients' drug treatment outcomes, as previous studies have already demonstrated a link between this relationship and outcome.

Although the effect that attitudes within a therapeutic setting are commensurate between the generic health care services and drug treatment services, comparisons made between levels of favourability between these two service types when specifically treating IDUs, have been found to differ (Landy et al., 2005; McLaughlin et al. 1996; McLaughlin et al. 2000), with DTPs principally indicating a more favourable attitude towards IDUs, than their generic health service counterparts. Thus, for the reason that favourable attitudes within drug treatment positively influences clients' treatment behaviours, resulting in improved treatment outcomes, then, it can be hypothesised that DTPs should induce more success in their clients' drug treatment outcomes than generic healthcare staff.

The care of opiate-using patients prior to 1998, was predominantly carried out by generic healthcare staff, with the emergence of treatment by specialist drug treatment services post 1998, when the treatment budget for drug interaction programmes to treat offenders who use illicit drugs rose, to £165-million (Day, 2006). A comparison of published drug treatment figures prior to this date, with more recently published figures, should indicate whether there had been a noticeable change in the rate of success in clients' drug treatment outcomes since the employment of DTPs to treat IDUs. Therefore, when determining leaving treatment free of dependency as a measure of success, yearly

figures published by the NTA, has indicated a steady rise in adult IDUs, ending treatment free from dependency (2005/06 = 6%, 2006/07 = 8%, 2008/09 = 15%, 2009/10 = 11%). Thus showing an improvement in drug treatment, albeit slowly and still very minimal when considering the amount of problematic drug-using adults currently in contact with drug treatment (In Oct 2010, this figure was reported as being 206,889), since DTPs predominantly took over the care of IDUs.

Whereas, conversely, a study by Day (2006) looking at completions of treatment being drug-free, in the North-West of England, found that of the 26,415 IDUs in treatment that were investigated, the percentage of IDUs entering into treatment and completing the programme had actually dropped from 5.8% in 1998 and 3.5% in 2002. The study concluded that, based on this sample, the success rates of drug treatment programmes were falling, thus suggesting that the shift from treatment of IDUs by generic healthcare staff to that of DTPs had not improved completion rates and dependence-free.

One plausible explanation for the divergence found between the NTAs figures and Day's study comes from an announcement by the Statistics from the National Drug Treatment Monitoring System (2010) stating that in 2009/10 the discharge codes and definitions were revised in order to improve accuracy of measurement and consistency of the way in which services subjectively coded their discharges. There is now a demarcation between clients that are entirely drug free on leaving treatment, and clients that are dependency-free from the drug with which they sought treatment for. Thus acknowledging the problem that in the past drug treatment services had free-rein to be economical with the truth when reporting their treatment completions. Therefore the divergence found between figures published by the NTA and Day's study are possibly as a result of the recording of figures by treatment services, whereby the recording of figures have in the past been open to interpretation and influenced by the ways in which drug treatment services have chosen to report them. Thus, putting the validity and reliability of previously published figures into question.

However, contra argument to the measurement of success based on drug-free dependency or treatment completion is whether treatment success should be measured on dependency free rates, or planned treatment completions. Although the amount of individuals actively engaged with drug treatment services in Britain has doubled over the past decade, suggesting that drug treatment

effectiveness is improving by the virtue that numbers have increased, retention rates should not necessarily be the most influential measure of success, as it can hide a myriad of factors such as differences between treatment services length of treatment programmes, or admission and discharge policies, as well as client profiles. Furthermore, retention rates, similarly to that of the NTA published figures on clients completing treatment dependency-free, can be subjectively reported and interpreted, exemplified by the fact that one client leaving treatment could be recorded as an 'early completion' leaver, which is more positive than recording them as a non-compliance leaver.

Hence, success should not be measured by simply getting numbers in treatment, but it should be measured by how many people come out of treatment having reached their intended goal, as set out in their initial care plan. This is a relatively new way of thinking about treatment effectiveness, and has come about in the past year, since the change of government in May 2010. Whereby the previous government proposed that drug treatment success be measured by way of numbers in treatment, whereas the current coalition government have since proposed that drug treatment success be measured by clients drug treatment outcomes, and with this in mind are about to embark on a pilot scheme known as 'Payment by Results', as proposed by the new Drugs Strategy in 2010, which attempts to improve the recovery of adults in drug treatment services, by incentivising the treatment system around clients drug treatment outcomes so that treatment services are no longer paid on process activity, but by the outcomes they achieve, through the social reintegration of their clients such as by being dependency free or by gaining employment (NTA website, 2011).

In line with this new governmental proposal, the effectiveness of drug treatment should no longer be considered as the number of adult problem drug users in Britain actively participating in drug treatment service (which as of Oct 2010, was a figure of 206,889), but successful drug treatment outcomes such as the number of adults successfully completing drug treatment free of dependency (which as of Oct 2010, was 11.4%, n = 23,680). The huge divergence of figures between numbers in treatment, and numbers successfully leaving treatment dependency free, highlights a problem with the current effectiveness of drug treatment services in Britain that needs addressing.

It can be forwarded that consideration needs to be made as to what factors may be at large that could potentially be barriers to treatment effectiveness, and which, by highlighting this area may aid in improvements to treatment. Perhaps one of the first places to start is by taking a look at the clients accessing treatment. The literature reviewed indicated the importance of stigma and how it could have a potentiating role in treatment effectiveness.

Illicit drug use has been considered by the societal majority as an attribute that is negative and discrediting, thus the severe social disapproval and reaction to an individuals' attributes, behaviours, beliefs and/or characteristics as perceived by others to be against the social norms, leads to negative mental classifications by others, and results in the ruination of an individuals' social identity. Subsequently, IDUs acquire a negative identity within society, because their behaviour has been deemed to be immoral and deviant in modern Western society. Consequently, IDUs have been subjected to the negative implications that this stigma has on them for a long time, such as Heathertone, Kleck, Hebl and Hull's (2002) proposition that by experiencing feelings of psychological distress, leads to the drug user viewing themselves contemptuously. Thus, there may be a reluctance of discreditable drug users, who have not yet revealed their drug use, to access drug treatment services because of the threat that social stigma entails, and this was demonstrated in a study by Reece, Tanner, Karpiak and Coffey (2007).

In line with symbolic interactionisms' looking glass theory, as proposed by Cooley (1902), an individual's self grows out of their interactions and perceptions of others, thus individuals will shape their own identities on the perceptions of others. This leads to the individual reinforcing other people's perceptions on themselves, as individuals shape themselves based on what other people perceive and confirm other people's opinion on themselves (which is also known as the expectancy effect). Consequently, Goffman (1963) proposed that IDUs will thus have a lower opinion of themselves because of this stigmatisation from society, which was supported by Richmond et al. (1972) of participants beliefs of their self and others; those who viewed themselves in a more positive manner had a higher regard for others, thus hypothesising that those with a lower opinion of them self, such as the stigmatised, will have a lower perception of others.

Thus, IDUs may not accurately perceive DTPs actual levels of favourability towards them, coloured by their own perceptions of themselves. Thus suggesting that perception could have a fundamental part to play in the effectiveness of treatment, in so far as, it does not matter whether or not DTPs have a more favourable attitude towards IDUs than generic staff, if the clients are not able to accurately perceive this favourability, and only see all society as being negative, then they will not benefit from these positive attitudes that have a positive impact on the client's treatment outcomes. Therefore, whether or not DTPs' exhibit favourable bias towards IDUs becomes irrelevant, if the client is unable to perceive it accurately, it will not have a positive impact on the client's treatment outcomes.

1.6.1 The importance of attitudes in drug treatment

The history of research on attitude seems to have largely centred on the argument of whether attitudes and behaviour have a reciprocal relationship. Investigations of attitudes began in Germany in the mid-1850s, with a focus on responses to certain classes of social stimuli (Antonek and Livneh, 1988). The British psychologist Herbert Spencer first used the term attitude in 1862, and by the turn of the century it was widely accepted by most social psychologists that a person's thoughts and actions were strongly influenced by attitudes (Antonek and Livneh, 1988). Summers (1971) stated that despite wide variation, the consensus was that an attitude was a predisposition to respond to an object rather than the actual behaviour toward the object.

Each person has their own attitude towards illicit drug use, which is often based on their own personal experience with, or knowledge of substance misuse, whether through personal use, through familial use, working with users, knowing users or images from the media. This also affects DTPs too, and thus they come to the role with preconceived attitudes towards illicit drugs and drug users. It is hoped that the majority of DTPs do receive adequate training, because, according to Cartwright (1980) training and education was found to be linked with improved attitudes within the drug treatment field.

In addition, support from work colleagues is important, as according to Peterson and McBride (2002), attitude was argued to be 'caught' from other work colleagues, and not 'sought', and are thus acquired from colleagues, it is therefore important to remember that attitudes not only have an effect on clients, but also on work colleagues, in order to reduce the impact that their personal attitudes can have within the TA, between DTP and client so that they are non-judgemental and more helpful to the client. However, training levels in current DTPs are still questionable (McLaughlin et al. 2000; Mistral and Velleman, 2001; Grove, Heuston, Gerada, Gossop and Strang, 2002; Tang, Wiste, Mao and Hou, 2005), thus attitudes can potentially interfere with the dynamics within the TA, and subsequently could have a significant influence on a client's success in drug treatment. It is therefore necessary to make DTPs aware of the attitudes that exist within specialist drug treatment services, how these attitudes are subsequently perceived by their clients, and what effect these attitudes have on treatment outcomes, so that they gain an understanding of how personal attitudes can affect their work.

1.6.2 How attitudes have been investigated in the past

There were three significant contributors to the measurement of attitudes; Thurstone (1928), Likert (1932) and Osgood (1957). Thurstone was one of the first to investigate attitude, and in 1928 purported that attitude indicated an individuals' inclinations, feelings, prejudice, bias, preconceived notions, ideas, fear, threat and convictions about a topic (Summers, 1971). Furthermore, that it was possible to measure this attitude on a single continuum, ranging from very favourable to very unfavourable, thus identifying an individuals' level of attitude towards the topic area, by asking respondents to indicate their agreement to a number of statements on the topic area. The idea that attitude could be measured was supported by Likert in 1932, who delineated that a more simple method of attitude measurement to Thurstones method, would also identify levels of favourability. Similar to that of Thurstones method, Likert proposed that an individual's single score would indicate their level of favourableness (Antonek and Livneh, 1988), however this was calculated by a summation of respondents' levels of agreement towards a number of statements on the topic area

Another important development in the measurement of attitude came in 1957 when Osgood developed the semantic differential scale which was purported to indicate an individual's level of favourability by their indication of levels of agreement to a series of bipolar evaluative scales.

Since the development of such attitude scales, they have been utilised in a number of topical areas to determine sample populations attitudes towards the area under investigation, and this is exemplified in a number of previous studies, such as disability (Mussen and Barker, 1943; Yaker, Block and Campbell, 1960) and mental illness (Cohen and Struening, 1962). One of the initial attitude scales developed for use within the field of substance misuse was the Drug Attitude Scale (DAS), developed in 1978 by Goodstadt, Cook, Magid and Gruson, and consisted of 60-attitude items associated to substance misuse, with sub-scales more specifically referring to 10 different drugs and alcohol. The scale was developed to measure personal attitudes and behaviours towards substance misuse, in particular, highlighting poor attitudes towards drugs and alcohol (for example, refusing to acknowledge the dangers of illicit drugs) in IDUs. The scale was used more recently, to measure treatment effectiveness, and was implemented as an assessment tool by DTPs at House of Hope/Stepping Stones (2011) to ascertain whether there had been treatment effects displayed as a change in clients' attitudes to their substance misuse. This was undertaken by carrying out pre and post-tests, as it was predicted that a change in attitude would demonstrate that effective treatment had taken place. This scale is more specifically related to IDUs' own perceptions of their use of substances, rather than of others' use.

In the past, measurement of attitude has been carried out directly, or indirectly, both of which can be argued to have limitations, particularly for the reason that different measures focus on the three different components of attitude; cognitive, affective and behavioural, whereby the cognitive response is a cognitive evaluation of the object that constitutes the individuals belief towards that object. The affective response indicates an individuals' attitude towards an object through their emotional response to it. Finally, the behavioural response is the individuals' verbal indication or behavioural tendency towards the object. Thus, according to Ajzen and Fishbein (1980) these three components of attitude do not necessarily always overlap. In general, the measurement of attitude can be divided into two basic components; those that measure attitude directly, such as attitude scales, and those that measure attitude indirectly, such as projective techniques.

One of the most direct ways of investigating attitude is simply by asking individuals what their attitude towards something is, however, self-image and social acceptance of others is so important to individuals, that their response will be influenced by social desirability, thus, the presence of others, such as in an interview setting or focus group could have an impact on the individuals response (Crowne and Marlowe, 1964). As such, direct measures of attitude have come under criticism that they often rely on the self-reported attitudes of participants, which can be influenced by the individuals desire to appear more well-adjusted, unprejudiced or open minded and thus may respond honestly to attitude scales because of the way this might appear to others that may be present, such as the researcher in the case of interviews, or other participants, in the case of focus groups.

In comparison, indirect measures of attitude, such as online methods of treatment, are on the one hand thought to solve the problem of participants needs for social desirability, through anonymity. Yet, can influence their results by the fact that they are unaware of what is being measured (which in itself has additional ethical issues). Thus, the problem with measuring attitudes indirectly is that participants are often required to interpret unclear or incomplete tests, whereby their attitude is inferred from their interpretation. This method relies on the notion that the participant will project their attitude onto the ambiguous situation. However, methods such as these can be criticised for providing general information which are not a precise measurement of attitude since it is qualitative rather than quantitative, and thus not an objective measure of attitude.

Attitude scales are standardised tests and require rigorous development and evaluative testing of reliability and validity before they can be used, thus they can be considered as being more reliable than standard questionnaires, and for this reason, attitude scales can be considered to be a controlled methodological quantitative tool, providing a firm foundation with which to base this research on. In addition, the need to implement a methodological tool that establishes control is also for the reason that attitudes are relatively constant, and thus when measuring attitude, it is necessary to employ a reliable measure that will reflect such constancy.

Furthermore, one of the longest running debates in social psychology is the relationship between attitudes and behaviour, with the general agreement that attitude is only one factor that can influence behaviour (Ajzen and Fishbein, 1980). Thus people do not always act in accordance with their beliefs, such as an IDU may believe that an illicit drug is harmful and addictive but will continue to use it. Therefore, people can act differently to others depending on factors such as their desire to uphold social acceptance. With this in mind, individuals' actual attitudes are not the only thing that can be considered as being important in the TA. Perception is important, as, in accordance with SIT, individuals are able to live and work together more effectively, through the way in which they perceive others to view them.

This idea was supported by Richmond et al. (1972) who conducted a study investigating 150 undergraduates' beliefs of themselves and others, and reported that those who viewed themselves in a more positive manner had a higher regard for others. Thus supporting the proposition that IDUs, who have a lower opinion of themselves (Goffman, 1963) which occurs through years of stigma from society, then it is likely that they will have a lower perception of others. This may be why drug users were found to perceive a lower attitude from their DTP's actual level of favourability, because this low opinion has been influenced by their opinion of themselves. Conversely, this might be why DTPs were shown to have a higher opinion, for the fact that they have a higher opinion of themselves, and so, perceive others more favourably.

There are a number of reasons why the current research has chosen to utilise an attitude scale to investigate attitude within the drug treatment service; (1) there are a number of different sample groups to be investigated in this thesis (i.e. the general public, DTPs, current drug users in treatment and previous drug users having had treatment), thus a measure of attitude is required that can be diverse in its usage in a number of different ways. (2) For the reason that one of the groups to be investigated is a stigmatised group in society (IDUs), as well as the topic of the research (illicit drug use) can be considered as being a socially sensitive area because it is discussing an illegal activity, then, the proposed method of research needs to be a method that will aid in collecting information from this group of people. With this in mind, the method of attitude scales has been chosen for the reasons that (1) it can be used in a number of different data collections to collect information from the number of different sample groups proposed for this research, and (2) it is a method that can

uphold anonymity, which will hopefully be the best way of obtaining information from a stigmatised group, such as IDUs. Therefore, by utilising a method of data collection that allows the participant to remain anonymous, assists in their likelihood of telling the truth about their true opinion and attitude towards illicit drug use and users.

Avid proponents of attitudinal scales as a measure of attitude, such as Allport (1925), Thurstone (1928), Likert (1932), Torgerson (1958), Erwin (2001), Payne and Payne (2004) and Narli (2010) argue that scaling makes the measurement of human judgment, scientific (McIver and Carmines, 1981), and according to Torgerson (1958), should be considered to be as important as undertaken natural science investigations.

In the past, attitude scales have been utilised in research on illicit drugs and drug use to effectively identify important factors and issues of drug treatment. This was exemplified by McCormick, Bryant, Sheridan and Gonzalez's (2006) who used an attitude scale, as a postal survey, to identify four principal factors that were found to influence community pharmacists' levels of training and attitudes towards providing services for IDUs attitudes in treatment, these being; the general results of dispensing methadone to opioid misusers; the effect of opioid-dependent clients' on a pharmacy; reducing harm associated with drug use; and engaging with drug users, which explained 57% of the variance. In addition, having and wanting training was found to positively associate with all four of the attitude factors, with 26% of respondents reporting to having had previously undertaken training about the management of opiate-misuse. Subsequently, these findings suggested that attitudes towards various aspects of service provision to IDUs may not be as simple as previously perceived.

1.7 Rationale for the project and an introduction to the empirical studies

The proposed research question for this current project is as follows;

Do DTPs exhibit favourable bias towards IDUs, is this favourability perceived within the TA between DTP and client, and does it have any implications on clients' drug treatment outcomes, in terms of improving measures of social reintegration

In order to adequately address this proposed research question, there are four fundamental components to examine;

1. The first aim of this project was to develop a versatile tool for measuring attitude, which could be used in a number of ways to identify actual levels of favourability, perceived levels of favourability, and the relationship between levels of favourability and treatment outcomes. The tool will require a series of validation tests to verify its validity and reliability before it can be used with knowledge of its accuracy.
2. The second aim of this project was to identify the general public's levels of favourability towards IDUs, then to identify DTPs' actual levels of favourableness, so as to ascertain whether DTPs exhibit favourable bias towards drug users, in comparison to the general public. Then, to identify clients' perception of DTPs' levels of favourability, so as to identify whether clients do perceive DTPs' levels of favourableness.
3. The third aim of this project was to investigate the treatment effect that client perception had on drug treatment outcomes.
4. The final aim of this project was to identify any recurrent themes of aspects of drug treatment that were attributed to treatment success, and to see if they supported or refuted the notion that favourability within the TA has an impact on treatment effectiveness.

Therefore the empirical section of this thesis will consist of eight inter-related studies. Study one represents the development of a Thurstone scale for measuring attitudes towards illicit drugs and drug users. The rationale for this study was that the method of scale generation implemented in the

Thurstone technique required that of an entirely new scale to be created solely by the participants involved in the study, thus, a totally unique, and participant driven scale was produced by participants who had current contact with IDUs, and could thus provide an insight into a current range of up-to-date favourable and unfavourable attitudes that IDUs might encounter. The measurement tool was then utilised in the following seven studies to measure participants' actual and perceived levels of favourableness towards illicit drugs and drug users.

In order to verify the reliability and validity accuracy of the developed scale from study one, a series of validating techniques was then required. Thus, study two used a correlation technique to evaluate the reliability of the scale by employing the test-retest reliability method in order to explore general public attitudes towards illicit drugs and drug users. Study three investigated the predictive quality of the developed scale. The rationale for this was two-fold; firstly, to see if the scale could accurately predict participants' perceived readiness for treatment, based on hypothetical scenarios whereby the client in treatment was manipulated by age and drug of choice. Secondly, to see if the scale could identify levels of favourability between a sample group of the general public and a sample group of DTPs.

The rationale for study four was three-fold; firstly, to undertake an empirical test of the developed scale on a sample of the general population in order to complete the series of validation tests. Secondly, to ascertain a bench-mark level of favourability towards IDUs, for which future comparisons could be made. Thirdly, to explore the scales psychometric properties on a sample population, as well as to investigate potential differences in participant's overall scores to the attitudes scale, indicating their degree of favourableness towards illicit drugs and drug users on the basis of participants' demographic characteristics (for example, age, gender) and their experience with illicit drugs and illicit drugs users (e.g. working with IDUs, having friends that use illicit drugs).

Having established a level of favourability towards illicit drugs and drug users, the scale was then used to explore DTPs' levels of favourability in study five, to identify whether DTPs do in fact demonstrate favourable bias towards IDUs. Again, the rationale for this study was two-fold; firstly

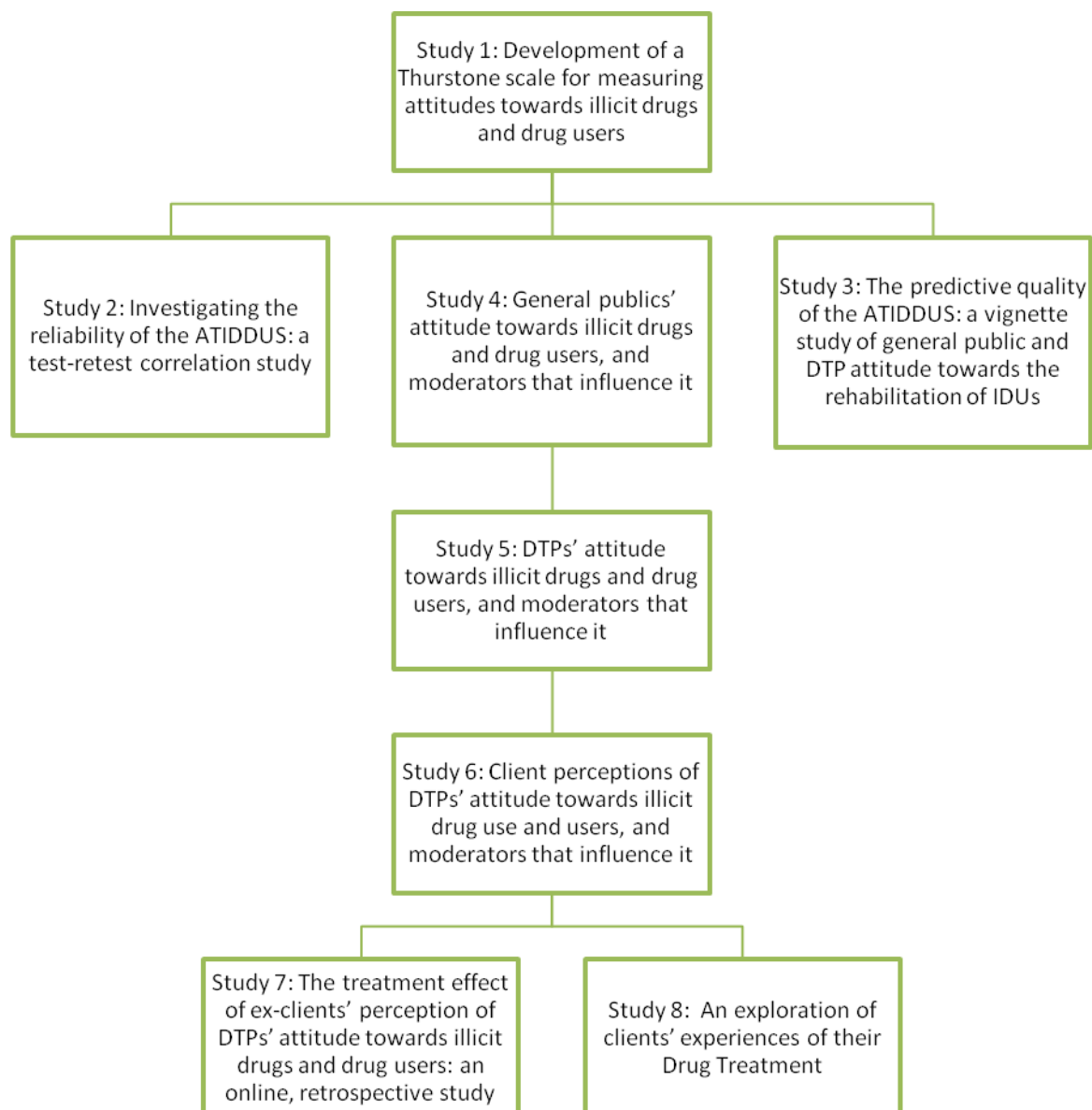
to identify DTPs' levels of favourability, and secondly, to identify moderators that influenced DTPs' attitudes towards illicit drugs and drug users.

Having identified a level of favourability in DTPs, study six used the developed scale to establish clients' perceived level of favourability in DTPs. The rationale for this study was based on previous research which indicated that perception of attitude is equally as important as actual attitudes, and that clients need to perceive favourable bias from others, in order for it to have an impact on their treatment outcomes. Thus, study six will investigate how clients perceive their DTPs' favourability towards illicit drugs and drug users, and comparisons will be made to the actual levels of favourableness identified in study five. Similarly to studies four and five, this study will also examine moderators that may impact on perceived levels of favourability.

Study seven is a retrospective study utilising the developed scale to again explore clients' perceived levels of favourability within the TA in drug treatment services, with a more specific look at how this perception of high or low favourability has influenced client' treatment outcomes. The rationale for this study was that at this stage of the project, no such evidence of the treatment effect that favourable or non-favourable attitudes within the TA had been established. Thus, this study takes a retrospective look at individuals who have previously been through drug treatment, and examines their perception of favourability of their last DTP in relation to their current treatment outcomes, in terms of their current drug use, criminality, and health and socio-economic status.

Finally, the rationale for study eight is to explore aspects of treatment deemed to be attributing to treatment success, on a one-to-one basis among current clients and DTPs who themselves had previously been clients.

Figure 1: Diagrammatic representation depicting the inter-relationships between the component studies of the research project



2 CHAPTER TWO: Development and Standardisation of the Attitudes towards Illicit Drug and Drug Users Scale

2.1 Study One: Development of a Thurstone scale for measuring attitudes towards illicit drugs and drug users

2.1.1 Introduction

The meaning that an individual associates to another person, or object, has a dramatic effect on how they socially interact with them/it (Blumer, 1969). Thus, in terms of drug treatment, it can be argued that associated meanings to the dyadic relationship between DTP and client can have considerable impact on a client's drug treatment outcomes. Therefore, the influence of others can have a fundamental effect on therapeutic change (Anderson, 1994). As the literature reviewed has already established, clients' respond positively to perceived favourable bias from DTPs (McLaughlin et al. 2000). Conversely, clients have been found to deliberately avoid being labelled as difficult by DTPs, because of their understanding of the negative implications that this would have on their treatment (Johnson and Webb, 1995). Consequently, clients who had a good relationship with their DTP have been found to have improved positive outcomes (Phillips and Bourne, 2007). Thus, it is therefore important to firstly establish the level of favourability towards IDUs that exist within the TA; in terms of both actual favourable bias from DTPs, and perceived favourable bias from clients. Moreover, to establish the impact that favourable bias has on clients' treatment outcomes.

In order for this to occur, the way formation of bias in relationships needs to be considered. In the past, the use of attitude scaling has been particularly useful when investigating marginalised groups in society, particularly when exploring societal attitude to stigmatised groups, such as attitude studies of disability by Mussen and Barker (1943) and Yuker, Block and Campbell (1960), and attitudes to mental illness by Cohen and Struening (1962). This method allows for anonymity to be maintained, thus, is a useful method of investigating participants' attitudes towards a sensitive topic area, as under these conditions, participants feel more at ease at providing an honest answer.

Similarly, attitude scaling is an appropriate measure for investigating levels of favourableness towards IDUs, as they too can be considered as a stigmatised group in current western society. Consequently, a number of attitude scales have previously been devised to investigate a range of aspects of attitude, that might have implications on illicit drug use; these may be in terms of attitude towards IDUs, IDUs own attitudes towards their drug use, or in terms of aiding education development of substance misuse, for example in investigating young peoples' attitudes towards substance misuse. One of the initial attitude scales developed for use within the field of substance misuse was the Drug Attitude Scale, developed in 1978 by Goodstadt, Cook, Magid and Gruson, which was more recently used for educational purposes by studies such as Moreira, Silveira and Andreoli (2009) to explore educators' knowledge about, and attitudes towards drug abuse by students. In addition, Bares, Andrade, Delva, Grogan-Kaylor and Castillo (2011) explored young peoples' attitudes towards the use of illicit drugs; attitude studies such as these can be used to facilitate educational practice.

There have been three significant contributors that can be attributed to the measurement of attitudes; Thurstone (1928), Likert (1932) and Osgood (1957). Thurstone purported that the measurement of an attitude was significant because it gave indication to an individuals' inclinations, feelings, prejudice, bias, preconceived notions, ideas, fear, threat and convictions about a topic (Summers, 1971). Furthermore, that it was possible to measure this attitude on a single continuum, ranging from very favourable to very unfavourable, thus identifying the individual's level of attitude towards a topic area. Similarly to Thurstone, Osgood and Likert agreed that attitudes could be measured in terms of identifying a level of favourability (Antonek and Livneh, 1988). All three contributors agreed that that this could be achieved by calculating an individual's overall score to an attitude scale, by the summation of participants' agreement towards a number of statements on the topic area, which thus indicated their overall level of favourableness.

Examples of these scales can be seen in previous research of substance misuse. For example, the Drug Attitude Scale (Goodstadt, Cook, Magid and Gruson, 1978) implemented a Likert-style scale to investigate the use of illicit drugs. It consisted of sixty scale items, generated by the author, to which participants were asked to indicate their level of agreement to a range of answers. The scale was later utilised by Campbell and Chang (2006) on individuals in a residential substance abuse

programme, and their reported findings that the scale had very good internal consistency reliability with a reported coefficient alpha of 0.87 indicated that the scale was generalisable to clinical practice. This scale has predominantly been used to establish participants' beliefs of their own drug use rather than as an indicator of attitudes towards illicit drug use by others, such as in Bares, Andrade, Delva, Grogan-Kaylor and Castillo's (2011) study of the gender differences of participants, in relation to their own perceptions and attitudes towards the perceived benefits of using substances.

More recently, the Attitudes towards Drug Use Scales (ATDUS) developed by Gouveia, Pimentel, Queiroga, Meira and Jesus (2005), to look at students' attitudes and behaviours towards the use of marijuana used Osgood's proposed method of semantic differential scaling. The scale consisted of nine bipolar pairs of adjectives generated by the authors, which had corresponding scores ranging from -4 to +4. Participants were required to indicate their level of agreement to scale items and the subsequent summation of these scores indicated their level of favourableness towards attitudes to drug use.

Factor and predictive validity tests carried out on the ATDUS by Gouveia, Pimentel, Medeiros, Gouveia and Palmeira (2007) on 276 undergraduate students, reported that the scale was able to predict the potential engagement of young peoples' use of illicit drugs. In addition, similarly to the conclusions drawn from the DAS, findings from Gouveia et al. (2005) and Gouveia et al.'s (2007) studies indicated that the scale was more suited to that of investigating participants' attitudes towards their own use of illicit drugs. This was particularly exemplified in Gouveia et al.'s (2007) discovery that participants' scores on the ATDUS significantly explained the condition of being a drug user, which accounted for 79.3% of the variance.

The Substance Abuse Attitude Survey (SAAS) was developed in 1985 by Chappel, Veach and Krug to measure the attitudinal objectives in medical education of the misuse of alcohol and drugs. The scale consisted of a number of attitude statements, generated by the authors, which related to various factors of substance misuse, thus giving an indication to a participants' attitude, in respect of their permissiveness, treatment intervention, non-stereotypes, treatment optimism, and non-

moralism. In spite of its inclusion of alcohol, the wording of statements utilised in the SAAS appeared to be the most appropriate for this current project, for the reason that the survey items included a range of favourable and unfavourable attitude towards substance misuse, and referred to a number of different aspects of illicit drug use, for example, drug treatment, and the moral implications of illicit drug use. This was particularly exemplified in survey items such as, “an alcohol- or drug-dependent person who has relapsed several times probably cannot be treated”, “an alcohol- or drug-dependent person cannot be helped until he/she has hit rock bottom” and “alcoholism is associated with a weak will.”

However, the SAAS is best utilised as a series of open-ended scale items with which participants discuss their agreement or disagreement. This was demonstrated in the ‘Tools to Strengthen Families and Communities’ (2006) who used the scale to assist DTPs in their gaining an awareness of their own attitudes towards substance misuse. Consequently, the scale was used as a qualitative discursive tool. It thus did not quantitatively measure attributes or traits, or provide comparable total scores, which gave indication to participants’ levels of favourableness.

Whilst a Thurstone scale may have the benefits of providing a strong quantitative foundation to a study, the qualitative nature demonstrated by the SAAS highlights the possibility that such a scale could have in providing a more discursive element to research, thus giving the opportunity to delve deeper into the symbolic and emergent aspects arising from the quantitative nature that the research uncovers, particularly in terms of exploring the meaning that these findings have (Gopal and Prasad, 2000). Thus, the Thurstone scale demonstrates its versatility in the way that it can be utilised in a mixed methods approach, thus in accordance with symbolic interactionism, strengthening the theoretical findings of this research, by enhancing the reliability and validity of the findings.

The fundamental difference between the methods of scaling used in the aforementioned research is the believed dimensionality of the attitude being investigated. For example, those multi-item attitude studies utilising a Likert or semantic differential scaling technique, believe that attitudes are typically multi-dimensional, and thus allowing for an exploration of the finer elements of attitudes.

Whereas, Thurstones method assumes that the attitude being measured has only one single dimension. Therefore, in this study the scale addresses favourable and unfavourable attitudes towards illicit drugs and drug users, with participants only being asked to rate each attitude statement in terms of where they think the statement lies on the dimension of favourable to unfavourable.

Whilst the other scales may be able to argue superiority in their ability to investigate more in-depth subtleties of alternative dimensions of attitude, the principal criticism of these scales, in terms of their appropriateness for this study, is the manner in which they were ultimately created. Thurstone devised a measure of attitude that utilised a completely unique method of scale development. Where alternative scale development processes required the author to devise scale items and could thus be argued to be subjective, and formed on preconceived knowledge, the generation of the scale items using Thurstones method, requires the scale generation process to be entirely participant driven by those individuals who are drawn from the population of interest to the study. These participants produce all scale items with no influence from the researcher. In accordance with the theory of symbolic interactionism which contends that in order to gain a true understanding of an area of investigation, it must be understood from the point of view of the individual committing that behaviour, without any preconceived ideas and prior assumptions from the author, thus, the inductive method utilised by Thurstone allows for conclusions to follow observations. Thus, in accordance with the theory of symbolic interactionism, it ensures that the scale is devised from participants' lived experiences with illicit drugs and drug users. Whereas, in comparison, the other methods of scaling implement a deductive method, whereby the author is required to first generate the scale items, before observations can be made, with which conclusions can then be made on.

Thus, for the reason that the current project seeks to investigate attitudes of a stigmatised group in treatment from a symbolic interactionist perspective, and that the area of research is a stigmatised group, the Thurstone method allows the participants to have the opportunity to voice their own opinions of treatment, based on their lived experiences within treatment (Goffman, 1959). This was exemplified by interactionist Prus (1996) who believed that in order to gain an in-depth understanding of people and organisations, participants' lived experiences needed to be shared. He achieved this through phenomenological research, utilising methods of observations, participant-

observation and interviews, and then describing the findings through writing. Writing the findings is an essential part of research to symbolic interactionist theory because it allows for the knowledge of attitudes that occur within the field of drug treatment, to be used to challenge existing assumptions in treatment, in terms of policy, training and education.

2.1.2 Rationale

This study addresses the need for an instrument to measure the levels of favourable attitudes within the TA in the treatment of IDUs, in terms of both the actual attitudes that people have towards IDUs, and in terms of the perceived attitudes towards IDUs that users themselves may observe. Future use of this measure can then investigate the resultant influence that such attitudes have on drug treatment success. Whereas previous instruments have predominantly assessed the individual's attitudes to their own use of illicit drugs, this current measure will examine individuals attitudes to other peoples use of illicit drugs. In addition, this measure will also employ a unique scale development technique which will allow the scale to be developed purely by the participants of the study, with no researcher involvement, thus scale development is in no way influenced by the researchers own preconceptions, beliefs and interpretations of theory. The developed measure will therefore be the only one of its kind to date, that will investigate attitudes towards illicit drugs and drug users from the perspective of the participants that take part in this research project. Its contribution to the field of study will enable an examination of attitudes for favourableness towards drug use and drug users which is central to measuring effectiveness of drug treatment programmes.

2.1.3 Research Question and Objectives

Research question: Can an effective tool for measuring actual and perceived attitudes towards illicit drugs and IDUs be developed, demonstrating the range of favourable and unfavourable attitudes that IDUs encounter?

- To attain one-hundred attitudes statements, towards illicit drugs and drug user, generated by the participants of this study
- To obtain participants judgement ratings of the one-hundred attitude statements, in terms of where the statements lie on the favourability continuum
- To compute the scale values for each statement

- To minimise the number of items on the scale using a number of scale reduction procedures
- To administrate the final scale

2.1.4 Method

2.1.4.1 Design

The Thurstone scale method of equal appearing intervals was selected for use in this study to produce a measurement of attitude that was entirely driven by the participants, thus there was limited researcher influence. From a symbolic interactionist perspective, the scale can thus be devised with no preconceptions, knowledge or ideas from the researcher that would influence the way in which participants will drive the formation of the scale. Consequently, all conceptions about illicit drug use and users that were produced as a result of this current study were as a result of the inductive research derived directly from the participants' involvement with the study, based on their personal experiences of illicit drugs and drug users, and influences from research and broadcasting they may have encountered.

2.1.4.2 Pilot study

The instructions as detailed in the 'procedure' section were first piloted on three DTPs; the demographic characteristics of the sample was that all participants were female, and between the ages of 25 – 35 years. The pilot was conducted on a small sample from the intended target population of the main study, thus, for the reason that this group was fairly limited, only a few participants were required (Clarke-Carter, 1997). Furthermore, these participants were not then used in the proceeding study. No modifications were made to the study following the undertaking of this pilot study, as the design and procedure of this study was deemed to be sufficient for each participant to successfully generate ten attitude statements each, with thirty attitude statements in total, that had a range on the continuum between favourable to unfavourable.

2.1.4.3 Participants

Recruitment of participants: The methodology employed in the current study requires participants who are considered to have expertise in the area being researched (Thurstone, 1930). Thus, participants were recruited from a drug treatment service, because they were deemed as having a sufficient understanding of the concept being assessed, since not only did they have daily contact with illicit drugs and drug users, but some were also recovered IDUs themselves. As such, purposive sampling was utilised, as participants were selected based on their knowledge of illicit drugs and drug use, from their professional background (Polit and Beck, 2004). One drug treatment service within the Berkshire area was contacted via telephone communication, and later by email, to ask for volunteers to participate in the current study. Please see Appendix 1.2 for the recruitment email.

Initially, 12 individuals accepted to take part in the study, however on the day of the data collection, one individual was unwell and one individual was unable to attend due to unforeseen work priorities. Thus, eliciting a sample of ten self-selecting individuals.

Demographics of participants: All participants worked within drug treatment services with IDUs, with the range of experience being between just under one year and 13 years in the field. In terms of the gender composition, eight (80%) participants were female and two (20%) were male. The age range of participants was from 21 to 59, with a mean age of 36 years. The ethnic origin of participants were, eight (80%) participants classified themselves as 'White British', one (10%) participants classified them self as 'White Other', and one (10%) participant classified his/herself as 'Afro-Caribbean'.

2.1.4.4 Ethical Implications

The current study was conducted on a sample of DTPs. The general description of the study was explained to the sample. The study was undertaken in a clinical practice setting (after a team meeting). This was within the researchers' level of competence, having previously been clinically trained in drug treatment and working directly with IDUs and DTPs for a period of three years prior to the commencement of this research.

Formal ethical approval was granted by the Society and Health Faculty Ethics Committee at Buckinghamshire New University prior to the commencement of this study, and a regard and understanding for the British Psychological Society Code of Harm Research Ethics (2010) was considered. Thus, the researcher was covered for public liability insurance, by Buckinghamshire New University, should participants require financial support in the way of counselling, for example, as a result of being traumatised by the participation in this study. According to the British Psychological Society Code of Harm Research Ethics (2010) participants should not be put under any greater harm than they would normally be exposed to in everyday lives, and in this instance, psychological risk to participants was considered to be minimal.

In the current study, participants were not able to remain anonymous to the researcher; however they were assured that their identities would not be revealed to others. Furthermore, as the sample group was small, participants could possibly be identified from their demographics, so confidentiality was considered to be more difficult. However, participants were assured that what was learnt directly from each participant would not be revealed in association with their specific details.

Participants were approached politely, with respect, and with the recognition that they had the right to refuse to take part in the study. It was made clear to participants that they had the right to withdraw from the study during the process of data collection, and without reason. Furthermore, they had the right to inform the researcher that any information collected up to that point, could not be used in the study. Participants were reassured that they were not being individually tested, thus, they did not need to be concerned with their individual performance in the study, as the researcher was looking at the performance of the entire sample group. Written informed consent was obtained from each participant and kept on file by the researcher, separately to participants' responses. This was following the knowledge of what was required from each individual in their participation. Please see Appendix 1.4 for the consent form.

2.1.4.5 Measure

The purpose of the current study was to develop a measure for investigating participants' levels of favourableness towards illicit drugs and drug users. Thus the developed scale is unique and developed specifically to address the research aims of this thesis. For this reason, and in accordance

with Thurstones (1928) assertion that an experimental test must be conducted on a newly developed scale, before it can be accepted as having validity, proceeding studies, two, three and four will carry out a series of tests to verify the scales reliability and validity accuracy before it can be used to explore attitudes within specialist drug treatment. It is therefore proposed that study two will assess the scales' reliability by exploring the scales reproducible accuracy with a test retest investigation. Study three will address the scales predictive validity by exploring whether participants' levels of favourableness towards illicit drugs and drug users can be predicted from drug users' gender, age and drug of use as identified in a number of vignette scenarios. Finally, study four will investigate the psychometric properties of the scale and the potential differences in participant's scores on the scale, on the basis of respondent's demographic characteristics and their experience with illicit drugs and drug users.

2.1.4.6 Procedure

Participants were provided with clear instructions on an information sheet (please see Appendix 1.3) so that they were fully informed of what was being asked of them, what was being measured by the researcher and that their statements needed to be written in such a way that a reader could 'agree' or 'disagree' with the statements. It was highlighted to the participants that they were not being asked to give their own personal attitudes, but a range of favourable and unfavourable that the general public may have towards illicit drugs and drug users. Signed consent was obtained from each of the participants prior to the commencement of the study.

In brief, six steps were employed to produce the Attitudes towards Illicit Drugs and Drug Users' scale (ATIDDUS), in accordance with Thurstone and Chave's 'The Measurement of Attitude': Chapter 2 - Construction of an Attitude Scale (1929) suggested method of scale development;

Step 1: Generating 100 attitude statements:

Ten participants, working within drug treatment, and thus having a wide understanding of the area being researched, were asked to produce ten statements of attitudes towards illicit drugs and drug user statements; worded in such a way that they represent the complete range of both favourable

and unfavourable attitudes (Clarke-Carter, 1997). As a consequence, a compilation of one-hundred attitude statements were generated (Thurstone, 1928).

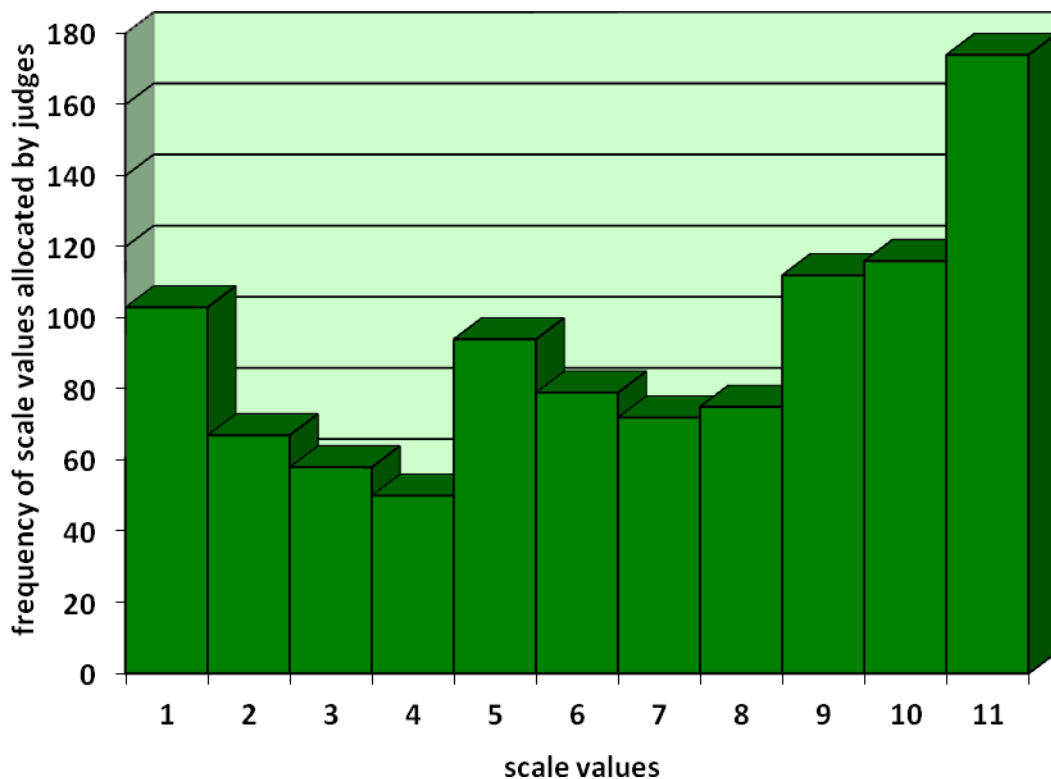
Step 2: Judging the 100 attitude statements:

The same ten participants, on the same day, were then asked to rate each one of the one-hundred attitude statements generated in step one, on an 11-point scale. The generated statements were numbered by the researcher, and were individually read out to the same group of participants. Participants were asked to privately rate each statement, in terms of how favourable or unfavourable they were thought to be; a rating of one indicating a most unfavourable statement, and a rating of 11 indicating a most favourable statement. It was made clear that participants were not being asked to rate statements as to their own personal agreement, but to consider how much each statement supported or opposed the issue of attitudes towards illicit drugs and drug users (Breckler, Olsen and Wiggins, 2006). Participants were asked to use all the scale items (one to 11) so as not to cluster all the scale values, therefore producing an evenly distributed range of scores.

Step 3: Plotting a histogram:

Thurstone (1928) expressed how valuable the descriptive properties of a histogram were in displaying the distribution of attitudes for all the ten participants judging the statements. Therefore, as per Thurstones (1930) proposal, the results of judges' allocated scale values were then plotted by the researcher, after the meeting, on a histogram. This gave indication of the frequency with which each score value was selected for the attitude statements; figure 2 shows the plots on the histogram.

Figure 2: Histogram showing frequency with which scale values (between 1 and 11) were allocated by judges



(1 = less favourable statement, 11 = more favourable statement)

The histogram in figure 2 indicates that more favourable attitude statements were identified with greater frequency by judges, and this is particularly evident in scale value eleven indicating the most favourable attitude statements and the most frequently selected scale value by judges.

Step 4: Computing scale values for each statement:

The median and standard deviation values for each statement were then calculated; median values indicating the central value of judges' scores, and the scale value for that statement, and the standard deviation values indicating the variation from the mean, thus demonstrating the agreement between judges of the ratings allocated to each statement. The median value becomes the allocated score value for each scale item, because they indicate the strength of the item, thus a

favourable attitude will have a higher median/scale value than a less favourable statement that will have a lower value median/scale score.

Step 5: Sort the list by median and standard deviation values:

The 100 generated statements were then tabulated by the median values in ascending order, and within that, in ascending order by their standard deviation values so as to facilitate in the selection of items for the final scale (Thurstone, 1928). This process thus indicates those statements with which participants most commonly agreed on.

Step 6: Selecting the final scale statements:

In accordance with Thurstones (1928) recommendation that a scale should have between 20 and 30 statements, 25 statements were then selected from the 100 generated in step one by implementing Thurstones proposed criteria of exclusion;

- I. Statements for the final scale were selected at equal intervals across the range of eleven scores (Trochim, 2006).
- II. Then, in accordance with Thurstones 'criterion of ambiguity', statements with high variance, that were too greatly dispersed on the favourable-unfavourable continuum (identified from the standard deviation scores) were discarded because they indicated a lack of agreement in judges scale allocation, and thus a lack of reliability (Cooligan, 1999).
- III. Finally, in accordance with Thurstones 'criterion of irrelevance', statements that had been repeated, were ambiguous, or would not elicit an 'agree'/'disagree' answer were discarded (for example, one statement that had been repeated was "drug users are weak"). When the best statistical choice indicated such a statement, the next statistically appropriate choice was made.

2.1.5 Results

Table 1: The twenty-five item scale of statements of attitudes toward illicit drugs and drug users

Statements	Statement No.	Scale value
All drug takers are thieves	32	1.5
Drug addicts have more money than sense	38	2.5
Drug users deserve everything they get	48	2.5
All drug users are criminals	39	3.5
Drug users are violent	33	3.5
Drug users are dishonest	49	4
Rehab doesn't seem to work for most people	84	5
Drug addicts don't like their life	86	5
Drugs scare me	31	6
Drug addicts are 'non-focused' and need direction	82	6
Drug users are unhygienic (e.g. sharing needles and contracting HIV)	95	6
Drug users are unreliable	35	6.5
It's wrong to take drugs	1	7
Drug users are untrustworthy	23	7
Drug addicts are lonely people	81	7
Drug addicts are emotionally troubled	76	8
Drug users makes me feel uncomfortable	28	9
Drug addiction is a sickness	75	9
It is easier to stay on drugs than it is to come off	77	9
You cannot make someone address their drug problem if they don't want to	51	9.5
Some drugs are more harmful than others	2	10
Most drugs are addictive	6	10
Some people do smoke cannabis for medicinal purposes, and that is ok	98	10
Drugs ruin lives	27	11
Drug addiction is class-less	56	11

2.1.5.1 Administering the scale

The subsequent scale can now be used to measure attitudes towards illicit drugs and drug users by asking participants to indicate whether they agree or disagree with each statement item on the scale. Each scale item is associated with a particular score, thus participants' agreement or disagreement to each item will provide 25 scores that will be summed to give an overall score. The overall score will indicate participants' level of favourability towards illicit drugs and drug users. In accordance with Thurstone and Chave (1929), this is achieved by summing together all the scale item values that the participant agreed with, and then calculating their arithmetic mean. Thurstone and Chave proposed that this was a reasonable method to obtain participants' total scores because each interval of the scale was equally represented by a range of favourable and unfavourable attitudes, in this case there are 25 attitude statements that are graduated fairly evenly on the continuum (i.e. for the reason that a few statement items of each scale value was selected for the scale), thus there were approximately the same number of favourable and unfavourable attitudes available for the participant to select. Please see Appendix 1.1 for the full ATIDDUS.

According to Breckler et al. (2006), participants' total scores reflect the average scale value of the statements with which they agreed, because of summation and division of scale items values by the amount selected. Subsequently, each participant has a resultant total score on the one to eleven favourability continuum, whereby low scores are indicative of unfavourable attitudes towards illicit drugs and drug users, and high scores of more favourable attitudes. Trochim (2006) argued that one of the benefits of carrying out this procedure was that it sought to demonstrate potential differences between participants with more favourable attitudes and participants with less favourable attitudes. For example, participants with a more favourable attitude, agreeing with a large number of more favourable statements (which would have higher scale scores allocated to them) would have a higher total score in comparison to a participant with a less favourable attitude, who may have only agreed with a few more negative statements (thus having been allocated lower scores).

2.1.6 Discussion

2.1.6.1 Summary of findings

The result of this study showed that it was possible to employ participants to entirely produce a successful measure of attitudes towards illicit drugs and drug users, without any influence from the researchers' own preconceptions, beliefs and ideas, by using Thurstones scale development method of equal appearing intervals. The resultant scale comprised of a range of interval level scale items that would indicate future participants' levels of favourability towards illicit drugs and drug users, dependent on the scale items with which they endorsed.

2.1.6.2 The results in context with previous research

The fact that the scale has successfully produced interval level data means that the scale is capable of indicating the extent of the difference between items, thus data collected in this way has the capacity to explore differences between participants levels of favourability on an attitude scale. Whereas in comparison, this statistical comparison is not always possible as other previously developed scales (such as the DAS and ATDUS), utilising different types of scales will therefore collect different types of information, which are subsequently measured in a different way.

The scale items generated in the ATIDDUS demonstrated the range of attitudes on a continuum, from favourable to unfavourable, in accordance with Thurstone (1928), and Thurstone and Chave's (1929) expectations. Thurstones (1928) model stated that attitude is represented as a place on the attitude continuum, with opinions strongly in favour of the issue being investigated on one side and opinions that were strongly against the issue on the other. Scale items with a lower scale value, should indicate a less favourable attitude towards illicit drugs and drug use, whereas, scales items allocated with a higher scale value would indicate a more favourable attitude towards illicit drugs and drug use, and in the scale developed, this was found to be case. This is exemplified in the ATIDDUS whereby unfavourable attitudes are represented with statements such as "All drug takers are thieves", and favourable attitudes are represented with statements such as "Drug addiction is class-less". Furthermore, the majority of negative statements refer to drug users, whereas positive

statements refer to more general use of drugs. This has potentially occurred as a result of the long term stigmatisation of IDUs, resulting in there being viewed as a negative stereotype.

In addition, Thurstone also purported that mid-way through the attitude continuum, at approximately scale value six, a noticeable change occurs between favourable to unfavourable attitudes, which again was also found. For example, the statement in the centre of the continuum was “Drugs scare me”, which represented an attitude that was neither favourable, nor non-favourable. Not only did the developed scale reflect Thurstones proposed attitude continuum, but it also unearthed a change in blame of illicit drug use, from the individual on the unfavourable side of the continuum, to other reasons for illicit drug use, on the other side of the continuum. This is exemplified in scale items where blame of illicit drug use was directed at the individual, “Drug users deserve everything they get”, and conversely, where blame was directed away from the individual, “Drug addiction is class-less”. These scale items thus indicate that favourable attitudes towards illicit drugs and drug users on this scale, sought to find other explanations for illicit drug use, than simply blaming the individual. Whereas, on the other hand, the unfavourable attitude scale items on this scale seemed to blame the individual for their drug use.

The fact that the change in direction of blame of illicit drug use has occurred in the development of this scale, suggests the likelihood that the scale demonstrates content validity. Furthermore, the success in the development of the scale in the way that Thurstone (1928) proposed that it would indicate that the scale adequately measures a range of favourable and unfavourable attitudes towards illicit drugs and drug users, because Thurstone also stated that this range would not occur, if another method of collection was employed. For example, a random collection of attitude statements would not necessarily produce a continuum, as Thurstone suggested, they would fail to produce neutral statements and therefore run the risk of the scale dividing into two parts; a favourable opinion and an unfavourable opinion.

However, there is an element of subjectivity by the researcher, when determining whether a scale has content validity. Thus, the fact that this developed scale has statement items concomitant to that of the previously developed Substance Abuse Attitudes Survey (Chappel et al. 1985) also supports that the content on the scale is measuring attitudes towards illicit drugs. The SAAS appeared to be the most relevant survey to this current project, however it was discounted for use

for several reasons. Firstly, and most importantly, that it was not a survey that had been devised by participants, based on their own personal experience of illicit drug use, which is an influential part of the symbolic interactionist perspective. Secondly, that it was a survey of substance misuse, thus the dialect used in the survey included alcohol as well as illicit drugs. Whereas, this current project focuses solely on attitudes towards illicit drugs users, thus the SAAS would not have been completely transferable to this project and amendments would have had to be made to the survey in order to extract any reference to the use of alcohol. However, exclusivity of illicit drug use could be adhered to in the methodology employed for the scale development in this study because the researcher was able to inform participants that the attitudes they had to consider was towards illicit drugs and drug users.

2.1.6.3 Limitations of the study

One limitation of this study was identified, and was inherent in the questionnaire design utilised. This was the effects of variance that may have arisen when the data was collected, as all measures were taken at the same time, and in the same way. Thus, it was not possible for the researcher to control all variables that might have influenced participants' generation of the statements, such as their current mood, the effect of others being present in the undertaking of this task, and their age, gender and ethnicity, as well as their levels of experience with illicit drugs and drug use. However, it is proposed that analysis of variance will be used to investigate a number of possible confounding variables in later studies, in order to see if they have an influence on levels of favourability.

2.1.6.4 Future work proposed

The developed scale will undergo a series of validation tests in order to establish its reliability and validity properties, before it can be used to accurately investigate actual and perceived attitudes that exist within specialist drug treatment, and the subsequent impact these have on clients drug treatment outcomes.

2.1.6.5 Conclusion

This study utilised DTPs to successfully create an up-to-date attitudes toward illicit drugs and drug use scale, thus representing perceived current societal attitudes and social acceptability, based on their personal experiences of illicit drugs and drug users. The scale would appear to have content

validity at investigating a range of favourable and unfavourable attitudes towards illicit drugs and drug users, however further exploratory tests are required before its reliability and validity attributes can be conclusively ascertained. Once this has been established, the proposed continuation of this research is to use the developed scale to investigate actual and perceived attitudes that exist within specialist drug treatment, and the subsequent effect that these attitudes have on clients' drug treatment outcomes. This study has developed an effective tool for measuring actual and perceived attitudes towards illicit drugs and IDUs. The scale has demonstrated a range of favourable and unfavourable attitudes that IDUs encounter, and thus appears to have good content validity. The next study will begin the standardisation process of the ATIDDUS, by examining whether it accurately measures the general public's favourability towards illicit drugs and IDUs, by using a test retest reliability method.

2.2 Introduction to the validation studies

Thurstones' (1928) recommendation that newly developed scales must first undergo rigorous testing before they can be accepted as valid and used in an exploratory capacity, thus underpins the necessity for the series of standardised tests on the ATIDDUS performed in this chapter. The testing of the scale will be executed in three different ways whilst utilising samples drawn from the general public; (1) to explore the scales' test and retest reliability, (2) to measure the scales predictive validity, and (3) by performing an empirical test on the scale so as to standardise it. In addition to confirming the scales validity and reliability properties, these tests will also provide knowledge of a baseline attitudinal level towards illicit drugs and drug use, of the general public, for which future comparisons can be made in later studies when investigating levels of attitudes within specialist drug treatment services.

Validity and reliability are two separate entities; validity is the accuracy of the scale, whereas reliability is the scales precision. A scale can have validity without having reliability, indicating that there are large random errors associated with the measurement of the scale. A scale can also have reliability without having validity, indicating that the scale has systematic biases. Therefore, if the scale is found to have validity but lack reliability, it will accurately represent attitudes towards illicit drugs and drug users, however, the scale will lack consistency in the measurement of the attitudes, making respondents' responses to the scale difficult to use. On the other hand, if the scale is found to have reliability but lacking validity then the scale will generate consistent results, but, the scale will be measuring something other than attitudes towards illicit drugs and drug users. Thus, it is preferential to have a scale that conforms to standards for both reliability and validity (DeCoster, 2005).

Whilst the majority of previous research carried out on social interactions, such as the TA, has predominantly been of a qualitative nature, the initial validation studies carried out in this project require a firm statistical quantitative foundation, following which in-depth qualitative studies can be conducted to examine in more detail the important human interactional issues highlighted in these preliminary exploratory studies. However, when determining the most efficient research tool to distribute the scale to the general public, a number of issues had to be considered. Most importantly, the fundamental feature of this chapter was to standardise and validate the scale, therefore it was necessary to consider research methods that would produce empirically-rich data to statistically explore such properties. In addition, it was important to consider that the subject area

of this research was that of a sensitive and illegal nature, involving a vulnerable stigmatised group, thus the chosen research tool must also be capable of yielding good response rates in this situation, as well as to encourage openness and honesty from participating individuals. Thus, a range of research methods was considered, before the decision to use questionnaires was made, and this decision process will be discussed in subsequent sections.

The use of one-to-one interviews at this stage of the project of attitudes towards illicit drugs and drug users was excluded for a number of reasons. First and foremost was the fact that interview techniques predominantly produce qualitative data whereby the researcher identifies themes in respondents' responses, thus, consequent data from interviews would not provide quantitative data. Whilst this approach may not be suitable at this stage of the project, this technique may however be more usefully employed in later stages of this project, to investigate any emerging themes that may have arisen from such preliminary quantitative research techniques.

Interviews may provide a more in-depth exploration of the research area, providing 'quality' over 'quantity', but they are notoriously expensive and time consuming for the researcher, thus yielding smaller sample sizes than research techniques such as questionnaires would. Consequently, for the reason that there is a desire to base the foundations of this entire research project on as large a sample size as possible, initial exploratory techniques using interviews would not be suitable enough at this stage. In support, Albert (2005) reported that larger sample sizes were more likely to produce more trustworthy data, and according to Lee and Baskerville (2003), larger sample sizes can claim generalisability from their findings whereas studies based on small sample groups are often dismissed because of their lack of generalisability and representativeness.

Qualitative studies previously performed in the field of drug treatment exemplify the production of such small sample sizes, for example, McLaughlin et al. (2000) yielded 20 respondents, Lowenberg (2003) yielded 24 and McLaughlin et al. (2006) yielded 35. Thus claims by Lee et al. (2003) that sample sizes of around ten and twenty respondents would not be large enough to make statements about numbers and proportions (such as the reporting of percentages of the sample), support the argument that methods such as these, that produce small sample sizes, would not be sufficient to accurately report on the standardisation and validation claims that this research is seeking to produce. Whereas, comparatively, quantitative methods that have been previously employed in the field of drug treatment, such as those by Campbell and Chang (2006) who yielded a sample size

of 128 when investigating the Drug Attitude Scale (DAS) by way of a questionnaire, and Munder, Wilmers, Leonhart, Linster and Barth (2010) who achieved a sample size of 331 when they surveyed respondents with the Working Alliance Inventory (WAI), support the proposition that survey methods would be more likely to produce a greater participation in the proposed studies.

The nature of this project is that of illicit drug use, which is a sensitive issue as it involves a stigmatised group and requires respondents to impart their personal feelings on an illegal activity. In light of this, the potential for researcher presence to skew the findings from the initial study was considered. For example, in an interview setting, Lee (1993) purported that interviewees often felt intimidated by the presence of the researcher, and as such, were less likely to express their true feelings, which is particularly so when discussing respondents own personal views (Albrecht, Johnson and Walther, 1993). Hence, it is likely that respondents will be unwilling to express their own personal opinions towards the use of illicit drugs and IDUs, in the presence of another, for the reason that Crowne and Marlowe (1964) claimed that individuals constantly strive for social approval from others and will be less likely to impart responses to a researchers questions that may make them appear to be closed-minded and prejudiced. If respondents felt that their responses to the scale were being evaluated, then their answers may be biased towards socially desirable responses. This can be especially true when the subject area is of a sensitive nature, such as illicit drug use (Tourangeau and Yan, 2007). Therefore, the nature of this project potentially has an effect on the willingness for people to both engage, and to be truthful, as Webster (1997) identified that there was a significant interaction effect between certain topic areas and researcher presence. It is for this reason that anonymity is a fundamental feature of this project, as it will improve the chances of eliciting engagement, and honest answers from respondents.

This point provides more support to the claim that one-to-one interviews at this stage of the project would not be suitable, whereas, on the other hand, anonymous questionnaires would be more likely to encourage honest responses from respondents for the reason that there is no researcher presence to influence respondents' responses. Consequently, a survey method, which is one of the more commonly used research tools in the social sciences to achieve quantitative data was decided upon, as this method of research would not only distribute the attitudes scale to the largest group of the sample population, but would also be more likely to achieve participation.

The first validation study will report on the reliability and stability of the scale, by using the test retest method (Shuttleworth, 2008). This method expects that when a measure is taken from a respondent on two separate occasions, a measure with good reliability and stability will produce a very similar correlational result (Clarke-Carter, 1997). The second validation study will investigate the scales validity as a predictor of perceived readiness for drug treatment of clients, in two population samples; the general public and DTPs. According to Alexander and Becker (1978), the use of vignettes is supported as a means of producing more valid and reliable measures of respondents' opinions, than simply using abstract questions that are typically found in opinion questionnaires. The third validation study will carry out a standardising process on the scale. Thus, in accordance with Thurstone (1928), the scale will undergo rigorous validating and standardising testing, and can then be used in an exploratory capacity in clinical practice. Furthermore, the use of a number of different reliability and validity techniques on the scale will serve to methodologically triangulate the findings, thus making them more trustworthy.

2.3 Study two: Investigating the reliability of the ATIDDUS: a test-retest correlation study

2.3.1 Research Questions and Objectives

Research Question: Does the ATIDDUS display good test retest reliability?

- To undertake a test, and then retest of the ATIDDUS on a sample population
- To carry out correlational analysis of respondents' overall scores of the ATIDDUS, between the test, and the retest, to see if there is a relationship between scores, thus identifying that the scale has good reliability and stability

2.3.2 Method

2.3.2.1 Design

The investigation was a test-retest reliability study, employing a within-subjects design as the scale was repeated on the same group of respondents in data collection one (the test) and data collection

two (the retest). Consistent scores from the scale between the two data collection points will indicate that the scale is a reliable measure. This method of reliability testing relies on the fact that there are no confounding factors for the sample in the intervening time interval. This scale was deemed suitable for the test-retest method, as there should be little chance of respondents' experiencing a sudden change in attitude towards illicit drugs and drug users in the time period between test and retest. This is for the reason that, even though attitude has been argued to be changeable over time (Kolman, 1938), according to stigma theory, attitudes to substance misuse are pervasive and difficult to change (Lloyd, 2010), thus, respondents' attitudes should remain fairly constant between the short interval period of two weeks, proposed for this study. It is however impossible to remove confounding factors entirely, thus for this reason, and for the purpose of methodological triangulation, the method implemented in this study is part of a series of reliability tests performed on the scale, in an attempt to accurately confirm its stability, reliability and validity before using it for investigative purposes.

2.3.2.2 Respondents

Recruitment of respondents: A total of 50 respondents were contacted face-to-face and asked if they would voluntarily participate in the current study by completing the scale (data collection one). The same sample of respondents were then asked to complete the scale between one and two weeks later, and 43 completed scales were obtained (data collection two). This was an opportunity sample for the reason that respondents used in this study were members of the general public who were available at the time, to the researcher.

Attrition rate: The study produced a 14% attrition rate, as seven respondents from data collection point one, were unavailable to retake the scale at data collection point two.

Demographics of respondents: All respondents were recruited within the Buckinghamshire and Berkshire area. In terms of the gender composition, 29 were female (67.4%) and 14 were male (32.6%). The majority of respondents were in the age group 26 – 35 years (n=39.5%). The majority of respondents classified their ethnic origin as 'White British' (90.7%).

2.3.2.3 Ethical considerations

The current study was conducted on a sample of the general public. The general description of the study was explained to the sample and respondents were informed that they would be undertaking two questionnaires at different times (approx. one to two weeks apart) in the data collection process of this study. Respondents were not informed that they would be identical questionnaires, as it was felt that this could influence respondents' responses.

Respondents were not able to remain anonymous, as they had to be followed up at a later stage. Therefore respondents were asked to use an alias on the questionnaires, so that test and retest questionnaires could be identified and linked together. The use of aliases was decided upon, as it was felt that respondents would be more likely to remember a name, rather than an allocated number. No aliases were duplicated by respondents in this process. Consequently, respondents were assured that their true identities could not be revealed. The use of an alias thus improved confidentiality. Furthermore, respondents were informed that what was learnt directly from each respondent would not be revealed in association with their specific details.

Respondents were approached by the researcher, and asked if they would like to take part in the study. They were informed that they should not feel compelled to do so and that they could withdraw from the study at any time (as questionnaires were identifiable by the use of an alias). Respondents were reassured that they need not be concerned with their own individual performance in the study, as the researcher was looking at the performance of the entire sample. Respondents were informed that by reading the provided information sheet (informing them of the requirements of the study), and in returning their questionnaires, they were automatically consenting to participate in the study.

Formal ethical approval was granted by the Society and Health Faculty Ethics Committee at Buckinghamshire New University prior to the commencement of this study, and the researcher was covered for public liability insurance, should respondents require financial support in the way of counselling following the participation in this study. According to the British Psychological Society Code of Harm Research Ethics (2010) respondents should not be put under any greater harm than

they would normally be exposed to in everyday lives, and in this instance, psychological risk to respondents was considered to be minimal.

2.3.2.4 Measure

The ATIDDUS consists of twenty-five items which represent a wide range of attitudes towards illicit drugs and drug users, to which the respondents are asked to indicate whether or not they were in agreement with the statement. Favourability of attitudes was determined by respondents' overall scores to the attitude statements with which they endorsed, on the scale; high scores indicating a more favourable attitude and low scores indicating a less favourable attitude. Please see Appendix 2.1 for the full questionnaire.

2.3.2.5 Procedure

Three steps were employed to statistically test and then retest the ATIDDUS;

- Step 1 – The Test (data collection one)

Questionnaires, including the 25-item ATIDDUS and additional demographic questions, exploring respondents' gender, age and ethnicity, were handed out to 50 respondents. Information sheets were provided with the questionnaires, informing that; (1) respondents should adopt a pseudonym and mark the questionnaire accordingly, so that anonymity could be adhered to, and so that the two conditions could be linked together once the second condition had been completed, (2) respondents would be required to complete a second questionnaire between one to two weeks later (they were however, not informed that this would be the same scale repeated, as this knowledge may be a confounding factor that would intervene with individual differences between the two conditions), (3) respondents should indicate their agreement or disagreement to the 25-item attitude scale, by marking with a tick, those to which they agreed with, (4) respondents were giving automatic consent to participate in the study by completing and returning the questionnaires, (5) respondents had the right to withdraw. Please see Appendix 2.2 for the information sheet for study two.

- Step 2 – The Retest (data collection two)

The same questionnaire was distributed to the original set of respondents and took between one and two weeks to collate. This interval period was decided upon, in line with a study carried out by Marx, Menezes, Horovitz, Jones and Warren (2003), which sought to gain clarification as to the most effective time period between test and retest. They reported that both short and long time intervals potentially had disparaging effects on findings; short time intervals can negatively influence the retest results because of the effect that memory, practice and/or mood can have. Equally, longer time intervals can increase the chance that a change in status may occur in the respondent within this time, which is considered to be a compromise between recollection bias and unwanted clinical change. Whereas, anywhere in between two days and two weeks was sufficient enough not to compromise results.

Again, respondents were informed of the information as above, without the requirement to undertake a further questionnaire. At the second data collection point, seven of the original sample population had become unavailable to the researcher, and so, retest questionnaires were unable to be performed. Those original seven questionnaires were subsequently withdrawn from the study as test retest analysis was not possible.

- Step 3 - Investigating respondents' overall scores

Respondents' completed questionnaires from data collection point one and data collection point two were joined together through the aliases respondents had adopted. Respondents' overall scores from the test retest conditions were then quantified for statistical testing, and correlational analysis was performed. Shuttleworth (2008) purported that any correlation scores of $r = 0.7$ and above, and Kline (1993) that $r = 0.8$ and above, would be an acceptable Pearson's product moment correlation value, to demonstrate the stability and reliability of the scale at measuring respondents' attitudes towards illicit drugs and drug users; with high test-retest correlations indicating a reliable scale and low correlational scores indicating poor reliability of the scale (Pallant, 2007).

2.3.3 Results

2.3.3.1 Descriptive statistics

Figure 3: Histogram demonstrating distribution of general publics' scores from test

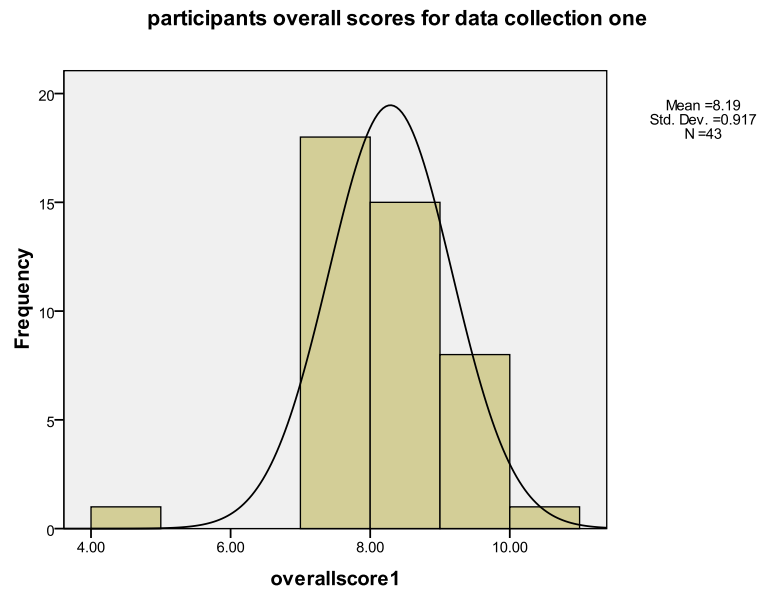


Figure 4: Histogram demonstrating distribution of general publics' scores from retest

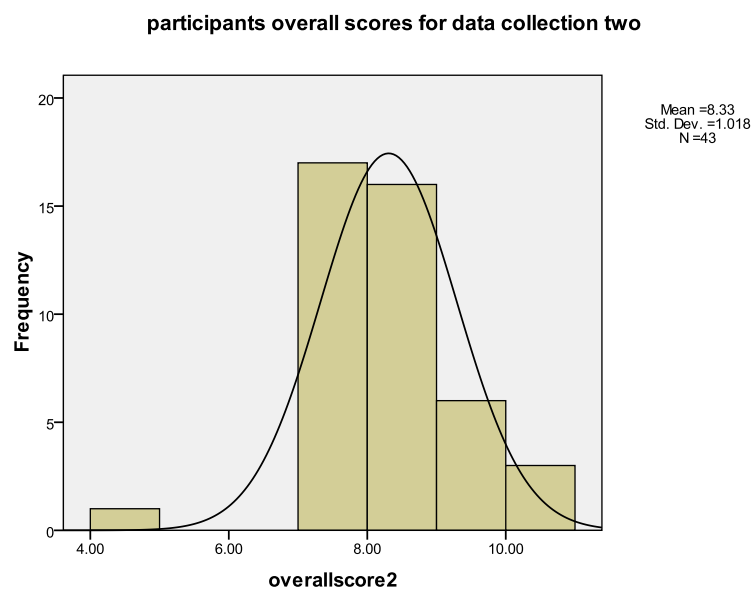
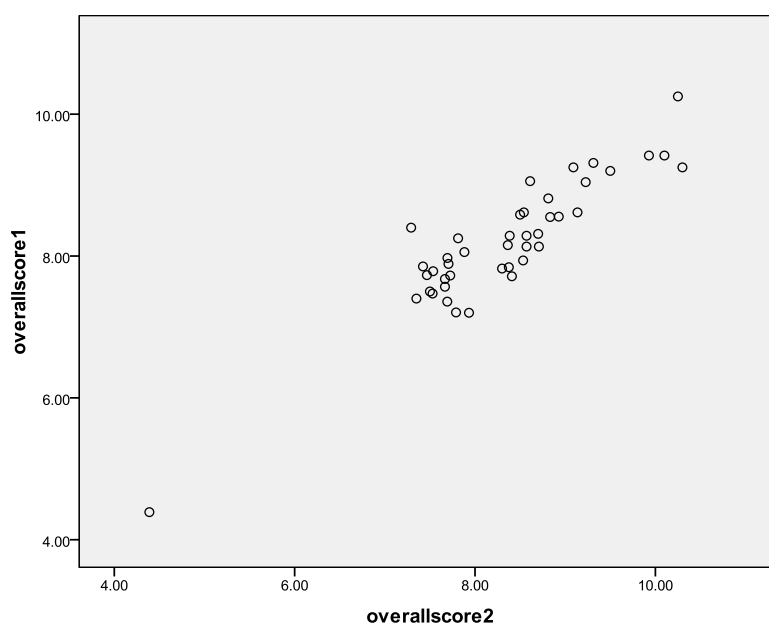


Table 2: Means and standard deviation comparisons from test and retest

	Mean	Standard Deviation
Test (data collection 1)	8.19	0.917
Retest (data collection 2)	8.33	1.018

There was no significant difference in the mean scores between the two conditions, which supports Petersen and Thurstones (1932) view that a difference in value of below 0.38 between scores was not sufficient enough to represent a difference in levels of favourability, thus indicating that the scale had not identified a significant change in attitude towards illicit drugs and drug users between test and retest.

Figure 5: Scatter plot of the correlation relationship between general publics' overall scores in test and retest

The relationship between the test and retest should be linear, as represented by a straight line through the scatter plots, as the graph above demonstrates. The scatter plot demonstrates that respondents' overall scores are clustered and arranged in a narrow linear shape, thus suggesting

that a strong linear correlation will be found. Furthermore, the scatter plot identified one low deviant score (mean = 4.39). Since the data analysis being conducted examined whether respondents' overall scores had changed from data collection point one, and data collection point two, this outlier need not be eliminated in the data analysis process, as its existence will not give misleading results.

2.3.3.2 Inferential statistics

According to Clarke-Carter (1997), the three main assumptions of Pearson's Product Moment Correlation test are that; (1) both variables are on interval level measurement and have at least 20 different values in the scale, (2) the variables are bivariately normal in the population, each variable will be normally distributed in the population and for each value of one of the variables, the other variable will be normally distributed, and (3) the scores in one variable will be independent, as they will not be influenced by other scores in that variable.

Thus, Pearson product-moment correlation coefficient was used for analysis as, (1) respondents' overall scores were derived from interval level data and the scale consisted of 25 items, (2) Statistical analysis was carried out to ensure that scores were normally distributed (known as 'assumptions of normality'), as demonstrated in the bell shaped curves on the histograms, had linearity, as demonstrated by the line of best fit across the scatter plot (figure 5), and (3) that the variability of scores from data collection point one should be similar to that of data collection point two (known as 'homoscedasticity').

Correlational analysis identified a strong, positive correlation between the two variables, $r = .918$, $r^2 = 0.84$, $n = 43$, $p < .0005$. This high correlational value indicates that the scale has good test-retest reliability, as Kline (1993) proposed that the correlational value needs to be $r = 0.8$ or above to demonstrate reliability of the scale, furthermore, that the minimum variance in which the results from the first data collection point, were accounted for by the variance in the second data collection point should be <64%. The reliability coefficient identified in this study was that 84% of variance in overall scores from the first data collection could be explained by the variance in the overall scores from the second data collection point, with which it was correlated. Subsequently, the findings from this study indicate that respondents' levels of favourableness towards illicit drugs and drug users had not changed significantly between each test. Therefore, the 25-item scale successfully measured respondents' levels of favourableness towards illicit drugs and drug users.

2.3.4 Discussion

The current study was conducted to establish whether the ATIDDUS had stability and reliability. According to Larkey and Knight (2002), this is measured by investigating how free from random error the scale is, whereby the level of reliability is indicative of how consistently the scale measures the variable of levels of favourability towards illicit drugs and drug users. As this reliability is most evident in repeated measure tests, the test-retest method was decided upon (Kline, 1993).

The fact that a strong, positive correlational relationship between the test and retest of $r = 0.9$ was found, not only indicates that the ATIDDUS had very good test-retest reliability, but also, that attitudes towards IDUs do remain fairly static over a short period of time (for example, a one to two week period). This is contra to Bohner and Wanke (2002) delineation that attitude is not constant, and is changeable over time (Kolman, 1938), and is supportive of Lloyd's (2010) claim that according to stigma theory, attitudes to substance misuse are pervasive and difficult to change.

2.3.4.1 Conclusion

The main findings from this current study showed that: (a) most respondents exhibited a fairly favourable attitude towards illicit drugs and drug users; (b) respondents' attitudes towards illicit drugs and drug users had not changed significantly over a two-week period, thus demonstrating the stability of the scale; (c) a strong linear correlation was produced between the two collection points, thus indicating that the scale was a reliable instrument for measuring respondents' levels of favourableness towards illicit drugs.

Although this current psychometric study provides good evidence of the scales reliability and stability as a measuring tool for levels of favourability towards illicit drugs and drug users, at this early stage the scale is still considered to be experimental and thus requires further validation testing before it can be used in an exploratory capacity within clinical practice to investigate actual and perceived favourability towards illicit drugs, and the impact that this may have on clients' drug treatment outcomes.

This study commenced the standardisation process of the ATIDDUS. The scale demonstrated good test retest reliability, and thus was found to accurately measure the general publics' levels of favourability towards illicit drugs and IDUs. The next study will thus continue the standardisation

process of the ATIDDUS, by examining whether it can accurately predict general publics' perceptions of the readiness for treatment, of hypothetical IDU clients.

2.4 Study three: The predictive quality of the ATIDDUS: a vignette study of general public and DTP attitude towards the rehabilitation of IDUs

2.4.1 Research Question and Objectives

Research question: Does the ATIDDUS display good predictive validity?

- To investigate whether the ATIDDUS has the ability to predict perceptions of treatment readiness, the notion being that these attitudes will influence the likely responses to a client irrespective of the characteristic of the user and the experience and characteristics of the respondent
- To investigate whether the individual differences of the client in the vignettes has an impact on respondents' levels of favourableness of their attitudes towards illicit drugs and drug users
- To investigate potential differences in respondents' scores, on the basis of demographic characteristics

2.4.2 Method

2.4.2.1 Design

This quasi-experimental study combines (1) the developed 'attitudes towards illicit drugs and drug users' scale, (2) a sub-scale from DeLeon and Jainchill's (1986) Circumstances Motivation Readiness Suitability (CMRS) scale, which has been used in the past to identify individual differences that predict readiness for treatment, and (3) a series of hypothetical scenarios, to investigate the developed scales ability to predict perceptions of treatment readiness.

In the hypothetical scenarios, the main character was a client presenting for drug treatment, and two characteristics of the client was manipulated; age (young or old) and drug of choice (cannabis and alcohol, or heroin), thus producing four separate scenarios. This design was employed to see if respondents' attitudes towards IDUs would consistently bias their judgment, with regards to perceptions of treatment readiness, across the four different hypothetical scenarios.

The characteristics of the client that were manipulated were chosen in accordance with findings by Soyez, DeLeon, Rosseel, Broekaert (2006) that age and drug severity were identified by the CMRS scale, as moderators for predicting retention. Furthermore, it was decided that gender would not be manipulated, as the majority of clients in drug treatment are male (NTA for Substance Misuse, Oct 2011), thus making the vignettes more representative of clients in treatment. Furthermore, the scenarios were disseminated to two sample groups, general public and DTPs, to see if differences in perception between the two groups was noticed, as, from a review of the literature, it was expected that DTPs would exhibit a more favourable attitude towards IDUs, than the general public because of the social stigma that is attached to drug using (Lloyd, 2010). Consequently, the study had three independent variables; 1) young/old, 2) heroin/cannabis and alcohol, 3) general public/DTPs.

Respondents were asked to complete the ATIDDUS and their overall scores represented the dependent variable. In addition, respondents were also asked to read one of the hypothetical scenarios, and indicate their perceived level of agreement on a Likert-scale, of the client's readiness for treatment, thus this study was a between-subjects design for the reason that respondents were exposed to one of the four conditions on only one occasion, so that they did not become aware of the differing variables which could have subsequently had an influence on their responses (Clarke-Carter, 1997). Demographic characteristics were also asked, so that potential differences in respondents' scores could be explored, on the basis of respondents' individual differences. The dependent variable was respondents' overall scores on the Readiness for Treatment scale. Respondents' scores on the ATIDDUS were used as the covariate in this analysis.

2.4.2.2 Respondents

Recruitment of respondents: Four hypothetical scenarios were created, from the manipulation of age and type of drug/alcohol used. In accordance with Tabachnick and Fidell's (2007) proposed method of sample calculation, at least 15 respondents for each manipulation was required. Furthermore, two sample groups were required; the general public and DTPs. Thus, a total of 60 respondents was required from both sample groups; at least 120 respondents in total.

In order to achieve a good response rate, Clarke-Carter (1997) proposed that questionnaires that were collected 'face-to-face', yielded a better response rate than postal questionnaires. For example, Cook, Dickinson and Eccles (2009) doctors' responses to healthcare postal questionnaires yielded on average, a 57.5% response rate. However, when the subject area is that of a sensitive nature, respondents are more likely to respond honestly when they can complete the questionnaire on their own and they can remain anonymous. For this reason, the researcher attended treatment services and disseminated questionnaires, allowing for DTPs' to complete the questionnaires and return immediately, or to return the questionnaires at a later date by self-addressed envelope (SAE). For the general public sample group, questionnaires were disseminated to undergraduate students at the university, and to members of public that were available to the researcher. Again, respondents were informed they could complete and return the questionnaire immediately to the researcher, or to return the questionnaire by post. This was therefore an opportunistic sample.

In addition, a study by Edwards, Roberts, Clarke, DiGuseppi, Pratap, Wentz and Kwan (2002) investigating methods of increasing survey response rates, identified several other factors that were utilised in the collection of this sample, in order to improve response rates; (1) the questionnaires were kept to a short length, (2) where questionnaires could not be returned directly to the researcher, a stamped return envelope was supplied, (3) questionnaires designed to be of more interest to respondents were more likely to be returned, thus it was expected that a good response rate would be found in DTPs, (4) questionnaires originating from universities were more likely to be returned, in comparison to commercial organisations, thus all paperwork supplied to respondents had the universities logo on them.

In accordance with Cook et al.'s response rate, it was decided that twice as many questionnaires than was needed would be disseminated, and should yield the required response of 15 questionnaires per hypothetical scenario, thus 240 questionnaires were disseminated (30 per vignette, was distributed).

Response rate: A total of 120 questionnaires were distributed to DTPs (these included 30 of each of the four vignette scenarios), and a further 120 were disseminated to the general public (again this included 30 of each of the four vignette scenarios). The study produced a 63% response rate, as 151 completed questionnaires were returned (76 DTPs and 75 general public).

Demographics of respondents: Approximately half of the sample was from the general public (51%) and half were DTPs (49%). In terms of the gender composition, 66.6% of respondents were female (33.3% gen pub and 33.3% DTPs), and 33.3% were male (17.7% gen pub and 15.6% DTPs). The age range of respondents was from eighteen to sixty-five.

Chi-squared analysis was then performed on respondents' demographic characteristics, to see if being from either the general public sample or the DTP sample, had an impact on differences in attitude. The analysis revealed that age and ethnicity varied attitudes between groups:

Gender: A Chi-square test for independence (with Yates Continuity Correction) indicted no significant association between gender and being in either the DTP sample, or in the general public sample: $\chi^2 (1, n = 151) = 0.03, p = 0.86, \phi = 0.73$.

Age: A Chi-square test for independence indicted there was a significant association between age and being in either the DTP sample, or in the general public sample: $\chi^2 (1, n = 151) = 14.24, p = 0.01, \text{Cramer's } V = 0.31$.

Ethnicity: A Chi-square test for independence indicted there was a significant association between ethnicity and being in either the DTP sample, or in the general public sample: $\chi^2 (3, n = 151) = 14.80, p = 0.002, \text{Cramer's } v = 0.33$.

2.4.2.3 Ethical considerations

The current study was conducted on two sample groups, the general public and DTPs, and the general description of the study was explained to them on the information sheet. Respondents were able to remain anonymous by not providing any personal details, as they were not followed up at a later stage. Respondents were approached by the researcher, and asked if they would participate in the study. They were informed that they were not required to do so, and should they participate, they could withdraw from the study at any time, up until they had returned their questionnaires (the anonymity of the questionnaires meant that returned questionnaires could not be traced to an individual). Respondents were informed that the researcher was only examining responses of the whole sample group, thus they need not be concerned with their own individual performances. Furthermore, that by reading the information sheet, and then by completing and returning the questionnaires to the researcher, that they were automatically giving their consent to participate in the study.

Formal ethical approval was granted by the Society and Health Faculty Ethics Committee at Buckinghamshire New University prior to the commencement of this study, and the researcher was covered for public liability insurance. Respondents were not considered to be put under any greater harm than they would normally be exposed to in everyday lives, thus psychological risk was considered to be minimal.

2.4.2.4 Measure

Three measures were included in this study and were presented to the respondents in the order outlines below. It is intended that these measures will identify whether the scale can be used to identify respondents' perceptions of readiness for treatment of potential clients, independently of other factors that might influence their judgment. Please see Appendix 3.1 for the full questionnaire.

Measure 1: The ATIDDUS

Two sample populations; the general public and DTPs were asked to complete the 25-item attitudes scale (ATIDDUS), in order to identify their levels of favourableness towards illicit drugs and drug users, as indicated by their overall scores to the scale (whereby, an overall score of 11 indicated a favourable attitude, and a score of 1 indicated a less favourable attitude). In the previous test-retest study, the average mean scores for respondents were 8.19, and 8.33 respectively, indicating that most respondents had a fairly favourable attitude.

Measure 2: The hypothetical scenarios (the vignettes)

The vignettes were developed from clinical experience, by the researcher, and depicted a client currently attending drug treatment rehabilitation. Aspects of the client that were manipulated were the clients' age (21-years or 50-years) and type of substance misuse (heroin or cannabis and alcohol). A Gunning (1952) Fog Index test of readability was carried out on the scenario prior to its use in the study, and the material was found to have a reading age level of approximately fifteen years.

Measure 3: The 'Readiness for Treatment' scale

To assess perception of the hypothetical clients' readiness for treatment, a sub-scale from DeLeon and Jainchill's (1986) Circumstances, Motivation and Readiness Suitability scale (CMRS) for substance misuse treatment, was employed. The 25-item CMRS questionnaire was originally developed for use with adults in a therapeutic community setting, to predict retention in treatment, and consists of four scales; Circumstances (to measure external motivations), Motivations (to measure internal motivation), Readiness (to engage in treatment), and Suitability (the perceived appropriateness of the treatment modality). Internal consistency of the Motivation, Readiness, and Suitability scales is adequate, with Cronbach's alphas ranging between .70 and .81; however, the reliability of the Circumstances scale was lower (approximately .44). For the total scale, internal consistency reliability is .87 (DeLeon, Melnick, and Kressel, 1997).

Respondents indicated their level of agreement to statements about the client's readiness for treatment on a 5-point Likert-scale, ranging from 'strongly agree' (with a score value of 5) to 'strongly disagree' (with a score value of 1). The statements included items such as: "Mr A needs to stay in drug treatment", "This kind of treatment programme is not likely to help Mr A". Generally, statements are worded positively towards the client being ready for treatment, however, on the few occasions where statements are worded negatively, scores were reversed by the researcher, before analyses of respondents' total scores were conducted (as per DeLeon and Jainchill's recommendations). A summation of respondents' responses thus indicates their level of agreement to the clients' readiness for treatment, with a higher score indicating a higher perceived readiness for treatment.

2.4.2.5 Procedure

Respondents were provided with a copy of the questionnaire, an information sheet and a self-addressed envelope, should they wish to return the completed questionnaire by post. The questionnaire included, one variation of the vignette, with a 'readiness for treatment' Likert scale, the 25-item ATIDDUS, and additional demographic questions, exploring respondents' gender, age and ethnicity. Information sheets provided with the questionnaires, informed that; (1) respondents should not make reference to their name on the questionnaire, so that anonymity could be adhered to, (2) respondents should read through the hypothetical scenario, and score the following statements about the scenario, out of 5, depending on how much they agreed with the statements (3) respondents should indicate their agreement or disagreement to the 25-item attitude scale, by marking with a tick, those to which they agreed with, (4) respondents were deemed to be indicating consent to participate in the study by completing and returning the questionnaires, (5) respondents had the right to withdraw. Please see Appendix 3.2 for the information sheet for study three.

Respondents were given a short account of a hypothetical situation of an illicit drug and/or alcohol using client accessing drug treatment, where factors of the clients' age (young or old) and drug of choice (cannabis and alcohol, or heroin) was varied across the conditions. The following example is that of the first hypothetical scenario of a younger client with alcohol and cannabis use;

“Mr A is a 21-year-old single, father of two. He no longer lives with his children, and before going into prison he usually saw them at weekends. He is not currently in employment, and has recently left prison following a 6-week custodial sentence for burglary. Mr A transferred straight from prison into a 12-week residential rehabilitation treatment programme, whereby he is in his second week. He has to reside, attend and actively participate in daily activities of treatment, group work and one-to-one counselling for his long-term cannabis and alcohol dependency, as well as abide by the rules and regulations of the rehabilitation centre, one of which being to abstain from drugs and alcohol whilst in attendance. It is expected of him that he will complete the full 12-week programme before he is allowed to go home. Although he is allowed to make telephone calls to his children, he is not allowed to visit them until the 12-week period of treatment is completed”.

2.4.3 Results

This study was carried out in combination with the ATIDDUS, to see if the scale can independently predict potential bias in individual's perceptions of a drug user's readiness for treatment.

2.4.3.1 Descriptive statistics

Table 3: Means and standard deviations for ATIDDUS and Readiness scale

	ATIDDUS	Readiness for treatment scale
All respondents	Mean = 8.34 SD = 0.88	Mean = 28.55 SD = 3.11
General Public	Mean = 8.06 SD = 0.92	Mean = 28.17 SD = 3.16
DTPs	Mean = 8.61 SD = 0.75	Mean = 28.92 SD = 3.04

2.4.3.2 Inferential statistics

Research questions and planned analysis:

1. *Does respondents' levels of favourability, as demonstrated by their overall scores on the ATIDDUS mediate respondents' perception of 'readiness for treatment'?*

A series of one-way between-groups analysis of variance was computed to explore the impact that each of the manipulated independent variables (age / nature of drug habit / sample group) had on respondents' perceptions of readiness for treatment, as measured by the CMRS scale.

Table 4: Significance values for the manipulated independent variables in the vignettes

Independent variable	Sign.	Effect size
Age	0.524	0.00
Nature of drug habit	0.746	0.00
Sample group	0.141	0.01

Analysis indicated no significant differences and small effect sizes in the manipulated independent variables, thus differences in age / nature of drug habit / sample group, did not impact on respondents perceptions of readiness for treatment.

2. *Do attitudes towards illicit drugs and drug users independently predict readiness for treatment when controlling for the effects of the variables manipulated in the vignette and the sample selected?*

A factorial analysis of covariance was then carried out to investigate whether the ATIDDUS (the covariate), had an impact on respondents' perceptions of treatment, in association with the manipulated independent variables (age / nature of drug habit / sample group).

After adjusting for respondents' scores on the attitude scale, no significant difference was found between the three fixed factors on readiness for treatment scores; $F_{(1,142)} = .498, p = .482$, partial eta squared = .003. Furthermore, there was no relationship between the ATIDDUS scores and the Readiness for Treatment scores, as indicated by a partial eta squared value. The fact that there was no relationship between respondents' levels of favourability (as measured by the ATIDDUS) and perceived readiness for treatment (as measured by the CMRS) was also confirmed by Pearson product-moment correlation coefficient: $r = 0.06, n = 151, p = 0.24$.

2.4.4 Discussion

Statistical analysis revealed that there was no relationship between the manipulated independent variables (age, nature of drug habit and sample group), and the perceptions of readiness for treatment. Furthermore, that the ATIDDUS also did not have an impact on respondents' perceptions of readiness for treatment. This finding implies that it does not matter what level of favourability towards illicit drugs and drug user a DTP has, it does not have an effect on their anticipated working attitude.

This finding fails to support that of previous literature, which indicated that DTPs' attitudes towards illicit drugs and drug users would be associated with the way they behave towards clients, because

of the fact that attitude generally predicts behaviour (Wickler, 1973). The view that attitude has both affective and belief components, suggests that attitudes and behaviour should be consistent, and as such, according to Fishbein and Ajzen's (1975) Reasoned Action Theory, attitude predicts behaviour. Thus, a relationship between positive attitudes towards IDUs and positive working attitudes should have been found. Yet, this was not found to be the case, and the study concluded that favourability did not have an effect on DTPs' working attitude.

This phenomenon may have occurred as individuals do not always behave in the way that they say they are going to behave. Fishbein and Ajzen (1980) later stated that intention to behave can be determined by a perception of how others will view their behaviour (known as 'social desirability'). Thus respondents may have self-reported a higher level of readiness for treatment to be socially desirable to the researcher. Furthermore, Moodley-Kunnie (1988) argued that belief of behaviour is not always a precursor to actual behaviour. Hence how a person says they will behave, is not necessarily the same as how they will actually behave. Therefore, noticeable disparity may be found between DTPs' self-reported working attitudes, and actual attitudes, and could potentially account for the lack of a relationship found in this study, between levels of favourability and readiness for treatment.

Furthermore, in reference to the DTP sample, according to the theory of symbolic interactionism, the self, identities and relationships with others are symbolic entities which are developed and changed through interactions with others (such as those that occur within the TA). Subsequently, time and experience would be needed in order to develop and gain meaning between favourability and readiness for treatment. Whilst this is possible in the DTP sample, the general public will not have had the opportunity to do so. However this idea only gives an explanation as to why it was the case that no relationship was found in the general public sample.

2.4.4.1 Limitation of the study

The readiness for treatment sub-scale from the CMRS was implemented in the current study because it was a pre-developed and used tool, promoting good internal consistency reliability, and appeared suitable for investigating perceptions to the hypothetical scenarios. However, in the past,

the CMRS had only been used to assess clients' own likelihood of compliance in treatment, rather than to explore perceptions of others' readiness (DeLeon, Melnick, Schoket, and Jainchill, 1993; Melnick, DeLeon, Hawke, Jainchill and Kresell, 1997; Handelsman, Stein and Grella, 2005; Soyez, DeLeon, Rosseel, Broekaert, 2006). Thus, although it was considered potentially suitable as a tool to investigate perceptions of others' readiness, perhaps the reason that it did not yield any significant findings was that it is perhaps best suited only to assess clients' perceptions of their own readiness for treatment.

2.4.4.2 Conclusion

The main findings from this current study showed that; (a) most respondents exhibited a fairly favourable attitude towards illicit drugs and drug users, (b) most respondents perceived a fairly good readiness for treatment in all hypothetical scenarios, (c) factors of a client's age, the nature of their drug habit, or whether the respondent was a DTP or from the general public, did not have an effect on respondents' perceptions of readiness, and (d) levels of favourability towards illicit drugs and drug users did not have an effect on DTPs' working attitude.

Thus, this current psychometric study did not provide good evidence of the scales ability to predict perceptions of treatment readiness. Consequently, respondents' attitudes towards illicit drugs and drug users did not influence their response to a hypothetical client. Similarly, characteristics of the client were also not found to influence perceptions of readiness for treatment. The scale is thus still considered to be experimental, and requires further validation testing before it can be used in an exploratory capacity within clinical practice to investigate actual and perceived favourability towards illicit drugs, and the impact that this may have on clients' drug treatment outcomes.

This study has furthered the standardisation process of the ATIDDUS, by examining the predictive qualities of the scale. Yet, it was not found to accurately predict general public and DTP perceptions of the readiness for treatment, of hypothetical IDU clients. The next study will further the standardisation process of the ATIDDUS, by examining whether the ATIDDUS can effectively measure levels of favourability in the general public, and whether individual differences in the sample population are found to moderate favourability.

2.5 Study four: General publics' attitude towards illicit drugs and drug users, and moderators that influence it

2.5.1 Research Question and Objectives

Research question: Can the ATIDDUS effectively measure levels of favourability in the general public, and do individual differences in the sample population moderate favourability?

- To examine the general publics' levels of favourableness towards illicit drugs and drug users, using the ATIDDUS
- To explore potential differences in respondents' scores, on the basis of their demographic characteristics and experience with illicit drugs and drug users
- To investigate the psychometric properties of scale distribution

2.5.2 Method

2.5.2.1 Design

A questionnaire method was used to collect the data, which was then used to compare respondents' overall mean scores of the 'attitudes towards illicit drugs and drug use' scale. Questions explored respondents' demographic characteristics (for example, age, gender and ethnicity), their levels of favourableness towards illicit drugs and drug users (the 25-item ATIDDUS), and their experience with illicit drugs and drug users (personal, working, family and/or friends' use). Respondents' levels of favourableness towards illicit drugs and drug users, was determined by their overall mean scores to the ATIDDUS. Potential differences in 'attitudes towards illicit drugs and drug users' scores between respondents on the basis of their demographic or experiential characteristics were explored with a series of one-way between-groups analysis of variance and post-hoc tests (in cases where variables had three or more groups).

2.5.2.2 Pilot study

A pilot study was initially conducted on five members of the general public to check that questionnaires were comprehensible to respondents (as per the instructions set out in the procedure section below). The demographic characteristics of the sample were that two

respondents were male, three were female, and all respondents were between the ages of 28 – 45 years. The pilot was conducted on a small sample from the intended target population of the current study, and respondents were not used again in the proceeding study (Clarke-Carter, 1997). No modifications were deemed necessary following this pilot study.

2.5.2.3 Respondents

Recruitment of respondents: The intended sample population for this study was the general public, and this sample was obtained by the distribution of a total of 500 questionnaires to undergraduate university students, colleagues and their associates, disseminated within the Buckinghamshire and Berkshire area. Subsequently, those that responded were a self-selected sample, for the reason that they had chosen to take part in this study. All potential respondents were provided with an information sheet detailing full instructions on how to participate in the study. Information sheets provided with the questionnaires, informed that; (1) all information collected in the study would be anonymous, (2) respondents were provided with a self-addressed pre-paid envelope with which to return their completed questionnaire, thus ensuring that questionnaires could not be identified. (3) respondents should indicate their agreement or disagreement to the ATIDDUS, by marking with a tick, those to which they agreed with, (4) respondents were giving automatic consent to participate in the study by completing and returning the questionnaires, (5) respondents had the right to withdraw, (6) respondents were thanked for their time in undertaking the questionnaire. Please see Appendix 4.2 for the information sheet for study four.

Response rate: A total of 224 (45%) questionnaires were returned, however three had to be excluded from the analysis process, as the ATIDDUS had not be completed. Thus, a total of 221 (44%) questionnaires were successfully completed and returned to the researcher.

Demographics of respondents: The majority of respondents were women (n = 134, 60.6%), and 18 people (8.1%) failed to specify their gender. In relation to ethnicity, the sample group was predominantly white UK; 157 reported to being of White ethnic origin (71%), ten classified themselves as Black (4.5%), 20 were Asian (9%), 11 recorded themselves as Other (5%), and 23 failed to specify their ethnic origin (10.4%). The sample group was divided into six groups in respect of age

differences; 18-25 years (n = 98, 44.3%), 26-35 years (n = 41, 18.6%), 36-45 years (n = 37, 16.7%), 46-55 years (n = 25, 11.3%), 56-65 years (n = 15, 6.8%) and 66+ years (n = 2, 0.9%). Three respondents failed to indicate their age group (1.4%).

Respondents' experiences of illicit drugs and drug users was also explored, with respondents reporting to having some personal experience as follows; 19 respondents reported to currently using illicit drugs (8.6%), 83 reported to having previously used illicit drugs (37.6%), 34 reported that they had current experience with IDUs (15.4%), and 56 had previous experience with IDUs (25.3%). A total of 35 respondents said that a family member was currently using illicit drugs (15.8%), and 80 respondents said that a family member had previously used illicit drugs (36.2%). There were 98 respondents that reported that they had a friend who was currently using illicit drugs (44.3%). Also, 129 respondents reported that they had a friend who had previously used illicit drugs (58.8%).

2.5.2.4 Ethical considerations

The researcher disseminated questionnaires to members of the general public, via University lectures and seminars, and to friends and colleagues available to the researcher. Thus the majority of respondents were not met on a one-to-one basis by the researcher, so all information regarding the study had to be informed by information sheet. Thus, the general description of the study, the fact that respondents would remain anonymous, and that they had the right to withdraw from the study without reason, up until questionnaires had been returned (as they were non-identifiable), were all informed via the information sheet. By reading the information sheet, and returning the questionnaires, respondents were automatically giving their informed consent to respondent in the study.

The researcher was granted formal ethical approval by the Society and Health Faculty Ethics Committee at Buckinghamshire New University prior to the commencement of this study, and hence was insured for public liability. Furthermore, psychological risk to respondents was considered to be minimal.

2.5.2.5 Measure

The ATIDDUS used in this current study to explore the sample populations' attitudes towards illicit drugs and drugs users scale, was developed in study one, using Thurstones (1928) method of equal-appearing intervals scale development procedure. The scale consists of a range of twenty-five favourable and unfavourable attitude statements towards illicit drugs and drug users, with which respondents can agree or disagree; respondents' resultant scores from the scale thus indicates their level of favourability towards illicit drugs and drug users.

This current study is a questionnaire using the ATIDDUS in order to test the properties of the scale. It has only been used previously to explore the scale's test-retest reliability, and to explore the scales predictive validity of DTPs' attitudes to hypothetical clients in work-related scenarios. Therefore, it will be the first time the scale has been used to investigate a sample population's levels of favourability towards illicit drugs and drug users, in relation to their potential differences of favourability in relation to respondents' demographic characteristics as well as their own experiences with illicit drugs and drug users. The questionnaire would thus elicit responses that could be analysed to reveal potential moderators that influence differences in favourability. Please see Appendix 4.1 for the full questionnaire.

2.5.2.6 Procedure

The scale was presented to respondents as a questionnaire, with additional questions to explore the sample population's demographic characteristics (for example, gender, age, ethnicity), as well as their experience with illicit drug use and drug users (for example, respondents current use of illicit drugs). Thus relationships between respondents' levels of favourableness and characteristic differences could be explored. The resultant empirical data collated from respondents' questionnaires was then statistically investigated through a series of one-way between-groups analysis of variance tests using the SPSS statistical package version 17.

2.5.3 Results

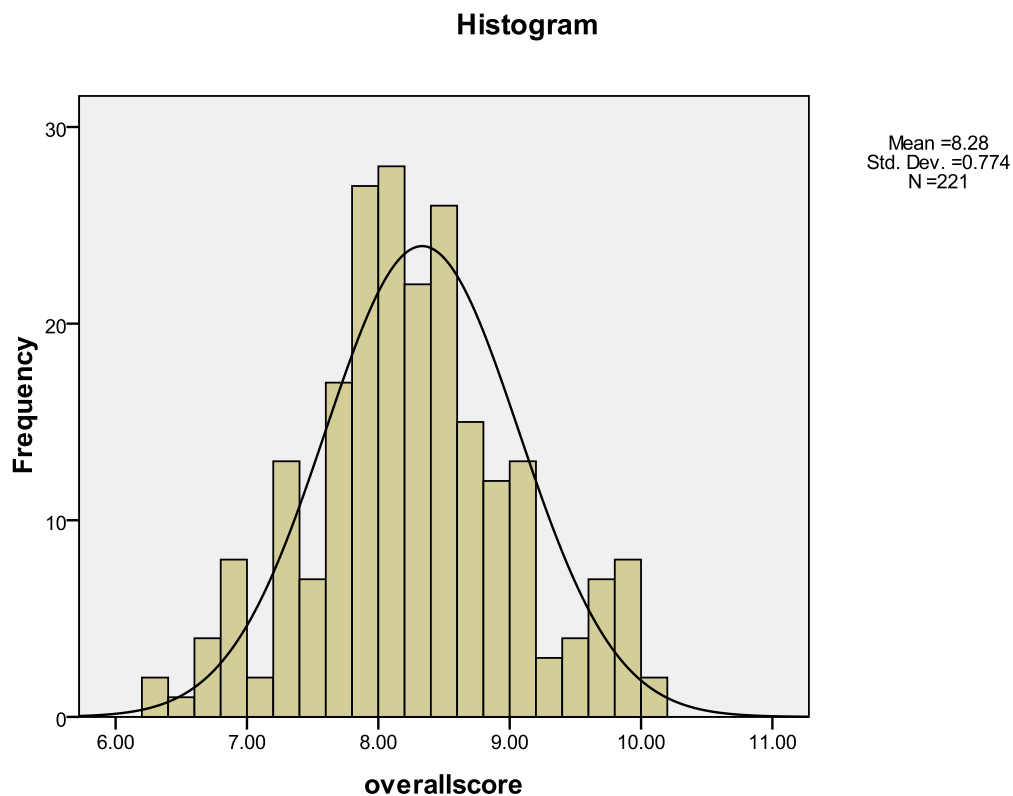
2.5.3.1 Descriptive statistics

Computation of descriptive statistics for the scale revealed that the average mean score value for all respondents was found to be 8.28, demonstrating that most respondents had quite a favourable attitude towards illicit drugs and drug users, since the possible range of score was from one to eleven. The standard deviation value (SD = 0.774) demonstrated that there was a relatively small variation in respondents' overall scores, and the range was, from the lowest overall score of 6.33, to the highest overall score of 10.13.

The mean score of 8.28 was central to the upper and lower bound values at a 95% confidence interval level (values reported as being; lower: 8.17 and upper: 8.38). This therefore indicates that respondents' overall scores were likely to be representative of 95% of the population (Field, 2000) as the confidence interval range values indicate whether there is confidence and certain probability that respondents' overall mean scores of the scale are representative of 95% of the population (Hinton, Brownlow, McMurray and Cozens, 2004).

Skewness values, giving an indication of the symmetry of the distribution of respondents' overall scores, and Kurtosis values providing information on the 'peakedness' of the distribution of scores, were reported to be 0.153 and 0.056 respectively. These score indicate that respondents' scores will be reasonably normally distributed (Pallant, 2007). Furthermore, Tabachnick and Field (2007) recommend that a histogram should also be used to investigate the shape of the distribution of scores to assess the normality of the distribution of scores.

Figure 6: Histogram of the frequency distribution of general publics' overall scores on the ATIDDUS



The histogram indicates that, although the overall scores ranged from the lowest of 6.33, to the highest of 10.13; the majority of the sample had a relatively favourable attitude towards illicit drugs and drug users.

2.5.3.2 Inferential statistics

A series of one-way between-groups analysis of variance was used to explore potential differences in respondents' levels of favourableness, on the basis of their demographic characteristics and experience with illicit drugs and drug users.

However, one-way ANOVAs assume that samples are obtained from populations of equal variance, meaning that there is sufficient variability of respondents' overall attitude scores for each of the variables investigated (Pallant, 2007). In order to accurately test for this, the Levene's test for equality of variance was carried out as part of the one-way analysis of variance. The data output of the Levene's tests carried out on each of the variables found no values <0.05 indicating that the assumption of homogeneity of variance was acceptable (Kinnear and Gray, 2000).

Table 5: ANOVA analysis results for paired comparisons of the general public sample

	Sign.	Mean comparisons	Mean score difference	Effect size
Gender	0.316	Male (M = 8.20, SD = 0.81), female (M = 8.31, SD = 0.76)	0.11	0.005 (small)
Age	0.469	26 – 35 yrs (M = 8.44, SD = 0.62), 66+ (M = 7.97, SD = 0.86)	0.47	0.02 (small)
Ethnicity	0.000**	White (M = 8.42, SD = 0.75), Black (M = 7.59, SD = 0.65)	0.83	0.12 (med – large)
Personal experience of current drug use	0.000**	Yes (M = 9.06, SD = 0.78), No (M = 8.20, SD = 0.73)	0.86	0.10 (medium)
Personal experience of previous drug use	0.000**	Yes (M = 8.54, SD = 0.80), No (M = 8.12, SD = 0.71)	0.42	0.07 (medium)
Currently working with drug users	0.004**	Yes (M = 8.63, SD = 0.80), No (M = 8.21, SD = 0.75)	0.42	0.04 (small – med)
Previously working with drug users	0.007*	Yes (M = 8.52, SD = 0.77) No (M = 8.20, SD = 0.76)	0.32	0.03 (small – med)
Vicarious experience of family member currently using	0.248	Yes (M = 8.46, SD = 0.70), No (M = 8.23, SD = 0.78)	0.22	0.01 (small)
Vicarious experience of family members previously using	0.007*	Yes (M = 8.50, SD = 0.79), No (M = 8.14, SD = 0.74)	0.39	0.04 (small – med)
Vicarious experience of friends currently using	0.009*	Yes (M = 8.45, SD = 0.82), No (M = 8.15, SD = 0.73)	0.30	0.04 (small – med)
Vicarious experience of friends previously using	0.016*	Yes (M = 8.40, SD = 0.76), No (M = 8.09, SD = 0.76)	0.31	0.04 (small – med)

N = 221 respondents

* = p <.05; ** = p<.005 are the significance levels found

Significant differences:

The table above indicates that eight characteristics were found to significantly influence general public favourability; (1) ethnicity (those with white ethnic origin, exhibited more favourability): $F_{(3,194)} = 8.534, p = 0.000$, accounting for 12% of the variance explained. (2) Personal experience of current drug use (those with personal experience of current use, exhibited more favourability): $F_{(1, 219)} = 23.207, p = 0.000$, accounting for 10% of the variance explained. (3) Personal experience of previous drug use (those with personal experience of previous use, exhibited more favourability): $F_{(1, 219)} = 16.877, p = .000$, accounting for 7% of the variance explained. (4) Currently working with IDUs (those currently working with IDUs, exhibited more favourability): $F_{(1, 219)} = 8.469, p = .004$, accounting for 4% of the variance explained. (5) Previously working with drug users (those who had previously worked with IDUs, exhibited more favourability): $F_{(1, 219)} = 7.471, p = .007$, accounting for 3% of the variance explained. (6) Vicarious experience, from family members previously using drugs (those with vicarious experience of family members previously using, exhibited more favourability): $F_{(2, 218)} = 5.062, p = .007$, accounting for 4% of the variance explained. (7) Vicarious experience, from friends currently using (those with friends who currently used, exhibited more favourability): $F_{(2, 220)} = 4.871, p = .009$, accounting for 4% of the variance explained. (8) Vicarious experience, from friends previously using (those with friends who previously used, exhibited more favourability) $F_{(2, 218)} = 4.242, p = .016$, accounting for 4% of the variance explained.

Mean score comparisons:

Petersen and Thurstone (1932) reported that differences in mean scores of >0.38 were sufficient enough to represent a difference in levels of favourability. In comparisons between the highest and lowest mean scores for each variable, these were discovered in; age, ethnicity, current personal use, previous personal use, currently working with IDUs, family previously using illicit drugs.

Effect size:

Partial eta squared effect size was calculated to indicate the proportion of variance of each dependent variable, that was explained by respondents' overall level of attitude towards illicit drugs and drug users. Small effect sizes account for approximately 1% of the variance explained; medium effect size accounts for approximately 6% of the variance explained, and a large effect size accounts

for approximately 13.8% of the variance explained (Pallant, 2007). Characteristics that were found to influence the general public favourability of ethnicity and personal experience of illicit drug use, were shown to have large effect sizes, and thus, accounted for a large proportion of the variance explained. Whereas, characteristics of personal experience of previous drug use, currently working with drug users, previously working with drug users, vicarious experience of family members previously using drugs, friends currently using, and friends previously using, were shown to have medium effect sizes, and thus accounted for a medium proportion of the variance explained.

2.5.4 Discussion

The rationale for conducting the current study was to carry out comparative analysis on the newly developed ATIDDUS exploring potential differences in attitudes based on demographic and experiential characteristics. Firstly, to see if respondents' differences impacted on levels of favourability. Secondly, to investigate whether individuals with a personal history of substance misuse or vicarious experience of illicit drug use, via friends and family members, may be particularly drawn into the profession of working with IDUs. Furthermore, by gaining a base line level of favourability in the general public, future sample populations can thus be compared.

2.5.4.1 Summary of findings

The results of the investigation showed that overall, the majority of the population sample in the study had a favourable attitude towards illicit drugs and drug users. This was demonstrated by the samples overall mean score from the scale, being a value of 8.28, from a possible one to eleven score rating; a score of one indicating a very unfavourable attitude, whereas a score of eleven indicates a very favourable attitude towards illicit drugs and drug users. Furthermore, the low standard deviation score found ($SD = 0.774$) that respondents' scores were very similar in rating, and for this reason, it can be concluded that the majority of the sample had a favourable attitude.

When respondents' individual differences were investigated using a series of one-way ANOVAs, a number of statistically significant differences were discovered, indicating the following individual differences impacted on respondents' levels of favourability. These were; (1) ethnic differences – the White ethnic group had a more favourable attitude towards illicit drugs and drug users, than those from Black and Asian ethnic groups, (2) respondents' current use of illicit drugs - those who

currently used illicit drugs, had a more favourable attitude, than those did not currently use drugs, (3) respondents' previous use of illicit drugs - those who had previously used illicit drugs had a more favourable attitude, than those respondents who had not, (4) respondents' currently working with IDUs - those who were currently working with IDUs had a more favourable attitude, than those who did not, (5) respondents' previous experience of working with IDUs - those who had previously worked with IDUs had a more favourable attitude, than those who had not, (6) having family who have previously used illicit drugs - those with family who had previously used illicit drugs had a more favourable attitude, than those who did not, (7) having friends that currently use illicit drugs - those who had friends that were currently using illicit drugs had a more favourable attitude, than those who did not, (8) having friends who previously used illicit drugs - those who had friends who previously used illicit drugs had a more favourable attitude, than those who did not.

2.5.4.2 The results in context with previous research

Comparisons were made between the findings from this study, and that of previous research. Firstly, with the two demographic characteristics that did not yield a relationship between individual differences and levels of favourability; age and gender.

Age differences were not found to impact on levels of favourability. This finding concurred with that of the ESRC (2005) who reported an overall general acceptance of illicit drug use, observable cross-generationally. Gender differences were also found to not impact on favourability. Thus supporting Roberts (2009) findings of non-significant differences, in general public opinions towards drug addiction, between age groups and genders. However, conflicting research by Atha et al.'s (1999) suggested that there were notable differences in favourability between genders; with males having a more positive attitude towards marijuana than females. Although, males were also found in Atha et al.'s study, to be more likely to use marijuana, thus suggesting that experience may actually be affecting favourability, rather than differences in gender.

Furthermore, males have been found to be more open about their drug use, whilst females are more likely to conduct their use in privacy (Ortiz, 2006). This is probably as a result of illicit drug use being more widespread and socially acceptable in males rather than females. This suggests that women

may be using illicit drugs as much as men, but that it is hidden through fear of stigmatisation and social disapproval. Consequently, according to NTA online statistics (accessed May, 2012), women remain underrepresented in the treatment system, possibly through a desire not to be labelled as an IDU and stigmatised. Thus, if it is the case that experience affects favourability, the fact that no difference in gender were noted in the current study may have occurred because both groups have the same levels of experience.

However, favourability differences found between ethnic groups in this study, potentially suggest contra evidence to the notion that experience, rather than demographic difference, drives favourability. In the current study respondents from a White ethnic origin demonstrated a more favourable attitude towards illicit drugs and users. Similarly to that of the gender composition in treatment, this group forms the majority of clients in drug treatment (Kandel et al. 1983), as confirmed more recently by the NTA online statistics (May, 2012). Again, as with females, ethnic minority groups are less likely to present for treatment, because they are less willing to admit to substance abuse (Ott et al. 2003), in order to avoid stigmatisation (Kelly et al. 2010). Thus, it may be that illicit drug use is as prevalent in ethnic minority groups, but that it remains hidden. However, if this were the case, in accordance with the theory that experience drives favourability, it should then follow that there would be no difference found in levels of favourability between ethnic groups. Yet, differences were noted. Consequently, it may be that illicit drug use is not as widespread in ethnic minority groups in the UK, and this was supported by the 2009/10 British Crime Survey stating that adults from a White ethnic group (9.0%) generally had higher levels of any drug use than those from non-White background (5.8%) (NHS Information Centre, 2011). Thus, less personal and vicarious experience in ethnic minority groups equated to lower levels of favourability, hence supporting the notion that experience drives favourability.

Personal and vicarious experience, in relation to levels of favourability, was then more directly explored in the current study; by investigating respondents own personal experience with illicit drugs, whether they had ever worked with IDUs, and whether they had experience of family and friends using illicit drugs. This analysis highlighted a number of statistically significant differences, thus providing more evidence to suggest that experience is a key feature of favourability.

The fact that current and previous use of illicit drugs was found to impact on favourability; those with experience demonstrating a more favourable attitude, concurred with existing research by Parker et al. (1998) and Martins et al. (2005) who also found that personal use of illicit drugs associated with the improvement of favourability towards IDUs. Furthermore, having friends who used illicit drugs was also found to improve favourability, and this was supported by Parkers claims that having friends who used illicit drugs, was a factor associated with improving levels of favourability. This was similarly noted by the Drugs, Young People and Service Provision (2004) who reported that young people were more tolerant of illicit drug use among their peers. Furthermore, that young people using cannabis and ecstasy were more likely to have friends who approved of these drugs (Martins et al. 2005).

Having family members who had previously used illicit drugs was also found to improve levels of favourability, supporting findings by Ormston et al. (2010) who agreed that family members who had, or were using illicit drugs, improved favourability. However, the current study did not support the view that having a family member currently using, improved favourability. This discrepancy perhaps occurred as a result of the varying fiscal and emotional impact that a family members' continued use of drugs has.

The current study demonstrated that currently or previously working with IDUs improved favourability in respondents. From factors addressed in a review of the literature, this project hypothesised that DTP would demonstrate a more favourable attitude towards IDUs, however, an overall dearth of research on this specific area has yet to confirm or dispute this. The majority of pre-existing research is more general practitioner specific, with a number of studies demonstrating their low levels of favourability (Romney and Bynner, 1972; Cohen, Schamroth, Nazareth, Johnson, Graham and Thomson 1992; Melby, Boore and Murray, 1992; Blank and Nelles, 1993; McLaughlin et al. 1996; Carroll, 1996, McLaughlin et al., 2000; Mistral and Velleman, 2001; Saitz et al. 2002; Tang, Wiste, Mao and Hou, 2005, McLaughlin et al. 2006).

However, the findings from the current study demonstrate that those who have worked directly with IDUs, had a more favourable attitude, thus providing some evidence to this hypothesis.

Whereas, alternatively, research by Roberts et al. (1995) reported that a lack of contact with IDUs, in a working capacity, was found to associate with more negative attitudes. This suggests that the disparity between GP and DTP levels of favourability stems from their divergent levels of contact with IDUs; GPs having very limited contact, and DTPs having more time to build up a TA.

Thus, the pre-existing studies mentioned, concomitant with the findings from the current study, provide some evidence to suggest that both personal and vicarious experience with illicit drugs and users, is associated with improving favourability. This notion is supported by Allport's (1954) intergroup contact theory, which predicted that contact increases positive attitudes. This is particularly useful when dealing with stigmatised groups such as IDUs, as in accordance with Allport, contact is one of the most effective ways of reducing prejudice between majority and minority group members. This is achieved through the communication with others, eliciting an understanding and appreciation of another's perspective, which reduces issues of prejudice, stereotyping and discrimination.

Finally, the findings from the current study indicated that the general public exhibited a fairly favourable attitude towards illicit drugs and drug users. This finding disputes that of Reis et al.'s (1994), which found that over half of their general public sample population, when surveyed on the impact of anti-drug advertising, displayed a negative attitude towards IDUs (n=52%). Several years later, this was again supported in the MORI 2000 survey of attitudes to illicit drugs, reporting that which the general public had a fairly negative attitude towards illicit drugs and illicit drug use. This was exemplified in the majority disagreement to statements such as 'taking drugs is a matter of personal choice and should not be against the law' (n=69%) and, by respondents rating heroin dealing as a priority crime for policing. Similarly, Luty and Grewal (2002) also reported negativity in British public attitude to IDUs, regarding 'drug addicts' as not suffering from a mental illness, and being untrustworthy, deceitful and unreliable.

However, more recent research supports the findings from the current study, that the general public do not exhibit truly negative attitudes towards IDUs. The ESRC (2005) stated that the general public's attitudes towards illegal drugs in Britain were changing, demonstrated through the change in Britons' support of the legalisation of drugs over the past two decades. Roberts (2009) noted that

public attitude towards drug addiction and treatment appeared to be grounded in compassion, which was demonstrative in an overwhelming acceptance that IDUs needed help and support with addiction, and that the general public showed awareness that individual became addicted to illicit drugs because of problems in their lives. A possible reason why this shift of public opinion has changed over time is that the use of sensible recreational illicit drug use among young people has become much more acceptable and as common place as cigarette smoking and excessive drinking (Parker, Aldridge and Measham, 1998).

However, according to Roberts (2009), it was arduous to say precisely what the general public's opinions towards illicit drugs use was, because of the paucity of research in this specific area. This consequently promoted the commissioning of Roberts' public opinion poll, on behalf of Drugscope. The poll reported that one in five respondents had personal or vicarious experience with drug addiction (although the majority was vicarious). Furthermore, that public attitude towards drug addiction and treatment was grounded in compassion, as they showed clear understanding of the need for IDUs to have help and support with overcoming addiction. Furthermore, that people became addicted to drugs becomes of other problem in their lives. Roberts' research thus collaborated findings from previous research by Smart Justice (2006), who carried out a poll on adults from the general public that had been victims of crime. The study showed that half of the population sample thought that in order to reduce criminal behaviour, criminally active IDUs should be dealt with by way of community drug treatment programmes. Whereas, only a third said they should be imprisoned. This indicated that the majority of the population surveyed believed that criminally active addicts be dealt with by way of treatment, not punishment, which thus demonstrates a predominantly compassionate view towards IDUs.

However, Roberts warned that although the study had shown high levels of respondents with experience of illicit drug use and users, concomitant with an overall compassionate attitude from the sample, it should not be inferred that experience necessary equated to favourability. This was for the reason that further analysis indicated respondents' attitudes, with and without personal experience, was broadly similar. Similarly, that the attitudes of those with vicarious experience, were also broadly in line with those of the general public. Similarly, in this current study, the mean score values between those that had experience, and that did not, also appeared to be similar, as they predominantly all fell in the score value 8 category. However, in accordance with Petersen and Thurstone (1932), value differences between mean scores of 0.38 or above, were sufficient enough

to represent a difference in levels of favourability. Thus, noticeable differences in experience were represented in; current personal use, previous personal use, currently working with IDUs, family previously using illicit drugs. Furthermore, borderline differences were noted in; previously working with IDUs, friends currently using and friends previously using. This study thus concludes that these factors of experience impacted on levels of favourability. Consequently, Roberts concurred that personal experience should be considered as far more important as is generally recognised, as it is often the case that drug policy specialists generally believe that general public understanding of illicit drug use predominantly comes from the media and politicians, whereas this is not found to be the case.

2.5.4.3 Practical implications of the findings

The fact that individual differences, in terms of levels of personal and vicarious experience, have been found to have an influence on levels of favourability towards illicit drugs and drug users, could have considerable implications on the recruitment and training of DTPs. For example, it was found to be the case that those respondents with experience of IDUs, exhibited a more favourable attitude, thus it is possible to suggest that respondents with experience of illicit drugs will make the most effective DTP, particularly if they are themselves an ex-addict, as it may be that they are potentially more aware of the IDUs' situation, and thus, has a better understanding and empathy with their client. Alternatively, a more favourable attitude might have a negative effect, as it might be the case that clients respond better to unfavourable attitudes. Thus, at this stage it is not yet known what impact a favourable attitude will have on the treatment effect or the TA, and therefore, it is not possible to state that a DTP with a favourable attitude will necessarily make a more effective worker. There is thus a requirement for further research in the area of the treatment effect of a favourable, in particular, if lower favourable attitudes within the TA have a detrimental effect on drug treatment.

Furthermore, the conclusion that the more experience an individual has with IDUs, the more favourable their attitude, suggest that DTPs will have a more favourable attitude toward IDUs, than the general public. The findings from the current study that those respondents who worked with IDUs, exhibited more favourable attitudes, supports this notion. However, this is an area that requires more specific analysis, to confirm that DTPs have a more favourable attitude, and whether

factors relating to experience, such as length of time in employment, and levels of training, have an influence on this.

2.5.4.4 Limitations of the study

Two limitations of the study were identified:

Firstly, that the nature of the drug use in this study was perhaps not specific enough. Roberts (2009) specified that their survey related to drug addiction, whereas this was not as clearly defined in the current study. Instead, respondents were asked if they had experience of illicit drugs or drug users, with no explicit mention as to whether this was addiction or recreational use. Thus, there may well have been disparity between levels of favourability between respondents with recreational drug use experience, and those with addiction experience.

Secondly, that although the sample group in the current study was proposed as being the general public, the fact that some respondents claimed to be either currently, or having previously worked with IDUs, demonstrates that this sample group was not entirely specific to the general public. Thus, although the majority of the sample were from the general public (84.6% did not currently work with IDUs, and 74.7% had not previously worked with IDUs), the sample included a representation of DTPs (15.4% currently worked with IDUs, and 25.3% had previously worked with IDUs), which could have had influence on the overall level of favourability. Yet, the difference between the general public respondents, and the DTPs respondents was still significant enough to demonstrate that there was a noticeable difference in levels of favourability, in terms of significance values ($p = 0.004$, and $p = 0.007$ respectively).

2.5.4.5 Conclusion

The main findings from this current study showed that; (a) the general public exhibited a fairly favourable attitude towards illicit drugs and drug users; (b) DTP respondents exhibited a more favourable attitude than general public respondents, (c) ethnicity and a number of factors relating to experience with illicit drugs and drug users was found to influence levels of favourability towards illicit drugs and drug users, (d) most importantly, individuals with personal and vicarious experience with illicit drugs and/or drug users had a more favourable attitude than those who did not, (e)

finally, that the study was successful at standardising the ATIDDUS, for the main reason that the scale demonstrated discriminant properties that distinguished differing attitudes between divergent groups of people, on the basis of their familiarity with, and experience of illicit drugs and drug users.

This study has furthered the standardisation process of the ATIDDUS by identifying its capability of discovering favourability differences in the general public. Yet, it is not known at this stage whether DTPs will exhibit favourable bias towards IDUs, in comparison to this sample of the general public, and this needs to be further explored. The next study will utilise the ATIDDUS in clinical practice to examine current DTPs levels of favourability, and to identify individual differences in the sample population that moderate levels of favourability.

3 CHAPTER THREE: Moderators of favourability

3.1 Study five: DTPs' attitude towards illicit drugs and drug users, and moderators that influence it

3.1.1 Rationale

This study follows that of the previous study, and utilises the same methodology, to investigate a comparative sample group of DTPs. The purpose of the previous study was two-fold, (1) to carry out a comparative survey on the scale, before it could be used in clinical practice, (2) to identify levels of favourability towards IDU, in the general public. The previous study concluded that the scale had been successful at gaining the general public's levels of favourableness towards illicit drugs and drug users, and at identifying demographic and experiential characteristics of the sample population in which moderate their attitudes towards illicit drugs and drug users. Subsequently, the purpose of the current study is to examine DTPs' levels of favourability, and to identify any potential moderating factors that influence levels of favourability towards illicit drugs and drug users.

The scale identified that the general public sample had a more favourable attitude than expected. This was in contrast to research identified in the literature review, such as the MORI survey of 'Attitudes to Illicit Drugs' (2000) which demonstrated that the general public had a fairly negative attitude towards illicit drugs and illicit drug use, and in studies by Luty and Grewal (2002) who reported negativity in public opinion to people with drug dependency. More recently, public opinion showed concern for drug abuse, and did not support the notion that specific substances should be legalised as the best course of action (Morris, 2010). Therefore, the following study used the developed scale to explore the levels of favourability towards illicit drugs and drug users, within the TA, between DTPs and clients in order to answer the part of the research question that proposes that DTPs have a more favourable attitude towards illicit drugs and drug users than the general public.

In order to investigate whether favourable bias has an impact on treatment outcomes, it was first necessary to investigate the general public's level of favourability, which was discovered to be higher

than anticipated. This finding supported research by the ESRC's (2005), study measuring the changing attitudes towards illegal drugs in Britain. The study reported that there had been a shift in support of the legalisation of drugs over the past two decades (12% in 1983 supported legalisation, compared to 41% in 2005), suggesting that public attitude is improving, possibly as a consequence of the 'normalisation' of some illicit drugs (Parker, Aldridge and Measham, 1998).

Furthermore, the ESRC (2005) study reported that this acceptance of illicit drug use is observable cross-generational, with the suggestion that it is the public perception of drugs' harmfulness that is causing the relaxation of public opinion; in particular, the research reported that cannabis is now believed to be less addictive and harmful, and a cause of crime and violence, than was previously believed by the public. In accordance with the previous study identifying that experience improved attitudes, a shift in the general public's attitude may have occurred as a result of the general public having more personal and/or vicarious experience with illicit drug use. For example, a survey conducted in the UK, demonstrated that one-fifth to one-quarter of the samples had personal knowledge of someone with drug addiction (Roberts, 2009; Crisp, Gelder, Goddard, and Meltzer, 2005).

However, in order to see whether DTPs exhibited favourable bias towards IDUs, the same study needs to be conducted on a sample of DTPs; their level of favourability can be confirmed by comparing it to that which was identified in the general public study. The general public study identified moderators that influenced favourability, thus the current study will also explore similar individual differences in terms of the effect they have on levels of favourability. Furthermore, since both personal and vicarious experience of drugs and drug users was associated with more favourable attitudes, it is anticipated, that DTPs will have more favourable attitudes than the general public due to their more extensive experience with drug users. However, it is recognised that it may also be the case that DTPs hold less favourable attitudes, due to factors associated to working with IDUs for many years that might elicit feelings of despondency, negative attitudes, or burnout (Kirk-Brown et al., 2004).

The literature review highlighted a need to identify DTPs' levels of favourability towards IDUs, because of the disparity between studies asserting that those who work with IDUs will have a more favourable attitude and those that report that workers will have a less favourable attitude (Peckover and Chidlaw, 2007). This is particularly exemplified in the studies that have looked at the relationship between experience and favourability. In accordance with Allport (1954) and Pettigrew and Tropp (2006), social contact reduces prejudice, thus experience should improve attitude. A view that was supported by Carroll (1996) who looked at attitudes within general healthcare, of staff working with IDUs, and reported that different levels of favourable attitudes towards IDUs were dependent on clinical grade; senior staff members demonstrated more favourable attitudes towards IDUs' than their lower grade counterparts. These findings imply that the longer an individual has worked within a service and has more experience they have, and the more favourable their attitude is likely to be. This is denoted by the assumption that in having senior positions, they are more likely to have been worked with IDUs for a longer period of time. This supports research on other stigmatised groups, indicating that increased contact with a stigmatised population, such as individuals with a disability, is associated with reduced negative attitudes towards that group (Herek and Capitanio, 1996, and Werth and Lord, 1992).

Alternatively, the more favourable attitudes might be related to the reduced time that staff in senior positions spend in direct contact with their client group and thus have less opportunity to form negative opinions or to experience burnout. This is for the reason that individuals who work directly with those who have experienced great trauma, for many years, are more prone to experiencing long-term exhaustion and diminished interest in the work they are undertaking (Kirk-Brown et al., 2004). Consequently, according to Miller et al. (2001), there is often a dearth of experienced DTPs in drug treatment services, because they reach burn-out quicker than generic healthcare workers. This is supported by Saitz et al. (2002) who demonstrated that staff working with IDUs were found to demonstrate lower job satisfaction, compared with any other health care provision, thus it might be the case that DTPs will have exhibit lower favourability. Greater long term exposure may lead to less favourable attitudes, as a consequence of the perceived fruitlessness of the role, whereby, DTPs are seeing the same clients coming back time and again, thus seeing few success stories. This can result in feelings of learned helplessness and perceived personal failures, as they feel powerless to control the situation.

3.1.2 Research Question and Objectives

Research question: Do DTPs exhibit favourable bias towards IDUs, in comparison to the general public, and do individual differences in the sample population moderate favourability?

- To examine DTPs' attitudes towards illicit drugs and drug users, using the ATIDDUS.
- To explore the characteristics of the sample population, in relation to potential differences in respondents scores on the basis of demographic characteristics and experience with illicit drugs and drug users.
- To investigate the psychometric properties of scale distribution
- To compare DTPs levels of favourability, with that of the general public sample
- To explore themes in DTPs' responses, related to drug treatment and the TA, which are considered to influence treatment
-

3.1.3 Method

3.1.3.1 Design

A cross-sectional survey was used to compare respondent's overall mean scores of the ATIDDUS and to investigate the potential moderating effect of a number of demographic and experiential variables. A series of one-way between-groups analysis of variance with post-hoc tests (in cases where variables had three or more groups) was carried out to explore the relationships between the sample population's characteristics and experiences with illicit drugs and drug users, in relation to respondent's overall mean scores on the ATIDDUS.

3.1.3.2 Respondents

Recruitment of respondents: The intended sample population for this study was a purposive sample of drug treatment workers, and the sample was obtained by the distribution of a total of 300 questionnaires, to 60 drug treatment organisations (including day centres, prescribing agencies, in-patient clinics, prisons with drug treatment facilities and residential rehabilitation centres) in London and the South. Please see Appendix 5.2 for the recruitment letter. Those who responded were a self-selected sample, for the reason that they had chosen to take part in this study. All potential respondents were provided with an information sheet detailing full instructions on how to

participate in the study. Information sheets provided with the questionnaires, informed that; (1) All information collected in the study would be anonymous. (2) Respondents were provided with a self-addressed pre-paid envelope to return their completed questionnaire, thus ensuring that no completed questionnaires could be identified. (3) Respondents should indicate their agreement or disagreement to the 25-item attitude scale, by marking with a tick, to indicate agreement. (4) Respondents were giving automatic informed consent to participate in the study by completing and returning the questionnaires. (5) Respondents had the right to withdraw. (6) Respondents were thanked for their time in undertaking the questionnaire. Please see Appendix 5.3 for the information sheet for study five.

Response rate: A total of 98 (32.7%) questionnaires were returned. No questionnaires had to be excluded from analysis, as all had been completed successfully. Postal questionnaires were implemented in the current study because they have been shown to be an effective means of data collation and preserving anonymity, in the field of illicit drug treatment, by their high response rate (Davies and Huxley, 1997). The study therefore used 98 self-selected respondents.

Demographics of respondents: The majority of the sample group were female (64% female, 36% male), and 81% were of a White ethnic group. There was a fairly even split between the two age groups in the sample, 49% were between 18 and 40 years, and 50% were 41 years and above (1% of the sample failed to specify their gender). The majority of the sample (N = 44%) had worked with IDUs for between five and ten years in total.

3.1.3.3 Ethical considerations

The current study was conducted on a sample of DTPs, and a general explanation of the study was made clear to respondents in the information sheet. Respondents were not met face-to-face by the researcher, as questionnaires were disseminated to service managers at drug treatment centres, with the request that they be forwarded on to potential respondents. Respondents were informed that they would remain anonymous, and that they did not have to participate in the study. Furthermore, that respondents could withdraw from the study at any time, until they had returned the questionnaires to the researcher. Respondents were also informed that in reading the

information sheet and returning their questionnaires, they were automatically giving their informed consent to participate.

The researcher was granted formal ethical approval by the Society and Health Faculty Ethics Committee at Buckinghamshire New University prior to the commencement of this study, and hence was insured for public liability. Furthermore, psychological risk to respondents was considered to be minimal.

3.1.3.4 Measure

In addition to the ATIDDUS, and questions relating to respondents' demographic, and experiential differences with IDUs and illicit drugs, some open-ended questions were included to explore aspects of treatment and the TA that were deemed to be influential in drug treatment. The questionnaire would thus elicit responses that could be analysed to reveal potential moderators that influence differences in favourability. Please see Appendix 5.1 for the full questionnaire.

3.1.3.5 Procedure

The scale was presented to respondents as a questionnaire, with additional questions to explore the sample population's demographic characteristics (for example, gender, age, and ethnicity), their experience with illicit drugs and IDUs (for example, length of time working with IDUs). Furthermore, respondents were asked the nature of their contact with clients, and to state which models of care (2002) tier their role provided. The NTA outline a four tier framework for the commissioning and provision of drug treatment. These include; tier one services providing the screening and referral of IDUs on to treatment, and include services such as GPs, social workers and probation. Tier two services provide open access treatment to IDUs, where they can engage in treatment but are not required to have a high level of commitment to the treatment. Service such as these include, needle exchanges, outreach and drop-in clinics. Tier three services provide more structured community-based treatment, with a commitment to attend, and include treatment such as counselling/key working sessions and structured day programmes. Tier four services provide residential treatment for those presenting with the highest needs, thus include services such as inpatient detoxes and residential rehabilitation centres. In ascertaining the type of tier service that the DTP work, and the

nature of their role, will allow for investigations to be made as to the type of contact they have with clients and whether it impacts on their favourability. Finally, some open-ended questions were also included, as discussed in the previous section.

The resultant empirical data collated from respondents' questionnaires was then statistically investigated through a series of one-way between-groups analysis of variance.

The process of data analysis of the open questions followed that of Braun and Clarke's (2006) guide for performing thematic analysis. The process requires that the qualitative data is first transcribed by the author; however, as these were written qualitative responses on a questionnaire, this process had already been carried out by the participants. Thus, analysis began with the proof reading and highlighting of key phrases (Sandelowski, 1995), of the responses. Braun et al. report that any relevant or appropriate comments were noted in this process, for later consideration of the themes and recurring ideas. Thus, the qualitative responses were collated together, to start looking for recurrent themes in the data set. When themes were then considered, Braun et al. proposed that the keyness and frequency with which information appears, was necessary. In addition, prevalence is also important, for example, themes that were repeated by different participants among the data set. Thematic analysis required a continual process of reading through the qualitative responses, searching for patterns, noting ideas and coding, with note taking throughout, until a list of themes were identified by their nature of being of interest, of repetition, or having fitted into categories. Subsequently, themes were identified and the collated extracts from the narrative were utilised to exemplify the claims and analysis made.

3.1.4 Results

3.1.4.1 Descriptive statistics

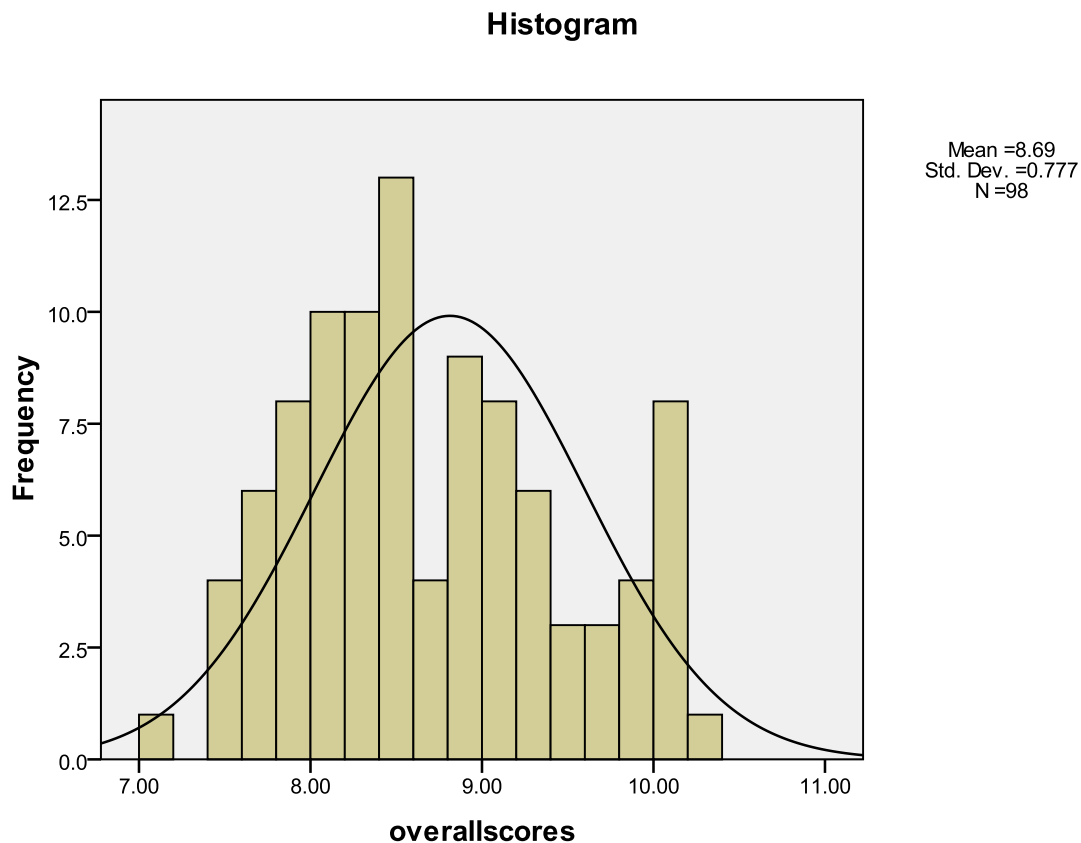
The average mean score value for all DTP respondents was found to be 8.69, demonstrating that most respondents had quite a favourable attitude towards illicit drugs and drug users. In comparison to the general public sample (mean = 8.28). Whilst this difference of 0.41 appears fairly small, Petersen and Thurstone (1932) report that a value difference of >0.38 between scores is sufficient

enough to represent a difference in levels of favourability. The standard deviation value ($SD = .777$) demonstrated that there was a relatively small variation in respondents overall scores, and the range was, from the lowest overall score 7.03, to the highest overall score 10.33.

Furthermore, the statistical data demonstrated that the respondents overall mean score was 8.69, which was central to the upper and lower bound values at a 95% confidence interval level (lower: 8.54 and upper: 8.85), indicating that respondents' overall scores were likely to be representative of 95% of the population (Field, 2000).

Skewness values, giving an indication of the symmetry of the distribution of respondents' overall scores, and kurtosis values providing information on the 'peakedness' of the distribution of scores, were reported to be 0.313 and -0.691 respectively. These scores indicate that respondents' scores will be reasonably normally distributed (Pallant, 2007). Furthermore, Tabachnick and Field (2007) recommend that a histogram should also be used to investigate the shape of the distribution of scores to assess the normality of the distribution of scores.

Figure 7: Histogram of the frequency distribution of DTPs' overall scores on the ATIDDUS



The histogram indicates that, although the overall scores ranged from the lowest of 7.03, to the highest of 10.33, the majority of the sample had a relatively favourable attitude towards illicit drugs and drug users.

3.1.4.2 Inferential statistics

A series of one-way between-groups analysis of variance was carried out on SPSS version 17, to explore a number of demographic and experiential variables on respondents' overall attitude scores based on their answers on the ATIDDUS.

The Levene's test for equality of variance was carried out for each of the one-way analysis of variance tests to investigate whether there was sufficient variability of respondents overall scores. Only one statistical significance value was found, for 'treatment type', which indicated that there was evidence of heterogeneity of variance, meaning that if a statistical difference had been found here, then the sample variances was unlikely to have occurred based on random sampling (however no statistical difference was reported).

Table 6: ANOVA analysis results for paired comparisons of the DTP sample

	Sign.	Mean comparisons	Mean score diff'	Effect size
Gender	0.629	Male (M = 8.74, SD = 0.86), female (M = 8.66, SD = 0.77)	0.08	0.002 (small)
Age	0.048*	18 - 40yrs (M = 8.86, SD = 0.64), 41yrs+ (M = 8.54, SD = 0.83)	0.32	0.04 (small – med)
Ethnicity	0.894	Asian (M = 8.88, SD = 0.81), White (M = 8.66, SD = 0.79)	0.22	0.007 (small)
Contact	0.031*	Keyworker (M = 9.00, SD = 0.75), Residential (M = 7.86, SD = 0.38)	1.14	0.21 (large)
Tier service	0.060***	Tier 3 (M = 8.80, SD = 0.69), Tier 1 (M = 8.14, SD = 0.75)	0.66	0.10 (medium)
Length in current role	0.761	0-1year (M = 8.76, SD = 0.89), 15years+ (M = 8.25, SD = 0.29)	0.51	0.02 (small)
Length working with IDUs	0.656	0-1year (M = 9.34, SD = 0.69), 15+ (M = 8.47, SD = 0.83)	0.87	0.06 (medium)
Previous use	0.850	No (M = 8.70, SD = 0.81), Yes (M = 8.67, SD = 0.76)	0.03	0.00 (small)
Strongest drug prev used	0.257	Cannabis (M = 8.92, SD = 0.71), Heroin (M = 8.40, SD = 0.83)	0.52	0.09 (medium)
Prev receiving treatment	0.530	No (M = 8.77, SD = 0.70), Yes (M = 8.28, SD = 0.87)	0.49	0.07 (medium)
Types of treatment rec'd	0.435****	Residential (M = 8.03, SD = 0.04), Counselling (M = 7.52, SD = 0.02)	0.51	0.31 (large)
Received training	0.471	No (M = 9.01, SD = 1.18), Yes (M = 8.68, SD = 0.77)	0.33	0.01 (small)
Training type rec'd	0.644	Work based (M = 8.75, SD = 0.75), Higher Ed (M = 8.48, SD = 0.58)	0.27	0.00 (small)
Training length	0.888	Combi (M = 8.70, SD = 0.73), Several years (M = 8.56, SD = 0.57)	0.14	0.00 (small)
Was training adequate	0.752	Yes (M = 8.69, SD = 0.76), No (M = 8.61, SD = 0.27)	0.08	0.01 (small)

N = 98 respondents* = p <.05; ** = p<.005; *** = Borderline at p<.05, **** = No sign diff, but large effect size

Significant differences:

The table above indicates that two characteristics were found to significantly influence client perceptions of DTPs' favourability; age (those from the younger age group, 18 – 40 years, exhibited more favourability): $F_{(1, 95)} = 4.023, p = 0.48$, accounting for 4% of the variance explained. Type of contact with IDUs (those who had regular key-working sessions, exhibited more favourability): $F_{(11, 85)} = 2.074, p = 0.31$, accounting for 21% of the variance explained. Furthermore, a borderline significant difference was found in the type of tier service that the DTP worked in (again, those who saw clients at regular key-working sessions, exhibited more favourability in comparison to those who saw clients on a daily basis in residential care): $F_{(4, 86)} = 2.358, p = .06$, accounting for 10% of the variance explained.

Effect size:

Partial eta squared effect size was calculated to indicate the proportion of variance of each dependent variable, that was explained by respondents' overall level of attitude towards illicit drugs and drug users. Small effect sizes account for approximately 1% of the variance explained; medium effect size accounts for approximately 6% of the variance explained, and a large effect size accounts for approximately 13.8% of the variance explained (Pallant, 2007). The characteristic of age was shown to have a small effect size, and thus, accounted for a small proportion of the variance explained. Whereas, the characteristics of 'type of contact' and 'tier service' were found to have large effect sizes, thus accounting for large proportions of the variance explained. Some characteristics demonstrated a moderate to large effect size, yet, no statistical significance was reached. However, as the sample size for this study was fairly small, these findings suggest that a slightly larger sample size might have in fact achieved statistical significance.

3.1.4.3 Qualitative responses

Several open ended questions were included in the questionnaire, in order to obtain richer qualitative data, of respondents' attitudes towards illicit drugs and drug users and beliefs on the usefulness of the TA. These questions included; aspects of treatment considered as being positive and negative and, treatment success for a client and a DTP.

Responses were thematically analysed, using the Braun and Clarke (2006), to look for recurring themes in respondents' responses;

Positive influences on treatment:

A number of positive themes emerged from respondents' responses as to aspects in the TA that were believed to facilitate effective drug treatment; firstly, respondents believed that it was possible for DTPs to successfully influence clients' treatment outcomes. A respondent conveying their own experience in drug treatment that had positively influenced their treatment at a residential rehabilitation centre commented that,

"a feeling of unconditional love from all, counsellors, doctors, nurses and even cooks. They were nice and warm, loving people. I was taken by surprise and returned that respect".(No. 24)

Furthermore that the *"on-going support"* (No. 62) and that the *"counsellor would listen"* (No. 66) all highlighted the importance of the DTP's input in the TA. When asked what their idea of success as a DTP, recurring themes in respondents' comments were to provide a supportive and trusting TA, as exemplified in the following statement,

"To provide a safe, empathic, non-judgemental environment" (No. 1)

Similarly, respondents believed that clients could influence their own treatment outcomes. This was highlighted in comments such as,

"(treatment) allowed me to confront and understand the demons and symptoms (that) I had been self-medicating over the years" (No. 45)

Negative influences on treatment:

Respondents appeared to be aware of the unhelpful nature that an unfavourable attitude within the TA, had on effective treatment. This was exemplified in numerous respondents' comments, for example,

"(Having) a dogmatic approach in treatment is unhelpful" (No. 46)

"controlling counsellor" (No. 66)

"counsellors using fear-based methods to control" (No. 66)

And,

"old AA style messages to control, i.e. if you don't listen to your group, or attend meetings you will die ..." (No. 66)

Furthermore, a lack of training and understanding of illicit drug use, in the role as a DTP, was also felt to obstruct treatment. Respondents who themselves had previously undergone drug treatment for illicit drug use, were asked to comment on what aspects of treatment they had experienced as being unhelpful. The statements forthcoming revealed a number of themes which included the clients awareness of a lack of knowledge in the practitioner,

"...batty bird thought she knew about drugs, and I thought what the hell does she know?"(No. 24)

And,

"...my doctor who didn't understand dependence and who failed to help in any way"
(No. 45)

A possible reason why clients found a lack of knowledge and understanding of illicit drug use in DTPs to be unhelpful, is that they may have felt that the information they were receiving was in inaccurate and thus detrimental to their progress, as demonstrated in the following statement,

"...people giving the wrong information" (No. 24)

3.1.5 Discussion

The rationale for conducting the current study was to explore DTP's attitudes towards illicit drugs and drug users, for levels of favourability, and potential moderators that may influence this favourability. This was carried out by asking respondents to complete the ATIDDUS, and to answer questions on their demographic characteristics and their current and previous experience with illicit drugs and drug users. Descriptive and inferential statistics were carried out on the resultant data, to explore the psychometric properties of the scale in terms of relationships between these variables and levels of favourability.

The results of the investigation showed that the DTP sample from the current study exhibited a favourable attitude towards illicit drugs and drug users. This was demonstrated by the samples' overall mean score of the scale being a value of 8.69 (the least favourable attitude being a score rating of one and the highest favourable attitude being a score of eleven). Furthermore, the low standard deviation score that was found ($SD = 0.777$), indicated that respondents' scores were very similar in rating, thus the majority of the sample was found to display a favourable attitude.

When this level of favourability was compared to that of the general public sample from study four (mean = 8.28), according to Petersen and Thurstone (1932) the difference between these two score values signified a noticeable difference in levels of attitude. Thus confirming that DTPs in this study, do appear to have a more favourable attitude than the general public, which is important in terms of treatment because, according to McLaughlin et al. (2000) IDUs' crave care and treatment, and

respond positively to treatment from staff members who are knowledgeable, understanding, caring and skilled. Furthermore, when this was explored in the qualitative questions on the questionnaire, respondents exhibited awareness that DTPs could successfully influence clients' treatment outcomes, as well recognising the unhelpful nature that an unfavourable attitude within the TA, had on effective treatment. Similarly, when asked what their ideas of success for a DTP, recurring themes in respondents' comments were "to provide a safe, empathic, non-judgemental environment".

This is a significant finding in terms of the TA, as research reviewed previously had neither confirmed nor denied that DTPs' actually exhibited a more favourable attitude towards IDUs, merely that it was perceived that DTPs' would have a more favourable attitude as exemplified in a study by McLaughlin et al. (2006) who reported that most general healthcare professionals displayed a desire for specialist drug services and DTPs to take over the care of IDUs because they believed that DTP would have a more favourable attitude towards them and have the appropriate knowledge and skills to improve the chance of IDUs becoming dependency-free.

Relationships between respondents' levels of favourability and their individual differences were then explored by a series of one-way ANOVAs, to identify moderators that influenced favourability. The only demographic characteristics found to be significant was age; DTPs between the ages of 18 – 40 years were found to exhibit more favourable bias, than those who were in the 41+ years age group. This supports the hypothesis that non-discursive similarities within the TA can potentially influence favourability, because of the positive meaning associated to the alliance, through the process of identification (Stone, 1962). Thus, it could be expected that younger, male workers would exhibit more favourable attitudes, for the reason that the majority of clients in treatment are young and male (NTA for Substance Misuse, Oct 2011).

Yet, characteristics of gender and ethnicity did not yield a significant difference in levels of favourability. The finding that gender did not have an impact on favourability, supported previous work by Albers et al. (2002), who reported no associated differences in students' attitudes and perceptions of harm towards substance misuse, in males and females. The similarity in these

findings implies that simply being male or female does not necessarily equate to a more or less favourable attitude towards illicit drugs and drug users.

When the findings from the current study were compared to that of the previous study, which was conducted on a sample group of the general public, diverging results were noticed. The previous study reported that experience was found to have an influence on respondents' levels of favourability, whereas this was not found to be the case in the current study. Perhaps the disparity between these two studies was caused by the fact that the majority of the general public in the first sample, had not chosen to work with IDUs, whereas all of the respondents from the second sample were working with IDUs. Consequently, DTPs may be predisposed to have a more sympathetic nature towards IDUs (and this is supported by a comparison of the mean scores between the general public and the DTPs). However, this may have been gained over time, with experience. This notion was supported by a review of the literature by Lloyd (2010) and indicated that in the US, those staff electing to work with IDUs demonstrated more compassion to their clients, than staff that had not elected to work with users. Thus, motivation also appears to influence favourability.

One variable that was found to influence respondents' levels of favourability was the different types of working contact which DTPs had with IDUs. Furthermore, the different tier services that DTPs experienced IDUs in, was found to be nearly significant. Interestingly, both variables can be considered to be the same variable, as, according to the definition of a tier, from the Models of Care: for the treatment of adult drug misusers (2002), treatment services for IDUs can be grouped into four broad bands of tiers. Therefore, a 'tier', simply describes what type of drug treatment service it is, and thus provides knowledge as to the type of contact that the service will have with a client. For example, an individual attending a needle exchange service at a pharmacy (considered as a tier one service), will have far less contact with a regular DTP, than an individual in residential rehabilitation (considered as a tier four service). The fact that statistical analysis identified a significant difference in contact, and this was supported in the near significant difference found in tier types, indicates that social contact has an impact on favourability. This concurs with Allports' (1954) social contact hypothesis, that increased contact improves the relations between groups who are experiencing conflict. Consequently, contact reduces prejudice between majority and minority groups.

However, when this relationship was explored in further depth, it was found that key-worker DTPs exhibited a more favourable attitude, in comparison to residential rehabilitation DTPs. This finding suggests that one-to-one contact on a regular basis (for example weekly or fortnightly in key-working sessions) develops a good working rapport within the TA. Whereas, where contact between client and DTP is on a daily basis, such as is the case in residential rehabilitation centres, favourability is considerably lower, suggesting that there is a saturation point of contact. Thus, over exposure, from seeing one another on a daily basis, has the effect of reducing levels of favourability. This may occur, as members of staff who have daily contact with patients (such as in a residential rehabilitation environment), were purported to be those with least specialised training, according to Fuller and Unwin (2004). Consequently, low grade healthcare staff members, have been found to suffer from high levels of 'burnout' (Novak and Chappell, 1994; Porter, 1992). Gibbs, Beutrais and Surgenor (2010) found that high emotional exhaustion and low personal accomplishments was associated to burnout, and this had a significant impact on negative attitudes towards the patient. This perhaps relates to residential rehabilitation staff that see clients on a daily basis, because they are continually working directly with individuals who have experienced great trauma, thus resulting in feelings of despondency in their working life (Kirk-Brown et al., 2004).

The fact that contact influences favourability, was further supported by the results of a standard multiple regression analysis on recovered DTPs; levels of favourability were influenced by whether the DTP had previously undergone counselling as a means of overcoming addiction. This supports the notion that contact on a regular basis, influences both the client, and the DTP, by strengthening the rapport in the TA.

Consequently, it is the amount of contact that the DTP has with the client that influences favourability, which supports the theory of symbolic interactionism that meaning develops through contact with others, which improves rapport between one another (from Goffman's "presentation of self in everyday life", 1959). Furthermore, symbolic interactionism also states that a positive rapport will have a positive impact on treatment outcomes; however the treatment effect of a positive or negative favourable bias towards illicit drugs and drug users is not yet known at this stage of the research project, and will need to be explored.

Until the treatment effect of levels of favourability is known, it is not possible to claim that an individual with favourable bias would make a more effective DTP, than one with lower favourability. For example, although Stone's proposal that younger DTPs may develop an enhanced TA with clients' because of the non-discursive identification, according to Ormston et al. (2010), younger respondents display a less favourable attitude towards illicit drugs. Martin, Garske, Davis (2000) reports that this has an impact on the quality of the TA, and subsequently, worsens treatment outcomes. Furthermore, the fact that clients may be able to identify with their DTPs, may have a negative consequence on treatment. By acknowledging the similarities in combination with the realisation of how far removed the client is from their DTP, could negatively affect the client's self-efficacy, resulting in their putting up another potential barrier to treatment.

In addition, the previous study unearthed a number of variables that had a significant effect on favourability, and from these findings, it has been concluded that individual differences were found to have an influence on favourability towards illicit drugs and drug users and could have considerable implications on the recruitment of DTPs. However, the current study failed to identify any differences in demographic characteristics, or experience, thus suggesting that it is not possible to 'cherry pick' DTPs, based on their individual differences.

When standard multiple regression was performed to further explore ex-IDU DTPs' predictors of levels of favourability, the model was found to be statistically significant and accounted for 17.6% of the explained variance ($F_{19,97} = 2.093$, $p = 0.12$). The only variables found to statistically contribute to the model were, having previously been a user of cocaine, and having undergone counselling as a means of overcoming addiction. Furthermore, several borderline statistically significant trends were found. It was concluded that respondents' previous drug use, and treatment, impacted on their attitudinal levels towards illicit drugs and users; those who reported to previously using cocaine were slightly more favourable and those who had received counselling significantly less favourable.

3.1.5.1 Conclusion

The main findings from this current study showed that: (a) DTPs displayed favourable bias towards illicit drugs and drug users; (b) age was found to significantly influence favourability, with DTPs in the younger age group exhibiting a more favourable bias, than those from the older group. Also,

different levels of contact with clients was the only variable found to influence levels of favourability towards illicit drugs and drug users; (c) Personal and/or vicarious experience was not found to influence favourability, yet, types of contact with clients did; DTPs who had regular contact, such as weekly key-working sessions, exhibited more favourable bias, than DTPs who had daily contact, such as residential rehabilitation staff. (d) Contrary to the general public sample, experience was not found to influence levels of favourability, (e) respondents understood that DTPs could positively influence clients' treatment outcomes, and that unfavourable attitudes were unhelpful to the treatment process. However, at this stage it is not known whether clients are able to perceive favourable bias within the TA, and this needs to be further explored. The next study will again utilise the ATIDDUS in clinical practice, to examine whether current drug treatment clients can perceive favourable bias in DTPs, and whether individual differences in the sample population moderate this perception of favourability.

3.2 Study six: Client perceptions of DTPs' attitude towards illicit drug use and users, and moderators that influence it

3.2.1 Rationale

This study follows that of the previous study which reported that DTPs exhibited favourable bias towards illicit drugs and drug users, in comparison to the general public. Thus, the purpose of the current study is to identify whether drug treatment clients can potentially perceive differences in DTPs' attitudes towards illicit drugs and drug users and to determine whether their perceptions of perceived favourability, are systematically shaped by their own demographic characteristics and experience with drug treatment.

Perception is important to the theory of symbolic interactionism as, the interpretation of others has been highlighted as a key feature of how the self, identities and relationships are formed and adapted. Thus, clients' perceptions of their DTPs attitudes can potentially impact upon their treatment outcomes; if clients perceive negative attitudes then it is likely that they will be less successful in their treatment outcomes, in comparison to clients who perceive their DTPs as having

more favourable attitudes. This was supported by studies by Phillips and Bourne (2007) who reported that biased positive attitudes held by DTPs demonstrated a positive relationship with clients' drug treatment outcomes. That is, negative attitudes projected by DTPs, had a negative effect on clients' treatment (McLaughlin et al. 1996) and more favourable attitudes were associated with better treatment outcomes.

However, a review of the literature has highlighted debate as to whether clients are actually capable of accurately perceiving DTPs. This was exemplified in a study by Moodley-Kunnie (1988) investigating the attitudes and perceptions of healthcare professionals towards illicit drugs and drug users, which reported that there was a lack of consensus between DTPs' positive attitudes, and the negativity that they were perceived to display. These findings suggest that either, perception is not always accurate, or that belief is not a precursor to behaviour (as was argued by Fishbein and Ajzen, 1975, 1980).

However, in contrast, findings by McLaughlin et al. (2000) reported that clients' were capable of perceiving poorer care from general practitioners, in comparison to DTPs. Similarly, numerous studies have identified a relative lack of knowledge and training in DTPs (Soverow, Rosenberg and Ferneau, 1972; Beauvais, Spooner and Oetting, 1991; Gorman and Morris, 1991; King, 1997; King et al. 1998). According to McLaughlin et al.'s (2000) findings, these deficits were readily identified by about three-quarters of their illicit drug-using population sample, who claimed that they would often use this lack of understanding and knowledge to their advantage. Thus, the findings from these studies suggest that clients are in fact capable of accurately perceiving DTPs, even though DTPs have in the past been found to be unaware of how they are perceived by clients (McLaughlin et al. 2006).

The rationale for this study was to determine whether the modified scale can successfully elicit a range of perceived attitudes towards illicit drugs and drug users that might be held by DTP and to ascertain whether these perceptions are likely to be systematically biased by the client's own demographic and experiential characteristics. Furthermore, the questionnaire will permit a better understanding of the importance that the TA holds for the client.

3.2.2 Objectives

- To examine client perceptions of DTPs' levels of favourableness towards illicit drugs and drug users, using the ATIDDUS
- To investigate potential differences in respondents' perceived levels of favourability, on the ATIDDUS, on the basis of clients' demographic characteristics and their experience of current drug treatment interventions
- To explore themes in clients' responses, related to drug treatment and the TA, which are considered to influence treatment

3.2.3 Method

3.2.3.1 Design

An independent group design was used to compare respondent's overall mean scores of the ATIDDUS, thus indicating their perception of favourableness of their DTP, towards illicit drugs and drug users. A series of one-way between-groups analysis of variance with post-hoc tests (in cases where variables had three or more groups) was carried out to explore the relationships between the sample population's characteristics and experiences with illicit drugs and drug users, in relation to respondent's overall mean scores of the ATIDDUS. Furthermore, standard multiple regression was computed to investigate predictors of clients' perception of DTPs attitude.

3.2.3.2 Respondents

Recruitment of respondents: The intended sample population for this study was drug treatment clients, and the sample was obtained by the distribution of a total 300 questionnaires, to 60 drug treatment organisations (including day centres, prescribing agencies, in-patient clinics, prisons with drug treatment facilities and residential rehabilitation centres) in London and the South. The questionnaires were posted to the treatment services, and were asked to disseminate to their clients. Please see Appendix 6.2 for recruitment letter. Those that responded were a self-selected sample, for the reason that they had chosen to take part in this study. All potential respondents were provided with an information sheet detailing full instructions on how to participate in the study. Information sheets provided with the questionnaires, informed that; (1) all information

collected in the study would be anonymous, (2) respondents were provided with a self-addressed pre-paid envelope with which to return their completed questionnaire, thus ensuring that no completed questionnaires could be identified. (3) respondents should indicate their perceived agreement or disagreement of their DTP, to the 25-item attitude scale, by marking with a tick, those to which they believed their DTP would agree with, (4) respondents were giving automatic consent to participate in the study by completing and returning the questionnaires, (5) respondents had the right to withdraw, up until they returned the survey to the researcher (6) respondents were thanked for their time in undertaking the questionnaire. Please see Appendix 6.3 for the information sheet for study six.

Response rate: A total of 45 (15%) questionnaires were returned, however two had to be excluded from analysis, as the ATIDDUS had not been completed. Thus, the study used a purposive sample of 43 respondents, as the sample was selected from a predefined group of drug treatment clients, for the purpose of the study. However, as questionnaires were sent to drug treatment services and were asked to be disseminated to their clients, it was unknown as to how many questionnaires actually reached clients. It is possible that a number of organisations failed to distribute questionnaires, thus the response rate from genuine clients might potentially have been higher.

Demographics of respondents: There were more males in the sample than females (males = 86% and females = 12%), and the majority of the sample were of a White ethnic group (86%). The majority of the sample was in the 30 – 39 age group (56%), with an overall age range between 19 and 61 years. Eight respondents had used the treatment service for less than one month (19%), 21 had used the service between one month and one year (49%), 13 had used the service for over one year (30%), and one failed to specify. This sample reflects that of the population of IDU clients, as the latest figures (accessed from the NTA website, May 2012), report that 73% of clients in treatment are male, 83% are of White ethnic origin, and the average median age is 34 years.

3.2.3.3 Ethical considerations

The current study was conducted on a sample of drug treatment clients, and the general description of the study was explained to the sample in the information sheet. Respondents were not met on an

individual basis by the researcher instead questionnaires were posted out to treatment centres with the request to disseminate questionnaires to potential respondents. Thus, respondents were able to remain anonymous to the researcher, and they were not followed up at a later stage. The information sheet informed that respondents would remain anonymous. Further, they were informed that they were not required to participate, and that they could withdraw from the study at any time until they had returned the questionnaire to the researcher. In addition, that by reading the information sheet, and returning their questionnaire, they were automatically giving informed consent to participate in the study.

The researcher was granted formal ethical approval by the Society and Health Faculty Ethics Committee at Buckinghamshire New University prior to the commencement of this study, and hence was insured for public liability should any respondent require financial support, in the way of counselling, following the study. In accordance with the British Psychological Society Code of Harm Research Ethics (2010), respondents should not be put under any greater harm than they would normally be exposed to in everyday lives. However, in this study, psychological risk to respondents was considered to be of minor risk of distress, caused by the consideration of other peoples' opinions of their selves. However the benefits from the research, was considered to outweigh the potential psychological risk that respondents may be exposed to in the undertaking of this study. Nonetheless, potential psychological risk was safe guarded by providing respondents with the details of a list of relevant helpline and support groups, such as the Samaritans, and TalktoFrank.

3.2.3.4 Measure

In contrast to the previous study, the instructions for the ATIDDUS were amended to inform respondents, that they were required to consider and respond to the scale, in accordance with their belief of their DTPs' attitude towards illicit drugs and drug users. Similarly to the previously study, the questionnaire included questions on respondents' demographic and experiential characteristics, and some open-ended questions relating to aspects of drug treatment and the TA. The questionnaire would thus elicit responses that could be analysed to reveal potential moderators that influence differences in perceived favourability. Please see Appendix 6.1 for the full questionnaire.

The readiness for treatment Likert scale used in the questionnaire for respondents to rate their level of agreement to aspects of their own treatment, was adapted by the researcher from De Leon's (1993) 'Circumstances, Motivation and Readiness Scales for Substance Misuse Treatment', and had been previously used in this current project to assess hypothetical clients' readiness for treatment in the vignette study (study 3). In this study, the readiness for treatment scale was employed as a tool to draw further information from respondents, with which relational analysis to respondents' perceived levels of favourableness could be made, so as to investigate whether aspects of readiness for treatment had an impact on perception.

3.2.3.5 Procedure

The procedure follows that of studies four and five. However, contra to the previous studies, respondents were not asked to indicate their own agreement or disagreement to the attitude statements on the scale, instead, respondents were asked to consider their DTPs beliefs of the statements. Consequently, respondent's perception of their DTPs' favourableness towards illicit drugs and drug users was indicated by their overall mean scores, calculated from the scale; higher scores representing the perception of a more favourable attitude and lower scores representing the perception of a less favourable attitude for DTPs.

The resultant empirical data collated from respondents' questionnaires was then statistically investigated through a series of one-way between-groups analysis of variance. The process of data analysis utilised in this study, followed that of Braun and Clarke's (2006) guide for performing thematic analysis.

3.2.4 Results

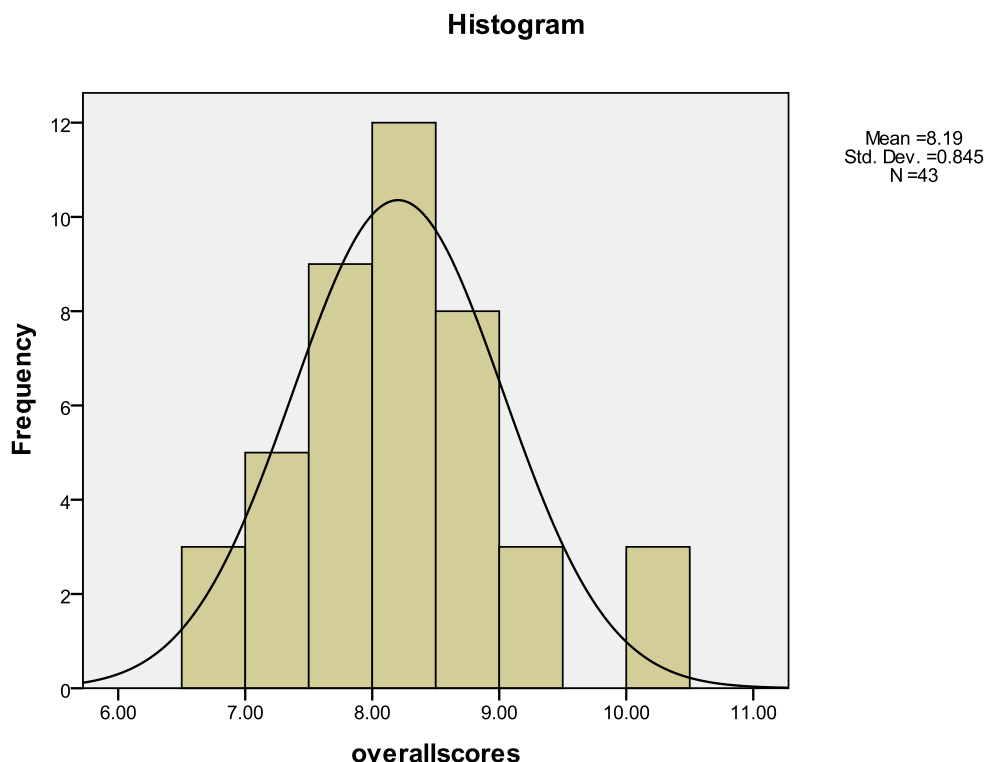
3.2.4.1 Descriptive statistics

An overall score from the scale was calculated for each respondent; higher overall scores indicated the perception of a more favourable attitude towards illicit drugs and drug users, whilst lower overall scores indicated IDU's perception of a less favourable attitude towards illicit drugs and drug users. The average mean score value for all respondents was found to be 8.19, demonstrating that

most respondents were found to perceive quite a favourable attitude towards illicit drugs and drug users from their DTPs on the Thurstone scale 'one-to-11' favourability continuum. However, the mean attitude of the clients (mean = 8.19), in comparison to the DTPs in study five (mean = 8.69), indicates a difference of 0.5, which represents that clients perceive their DTPs as holding a less favourable attitude than a group DTPs indicate their actual level of favourability towards illicit drugs and drug users to be. Petersen and Thurstone (1932) suggest that value difference of >0.38 between scores is sufficient to represent a difference in levels of favourability. The standard deviation (SD = 0.85) demonstrated that there was a relatively small variation in respondents' overall mean scores, and the range was from 6.65, to 10.17, with the upper and lower bound values at a 95% confidence interval level being 7.93 and 8.45 respectively. That is that 95% of the respondents' overall mean scores fell within this relatively narrow range (Hinton, Brownlow, McMurray and Cozens, 2004).

Skewness values give an indication of the symmetry of the distribution, and the skewness value found was 0.495, indicating that overall scores will be clustered towards the left side of histogram, demonstrating that the majority of respondents overall scores were of the lower values; known as a positive skew. In addition, the kurtosis value of 0.276 provided information on the 'peakedness' of the distribution of scores, which suggested that the distribution of overall mean scores demonstrated a relatively strong central peak. Since both the skewness and kurtosis values were very close to the value of 0, this indicates that the scores were reasonably normally distributed (Pallant, 2007).

Figure 8: Histogram of the frequency distribution of clients' overall scores on the ATIDDUS



The histogram indicates that, although the overall scores ranged from the lowest of 6.65, to the highest of 10.17, the majority of the sample perceived their DTP had a relatively favourable attitude towards illicit drugs and drug users.

3.2.4.2 Inferential statistics

A series of one-way between-groups analysis of variance was carried out on SPSS version 17, to explore the impact of a number of variables on clients' perceptions of DTPs favourability, based on their answers of the ATIDDUS.

The Levene's test for equality of variance was carried out for each of the one-way analysis of variance tests to investigate whether there was sufficient variability of respondents overall scores; all tests were not significant (all values $>.05$), thus demonstrating that the assumption of homogeneity of variance was not violated (Pallant, 2007).

Table 7: ANOVA analysis results for paired comparisons of the client sample

	Sign.	Mean comparisons	Mean score difference	Effect size
Gender	0.654	female (M = 8.38, SD = 0.53), Male (M = 8.20, SD = 0.87)	0.18	0.005 (small)
Age	0.152	18-40 (M = 8.30, SD = 0.88), 41+ (M = 7.39, SD = 0.71)	0.91	0.05 (small – med)
Ethnicity	0.567	Black (M = 8.62, SD = 0.43), White (M = 8.14, SD = 0.83)	0.48	0.03 (small)
Current use	0.003**	Yes (M = 8.69, SD = 0.67), No (M = 7.91, SD = 0.80)	0.55	0.20 (large)
Goal	0.388	Recreational (M = 8.52, SD = 0.55), Dependency-free(M = 8.20, SD = 0.83)	0.32	0.02 (small)
Tier	0.011*	Tier 2 (M = 8.73, SD = 0.65), Tier 4 (M = 7.79, SD = 0.85)	0.94	0.22 (large)
Length at service	0.896***	15yrs+ (M = 10.08, No SD) 11mths (M = 6.78, No SD)	3.30	0.50 (large)
Future use	0.997	No (M = 8.19, SD = .57), Yes (M = 8.19, SD = .89)	0	0 (none)
Referral	0.322	Other (M = 8.68, SD = 1.04), Self-referral (M = 8.11, SD = 0.89)	0.58	0.06 (medium)
Service referral	0.528***	Police (M = 9.40, No SD), Keyworker (M = 7.70, No SD)	1.70	0.57 (large)
Attendance	0.308***	Weekly (M = 8.68, SD = 1.02), Daily (M = 7.94, SD = 0.77)	0.74	0.14 (large)
Other service	0.302	Yes (M = 8.39, SD = 0.83), No (M = 8.09, SD = 0.85)	0.30	0.03 (small)

N = 43 respondents.

* = $p < .05$; ** = $p < .005$ are the significance levels found, *** = No sign diff, but large effect size

Significant differences:

The table above indicates that two characteristics were found to significantly influence client perceptions of DTPs' favourability; (1) whether or not clients were currently using illicit drugs or not (those who were currently using, perceived more favourability); $F_{(1, 40)} = 10.267, p = 0.003$, accounting for 20% of the variance explained. (2) The type of tier service the client was currently attending (those who attended a tier 2 service, such as open access services, whereby regular key-working sessions are available, perceived more favourability); $F_{(2, 37)} = 5.165, p = 0.11$, accounting for 22% of the variance explained.

Effect size:

Partial eta squared effect size was calculated to indicate the proportion of variance of each independent variable, that was explained by respondents' overall perception of DTPs attitude towards illicit drugs and drug users. Small effect sizes account for approximately 1% of the variance explained; medium effect size accounts for approximately 6% of the variance explained, and a large effect size accounts for approximately 13.8% of the variance explained (Pallant, 2007). Both characteristics that were found to influence clients' perceptions, were shown to have large effect sizes, and thus, accounted for a large proportion of the variance explained. Again, characteristics were found that demonstrated a moderate to large effect sizes, but had not reached statistical significance. As the sample size was fairly small in this study, but a good effect size was found, then, statistical significance may have been achieved with a larger sample.

Correlational analysis:

The relationship between respondents' perceived levels of DTPs' favourability (as measured by the ATIDDUS) and respondents' self-reported readiness to undergo drug treatment (as measured by the readiness for treatment scale) was then explored using Pearson product-moment correlation coefficient. However, no significant correlation was found: $r = -.065, n = 43, p = 0.677$, indicating that there was no relationship between a clients' perception of their own readiness for treatment and the clients perception of the DTPs' attitude towards illicit drugs and drug users.

3.2.4.3 Qualitative responses

Several open ended questions were included in the questionnaire, in order to obtain richer qualitative data of respondents' perception of treatment, and the TA. These questions included; how they considered the TA, the importance of the DTPs perception of their self, positive and negative aspects of drug treatment, and factors relating to treatment success.

Responses were thematically analysed for recurring themes in respondents' responses;

Positive influences on treatment:

A number of positive themes emerged from respondents' responses to aspects of the TA that were believed to facilitate effective drug treatment. The fact that respondents were self-selected, thus suggests the abundance of positive responses relates to their willing to express positive influences. Firstly, the majority of respondents reported that they had a good working relationship with their DTP, for example, respondents commented that the relationship was,

"Excellent, amicable, friendly yet professional" (No. 8)

And, that DTPs were believed to be empathic,

"He's down to earth and understanding" (No. 25)

Furthermore, in support of findings from the previous study, clients acknowledged that an important aspect of treatment was that DTPs were knowledgeable, for example,

"It is a positive relationship and he has a lot of experience from which I can draw" (No. 29)

Not only were relationships reported as being positive, but, respondents also claimed that they found the DTPs opinion to be extremely important. This was exemplified in comments such as,

"It is important to me as good comments from her give me a boost" (No. 2)

And,

"I can reassure myself. His opinion is important. I listen to what he has to say" (No. 29)

Furthermore, that the DTPs' opinion was deemed as being motivational,

"...quite important because it gives me the motivation and lets me know I'm worth helping" (No. 34)

Thus, in accordance with the theory of symbolic interactionism, these quotes support the notion that meaning is an important aspect of developing the self and identities.

In several cases, respondents reported that treatment not only helped with overcoming their physical addiction, but by addressing it cognitively too. This is exemplified in comments such as,

"I have managed to stay clean, (and) am learning to deal with my issues rather than mask them with drugs" (No. 17)

"Being able to detox(ify) and start dealing with my past life and feelings around it" (No. 16)

“Understanding my actions due to my emotions, good routine and accountability, give me a positive attitude to my future” (No. 23)

“I have built up my confidence and self-esteem and have a number of strong relationships” (No. 29)

“I’ve learnt to be responsible for myself and others and picked up a lot of life skills I never had” (No. 32)

And,

“Learning about myself, behaviour and attitudes towards drugs” (No. 31)

These aspects of treatment can only be achieved when the TA is considered as being supportive, and thus provides good evidence of the useful aspects that a positive TA can bring. Similarly, the desire for social reintegration appeared to be one of the motivating factors of addressing drug use, as exemplified in the following statements,

“to be able to function effectively both psychologically and in society” (No. 8)

“to be able to confidently enter society” (No. 8)

“to change one’s attitude towards drug use, as a coping mechanism” (No. 19)

“contribute positively to society” (No. 23)

“learn(ing) to cope without drugs” (No. 32)

And finally,

*“to fit back into the community with a job, housing and a future, to look forward to”
(No. 34)*

Negative influences on treatment:

However, contradictory findings were reported. When respondents were asked about their TA, some commented that it was,

“unstable” (No. 21)

And that,

“...I only see him once every 3 months, and then it’s only a quick “how are you” and a urine test, doesn’t help much” (No. 39)

This statement implies that non-frequent meetings between DTPs and clients, has a detrimental impact on the development of a positive TA.

Others regarded the TA to be an important part of treatment, but were more aware of its manipulative nature. One respondent commented that it was,

“...only in as much as, I get better treatment if, they have a good opinion”(No. 40)

Thus indicating the clients’ awareness of the importance of having a good TA, in relation to the impact that it had on gaining more useful treatment. Furthermore, respondents’ perception of the TA was marred by the understanding of power that DTPs had over clients,

"In some ways his opinion is important, as he has control over my life. He can take my script off me if he decided to" (No. 39)

And furthermore that,

"his opinion is very important as far as my recovery is concerned, personally doesn't really matter" (No. 23)

Therefore, indicating that at times, the DTP is being used merely at a practical level, rather than attaching any real personal meaning to the relationship.

3.2.5 Discussion

The rationale for conducting the current study was to examine clients' perceptions of DTPs' levels of favourableness towards illicit drugs and drug users, using the developed scale, and to investigate potential differences in respondents' perceived levels of DTPs' favourability, on the basis of their demographic characteristics and experience with drug treatment. This was carried out to see whether the ATIDDUS could successfully elicit a range of perceived attitudes towards illicit drugs and drug users that might be held by DTP. Further, to ascertain whether these perceptions were likely to be systematically biased by the client's own demographic and experiential characteristics. Consequently, a series of One-way analysis of variances were employed to look for these differences.

The results of this investigation showed that clients perceived their DTPs to possess fairly favourable attitudes towards illicit drugs and drug users in DTPs. However, this was lower than the level of favourableness of attitudes expressed by a group of DTPs in relation to reporting their own attitudes. This was particularly significant when comparisons were made to DTPs, as according to Petersen and Thurstone's (1932), value differences of >0.38 between attitude scores on the ATIDDUS represented a considerable difference in levels of favourability. This may have been found

for several reasons; firstly, that there was disparity between how DTPs viewed, or were perceived to view clients. Either DTPs pretended to hold more favourable views than they actually did, or, that clients were perceiving DTPs more negatively than their actual levels, possibly as a result of years of stigmatisation. However, this was not a direct comparison of DTPs favourability, and their own clients' perception of their DTPs favourable bias, thus the clients that the DTPs actually had, may have been different to those in this questionnaire.

It is not an uncommon phenomenon for disparity to occur between real and perceived attitude within the TA. Plaas (2002) and Shattell (2002) both highlighted differences between the general beliefs that nurses were regarded by patients in a positive manner, and the negative way in which patients actually described nurses. More specifically, Moodley-Kunnie (1988) reported a lack of consensus between DTPs' reported positive attitudes, and the way that they were negatively perceived. Such studies support the findings from the current study, and provide evidence for the fact that, either, perception is not always accurate, or that self-reported belief is not a precursor to behaviour.

One reason why perception may not be accurate is that individuals are often found to misperceive their personal abilities (Squintani, 2006). More explicitly to this sample group, is that illicit drug use has been stigmatised for so long, that the negative effect of stigmatisation impacts on the way in which clients perceive the reactions from others (Lloyd, 2010), which supports Goffman's (1963) argument that negative perception from others, whether they are accurate or not, occur as a result of the years of stigmatisation endured.

Perception is an important concept in the development of the self, as it affects the way in which individuals interact with one another, through the interpretation of others. Richmond et al. (1972) showed that individuals with high regard for themselves, regarded others in a more positive manner, thus IDUs, who, according to Heathertone, Kleck, Hebl and Hull's (2002), have a low opinion of themselves through years of stigmatisation, will perceive others in a less positive way, and this possibly explains why this sample perceived lower level of favourability than both the general public and in DTPs. Thus, in accordance with Festinger's (1954) social comparison theory, IDUs will

evaluate themselves in a negative manner, by making comparisons to the negative perceptions from others.

This implies areas of work to be addressed in treatment, in order to improve clients' perceptions of others, to that of how they are actually perceived. This would have a positive impact on treatment outcomes, as, according to Bandura (1997) individuals with higher levels of self-efficacy feel more in control of their life, and are thus, more likely to manage drug treatment more positively than individuals with low self-efficacy. Subsequently, self-efficacy has in the past, been instrumental in drug treatment, and has been incorporated into drug treatment programmes such as Marlatt et al.'s (1985) Relapse Prevention Therapy. RPT works on improving a clients' self-efficacy, by exploring high-risk situations for the client and assisting in developing coping strategies, so that the clients' belief in their own ability not to relapse will improve.

Not only do adjustments to treatment need to be made on behalf of the client to improve their awareness of others, but also improvements need to be made in terms of improving DTPs knowledge in this area, as DTPs have been shown to be unaware of how they are perceived by clients (McLaughlin et al. 2006). DTPs do not always appreciate the power that the TA has on the client, for example, Altschul (1971) demonstrated that nurses need to be made more aware of the factors within the alliance, relating to power, social and cultural aspects, and interpersonal competence, that have considerable influence on clients' treatment outcomes. This was exemplified by the fact that DTPs did not knowingly or willingly set out to have an unhelpful effect on the clients' treatment, however, unfavourable attitudes were found to result in the client feeling negative about themselves and the drug treatment they were receiving (McLaughlin et al. 1996). A potential consequence of this is that the client self-fulfils the prophecy of negativity, and behaves accordingly, even if the perception has been wrongly appraised.

It can be argued that care is needed to ensure that when working with this vulnerable group, that DTPs are aware of how they are actually perceived, along with the need for reflection, moderation and adaption, so that treatment is delivered in such a way that is understandable to its audience. The fact that symbolic interactionism believes that the development of the self is a work in progress,

and that perception is a key feature of how the self, identities and relationships are formed and adapted, suggests that it is possible to alter and improve perception of others. Therefore, if DTPs are made aware of the impact that their opinion can have on the client, then, DTPs can work on improving client perceptions of others.

Thus, the relational aspect of treatment appears to have a considerable influence on treatment success; not only was this established in the current study, but in the preceding study carried out on DTPs. In both studies, the type of contact, in relation to how frequently the DTP and client met, was found to have a significant impact on levels of favourability. In the previous study this was derived by the type of treatment service the DTP worked for, and in the current study, by the tier service the client was attending; both a derivative of the same thing, the amount of therapeutic contact being undertaken. Mean scores from both studies showed that when contact was on a regular basis, such as weekly meetings (i.e. key-working), then levels of favourability was reported as higher, in comparison to when contact was on a daily basis, at residential rehabilitation settings. These findings support symbolic interactionisms' notion that regular contact is needed to develop a rapport between two individuals, however, there appears to be a saturation point, whereby overexposure can cause an inverse effect in levels of favourability. Thus, Allport's (1954) social contact hypothesis purports that contact can also exacerbate and perpetuate prejudices in some cases. For example, DTPs may be threatened, or subjected to other abusive interactions that would reduce their levels of favourability.

According to Bem (1967), perception can be influenced by a variety of factors, including the intensity of the stimulus, thus, a difference between levels of favourability found in varying types of contact may be as a result of the divergent intensity and stimulus levels that contrasting treatment services have. Subsequently, different levels of favourability found between key working TAs, and residential rehabilitation TAs may occur as they provide completely different environments for a TA to develop. Similarly, another variable found to significantly impact on perceived levels of favourableness in the current study was clients' current use of illicit drugs, which again would be potentially influenced by the different stimuli experienced between those clients still using illicit drugs, and those that were dependency-free.

Furthermore, another reason why less favourability may have been found in rehabilitation centres is that according to Knaevelsrud et al. (2006), there is an inverse relationship between those patients with most severe problems, and, having a less positive therapeutic relationship. Thus, clients residing in rehabilitation centres will have potentially worse problems than those in key working sessions, due to the intensity of the treatment. Thus, clients in residential rehabilitation will have less of a positive relationship with their therapist, which is potentially why less favourability was found to be perceived in residential rehabilitation staff. This is supported by the notion that Models of Care (2002) declare that tier four, residential treatment is for those IDUs with the highest need. Consequently, they are likely to be the most chaotic, and potentially damaged. Thus, in accordance with Kirk-Brown et al. (2004) stating that many years working directly with people who have experienced great trauma, causes staff to have long-term exhaustion and diminished interest in work.

However, the similarities found in clients' perceptions of favourability in levels of contact, between the DTP study, and the current study, indicates that clients were in fact capable of perceiving the fluctuation in favourability between key-working DTPs and residential rehabilitation staff, the only difference is that they generally perceive this level of favourability to be lower. This is perhaps as a result of their awareness for the fact that IDUs are quite often negatively stereotyped.

Furthermore, when questioned on aspects of their treatment, clients also showed an awareness and perception of DTPs' levels of knowledge and training.

3.2.5.1 Conclusion

The main findings from this current study showed that: (a) clients generally perceived a fairly favourable attitude towards illicit drugs and drug users from their DTPs, (b) however, clients perception of favourability was significantly lower than a groups of DTPs levels of self-reported favourability, and (c) clients perception of favourability was also lower than that reportedly held by a sample from the general public. (d) different levels of therapeutic contact between client and DTP was found to impact on client perception of DTPs' level of favourability, (e) clients who had regular contact with DTPs perceived a more favourable attitude, and clients who encountered DTPs on a

daily basis had a less favourable attitude, suggesting that there is a saturation point of favourability (f) whether clients were currently using illicit drugs, had an impact on client perception of DTPs (clients who currently used drugs, perceived a more favourable attitude, than those that did not).

This study has found that current drug treatment clients underestimate favourable bias in DTPs. Furthermore, the ATIDDUS identified a number of individual differences that moderated perceived favourability. However, it is not possible to state at this stage the treatment effect that perceptions of favourability have. Thus, the next study will examine whether perceived favourable bias has an impact on clients' drug treatment outcomes, demonstrated by successful measures of ex-clients' reintegration into society.

3.3 Study seven: The treatment effect of ex-clients' perception of DTPs' attitude towards illicit drugs and drug users: an online, retrospective study

3.3.1 Rationale

This study follows that of the previous study which reported that drug treatment clients perceived a fairly favourable attitude from DTPs, although, at a significantly lower level than DTPs' actual self-reported levels of favourability. However, it is not yet known what effect DTPs attitude towards illicit drugs and drug users will have on treatment outcomes. Thus, the purpose of the current study is to identify whether there is a treatment effect from DTPs' favourability towards clients, and to identify which aspects of previous clients' measures of social reintegration, such as employment status, housing status, marital status and continued use of illicit drugs, that this may impact on. This will be carried out by retrospectively, investigating relationships between the perceived levels of favourableness of DTPs, from respondents who had previously undertaken drug treatment, and, potential treatment effect variables.

The decision to utilise a secure online database in the data collection process of this current study, came from Knaevelsrud et al.'s (2006) study of therapy conducted over the internet. Their study reported that the internet had been an effective method at engaging traumatised patients in therapy. Further, that they were able to establish a stable and positive therapeutic relationship online. Thus, the use of the internet was considered as potentially being an effective method of eliciting information from IDU, how could also be considered traumatised. Furthermore, Utz (2000) and Suler (2004) reported that individuals were more likely to self-disclose and be open and honest when there was visual anonymity, thus, the more private the method of data collection, the more likely respondents are to be open and honest in their responses.

The fact that IDUs utilise the internet, is reflected in the Narcotics Anonymous (NA) UK user forum currently reporting that they have 1731 forum users (in May 2012). Furthermore, treatment figures indicate that it is males who are more likely to have been in drug treatment than females (reported figures were published on the NTA website, accessed in May 2012). Thus, as Bimber (2000) reported that men use the internet more intensely than females, an online questionnaire design may potential be an effective tool at reaching this proposed sample group.

Respectively, online questionnaires of illicit drug use have in the past yielded good response rates; with Warburton et al. (2005) generating 123 respondents to an internet questionnaire investigating the views and experiences of heroin users. However, Warburton's study highlights the potential issue with online studies on drug addiction, of the assumed information that can be drawn from those respondents who choose to respond. For example, Warburton found that heroin users were keen to self-report that they did not consider themselves to be drug addicts, and wanted to avoid such a label. Thus, it can be assumed that those who chose to respond, did so because they felt strongly enough about such an issue, whereas, in comparison, those that did not respond, were perhaps continuing to use heroin, and as such, their chaotic lifestyles did not lend itself to having access to, or the desire to be involved with an online study on heroin use; consequently implying the need to utilise additional, alternative methodologies, in order to gather information from such a hidden population.

Modern technology today allows for the use of online web surveys, whereby a larger amount and variation of respondents can be reached. Therefore, methodologies utilising techniques where respondents can remain anonymous will inevitably not only yield a higher response rate, but more reliable results, as they will not be affected by adverse factors such as dissonance, expectancy and influence from the researcher's presence. On-line questionnaires are particularly helpful in reducing levels of felt shame on disclosure of potentially stigmatising information, and are associated with an increased sense of confidentiality and anonymity (Read, Farrow, Jaanimägi and Ouimette, 2009).

3.3.2 Research Question and Objectives

Research question: Is there a treatment effect of favourable bias, in relation to clients' drug treatment outcomes?

- To examine former-clients' retrospective perceptions of their DTPs' attitudes towards illicit drugs and drug users, using the ATIDDUS
- To investigate potential differences in former clients' retrospective perceptions of their DTPs' attitudes towards illicit drugs and drug users on the basis of their demographic characteristics and their experiences with previous drug treatment interventions

- To examine the treatment effect of perceived favourability, by investigating former clients' self-reports of current use of illicit drugs, criminality, health and socio-economic status, in association with their retrospective perceptions of their DTPs' attitudes towards illicit drugs and drug users

3.3.3 Method

3.3.3.1 Design

This was a cross-sectional, retrospective self-report web-based questionnaire exploring former drug treatment clients' perception of their DTPs' attitudes towards illicit drugs and drug users and their current psychosocial functioning (e.g. factors representative of social integration and self-efficacy). The purpose of a retrospective study is to firstly obtain the data in relation to the exposure and outcome, and then to establish if the suspected exposure had an effect on the outcome. A series of one-way between-groups ANOVAs was carried out to explore the relationships between the sample population's characteristics and experiences with drug treatment, in relation to respondent's overall mean scores of the ATIDDUS. Furthermore, logistic regression was computed to investigate predictors of clients' reduction of drug use. However, cause-and-effect cannot be certain in retrospective studies, as confounding factors, such as life changes (e.g. getting married, moving away from the area) may also have influenced the results between the period of time between end of treatment, and the undertaking of this study. Thus care must be made not to make generalisations from the findings.

3.3.3.2 Respondents

Recruitment of respondents: The intended sample population for this study was individuals who had previously attended drug treatment services for assistance with a class A drug problem. The sample was obtained by the distribution of an email to a number of people (including colleagues, friends, DTPs, Narcotics Anonymous), asking for volunteers who fit the criteria, to undertake an online questionnaire. The email also requested that the recipient forward the email on to as many other people as possible. Please see Appendix 7.2 for the recruitment email. Those that responded were a self-selected sample, for the reason that they had chosen to take part in this study.

Those respondents that undertook the online questionnaire were informed, at the start of the questionnaire, that; (1) the questionnaire was carried out by a professional, secure web-survey provider, so as to ensure that all responses would be completely anonymous, furthermore, that neither email nor IP addresses would be visible to the researcher, (2) the study had been approved by the Faculty Ethics Committee as being sensitive to the needs of the respondents, (3) that respondents would automatically be giving their consent to take part in the study by completing the on-line questionnaire, (4) that respondents had the right to withdraw from the study, up until the questionnaires had been submitted, because of its anonymity, the questionnaire could not be traced back to the respondent in order for it to be withdrawn, (5) respondents were thanked for their time in undertaking the questionnaire. Please see Appendix 7.3 for the information sheet for study seven.

Response rate: The online questionnaire ran for a period of nine months and achieved a purposive predefined sample of 29 ex-drug treatment clients, for the purpose of the study. Due to the nature of the recruitment process, whereby people were asked to forward the email on, it was unknown as to how many people the email request reached, thus, it is impossible to give a response rate percentage. All questionnaires were completed in full, and could therefore be included in the analysis process.

Demographics of respondents: The majority of the sample were male (males = 59% and females = 41%), and 93% were of a White ethnic group. The majority of the sample was in the 40 years and below age group (younger = 62%, older = 38%). The range of ages was that the youngest was 25 years, and the eldest was 63 years. In terms of potential measures of successful social reintegration, 52% were married or were cohabiting, 24% had an undergraduate degree and 24% had GCSE level qualifications, 55% were employed on a full time basis, and 72% were not currently using illicit drugs.

3.3.3.3 Ethical implications

The current study was conducted on a sample of respondents who had previously attended drug treatment, and was conducted over a reputable online survey site known as 'Psychdata'. Thus,

respondents had to be fully informed on how to participate, via a recruitment email from the researcher. Furthermore, this email informed how to reach the online survey site. Respondents were informed via this email and the introduction section to the questionnaire, of the general description of the study. In addition, they were informed that the site was a secure site, and that they could not be linked to their responses. They would therefore remain anonymous, and thus should adopt an alias when entering into the site. It was made clear to respondents that once they had completed the online questionnaire, that it could not be withdrawn from the study (as it was non-identifiable to individual cases). Respondents were informed that by reading the information sheet and returning their questionnaires, they were automatically giving informed consent to take part in the study.

Prior to its commencement, the researcher obtained formal ethical approval from the Society and Health Faculty Ethics Committee at Buckinghamshire New University, for the study, and it was approved as being sensitive to the needs of the respondents (for which respondents were informed in the email). Consequently, the researcher was covered for public liability insurance, by Buckinghamshire New University, should respondents require financial support in the way of counselling (as a result of being traumatised by the participation in this study). Respondents were provided with a contact email for the researcher, should they require any further help or information regarding this study. In addition, following participation of the study, the end note of the questionnaire informed respondents of some relevant helpline details, or for those connected to Bucks New University, that free counselling was available, should it be required.

According to the British Psychological Society Code of Harm Research Ethics (2010) respondents should not be put under any greater harm than they would normally be exposed to in everyday lives, and in this instance, psychological risk to respondents was considered to be of minor risk of distress, caused by the consideration of other peoples' opinions of their selves. However the benefits from the research, was considered to outweigh the potential psychological risk that respondents may be exposed to in the undertaking of this study. Nonetheless, potential psychological risk was safe guarded by providing respondents with the details of help lines and support groups. Please see Appendix 7.4 for the questionnaire's end note.

3.3.3.4 Measure

The questionnaire was made available to respondents using a secure online web-based survey site known as Psychdata. It included the ATIDDUS, to determine ex-clients' perceptions of DTPs attitudes towards illicit drugs and drug users, the general self-efficacy scale (Schwarzer and Jerusalem, 1995), to determine ex-clients' beliefs in their abilities to succeed, and the readiness for treatment scale (De Leon et al. 1993), to determine ex-clients' perception of their own prior readiness for treatment. In addition, open-ended questions (produced by the researcher) were included to elicit more general responses regarding respondents' experiences with treatment. Furthermore, questions on respondents' demographic characteristics, aspects of their current socio-economic status, and their personal experience with illicit drugs, and drug treatment were also included. Please see Appendix 7.1 for the full questionnaire.

The General Self-Efficacy scale was used in this study was devised by Schwarzer and Jerusalem (1995). The scale consisted of 10 items on a Likert scale, and was reported to have a satisfactory internal reliability by Cronbach's alphas ranged from .76 to .90, with the majority in the high .80s. The readiness scale used in this study consisted of one the subscales from De Leon et al.'s (1994) Circumstances Motivations Readiness and Suitability scale. The readiness scale was answered on 5-point Likert-like scales ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The internal consistency of the M, R, and S scales was reported as being adequate, with Cronbach's alphas ranging between .70 and .81.

3.3.3.5 Procedure

A recruitment email was sent out to colleagues, friends, DTPs, Narcotics Anonymous asking for volunteers to take part in an online questionnaire of attitude towards illicit drugs and drug users, and a link to the survey site was included. The reputable and secure web-based survey site known as Psychdata, was used in this study, and had previously been used by Wager (2011), to investigate sexual revictimisation, successfully eliciting 234 responses. All responses to the questionnaire remained anonymous. Respondents were asked to complete the online questions, and were given the opportunity, throughout the course of the questionnaire, to add any further comment by the use of open dialogue boxes. In relation to the ATIDDUS, respondents were asked to indicate their

perception of their previous DTPs' agreement or disagreement to the range of favourable and unfavourable attitude statements towards illicit drugs and drug users, by endorsing those statements with which they agreed.

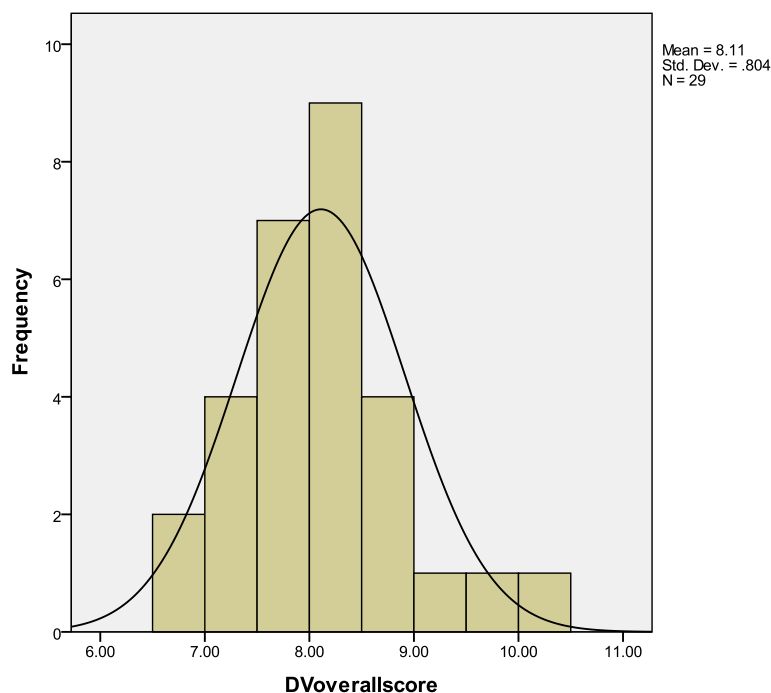
3.3.4 Results

3.3.4.1 Descriptive statistics

An overall mean score from the ATIDDUS was calculated for each respondent; higher scores indicated a more favourable attitude towards illicit drugs and drug users. The average mean score value for all respondents was found to be 8.11, demonstrating that most respondents were found to perceive their DTPs' to hold quite a favourable attitudes towards illicit drugs and drug users.

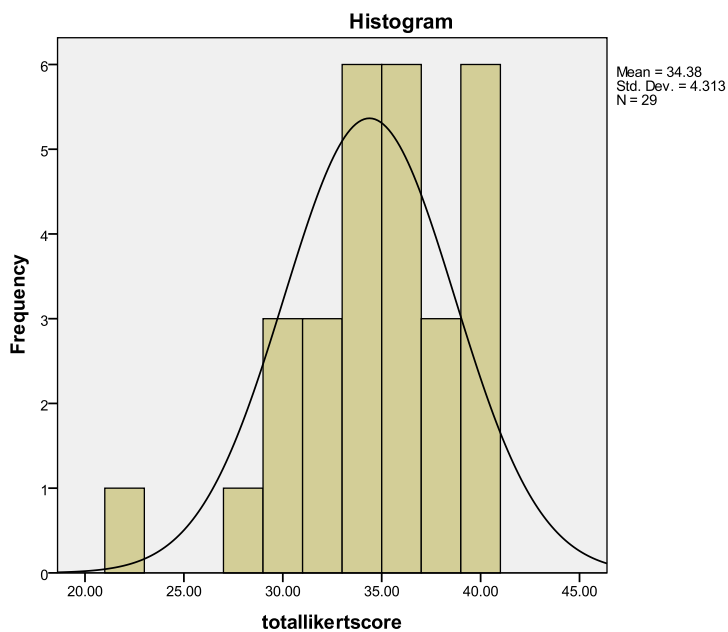
The skewness value found was 0.493, indicating that as in the previous study there was a slight positive skew to the distribution and again similar to the previous study with the client group the distribution demonstrated considerable 'peakedness' (kurtosis = 0.702).

Figure 9: Histogram of the frequency distribution of ex-clients' overall scores on the ATIDDUS



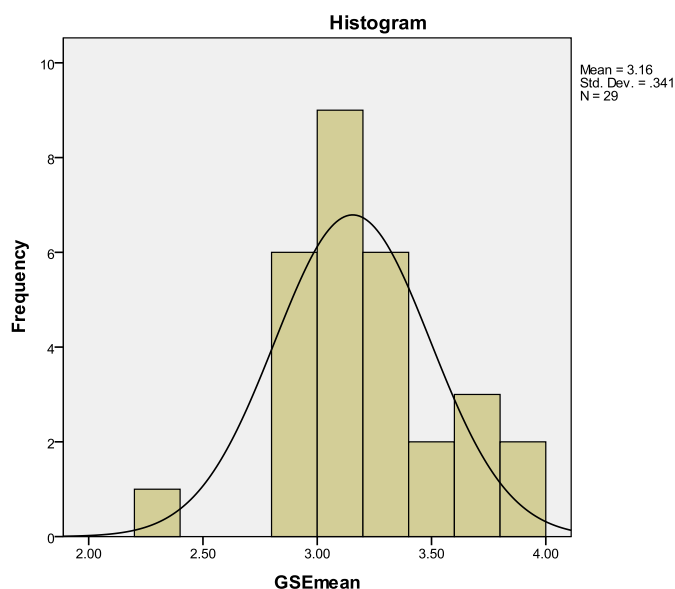
The histogram indicates that, although the overall scores ranged from the lowest of 6.65, to the highest of 10.08, the majority of the sample perceived a relatively favourable attitude towards illicit drugs and drug users, from DTPs.

Figure 10: Histogram of the frequency distribution of ex-clients' scores on the readiness for treatment scale



The histogram indicates that, although the overall scores ranged from the lowest of 22, to the highest of 40, with an overall mean of 34.38, the majority of the sample reported that they had felt ready to engage in drug treatment.

Figure 11: Histogram of the frequency distribution of ex-clients' scores on the General Self Efficacy scale



The histogram indicates that respondents' scores ranged from the lowest score of 2.30, to the highest of 3.90, with an overall mean of 3.16. Thus, in accordance with Schwarzer (2011) who reported that the majority of means from this scale will be around 2.90, the overall mean score from this sample group indicates that they reported to having a high level of self-efficacy.

Respondents' means on the GSE and Readiness for Treatment scales were towards the higher values, indicating that respondents self-reported to being ready for treatment, and that they believed they could achieve success in treatment. This potentially occurred, as those that were responding to the questionnaire were more likely to have actually achieved success in treatment.

3.3.4.2 Inferential statistics

A series of one-way between-groups analysis of variance was carried out on SPSS version 19, to explore a number of variables on respondents' overall attitude scores based on their answers of the ATIDDUS. The Levene's test for equality of variance was carried out for each of the one-way analysis of variance tests to investigate whether there was sufficient variability of respondents overall scores; all tests were not significant (all values $>.05$), thus demonstrating that the assumption of homogeneity of variance was not violated (Pallant, 2007).

Table 8: ANOVA analysis results for paired comparisons of the ex-client sample

	Sign.	Post hoc / Mean comparisons	Mean score diff'	Effect size
Gender	0.918	Female (M = 8.16, SD = 0.88), Male (M = 8.08, SD = 0.77)	0.08	0 (none)
Age	0.833	18 – 40 (M = 8.17, SD = 0.89), 41+ (M = 8.01, SD = 0.66)	0.16	0 (none)
Ethnicity	0.233****	White-Irish (M = 8.75, SD = 1.09), Black (M = 7.61, No SD)	1.14	0.13 (large)
Current marital Status	0.792	Single (M = 8.19, SD = 1.14), Married (M = 7.98, SD = 0.56)	0.21	0.05 (small-med)
Highest qualification	0.424****	None (M = 8.84, SD = 1.76), Undergrad (M = 7.54, SD = 0.74)	1.30	0.27 (large)
Currently employed full time	0.034*	Yes (M = 8.27, SD = 0.78), No (M = 7.65, SD = 0.80)	0.62	0.46 (large)
Did you previously use heroin	0.388	No (M = 8.41, SD = 1.03), Yes (M = 8.03, SD = 0.81)	0.38	0.03 (small)
Main drug of choice previously used	0.388	Crack (M = 8.96, SD = 1.59), Heroin (M = 7.95, SD = 0.68)	1.01	0.03 (small)
Current use of drugs	0.683	No (M = 8.15, SD = 0.85), Yes (M = 7.59, SD = 1.10)	0.56	0.04 (small)
Did you engage in community group work	0.220	No (M = 8.25, SD = 0.90), Yes (M = 7.77, SD = 0.69)	0.48	0.07 (medium)
Drug treatment found to be successful	0.164****	one-to-one (M = 8.87, SD = 0.93), Prison based (M = 6.78, SD = No SD)	2.09	0.35 (large)
Last drug service attended	0.414****	one-to-one (M = 8.51, SD = 0.10), Prison based (M = 6.78, No SD)	1.73	0.24 (large)
Still attending treatment	0.075***	No (M = 8.46, SD = 0.85), Yes (M = 7.81, SD = 0.80)	0.65	0.14 (large)
Have you reached your goal?	0.322****	Yes (M = 8.33, SD = 0.97), Nearly there (M = 7.47, SD = 0.97)	0.86	0.16 (large)

N = 29 respondents / * = p <.05; ** = p <.005; *** = borderline at p <.05, **** No sign diff, but large effect size

Significant differences:

The table above indicates that one characteristic was found to significantly influence ex-clients' perceptions of DTPs' favourability; (1) whether the client was currently in full time employment (with those currently employed, having perceived more favourability in treatment): $F_{(5, 18)} = 3.109$, $p = 0.034$, accounting for 46% of the variance explained. In addition, one borderline significant difference was found; (1) whether the ex-client was still attending some form of aftercare/support group (those that were no longer attending had perceived more favourability): $F_{(1, 21)} = 3.511$, $p = 0.075$, accounting for 14% of the variance explained.

Correlation analysis:

The three scales utilised in this study (ATIDDUS, readiness for treatment, general self-efficacy) were then correlated to see if there were any relationships between them;

- *ATIDDUS and Readiness:* The relationship between respondents' perceived levels of DTPs' favourability (as measured by the ATIDDUS) and respondents' self-reported prior readiness to undergo drug treatment (as measured by the readiness for treatment scale) was investigated using Pearson product-moment correlation coefficient. No significant correlation was found: $r = -.249$, $n = 29$, $p = 0.193$.
- *ATIDDUS and General Self-efficacy:* The relationship between respondents' perceived levels of DTPs' favourability (as measured by the ATIDDUS) and respondents' self-reported self-efficacy (as measured by the GSE scale) was investigated using Pearson product-moment correlation coefficient. No significant correlation was found: $r = -.203$, $n = 29$, $p = 0.290$.
- *Readiness for Treatment and Self-efficacy:* The relationship between respondents' self-reported prior readiness to undergo drug treatment (as measured by the readiness for treatment scale) and respondents' self-reported self-efficacy (as measured by the GSE scale) was investigated using Pearson product-moment correlation coefficient. No significant correlation was found: $r = -.095$, $n = 29$, $p = 0.624$.

Exploring the 'Treatment Effect' with Logistic Regression:

The impact of a set of predictors, including the ATIDDUS, on respondents' self-reported reduction in drug use (the dependent variable), was then explored, in order to see if non-drug use could be considered to be a treatment effect of perceived levels of favourability, as indicated by respondents' responses to the ATIDDUS.

The variable "Are you still using illicit drugs" was collapsed into a dichotomous dependent variable of 'Yes' or 'No', as it had originally been presented to respondents with a number of possible responses, and as this was a small sample size, a number of the options had few numbers with which to analyse. Thus, a reduction in drug use was considered to be responses of 'No', or 'Occasional use', and 'Yes' responses were considered to be a non-reduction in use.

Direct logistic regression was performed to assess the impact of a number of factors on the likelihood that respondents would report that they had reduced their use of illicit drugs following drug treatment. The model contained five independent variables; age, gender, ATIDDUS, readiness for treatment scale and the general self-efficacy scale. The full model containing all predictors was statistically significant, $X^2 (5, N = 29) = 22.44, p < .001$, indicating that the model was able to distinguish between respondents who reported and did not report a reduction in drug use following treatment. The model as a whole explained between 53.9% (Cox and Snell R square) and 84.3% (Nagelkerke R squared) of the variance in reduction of use status, and correctly classified 93.1% of cases. As show in table 11, only one independent variable, the readiness for treatment scale, had a borderline statistically significant contribution to the model.

Thus the strongest predictor of reporting non-drug use was respondents' self-reported prior readiness for treatment, recording an odds ratio of 3.13. This indicated that respondents, who reported to being more ready for treatment, were over three times more likely to report non-drug use following treatment, than those who reported to being less ready for treatment, controlling for all other factors in the model.

Table 9: Logistic regression analysis predicting likelihood of reporting a reduction in drug use

	<i>B</i>	<i>S.E.</i>	<i>Wald</i>	<i>df</i>	<i>p</i>	<i>Odds ratio</i>	<i>95% C.I. for Odds Ratio</i>	
							<i>Lower</i>	<i>Upper</i>
Gender	-2.009	2.565	.614	1	.433	.134	.001	20.454
Age	-25.173	8321.593	.000	1	.998	.000	.000	
Readiness scale	1.141	.709	2.593	1	.107	2.007	.781	12.554
GSE scale	17.389	14.028	1.537	1	.215	35657953.57	.000	3.11E19
ATIDDUS	.696	1.64	.18	1	.670	2.007	.081	49.571

3.3.4.3 Qualitative responses

The process of data analysis utilised in this study, followed that of Braun and Clarke's (2006) guide for performing thematic analysis.

Several open ended questions were included in the questionnaire, in order to obtain richer qualitative data of respondents' perception of treatment, and the TA. These questions included; aspects of drug treatment considered to be of most benefit, ex-clients' prior treatment goals, the number of treatment episodes through their drug career, and the type of drug treatment ex-clients had been engaged in. Responses were thematically analysed for recurring themes in respondents' responses; and three main aspects of treatment were observed. Firstly, that in general, drug treatment was perceived by respondents in a positive manner, and secondly, that some deemed success in treatment as occurring externally to them, whilst some deemed success to come from within, and thirdly, what was determined to be treatment goals by respondents, varied from individual to individual.

Positive influences on treatment:

A number of positive themes emerged from respondents' responses to aspects of treatment that were believed to facilitate effective drug treatment. However, on a number of occasions, alternative features, apart from the TA were proposed by respondents. For example, one of the most popular recurring themes when asked about the beneficial nature of drug treatment was the safety aspect that entering into a residential rehabilitation situation provided to the individual. This feature was thus not about the specific nature of the TA between DTP and client, but the environmental nature that treatment offered, as some kind of 'protective blanket', with which an individual could hide away from the world and recover, without the stresses and strains of their normal everyday lives. This was exemplified in direct quotes such as;

"Even though the rehabs were good and beneficial I found that once I had left the secure safe environment it was really hard to adjust and I found myself really struggling. The community based programmes were hard as I was still living in my home environment but attending the day programme while dealing with real day-to-day issues and temptations which I believe is the main reason I am still clean today" (No. 4)

And,

"it took me away from my home town, friends and dealer problems, and it gave me enough time away to start to think clearly and maintain my progress and gave me the chance of a new start new friends and choice in a place I was not known and no one knew me so I could be who and what I wanted to be without being judged on my past behaviour". (No. 5)

Furthermore,

"after a long time of problematic using, and being out of control, residential rehab is the only way to get clean and stay clean, relocation is important, as it is a new start away from other users", and "safe place low temptation to use". (No. 13)

Finally,

“Allowed me the time to pull back from the world, be nurtured and ultimately find myself again”. (No. 18)

Another feature of treatment that was highlighted was the empathy that other clients had, that was felt to assist respondents in their own recovery. For example,

“I found it easier to get off drugs knowing others are going through it as well, and to talk to these people was a great help” (No. 8)

And,

“Resi rehab got me through the first five of the twelve steps and released a lot of resentment, but I still had no desire to stay clean or continue life. I initially attended NA meetings as a way to get out away from home in order to use. In the meetings I witnessed peer support by people succeeding in recovery, a message of hope, I learnt about a need for honesty, dependence-free being advisable and that recovery was actually feasible in spite of horrific life experiences and that it was potentially worthwhile”. (No. 27)

Furthermore, the support that treatment provided was also indicated as a beneficial feature,

“Rehab was the only treatment that helped me become completely dependency-free. Other treatment and detoxes were just papering over the cracks in my life and did not stop me using for more than a week or so. I really needed a supportive residential treatment option to break my habit and start a new life (totally restructured)” (No. 11)

And,

“the best structure and support” (No. 26)

“The help I got” (No. 3)

And,

“The good support from treatment” (No. 28)

Finally, the TA between DTP and client was highlighted as an influential part of effective drug treatment. Respondents indicated the importance of feeling listened to and cared for within this relationship, and that DTPs were able to understand and displayed a non-judgemental environment for treatment. For example,

“Could be open and honest, felt listened to, that the counsellor cared and had time for me” (No. 23)

And,

“1:1 discussion helped to focus on myself in all aspects of my life. That provided me with more understanding of my problems” (No. 24)

In addition,

“I felt I would not cope well within a group of strangers and felt reassured that by having a one-to-one session I would not feel embarrassed or nervous about talking about personal issues, as there would be no judgement in the room” (No. 25)

Respondents’ Locus of control:

Another aspect of treatment that was highlighted referred to the way in which the respondents viewed their success in treatment. Known by Rotter (1966) as an individuals’ locus of control, refers to how much the individuals believes they can control what affects them in life. Individuals who believe that they are in control of their own life and that success in treatment occurred as a result of their own actions. This was exemplified in a comment by one respondent of,

“The only requirement for membership (to dependence-free) is a desire not to use” (No. 1)

This comment demonstrates how the respondent shows understanding that the achievement of doing well in treatment, has to come from the individual. Whereas on the other hand, respondents demonstrating an external locus of control believe that the success in treatment has come from either their environment, some higher power or from another person, which is exemplified in a respondent’s comment of,

“Yeldhall Manor rehab has given me a life free from drugs” (No. 6)

This aspect of treatment success has not yet been examined, and appears to have an influential role in treatment success, thus should be explored in more detail in proceeding studies.

Ultimate treatment goals:

A final theme that emerged in the qualitative responses was in relation to respondents’ treatment goals. Respondents expressed a diverse range of responses that was perhaps contra to popular belief. Although, it may commonly be thought that a clients’ ultimate treatment goal might be to become dependency-free from the use of illicit drugs, and in general, this was commonly reflected in the majority of responses, a number of respondents’ responses suggested otherwise. Responses such as,

“to reduce the prescribing” (No. 24)

And particularly those that failed to refer to their use of illicit drugs, as demonstrated in the following comments, demonstrate that the focus on drug treatment was not simply to stop using illicit drugs.

“get a life and a job” (No. 25)

“A complete change of lifestyle in every area (attitudes, responsibility, relationships, work etc)” (No. 20)

“Sort my life out, regain control” (No. 4)

Similarly, in some case, the desire to become dependence-free was concomitant with other aspects of their life, as exemplified by,

“To get clean and maintain a positive way of living” (No. 13)

“to give back, and stay clean” (No. 19)

And,

“Fellowship” (No. 27)

Some comments implied that they did not want to achieve complete abstinence, but a life that was free of drug-use dependency,

“stop using heroin daily”(No. 6)

And,

“To not be reliant on using drugs every weekend to have a good time” (No. 3)

“continued freedom from active addiction” (No. 7)

And,

“to not be dependent on the use of Cannabis to calm down/relax” (No. 5)

These responses highlight the need to not simply measure treatment outcomes purely in terms of becoming dependence-free, but to take a more generalised view of holistic improvements to clients' lives.

3.3.5 Discussion

The rationale for conducting the current study was to investigate whether clients' perception of DTPs' favourability towards illicit drugs and drug users, had a treatment effect on clients' treatment outcomes. Furthermore, to identify what the treatment effect was; in terms of measures of successful social reintegration, such as employment status, housing status, marital status and reduction in illicit drug use. This study was carried out retrospectively by requesting that ex-clients undergo an online questionnaire about their previous drug treatment experience, their perception of their previous DTP, and their current lifestyle, in order to see if any relationships between the perception of favourableness, and potential treatment effect variables could be identified. A series of one-way ANOVAs were employed to investigate potential significant differences in respondents' perceptions of favourableness, and their individual differences in a number of variables. Furthermore, correlational analysis was employed to explore any relationships between the three scales implemented in the questionnaire. Finally, Logistic Regression was used to investigate whether a set of predictors, including the ATIDDUS, had an impact on respondents' self-reported reduction in illicit drug use, in order to see if a reduction in drug use could be considered to be a treatment effect of perceived levels of favourability, as indicated by respondents' responses to the ATIDDUS.

The results from the ATIDDUS in this investigation indicated that most respondents were found to perceive quite a favourable attitude towards illicit drugs and drug users from their previous DTPs (mean = 8.11). Furthermore, that this level of perceived favourability supported that of the previous study on current clients, which bore a mean value of 8.19 to the ATIDDUS, suggesting that current and previous clients both perceived the same level of favourability from DTPs. When investigations were made as to which variables influenced respondents perception of favourability, two borderline significant values were produced; currently being employed full time, and continuing to attend drug treatment. Effect size values, illustrated that larger sample sizes were highly likely to produce significant values.

An analysis of the means indicated that those respondents who were not currently employed full time, perceived lower levels of favourability, in comparison to those respondents who were currently employed full time. However, it cannot be surmised from this investigation that higher levels of perceived favourability is a causal factor of gainful employment, as the investigation did not directly show that employment was a definitive consequence of perception of favourability. Yet, the fact that Jones, Weston, Moody, Millar, Dollin, Anderson and Donmall (2007) reported from the Drug Treatment Outcomes Research Study, that most new referrals into drug treatment (77%) were unemployed, indicates that gaining full time employment may potentially be a treatment effect of higher levels of perceived favourability from DTPs. However, care needs to be taken to not make causal statements about the relationship and association between the perception of favourability and the treatment effect, as it may be the case that confounding variables, such as having a settled family life, may also influence the gaining of full time employment. It is for this reason that more research would be required on the cause and effect of these variables, before causal statements can be made with certainty.

This is similarly the case for the other borderline significant difference found, where mean scores indicated that those respondents who were still attending drug treatment were found to perceive a lower level of favourability in DTPs, than those who were no longer attending treatment. Again, although there is a potential causal relationship between perception of favourability and the likelihood of staying in treatment, this study cannot categorically conclude that a client no longer requiring drug treatment is a treatment effect of higher levels of perceived favourability from DTPs. In addition, it is also not possible to conclude that continuing to engage in drug treatment should be

seen as negative, as this will vary between individuals. For example, some individuals may feel the need to continue to engage in treatment so as to have the on-going support that groups such as Narcotics Anonymous offer over the long term. Conversely, other individuals may continue to engage with treatment services, for the reason that they continue to relapse in their use of illicit drugs.

The three scales utilised in this study (the ATIDDUS, readiness for treatment and GSE) were then correlated to see if there were any relationships between them, however none were established. Furthermore, logistic regression analysis was employed to see if a treatment effect of non-drug use could be predicted by the three scales, as well as by respondents' age and gender. The results identified that only one independent variable, the readiness for treatment scale, had a near-borderline statistically significant contribution to the model, thus the strongest predictor of reporting non-drug use was found to be respondents' self-reported prior readiness for treatment. This is not an unexpected finding, as according to Hill (1937), an individual can increase achievement through optimistic thought processes, thus, those individuals that were motivationally most ready to address their treatment, succeeded in achieving a reduction in drug use.

However, what was surprising was that although, in general, respondents reported to having higher levels of self-efficacy, even Schwarzer (2011) proposed as a general average ($n = 2.90$), this scale was not found to predict non-drug use. It was expected that the belief that one could achieve, would influence the behaviour of achieving, yet this was not found to be the case, thus the lack of consensus between clients' reported high levels of efficacy, and the fact that efficacy did not contribute to the model, implies that either one's own perception of their self is not always accurate, or that belief is not a precursor to behaviour. Also self-efficacy may have changed with either successful or unsuccessful treatment outcomes, whereby a clients' belief that they can achieve a task improves following treatment considered successful, and decreases following treatment where a client may have 'dropped out'. Furthermore, the fact that the ATIDDUS was also not found to predict a reduction in drug use, is that maybe the wrong treatment variables were being investigated. Thus, it may not be that the respondents' perceived levels of favourability, as indicated on the ATIDDUS, could predict a treatment effect of a reduction in drug use.

This may have been found to occur, as the qualitative responses from the open-ended questions in the questionnaire suggested that not all respondents wished to achieve dependence-free following drug treatment. Although the majority of respondents indicated that they would like to be dependency-free, a number of respondents expressed alternative treatment outcomes, such as improvements to lifestyles, or to obtain employment. Thus, looking at a reduction of drug use as a treatment effect may be influenced by the fact that a number of respondents did not necessarily desire this as their overall treatment goal. Perhaps those respondents with more realistic treatment goals were more likely to complete drug treatment and feel successful in their outcomes, rather than to feel a constant sense of failure caused by the conflict and pressure to achieve complete dependence-free. This suggests a further area of exploration, similarly, does the fact that respondents' locus of control were also highlighted in the qualitative responses, suggest that a future aspect of research may be to investigate the effect that the variable of an individuals' internal or external locus, has on influencing success in treatment.

3.3.5.1 Limitations of the study

One of the biggest challenges faced in accessing this sample group is to obtain a large enough number of respondents that will actively participate in research based on illicit drug use. This is for a number of reasons, firstly, that the subject area is that of an illegal nature, and as such, respondents are been asked to admit to participating in an illegal activity. In order for someone to confidently do this would require trust and rapport, which is not something that is achieved in a short term data collection procedure. Thus, lending itself to longer term exploratory ethnographic research, however, this is not always possible, with the constraints of time in undertaking research. Secondly, this sample group, are already well known for being distrusting and suspicious of anyone that would appear to be in power or control over them, because of the years of stigmatisation and negativity that they will have received from others. They are therefore, more likely to be distrusting, and unwilling to engage in such research. This was particularly exemplified in the refusal of Narcotics Anonymous online user forum to place a link to the survey site on their message board, even though it was explained to them that the questionnaire was being carried out by a professional, secure online survey company, and that all information about respondents remained completely anonymous. Furthermore, and most importantly, that the production of this research project was to assist in the improvement of current drug treatment provisions, so although the undertaking of this

questionnaire was not directly beneficial to the respondent, it would help others in the future going through drug treatment.

Thus, innovative ways in which information from this sample group needs to be considered, so that the voice of the drug user can be heard. It was for this reason that the methodology utilised in this study was decided upon, so as to use a number of different methods to approach such a group. However, similar to the previous study that utilised a questionnaire method to gain direct information from clients, low response rates were once again encountered. Hence suggesting a further need to utilise a number of different methodologies, so as to approach this target sample group in a number of ways, and obtain the largest group possible. The voice of the drug user should be an essential feature of a piece of research that investigates the effectiveness of drug treatment on behalf of the drug user.

Another limitation of this study design was that those respondents, who responded, only did so because they had experienced favourable attitudes in treatment, or had been successful in treatment, or a combination of both. Whereas, those who experienced unfavourable attitudes in treatment may still be continuing to use illicit drugs, thus their lifestyles were too chaotic to undertake an online questionnaire. Those individuals unsuccessful in treatment are likely to remain a hidden group, and are consequently much harder to obtain. One potential way in which this group could be accessed is to undertake interviews with current drug users attending treatment services, and this is suggested for further research.

3.3.5.2 Conclusion

The main findings from this current study showed that: (a) ex-clients generally perceived a fairly favourable attitude towards illicit drugs and drug users from their previous DTPs, (b) furthermore, that this level of perceived favourability was equivalent to that of the previous study on current clients, thus supporting the levels of favourability that this sample group perceived, (c) variables of currently being employed full time, and no longer continuing to attend aftercare or a support group, was found to be associated to the perception of favourable bias in drug treatment, (d) however, the strongest predictor of the treatment effect of non-drug use, was found to be respondents' self-

reported prior readiness for treatment. The next study will examine identifiable themes from interviews with current clients and recovered DTPs, of aspects of drug treatment that are considered to facilitate treatment success. Furthermore, whether these themes support the notion that favourability in the therapeutic alliance has a considerable impact on clients' drug treatment outcomes.

4 CHAPTER FOUR: Thematic analysis of moderators of treatment success

4.1 Study eight: An exploration of clients' experiences of their drug treatment

4.1.1 Rationale

The purpose of this current study was to explore the clients' experiences of undergoing drug treatment, specifically their perceptions of the TA, and the impact this had on their treatment outcomes.

Previous studies in this thesis utilised a questionnaire method, as a means of gaining honest responses to sensitive information on illicit drug use, as this method was considered as non-threatening and non-inhibiting. Yet, to undertake a questionnaire, respondents require some literacy skill. The fact that McLaughlin et al. (2000) found that a quarter of their client group of IDUs did not possess any basic educational qualifications, suggests that some IDUs from this research project may have been omitted from the previous studies because of a lack of literacy skills. The following study will therefore use interview methodology, whereby all information can be read to the interviewees, thus individuals will not be omitted from this study based on their literacy skills.

The research design implemented in this current study utilised a method more synonymous to that of SI theory, carrying out qualitative research within a clinical setting. This method not only methodologically triangulated the research already carried out in this project, by supporting or disputing findings from the quantitative studies, but also, to explore in more depth, the issues that had previously been identified in the preceding studies.

SI theory supports the view that theoretical research should be undertaken within clinical practice, gaining an understanding of the world by combining professional knowledge with conceptual knowledge (Schön, 1983). Thus allowing for new forms of theory, interpretation and intelligibility, to be borne out of real-world interactions, rather than simply focusing on taken for granted

assumptions of the culture (Gergen, 1991); informing of what maybe to come, rather than what there is now. Consequently, this final study will not only support or dispute what has already been discovered from the undertaking of this project, but will also seek to identify new themes yet to be recognised.

Contra to quantitative analysis, which applies rigidity and standardisation to the data collection process, qualitative methods excel in the ability to be adaptive to their environment, and as such, can be argued as a more effective technique to use within real-world events such as in clinical practice. The data collection process requires constant consideration and reaction, allowing for manipulations to be made to data collection, in accordance with the real-life events that occur within this process. Therefore, in accordance with the SI theory, research is often led by real-world occurrences, and is less likely to make predictions. For this reason, Pope, Ziebland and May (2000) posits that the analytical element of qualitative research should begin during the period of data collection, which can thus be responsive and adaptive to the interviewees. Consequently, the researcher reacts to the interviewees, rather than interviewees being driven by the data collection process. In an interview setting, this is exemplified when the interview schedule takes a back seat to a more 'informal chat', which may yield more information than simply adhering to the interview schedule. Thus, the procedure of data collection is developed by the dynamics of the interviewer and interviewee, and the questions being asked (Bishop, 2007). Moreover, interview questions can be refined and hypotheses can be developed, as a response to the data collection process. Similarly, the identification of recurring themes can also begin, allowing for further enquires to be made in proceeding interviews, and deviant or negative cases that are counter to the emerging hypotheses can be explored.

According to Bowen (2005) the main strengths of qualitative research is the depth and detail that the data yields, and as such, provides more clarity to the understanding of phenomena and lived experiences. Thus, the implementation of a qualitative approach for this study will allow for a more in-depth look into aspects of treatment that impact on treatment outcomes, as well as adhering to the notion of SI theory, by directly observing the behaviours and interactions of interviewees, and by enabling interviewees to voice their own lived stories and experiences in treatment.

Qualitative analysis shares the commonality that there is a search for themes and patterns across a data set; with repeated patterns of meaning being guided either by a general or specific research question. There are several methods of qualitative analysis, differing in the manner with which they attempt to describe the patterns across the data set; thematic analysis, discourse analysis, thematic decomposition analysis, interpretative phenomenological analysis and grounded theory. Although there is no ideal method, for the reason that they vary slightly, the method chosen should be dependent on what the researcher is attempting to undertake. For example, IPA is theoretically bound, and thus seeks themes that relate to theory. This is achieved by placing great emphasis on individual experience (Holloway and Todres, 2003), examining individuals everyday experiences of reality, so as to understand the phenomenon being studied (McLeod, 2001), and is thus based on phenomenological epistemology (Smith, Jarman, and Osborn, 1999; Smith and Osborn, 2003). In contrast, grounded theory seeks to identify theories that are grounded in the data (McLeod, 2001), thus data analysis is directed towards theory development (Holloway et al, 2003).

Whereas, discourse analysis identifies a wide range of pattern-type analysis in the data, from patterns that are socially produced (social constructionist epistemology) and no discourse analysis of the data is conducted, to analysis similar to an interpretive form discursive analysis (Clarke, 2005). Similarly, thematic decomposition (for example, Stenner, 1993; Ussher and Mooney-Somers, 2000), also identifies patterns in the data, but with the notion that language comprises of meaning, and that meaning is a social entity.

Thematic analysis is also employed to identify, analyse and report patterns in a data set, and, although it is widely used, there is no definitive agreement as to how it is performed. Consequently, Braun and Clarke (2006) produced a paper to try and achieve some clarification and standardisation to this process, and this was often called upon in the undertaking of this current study. Thematic analysis was preferred for this study was that it allowed for flexibility in its analysis, as it is not tied to pre-existing theoretical frameworks. Thus it can be employed within different theoretical frameworks to do different things; either being essential or realist, by reporting on experiences, meanings and reality (known as essentialism), or by being constructionist, exploring the ways that events, realities, meanings and experiences are created within society (known as constructionism). Additionally, a combination of the two can be examined (known as contextualism), looking at ways

in which individuals make meaning of their experiences, and how the social context impacts on these meanings. This will be of benefit to the current study, as not only does thematic analysis reflect on reality, but it also helps to explain reality (Braun and Clarke, 2006).

Research epistemology or the limitations on knowledge, guides what can be said about the data and can inform how meaning is theorised. Whereas, an essentialist/realist approach would argue that theories can be developed from the real-world occurrences of motivations, experiences and meanings. This is because this approach assumes a unidirectional relationship between meaning and experience, and language, which reflects and enables the articulation of meaning and experience (Potter and Wetherell, 1987; Widdicombe and Wooffitt, 1995). On the other hand, a constructionist approach takes a more in-depth look, arguing that meaning and experience are socially produced and reproduced, rather than being inherent (Burr, 1995). Constructionist thematic analysis thus does not focus on motivation or individual psychologies, but theorises on the socio-cultural contexts and structural conditions.

Thematic analysis can be performed in one of two ways; inductively, whereby theories are developed from the data set, or deductively, whereby pre-existing theories direct the line of enquiry of the data set. However, Lincoln and Guba (1985) posit that explanations of social phenomena should be investigated with minimal a priori expectations, and similarly, Ryan and Bernard (2003) proposed that most themes are induced from empirical data, and even with a fixed set of open-ended questions, the themes that arise cannot always be anticipated before analysing the data (Dey, 1993).

Furthermore, the method of inductive thematic analysis strongly supports the overarching theory of SI underpinning this project. SI pertains to the concept that true knowledge comes from the understanding of an individuals' behaviour, acquired directly from that individual. This study will thus continue in the same vein as the overall project, seeking to give voice to the interviewee, by allowing them to express their opinions and knowledge of their own lived experiences of drug treatment and the therapeutic alliance. Consequently, findings are based on interviewees' lived

experiences rather than driven by analytical preconceptions and theoretical underpinnings, and according to Patton (1990), the theories formed, will have strong links with the data set.

Yet, for the reason that this current study is preceded by seven inter-related studies on the impact that attitudes within the therapeutic alliance has on clients' treatment outcomes, and an extensive review of the literature, it cannot be said that a priori knowledge is non-existent. Thus, although the qualitative data collated in this study is predominantly of an inductive nature, there is an element of deductive knowledge. Not only does the literature review provide some deductive knowledge, but, according to Tuckett (2005), it sensitises the researcher to the more subtle features of the data. Moreover, the literature review indicates a more theoretical approach to the research, as it narrows the analytic field of vision, focusing the researcher on more specific areas highlighted in the data set.

4.1.2 Objectives

- To explore potential themes of aspects of drug treatment, that influence clients' successful outcomes, in the data set of clients currently undergoing drug treatment
- To explore potential themes of aspects of drug treatment, that influence clients' successful outcomes, in the data set of practitioners who have previously personally experienced drug treatment, and are now currently working within a drug treatment setting.

4.1.3 Method

4.1.3.1 Design

This study employs a phenomenological approach, as it is concerned with how the individuals included in this study make sense of their world, without any preconceptions from the researcher. Thus, it places great emphasis on examining individuals' everyday experiences of reality, so as to understand the phenomenon being studied (McLeod, 2001, Holloway and Todres, 2003). This approach is concomitant with that of symbolic interactionism, and was believed to have influenced Blumer, as it favours an interpretive approach to human behaviour (Bryman, 2001). Empirical observations of phenomena of human behaviour inform theory, hence providing an inductive approach, rather than been based on preconceived notions. In addition, this study further gives the

opportunity of those being researched to voice their own opinions of treatment, based on their lived experiences within the field of drug treatment (Goffman, 1959), thus a phenomenological approach is most appropriate. A number of interviews will be conducted, and findings will be transcribed and analysed using thematic analysis; the writing process is an essential part of research to symbolic interactionism, as it will allow for findings to inform and potentially challenge existing assumptions in treatment (particularly in terms of policy, training and education).

The data collection process consisted of two sets of in-depth, open-ended interviews, guided by an interview schedule, prepared by the researcher. The first set of interviews was with a sample group of drug treatment service clients, and the second set of interviews consisted of current DTPs, who had themselves previously undergone drug treatment, for their own use of illicit drugs. In accordance with Patton (cited in Rubin and Babbie, 2001), the use of the interview schedules allows for some structure and standardisation of the interviews, in comparison to a completely unstructured informal conversational interview. However it was not followed implicitly, allowing for more open discussion between interviewer and interviewee to naturally occur.

Furthermore, the write-up for this study will be refer to the author in the personal pronoun, this is in accordance with the most recent APA 6th edition (section 3.09), which states that in qualitative research active voice/first-person personal pronouns should be utilised in order to clarify any ambiguity as to which researcher is being referred to when presenting the process of data collation and the findings.

4.1.3.2 Pilot study

A pilot study was carried out on two interviewees who had recently commenced drug treatment. Both interviewees were male, and their ages were 28-years and 42-years. Both interviewees described their ethnic origin as White British, and were current IDUs.

The interviews originally conducted in the pilot study consisted of a range of measures, presented to the interviewees in the order as follows; demographic questions, current treatment episode,

previous treatment episodes, readiness for treatment scale, General Self Efficacy scale, Treatment Outcomes Profile (NTA, 2007), The ATIDDUS, and exploratory qualitative questions on treatment and drug workers.

It was however decided that all of the scales should be removed for the interview transcript, for two reasons; (1) interviews were taking too long for interviewees to concentrate (over a one hour period), (2) all of the scales failed to elicit any fruitful qualitative responses, and less time was spent on informal chat where interviewees were able to speak more freely, which would have precluded the ability to gain rich thick data. Furthermore, it was considered that a prolonged sequence of questions would lead to disengagement from interviewees. The Treatment Outcomes Profile was however kept in the interview transcript, as it was considered useful at eliciting information on interviewees' current use of drugs, their criminal behaviour and their health and social functioning. Please see Appendix 8.1 for the modified interview schedule.

4.1.3.3 The Interviewees

The intended sample populations for this study was, (1) individuals who were currently attending some form of drug treatment for illicit drug use, and (2) individuals who were recovered DTPs, who had themselves previously undergone drug treatment for their own use of illicit drugs. Two sample groups were used, as according to Bishop and Syme (1996) communities hold different truths. Thus investigating two similar, but slightly differing communities (current users, and previous users who are now drug practitioners), allows for the opportunity to reveal emerging themes from each group, to see if similar themes arise, or whether they differentiate between the two groups.

Interviewees from the first sample group were recruited in person, by my attendance at a homeless drop-in center. I made myself available at the project on a number of occasions, and conversed with potential interviewees whilst they attended the drop in center, and used this time to discuss the intended research to see if any individuals were of interest. In contrast, the second sample group, of recovered-IDU DTPs, was recruited by email to local treatment services, informing of the recruitment of interviewees for this study. Please see Appendix 8.2 for recruitment email.

Demographics of interviewees: There were seven interviewees in total; four clients and three recovered-IDU DTPs. The majority of the sample were male (five males and two females), and all were of White ethnic origin. The age range of the interviewees was from twenty-eight to fifty-four years.

4.1.3.4 The interviewer

With regards to my own background I had been clinically trained and worked for a number of years within the field of illicit drug treatment to undertake roles such as; the provision of one-to-one key work sessions, facilitate structured day group-work treatment sessions, carry out drug treatment assessments and court reports, and to recruit illicit drug using individuals in HM court settings. Consequently, I had pre-existing wealth of knowledge and experience working directly with illicit drug using clients, as well as with DTPs. Thus, I felt I was fully prepared and skilled to undertake the interviews carried out in this current study. However, I was aware that my pre-existing awareness of working with IDUs, created the possibility that it could impact on the way in which I conducted and interpreted the interviews. On the one hand, potentially causing interviewer preconceptions as to how the interviews would run, and thus interviewer bias might influence the dynamics between my interviewee and me. Alternatively, the fact that I had experience could also have a more positive impact on the dynamics, by being more at ease with individual interviewees, thus, they would be more likely to feel comfortable at being open and honest with the interviewer. The fact that the majority of interviews appeared to be comfortable enough to talk during the interviews, with limited encouragement required from myself, suggests that the latter was true. On only one instance was an interviewee displaying feelings of unease and distrust, but this very quickly dissipated once a rapport between myself and the interviewee was established in the undertaking of the interview, thus supporting the notion that experience in the researcher enabled the interviewee to quickly feel comfortable.

4.1.3.5 Ethical consideration

The current study included interviews with current drug treatment clients, and DTPs who had themselves previously attended drug treatment for illicit drug use, thus different ethical issues were considered for each group.

The client interviewees:

Interviewees were recruited on a one-to-one basis at the drop-in centre by me. In order to gain some trust and rapport with the clients before the commencement of the interviews, I attended the centre on a number of times, to chat with potential clients, so that they became familiar with me, and were thus, less suspicious of my being at the centre.

Clients were informed that they were not required to engage in the study, and that there would not be any negative repercussions through non-engagement. Although clients that participated, were not anonymous to myself, I made it clear to them that their responses would not be linked to their personal details, and for the purposes of the study, they would be allocated an alias with which they would be known by. I informed interviewees that they could withdraw from the study at any time, and without reason. Furthermore, they had the right to request that any information collected up to that point, could not be used in the study.

Prior to the commencement of each interview, I read out the information sheet and the consent form to the interviewee, and both the interviewee and I signed the consent form. Interviewees were informed that the consent forms would be kept on file by me, but that they would be separated from their interview transcripts, so that they remained anonymous to others. Please see Appendix 8.3 for the information sheet and Appendix 8.4 for the consent form.

A small monetary offer of £10 in shopping vouchers was offered to all interviewees, in order to try and improve recruitment. This was not considered to be a disproportionately large amount of money, thus would be unlikely to elicit responses solely based on monetary gain. Rather it was offered as a symbolic payment for the inconvenience caused through participating in the study. This amount was agreed between the drug treatment service and myself, and was approved by both the ethics committee and the treatment service.

The DTP interviewees:

The DTP group was recruited via email and telephone communication, and were informed that they were not required to take part in this study. Similarly to that of the client group, DTPs would not be anonymous to me, and so, for information to remain as confidential as possible, it was again made clear that all responses would not be linked to their personal details. Thus, for the purposes of the study, they would be allocated an alias with which they would be known by. I informed interviewees that they could withdraw from the study at any time, and without reason. Furthermore, that they had the right to request that any information collected up to that point, could not be used in the study.

Prior to the commencement of each interview, the interviewee read the information sheet and the interviewee and I signed the consent form accordingly. Again, interviewees were informed that the consent forms would be kept on file by me, but that they would be separated from their interview transcripts, so that they remained anonymous to others. Please see Appendix 8.3 for the information sheet and Appendix 8.4 for the consent form.

Rigour: Member checking for both groups after interview process:

In order to clarify the rigour of the study, it is normal research behaviour to member check gathered information, so as to improve the accuracy, credibility, validating, and transferability of the study. This is usually carried out by providing interviewees with an interpretation or report, of the themes identified from the interview transcripts, and also to give the interviewees the opportunity to amend or delete information that they later regret disclosing. Thus, interviewees from the study can confirm if they are in general agreement of the findings, and are happy for their information to be used. Yet, the client interviewees in this study would have been difficult to revisit, due to their chaotic lifestyles, and in some cases, interviewees may have also been unable to read the report due to literacy skills. It was therefore decided that the report was to be shown to an individual with an awareness of the subject area. Thus a current DTP (who had not been involved in the study) was asked to read over the transcripts and verify the themes identified. This process was carried out, and there was general agreement with the themes, validating their accuracy. Interview transcripts, and a report of the general thematic findings were however emailed to the respective DTP

interviewees, and all were happy for their information to be included, along with general support for the themes.

Prior to the commencement of this study, formal ethical approval was granted by the Society and Health Faculty Ethics Committee at Buckinghamshire New University. In addition, a regard and understanding for the British Psychological Society Ethical Guidelines (2010) was considered. Consequently, I was covered for public liability insurance, by Buckinghamshire New University, should any of the interviewees require financial support in the way of counselling, following the study. Interviewees should not be put under any greater harm than they would normally be exposed to in everyday lives, and in this instance, psychological risk to interviewees was considered to be of minor risk of distress, caused by the consideration of other peoples' opinions of their selves. However the benefits from the research, was considered to outweigh the potential psychological risk that interviewees may be exposed to in the undertaking of this study. Nonetheless, potential psychological risk was safe guarded by informing interviewees that, if needed, counsellors were available, that the researcher could be contacted after the data collection process by email or through their treatment service and that details of relevant help-lines and support groups were also available.

4.1.3.6 Measure

The interview schedule was produced by myself, and consisted of questions of interviewees' demographic characteristics, their current and previous treatment episodes, and exploratory questions relating to their experiences of drug treatment and the TA. Questions from the Treatment Outcomes Profile (NTA, 2007) were asked to the client group, as these elicited information of their current use of drugs, criminality, and social and health functioning. It was anticipated that these interviews take approximately 45 minutes. Please see Appendix 8.1 for interview schedule.

4.1.3.7 Procedure

This involved two steps; the data collection process, and the data analysis process

The data collection process:

The client group: Client interviews were recruited through my attendance at a local homeless drop-in project. I attended the service on a number of occasions, so that potential interviewees would become familiar with me and I could build up some rapport with the group. The interviews were all conducted at the project; this assisted the interviewee in feeling more comfortable, by being in familiar surroundings. All interviews were audio recorded, using a Dictaphone, and the permission to record was sought from the interviewee prior to the recordings. I read out the information sheet and the consent form to each of the interviewees, at the commencement of the interview, and the consent form was signed by the interviewee and me. All interviews took approximately 45 minutes to one hour, and followed an interview schedule, with any deviations from the schedule encouraged by myself. At the close of the interview, interviewees were asked if they would like to ask any further questions, or had any concerns or further information they would like to share. They were then thanked for their time, provided with the monetary voucher, and were informed that there was information on support groups and help lines, should they be required. Furthermore, that they could make contact with me at a later date, should this be required.

The DTP group: It was agreed that all DTP could be interviewed at their respective treatment centres, in their lunch breaks, thus, similarly to that of the client group, DTPs were interviewed in familiar surroundings, and were not required to take extra time out of their working day to travel to a different location. Contact had already been made with DTPs prior to meeting them, by phone or email, and prior to the commencement of the interview, myself and the interviewee had an informal chat, not specifically related to the interview and research project, so as to build up some rapport and feeling of comfort, before the interview commenced. Again, interviews were audio recorded, and permission was granted from interviewees prior to the interview. The interviewee was asked to read the information sheet prior to the commencement of the interview, and the consent form was signed by the interviewee and me. The interviews took approximately 45 minutes, and followed an interview schedule. Where interviewees deviated from the schedule, this was encouraged by me, in order to elicit more fruitful responses. At the close of the interview, the interviewee was given the

opportunity to ask any further questions, or add any further information to what had already been discussed. Furthermore, interviewees were asked if a complete copy of their transcript interview, with an overall report of the themes identified, could be emailed directly to them, to be read through and verified; all of which agreed. They were then thanked for their time.

Please see Appendix 8.2 for the information sheet and 8.3 for the consent form.

The data analysis process:

The process of data analysis utilised in this study, followed that of Braun et al.'s (2006) guide for performing thematic analysis. However, this was only for guidance as there should be no fixed rules as to how thematic analysis should be carried out. According to Patton (1990), flexibility is a necessary when fitting the research questions with the data.

I commenced the data analysis process by first transcribing the interview audio recordings. Any relevant or appropriate comments were noted in this process, for later consideration of the themes and recurring ideas. This was carried out in accordance with Sandelowski (1995) notion that the analysis of the text usually begins by simply proof reading and highlighting key phrases, and in recordings, this is likely to begin in the process of transcribing (Bogdan and Biklen, 1982). Once this had been completed, I listened to the audio recordings again whilst reading through the transcripts, to check for errors. Furthermore, this process allows for a familiarisation of the data (Riessman, 1993). Again, any appropriate comments were made a note of, for recurring meanings and issues.

When themes were then considered, Braun et al. (2006) proposed that the keyness and frequency with which information appears, was necessary. In addition, prevalence is also important, and has been reported on in many ways, in studies that have utilised thematic analysis, for example, "the majority of interviewees" (Meehan, Vermeer and Windsor, 2000: 372), "many interviewees" (Taylor and Ussher, 2001: 298), or "a number of interviewees" (Braun, Gavey, and McPhillips, 2003: 249). Thus, these concepts were used in the process of identifying themes. Analysis then required a continual process of moving backwards and forwards through the data set, searching for patterns,

noting ideas and coding, with note taking throughout. Eventually, I had produced a list of ideas from the data set, identified by their nature of being of interest, of repetition, or having fitted into categories. Furthermore, according to Agar (1973), indigenous typologies should also be looked for in the data set, and this was exemplified in Agar's description of IDUs' understanding of 'shooting up', yet these were not found.

In the undertaking of the interviews a number of interesting occurrences was noted. Firstly, that the same message was often repeated throughout the text, and this was a phenomenon that was highlighted by Braun and Clarke (2006). In the set of interviews, it was often found to be the case that interviewees would repeat the same message again and again throughout the course of the interview. For example, one interviewee made mention to the fact that she had a lack of trust in the treatment services, caused by her history of failure in treatment. Another repeatedly that she had received a lack of support through treatment, that childcare had been a big issue for her. Such repetition merely strengthens the importance that these themes have for these interviewees, and are thus necessary to report as themes.

Similarly, two words were repeatedly referenced throughout the interviews; in the client group it was 'trust', and this was mentioned across the interview set on 17 occasions, and in the practitioner group, the word 'support' was mentioned on 24 occasions. Such repetition clearly indicates themes that need to be closely examined, and this was carried out in the data analysis process, with both concepts being identified as significant themes at influencing success in treatment.

Coding was performed manually by reading through the transcripts and highlighting statements, as suggested by Braun et al. (2006). However, a general criticism of thematic analysis from Bryman (2001), is that the context is often missed, thus notes were also made as to where these statements had come from, in relation to the text, so that they could be placed into context, where necessary. Once all the relevant data had been coded, they were manually sorted into different themes, and all supporting statements were brought together into groups. The themes were mapped onto a flowchart, to see how they related to one another. In this process, subthemes were identified from overarching themes. Additionally, miscellaneous themes were identified; and these related to the

accumulation process of treatment, and whether drug treatment services were improving or declining. Although these did not fit into the overarching themes of aspects of treatment that were considered to improve treatment effectiveness, they were however considered as important, and their keyness to drug treatment, meant that they should be considered as additional themes.

I then reviewed the themes, to see if there was enough data and evidence to support them. In addition, the identification of what each theme was about, as well as deciding upon the theme name was carried out. The collated extracts were then reported on with narrative, providing interesting statements that supported the claims and analysis made in the narrative. The concluding themes were produced on flowcharts, and these were disseminated to the DTP interviewees, along with their individual interview transcripts.

Please see Appendices 8.6 and 8.7 for the table of themes.

4.1.3.8 Synopsis of the interviewees

All interviewees have been given pseudonyms by the researcher, so as to maintain anonymity.

Interview Set One: The Client Group:

Interviewee 1: Andy is a 42 year old white British male who is currently addicted to illicit drugs. He originated from Liverpool. He is currently single and is of no fixed abode, and resides in a squat. He is currently unemployed. His highest educational achievement was a City and Guilds in maths and English, and he also undertook a YTS scheme. He currently attends 'T2', a community-based treatment centre, for one-to-one key-working sessions, and prescribing, and has been going there for one month on a fortnightly basis. He has been in and out of treatment for about 24 years, since the age of 18. He has experienced a lot of different drug treatment services, ranging from group work therapy, day programmes, one-to-one, prescribing, to rehab. His treatment goal is to be abstinent. He is currently drinking on a daily basis, and is injecting heroin occasionally and does not share needles or other works. He uses crack cocaine if it is available, and the only criminal activity he reports to doing is handling stolen goods. When asked to rate his psychological and physical

health out of 10, he states that it is quite good and rates them both as 7. He rates his overall quality of life as 5, saying that although it is not great, it is not terrible either. He was paid £10 in Tesco vouchers to undertake this interview.

Interviewee 2: Becca is a 28 year old female, is of white British ethnic origin, is single and is currently addicted to illicit drugs. She is unemployed, and is not in receipt of any benefits. She has children that have been taken into care, and a long term on-off domestic-violent partner who is currently in prison. She is of no fixed abode, and is currently residing in a squat. She is from a travelling family, and gives this the reason for why she did not attend school; she thus has no educational achievement. She has recently started attending a treatment service known as SMART CJS, which is a registered drug treatment charity, for prescribing and counselling, at the time of interview, she had been on two occasions. She describes herself as having been in and out of treatment for a long time, as she has been using for about 10 years. She is currently using heroin intravenously, and alcohol daily, and crack cocaine occasionally, and has been sporadic in her use of prescribed methadone. She does not share needles, but does share other works (i.e. spoons). Her treatment goal is to improve her life. She reports to not committing any crime at the moment. She describes her psychological and physical health as a 5 on a 0 – 10 scale, but rated her overall quality of life as a zero. Becca was paid £10 in Tesco vouchers to participate in this interview.

Interviewee 3: Charlie is a 51 year old white British male, and is an illicit drug addict. He is of white British origin, and is currently single. He is a self-employed window cleaner, and is currently of no fixed abode, and resides in a squat. He reports that his highest educational achievements at school were in maths and spelling, but that they were not very high as he is dyslexic. He is seeing a drug treatment counsellor on a one-to-one basis, once a month, and has attended four times so far. This is the first time he has been in drug treatment, and reports that his treatment goal is to be abstinent from drugs. He reports to using heroin on a daily basis, and does not inject. He does not use crack cocaine, or any other drugs. He is not currently committing any crime, but informs that he does have a criminal record. When asked to rate his psychological health out of 10 he says it is really good and rates it as a 10, his physical health he rates as a 6, and his overall quality of life, he also rates as a 10, saying that he is always happy. Charlie was paid £10 in Tesco vouchers to participate in this interview.

Interviewee 4: Dan is a 46 year old white British male, who is an illicit drug addict. He is single, and is unemployed; he currently is in receipt of income support. He is of no fixed abode, and reports that he did very well in school, achieving O-Levels and CSEs. He is currently attending the treatment service T2, and receives key-working sessions and fortnightly prescribing with a doctor. He is currently hoping to get into a residential rehabilitation service. He reports to currently using alcohol and methadone daily, with heroin being used every week or so, and has not injected in the last four weeks. He reported to not using crack cocaine, or any other drugs. He says that he is more or less off the drugs now, but is still using methadone, and his treatment goal is to get off the methadone. He reports that he gave up crime a long time ago. He reports his psychological health as being mediocre; going through phases of being dead alert, or being really depressed. When asked to rate it out of 10, he said 5. Physical health was rated as 3 to 4 as he felt that he needs to see a doctor about various pains he had. When asked about his overall physical health, he reported that it was 2 out of 10. Dan was given £10 in Tesco vouchers for participating in this interview.

Interview Set Two: The Practitioner Group:

Interviewee 5: Ed is a 54 year old male, white British DTP, who was previously addicted to illicit drugs and attended drug treatment. He described his ethnic origin to be white British. He is currently married and living in a rented flat. He stated that his highest educational achievement was a couple of CSEs, and a YTS in carpentry. He disclosed that he was predominantly a daily IV heroin user for 20 years, but also would use crack cocaine occasionally. He has used methadone before, and these have been both prescribed and illegally. Ed is currently employed full time at Turning Point, a community-based treatment centre, for a year, as a key worker. His role includes providing one-to-one key-working sessions, and facilitating group-work sessions. Previous to this, he worked for approximately five years at SMART as an arrest referral officer, visiting with potential clients in police custody, when they had just been arrested. In addition, he held a case load of clients, that required key-working one-to-one sessions, and help with other social aspects, such as housing and prescribing. Ed personally, previously engaged in three residential rehabilitations, some one-to-one counselling, and numerous prescribing, having been in and out of treatment for approximately 20 years. He still regularly attends NA meetings.

Interviewee 6: Faye is a 53 year old white British female DTP, who was previously addicted to illicit drugs and attended drug treatment. She is a divorcee and is currently single, she has children. She rents a property, and when asked about her highest educational qualification, she said that she had achieved CSEs in Maths and English, and had recently completed an NVQ level 3. She previously smoked heroin on a daily basis, and used alcohol most days, but did not use any other drugs. She was on a methadone prescription for some time, which assisted her in stopping her use of heroin, along with her strong determination to stop smoking heroin. She sporadically attended a day treatment programme, but due to childcare issues, she was unable to attend on a regular basis, apart from this she only saw a GP for prescribing. Faye used heroin on and off for a 10 year period, and attributes the commencement of her drug use to a breakdown of a marriage and having to deal with two young children alone. She maintains she kept her drug use a secret from others, and was able to maintain a relatively normal way of life in appearance. She has been employed full time as a drug treatment probation worker for the past three years and has not worked with drug users prior to this time. Her role requires her to see a caseload of clients on a court order on a regular basis, to assist with social requirements, such as housing, and to provide one-to-one key working sessions, in addition, she maintains the enforcement side of treatment, ensuring that clients are attending all appointments required of them, and she writes regular reports on her clients for court reviews.

Interviewee 7: Gary is a 41 year old white British male who is a DTP, but was previously addicted to illicit drugs and had attended drug treatment. He is married, and resides in a council house. He claims to have not been very good at school, possibly only achieving a few CSEs. He was previously a heroin and crack user for a period of approximately 15 years; smoking heroin on a daily basis, and crack cocaine a couple of times a week. His previous drug treatment involved attending a structured day programme on three separate occasions, with one time fully completing the course; other times were finished early due to him dropping out, and being imprisoned. He also attended a drug clinic whereby he saw a doctor for a methadone prescription. He informed that he only ever had a fixed treatment goal of becoming abstinent towards the end of his drug career, and he maintains that this gave him the drive to finally come off heroin. He is currently employed on a full time basis by SMART as an arrest referral officer, whereby he visits arrested IDUs in police cells in an attempt to engage them into treatment; he also has a caseload of IDUs that he provided one-to-one key working sessions. Prior to this, he had volunteered in SMART's mentoring scheme.

4.1.4 Results

The following two flowcharts presented in Figures 12 and 13 depict the aspects of drug treatment that were considered by participants, in both data sets, to influence clients' successful outcomes. The themes are based on the interpretations of the transcriptions from the two data sets; the following main themes were identified;

Figure 12 (data set one – the client group): (1) The dynamics of the therapeutic alliance, which was considered to be multifaceted and thus required three further sub-themes; (i) practitioners' attitude, (ii) continuity of practitioner, (iii) trust, and (2) the clients' locus of control, and finally, (3) the practicality of the treatment service, which was sub-divided into (i) flexibility, (ii) aftercare, and (iii) the provision of social reintegration opportunities.

Figure 13 (data set two – the DTP group): (1) The dynamics of the therapeutic alliance, which, again considered to be multifaceted and requiring further division into two themes; (i) favourable and unfavourable dynamics within the relationship between practitioner and client, (ii) support, and (2) The clients' mental attitude towards treatment, (3) The practicalities of the treatment service, which was further sub-divided into (i) the provision of aftercare, and (ii) barriers to treatment. Furthermore, issues that had been raised in the previous set of interviews by current clients, that (1) drug services had worsened, and (2) that the accumulation process of treatment episodes had an influence on treatment outcomes, was also explored.

Figure 12: Flowchart of aspects of drug treatment, influencing clients' successful outcomes (client group)

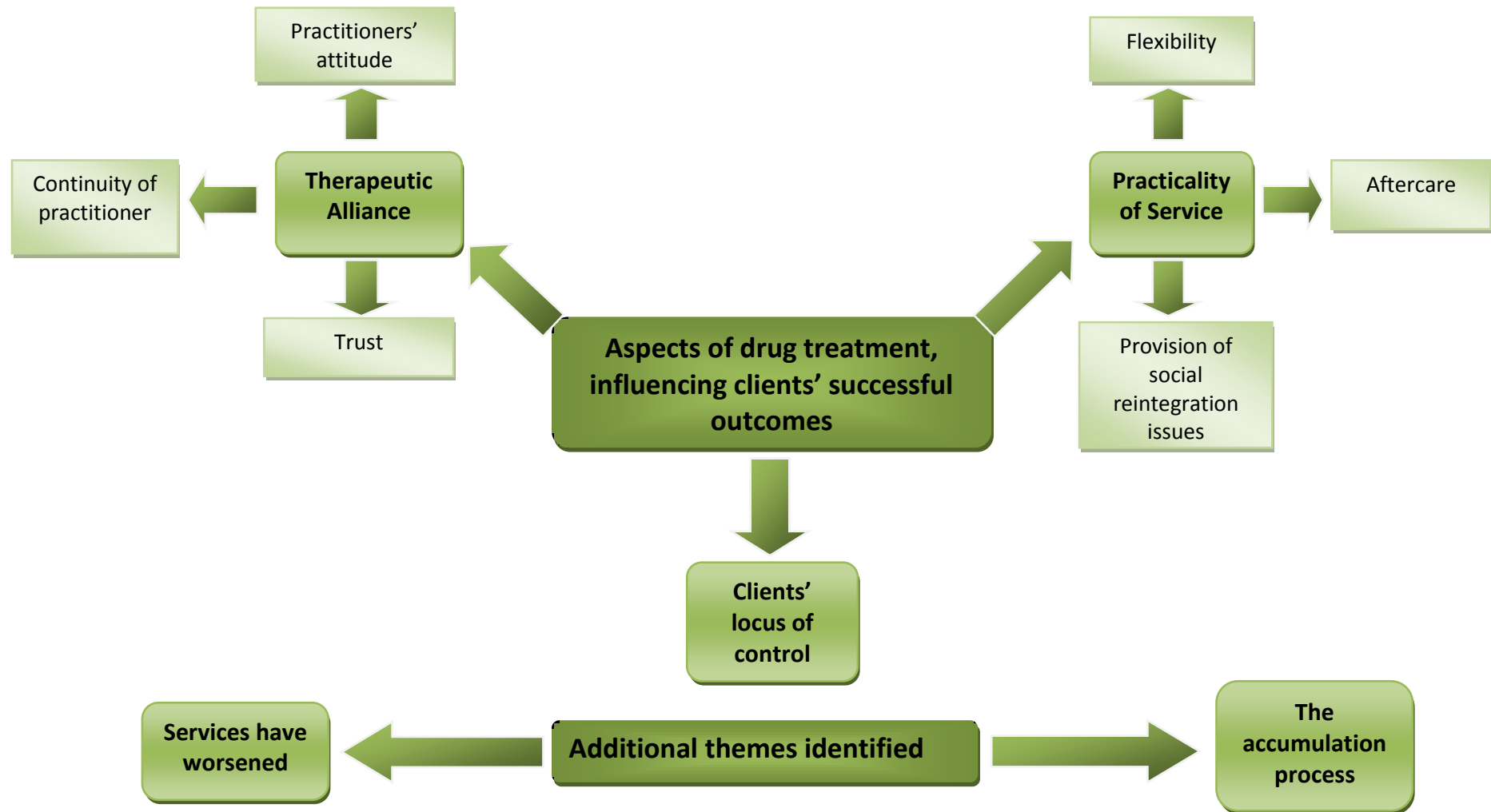
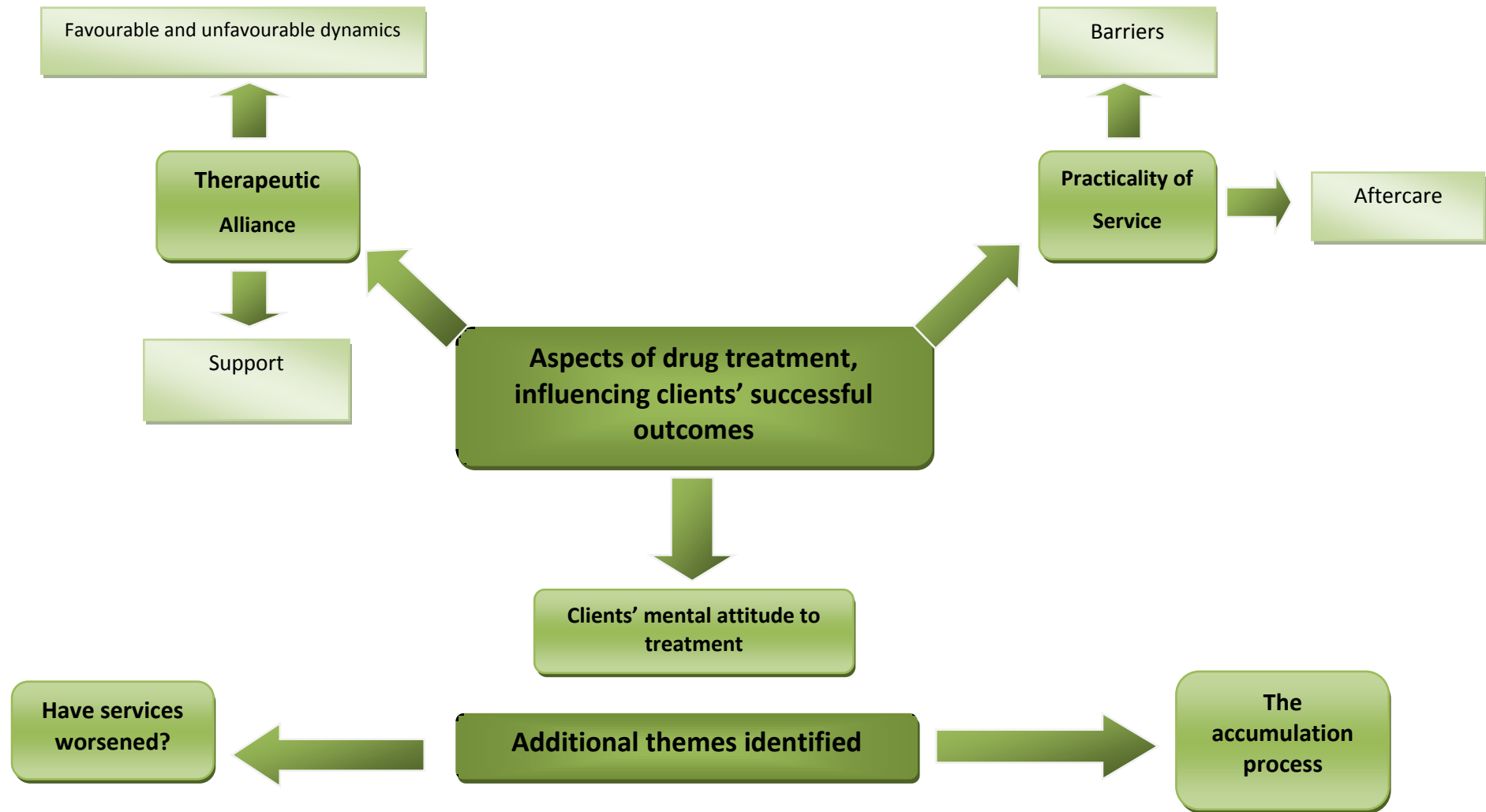


Figure 13: Flowchart of aspects of drug treatment, influencing clients' successful outcomes (DTP group)



4.1.4.1 Interview Set One: The Client Group

Within the first group (the client group), the main issue to be addressed from this study, and was predominantly identified in interviewees' responses, was the aspects of treatment that could be attributed to having an influence on treatment success. This was considered not only useful because it is the focus of the entire project, but issues that are highlighted come directly from those who are using the services and can thus be considered to be most knowledgeable in this issue. Within this research question, three main themes were identified; (1) The dynamics of the therapeutic alliance, which was considered to be multifaceted and thus required three further sub-themes; (i) practitioners' attitude, (ii) continuity of practitioner, (iii) trust, and (2) the clients' locus of control, and finally, (3) the practicality of the treatment service, which was sub-divided into (i) flexibility, (ii) aftercare, and (iii) the provision of social reintegration opportunities.

Predominantly, the main feature to arise in success in treatment, which supports findings from previous studies in this project, was the nature of the therapeutic alliance between practitioner and client. This was deemed so influential, that it was considered to be multifaceted, with a number of factors having influence on the therapeutic alliance, thus indicating the need to sub-divide the theme of the therapeutic alliance, into a further three factors.

The attitude displayed by the practitioner was signified as an important part of the treatment process, for example;

"...she's very good", R – "Is there anything you think that she does or says that makes you think she's very good?", C - "No, it's just her attitude and the way she comes over to you". (C)

In support of previous research as reviewed by Lloyd (2010), most interviewees reported that practitioners had a caring nature, and that it was preferable to the attitudes they had experienced in generic healthcare. The disparity between practitioner and generic health staff was attributed by the interviewees to be as a result of a choice of work; with practitioners displaying a more favourable attitude, for the reason that they had chosen to work directly with drug users, whereas generic healthcare staff had not made this decision to work directly with IDUs, as in general, they worked with the general public, only seeing IDUs on an occasional basis;

“Well, I think most of ‘em have been the same, always take an interest in you. You can tell them from people, that they’re in it cos they care”, R - “How do you?”, A - “Like you get a feeling about someone, and you know that they’re doing the job cos they do really care about you. Sometimes they don’t though, but that’s not been very often” (A)

And,

“I’ve seen a lot of people in my time, and I know when someone is truly interested, or they just doing a job. Most of them I’ve seen have been very good and supportive. But then they’re probably doing this job cos they wanted to” (A)

The reason for this disparity may be two-fold; firstly though a desire to work with users, and secondly, through greater contact with IDUs improving levels of favourability, as had been shown in the previous studies in this project.

On the other hand, interviewees have also experienced non-caring practitioners;

“Yeah, she was a bitch”, R – “Why do you say that”, B - “Cos she didn’t care about me” (B)

However, this may be more as a result of the lack of a chance to build up a therapeutic relationship. The interviewee that made this comment, also indicated that they never stayed in treatment episodes for very long, never saw the same practitioner on a regular basis, and thus, never felt comfortable or open enough to share in therapy sessions, thus treatment sessions were unlikely to successfully achieve their goals;

“well, to be honest, I’ve never gone to treatment for longer than a couple of weeks, so I’ve never really seen the same person to feel comfortable with, it feels like a new person every time, and I hate having to go through my story again and again. It’s embarrassing. It makes me feel more shit about myself having to keep telling new people over and over about my life, my family, stuff I’ve done, and what been done to me, why should I have to keep saying it all the time. It never makes me feel any better; to be honest it just makes me feel worse keep going over old ground. And then you don’t know who to trust, whether they’re just gonna pass it on to their mates and stuff, like when social services got involved. I think that’s the main thing that puts me off.” (B)

This indicates that clients have a desire for continuity in regularly seeing the same practitioner, over a prolonged period, and that this attributes to feelings of being more at ease and subsequently being able to open up and discuss the vulnerable issues that might be associated to their use of drugs;

"...I prefer it to be one person, it's like when you go to the hairdresser, you know, you want to go to the same person" (D)

And,

"What do you think makes a good drug worker", A – "Well, like, many years ago, back when I was living up north, I had a fantastic worker, his name was Frank. I went and saw him on and off for about 15 years. When he died I was devastated, he'd been like a dad to me, in fact he died in the same year as my dad, that set me back a bit". R – "I'm sorry. Did you feel very close to him then", A – "Yeah, I could say anything to him", R – "You trusted him", A – "Yeah, I could really open up. You see, I think it's hard to get a trusting relationship with someone you don't know. For me, it probably takes 4 or 5 years to feel able to talk about stuff. I could do that with him. Mind you, I don't think that there are those people that you can just instinctively talk to, you know like you get a gut feeling that you can talk to them, and then it's much quicker to be able to trust someone. Although I have trusted other people in the past, and ended up getting stabbed in the back." A – "If you can trust someone, it makes a big difference", R – "Yeah, and you were able to trust Frank as your drug worker", A – "Yeah, well I'd know him for er, years, since I was a kid. He was from the community, and I er grew up on the same estate where he was with his kids, and we used to play football together", R – "Oh ok" A – "And then the drugs started happening, and he became a drug worker. Then when I started seeing him, I felt comfortable with him, cos I already knew him. I was happy to go and see him, and he really helped me. Gave me someone to talk to. And he knew the truth, so like if I started bullshitting him, he'd just say to me, look that's bullshit. Its cos he knew me, and wouldn't put up with any crap. That's why I knew I had to be honest with him, or there was no point. How else was he gonna help me?", R – "so you had a good relationship", A – "Yeah, we had a good relationship", R – "Good. And you never had that since with anyone else", A – "no, but to be honest though, I've never seen anyone for that long to be able to feel comfortable with someone, not that I mind talking to people, it's just that he really knew me" (A)

Thus indicating that long term contact does appear to improve the TA, and subsequently improves treatment outcomes for the fact that clients will be able to use their therapeutic time more effectively, by feeling able to discuss important issues that may relate to their drug using behaviour.

Subsequently, a combination of a caring nature displayed by the practitioner within the TA, and continuity of seeing the same person, allowed for the client to develop trust;

“But if you found someone you could trust, and that you felt comfortable with, maybe they could help you understand your feelings, which might then help with your using”, B – “Yeah, but like I say, no one’s ever been there for me, like long enough, for me to feel like I can trust” (B)

In addition, the client shows appreciation for the need to first develop a relationship before trust is possible;

“And they might be things that you don’t want to talk about”, D – “Yeah, you’ve got to build like a confidence thing with them” (D)

Furthermore, that the client recognises that trust is a helpful aspect of treatment;

R- “What about when you first meet him?”, D – “I can’t really remember to be truthful, I treat everyone on the same level, but the problem with like Equinox, is like the people I’ve known there for ages I’ve got a certain amount of trust, if you can’t put trust, in somebody, you’d get nowhere” (D)

Interestingly, one interviewee commented that this trust had to be reciprocal to work;

“ Not just drug workers, but anybody, but especially drug workers, right cos you know, at the same time, they got to realise to trust you” (D)

A lack of confidence in the relationship, results in clients not feeling capable of properly opening up to the practitioner;

“ I don’t know really, but with me, I do hold a lot of things back, you know, but like, it’s like a defence mechanism in a way” (D)

It would appear also, that the client does not always appreciate the potential link between their personal issues and their use of illicit drugs. Maybe, that by addressing this link in treatment, it might help to engage the client, particularly where there is a lack of connection felt between client and DTP;

“Well, I’ve had counselling before, and all they want to talk about is your personal stuff, not your drugs”, R – “Ok”, B – “So it’s a waste of time. And they’re not confidential, it just makes me embarrassed talking about stuff like that to them” (B)

And,

“yeah, to a certain degree, cos you can’t turn round and say I done this that and the other, cos its none of their business really, whatever it was, but as long as it’s to do with that subject that they’re talking about” (D)

There are a number of other features that clients have highlighted in these discussions, which may also be attributed to the build- up of a success therapeutic alliance, one which trust and confidence is developed. These being, that the client feels that they are being treated with respect;

“Well, so far every time I’ve been the doctors always turned up late. Once I was left waiting about for 45 minutes, that really pissed me off, sorry for swearing, it’s just that I think it’s a bit hypocritical really, they tell you to be there at a certain time, and if you’re late they send you away, but then it’s alright for them to leave you hanging around for as long as they want, and that’s just supposed to be ok.” (B)

This quote demonstrates the importance of the DTP being knowledgeable in their subject, which is an issue that has often been raised in preceding research. For example, McLaughlin et al. (2000) reported that the majority of their illicit drug using population sample claimed that they were able to identify this lack of knowledge and understanding in their specialist drug practitioner.

“Well, they gotta know what they’re doing, half the time they aint got a clue. I wanna feel like I can see someone who knows what I’m talking about” (B)

Furthermore, clients also report to finding straight talking in practitioners a helpful aspect of treatment;

“Well, she’d probably tell me off, but that’s what she’s there for. I’d understand”, R – “So does she come across as if she could be quite strict? Is that something that you’d feel like you’d want?”, C – “No, if she knows that I’m doing wrong, she can tell by the way you talk and by your face. But, no, she’s a very nice lady”. (C)

It is potentially for this reason that the debate about whether an ex-drug using practitioner thus makes the more preferred practitioner, than a non ex-user, as they have more empathy and understanding about the realities of drug use, which is often debated in drug treatment, and similarly, was highlighted in these interviews;

“It’s hard to explain, you’ve got to experience it for yourself, so in other words, if someone’s been on drugs for 20, 30 years right, and then they get clean, and become a drug worker, that’s one of the best workers your ever gonna get , cos in the end they’ve experienced it for themselves, you can’t get someone coming in and reading out of a book and going ‘blah blah blah’, cos there’s things that he’ll say like Dan I’m not going through this with you and I’m not through all that with you cos you’ve done all this and you’ve done all that before, but some other people don’t, and they want to start again” (D)

The second significant theme found was the feeling of whether a clients’ success in treatment, was related to their demonstrating an internal, or external locus of control. According to Rotter (1954), individuals with an internal locus will relate all life occurrences to factors coming from within their selves, whereas, conversely, individuals displaying an external locus will attribute any occurrences on their lives as having been the result of factors beyond their control. Thus those who believe that they are powerless to overcoming addiction are less likely to succeed. When related to drug users in treatment, a number of external factors were repeatedly attributed to failures in treatment by the interviewees from group one. This can be exemplified by comments such as;

“...And I’m always rushing around at the moment, I was supposed to go for a medical over Reading last week, or the week before, I didn’t find out till 2 days before the

Monday, so, no money to get there, no medical evidence, and I thought, oh here we go, I always seem to be running around, and chasing my tail" (D).

Thus, difficulties in getting to appointments and a lack of financial resources were identified as reasons why treatment did not always go according to plan. Similarly;

"...you know, and it's getting harder and harder and harder, but like one thing that does annoy me is right, I moved from Slough to Windsor because I thought Windsor DIP/SMART whatever you call it, prescribing doctor, would come over to Windsor, but they don't, you still gotta go over to Maidenhead, so that's cost me £4 every time I go over, which really isn't a lot, but it is when you aint got it, you know and it would be nice if every fortnight or whenever it is" (D)

In addition, the chaos attributed to the life of a drug user was also indicated as being part of the problem as to why success in treatment is so difficult;

"...But because I've been about and using different addresses, this that and the other, for my mail, you know and all of a sudden they send it to an address, or whatever, and nobody keeps your letters for you anymore, and they just chuck them in the bin. And I haven't got time to keep running around after this and running around after that, all the other problems" (D)

Likewise, another interviewee commented;

"...I've never really stayed very long in treatment in the past. But I do want to this time. It's just that there was a cock up with the appointment letter, I didn't get it till after the appointment, and I knew I shoulda' been getting one, but cos I don't have a proper address, I'd given them a friend's address, but I never go it till it was too late. I suppose it my fault really, I knew they was gonna write to me, but I didn't really do nothing about it, I shoulda' chased them up or gone in there or something. I am gonna try harder this time though, cos I do wanna get help, and stay on a script." (B)

In addition to problems of financial resources and travelling to appointments, other IDUs that the client associated with were also considered as a trigger to use illicit drugs;

“Hmm, yeah, I’ve been in there before, three or four times. The first time it didn’t work, the second time didn’t work, the third time I done really well, I got a place out of it, but the place I got, everyone was doing drugs so I got back on it again. I went back in again but I didn’t think I got the right treatment in there” (D)

However, some interviewees were able to attribute getting off drugs to aspects of their own control, for example, one interviewee commented;

“Yeah, I just walked out. Been in and out of treatment ever since. You see I do want to get off the gear, always have in a way, but sometimes some more than others, so like when I’m strong about getting off the gear, I probably last longer, but when I don’t really want to, or guess like you’re made to, then you’re never gonna do it” (A)

And further;

“...wasn’t ready to get off it, hadn’t hit rock bottom, was still enjoying myself too much on it” (A)

Thus demonstrating that he had the knowledge and awareness, that success in treatment ultimately had to come from within, and that it was attributed to a state of mind and readiness to address the drug use. This quote is counter to the other examples, as this interviewee is not attributing failure in treatment to other users, missed appointment letters or having to travel, but to his own readiness to address his drug use. Therefore, supporting the notion that success in treatment has to come from within, that in having the realisation that is has to be the right mental attitude towards getting off drugs that will play an important role in success in treatment;

“I think it was around Christmas time or just before when I started thinking to myself no, I’ve got a full driving licence, do you know what I mean, like, and I’m getting old and all, I can’t keep going on like this, maybe now and again, but not every day, not like every single penny could spend it on this that and the other, but I can’t do that you know, and it’s not just that, I’ve seen a few other people that haven’t even been in rehab

or nothing. I see my mate the other day and she, I didn't recognise her, I was like bloody hell" (D)

However, this realisation can also have a detrimental effect on treatment, for example;

"Last time I went to see them, they're like right we're gonna get you off the gear, but they can't do it, I can't do it. Couldn't even do it for me kids, no one's gonna. They was really upset when the kids went. And now I just can't face 'em anymore" (B)

Thus demonstrating that a negative belief in oneself, such as in this case, feelings of embarrassment and hopelessness, is an internal feature that can have a harmful effect on treatment success by way of continuing the use of drugs, whether the user is aware of this unconscious negative drive or not.

The third theme identified in aspects of treatment that impacted on success in treatment, incorporated far more issues related to the practical nature of the service, rather than of a psychological or relational nature. These included, how flexible the service was, and whether the service provided good aftercare for clients. The practical nature of services has already been touched on in some of the preceding quotes, for example, in those related to clients demonstrating an external locus of control, interviewees talked of needing to travel to services. Thus, quotes such as these can be considered to be useful in more than one theme. However, more specifically, interviewees commented that;

"You see, when you've living on the streets, you can't always be ready to get on for an appointment, especially in another town, like what were expected to do here. I don't always have the money, or I've got the dog to think about. So for me, the fact that they can be flexible makes a huge difference, as long as I don't take the piss out of it, I feel confident that I'm gonna do alright with them, cos they want to help me and fitting me in when they can is quite important" (A)

And,

“Yeah that happened to me twice that did. You know what I mean, that’s another reason why I came over to Windsor, and they say to me, as long as your here before 4 o’clock Dan, ‘blah blah blah’, no problem, and I’ve rung them up and said can the doctor write my script up and go and collect it, yeah, now, they’ll do that for me sometimes, not all the time, I don’t take the mickey out of it, but in Slough they won’t do that” (D)

A lack of flexibility in a service was even attributed by one interviewee to failure in treatment in the past;

“like if I’m gonna be late, or I can’t get down there to the appointment, I’ve just give em a ring and told them and they’ve said, no problem come along a bit later or something. That helps a lot, cos in the past some places have been like, no if you can’t make it then, you’ll have to wait till next week. That’s how I’ve been kicked off scripts before. You see, when you’ve living on the streets, you can’t always be ready to get on for an appointment, especially in another town, like what we’re expected to do here” (D)

One of the most important features of working with a drug user is the awareness and understanding of a need to react and deal with crisis situations as and when they occur, thus not always being able to work to schedule. When working with clients who are at times very chaotic, in their lives, and in their treatment needs, practitioners’ have to be adaptive and as such, cannot always maintain a regimented approach to work. Thus, quite often, the role of the practitioner is to react to crises when they occur, for example, sudden homelessness, illness, or imprisonment. Thus highlighting the need for practitioners’ to maintain some flexibility when dealing with such clients;

“Is that because your life is quite chaotic”, A – “Look, when you’re on the street, or if you’re a user, life is always chaotic, always running from one situation to the next, your first thoughts aren’t, oh I gotta be at this appointment at this time, so being flexible is important. More places should be like that, I think it’d make a big difference”. (A)

And,

“[E]verybodies got so much problems that need sorting out that, do you know what I mean, and you do get allocated a key worker, but that key workers just fix that problem for that person, and share it with three or four other people, just to cut corners, and get things done, cos it doesn’t work” (D)

However, when this occurs, it can often lead to feelings of resentment in those clients that have to be prioritised as less urgent, thus resulting in their having to wait;

*“yeah, that’s what I’m saying, I’ve come downstairs for them to pick me up at 3 o’clock and they haven’t been there, they’re too busy talking to the next person or doing something else, or something else has happened, yeah and they gotta a board, they gotta board in there and at night time, they’ll write on the board all the rooms, 1 to 10 and the person’s name or whatever, and it will say so and so’s appointment at 3 o’clock, so and so has this at some sort of time and, you know, it’s put in the book the night before and the staff put it on the board so they know they’ve got to take you here there and everywhere, but then its oh, we can’t do that cos we’re doing that, it’s not just me”
(D)*

Perhaps these feelings of a lack of patience occurred as a result of the need for instant self-gratification, which can be related to the use of illicit drugs.

Another aspect of practicality is that the service must provide adequate aftercare;

“it’s like, the thing is, with drugs it’s like I don’t know about with drink, but with drugs its quite easy coming off it, it’s the staying off it that’s the hard bit.” (D)

Thus, the need for aftercare should be an essential part of treatment, to ensure that success is continued;

“You can’t just go somewhere and they kick you out afterwards, they say there’s aftercare, but it aint like what it’s supposed to be” (D)

And,

“Yeah like a detox right. But because I’m on 65ml of meth, detox-ing off 65ml of meth is a nightmare, not many people can do it, you know, and not just that, I feel, I said to him, I said I don’t wanna do that, he says why Dan, I said cos it feels like someone saying let’s pass the problem onto the next people, cos it’s called a rotating bed, and you’d only end up being in it for a week”, R – “So regardless of whether you need to stay”, D – “And

then I've got to come all the way back again, and then I'll be back down the homeless route again" (D)

Thus exemplifying that in order to achieve successful outcomes, there is also a need for services to ensure the provision of other important aspects of social reintegration, alongside drug treatment;

"the first time I was in there I was allowed out after 6 weeks, the second time I was only in there for 6 or 7 weeks and I left, cos someone said, oh well we can help you with your drugs, but we can't house ya, so I said what's the point me being here cos it's snowing outside" (D)

And,

"Do you know what I mean, there's no good going, ok, no more methadone this week. That's why I said no leave it and he said you know I agree with ya, you know, it's like when I was in Equinox before and like could of gone into rehab in Plymouth secondary, and that was like for 6 weeks, but what happens is they couldn't promise me somewhere to live when I came back, and I would have been coming back in the winter, and I thought I'd do all this for nothing" (D)

Finally, although this piece of research was predominantly driven deductively by the predetermined knowledge of the therapeutic alliance as having an influential role in treatment success, the research remained inductive, as it allowed for the voice of the client to highlight aspects of this role that might not have yet been thought of. Similarly, some additional themes were presented within the interviews, which the interviewer had not previously considered. Thus, these themes were entirely induced from the undertaking of the research.

One interviewee claimed that in their opinion, drug treatment services were actually declining in their performance. This was attributed to a lack of resources, due to an influx of drug users on services that were not large enough, or resourced enough to cope;

“[W]ell, cos there are so many more people that need treatment now for drug abuse, much more than there ever used to be, so now they’re so overstretched, and much harder to get in. Like, if you decided one day, that’s it, I’ve had enough I want treatment, you have to go on the waiting list for months, and then by the time they say oh we’ve got you a place, you’re like well back into then and don’t care about coming off. Once upon a time, you’d say, I wanna go into rehab, and they’d send you to rehab. Now you’ve gotta wait for them to decide if they’ve got the money to send you or not. It never used to be like that. Getting money for rehab is a nightmare now, but I do understand why, there’s so many people that need treatment now.” (A)

Similarly, another issued raised in these interviews, which had not investigated previously, was the role that an accumulation process in treatment had on overall success. What this means is that a drug user will often have numerous treatment episodes throughout their drug career, but is there an accumulation process that occurs throughout these different treatment episodes. Similar to that of the concept of a puzzle, pieces of information and knowledge learned at different aspects and stages of treatment, over time, are slotted together, and have a resultant effect in helping the final treatment episode, the one that is successful. This notion is exemplified in quotes such as;

“Hmm, yeah, I’ve been in there before, three or four times. The first time it didn’t work, the second time didn’t work, the third time I done really well, I got a place out of it, but the place I got, everyone was doing drugs so I got back on it again. I went back in again but I didn’t think I got the right treatment in there” (D)

Whereas, on the other hand, it can also be argued that numerous treatment episodes, especially those were deemed to have failed, may negatively influence the forthcoming new treatment episode, for example;

“Er, I guess so, it’s just that what happened in the past put me off a bit. It makes me suspicious about trusting anyone, special someone I don’t know, and that can pull me off a script like that (clicks fingers), or take me kids off me.” (B)

Please see Appendix 8.5 for an example of an interview transcript.

4.1.4.2 Interview Set Two: The Practitioner Group

The interviews with IDUs were followed by interviews with current DTPs, who had themselves also been through drug treatment at an early stage in their life. This particular sample was selected to see if their prior knowledge or treatment as a client, and their current knowledge and experience as a DTP could provide more evidence to support or dispute the issues highlighted in the previous sample. Subsequently, suggested themes by the client group as to what might work within treatment, can be supported or refuted by those recovered-IDU DTPs, who have actually been through treatment themselves. Furthermore, this study can examine whether any experiences the DTPs had encountered in the TA when they undertook treatment, had been carried through to the way in which they work now, with the client group.

Similarly to the first group, the research question followed preceding work in this project, to look at aspects of treatment that could be attributed to a clients' success in treatment. This was divided into three themes; (1) The dynamics of the therapeutic alliance, which, again similarly to that of the previous set of interviews, was deemed to be multifaceted and requiring further division into two themes; (i) favourable and unfavourable dynamics within the relationship between practitioner and client, (ii) support, and (2) The clients' mental attitude towards treatment, (3) The practicalities of the treatment service, which was further sub-divided into (i) the provision of aftercare, and (ii) barriers to treatment. Furthermore, issues that had been raised in the previous set of interviews by current clients, that (1) drug services had worsened, and (2) that the accumulation process of treatment episodes had an influence on treatment outcomes, was also explored.

It is impossible to draw away from the prominent feature of the therapeutic alliance, when exploring the research question as to what factors have a considerable impact on clients' treatment outcomes. Studies throughout this project have all highlighted its fundamental influence on treatment, and findings from this set of interviews, does not make exception. Not only are the dynamics of the therapeutic alliance important to this group of interviewees, but they have also had first-hand experience of how favourable and/or non-favourable attitudes have actually impacted on their own personal drug treatment. Thus, any findings from this group of interviews will validate those issues that were drawn from the preceding interviews with current drug users.

Having a good relationship between practitioner and client is so important to treatment outcomes, and is found to promote a clients' engagement and retention, as displayed in the following quote;

"...I think it made a difference whether you were keen to go in and see them or not, like I said about Carol, I liked her, so I enjoyed going in and seeing her, if you don't like someone, you're not so likely to be keen to go in. I never really had a bad drug worker though" (E)

And similarly, there was a knowledge that therapeutic time should be worthwhile, as without a rapport better practitioner and client, honesty and trust could not be established, which is a fundamental part to effective therapy;

"yeah, of course, you can't have a good relationship between a client and a workers if there's no trust and honesty, otherwise it's just they come in bullshit you, and then they're off and nothing really gets addressed" (E)

The interviewees understanding of both sides of the treatment system appear to provide an improved knowledge of how genuine the rapport between practitioner and client is;

"yes I think so, they're always pretty good at coming in, and I take the time to talk and listen with them, and they seem to be genuine, it's a two way thing, you've got to be genuine, and they will too" (F)

Similarly, this quote also supports an issue highlighted in the previous set of interviews, that the relationship between DTP and client should be dyadic; that the client should perceive trust, but so to, should the DTP.

The following quote exemplifies how time needs to be taken to develop trust and honesty within the therapeutic alliance, which again was an issue highlighted in the previous studies, and perhaps this deeper level of understanding comes from their having personally experienced both sides of the treatment system;

"I try and encourage them to open up, but you can't make someone. And I think if they feel rushed into it too soon, when they're not ready, then it will frighten them off. So what I try to do is take a gentle approach. When I first meet someone just have a nice chat, like we're on the same level, helps put them at ease. Then see 'em for a while, before getting too into their private life, someone's only going to do this when they feel comfortable, and I think in my experience, you only feel comfortable with someone when you've got to know them a bit first. It's like that in all sort of relationships, like when you make friends with someone, you would open up and tell em everything straight away would you, you'd want to get to know them first, it's no difference really."
(E)

When asked if they had received a favourable response from DTPs' in the past, the majority of the interviews were in agreement that they had. This was exemplified in comments such as;

"er, well, they listened to you. You felt like they had time for you, not rushed, or that they didn't care. I think that's good. When someone's rude to you or couldn't care less, then you don't want to have anything to do with them. That's probably why people stayed at the centre, cos they were a nice group, and we used to sit around and have a laugh, and it felt comfortable" (G)

And,

"She really cared about her clients, always gave you the time of day. When I saw her she never made you feel rushed, you could really sit down and open up to her" (E)

Comparatively, negative experiences in generic services were demonstrated in comments such as;

"...I, er, once had to take my mate into A and E, cos he injected and he'd got this really swollen leg. Everyone was saying it was a DVT, which is serious, you know, you can lose a leg or something. Anyway, we went to A and E and told them, well they treated us like the scum of the earth. They made us wait hours and hours, and then when they saw us and the doctor was asking us how it happened, he was so rude to my mate, cos he was a drug user, or maybe cos he'd done it to himself. Even the nurse, when she had to take

some blood, and she was really struggling, cos my mate didn't have many veins left, she was sarcastic and stroppy to him. It was embarrassing; I would never have done that again" (G)

And,

"...of course, no one wants to go and see someone they don't like, I was like that with my doctor, he was quite judgemental and unsympathetic to me, what with having the kids and everything, well I don't know if he was that's just how I felt it was, probably looking back it was cos I was feeling shit about myself then, so I just assumed he felt the same way?" (F)

However, the above quote highlights the importance that perception can have on treatment. In this case, the interviewee demonstrates how and why there may be disparity between clients' perception of favourability from others, and actual levels of favourability.

Furthermore, as had already mentioned in the previous interviews, perhaps this disparity between specialist DTPs and generic healthcare staff is that drug practitioners' have deliberately chosen to work with IDUs, whereas generic healthcare staff, have not. This notion was again repeatedly suggested in the interviews with this sample group;

"...They've all been ok as I remember. But then I think they sort of do this job, for one reason or another, cos they want to" (E)

And,

"...GPs do their jobs cos they want to work with the community, drug workers do their jobs cos they want to work with drug users, for whatever reason, like maybe cos they've been one themselves like me, or they lost someone to it or a friend used, or I dunno, maybe just have a particular interest, but GPs, dealing with drug addicts, it just the bad bit of their jobs, so that's probably why they aren't so tolerant, or understanding, or aren't so sympathetic, it's just a lot more in and out, job done. I can see that from both sides, for being a drug addict and going to see my GP for meth, and on the other side, as working with clients that have to go and see the GP" (E).

Even though the negativity in generic healthcare staff experienced by these interviewees, and is still apparent in current drug users, according to this sample group, it need not have a considerable negative impact on treatment outcomes, so long as the drug treatment being offered alongside generic healthcare is favourable;

"...I think as long as someone has a good drug workers they can speak to, doesn't really matter what the doctor's like, as long as they not rude or anything, but if it is just a case of in and out, sign the script and so on, then that's alright, they're not interested in how their patient's week has been, and they not paid to ask, do you know what I mean" (G)

Needless to say, the sample group also highlighted the need to have 'tough love' in treatment. Although there is a necessity to have a good rapport between practitioner and client, it was implied on numerous occasions, that clients did not desire a practitioner that would be easy to manipulate and did not warrant respect;

"Yeah, it was alright. Most of the time they were alright. Sometimes I think they let us get away with too much, you know sitting around a lot chatting, not really working" (G)

Thus supporting findings from the first set of interviews, suggesting that practitioners who were seen as 'straight talking' and could see through dishonesty were more effective practitioners. This was exemplified in comments such as;

"So you felt able to be honest with her?", E – "Completely, but then I'd known her years, she knew all the bullshit, so there was no point bullshitting her. I just would say it like it was, and she was fine with that" (E)

And,

"...when I need to come down hard, I do, and I think they respect me for that. Maybe it's a bit like children, always pushing the boundaries so that they know how far they can push you." (F)

As long as this was delivered in a respectful manner;

"...because I also provide the legal side to it, I do sometimes have to play the tough guy, but I think there are ways of doing it. People need to be treated on the same level, so like, you don't want to talk down to them, or to like be patronising. They see through that straight way, but then equally, I think they see through a push over, and know exactly how to play them. So it's a case of being somewhere in the middle, treat them like human beings, but don't take any crap!" (F)

Potentially one of the main reasons why clients respected 'tough love', was that they knew that they could manipulate situations to their advantage.

"these guys are not stupid, they know an easy ride when they see one, say if like someone's too nicey nicey to stand up to them, or if someone can't be bothered with them, they'll just use them to their advantage, erm, you know, manipulate them into whatever they want them to do" (F)

One particular area that has repeatedly been exposed as an aspect of potential manipulation is in the practitioner having a lack of knowledge;

"...well, GPs are there just to do their job, they don't want to talk about what's going, and they generally have no knowledge whatsoever about it, all they do is write out the script. So like, you could go in there and blag needing this and that prescription, you know like DF118s, sleeping pills, up your meth, whatever, and mostly they just did it, just to get shot of you as quickly as possible. I think they still do. It's the lack of knowledge they have that clients take advantage of. You just say the right things at the right times, and they give you what you want. That's what I've got to be carefully with now with my clients, that they don't take the piss out of the prescribing doctor" (E)

However, even though the client can use it to their advantage, it is predominantly cited as a criticism by clients, as an area of ineffectual treatment;

"Would it have put you off if she hadn't of been knowledgeable?", E – "Yeah definitely. I see that with my clients now. The one thing they complain a lot about is like GPs who

really don't understand, they just dish out the drugs and send them away. It's like there's a lack of understanding about being a drug user, so they just do the necessary and then send them off. It was like that in my day too" (E)

This is perhaps one of the reasons why ex-users might make more effective DTPs, because of their first-hand knowledge, awareness and experience of both sides of the treatment system. This theme was highlighted several times by this sample group;

"...I think that ex-users might have an easier time with clients cos that understanding helps them to open up quicker. That fact that you know someone else has been there done that, makes you more trusting quicker, and I then you can get straight into the counselling side of treatment. Without that previous experience, a user is probably a bit more distrusting and finds it harder to open up, cos they thinking that whatever they might say might upset or put that person off them" (G)

And,

"...Like if I was to say to you that one day I was so desperate for a bag that I mugged an old lady, if you'd never been a user, and you've never had to do bad stuff like that, you might end up making some really bad judgements about me. Its gonna take me longer to open up to someone whose never been through it, then it would with people that have actually lived a similar life. That's why NA is so good for me, everyone there has been through it and has that deeper understanding, so you know that they're not gonna judge, cos one way or another, they've all done terrible things" (G)

This last comment hints to a counter argument to ex-users being the most effective practitioners', as it suggests that there are other aspects of the practitioner could be seen as just as effective, if not more so;

"No, she was never an ex-user, so just was a nice person. Wanted to be in the job, you could tell that about her, from her manner, and from the fact that she was there doing that job for so long. Never got pissed off, you never caught her on a bad day. All workers should be like that, I looked forward to seeing her" (E)

And similarly, in relation to the notion that knowledge would be at a deficit in a non-ex-user;

“Do you think that from the fact that she’d never been a user, that she wasn’t that knowledgeable?”, E - “No, she knew what she was on about, I never thought she didn’t. She probably learnt it from working with drug users all those years or something. Maybe training?” (E)

The following quote highlights quite clearly why being an ex-user should not be a prerequisite to being a DTP;

“...You see like when you compare my life story with another ex-user, my heroin use was completely different. Mine was just a little bit here a little bit there, not like some who’ve come back from daily injecting and now work with addicts. I don’t think they’re necessarily better or worse, and I don’t think I am, we all just have different stories. Just because someone has never used before, doesn’t mean they haven’t experienced addiction in some other way, like an alcoholic father, or maybe they’ve had a problem with food in the past, addiction is addiction, whatever its too, I think pretty much everyone’s got some story to tell about that, but they’re all different, so no, I don’t think that makes a difference on whether you’re a good worker” (F)

However, interviewees were asked as to whether they used the experiences that they had encountered in their treatment, when working with clients now. All interviewees provide examples of doing so;

“...I think it probably helps cos I’ve been there before, like, I know first-hand what they’re going through. That’s not to say that someone who hasn’t been through it can’t get on with a user, like I’d said about Carol, it’s just that it’s probably easier and quicker to build up that rapport, it probably comes a bit more naturally, cos talking to drug users has been my life!” (E)

Similarly,

“It certainly helps me, its means I can understand where they’re coming from, I think unless you’ve been a user yourself, it’s impossible to do that” (G)

Thus suggesting that ex-users have a wealth of knowledge and experience that can be beneficial in providing treatment to current users, and is perhaps most advantageous when working concomitant with non-ex-using practitioners who have chosen to work in the field, due to their love for the nature of the work. Thus, improving the effectiveness of a treatment service from having a combination of two types of practitioners within a service.

The second fundamental dynamic of the therapeutic alliance, that was repeatedly referred to by interviewees when discussing effectiveness in treatment, was the need for support. Although there was an awareness that the catalyst for addressing issues with drugs essential had to come from the client, there was frequent acknowledgement made to the considerable impact that support had on achieving and continued abstinence;

“...Erm? I think for me, it ultimately came from myself. But having the support from others made a huge difference. It's one thing deciding you want to get off the drugs, but you do need help to do it. And not just to get off the gear, but to stay off it, it's a constant battle; I'll probably have it in my head for the rest of my life. But then that's why you get help from others. So I guess what I'm saying is that it's a lot to do with yourself making your mind up to it, and a lot to do with having a support network from others” (G)

This was for the reason that there was an understanding that a client could not be made to do anything against their own will;

“ Er, no. I’m a firm believer that it has to come from the client. I can’t make a person do anything, they have to do it for themselves, the only I thing I can do is aide. Like I said before state of mind has a huge part to play in recovery, that and support” (F)

Similarly,

"...if someone gets that thought in their head to use, there's nothing they could of done." (G)

Essentially, support is one of the fundamental roles that the practitioner can provide in treatment;

"By being supportive and caring, and by helping with all the potential blockers that addicts face in society, like getting a job, getting a house. All these kinds of things" (F)

Thus, these interviews showed an awareness that they were incapable of solely facilitating any change in the client, but that their support and guidance had a considerable influence on a clients' treatment outcomes. Thus, practitioners did not have a direct effect on outcomes, however, they had an indirect effect by way of assisting in the building of the knowledge, confidence and understanding, as well as assisting in the client acquiring the necessary means to psychologically get into the right mind set to get off drugs, as well as providing the necessary practical support for social reintegration, such as housing an employment;

" Well like I said before, not really affecting their outcomes, as in, if I do this for you, it will stop you from using drugs. But like, giving them the tools to learn how to get to that point of wanting to get off drugs, like, giving them the encouragement and support, a lot of them have ever had that before" (F)

Consequently, the other influential feature attributed towards success in treatment, alongside that of the TA, was considered to be the clients' mental attitude towards treatment. Moreover, this was frequently referred to by these interviewees, as being most accountable to their success in treatment, over and above that of relationships within the therapeutic alliance.

Interviewees commented that they were not ready to seriously address their drug issues, until they were in the right mind state;

"I just wasn't ready for it. I found the whole thing too much, I couldn't cope, and I probably wasn't ready to get off the gear then. Cos when I went the first time, it was

part of an Order, whereas the last time I went, it was cos I was at rock bottom and had enough of my life, I wanted to get to rehab and get off the gear. That's probably the big difference, I really felt ready to do it and I was the one to make the decision to get help, not being told to go by a Judge" (E)

And,

"No, they were nice, as I can remember. Caring people, they wanted to help. It's just that I wasn't in the right mind set to deal with it. I say that to clients now when I see them, you've got to be doing this for the right reasons, not cos your girlfriend, or cos Probation are wanting to get you off the drugs, I think that you will only do it when you've made your mind up to it" (E)

One interviewee informed that she was even able to stop her drug use, predominantly on will-power, with limited support from treatment providers and friends and family;

"I knew it couldn't go on forever, I had to stop, so I just cut down on the amount I was smoking every day, and used the methadone to stop. It was hard. I think I used it most when times were most hard for me, my husband had left, I'd got two small kids, and was stuck indoors all day long, I found it all very stressful, the heroin just helped me deal with it. It didn't knock me out or anything like that, just chilled me out so I wasn't too stressed with the kids. Like I said before, no one really knew I was even using it; they'd probably be surprised if they knew! When things got easy over time, what with the kids getting older and being at school most of the day, I didn't feel so stressed and confined to the house; it was easier to do it then. It's all about being in the right frame of mind to do it, I think that if it's what you really want, and your determined enough, that's the best way to do it, but you're never really going to do it until you're mentally ready" (F)

Having being in the right frame of mind to address drug issues, is half the battle;

"Yes, I really wanted to get off drugs. I think that if someone goes into treatment with the real desire to get off drugs, then they half way there, you see in my line of work, you

see this quite often, that people say they want to get off the gear, but in reality they don't want to, maybe they just want a get out of jail pass by getting a drug treatment order. But I think if someone goes into treatment really wanting to stop, then it's the most important bit, it's all about being in the right frame of mind. Your job as a good drug worker is to help them to achieve it." (F)

Perhaps acquiring the right mentality to address the drug issues comes from having the right treatment goal;

"It wasn't until the last time I was inside I thought, this can't go one, I've got to get off it for good this time, and that's when I did. So yeah I suppose I did have a goal at the end, but that's what makes you focus, wanting to get off it. All the time you're just floating about, you just don't do it..." (G)

This is an area of treatment that the practitioner can actively help the client to achieve, and was an idea that was confirmed by interviewees;

"Yeah. Totally, think that's the role of the worker, to try and make treatment a positive thing for these guys. They had so much rubbish in their lives, and are so chaotic, half of them have never had anyone positive and, well, like a positive role model to follow, I know I didn't. I think that a drug worker can really offer that. Sort of encourage them into it, even if they don't feel ready" (F)

Similarly,

"Do you still think that now with your clients?", F – "To a certain extent, yes. I think they need to be mentally ready to stop, I think we can help in treatment through, like giving them the right encouragement, and gradual push, so that they themselves get to that mental readiness, if you know what I mean" (F)

Consequently, coercive treatment should not be seen as a negative thing, which is often the way in treatment, for example;

"...I think the problem is that you in there with a load of other users trying to get off the gear, and some that don't want to get off the gear, they just don't want to go to jail, so they get a court order instead, so then everyone's sitting around, and everyone wants to use, and someone says they've got a bit of gear, and it buggers all of us up" (G)

And,

"...try and make it more serious, not that you can, put getting rid of all those who don't actually want to be in there would help. But what with all these Court Orders, you're always going to get these in there" (G)

Since coercive treatment is a way of engaging individuals into treatment, even if they do not necessarily feel ready to address their drug issues, the role of the practitioner can be to guide and assist the clients thought process to develop the right frame of mind to address their issues. This was exemplified in a number of comments;

"...I think that you will only do it when you've made your mind up to it. Mind you, that's not to say that people on Orders are a waste of time, cos it does help some..." (E)

And,

"You see, all the ones I see aren't in drug treatment by choice, they've been made to address their drug problems by a Judge, so pretty much all of them aren't at that stage that they want to get off the gear, although they might say that when your assessing them! But I think that making them go into treatment is not a bad thing, these are people that strongly disagree with it, but in my opinion, getting anyone into treatment one way or any other is good, it can start to get them ready to get off the gear." (F)

The third main theme identified in interviews with the practitioners, and was previously identified in the client group, was the practical aspects of the treatment services, as having an influence on

success in treatment. These were more specifically defined as (i) the provision of aftercare, and (ii) barriers to treatment.

A commonly occurring theme in interviewees' comments was that aftercare was an essential feature of maintaining successful outcomes in treatment once they had been achieved. Although this theme was not indicated as a tool for achieving successful outcomes, it was repeatedly considered, by interviewees, to be a key factor of effective treatment. This was exemplified in the following comment;

"People need to be supported through treatment, but it is often forgotten after treatment and in my experience, the on-going support is what helps you keep off it. It's a bit like saying, it's er easy to get off the gear, but staying off it is the hardest it. So quite often the time when support is most beneficial is when treatment has finished. That's when clients are most vulnerable. What's why I always try and get them to go to places like NA, cos really the aftercare support round here is pretty bad." (E)

Although considered to be extremely important, treatment services were criticised for not always providing adequate aftercare to clients;

"Yeah sure, but that's nothing new, there's never been very much aftercare for people finishing treatment" (E)

Often, other forms of aftercare are then sought by clients, for example;

"And I still do that now, at NA meetings, as for me having the support from others, and knowing that they are going through the same thing as you are really helps, even though I've been clean now coming up for 7 years, I still need that crutch" (E)

The second sub-theme to emerge in the practical nature of treatment services was that there were often barriers in drug treatment, which discouraged engagement with services, and thus impacted on success in treatment. The only female from the group highlighted issues of childcare and that

treatment services were predominantly male orientated, which in her experience, had both been barriers to her treatment;

“But it’s hard, when you’re a woman on your own, and you’ve got kids, it’s still the same now, it’s a blocker into treatment I think, having been through it myself, I know how hard it is. There’s just no childcare facilities with these treatments services, so if you have kids at home and no help with childcare, there’s just no way of doing it. I probably stayed on and off three months, but I was very nervous about doing it, like I say, I didn’t want them to take my kids into care, so I said I was fine and the childcare stopped, then I couldn’t go any more. I just carried on seeing the doctor, and gradually weaned myself off the heroin” (F)

And,

“...the support for women in treatment is still as rubbish as ever, there’s still no childcare facilities, so to my way of thinking, that’s not changed at all. Treatment services are very male orientated, and I know that’s cos most people in treatment are males, but maybe we need to consider why. From my experience, if you’re a woman and you haven’t got any extra help with the kids, or you turn up and it’s all boys, it’s not very encouraging really. That is an issue that still needs addressing” (F)

Finally, the unexpected theme that drug treatment services had worsened, that was identified in the previous group, was thus explored in the practitioner group, to see if there was any support to this claim. It was however found, that interviewees from this group focused on improvements to the generic healthcare system, predominantly GPs, and that there was disparity in their beliefs as to whether there had been any improvements. For example, one interviewee thought that treatment from GPs had worsened, and that this was as a result of their lack of tolerance to the vast amount of drugs now in the system;

“So you don’t think GPs attitudes have changed much over time?” E – “no, not really, I guess maybe they’ve become a little more tolerant because they’re having to see so many more, but I don’t know if that improves attitudes or makes them worse, cos we got so many more addicts now that we did back when I was on it, so maybe they more fed up with seeing them all the time. I don’t really know?” (E)

Conversely, contradictory claims from another interviewee, was that this influx of drug users in the system had actually improved GPs attitudes, due to their increased contact with drug users, which improved their knowledge and understanding;

“Er, yeah, i think it’s alright just to pop in and get their script, as long as you’re not made to feel like scum. But I think doctors are getting more understanding anyway, cos they are seeing more and more users now, they probably getting a bit more desensitised to it now” (G)

A further area of exploration, identified in the preceding interview set, was that the accumulation of a number of treatment episodes, over the course of an individuals’ drug career, also influenced successful outcomes in treatment. This was exemplified in the following comments;

“...I think that you probably get a build-up of treatment, like you might learn a bit from this one, and then a bit from that one, do you know what I mean” (E)

And,

“Maybe not this time, or the next, but it’s like a gradual process, and bit by bit they acquire the knowledge and understanding that it takes to get them to that right frame of mind, like I said earlier. I’m not saying I’m right, it’s just my opinion.” (F)

More specifically;

“...er, yeah, like one of the times I went into treatment, I managed to stay for a couple of weeks, and I was learning what it was like to actually sit down in a group and open up and share. When I’d first ever gone in to rehab, I was totally shocked by the whole thing, that I just walked out, it was too much. But the next time, I suppose I knew what to expect a bit. And I stayed longer and got involved more, actually quite enjoyed it” (E)

Consequently, as the accumulation process had been suggested in the previous interviews, by those who had not yet reached success in treatment, and was not subsequently mentioned on a number

of times by practitioners who had reached success in their own treatment, it confirmed the fact that the accumulation process was another feature attributing to success in treatment.

4.1.5 Discussion

4.1.5.1 Reflexivity

According to Bishop et al. (2002), Denzin and Lincoln (2000) and Flick (2002) reflexivity of the researcher is a fundamental tool of qualitative research. Allowing the researcher to heighten self-awareness in action (Reeves, 1994), it requires the researcher to reflect on the events, before, during and after they have occurred, as well as to have an awareness of surreptitious agendas that might influence needs, preferences, perceptions and emotions (Hughes, 2006). The researcher must not only have awareness of the multiple influences that they have on the research process, but, also to have an awareness of how the research process affects them (Gilgun, 2010).

Problems encountered in the data collection process:

The first problem encountered in this study was that there was generally a lack of uptake in interviewees. I originally began advertising at local drug treatment services for volunteers to engage in research on attitudes within treatment, however this elicited no response. The next course of action was that I attended drug treatment services, so that potential interviewees were able to see who I was before undertaking the interviews, so to familiarise themselves with me, and try and build some rapport. Again, this also elicited no response; individuals that I approached about participating in the study, said that they were too busy to be involved, or that they were simply uninterested.

It was then decided, between the local Drug Action Team and I, that a monetary incentive would be used, and that I would attend the local homeless drop-in project for potential interviewees. This was given ethical approval by the University's Board of Ethics. The decision to use a monetary incentive came from social exchange theory, suggesting that it would increase interviewees' willingness to be involved (Dillman, 1991, 1999). Consequently, a £10 Tesco voucher was agreed upon for

interviewees willing to give their time to the interview. This amount was deemed to be acceptable, as it was considered to be a worthy value for one hour of an individual's time, and could be used to buy something of worth, rather than having been of a cash value that could be used on illicit drugs. The vouchers were funded by me.

The issue of providing a monetary incentive has in the past received criticism, for example, that people would only get involved in the study for the financial gain (Hansen, 1980). However, the fact that including a monetary incentive elicited some response, suggested that it was a necessary feature of this research. In addition, research by Simmons and Wilmott (2004) reported that the general consensus was that use of monetary incentive, however small, was effective at increasing response rates in postal, telephone and face to face surveys. Furthermore, they reported that incentive payments improved the quality of data, in terms of its completeness and accuracy, however, they purported that certain groups would be more attracted to incentives. Thus, in this study, homeless individuals would have been more likely to want to undertake the interviews based on the monetary incentive. However, it was considered a necessary means to recruit interviewees for this study.

A second potential problem that arose when recruiting interviewees, and probably equated to the reason why there was very limited uptake in interviewees for the interviews, was a general feeling of distrust from individuals. When approached and asked whether they would like to engage in the research, they often appeared suspicious and inquisitive as to why it was being carried out, and for whom it was being undertaken. This appeared to dissipate when I visited the project on a number of occasions, thus suggesting that by having an awareness of who the researcher was, they became more at ease. Thus it was concluded that one way to reduce feelings of anxiety in potential interviewees was a continued researcher presence at the project, and this was carried out over a number of weeks.

Finally, how honest interviewees were in the interview setting was questionable. On face value, interviewees seemed open and willing to engage, however, one interviewee contradicted himself by stating that;

“... I wanted to get some funding for a naltraxone implant, but they’re like £1800, and I know I could get the money together if I wanted. But I asked for funding, and they said no” (A)

Yet, he also claimed to being unemployed, and admitted to committing minimal amounts of crime. Thus demonstrating a discrepancy in his story, possibly as a result of an unwillingness to divulge criminal activity to an unknown person. It could only be assumed that what interviewees were informing as to their experience in drug treatments was more honest, as truths here would not incriminate them in illegal matters.

Having said that, one interviewee was noticeably found to detract from the interview, and although he appeared to talk for an average amount of time, in a comfortable manner, his transcriptions revealed that he often digressed from the subject of his own drug treatment, to that of stories of a friend in prison, and how he was having to look after a dog, or to information on his girlfriends. Overall, he reported that everything in treatment was fine, that he was happy, and that it was all good. These responses perhaps suggest a lack of unwillingness to honestly share how he was really feeling, and how his treatment was actually going. The difficulty here is that individuals cannot be made to tell the truth, and that there has to be a certain element of trusting what the interviewee is saying is correct. Very few interesting statements came from this interviewee, to either support or dispute themes, thus, concluding that by his lack of useful responses, he naturally eliminated himself from the majority of the theme analysis. As such, he did not wrongly influence the themes by potentially withholding information.

Alternatively, this may have occurred because of the chaotic minds of individuals still using illicit drugs, reflected in the content of their interviews, as they found it hard to focus on just one questions. Similarly, some were found to treat the interview more as counselling session, possible as a result of their familiarity to this type of discussion. On reflection, I should have made interviewees aware at the beginning of the interview, that I was unable to help with any current issues that a key-worker could help with. This may have thus discouraged them from engaging in dialect relating specifically to current situations that needed resolving.

4.1.5.2 Summary of findings

The rationale for conducting the current study was to investigate the final part of the research question, which was to identify aspects of treatment, specifically the therapeutic alliance, which impacted on clients' treatment outcomes. This was carried out in order to investigate clients' experiences of drug treatment services and factors they associate with successful treatment. The research design that was utilised in this study, was not only considered as more appropriate to research carried out within clinical settings, but also, was more widely used in SI theory, the overarching theory of this project. This method not only methodologically triangulated the research already carried out in this project, by supporting or disputing findings from the quantitative studies, but allowed for a more in-depth exploration of the issues previously identified in the preceding studies. There was no specific research question, but a more general research question, looking at aspects in treatment that influenced treatment outcomes, so that themes identified remained as inductive as possible.

Two sample groups were utilised; current drug treatment clients, and current DTP, who had previously undergone drug treatment for addiction. This was for the reason that although the sample groups differed, they shared a commonality of personally attending treatment. Current clients were able to comment on aspects of treatment that they thought were assisting their drug treatment, whilst practitioners were able to comment on factors that they felt had actually influenced their treatment success.

The results from the interviews highlighted similarities in the themes identified from both sample groups. When the client group data set was explored for aspects of treatment that could be attributed to having an influence on treatment success, three main themes were identified; (1) The dynamics of the therapeutic alliance, which was further sub-divided into themes of, (i) practitioners' attitude, (ii) continuity of practitioner, (iii) trust. (2) The clients' locus of control, whereby clients predominantly demonstrated either an external or internal locus. (3) The practicality of the treatment service, which was sub-divided into themes of, (i) flexibility, (ii) aftercare, and (iii) the provision of social reintegration issues. In the exploration of the data set, two further issues were identified. Although these did not correspond specifically to aspects of treatment that impacted on success, they were considered to be relative to the general research question, in their relevance and

prevalence. These additional themes were, (1) Drug services were thought to have worsened, (2) There is an accumulation process of treatment.

Similarly, when the DTP data set was explored for aspects of treatment that could be attributed to having an influence on treatment success, three main themes were also identified, with only slight variation on the previous group; (1) The dynamics of the therapeutic alliance, which was sub-divided into two themes, (i) the relationship between practitioner and client, and (ii) support. (2) The clients' mental attitude towards treatment. (3) The practicalities of the treatment service, which were sub-divided into two themes, (i) the provision of aftercare, and (ii) barriers to treatment. Finally, the accumulation process identified in the previous data set was also evident, and the question raised in the previous group, that drug treatment services had worsened, was also explored. Although no general consensus was found, there were a number of relevant comments made.

4.1.5.3 The results in context with previous research

The themes identified in this study were compared to those identified in preceding studies, 5, 6 and 7, which utilised open-ended questions in questionnaires, to gather more qualitative responses from interviewees on aspects of treatment that influenced outcomes. Similar to that of the current study, the sample groups included current clients, current practitioners, and individuals who were currently, or had previously undergone some form of drug treatment. A number of similarities in responses were recognised.

Firstly, DTPs appeared to be aware of the importance of attitude within the TA, recognising that an unhelpful nature had unconstructive effects on treatment outcomes. Furthermore, current IDUs claimed that they found practitioners opinions to be extremely important. Thus, the TA between DTP and client was considered to be an influential part of effective treatment; in the study the client group stressing the importance of trust, and the DTP group reporting the importance of support. In addition, interviewees in the previous studies indicated the importance of feeling listened to and cared for within this relationship, and that DTPs were able to understand and displayed a non-judgemental environment for treatment.

DTPs believed that it was possible for practitioners to successfully influence client' treatment outcomes, with IDUs reporting that treatment not only helped with overcoming their physical addiction, but by addressing it cognitively too. However, in the current study, this influence was noted more as an indirect response, by assisting clients in the building of the knowledge, confidence and understanding, as well as assisting in the clients acquisition of the necessary tools to achieve success in treatment (in terms of psychologically preparing them, and providing the necessary practical support for social reintegration, such as housing and employment). Furthermore, interviewees from the online study (study seven) also supported the notion that empathy displayed in other clients, had assisted their own recovery. Thus providing support for the theme identified in this study, that recovered IDU DTPs possibly make preferred DTPs, to clients, due to their understanding and experiences of the realities of drug use, which is a subject area often debated in drug treatment.

IDUs from the preceding study reported that contact within the therapeutic alliance was important, as non-frequent meetings between practitioners and client, resulted in a lack of rapport between the two, which had a detrimental effect on favourability. This was supported in the current study as long-term contact was thought to improve the TA, and subsequently improve treatment outcomes. It is clear that developed rapport allowed for therapeutic time to be used more wisely, with more open discussion about issues relating to drug use.

Contact, particularly the continuity of seeing the same practitioner, was considered as an important factor of treatment success, and was exemplified in clients from the current study reporting disparity between the way in which they viewed their DTP; Becca who had a history of non-engagement and thus no continuity in seeing the same practitioner, was repeatedly negative about drug treatment and practitioners. Conversely, Andy talked highly of treatment, and had experienced long term treatment counselling with the same practitioner, over a number of years. These examples suggest that rapport between practitioner and client improves with contact, and subsequently affects the way in which clients perceive treatment. Furthermore, the disparity between Becca and Andy can also be explained by Goffman theory of the virtual social identity. He purported that individuals make judgments of others at the first meeting, based on perceptions, and this is known as the virtual social identity. However, once a degree of contact and rapport has been established, the way in

which the other individual is regarded is likely to change, as it is now based on perceptions of the practitioners' real social identity.

A further common theme identified in this study, which supported the previous studies, was that a lack of training and understanding of illicit drug use in practitioners was felt to obstruct treatment. The current study found that interviewees felt that practitioners should be knowledgeable in their subject, and that they wanted to see someone who knew what they were talking about. This was highlighted in a previous study by McLaughlin et al. (2000) who reported that the majority of their illicit drug using population sample claimed to be able to identify this lack of knowledge and understanding in their DTP. In addition, clients from the previous study reported being aware of how this could be manipulated, which was also exemplified in the current study by a interviewee stating that prescriptions could be "blagged" from GPs, who had relatively little knowledge and understanding. Yet, interviewees reported that they did not desire a practitioner that could be easily manipulated, and did not warrant respect.

IDUs from the preceding study also reported that perception of the TA was marred by the understanding of power that DTPs had over clients, and this was evident in the current study. One interviewee commented that their GP was quite judgemental and unsympathetic. However, she also commented that, this may not have been how he actually felt, but that was how she had perceived him to be. Thus, supporting the disparity found between clients' perception of favourability from others, and actual levels of favourability in study 6. This likely occurs as a result of the years of stigmatisation that drug users have endured (Goffman, 1963 and Lloyd, 2010).

When exploring the practical nature of treatment services, and their impact on outcomes, interviewees from the online study (study seven) reported that there was an element of safety that was associated with entering into a residential rehabilitation, by providing a 'protective blanket' for the client, which assisted their treatment. Furthermore, that the support from treatment provided was also indicated as a beneficial feature. This was exemplified by one interviewee who commented that residential rehabilitation was the only treatment that had helped him to achieve complete abstinence. This supports the theme from this current study, that the practical nature of the

treatment service was also important. In addition, the flexibility of services was also cited on a number of occasions as having an important impact on treatment success, which supports research by Stevens et al. (2008) who found that service users reported that inflexible agency workers and services, who were not responsive to their needs, and did not encourage treatment engagement.

Another aspect of treatment that was highlighted in the previous studies from this project, and was subsequently identified as a theme in the current study, was the way in which interviewees viewed their success in treatment; some believing that they were in control of their own life and that success in treatment occurred as a result of their own actions. Whereas, others attributed success to factors which were beyond their control. Thus, suggesting that a interviewees' locus of control must play a value part in treatment success. Identifying this, would allow for areas of work within the TA to work on making interviewees more aware of factors that might influence their use of drugs. Similarly, state of mind was frequently identified as a causal attributer to successful outcomes, and perhaps the acquisition of a positive mental attitude towards treatment, comes from the realisation that treatment success must come from within. Moreover, this was frequently referred to by interviewees in this study, as being most accountable to their success in treatment, over and above that of the dynamics within the TA.

Finally, the fact that there is variation in clients' treatment goals suggests another possible influence that might impact on treatment success. When questioned, the client group from this study and the sample group from the online study reported various treatment goals; although abstinence was commonly reported, it was not always the goal. Perhaps it is the case that an individual who is more reasonable in their treatment goal, i.e. to say they want to reduce their use, is more likely to gain success, than someone who simply says they want to achieve complete abstinence. Hence, setting realistic goals that can be achieved produces greater confidence, and can be the first steps towards becoming dependency-free, as self-esteem and the belief in oneself develops. Thus, feeling generally more successful, by reducing their drug use, than a client, who is struggling to achieve dependency-free living. However, disparity was particularly evident in the current study between practitioners and clients, for example, one client reported a very general treatment goal, "to live better than this", with no specific mention giving up drugs specifically. Whereas, the practitioner sample appeared

more specific, with one stating that treatment goals was more of an 'all or nothing' situation, and that simply reducing in drug use, was not enough for an addict.

Two additional themes were identified, that were considered themes due to their relevance to the general research question, as well as to the prevalence with which they appeared in the text. These were (1) the debate as to whether treatment services had worsened over time, and (2) that there was an accumulation process associated with success in treatment. The debate brought about by one member of the client group, was that an influx of IDUs onto the system had overloaded services, which were unable to provide the relevant care and resources to their clients, thus services had worsened. However, when this was investigated in the practitioner group, although they focused on generic healthcare, a reciprocal effect to the notion of an influx of clients was noticed. Firstly, and in agreement with the client group, was that this influx had caused a general lack of tolerance with GPs, thus potentially supporting the concept that services had not improved. Whereas, conversely, another interviewee reported that generic healthcare had improved, because of this influx, which had resulted in GPs knowledge, understanding and attitudes improving, due to their increased contact with drug users

The second theme identified, that was more general to the research question, was the notion of an accumulation process in treatment. Already cited in the NTA's 'Towards successful treatment completion – a good practice guide' (2009), as being a fundamental issue in long term treatment, it was reported that there was a long-term cumulative effect of treatment. Thus, each treatment episode for a client, whether it be success or unsuccessful, should be seen as a part of their treatment journey. Similar to that of a puzzle, the accumulation of all parts of treatment would eventually fit together to create an overall successful treatment outcome. With this in mind, each treatment episode should be seen as just a small part of the whole treatment journey, and as such, practitioners are not likely to see overall success in clients regularly.

4.1.5.4 Limitations of the study

The main problem encountered in this study was the general lack of willingness of individuals to engage in such a study. This has been continually the case through the undertaking of this project,

which has thus called for a number of innovative methodologies, in an attempt to access as many individuals as possible, within the field of drug treatment. This has possibly occurred because the subject area has been that of a stigmatised and illegal nature. Furthermore, current drug using clients are already well known for being distrusting and suspicious of anyone that would appear to be in power or control over them, because of the years of stigmatisation and negativity that they will have received from others. They are therefore, more likely to be unwilling to engage in such research.

Consequently, for this study, the use of a monetary incentive was a necessary means to obtain interviewees for the study. Although a possible criticism of the study was that interviewees only became involved for the monetary incentive, without it, there would have been no client group in this study, which was a group that was deemed as essential to this study. The amount of a £10 Tesco voucher was deemed to be an acceptable payment for an hour of an individuals' time, and could be used to buy something of worth, rather than having been of a cash value which could have been used to purchase illicit drugs.

4.1.5.5 Conclusion

The main findings from this current study showed that there was a number of aspects of treatment that could be attributed to having an influence on treatment success, and in the main, this was concomitant to both sample groups. Thus, the themes identified as having an impact on treatment outcomes were; (1) The dynamics of the therapeutic alliance, which encompassed (i) practitioners' attitude, (ii) continuity of practitioner (otherwise known as contact), (iii) trust, (iv) the relationship between practitioner and client, and (v) support. (2) The clients' mental attitude to treatment and their locus of control. (3) The practicality of the treatment service, which encompassed, (i) flexibility (ii) aftercare (iii) the provision of opportunities for social reintegration, and (iv) barriers in treatment. In addition, relevant issues associated to the treatment process were also identified; (1) that services were considered to have worsened in the client group, although no agreement of this was found in the practitioner group, and (2) that there was an accumulation process of treatment that also influenced treatment success.

The practical implications of this study support the notion that the TA is considered to be a fundamental role in treatment effectiveness, by both client and DTP; with DTPs reporting to being aware of the importance that favourable attitudes within the TA has on clients' treatment outcomes, and the recognition that an unhelpful nature in treatment has unconstructive effects on outcomes. Similarly, clients reported that they found their DTPs opinions in treatment, to be extremely important. Yet, clients showed a lack of understanding and awareness of the importance of discussing personal issues within the TA, and how they might relate to their use of illicit drugs. This is important in terms of treatment, firstly, that by addressing this link, it might help to engage the client, particularly where there has been a lack of connection felt between client and DTP. Secondly, to further demonstrate the continued disparity that has been evidenced throughout the course of this thesis, between DTPs awareness and clients' perceptions, within the TA. This therefore indicates and provides more evidence for the notion that making the DTP more aware of their impact on the client should be a specific area of work and training.

5 CHAPTER FIVE: Implications and Conclusions

The findings from the eight inter-related studies carried out in the process of this project appear to offer some to support the notion that DTPs do have significant impact on their clients' drug treatment outcomes. The purpose of the initial study was to develop a means of assessing DTPs self-reported levels of favourability towards IDUs and drug use, and to measure clients' perceptions of their DTPs favourability. Studies two, three and four sought to validate and standardise the scale. The scale was initially considered to have content validity, as the development process generated a range of favourable and unfavourable attitudes towards IDUs and drug use, representative of current societal attitudes and social acceptability. Statistical analysis of the responses to the questionnaire in the validation process revealed that the scale also had good test-retest reliability. The scale was not found to demonstrate predictive validity, in terms of being able to predict participants' perceptions of a clients' readiness for treatment, however, it was used on a number of different sample groups, to investigate and identify self-reported and perceived attitude, as well as its impact on treatment outcomes (studies five, six and seven). Finally, an in-depth exploration of the potential causative factors of drug treatment success was explored with current and previous clients, in an attempt to clarify, substantiate and triangulate the findings from the preceding studies.

One of the most significant findings from this project was that the general public was found to exhibit a fairly favourable attitude towards IDUs, suggesting that public opinion is improving. Previous to this finding, the MORI survey of attitudes to illicit drugs (MORI, 2000), demonstrated that the general public exhibited a fairly negative attitude. This was supported by Luty and Grewal (2002) who reported that drug addicts were regarded by the general public, as being untrustworthy, deceitful and unreliable. However, it could be argued that this finding demonstrates that the proportion of individuals with either personal and/or vicarious experience of IDUs appears to be increasing over time. Hartnoll, Mitcheson and Lewis (1986) reported that since the 1970's, the number of regular opiate users had increased at least ten-fold. More recently, UK studies of individuals' experiences with drug addiction, reported that illicit drug use was now more fairly common place within the general public, with one-fifth to one-quarter of the samples reporting to have had personal knowledge and experience of illicit drugs (Roberts, 2009; Crisp, Gelder, Goddard, and Meltzer, 2005). The fact that this was concomitant with findings from the Economic and Social Research Council (2005) that there had been a progressive shift in public opinion over support for the legalisation of some illicit drugs over the past two decades, suggests a relationship between

increased experience and attitudes improving. This is possibly as a consequence of the 'normalisation' of some illicit drugs, which was exemplified by Parker, Aldridge and Measham's (1998) finding that the use of recreational drugs among young people, becoming more acceptable and as common place as cigarette smoking and excessive drinking. Similarly, the ESRC (2005) reported that cannabis was now generally regarded by the public to be less addictive and harmful, and less of a cause of crime and violence, than it used to be regarded.

It was also shown that DTPs exhibited a more favourable attitude towards illicit drugs and IDUs, than that of the general public. This finding supports a number of assumptions that predicted that DTPs would demonstrate a favourable bias, for example; (1) that staff who chose to work with IDUs, demonstrated more compassion towards their clients (Lloyd, 2010), (2) that increased working experience with IDUs indicated a more favourable attitude (Carroll, 1996), (3) that a lack of contact with IDUs was found to be associated to more negative attitudes (Roberts and Sims, 1995), (4) and that training and education was linked to improved attitudes within the drug treatment field (Cartwright, 1980).

DTPs were found to exhibit favourable bias, yet, clients' perception of favourability was significantly lower than a groups of DTPs levels of self-reported favourability. Furthermore, clients' perception of favourability was also lower than that reportedly held by a sample from the general public. This might support the notion proposed by social identity theory that many years of stigmatisation results in IDUs having a lower perception of their selves, which disrupts their social interactions with others thus seeing themselves far removed from mainstream society which leads to low levels of self-esteem and self-worth (Link, Elmer, Struening, Phelan and Nuttbrock, 1997). Subsequently, a less favourable perception of the self will result in a lower perception of attitude from others (Goffman, 1963).

Aspects within the TA were then explored, to see if factors associated to the DTP and/or the client, influenced self-reported and perceptions of attitude, and perceptions of readiness for treatment. A client' age and nature of their drug habit, was not found to affect participants' perceptions of a clients' readiness for treatment. Yet, differences were noticed in relation to individual differences in

the participant, thus suggesting that it might be factors associated with the DTP that might influence levels of favourability. However, the only demographic characteristic difference identified, was that of ethnicity which was found to impact on favourability (study four). In support of the notion that experience influences favourability, this may have occurred as illicit drug use is not as widespread in ethnic minority groups in the UK. Therefore, having less personal and vicarious experience may have influenced lower levels of favourability. Whilst, the most noticeable and significant findings of differences in favourability in study three (of predominantly a general public sample), that was related to individual differences of participants personal and/or vicarious experiences with IDU and drug use; those self-reporting personal and/or vicarious experience, exhibited a significantly higher level of favourability, than those who did not.

Conversely, when explorations were made exclusively of a sample of DTPs (study five), personal and/or vicarious experience was not found to influence levels of favourability. Yet, levels of contact with clients did; DTPs who had moderate contact with clients (in terms of weekly or fortnightly sessions) exhibited more favourability, whereas DTPs who encountered clients on a day-to-day basis, such as in rehabilitation, actually exhibited less favourability. This implies that social contact can exacerbate and perpetuate prejudices in some cases, as exemplified by DTPs being threatened or subjected to other abusive interactions, on a more regular basis. This can be particularly so in residential settings, where, according to the NTA's Models of Care (2002), care is given to those with the highest need. Thus, in this environment, clients are likely to be chaotic and potentially damaged. Subsequently, working in this environment is likely to have an impact on attitude, as according to Kirk-Brown et al. (2004), staff working with individuals who have experienced great trauma, are more at risk of having a lack of interest and long-term exhaustion (Kirk-Brown et al., 2004). This supports Knaevelsrud et al.'s (2006) notion of an inverse relationship between those patients with most severe problems, and, having a less positive therapeutic relationship.

Secondly, the discovery that daily contact had a detrimental effect on favourability, suggests a saturation point in levels of favourability, which is related to the frequency of TA contact. According to Buunk and Schaufeli (1993), in workforce relationships, strain is caused by an unequal balance between two staff members, the manager and the subordinate, which can be related to the relationship of DTP and client in the TA. In addition, nursing literature has reported that members of

staff, who have daily contact with patients, tend to be those with least specialised training (Fuller and Unwin, 2004). Further, low grade healthcare staff has been found to suffer from high levels of 'burnout' (Novak and Chappell, 1994; Porter, 1992). This perhaps occurs as a result of high emotional exhaustion and low personal accomplishments (as was demonstrated Gibbs, Beautrais and Surgenor, 2010); feelings that may be more frequently experienced by residential staff who are working directly with individuals who have experienced great trauma (Kirk-Brown et al., 2004). Consequently, Gibbs et al. (2010) demonstrated that high levels of burnout were significantly associated with negative attitudes towards the patient. These findings support the notion that there is a saturation point in contact; overexposure caused by daily contact creates an inverse effect on favourability towards the client.

Not only were levels of contact found to impact on DTPs self-reported favourability, but also on clients' perceptions of favourability. DTPs and clients both reported more favourable attitudes in moderate contact (e.g. weekly), in comparison to high level contact (e.g. daily basis), which was associated to a less favourability. This demonstrates that clients' perceptions of favourability corresponded with DTPs, but to a lesser extent. Thus adjustments need to be made to treatment on behalf of the client, to improve their awareness of others. DTPs need to be made aware of the impact that their own opinion can have on the client, then, DTPs can work on improving client perceptions of others. This is achievable, as according to symbolic interactionism, the development of the self is a work in progress, and can be reflected on, moderated and adapted, therefore, it is possible to alter and improve perception of others.

The treatment effect of perceived levels of favourability was then explored, in terms of the impact that it had on clients' treatment outcomes (study seven). Relationships were identified between ex-clients' perceptions of favourability in DTPs, and current full time employment, and/or no longer needing to attend drug treatment services. These associations suggest that the ex-clients had attained some degree of social reintegration.

Yet, it cannot be concluded with certainty that it was the DTPs perceived favourability that caused these responses, particularly as the time lapse between the completion of treatment, and the

undertaking of the questionnaire was varied. Thus other factors may have facilitated or inhibited clients' social reintegration, such as life changes (e.g. getting married, moving away from the area). These may have occurred between these two points, to influence or effect ex-clients' successful reintegration. Further, it may also be the case that ex-clients who had reported aspects of successful reintegration, may have entered into drug treatment with a more positive mental attitude towards treatment, than those who had not reported aspects of successful reintegration. A clients' positive mental attitude could have influenced how they perceived others, and subsequently, their treatment success may have been more a consequence of their own positive mentality. For example, those who have been coerced into engaging with drug treatment services will approach treatment with a lower motivation to recover than those who have voluntarily self-referred, which according to White (2008) was found to be related to long term treatment goals. This is implied by the finding that clients' self-reported readiness for treatment was found to be the strongest predictor for non-drug use. Therefore demonstrating the importance of clients' psychological motivation for, and readiness to, address their drug use. It is therefore necessary to treat the findings of this study with caution and to not make sweeping generalisations about the findings from this study. Instead, it is only possible to suggest that perceptions of favourability would appear to have some importance in the success of treatment, as a link between higher levels of perceived favourability was found in association with aspects of treatment success.

Clients' positive mental attitude to treatment was a finding in the final study, as one of the underlying dimensions attributing to treatment success (study eight). State of mind towards becoming dependency-free, was frequently identified as a causal attributer to successful outcomes. Perhaps the acquisition of a positive mental attitude towards recovery is borne from the realisation that to be successful in treatment, it has to come from within. This was demonstrated in respondents and interviewees responses, showing an understanding that, in order to do well in treatment, it had to come from the individual. Further, that success came from perceiving that they were in control of their own life and actions.

Practicalities of the treatment service was also highlighted as a dimension of treatment success, with issues such as the service being flexible, providing adequate aftercare and assistance with social reintegration issues (such as housing, etc.) being reported by clients. Another aspect of treatment

that was discovered was the notion that the accumulation of a number of different treatment episodes had a long-term cumulative effect on treatment success. Thus, each treatment episode, whether it be considered as successful or not, should be seen as a part of the treatment journey, and attributing to the goal of becoming dependency free.

Finally, the most relevant dimension of treatment success highlighted in the final study, and most frequently occurring theme, was the importance of the TA, and how dynamics within this relationship impacted on treatment. A number of features within the TA were emphasised by the interviewees, and these related to issues of DTPs' attitudes, the relationship between DTP and client, continuity of DTP, and feelings of trust and support. These qualitative responses from interviewees, reinforces the notion that the TA has considerable influence over treatment outcomes.

The findings from this project advocate two main implications on clinical practice; firstly, the implication of individual differences on recruitment, and secondly, the implication of clients' perception on treatment success. Implications of individual differences on favourability have potential connotations on the recruitment and selection process of DTPs, in terms of purposefully selecting those who should, on paper, display a more favourable attitude. However, the problem arising from this is that it makes the generalised assumption that all individuals with certain characteristic differences, would think, feel and behave in the same way, yet this is not always the case. Furthermore, the only study from this thesis that reported demographic characteristic differences, was ethnic differences in the general public sample (study four). However, this may have actually occurred as a consequence of the levels of personal and vicarious exposure that different ethnic groups may have with IDUs and drug use. For example, the 2009/10 British Crime Survey reported that adults from a White ethnic group (9.0%) generally had higher levels of any drug use, than those from non-White background (5.8%) (Eastwood, 2011). This implies that individuals from ethnic minority groups may have lower levels of favourability because of their limited experiences with drugs and drug users.

A further individual difference that was highlighted in the online study (study seven), and the interview study (study eight) related to whether the DTP was a recovered-addict or not. Both

studies emphasised the importance that perceived empathy in treatment, had on assisting with their own recovery. This process of identification and vicarious experience of another is perhaps thus best suited to a recovered DTP, who has personally experienced addiction, treatment and recovery. Yet, Doukas and Cullen (2010) draw attention to the potentially two-fold problem associated with recovered addicts as DTPs; firstly, the risk of relapse, and secondly, the over involvement with clients and work, and an over identification with clients. Thus, the recovered DTP may well be subjectivity influenced by their own personal perspective and beliefs, in their clinical working practice by the methods that worked in their own recovery. Whereas, non-recovering DTPs have the ability to remain independent and objective. In addition, the fact that this project identified that personal and/or vicarious experience was not found to influence DTPs levels of favourability indicates that recovered addicts do not necessarily display differing levels of favourability to non-recovered DTPs.

However, ex-clients and current clients both emphasised the importance of having a DTP who was a recovered addict. This was for the reason that empathy displayed in others was considered to be helpful to recovery, due to their personal understanding and experience of the realities of illicit drug use. This suggests the valuable worth that recovered DTPs have within the treatment service. Being as favourability was not found to differ between recovered and non-recovered DTPs, it implies that clients like working with recovered DTPs for reasons other than favourability. Maybe it is the process of being able to identify with them, which assists in the building of a good therapeutic rapport. This was exemplified by the dramaturgical importance placed on the impact that a DTPs' non-discursive expressive apparatus has on clients, such as their clothing or hairstyle (Stone, 1962). Therefore, perhaps the best working practice is to have a service of recovered DTPs working concomitantly with non-recovering DTPs. The wealth of knowledge and experience that a recovered DTP can bring, combined with an objective nature from the non-recovering DTP, would provide a holistic service. Consequently, information, ideas and suggestions of techniques could be shared between both types of DTPs on cases, in supervision and case management meetings.

The second main implication on clinical practice was clients' perceptions of others needed to be enhanced in order to bring them in line with how they are viewed by others. Theory that suggests how this can be achieved, originating from symbolic interactionism, is that of identity control theory (Stets and Burke, 2000; Stryker and Burke, 2000). This theory pertains to the notion that personal

identity is rooted in an individuals' social structure, thus relations with others is significant. What is of particular importance is how an individual views their own identity, and how they respond to the perceived reactions of others. Thus, whether they feel that the perception from others is approving or disproving, will influence the development of their identity. IDUs are often stigmatised, and associated with various negative labels and stereotypes which forms low levels of self-esteem and self-worth (Tajfel and Turner, 1986). Consequently supporting the notion that perception from others, will impact on performance and thus it is an important aspect of treatment to address.

According to identity control theory (Burke, 2006), if the individual perceives negativity, then they will seek to change their identity to that of a more positively regarded one. This implies that if a client perceives negativity from their DTP, then they will try and change their behaviour to be more positive. However, this is not usually found, which suggests that other factors within treatment play an important role. Subsequently, the long-term stigmatisation of IDUs, purported by Goffman (1963) and Lloyd (2010) can be influential. Stigmatisation causes the client to believe perceived negative perceptions from others, and instead of seeking to change it, they accept it. Thus, in accordance with Cooley's concept of 'the looking glass self', a perceived negative identity from a DTP, will be reflection on the client, and will be internalised. This will occur as the client will learn to become this perceived negative image of an IDU, and will be adjusting their behaviour accordingly, resulting in a self-fulfilling prophecy emerging (Davies, 1996).

Thus imagined contact theory (Crisp and Turner, 2009) (ICT) can be an important theory used in treatment, as it provides DTPs with the knowledge and understanding of identifying particular behaviours in clients that can be associated with the client perceiving a negative perception. Since this research demonstrates that clients are underestimating perceptions, DTPs need to be made aware of the fact that clients may perceive negativity, even when the DTP does not feel they are portraying negativity. Furthermore, the fact that Altschul (1971) reported disparity between nurse and patients' perceptions of one another (patients reported the TA to be of therapeutic value, whereas, nurses expressed doubt over its value), implies that DTPs can be unaware and unappreciative of the power of their interactions on the clients' treatment outcomes. Similarly, McLaughlin and Long (1996) reported that although DTPs did not knowingly or willingly set out to have a negative effect on clients' treatment, any negative attitudes were found to negatively affect

the client. Thus, DTPs require empathic social skill training, and to understand the importance of over inflating their exhibited favourability towards the client.

However, this does not support the claims made by DTPs (study five), that they were aware of the positive influence that they had on clients' treatment outcomes, and that unfavourable attitudes were unhelpful to treatment. Although DTPs were aware of the impact they could have, they perhaps remain unaware of how they are truly perceived by clients, thus indicating a training requirement. Incorporating ICT into training programmes will seek to improve the awareness of perceived favourability within the TA, and how it can improve relations and subsequent outcomes. Yet, Crits-Cristoph, Ring-Kurtz, McClure, Temes, Kulaga et al. (2010) disseminated feedback to DTPs on clients' perceptions of the TA, and found that it had no effect on their clinical performance. However, feedback was not given to DTPs on a case-by-case basis, and was thus cumulative across the caseload. Consequently, DTPs were not able to specifically identify, for each client, where their working methods needed adjusting. Perhaps it would have been more beneficial to provide DTPs with individual feedback on each of their clients' perception of the TA, thus, making DTPs more aware of any disparity between the DTPs perception of the TA, and the clients' perception. This implies that work is required to develop DTPs' understanding of the importance of perception in treatment.

Consequently, the implications of the findings from the overall project reveal several dimensions of DTP training that must be addressed. Firstly, as already discussed, that DTPs need to be informed of the importance of perceived favourability, particularly, how clients have been found to underestimate this favourability, and thus remain with a sense of feeling stigmatised; a feature that DTPs appear to be unaware of. Thus, in accordance with ICT, this can be achieved by making DTPs perceptive to behavioural characteristics that might associate with clients that pertain to perceived low favourability. DTPs will then be aware of when it is necessary to overemphasise their genuine favourability towards clients, in order to increase the clients' perception. Secondly, of ways in which DTPs levels of favourability can be further increased to improve clients' underestimated perceptions.

The inclusion of imagined contact theory into DTP training programmes, proposes that imagined positive encounters with out-group individuals, promotes more positive in-group attitudes (Crisp, Stathi, Turner and Husnu, 2008). Consequently, by encouraging DTPs to mentally simulate a positive out-group encounter, favourability towards clients will be improved and stereotypes will be reduced. Thus, in-group anxiety will be curtailed, and the individual will start to perceive more positivity in others (Crisp and Turner, 2009). Thus prejudice and perceptions could be influenced by simulated social contact. Imagined contact has been demonstrated in the past, as being particularly useful when dealing with groups that are unlikely to have contact with one another, or where it is impractical. This was demonstrated by Husnu and Crisp (2010) who sought to improve attitudes between Turkish and Greek residents of Cyprus. This form of training would be of particular use to DTPs who had never previously worked with clients, as according to the findings from this project, individuals who had not worked with IDUs exhibited lower levels of favourability. This is proposed as work-based training is perhaps not necessarily the most helpful to clients. For example, if individuals without working experience display lower favourability, which consequently has a detrimental effect on treatment, then it would be unhelpful for clients to be involved in training up new DTPs. In agreement, Crisp et al. suggests that the inclusion of imagined contact into training programmes to improve intergroup relations would be of particular interest to policymakers and educators.

Furthermore, there is also a requirement to assist the client in feeling more empowered in their treatment journey. The perception of having more control over life situations means that clients will feel more encouraged to achieve tasks, such as becoming dependency-free (Comer, 2004). Thus, empowerment can be achieved through encouraging clients to take a proactive role in aspects of their treatment, such as in care plans. According to Wright (1996), in the workforce, this process empowers the subordinate by allowing them to acquire and use the power needed to make decisions affecting themselves. When subordinates were made to feel empowered and in control, they responded more positively (Hollander, 1995). Workforce empowerment can be related to drug treatment, as this is also an environment where inequality is present. Within the TA, power is given to the DTP by the client, as they are deemed to be the 'expert' (Parson, 1951; 1975). Thus, feelings of being overpowered and of authority are likely to be common place in drug treatment, particularly when 30% of clients having been referred into treatment though the CJS (taken from statistics published on the NTA website, accessed May 2012). Thus, coercive treatment will exert even more of an unequal balance, from the perception of authority and control that it has over CJS IDUs.

Thus an important aspect of treatment is to facilitate feelings of empowerment in the client, by attempting to balance the perceived inequitable nature between DTP and client. Lambert, Street, Cegala, Smith, Kurtz and Schofield (1997) identified seven dimensions of patient-centred care, which could be utilised as a way of empowering the client in their treatment journey. The implication is that this can be achieved by a combination of client involvement, mutual participation in decision-making, interpersonal relationships and the building of trust. Thus, the notion of patient-centred care proposes that there is; (1) respect for clients' values, preferences, and needs, (2) coordination and integration of care (i.e. clients care plans), (3) the provision of information, communication and education, (4) physical comfort for clients, (5) emotional support and the alleviation of anxiety in clients, (6) an inclusion of family and friends in clients' treatment, and finally, (7) adequate aftercare support for clients, by way of transition and continuity after treatment. Importantly, this concept supports the symbolic interactionist notion that the TA is dyadic, and that both DTP and client play an influential role in improving treatment effectiveness.

Therefore, the inclusion of empowerment into DTP training would also be of benefit to treatment outcomes. According to Wood, Englander-Golden, Golden and Pillai (2010), in order to improve addiction treatment outcomes, the self and others must be empowered. Their study proposed that this could be achieved by the addition of a new training programme into addiction treatment, which primarily focused on the enhancement of motivations, cognitive-behavioural coping skills, social support and group cohesiveness. Thus they proposed that a training programme must encompass aspects of interpersonal, interactive and experiential aspects of treatment. This therefore demonstrates their agreement with the notion that social interactions (such as the TA) and DTP experience have significant implications on treatment outcomes. It was consequently confirmed that training significantly increased empowering communication, self-esteem and quality of group life in the treatment group. However, due to the infancy of the proposed training, long-term effects of this training programme, on client relapse was unknown. Moreover, the training programme was co-created by participants, thus supporting the notion that individuals working within treatment field should be included in the development of measures and techniques to be utilised within clinical practice. This is similar to the development of the ATIDDUS in the current project, which implemented Thurstone's technique of scale development, and generated an attitude scale driven by its participants.

However, if perceived inequity and underestimated favourability within the TA is not properly addressed, then there will continue to be disparity between DTP exhibited favourability and clients' perceptions of DTP favourability. Consequently, this suggests that clients may not be able to benefit from the favourable bias exhibited by DTPs, in terms of establishing a good rapport and the subsequent impact it might potentially have on treatment outcomes. Therefore treatment success may not be seen to improve. However, these suggestions for improvements to DTP training are likely to be supported by current government initiatives. The latest drug strategy (2010) calls for treatment providers to go beyond increasing numbers into treatment, supporting the notion that "recovery is achievable for all", and should be the central aim to all clients' treatment episodes (NTA, 2011). Thus, new ideas and initiatives are currently being sought to improve ways in which clients can be successfully processed through the treatment system, achieving dependency-free living and social reintegration at the conclusion of their treatment.

5.1 Future directions and concluding thoughts

Significant changes are proposed by the government in drug treatment; instead of simply increasing numbers into treatment, the proposed goal is to ensure that clients actively progress through the treatment system, becoming dependency-free and socially reintegrated. Suggested ways in which this can be achieved, have been the inclusion of the client in their own care plan. In making clients more proactive and central to their treatment, which encourages feelings of empowerment and control. Consequently, clients will be less likely to suffer from learned helplessness, and therefore approach treatment with the belief that they can achieve tasks such as being dependency-free. Empowering the client in treatment will increase their self-esteem and self-worth (Tajfel and Turner, 1986), which will subsequently improve the way they perceive their self, and thus, the way they think they are perceived by others (Goffman, 1962).

An area that can be suggested to make improvements to clients' treatment outcomes is to inform DTPs of the considerable impact that they have on clients' outcomes. DTPs claimed a certain amount of awareness for their role in effective treatment, yet, their awareness of how they are perceived by clients is questionable. However, the aim of this investigation was not to imply blame of past low success rates in treatment, on DTPs, but to investigate the role of the DTP as a potential source of improving treatment outcomes. The apparent impact that perception of favourability

appears to have on TA rapport, might be attributable to the theory of symbolic interactionism, as the client appears to look upon their DTP as a significant other, thus social interactions within this TA might assist in the development and formation of the clients' self. In addition, this theory puts humanity at the heart of treatment effectiveness, because it pertains to the notion that successful reintegration and dependence free living, stems from the dyadic relationship between DTP and client.

However, a grey area of this research is the discrepancy found from ex-client and current clients advocating preference for the desire to work with DTPs who have identification and vicarious experience. This implies that DTPs are best suited to recovered addicts, who have personally experienced addiction, treatment and recovery. Yet, the findings that there was no difference in favourability between recovered and non-recovered DTPs, suggests that clients demonstrate a preference for working with recovered DTPs for reasons other than perceived favourability. This may potentially be in terms of the dramaturgical importance of identification. However, it may also be that clients are more willing to accept 'tough love' treatment from recovered addicts, and that this has more effect on treatment success. Thus implying a very interesting and additional line of further investigation for the future.

Drug treatment exerts a considerable financial strain on the economy, and so, it is important to do everything possible to improve effectiveness. Thus, the objective of this thesis was to identify one potential source of improving treatment outcomes, both in terms of making treatment services more effective, and in helping those going through treatment.

Previous research indicated that good TA rapport has considerable impact on clients' treatment outcomes. The findings from this research support this view, particularly that there is an association between DTPs favourability towards IDUs, and IDUs treatment outcomes; the importance of continuity, trust and support was highlighted by clients as aiding treatment outcomes. The research found that DTPs exhibited favourability bias in comparison to general public (yet this was significantly underestimated by clients). Furthermore, that there was an association between ex-clients perceived favourable bias and their being in current employment, and/or no longer needing

drug treatment support, suggesting that DTPs perceived favourable bias potentially had some impact on clients' treatment outcomes. Reported statistics for drug treatment outcomes are still low (latest NTA figures in 2012 proposed that 13.7% of clients exiting from treatment were dependency-free). Thus, if clients' perceptions of DTPs favourable bias can be increased, then improves outcomes, then this might be reflected in an increase of numbers of client drug treatment drug free.

The fact that this research discovered that clients significantly underestimated DTPs' favourability, highlights an important aspect of treatment and training. This is one feature of treatment that is amendable to change, which may bring about an abundance of benefits to treatment. Thus, it is not just strategies that seek to raise clients' perceptions and sense of empowerment that is considered a necessity in improving treatment efficiency, but that DTPs need to be more aware of the implications of their behaviour on influencing others, in relation to how clients' perceive and associate meaning to the TA.

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1 Study One

1.1 The ATIDDUS



Please answer ALL statements; place a tick beside each of the following statements with which you agree, and a cross beside the statements with which you disagree.

1. Drug users are unreliable
2. Drug users are violent
3. Most drugs are addictive
4. Drug addicts are lonely people
5. Drug addicts have more money than sense
6. It's wrong to take drugs
7. Drugs ruin lives
8. All drug takers are thieves
9. Drug users are untrustworthy
10. Drug addiction is a sickness
11. Some people do smoke cannabis for medicinal purposes, and that is ok
12. Drugs scare me
13. Drug addiction is class-less (i.e. working class, middle class)
14. Drug users are unhygienic (e.g. sharing needles and contracting HIV)
15. Drug addicts are 'non-focused' and need direction
16. All drug users are criminals
17. Drug use makes me feel uncomfortable
18. It is easier to stay on drugs than it is to come off
19. You cannot make someone address their drug problem if they don't want to
20. Drug addicts don't like their lives
21. Some drugs are more harmful than others
22. Drug addicts are emotionally troubled
23. Drug users deserve everything they get
24. Rehab doesn't seem to work for most people
25. Drug users are dishonest

1.2 Recruitment email

Dear Service Manager,

Further to our recent telephone conversation, I am writing to inform you of the details of my PhD research, at Buckinghamshire New University, on the effect of attitudes within drug treatment services.

I am writing to see if your service would be willing to take part in this research.

I am looking for volunteers to attend a meeting where they would be required to generate a number of attitude statements to illicit drugs and drug users. Ideally, I am looking for 10 participants.

Having worked in several drug agencies over the past years, I fully appreciate that your staff are very busy. I anticipate that the meeting should only take approximately 45 minutes to one hour, but I will try and be as brief as possible!

If possible, I would like to attend your treatment service, to carry out this meeting.

Please be assured that all responses will be kept completely confidential, and that the study has been approved by the University's Faculty Ethics Committee as being sensitive to the needs of the participants.

I would be extremely grateful if you could forward this email around to your colleagues.

Please feel free to contact me with any queries you may have regarding this piece of research.

Many thanks in advance,

Nicola Mallowan
PhD Research Student in Psychology

Buckinghamshire New University
Queen Alexandra Road
High Wycombe
Bucks
HP11 2JZ

Email: nmallo01@bucks.ac.uk

1.3 Information sheet



- The purpose of this study is to determine:
 - the attitudes agency staff workers/key-workers, who work with class A service users, have to drug users.
 - AND,
 - the perceived attitudes of the agency staff/key-workers, by the service user.
- The study is being conducted by Nicola Mallowan, PhD student at Buckinghamshire Chilterns University College.
- If you choose to take part in this study, you will be asked to complete a consent form and return it to the researcher. Information provided on the consent form will not be used in the study, but will be filed as recordable evidence of your consent to participate in this study.
- The study will require you to generate 10 statements that describe the attitudes that people may have towards substance misusers. Please consider a wide spectrum of attitudes, ranging from extremely negative to extremely positive. These are not your own personal views. Please use the plain sheet of paper provided.
- These statements will be collected together to produce 100 attitude statements. The researcher will then read the statements out, and you will be asked to score each of the 100 statements from 1 to 11, depending on how favourable or unfavourable you believe the statements to be (score 1 for a very unfavourable statement, and score 11 for a very favourable statement).
- You do not have to take part in this study, and you do not need to provide a reason why you do not wish to take part in this study.
- You have the right to withdraw at any time during this study, and you are not required to give a reason for withdrawing.
- All information collected in this study will be kept confidential.

1.4 Consent form



Please tick the appropriate boxes:

I have read and understood the project information sheet

I have been given the opportunity to ask questions about the project

I agree to take part in the project.

I understand that my taking part is voluntary; I can withdraw from the study at any time and I will not be asked questions about why I no longer want to take part

I do not want my name used in this project

I understand my personal details such as name phone number or address will not be revealed to people outside of this project

I understand that my words may be quoted in publications, reports, web pages, and other research outputs but my name will not be used

I agree for the data I provided to be archived at the UK Data Archive

I understand that other researchers will have access to these data only if they agree to preserve the confidentiality of these data

I understand that other researchers may use my words in publications, reports, web pages and other research outputs but my personal details will not be associated to the quotes

I agree to assign the copyright I hold in any materials related to this project to Nicola Mallowan

On this basis I am happy to participate in the “evaluative study of the influence of attitudes within the therapeutic alliance, on clients’ treatment outcomes” study.

Name of ParticipantSignature.....Date.....

Name of Researcher.....Signature.....Date.....

If you have any queries or concerns, please contact: Nicola Mallowan at nmallo01@bucks.ac.uk, or through your drug treatment service, which will be able to make telephone contact on your behalf

(One copy to be kept by the participant, one to be kept by the researcher)

2 Study Two

2.1 The survey



Please indicate the following that applies to you:

Gender: Male / Female

Age: 18 – 25 / 26 – 35 / 36 – 45 / 46 – 55 / 56 – 65 / 66+

Ethnicity (please specify): _____

Please answer ALL statements; place a tick beside each of the following statements with which you agree, and a cross beside the statements with which you disagree.

1. Drug users are unreliable
2. Drug users are violent
3. Most drugs are addictive
4. Drug addicts are lonely people
5. Drug addicts have more money than sense
6. It's wrong to take drugs
7. Drugs ruin lives
8. All drug takers are thieves
9. Drug users are untrustworthy
10. Drug addiction is a sickness
11. Some people do smoke cannabis for medicinal purposes, and that is ok
12. Drugs scare me
13. Drug addiction is class-less (i.e. working class, middle class)
14. Drug users are unhygienic (e.g. sharing needles and contracting HIV)
15. Drug addicts are 'non-focused' and need direction
16. All drug users are criminals
17. Drug use makes me feel uncomfortable
18. It is easier to stay on drugs than it is to come off
19. You cannot make someone address their drug problem if they don't want to
20. Drug addicts don't like their lives
21. Some drugs are more harmful than others
22. Drug addicts are emotionally troubled
23. Drug users deserve everything they get
24. Rehab doesn't seem to work for most people
25. Drug users are dishonest

2.2 Information sheet



- The purpose of this study is to research the attitudes that occur within specialist drug services towards illicit drugs and drugs users, and the effects attitudes can have on drug treatment.
- The terms 'illicit' meaning illegal, and 'drugs', as specified by the Misuse of Drugs Act, for example,
 - Class A drugs: Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (if prepared for use) amphetamines (if prepared for injection)
 - Class B drugs: Amphetamines, Methylphenidate (Ritalin), Pholcodine
 - Class C drugs: Cannabis, tranquilisers & some painkillers, GHB (Gamma hydroxybutyrate), ketamine
- The study is being conducted by Nicola Mallowan, PhD student at Bucks New University, who can be contacted at nmallo01@bucks.ac.uk if you have any questions or queries.
- If you choose to take part in this study you will also be asked to complete 25 statements that you will be asked to either agree or disagree with. Please don't worry, your answers will remain anonymous.
- You will be required to undertake a further service in approximately one week's time, so please mark your questionnaire with a 'nickname', so that your surveys can be linked, but you will remain anonymous.
- Please return the completed questionnaire in the self-addressed envelope provided, or directly to the researcher.
- You do not have to take part in this study, and you do not need to provide a reason why you do not wish to take part.
- You have the right to withdraw at any time during this study, and you are not required to give a reason for withdrawing.
- You will automatically be giving your consent to take part in this study by completing and returning the questionnaire.
- All information collected in this study will be kept confidential.
- The researcher wishes to thank you for taking part in this study!

3 Study Three

3.1 The survey



Please indicate the following that applies to you:

Gender: Male / Female

Age: 18 – 25 / 26 – 35 / 36 – 45 / 46 – 55 / 56 – 65 / 66+

Ethnicity (please specify): _____

Please answer ALL statements; place a tick beside each of the following statements with which you agree, and a cross beside the statements with which you disagree.

1. Drug users are unreliable
2. Drug users are violent
3. Most drugs are addictive
4. Drug addicts are lonely people
5. Drug addicts have more money than sense
6. It's wrong to take drugs
7. Drugs ruin lives
8. All drug takers are thieves
9. Drug users are untrustworthy
10. Drug addiction is a sickness
11. Some people do smoke cannabis for medicinal purposes, and that is ok
12. Drugs scare me
13. Drug addiction is class-less (i.e. working class, middle class)
14. Drug users are unhygienic (e.g. sharing needles and contracting HIV)
15. Drug addicts are 'non-focused' and need direction
16. All drug users are criminals
17. Drug use makes me feel uncomfortable
18. It is easier to stay on drugs than it is to come off
19. You cannot make someone address their drug problem if they don't want to
20. Drug addicts don't like their lives
21. Some drugs are more harmful than others
22. Drug addicts are emotionally troubled
23. Drug users deserve everything they get
24. Rehab doesn't seem to work for most people
25. Drug users are dishonest

Please read the following paragraph then answer the statements below:

“Mr A is a **21-year-old / 50-year-old** single, father of two. He no longer lives with his children, and before going into prison he usually saw them at weekends. He is not currently in employment, and has recently left prison following a 6-week custodial sentence for Burglary. Mr A transferred straight from prison into a 12-week residential rehabilitation treatment programme, whereby he is in his second week. He has to reside, attend and actively participate in daily activities of treatment, group work and one-to-one counselling for his long-term **cannabis and alcohol / heroin** dependency, as well as abide by the rules and regulations of the rehabilitation centre, one of which being to abstain from drugs and alcohol whilst in attendance. It is expected of him that he will complete the full 12-week programme before he is allowed to go home. Although he is allowed to make telephone calls to his children, he is not allowed to visit them until the 12-week period of treatment is completed”.

Please indicate by circling below, on a scale of one-to-five, the extent to which you agree with each of the statements below (5 represents strongly agree and 1 strongly disagree):

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Mr A needs to stay in drug treatment	5	4	3	2	1
This treatment is giving Mr A a chance to solve his drug problems	5	4	3	2	1
This kind of treatment programme is not likely to help Mr A	5	4	3	2	1
This treatment programme can really help Mr A	5	4	3	2	1
Mr A wants to be in drug treatment	5	4	3	2	1
Mr A is likely to be too distracted by outside responsibilities to be in this treatment programme	5	4	3	2	1
Mr A is in this treatment programme only because it is required	5	4	3	2	1
This treatment programme is likely to be too demanding for Mr A	5	4	3	2	1

Thank you for your participation!

3.2 Information sheet



- The purpose of this study is to validate a scale to be used in future research as a questionnaire on attitudes to illicit drugs and drug use
- The terms 'illicit' meaning illegal, and 'drugs', as specified by the Misuse of Drugs Act refers to,
 - Class A drugs: Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (if prepared for use) amphetamines (if prepared for injection)
 - Class B drugs: Amphetamines, Methylphenidate (Ritalin), Pholcodine
 - Class C drugs: Cannabis, tranquilisers & some painkillers, GHB (Gamma hydroxybutyrate), ketamine
- The study is being conducted by Nicola Mallowan, PhD student at Buckinghamshire New University
- If you choose to take part in this study you will also be asked to complete some demographic questions (gender, age and ethnicity), followed by indicating whether you agree or disagree with 25 statements. Finally, there is a hypothetical scenario about a illicit drug user engaging in treatment. Please read the scenario, and complete the questions. Please don't worry, your answers will remain anonymous, and you will not be linked in any way to your answers (this is NOT what the researcher is looking for!!)
- Please return the completed questionnaire, sealed in the envelope provided, to the person who gave you the questionnaire. The envelope will not be opened until all completed questionnaires have been collected, so that you cannot be identified by your completed questionnaire
- The only information the study is looking for is your **honest** answers to the questionnaire
- You do not have to take part in this study, and you do not need to provide a reason why you do not wish to take part
- You have the right to withdraw at any time during this study, and you are not required to give a reason for withdrawing
- You will automatically be giving your consent to take part in this study by completing and returning the questionnaire
- All information collected in this study will be kept confidential
- The researcher wishes to thank all of those who take part in this study!

4 Study Four

4.1 The survey



Please indicate the following that applies to you:

1. Gender: Male / Female
2. Age: 18 – 25 / 26 – 35 / 36 – 45 / 46 – 55 / 56 – 65 / 66+
3. Ethnicity (please specify): _____

Please answer ALL statements; place a tick beside each of the following statements with which you agree, and a cross beside the statements with which you disagree.

1. Drug users are unreliable
2. Drug users are violent
3. Most drugs are addictive
4. Drug addicts are lonely people
5. Drug addicts have more money than sense
6. It's wrong to take drugs
7. Drugs ruin lives
8. All drug takers are thieves
9. Drug users are untrustworthy
10. Drug addiction is a sickness
11. Some people do smoke cannabis for medicinal purposes, and that is ok
12. Drugs scare me
13. Drug addiction is class-less
14. Drug users are unhygienic (e.g. sharing needles and contracting HIV)
15. Drug addicts are 'non-focused' and need direction
16. All drug users are criminals
17. Drug use makes me feel uncomfortable
18. It is easier to stay on drugs than it is to come off
19. You cannot make someone address their drug problem if they don't want to
20. Drug addicts don't like their lives
21. Some drugs are more harmful than others
22. Drug addicts are emotionally troubled
23. Drug users deserve everything they get
24. Rehab doesn't seem to work for most people
25. Drug users are dishonest

Please indicate the following that applies to you,

About yourself:

Do you have **current** experience with using illicit drugs: Yes / No

Do you have **previous** experience with using illicit drugs: Yes / No

Do you have **current** experience of working with illicit drug users: Yes / No

Do you have **previous** experience of working with illicit drug users: Yes / No

About your family:

Does any member of your immediate family (parents, siblings, partner, children) have **current** experience with using illicit drugs: Yes / No / Unknown

Does any member of your immediate family (parents, siblings, partner, children) have **previous** experience with using illicit drugs: Yes / No / Unknown

About your friends:

Do any of your close friends have **current** experience with using illicit drugs: Yes / No / Unknown

Do any of your close friends have **previous** experience with using illicit drugs: Yes / No / Unknown

The researcher wishes to thank you for your time and patience in completing this questionnaire!

4.2 Information sheet



- The purpose of this study is to research the attitudes that occur within specialist drug services towards illicit drugs and drugs users, and the effects attitudes can have on drug treatment.
- The terms 'illicit' meaning illegal, and 'drugs', as specified by the Misuse of Drugs Act, for example,
 - Class A drugs: Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (if prepared for use) amphetamines (if prepared for injection)
 - Class B drugs: Amphetamines, Methylphenidate (Ritalin), Pholcodine
 - Class C drugs: Cannabis, tranquilisers & some painkillers, GHB (Gamma hydroxybutyrate), ketamine
- The study is being conducted by Nicola Mallowan, PhD student at Bucks New University, who can be contacted at nmallo01@bucks.ac.uk if you have any questions or queries.
- If you choose to take part in this study you will also be asked to complete some questions about yourself, followed by a further 25 statements that you will be asked to either agree or disagree with. Please don't worry, your answers will remain anonymous, and you will not be linked in any way to your answers.
- Please return the completed questionnaire in the self-addressed envelope provided (the postage has been prepaid).
- You do not have to take part in this study, and you do not need to provide a reason why you do not wish to take part.
- You have the right to withdraw at any time during this study, and you are not required to give a reason for withdrawing.
- You will automatically be giving your consent to take part in this study by completing and returning the questionnaire.
- All information collected in this study will be kept confidential.
- The researcher wishes to thank you for taking part in this study!

5 Study Five

5.1 The survey



Part One

Please specify the following.

1. Gender: _____
2. Age: _____
3. Ethnicity: _____
4. Please describe the nature of your contact with your client group (e.g. key worker / drop in etc...): _____
5. Which models of care tier does your role provide: _____
6. What is your length of service in your current role: _____
7. What is your total length of service working with illicit drug users: _____
8. Do you currently use illicit drugs: _____
9. Have you previously used illicit drugs: _____
10. If you have answered yes to either questions 8 or 9, what types of illicit drugs have you used: _____
11. If you have used illicit drugs, did you receive drug treatment for your illicit drug use: _____
12. If you answered yes to question 11, which drug treatment did you undergo? _____
13. If you answered yes to question 11, please can you state the positive aspects of this treatment? _____
14. If you answered yes to question 11, were there any aspects of your treatment you found to be unhelpful? _____
15. What is your idea of success for **an illicit drug user** in treatment? _____
16. What is your idea of success of **your role** as a specialist drug practitioner? _____
17. Have you received any training to undertake your job? _____

18. If you answered yes to question 17, what training have you received to undertake your job? _____
19. If you answered yes to question 17, how long was the training for? (e.g. one day course / several training events / certificate in substance misuse) _____
20. If you answered yes to question 17, do you feel that this training has been adequate enough to undertake your job successfully? _____

Part Two

Please answer ALL statements; place a tick beside each of the following statements with which you agree, and a cross beside the statements with which you disagree.

1. Drug users are unreliable
2. Drug users are violent
3. Most drugs are addictive
4. Drug addicts are lonely people
5. Drug addicts have more money than sense
6. It is wrong to take drugs
7. Drugs ruin lives
8. All drug takers are thieves
9. Drug users are untrustworthy
10. Drug addiction is a sickness
11. Some people do smoke cannabis for medicinal purposes, and that is ok
12. Drugs scare me
13. Drug addiction is class-less (i.e. working class, middle class)
14. Drug users are unhygienic (e.g. sharing needles and contracting HIV)
15. Drug addicts are 'non-focused' and need direction
16. All drug users are criminals
17. Drug use makes me feel uncomfortable
18. It is easier to stay on drugs than it is to come off
19. You cannot make someone address their drug problem if they don't want to
20. Drug addicts don't like their lives
21. Some drugs are more harmful than others
22. Drug addicts are emotionally troubled
23. Drug users deserve everything they get
24. Rehab doesn't seem to work for most people
25. Drug users are dishonest

The researcher wishes to thank you for your time and patience in completing this questionnaire!

5.2 Recruitment letter



Dear Service Manager

I am a PhD research student at Buckinghamshire New University and am currently looking at attitudes that occur within specialist drug services towards illicit drugs users, and the effects attitudes can have on drug treatment.

I am writing to see if your service would be willing to take part in this research.

Having worked in several drug agencies over the past years, I fully appreciate that your staff are very busy, however the questionnaires should only take five minutes to complete, and I would be extremely grateful for the time given.

I have enclosed five questionnaires, if you could possibly find five willing members of staff (yourself included if you wish!). You will find an information sheet and a questionnaire (one for each person) in the self-addressed envelopes. If your staff could complete the questionnaire, and return it in the provided envelope, as this is already addressed and postage paid.

Please be assured that your drugs service will remain anonymous, as will the respondent.

With thanks in advance,

Nicola Mallowan

PhD Research Student in Psychology
Buckinghamshire New University
Queen Alexandra Road
High Wycombe
Bucks
HP11 2JZ Email: nmallo01@bucks.ac.uk

5.3 Information sheet



- The purpose of this study is to research the attitudes that occur within specialist drug services towards illicit drugs and drugs users, and the effects attitudes can have on drug treatment.
- The terms 'illicit' meaning illegal, and 'drugs', as specified by the Misuse of Drugs Act, for example,
 - Class A drugs: Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (if prepared for use) amphetamines (if prepared for injection)
 - Class B drugs: Amphetamines, Methylphenidate (Ritalin), Pholcodine
 - Class C drugs: Cannabis, tranquilisers & some painkillers, GHB (Gamma hydroxybutyrate), ketamine
- The study is being conducted by Nicola Mallowan, PhD student at Bucks New University, who can be contacted at nmallo01@bucks.ac.uk if you have any questions or queries.
- If you choose to take part in this study you will also be asked to complete some questions about yourself, followed by a further 25 statements that you will be asked to either agree or disagree with. Please don't worry, your answers will remain anonymous, and you will not be linked in any way to your answers.
- Please return the completed questionnaire in the self-addressed envelope provided (the postage has been prepaid).
- You do not have to take part in this study, and you do not need to provide a reason why you do not wish to take part.
- You have the right to withdraw at any time during this study, and you are not required to give a reason for withdrawing.
- You will automatically be giving your consent to take part in this study by completing and returning the questionnaire.
- All information collected in this study will be kept confidential.
- The researcher wishes to thank you for taking part in this study!

6 Study Six

6.1 The survey



Part One

Please specify the following.

1. Gender: _____

2. Age: _____

3. Ethnicity: _____

4. Are you currently using illicit drugs? YES / NO

5. What is your ultimate goal in regards to your drug use (please circle most appropriate)

Recreational or occasional use / Totally drug-free / Continue dependent use

6. Please choose (and state) one TYPE of specialist drug service that you are currently working with, to answer questions. Please do not actually give the name of the service, in order to keep it anonymous (for example, if you are attending a rehab, please state 'rehab' rather than the name of the rehab:

7. How long have you been using this service: _____

8. Do you intend to continue using this service for the future? YES / NO

9. Did you volunteer to attend this service, or were you made to feel you had to attend? _____

10. If you had to attend, who made you? _____

11. How often do you attend this service (please circle most appropriate):

Every day / several times per week / once weekly / fortnightly / monthly / other

12. Are you currently attending other drug treatment services? YES / NO

13. Please answer whether you agree or disagree with the following statements about yourself and the drug treatment service you have selected above:

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
You need to stay in treatment					
This treatment is giving you a chance to solve your drug problems					
This kind of treatment program is not helping you					
This treatment program can really help you					
You want to be in drug treatment					
You have too many outside responsibilities now to be in this treatment program					
You are in this treatment program only because it is required					
This treatment program seems too demanding for you					

14. How would you best describe your relationship with your drug worker? _____

15. How important is your drug workers opinion of you, to you? _____

16. Please can you state the positive aspects of your drug treatment from this service? _____

17. Are there any aspects of your treatment you found to be unhelpful? _____

18. What is your idea of success for an illicit drug user in treatment? _____

Part Two

Please answer the following statements HOW YOU THINK YOUR DRUG WORKER (from the previously mentioned service you have chosen) would answer.

Please answer ALL statements; place a tick beside each of the following statements with which you think he/she would agree, and a cross beside the statements with which you think he/she would disagree.

1. Drug users are unreliable
2. Drug users are violent
3. Most drugs are addictive
4. Drug addicts are lonely people
5. Drug addicts have more money than sense
6. It is wrong to take drugs
7. Drugs ruin lives
8. All drug takers are thieves
9. Drug users are untrustworthy
10. Drug addiction is a sickness
11. Some people do smoke cannabis for medicinal purposes, and that is ok
12. Drugs scare me
13. Drug addiction is class-less (i.e. working class, middle class)
14. Drug users are unhygienic (e.g. sharing needles and contracting HIV)
15. Drug addicts are 'non-focused' and need direction
16. All drug users are criminals
17. Drug use makes me feel uncomfortable
18. It is easier to stay on drugs than it is to come off
19. You cannot make someone address their drug problem if they don't want to
20. Drug addicts don't like their lives
21. Some drugs are more harmful than others
22. Drug addicts are emotionally troubled
23. Drug users deserve everything they get
24. Rehab doesn't seem to work for most people
25. Drug users are dishonest

Thank you for your time and patience in answering this questionnaire!

6.2 Recruitment letter



Dear Service Manager,

You may remember that I wrote to you recently with regards to some help with a piece of research I am currently undertaking at Buckinghamshire New University for my PhD, looking at attitudes that occur within specialist drug services towards illicit drugs users, and the effects attitudes can have on drug treatment.

I am writing to you once again, firstly to thank you for your kind participation in the research, I have had a tremendous response, and have found your comments to be both highly insightful and at times humorous! Secondly to ask whether you would mind contributing further to the research with a look at attitudes in treatment from the perspective of the client (the illicit drug user).

I feel it important to mention (something that I forgot to inform you last time) that the statements were not produced by me (these are not necessarily the attitudes I have towards illicit drug users!), but generated by a sample from the general public with regards to their attitudes towards illicit drugs and drug use. This is especially to all of you working in residential treatment facilities, and the statement that rehab doesn't work for most people!

Again, similarly to the previous questionnaire, this questionnaire for the clients should only take approximately five minutes to complete, and I would be extremely grateful for the time given.

I have enclosed five questionnaires, if you could possibly find five willing clients to your service. You will find an information sheet and a questionnaire (one for each person) in the self-addressed envelopes. If your clients could complete the questionnaire, and return it in the provided envelope, as this is already addressed and postage paid.

Please be assured that your drugs service will remain anonymous, as will the respondent.

With thanks in advance,

Nicola Mallowan
PhD Research Student in Psychology
Buckinghamshire New University
Queen Alexandra Road
High Wycombe
Bucks
HP11 2JZ
Email: nmallo01@bucks.ac.uk

6.3 Information sheet



- The purpose of this study is to research the attitudes that occur within specialist drug services to illicit drugs and drugs users, and the effects attitudes can have on drug treatment.
- The terms 'illicit' meaning illegal, and 'drugs', as specified by the Misuse of Drugs Act, for example,
 - Class A drugs: Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (if prepared for use) amphetamines (if prepared for injection)
 - Class B drugs: Amphetamines, Methylphenidate (Ritalin), Pholcodine
 - Class C drugs: Cannabis, tranquilisers & some painkillers, GHB (Gamma hydroxybutyrate), ketamine
- The study is being conducted by Nicola Mallowan, PhD student at Bucks New University, who can be contacted at nmallo01@bucks.ac.uk if you have any questions or queries.
- If you choose to take part in this study you will also be asked to complete questions about yourself and your treatment, followed by a further 25 statements that you will be asked to either agree or disagree with. Please don't worry, your answers will remain anonymous, and you will not be linked in any way to your answers.
- Please return the completed questionnaire in the self-addressed envelope provided (the postage has been prepaid).
- You do not have to take part in this study, and you do not need to provide a reason why you do not wish to take part.
- You have the right to withdraw at any time during this study, and you are not required to give a reason for withdrawing.
- You will automatically be giving your consent to take part in this study by completing and returning the questionnaire.
- All information collected in this study will be kept confidential.
- Should you require any support after completing this survey, please be advised of the following support contacts:

Samaritans, http://www.samaritans.org/talk_to_someone.aspx, Tel. 084457 90 90 90,
Email: jo@samaritans.org

FRANK, <http://www.talktofrank.com/>, Tel 0800 77 66 00
- The researcher wishes to thank you for taking part in this study!

7 Study Seven

7.1 The survey

Demographic Questions :

1) How old are you?

2) What is your gender?

Male

Female

3) What is your ethnicity?

Asian - Pakistani

Asian - Indian

Asian - Bangladeshi

Asian British

Asian other

Black - Afro-Caribbean

Black-African

Black-West-Indian

Black-British

Black other

White-British

White-Irish

White-European

White other

Oriental

Other (Please specify)

4) Your marital status

Single

Married/ Cohabiting

Separated/divorce

- Widowed
- Other (Please specify)
-

5) Your highest educational qualification

- None
- GCSE/O-Levels/CSEs
- A-Levels
- HND/ Foundation Degree
- Undergraduate Degree
- Post Graduate Qualification
- Other (Please specify)
-

5) What is your current employment status?

- unemployed and seeking employment
- unemployed and not seeking employment
- employed part time
- employed full time
- self-employed
- currently claiming benefits (for example JSA, incapacity etc)
- student
- Other (Please specify)
-

Questions about previous drug use:

*) What type of drugs did you previously use (please tick as many as is appropriate)

- heroin, and or other opiates
- crack cocaine
- cocaine
- amphetamine
- lsd

- ecstasy
- cannabis
- magic mushrooms
- ghb
- methamphetamine
- Other (Please specify)

*) Would you like to add any comment?

(1000 characters remaining)

*) How would you describe your previous drug use,

- dependent use
- problematic regular drug use
- regular recreational use
- irregular recreational use
- Other (Please specify)

*) Would you like to add any comment?

(1000 characters remaining)

Questions about current drug use:

*) Are you currently using drugs?

- No
- Yes

Occasional use

*) If you replied 'yes' or 'occasional use' to the previous question, how would you describe your current drug use,

- dependent use
- regular recreational use
- irregular recreational use
- Other (Please specify)

*) Would you like to add any comment?

◀
▶

(1000 characters remaining)

*) If you replied 'yes' or 'occasional use' to question *, please can you tick those drugs you still use, whether it be occasional or dependent (please tick as many as is appropriate):

- heroin, and or other opiates
- crack cocaine
- cocaine
- amphetamine
- lsd
- ecstasy
- cannabis
- magic mushrooms
- ghb
- methamphetamine
- Other (Please specify)

*) Would you like to add any comment?



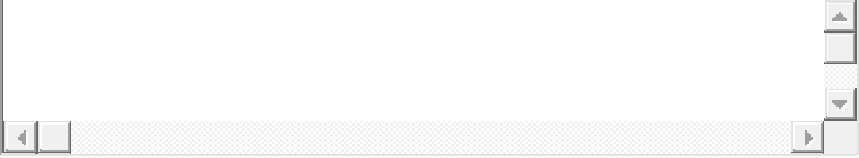
(1000 characters remaining)

Questions about previous drug treatment undertaken:

***)** What types of drug treatment services did you engage in?

- SDP
- resi rehab
- inpatient detox
- prison based treatment
- community prescribing
- one to one counselling
- Other (Please specify)

***)** Would you like to add any comment?



(1000 characters remaining)

***)** How long would you estimate that you were you in drug treatment in total? (please note, this probably includes a number of different drug treatments)

- 0 – 6 months
- over 6month – 12months
- over 1 year – 2 years
- over 2 years – 3 years
- over 3 years – 4 years
- over 4 years – 5 years
- over 5 years – 10 years

- over 10 years – 15 years
- over 15 years – 20 years
- over 20 years +
- Other (Please specify)

*) Would you like to add any comment?

(1000 characters remaining)

*) What types of drug treatment services have you engaged in?

- SDP
- resi rehab
- inpatient detox
- prison based treatment
- community prescribing
- one to one counselling
- Other (Please specify)

*) Would you like to add any comment?

(1000 characters remaining)

*) What type of drug treatment services did you find to be most successful to your recovery (please tick the one you found most helpful)?

- SDP
- resi rehab

- inpatient detox
- prison based treatment
- community prescribing
- one to one counselling
- Other (Please specify)

*) Would you like to add any comment?

◀▶

(1000 characters remaining)

*) What do you feel your ultimate treatment outcome goal whilst attending your last drug treatment service?

◀▶

(1000 characters remaining)

*) Would you like to add any comment?

◀▶

(1000 characters remaining)

Instructions: For each of the following listed statements, please could you indicate the degree to which you can remember you **previously** felt at the time when you were receiving your last drug treatment:

a)	<p>You need to stay in treatment</p> <ul style="list-style-type: none"><input type="radio"/> Strongly Agree<input type="radio"/> Agree<input type="radio"/> Undecided<input type="radio"/> Disagree<input type="radio"/> Strongly Disagree
-----------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

b)	This treatment is giving you a chance to solve your drug problems <input type="radio"/> Strongly Agree <input type="radio"/> Agree <input type="radio"/> Undecided <input type="radio"/> Disagree <input type="radio"/> Strongly Disagree
c)	This kind of treatment programme is not helping you <input type="radio"/> Strongly Agree <input type="radio"/> Agree <input type="radio"/> Undecided <input type="radio"/> Disagree <input type="radio"/> Strongly Disagree
d)	This treatment programme can really help you <input type="radio"/> Strongly Agree <input type="radio"/> Agree <input type="radio"/> Undecided <input type="radio"/> Disagree <input type="radio"/> Strongly Disagree
e)	You want to be in drug treatment <input type="radio"/> Strongly Agree <input type="radio"/> Agree <input type="radio"/> Undecided <input type="radio"/> Disagree <input type="radio"/> Strongly Disagree
f)	You have too many outside responsibilities now to be in this treatment programme <input type="radio"/> Strongly Agree <input type="radio"/> Agree <input type="radio"/> Undecided <input type="radio"/> Disagree <input type="radio"/> Strongly Disagree
g)	You are in this treatment programme only because it is required <input type="radio"/> Strongly Agree <input type="radio"/> Agree <input type="radio"/> Undecided <input type="radio"/> Disagree

	<input type="radio"/> Strongly Disagree
h)	This treatment programme seems to demanding for you <input type="radio"/> Strongly Agree <input type="radio"/> Agree <input type="radio"/> Undecided <input type="radio"/> Disagree <input type="radio"/> Strongly Disagree

The Attitudes towards Illicit drugs and drug users scale:

Please answer ALL statements; place a tick beside each of the following statements with which you agree, and a cross beside the statements with which you disagree.

1. Drug users are unreliable
2. Drug users are violent
3. Most drugs are addictive
4. Drug addicts are lonely people
5. Drug addicts have more money than sense
6. It's wrong to take drugs
7. Drugs ruin lives
8. All drug takers are thieves
9. Drug users are untrustworthy
10. Drug addiction is a sickness
11. Some people do smoke cannabis for medicinal purposes, and that is ok
12. Drugs scare me
13. Drug addiction is class-less (i.e. working class, middle class)
14. Drug users are unhygienic (e.g. sharing needles and contracting HIV)
15. Drug addicts are 'non-focused' and need direction
16. All drug users are criminals
17. Drug use makes me feel uncomfortable
18. It is easier to stay on drugs than it is to come off
19. You cannot make someone address their drug problem if they don't want to
20. Drug addicts don't like their lives
21. Some drugs are more harmful than others
22. Drug addicts are emotionally troubled
23. Drug users deserve everything they get
24. Rehab doesn't seem to work for most people
25. Drug users are dishonest

7.2 Recruitment email

Dear All,

I am looking for volunteers for an on-line survey on attitudes within drug treatment services, and the effects they have on drug treatment outcomes.

To undertake the survey I need participants who are;

- Over the age of 18
- Have undergone some form of treatment for illicit drug use (which could be **anything** from methadone prescribing to residential rehab).

If this is not you, you can still help! Please could you forward this email on to as many people as possible, as I am seeking to recruit over 500 participants.

The survey will take between 5 and 30 minutes to complete. In order to maintain complete anonymity and confidentiality, the survey is carried out by a professional, secure web-survey provider (known as Psychdata). To ensure that all responses will be completely anonymous, neither email nor IP addresses will be visible. The study has been approved by the Faculty Ethics Committee as being sensitive to the needs of the participants.

You can find the survey at: <https://www.psychdata.com/s.asp?SID=133169>

The survey is **#133169** and before you enter the survey you will be asked to set up a nickname and password, so that if you have not completed the survey you can save your answers and return to it at a later date. When you get into the survey it will be called "Experiences of Drug Treatment Services Survey" (*So that you know you are in the right place!*).

Please feel free to contact me with any queries you may have regarding the survey.

Many thanks in advance for taking the time to complete the survey, or for forwarding it on!

Best wishes

Nicola Mallowan
PhD Research Student in Psychology

Buckinghamshire New University
Queen Alexandra Road
High Wycombe
Bucks
HP11 2JZ

Email: nmallo01@bucks.ac.uk

7.3 Information sheet (online)

Experiences of Drug Treatment Services Survey

This study is examining the effectiveness of drug treatment services; particularly the part 'attitude' within treatment has on outcomes for service users.

I am only looking for people who are over the age of 18 years and have previously undergone some form of drug treatment for illicit drug use (which could be anything from community prescribed medication to inpatient residential rehab). Completion of the survey may take between 5 minutes and 20 minutes. In order to maintain complete anonymity and confidentiality, the survey is carried out by a professional, secure web-survey provider. To ensure that all responses will be completely anonymous, neither email nor IP addresses will be visible. The study has been approved by the Faculty Ethics Committee as being sensitive to the needs of the participants.

You will automatically be giving your consent to take part in this study by completing the on-line survey. Please be aware that you have the right to withdraw from the study at any time whilst completing the survey, however, once the survey has been completed and submitted because it is confidential, your survey will not be able to be tracked down and therefore omitted from the survey, should you wish to withdraw after completing the survey.

When undertaking the survey, please note that if you feel uncomfortable answering any of the questions please leave it blank and move on to the next section. Also, throughout the survey there are a number of comment boxes so that you can add any additional information should you wish to.

Please note that one of the design features of the survey means that you should only move on to the next page if you have completed the one which is visible. There is no facility to go back where you have already been. Sorry, this is not my design feature, rather one that is built in by the survey providers.

I would like to thank you in advance for your time in carrying out this on-line survey. It is hoped that the findings from this research will give an insight into attitudes within drug treatment services, and how they impact on treatment outcomes, which will be useful in terms of providing training and education to those practitioners who specialise in working with illicit drug users.

If you have any questions please feel free to contact me:
Email: nmallo01@bucks.ac.uk

7.4 End note (online)

You have now completed the survey. By clicking continue below your responses will be entered into the database.

If you feel you have anything still to add please feel free to use the comments box below.

Thank you for taking the time to complete this survey, your responses will be a valuable contribution to this study.

Some of these questions may have disturbed upsetting memories, which could leave you feeling somewhat low or unsettled. A list of possible sources of support is provided below. Additionally, employees and students from Bucks New University can contact the Counselling Services at the University.

Thank you for your help and time.

Support Contacts

(1) Samaritans

http://www.samaritans.org/talk_to_someone.aspx

Tel. 084457 90 90 90

Email: jo@samaritans.org

(2) FRANK

<http://www.talktofrank.com/>

Tel 0800 77 66 00

24 hours a day, 365 days a year

8 Study Eight

8.1 The interview schedule



Interview Number: _____

Date: _____

Demographics

Name: _____

Male/female: _____

Age: _____

Ethnic origin: _____

Marital status (e.g. single, married): _____

Employment status (e.g. JSA, temp unemployed): _____

Accommodation status (e.g. hostel, homeowner): _____

Highest educational qualification (e.g. GCSEs): _____

Current treatment episode

Name of the service (e.g. T2): _____

Type of service (e.g. SDP): _____

How long have you been attending (e.g. days/months): _____

How often do you attend (e.g. daily): _____

Is this your first treatment episode (Y/N): _____

What is your opinion of this service: _____

What is your opinion of your drug worker: _____

What is your treatment goal (e.g. abstinence): _____

Previous treatment episodes

Name of the service (e.g. T2): _____

Type of service (e.g. SDP): _____

How long have you been attending (e.g. days/months): _____

How often do you attend (e.g. daily): _____

What was your opinion of these services: _____

What was your opinion of your drug workers: _____

How many treatment episodes in total: _____

How long in previous treatment in total: _____

What was your treatment goal: _____

Evaluation of treatment and services

Good aspects of treatment: _____

Bad aspects: _____

Your relationship with your drug worker: _____

Any other comments: _____

Treatment Outcomes Profile

Name of client	D.O.B. (dd/mm/yyyy)	Name of keyworker
TOP interview date (dd/mm/yyyy)	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Treatment stage: Modality start <input type="checkbox"/> Discharge <input type="checkbox"/>
		Care plan review <input type="checkbox"/> Post-discharge <input type="checkbox"/>

Section 1: Substance use

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average	Week 4	Week 3	Week 2	Week 1	Total
a Alcohol	<input type="text"/> units/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Opiates	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Crack	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
d Cocaine	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
e Amphetamines	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
f Cannabis	<input type="text"/> spliff/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
g Other problem substance?	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

Name.....

Section 2: Injecting risk behaviour

Record number of days client injected non-prescribed drugs in past four weeks (if no, enter zero and go to section 3)

	Week 4	Week 3	Week 2	Week 1	Total
a Injected	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Inject with needle or syringe used by someone else?	Yes <input type="checkbox"/> No <input type="checkbox"/>				<input type="text"/> Enter 'Y' if any yes, otherwise 'N'
c Inject using a spoon, water or filter used by someone else?	Yes <input type="checkbox"/> No <input type="checkbox"/>				

Section 3: Crime

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Drug selling	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Theft from or of a vehicle	Yes <input type="checkbox"/> No <input type="checkbox"/>				<input type="text"/> Enter 'Y' if any yes, otherwise 'N'
d Other property theft or burglary	Yes <input type="checkbox"/> No <input type="checkbox"/>				
e Fraud, forgery and handling stolen goods	Yes <input type="checkbox"/> No <input type="checkbox"/>				
f Committing assault or violence	Yes <input type="checkbox"/> No <input type="checkbox"/>				<input type="text"/> Enter 'Y' or 'N'

Section 4: Health and social functioning

a Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0-20

Record days worked and at college or school for the past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days paid work	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Days attended college or school	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

d Client's rating of physical health status (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0-20

Record accommodation items for the past four weeks

e Acute housing problem	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> Enter 'Y' or 'N'
f At risk of eviction	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> Enter 'Y' or 'N'

g Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0-20

8.2 Recruitment email

Dear Service Manager,

Further to our recent telephone conversation, I am writing to see whether any members of your team would be willing to take part in my research on the effect of attitudes within drug treatment services.

I am looking for a number of volunteers who are current drug treatment practitioners, but have personally been through drug treatment in the past. The interviews will include questions on the interviewees' demographic characteristics, their current and previous treatment episodes, and exploratory questions relating to their experiences of drug treatment and the TA. It is intended that the interviews should take approximately 45 minutes.

If this is possible, I would be grateful if I could attend your treatment service, to carry out these interviews.

Please be assured that all responses will be kept completely confidential, and that the study has been approved by the University's Faculty Ethics Committee as being sensitive to the needs of the participants.

I would be extremely grateful if you could forward this email around to your colleagues.

Please feel free to contact me with any queries you may have regarding this piece of research.

Many thanks in advance,

Nicola Mallowan

PhD Research Student in Psychology

Buckinghamshire New University

Queen Alexandra Road

High Wycombe

Bucks

HP11 2JZ

Email: nmallo01@bucks.ac.uk

8.3 Information sheet



- This study will look at the effect of attitudes in drug treatment, on clients' treatment outcomes.
- If you choose to take part, you will be asked to attend five short meetings over your treatment. You will be asked about your drug use, crime, health, work, and housing. Also, your views on your treatment service and drug worker. The meetings will take place in private, at your treatment centre. No extra time will be asked of you outside your treatment.
- The researcher will be asking you to think about your drug worker's feelings towards you, which may make you feel upset. If this happens, you are welcome to contact the researcher to discuss this further. You will also be given details of help and support groups should you wish to contact them.
- Although the study may not assist your current treatment, findings will help future clients' in drug treatment.
- You do not have to take part in this study and you do not need to provide a reason why you do not wish to take part. You also have the right to withdraw from this study at any time and you do not need to give a reason.
- All information from this study will be kept private and confidential by the researcher, in a safe and secure way.
- The study is being carried out by Nicola Mallowan, a PhD student at Bucks New University, who can be contacted at nmallo01@bucks.ac.uk, or via your treatment service.
- Thank you for taking the time to read this information sheet!

8.4 Consent form



Please tick the appropriate boxes:

I have read and understood the project information sheet

I have been given the opportunity to ask questions about the project

I agree to take part in the project. Taking part in the project will include one short interview

I understand that my taking part is voluntary; I can withdraw from the study at any time and I will not be asked questions about why I no longer want to take part

I do not want my name used in this project

I understand my personal details such as name phone number or address will not be revealed to people outside of this project

I understand that my words may be quoted in publications, reports, web pages, and other research outputs but my name will not be used

I agree for the data I provided to be archived at the UK Data Archive

I understand that other researchers will have access to these data only if they agree to preserve the confidentiality of these data

I understand that other researchers may use my words in publications, reports, web pages and other research outputs but my personal details will not be associated to the quotes

I agree to assign the copyright I hold in any materials related to this project to Nicola Mallowan

On this basis I am happy to participate in the “evaluative study of the influence of attitudes within the therapeutic alliance, on clients’ treatment outcomes” study.

Name of ParticipantSignature.....Date.....

Name of Researcher.....Signature.....Date.....

If you have any queries or concerns, please contact: Nicola Mallowan at nmallo01@bucks.ac.uk, or through your drug treatment service, which will be able to make telephone contact on your behalf

(One copy to be kept by the participant, one to be kept by the researcher)

8.5 Example of a transcript (Andy)

Interview with 'Andy' – Participant No 1 – 2 Feb 2012

N – So you're known as 'Andy' right

S – Yeah that's me

N – Ok, and how old are you 'Andy'

S – Er, I'm 42

N – And how would you describe your ethnic origin

S – I'm British

N – Ok, so white British

S – Yeah

N – What's your marital status at the moment

S – I'm single

N – And are you working

S – No

N – Where are you living at the minute

S – Er, in a squat here, in Windsor

N – And when you were at school, can you remember what kinds of qualifications you got?

S – Yeah, i got a City and Guilds in maths and English, and I did a YTS scheme

N – Ok, so in this part of the questionnaire, i want to ask you about the drug treatment you are currently receiving,

S – Ok

N – So, firstly, what's the name of the treatment service you're currently going to

S – Its T2 in Maidenhead

N – Er, ok, and what sort of treatment are you going there for

S – Well, getting my script and a bit of one to one

N – So like counselling?

S – Yeah

N – And how long have you been going there

S – Oh not long, i started about a month ago

N – And how often are you supposed to go, once a week?

S – No it's every other week

N – So you've probably only been twice so far then

S – Yeah, about that

N – And is this your first time in treatment for drug use

S – No way! I've been in and out of treatment for about 20 odd years, probably since i was 18, so what's that, 24 years?

N – So you've had a lot of experience of different treatment services

S – Yeah a lot, and now just from 'ere, but all round. I started off in Liverpool and moved down this way a few years back

N – well, that interesting then, to talk to you about your opinion of how different services from different area are

S – Yeah

N – but, starting with the service you're going to now, how do you find them, if i were to ask you what your general opinion of the service is, I know it's still early days

S – No, they're great. I'm pleased with them, they always listen to me, and you can tell that they're like... caring about you. Yeah, they're always showing concern for your well being, and try and help out with stuff, like at the moment, they're looking at trying to sort out my housing situation. But cos i got Buster, it's gonna be difficult. But they have said they'll get on it and try and find me somewhere. But i aint going unless Buster can come too. No way I'm leaving him, me and him are in it together

N – Where did you get Buster from

S – Oh I found him tied up one day

N – What and you took him?

S – Yeah, well i knew who he belonged to, and they didn't look after him very good, so i saved him, we've been together ever since

N – Oh ok, and he's a good dog?

S – Yeah, he looks after me good, if I'm like a sleep on the street, he guards me

N – That's good then. So getting back to the questionnaire, would you say that you're happy so far with the service you've had at T2?

S – Yeah, i think they brilliant, got no complaints. I also think they are very flexible which helps a lot

N – How do you mean

S – like if I'm gonna be late, or i can't get down there to the appointment, I've just give em a ring and told them and they've said, no problem come along a bit later or something. That helps a lot, cos in the past some places have been like, no if you can't make it then, you'll have to wait till next week. That's how I've been kicked off scripts before. You see, when you've living on the streets, you can't always be ready to get on for an appointment, especially in another town, like what were expected to do here. I don't always have the money, or I've got the dog to think about. So for me, the fact that they can be flexible makes a huge difference, as long as i don't take the piss out of it, i feel confident that I'm gonna do alright with them, cos they want to help me and fitting me in when they can is quite important.

N – Is that because your life is quite chaotic

S – Look, when you're on the street, or if you're a user, life is always chaotic, always running from one situation to the next, your first thoughts aren't, oh i gotta be at this appointment at this time, so being flexible is important. More places should be like that, i think it'd make a big difference.

N – Yes, I agree, although perhaps it's not always possible for them to do that?

S – Yeah, see travelling is another thing, probably the only problem with T2 that i can see

N – What do you mean, where it is

S – Yeah, it's too far to walk, but then it costs a lot of money to get a bus

N – So if they could come to you that would be even better

S – Yeah course

N – From the good things you've said about T2 though, do you think this is better than some of the treatment you've had in the past?

S –well, i think most of 'em have been the same, always take an interest in you. You can tell them from people, that they're in it cos they care

N – How do you?

S – Like you get a feeling about someone, and you know that they're doing the job cos they do really care about you. Sometimes they don't though, but that's not been very often

N – And what specifically do the drug workers do, that makes you think they are caring

S – Well like listening to you, I've seen a lot of people in my time, and I know when someone is truly interested, or they just doing a job. Most of them I've seen have been very good and supportive. But then they're probably doing this job cos they wanted to

N – Yes. What is your ultimate treatment goal at the moment?

S – To get off the gear

N – Ok, so the next bit of the questionnaire is to ask you in a bit more detail about some of the old treatment services you've been to, I know we already touched on this a bit

S – Yeah ok

N – So, what types have you done?

S – Er, group stuff, you know like day programmes where you go every day and talk in groups, some one-to-one, rehab

N – And you've, er, been on a script before

S – Yeah. Loads of times

N – And you say that all in all you've been in and out of treatment for the last 20 odd years

S – Yeah, the first time I went in was when I was 18, I remember that I'd been on it for a few years, and I was young to go into rehab. I was only 18. Didn't work though, managed a few days.

N – What happened

S – wasn't ready to get off it, hadn't hit rock bottom, was still enjoying myself too much on it

N – Ok, so you left early then

S – Yeah, I just walked out. Been in and out of treatment ever since. You see I do want to get off the gear, always have in a way, but sometimes some more than others, so like when I'm strong about getting off the gear, I probably last longer, but when I don't really want to, or guess like your made to, then you're never gonna do it

N – Yeah. So do you think that overall, treatment services have got better over time, cos you've been in and out a lot, do you think you've seen an improvement in the services.

S – Er, not, I'd say they've got worse

N – Really? That surprises me, why would you say that

S – well, cos there are so many more people that need treatment now for drug abuse, much more than there ever used to be, so now they're so overstretched, and much harder to get in. Like, if you decided one day, that's it I've had enough I want treatment, you have to go on the waiting list for months, and then by the time they say oh we've got you a place, you're like well back into then and don't care about coming off. Once upon a time, you'd say, I wanna go into rehab, and they'd send you to rehab. Now you've gotta wait for them to decide if they've got the money to send you or not. It never used to be like that. Getting money for rehab is a nightmare now, but I do understand why, there's so many people that need treatment now.

N – Hmm, yeah, I understand, that is an interesting point

S – Hmm (agrees). I wanted to get some funding for a naltraxone implant, but they're like £1800, and I know I could get the money together if I wanted. But I asked for funding, and they said no

N – Yes, I'm not sure that you can get it through the NHS in this area because it is so expensive

S – Yeah probably

N – And over all this time you've been in and out of treatment, you must have seen a lot of drug workers

S – Yeah

N – What do you think makes a good drug worker

S – Well, like, many years ago, back when i was living up north, i had a fantastic worker, his name was Frank. I went and saw him on and off for about 15 years. When he died i was devastated, he'd been like a dad to me, in fact he died in the same year as my dad, that set me back a bit.

N – I'm sorry. Did you feel very close to him then

S – Yeah, i could say anything to him

N – You trusted him

S – Yeah, i could really open up. You see, i think it's hard to get a trusting relationship with someone you don't know. For me, it probably takes 4 or 5 years to feel able to talk about stuff. I could do that with him. Mind you, i dont think that there are those people that you can just instinctively talk to, you know like you get a gut feeling that you can talk to them, and then it's much quicker to be able to trust someone. Although i have trusted other people in the past, and ended up getting stabbed in the back.

N – How do you mean? What happened?

S – Oh well, there was this bloke i was on the streets with, i helped him out with something, and then when i needed him, he was off, he just used me

N – Oh right

S – Yeah, makes me more wary now

N – Yes I'm sure.

S – If you can trust someone, it makes a big difference

N – Yeah, and you were able to trust Frank as your drug worker

S – Yeah, well I'd know him for er, years, since i was a kid. He was from the community, and i er grew up on the same estate where he was with his kids, and we used to play football together.

N – Oh ok.

S – And then the drugs started happening, and he became a drug worker. Then when i started seeing him, i felt comfortable with him, cos i already knew him. I was happy to go and see him, and he really helped me. Gave me someone to talk to. And he knew the truth, so like if i started bullshitting him, he'd just say to me, look that's bullshit. Its cos he knew me, and would put up with any crap. That's why i knew i had to be honest with him, or there was no point. How else was he gonna help me?

N –so you had a good relationship

S – Yeah, we had a good relationship

N – Good. And you never had that since with anyone else

S – no, but to be honest though, I've never seen anyone for that long to be able to feel comfortable with someone, not that i mind taking to people, it's just that he really knew me

N – Ok, so now i just want to ask a few things about your drug use, health and any criminal activity

S- Ok

N – So are you drinking

S – Yes

N – Is that daily

S – Yeah

N – and what about heroin

S – Yeah on and off at the minute

N – So, is that daily or a bit more occasional then

S – Er yeah, occasionally

N – And er, what about crack

S – If it's about, but not often

N – ok, and anything else, cannabis?

S – No, nothing else, just mainly drinking and heroin really

N – Ok, and are you injecting

S – Yeah sometimes

N – ok, and what about sharing needles

S- No

N – Or sharing spoons, or water, not necessarily the needle, but the other bits

S – Er, no

N – Right, erm, what about any criminal activity at the moment

S – No, nothing

N – So no to shoplifting, drug selling, theft?

S – (Shakes head)

N – Handling

S – Erm, yeah a bit of handling

N – Ok, anything else? Any assaults?

S – No, nothing like that. Just a bit of handling if i need to

N – Ok. And how about your psychological health at the moment, erm, if you had to rate it out of 10, in terms of whether your suffering from say like depression, or anxiety, something like that, like erm emotion problems, what you would say.

S – What it's out of?

N – Er, 10. 10 if it's really good, and 0 is if it's really bad

S – Erm? I'd probably say it's quite good at the minute, so 7?

N – ok, and what about your physical health? How would you rate that

S – Er, probably about the same

N - Ok, and finally, how much would you rate your overall quality of life right now?

S – Erm, probably in the middle

N – So about 5

S – Yeah 5. It's not great and it's not terrible right now

N – Ok, great. So that's the end of the questions. Thank you, thanks for your time.

S – Is that it

N – Er, yes, that' s the end of the questionnaire

S – Good

N – ok, sorry to keep you so long

S – That's alright, i just gotta...

N – Is there anything you want to ask me about the questions

S – Nah

N – Or are there any other comments you want to make, that you haven't had the chance to say

S – Er, no

N – Any other comments about treatment that you've found particularly helpful

S – No. It's just that I've gotta get off now, someone's waiting for me

N – Well, ok, thank you for your time, it has been really interesting speaking to you

S – Ok

N – If you want to speak to me again, then my contact details are downstairs with Mark. And I've got a couple of support line details and numbers, in case you want to speak to anyone else about anything that might have come up today that's upset you

S – Yeah ok

8.6 Theme table for clients

Themes Identified	Andy	Becca	Charlie	Dan
Aspects of treatment influencing outcomes:				
1. Therapeutic alliance:				
<i>Practitioners attitude</i>	+ve attitude = caring / interested / honest / wants to do their job	-ve attitude = lack of knowledge / dishonest / didn't care	+ve attitude = tries to help / firm but fair	+ve attitude = prac possible ex-user -ve attitude = lack of knowledge
<i>Continuity of practitioner</i>	Long term continuity with same practitioner	Never had continuity	Currently seeing same person	Impt – “like seeing a hairdresser, you want to see the same one”
<i>Trust</i>	Long term pract relationship = trust	No long term prac relationship = no trust	–	Need to build a relationship for trust
2. Practicality of the service:				
<i>Flexibility</i>	+ve = Flexible with appts -ve = travel / money / chaotic life	–	–	+ve = Flexible with appts -ve = travel / money / chaotic life
<i>Aftercare</i>	–	–	Lack of aftercare support	–
<i>Provision of social reintegration issues</i>	Helping with housing	–	Helping with housing	Helping with housing
3. Clients locus of control	Internal – e.g. “when I’m ready”	External – e.g. “didn’t get letters”	External – e.g. “illness stopped treatment”	External – e.g. “other people are triggers”
Additional themes identified:				
1. Services have worsened	Yes – overstretched / lack of resources	–	–	Yes – overstretched / not enough staff
2. The accumulation process	In and Out	In and Out	First time	In and Out

8.7 Theme table for DTPs

Themes Identified	Ed	Faye	Gary
Aspects of treatment influencing outcomes:			
4. Therapeutic alliance: <i>Favourable/unfavourable dynamics</i>	+ve = Doesn't need to be an ex-user / Honest / encouraging / caring -ve = lack of knowledge in GPs	+ve = Genuine / trusting / listen / perception is impt / firm but fair / +ve relationship impt / encouraging -ve = GPs attitude, judgemental	+ve = trust / non-judgemental / ex-users as prac are preferable / feel listened to / good rapport impt -ve = Not firm enough / -ve GPs
<i>Support</i>	Clients need to feel supported through treatment, and afterwards / support is an impt part of treatment	A lack of support from social services is a blocker / support plays a part in recovery	Good support network from others impt
5. Practicality of the service:			
<i>Barriers</i>	–	For women: lack of childcare, and male orientated services	–
<i>Aftercare</i>	Need long term support / not much aftercare around	–	Still attends meetings
6. Clients mental attitude	State of mind impt, and being ready for treatment / coercive treatment doesn't work	Mental readiness v impt / coercive treatment is ok	Right frame of mind needed / non-coercive treatment better
Additional themes identified:			
3. Have services worsened?	Not sure – more clients in system now, but possibly more tolerant now	Same barriers for women	No – seeing more clients and improving
4. The accumulation process	Yes – learn from each treatment episode	Yes – gain knowledge & understanding	–