

**REVISED MANUSCRIPT**

**COOPERATION IN DRUG TREATMENT SERVICES: VIEWS OF  
OFFENDERS ON COURT ORDERS IN SCOTLAND**

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**Abstract**

Accessing client perspectives about cooperation in substance misuse treatment offers important information to enhance services and improve drop-out rates. This article reports upon qualitative data from a localized study of service needs of offenders in Scotland who were undertaking community-based court orders. The views of 27 men and 2 women on their current and recent treatment offers rich insights into factors influencing their cooperation in treatment. In contradiction to the voluntaristic ideology of treatment services, their voices identify the criminal justice system as offering strong support in the completion of treatment programmes.

Keywords: drug users, drug treatment, cooperation, court-mandated treatment

## **Introduction**

At the heart of the current UK Government's ten year strategy for tackling drug misuse is to improve 'the participation of problem drug misusers, including prisoners, in drug treatment programmes which have a positive impact on health and crime' (Cabinet Office 1998). With significant capital investments, drug treatment services have been responding to UK policy concerns about the number of problematic drug users involved in acquisitive crime.

Across the UK, police 'arrest referral schemes' identify drug-offenders and refer them to treatment (Edmunds et al. 1998; Edmunds et al. 1999; Edmunds et al. 2000) and in some areas of England and Scotland, court-ordered treatment can be provided to drug misusing offenders through Drug Treatment and Testing Orders (Turnbull et al. 2000; Eley et al. 2002a). Criminally involved dependent drug users living in Glasgow or Fife, typically heroin users, may also be provided with court-ordered treatment through Scotland's first pilot drug courts (Eley et al. 2002b; McIvor et al. 2003). Prison-based initiatives have also been established. Drugs throughcare has been developed in England and Wales (Burrows et al. 2001) while the Scottish Prison Service Transitional Care Initiative aims to link short term prisoners with drug problems (those serving up to 4 years) into a range of drug and other services in the community in the 12 week period following their release (Scottish Prison Service 2000). This forms part of a reported 'additional £10 million allocation over three years to the provision of case workers, transitional care services and 'new innovations in addiction' projects' (Neale and Saville 2004, p. 214).

Statutory and non-statutory service providers are involved in the delivery of drug treatment. Funded by health or social services, statutory drug agencies are mainly staffed by social workers and nurses working with doctors and (possibly) unqualified staff or volunteers. Non-statutory drug agencies are usually registered charities whose staff roll may include ex-users, staff without social work or addiction qualifications and qualified professional staff (Neale 1998). Problematic drug users are also often in contact with broader generic agencies offering, for example, education and employment training, housing and social services as well as interpersonal skills provision such as counselling and anger management.

Given the scale of the publicly funded investment into drug treatment services through criminal justice system-based initiatives across the UK, this article is timely in exploring factors influencing cooperation of offenders with drug treatment services after the point of help-seeking.

Drug users' views have been considered as highly relevant to identifying drug users' particular needs (Royffe and Gledhill 1998; Neale 2002). Qualitative research methods are particularly effective when exploring complex issues (Mason 1996). Qualitative research examining drug users' motivation for help-seeking, participation in drug services and reasons for attrition suggests that a close matching of user expectations of the service with actual services provided and facilitated for them encouraged concordance with treatment (Biernacki 1986; Neale, 1998; Neale 2002; McKeganey and McIntosh 2002). Recent research exploring client access and

drop out in drug services has recruited drug agency service users to conduct interviews with the service users of participating agencies in the belief that as drug users they may elicit honest accounts as to service users' preferences (SDF & ISD 2002, p. 6).

Previous studies have considered the gendered nature of participation in drug treatment services in Scotland (Neale 1998). Data from the National Drug Treatment Monitoring System (NDTMS) suggests that the current ratio of men entering treatment compared to women is 3:1 and has remained constant since 1996. Less attention has been given to the small and significant pool of drug users who are also in frequent contact with the criminal justice system and their views on participation in services.

The aim of this article is to develop some broader themes emerging from a small scale study (Beaton et al. 2001) of the service needs of young offenders who misuse substances in a specific geographical area of Scotland. Accessing client perspectives about cooperation in substance misuse treatment offers important information to enhance services and improve drop-out rates.

### **Outline of the Study**

Participants for the study were opportunistically recruited through criminal justice social work professionals in one geographical area of Scotland. Following agreement of the Head of Criminal Justice Social Work in the area, KB contacted

identified Criminal Justice workers with the aim of accessing suitable participants who had current or recent substance misuse issues and were undertaking a community based court order to take part in group or individual interviews. This article reports on qualitative data collected from group interviews with 27 men and two women, aged 18-45 years, who were undertaking either a Supervised Attendance Order or a Community Service Order in June-August 2001. Supervised Attendance Orders require offenders to undertake between 10 and 60 hours of supervised activities as an alternative to imprisonment for fine default (see Levy and McIvor 2001). The Community Service Orders had no drug treatment provision while a short drug and alcohol misuse programme was optional to those on the Supervised Attendance Orders.

The recruitment of participants through criminal justice social work channels rather than through drug treatment agencies was beneficial to the research methodology in two ways: i) it allowed the study to focus on a specific group of drug users' experiences and ii) it enabled the research team to gather data on individuals who were in treatment as well as those who had previously sought help for their substance misuse and were not currently in contact with drug treatment services. Further strengths of this approach included the relative speed of data collection and the legitimacy of the study to the participants and professionals given by the reputation of KB in respect of substance use work, groupwork and interviewing techniques. Limitations of this approach included the possible ethical implications of the rapid process of gaining informed consent. The ease of withdrawal from the

study was emphasized and one participant did choose to do so. It was not possible, in this instance, to include in the sample offenders from ethnic minority groups, because they were not represented in the wider population from which the sample was drawn. Another limitation of the recruitment process was that only two women were available to take part in the group interviews: women are, it has been shown, under-represented among offenders on community service (McIvor 1998) and most of the present sample were subject to this type of court order.

Eight group interviews with between 2-5 individuals were conducted using a topic guide. An intuitive approach by KB allowed for the realities of men and women's lives to be revealed. Group interviews were between one to two hours in duration. Subject to securing the offenders' consent, the responses were tape-recorded and transcribed verbatim. It should be noted that while every attempt has been made to present the offenders' views in their own words, the extracts presented in this paper have been edited for accessibility to a wider readership.

Table 1 summarises the key background details of the contributors to each of the group interviews. Twenty five participants were on Community Service Orders and four were completing Supervised Attendance Orders. All of the participants described themselves as having either current or past substance misuse problems. The majority were still experiencing problems with their drug or alcohol use, as partially evidenced by their offending behaviour and subsequent community disposal, with 6 individuals describing their 'use' as controlled usually after reducing

drug use of a problematic nature. Most people reported opiate problems but this was not exclusive. Other types of drugs whose use was mentioned as having been ‘problematic’ were ecstasy, amphetamines, cannabis, cocaine (including crack cocaine), tranquilizers (mainly valium) and alcohol.

(Insert Table 1 about here)

The participants’ accounts suggested that since their youth that they all had tried most approaches (often more than once) to drug treatment and could articulate positive and negative aspects of service delivery that concurred with previous research in the area (Neale 1998). At the time of the study 15 of the participants were currently receiving treatment for either alcohol and/or drug problems. All these individuals had accessed services via their GP and were engaging with medical interventions such as substitute prescribing namely methadone, anti-depressants and tranquilisers. Of the 14 research participants who were not currently receiving any service for problematic substance use, two people felt they did not have a service need, one person was trying to ‘deal with *their* problems *themselves*’, two people had accessed controlled drinking programmes through their GPs, two people described themselves as having relapsed back to heroin use after having received treatment and seven people claimed to be abstinent or ‘clean’.

Data analysis began with the identification of key themes. The verbatim transcripts of the group interviews were coded and analysed using a constant

comparative method. The following sections will consider the offenders' perspectives on cooperation and communication during treatment and ways of improving participation in treatment. Finally the implications for drug treatment services and the criminal justice system are considered.

### **Cooperation and Communication during treatment**

Drug use, particularly heroin dependence, cannot be treated without the co-operation and commitment of the client as treatment is a process in which the client takes an active role. In our study, around half (15/29) of the participants acknowledged that their own actions made them, at times, uncooperative in drug treatment for workers. For example, one male drug user reportedly ignored correspondence from his social worker about accessing drug treatment after he had initiated referral for his problematic drug use:

I mean they did offer it...to be fair.. they sent me a letter saying if you don't reply, then the appointment will be ignored sort of thing.. so it went in the bin (2.1)

Respondents reported that they had missed appointments without apology, had quit treatment that they felt was not right for them and had undertaken self-detoxification despite being on a substitute prescribing programme. Some had left methadone programmes because of a lack of faith in the speed of recovery while others wished to pursue a totally drug free life.



In the offenders' accounts, three crucial factors were commonly cited as reasons for their cooperation (or rather lack of it) with treatment providers. These factors are appointment attendance, negotiation over treatment plans (including methadone regimes) and continued use of street drugs while in treatment.

### *Appointment attendance*

The participants recognised that drug using clients like themselves frequently failed to show at treatment appointments for a variety of reasons, which in their words were 'legitimate'. They perceived attendance to be a cause for concern for drug service workers and could lead to them being labeled as 'non-compliant', 'lacking motivation', 'immature' and/or 'difficult'. Hussein Rassool argues that 'social prejudice, negative attitudes and stereotyped perceptions of problem drinkers and drug users are widely held among health care professionals' (Hussein Rassool 1998, p. 69). This could be explained in part by the dominance of the medical model in shaping current public health thought about the causes and treatment of alcohol and drug addictions that have often been viewed as diseases. The medical model posits the individual as the locus of the drug misuse problem and generally ignores social, economic and political context. Drug users seeking treatment are not considered to be rational agents in control of their lives but dependent, weak-willed, passive and emotionally unstable (Taylor 1993; Friedman and Alicea 1995).

### *Negotiation over Treatment plans*

The development of treatment plans for the reduced use of and eventual abstinence from illicit drugs was a second major area where participants felt that they had been challenging to professionals. One male participant eloquently described how he exercised his consumer rights to choose a doctor who, in his view, was willing to work in partnership with him over his treatment plan:

the amount of GPs that I went through trying to come off and never getting anywhere because they weren't interested. (7.1)

Many of the participants who had sought help for problematic opiate use reported that they perceived a lack of humility and sensitivity in their communication with health professionals regarding access to prescribed opiate substitutes such as methadone. As one male respondent explained:

A lot of GPs won't give you the time of day .. I had one a couple of weeks ago, I walked out. My Methadone was getting picked up because by the time I got home from work the chemist was closed. But he wanted me to travel away to a different town to pick up my methadone myself and I told him that I wasn't doing it and he said that is what I am telling you to do and I said well you can keep your prescription and I just walked out... he was just changing it to make it harder for me, and I just told him to f\*\*k off and I walked out. They will put a lot of obstacles in your way (7.4)

Participants held the view that a client's methadone reduction regime should be mutually agreed with them by drug service workers or health professionals. In the group interviews it emerged that there was a mismatch between professional

expectations of an appropriate rate of methadone reduction and client aspirations with respect to how quickly their dosage could be reduced.

I want tae get that down 5 mls or 2, at least 2 mls a week. She (the nurse) says no, it would be 2 mls a month. At that rate, you'd be on it for years. (4.1)

She (the nurse) doesn't want tae take me off the Methadone, ah had tae take myself off the Methadone... the only thing they done for me is got me on the Methadone programme, ... they would have kept me on it for ever. (4.2)

Poor communication about methadone regimes had lead to client frustration at a lack of progress. This had precipitated some participants to make decisions to exit from services, attempt self-detoxification or relapse into using their drug of choice.

#### *Continued use of street drugs during treatment*

The other area of cooperation and communication in treatment emerging from the group interview data is the continued use of street drugs. Many participants said that they had regularly 'topped up' substitute prescribed programmes with illicit drugs, usually their drug of choice but sometimes whatever drugs were available. The participants emphasized that, from their perspectives, such relapses were not indicative of a lack of motivation towards abstinence and dissatisfaction with their drug service provider(s). Most argued that they were committed to their drug treatment at the time but stressed that relapse was a rational response to exceptional circumstances such as bereavement, acute poverty, violence and family conflict. As

one participant explained, 'Sometimes you're that stressed out you just turn tae drugs' (4.2).

### **Improving Participation in Treatment**

Despite presenting the case that a lack of cooperation in treatment was often related to communication between professionals and clients, there was a consensual view from our participants that tough measures were needed to respond to clients 'wasting' the services. For example, failure to show at treatment appointments was perceived to be costly in resources and contributed to long waiting lists:

I say you miss one appointment an' that's you, you're off his list (7.4)

Recent research on mandated drug treatment has reported that addiction workers, doctors and other health care professionals perceive failure to show at appointments or 'non-compliance' with drug treatment as irrational when help is being offered (Eley et al. 2002a).

Punitive measures were also proposed for clients who continued to take street drugs while in treatment:

If they're no wantin' tae come off it, what's the point o' goin' tae a counsellor, cos then they're just wastin' the counsellor's time (4.1)

The people that don't want tae come off it shouldnae be on it [the programme] in the first place.. to be helped .. get rid of them (6.2)

Interestingly, given the participants' current relationship with the Scottish courts at the time of the group interviews, there was a clear message that the criminal justice system could play an important role in ensuring a client's compliance with substance use services:

you've been in trouble with the law ... you stick to this programme, we'll help you get off it, we'll help you get back on track, and just try and give them a light at the end of the tunnel, to go for. And then.. there's a big black hole if they don't comply with it. (3.3)

You stick to this, you sort out your problem, we're going to help you sort it out and this is what's going to happen if you don't stick to it (6.1)

Mandated drug treatment, as part of a court order, was felt to provide a strong incentive to attend appointments, co-operate with treatment regimes and become and remain drug free. In particular, the possibility of breach was perceived to serve as a deterrent to continued drug use while in treatment. For this reason some participants suggested that the courts should have the option of requiring offenders to undergo residential treatment for drug use. Scottish Courts can impose probation orders with additional conditions relating to both drug treatment and residence. However, few orders specifying residential treatment are made possibly as a result of the limited available provision.

A small proportion of the participants, on the other hand, felt that the threat of penalty for a lack of cooperation with treatment services would not be a deterrent: 'You cannae threaten them with anythin' because they've no' done anythin' wrong' (3.4).

## **Implications for Drug Treatment services and the Criminal Justice System**

The offenders with current or recent substance misuse in our study expressed little reservation about being coerced into drug treatment by the courts. There is some evidence that coercion can increase the chances of successful outcomes because court mandated clients stay in treatment longer than do those who enter services on a voluntary basis (Anglin et al. 1989; Anglin and Hser 1990; Harrison and Blackenheimer 1998). In general, flexible service provision that enables 'tailor made' treatment programmes to be provided will usually produce better results (Anglin and Hser 1990) within the criminal justice context.

While the majority of the 29 respondents reported satisfaction with at least one local service provider, their accounts reflected their desire for a 'holistic' approach to their substance misuse to address their needs and effect a long term recovery. Recent research has indicated that a 'more person-centred approach to health and social care could improve client outcomes' (EIU 2001). For many drug users in the present study, the realization that a typical drug service could not offer a 'one stop shop' resource had contributed to their lack of engagement with the treatment and eventual departure. Practical support, such as help with accessing benefits, housing and job-seeking, was a common reason for accessing local drug treatment services in the first place (Beaton et al. 2001). During episodes of treatment, many participants reported that cost of transport to treatment, debt recovery, ill health and threat of violence were all local barriers to maintaining

attendance at treatment. Participants argued that if there was tangible support available for the social and economic realities of their lives, then getting off drugs and living a drug-free life could be an attainable goal. Articulating their 'choice' over leading drug-free lives, participants emphasised the realities of the socially excluded lives of drug misusers:

Come off drugs... that's you solvin' one problem out of many,. . . the drug users will no' see drugs as a problem, their life's a problem .. . an' they're using drugs tae escape their life. (3.2)

The group of clients who participated in our study had used, at some time, all of the drug service approaches available. Methadone prescribing, although appreciated by some clients, was felt to be an 'one size fits all' approach to giving up drugs. Lack of mutual agreement and effective communication concerning methadone regimes was one key area where difficulties arose. While the clients were reflexive about their unco-operative behaviours and absences from treatment, this was commonly regarded as being a rational response to what they perceived to be disinterested or obstructive attitudes on the part of service providers or legitimate reasons in their private lives.

Some recognised what was, from their perspective, a 'bad' or 'unsuccessful' treatment episode and voted with their feet. Others were unable to sustain treatment as a result of 'going to ground' due to risk of interpersonal violence, debt recovery or ill health.

The established high rates of voluntary and involuntary exits from drug treatment and risk of relapse have implications for the implementation of court orders including drug treatment as a condition. In the pilot Drug courts in the city of Glasgow and Fife, Scotland the assessment of the suitability of offenders for Orders considers the quantity and quality of previous drug treatment episodes (Eley et al. 2002; Malloch et al. 2003). Hussein Rassool (1998) has argued that there is a sense of impatience and intolerance of drug users among criminal justice professionals, social workers and addiction workers. It was unexpected that drug users themselves would differentiate between clients 'worthy' of a place in treatment (irrespective of whether voluntary or mandated) and those who are 'wasteful'. For both professionals and clients this could be considered a rational response to the predicament of too few resources for too great a problem.

### **Conclusion**

Our research was a relatively small-scale, localised study with an opportunistically recruited group of criminal justice social work clients and no claims to wider representativeness of the findings can be made. Moreover the recruitment of research participants through existing criminal justice social work caseloads – on which women are typically under-represented - may have contributed to their under-representation in the research. These limitations aside, the accounts provided by the participants in this study cannot simply be dismissed as unreliable and idiosyncratic. Rather, they provide an insight into the experiences, views and preferences of service users themselves.



Recent legislative change to establish the Drug Treatment and Testing Order and the pilot Drug Courts in Scotland and other jurisdictions (Walker 2001) are premised on the need for flexibility and patience in the treatment and rehabilitation of drug-involved offenders. Drug treatment services need to be able to address the needs of drug users at various points in the criminal justice system in flexible ways that are cognizant of the 'careers' of problematic drug users. Our study suggests that one specific group of substance misusers, in contact with the criminal justice system, can articulate their needs ably and their perspectives should be considered in the provision of needs led rather than service led treatment. In contradiction to the voluntaristic ideology of treatment services, their voices identify the criminal justice system as offering strong support in the completion of treatment programmes. There is a need for services to be increasingly willing to review their communication strategies to fully engage with clients who are all too easily dismissed and excluded from service provision and to do so, where necessary, in the context of court-mandated treatment.

**Table 1: Characteristics of 29 participants of group interviews**

<b>Group ID</b>	<b>Gender</b>	<b>Order</b>	<b>Problematic use</b>	<b>Current treatment</b>	<b>Recent treatment</b>
1.1	M	SAO	Alcohol	Psychiatrist	-
1.2	F	SAO	Heroin	Methadone, GP	-
2.1	M	CS	Polydrug + alcohol	-	Counselling, GP
2.2	M	CS	Alcohol	(Abstinence)	-
2.3	M	CS	Methadone	Methadone, counselling	-
2.4	M	CS	Crack + cannabis	(Self-detox)	-
3.1	M	CS	Alcohol	(Controlled drinking)	GP
3.2	M	CS	Alcohol	(Controlled drinking)	GP, self help
3.3	M	CS	Polydrug + alcohol	GP	-
3.4	M	CS	Ecstasy + cannabis	GP	-
4.1	F	CS	Heroin	-	Methadone, Rehab, GP
4.2	M	CS	Heroin	Methadone, GP	-
4.3	M	CS	Polydrug + alcohol	-	Methadone, GP
4.4	M	CS	Alcohol	counselling	-
5.1	M	CS	Cannabis	-	-
5.2	M	CS	Alcohol	GP	-
5.3	M	CS	Painkillers	Methadone/diazepam, GP	-
5.4	M	CS	Cocaine	Valium, GP	-
5.5	M	CS	Heroin	-	Self detox
6.1	M	SAO	Alcohol	(Abstinence)	-
6.2	M	SAO	Alcohol	(Abstinence)	-
7.1	M	CS	Heroin	(Abstinence)	Rehab, methadone
7.2	M	CS	Alcohol	Alcoholics Anonymous	-
7.3	M	CS	Alcohol + painkillers	GP	-
7.4	M	CS	Heroin	Methadone, counselling	-
8.1	M	CS	Alcohol + solvents	GP	-
8.2	M	CS	Cannabis	Antidepressants, GP	-
8.3	M	CS	Alcohol	(Abstinence)	-
8.4	M	CS	Alcohol	(Abstinence)	-

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