

# **Coercion, Drug Treatment and the Criminal Justice System: A Service User Perspective**

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**This thesis is submitted in partial fulfilment of the requirements for  
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## **Declaration**

Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied within this thesis are the work of the named candidate and have not been submitted for any other academic award.

Signed:

A handwritten signature in black ink, appearing to read 'Marie-Edith Tiquet', with a large, stylized flourish at the end.

Marie-Edith Tiquet

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## Table of Contents

<b>Abstract .....</b>	<b>9</b>
<b>Introduction .....</b>	<b>10</b>
Motivation for Research.....	12
Aims of the Research.....	14
<b>Chapter 1: Understanding Coercion .....</b>	<b>18</b>
The Rise of Coercion – A Political Approach to Crime Control .....	18
Substance Use and Crime.....	20
Multi-Agency approach to substance misuse .....	22
Criminalisation, Coercion and Public Protection .....	23
The Development of Drug Treatment Provision and Increased Monitoring.....	27
A Move towards Rehabilitation and Behaviour Change.....	30
Conceptualising Coercion.....	33
Successful Completion of Treatment .....	34
Defining Substance Abuse and ‘Addiction’ .....	35
Relapsing Nature of Drug Abuse .....	37
Motivation and Self Determination Theory .....	38
Translating Policy into Practice – How compatible is Coercion with Drug Treatment? .....	40
Choice, Informed Consent and Capacity .....	41
Restriction of Liberty and Public Protection.....	44
Improvements to Treatment Provision .....	45
Enforcing Coercive Measures .....	48
<b>Chapter 2: Methodology: An Interpretative Phenomenological Approach to Understanding Coercion.....</b>	<b>50</b>
The Research Setting.....	50
Methodology.....	52
Advantages of Qualitative Research Methods .....	52
Limitations of Quantitative research methods.....	53
Epistemological Approach.....	56
Interpretive Phenomenological Analysis.....	56
Focus groups .....	60
Semi-Structured Interviews.....	68
Research Ethics .....	69
<b>Chapter 3: Findings and Discussion: Experiencing Coercion.....</b>	<b>72</b>
Focus Group Analysis .....	72
Results .....	73

Participant Demographic Information .....	73
Super-Ordinate Theme1: Coercion.....	74
Super-Ordinate Theme 2: Challenges of Engaging in Coerced Treatment .....	79
Super-Ordinate Theme 3: Enhancing Factors.....	82
Super-Ordinate Theme 4: Recommendations.....	84
Semi-Structured Interviews.....	85
Results .....	86
Participant Demographic Information .....	86
Super-Ordinate Theme 1: The Concept of Coercion .....	90
Super-Ordinate Theme 2: Enabling Positive Behaviour Change .....	102
Super-Ordinate Theme 3: Self-Determination .....	110
Super-Ordinate Theme 4: Recommendations.....	118
<b>Chapter 4: Conclusion.....</b>	<b>120</b>
Implications for Practice.....	124
Recommendations for Future Research.....	126
<b>References .....</b>	<b>128</b>
<b>APPENDIX A .....</b>	<b>146</b>
<b>APPENDIX B.....</b>	<b>148</b>
<b>APPENDIX C.....</b>	<b>153</b>
<b>APPENDIX D .....</b>	<b>157</b>
<b>APPENDIX E.....</b>	<b>161</b>

**List of Figures**

**Table 1: Focus Groups Thematic Analysis.....73**

**Table 2: Interviews Thematic Analysis.....86**

**Table 3: Overview of Interview Participants.....87**

## List of Abbreviations

<b>AA</b>	<b>Alcoholics Anonymous</b>
<b>CJIP</b>	<b>Criminal Justice Interventions Programme</b>
<b>CSEW</b>	<b>Crime Survey for England &amp; Wales</b>
<b>DIP</b>	<b>Drug Interventions Programme</b>
<b>DIR</b>	<b>Drug Information Record</b>
<b>DRR</b>	<b>Drug Rehabilitation Requirement</b>
<b>DSM</b>	<b>Diagnostic and Statistical Manual of Mental Disorders</b>
<b>DTTO</b>	<b>Drug Treatment Testing Order</b>
<b>EMCDDA</b>	<b>European Monitoring Centre for Drugs and Drug Addiction</b>
<b>IOM</b>	<b>Integrated Offender Management</b>
<b>IPA</b>	<b>Interpretative Phenomenological Analysis</b>
<b>MAPPA</b>	<b>Multi Agency Public Protection Arrangements</b>
<b>MARAC</b>	<b>Multi Agency Referral and Assessment Conference</b>
<b>MI</b>	<b>Motivational Interviewing</b>
<b>NTA</b>	<b>National Treatment Agency</b>
<b>NTORS</b>	<b>National Treatment Outcome Research Study</b>
<b>PDU</b>	<b>Problematic Drug Users</b>
<b>QTC</b>	<b>Quasi Compulsory Treatment</b>
<b>RA</b>	<b>Required Assessment</b>
<b>RoB</b>	<b>Restrictions on Bail</b>
<b>SDT</b>	<b>Self Determination Theory</b>
<b>UN</b>	<b>United Nations</b>
<b>UNODC</b>	<b>United Nations Office on Drugs and Crime</b>



## **Abstract**

In the early 1980s, it was perceived that substance misuse and crime were linked and that drug users were responsible for a disproportionate amount of acquisitive crime being committed which led to the introduction of coercive measures. The causal relationship between drug use and crime has since been contested with attempts made to manage problematic drug use without appreciating the nature and underlying causes of substance misuse, such as assumptions relating to compulsion, ethics, motivation and self-determination. The effectiveness and appropriateness of contemporary drug policy has since consequently been due to the heterogeneous nature of coercion, as experienced by service users. With the changing focus of the government in the management of drug using offenders through the recovery agenda, albeit with the continued use of coercive measures, an in-depth exploration of drug using offenders' experiences is essential to inform our understanding of the dynamics of coercion in their management. A qualitative approach is adopted using focus groups and semi-structured interviews to enable the views of participants to be explored. The use of Interpretative Phenomenological Analysis and the researcher's experience of working in the substance misuse field facilitate a grounded understanding of drug users in the criminal justice system, giving meaning and context to experiences of coercion. This research found that substance use fosters loneliness, shame, fear, low self-confidence and causes individuals to go against their values which creates barriers to their ability to access treatment. To avoid prison was the main reason participants accepted coerced treatment however, this did not mean that they were not motivated to address their substance use or make changes to their lifestyles. Instead, coercive measures were found to create an opportunity to face challenges and access treatment, providing there were elements of their life they wanted to change. If they had not reached a point where they had 'enough', it was found unlikely that coerced treatment would be accepted or commenced. Through coercion, participants did not feel pressures or threats to remain in treatment and were not necessarily unwilling. They gained the ability to foster relatedness and stability which enabled positive behaviour change. Length of sustained engagement in treatment was dependent on participants' levels of motivation and treatment services' ability to increase their autonomy and competence which has important implications for practice.

## Introduction

Problematic drug users (PDU) are defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2017) as 'injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines'. There are around 320,000 PDU in the UK with over half receiving treatment in the community and a quarter receiving treatment in prison (NTA, 2012). Furthermore, the UK illicit drug market is estimated at being worth between £4 billion and £6.6 billion with Class A drug use generating an estimated £15.4 billion in crime and health costs each year (Home Office, 2007b). With drug use and its related crime costing the economy large amounts of money, the debate around 'what works' in reducing reoffending and steering drug using offenders away from crime towards a fulfilling life has been on-going for several decades. Research over the last 20 years has evolved and developed with a view to implement interventions in place of imprisonment which would address individuals' needs and rehabilitate them to conform to the rules and regulations of society. With the latest government reform of the UK drug policy (Home Office, 2010), the debate between recovery and harm reduction continues. Over the last twenty years, the British government has attempted to strike a balance between punishment and rehabilitation, and taken a harsher approach to address acquisitive crime which was believed to be disproportionately committed by drug users (UKDPC, 2008). Moving away from the medical model it had adopted in the early part of the twentieth century, along with its failure to contain substance misuse and its related crime, coercion was introduced with drug treatment becoming a sentencing option. Substance misuse was identified as one of the main causes of crime which greatly impacted societies across England and Wales and needed to be controlled. Despite the lack of research at the time justifying the effectiveness of such harsh measures (Strang & Gossop, 2005); the UK joined the rest of the world by moving towards legal enforcement to stamp out substance misuse through coercion. Declaring a war against drugs, coercion became a core component in the management of substance misuse and crime control.

Coercion has been defined as follows: a process whereby an (unwilling) individual is persuaded to do something by using force or threats (Seddon, 2007). This simple definition shows that coercion is an idiosyncratic phenomenon whereby an individual needs to be unwilling and, leverage needs to be used and perceived by the individual as force or a threat. To date, research assessing the effectiveness of coercion has paid little attention to these variables. It generally assumes recipients of coercion are unwilling and experience threats, and referral routes into treatment (i.e. through court programmes as opposed to voluntary engagement

into treatment) are used to determine whether individuals are coerced or not (Gregoire & Burke, 2004; Perron & Bright, 2007). It is also important to recognise that the application of coercion is varied. The United States of America for example have exerted different variations in jurisdictions and states whereby some have decriminalised and legalised some drug use, whilst others have enforced drug treatment through the criminal justice system and individuals are not given a choice. Other countries such as England and Wales, make use of what has come to be known as quasi-coercion whereby individuals are given some choice in this process (Stevens, 2012). Consequently, how coercion is experienced by service users and how it is applied in a research setting are not explored which could entail methodological failings in evaluating its effectiveness as a crime control and substance misuse management approach. As addressed, the terminology of coercion is three-fold and addressing this concept would require research to explore and describe how coercion is being applied in the research setting; the measures used to enforce coercion and how it is experienced by individuals. Furthermore, coercion is a complex process which is not limited to legal pressures; failing to take this into consideration within research may be an explanation for inconsistencies in research findings (Stevens, McSweeney, van Ooyen, & Uchtenhagen, 2005; Wild, 2006). In their review of literature on coercion published between 1988 and 2001, Wild, Roberts and Cooper (2002) found that less than a quarter of empirical research used an independent measure of coercion aside from referral routes. Researchers have increasingly explored how factors such as social pressures (such as family and friends) may impact on individuals' engagement in treatment to evaluate the effectiveness of legal coercion (Marlowe, Merikle, Kirby, Festinger, & McLellan, 2001; and McSweeney, Stevens, Hunt, & Turnbull, 2007). In more recent years, efforts have been made to establish how legal and other social pressures are perceived by individuals (Wild, Cunningham & Ryan, 2006; Stevens, Berto, Frick, Hunt, Kersch, McSweeney, Oeuvray, Puppo, Santa Maria, Schaaf, Trinkl, Uchtenhagen, & Werdenich, 2006). However, they have more recently been criticised for failing to address the role of psychological pressures and self-determination and recipient's experiences (Wild, 2006; and Urbanoski, 2010). This would enhance our understanding of how and why coercion can impact on drug using offenders and its effectiveness in contemporary drug policy. It is therefore important to understand first and foremost what coercion might mean to individuals and factors which may impact on this; whether in the application of coercion in the criminal justice systems or through other influential factors in individuals lives.

Research over the last 50 years has looked at a variety of treatment and rehabilitation options for drug misusing offenders and how individuals and communities can be sheltered from the

damage substance misuse causes. Debates have taken place around the success of coercive interventions into drug treatment at various stages of treatment (entry into treatment: Wild et al, 2006; Marlowe et al, 1996; Retention: Young, 2002; Longshore & Teruya, 2006; Outcomes: McSweeney, Stevens & Hunt, 2006; Perron & Bright, 2007; Reuter & Stevens, 2008) and its impact on recidivism (Young, Fluellen & Belenko, 2004; Marshall & Hser, 2002; Parhar, Wormith, Derkzen & Beauregard, 2008). Conclusions have been spread across the spectrum with some finding a positive link, others finding no or inconclusive links, and providing limited suggestions for a move towards effective drug policy in the management of substance misuse and crime control. Although some coercive measures have been found successful in aiding drug using offenders to access and successfully complete treatment (NTA, 2012; Perron & Bright, 2007), the extent to which legal coercion, as opposed to other social pressures and self-determination, has contributed to this has been greatly contested and remains ambiguous (Reuter & Stevens, 2008; McSweeney et al, 2007).

Drug dependence has been described as a “health disorder with social causes” (NTA, 2009) and drug related policies have shifted back and forth between medical and psychosocial approaches to address it. To gain an understanding of the evolution of coercion in drug treatment and its justification in contemporary drug policy, it is important to understand how substance misuse came to be defined as a social problem and to evaluate the impact policy has had on recidivism and the prevalence of substance misuse. In line with the 2010 drug strategy (Home Office, 2010) which encourages service users’ views to be sought in the design of treatment services, service users’ experiences have been placed at the core of this research to enable a different perspective and enhance our understanding of what it means to be coerced into treatment through the criminal justice system. To further understand the role of coercion in the management of substance misuse and crime control, it would be of benefit to explore whether recipients of legal coercion are unwilling, if they feel forced and experience threats to access and engage in drug treatment through criminal justice routes. This empirical approach could enhance our understanding of coercion to guide drug policy and treatment provision.

## **Motivation for Research**

I have worked in substance misuse treatment services in London since 2004 and I have been able to experience first-hand the impact drug policies have had on drug using offenders and treatment services. Through managing a General Practitioner Shared Care Scheme, I continue to experience the remains of the British System from the 70s and 80s despite efforts from the

government to promote recovery and control substance misuse (Strang & Gossop, 2005). I still come across general practitioners (GP) who prescribe large amounts of methadone with limited oversight and monitoring of individuals. Despite drug and alcohol treatment services' attempts to engage these GPs and increase partnership working to support drug users, some remain reluctant to make use of available interventions. This means that service users are not being supported to move away from substance misuse as recommended by the 2010 drug strategy (Home Office, 2010). Offenders who misuse substances have historically been extremely hard to reach individuals who were reluctant to engage due to barriers such as stigma, mental health and waiting times associated with access to treatment (NTA, 2006; Peterson, Schwartz, Mitchell, Reisinger, Kelly, O'Grady, Brown & Agar, 2010, Radcliffe & Stevens, 2008). At the turn of the century, I experienced first-hand the positive impact changes in drug policy and new initiatives had by introducing funding into drug treatment services which greatly reduced waiting times and, for the first time, enabled treatment services to offer something tangible to individuals (NTA, 2006).

Working in this field, I often get asked what our success rate is. My answer has always been the same: it depends how you define success. Success is hard to characterise and can be measured in different ways; through harm minimisation alone, individuals' lives can be improved by providing safer injecting techniques and encouraging someone to smoke rather than inject. Through substitute medication, individuals can be assisted in reducing their use and becoming abstinent (NTA, 2013). Furthermore, engagement in treatment can support them to maintain stable accommodation, improve relationships and access education, training and employment (Stevens et al, 2005). From social to health benefits, success is present in every case I come across. However, looking at success from a crime control perspective can be harder to identify. For some individuals, offending is a means to pay for drugs. For others, it is a way of life and an ability to sustain a lifestyle they have developed whereby drug use became part of it but is not necessarily the driving factor in their behaviour (Hough, 1996). In terms of individuals successfully moving away from drug use and offending, despite changes in government policies, one thing remains certain from my experience of working within criminal justice drug and alcohol services: sometimes it works, sometimes it does not. Although services have become better equipped to track individuals and ensure they are offered support at every stage of the criminal justice system; from my experience, acceptance of treatment and sustained engagement with services remains ad-hoc and inconsistent regardless of the services provided or changes that have been made within drug policy. Through this research, I aim to explore the views of participants in light of my own practice

experience in the hope that treatment services and provision can adopt practice and processes which can enhance service user experience and inform drug policy and practice.

## **Aims of the Research**

Assessing how coercion impacts on substance using offenders is by no means straightforward and several conceptual issues must be addressed to design a meaningful methodology. Wild (2006) and Urbanoski (2010) considered that, to successfully evaluate the effectiveness of coercion, especially with an aim to guide policy and practice, it is imperative that individuals' perspectives and experiences are sought, and for the heterogeneity of treatment and social controls to be considered. Although the latest drug strategy (Home Office, 2010) is moving away from the previous harm reduction approach (Home Office, 1998) towards a focus on outcomes and recovery, coercive measures are still present in the management of substance users in the criminal justice system. An evaluation of coercive factors that inhibit and enable effective substance use management and crime control is necessary. The aim of my research is to address coercion from a different perspective by exploring how it is experienced by drug using offenders, what it means to be coerced, how psychological and external factors, and self-determination interact with each other when individuals access drug treatment through criminal justice routes. Consequently, this would provide a more grounded understanding of coercion to assist the evaluation of the management of substance misuse and crime control in contemporary drug policy. More specifically, the aims are as follows:

- To explore service users' experiences of coercion as a means of substance management or crime control
- To understand how social / psychological factors impact on service users' experience of legal coercion
- To explore service users' views of what makes treatment effective and identify implications for practice to improve service user experience
- To evaluate the terminology of coercion in research and policies according to service users' experiences and perception.
- Achieve all of the above through the lens of IPA and the researcher's experience in the drugs field

To date, quantitative methods and standardised assessment tools have been a leading choice in criminology and criminal justice (McSweeney et al, 2006; Stevens et al, 2006; Schaub, Stevens, Berto, Hunt, Kersch, McSweeney, Oeuvray, Puppo, Santa Maria, Trinkl, Werdenich &

Uchtenhagen, 2009; Wild et al, 2006). Unfortunately, the effectiveness of coercive measures in drug policy has been contested and inconclusive due to perceived methodological failings (McSweeney et al, 2007; Stevens, Berto, Heckmann, Kersch, Oeuvrau, Van Ooyen, Steffan & Uchtenhagen, 2005b). Researchers have failed to fully explore how coercion is being administered by professionals, how reported perceived pressures are manifested, and how these influence self-determination and impact on behaviour change. Increasing our understanding of coercion and how it impacts drug using offenders (Wild et al, 2006; Stevens et al, 2005), should assist in our understanding of its effectiveness. The use of a qualitative methodology in this research will allow an in-depth exploration of service users' experiences, building further on theories and findings from previous research to contribute to the development of future research. The use of an idiographic and inductive approach through Interpretative Phenomenological Analysis (IPA) will enable a full examination of how coercion is experienced by service users and assist in our understanding of how coercive measures impacted on their substance use and offending behaviour. Stevens et al recognised that "by focusing resources on coercion, we risk diverting them from other measures that may be more effective in improving health and reducing crime" (2005, p.207). The use of IPA will enable me to explore the interaction between social, legal and psychological elements to enhance our understanding of their impact on individuals' self-determination through treatment. In-depth interviews, as opposed to standardised assessment forms, will enable participants to fully reflect on their experiences and their perceptions. Furthermore, it will allow me to identify aspects of UK Drug Policy and drug treatment which are crucial in their recovery. The hermeneutic and phenomenological approaches of IPA will also enable me to draw on my experiences in the field and provide an enhanced evaluation of how individuals make sense of their experiences and their world, and identify measures which are successful in managing substance misuse and crime control. Having worked within the research setting for several years, I have gained extensive experience and knowledge of systems and how coercion is being implemented and experienced by service users. This will enable me to elicit further data from service users but also facilitate personal reflections relating to my experiences of working with service users in this field. Qualitative research using Interpretative Phenomenological Analysis remains limited within substance misuse and crime control research (Smith, Flowers & Larkin, 2009). Its use in this research will highlight its benefits in generating a thorough evaluation of participants' views, adding to our understanding of key factors within coercion.

To enhance our conceptualisation of coercion, this research will use a qualitative approach focusing on one research setting: the London Borough of Hackney. Through this process, the

heterogeneity of coercion, treatment provision, drug using offenders and enforcement services can be explored. This will help to develop a full understanding of individuals' experiences of a shared treatment system and the application of coercion within the criminal justice system. There are limitations within this research about generalisability but there are advantages in providing in depth information and reflections on lived experiences. The method will develop our understanding of coercion by exploring how this is experienced by individuals and providing further guidance and focus for future research. A focus group will be used as a preliminary research method to adopt a genuine grounded approach to identify shared experiences and perceptions of coercion to formulate a schedule for in-depth interviews based on super-ordinate themes. Interviews will subsequently enable me to gain a greater understanding of service users' experiences of coercion. The use of IPA will provide me with the ability to analyse the impact of coercion according to service users and enable the identification of aspects contributing to effective approaches to substance misuse and crime control management. This will further contribute to research and debates around the use of coercion in drug policy, providing a better-grounded theory and suggestions for future qualitative and quantitative research and effective drug policy. It will also contribute to the literature on coerced drug treatment by providing a different approach coercion and enabling the identification of factors that enhance service users' experience of drug treatment.

To achieve the aims of this research, I will structure this thesis in the following manner:

Chapter one will provide an introduction of coercion in the management of substance misuse and crime control and how it came to be embedded into drug policy. I will set out to explore the perceived link between drug use and crime and how this may contribute to our evaluation of coercion as a crime control approach. I will then address the conceptualisation of coercion and definitions which must not be overlooked as they are important to my evaluation of coercion. Research around the effectiveness of coercion will also be explored, highlighting lessons learnt and ignored which will lead to an evaluation of translating policy into practice.

Chapter two will explain the research methodology by justifying the use of a qualitative method through IPA to address the aims of the research. It will provide a detailed evaluation of the methods used and the interview schedule formulated. The sample and research setting will be described followed by an in-depth ethical evaluation of the research.

Chapter three will describe the findings and provide a detailed analysis of the focus groups and in-depth interviews. These will be sectioned under the overarching themes that emerge from the focus groups: Coercion, Challenges of Engaging in Treatment, Enhancing Factors and



Recommendations, and from the interviews: The Concept of Coercion, Enabling Positive Behaviour Change, Self-Determination and Recommendations. This will provide the reader with a structured approach to our understanding of how legal coercion is experienced and lived by individuals in the London Borough of Hackney.

Chapter four will offer a detailed conclusion to this research with an exploration of its contribution to our understanding of coercion. It will also offer recommendations for future research and elicit suggestions for the improvement of service provision for drug using offenders.

## **Chapter 1: Understanding Coercion**

To assist our understanding of the use of coercion in drug treatment, this chapter will review legislative developments which have contributed to current policy in England and Wales to understand its aim in relation to the management of substance misuse and crime control. It will then evaluate the implementation of coercion in substance misuse and review literature relating to the effectiveness of coercion. This will provide a sound basis to explore of the potential impacts of coercion and policy on drug using offenders and their effectiveness in practice.

### **The Rise of Coercion – A Political Approach to Crime Control**

The United Nations Single Convention on Narcotic Drugs of 1961 shaped a turning point in global prohibition and dealing with substance misuse by introducing deterrent and punitive measures to address drug users. This introduced a major shift in the treatment of drug users in England and Wales from the prescription of heroin and cocaine to methadone, and through the introduction of psychosocial interventions. The United Nations (UN) combined and expanded previous drug treaties into a coherent and all-encompassing single convention, forming the foundation for a new global penal response to drug use, classifying drugs by virtue of their danger on health, risk of abuse and therapeutic values (Bewley-Taylor, 2003). This formally introduced the classification of illicit substances and criminalisation of drug use, whilst ensuring their availability for medical and scientific purposes.

In 1971, the UN introduced an addition to the 1961 convention on psychotropic substances following growing global concerns around their harmful effects by including synthetic drugs such as amphetamines, barbiturates and LSD. As a response, the Misuse of Drugs Act 1971 was introduced in England and Wales to prevent the non-medical use of certain drugs. It initiated laws to control not just medicinal drugs, but also drugs with no known medical uses. To enforce these, the police were given powers to stop, detain and search people or premises on reasonable suspicion that they were in possession of a controlled drug. Its application in England and Wales maintained elements of the British System with the continued use of substitute prescribing as an element of managing drug use. The introduction of the Misuse of Drugs Act 1971 pioneered the deterrence and punishment of substance misuse and has shaped our government's strategies on drug policy and the rehabilitation of drug using offenders ever since.

In the 1980s, deindustrialisation, mass unemployment and destabilisation of communities led to an unprecedented rise in substance misuse amongst young white, unemployed males where discarded communities had provided “a land fit for Heroin” (Dorn & South, 1987). The advent of HIV and AIDS also saw exceptionally high rates of over 50% of HIV infections amongst injecting drug users in some areas (Robertson, 2005) which forced the government to review their approach to substance misuse. In an attempt to prevent the HIV virus reaching non-drug using communities, it developed a harm reduction approach to substance misuse where drug users became a crucial in reducing the health harms linked to substance misuse. Processes and structures were identified to mitigate the spread of HIV / AIDS; needle exchanges were introduced, the prescription of methadone was expanded, free condoms were supplied and the provision of health education was increased (Robertson, 2005).

In 1988, the UN introduced a new Convention to deal with the growth of international trafficking in illegal substances in the 1970s and 1980s which previous conventions had addressed in a limited fashion. The 1988 Trafficking Convention presented comprehensive measures against drug trafficking, where criminal offences were established for possession, purchase or cultivation of drugs as well as criminalising personal possession and use (United Nations, 1988). Criminalisation and punishment became the foundation and direction of the UN to stamp out illicit drug trafficking.

Faced with increasing health related concerns, crime and damages to communities (UN, 2014), the government introduced new drug strategies to tackle what had become a social and health problem in its fight against crime, adopting a more engaged approach to contain the problem of substance related crime. The introduction of legal coercion as a means of substance misuse management and crime control that followed highlights a politically driven philosophy. The first national Drug Policy, Tackling Drugs Together (Home Office, 1995), was geared towards punishment with a criminalisation approach to deal with drug users and drug related offences. Drawing on political debates around the link between drugs and crime taking place in the United States, the UK adopted a similarly ‘robust’ approach to drugs and crime. The management of substance misusers therefore went from the health stance it had experienced to date towards a criminal justice led approach. It no longer saw the impact of substance misuse as a public health problem but one essentially linked to criminality which needed to be eradicated. Without any scientific proof, drug use came to be seen as the main cause of crime and it was suggested that if drug users engaged in treatment (either voluntarily or coerced), crime rates would decline (Buchanan, 2011).

### ***Substance Use and Crime***

Early drug strategies and their use of coercion have often been criticised for their misplaced assumption that drug and crime have a deep connection, and enabling access to drug treatment would eradicate a high number of crimes committed (Reuter & Stevens, 2008). This link has been the basis for changes that have occurred in UK drug policy during the 1990s and has been one of the most researched areas of drug policy worldwide (Parker, Bakx & Newcombe, 1988; McGregor, 2000; Bennett & Holloway, 2009; Seddon, 2006). The most widely cited explanation on the link between drugs and crime is Goldstein's tripartite conceptual framework (1985) who divided this into psychopharmacological, economic-compulsive and systemic elements. They argued that drug related offending results from drugs' ability to alter functions of the brain through decreasing inhibitions and cognitive functioning and their compulsion to fund their addictions through crime. Furthermore, they felt that drug users, traffickers and dealers abide by their own rules which fall outside of society. Drug users commit crime; however, this relationship is more complex than Goldstein perceived. His framework provided a theory on the relationship between drugs and crime, enabling a basic understanding of drug users' relationship with crime and providing reasons as to why an individual may come to commit crime. As a basis for drug policy, its use and interpretation has often been taken out of context. The model has since been widely criticised for being under developed, specifically around its lack of consideration of the causal relationship between different crimes and drugs, and whether drug use is a result of offending behaviour or if offending behaviour is the onset of substance misuse (Bennett & Holloway, 2009; Stevens, 2011). The lack of consideration around the inter connections between the three parts of the model (Parker & Auerhahn, 1998) has also been condemned. Furthermore, Stevens (2011b) identified various methodological failings within research asserting its efficacy. He highlights the lack of justification and definition around the precise link between drug use and crimes committed, whereby if drug use was present in any individual's records, it was deemed to be a contributing factor.

Hough (1996) noted whilst addressing the relationship between drug use and property crime, that not all dependent drug users offend with the sole purpose of gaining funds for their drugs; this could also be for food, housing and other necessities. Failing to address the driving factor of the crime prior to it being committed has been the downfall of much research carried out to date. As Reuter and Stevens (2008) also notably argued, findings based on National Treatment Outcome Research Study (NTORS), which suggest that reductions in offending are because of drug treatment, could be linked to other consequences due to similar reductions

perceived in other untreated groups and lack of comparison groups. Furthermore, Stevens (2011b) highlights that the use of arrestees within research are not a true representation of the offending or drug using population due to social inequalities. He notes that problematic drug use is higher in deprived areas with its harmful effects on society being more concentrated in deprived areas (Stevens, 2011b). Thus, addressing underlying problems such as unemployment and poverty would be of benefit, as recommended in the 2010 Drug Strategy (Home Office, 2010), as adopting a crime reduction and treatment approach alone would not address these underlying issues. Since the launch of the Drug Strategy 2008 (Home Office, 2008), several developments have been made to address offending behaviour and substance misuse. It has been recognised that individuals who offend and use substances have a variety of interlinked needs which require a holistic approach to their rehabilitation to tackle the complexity of drug related offending.

The tripartite model, as well as other research seeking to substantiate the link between substance misuse and crime, has also been criticised for its lack of attention to the drug using population (White & Gorman, 2000). It is important to bear in mind that not all offenders are dependent on substances and not all drug users commit crime. For offenders, drug use can be merely present as an occasional reward to have a good time (Hough, 1996). Research of hidden drug users has shown that Class A drug use does not always lead to criminal activity and that heroin can be used in a controlled and non-problematic way (Warburton, Turnball & Hough, 2005). Comparably, through reported drug use, it is possible that individuals are no longer (problematically) using substances. Stevens (2007) criticised Mumola's (1999) study for its unrepresentative sample of offenders in a US prison setting. He felt that the sample was largely made up of offenders who had been incarcerated for drug related offences and Mumola assumed that if a participant had misused substances at any time in their life, this was a causal factor in their offending. Other shortfalls have been based on the use of previous convictions of drug users as substantiation of a link between drug use and crime but also as a basis for estimated figures. As Stevens (2011b) argues, drug use is more widely spread than dependence, and reducing inequalities will inevitably reduce the link between drugs and crime. Figures from the Crime Survey for England and Wales showed that a third of the population (35.6%) had admitted using illicit drugs at some point in their life, (CSEW, 2014). However, less than 2% of the population develop problematic crack or opiates use (NTA, 2012).

From the research carried out to date, there would appear to be a parallel between drug use and crime. However, the causal link between the two is extremely complex and eradicating substance misuse would not necessarily solve drug users' related offending as their reasons

for offending may not be to fund their drug use. The cost of drug related crime can be seen as a minority of overall crime but offending remains an important part of this despite causes being uncertain.

### ***Multi-Agency approach to substance misuse***

Multi-agency working was at the heart of the 1995 drug strategy (Home Office, 1995) with the key message being that agencies must work closely in partnership and share information to address and tackle substance misuse and its related crime. Police forces were required to implement local drug strategies to address drug related crime to reduce the harm caused to communities. Reporting procedures were identified and formalised to monitor progress made and to discern examples of best practice. Enforcement strategies such as the use of coercion through court-based referrals or as a condition of probation orders, were recognised as useful resources. However, difficulties in defining and measuring drug related crime and the lack of benchmark data made it challenging for police forces to design realistic key performance indicators. This made the drug strategy (Home Office, 1995) problematic and difficult to implement, comply with and work towards (Newburn & Elliot, 1998).

Despite a stronger crime control approach within policy, harm reduction remained an important aspect in the management of substance misuse. Arrest Referral schemes were developed in different forms through areas of the UK. These consisted of a partnership between the police and community drug services where individuals detained by the police were given the opportunity to receive independent advice around their drug use and be referred into treatment whilst detained in police custody. This enabled hard to reach individuals to engage voluntarily into treatment and provide them with harm reduction interventions to minimise the health impact of substance misuse. By 1998, 54% of police forces had introduced arrest referral schemes within their areas (Newburn & Elliot, 1998). Although they had been encouraged across the UK from the 1980s, it was not until the introduction of the drug strategy "Tackling Drugs to Build a Better Britain" (Home Office, 1998) that this became a requirement for all custody suites across England and Wales. This remains an important element of contemporary drug policy. Arrest Referral workers provided detainees with harm reduction interventions, such as safer injecting and overdose prevention, as well as access to treatment. Annual monitoring data showed that, between October 2000 and September 2001, 48,810 individuals were seen by arrest referral staff, with over half subsequently engaging in treatment on a voluntary basis (Drug Prevention Advisory Service, 2002). Between 2004 and 2005, figures showed a 98% increase in the number of individuals

entering treatment compared to 1998 (Home Office, 2006) which consequently led to an alleged reduction in the number of drug related deaths in England and Wales and drug related crime, suggesting evidence of the positive impact of partnership working and the strategy on reducing drug related harms.

Building on the developments of the 1995 drug policy, partnership working became a key feature of the New Labour government to embrace public health issues. It was trusted that forging partnerships between social and police authorities would lower crime rates. Through the development of the voluntary sector in the 1970s and the range of services becoming available to service users (Turner, 2005), the opportunity to harness their benefits and make contributions to the aims of the government became apparent. The public, private and voluntary sector became required to work together to support individuals in eradicating drug related offending. The efficacy of partnership working in reducing health inequalities and improve outcomes has however been debated over the years (Pycroft & Gough, 2010). Financial constraints, senior management and other processes have been found to play an important role in the failings of the government to reach policy outcomes (Perkins, Smith, Hunter, Bamba & Joyce, 2010).

### ***Criminalisation, Coercion and Public Protection***

In 1997, the New Labour government took pre-emptive action to respond to risks of criminal behaviour. This saw an incursion of criminal justice into more areas of life through the increase of criminal offences such as Anti-Social Behaviour Order. Moving further away from health towards crime control (Stimson, 2000), New Labour opted for a more punitive rather than welfare orientated approach to crime control. Coercive measures were introduced with local authorities and welfare agencies became increasingly involved in the surveillance and punishment of offenders (McLaughlin, Muncie & Hughes, 2001). Public protection became a vital and essential aim which often “over rides civil liberties” (Silvestri, 2011, p.8). The 1998 “Tackling Drugs to Build a Better Britain” (Home Office, 1998) strategy saw a further shift in the government’s focus and its views of drug using offenders. Through linking the criminal justice system to drug treatment sectors, New Labour aimed to reduce the harm drug misuse, anti-social and criminal behaviour caused societies, and the demand for drugs through increasing coercive measures. Following the growth of criminalisation and expenditure that incurred, the government needed to find ways of managing less serious crime more effectively. Economy and effectiveness became a focus over quality of services, safeguards and justice (Buchanan, 2011).

At the time, limited literature and expertise in this area was available to identify the extent of the problem or to enable clear and effective policies to be formulated. The government referred to limited (and mainly American driven) research which identified an entrenched link between substance misuse and crime. This supported that substance misuse did not occur in isolation and was often linked to other social problems to implement the strategy. Although providing limited insight and rationale to its approach as previously addressed, it stated that crime would be solved by engaging substance users into drug treatment (Home Office, 1998). Targets were introduced for the first time but limited information and data were provided as a baseline when the strategy was launched which restricted our ability to fully evaluate the success of the strategy by comparing data. It was therefore criticised for its ambiguous aims in relation to drug treatment and whether outcomes should be measured in terms of the improvement in the health and social capital of drug users, the reduction of drug-related crime, or both (Webster, 2007; Hunt & Stevens, 2004).

A perceived prevalence of drug use amongst offenders of particular types of crime was subsequently identified which led to the introduction of “Trigger offences” through the Criminal Justice and Court Services Act 2000. This gave rise to new measures to identify drug using offenders and steer them into treatment. It provided law enforcement agencies with powers to test individuals over the age of 18. Where testing had previously been made available in prison settings, they became available to the probation service as part of community orders and licence conditions and in custody suites. This opened new channels for crime control and the monitoring of substance users; if someone was using illicit substances, this would come to be known and measures would be put into place to monitor use and lead to coerced treatment, to reduce the negative impact on health and the wider community. Official statistics claimed that the strategy was successful and effective in increasing the number of drug misusing offenders accessing treatment and raising awareness around the harms of substance use (Home Office, 2007c). However, the lack of robust methodology to evaluate the impact of the drug policy created increasing doubt amongst academics around the success of the strategy and confidence in its purpose. The success of the policy and ‘what worked’ was at the time measured through outputs and the number of individuals accessing treatment as opposed to outcomes and what happened to them once they entered treatment. Monaghan (2012, p.30) described this failure as the government wanting to “change the behaviour of ‘problematic’ populations without fully appreciating the underlying causes”. Little attention was paid to the treatment being provided and services’ lack of resources to address these ranging issues.



As a response to the growing evidence linking drug use and acquisitive crime Drug Treatment Testing Orders (DTTO) were introduced through the Crime and Disorder Act 1998. Imprisonment having had limited success in steering drug-using offenders away from drugs and crime (Stevenson, 2011), they were introduced to counteract the perceived problem of drug related acquisitive crime by investing courts with powers to sentence offenders to drug treatment as an alternative to imprisonment. These new guidelines differed from previous orders as they enabled the courts to monitor individuals and their progress more closely through regular reviews and mandatory drug testing. This facilitated a more rehabilitative approach for those whose drug use was linked to their offending behaviour as an alternative to imprisonment. This new model was initially piloted in three areas and rolled out across England and Wales in 2000. Although reconviction rates stood at 53% for those who had completed their orders compared to 91% for those who had breached their orders. Only 30% successfully completed their orders (Hough et al, 2003). However, successful completion of DTTO is ambiguous as it does not entail that individuals have stopped using illicit substances or offending but rather engaged with services as directed. An evaluation of the pilot by Hough and his colleagues (2003) found that, despite reduced reconviction rates for those who had completed their orders, such an approach is more complex and not as straightforward as anticipated and described it as follows:

*“The failure to find any predictors of success amongst demographic or criminal history variables is an important finding in its own right. It implies that the point at which drug-dependent offenders decide – or can be persuaded – to address their drug problems is a product of more idiosyncratic characteristics.”* (Hough et al, 2003, pp.1-2)

This presented an initial indication of the complexity of substance misuse and its related crime, and warning to future research and policy makers around the potential shortfalls of ambiguous aims and criteria relating to coercion. The launch of DTTOs established an expansion of drug treatment services to assist in the rehabilitation of drug using offenders, with the reduction of drug-related crime, and to further increase of the number of drug users accessing treatment in the community. This was however criticised on two levels; one for potentially impacting on the service provision of drug users wanting to access drug treatment voluntarily by depriving them of quality access to treatment, and for the ethical implications of coercing individuals into drug treatment (Seddon, 2007) which will be further explored in the next section.

The Tough Choices initiative was piloted in 2005 and subsequently rolled out nationwide in 2006 as part of a proposal of the Drugs Act 2005 to ‘encourage’ drug using offenders to access

in treatment. It was introduced to further steer Problematic Drug Users (PDU) into treatment by expanding coercion from the point of arrest; providing offenders with the choice to access treatment or face imprisonment. This was made up of three different parts: Test on Arrest, Required Assessments and Restrictions and Bail (RoB). Building on the previous Test on Charge, Test on Arrest was introduced in 2005 whereby an individual would be drug tested for heroin and cocaine following an arrest for a trigger offence (regardless of whether the individual was subsequently charged). The Required Assessment process also changed and individuals were consequently required to attend two assessments as opposed to one (the second usually carried out in the community), with a qualified drugs worker. Test on arrest and required assessments became mandatory processes where individuals were legally required to comply with. Further criminalising drug using offenders, failure to comply with these requirements (drug testing or assessments) meant that individuals would face a fine of up to £2,500 or up to three-month imprisonment. However, I am yet to see an individual receiving an additional fine or imprisonment for this as it is usually dealt with their other offences at court. When arrested specifically for that offence, this is usually treated as 'time served' due to time spent in police custody and they are then released with no other conditions or requirements. Following a successful assessment, an individual could then be eligible for Restrictions on Bail which refers to section 19 of the Criminal Justice Act 2003 whereby drug treatment could be made part of an individual's bail condition. Although not a mandatory process, individuals eligible for Restrictions on Bail must provide consent to engage in treatment and declining this option would most likely result in them being remanded in custody until their next hearing, if they were not sentenced on the day. In my experience, although this was used effectively when it was first introduced, most individuals are now being released on other conditional or unconditional bail if they decline treatment. Failing to comply with their bail conditions could result in individuals being breached and therefore receiving further criminal convictions. However, I am yet to come across a drug and alcohol service which enforces failure to comply with RoB by reporting this to the police. Feedback relating to engagement with bail conditions is usually provided at the individual's next court appearance. Unlike Required Assessments where failure to attend is reported to the police within 24 hours and a warrant is used for their arrest and brought back to court, failure to comply with RoB appointments are not enforced. I believe that this is mainly due to a lack of guidance around the development of processes between drug and alcohol services and the police to enforce this.

As Buchanan (2011) identified, the government's criminalisation of various behaviours increased the number of individuals sentenced to imprisonment which defeated the aims to reduce the prison population and substance related harms despite the extensive funding invested in policies. Over the last decades, drug testing has become an important and established tool of coercion in drug treatment. Although its initial purpose was a way of identifying drug users and monitoring progress and compliance rather than penalise drug use, it most generally leads to coerced treatment. However, it is important to note that a failed (positive) drug test did not necessarily incur negative sanctions. As a result, and due to its associated costs, its role and purpose in criminal justice is still being contested. Birdwell and Singleton (2011) suggested clarity around its purpose to enable a clear approach to drug testing to ensure it remains necessary and reduces costs. The government's approach to manage the increased costs incurred through criminalisation was the introduction of targeted testing in April 2012. Its aim was to move away from mandatory drug tests for trigger offences and encourage testing under inspectors' authority with a view of reducing the number of negative and disputed drug tests, and in effect reducing costs and saving staff time. Police and Drug workers were required to be more proactive in identifying which arrestees should be tested and 'screen out' (i.e. not drug test) individuals where drug use was not considered to be a driving factor in their offending to increase the percentage of positive tests and therefore cut costs. Should there be any disagreements or lack of intelligence regarding an individual to decide, it was advised that a drug test should be conducted. The message sent out following the first-year review was "think offender, not offence" (Martin, 2013). Following a pilot carried out in London between 2012 and 2013, it was found that targeted testing saved £250,000 with 14,362 decisions made not to test (Martin, 2013).

### ***The Development of Drug Treatment Provision and Increased Monitoring***

With treatment becoming more coercive to satisfy policy requirements, a shift towards abstinence became apparent in the government's approach to substance misuse in 2000. The United Nation Office on Drugs and Crime launched the United Nations Drug Control Programme (UNDCP) with the slogan "A Drug Free World – we can do it" (Arlacchi, 1998). This notion seemed to lead government focus and policy development towards outcomes relating to individuals becoming abstinent from substances and thus harsher coercive measures. Along with trigger offences, the Criminal Justice and Court Services Act 2000 introduced new abstinence orders and abstinence requirements which required offenders to abstain from using heroin and crack cocaine and undergo drug testing as a monitoring measure (Bennett & Holloway, 2005). It is worth noting at this stage that I have never experienced one being

granted in over ten years of working with drug using offenders. To assist with these new interventions, the National Treatment Agency (NTA) was created in 2001 to increase the availability, capacity and effectiveness of treatment for substance misuse in England & Wales. Models of Care (NTA, 2002) were subsequently introduced in 2002 to provide a new four-tiered conceptual framework for commissioned drug treatment services to be applied to local areas with flexibility. The Implementation of the framework aimed at ending the wide variations of treatment and to ensure local areas had a similar basic range of interventions. These were subsequently reviewed in 2006 (NTA, 2006) to improve and develop the quality and effectiveness of drug treatment. The tiers are set out as follows:

*Tier 1:* Relates to non-substance misuse specific services requiring interface with drug and alcohol treatment and should provide access to a full range of health promotion advice and information and drug and alcohol screening, assessment and referral mechanisms.

*Tier 2:* Refers to open access drug and alcohol treatment services which should provide a range of services such as drug- and alcohol-related advice, information and referral services including easy access or drop-in facilities.

*Tier 3:* Provides structured community-based drug treatment services community care assessment and care management.

*Tier 4:* Relates to residential services for drug and alcohol misusers.

In 2003, the Criminal Justice Act was introduced which reinforced the shift in the treatment of drug using offenders. The police were given more powers to “stop and search” and the ability to issue conditional cautions and major changes were made to sentencing practice, specifically relating to serious offences. Although again, in my experience conditional cautions were rarely used due to the administrative time required which deterred police officers from using it. Additionally, Drug Treatment and Testing Orders and other community orders were reviewed and new processes for dealing with crime were introduced, giving courts more powers to identify options tailored to the individual. All community sentences were replaced by one community order with the opportunity of specific requirements being added to it such as drug treatment, unpaid work and curfews amongst others (Sentencing Guidelines Council, 2003). Drug Rehabilitation Requirements (DRR), which were introduced through the Criminal Justice Act 2003 to replaced DTTO, enabled treatment programmes to be more tailored to individual needs rather than one programme for all. This reinforced the government’s move towards abstinence to eradicate substance misuse as well as its related offending. Continuing its move

away from harm reduction in line with the UNDCP's strategy on crime and punishment, sentencing became tailored to the individual to maximise outcomes.

A prime example was the introduction of the Criminal Justice Interventions Programme (CJIP). This initiative was established to further assist in steering drug misusing offenders 'out of crime and into treatment' through a case management approach to enable access to treatment and support from individuals' first contact with the criminal justice system and beyond into resettlement. Further emphasising a multi-agency approach to crime control, its aim was to ensure drug using offenders were efficiently supported and monitored throughout their time within the criminal justice system, i.e. police station, probation, prison, courts, etc. to reduce reoffending and drug use (Home Office, 2002). Developed by the Home Office and the National Treatment Agency, it required criminal justice and treatment agencies to work together with other services to provide tailored solutions and fast track access to treatment. In 2004, CJIP became the Drug Interventions Programme (DIP) which was founded around the basis that partnership working was extremely important in addressing complex and problematic drug users who were thought to be responsible for the majority of crime. It was believed that, through a joined-up system of referral pathways where community and prison agencies communicated with each other, shared information and were responsible for the outcome of referrals, individuals would be less likely to fall out of treatment. It was also felt that providing seamless and fast access into treatment would increase retention rates and therefore reduce the need to engage in crime. In the first year of its implementation, drug related crimes reportedly decreased by one fifth (Home Office, 2006). The Drug Interventions Programme initiative saw the number of drug using offenders accessing treatment totalling 57,000 nationally between 2009 and 2010 (Home Office, 2011a). Although outcomes had still not been defined or established, it was felt that consistency in access to drug treatment and the provision of harm reduction interventions could only be a positive response to substance misuse and the need for crime control.

Whereas services had become crowded and resources strained in the late 1990s through the rapid increase of individuals accessing treatment which had led to long waiting lists, increases in funding made fast track access into drug treatment available. Treatment services increased their provision of interventions to substitute prescribing, day programmes, access to inpatient residential rehabilitation, education training and employment, support around housing and benefits amongst others. For service users, these developments made access to treatment easier and quicker, with treatment options more tailored to individual needs. For practitioners on the ground and services delivering interventions, developments in drug policy became a

challenge. The recording of information relating to offenders accessing drug treatment services increased to such a level whereby practitioners were spending more time completing paperwork and recording information rather than assisting and supporting offenders away from drug use and crime. The Drug Information Record (DIR), a national recording tool, was introduced to record information relating to drug using offenders to enable their movements through the criminal justice system to be recorded and monitored as well as the performance of treatment services. At its longest, this tool was 21 pages and was not considered an assessment tool; this entailed that service users needed to sit through hours of assessment time prior to receiving the treatment and support they were seeking.

Making use of the enforcement of drug testing measures at every stage of an individual's journey through the criminal justice system and their attempts to further direct substance users into criminalisation marked the government's commitment to coercion. With the perceived success of previous strategies to engage individuals into treatment, the government moved further forward to guarantee more individuals into treatment and further increase successful outcomes.

### ***A Move towards Rehabilitation and Behaviour Change***

In contrast with previous drug strategies, the 2008 "Drugs: Protecting Families and Communities" (Home Office, 2008) identified a shift towards behaviour change of PDU. Moving away from the previous strategies which appeared to be set on containing drug users on maintenance programmes (Monaghan, 2012), this strategy became more explicit about the need for the rehabilitation of drug users and sustained abstinence. Still very much entrenched in the belief that the vast proportion of criminality is drug related, the strategy provided carrot and stick to encourage and facilitate the reintegration of drug using offenders in employment. It placed more emphasis on the quality of drug treatment provision, addressing an ongoing commitment to tackle substance use and its related crime, and introduced a new notion of abstinence from drug dependency by instilling behavioural change in PDU. The government introduced several changes to social policies in addressing substance misuse along with new measures to support drug using offenders in their rehabilitation, recovery and aftercare. Where previous strategies had been more concerned on outputs through a crime control approach than outcomes, this latest strategy changed the way drug treatment had been addressed to date. More resources were being put in place to support drug users to gain the skills to reintegrate into society such as housing provision along with education training and employment. Substance misuse was finally recognised as an issue which needed to be

addressed from various social roots rather than just from the medical model of addiction. The Department of Work and Pensions (2008) endorsed this change by introducing incentives to assist drug users in accessing treatment and work-related courses whilst having the ability to stop benefits if individuals failed to address their substance use. The strategy recognised the impact of substance misuse on children and families, and acknowledged the need for more structured pathways to be identified between drug services and Children Social Care to support families as units.

Following on from the development of previous strategies, the Coalition government of Conservatives and Liberal Democrats introduced a new drug strategy in 2010. The Reducing Demand, Restricting Supply and Building Recovery: Supporting People to Live a Drug Free Life strategy (Home Office, 2010) placed further emphasis on moving drug using offenders away from crime, into treatment and out of treatment. The concept of abstinence was reintroduced as 'recovery' (Leighton, 2015) which highlighted a further move away from maintenance prescribing towards rehabilitation and reintegration. The purpose was to see drug using offenders move towards a drug free lifestyle through increasing the number of offenders successfully completing high quality treatment and sustain abstinence as opposed to targeting and engaging low level offenders into treatment. This new notion however provides a lack of clarity and ambiguity due to little guidance given around what the journey of recovery should look like and what it should entail. However, 'Recovery Capital' has been used to form a basis to the drug policy and identify aspects of an individual's life needing to be addressed to maximise sustained abstinence and reintegration (Best & Laudet, 2010). Recognising that recovery is a personal journey and that all individuals have varying needs and issues; the latest drug policy moved towards personalised treatment provision by widening the range of services available and enabling all with the opportunity to rebuild their lives. More emphasis being placed on interventions and services to provide better outcomes for service users, leaving local councils to identify what worked in their area and to implement changes as they saw fit. There are three main overarching principles to this strategy: citizenship, well-being and freedom from dependence, marking a person-centred journey through drug treatment. The purpose being to see drug using offenders move towards a drug free life through increasing the number successfully completing high quality treatment whilst building on their recovery capital (Best & Laudet, 2010).

The management of substance misuse and crime control became increasingly concerned with maintaining and sustaining the successes of engagement into treatment and ensuring that, once an individual had completed treatment and reached abstinence, this would be for the

rest of their life. Learning from previous strategies that saw criminalisation as a driving factor for policies worldwide, the United Nations Office on Drugs and Crime (UNODC) published 'From Coercion to Cohesion' in 2010 which suggested that punishment was not an appropriate way to address substance misuse. It identified "early identification, treatment, education, aftercare, rehabilitation and social reintegration" (UNODC, 2010, p.1) as practical measures for a health orientated approach to substance misuse. The latest Drug Strategy (Home Office, 2010) appears to have made changes in line with recommendations from this publication (Home Office, 2010). It expands its focus to all drugs rather than limiting itself to Class A substances to include alcohol, legal highs and dual diagnosis in line with new trends in substance misuse across the world. Whereas previous drug policies did not reach out to those who were able to manage their drug use effectively without it becoming problematic, it disregarded those who used other non-class A drugs and who were able to continue their lives as well-respected citizens (Buchanan, 2010; Monaghan, 2012; Transform, 2007). The impact of the 2010 drug strategy (Home Office, 2010) can be seen in the increase in drug users accessing treatment for cannabis use which saw an 11% increase in the number of individuals accessing treatment between 2010 and 2011 (NTA, 2012).

Despite the latest drug strategy assigning more prominence on interventions and services to provide better outcomes for service users, the Criminal Justice Act of 2003 and its coercive measures such as Drug Rehabilitation Requirements remain key principles in our approach to drug users through the criminal justice system which fails to fully address recovery in line with the drug strategy. As mentioned, requirements for coercive measures are only for individuals to engage and remain in treatment as opposed to exploring improvements relating to levels of use and offending behaviour. Despite coercive measures' successes in relation to previous drug strategy to steer drug using offenders into treatment, they do not appear to be compatible with the latest drug strategy and recovery. Furthermore, it fails to explore prevention, drug education and harm reduction which are important aspects in supporting recovery and maintaining public health. Furthermore, it continues to fail to take into consideration scientific evidence relating to the link between drugs and crime and requirements for evidence-based treatment provision. However, it may present as a successful crime control strategy as it would provide drug users (whether dependent or recreational) with access to holistic treatment and interventions which have been found to reduce reoffending (regardless of the link between drug use and crime). The increased resources and treatment provision from drug services should assist in enabling drug using offenders to



address some of the causes of their offending and in turn, reduce drug related crime. As Stevens (2007) noted, drug users' offending behaviour is usually at its peak prior to arrest which leads into help seeking behaviours. Therefore, the use of coercive measures could target a high number of drug users and reduce drug related crime. Drug treatment services need to ensure that all aspects such as unemployment, lack of stable accommodation and education and training opportunities, which are as important in the rehabilitation of offenders (Hough, Clancy, McSweeney & Turnbull, 2003), are addressed to promote recovery. In their publication around the UK's approach to substance misuse, the UK Drug Policy Commission identified that "different policies need to work together rather than against each other to promote Recovery" (2012, p.18). Some aspects of coercion such as retention and successful completions of treatment (Perron & Bright, 2007; Mark, 1998) appear to work in addressing substance misuse and reducing recidivism, however, to what extent exactly is still unclear. Therefore, research around how initiatives are experienced by individuals coerced into drug treatment would enable a clearer understanding of the impact of drug policies on steering offenders away from substance misuse, crime and into recovery, and how other social and psychological factors can impact of motivation.

## **Conceptualising Coercion**

Extensive research has been carried out around the effectiveness of coercion in reducing substance misuse and crime. With governments worldwide trying to implement drug policies and initiatives to reduce the harm caused by drugs to individuals and communities, research has developed to focus on coercion in drug treatment to identify 'what works'. To date, findings have recognised that coercion can have a positive impact on entry into treatment (Polcin & Weisner, 1999; Joe et al, 1999; Gregoire & Burke, 2004), retention (Hiller, Knight, Broome & Simpson, 1998; Loneck, Garrett & Banks, 1996; Perron & Bright, 2007) and outcomes (Mark, 1998; Brecht, Anglin & Wang, 1993; Anglin et al, 1989). However, other studies have found no significant differences between coerced and voluntary individuals (Allan, 1987; Simpson & Friend, 1988; Hiller, Knight, Devreux & Hathcoat, 1996). In recent years, researchers have delved further to understand discrepancies in findings. Marlowe et al (1996) found that psychosocial pressures were more influential than legal pressures to encourage individuals to enter treatment. Amongst others (Farabee et al, 1998; Knight, Hiller, Broome & Simpson, 2000; Marlowe, Merikle, Kirby, Festinger & McLellan, 2001), Young (2002) found that coercion is successful, but non-legal coercive aspects should be taken into

consideration when evaluating the impact it has on motivation. With recent reform of the UK drug policy, the search for 'what works' continues.

To understand the potential impact of policies on drug using offenders, it is important to understand how drug abuse has been defined and evaluated. Research addressing the effectiveness of legal coercion in drug treatment has often explored the relationship between internal and external factors which could enhance individuals' motivation to engage in treatment. This has included recommendations from families, GPs and employers, and health concerns which could impact on service users' decision to access treatment. Furthermore, the nature of substance dependence and motivation shouldn't be overlooked as it will impact on our evaluation of coercion.

### ***Successful Completion of Treatment***

Successful completion of treatment can be interpreted in different ways and it is important at this stage to identify what is meant by this. As mentioned in the previous section, successful completion of Drug Treatment and Testing order and Drug Rehabilitation Requirements are measured according to an order being completed without being breached. Whether an individual successfully becomes abstinent from illicit substances whilst in treatment, or completes treatment and achieves abstinence is not relevant to its success.

On the other hand, Public Health England defines successful completion of treatment as the "number of users of opiates [non-opiate/alcohol] that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment" (PHE, 2017). This means that, for an individual to be deemed to have successfully completed, they must have reached abstinence from their drug of choice and prescribed substitute medication, and not represented in treatment within 6 months of them leaving treatment services (2017).

It was identified in the previous section that the latest drug strategy (Home Office, 2010) is increasingly concerned with the reintegration of drug users into communities and improvements in health outcomes. Research has identified that drug treatment has an array of benefits for substance users (Anglin, Bretch & Maddahian, 1989; McSweeney et al, 2006), however, soft outcomes measured by the National Drug Treatment Monitoring System, such as improvements in physical and mental health and quality of life, are more difficult to interpret. In my experience of working in the field, measuring an individual's perception of their physical and mental health, and their overall quality of life can vary immensely depending on how they are presenting on the day. For example, if an individual's treatment aim is to reach abstinence and they have managed not to use any illicit substances for a few days, they

may score themselves higher than if they had just lapsed or if they had had a recent bereavement. Soft outcomes are important for drug and alcohol services but they cannot be meaningfully reported on.

Furthermore, the government's aims and views of successful outcomes may not be individual's views on how they should lead their lives. The drug strategy 2010 talks about recovery and reintegration. Having moved away from the concept of abstinence, it recognises that drug users can still function and have meaningful lives despite their substance use. However, the definition of successful completion does not allow individuals to maintain recreational use of Heroin or Cocaine. This means that, although it is possible for individuals to maintain recreational use of other substances such as cannabis or alcohol amongst others, Heroin and Cocaine users must reach abstinence to be regarded as successful completions, despite what their treatment goals may be. This has become an increasingly difficult challenge for drug and alcohol services whereby it is not possible to discharge someone from treatment successfully despite them having reached their treatment goals. Although numbers remain rather low in these instances, it creates a challenge for professionals in the field who have to manage conflicting views of discharging an individual unsuccessfully or potentially force an individual to work towards abstinence when this was not their goal. This could have a negative impact on service users but also on treatment services who are in part funded according to the number of successful completions they achieve.

Some drug and alcohol services are also monitored on the number of individuals who accept Hepatitis B vaccinations. However, an individual who is not taking part in high risk behaviours such as injecting, and who merely smokes cannabis once a week may not feel that they would benefit from such vaccinations. However, most of Public Health England commissioners see this as a successful intervention which again could have a negative impact on service users and services who are funded through payment by results.

The qualitative nature of this research will enable me to gain a further understanding of what individuals perceive as important areas in their treatment and how these correspond to the aims of the government in the effectiveness of its interventions.

### ***Defining Substance Abuse and 'Addiction'***

Over the years, there have been controversies around the definition and nature of substance misuse, and whether it should be addressed as a medical condition, psychological, social one. Originating from the medical model of disease, substance dependence has been described as 'addiction' which is still perceived by some as a disease with biological, neurological, genetic, and environmental sources of origin which triggers discomfort, dysfunction, or distress to the

individual and where drug using behaviour is sustained despite its harmful consequences. The Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) remains the most popular and most widely used definition of addiction amongst medical professionals to ascertain dependency and most specifically the level an individual's dependency to substances. It defines addiction as a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two symptoms occurring within a 12-month period (American Psychiatric Association, 2013) from the following:

- Consuming more than originally planned
- Wanting to cut down or stop but not being able to do so
- Spending considerable time trying to obtain substances
- Inability to carry out daily tasks due to substance use
- "Craving" the substance
- Persistent substance use despite its negative effect on physical health and wellbeing
- Persistent substance use despite its negative effect on social circumstances
- Persistent substance use in physically dangerous situations
- Decrease in social activities due to substance use
- Increased tolerance to substances through need to use noticeably larger amounts to get the desired effect or experiencing less of an effect after repeated use of the same amount.
- Increased withdrawal symptoms after stopping use which can include anxiety, nausea/vomiting or hand tremors.

The latest edition no longer uses the terms substance abuse or substance dependence and describes this as "substance use disorders" which are defined as mild, moderate, or severe to indicate the level of severity depending on the number of symptoms experienced by an individual (DSM 5, American Psychiatric Association, 2013). This definition has been widely criticised both within and outside of mental health disciplines for being vague, incompatible with behaviour as, for one to be addicted, dependence and compulsion must be present, and as it fails to address aetiology (Goodman, 1990; O'Brien, Volkow, & Li, 2006)

The term addiction had recently been less and less employed within drug policy due to its medical connotation. The government is moving away from the medical model in its approach to substance related crime and the move from the use of the term 'addiction' to 'problematic drug use' provides an interesting nuance of the government's approach to tackle substance misuse and its related crime. It no longer aims to address substance misuse through

maintaining individuals on opiate substitute medication but rather adopts a holistic approach, to tackle substance misuse and its related offending (Home Office, 2010). Despite this move away from the medical model, in my experience, drug treatment continues to be largely lead by clinical governance, for opiate and alcohol users, as levels of dependence need to be effectively measured to appropriately prescribe individuals in a safe manner.

Mutual aid fellowship groups such as Alcoholics (AA) and Narcotics Anonymous (NA) which play a vital role in the recovery of numerous individuals describe addiction as an illness. Although their literature states that their purpose is not to define addiction, it is widely regarded by its members as an illness. NA for example state that it is their “experience with addiction is that when we accept that it is a disease over which we are powerless, such surrender provides a basis for recovery through the Twelve Steps” (NA, 2017). Like the DSM 5 definition, they explain how drugs control them and they “live to use and use to live. Very simply, an addict is a person whose life is controlled by drugs.” (NA, 1988). In their pamphlet called *Am I an Addict?* (NA, 1988), Narcotics Anonymous list a series of 30 questions relating to an individuals’ substance use to help them ascertain whether they are an ‘addict’. Of these, at least 11 questions can easily be related to the 11 symptoms of the DSM 5. However, as with the medical model of addiction, not all subscribe with this view. Through my experience in the field, some individuals do not concur with the view that addition is a disease that cannot be cured and this approach, although extremely popular and effective for some, does not work for everyone affected by substance misuse. The 12-step programme however remains very popular and effective, regardless of individuals agree with its approach to substance use.

### ***Relapsing Nature of Drug Abuse***

With regards to whether drug taking behaviour is voluntary or not, it has been recognised that although the initial decision to use is mostly voluntary, when dependence is established, a person’s ability to exert self-control can become impaired (National Institute on Drug Abuse, 2017). This is an impairment of motivation which includes biological, psychological and social aspects (Pycroft, 2010). Relapse rates within drug use have been found to be similar to those with diabetes, hypertension, and asthma, which also have both physiological and behavioural components (National Institute on Drug Abuse, 2017). Like these conditions, drug treatment requires changing deeply imbedded behaviours and lapses indicate that treatment needs to be adjusted or changed. Compulsion and its link to relapse within substance abuse has been greatly explored and has provided some foundations relating to its relapsing nature (O’Brien,

Childress, Ehrman, & Robbins, 1998). The extent to which conditioning through treatment and experiences can explain or impact on compulsion is yet to be determined.

With regards to the recovery agenda (Home Office, 2010) and Public Health, requirements and expectations are for individuals to complete drug treatment, abstinent from their drug of choice. In the London borough of Hackney, figures show that one in three individuals who were in treatment between 20015 and 2016 had more than four previous treatment attempts (Lindsell, 2017). Although the relapsing nature of substance use is common amongst research, the number of times individuals have accessed treatment has never (or minimally) been a variable measured within research on the effectiveness of coercion (Marchall & Hser, 2002; Gregoire & Burke, 2004) and may play a role in inconsistencies amongst research relating to the effectiveness of coercion.

### ***Motivation and Self Determination Theory***

Motivation to engage in drug treatment has been greatly debated, specifically with regards to how it can lead to successful outcomes (Gregoire & Burke, 2004; De Leon, Melnick & Hawke, 2000). Simpson and Joe (1993) for example, identified three dimensions of treatment motivation: drug problem recognition, desire for help, and treatment readiness to predict treatment retention or outcomes. In their research, however, Longshore & Teruya (2006) found that motivation at treatment intake is an inconsistent predictor of treatment retention and outcomes.

Research on the transtheoretical model of behaviour change (Prochaska & Norcross, 1994) has conceptualised motivation through stages of change. Blanchard Morgenstern, Morgan, Labouvie & Bux (2003, p. 57) described the stages of change as a “heuristic for understanding motivation and more specifically readiness to change”; an individual must first gain recognition of problems caused by drug use (the contemplation stage), consider the possibility of change (the preparation stage) and finally acting on a decision to change (the action stage). Scoring systems have also been adopted in research to explore the effectiveness of motivation in treatment outcomes (see Carbonari & DiClemente, 2000; Najavits, Gastfriend, Nakayama, Barber, Blaine, Frank, Muenz, & Thase, 1997; Smith, Hoffman & Nederhoed, 1995). However, rating according to treatment resistance has been debated as to whether this should constitute low motivation to change. Longshore & Teruya (2006) argue that a distinction should be made between resistance (ambivalence or refusal to treatment) and reactance (motivational state to address perceived threats to one’s freedom), and that readiness for treatment and resistance should be measured on two distinct constructs.

Several researches around the effectiveness of coercion have considered individuals' motivation as a predicting factor (Stevens et al, 2006; Downey, Rosengren & Donovan, 2000; Ryan, Plant & O'Malley, 1995; Marin, 1995). Although findings have been varied, it has given rise to some interesting concepts and suggestions when assessing coercive treatment. For example, Longshore & Teruya (2006) found that readiness for treatment predicted treatment retention in the first six months whilst resistance to treatment predicted drug use for those coerced into treatment. However, their research only measured motivation prior to treatment start. It is well known that motivation is not a constant or steady state but rather a dynamic process. Stevens and his colleagues (2006) found that motivation can be increased through professional expertise to address individuals' needs and provide a "smooth transition into an appropriate and attractive treatment placement" (p.17). Downey and her colleagues also found that identity-related motivation predicted successful behaviour change compared to individuals whose motivation was more linked to social influences, health and legal issues. This was echoed in Freedberg & Johnson (1978), Simpson et al (1997) and Farabee, Prendergast & Anglin (1998) who found that internal motivations were predictors of successful treatment outcomes.

As a result of the increasingly recognised impact internal factors can have on motivation and behaviour change, Self-Determination Theory (SDT; Deci & Ryan, 1985) has become an increasingly explored topic in the effectiveness of coercion. As Wild and his colleagues (2006) identified, SDT provides a useful perspective as it characterises motivation "on a continuum, ranging from activities that are completely initiated and controlled by external social forces, to activities that are fully self-determined" (Wild et al, 2006: 1860). SDT argues that the initiation and maintenance of positive behaviours requires individuals to "internalise values and skills for change, and experience self-determination" by attending to their experiences and motivation (Ryan, Patrick, Deci & Williams, 2008: 2). It focuses on the process through which an individual develops motivation to initiate and maintain behaviour change. It identifies autonomy, competence and relatedness as vital to sustain behaviours which are conducive to health and wellbeing. SDT acknowledges *autonomous motivation* as an important aspect of initialising and maintaining behaviour change (Ryan et al, 2008, p.3); for positive behaviours to be successfully maintained, it is important for individuals to value and endorse the importance these behaviours. This can be enhanced by practitioners through assisting individuals to explore resistance and barriers to change. In contrast, it rejects *controlled motivation* as nurturing positive behaviour change (Ryan et al, 2008, p.3). These are experienced when an individual initiates behaviours for external reward which can be through

avoiding punishment, gaining praise or using incentives by practitioners which have been found to be unrelated to long term behaviour change. For an individual to be able to increase their autonomy, it is important for them to have the confidence and competence to change (Ryan et al, 2008). In practice, this requires practitioner to provide feedback on an individual's progress and to provide them with the skills to address barriers. For these two components to be successful, SDT recognises the importance of the relationship between the individual and the practitioner. Ryan and his colleagues (2008) state that being respected, understood and cared for is essential for internalisation to occur.

In their research, Stevens et al (2006) found that individuals coerced in treatment could be motivated despite controls as their decision to enter treatment could be autonomous despite controls and restraints imposed by courts. Similarly, Wild, Cunningham and Ryan (2006) found that regardless of social pressures, individuals sought help because they identified with the goals of treatment and made a personal choice to engage. To date, Motivational Interviewing has been a leading choice in the treatment of drug using offenders, providing a "client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002: 25). However, it has been criticised for being atheoretical (Draycott & Dabbs, 1998) and little exploration having been placed on how and why it can be effective (Miller, 1999; Markland, Ryan, Tobin & Rollnick, 2005). It has been suggested that SDT could provide a useful theoretical framework and comprehensive rationale for understanding the effectiveness of motivational interviewing (Ginsberg, Mann, Rotgers & Weekes, 2002; Foote, DeLuca, Magura, Warner, Grand, Rosenblum & Stahl, 1999; Markland, Ryan, Tobin & Rollnick, 2005).

With this in mind, the next section will explore how policy has been translated into practice and will reflect on how practitioners and coerced individuals may respond to coercive pressures and explore the likely outcome of policies being able to impact on drug using offenders in the way it had initially intended to.

## **Translating Policy into Practice – How compatible is Coercion with Drug Treatment?**

Following the introduction of the Misuse of Drugs Act 1971, the ethicality of coercive drug treatment has been repeatedly questioned. The deterrence and punishment of substance misuse has brought much controversy around the extent to which an individual should be punished or assisted through rehabilitation. Although initially very much disposed towards



punishment; the focus of the 2010 strategy has been more around rehabilitation whilst maintaining punishment which brings a more complex nature to coercion, raising several ethical concerns around its use. There have initially been concerns about the use of treatment centres as punishment rather than therapeutic (Szasz, 1963), but also the extent to which individuals can provide informed consent to drug treatment following an arrest (Seddon, 2007). To gain a further understanding of coercion, it would be beneficial to evaluate the ethical concerns of translating policy into practice and to address the potential impact of coercive measures on drug using offenders to ascertain the impact of policies. It is important at this stage to differentiate between quasi-compulsory and compulsory treatment. As previously discussed, all coerced treatment in England and Wales is quasi-compulsory which means that some form of consent is sought from individuals prior to their engagement in treatment.

### ***Choice, Informed Consent and Capacity***

The ethics of coerced drug treatment and the notion of “choice” in the British context are important aspects which have been regularly debated. It has been argued that coercing people into treatment as part of criminal justice sanctions could be a potential breach of Human Rights (Seddon, 2007) due to the nature of its use by the government. In particular, questions have been raised around the use of legal coercion and whether it is used for the benefit of the individual or society.

Refusing treatment was held as a right by the European Commission on Human Rights (Wicks, 2001); individuals are free to live unhealthy lifestyles if they wish to, without having to be forced into treatment. Choice within coercion is important as it challenges the frequent assumptions in contemporary research, as well as in the definition of coercion, that those coerced into treatment are unwilling candidates. For quasi compulsory treatment, choice is an important variation to coerced treatment in other countries. It is important to identify that the Criminal Justice Act 2003 states that individuals must comply with drug treatment should this be made part of their community order. “The offender expresses his willingness to comply with the requirement” appears in various sections of the Act which highlights the importance of consent within the Act. Clear guidelines are also provided in the event of treatment plans or requirements being amended whereby the individual’s consent must be sought prior to any changes being made. In addition to this, should an individual no longer wish to comply with treatment requirements and withdraw consent to engage, reference is made to orders being revoked and individuals being resentenced. However, as an individual must choose between

imprisonment and drug treatment, Hough (1996, p.36) argued that drug treatment in British drug policy is 'an offer they can't refuse', therefore shifting the cost-benefit ratio in favour of treatment. Like Seddon (2007), he argues that facing the imminent possibility of being remanded in custody can shift an individual's choice in favour of treatment without necessarily making a fully informed decision relating to the requirements and consequences (Hough, 1996). Additionally, Stevens et al (2005b) found that imprisonment can at times be appealing to drug using offenders. The frequent assumptions in contemporary research that those coerced into treatment are unwilling candidates have been challenged (Farabee, Shen & Sanchez, 2002; Longshore et al, 2004; Hiller, Knight, Leukefeld & Simpson, 2002). Seddon (2007), amongst others, assumes that some individuals may perceive custody as a less attractive option. From my experience working with drug using offenders, imprisonment can provide entrenched, chaotic and homeless drug users with better opportunities as it provides them shelter and regular access to food, as well as a 'break' from drug use. Under the sentencing guidelines in the UK, the length of a DRR (as well as previous DTTO) could potentially be longer than a custodial sentence, which again could deter individuals from accepting coerced treatment. For example, an individual may receive 28-days imprisonment for a shoplifting offence, whereas, were they sentenced to a DRR, this would be for a minimum of six months. Custody may therefore be more attractive to those who have no interest in drug treatment and / or do not have the motivation to engage in it. Attempts have been made to address this however through the introduction of the Offender Rehabilitation Act 2014 which introduced Rehabilitation Activity Requirements (RAR) following a custodial sentence. Like DRR, it requires offenders to engage in drug treatment following a custodial sentence for a specified period. However, this usually tends to be shorter than if an individual was sentenced to a DRR. Though, in my experience, since their introduction in 2014, there has been a lot of confusion around their use and I am yet to experience an individual being required to engage in drug treatment as part of their RAR.

Seddon (2007) further criticised the British government around its use of coercion where consent given could be distorted. He addresses the potentially stressful impact being in a police station could have on individuals to provide informed consent. However, he fails to recognise that, in police stations, individuals are only required to provide consent to attend and remain for the duration of an assessment, as opposed to consenting to engage in treatment. On the other hand, an individual may be taken straight from the police custody to court following charge (as opposed to being given police bail) and assessed for Restrictions on Bail. In this case, the individual must make an immediate informed decision to engage in drug

treatment. Stevens and his colleagues (2005) found that, individuals who took part in their research felt that they were provided with appropriate and fair choices and could provide informed consent to their treatment. As identified before, most individuals in treatment have had previous treatment (Lindsell, 2017) which would lead us to believe that they have a good understanding of requirements and make an informed judgement despite the environment they may be in. Furthermore, drug workers have a duty to identify an individual's ability to give informed consent. The requirement for genuine and informed consent has been at the forefront of professional ethics for health workers. In addition, subsection (1)(a) of section 209 of the Criminal Justice Act 2003 describes a Drug Rehabilitation Requirement whereby an individual:

“must submit to treatment by or under the direction of a specified person having the necessary qualifications or experience with a view to the reduction or elimination of the offender's dependency on or propensity to misuse drugs”

This highlights that not only is an individual required to accept treatment, they must also display motivation to reduce or cease their substance use. As identified however, motivation is not a static process and can vary across time (Stevens et al, 2006). Furthermore, willingness to address substance misuse prior to treatment start is not a reliable indicator of engagement and retention in treatment (Longshore & Teruya, 2006) as motivation can vary and be increased through various aspects. Although Self-Determination Theory states that controlled motivation and external regulations such as legal coercion cannot sustain positive behaviour change (Ryan et al, 2008) Longshore, Prendergast and Farabee (2004, pp.115-116) identified that external pressures can be 'transformed' into internal pressures. Practitioners can also support individuals to do so by addressing their needs and provide appropriate treatment accordingly (Stevens et al, 2005) which could in turn assist individuals to value new behaviours and endorse them. This would lead us to believe that regardless of an individual's motivation to access treatment; be it to avoid imprisonment or other perceived short-term rewards, sustained behaviour change could be sustained over time with the appropriate support.

Seddon (2007) questions whether health professionals should decline to treat individuals whose consent is not genuine. As mentioned, within drug treatment genuine informed consent and capacity are at the forefront of all assessment for suitability, particularly if there are doubts around individuals' ability to first understand the requirements of an order and their ability to make an informed choice, but also to comply with the required treatment components of an imposed conditional bail or community order. It is therefore important for practitioners to take all aspects into consideration when assessing an individual's suitability

for treatment. As a practitioner, and later as a manager supporting other practitioners, deciding whether an individual is suitable for treatment has always been a challenge. As mentioned previously, motivation is not a constant process and theories of motivation assume that people initiate and maintain behaviours with the premise that these will lead to desired outcomes or goals. These goals could be short terms and change regularly which makes it more challenging for an individual to fully understand the what and why of goal pursuit (Deci & Ryan, 2000). On average, practitioners carry out an assessment relating to an individual's suitability for drug treatment within two hours which gives limited time to fully assess an individual's motivation and explore this concept. Stevens and colleagues identified similar findings in interviews with professionals who reported difficulties in identifying whether individuals are "ready for treatment or just trying to get out of prison" (2006, p.11). As practitioners, the question for us ultimately is: is treatment available to meet this individual's needs? Therefore, providing the individual shows insight into their substance use and acknowledge that they would benefit from professional support to address it, the answer would most probably be yes, as long as they have appropriate accommodation to effectively engage in treatment. Failure to take this into consideration could set offenders up to fail and potentially have a detrimental effect on their drug use, health and engagement with services.

### ***Restriction of Liberty and Public Protection***

Morris (1974) raised concerns regarding policies which impose rehabilitation on crime prevention grounds for the sole purpose of protecting others. Gostin (1991) felt that this would be ethical providing it does not restrict the liberty of individuals more than alternative sentencing options appropriate to the offence committed, it is aimed at those most in need of treatment and that it is consistent with due legal process. It has been argued that measures used to deal with problematic drug users in the UK fail to comply with these conditions in various ways. Seddon (2007) for example argued that individuals who were arrested and tested positive for Class A drugs could face further criminal charges for failing to comply with their Required Assessments (RA) despite initial charges being dropped. It is important to note however that through the RA process, individuals are only required to attend and remain, they are free to not engage or take part in the assessment if they are opposed to it. Thereafter, they are free to choose whether they would like to engage in treatment. Unlike in the United States and other European countries, UK Drug Policy provides individuals with a choice, although constrained. On the other hand, DRR for trigger offences could potentially be longer than custodial sentences. As previously mentioned, an individual may receive 28-days imprisonment for a shoplifting offence, whereas, a DRR would be for a minimum of six months.

Hunt and Stevens (2004) amongst others criticised the turn of UK drug policy in the late 1990s towards a crime reduction and community safety perspective. They argue that the government's new definition of harm reduction was in fact aimed at reducing the harm caused by illicit substances to communities as opposed to the individuals themselves. Steering policies away from health concerns towards crime reduction, paying little attention to the wellbeing of drug users within programmes designated to help them. It could be argued that coercion was only implemented for the benefit of the state as a way of controlling crime rather than for the previously well represented harm reduction stance in legislations where the health of the individual was paramount to the control and treatment of drug users. However, this has greatly improved through the last two drug strategies, whereby the wellbeing of those accessing treatment is paramount in the delivery of treatment services. Furthermore, since the shift to Public Health England, the Public Health Outcomes Framework (Department of Health, 2013b) has provided further guidance and assistance to commission services to deliver treatment which put individuals' needs and health at the centre. Although contemporary policy addresses substance misuse within the realm of health prevention, coercive measures used in the management of drug using offenders remain unchanged. Despite this, my professional experience in the field supports an improvement in health-related concerns. Service delivery according to health outcomes is closely monitored. It is no longer sufficient for services to report positively on whether individuals are offered and accept blood borne virus testing and vaccinations, there is a requirement to provide supporting evidence of this being carried out through identification of community pathways into hospitals, GPs or other primary care settings for testing to be confirmed or treatment to be initiated. Reporting requirements are no longer restricted to engagement and completion in treatment but rather to encompass how and why treatment positively impact individuals' wellbeing.

### ***Improvements to Treatment Provision***

Previous drug strategies argued that the involvement of Criminal Justice agencies in treatment interventions moved the objective of drug treatment to reduce harm towards a crime reduction focus (Seddon, 2007). However, since the 2008 drug strategy, there have been marked improvements in the availability and quality of treatment (NTA, 2009). The introduction of the Models of Care (NTA, 2002 & 2006) provided guidance on the delivery of drug treatment services across England & Wales which is regardless of individuals' involvement in the criminal justice system. In addition, introducing drug treatment as a crime control measure developed rapid access into treatment and prescribing which research has been found to bestow better outcome rates by providing treatment when motivation levels

are up and subsequently increases retention rates (NTA, 2013). Although this was initially for individuals accessing treatment through criminal justice routes, my experience in the field has enabled me to see the wider positive impact this has had on waiting lists for both voluntary and coerced individuals. Regardless of the aims of the government for introducing new measures (i.e. as a crime control approach), the vast range of resources which have been made available to all cannot be dismissed. Opioid prescribing, found to be effective in reducing offending rates amongst heroin users (Gossop, Marsden, Stewart & Treacy, 2001), has been found to be an effective approach to address substance misuse and other presenting issues such as physical and mental health (NTA, 2012). Primarily, prescribed opioids can only be used as an intervention for those who are physically dependent to opiates and must follow clinical guidance (Joe, Simpson & Broome, 1999). The National Treatment Agency (2012a & 2013) released information regarding the benefits of combining psychosocial interventions alongside prescribing services.

The government previously lacked consideration into health and income inequalities and the array of underlying personal and social disadvantages: drug and alcohol use, poor education, limited employment experience, mental and physical health problems, negative attitudes, poor self-control, limited life skills, poor housing, fractured family networks, limited financial support and debt. Extensive research has identified the effectiveness of treatment in addressing and reducing health-related problems, improving social functioning as well as reducing crime (Gossop, Marsden, Stewart, Lehmann & Strang, 1999; Gossop, Marsden, Stewart, Lehmann, Edwards, Wilson & Segar, 1998). Following the reorganisation of the National Health Service in England and Wales in 2013, the National Treatment Agency for Substance Misuse was amalgamated into Public Health England. Its aims are to protect and improve health, and address inequalities in an integrated approach to health and wellbeing. It became recognised that drug treatment requires health and social factors to be considered to effectively support individuals in moving away from substance misuse. With public health becoming an increasing concern, resources are being deployed away from substance misuse and crime control towards a wider public health agenda. In addition to rapid prescribing, drug strategies over the last two decades developed evidence-based treatment services with more resources being made available such as education, training and employment opportunities as well as support for families and friends to ensure individuals are supported outside of treatment services to maintain recovery.

The social sector has however seen many cuts because of the austerity measures since the Coalition government. Although drug treatment services were not initially directly affected by

this, it experienced adverse effects (Roy & Buchanan, 2015). Where it had been accepted that drug using offenders need to develop their 'recovery capital' (Best & Laudet, 2010) through access to employment, education and housing amongst others, local authorities faced cuts and reforms hindered these possibilities, impacting on the most vulnerable. Changes within the welfare state since have also impacted on drug users' ability to access and maintain stable accommodation (Roy & Buchanan, 2015), defeating the objectives of the drug strategy 2010. Drug treatment services have also been requested to work towards recovery which, with a lack of clarification around targets, has made the process increasingly difficult to implement (Leighton, 2015). Reductions in funding for better quality treatment has, in the last six years, been a bigger challenge with organisations bidding for services across London, identifying ways to provide and sell better value for money services but incidentally being unable to deliver what was promised due to lack of resources. The consequent impact of this on service users can be disastrous due to transition between providers, practitioners being unable to deliver services offered and services being under pressure to perform to a high standard with to high caseloads and limited resources.

With the government developing the latest drug strategy to encompass users of all drugs and alcohol, there has been an increase in non-Class A drug users accessing treatment. Although numbers in treatment are declining, opiate users continue to make up for most individuals in treatment (52% between 2015 and 2016 compared to 65% in 2005-2006: PHE, 2016). The number of alcohol users almost doubled between 2005-2006 and made up for 16% of the treatment population compared to 2015-2016 when 29% were accessing services. Similarly, in 2015-2016, there was a 77% increase in the number of individuals using New Psychoactive Substances (NPS) accessing treatment compared to the previous year. Through my professional experience in the field, it has been apparent that treatment provision has greatly increased. The provision of alcohol specific interventions and detoxification programmes have been made widely available along with the appointment of Accident & Emergency nurses to provide support and expertise in hospitals to assist with the treatment of alcohol related health concerns. To respond to the demands of the community, my team and I are constantly developing new group programmes and interventions to support a new range of users, such as NPS users, accessing treatment to ensure that we are providing appropriate interventions and able to meet the changing needs of our service users.

Despite controversy around the effectiveness of drug policies, there have been benefits to the introduction of coercion in England and Wales, specifically with regards to treatment provision. However, research has provided limited insight as to why treatment sometimes

works and why it does not. As previously mentioned, Coercion has been implemented in very different ways across the world and research often fails to provide description of this in methodologies. This may have limited our understanding of its effectiveness and led to the misinterpretation of finding.

### ***Enforcing Coercive Measures***

As a response to growing evidence based research, the United Nations Office on Drugs and Crime published a paper providing good practice guidelines around the use of treatment referrals as criminal justice sanctions to steer drug policies towards public health rather than criminal justice (UNODC, 2010). Although not eradicating the need for treatment to be used as a way of sanctioning individuals, it provides suggestions in ways drug treatment can be introduced ethically as a way of addressing substance misuse. It also stresses the benefits of coercion through both legal and social routes as a way of initiating treatment. It draws on research from Wild (2006), Marlowe et al (1996) and Stevens et al (2006) which have identified the positive impact social pressures can have in encouraging individuals to address their substance misuse, providing there remains an element of choice.

This chapter has provided a comprehensive overview of the application of coercion in England & Wales and developments made over the years in the management of substance misusers. It has provided some insight into how policy is translated into practice and explored the potential barriers to policy having its desired impact on drug using offenders and exposed the complexity of coercion and human motivation. Drug treatment through criminal justice routes was primarily introduced to provide treatment for heroin and crack users. However, since the implementation of the 2010 strategy, there has been a shift in service provision for all drug users. Unfortunately, research on the effectiveness of coercion has provided little insight into what makes it effective and what does not. Several aspects need to be taken into consideration when addressing coercion such social and interpersonal pressures as well as the implications of substance use on cognition and motivation. Failing to address these in our evaluation of coercion and related policies could impact on our ability to effectively understand and evaluate coercive measures. Stevens (2012, p.10) identified, quasi-compulsory drug treatment can be ethical providing ethical standards are applied. However, the argument made relating to the use of coercion whereby individuals are 'threatened' into treatment is not strong. Further research around whether they are unwilling and unreceptive recipients is therefore necessary to ascertain experiences of coercion and how this is perceived. This would also provide a further understanding of aspects of coercion which are effective in the management



of substance misusing offenders to provide further guide policies. Although coercive measures are still in place, the government's move towards assessing the success of interventions through outcomes of drug treatment is an important step in the management of substance misuse. More information needs to be gathered to identify what makes treatment work when accessed through the criminal justice system. This research will provide further understanding to develop treatment services which address substance misuse from service users' perspective. The next chapter will address how the epistemological approach to this research could bridge these gaps in knowledge by exploring how coercion is experienced by drug using offenders to enhance drug policies and outcomes.

## **Chapter 2: Methodology: An Interpretative Phenomenological Approach to Understanding Coercion**

Over the last three decades, extensive amounts of quantitative research have been carried out to identify what works in reducing the harm caused by drugs to individuals and communities. However, as addressed in the previous chapter, the success of coercion in crime control and the management of substance misuse remain ambiguous. This chapter introduces the epistemological approach to this research. It will start by looking at the research setting to provide a full understanding of the treatment system and move on to how the use of a qualitative approach will enable the aims of this research to be met. It will provide an exploration of how the use of Interpretative Phenomenological Analysis (IPA) could enhance our knowledge and understanding of drug using offenders and how coercive treatment can be experienced. It concludes by addressing the ethical implications of this research and a reflective account of the methodology used.

### **The Research Setting**

The London borough of Hackney was selected as the case of interest for this research as this is where I worked as a senior practitioner between 2008 and 2013 within the Drug Interventions Programme (DIP). During this time, I was able to develop an extensive knowledge of the service provision as well as a comprehensive insight into the processes and delivery of coercive treatment in this borough which will be invaluable in my analysis of the data. Another reason for this setting to be chosen was for ease of access to participants and data. As Interpretative Phenomenological Analysis explores how people ascribe meaning to their experiences in their interactions with their world, working in the substance misuse field for over ten years, and in the research setting for over five years, my knowledge of this client group and understanding of the setting will provide an added advantage when analysing the data.

At the time this research was carried out, the treatment system in the London borough of Hackney was made up of three drug treatment providers; the first was responsible for the delivery of DIP. The second provider was the main community drug and alcohol service responsible for delivering day programmes, substitute prescribing, needle exchange, and GP shared care. The last provider was responsible for delivering specialist prescribing to complex and high-risk service users; i.e. those who had unstable dual diagnosis, high support physical health, and / or any other complicating factors which required specialist care.

The treatment provision available to individuals accessing services on a voluntary basis or through coercion comprised: prescribing, psychosocial interventions, needle exchange, harm reduction interventions, assertive outreach, testing for blood borne viruses, assessment for and access to residential and other funded treatment services (NTA, 2002), counselling, stimulant specific interventions, alternative therapies, alcohol and drug specific group programmes, access to education, training and employment (ETE), benefits and other legal support, GP shared care, women specific interventions, and peer support groups such as Narcotics Anonymous and SMART Recovery. In addition to these, services had access to specialist housing and dual diagnosis workers, prison link workers, and a family service that provided carers' support and family therapy. The heterogeneity of this borough cannot be overlooked but the variety and extensiveness of treatment interventions should provide us with reassurance that individuals' needs could be comprehensively addressed which has been identified as an important aspect in the success of coercion (Polcin & Weisner, 1999)

At the time of the research, partnership working was a key element of the treatment system in Hackney. This included joint working between drug treatment services, housing providers, primary and other healthcare services, probation, ETE services, the Jobcentre Plus and children services amongst other, ostensibly to enable a holistic and supported approach to addressing individuals' goals and recovery. Drug treatment providers were invited to a variety of regular partnership meetings to maximise joint working and to safeguard individuals. Among these were the Multi Agency Referral and Assessment Conference (MARAC) for victims and perpetrators of domestic violence, Multi Agency Public Protection Arrangements (MAPPA) meetings with the London Probation Service, Integrated Offender Management (IOM) and Drug Rehabilitation Requirement (DRR) case management meetings. Dual Diagnosis Complex Case Panel meetings were also available where service provision and care of clients was discussed to maximise the intervention and treatment provided. Child Protection Conferences and Safeguarding Clinical Supervision were also available. In-house clinical meetings took place within all drug treatment providers where service users were discussed and recovery promoted through the discussion of interventions provided to service users and feedback and suggestions shared through teams. This London borough therefore had a wealth of resources and treatment provision for individuals accessing treatment which should have rendered engagement and retention into treatment easier (NTA, 2002). However, as addressed in the first chapter, partnership working between agencies delivering treatment services could impact on successful outcomes (Perkins et al, 2010) but it has also been identified that

partnership working between criminal justice drug services and the police can be effective (Best et al, 2010).

Between July 2013 and August 2014, there were 1484 drug users in drug treatment in the London Borough of Hackney. Between 2012 and 2013, it had successful completion rates of 8.11% for opiate users and 37.69% for non-opiate users (PHE, 2015) whereby individuals had completed treatment drug free or as occasional users (not heroin or cocaine) (PHE, 2017).

## **Methodology**

Studies on coercion have provided various findings regarding its effectiveness in drug treatment. Most US studies concluded that coercion works (Anglin, 1988; Farabee et al, 1998) and non-US studies were inconclusive on the matter due to perceived methodological failings (McSweeney et al, 2007; Stevens et al, 2005b).

In comparison to the majority of studies carried out to date, the aims of this research were to explore service users' experience of coercion as a means of substance misuse management and crime control, and understand the role social and psychological factors play in these. Furthermore, it aimed to understand service users' views of what makes treatment effective and identify implications for practice. My knowledge and experience of the field and research setting will provide further depth and understanding within this research by providing additional data and the opportunity to challenge and reflect my own experiences. Taking this into consideration focus groups were used to inform the interview schedule to provide an initial objective stance to the research in identifying pertinent themes for service users in their experience of coercion. Semi-structured interviews were then carried out and Interpretative Phenomenological Analysis was used to enable a full understanding of service users' experience of coercion to meet the aims of this research. In the next sections, I will explore the benefits of qualitative and some of the limits of quantitative research methods to enable a rationale for the chosen methodology and how it will assist in meeting the aims of this research.

### ***Advantages of Qualitative Research Methods***

The role of coercion in drug treatment has given rise to much debate and inconsistent theories. Qualitative methods are sensitive to the unique personal experiences, perceptions, beliefs and meanings of individuals and can therefore capture the subjective reality of drug treatment programmes which impact on individuals. In their study around the use of qualitative methods in addictions, Neale, Allen and Coombes found that the use of quantitative research is

“mainstream” (2005, p.1590). They felt that qualitative research is often not the preferred option by policy makers and commissioners due to its inability to provide hard facts and despite their advantages in identifying emerging trends in drug consumption and hard-to-reach groups. The use of qualitative methods will enable me to identify and gain an in-depth understanding of coercion from a service user’s perspective which will inform study and practice with its rich data. Tewksbury (2009) described qualitative research methods as a micro-level issue which provide more informative and richer investigations combined with a depth of understanding of crime, criminals and justice system operations and processing.

The aims of this research are to understand how service users experienced coercion as a means of substance misuse management and crime control and identify how social and psychological factors impact on them. As Tewksbury, DeMichele & Miller noted when carrying out research, it is important to consider what criminology and criminal justice aims to accomplish: “describe, explain or inform” (2005, pp.266-267). This research aims to explore individuals’ experiences of coercion; as Berg (1995, p.3) described “experiences cannot be meaningfully expressed by numbers”. The use of qualitative methods will provide a foundation for theoretical understanding of the views and experiences of participants. Qualitative paradigms offer the ability to develop an idiographic understanding of participants; identify new themes by exploring how coercion is experienced within their social reality and the impact this has on their engagement in treatment (Bryman, 2008). The use of Interpretive Phenomenological Analysis (IPA) with a combination of focus groups and in-depth interviews in this research will provide the richness and depth of data required to gain a comprehensive understanding of the role of coercion in crime control and substance misuse management, enabling a clearer understanding of the impact of coercive measures have on individuals in this setting. The combination of two research methods will complement each other’s potential weaknesses, providing invaluable and rich data to facilitate our understanding of the complexity of bio-psycho-social phenomena, and as such, provide possibilities to inform drug policy.

### ***Limitations of Quantitative research methods***

Research around the effectiveness of coercion has mainly been of a quantitative nature, considering generalisation as opposed to its impact on individuals (Young, 2002; Parhar et al, 2008; McSweeney et al, 2007). Quantitative methods enable researchers to make reliable predictions around the impact of substance misuse and crime, and its numerical data can support and challenge theories on a broad range of matters which remain invaluable tools in

policy making. They provide validity and reliability which can lead to hypothetical generalisations (Hoepfl, 1997) although can generate problems of reductionism and decontextualisation which could hinder the aims. Quantitative research does not intend to explore individuals' experiences; it pays attention to matters such as outcomes and holds the "ability to make correct predictions" (Worrall, 2000, p.354). The use of quantitative methods to ascertain whether coercion positively impacts on individuals may present conflicting views when interpreting data. As previously discussed, research around the effectiveness of coercion has been debated with studies providing varying theories around its effectiveness. As explored in the previous chapter, substance misuse and its related offending is a complex phenomenon and drug using offenders present with equally as complex needs. How we understand their world and their needs may impact on how we interpret quantitative data. For example, most of the research the government uses as a basis for its changes in, and evaluation of, policy is from quantitative research based on statistics from NTORS (Gossop, 2005a and 2005b; Gossop et al, 2001; Gossop, Marsden, Stewart & Witton, 2006). They estimate costs of crime and drug treatment, as well as offending behaviour, reached by estimating figures gathered through reports of drug users entering treatment and police custody in England and Wales. This has been greatly criticised by Gossop and his colleagues (Gossop, Marsden & Stewart, 1998a; Gossop et al, 2006) as these assume that all arrestees who have tested positive for Class A drugs have offended for that sole purpose which would be erroneous and provide inaccurate figures. For example, an 80-year-old may be arrested for shoplifting and test positive for opiates due to being prescribed codeine medication and not dispute the test. Furthermore, a young professional may be arrested for possession of class A drugs whilst on a night out or at a festival. Their levels of offending may be very different to those of a dependent opiate user who does offend. Similarly, Stimson, Hickman and Turnbull (1998) criticised Home Office research for failing to recognise the over representativeness of drug users in its sample which leads to the wrong assumption around the link between drug use and offending. Drug using offenders are more likely to come into contact with the criminal justice system and be arrested for acquisitive crimes. Using such figures based on the drug using population or offender population to generate an estimate of the costs of drug related crime and the perceived reductions in drug related crime would therefore be misleading and inaccurate without having an accurate understanding of drug users.

Despite Wild and his colleagues (Wild, 2006; Wild et al, 2006; Wild, Roberts & Cooper, 2002; Wild, Newton-Taylor & Alletto, 1998) substantially contributing to our understanding of coercion relating to how coercion is perceived by its recipients, their use of standardised

assessments tools limit our ability to fully understand and appreciate the heterogeneity of recipients, treatment programmes and the professionals involved in the delivery of coercive measures. Standardised forms are developed with aims very specific to the research study which, when used in different contexts of coercion will inevitably lose some of their objectives. The use of these tools can provide limited insight into how coercion is experienced by individuals to induct theories on the impact and effectiveness of coercion. In their research, Stevens and his colleagues (2006) adopted a new using between method triangulation. They carried out standardised assessments as well as semi structured interviews with both service users and professionals which provided an empirical approach to their research. The combination of the use of qualitative and quantitative methods offered comprehensive insight and understanding into the results of their research, such as some of the positive impacts coercion can have on individuals' behaviours which may not be qualified by research as successful outcomes, providing a better understanding of drug users' experiences. Few other researchers have used qualitative methods to address and assess coercion. In 2008, Stevens, Radcliffe, Sanders and Hunt carried out another piece of research looking at individuals who exited treatment early. Their use of qualitative and quantitative methods enabled a better understanding of factors linked to early exit with the ability to delve further into responses and illicit reflection. In their analysis, they identified that individual motivation was the main factor initially reported as contributing to early exit. However, upon further exploration, participants identified other aspects of treatment delivery and services which had contributed to their early exit. This highlights the benefits of qualitative methods in exploring issues to a deeper level, to understand the impacts and confirm answers provided.

Adopting quantitative research methods is beneficial to generalise findings and provide a wider presentation of issues relating to substance misuse and offending. However, it does not initiate an exploration or provide an understanding of coercion, therefore stipulating very constrained recommendations on how to address drug use and its related offending behaviours from a drug strategy viewpoint. Short of having entirely controlled environments, social research retains the complexities of human and social behaviours, rendering the chosen use of research methods according to the aims of research extremely important. The grounded approach of this research would therefore not benefit from the use of quantitative research methods. Every drug user is unique which will suggest difficulties in attaining an all-fitting, all-encompassing drug policy. Qualitative and quantitative methods each have their own benefits and will provide invaluable findings in our understanding of the link between drug use and crime and the effectiveness of coercion in the management of substance misuse and crime

control. Qualitative research remains limited in drug policy and, as Seddon (2000) suggested, there is a great need for more qualitative research to be carried out to gain a further understanding of the relationship between drugs and crime to enhance quantitative research. As local authorities were tasked to implement the drug strategy to the requirements of their respective areas (Home Office, 2010), addressing the complexities and needs of each community would increase our understanding of how coercion and drug policies impact on drug users. The use of qualitative methods would enable local authorities and the government to potentially implement new initiatives that would be of benefit to them by enhancing our understanding of service users' experiences. This could also generate knowledge for the subsequent use of quantitative methods.

## **Epistemological Approach**

The aims of this research are to understand what it means to be coerced and the impact coercive measures can have on service users. This research comprises two methods of data collection. The first is the use of focus groups as a preliminary tool to identify themes in our understanding of how coercion is experienced by individuals and to enable the structuring of the interview schedule. Due to my experience in the field and in this setting, it is important to reduce the potential impact of my views and knowledge and provide an objective formulation of interview questions whilst still enabling an enhanced exploration of service user perspective. The second data collection method is the use of semi-structured interviews to enable a more focused understanding of coercion as a means of crime control and substance misuse management and to assist in identifying how social and psychological factors impact on experiences. The use of IPA to analyse the data will enable an insight into the impact of coercive measures in the management of substance misuse and crime control amongst participants in this research. It will provide the richness of data needed to ascribe meaning to service users' experiences in their interactions in coerced treatment.

### ***Interpretive Phenomenological Analysis***

Interpretative Phenomenological Analysis (IPA) was introduced in the mid-1990s by Smith (1996) and is firmly rooted in concepts from three key areas of the Philosophy of Knowledge: Phenomenology, Hermeneutic and Idiography. It is a qualitative approach used to allow a rigorous exploration of how individuals make sense of their experiences and social cognitions. It aims to understand and interpret the experiences of individuals through a detailed



examination of their and my reflections on the significance of these experiences which will be ideal to meet the aims of this research.

### ***Phenomenology***

The first theoretical underpinning of IPA comes from Phenomenology. Phenomenology was developed in the early 20<sup>th</sup> century by Husserl and later expanded by his students and colleagues, such as Heidegger, Merleau-Ponty and Sartre. With systematic structures of reflection, phenomenology seeks to examine properties and structures of lived experience through a set of steps including description, phenomenological reduction and search for essences (Giorgi, 1997) which will assist in exploring the importance of legal, social and psychological factors in coercion.

Husserl (1927) developed notions of reflection to describe and understand experiences through systematic and intentional structures of the consciousness. He explored individuals' different experiences of "things", which he described as the experiential content of consciousness, to identify subjective experiences and their essence; exploring one particular element of these in order to remove assumptions and preconceptions of a particular event. Heidegger (1962) further developed phenomenology and Husserl's approach by identifying the importance of *Dasein* (literally translated as 'there-being'). He felt that it was not possible to describe the world and experiences without addressing individuals' assumptions, preconceptions and the world they lived in. Even when a person is alone, the world will continue to exist around them which will undoubtedly influence their experiences, developing the concept of inter-subjectivity. This is an important element in this research as the aim is to understand how coercion is experienced by individuals; i.e. what coercion looks like through their eyes.

The use of a small sample in this research will enable the exploration of these experiences to create shared themes whilst still recognising that individuals' experiences are unique and cannot be generalised. IPA provides an interpretative basis for its concept. Stipulating an interpretive approach whereby experiences of coercion into drug treatment and how these are perceived play a key role in this analysis. It provides a meaning to how objects, relationships, language, culture as well as self-consciousness within this world which will enhance my interpretation of individuals' experiences. The meanings an individual ascribes to experiences are of central concern but are only accessible through an interpretative process. My knowledge of the field and the setting will provide invaluable assistance in understanding their world as I have an in-depth understanding of their environment in Hackney, treatment

provision and processes as well as who workers are. This will enable me to picture their experiences and visualise their experiences, providing depth and understanding. In this research, phenomenology plays an important role. As stated earlier, most of research carried out on coercion has been based on assumptions relating to what it means to be coerced into treatment (Gregoire & Burke, 2004; Perron & Bright, 2007). The use of this approach will enable me to gain a better understanding of people's experiences and interpretation of coercion. It will look at coercion through their eyes, considering what their world looks like, how they see themselves in relation to this, which should provide a better understanding of how and why factors enhance and hinder their experiences of and responses to coercion.

### ***Hermeneutics***

The second major influence of IPA is Hermeneutics. Hermeneutics emerged in the late eighteenth to early nineteenth century through the work of Schleiermacher (1998) to identify the methods and reasons for interpretation of written, verbal and non-verbal communication. Initially developed to understand and interpret biblical texts, this was in later years expanded to include historical and philosophical texts. Hermeneutics provides a comprehensive description of the relationship between the person, the phenomenon and the interpreter. My knowledge of the treatment and criminal justice system in the chosen setting as well as my experience in working with drug users will provide an advantage in my analysis of individuals' responses.

Hermeneutics forms an important part of IPA as it provides a routed interpretive phenomenological approach to analysis, taking into account various influential aspects to a person's experience and how these are translated both by the person but also by the interpreter. The use of hermeneutics will enable a more detailed analysis of interviews to fully understand and appreciate individuals' experiences by keeping them at the forefront of the analysis whilst maintaining an awareness of one's beliefs, knowledge and experience through interpretation. IPA acknowledges that my engagement with the transcripts has an interpretative element whereby, through explicit processes, it becomes possible to access individuals' social cognition. My experiences in the field and within the research setting will therefore enable a deeper understanding of how coercive factors impact crime control and substance misuse management within drug treatment.

IPA recognises that the researchers will influence the interpretation of these experiences according to "common-sense thinking of men" (Schutz, 1962, p.59). Phenomenological research has been criticised for how texts and dialogues are being examined due to the

researchers' interpretation of the difficulties in keeping one's values, beliefs and experiences out of the research (Hughes & Dumont, 1993). Through my methods, I will need to maintain an awareness of preconceived views on coercion, providing a justified interpretation of the text whilst enabling my experience of the setting and working in the field to enhance reflection and analysis. As a first measure to enable an objective approach to this research, the use of a focus group to inform an interview schedule will enable me to manage my views appropriately to minimise their impact which is important in the initial stages of this research. Maintaining an awareness of the potential impact of my views and perceptions of coercion is also necessary to ensure additional questions enhance our understanding of coercion rather than elicit views. This process will provide an opportunity to challenge my experiences of working with service users and provide a more in-depth understanding of service users' experiences of coercion, delving deeper into their world. My wealth of experience and knowledge will however be invaluable in the analysis of transcript and provide added data to analyse and understand participant responses and interpretations of their world, therefore enhancing the research rather than hindering the process.

### ***Idiography***

The final approach which has an important influence on IPA is idiography. Idiography is a description of a specific phenomenon with unique properties and histories. Maykut and Morehouse (1994) characterised it as a richly detailed and uniquely holistic representation of words and actions that attempt to describe a situation as experienced by its participants. In this research, idiography plays an important role as it provides a more comprehensive understanding and insight into a case study. As Platt (1988) identified, the use of a single case study can be justified when describing something intrinsically and can point to flaws in existing theoretical claims. As identified in the previous chapter, research on coercion has given rise to differing views on its impact on substance misuse and crime management which have often been founded on the use of nomothetic, taking away the variations in treatment services, individuals' background, values as well as variations in the application of policies and acts. The use of IPA will enable an exploration of the impact of accessing drug treatment through criminal justice routes from drug using offenders' perspectives. Combined with my experience of the setting and knowledge of the use of coercive measures in Hackney, this will allow a more in-depth understanding of coercion and how factors can impact on service users' experiences. Adopting an idiographic approach will enable an insightful analysis of theories' assumptions, preconceptions, leading to a potential evaluation of current policies and concepts. As already addressed, coercion and drug using offenders are not homogeneous; the use of idiography will

enable the exploration of participants' views through reflection and expression of accounts which will enable a comprehensive analysis of their world.

Understanding individuals' relationship with social, legal and psychological factors will provide us with a more grounded understanding of their experience of coercion. As phenomenology grounds its philosophy in the subjective experience of participants, the use of IPA will enable a more grounded understanding of the impact coercion into drug treatment has on individuals and their experiences in the management of substance misuse. This approach will enable an exploration of whether individuals are indeed unwilling and whether threat are experienced. Research addressing how coercion is perceived have been based on standardised assessment tools which limit the interaction between researcher and participants, providing little insight into our understanding of what responses mean. My knowledge and experience of substance misuse and working in the setting will add invaluable data to this research, enabling further reflection and understanding of individual experiences of coercion and its impact on the management of substance misuse. This will enable a different approach and wider understanding of the impact of coercion on individuals.

### ***Focus groups***

Focus groups were used in this research to inform the interview schedule through the generation of key themes to further explore in the semi-structured interviews. This section will explore the benefits of this method and how this will assist in meeting the aims of the research, and provide a description of how participants were selected.

A focus group is a qualitative research method originally developed in Market Research in the 1920s as a way of generating information from consumers to optimise outputs and customer satisfaction. In the 1950s, sociologist Robert Merton developed the notion of focussed group interview (Merton & Kendall, 1946; Merton, Fiske & Kendall, 1956) and applied its use in research. However, it was not until the late 1980s, early 1990s that focus groups generated interest and popularity (Kreuger, 1988; Morgan, 1988; Merton & Kendall, 1990). Useful insights were introduced relating to the use and qualities of focus groups and their benefits. Kitziinger (1994) recognised the importance of interactions between participants in the success of the methodology of focus groups. She provided in-depth description around the use of focus groups and the importance of exploring interpersonal interactions. Focus groups can provide a safe forum to express views whereby participants are not obligated to answer every question. Participation may also be empowered be each other through group membership, by

being valued by the researcher, and by having a potential impact on the future delivery of services.

Morgan described the “most striking feature” of the focus group as the presence of a facilitator (1996, p.144). A Focus group is a group discussion of 8 to 12 participants where a topic is being discussed. It differs from commonly used group discussions in the sense where focus groups have a set discussion topic with it being led by a facilitator. Focus groups have previously been described as group interviews whereby participants are being asked to discuss their knowledge and experiences. Amongst others, Bryman (2008) argued the difference between focus groups and group interviews, highlighting the importance of group interactions within a focus group in relation to what is being discussed. The use of a facilitator enables discussions to be directed, steering the discussion in the areas of interest. Despite the need for an objective direction within the focus groups, my experience and knowledge of the research setting will enable me to explore coercion and participants’ experiences in more depth, without having to gain clarification around the setting, and further delve into pertinent areas which will assist in meeting the aims of this research. Focus groups also enable disagreements and inconsistencies to be explored, providing insight into the sources of complex behaviours and motivations (Morgan & Krueger, 1993; Morgan, 1996). Sim (1998) identified that the skills and attributes of the facilitator will have a powerful influence of the quality of the data collected. In this research, my knowledge and experience of working with substance users, in Hackney specifically, will be particularly beneficial in this aspect by further enabling reflection of specific areas around the use of coercion. Morgan (1996) made an interesting and valuable point by stating that the involvement of the facilitator should be linked to the research goals. My role as a facilitator within this research is very important due to my experience and knowledge of the area of research, treatment setting and service users. It will be important however to bear in mind the importance and influential impact of the facilitator when developing my method.

Focus groups have been appreciated for the wealth of data they generate. Combined with the use of IPA, they will provide in-depth information on the dynamics of participants’ knowledge and experiences which would not necessarily be possible during surveys. Morgan & Krueger described how focus groups provide insight into the sources of behaviours and motivations (Morgan & Kreuger, 1993, p.139). In addition to this, group interactions also bring a new dimension of understanding to the data collected where perspectives and critical comments can be developed along with an exploration through participant interactions of types of solutions. They have been known to generate more critical comments than interviews (Geis,

Fuller & Rush, 1986; Watts & Ebbutt, 1987) which will provide me with the ability to further explore experiences and enable challenges from other participants, which is ideal for generating questions and areas of interest for in-depth interviews.

One of the main criticisms of focus groups is that, although it provides information regarding views and perceptions, it fails to explore this on a deeper level. Although Fowler (1993) commented on the use of focus groups as a secondary data collection method to identify an appropriate domain of content for the development of structured interviews, for this research, the focus group is used as a preliminary tool to gather information to formulate an interview schedule to subsequently further address personal experiences in further depth through interviews. Group dynamics also makes it difficult for research to infer on attitudinal consensus and to measure strength of opinion. However, the aims of the thematic analysis are to distinguish common themes of individual's experiences and perceptions of coercion to inform the interview schedule and limit the influences my experience and knowledge of the subject could have in defining it. The subsequent use of IPA will enable a clearer understanding of strength of opinions during the focus group following reflection of experiences.

Group composition has been recognised as an important aspect of the use of focus groups in terms of the validity of data collected (Carlsen & Glenton, 2011). It has been recognised that already formed groups will enable ease of discussion and interaction between participants, and reinforce roles and dynamics of potentially dominant participants, further silencing individual voices (Kitzinger, 1995). Confidentiality has however caused some difficulties in the focus group process. Pre-existing groups may make self-disclosure more difficult, especially around sensitive issues, but it has been acknowledged that they groups can encourage challenging disclosures and enable recollection of experiences and the exploration of solutions to improve service delivery (Kitzinger, 1995). On the other hand, newly formed groups may impact on how quickly the group is able to form and for participants to become comfortable in the setting. Where individuals do not know each other, depending on the homogenous aspects of the groups, it may be more difficult for participants to relate to each other's experiences and views (Kitzinger, 1995).

IPA usually employs semi structured interviews to gather information as it enables rich and extensive data to be collected for analysis. More recently however, researchers have started to make use of focus groups (Flowers, Knussen & Duncan, 2001; Flowers, Duncan & Frankis, 2000; Flowers, Duncan & Knussen, 2003; Dunne & Quayle, 2001) within IPA. Smith (2004) expressed his concerns around their use due to potential group dynamics which could significantly impact on the participants' description of their world. As discussed above, the aim

of the focus groups in this methodology is to generate new ideas and identify perceptions around the role of coercion in the management of substance misuse. The use of focus groups will enable me to generate information regarding views and perceptions in the London borough of Hackney relating to the processes and impact of coercive measures on individuals. Furthermore, it will provide new information regarding other important aspects of engagement and successful completion in treatment in this particular borough to assist in the formulation of the interview schedule.

***The Method:***

The focus group schedule was structured with three broad questions relating to participants' experiences of accessing drug treatment through criminal justice routes and their motivating factors, followed by two additional questions to explore other areas which may not have been covered. Questions were as follows (appendix D):

1. Briefly outline your experience of accessing drug treatment through the criminal justice system (through police stations and courts) – (What worked in getting you to engage and complete treatment? What did not work so well?)
2. How much of a choice did you feel you had in this process? (When engaging in treatment through the courts, did you feel that you had a fair choice to engage in treatment? What were your motivating factors to engage or not engage in treatment at the time?)
3. Looking back on your experience of drug treatment, what would you say were the main motivating factors to get you to engage (and complete) treatment? (Social factors, Treatment experiences – setting etc., Treatment options – funded and CDS, types.
4. What are your views on the use of coercion in the criminal justice system?
5. And finally, what do you think could be improved in the provision of drug treatment?

With the aim of the research being to explore individuals' experiences of coercion and identify how factors impact upon those experiences, this approach facilitated participants' reflections on their experiences, enabling the generation of new knowledge for this research. This style fostered interaction between participants, allowing the group to form and participants to feel more comfortable in their environment. Kitzinger's (1995) suggestion that a facilitator should start off with a more observatory role in the beginning of a session and then have a more

involved role towards the end was followed. This also enabled me to limit the influence of my views on participants' and develop the coproduction of data to meet the aims of the research. More specific questions relating to participants' views on processes and treatment services were used to provide an understanding and permit discussions around inconsistencies and disagreements around perceptions and experiences. Halloran and Grimes (1995) discussed the need of an active facilitator to further encourage discussion of a topic. This approach enabled additional questions to be elicited to identify important themes for the structuring of the interview schedule and gain a good overview of participants' experiences.

As one of the aims of this research was to explore service users' experiences of coercion as means of substance management, I used purposive sampling to enable richness of data. The focus group was initially opened to service user representatives for the London Borough of Hackney and accessed through the Service User Involvement Council. Engagement with the Service User Involvement Council meant that individuals had reached a positive point in their recovery and had gone through a substantial amount of treatment. This provided my research with participants' insight, knowledge and experience of drug treatment services and referral routes I required to generate adequate questions for in-depth interviews. Unlike most focus groups, I opted to access an already established service user group in the community. My reasoning behind this was to ensure participants were able to freely discuss issues around their drug treatment and experiences in a safe environment where they trusted individuals. In addition to this, having been through similar paths and supporting each other through the service user involvement council enabled participants to challenge their views and reminisce on shared experiences within the focus group. Middleton and Edwards (1990) discussed the impact of collective remembering which was appropriate and beneficial to my research. Kitzinger (1994), and Khan and Manderson (1992) further identified the benefits of pre-existing groups as a way of enhancing the social contexts within which ideas are formed. The focus groups facilitate the discussion around coercion and the articulation of views and ideas in this social network.

A date was arranged for the focus group to take place with the Hackney Service User (SU) Development Worker who informed all representatives at the monthly Service User Involvement meeting the previous month for them to take part in the focus group. All representatives were subsequently contacted by phone by the SU development worker in the two days leading to the focus group as a reminder. Unfortunately, only two service user representatives attended the focus group and neither had previous experience of being coerced into drug treatment or a history of drug use. The focus group however went ahead to



further inform the experiences of service users in treatment, and specifically those of individuals who have been in treatment with coerced individuals.

I subsequently decided to arrange another focus group and a new date was arranged with the Service User Development Worker. Upon reflection of the initial focus group and its outcome, I decided to open the focus group to all services users in the London borough of Hackney who had been involved with the criminal justice system. I felt that this would enable me to maximise attendance, as well as provide a wider range of views and descriptions of participants' experiences of coercion within the criminal justice system. Participants were again accessed through the SU development worker who sent out email invites to all three treatment providers within the borough and service user representatives once again. Follow up emails and phone calls were made in the two days leading to the focus group again to encourage attendance. On this occasion, three service users attended. Although these were not pre-formed groups, all participants knew each other well and attended similar peer support groups which enabled them to reflect on their experiences and assist in the recollection process in a similar way to formed groups (Middleton & Edwards, 1990). They were able to challenge each other on their views because of shared experiences which rendered the focus group very successful in generating a wealth of data.

All participants had previous engagement in drug treatment through criminal justice routes, two had history of drug misuse, and one had a history of alcohol use only. All service users who took part in the focus groups were male. It is important at this stage to reflect on the small number of participants in the focus groups. Despite the low number of participants during this focus group, it was felt that these provided detailed material relating to already known knowledge and generated new themes to formulate the in-depth interview schedule. The aims of the focus groups were to provide direction for the interview schedule to generate themes in addition to already known research to ensure I adopted an open approach to this research. My knowledge and experience of the field had the potential to impact on my interview schedule by overlooking potential avenues to explore. The use of focus groups enabled me to be directed by service users in my research rather than by my views on the subject whilst enabling my knowledge and experience to provide further depth and enhanced understanding to the data. Despite these small numbers, it is important to highlight that this was not a group interview and that I was able to facilitate interactions and reflection between participants as opposed to eliciting answers from individual participants.

### ***Developing the interview schedule***

The use of focus groups enabled the development of key themes relating to how coercion is experienced by service users which has been invaluable for this research. It provided a greater understanding of the benefits participants gained from coerced treatment and elements which were key in sustaining their engagement in treatment. The focus groups identified that, regardless of service users' motivation to engage and readiness to access treatment, coercion provided them with the ability to access treatment and the skills to make positive behaviour change. The focus groups reinforced the fact that engagement in drug treatment is a complex and heterogeneous process which is constantly changing and influenced by various factors. Through the focus groups, it became evident that there are other important psychological and social factors that can influence individuals' treatment experience. The focus groups enabled the identification of skills, knowledge and information that assisted participants in making positive changes to their lifestyles and supporting their recovery which have lacked from research on the effectiveness of coercion.

The analysis of the focus group identified different stages of coercion which appeared key in participants' changes in motivation. It was found that exploring the interactions of social, psychological and legal factors at different stages of the treatment journey: access and initial engagement in treatment and sustained engagement, would be of benefit. This would enable a further understanding of their role during each stage and provide enhanced knowledge of their relationship on how coercion is experienced. A substantial part of the focus group provided discussions around the importance of keyworkers and peer support which were reported to have a great influence on the success of drug treatment. Further exploration into how these impact on service users to enable effective engagement into treatment would be of use to further enhance our understanding of coercion and how this is experienced by service users.

The Themes that emerged from the focus group provided a timeline of the processes individuals went through in their recovery. A description of their world when actively using substances became apparent. Their journey subsequently seemed to take them through challenges they may have encountered whereby they questioned their drug use and lifestyle. Participants subsequently recognised the benefits of addressing their substance use and, once they accepted treatment and engaged, they identified additional benefits which sustained their engagement. Based upon these cornerstones in participants' journey, the following interview schedule was devised which identified and recognised these areas. A schedule

comprising 8 questions with possible supplementary questions was devised as follows (appendix D):

1. Could you describe your experience of drug treatment?
2. What were the main factors to encourage you to access treatment? (How much of an influence did Social / psychological / legal factors have on you at the time? Why? How did these make you feel?)
3. In terms of staying in treatment, what would you say were the main factors keeping you engaged in your treatment programme? (How much of an influence did Social and Legal factors have? Why?)
4. Taking away your involvement in criminal justice processes at the time, how ready were you to change? For what reasons? (How much of a choice do you feel that you had in this process? What were your options? How fair do you think the process was? Do you think you were in the right frame of mind to make the decision to access treatment?)
5. Looking back on the influences you have experienced (cite examples from legal, social & psychological), which would you say were the most influential in getting you to change your behaviour around your drug / alcohol use and offending? (Did these change at any point in time? What were their relationships to each other? Do you feel that social and legal factors fed into your psychological influences?)
6. How does your experience of treatment through the CJS differ from when you have accessed treatment voluntarily? (In your experience, do you feel that you have benefited from being coerced in anyway? How would you compare your relationship with drugs / alcohol before treatment and now? Has this been different when accessing treatment voluntarily to through CJ routes?)
7. Speaking specifically about you, how could the CJS be more effective in the provision of drug treatment? What would (have) helped you more?
8. And finally, is there anything else that you feel may be useful for this study?

These were formulated to look at factors enabling access and sustained engagement in treatment, readiness to change to enable a reflection of these accounts, factors which have enabled change and how these differ between accessing treatment through criminal justice routes and voluntarily. Despite the identified benefits of coercion, peers and facilitators, I chose not to specifically enquire about these in the interview schedule to enable individuals

to openly share their experiences without leading them towards specific answers. Focus groups informed my knowledge for the interviews and will enable me to prompt into certain areas during the interviews as well as through my analysis to fully establish their impact on individuals' experiences.

### ***Semi-Structured Interviews***

The use of qualitative interviews, as described by Bryman (2008, p.438), "enables the flexibility and richness of data" sought for this research to assist with our understanding of how coercion is experienced. In contrast to focus groups, qualitative interviews enable participants to reflect on their thought process, views and perceptions whilst providing an in-depth account of them. Interviews also enable researchers to seek clarification and delve into themes that arise, providing an opportunity to explore these further. Previous research has identified that coercion is a very complex aspect (Hough et al, 2003).

Due to my experience and knowledge in the field, I decided to opt for semi structured interviews to carry out this research to ensure a controlled approach to limit the impact of my views and experiences and not lead participants in their reflection but rather enhance exploration. The use of interviews will enable me to delve deeper into participants' views and experiences, to gain a fuller understanding of their perceptions and experiences of coercion and treatment provision.

### ***The Method:***

To enable richness of data within this research, I used purposive sampling. Participants were also accessed through the Hackney Service User Development Worker who sent out invitations via email to service user representatives and all drug treatment providers within the borough to disseminate to service users. The only criterion was for individuals to have been involvement with the criminal justice system.

Sample sizes for IPA tend to be generally small as the richness of the data and comprehensiveness of the analysis is most important. The limits of the research, the richness of individual cases and constraints must be taken into account (Smith et al, 2009). In terms of this research, I aimed to interview 6 to 10 individuals within the London borough of Hackney to ensure data achieved saturation where no new or relevant information emerged. Participants from the focus group who had consented to being contacted to take part in the interviews were also contacted by the Hackney Service User Development Worker. This sampling method and selection criteria provided comprehensive insight into participants' experiences of coercion within the criminal justice system.

I provided the Service User Development Worker with two days for participants to be booked in for interviews. Two participants attended on the first day and two on the second day. I subsequently started the analysis of the interviews and felt that additional data was needed to continue building an informative analysis of participants' experiences of coercion. I subsequently arranged to interview further participants a month later, following the same process as before. On this occasion, two participants attended on the first day and one on the last day, giving me a total number of seven participants. All interviews were voice recorded and subsequently transcribed.

## **Research Ethics**

Social research is a dynamic process which involves researchers and participants. This necessitates extreme care to ensure that each party is kept safe and no adverse effect to the individuals and society as a whole is caused by the research. Ethical issues are a very important aspect to consider in social research which needs to be addressed with considerable caution and care. In order to identify the likely impact of the research on society as a whole, researchers must keep to a set of rules and regulations on the way data is collected and presented, as well as a code of conduct which must be adhered to (Coolican, 2001) to minimise harm to participants.

Diener and Crandall (1978) classified ethical principles for social research into four categories: harm to participants, lack of informed consent, invasion of privacy and deception. Undertaking this research as a practitioner-researcher required extreme care to avoid harm. As I was working as a Senior Practitioner within the London borough of Hackney prior to my research being carried out, there was a possibility that I could come across individuals with whom I had previously worked with. To minimise any role conflict, I ensured that service users I have ever worked with did not take part in this research. In order to do so, the Service User Involvement worker checked with all service users whether they had worked with me in the past and I subsequently confirmed this at the beginning of each interview.

Professional practice and ethical standards require researchers to fully inform participants on the nature of the research and getting informed consent from them (Blaxter, Hughes & Tight, 2001). Ethical approval was gained from the University Ethics Committee through the University of Portsmouth and their key principles were upheld for my research proposal. My REC reference number is: 12/13:17 (Appendix A). As this study involves face to face contact with service users, each participant was provided with an information sheet (see appendix B) which clearly outlined the purpose of the research, what would happen during the focus group

and interviews and what was expected of them. In addition to this, it provided participants with comprehensive information regarding confidentiality and anonymity, describing the process of data collection and the removal of any potentially identifiable data. The information sheet also informed participants that participation was entirely voluntary and could be withdrawn at any part of the process, ensuring informed consent was given. Participants were also informed that focus group and interviews would be recorded and that findings from this research would be used for my qualification and possibly in publication.

All participants were also requested to sign a consent form (see appendix C) before the focus group and interviews which again outlined the purpose of the research and how the data collected would be used and analysed. These were fully discussed with the participants before the interviews to ensure they understood its content and to avoid any assumptions that participants could read. Participants were also provided with the opportunity to discuss any queries or concerns relating to the research or confidentiality before and after the focus groups as well as the interviews. All collected information was non-attributable by using a code relating to each participant and were stored in a locked cabinet which only I had access to prior to transcription, and the tapes were then destroyed in accordance with data protection regulations following completion of my analysis. Although some demographic information was recorded, no identifiable details could be derived from these.

Prior to the focus group and interviews starting, participants were reminded of the purpose of the research, given the opportunity to further discuss the purpose of the research and for their questions to be answered prior to consent being taken. Great care was taken in order to safeguard participants during this research. Minimising the sensitive information collected and coding ensured anonymity and confidentiality during this research to avoid impacting on participants' privacy. In order to do this, all communication with participants and bookings were made through the Hackney Service User Involvement worker. This meant that I did not have any records of participants' names or contact details. No potential physical harm was identified prior to the research due to the nature of the methods used. However, although the research questions during focus groups and interviews were not designed to cause participants any psychological stress or anxiety, discussions around past experiences of drug treatment and recalling personal experiences could have impacted participants on this level. Through my experience of working with this client group, I have gained skills and experience in dealing with sensitive and complex issues appropriately. I was able to ensure participants were safe throughout the study and assisted them with dealing with any potential difficulties that could have arisen from taking part in the research. Participants were also given the

opportunity to speak to the Service User Development Worker or their keyworkers following the interviews to ensure they had the opportunity to discuss any issues further.

Confidentiality and its limits within the focus group were clearly explained to participants prior to consent being given and, despite the group being encouraged not to share any information discussed during the focus group, I informed them of my limitations regarding this. As a result, I encouraged participants to only disclose information and experiences they felt comfortable with to minimise the potential harm the research could cause and gave them the opportunity to come and speak to me privately after to discuss any experiences or views they did not feel comfortable sharing with the group if they felt it would be relevant to the research. Following the focus groups and interviews, participants were given the opportunity to discuss how they felt the group went which enabled me to identify any potential stress and anxiety they could have incurred and offered them the ability to speak with me privately or with the service user involvement worker should they require to.

This study was designed to identify service users' perceptions and experience of coercion. This should not impact on the reputation of any organisations or individuals within the London borough of Hackney as only participants' perceived experiences and views were being sought around the impact of coercion rather than their views of specific processes within the treatment system.

The next chapter will look at the analysis of the focus groups and interviews. It will provide information relating to the participants of this research to gain a further understanding of their background to increase our understanding of how coercion is experienced. This will assist in our exploration of how coercive measures and contemporary drug policies could impact service users and enable the identification of effective factors in the treatment and rehabilitation of drug using offenders.

## **Chapter 3: Findings and Discussion: Experiencing Coercion**

Involving service users in the evaluation of contemporary drug policy has been recommended in both research (Wild, 2006; Urbanoski, 2010) and UK policies (Home Office, 2010; Department of Health, 2012). As discussed throughout this thesis, there have been conflicting views around the effectiveness of coercion as a crime control and substance misuse management approach. Accordingly, Stevens and his colleagues (2006 & 2008) explored a more comprehensive analysis of service users' views on the coercive disposition of legal, psychological and social factors on their treatment using between method triangulation. Despite finding inconclusive results in their research, they suggested that there was no significant difference between coerced and voluntary individuals in treatment outcomes. With this in mind, the use of Interpretative Phenomenological Analysis was chosen in this research to enable a better understanding of the heterogeneity of coercion. As suggested by Smith (1996), descriptive, linguistic and conceptual elements were explored to analyse the focus group transcripts. In addition, reflections of my experiences in the field were drawn upon to further support findings and enhance our understanding of coercion. Themes were identified and represent areas which made an invaluable contribution to our understanding of coercion and what it means to be coerced. They also illustrate participants' recommendations on improvements that could be made to current drug policy to improve outcomes, treatment and recovery. This chapter will provide an analysis of the findings from the two focus groups and seven semi-structured interviews. It will explore how participants' experiences relate to contemporary research and build on our knowledge and understanding of coercion in line with the aims of this research.

### **Focus Group Analysis**

The focus groups were a key part to the development of this research. Their aim was to identify key themes which were pertinent in Hackney residents' experience of coercion to enable the identification of the interview schedule. IPA was used to analyse the focus group transcripts which enabled me to identify themes and patterns to formulate interview schedule to ensure appropriate measures were taken to explore how coercion is experienced and the impact other factors could have on these experiences.



## Results

Table 1 below provides an overview of the super-ordinate and sub-themes from the focus groups and key words from participants.

Themes	Line	Key words
<b>Super Ordinate Theme 1: Coercion</b> Sub Themes: Choice Get Out of Jail Benefits	392 8 498	There's only two choices Get out of jail free I'm reading books now
<b>Super Ordinate Theme 2: Challenges of Engaging in Coerced Treatment</b> Sub Themes: Enough Behaviour Change	298 157	I've just had enough it's gonna take probably at least 10 years to actually get out of that routine
<b>Super Ordinate Theme 3: Enhancing Factors</b> Sub Themes: Peers Keyworkers	80 232	I learn off of these guys Biggest part for me was the quality of the facilitators
<b>Super Ordinate Theme 4: Recommendations</b> Sub Themes: Non-Treatment Activities Separate coerced & voluntary individuals	538 57	Little taster things it doesn't really bother me

Table 1: Focus Groups Thematic Analysis

### Participant Demographic Information

Information was drawn from the focus group transcripts as an introduction to the participants. The names of the participants were changed to maintain their anonymity and confidentiality.

*Sean* and *Alan* took part in the first focus groups. They were both alcohol users who had never been involved in the criminal justice system. Both identified having been abstinent from illicit substances for over six months.

*Fred* was a 39-year-old male. He reported heroin and crack as his substances of choice. He had been involved in the criminal justice system for many years and started using substances in his late teenage years. At the time of the focus group, he reported being abstinent from illicit substances but still being prescribed methadone.

*Graeme* was a 50-year-old male. He reported crack being his primary substance of choice with heroin as his secondary substance. He stated that he had been using substances for over 30 years and was on the integrated offender management scheme. He explained that he had had

several lengthy prison sentences for burglaries. At the time of the focus group, he reported that he had not yet reached abstinence and was still using recreationally.

*Michael* was a 54-year-old male. He reported that he had been using alcohol problematically since his early twenties but that he had never used any other substances. He explained that he had been abstinent from alcohol for 12 days at the time of the focus group.

### ***Super-Ordinate Theme1: Coercion***

Participants were initially asked to describe their experiences of accessing drug treatment through criminal justice routes. This provided insight into what it meant to them to be coerced into treatment and aspects which they felt were important through their experiences. They provided an account of what led them to accept coerced treatment and the benefits they experienced through this as a result.

#### ***Sub-Theme: Choice***

Participants were asked how much of a choice they felt they had to accept or decline treatment. *Michael* was very clear in stating that he did not have a choice as he needed treatment. As he described his experiences, it became apparent that this was in relation to his physical health and wellbeing rather than not being given the option to either accept or decline the order. He described how the decision was taken out of his hands because of the impact his substance use had on his life and had he not accepted, he most probably would have died. His sense of a lack of choice was therefore due to the detrimental impact his alcohol use had on his physical and mental health as opposed to a lack of choice from the criminal justice system. In my line of work, I have on occasion come across service users who are equally desperate to be given the chance to address their substance use and feel that they do not have any other choice but to engage in treatment, or at least try, due to the impact of their substance use. This does not necessarily entail that they are ready to address their substance use but rather that they feel desperate measures need to be taken in order for them to survive. *Fred* and *Graeme* on the other hand were non-committal when providing answers to this and were very hesitant:

*“Erm... well, there’s only two choices either you do the DRR or go to jail and you’re gonna take whatever’s not going to jail” (Fred, I.206)*

From this statement, it would appear that they had an element of choice but that this is very much presented in favour of treatment as *Hough* predicted (1996). *Fred* however later explained how, in the past, he had been approached by drugs workers whilst in police custody

but declined to speak to them and never contemplated the possibility of being granted Restrictions on Bail as he knew he was going to prison and was ready for that. He also explained:

*“Theiving and going to prison, you know what I mean? It’s easy, that cycle’s just so easy for me” (Fred, l. 172)*

This would suggest that prison was not necessarily a deterrent, at least at one point in his life, and that this choice may not necessarily have been swayed towards treatment.

Both went on to explain how difficult it can be for individuals to access and seek treatment and drew on the benefits of coerced treatment rather than answer the question. From this, it would appear that, whether they experience an element of choice or not was irrelevant to them due to the benefits they experienced out of accessing coerced treatment.

None of the participants talked about pressures or threats from criminal justice agencies or key workers through this process. This is not to say that they did not experience any but these were not factors which were explored during the focus groups. Asking the question more specifically may have provided further insight into this notion of choice and an understanding of whether individuals experience pressures or threats, and the potential impact these could have on their feeling of choice.

#### ***Sub-Theme: Get out of Jail***

Similar to Stevens et al’s (2006) findings, Fred and Graeme identified their main reasons for accepting coerced treatment as a way of avoiding prison. Graeme justified his reason for avoiding prison by explaining that had he not accepted coerced treatment, he would have received a lengthy prison sentence due to the nature of the crime he had committed:

*“... it was more really a get out of jail free [...] I weren’t gonna get six months, I’m talking about years you know what I mean” (Graeme, l.133)*

However, he went on to explained how he was only able to complete four weeks on his Drug Rehabilitation Requirement (DRR) before being breached and receiving a lengthy custodial sentence. Young (2002) found that those who faced prison sentences over three years were more likely to remain in treatment. Although Graeme remained in treatment for only four weeks, he reported being able to achieve abstinence. This was supported by him being in residential treatment which requires individuals to be abstinence from illicit substances. Similarly, Fred explained that, despite not being ready and accepting the order to avoid prison,

he was able to successfully complete his order, reduce his drug use and start building his life as a result:

*“Yeah I completed it as well. Cos even though I wasn’t ready, yeah quite... I knew I was using quite a lot so I thought that I could control it” (Fred, I.54)*

Despite stating that he was not ready, he later explained that, at the time he accepted his DRR, he believed that he was ready to address his drug use. He explained some of the complexities of motivation and how his engagement in treatment, he has learnt to realise that he was not fully ready or motivated to address his substance use. Through my experience of assessing individuals’ suitability for drug treatment, to avoid prison is very often the answer I get from service users as the reason why they want to access drug treatment. When I explore this further however, it becomes evident that they have some insight into the impact of their drug use on their lives and they have elements of motivation to address their drug use. Despite this not being their main reason, it does not always entail that they are not ready for treatment or to make changes. Fred and Graeme’s experiences would appear to be consistent with my experience of assessing individuals for DRRs whereby, although not ready to fully address their substance use, they did want to make changes to their lives.

On the other hand, Michael reported being ready and identified that he needed to engage in treatment at the time he was offered an Alcohol Treatment Requirement. His motivation was based mainly on the impact his alcohol use had on his life at the time and a conscious decision to stop using:

*“Well basically I needed to sort my life our [pause] cos [hesitation]... it was just hell” (Michael, I.21)*

Through his account, it became evident that his alcohol use had a negative impact on his physical health and social circumstances which was a motivating factor in him accepting treatment. Fred asked him whether he would have access treatment if he hadn’t been offered an ATR to which he replied that that was a very hard question but he probably would not have. This is similar to Marlowe and colleagues’ (1996) findings which identified that psychological, social, medical factors played a more important role in treatment entry than legal coercion although in this instance, enhanced by the opportunity coerced treatment created.

Despite getting out of jail being the most common factor amongst participants, this did not appear to have any bearing on their motivation (or lack of) to engage in treatment. Despite an initially perceived low motivation to engage, Graeme and Fred both managed to sustain engagement in treatment and make positive changes to their lives.

### ***Sub Theme: Benefits***

Through their accounts, participants identified the benefits of coerced treatment and factors which enabled positive behaviour changes. Although neither Graeme or Fred were ready to address their substance use, they provide ample reports relating to what they had gained from coerced treatment and the positive impact this opportunity had on them. Fred explained this as follows:

*“It made, it made me see what I can get out of it, you know what I mean? Cos I wasn’t ready to do it at the time yeah, but it made me realise what was out there when I was actually ready to do it, you know what I mean?” (Fred, I.9)*

He reflected on his experience of coercion, how this enabled him to control his use and, despite not being ready. Although he explained that he hadn’t sustained abstinence from illicit or prescribed substances whilst in coerced treatment, he was still able to control and reduce his drug use. He went on to explain how it provided him with the skills to gain better control of his drug use as follows:

*“going to rehab and everything kind of helped me understand what I was going through, understand my, my urges, my cravings and why I was doing things, impulses an stuff like that and yeah I kind of thought I was going mad but then ... when I went to rehab I realized it wasn’t just me, everyone’s going through the same thing you know what I mean but erm... so I actually tried to think that I could erm, I could try and control it kind of thing, you know what I mean so... even though I wasn’t ready, it did cut me down a bit you know what I mean so, well for an amount of time you know what I mean” (Fred, I.206)*

He continued by highlighting how coerced treatment also enabled him to start building a stable life and stop offending. Blanchard, Morgenstern, Morgan, Labouvie and Bux, (2003), and Longshore and Teruya (2006) found that individuals may be willing to engage in treatment, but not ready to make changes to their behaviours. However, Fred’s experience provided some insight into how and why coercion could lead to positive behaviour change regardless of readiness to change. Michael similarly expressed how he had managed to build his life through treatment which consequently had a positive impact on his psychological and physical health. This supports research which found that motivation is linked to positive changes in health behaviour (Wild et al, 2006; Deci & Ryan, 2008). Participants also identified that whilst they were engaged in drug treatment, coerced or voluntary, they stopped offending as per McSweeney and colleagues’ (2007) research.

These findings accurately reflect my experiences in the field. As a substance misuse worker, I have regularly experienced how levels of motivations can vary. However, if an individual is open to change, I have seen how engagement in treatment more often than not leads to positive behaviour change, regardless of how little or short the change is maintained for. As Fred identified:

*“I don’t know, it’s hard to tell from the people that are genuine or people that are just the ones that want to do it to get out of jail you know what I mean? It’s hard to tell the difference but I don’t support... I think just to give people that chance anyway, just to make them... just to make them see what they could get... you know what I mean? In terms of when they are ready for it you know what I mean? I think it’s good; it’s done me a world of good” (Fred, I.401)*

Fred’s views were that there can always be benefits to treatment, coerced or voluntary, but this depends mainly on whether individuals are willing to use the skills taught. Regardless however, even if an individual does not make changes at the time of treatment, these are skills that they can use in the future, when they are ready to address their substance misuse or make changes to their lives. These are similar to Schaub and colleagues’ (2009) findings that identified reductions in crime, substance use and improvements in health and reintegration in coerced and voluntary individuals.

Through his accounts, Graeme explained how he did not know anything about treatment or what was available prior to accepting coerced treatment. He explained how, at the time he was offered a DRR, he had never had any experiences of treatment and as a result did not understand what he was agreeing to as he did not understand the purpose of treatment or what this entails. Although this was explained to him prior to him accepting the DRR, he explained that he did not understand one’s role in a group setting or that it would require him to discuss his experiences, be challenged on his beliefs and the emotional difficulties this entailed. As a result, he disengaged from treatment as he was not ready for such an emotional challenge.

Participants’ accounts showed that despite avoiding prison being the main factor in them accessing treatment, they gained a variety of benefits through accepting coercion. Reduced drug use, not offending, gaining skills to reach and maintain abstinence were some of the most important benefits they identified from coerced treatment. Ultimately, they felt that, regardless of whether individuals were ready to access treatment, coercion could provide access to treatment which wasn’t something that they had experienced or even thought about

doing previously but had assisted them later in their lives when they were ready to change and address their drug use.

### ***Super-Ordinate Theme 2: Challenges of Engaging in Coerced Treatment***

As they recalled their experiences of coercion, participants talked at length about the difficulties and challenges they faced to maintain engagement in drug treatment. These were identified as an important aspect to understand how social and psychological factors can have on an individual's experience of coercion and treatment, and impact sustained engagement in treatment.

#### ***Sub-Theme: Enough***

Understanding the impact of substance use has on life and behaviours provided an insight into some of the challenges participants faced in maintaining or even accessing drug treatment. Farabee and colleagues stated that, to make positive changes, individuals must "hit rock bottom" (1998, p.3). When recalling factors which led them to engage in treatment, participants similarly talked about reaching a point in their lives, where they have had enough and decided to make changes.

*"I just thought I've just had enough you know, there's times when you think you've just had enough you know..." (Fred, l.298)*

They reflected on being too old and realising that they needed to make changes to their lives as they may not have long left to live meaningful and happy lives. They also explained how they had had enough of the impact of their substance use on their relationships. Michael talked about the impact his substance use had on his relationship with his sister and how she no longer wanted to speak to him or see him as a result. He explained how he had tried to rebuild their relationship when he reached abstinence but due to the years of disappointment, she no longer believed him and had no interest in renewing their relationship. He explained how, as a result, he spent a lot of time on his own. Despite having acquaintances he often drank with, he always felt alone which eventually led him to seek treatment. Chris identified that he had neglected his family through his substance use and acknowledge that this led to him having enough, realising the impact his substance use had on his relationship with them and his behaviour towards them which he no longer wanted to inflict on them.

As participants described their experiences of what led them to treatment, it became apparent that they all reached a point in their lives where they became increasingly aware of the negative impact their substance use had on different areas of their lives and wanted to make

changes. Despite having had enough, it was unclear from their accounts the impact this had on their motivation to change as all reported varying outcomes of success to their subsequent treatment experiences. The next sub-theme may further assist our understanding.

### ***Sub-Theme: Behaviour Change***

As they recalled their experienced of coercion and treatment, participants described the impact of substances on their health and behaviours. They described factors which made it more difficult for them to access and maintain engagement in treatment. They identified that, regardless of their readiness and motivation to engage in treatment, there were various challenges they faced which often led them to relapse. Participants went on to explain the difficulties of the process of change and the challenges these bring. Fred recalled an interesting account of his experiences which provided a good insight into the obstacles he faced:

*“you got to think though, it’s not like... I was talking to my sister the other day and she was saying I was going on thinking oh my life’s standing still, it’s not going anywhere and feeling a bit depressed and she was saying to me well you’ve got to think of it as a lifetime, over 20 years I’ve been using drugs you know what I mean and that... 20 years is something that you’ve been doing for so long... it’s not gonna take two days to stop doing you know what I mean, it’s gonna take probably at least 10 years to actually get out of that routine kind of thing cos every little hardship that I come across, I seem to turn to what I know, it’s easy for me you know what I mean, which is going back into drugs or going with old friends you know what I mean and just that cycle, it’s easy” (Fred, l.158)*

Behaviour change is difficult and this account provides some insight as to why. As his sister pointed out, Fred had been using substances and leading a lifestyle for some years and breaking these habits and behaviours would take a considerable amount of time. Recovery and treatment are not only about stopping the substance but stopping the behaviours and way of life associated with it. This is something I often tell my service users as relapse can have a detrimental impact on service users whereby they may give up on their recovery and disengage from treatment. It is important to note that some have been coping with life with substances for many years. For example, I have worked with service users who experienced traumatic events in their childhood, such as bereavement or sexual assaults, and as a way of dealing with these, they resort to drug use to help them forget about the feelings they experienced as a result. Drug use is the only way they know to deal with their feelings and emotions and as a result will always revert to drug use when things get difficult. In order to support them through treatment, it is important to teach them how to process their feelings



in a different and healthier way. As Fred identified, this can take a long time. Participants identified that through treatment and recovery, they need to learn new ways of coping with life and emotions which can take time and commitment. Michael talked about his cynicism following several attempts to address his substance use and asking himself how long he would be able to sustain abstinence this time around. He explained how, on occasions, this hindered his ability and willingness to access treatment due to the challenges and difficulties this entailed. All participants agreed that it takes time for them to change their behaviours and to be able to sustain these behaviours and in order for them to be able to overcome obstacles of recovery, they need to be equipped with the right skills and support to overcome these successfully.

Participants also went on to recall how substance use took over their lives and became the focus of their day to day routine. They explained how this made it difficult for them to subsequently engage and stay in treatment due to the triggers these may bring. Graeme explained this as follows:

*“My life is all about taking drugs and making money for the drugs so you take the drugs out of the equation there’s nothing, nothing there, just a big gap, big void to fill you know what I mean? I got to the point where I was just doing drugs cos I was bored you know” (Graeme, l. 464).*

I often hear service users talking about boredom and reporting similar feelings. This is something that I always challenge with my service users as boredom is relative. There is always something one can do to fill their day; whether this is going to a museum, going for a walk, grocery shopping, laundry or cleaning. The may not be appealing to service users when this isn’t something that they have experienced or even contemplated before. Recovery requires individuals to view these simple day to day tasks in different ways as they are important parts of treatment and recovery. As a drugs worker, I am always aware of the need to include meaningful activities such as education, training and employment, acupuncture or football, to support service users through their recovery. As Pahar and colleagues (2008) identified, levels of treatment structure can impact on successful outcomes. Participants explained that, if treatment isn’t fulfilling or structured enough, this will leave a lot of empty time for them to think about substances and likely lead them back to substance use.

This super-ordinate theme has highlighted the challenges participants faced in accessing and staying in treatment. Despite a reported motivation to address their substance use following increased awareness of the impact of substance use on their lives, they faced many challenges they needed to overcome to sustain engagement in treatment. Participants’ accounts suggest

that, regardless of their levels of motivation to address substance use, they need to have competence to overcome these obstacles. What helped participants through their recovery will be addressed in this next super-ordinate theme.

### ***Super-Ordinate Theme 3: Enhancing Factors***

As they talked about the challenges of recovery, participants identified elements which were key in their ability to maintain engagement in treatment: peers and keyworkers.

#### ***Sub-Theme: Peers***

When relaying their experiences of coerced treatment, participants talked at length about what they gained from their peers. They described the benefits of peer support both as a source of support by developing healthy relationships, and knowledge where they could learn from peers' experiences. Participants explained how being with peers and sharing experiences enabled them to reflect on their progress and provided them with new ways of dealing with situations.

Through their accounts, they expressed a sense of comfort in being able to share struggles with people who have had similar experiences. They explained how this made them feel less alone as they realised they are not the only ones struggling with challenges. Participants explained how sharing experiences, feelings and struggles in groups with peers who understand these, assists them in not being judged and empathise with them which is important to their recovery.

*"It definitely helps and you know it's like sitting down in that environment that you know... and you feel safe around you know what I mean?" (Fred, 1.785)*

Having worked in the field for some years, I often see how difficult it is for service users to be open and honest about their experiences and the side effects of their substance use. Substance use has a variety of unpleasant side effects, such as paranoia for crack use (Smart, 1991), which service users are not always aware of. These side effects can be frightening if a person does not understand where they are coming from. Through treatment, it is important to educate service users around these as it can provide reassurance and relief that there isn't something deeply wrong with them. Discussing this in groups can enable discussions with peers and create a safe environment where they are not judged. As participants identified, through sharing experiences and concerns, the challenges described in the previous theme became easier for them to deal with as they were no longer alone experiencing these challenges and gained new skills from them to overcome them.

### ***Sub-Theme: Keyworkers***

The quality of the workers also appeared throughout the focus group as an important aspect of recovery and enabling sustained engagement in treatment. Everyone recognised their keyworkers as being invaluable in their recovery as they assisted them in making positive behaviour change. Michael explained how his keyworker played a vital role in him being where he was:

*“I think they do go the extra mile... yeah they do go that extra mile you know what I mean, definitely go the extra mile” (I.901)*

In describing some of the qualities that their workers had, passion and dedication were identified as important traits. Participants talked about the mutual respect they had developed with their workers. They explained how their keyworkers appeared dedicated to their recovery which they felt was an important aspect of their sustained engagement in treatment. They described how this enabled them to be more open and honest about the challenges they faced which in turn provided them with additional skills to continue to address their drug use and sustain engagement in treatment. Empathy is an important aspect that participants appreciate as it enabled learning and recovery. As Fiorentine, Nakashima and Anglin (1999) identified in their research, the client-practitioner relationship, along with treatment characteristics, are strong predictors in retaining individuals in treatment.

*“yeah but I think a lot of people actually from the DIP they they...they’re, they’re very engaging you know what I mean, even, even if they’re not your keyworker, they will still sit down and approach you and ask if you’re ok and spend sort of 5, 10 min with you and talking to you, you know what I mean which is, you know, which is good man... you know...” (Michael, I.751)*

Making time to speak to service users was also an important feature of good facilitators and workers. The above extract highlights that this is not limited to keyworkers but to the service in general, having staff who make time for anyone and everyone within the service appears to have a very big impact and a good predictor into whether someone will come back and / or continue to access the service. As addressed earlier, having an environment where individuals feel safe and not judged was identified as a key part in recovery to sustain engagement.

Keyworkers and peers played an important role in participants’ sustained engagement in treatment and recovery. Despite the challenges and difficulties they faced, they made it easier for them to sustain engagement in treatment and face obstacles rather than give up and disengage.

### ***Super-Ordinate Theme 4: Recommendations***

At the end of the focus groups, participants were asked their views on how coerced and voluntary treatment could be improved.

#### ***Sub-Theme: Non-Treatment Related Activities***

Participants identified the need for more outings to take place through treatment where service users could further develop healthy relationships and structure to their weeks. As they identified through their accounts, peers support was a very important aspect of treatment as it provided them with the ability to share experiences and develop healthy relationships. Furthermore, as they talked about the importance of structure and filling their lives with activities, they identified that doing things which were non-treatment related was also needed to show them what was out there, what they could do and how they could enjoy life without having to take drugs or other substances.

Participants also identified the need for sessions around life skills to be included in treatment. They explained how although they can be signposted to various organisations to learn skills around CV writing etc, having “*little taster things*” (Fred, I.538) would be better for them to experience these rather than having to feel like they are committing to a full programme they may not be ready for. They suggested cooking groups, IT course, CV writing, work experience as areas they would be keen to have incorporated into their treatment to support them through their recovery.

#### ***Sub-Theme: Separate Coerced and Voluntary service users***

Participants from the first focus groups provided limited insight into this research as none had experienced drug treatment. Through their experience of voluntary treatment however, they identified the negative impact being in groups with service users who had been coerced into treatment and recommended that coerced individuals be in different group programmes to voluntary service users. This concept was further explored in the second focus group but participants reported that they did not feel that coerced individuals who were not ready to access treatment impacted on their motivation to engage in treatment:

*“I think for me [laughter] the only thing is that like, erm, you get used to see the same people. Yeah and erm... so when someone’s like, that’s not particularly [pause]... they’re there cos they have to be there and you can see that they don’t want to be there. I think for me it doesn’t really bother me... it kind of makes me realise that erm... it just makes me realise where I am” (Fred, I.58)*

As Fred, Graeme and Michael discussed this, there was a lot of laughter and uncertainties about their views on this. As they explained their experiences of this, it became apparent that they could relate to these individuals and did not want to admit the negative impact this could have on those who may be more ready and willing to address their substance use. As they recognised the benefits of treatment on individuals despite readiness to change, they may have been reluctant to acknowledge the negative impact this had on others due to the positive impact treatment can have. As Fred stated, *“give people that chance anyway”* (l. 403). It is also possible that participants were concerned about the potential consequences of their answers due to my role in the field and were worried that this client group may be stopped from accessing treatment which they did not want to be responsible for.

It is important to identify at this stage that the participants in the first focus group were alcohol users as opposed to drug users which may also have impacted on their views of drug users and coerced drug users. Despite this, they provided an interesting insight into the impact drug using offenders can have on non-coerced individuals which is important and can improve practice for the benefits of both coerced and voluntary service users. The analysis of the focus groups provided interesting findings which suggested a timeline around variations in how distinct legal, social and psychological factors impact on individuals at different stages of their treatment and through the criminal justice system.

## **Semi-Structured Interviews**

The focus groups provided some important insight into how coercion is experienced and enabled me to identify aspects which participants felt played an important role in their experiences. The findings reinforced that, despite being coerced into treatment, participants were not unwilling to engage in treatment as the definition of coercion would lead us to believe (Seddon, 2009). They reported having some element of choice however this remained unclear and exploring this further in the interviews was needed to provide further insight into how coercion is experienced and whether individuals experience pressures or threats to engage in coerced treatment. As per Marlow et al's (1998) findings, the focus groups also identified social and psychological challenges that participants experienced which appeared to play an important role in their entry and sustained engagement in treatment. The findings enabled me to identify pertinent factors for participants in their experiences of coercion which I may not have held as much importance to without using focus groups to develop the interview schedule. They made me realise that despite levels of motivation to address one's

substance use, individuals' circumstances and the impact their substance use has on them can act as an obstacle to or reinforce treatment. Motivation alone is not enough to support service users in making positive behaviour changes and sustaining this, treatment and relationships can play an important part in supporting individuals to engage in treatment. As result, the interview schedule was developed as a way of enhancing these and develop our knowledge and understanding of coercion to understand how social and psychological factors impact on experiences and what makes treatment effective.

## **Results**

Table 2 below illustrates the super-ordinate and sub-themes from the semi-structured interviews as well as key words and statements from participants:

<b>Themes</b>	<b>Line</b>	<b>Key words</b>
<b>Super-Ordinate Theme 1: The Concept of Coercion</b> Sub-Themes: Avoiding prison Benefits of coercion Legal pressures	Andrew:83 Alex: 113 Steve: 295	Just to get me out the for a couple of weeks Probation planted a seed in me No, I didn't feel coerced
<b>Super-Ordinate Theme 2: Enabling Positive Behaviour Change</b> Sub-Themes: Enough Goals and Aspirations A Need for Competence	Dave: 80 John: 525 Alex: 365	Sick and tired of being sick and tired I want a better quality of life I was building my foundations on sand and it kept crumbling
<b>Super-Ordinate Theme 3: Self-Determination</b> Sub-Themes: Autonomous Motivation Stability Relatedness	Harry: 153 Andrew: 168 Andrew: 72	If I'm not gonna help myself, no one else is gonna Hostel. Don't want to lose my hostel The people before him, I used to argue with them all the time
<b>Super-Ordinate Theme 4: Recommendations</b> Sub-Themes: Harsher Sentences Early Intervention	Alex: 533 Alex: 537	there should be a tough line you're never gonna know

*Table 2: Interviews Thematic Analysis*

## **Participant Demographic Information**

Demographic information was collated at the end of each interview for all participants who took part in this research. The seven participants who took part in the interviews shared similar characteristics with each other and the wider drug sing population. They were between the ages of 36 and 40; the median age of individuals in treatment between 2013 and 2014 was 36

(PHE, 2014). The average age for first accessing treatment within this sample was 31 years old. PHE (2014) found that, on average, individuals seek treatment within eight years of initiation of their use individuals and as the majority start using drugs in their late teens and early twenties (PHE, 2014), this sample shows some slight differences to the wider population with the majority accessing treatment within the first 5 years of their drug use. Just over half of participants in this research had used heroin, cannabis and alcohol, with 71% having used crack and cocaine at some point in their lives. Participants provided information relating to the types of treatment services they had accessed over the years; all had received one to one support, and 57% had engaged in group work and substitute prescribing. Only 42% had received inpatient residential treatment, community detoxification and inpatient detoxification programme. Finally, 6 out of the 7 participants had experienced coercion through Drug Rehabilitation Requirement, Restrictions on Bail and probation requirements. Further information relating to participants can be seen below in table 3.

	Andrew	John	Steve	Alex	Tom	Dave	Harry
> 3 years substance misuse	✓	✓	✓			✓	✓
> 3 years history of offending	✓	✓		✓		✓	✓
Experience of DRR / DTTO	✓	✓	✓	✓		✓	✓
IOM Scheme	✓	✓		✓		✓	✓
Supportive social network (as defined by the participants)	✓	✓			✓	✓	✓
Peer support (as defined by the participants)		✓		✓			
Experience of residential treatment		✓	✓			✓	
Currently abstinent from illicit and prescribed substances		✓		✓			
Currently abstinent but prescribed substitute medication	✓				✓	✓	✓
Currently on licence / community order			✓			✓	
Previously reached abstinence through DRR		✓		✓		✓	✓

*Table 3: Overview of Interview Participants*

Following my analysis of the interview transcripts, I felt that I had reached saturation. The last two interviews carried out provided no new or relevant information for the research and I felt I had gained a good understanding of the participants' experiences. There are limitations to

this research which include the data sample which is all male and, as table 3 highlights, shared similar experiences of treatment and coercion. The majority of the service users interviewed had a similar history of accessing treatment both through the criminal justice system and on a voluntary basis. Furthermore, they shared similar views and experiences of treatment and the criminal justice system which was however, extremely informative to my research. Although one individual, Tom, had very different views, I could not identify any additional themes that arose from my analysis. Interviewing further individuals who shared similar experiences to him may have enabled an interesting comparison of these groups and further insight into nuances between entrenched drug using offenders and individuals who have had limited experiences of drug use. However, I felt that this would deviate from the aims of my research and was not necessary to meet them.

Further information was gathered from participants' accounts and the below were put together to provide an enhanced understanding of their experiences as an introduction to the themes. The names of the participants were changed to maintain their anonymity and confidentiality.

*Andrew* was of Scottish decent and reported first accessing treatment voluntarily through his GP in the late 1990s. He described a long history of offending behaviour and drug use which extended over 20 years during which he was never in the community for more than a couple of months at a time. At the time of the interview, he was on the Integrated Offender Management (IOM) scheme but was not required to engage with them. He described being offered a DRR on one occasion but following failure to engage with services he was remanded in custody shortly after. He reported heroin and alcohol as being his most problematic substances. At the time of interview, he was doing well in his recovery and has not been in prison for over a year. He reported being stable on a methadone prescription with no illicit substance use. However, he stated that he still enjoyed a social drink but that this was no longer problematic. He had stable housing, a partner and was only receiving treatment through the Hackney Drug Intervention Programme.

*John* spent the early part of his life in America with his family but was deported in his early 20s. He described himself as a criminal and a drug user with crime becoming a part of his life many years before his drug use. At the time of the interview, he was on the IOM scheme with who he engaged with voluntarily. He reported starting using heroin and crack in his mid-20s. He received a DRR two years prior, which he completed and subsequently maintained abstinence for the following 18 months until he relapsed. He stated that he had accessed treatment on a voluntary basis on several occasions but mainly in prison. He had a 10-year-old



son who he was trying to get back into his custody. At the time of the interview, he was abstinent from all illicit substances and was not on any substitute medication. He engaged with peer support groups such as Narcotics Anonymous (NA) and in treatment through the Hackney Drug Intervention Programme. He reported feeling stable and committed to his recovery.

*Steve*, at the time of interview was on a DRR which had been granted two months prior. He reported having been granted several DRRs in the past and never fully engaged but was never breached for failing to comply with their requirements. He stated that he completed at least two DRRs but never reached abstinence. He reported having accessed voluntary treatment on several occasions but felt that he was not receiving the same support. He described being a heroin user and stable on methadone despite still using illicit substances on occasions. He was engaging with the Hackney Drug Intervention Programme.

*Alex* reported having accessed treatment nationwide with his first experience being in 2001 when he managed to reach abstinence. He received his first DTTO in 2002 where he was required to attend residential treatment for his drug and alcohol dependence. He stated completing it despite not being ready. However, he maintained abstinence for the following three years before relapsing. At the time of interview, he had been abstinent from illicit and prescribed drugs for 13 months. He was engaging in peer support groups such as SMART, NA and Alcoholics Anonymous (AA) as well as treatment through the Hackney Drug Intervention Programme.

*Tom* was a musician by trade. He reportedly started using substances 3 years prior and had never been involved in the criminal justice system until September 2014 when he was arrested. He stated that he consequently accessed treatment through the Required Assessment process as he recognised he needed treatment. At the time of interview, he had never received a DRR or community order. He explained that he was using heroin dependently prior to his arrest and had since stabilised on a methadone prescription and had not used illicit substances since. He reported having a son and a strong support network of individuals who have never used substances.

*Dave* reported first accessing treatment through a DTTO in 1993 where he engaged in treatment for 6 weeks until he was breached. He reported being subsequently granted a DRR in 2005 where he was required to access residential treatment. He explained how he completed the first stage and successfully moved on to the second stage where he maintained abstinence for several months as he felt ready to address his substance use. In 2008, he

reported how he referred himself to residential treatment but only completed 5 days. He explained that he had a long history of substance misuse and offending and was on the IOM scheme with whom he engaged with as part of his license condition. He stated accessing several treatment programmes in prison which he had enjoyed. At the time of interview, he was stable on substitute medication and had been abstinent from illicit substances for several months. He was engaging in treatment through the Hackney Drug Intervention Programme. He reported having a son who played an important part in his sustained recovery.

*Harry* reported first accessing treatment in the community as part of a DRR and subsequently reaching abstinence for several months. He stated that heroin was his most problematic substance which had led to his offending behaviour. At the time of interview, he was on the IOM scheme but was not required to engage with them. He had accessed treatment on a voluntary basis on a couple of occasions in the past but relapsed several months after reaching abstinence. At the time of the interview, he was being prescribed substitute medication, had not used illicit substances for some weeks and was engaging in treatment through the Hackney Drug Intervention Programme. He explained that he had a partner who was very supportive.

The following section provides the results an analysis of the semi-structured interviews. It presents the super- and sub-ordinate themes that arose from these interviews and draws on research to date to explain how coerced treatment is experienced in this research setting. Furthermore, it explores how these findings can widen our understanding of the effectiveness of coercion on crime control and substance misuse management in line with the aims of this research.

### ***Super-Ordinate Theme 1: The Concept of Coercion***

Research has often been concerned with the success of coercion, making assumptions around how this is experienced by individuals and providing theories relating to its success. Through this research, it has become apparent that individuals' experiences and the journey of recovery cannot be taken for granted when exploring the impact of coercion in the management of substance misuse and crime control. How coercion is experienced and how policy is translated into practice are important aspects to explore in its understanding.

#### ***Sub-Themes: Avoiding prison and Readiness to Change***

As identified in the focus groups, coercion and the opportunity of engaging in drug treatment as part of a community order is most often used as a way of avoiding prison (Stevens et al, 2006). But what does this mean in the context of coercion and the aims of drug policy? All interview participants identified avoiding prison as the main reason for accepting treatment

apart from Tom and Harry. Tom had never been to prison and had never been offered a Drug Rehabilitation Requirement (DRR) and Harry reported wanting to address his substance misuse when offered the opportunity. When recollecting their lives as drug users, the cycle of imprisonment and drug use, participants reported prison as the norm in their lifestyle, something that provided them with respite and that they sometimes saw as a positive. Andrew for example reported how he enjoyed spells in prison as it provided him with some down time, away from substance use and giving his body a rest from the abuse he was putting it through. On the other hand, Alex reported that going to prison further enabled his drug taking behaviour as he knew all the dealers in prison and was provided with free drugs every week. He explained how this made his drug taking easier as everything was there, he did not have to go far to meet his dealers or pay for the drugs compared to when he was in the community. So, if they accepted prison as part of their drug using lives and somewhere where they could sustain their drug use, have food brought to them, why did they want to avoid this and opt for drug treatment?

Andrew, John, Steve, and Dave reported accepting DRRs in the past but not having any interest in addressing their drug use and conceded that they knew they would eventually breach their orders due to non-compliance. They explained that they wanted to be able to continue using substances and sustain their lifestyles. I explored this further with Dave who explained how he had had enough. When asked what he'd had enough of, he replied as follows:

*“Going to prison. I’ve spent nearly 20 years in prison, I’ve had enough. What they call in, in fucking prison cells... “sick and tired of being sick and tired”. I’m sick and tired of being sick and tired”. (Dave, l. 79)*

However, he later explained how he *“loved the drug too much”* (l. 208) which was why he faced difficulties in fully engaging in treatment. Prison had become the norm in his life and lifestyle, although this did not deter him from committing crime and using substances. He had had enough of being in and out of prison which he was aware was caused by his drug use. He eventually expressed an understanding that, as long as he loved using substances, he would continue to be in and out of prison, regardless of how sick and tired he was of imprisonment. This provides some insight as to why participants, despite knowing that they would eventually end up in prison, wanted to avoid prison. As they reflected on their experiences and discussed the impact of their substance use on their lives, it became apparent that it was not their drug use they had had enough of when accepting coerced treatment but rather its associated lifestyle which corresponds with Longshore & Teruya’s (2006) theory on resistance and reactance. When assessing individuals for their suitability of drug treatment as part of a

community order, I similarly often hear that prison is not a deterrent as the majority have had numerous spells in prison, but rather that they have had enough of the cycle of going in and out of prison and the impact their substance use had on their lives. Their levels of engagement thereafter are generally varied. So, does wanting to avoid prison mean that they are not ready for treatment?

John, Steve, Alex and Dave reported that, despite wanting to avoid prison, they engaged in treatment which led to positive behaviour change. Although this wasn't the case in their first experiences of DRRs, on at least one occasion they recalled engaging in treatment and making positive changes to their lifestyles. Steve initially reported that he was not ready for treatment and only accepted treatment to avoid prison. However, as he recalled his experiences, he began to recognise that there was something he wanted to change:

*"The only thing that made me come back before was the script, but then again, I did want to change but it was so hard, you know what I mean?" (Steve, I: 94)*

He felt there was something he was ready for. Through their accounts, it became apparent that participants had concluded that they were not ready for treatment by looking back on their experiences. However, at the time they accepted the DRRs, they all reported being open to change and wanting to change something. When asked whether he was aware that he was not ready to change at the time, Alex replied as follows:

*"Anything was better than nothing at the time. I believed change, I believe I could change, I wanted to change. [...] My surroundings back then weren't as happy and I didn't fit in anywhere, I didn't fit in, I was a bit of a loner, I couldn't trust anyone. So they did say: you're gonna be in a place with a number of residents and you're gonna be working together and doing this programme and you'll be going on trips and stuff." (Alex, I:290)*

Alex's account shows that despite recognising now that he was not ready, he acknowledged that, at the time he was offered the opportunity of a DRR, he thought he was ready. One of the most important aspects of drug treatment is to support individuals to reflect and learn from their experiences (Miller & Rollnick, 2002). As a practitioner, I often spent time with my service users exploring their views, successes as well as lapses and relapses; what happened that led them to fail or to succeed. Enabling reflection of experiences through motivational interviewing supports individuals to learn about their triggers, their cravings and their behaviours which can lead to positive behaviour change (Miller & Rollnick, 2002). Alex's recollection of events when he was using substances highlighted the loneliness he felt and

experienced. As the quote above shows, he was alone and could not trust anyone. Drug treatment places a lot of emphasis on the importance of building a positive network, enabling reflection to assess the basis and realness of friendships when substances are involved (Miller & Rollnick, 2002; Best & Laudet, 2010). Alex's extended experience of treatment would more than likely have assisted him in his reflection of his experience and what led to him accepting a DRR. Treatment seemed to have enabled participants to believe that wanting to avoid prison is not enough of a motivating factor to stop substance misuse and therefore reflecting that they were not ready to engage in treatment.

Self-determination theory and the impact of *controlled motivation* and autonomy (Ryan et al, 2008) could assist us in understanding the positive behaviour change that participants experienced despite reporting that they were not ready to engage in treatment. Ryan and his colleagues (2008) explained how *external regulations* can impact on an individuals' self-determination only to get an external reward; in participants' case, the ability to sustain drug use or to avoid punishment. Similarly, Farabee and his colleagues (1998, p.7) found that "both external and internal motivations play important roles in the treatment process and relapse". On the other hand, Ryan and his colleague's theory found that *controlled motivations* were unrelated to long term adherence and sustained behaviour change (Ryan et al, 2008). In John, Alex and Dave this was the case as, on at least one of their experiences of a DRR, they relapsed shortly after the end of their orders. However, on other occasions, they sustained their engagement and completed their orders. This would suggest that wanting to avoid prison does not entail a lack of motivation to engage in drug treatment but rather a misplaced motivation which may render treatment more difficult. Is it possible that wanting to avoid prison is also a motivational factor in drug using offenders who access treatment on a voluntary basis? If so, it is likely that if treatment fails, they will similarly conclude that they were not ready to address their substance misuse. In this case, what does being treatment ready mean? What is the expected outcome of someone who is truly ready for treatment? The following sub-theme may assist us in answering these questions.

### ***Sub-Themes: Benefits of coercion***

Participants' experiences of coerced drug treatment so far have revealed that individuals' initial motivation for accepting treatment is linked to their desire to avoid prison and change some aspects of their lifestyle as opposed to abstaining from illicit substances. However, all participants recognised that, despite not being 'ready', coercion did have some benefits. When asked whether he felt that coercion and DRRs worked, Steve replied:

*Steve: "Yeah of course it works, yeah."*

*Interviewer: "In what sense does it work?"*

*Steve: "Well, there's always going to be a percentage where someone's going to want that treatment, you know what I mean? They might be too shy to ask for treatment or too scared, you know what I mean?" (Steve, l.343)*

Steve's account highlights some of the barriers to treatment, why individuals may not access treatment and how coercion can overcome some of these. As Steve identified, participants reported feelings of shame, low self-esteem and low confidence which made them feel unable to change and too embarrassed to ask for help. In their research on the stigma of drug use and the impact this had on entry and retention in treatment, Radcliffe & Stevens (2008) found similar findings. Andrew, Steve, Alex and Dave explained how they weren't honest with their support network about their substance use due to the shame of their actions. They explained how, as they came to realise the extent of their drug use and the impact this was having on their lives, fear of failure and fear of judgement became a noticeable pattern. By realising the damages, they had done to their mental and physical health as well as to their relationships with family and friends, they became frightened:

*"Every day I was scared. It was all fear-based. I was scared of being honest; I was scared of being judged". (Alex, l.382)*

They described how these fears inhibited them from seeking support and addressing their substance use. Andrew, John, Alex and Dave recalled how, when they first accessed treatment, they were not able to trust anyone and could not understand why someone would want to help them; they did not feel they deserved the support they were offered and consequently did not believe it would work for them. John and Dave also reported fear of showing weakness to their peers, Steve feared the impact of his substance use on his physical and mental health; Tom felt ashamed, and Andrew lacked hope. However, coming into contact with the criminal justice system and being referred to drug and alcohol services took away the shame and embarrassment of seeking treatment by creating an opportunity for them to depersonalise the process and access treatment. John recalled wanting to address his drug use and how coercion provided him with the ability to not look weak in front of his peers and used it as something he had to do rather than being honest; stating that this was something he wanted to do:

*“Yeah, it was erm, I went there, I went there cos I was in court and you have to go there and I started going there, I started going there every week, getting more insight but I USED it also, I used the fact of the court as an excuse to go. So nobody can say... like... I’m just selling out, I wasn’t selling out but I was going, I wanted to get more insight. I also used it as, you can go there on your own free will without the courts. But I used the courts as the thing that I was going.” (John, I.365)*

His account coincides with Stevens and his colleagues’ (2005) findings that he was not necessarily ready or wanted to address his drug use, but the DRR created an opportunity which made him curious and made him want to explore opportunities without the fear of losing respect from his peers.

Amongst drug users, it is not uncommon for individuals to go through treatment on several occasions (Lindsell, 2017) and the fear of failing and the potential impact this may have on their reputation or relationships with peers may be damaged. I often have conversations with service user around some of the challenges they face when accessing their suitability for drug treatment and advise them of what to expect and steps to take to enhance treatment experience and outcomes. If they engage in treatment and want to address their drug use, the reality is that they will need to break ties with their peers as the nature of their relationship will be very different and could impact on their recovery and ability to abstain from substances. Although most eventually recognise that friendships are always based on drug use and that they are not friends but rather acquaintances, the prospect of being alone without any friends is very scary for them. Furthermore, there is always the possibility of failure. If they engage in drug treatment and are not able to succeed and return to drug use, there will be a sense of shame and potential retaliation from old peers (Radcliffe & Stevens, 2008). I have often heard service users say when they first access treatment that they would never leave their ‘friends’ and talk about peers who left them to engage in treatment and eventually came back to their circles, having failed in their treatment. Drug users’ views of their peers can be harsh, especially when they are still in the early stages of their drug using lives and have not experienced treatment. I always feel that they fail to understand the reasons why their peers needed to remove themselves from these relationship, and on occasions, that there is a sense of jealousy and envy in them. Having the opportunity to shift the blame onto the system rather than owning their decision as John described, provides service users with the ability to return safely, without the shame or guilt of having left peers or failed to address drug use should they relapse. In John’s case, he acted as if it was never his intention in the first place and was ‘forced’ to do it.

Marshall and Hser (2002) found that those coerced into treatment were less likely to recognise a need for treatment. However, this sense of shame and low self-esteem in participants from this research may provide better understanding as to why this may be seen as the case. Stevens and his colleagues (2006) identified, some of the participants from their Quasi-Compulsory Treatment (QCT) group “were not willing or able to enter treatment without a ‘push’ from the criminal justice system” (p.16). As per Steve’s explanation as to why coerced treatment works, Alex’s account below provides further insight into what it means to be a drug using offender, the challenges they face and why a push from the criminal justice system would enable access to treatment:

*“How do I pluck up the courage to open up and say I need some help? Cos even though I was at my last point... I was still with my pride and ego telling me ‘oh, you’ll be alright son, just have a drink’.” (Alex, l.37)*

He disclosed a sense of denial, despite being aware of the impact of his substance misuse on his life, where he tried to convince himself that it would be ok; not because he did not recognise a need for treatment but rather because being in denial was easier for him to deal with what was happening in his life. I regularly see this pride in my service users but it often masks fear and shame. Participants always have good awareness of the negative impact of their substance use but they are also aware of the struggles of treatment amongst peers who have tried to address their substance use. Many who started using substances recreationally, probably saw peers develop a dependence and the impact substance misuse had on them. I often hear how service users always thought that they would never become like that, yet, somehow, they had and felt ashamed as they had been warned and indeed had warned themselves. All drug users go through this sense of denial and shame, regardless of whether they are coerced into treatment (Radcliffe & Stevens, 2008). Through committing crime, it is likely that they have more shame as their offending behaviour may go against their values. All participants recalled an existence where they went against their morals and values. Tom for example recalled not feeling *“comfortable doing what he was doing”* (Tom, l.124) and explained how he used to take out phone contracts and sell them to fund his drug use which is something he was not proud of.

Participants recognised however, that engaging in coerced drug treatment enabled them to learn skills and gain knowledge to make positive changes and move away from substance use:



*“Got all the tools in the bag; it’s whether you want to use them or not. I’ve got all the tools in my bag. I might need a little kick up the arse to memorise and remember but I’ve got all the tools in my bag I’ve learnt already.” (Dave, l.281)*

From the previous sub-theme, we identified three types of individuals: those who have no interest in making changes and will accept a DRR but will never actually access treatment, those who accepted DRRs, engaged in treatment and made positive behaviour change but, in hindsight, were not ready, and those who accepted a DRR, felt they were ready and made positive behaviour changes. This leads me to believe that, regardless of whether they were ready, or motivated for the right reasons (i.e. to address and stop their substance misuse as defined by the participants in this research), simply being open to treatment and to change can lead to positive behaviour change. Participants often reinforced the importance of being ready for treatment and wanting to change, however, through their accounts, it became apparent that they had themselves been ready for treatment just by being open to treatment. As per my question earlier, what does being treatment ready mean and what does it look like? The simple fact that participants could sustain engagement and abstinence, although sometimes for a limited period of time, would suggest that being open to change, accepting and engaging in treatment for over a month, can lead to positive behaviour change and abstinence. John recalled an occasion when he started attending a programme at a time when he stated he was not entirely ready to address his drug use. He explained how, although he initially had a reluctant approach to the programme and questioned its need to examine drug using behaviours, he continued with the programme which eventually led to him making positive changes:

*“I took it on board and after that, that stopped after a while and I just got on with life so... that’s what I mean, it’s not the means of things like that it’s the actions that you take in order for you to, to stay away from that type of stuff. That’s what helped me.” (John, l.294)*

With regards to Ryan et al’s (2008) self-determination theory and concept of autonomy, these findings would support that controlled motivations do not lead to sustained behaviour change. As Alex identified:

*“But MY thing is you... you can do that for the time being when you first come into recovery but then after that you have to come out of the realms of recovery, and enter the real world and face the real-world cos that is what recovery is going to give you. Recovery basically, you can replace the word recovery with... time for self-*

*development. You have to develop on yourself, nobody's gonna come out of that ship like that, you have to work on yourself, then, go forward. That's how I see it." (John, I.373)*

As per my experience of working in the field and what I often say to my service users, John's quote reinforces that achieving abstinence is easy but maintaining it is more difficult (Biernacki, 1986). Maintaining recovery when an individual's motivation is misplaced (such as wanting to address its side effects such as ill health and imprisonment), it will not be possible to sustain abstinence. In participants' case in this research, this was true as it did lead to relapse and may answer the question of what being 'treatment ready' means: accessing treatment to stop using substances rather than addressing their side effects. Ready or not, treatment can lead, even for a period, lead to positive behaviour change.

*"I've gone in there a boy and come out a man... it really, really changed how I feel about myself and people around me." (Alex, I.385)*

The question is, can treatment address controlled motivations and turn them into autonomous ones? This will be further explored in the next super-ordinate theme.

#### ***Sub-Themes: Legal pressures***

There are often assumptions that individuals are forced into treatment and that criminal justice agencies make use of threats and pressures to encourage and keep them in treatment (Seddon, 2007). This notion of being forced and participants' relationships with criminal justice agencies was explored during the interviews. Andrew, John, Alex, Dave and Harry were on the Integrated Offender Management (IOM) scheme which would suggest that probation and the police would be highly involved in their management and rehabilitation (Senior, Wong, Culshaw, Ellingworth, O'Keeffe & Meadows, 2011). From their accounts however, they reported did not report feeling any pressure or threats from probation to engage in treatment or comply with the requirements of their order / license conditions, but some conveyed some negative feelings towards probation. Through their accounts however, it was unclear whether they understood what I meant by pressure or the type of pressure they experienced. From John, who stated that he felt pressure from probation, this appeared to be more related to verbal reiteration of the consequences of failing to engage in their order rather than pressure that consequently impacted on his behaviour:

*"At that time, when I was in knee deep into crime, and then... smoking drugs, I looked at it as erm, how can I say, I looked at it as a being forced so... I would say it was the thinking and the people that's around me that type of thinking so it was like a block, I*

*thought in a different way like thinking "I have to do this, it's the courts" I'm not thinking about it as it's there to help me, so I'm thinking of it in a negative sense, when you actually realise they're looking to help me... [...] they had a little bit of an impact on me but it also, whilst you're in the frame of mind of using drugs you, you think they're against you... they're against you [...] so when you don't do it cos you're caught up in smoking drugs you just go on the run. So it's just, it's just... it's just erm... just a funny way of thinking, I'm telling you. And it's madness..." (John, I.313)*

John's experience would suggest that he experienced some form of pressure but he is not explicit in his recollection that he received actual verbal threats from his probation officer or the court. It appears to be more linked to his personal interpretation of the process "*I have to do this, it's the courts*". As mentioned in the previous sub-theme, John used the courts as an 'excuse' to his peers to engage in treatment; he explained that he was intrigued about treatment and wanted to make a change but was scared. Telling himself that he had no choice in the process may have been his way of depersonalising the process and allow him to try, make mistakes and potentially fail. Through reflection, he recognised however that his probation officer and the courts were merely there to help him and, had he potentially been more receptive to their help, he may have been able to make more effective behaviour change.

Through my experience, service users often have a very distorted view of the criminal justice system and they are rarely willing to accept or recognise that agencies are there to support them and help them through recovery. Similarly, participants in this research described how they felt that everyone was "against them" (John, I.312) and Alex acknowledged the following:

*"I was lying, manipulating and I blamed the system for everything you know" (Alex, I.62)*

I have witnessed service users shouting and becoming verbally abusive when accessing treatment services. If they missed their appointments and were not able to be seen, or if they had been stopped and searched by the police for example, they would attend services and express their sense of injustice for being penalised for their lack of agreement with rules and regulations. Through their anger, they explain how they feel that they are being treated unfairly and victimised; they cannot understand why things are happening to them and feel that they deserved more. Service users appear to have a lack of understanding of the purpose of services and agencies in their recovery and fail to take responsibility of their actions – past or present. I often reflect this back to service users, how their actions and behaviours have led them to situations they find themselves in, the choices they have and the consequences of

their actions. Although this can be the more difficult side of my job and needs to be approached appropriately, service users tend to eventually accept and acknowledge responsibility in given situations and apologise for their behaviour. Drug workers are highly trained to manage difficult conversations and challenging behaviour; highlighting consequences and their choices are part of treatment to support individuals through their recovery. As John explained, *“I didn’t realise that every action has a reaction”* (l.135). Alex recalled similar experiences of probation whereby his probation officer was there to reiterate the potential consequences of failing to comply with his order. However, he was able to internalise this into a positive experience whereby this encouraged him to change his behaviour. When asked about the impact courts and probation had on him, he replied:

*“Probation and the courts, magistrates; they’re all good people, really good people... [...] They’re all good people and all they’re doing is trying to make sense of the carnage I caused. That was a deterrent for me, but I was sick and tired of being sick and tired so I had to really pay attention to what was being said to me.”* (Alex, l.559)

His, as well as John’s, account suggest that being challenged with the consequences of their actions had the potential to influence behaviour change rather than being perceived as threats.

Harry similarly recalled a good relationship with his probation officer who was supportive of his rehabilitation and how he went above and beyond his responsibilities to assist him in making positive changes to his life. In their research, Stevens and colleagues (2006) found that those entering treatment through criminal justice routes felt more pressure to be there compared to their voluntary group. They found however that this increased pressure was not felt by all. This could be further explained by Ryan et al’s (2008, p.3) self-determination theory which refers to individuals acting to receive approval or praise *introjection* and leading to positive, although not sustained, behaviour change.

Andrew, Steve and Dave on the other hand, did not report feeling any pressures of threats from probation, the courts or drugs workers. Steve in particular reported that, through all the times he had been through the criminal justice system, he had no insight into what the IOM scheme did due to his limited engagement with the police and probation, and described them as a *“waste of space”* (Steve, l.184). Dave identified that despite failing to engage with the drug treatment requirement of his order and only attending 17 appointments over a period of 12 months, he was not breached. This would suggest that he did not experience any threats and, unlike John and Alex, did not view criminal justice agencies as a deterrent. As mentioned

previously, figures relating to the completion of DRR orders are ambiguous and do not entail that an individual has successfully completed treatment or stopped offending. This has also been my experience in the field and I have witnessed inconsistencies in breaching processes from probation officers. With pressures from the government to meet targets against successful completions of orders, there are inconsistencies amongst probation officers in enforcing compliance with orders due to workloads and lack of resources (Hedderman & Hough, 2000). Dave's account appears to suggest that probation did not enforce the requirements of his order imposed by the courts. However, he was on the IOM scheme and, through my experience, it is possible that Dave's keyworker and the IOM team may have played an important part in Dave not being breached. There are several occasions when as drugs workers, we see progress and changes that service users make and we can argue with probation that an individual should not be breached. Whilst on a DRR, service users are regularly required to attend a court review within the first 16 weeks of their orders (Criminal Justice Act 2003) where their keyworkers and probation officers are required to provide a written progress report. Despite some noncompliance, those involved in service users' care can highlight progress made and positive, although sometimes small, behaviour change and encourage for an order to be maintained or extended. This therefore could suggest that the application of policies into practice fails to translate as efficiently as laws would lead us to believe. On the other hand, John and Alex reported being breached for their orders when they failed to comply with them. However, this was following breach of residential treatment. With regards to their and other participants' experiences on a DRR in the community, none explicitly made any reference to missed appointments or lack of engagement with services which should have led to breach proceedings being initiated.

This super-ordinate theme has identified that participants in this research accepted coerced treatment as a way to avoid prison, however, this did not necessarily entail that they were not ready and could still lead to positive behaviour change. As Stevens et al (2006) found, although Quasi-Compulsory Treatment (QTC) does not reduce or increase individuals' readiness to change, it can illicit behaviour change and provide individuals with opportunities to gain some insight into their drug use and learn skills to use in future. Wild and his colleagues (2006) found, social pressures are unrelated to engagement in treatment but is rather influenced by personal choice and individuals' ability to relate to the purpose of treatment. Participants in this research reported that, although they were not ready for treatment, they sustained engagement in treatment and were able to make positive behaviour changes. All recognised

that, despite not feeling ready to address their drug use, they were motivated to change some elements of their lives which had been affected by their substance use. As a result, participants were able to make positive changes to their lives and behaviours. The length of sustainment of these behaviour change was however varied. As discussed, individuals' internalisation of behaviours and values from treatment and criminal justice processes can contribute to sustained recovery and change (Ryan et al, 2008). This leads us to question whether treatment could potentially impact on individuals' motivation and encourage autonomous motivation. To answer this question, the following super-ordinate theme will explore whether controlled motivations can be turned into autonomous ones exploring what assisted participants in this research to enable positive behaviour change, both through coerced and voluntary treatment.

### ***Super-Ordinate Theme 2: Enabling Positive Behaviour Change***

In order to increase our understanding of how social, psychological and legal factors can impact on service users' motivation, this super-ordinate theme will explore what led participants to access treatment, whether coerced or voluntary. As participants described their failed attempts to address their substance use, this provided a detailed account of challenges they faced when they contemplated or initiated behaviour change.

#### ***Sub-Themes: Enough***

When describing what had led them to engage in treatment, participants explained how they had had 'enough'. The previous super-ordinate theme addressed how participants had had enough of being in and out of prison, however, through accessing treatment on a voluntary basis, they recalled other factors linked to their drug use that they also grew tired of. As they recalled their experiences, participants described the behaviours they had adopted as drug users and the fears that they experienced. All portrayed their deceitful and selfish nature as a drug user where they regularly lied to their peers, their families and themselves in order to sustain their drug use.

*"For me it was easy; she's there at home with my son, I'm up here giving a fuck about nobody, being selfish if you understand me. Being selfish, not really thinking about her, my kid, my family or whatever." (John, I.233)*

Through my work, I am often faced with the challenging question of whether my service users are being honest; honest about their reasons for missing appointments, for failing to fully engage in treatment. In my experience and as participants explained, these lies are to either manipulate situations to sustain their drug use or as a result of their fear; fear to appear weak to peers and fear of failure as described in the previous theme. As Longshore and Teruya

(2006) Reactance Theory explained how an individual may agree to something to restore their freedom by engaging in a related behaviour. As Alex explained:

*“I destroyed a lot of people’s lives because of my stupidity, lies and manipulations... All this crap I did, and I got a kick out of it” (Alex, l.274)*

Despite stating that he got a “kick out of it”, Alex recalled these experiences with shame and embarrassment. He explained how, when he was using, he could not see the impact his behaviour had on other people, but as he grew tired of his lifestyle, he came to recognise that this was not the person he had been raised or wanted to be. Participants explained how, as they grew older, they came to recognise how their drug use had led them to behave against their own values; do things that, under normal circumstances, they would never have done. However, at the time of actively using, they explained how they did not realise this or as John explained, that they simply did not care. As per my experience in the field and participants’ accounts, understanding what makes individuals reach a point in their lives where they have had enough and access treatment lays in their experiences as drug users; the impact of substance use on their lives.

In addition to going against their values, participants explained how the impact of their drug use on their physical health was also a contributing factor to them seeking treatment. As their substance use developed, participants reported their growing concerns about the impact of their substance use on their health and wellbeing. Steve described this as follows:

*“I really didn’t want to be a battery basically: to take gear [heroin] to liven me up. Because the meth [methadone] wasn’t holding me, it was just getting me out of trouble or getting that sickness feeling away but I’d still need at least three bags. My strength was going... I couldn’t lift things up, I was so tired. I was just like a battery and it wasn’t fair on me having to be that way.” (Steve, l. 149)*

Steve’s account provided some insight into his experiences; how his opiate substitute medication was just a way for him to not go out offending for illicit substances and to stop him from experiencing withdrawal symptoms. However, as the dose was not high enough due to ongoing use on top, his tolerance increased, and he still needed to offend to get illicit drugs or he would have experienced withdrawal symptoms. Using on top enabled him to function from one day to the next, to do simple life tasks. Steve could have easily returned to his treatment provider to ask for his methadone to be increased, however, the fear of being judged and shame of his actions stopped him from discussing this with his keyworker.

As per other participants, Steve also reported feelings of paranoia, depression and physical symptoms such as weight loss. Over the last 20 years, there has been a drive to promote the harms of substances to service users (Home Office, 1998) which has had a positive impact in raising awareness amongst service users as well instilling fear. Through my experience, the potential health related harms of their substance misuse are something that all service users face at some point or another (Stevens et al, 2005). Blood Borne Virus testing has become part of drug treatment and is offered to all individuals accessing treatment. Encouraging testing can often be challenging as service users fear the results, and the consequences of their drug use. Steve described his experience of having to get tested for blood borne viruses and how he often made up excuses not to be tested or avoid getting his results. Having to face the consequences of their substance use can be difficult, however, participants recalled how they reached a point where they could no longer ignore the strain they had put their bodies and relationships through and needed to face the consequences of their actions which led them to access treatment.

*“Cos I’m older now, I’m realising it can’t go on forever... life don’t go on forever... 10 years ago, I was younger... stupider...” (Harry, 1.87)*

As they got older, the impact of substances on physical and mental health become more strenuous. They realised that they could not continue at the same pace as they once did, it took longer for their bodies to recover from strains, and substance use was not as enjoyable as it once was. I often hear service users telling me how substance use is not worth it anymore. They often talk about the ‘chase’ of that first hit; the way they felt when they first used the drugs but have never felt again despite years of trying.

As Farabee and colleagues (1998) found, having had enough was participants’ reason for accessing drug treatment, enough of lies, manipulations, the impact of their substance use and the lack of positive side effects of their substance use. The negatives of substance use started to outweigh the positives.

### ***Sub-Themes: Goals and Aspirations***

Participants explained how having had enough and the negative impact of their drug use eventually led them to look to the future, wanting a better way of life, away from substance misuse and its associated consequences. What may have been their aspirations when they started using substances, if they had any, changed over time and participants recalled reaching a stage in their lives where they wanted something different for themselves, from their lives:



*“Just to get my life back on track and that, do you know what I mean? And... have a future goal, getting back on track and that [...] Just not wanting to be messed up badly”*  
(Harry, 1.55)

In some case, participants identified an event which had led to this realisation. Tom for example stated that being arrested was a wakeup call for him which made him realise that substance use was not a path that he wanted to go down. However, for others, it was more of an acceptance of their situation and where their life had led them and recognising that enough was enough and they could not sustain their drug using life. These aspirations appeared to play a key role in participants’ motivations to seek treatment and positive behaviour change. Best & Laudet identified that aspirations and hopes can enable individuals to prosper “Human Capital” (2010: 4). Despite the strain of their substance use, participants came to realise the opportunities that were available to them and aspired to better life prospects:

*“I want a better quality of life, I want a quality of life that’s going to be able to, so I can support my son and myself; live my life, see my family and let the child grow up with love around him do you understand?”* (Dave, 1.525)

They started to realise that there was more to their lives than just using substances. In my work, I often see service users recalling similar experiences, explaining the impact their substance misuse has had on their lives and finally wanting a better life for themselves. Andrew, Dave and Harry identified family and friends as playing an important part in this. Andrew explained how he had nothing to live for, nothing to look forward to until he met his partner. He described how this made him realise he had not had an ‘adult life’ due to the cycle he had been caught in and brought on aspirations to have a job, house; a normal life and led him to access treatment:

*“My girlfriend kept me out for 16 months and that’s good going for me. Usually I’m out for a couple of weeks and away for a couple of months. [...] I got a life now. Still got arguing and things like that, every relationship, you know what I mean, but it’s a life. Something I’d never thought would happen again, you know what I mean...”*  
(Andrew, 103)

Harry described a similar experience when he met his partner and developed aspirations for a better life with her and for her. Through Andrew, Dave and Harry’s accounts, family and significant others were identified as important aspects in enabling them to access treatment. However, John’s experience provided a different aspect relating to the impact families and friends can have on individuals’ recovery. He explained how he had previously been in a stable

relationship with his partner whom he lived with, with their son. However, this simply enabled him to continue using substances. The important difference between John and Andrew's experience was that John, at the time, had not reached a stage where he'd had enough of his drug use and lifestyle, he was still enjoying the effects of drugs and its associated lifestyle. Whereas Andrew, as he explained, felt that he did not have anything to live for and had given up on his life until he met someone who showed him what life could be like, what he could have which was more important and more rewarding to him than substance use. John's subsequent experience provides similar insight whereby imprisonment assisted him in making positive changes:

*"When I'm in there, now my head is completely clean and clear. Then there is the fact that I want to be clean and clear so I'm going to listen to people." (John, I.545)*

His account highlights that it is not only the fact that he was in prison (or in a relationship) that supported him to access treatment, but because he wanted this for personal reasons. Through my experience of working in the field, I often hear service users accessing treatment or making positive changes because of pressures from close ones. However, one of the things I always say to them is that they need to make sure that their relationships are not the primary reasons for them wanting to address their substance use as this will not sustain behaviour change. When someone is using substances, and experience the ending of a relationship or goes through a difficult time, it is very likely that, as a coping mechanism to deal with these, substance use will be the first result or side effect. A common reason for this in my experience is that service users have not learnt other coping strategies to deal with emotions or with sometimes. As mentioned previously, service users often start using substances as a way of numbing their emotions and avoiding reality. It is likely that if someone stops their substance use for someone else, if difficult time arise or the relationship ends, they will resume their substance use to avoid dealing with their emotions if they have not learnt the skills to deal with them. The next sub-theme will provide more insight into why this may be.

### ***Sub-Themes: A Need for Competence***

Participants addressed what it means to be a drug user, the challenges and fears that they faced. As they recalled their experiences, they spoke about the challenges of treatment and described recovery as a long and hard process where change takes time. The focus groups explored the challenges participants faced to access treatment and maintain abstinence and the interviews identified similar themes and can provide a further understanding of how legal, social and psychological factors can impact motivation and improve experience and outcomes.

*“Just to get my life back on track and that, do you know what I mean? And... have a future goal, getting back on track and that [...] Just not wanting to be messed up badly”*  
(Harry, l.55)

There was a sense of desperation in Harry’s voice in this account, despite being stable in treatment at the time of the interview, there was a sense of fear that he could return to this lifestyle, something he was working very hard to ensure did not happen. He appeared desperate to get his life back on track, desperate to have a future which did not entail fear and deceit. I have seen service users in Harry’s situation where their lives have been taken over by substances again and again. It is easy for service users to return to substance use and this can have a devastating impact on them. Despite being motivated and desperate to change, substance use appears to force them to sustain behaviours that they don’t like seeing in themselves. As such, they hide away their shame, their fears and themselves through sustained drug use by numbing their emotions. However, through increased competence gained from treatment (coerced or not), participants explained how they learnt from their experiences and increased their self-confidence to continue with their treatment and recovery as opposed to giving in to their fears.

Self-determination theory identifies competence as an important aspect of treatment to encourage and sustain engagement in treatment (Ryan et al, 2008). It addressed the importance of service users’ developing and having the confidence and competence to change. Participants in this research talked at length about the difficulties they faced but also about the skills they learnt through treatment to enable them to overcome these and sustain their recovery. Despite this being a lengthy process, participants described how increased competence continued to enable them through their recovery.

*“First time around was a learning curve for me. I was building my... I think I was building my foundations on sand and it kept crumbling. But the older I got, the more time spent in recovery... it started to get more solid [...] But I really, really wanted to genuinely make a difference to change.”* (Alex, l.365)

Alex’s account shows that to be stable in recovery and maintain abstinence, he had to build strong foundations which was not an easy process and took time despite his motivation and dedication to change. Participants highlighted how each treatment experience provided them with additional skills to build these foundations of recovery; the more times they accessed treatment (coerced or not), or spent in treatment, the stronger their foundations became and they were consequently able to sustain abstinence. In my experience, service users often

access treatment, engage for a little while until they feel that they have learnt enough to be able to sustain abstinence on their own and leave treatment. However, as they have not completed treatment and failed to learn and gain all the skills needed to effectively reintegrate into society and sustain abstinence, they relapse and eventually come back into treatment. This was Harry's experience over the years. He recalled several occasions when he was engaging in psychosocial interventions and prescribed opiate substitute medication and how this made him feel better and think more clearly. Thus, he wanted to rapidly detox from prescribed opiate substitute medication and finish treatment. However, on each occasion, he relapsed shortly after and eventually returned to treatment a few months later. During his interview, he could reflect on his previous experiences and recognise the importance of psychosocial interventions alongside opiate substitute medication.

There are a lot of factors that need to be taken into considerations for service users when engaging in treatment, the difficulties of becoming abstinent and the life changes required to make treatment effective. As identified in the focus groups, most drug users have been in a cycle of drug use and offending behaviour for some years and it will take time to change these learnt behaviours (O'Brien et al, 1998). Service users have often been using substances since their teenage years and, as Steve explained, coping mechanisms and emotions were not fully developed which means that treatment will not simply be about addressing substance use but about learning how to deal with situations, feelings and reintegrating back into society:

*"it's not just stopping, especially when you're in a certain type of lifestyle cos obviously I was in a certain type of lifestyle and that means I didn't develop correctly so I had to do a lot of development in order to, to beat certain behaviours." (Steve, l.141)*

Through my experience in the field and participants' accounts in this research, it became apparent that individuals learn through their experiences: lapses and obstacles they face. Not everyone will respond to challenges in the same way so they cannot learn everything at once from a book. They need to learn about themselves, the way they react to experiences, their feelings, their reasons for using. For some, these are not things that they have experienced before, as teenage years were spend using substances and escaping reality through drug use. To do this, mistakes need to be made for them to learn. Through treatment, I always support service users to reflect on mistakes, lapses, experiences, as this enabled them to understand what led to these being made and ensuring that, should they find themselves faced with a similar obstacle in the future, they will have the skills and knowledge to make a different choice. These mistakes can however, be experienced by individuals as failure which could lead

back to drug use. Competence and confidence to change will support individuals to overcome these obstacles and fears in a positive way and sustain their engagement in treatment.

John's experience provides further insight into the important of competence and confidence in positive behaviour change. As identified, he had an important status amongst drug users in his community and felt that engaging in drug treatment would damage his reputation. Through his accounts, he reported feelings of safety and security amongst his peers; *"I didn't just take drugs, I took drugs to be part of something"* (John, l.107). He explained how this community stopped him from being able to recognise the impact of his substance use but also to gain the confidence to successfully address his substance use. He described however, how drug treatment in prison enabled him to increase his competence:

*"Sometimes you've just got to get yourself AWAY from certain people and their thinking cos the drug game is, is... the drug game you can easily... I believe that you can easily follow, follow everybody ideas."* (John, l. 92)

This shows that, whilst in the community, he was not able to really think about what he wanted for his future or recognise how his substance use went against some of his values. He followed his peers and did not appear to be able to think for himself. His spell in prison provided him with time away from his peers and substance use where he could engage in treatment. Thus, he was able to reflect on his life and experiences, explore what he wanted for his future which was to move away from substance use and become drug free, and gained skills and tool for change.

Through their accounts, participants shared the difficulties and fears they experienced as drug users. It provided an insight into the reasons why individuals come to access treatment on a voluntary basis and what it means to have 'enough' but also how substance use can hinder access to treatment. Through the development of goals and aspirations, participants were able to access treatment and overcome their fears. However, it became evident that fears could continue to impact on sustained engagement in treatment. These were either the same fears they previously had or new fears they were facing through their recovery such as fear of failure and losing everything they had gained through treatment. By developing confidence and competence through treatment, participants identified that challenges and fears became easier to deal with and consequently enabled them to develop skills to effectively address concerns to sustain engagement in treatment which is congruent with self-determination theory (Ryan et al, 2008). This would suggest that an important aspect of effective treatment

is to provide service users with the skills and knowledge to increase competence and confidence to change. The next super-ordinate theme will explore some of the importance of self-determination in positive behaviour change and further explore other aspects of treatment participants identified as invaluable in leading to behaviour change.

### ***Super-Ordinate Theme 3: Self-Determination***

Participants' accounts of their experiences of drug treatment, both coerced and voluntary, identified elements which assisted as well as hindered their ability to access treatment. Through the interviews, I further explored elements that supported participants in maintaining engagement in treatment and through their recovery. Self-determination was identified as an important aspect by all participants in sustained behaviour change. It is important to highlight at this stage however that participants were still going through their recovery, had not fully reached abstinence (i.e. from prescribed medication) and were still engaged in tier 3 treatment at the time of interview (NTA, 2006). This nuance is important to bear in mind through these accounts as they may differ from individuals who have completed treatment and have fully reintegrated back into their communities.

#### ***Sub-Themes: Autonomous Motivation***

In their research on partnership working and access to drug treatment, Best, Beswick, Hodgkins and Idle found that effective retention was "linked to the extent to which clients actively 'buy-in' or engage in the therapeutic process" (2010, p.367). Through participants' accounts, it became evident that, to initiate positive behaviour change, they must want treatment and be open to change for treatment to be successful.

Self-determination addresses the process through which an individual acquires motivation for positive behaviour change. It recognises autonomy as an important element to internalise and integrate motivations to sustain behaviour change. Ryan and his colleagues (2008) explained that, to sustain change, individuals need to personally endorse the importance of positive behaviour change and value them. These were elements that participants similarly described in their experience of change. As identified in previous themes, being 'ready' was an important aspect that all participants identified as key in accessing treatment. We explored what it means to have had enough of substance using lifestyle, the fears and challenges that service user experience and identified that need for an individual to be ready to make changes to their lifestyles, for one reason or another. Participants recalled how they had developed an awareness of the impact their drug use had on their behaviour and life and started to actively seek support and treatment to change for the better.

*“I wanted this, you know the same craving I had for substances it the same I have for the programme. I was desperate, not just desperate, I was willing to go to any lengths, any lengths to get clean, to change, and to be a better person. Not for anyone just for myself you know?” (Alex, l.488)*

This account is a very powerful insight into Alex’s motivation to become abstinent and move away from substances one might have. It reinforces some of the challenges and fears discussed earlier and the lengthy process recovery entails, it’s not just achieving abstinence, it’s maintaining this. Alex’s tone transpired a sense of desperation and determination; this was something that he really needed in order to survive and something that he really wanted for himself, for his life: a future, a better life. As addressed, participants explained that to maintain abstinence, sustaining engagement in treatment to learn skills and tools to address challenges is very important.

*“You have to want to change, or that seed’s got to be planted. That seed was planted in me for a long time but I just went the other route” (Alex, l.104)*

Alex’s statement provides some insight into the importance of autonomous motivation and how this needs to be something that individuals want for themselves, whatever the motivation behind wanting to change might be. He went on to explain how, despite having an awareness of the impact of his substance use for some time, he initially chose to ignore this as he did not feel they were important now. Andrew and Dave’s experiences discussed earlier showed that as they were not motivated to change when they accepted a DRR, they did not engage in treatment and did not make any changes to their behaviour. John and Steve reported accepting treatment for what transpired to not be the right reasons which led to them adopting positive behaviours to gain praise from others and to avoid punishment but resulted in early treatment exit and relapse. Congruent with self-determination theory (Ryan et al, 2008), controlled motivations were found to not sustain positive behaviour change amongst participants in this research.

Participants’ experiences highlight the importance of endorsing change and to value this. As a drugs worker, I often addressed service users’ values, explore the pros and cons of their drug use to enable them to develop autonomous motivation. However, through my experience, this is only the first step of treatment and something that I never really revisit when individuals sustained their engagement in treatment. I am unsure if this is common practice but, because of this research, it is something that I will take forward with my staff to ensure that motivations and “buy-in” are sustained through treatment (Best et al, 2010, p.7). As human beings, our

values and priorities change regularly, it is therefore important to ensure that the benefits of treatment through autonomous motivation are maintained through treatment by reviewing values regularly. Following the introduction of the latest drug strategy (Home Office, 2010), strength based assessments became increasingly popular, holding recovery capital as an important element in guiding individuals' values and beliefs which would suggest that, for the participants in this research, they would enhance sustained engagement in treatment and recovery (Best & Laudet, 2010).

*"It's not gonna work unless you want it to work, that's point blank. It won't work unless you want it to work." (John, I.572)*

All participants were very clear that, to make changes to their lifestyles and stop using substances, they needed to have some form of motivation. They identified that both autonomous and controlled motivations could lead to positive behaviour change. However, the length of sustained behaviour change appeared to be the denominating factor between these. It is important to highlight that, at the time of interview, participants were still going through their recovery, not all had reached abstinence and all were still engaged in Tier 3 treatment (NTA, 2006). Despite displaying motivation, it is possible that at the time of interview, some may have only been engaging in treatment as a result of controlled motivations and not realised or recognised this. John for example, at the time of interview was actively fighting for custody of his son who had recently been removed from his custody due to his drug use. A condition of him being able to work towards having his son back in his care was that he engaged in treatment and maintained abstinence. When asked how much of a factor this was in him engaging, he denied that this played any part and stated the wellbeing of his son as the key factor to him engaging in treatment. Although he may well have believed this was the case, through my experience and as I listened to his motivation to engage in treatment, I had doubts about whether this truly was autonomous as opposed to controlled motivation. At the risk of sounding cynical and wishing ill on the participants of my research, John's motivation appeared to be mainly driven by external factors; his son and not wanting him to lead the life he had led. In contrast to other participants, he was the only one who failed to display internalised motivation. Furthermore, he had an important status amongst his peers and although he was no longer in that circle, this still appeared to provide him with a sense of pride. As he recalled his experiences, it was apparent that he had changed through the years, learnt about himself and grew as a person. However, I was left feeling that he had become a more respected drug user amongst his peers and continued to be notorious which continued to remain important to him.



Most participants thought they had previously been ready to address their substance use when they accepted coerced treatment. However, through treatment, time and experience, they were able to reflect and articulate what went wrong and recognised that they were actually not ready. Through their interviews, participants reported being ready, they compared their previous experiences to their present ones in the past and what had changed for them this time around. However, it is possible that they still had some learning to do and despite appearing to display autonomous motivation, could disengage from treatment later. That having been said, it was apparent through participants' experience that autonomous motivation led to sustained engagement in treatment.

### ***Sub-Themes: Stability***

In addition to autonomous motivation, stability was identified by participants as an important factor in their ability to achieve sustained positive behaviour change. Participants described the need for a stable environment such as housing and structure to maximise the success of their treatment. John was only able to fully address his substance use when he was in prison as this provided him with the space, as well as the stability, he needed to fully immerse himself in treatment without having to think about his social status, cooking, cleaning and paying bills. Andrew, Alex and Harry recalled losing their accommodation whilst using substances due to the poor choices they had made in their lives. Gaining stable accommodation marked a turning point in their ability to make positive behaviour change and to sustain engagement. They explained how this enabled them to fully engage in treatment without having to worry about where they would sleep that night but also as something that was motivating them now as they did not want to lose it again. When asked what the main motivating factor was in keeping him engaged in treatment, Andrew was very clear and did not hesitate:

*“Hostel. Don’t want to lose my hostel. I know me and my girlfriend drink together but my hostel, got to spend 4 nights there, 3 nights...well, no 3 nights, 3 days with my girlfriend, go home to my hostel at night. That’s what’s mainly keeping me quiet.”*  
(Andrew, I.80)

Best & Laudet (2010, p.4) dubbed this part of “Human Capital” whereby an individual can gain tangible assets such as property and money. As discussed in the previous themes and in the focus group analysis, treatment enables participants to rebuild their lives which plays an important role in building one’s recovery capital (Best & Laudet, 2010). The fear of losing the stability they had gained played a very important role in keeping participants in this research

engaged in treatment. Treatment assisted them to gain accommodation and in turn improved their autonomy by valuing this.

Through my experience of working with drug using offenders, stability has always been at the core of holistic treatment delivered. For an individual to be able to fully engage and commit to treatment, it is very important for them to have access to stable accommodation. If an individual is sleeping rough each night, it is likely they will not sleep well and their ability to engage or retain information from key work sessions or groups programme will be difficult. Furthermore, as recovery requires individuals to make changes to their lifestyle, their ability to do so will be dependent on where they stay and their surroundings each night and will be difficult if they aren't in a stable environment. If an individual is staying on a friend's couch but their friend is actively using, or they have to commit crime to pay their friend for letting them stay, this will further hinder their ability to engage in treatment. Andrew recalled how stability positively impacted on his offending behaviour. As he no longer needed to get money to pay his peers to stay with them, he stopped offending and in turn was able to achieve abstinence from illicit drugs. Participants in this research and the service users I have worked with are very clear that if they need to offend for food, to pay friends for accommodation etc., they will always make a little bit more to buy themselves drugs as money is often a trigger for them to want to use substances.

As a substance misuse practitioner, if an individual has unstable accommodation, our first steps to engage the individual in treatment would be to support them in seeking accommodation. Similarly, when assessing individuals for drug rehabilitation requirements, it is more often than not that we would find them not suitable for a DRR if they do not have access to stable accommodation. It would be made clear that although they were suitable for drug treatment, their unstable accommodation makes them unsuitable for a DRR at that stage unless the courts or probation are able to support them in gaining accommodation. There have been occasions however when either individuals, or their solicitor, informed the judge / magistrates that they had found stable accommodation which led to the order being granted. Unfortunately, the majority of the time, this was not true and led to individuals breaching their orders as they weren't able to comply with their requirements, and being sentenced to imprisonment. It is therefore imperative for drug using offenders to have access to stable accommodation in order to initiate, let alone sustain, positive behaviour change.

In addition to stability in relation to housing, Harry identified stability in keyworkers as an important factor in his sustained engagement in treatment, or a cause for previous lack of engagement. He discussed the impact regular changes in keyworkers had on his ability to

engage in treatment as he had to build new relationships with workers and explain his story again. As the service manager of a drug and alcohol service, this is something that has often been brought to my attention through service user feedback. Service users feel that changes in keyworkers produce delays in their recovery and are obstacles to them achieving their goals. I always make sure that I bear in mind the impact inconsistency and changes can have on service users and their recovery. Having recently been through the reconfiguration of treatment services in two different boroughs, I have been able to experience first-hand the impact these disruptions can have on service users in terms of their access to treatment but also their sustained engagement. Service users can be resistant and need to adapt to changes that are being presented to them. Change management often concentrates on staff and is taught to line managers. However, there are benefits to practitioners understanding change management to enable them to support service users through these. As described by participants, stability is an important aspect in their recovery and should be approached carefully and addressed effectively within treatment services.

#### ***Sub-Themes: Relatedness***

A strong support network was also found to be an invaluable factor in the success of sustained behaviour change. This network was found to be through family and friends, peers or drug treatment keyworkers. As addressed in the previous super-ordinate theme, when asked what was keeping them in treatment, Andrew, Dave and Harry stated that their girlfriend had a big impact on their sustained engagement. Tom similarly indicated his family and John reported his son as influencing behaviour change. Stevens and his colleagues (2006) found, perceived pressure from friends and family appears to reduce readiness to change and consequently positive treatment outcomes. The differences between our findings may be due to participants in this research not experiencing pressures from their families or partners but rather developing autonomous motivation to sustain these positive relationships. Participants did not report feeling pressures from partners or family members. Had they been given an ultimatum to address their substance use however, this may have had different outcomes.

In addition to relationships with families and loved ones, the support network service users build with their peers through treatment was also identified as a very important factor in the success of their treatment.

*“One of my friends who... is erm... John is a good friend, we support each other you know? And he’s been a rock to me but there’s been a few other people who are classed as family, not cause we’re blokes but... sometimes... [sight]... erm, I don’t open up as*

*much to family as I do to close friends who are also in recovery, past criminality or addiction but when we have groups and we're talking and engaging with things, it brings out the best in me and you know." (Alex, I.144)*

Alex's story provided some insight into the unique relationship and support peers can provide. We previously explored the fears and challenges service users and participants in this research face (Radcliffe & Stevens, 2010), and Alex's experiences highlighted the support peers can give each other by being able to share experiences, successes as well as failures, and continuously encourage each other by reminding one another of their values and the reasons they are engaging in treatment. I previously reflected on the importance of reviewing values and reasons for individuals' engagement in treatment on a regular basis which this theme further demonstrates their benefit. By building a positive support network, participants explained how they could get support outside of their appointments from peers which was invaluable. Drug and alcohol service are mostly open Monday to Friday, from 9am until 5pm; on average, service users see their keyworkers once a fortnight but can engage in group programmes daily. This leaves a lot of time outside of their treatment to sustain their motivation. Participants identified that building a strong social network was another source of support when their keyworkers were not available to continue to learn from and reflect on experiences, and progress through their recovery. When looking at individuals' experiences and lives prior to drug treatment, John identified a sense of community with peers in his cycle of substance use and offending. It is therefore not surprising that the close and supportive network they build with peers through treatment became an invaluable factor in their sustained engagement in treatment. Alex continued that he called his support network his "*family*" (Alex, I. 392), unlike the rest of the participants, he explained how he did not have much contact with his family because of his drug use and his only source of support was through his peers. In their research, Dingle, Stark, Cruwys and Best (2014) explored a social identity approach to improve health and wellbeing. They found that following entry into treatment, participants' sense of belonging within treatment groups significantly increased and continued to increase through treatment, therefore having a positive impact on their health and wellbeing. Participants in this research similarly expressed how they felt that they could share experiences with peers without fear of being judged. As identified in the second theme, fear of judgement was an important factor which hindered their ability to access treatment.

Participants also identified their relationship with keyworkers an important aspect in sustaining recovery. Having a keyworker who will have a non-judgemental approach and who

they could trust was invaluable to them remaining in treatment, especially through the hard times (Fiorentine et al, 1999).

*“It’s all down to Tom cos Tom directed me the right way [...] I have respect for him, for what he’s done” (Alex, l.244)*

Keyworkers enabling participants’ choice in their treatment was also identified as an important factor. Andrew and Harry recalled occasions when their preferences were not sought prior to their treatment provision which led to negative experiences of treatment. Similarly, Stevens and his colleagues (2008) found that constrained treatment choices were linked to early treatment exit. Harry recalled struggles with his prescribed medication and explained how the doctor did not want to change his prescribed medication from liquid methadone to the tablet form (Physeptone). He explained how his keyworker at the time assisted him in preserving with his drug treatment programme:

*“Getting Laura as a keyworker kind of helped me cos I suppose with all the dramas going on, I would have just thought ‘fuck it man’. I would’ve just gone back to the way I was living.” (Harry, l.240)*

Relatedness, according to self-determination theory, plays a very important part in motivation which these findings have echoed (Ryan et al, 2008). Participants’ ability to relate to others, feel comfortable and not judged were identified as invaluable factors in their sustained engagement in treatment and ability to progress in their recovery. Several participants could recall poor relationships with keyworkers in the past which often led them back to drug use. Marlowe and his colleagues (1996) recognised in their research that strict keyworkers exerting threats often triggered drug-seeking behaviour which was shared with most participants. However, Alex recalled a positive relationship with a probation officer who he reported being stricter. It is important to highlight that Alex had been in the army and was used to authority and structure which he reported thriving on. For him, this type of relationship was effective. As identified so far, all service users have different values and what works for one will not always work for everyone. The concept of relatedness can assist us in further understanding these behaviours and highlight the need for nurturing it through treatment programmes to maximise outcomes according to individuals’ characters, goals and values (Ryan et al, 2008).

For the participants in this research, drug treatment and coercive treatment needed to be conducive to an environment where they were comfortable, with people they could trust and share their experiences and struggles, without being judged. Congruent with Self-Determination Theory (Deci et al, 2000), the notions of autonomy, stability and relatedness

played a very important part in their motivation to sustain positive behaviour change. Through exploring participants' experiences, both previous and current, it became apparent that for positive behaviour change to be sustained, autonomy and relatedness cannot be addressed in isolation to sustain behaviour change.

#### ***Super-Ordinate Theme 4: Recommendations***

All participants were asked for their views on how coerced treatment could be improved. In addition to the benefits they experienced and described in the previous themes, John and Alex also expressed how they felt the criminal justice system should be harsher towards drug using offenders and limit individuals' ability to sustain their drug using life.

##### ***Sub-Themes: Harsher sentences***

John grew up in the United States and throughout the interview highlighted differences between the British and American systems. He strongly felt that the British drug policy enabled drug users to continue with their lifestyle due to the lengthy treatment programmes and lack of consequences for continued drug use. He felt that drug treatment, and opiate substitute prescribing should not be allowed to be sustained over a long period of time but rather reduced from the outset over a limited period. As we have seen through participants' experiences, becoming drug free is not the difficult part of recovery, sustaining self-determination and not reverting to old behaviours is the most challenging aspect. Through a rapid detoxification programme, John felt that individuals would take their recovery more seriously and make less excuses to revert to old behaviours or sustain illicit substance use on top of their prescribed medication. He also explained that community treatment was not conducive to change and felt that treatment in prison would provide individuals with the environment and stability needed to elicit positive change. He suggested longer custodial sentences for offences such as shoplifting which are most often linked to substance misuse. His reasoning was to enable individuals to have enough time to make changes and learn from treatment. However, in my experience, although prison programmes can be effective in eliciting change and support individuals to reach and sustain their recovery, once released, it is very difficult for them to sustain their recovery. As drugs workers, we often see service users going through detoxification programmes whilst in prison and sustaining abstinence effectively through their sentence. However, following release, due to lack of stability and resources such as access to housing and benefits for three to six weeks, they relapse as they resume relationships with old acquaintances who are able and willing to offer them support such as money or somewhere to stay in exchange for drugs. As described by participants across

all themes, being released into the community without stable accommodation, not having their peers around them, and having to adapt to a change of lifestyle are each conducive to relapse or disengagement from services. This would suggest (and has, in my experience) that, regardless of the potential quality of prison treatment, individuals will be prone to relapse as it will hinder their positive behaviour change. In order to make prison programmes as effective as John's recommendation, there would need to be appropriate provision that enabled service users to have access to stable accommodation and benefits from the day of their release.

### ***Sub-Theme: Early Intervention***

Alex expressed similar feelings towards the criminal justice system and drug policy. He explained how he felt the government should be harsher with drug using offenders, to force them into treatment and impose change on them by reducing the availability of prescribed medication. When asked what harsher sentences would look like, he was not able to provide examples. However, he also suggested the need for recovery to be instilled into people from an early age. He explained how his involvement with the Narcotics Anonymous fellowship enabled him to reflect on his life and become a better person. He explained how this journey of self-discovery and self-respect should be shared with children from a young age to assist them in learning important life values and to give them the skills to never fall into substance misuse.

*"Personally, I take my hat off to any person engaging in the programme who are just trying... Like I said, if you don't try, you're never gonna know." (Alex, I.537)*

The findings of this research have been useful to help us understand drug using offenders and how coercion and drug treatment is experienced. Participants' experience recommended treatment to be conducive to the promotion of competence to increase self-confidence and learn skills, relatedness to enable relationships with peers, autonomy to ensure they value the changes they are making to their lives and stability to promote a safe environment where they can grow. It was felt however that the prescribing of substitute medication could be changed to encourage service users to develop autonomous motivation. The next chapter will provide a conclusion to this research by linking the aims of the research to these finding and provide recommendations for practice and future research.

## Chapter 4: Conclusion

This research has addressed the issue of coercion in the development of substance misuse management and the way in which it has come to be embedded in a dominant crime control approach. It identified that the foundations for this change lay in the perceived links between substance misuse and crime. However, this link is complex, heterogeneous and lacks clarity with respect to our understanding of the nature of coercion and has become discredited by researchers. Despite this, the use of coercive measures has continued to be a leading choice in the management of substance misuse which has given rise to debates regarding ethics and effectiveness. This research has promoted the importance of the nature of coercion and its definition, and elements of motivation and self-determination in the evaluation of the use and effectiveness of coercion. My experience in the field and the use of Interpretative Phenomenological Analysis enabled a grounded understanding of individuals' experiences, giving them meaning and provided some insight as to how the delivery of coercion may have impacted our evaluation of its effectiveness. It contributes to research to date by enhancing our understanding of coercion by exploring how it is experienced by drug using offenders and highlights its benefits in the management of substance misuse. Avoiding prison was the main reason why service users accepted coerced treatment. However, this did not mean that they weren't motivated to address their substance use and often led to positive behaviour change. Participants did not report experiencing any threats to engage in treatment but identified the challenges they faced as a result of the side effects of their substance use. Psychological and social factors greatly impact on their self-confidence and ability to access and engage in treatment. Motivation alone was not seen to be sufficient in supporting service users to engage in treatment. Treatment services must create an environment which is conducive to increasing competence, autonomy, relatedness and stability to enhance sustained engagement and recovery.

The first aim of this research was to explore service users' experience of coercion as a means of substance misuse management and crime control. This research found that, in the London Borough of Hackney, to avoid prison was the most common feature amongst participants. However, this did not necessarily entail that they were not ready for treatment. Participants described the impact of their substance use on their lives which eventually led them to positive behaviour change, having developed goals and aspirations for a better future. Some participants however, acknowledged that in the past, they had accepted coerced treatment to continue their drug using behaviour which was congruent with Longshore & Teruya's (2006)



Reactance Theory. Participants also described their motivations to avoid prison to address the impact of their substance use, regardless of whether they were ready to reduce or stop their substance use. They explained however, that prison was not a deterrent as it had benefits such as easy access to illicit substances, time away from substances, a roof over their head and regular meals. This research found that, if they were open to change, coerced treatment could have a positive impact on behaviour change and lead to reduced substance use and offending behaviour. The length of time this was maintained for however varied from weeks to years amongst participants. Coerced treatment was identified by participants as a gateway into treatment services which enabled the delivery of information about services available, advice around the effects of drugs and how to use these safely. With regards to threats and pressures, participants did not perceive any from criminal justice agencies to engage in treatment and reported making an informed choice to engage in treatment. Inconsistencies however were identified in breaching procedures which would lead us to believe that despite the aims of the government to enforce coercive measures, these are not consistently applied due to targets and work pressures (Hedderman & Hough, 2000). With regards to the Public Health Outcomes Framework (Department of Health, 2013b) which is becoming an important aspect of substance misuse management, coerced treatment had a positive impact on participants' health in reducing risks of the transmission of blood borne viruses, sexually transmitted diseases and overdose.

The second aim of this research was to understand how social and psychological factors impact on service users' experiences of legal coercion. Participants reported feelings of shame and fear as substance use made them go against their values and described how these stopped them from accessing treatment. Fear of failure, low self confidence and self-esteem were identified as important traits which prevented them from accessing treatment and seeking support. However, they explained how accessing coerced treatment supported them to put these feelings aside and successfully engage in treatment. Whether this was through controlled or autonomous motivation, participants identified how treatment subsequently enabled them to address these fears and challenges and no longer be guided by them. Participants also identified how developing hopes and aspirations of a better life for themselves and looked towards a future where they could be free from substances supported them to sustain engagement in treatment. This resulted from having had enough of the impact of their substance use on their lives or developed through treatment which led to positive behaviour change. Participants reported that access to treatment provided them with the

ability to gain and sustain stable accommodation which played an important part in their sustained engagement in treatment, in line with their aspirations for their future.

The third aim of this research was to explore service users' views of what makes treatment effective. Primarily, participants in this research reported that coerced treatment enabled them to learn skills to make changes and increased their motivation to change which led to abstinence. This research found that, even if individuals are not ready to address their substance use or stop using, access to treatment will provide them with skills that they will benefit from to enable positive change in the future, such as reduction in drug use and offending and increased motivation to change, when they are ready to change. The police and courts' ability to refer individuals for interventions and treatment in this setting have therefore been found to be elements of coercion which enable effective substance misuse management and crime control as it provides access to harm reduction and relapse prevention interventions, which increases motivation and in effect improves health, reduces crime and enables change. Other factors which were identified to contribute to sustained engagement in treatment were stable accommodation and an environment where service users could relate to peers and not feel judged. Treatment which is inductive of relatedness and autonomy were identified as invaluable to increase the sustained engagement of coerced treatment and recovery. Positive relationships with peers and keyworkers were found to play an important role. It enabled participants to relate to others, not feel judged, be comfortable and honest, having somewhere to share experiences with peers. This supported individuals to expand their autonomy by learning skills and increase their competence by having the support and faith of peers and workers, to sustain their recovery and achieve goals. In contrast, poor relationships with keyworkers and peers appeared to make coerced treatment less effective.

The fourth aim of this research was to evaluate the terminology of coercion in research and policies according to service users' experiences and perception. As discussed, the definition of coercion entails that individuals are unwilling, forced into drug treatment and perceive threats if they failed to comply. This research found that this was not the case for participants in this research. In this setting, imprisonment was not a deterrent as it became apparent that substance use could be sustained in prison with the added benefit of being fed and having a roof over their head which elicits an element of choice as opposed to feeling forced. Furthermore, participants did not experience any threats or pressures from criminal justice agencies such as probation, the courts and the police, to engage in treatment and played a minimal role on their motivation to engage and remain in treatment. Some individuals did report being unwilling to address their substance use and expressed concerns regarding the

possibility of their liberty being restricted due to the impact this would have on their ability to sustain their substance use. However, they maintained that they did not feel any pressures from criminal justice agencies to engage in this process and expressed that their ability to make informed decision enabled them to either decline treatment if they wished, or accept treatment if their motivation was to sustain their substance use. This can assist us in understanding individuals' feeling of choice and motivation to accept treatment. We can deduce that, within this research setting, participants did not experience any threat and were not forced to engage in treatment as individuals reported being willing and making informed choices to engage or decline treatment. These findings would therefore suggest that participants are likely candidates to accept drug treatment as opposed to imprisonment, therefore complying with the government's aim to steer drug using offenders into treatment. With regards to implications for practice this research found self-determination theory to provide an important foundation to our understating of individuals' motivation to engage in treatment and therefore increase the effectiveness of coerced treatment. Motivational Interviewing (MI) has been a preferred treatment programme within substance misuse services (Miller & Rollnick, 2002) and future research may benefit from exploring SDT alongside MI as effective treatment programmes. This research highlights that relatedness, autonomy and competence increased participants' motivation to change. Treatment programmes' failure to address individuals' self-determination may be a reason for these. By slowly moving away from offending and drug use, participants developed new values, morals and aspirations to change. Treatment in this setting assisted them in building autonomy and competence to achieve goals and comply with new found values. Relatedness provided the security and stability required for them to sustain behaviour changes. These concepts, which are the foundation of SDT, enable us to further support individuals to access, engage and successfully complete treatment. This research shows that, regardless of why individuals access treatment following a referral from criminal justice agencies, those who were ready and motivated made positive changes. This highlights the need for treatment services to explore incorporating SDT to their programmes where competence, relatedness and autonomy are addressed and individuals supported to make positive changes to enable effective coercive treatment. Furthermore, aftercare is an important element of recovery that drug treatment services must address comprehensively prior to discharge. It is important for self-determination to be sustained post treatment. Effective coercive initiatives will need to ensure that individuals have access to activities and peer support groups following treatment which will enable them to sustain their self-determination.

The final aim of this research was to achieve the above through the lens of IPA and the researcher's experience in the drugs field. My experience and knowledge of the field provided invaluable support during the semi-structured interviews a means of further exploring participants' experiences. Through the analysis, it enabled me to further understand individuals' experiences, placing myself in their shoes through this process, being able to see things through their eyes, including the insides of a police cell, courts, key work rooms, prison and drug and alcohol services. Understanding how participants feel and the issues that arise when they access services played a vital role in my ability to analyse their data and truly explore what it means to be coerced into treatment. Being able to draw on previous interactions and discussions I have had with service users through my career also enabled me to further understand their experiences and further explore pertinent issues of coercion without having to gain clarification or make assumptions relating to their experiences, treatment processes and programmes available in the setting.

There are some limitations to this research and it is important to bear in mind issues of generalizability from qualitative research. However, the aims of this research were to inform our knowledge and understanding of coercion and how this is experienced by individuals in a setting. Interpretative Phenomenological Analysis enabled the exploration of coercion from service users' perspectives. Although, the sample did not have any female participants, a high proportion were under the Integrated Offender Management scheme, making them some of the more prolific offenders in the borough, and ethnicity was diverse with less than half of the participants being white-British. Views may be very different to females and those with a limited history of offending. This was identified through this research with one individual who had only been involved in the criminal justice system on one occasion. Despite these findings and limitations, it has provided a more in-depth understanding of factors which can impact on our interpretation of coercion and some of the nuances in its application, giving further support in future research to understand inconsistencies in research findings relating to its effectiveness.

## **Implications for Practice**

This research has implications for practice and recommendations for the London Borough of Hackney. To fully support drug using offenders and maximise engagement in treatment, the findings would encourage a robust assessment process. Firstly, it would recommend a comprehensive assessment of individuals' motivation to identify their readiness to change. For

those who are less motivated, a pre-treatment programme based around developing and increasing autonomy, competence and relatedness in line with SDT (Ryan et al, 2008) would be of use to assist individuals to increase their motivation to change. Dropout rates are highest during the first 30 days of treatment (NTA, 2009b). A programme for 3 to 4 weeks may be of benefit for agencies to increase motivation and provide criminal justice service users with the opportunity to address and increase their motivation to change. The use of Restrictions on Bail during the period would be of assistance in assessing motivation and predicting sustained engagement post sentence. Research has found treatment to be most beneficial and to have sustained post-treatment outcomes when individuals are in effective treatment for 12 weeks or more (NTA, 2009b). However, the finding of this research would suggest that individuals may comply with the requirements of their bail conditions through the bail period but disengage thereafter. As we have seen, individuals do not perceive any pressures from criminal justice agencies such as probation once sentenced. However, pre-sentence, they are more likely to engage in drug treatment, even for short period of time, to minimise disruption to their lifestyle. Criminal justice agencies in the London Borough of Hackney may wish to contemplate making use of suspended sentences whereby individuals are required to engage in treatment for a three or more-month period prior to sentencing to enhance engagement and compliance in treatment. Despite reasons for sustaining engagement in treatment, drug using offenders would then benefit from effective treatment where sustained recovery is more likely to ensue. This would assist the government in striking a balance between rehabilitation and punishment, offering individuals the opportunity to engage in treatment, maximising the effectiveness of treatment whilst still being able to provide punishment should they have no interest in addressing their substance use and offending behaviour.

With regards to offending behaviour, findings from this research would suggest that drug treatment enables individuals to reduce offending rates regardless of the relationship between their drug use and offending behaviour. As was identified in this research, readiness to change and access to treatment coincides with changing values and goals. This would lead us to believe that, regardless of the cause of their offending, reductions in offending rates will go hand in hand with their recovery and rehabilitation. One benefit of drug treatment is that it will assist individuals in addressing both substance misuse and offending appropriately and effectively through sustaining self-determination.

## Recommendations for Future Research

This research has brought some interesting findings regarding drug users in the London Borough of Hackney. Future research would benefit from an in-depth exploration of individuals' motivation to engage in treatment and sustain their drug using lifestyles when accessing treatment through criminal justice routes. This would enable a different focus in our understanding of the effectiveness of coercion. The use of quantitative research methods, and the combination of qualitative and quantitative methods, would also enable generalisation and an interesting comparison in identifying differences in motivations of individuals who access drug treatment through criminal justice routes. In their research, Stevens et al (2008) enabled a wider perspective and understanding of coercion and its effectiveness using both qualitative and quantitative methods. A longitudinal study using qualitative methods would also be of benefit to further explore how motivation and self-determination change through and post treatment. Although at the time of this research all participants were stable in their treatment, recovery is a long process whereby abstinence is not necessarily sustained throughout. A longitudinal study would provide an understanding around how motivation changes through treatment. It would also enable us to identify factors linked to relapse post-treatment and insight into how recovery can be maximised by treatment services.

Closer evaluation and description of programmes for individuals who access treatment through criminal justice routes would also be of benefit. As Fiorentine and colleagues (1999) found, the quality and characteristics of treatment itself are the strongest predictors for retaining and helping drug users. Addressing the effectiveness of Self-Determination Theory on successful treatment outcomes would be of interest to further guide our delivery of successful treatment programmes considering the Public Health Outcomes Framework (Department of Health, 2013b). When addressing the impact of coercion and assessing its effectiveness in tackling substance misuse, it would therefore be invaluable for treatment to assess and address individuals' self-esteem and sense of autonomy when referred through criminal justice routes. As we have seen, although drug users have some insight into their lives, and the quality of their lives, their fears of the unknown and change impacts on their ability to recognise this and seek support. Coercive initiatives and programmes would therefore benefit from identifying a way of addressing these fears and thought patterns at an early stage to be successful in motivating individuals to engage in treatment.

Phenomenology has played a key part in enhancing our understanding of coercion. Substance use fosters loneliness, shame, fear and low self-confidence but coercive measures can create

an opportunity to access treatment which will provide them with the competence to effectively address those challenges. However, if an individual is not open to change, it is unlikely that coerced treatment will be accepted or commenced. An individual's motivation alone is not sufficient to effectively address substance misuse, treatment services need to promote competence, autonomy, stability and relatedness to support them in addressing their substance use, maintain engagement in treatment and successfully work towards recovery. The 2010 drug strategy took an effective step in addressing the heterogenous nature of substance use to ensure careful consideration is taken when implementing drug treatment services. More research needs to be carried out to identify the role of treatment in the success of coercion and treatment programmes developed to enhance successful outcomes.

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## **APPENDIX A**

Ethics Approval Letter and Research Ethics Review Checklist

Marie-Edith Tiquet  
Professional Doctorate Student  
Institute of Criminal Justice Studies  
University of Portsmouth

**REC reference number: 12/13:17**  
**Please quote this number on all correspondence.**

17<sup>th</sup> October 2013

Dear Marie-Edith,

**Full Title of Study:** Project Title Experiencing Coercion in Drug Treatment: A Qualitative Study

**Documents reviewed:**

Consent Form  
Interview Questions  
Letter  
Participant Information Sheet  
Protocol

Further to our recent correspondence, this proposal was reviewed by The Research Ethics Committee of The Faculty of Humanities and Social Sciences. I am pleased to tell you that the proposal was awarded a favourable ethical opinion by the committee, on the condition that the minor linguistic errors are corrected.

Kind regards,

FHSS FREC Chair  
**David Carpenter**

Members participating in the review:

- David Carpenter
- Richard Hitchcock
- Jane Winstone

## **APPENDIX B**

Focus Group and Interview Information Sheets

## **FOCUS GROUP INFORMATION SHEET**

**Title:** *Experiencing Coercion in drug treatment:  
A Qualitative Study*

Institute of Criminal Justice Studies  
Ravelin House  
Museum Road  
Portsmouth, Hampshire, PO1 2QQ

**REC Ref No:** 12/13:17

*I would like to invite you to take part in my research study. Before you decide, I would like you to understand why the research is being done and what it involves for you. Please remember that it is entirely up to you to decide if you want to take part in this study. Feel free to speak to me or your key worker if there is anything that is not clear. This study is to find out people's experiences of coercion, which is defined here as: persuading (an unwilling person) to do something by using force or threats. In this research, this will be relating to legal pressures from the criminal justice system such as courts, police and probation.*

### **What is the study about?**

I am asking people who are / have been service users of Hackney drug treatment services if they would like to take part in a study to find out about people's experiences of coercion in drug treatment and the impact this has had on their recovery.

### **Why is this study being done?**

Before you decide if you want to take part in this study, I would like to let you know why I am doing this research and what your part in it will be. You can ask me questions or talk about it with other people before you make your decision.

I am currently doing a Professional Doctorate in Criminal Justice through the University of Portsmouth. As part of this qualification I am doing a study to identify service users' experiences of coercion. I would like to find out your views of what is helpful, and what is not. I cannot promise that taking part in this study will help you personally, but I hope that it will get other people in the future to receive better treatment.

### **If I do take part, what will I have to do and who else will be involved?**

I will be asking people to take part in a group discussion (called a "focus group"). This will last for about one hour with up to 9 other participants. I will be asking the group questions about experiences of services over the years and what has worked in getting people motivated and engaged in drug treatment. I will tape record the questions and answers which only I and someone who will transcribe this will have access to.

Once the focus group has been recorded and other interviews have been completed, I will draw some conclusions about how people experience coercion, what works well and what can be improved in the delivery of drug treatment through criminal justice routes. The conclusions will be written up and shared with people but without anyone being able to recognise who took part. The findings may also be published in books or journals that professionals read. Your will not be identified by name and I will not present the findings in any way that you can be personally identified.

### **If I am interested in taking part what should I do?**

People who are involved with the Service User Council through Hackney Drug and Alcohol Action Team (DAAT) are being told about the study by Marilyn McKenzie (Hackney DAAT Service User Development Worker), who will go through this

information with you. Some WDP Hackney service users may also be asked to take part and will discuss this with their key workers.

***You are under no obligation to take part and you cannot be required to do so. Participation is purely voluntary.***

You will be notified of the time and place of the focus group. Taking part means that you will meet with me and other people taking part in the group. I will then make sure that you are clear about the aims of the research and if you are still happy to participate, I will give you a consent form to sign. I will then ask the group a number of questions and the discussion will be recorded.

***You don't have to take part and, if you say "yes" now, you can change your mind or leave the focus group at any time.***

### **What will happen to the tape and the written record?**

The tape will then be typed out by a secretary to review. Your name will not appear on the transcript. At the end of the study, your tape will be destroyed and the written records will be kept safely in line with the Data Protection Act.

It is possible that some of the data collected may also be looked at by authorised people from my university to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

### **Who is the researcher?**

My name is Marie Tiquet, I am the service manager for WDP Harrow; I have substantial experience in delivering drug treatment programmes and have been studying criminal justice for over 6 years.

### **What else do I need to know?**

This study is being overseen by the Institute of Criminal Justice Studies at the University of Portsmouth and complies with the requirements of University codes of ethical practice.

Following the focus group, you may be asked to participate in interviews which will look further into personal experiences of coercion and drug treatment. If you would like to be considered for these, I will give you an information sheet.

### **Contact Details**

If you would like to find out more information about the research or your data, please contact me: Marie Tiquet Mob: 07966595726 email: marie\_tiquet@hotmail.com

If you have concerns/questions about the research you would like to discuss with someone at the University, please contact:

Aaron Pycroft – Institute of Criminal Justice Studies, University of Portsmouth Tel: 023 9284 3933 email: Aaron.Pycroft@port.ac.uk

**Thank you for taking the time to read this information sheet**

**ask any questions**

## **INTERVIEW INFORMATION SHEET**



**Title:** *Experiencing Coercion in drug treatment:  
A Qualitative Study*

Institute of Criminal Justice Studies  
Ravelin House  
Museum Road  
Portsmouth, Hampshire, PO1 2QQ

**REC Ref No:** 12/13:17

*I would like to invite you to take part in my research study. Before you decide, I would like you to understand why the research is being done and what it involves for you. Please remember that it is entirely up to you to decide if you want to take part in this study. Feel free to speak to me or your key worker if there is anything that is not clear. This study is to find out people's experiences of coercion, which is defined here as: persuading (an unwilling person) to do something by using force or threats. In this research, this will be relating to legal pressures from the criminal justice system such as courts, police and probation.*

**What is the study about?**

I am asking people who are / have been service users of Hackney drug treatment services if they would like to take part in a study to find out about people's experiences of coercion in drug treatment and the impact this has had on their recovery.

A focus group has already been done as part of this research, which you may have participated in. These interviews will draw on some of the information gathered during the focus group and further expand on any coercion you may have experienced.

**Why is this study being done?**

Before you decide if you want to take part in this study, I would like to let you know why I am doing this research and what your part in it will be. You can ask me questions or talk about it with other people before you make your decision.

I am currently doing a Professional Doctorate in Criminal Justice through the University of Portsmouth. As part of this qualification I am doing a study to identify service users' experiences of coercion. I want to find out your views of what is helpful, and what is not. I cannot promise that taking part in this study will help you personally, but I hope that it will get other people in the future to receive better treatment.

**If I do take part, what will I have to do and who else will be involved?**

I am asking up to 10 people to take part in one-to-one interviews. Interviews will last for about one hour and will be audio recorded to help me analyse your answers once all interviews have been completed. I will be asking questions about any experiences of coercion over the years and your views around what you feel has worked in getting you motivated to engage in drug treatment.

Once the interview has been recorded and other interviews have been completed, I will draw some conclusions about how people experience coercion, what works well and what can be improved in the delivery of drug treatment through criminal justice routes. The conclusions will be written up and shared with people but without anyone being able to recognise who took part. The findings may also be published in books or journals that professionals read. Your will not be identified by name and I will not present the findings in any way that you can be personally identified.

**If I am interested in taking part what should I do?**

If you decide that would like to take part in this study, I will go through some information with you and arrange a suitable time, place and date for us to do the interviews. You are free to discuss taking part in this research with your key worker if you would like further information. Please note, however, that the contents of your

interviews and participation will not be discussed with any professionals involved in your care.

*You are under no obligation to take part and you cannot be required to do so. Participation is purely voluntary.*

I will then make sure that you are clear about the aims of the research and if you are still happy to participate, I will give you a consent form to sign.

*You don't have to take part and if you say "yes" now, you can change your mind or leave the interview at any time.*

### **What will happen to the tape and the written record?**

Once the interview has been done, the tape will then be typed out by a secretary to review. Your name will not appear on the transcript. At the end of the study your tape will be destroyed and the written records will be kept safely in line with the Data Protection Act.

It is possible that some of the data collected may also be looked at by authorised people from my university to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

### **Who is the researcher?**

My name is Marie Tiquet, I am the service manager for WDP Harrow; I have substantial experience in delivering drug treatment programmes and have been studying criminal justice for over 6 years.

### **What else do I need to know?**

This study is being overseen by the Institute of Criminal Justice Studies at the University of Portsmouth and complies with the requirements of University codes of ethical practice.

### **Contact Details**

If you would like to find out more information about the research or your data, please contact me:

Marie Tiquet Mob: 07966595726 email: [marie\\_tiquet@hotmail.com](mailto:marie_tiquet@hotmail.com)

If you have concerns/questions about the research you would like to discuss with someone at the University, please contact:

Aaron Pycroft – Institute of Criminal Justice Studies, University of Portsmouth Tel: 023 9284 3933 email: [Aaron.Pycroft@port.ac.uk](mailto:Aaron.Pycroft@port.ac.uk)

**Thank you for taking the time to read this information sheet.**

**Please feel free to ask any questions**



## **APPENDIX C**

Focus Group and Interview Consent Form

**FOCUS GROUP CONSENT FORM**

**Title:** *Experiencing Coercion in drug treatment:  
A Qualitative Study*

Institute of Criminal Justice Studies  
Ravelin House  
Museum Road  
Portsmouth, Hampshire, PO1 2QQ

**REC Ref No:** 12/13:17

**Name of Researcher:** Marie Tiquet

**Please initial box**

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
  
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. I understand, however, that the answers I may have already provided could still be used in the research.
  
3. I understand that data collected during the study may be looked at by individuals from the University of Portsmouth or from regulatory authorities. I give permission for these individuals to have access to my data.
  
4. I understand that I will be audio recorded during the focus group and give consent for this information to be used as stated in the information sheet.
  
5. I agree to take part in the above study.
  
6. I am happy to be contacted for possible participation in interviews after the focus group (please provide contact number: .....)  
.....)

*Name of participant:*

*Date:*

*Signature:* .....

*Name of researcher:*

*Date:*

*Signature:* .....

# INTERVIEW CONSENT FORM



**Title:** *Experiencing Coercion in drug treatment:  
A Qualitative Study*

Institute of Criminal Justice Studies  
Ravelin House  
Museum Road  
Portsmouth, Hampshire, PO1 2QQ

**REC Ref No:** 12/13:17

**Name of Researcher:** Marie Tiquet  
**initial box**

**Please**

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
  
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
  
3. I understand that data collected during the study, may be looked at by individuals from the University of Portsmouth or from regulatory authorities. I give permission for these individuals to have access to my data.
  
4. I agree to be audio recorded during the interview and for this information to be used as stated in the information sheet.
  
5. I agree to take part in the above study.

*Name of participant:*

*Date:*

*Signature:* .....

*Name of researcher:*

*Date:*

*Signature:* .....

## **Demographic Information**

**1. Are you:**

- Male  Female

**2. How old are you:**

- 18-25  31-35  41-45  
 26-30  36-40  46 or over

**3. How long have you been using substances for?**

.....

**4. What substances do you use? (please rate with 1 being the main drug of choice)**

- Heroin  Cannabis  
 Crack  Alcohol  
 Cocaine  Other (please specify.....)

**5. How long have you been in treatment for?**

.....

**6. How Old were you when you first accessed treatment?**

.....

**7. Which types of treatment have you experienced?**

- One to one sessions  Community Detoxification programme  
 Counselling  Day programme  
 Residential rehabilitation treatment  Group work  
 In patient Detoxification programme  Substitute prescribing

**8. Which types of coercion have you experienced?**

- Required Assessments  DRR / ATR  
 RoB  Probation Requirement

## APPENDIX D

### Focus Group and Interview Questions

## Focus Group

### Questions

13<sup>th</sup> May 2014



- 1. Briefly outline your experience of accessing drug treatment through the criminal justice system (through police stations and courts) –**
  - i. What worked in getting you to engage and complete treatment?
  - ii. What did not work so well
  
- 2. How much of a choice did you feel you had in this process?**
  - a. When engaging in treatment through the courts, did you feel that you had a fair choice to engage in treatment?
  
  - b. What were your motivating factors to engage or no engage in treatment at the time?
  
- 3. Looking back on your experience of drug treatment, what would you say were the main motivating factors to get you to engage (and complete) treatment?**
  - a. Social factors
  
  - b. Treatment experiences – setting etc.
  
  - c. Treatment options – funded and CDS, types
  
- 4. What are your views on the use of coercion in the criminal justice system?**
  
- 5. And finally, what do you think could be improved in the provision of drug treatment?**

- 1. Could you describe your experience of drug treatment**
  - a. through the criminal justice system (police stations and courts)
  - b. Residential, day programmes, 1:1 etc.
  
- 2. What were the main factors to encourage you to access treatment?**
  - a. How much of an influence did Social (group settings, peers, facilitators, family) / psychological / legal (courts, probation) factors have on you at the time?
  - b. Why?
  - c. How did these make you feel?
  
- 3. In terms of staying in treatment, what would you say were the main factors keeping you engaged in your treatment programme?**
  - a. How much of an influence did Social and Legal factors have?
  - b. Why?
  
- 4. Taking away your involvement in criminal justice processes at the time, How ready were you to change? And for what reasons?**
  - a. How much of a choice do you feel that you had in this process
  - b. What were your options?
  - c. How fair do you think the process was?
  - d. Do you think you were in the right frame of mind to make the decision to access treatment?
  
- 5. Looking back on the influences you have experienced (cite examples from legal, social & psychological), which would you say were the most influential in getting you to change your behaviour around your drug / alcohol use and offending?**
  - a. Did these change at any point in time?
  - b. What were their relationships to each other?
  - c. Do you feel that social and legal factors fed into your psychological influences?

**6. How does your experience of treatment through the CJS differ from when you have accessed treatment voluntarily?**

- a. In your experience, do you feel that you have benefited from being coerced in anyway?
- b. How would you compare your relationship with drugs / alcohol before treatment and now?
- c. Has this been different when accessing treatment voluntarily to through CJ routes?

**7. Speaking specifically about you, how could the CJS be more effective in the provision of drug treatment? What would (have) helped you more?**

**8. And finally, is there anything else that you feel may be useful for this study?**



## APPENDIX E

UPR16 Form – Research Ethics Review Checklist

# FORM UPR16

## Research Ethics Review Checklist



Please include this completed form as an appendix to your thesis (see the Postgraduate Research Student Handbook for more information)

<b>Postgraduate Research Student (PGRS) Information</b>		<b>Student ID:</b>	345108
<b>PGRS Name:</b>	Marie-Edith Tiquet		
<b>Department:</b>	institute of Criminal Justice Studies	<b>First Supervisor:</b>	Aaron Pycroft
<b>Start Date:</b> (or progression date for Prof Doc students)	September 2010		
<b>Study Mode and Route:</b>	Part-time <input type="checkbox"/>	MPhil <input type="checkbox"/>	MD <input type="checkbox"/>
	Full-time <input type="checkbox"/>	PhD <input type="checkbox"/>	Professional Doctorate <input checked="" type="checkbox"/>

<b>Title of Thesis:</b>	Coercion, Drug Treatment and the Criminal Justice System: A Service User Perspective
<b>Thesis Word Count:</b> (excluding ancillary data)	49,473

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University's Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study

Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

### UKRIO Finished Research Checklist:

(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: <http://www.ukrio.org/what-we-do/code-of-practice-for-research/>)

a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame?	YES NO	<input checked="" type="checkbox"/> <input type="checkbox"/>
b) Have all contributions to knowledge been acknowledged?	YES NO	<input checked="" type="checkbox"/> <input type="checkbox"/>
c) Have you complied with all agreements relating to intellectual property, publication and authorship?	YES NO	<input checked="" type="checkbox"/> <input type="checkbox"/>
d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration?	YES NO	<input checked="" type="checkbox"/> <input type="checkbox"/>
e) Does your research comply with all legal, ethical, and contractual requirements?	YES NO	<input checked="" type="checkbox"/> <input type="checkbox"/>


### Candidate Statement:

I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

<b>Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):</b>	12/13:17
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If you have *not* submitted your work for ethical review, and/or you have answered 'No' to one or more of questions a) to e), please explain below why this is so:

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<b>Signed (PGRS):</b>		<b>Date:</b> 3 <sup>rd</sup> July 3017
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