The Drug Treatment Outcomes Research Study (DTORS): Final outcomes report

Andrew Jones, Michael Donmall, Tim Millar, Alison Moody, Samantha Weston, Tracy Anderson, Matthew Gittins, Varunie Abeywardana and John D’Souza

This report summarises follow-up data from the Drug Treatment Outcomes Research Study (DTORS): a longitudinal study that explores the outcomes of drug treatment in England.

The overriding finding is that treatment reduces the harmful behaviours that are associated with problem drug use. The majority of treatment seekers received care-coordinated treatment, expressed satisfaction with their care, were retained in treatment beyond three months, reported significant and substantial reductions in drug use and offending, and improvements in mental well-being and social functioning. DTORS has measured a broad range of outcomes. Where comparable, the positive DTORS outcomes are equivalent to, or better than, those observed a decade ago by NTORS, the previous national outcomes study. Alongside the fact that the number of people in contact with treatment services has more than doubled over the last decade, this suggests that the drug-treatment system has been responding effectively by increasing numbers in treatment and improving treatment effectiveness.

Most improvements occur within the first few months of entering treatment. The changes in behaviour observed at first follow-up (three to five months after initial interview) are mainly only sustained at second follow-up (11 to 13 months), although there are some additional improvements during this later stage of treatment. This may suggest that there are opportunities to further capitalise on the early gains that are achieved. Further work is needed to establish whether these gains are sustained once treatment has stopped.

Levels of drug use declined rapidly within the first three months of starting treatment, and then continued at the same rate, for up to six months. These findings support the validity of the national performance indicator of retention in treatment for at least three months, but suggest potential value in longer measures of retention than currently employed as well as the need for treatment facilities to focus on a continuing process of change.
It is important to note that ‘new’ treatment candidates (those without previous treatment experience) showed levels of treatment retention that were significantly lower, suggesting the need for innovative work with this group during the early stages of treatment, in order to ensure that their successful treatment continues.

Treatment appears to have a significant impact on income from offending. However, no direct correlation with levels of drug use was distinguishable within these data. Among offenders interviewed for the baseline stage of this study (see Jones et al., 2007), legitimate income at first follow-up was just sufficient to pay for declared drug use. This suggests that a reduction in drug use achieved via treatment cannot, of itself, be expected to tackle all offending among the client group in the short term. However, continued improvement was recorded in the longer term.

Clients presenting for treatment via criminal justice sources demonstrate overall equivalent rates of retention and positive outcomes to those from other referral sources. Though the criminal justice system (CJS) does not appear to recruit from the treatment naive population any more than other referral routes, it appears to be an equally valid source of referral in terms of outcomes achieved. A third of CJS referrals stated that they would not have come to treatment without the pressure resulting from their legal involvement, although over half stated that they would have come to treatment anyway. Whilst this supports continued investment in diversion, at the same time it highlights the need to consider overlap between CJS and non-CJS client groups when formulating the focus of that investment.
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Context

The Drug Treatment Outcomes Research Study (DTORS) has been designed to update existing knowledge on the effectiveness of drug treatment in England, within the context of recent changing patterns of drug use, specifically the rise of crack cocaine, and an expansion in criminal justice referrals. The study comprised three key elements, namely: a quantitative study of outcomes, a qualitative study of treatment-related issues, and a cost-benefits analysis.

- This report describes the follow-up findings from the quantitative element of the study, subsequent to the description of the baseline sample, available at: http://www.homeoffice.gov.uk/rds/pdfs07/horr03c.pdf

Approach

- Baseline interviews were conducted with 1,796 adult treatment seekers as soon as an interview could be arranged after initial assessment for drug treatment at 342 agencies within 94 Drug Action Team areas.

- Follow-up interviews were conducted between three and 13 months after initial interview. A total of 1,131 initial follow-up and 504 second follow-up interviews were achieved. Results are presented in relation to sub-samples interviewed within two target catchment windows: first follow-up at three to five months and second follow-up at 11 to 13 months. These results are supported by longitudinal analyses incorporating all follow-up interviews, including those not achieved within the target catchment windows. The data have been weighted so as to be representative of adult treatment seekers in England and to account for non-response bias in follow-up data where significant differences were found between respondents and non-responders (see Technical Appendix).

Results

DTORS observed a number of positive outcomes following treatment contact. There were significant reductions in harmful behaviours associated with problem drug use.¹

Referral source

- CJS referrals resulted in equivalent levels of change to non-CJS referrals across nearly all outcomes.

Treatment received

- Eighty-three per cent received a care plan within three weeks of triage. Eighty-three per cent of these were happy with all or most of their plan. Seventy-seven per cent felt that the plan proceeded according to their expectations.

- Eighty-nine per cent started one or more modalities of structured care by first follow-up. Clients waited an estimated median of seven days from triage for treatment and 75 per cent started a treatment modality within 22 days from triage.

Treatment retention

- Seventy-six per cent of all eligible² treatment seekers and 89 per cent of those starting treatment were either retained for 12 weeks or completed planned treatment. At second follow-up, 81 per cent had been retained for nine months or completed planned treatment.

- ‘New’ clients with no previous experience of structured treatment were significantly less likely to start or be retained in treatment.

¹ Although direct comparisons with NTORS are not always possible due to methodological differences, DTORS results suggest equivalent or greater reductions in heroin and crack use, injecting, sharing and offending over similar time periods.

² Excluding those with less than 12 weeks potential retention at the time of follow-up interview.
Treatment length
- The majority of improvement in outcomes was achieved within 12 weeks of treatment but the rate of improvement continued between three and six months, with no significant change thereafter.

Changes in social functioning
- Employment levels improved from nine per cent at the time of the baseline interviews to 11 per cent at first follow-up and 16 per cent at second. The proportion classified as unemployed and not looking for work fell from 24 per cent to 17 per cent and 11 per cent.
- The proportion staying only in stable accommodation rose from 60 per cent at baseline to 67 per cent and 77 per cent at follow-up. Those staying only in unstable accommodation fell from 21 per cent to 15 per cent at second follow-up.
- The proportion of parents of dependent children having all their children living with them rose from 22 per cent at baseline to 34 per cent by second follow-up.

Changes in drug use
- All drug types were used by significantly lower proportions of respondents at follow-up interviews compared to at the baseline interviews.
- The proportion using heroin, crack, cocaine, amphetamines or benzodiazepines approximately halved by follow-up. The proportion using non-prescribed methadone or opiates other than heroin or methadone (such as morphine) fell by considerably more than half, whereas the proportion using cannabis or alcohol fell by considerably less.
- The proportion who reported each drug to be causing any problems at the time of interview fell, in all cases by a greater amount than the proportion actually using that drug.
- Among heroin users involved in the baseline interviews, 44 per cent had stopped using at first follow-up and 49 per cent had stopped using at second follow-up. Corresponding figures for stopping crack use were higher at 53 per cent and 61 per cent respectively.
- The mean weekly value of drugs used fell from £169 at baseline to £64 at first, and £63 at second follow-up.

Changes in offending
- The proportion who reported committing any acquisitive offences in the four weeks prior to interview fell from 40 per cent at baseline to 21 per cent at first follow-up and 16 per cent at second. The proportion who reported committing any high-cost offences fell from nine per cent at baseline to three per cent and four per cent at follow-up.
- Sixty-one per cent of those reporting some offending in the baseline interviews reported no offending in the four weeks prior to first follow-up, rising to 68 per cent at second follow-up.
- Recorded offences, except shoplifting, selling stolen goods and selling drugs, were reported by less than five per cent of the sample at either follow-up.
- The proportion who reported committing any crime specifically in order to fund their drug use fell from 22 per cent at baseline to eight per cent at first and seven per cent at second follow-up.
- Among those committing an offence in the four weeks prior to baseline interview, legitimate median monthly income was £188 below the value of drugs consumed. By first follow-up, legitimate median monthly income was £140 above the value of drugs consumed.

Changes in health
- Measures of mental well-being (SF12 scores) improved significantly by first follow-up (from 35 to 40) but stayed below the UK norm score of 52. Self-reported physical well-being scores (SF12) were similar to UK norms before and after treatment.
Changes in risk-taking behaviour

- Among the 57 per cent of injectors who reported sharing injecting equipment at baseline, 72 per cent did not share at first follow-up, rising to 77 per cent at second follow-up.

- Rates of overdose in the three months prior to interview among treatment seekers more than halved from nine per cent at baseline to three and four per cent at follow-ups.

- Opiate-specific overdose-associated behaviour (taking opiates in combination with other opiates, benzodiazepines or alcohol) fell among opiate users reporting the behaviour at baseline (76%) to 43 per cent and 48 per cent at follow-ups.

- Little change in the baseline proportion reporting unprotected sex (48%) was detected at either follow-up.

Implications

The majority of treatment seekers reported significant reductions in drug use and, where applicable, offending, affirming the overriding message that treatment is an effective means of reducing the harmful behaviours that are associated with problem drug use. Where comparable, the positive DTORS outcomes are equivalent to, or better than, those observed a decade ago by NTORS, the previous national outcomes study. Alongside the fact that the number of people in contact with treatment services has more than doubled over the last decade, this suggests that the drug-treatment system has been responding effectively by increasing numbers in treatment and improving treatment effectiveness.

The fact that improvements observed at first follow-up are mainly only sustained at second follow-up suggests that there are opportunities to further capitalise on the early gains that are achieved.

The continued reduction in drug consumption observed between three and six months in treatment suggests a potential value in measuring success levels of retaining clients for longer than the 12 weeks currently employed for national targets.

Those without previous treatment experience showed significantly lower levels of retention, suggesting the need for more innovative work with this group during the early stages of drug treatment.

The criminal justice system appears to be an equally valid source of referral in terms of outcomes achieved.
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1. Context

The Drug Treatment Outcomes Research Study (DTORS) is a major national evaluation of drug treatment in England. A previous study, the National Treatment Outcomes Research Study (NTORS) described the effectiveness of treating problem drug users between 1995 and 2000. However, in the subsequent decade there have been fundamental changes in the delivery of drug treatment in England and changes in the population receiving treatment.

DTORS was commissioned in order to refresh the existing evidence base on treatment effectiveness. The study comprises an outcomes survey of treatment seekers (Jones et al., 2007), a qualitative assessment of drug treatment (Barnard et al., 2009), and an economic analysis of the costs and benefits associated with drug treatment (Davies et al., 2009). This report presents the findings of the quantitative study measuring defined domain outcomes experienced by a national sample of people seeking structured community-based or residential (Tier 3 or 4) drug treatment between February 2006 and March 2007. The study aimed to answer the following questions:

How does drug treatment impact on the following outcomes?
- levels of drug and alcohol use;
- offending behaviour;
- physical and mental health; and
- wider social outcomes.

How does this vary by?
- different referral sources (specifically CJS/non-CJS);
- different pathways through drug treatment;
- drug use; and
- individual characteristics.

Background

Drug treatment and rehabilitation services are commissioned and provided in four tiers. Tiers 1 and 2 provide open access and non-structured drug treatment services; information, advice and harm-reduction services; screening for drug misuse; and referral to specialist drugs services. Tier 3 provides structured community-based drug treatment and rehabilitation services. Services in Tier 4 provide residential drug treatment and rehabilitation, aimed at individuals with a high level of presenting need. Tier 3 and 4 services account for around 70 per cent of total drug treatment costs.

Over the last ten years, the use of crack or cocaine nationally has risen from approximately 14 per cent of drug users at the time of the NTORS in 1996 (Department of Health, 1998) to 44 per cent in 2006 (NDTMS, unpublished). Concurrently, increasing use of referral schemes in the criminal justice system (CJS) has increased the proportion of drug-misusing offenders seeking treatment. Offenders who misuse drugs have been found to have more serious drug problems, which are potentially less responsive to treatment (Oerton et al., 2003, Millar et al., 2002; Sondhi et al., 2002, Stewart et al., 2000, Millar et al., 2002).

With substantial expenditure on drug treatment services, increases in the number and heterogeneity of drug users in contact with treatment facilities and changes in the treatment process, new evidence is needed about whether services are effective and an efficient use of resources.

Methodology

DTORS is a national, multi-site, longitudinal study designed to follow a sample of drug-treatment seekers over a period of up to 12 months from their presentation. It should be borne in mind that treatment seekers were assigned to treatment modalities independently, on the...
basis of clinical need, suitability and availability. That is, they received whatever treatment was clinically deemed to be the most suitable option available to them at the time of assessment. DTORS is not necessarily a suitable basis on which to judge whether particular types of treatment are intrinsically ‘better’ than others, even where a specific modality is significantly associated with an outcome.

Further, the DTORS study did not sample a non-treatment control group and so the findings cannot compare outcomes to a comparable group who did not receive drug treatment.

Sample
The study sample was recruited via 342 treatment facilities in 94 of the 149 Drug Action Team (DAT) areas in England. Within each randomly selected DAT, all agencies providing structured community treatment (Tier 3) or residential treatment (Tier 4), or referral were eligible to participate. Sampling took place over a period of four to seven weeks in each DAT. During the sampling window, any adult presenting for a new episode of treatment for their drug use (other than primary alcohol use) was eligible for inclusion. A total of 1,796 individuals were recruited for baseline interview between February 2006 and March 2007.

Of those recruited at baseline, 1,131 (63%) were interviewed again. The majority of initial follow-up interviews were conducted between three to five months after the baseline interview (n=886); these are referred to in the report as first follow-up (F1). A further 245 initial interviews were achieved outside this three- to five-month window and up to 12 months after baseline interview. Of the 886 followed up within three to five months, 504 were interviewed for a third time, between 11 and 13 months after their baseline interview; these are referred to as second follow-up (F2) and represent 57 per cent of F1. Interpretation of results has required consideration of response rates. Where significant differences were found between responders and non-responders (e.g. in ethnicity, stability of accommodation, use of heroin) data were weighted so as to be representative of adult treatment seekers in England and to account for non-response bias in follow-up data (see Technical Appendix).

Measures and procedure
The study utilised baseline and follow-up instruments developed specifically for DTORS, incorporating established and validated measures for items such as health status and motivational state. Questions covered the type of treatment received; social functioning, drug use, health-risk behaviour, offending, and mental and physical health (see Appendix 2 for research instruments in full). Baseline and follow-up interviews were undertaken by trained research interviewers, independent of treatment services, and elements of the interview were self-administered to minimise negative response bias. Following standard practice, all measures were self-reported. Drug use at follow-up interviews was validated via saliva screening, and achieved a minimum 86 per cent ‘match’.

Analysis
Analysis controlled for core covariates, specifically drug use reported at baseline interview, age, gender, referral source, previous treatment experience, severity of dependence, motivation, acquisitive offending, injecting, health score and receipt of each Tier 3 or Tier 4 modality, so as to isolate the effect of specific factors by adjusting for any bias caused by confounding factors. Results are generally presented for the sub-samples interviewed within the target catchment windows of three to five and 11 to 13 months, referred to as first follow-up (F1) and second follow-up (F2). These are supported by longitudinal analyses incorporating all follow-up interviews (i.e. including those outside of the target catchment windows). Potential bias arising from the time taken to re-interview respondents has been controlled for in the analyses.

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6 An overview of the sampling strategy adopted for the selection of DATs, treatment agencies and treatment seekers recruited to the study can be found in Home Office Research Report 3 (Jones et al., 2007) and in the technical appendix.
Data were weighted so as to be representative of the English treatment-seeking population as a whole and follow-up data were weighted to control for non-response. Results depicting differences between baseline and follow-up measurements are presented as weighted descriptives. Separate weights were attached to each wave of data collection. Any reported differences between subgroups are statistically significant at the 95 per cent level unless otherwise stated, and calculated, adjusting for the covariates listed above, using the statistical software package, STATA and taking account of weights, stratifications and primary sampling unit. No percentages are presented in relation to unweighted bases of less than 30.

2. Results

DTORS observed a number of positive outcomes following treatment contact. There were significant reductions in harmful behaviours associated with problem drug use. These are outlined below.

Referral source

All cases in which criminal justice personnel had direct input into the referral process were defined as CJS referrals. There were few significant differences between CJS and non-CJS referrals within the DTORS outcome data despite differences in characteristics and circumstances highlighted at baseline (Jones et al., 2007). Although CJS referrals were significantly more likely (92% vs 87%) to start a treatment modality, both groups demonstrated similar levels of treatment retention, and outcomes for the two groups were similar, except that CJS referrals reported higher cessation rates for crack use at second follow-up and, among those who continued to use heroin, CJS referrals reported a higher frequency and average daily value of use.

In order to examine the differential effect of specific forms of CJS referral, these were categorised as having: i) a Drug Rehabilitation Requirement (DRR) or other restriction on bail or ii) no attached legal consequences. These categories were compared with respect to the following major outcomes: levels of drug consumption, continued use of heroin, continued use of crack and continued acquisitive offending. No statistically significant (unadjusted) effects were observed in the extent to which these referral groups continued or discontinued use of heroin or crack, or of acquisitive offending. Voluntary CJS referrals appeared to reduce their consumption of drugs by less, but from a significantly lower baseline level. Although this warrants further investigation, the remainder of the report will refer to CJS referrals as a combined group.

Care planning

The national treatment framework (NTA, 2002; 2006) highlights the need for service users to have access to appropriate and effective assessment, care planning and care coordination. People who enter into drug treatment should receive a written and agreed care plan, which should be subject to regular review with a key worker or care coordinator. Service commissioners and providers are actively encouraged to use a structured care-planning approach to improve clients’ journeys through the treatment system, which is viewed as a cyclical process of assessment, delivery and review, identifying and responding to service users’ changing needs.

Client satisfaction is likely to be an important predictor of positive treatment outcomes. At first follow-up, 83 per cent of treatment seekers recalled discussing a care plan; for most of these (93%) this occurred at the agency to which they presented and within three weeks of presentation. The majority of treatment seekers who received a care plan indicated that they were happy with all (57%) or most (26%) of its contents. Only five per cent reported that they were not happy with the contents of the care plan. Most (86%) considered that they had started at least some of the treatment described in the care plan; 76 per cent considered that the care plan had proceeded in accordance with their original expectations; 87 per cent were aware of a named person who was in charge of their care plan; and 78 per cent indicated that they had been given the opportunity to review and, if necessary, change their care plan. Most (75%) had attended only one agency as part of the treatment described in their care plan.

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7 This means the level at which there is a one in 20 chance of an observed difference being solely due to chance.
8 Though direct comparisons with NTORS are not always possible due to methodological differences, DTORS recorded equivalent or greater reductions in, for example, heroin and crack use, injecting, sharing and offending over similar time periods.
9 A more detailed categorisation was attempted but there were insufficient cases in some categories to support analysis.
Treatment received

The delivery and available range of drug misuse treatment interventions has changed substantially over the past decade. The national framework (NTA, 2002; 2006) classifies treatment in four main ‘Tiers’, which reflect increasing intensity of intervention. This section considers the types of treatment that respondents experienced between baseline and follow-up interviews.

Most (89%) treatment seekers had received some form of structured Tier 3 or 4 treatment between baseline and first follow-up: 52 per cent had received substitute prescribing; 45 per cent specialist substitute prescribing; 13 per cent GP prescribing; 40 per cent structured counselling; 19 per cent residential rehabilitation; 18 per cent structured day care, and ten per cent in-patient detoxification (Figure 2). Almost all (96%) treatment seekers had received structured treatment by the time of second follow-up: 65 per cent had received substitute prescribing; 58 per cent specialist prescribing; 22 per cent GP prescribing; 40 per cent structured counselling; 26 per cent structured day care; 22 per cent GP prescribing; 21 per cent in-patient detoxification. Most of those interviewed at first (70%) or second (77%) follow-up were still receiving some form of structured treatment.

The average (mean) waiting time between assessment for treatment and starting the first treatment intervention was 20 days, although half the treatment seekers started treatment within seven days. There was no statistically significant difference between waiting times for CJS-referred treatment seekers and for those referred from other sources. CJS referrals were equally likely to receive community prescribing, counselling or in-patient services but more likely to receive day care (27% compared to 14%).

Details of treatment

Most (74%) of those who received substitute prescribing were initially provided with methadone; 27 per cent were provided with Buprenorphine. Most (75%) prescribing was initiated on the basis of a stable/maintenance dose. Most (80%) reducing doses were intended to reduce to nil prescribing. Half of those prescribed methadone received 40ml or less per day, 75 per cent received 60ml or less. Over half (56%) reported that they had initially picked up their prescription on a daily basis (24 or more days each month). Most prescribing (74%) was reported to have involved an element of supervised consumption.

Most (71%) of those who received structured counselling saw their counsellor/key worker for a one-to-one session at least once a week; 47 per cent attended group sessions at least once a week. Eighty-four per cent indicated that they enjoyed a good or excellent relationship with their counsellor.

For those who entered residential rehabilitation between baseline and first follow-up, the intended stay was usually (63%) between three and six months; for 26 per cent the intended stay was more than six months.

Over one-third of treatment seekers (36%) indicated that they had received Tier 2 interventions such as overdose advice (24%), safer injecting advice (24%) or needle exchange (21%), and/or other support services (73%) such as family support (40%), education services (33%), accommodation advice (32%) and access to leisure facilities (28%) (Figure 3). In total, 15 per cent of treatment seekers received Tier 3 or 4 services only.

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10 Tier 1 Drug-related information, advice, screening and referral by generic services; Tier 2 – Open access, non-care-planned drug-specific interventions; Tier 3 – Structured, care-planned drug treatment; Tier 4 – Drug specialist in-patient treatment and residential rehabilitation.

11 Substitute prescribing includes both specialist prescribing and GP prescribing.
Table 1  Modalities received by demographics

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Figure 3  Tier 2 and support services received between baseline and first follow-up

Forty-eight per cent received Tier 3 or 4 with additional Tier 2 or support services, and 25 per cent received Tier 3 or 4 with additional Tier 2 and support services. A further eight per cent received Tier 2 or support services only.

Treatment retention

Since it has been shown that clients who are retained in treatment for at least 12 weeks have better outcomes (Gossop, Marsden, Stewart and Rolfe, 1999), the extent to which clients are retained in treatment is now seen as a key indicator of the effectiveness of drug treatment (NTA, 2005). Of those recruited to DTORS and interviewed again, around three-quarters were retained for at least 12 weeks. Those with no previous experience of structured treatment, however, were less likely to start or be retained in treatment.

‘Treatment journeys’ were considered to be continuous until the start of any period of 21 days during which no treatment modalities were provided,\(^\text{13}\) based on self-reported modality attendance.

A total of 76 per cent of first follow-up treatment seekers eligible\(^\text{14}\) for this analysis, and 89 per cent of those starting treatment, were either retained in treatment for 12 weeks

\(^{13}\) The criteria used for assessing retention in treatment within NDTMS data applies the same treatment journey criteria i.e. broken only by a gap of more than 21 days between discharge and the start of another modality.

\(^{14}\) Interviewed at least 12 weeks after the start of their treatment journey.

12. Official National Treatment Retention figures for 2006/07 = 75 per cent (Source: National Treatment Agency).
or completed their planned treatment. Of the first follow-up treatment seekers eligible for analysis, 72 per cent remained in continuous treatment for 12 weeks. Fifteen per cent did not start treatment, but among those who started a modality only 16 per cent ceased their treatment journey within 12 weeks. Around half (48%) of those who ceased their treatment journey had been formally discharged. Among those discharged, 58 per cent completed their planned treatment, 32 per cent dropped out or had treatment withdrawn, and five per cent were imprisoned.

A total of 81 per cent of second follow-up treatment seekers eligible for this analysis, and 88 per cent of those starting treatment, were either retained in treatment for nine months or completed their planned treatment. Of the second follow-up treatment seekers eligible for analysis and assessed for treatment at baseline, 70 per cent had been retained in continuous treatment for nine months since baseline interview. Nine per cent did not start treatment. Among those starting a modality, 23 per cent ceased their first treatment journey within nine months. Most (70%) of those who ceased their journey were formally discharged. Among the latter group, 71 per cent completed their planned treatment, 23 per cent dropped out or had treatment withdrawn, and one per cent were imprisoned.

**Twelve-week retention**

Among those who started a treatment modality there was no difference in (12-week) retention between CJS- and non-CJS-referred treatment seekers. However, more of the CJS-referred treatment seekers were found to have started a modality, leading to better 12-week retention among this group overall.

The same effect was observed for baseline crack users, such that retention rates were the same as for non-users among those who started a treatment modality, but users were more likely to start treatment, leading to better (12-week) retention.

Treatment seekers not previously treated were significantly less likely to start treatment and, even if starting, were significantly less likely to be retained for 12 weeks (75% vs 87%).

Both referral source and previous treatment maintained significant associations within an adjusted model accounting for other covariates (age, gender, heroin use, motivation, offending).

**Nine-month retention**

Within an adjusted model which accounted for other covariates, previous treatment experience remained as the only significant factor in predicting retention.

**Social circumstances**

The extent to which drug treatment impacts on aspects of social circumstances was measured in terms of employment levels, legitimate income, accommodation status, relationships and residence of children.

**Employment**

The proportion of treatment seekers in paid employment increased from nine per cent at baseline to 11 per cent at first follow-up and to 16 per cent at second follow-up. At follow-up, those in employment were predominantly in full-time, permanent jobs (full-time – 79% at F1, 86% at F2; permanent – 81% at F1, 89% at F2).
The proportion in paid employment increased at each follow-up alongside a corresponding decrease in those classed as unemployed. However, the proportion classed as unable to work due to sickness increased. This may be due to a greater number of treatment seekers being properly diagnosed for illnesses although it is not known from these data whether this is the case. Increased levels of employment were observed amongst the majority of covariate subgroups at first follow-up, but did not emerge among those with previous treatment experience until second follow-up.

CJS referrals were less likely to be in employment at any point in treatment. Controlling for covariates and using longitudinal analysis, there is little evidence to suggest that any particular treatment modality was associated with greater improvements in employment than any other.

**Accommodation**

The proportion of treatment seekers who had stayed only in stable accommodation\textsuperscript{16} during the previous four weeks increased between baseline (60%), first follow-up (67%), and second follow-up (77%).\textsuperscript{17} The proportion who stayed only in unstable accommodation fell from 21 per cent at baseline to 15 per cent at second follow-up.

Controlling for covariates, there is some evidence to suggest that ongoing specialist prescribing was positively associated with residing in stable accommodation. However, where prescribing had been provided but had since stopped, there was no evidence of a positive impact. Females, new treatment seekers and non-users of heroin were more likely to report stable accommodation at any point. Those who were offenders at the time of the baseline interviews, and clients receiving counselling (whether ceased or not), were more likely to improve their accommodation status over time in treatment.

**Relationships**

The proportion of treatment seekers who reported having a partner did not change significantly by the follow-up interviews.

Among those who remained in a relationship at follow-up, treatment seekers mostly described their partners as similarly supportive as at baseline — although 19 per cent rated their supportiveness more positively and 20 per cent more negatively. The situation was similar when comparing baseline and second follow-up (57% the same, 19% more supportive and 24% less supportive). The proportion of treatment seekers who reported having a drug-using partner did not change significantly over the course of the follow-up interviews.

**Children**

Among those with children under the age of 16, the proportion having all children living with them fell from 22 per cent at baseline to 15 per cent at first follow-up, but rose to 34 per cent by second follow-up. For females the rates changed from 38 per cent to 25 per cent to 54 per cent. Increases were recorded across all subgroups, including primary crack users at baseline interview, among whom the figures changed from five per cent to 24 per cent at second follow-up.\textsuperscript{18}

**Legitimate income**

Treatment seekers reported a legitimate mean weekly income of £95 at baseline, £107 at first follow-up and £147 at second. Unsurprisingly, the legitimate income of those in employment was approximately three times higher than those not in employment.

For 49 per cent of treatment seekers, legitimate income increased between baseline and first follow-up; for 36 per cent it decreased. At second follow-up, compared to baseline, legitimate income had increased for 64 per cent and decreased for 29 per cent.

The nature of benefits received changed only marginally over the two follow-ups. Equivalent proportions (19% and 20%) were receiving no benefits at baseline and second follow-up. The proportion receiving many benefit payments (e.g. council tax benefit, Disability Living Allowance, housing benefit) increased by between five per cent and 15 per cent, which may be a result of benefits advice provided by the agencies.

In a longitudinal analysis controlling for employment and other baseline characteristics, there was no evidence that any specific modality was associated with a greater increase in legitimate income than any other. CJS referrals, crack users, offenders and females recorded lower income at any point in treatment, with older clients displaying a steeper increase in income over time in treatment.

\textsuperscript{16} Stable accommodation was that owned or rented by the respondent, or owned or rented by friends or family, whether the respondent paid rent towards it, or stayed rent free.

\textsuperscript{17} Individuals in residential treatment were recorded as staying in unstable accommodation.

\textsuperscript{18} This decrease may be explained by the proportion of parents in residential care at first follow up (approx 19%).
Drug use

During the course of treatment, many treatment seekers stopped using the drugs that they reported using at entry to the study. Lower rates of drug use were recorded at each follow-up. Furthermore, those that continued to use tended to use less. Most of the changes observed occurred by first follow-up. For most forms of drug use, no particular treatment modality was more associated with cessation than any other and the route into treatment (CJS or non-CJS) did not influence drug-use outcomes.

The proportion using each drug reduced significantly between baseline and follow-up (Figure 5). Most of this change occurred by first follow-up; indeed use of some drug types increased marginally, and levels of abstinence from all drugs decreased between first and second follow-up. The proportion of treatment seekers using heroin, crack, cocaine, amphetamine or benzodiazepines decreased between baseline and follow-up by around 50 per cent; the proportion using non-prescribed methadone or other opiates such as morphine, decreased by considerably more; but the proportion using cannabis or alcohol decreased by considerably less. The proportion who reported each drug to be causing problems fell substantially for all drug types, suggesting that continued use was often, in the client’s view, non-problematic.

Levels of consumption

The self-reported monetary value of personal substance use is utilised here as the main indicator of the level of use. There was a statistically significant decrease in the mean value used in the seven days prior to interview from £169 at baseline to £64 at first follow-up and £63 at second follow-up (median values £60, £10 and £12 respectively). Crack or heroin users, injectors and offenders at the time of the baseline interviews were more likely to report higher values of use at first follow-up. Non-CJS referrals reported higher average values of use at baseline but these had reduced to equivalent rates by follow-up. The value of use of cannabis and alcohol accounted for a relatively small but increasing proportion of overall mean consumption rising from 14 per cent at baseline to 22 per cent at second follow-up.

In a longitudinal analysis controlling for other variables, there was evidence that the value of substance use by crack users, offenders and those with high dependency scores was higher at any point, but that these groups exhibited a significantly higher reduction in the extent of their use as treatment progressed which indicates that impact in reduced drug use was greatest for those displaying the most problematic drug use.

Drug consumption over treatment duration

The following plot (Figure 6) uses Lowess smoothing techniques to provide a visualisation of outcome progress mapped against the number of days of treatment received between interviews. These plots estimate values where data are missing and are not reliant on treatment status at time of interview.

Higher levels of use at baseline were associated with larger reductions at follow-up: among those with both baseline and follow-up data, mean reductions of £82 by first follow-up and £53 by second follow-up, were observed. Neither referral source, nor the type of treatment modalities provided, exerted a significant effect on the extent of the reduction in consumption, but reduction at first follow-up was positively associated with use of heroin, crack, acquisitive offending and medium to high levels of dependence at baseline, meaning that the most obvious reductions were amongst those who were among the most problematic drug users. These associations were maintained at second follow-up.
Figure 6 shows that mean\textsuperscript{20} drug consumption falls sharply in relation to days treated. The majority of the reduction was achieved during the first three months, but improvement continues beyond this point with the maximum effect observed within six months. The pattern for reduction in all drug consumption was matched in the pattern of heroin and crack cessation.

**Use of heroin**

Forty-four per cent of heroin users at the time of the baseline interviews had ceased such use by first follow-up, and 49 per cent by second follow-up. There was a reduction in the amount of heroin consumed amongst those that continued to use. At baseline, the mean value of heroin consumed in the previous week was £129,\textsuperscript{21} falling to £77 among those still using heroin at first follow-up and £75 among those still using heroin at second follow-up (median values £60, £34 and £31 respectively).

There was also a decrease in the number of days on which heroin was used from 18 (in the previous 28 days) at baseline to 15 at both follow-ups (median values 21, 14 and 12 respectively). However, most continuing users persisted in using on a daily basis (albeit that the mean daily level of consumption was reduced). The mean (and median) Severity of Dependence Scores (SDS)\textsuperscript{22} fell from nine (out of a maximum of 15) to seven (F1) and seven (F2). Note that the SDS refers largely to the psychological aspects of drug use and cessation rather than actual levels of use.

Controlling for treatment modality and a range of other covariates, continued use of heroin at first follow-up was significantly associated with the use of crack at baseline.

In a longitudinal analysis, controlling for covariates, older clients and those with previous treatment experience were more likely to cease heroin use.

**Other opiates (not heroin or prescribed methadone)**

Only eight per cent of users of non-prescribed methadone or other opiates (such as morphine) at baseline reported continued use at either follow-up. Similarly, only 12 per cent of baseline users of other opiates reported continued use at first and 11 per cent at second follow-up.

**Use of crack**

Fifty-three per cent of crack users had ceased such use by first follow-up, and 61 per cent by second follow-up. Among crack users at the time of the baseline interviews, the mean value of crack consumed in the previous week was £115, falling to £32 at first and £37 at second follow-up (median values of £20, £0 and £0 respectively). SDS scores fell from a mean of six at baseline to three at first and two at second follow-up.

The value of weekly consumption fell to £67 among those still using crack at first follow-up but increased to £97 among those still using crack at second follow-up (median values £20, £29 and £30 respectively): that is, the minority who continued to use crack, did so at a higher level. The mean number of days of crack use in the past 28 stayed the same (mean values 11 days at baseline and first follow-up, 12 days at second follow-up).

At first-follow up there was no statistically significant association between referral source and continued use of crack, but by second follow-up 74 per cent of CJS referrals had ceased use compared to 54 per cent of non-CJS referrals. ‘Non-White’ ethnic minorities reported levels of continued use of 62 per cent (compared to 45% for ‘Whites’) at first follow-up and 50 per cent (compared to 37% for ‘Whites’) at second follow-up. Controlling for treatment modality and a range of other factors...
covariates, continued use at first follow-up was significantly associated with ethnicity, and continued use at second follow-up was significantly associated with referral source.

Only 15 per cent of crack users at baseline reported having received a crack-specific intervention by follow-up. Receipt of such an intervention was not significantly associated with whether or not crack use ceased.

In a longitudinal analysis controlling for covariates, baseline crack use was associated with a higher likelihood of receiving specialist prescribing. Clients still in residential rehabilitation were more likely to have ceased use, but not if they had left residential rehabilitation. Baseline heroin users were also more likely to cease crack use than non-heroin users.

**Cocaine**
Among those reporting use of cocaine powder at baseline, 25 per cent reported continued use at first and 32 per cent continued use at second follow-up.

**Cannabis**
Around half of cannabis users reported that they had ceased use by first (48%) or second (45%) follow-up. The monetary value used did not change among those who persisted to use cannabis.

**Alcohol**
While half of alcohol users had ceased use by first (50%) and second (48%) follow-up, continued use was positively associated with acquisitive offending at baseline and was more common among the group who received specialist prescribing.

Alcohol users at baseline consumed a median weekly value of £9, compared to £10 among those using alcohol at first follow-up and £12 among those using at second follow-up.

In a longitudinal analysis, controlling for covariates: being CJS referred, being new to treatment, being younger, and being an offender or having a lower health score at baseline, were all positively associated with alcohol use at any point. Alcohol use was most common among those who received specialist prescribing or counselling and least common among those who received day care or residential rehabilitation. Offenders at baseline were less likely to cease alcohol during treatment, while those with higher baseline health scores were more likely to cease use.

**Stimulants**
Among those reporting use of amphetamine at baseline, 41 per cent reported continued use at first and 29 per cent at second follow-up. Among those reporting ecstasy use at baseline, 20 per cent reported continued use at first follow-up and 29 per cent at second.

**Injecting**
Among those injecting at baseline (33% of the sample), 53 per cent had ceased injecting at first and 63 per cent at second follow-up.

Longitudinal analysis, controlling for covariates, showed that the odds of ceasing injecting were lower for clients who received GP prescribing but were higher for those who received day care.

**Drug use that commenced during the study**
A minority of treatment seekers reported use of drugs at follow-up that they had not reported using in the month prior to the baseline interviews. Of those interviewed at second follow-up who had not reported the drug at baseline, 13 per cent commenced or re-commenced heroin use, 13 per cent crack use, 16 per cent cannabis use, 23 per cent alcohol use and seven per cent benzodiazepine use.

**Offending**
Overall, lower levels of acquisitive offending and high-cost offending were recorded at follow-up. Among those who continued to offend, improvements in offending behaviour at follow-up, in terms of a decrease in its volume and/or the costs associated with it, were observed. Crack users, injecting users, users with high SDS scores, and those with previous treatment experience were more likely to offend than others at any point. However, neither referral source nor the type of treatment modalities received, were significantly associated with the level of acquisitive offending at any point (within the adjusted model).

At baseline, 40 per cent had committed an acquisitive offence within the last four weeks. This halved to 21 per cent at first and 16 per cent at second follow-up. This reduction occurred across all offence types. Lower-cost crimes were more prevalent than higher ones at all stages of the study: shoplifting was the most common offence, followed by selling stolen goods, drug dealing, and other stealing. Higher-cost offences (defined for the purposes of this report as burglary of a business or dwelling, theft of vehicle, bag snatching or robbery) (Brand and Price, 2000) were less prevalent throughout, but still reduced from nine per cent at baseline, to three and four per cent at each follow-up.

23 Those who had injected a drug in the four weeks prior to interview.
Figure 7  Levels of offending

Table 2  Proportions committing offences at follow-up

<table>
<thead>
<tr>
<th>Respondents who did commit acquisitive offences in four weeks before baseline interview</th>
<th>F1</th>
<th>F2</th>
</tr>
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<tr>
<td>No offences in previous four weeks to follow-up</td>
<td>61%</td>
<td>69%</td>
</tr>
<tr>
<td>Low-cost offences only*</td>
<td>32%</td>
<td>23%</td>
</tr>
<tr>
<td>High-cost offences**</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>Unweighted base</td>
<td>304</td>
<td>163</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondents who did not commit acquisitive offences in four weeks before baseline</th>
<th>F1</th>
<th>F2</th>
</tr>
</thead>
<tbody>
<tr>
<td>No offences in previous four weeks to follow-up</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>Low-cost offences only</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>High-cost offences</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Unweighted base</td>
<td>530</td>
<td>341</td>
</tr>
</tbody>
</table>

* Acquisitive crimes other than those defined as high cost for the purposes of this report.
** Burglary of a business or dwelling, theft of vehicle, bag snatching or robbery.

Looking at overall proportions for baseline and both follow-ups independently hides some of the individual change: 61 per cent of offenders at the time of the baseline interviews did not offend in the four weeks prior to first follow-up, rising to 68 per cent at second follow-up. Among baseline non-offenders, nine per cent had offended at first follow-up (8% at second). The majority of offences committed by this group were low-cost offences.

Longitudinal analysis revealed that the following factors were positively associated with being an acquisitive offender (self-reported) at any point in the study:

- higher Severity of Dependency Scores;
- crack use;
- injecting;
- previous treatment experience at baseline; and
- being younger.

No specific modality, nor baseline characteristic, was associated with greater change in acquisitive offending.
Further longitudinal analysis showed that the following factors were associated with committing high-cost crimes:

- baseline use of crack cocaine;
- injecting; and
- being younger.

Heroin users were less likely to be involved in high-cost crime. Those receiving day care at the time of follow-up reported a significantly greater reduction in high-cost crime.

It is very important to note that, even if offending did not cease entirely, there was a substantial decrease in its volume and/or the costs associated with it. Prior to treatment, 75 per cent of offenders had earned more than £25 from offending in the previous four weeks. At first follow-up, 72 per cent of baseline offenders (those committing an offence in the four weeks prior to baseline interview) had earned less than £25 from offending in the previous four weeks. The median number of offences committed by baseline offenders in the four weeks before interview, fell from eight at baseline to zero at both follow-ups. The median total of cash raised from offending in the same period fell from £123 to £0.

The proportion who reported committing crime in order to fund their drug use fell from 22 per cent at baseline to eight per cent at first follow-up and seven per cent at second. For baseline heroin users this figure fell from 31 per cent to ten per cent and nine per cent. For baseline crack users it fell from 35 per cent to 13 per cent and ten per cent.

Those committing acquisitive offences at baseline were using a monthly median of £188 of drugs more than the size of their legitimate income. By first follow-up, their legitimate income was a monthly median of £140 more than the drugs they were using, with a considerable majority earning more than they spent on drugs. By second follow-up monthly legitimate income had increased to £234.

Among those committing acquisitive offences at first follow-up the median monthly value of drugs used was only £6 above legitimate income, a considerable improvement, although legitimate income was still insufficient to cover both the value of drugs used and other living expenses.

Older treatment seekers reported higher offending income at all points, but longitudinal analysis, controlling for covariates, did not suggest that any particular baseline characteristic, or receipt of any particular treatment modality, was associated with a greater reduction in offending income than any other. However, there was a stronger association with a reduction in the number of offences committed for those with previous treatment experience and for baseline crack users. Use of crack or heroin was more positively associated with offending as treatment length increased.

**Offending and treatment duration**

Figure 8, based on Lowess smoothing techniques (see Appendix 1 for further details), shows that the proportion of respondents committing acquisitive crime continued to fall for approximately the first six months of treatment. There was no significant change from that point on however. The average income from offending among all clients displayed a similar pattern of reduction. However, among those continuing to offend, little overall reduction in income was observed until after the first three months.

**Health and risk behaviour**

**Health**

The SF12 scale, a standardised measurement of health outcomes, typically used to measure the health progress or decline of individuals in clinical settings, was used to measure
changes in mental and physical well-being. Mental well-being scores improved by follow-up but remained below the UK population norm. Though there was no significant change of physical well-being scores between the baseline interviews and follow-up, these were, in any case, close to population norms and many treatment seekers reported improvement in their perceived general health.

Although only a minority (17%) reported their general health as ‘poor’ at baseline, many reported improvements in their general health at follow-up. The proportion that rated their general health as ‘excellent’ or ‘very good’ increased from 20 per cent at baseline to 27 per cent at first and 25 per cent at second follow-up. The proportion rating their health as ‘good/fair’ increased from 53 per cent to 59 per cent and 62 per cent respectively.

**Mental health**

Mental health services: at the time of the baseline interviews, 37 per cent had previously been referred to a psychiatrist or other mental health professional. Fifteen per cent were referred to a mental health professional between baseline and first follow-up, with ten per cent being diagnosed with a mental health problem. Thirteen per cent were referred between first and second follow-up.

Compared to a UK norm score of 52, the mean SF12 mental well-being score increased from 35 at baseline to 40 at first and 42 at second follow-up. Controlling for baseline factors within a longitudinal analysis, at any point in the study those who received residential rehabilitation (whether or not still received), CJS referrals and primary users of drugs other than heroin had better SF12 mental health scores. Offenders showed a greater improvement during the course of treatment, whereas those receiving GP prescribing improved less.

**Physical health**

In contrast to the situation for mental well-being, no significant changes were observed in SF12 self-reported physical well-being scores between the baseline interviews and first or second follow-up (mean scores 48, 49 and 48 respectively). However, these are similar to the UK norm score of 51.

Longitudinal analysis, controlling for covariates, suggested that receipt of residential rehabilitation, baseline offending and lower age were associated with higher SF12 physical health scores throughout. Less improvement was reported among those who received GP prescribing and more among those receiving counselling.

**Treatment duration and physical and mental health**

Figure 9, based on Lowess smoothing techniques, shows that the SF12 score of physical well-being remained at a level similar to UK population norms throughout. Scores for mental well-being improved during time in treatment, levelling off below the population norm by the six-month point.

**Risk behaviour**

Levels of sharing fell considerably by follow-up among those who were sharing at the time of the baseline interviews; long-term continuing injectors recorded levels comparable to those at baseline. Rates of overdose risk among baseline opiate users also reduced, due to a reduction in opiate use. Rates did not improve among continuing opiate users. Few measurable effects were apparent with regard to risk-related patterns of sexual activity.

**Sharing**

Over half (57%) of baseline injectors acknowledged sharing during the four weeks prior to the baseline interviews, falling to 40 per cent among those injecting

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24 The figure of 57 per cent includes passing on equipment. The baseline figures do not include passing on equipment.
at first follow-up. However, a large proportion (72%) of baseline injectors ceased injecting altogether by first follow-up, increasing the relative impact on sharing.

Levels of syringe sharing fell from 39 per cent of injectors at baseline to 29 per cent of those still injecting at first follow-up. Seventy-three per cent of those sharing syringes at baseline had ceased this activity by first follow-up. Forty-seven per cent of injectors were sharing paraphernalia at baseline; this fell to 33 per cent of those still injecting at first follow-up. Seventy-one per cent of those sharing paraphernalia at baseline had ceased this activity by first follow-up.

Three-quarters (77%) of those who reported sharing injecting equipment at baseline had ceased to do so by the time of second follow-up. However, among those who continued injecting, 55 per cent reported sharing injecting equipment at second follow-up.

**Overdose**

Risk rates with respect to overdose exposure declined. At baseline, nine per cent of treatment seekers reported having experienced an overdose in the previous three months, reducing by more than half to four per cent at first and second follow-up.

Seventy-six per cent of opiate users in the baseline sample reported use of multiple opiates or opiates in combination with benzodiazepines or alcohol, behaviours associated with a heightened risk of overdose. Of these, 43 per cent reported similar combinations of use at first follow-up and 48 per cent at second follow-up. Thirty-seven per cent of baseline opiate users reported such polydrug use in combination with injecting, and this fell to 19 per cent at first and 21 per cent at second follow-up. These reductions appear to be due to users ceasing opiate use, rather than to a switch to safer patterns of continued use. Indeed, for those who continued to use opiates, use of ‘riskier’ combinations remained at the same level (76%) between baseline and first follow-up and increased to 87 per cent at second follow-up. It is likely that this reflects an increasing concentration of persistent high-risk behaviour among the group that continued to use opiates, rather than a treatment effect.

Continued engagement in opiate-related overdose risk behaviours at second follow-up remained more likely among those who had received prescribing and less likely among clients receiving counselling. By second follow-up, cessation of opiate-related overdose risk behaviour was positively associated with receipt of overdose advice.

**Unprotected sex**

Treatment does not appear to have had substantial effect on risk-related patterns of sexual activity. Half (48%) of treatment seekers reported engaging in unprotected sex in the three months prior to the baseline interviews, 43 per cent at first and 47 per cent at second follow-up. However, among those reporting this behaviour, 24 per cent reported unprotected sex with someone other than their regular partner at baseline compared to 18 per cent at first follow-up and 14 per cent at second.

### 3. Implications

Though the response rates achieved should be considered in any conclusions drawn, the large sample and coverage of areas, together with the use of weighting techniques, allows these results to be generalised to the population of drug-treatment seekers in England.

The overriding finding from this study is that treatment is associated with a reduction in harmful behaviours that are associated with problem drug use. The majority of treatment seekers received care-coordinated treatment, expressed satisfaction with their care, were retained in treatment beyond three months, reported significant and substantial reductions in drug use and offending, and improvements in mental well-being and social functioning. The number of people in contact with treatment services has more than doubled over the last decade; this suggests that the drug-treatment system has been responding effectively by increasing numbers in treatment and improving treatment effectiveness.

Most observed improvements occurred within the first few months of entering treatment. The changes in behaviour observed at first follow-up (three to five months after initial interview) are mainly sustained at second follow-up (11 to 13 months), although there are few additional improvements during this later stage of treatment. This may suggest that there are opportunities to further capitalise on the early gains that are achieved. Further work is needed to establish whether these gains are sustained once treatment has stopped.
Levels of drug use declined rapidly within the first three months of starting treatment, and then continued beyond this point with the maximum effect observed within six months. These findings support the validity of the national performance indicator of retention in treatment for at least three months, but suggest potential value in longer measures of retention than currently employed as well as the need for treatment facilities to focus on a continuing process of change.

It is important to note that ‘new’ treatment candidates (those without previous treatment experience) showed levels of treatment retention that were significantly lower, suggesting the need for innovative work with this group during the early stages of treatment, in order to ensure that their treatment continues.

Treatment appears to be associated with significant reductions in income from offending. However, no direct correlation with levels of drug use was distinguishable within these data. Among offenders interviewed for the baseline stage of this study (see Jones et al., 2007) legitimate income at first follow-up was just sufficient to pay for declared drug use. This suggests that a reduction in drug use achieved via treatment cannot, of itself, be expected to tackle all offending among the client group in the short term. However, continued improvement was recorded in the longer term.

Clients presenting for treatment via criminal justice referrals demonstrate overall equivalent rates of retention and positive outcomes to those from other referral sources. It therefore appears to be an equally valid source of referral in terms of outcomes achieved. A third of CJS referrals stated that they would not have come to treatment without the pressure resulting from their legal involvement, although over half stated that they would have come to treatment anyway. This is supportive of continued investment in CJS diversion to drug treatment.

Appendix 1: technical information

Sample size calculations

Sample size calculations used “amount spent on drugs per week” as the estimate of level of drug use. This method of measuring level of drug use was considered an optimal measure of drug use intensity and associated problems as it provides a proxy cross-measure of frequency and quantity and, in combination with earnings information, provides a direct insight into the potential personal and wider social impact of an individual’s drug use.

Initial sample size calculations

Prior to fieldwork, these calculations were based on detecting a difference of £25 between two groups in the level of change (fall) in weekly expenditure on drugs from baseline to follow-up with a significance level of 0.05 and 90 per cent power in a longitudinal study. The primary group of interest was criminal justice system (CJS) referrals vs other referrals (including self-referral).

The following assumptions were made:

- that a 30 per cent loss to one-year follow-up should be expected, as in previous research (Gossop et al., 1997);
- that a minority of participants (1:4) would be referred through the criminal justice system; and
- that within subject correlation was 0.2 and inter cluster correlation was 0.04.

This calculation provided an initial baseline sample requirement of 2,600 individuals.

Power of final sample

The power of the sample was revisited in the light of the final sample size of 1,796 drug treatment seekers interviewed at 342 treatment facilities across 94 DATs. With a 1:2 ratio of CJS to non-CJS referrals, a presumed 40 per cent loss to (first) follow-up and a within subject correlation of 0.5, this sample size had 89 per cent power to detect a £25 difference in the change in drug spend between CJS and non-CJS clients between the baseline and the first follow-up.

Baseline DAT, agency and client sample frame and selection

One-hundred DATs were selected to take part in DTORS. This large number was chosen in order to minimise the burden on each individual DAT, and to increase the power of the sample by decreasing the effect of clustering. DATs were chosen by dividing the 149 DATs within England into tertiles, according to the percentage of their referrals from the criminal justice system, and selecting 33–34 DATs...
from each tertile. Where DATs declined to take part, they were substituted at random from within the same CJS referral tertile. Six of these selected DATs (across a broad geographical spread) could not be covered by the end of fieldwork due largely to time constraints in meeting Mental Health Trust R & D conditions.

Within participating DATSs, all agencies providing Tier 3 or 4 drug treatment to adults were eligible for inclusion and were invited to participate. Only a small minority refused. The number of participating agencies within DATs varied from two to over 20.

All adult clients presenting for a new episode of treatment at each agency within the sampling window were eligible for inclusion in the study. Recruitment was initially over a period of four weeks but was later extended to five and then to seven weeks. In addition, a ‘pre-sample’ window was introduced. This was the two weeks prior to interviewing beginning (i.e. the main sampling window). Clients making their first visit during the pre-sample window and returning for their second or third appointment during the main sampling window were then eligible for interview.

Weighting

Baseline weighting

The DTORS sample was drawn from all those eligible for inclusion using a multi-stage complex sampling scheme. A consequence of the sampling scheme is that not every member of the study population has an equal chance of being selected. Because of this, and the tendency of some groups in the population to refuse to participate in surveys, the data need to be weighted to give a representative picture. If the data are not weighted some groups will be over- or under-represented.

The following outlines the issues taken into consideration in the weighting.

Selection weights

The population from which the sample was drawn consisted of every client who presented themselves for a new episode of treatment. Clearly not every member of the population had an equal chance of being included. For example, those who visited an agency with a short sampling window were less likely to be included than those visiting an agency with a longer sampling window. Because of this, different members of the population had unequal probabilities of being asked to take part in the study and therefore the data should be weighted to compensate for this.

As every client presenting at every agency in each selected DAT was selected to participate in the study, the only factors affecting the selection weight are the probability the DAT was selected and the length of the agency’s sampling window. The length of the agency’s sampling window is by far the more important of these factors as every DAT had an approximately equal probability of being chosen.

The lengths of these sampling windows varied considerably from four weeks to nine weeks. Ignoring the differing sampling windows would have given those agencies with larger sampling windows too high an influence on the survey estimates. Therefore, this was corrected by calculating a selection or sampling window weight as the reciprocal of the length of the window.

Non-response weights

There are three ways in which non-response errors can occur within this study:

- DAT non-response;
- agency non-response; and
- client non-response.

DAT non-response

Twenty-six of the DATs initially selected refused to take part in the study and were replaced by others. There are very little data available on individual DATs that could be used for non-response modelling. This was treated as non-informative non-response.

Agency non-response

A number of eligible agencies either refused to take part or were unable to do so due to other reasons (such as a lack of NHS Trust approval). Some information about agencies is held on the National Drug Treatment Monitoring System (NDTMS). For those agencies listed on NDTMS, certain information was known:

- the associated DAT;
- its throughput of clients; and
- the percentage of clients who were referred from the criminal justice system.

For weighting purposes, responding agencies were categorised on the basis of their CJS referrals and throughput, and then post-stratified to the population figures. The resulting weight was then trimmed to ensure that no agency had a disproportionate influence on the survey estimates. The resulting non-response weights varied from 0.58 to 1.76 (several agencies were not listed on NDTMS and were assigned an average weight).
Client non-response

A proportion of sampled clients did not take part because they were not approached about the study by agency staff or because they did not wish to participate.

The information available on non-responding clients is limited. Agencies were asked to record the age and sex of all refusers/missed clients, but in spite of best efforts this information was incomplete and could not be used in a formal non-response model.

Calibration weights

The agency non-response weights and sampling window weights were combined and calibration weights were then applied so that the achieved sample size matched certain NDTMS population characteristics: the client’s age group/sex and ethnicity.

Additional characteristics were considered: whether the client lived in a rural or urban area, took heroin or crack, or had injected drugs.

Calibrating to a variable indicating whether the client lived in a rural or urban area was a possibility given the availability of information on the postcode sectors of the population. However, many of these postcode sectors were missing and/or consisted of a partial postcode such as the postcode area (the first letter or two of the postcode). As such, the population information was not of sufficiently high quality to use for calibration purposes.

Another possibility considered was to calibrate to variables such as whether the client took heroin or crack, or had injected drugs. This information is available on the NDTMS database, so population characteristics could be calculated. However, not every responding individual could be matched to the NDTMS database. Furthermore, although information on these variables could be assigned to each responder based on their interviews, there were large mismatches between the answers they gave to the question in their interview and their information on the NDTMS database. Because of these mismatches, calibrating to these variables would not necessarily reduce bias and would have the effect of increasing the standard errors of the estimate.

Another consideration is the impact of the calibration. For some of these variables calibrating would have made minimal difference to the weights. For example, 64 per cent of the weighted sample stated that they had used heroin in the previous four weeks. This compares with NDTMS figures of 69 per cent, so calibrating to heroin usage would have made only a small difference to the weights. (The effect would have been larger with some of the other variables.) As a result of such considerations, these other variables were not used in calibration and the weights calibrated only on the client’s age group/sex and ethnicity.

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<thead>
<tr>
<th>Age group/sex</th>
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<td>Male 18–24</td>
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<tr>
<td>Male 40–44</td>
<td>7.5%</td>
</tr>
<tr>
<td>Male 45+</td>
<td>5.4%</td>
</tr>
<tr>
<td>Female 18–24</td>
<td>6.5%</td>
</tr>
<tr>
<td>Female 25–29</td>
<td>6.4%</td>
</tr>
<tr>
<td>Female 30–34</td>
<td>5.5%</td>
</tr>
<tr>
<td>Female 35–39</td>
<td>4.0%</td>
</tr>
<tr>
<td>Female 40+</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

The population figures used for calibration were obtained from the NDTMS database and are given below. Due to the small numbers in the ethnicity categories the figures were calibrated to the variable White/non-White rather than the full ethnicity variable.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Population proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>88.9%</td>
</tr>
<tr>
<td>Mixed</td>
<td>2.3%</td>
</tr>
<tr>
<td>Black</td>
<td>3.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.9%</td>
</tr>
<tr>
<td>Other</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Final baseline weights

The final weights ranged from 0.34 to 3.79, with the following percentiles.

<table>
<thead>
<tr>
<th>Percentile</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIN</td>
<td>0.3427</td>
</tr>
<tr>
<td>1</td>
<td>0.4022</td>
</tr>
<tr>
<td>5</td>
<td>0.5069</td>
</tr>
<tr>
<td>10</td>
<td>0.5171</td>
</tr>
<tr>
<td>25</td>
<td>0.6116</td>
</tr>
<tr>
<td>50</td>
<td>0.8752</td>
</tr>
<tr>
<td>75</td>
<td>1.3057</td>
</tr>
<tr>
<td>90</td>
<td>1.6326</td>
</tr>
<tr>
<td>95</td>
<td>1.9231</td>
</tr>
<tr>
<td>99</td>
<td>2.5920</td>
</tr>
<tr>
<td>MAX</td>
<td>3.7910</td>
</tr>
</tbody>
</table>
### Model for response to Wave 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
<th>p-value</th>
<th>Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isex</td>
<td>NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W1white</td>
<td>White/Not White</td>
<td>0.1%</td>
<td>+</td>
</tr>
<tr>
<td>W1age</td>
<td>18–24, 25–29, 30–34, 35–39, 40–44, 45+</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Tertile</td>
<td>NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W1FreqC4</td>
<td>Used crack in last four weeks (Y/N)</td>
<td>8.4%</td>
<td>-</td>
</tr>
<tr>
<td>W1Shp12m</td>
<td>Shoplifted in last 12 months (Y/N)</td>
<td>5.1%</td>
<td>-</td>
</tr>
<tr>
<td>W1Drg12m</td>
<td>Dealt drugs in last 12 months (Y/N)</td>
<td>&lt;0.1%</td>
<td>+</td>
</tr>
<tr>
<td>W1stable2</td>
<td>Three category variable made binary (Did respondent live in stable accommodation throughout the four-week period?)</td>
<td>&lt;0.1%</td>
<td>+</td>
</tr>
<tr>
<td>W1CfreqH4</td>
<td>Used heroin in last four weeks (Y/N)</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>W1CinjecOC</td>
<td>Injected crack in last four weeks (Y/N)</td>
<td>NS</td>
<td></td>
</tr>
</tbody>
</table>

#### Weighting of follow-ups

**Wave 2 weighting**

Two analyses were required for Wave 2 (first follow-up – F1): one for all Wave 2 responders, the other for people responding within 21 weeks. Because of this, two sets of weights were produced.

One-thousand-one-hundred-and-thirty-one out of 1,796 Wave 1 responders had a positive outcome to Wave 2. Eight-hundred-and-eighty-six of the 1,796 had a positive outcome within 21 weeks.

A range of potential explanatory variables were derived (from baseline of Wave 1 response or demographic data) and were included in stepwise logistic regression models.

It made sense to use the same explanatory variables to model both outcomes. A stepwise procedure (using a 10% entry level) was used. In addition, a decision was made to force in sex, age, and tertile variables. This gave the following variables as those to include in a final model.

The direction of effect was that:

- people from ethnic minorities were less likely to respond;
- those who had sold drugs in the previous 12 months were more likely to respond;
- while those who used crack or heroin, or injected crack (previous four weeks) were less likely to respond;\(^{25}\)
- those who shopped in the previous month were less likely to respond; and
- those who lived in stable accommodation throughout the previous four weeks were more likely to respond.

**Wave 3 weighting**

Seven-hundred-and-fifty-four respondents responded to Wave 2 in time to be followed up in Wave 3. Five-hundred-and-four of these responded to Wave 3.

First we needed to model entry to Wave 3, i.e. we created a model for those who responded in time to be followed up.

Modelling response to Wave 3 was limited due to the small sample size – stepwise logistic regressions found that only Tertile and W1stable2 (had stayed in unstable accommodation at some period) were statistically significant. (Those who had stayed in unstable accommodation were less likely to respond.) The table of variables is shown below. (Note that the age variable was combined into three categories).

**First follow-up**

Two sets of weights are provided for analysing the follow-up. The first weight, `wt_Wave2A`, weights all those in the follow-up to resemble the target population.

Although the follow-up can be analysed using `wt_Wave2A`, the re-interviews were spread over a long period of time and those interviewed at the end of the period could possibly have differences to those interviewed early on. A more useful analysis might be to analyse only those responding within a fixed period of their first interview. However, those responding soon after initial attempts at follow-up cannot

---

\(^{25}\) These three variables are positively correlated. (Indeed, many of the explanatory variables were correlated.) This needs to be considered when interpreting their p-values.
be regarded as typical members of the population (sample members who are difficult to locate will have longer elapsed times). This means that simply restricting any analysis to those responding within a fixed time may introduce some bias.

Because of this, a second weight, wt_Wave2B, is provided for those individuals who were re-interviewed within 21 weeks of their first interview. This corrects for the tendency of “difficult to reach” people to be under-represented in the 21-week group.

There were 1,796 productive baseline interviews. One-thousand-one-hundred-and-thirty-one of these responded to the follow-up and hence have a wt_Wave2A weight, but only 886 responded within the 21-week period.

Two logistic regression models were constructed to estimate response probabilities — the first to model response to the follow-up, the second to model response within 21 weeks. The same explanatory variables were used in both models (these explanatory variables were derived from baseline data or from the initial interview).

A wide range of explanatory variables was considered and stepwise selection routines identified a subset to be significant predictors of response.

The variables identified from the baseline data were the respondent’s age group and ethnicity (coded as White/non-White), and the DAT’s tertile. In addition, the respondent’s sex was included into the model.

Several variables from the Wave 1 responses were also found to be significant predictors. These were whether the respondent had:

- used crack in the previous four weeks;
- used heroin in the previous four weeks;
- injected crack in the previous four weeks;
- shoplifted in the previous year;
- dealt drugs in the previous year; and
- lived in stable accommodation in the previous four weeks.

Logistic regression models using these variables were created to estimate response probabilities. Non-response weights were calculated as the reciprocal of the response probabilities and trimmed at the 0.5 per cent and 99.5 per cent percentiles. Trimming ensured that no respondent was given a disproportionately high or low influence in the analyses. The non-response weight was then combined with the Wave 1 weight and scaled to have mean 1. This gave the final analysis weights wt_wave2A and wt_wave2B. Summary statistics of these weights are shown below.

<table>
<thead>
<tr>
<th>Percentile</th>
<th>wt_wave2A</th>
<th>wt_wave2B</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIN</td>
<td>0.34</td>
<td>0.29</td>
</tr>
<tr>
<td>1</td>
<td>0.40</td>
<td>0.36</td>
</tr>
<tr>
<td>5</td>
<td>0.47</td>
<td>0.43</td>
</tr>
<tr>
<td>10</td>
<td>0.50</td>
<td>0.47</td>
</tr>
<tr>
<td>25</td>
<td>0.59</td>
<td>0.59</td>
</tr>
<tr>
<td>50</td>
<td>0.85</td>
<td>0.84</td>
</tr>
<tr>
<td>75</td>
<td>1.29</td>
<td>1.25</td>
</tr>
<tr>
<td>90</td>
<td>1.71</td>
<td>1.77</td>
</tr>
<tr>
<td>95</td>
<td>2.04</td>
<td>2.06</td>
</tr>
<tr>
<td>99</td>
<td>2.74</td>
<td>2.88</td>
</tr>
<tr>
<td>MAX</td>
<td>5.14</td>
<td>4.24</td>
</tr>
</tbody>
</table>
Second follow-up

Although 1,131 respondents responded to the first follow-up, only 754 of them responded in time to be followed up a second time. Weighting the second follow-up had to take this into account as those who were not followed up were not a typical subset of the population and ignoring this could have led to potential bias. This was accounted for by calculating a special entry weight for the 754 people followed up. It was then necessary to calculate a non-response weight for these individuals (504 of the 754 people responded in Wave 3). Modelling this non-response was limited due to the relatively small sample size, so a simple logistic regression model used only the DAT’s tertile, the respondent’s age, and whether they had lived in unstable accommodation. The non-response weight was then combined with the entry weight and scaled to have mean 1 to produce the analysis weight $wt_{wave3}$.

Unlike the first follow-up, all interviews on the second follow-up took place within a standard timeframe (between 11 and 13 months after the baseline interview); therefore all second follow-up interviews were used in the analysis, and only one weight was used.

The summary statistics of this weight are shown below.

<table>
<thead>
<tr>
<th>Percentile</th>
<th>$wt_{wave3}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIN</td>
<td>0.30</td>
</tr>
<tr>
<td>1</td>
<td>0.34</td>
</tr>
<tr>
<td>5</td>
<td>0.39</td>
</tr>
<tr>
<td>10</td>
<td>0.43</td>
</tr>
<tr>
<td>25</td>
<td>0.56</td>
</tr>
<tr>
<td>50</td>
<td>0.86</td>
</tr>
<tr>
<td>75</td>
<td>1.24</td>
</tr>
<tr>
<td>90</td>
<td>1.76</td>
</tr>
<tr>
<td>95</td>
<td>2.24</td>
</tr>
<tr>
<td>99</td>
<td>2.99</td>
</tr>
<tr>
<td>MAX</td>
<td>4.39</td>
</tr>
</tbody>
</table>

Analysis

All tests described below were run in STATA and incorporated the appropriate weighting scores described above in addition to survey design details of stratification (around tertiles of CJS referral) and the primary sampling unit (namely DAT of treatment) via the SVY command.

The data were primarily analysed in two ways.
1. For ease of translation and accessibility to a wide audience, results were presented in relation to two distinct follow-up periods, specifically three to five months post baseline and 11 to 13 months post baseline. Each follow-up period was compared to baseline separately, both descriptively and, following conversion of the data into a long format, by employing the marginal modelling techniques, bivariate logistic or bivariate linear regression depending on the nature of the outcome measured. A binary indicator variable was created and included in the model to determine the effect of changes between interview points and whether these were significant. (Note, as the model accounts for clustering in the sample at the highest level i.e. DAT, there is no need to further account for clustering around the subject ID, as would normally be the case, due to the principal of the Huber-White Sandwich Estimator of variance). All models were adjusted for a standard set of covariates selected a priori, in order to reduce any potential bias caused by confounding; these included:
   a. Primary drug (heroin, crack, other)
   b. Referral source (CJS, other)
   c. Age (in years)
   d. Use of heroin in four weeks prior to baseline (yes, no)
   e. Use of crack in four weeks prior to baseline (yes, no)
   f. Gender (male, female)
   g. Receipt of in-patient detoxification (not received, received but stopped, still receiving)
   h. Receipt of GP prescribing (not received, received but stopped, still receiving)
   i. Receipt of specialist prescribing (not received, received but stopped, still receiving)
   j. Receipt of counselling (not received, received but stopped, still receiving)
   k. Receipt of structured day care (not received, received but stopped, still receiving)
   l. Receipt of residential rehabilitation (not received, received but stopped, still receiving)
   m. Injected in four weeks prior to baseline (yes, no)
   n. Committed acquisitive offending in four weeks prior to baseline (yes, no)
   o. Circumstances, motivation and readiness score (quartiles)
   p. SF12 health score (SF6D)
   q. Used less drugs than normal in four weeks prior to baseline (yes, no)
   r. Restricted in movement in four weeks prior to baseline (yes, no)
   s. Severity of Dependence Score (none, low, medium, high)
   t. Previous treatment experience (yes, no)

Additional factors and covariates were added to the model according to necessity. Any results presented in relation to observed differences between groups were significant within the adjusted model (p<0.05 unless otherwise stated).

2. Longitudinal modelling techniques were employed to incorporate all follow-up interviews for all subjects regardless of how many were conducted or when, including the first follow-up interviews that fell outside the three-to-five-month catchment window. This provided a broad distribution of time in treatment across the sample, allowing for the testing of interactions between outcomes, covariates and length of treatment. Due to the long tailed nature of the time-in-treatment variable, un-measured confounding that could cause endogeneity in the time-in-treatment variable was deemed a concern and hence, where practical, Instrumental Variable regression (or two-stage least squares) was employed. In this case, time taken to achieve the follow-up interview was agreed to be the most appropriate Instrumental Variable available. Along with the sample survey weighting and the clustering principal, the same covariates listed in (1) above were included in all models with the number of days of treatment received replacing the indicator variable as the primary indicator of interest. Selected covariates were further tested for interactions with time in treatment and specific outcomes. This allowed results in the report under the longitudinal headings to be presented in terms of significant associations between covariates and outcomes and any changes to these over time in treatment.

Attempts were made to gain baseline interviews as soon as was possible after a respondent’s initial assessment at a participating agency in order to minimise the effect of early treatment contact. It was not always possible to conduct an interview before the receipt of a treatment so cases were labelled as either not starting treatment by the time of interview, starting less than four weeks before interview or starting four or more weeks before interview. The latter group were typically excluded from outcome analysis based on individual follow-up data. All cases contributed to the longitudinal analysis, with baseline data relating to those already in treatment contributing to outcome measurement.

**Lowess plots**

Lowess smoothing techniques provide a locally weighted scatterplot smoothing. A separate weighted regression is performed for every point in the data, in this case, across a time series. Each regression uses a percentage of the data called the bandwidth (the larger the bandwidth the smoother the Lowess line), so if bandwidth is set at 0.40 then the
lowess smoothing will use $0.40\times$No of data points. At each data point it will then weight the data it is using depending on its distance. Hence, if there is a missing gap it will use data from both sides of a missing area and weight it accordingly.

**Cox regression**

A Cox regression, also known as proportional hazards regression, is a method that can be applied to a survival analysis in order to highlight significant independent effects of a number of variables on a particular event, in this case, cessation of treatment. The Cox proportional hazard model compares the change in the probability of a subject ceasing treatment called the hazard function when covariates are included in the model (set from 0 to 1).

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**Appendix 2: DTORS wave 2 (first follow up) Questionnaire Instrument**

**Outline**

A. Introduction & social circumstances (1)

B. Treatment pathways, treatment history, goals & motivation

C. Drug behaviour

D. Risk behaviour (self-completion)

E. Offending behaviour (self-completion)

F. Mental/physical health

G. Social circumstances (2)

H. Saliva testing

I. Recontact consent and stable addresses

A. Social circumstances (1)

There is a possibility that towards the end of the interview, I will ask for your consent to do a saliva test to see whether you have taken certain drugs in the last 48 hours. As with the interview, if you are selected your participation is entirely voluntary.

**IF NECESSARY** We are aiming to test 200 of the people taking part in the research, selected at random, so that we can prove the accuracy of what everyone is telling us about their drug use.

I would like to remind you that everything you tell me will be treated in strict confidence in accordance with the Data Protection Act, and will be used for research purposes only. Many of the questions I will ask you are the same or similar to the questions in your previous interview. This is because we are interested in how your circumstances may have changed over time.

First I would like to ask you a few questions about yourself and your circumstances.

Can I just check, is your full name (*forename and surname from sample)?

1: Yes  
2: No

**INTERVIEWER:** IS THIS BECAUSE RESPONDENT HAS CHANGED NAME (E.G. GOT MARRIED) OR IS IT A DIFFERENT PERSON?  
IF IT IS A DIFFERENT PERSON, CHECK THAT YOU HAVE ENTERED THE CORRECT SERIAL NUMBER.

1: Respondent changed name  
2: Different person

**INTERVIEWER:** CODE SEX OF RESPONDENT

1: Male  
2: Female

And can you give me your date of birth?
Which of the following best describes you?

1: Married
2: Living with a partner
3: Single
4: Divorced
5: Separated
6: Widowed
97: Other (please specify)

Which of the things on this card describes what you are doing at the moment?

1: In paid employment (including self-employment, temporary and part-time work)
2: On a government scheme for employment training
3: Full-time education (school/college/university, including on holiday)
4: Unemployed but looking for work or training
5: Unemployed but not looking for work
6: Permanently unable to work because of long-term sickness or disability
7: Retired from paid work
8: Looking after home or family
97: Doing something else (please specify)

And where do you expect to be staying in 3 months time?

1: Accommodation that you own or rent
2: Accommodation owned by friends or family (where you pay rent)
3: Accommodation owned by friends or family (stay rent free)
4: In a squat
5: In a hostel (residential)
6: In a hostel (night drop-in centre)
7: Slept rough on the streets, in a park etc (without a roof overhead)
8: In inpatient or drug or alcohol treatment
9: Other medical establishment
10: In prison or other custody
11: In a mobile home or caravan
97: Other (please specify)

Can I just check do you have a spouse or partner at the moment?

1: Yes
2: No

Can I check does your spouse or partner also use drugs?

1: Yes
2: No

On a scale from one to five (where five is the best), how supportive would you say your relationship is?

How many children under the age of 16 do you have?

1: Accommodation that you own or rent
2: Accommodation owned by friends or family (where you pay rent)
Where do they live at the moment?

1: With respondent
2: In care
3: With other family members
4: With their father/mother (the other parent)
5: Elsewhere

How many of your children live with you?

How many of your children live in care?

How many of your children live with other family members?

How many of your children live with their father/mother?

How many of your children live elsewhere?

B. Treatment pathways, goals and motivation

I’d now like to ask you some questions about treatment services you may have received.

You may recall we first interviewed you (on [^last interview date]) after you had presented at (^agency name) on (^date of triage interview). Around that time did you meet with someone from this agency to talk through a care plan, that is, to map out what sort of treatment you should get at what time?

1: Yes
2: No

Have you met with anyone at any agency at any time since (^date of triage interview) to talk through a care plan?

1: Yes – this agency but beyond three weeks after (^date of triage interview)
2: Yes – other agency
3: No

How many weeks was it after you first presented yourself at (baseline agency) before you discussed a care plan (whether it was at that agency or somewhere else)?

At the time, how much of the care plan would you say that you were happy with?

1: All
2: Most

Did you start any of the treatment outlined in this care plan?

1: Yes
2: No

Has the care plan proceeded according to your original expectations?

1: Yes
2: No

Do you feel that there has been a particular person in charge of your care plan that you could always discuss it with?

1: Yes
2: No

And have you had an opportunity to review your care plan with this person and change it if necessary?

1: Yes
2: No

Have you attended more than one treatment agency as a part of this care plan?

1: Yes
2: No

How many treatment agencies have you attended as part of the care plan?

Have all the treatment services you have received since (^date of triage interview) been part of a care plan?

1: Yes
2: No

Were there any specific treatment services from agencies that you were unhappy with?

1: Yes
2: No
You said that you started the treatment initially agreed on your care plan. Have you stopped treatment for any reason since, and subsequently restarted again?

1: Yes
2: No

Do you feel that you started treatment again:

1: as part of the ongoing care plan; or
2: did you just start afresh (independent of the agreed care plan)?

Which of these types of structured treatment have you received (at any agency) since (^date of triage interview)?

1: Inpatient detox
2: Substitute prescribing from a drug team doctor
3: Substitute prescribing from a GP
4: Counselling
5: Daycare/Structured day programmes
6: Residential rehab
7: SPONTANEOUS: None of the above

Can I just check, have you received any structured or residential treatment for your drug use since we last interviewed you?

1: Yes
2: No

Please look at this calendar. As a reminder, you presented at (^agency name) on (^date of triage interview) and we conducted our first interview with you on (^last interview date). Can you tell me in which week you started inpatient detox?

Which of these drugs were you receiving inpatient detox for?

1: Heroin
2: Methadone (not prescribed to you)
3: Other Opiates (eg, morphine, diamorphine, Subutex, codeine, dihydrocodeine (DF118s), Opium)
4: Crack cocaine
5: Cocaine powder
6: Amphetamines (not prescribed to you)
7: Cannabis (Hash, resin, solids, grass, weed, skunk etc)
8: Ecstasy
9: Hallucinogens (e.g. mushrooms, LSD, ketamine)
10: Alcohol
11: Benzos ('Tranquillizers or sleeping pills) NOT prescribed to you
12: Solvents (e.g. glue, aerosols)
13: Any other drugs (not already listed)
14: SPONTANEOUS: Was not getting (^type of treatment) for any drugs

Have you left inpatient detox for any reason since you started it, not counting very short breaks of only a few hours?

1: Yes
2: No

So why did you stop receiving it?

1: Treatment complete, drug free
2: Treatment complete, not drug free
3: Treatment withdrawn/kicked out
4: No appropriate treatment available
5: Referred on
6: Dropped out
7: Moved away
8: Went to prison
97: Other

And when did you stop receiving it?

INTERVIEWER: ASK OR CODE ‘So are you still in inpatient detox?’

1: Yes
2: No

And have you started inpatient detox again at all since (^Binsp)?

1: Yes
2: No

(\^Was your inpatient detox/When you first started inpatient detox since your last interview, was it) planned to be a total detox, or was it planned to reduce the level of use of (^drug(s) from BinWhi)?

1: Total detox
2: Reduce the level of use
3: SPONTANEOUS: Both detox and reduction (for different drugs)

What was the planned (^detox/reduction/detox and reduction) time?
What was the planned rehab time after (^detox/reduction/ detox and reduction), if any?

Please look at this calendar. As a reminder, you presented at (^agency name) on (^date of triage interview) and we conducted our first interview with you on (^last interview date).

The following questions are about substitute prescribing, which I will refer to as receiving a prescription.

Can you tell me in which week you started receiving a prescription?

When you started this prescription, was it from a GP or a drug team doctor?

1: GP
2: Drug team doctor
3: SPONTANEOUS: both/started with one then switched to the other

Which of these drugs were you receiving a prescription for?

1: Heroin
2: Methadone (not prescribed to you)
3: Other Opiates (eg. morphine, diamorphine, Subutex, codeine, dihydrocodeine (DF1 18s), Opium)
4: Crack cocaine
5: Cocaine powder
6: Amphetamines (not prescribed to you)
7: Cannabis (Hash, resin, solids, grass, weed, skunk etc)
8: Ecstasy
9: Hallucinogens (e.g. mushrooms, LSD, ketamine)
10: Alcohol
11: Benzos ('Tranquilizers or sleeping pills) NOT prescribed to you
12: Solvents (e.g. glue, aerosols)
13: Any other drugs (not already listed)
14: SPONTANEOUS: Was not getting (^type of treatment) for any drugs

Have you stopped receiving a prescription for any reason since you started it?

1: Yes
2: No

So why did you stop receiving it?

1: Treatment complete, drug free
2: Treatment complete, not drug free
3: Treatment withdrawn/kicked out
4: No appropriate treatment available
5: Referred on
6: Dropped out
7: Moved away
8: Went to prison
97: Other

And when did you stop receiving it?

INTERVIEWER: ASK OR CODE ‘So are you still receiving a prescription for your drug use?’

1: Yes
2: No

And have you started receiving a prescription for your drug use again since (^Subsp)?

1: Yes
2: No

(^Was your prescription initially planned as/When you first started on a prescription after your last interview, was it initially planned as) a stable or reducing dose?

1: Stable dose
2: Reducing dose

Was the plan to reduce to a set level, or to none?

1: Set level
2: None

Over what time period was this reduction planned for (in weeks)?

(^When you first started on a prescription after your last interview can/Can) you tell me if you were prescribed any of these drugs?

1: Methadone
2: Subutex
3: DF1 18s
4: Naltrexone
5: SPONTANEOUS: none of these
What was the initial daily dose of ^BModSDr? Please give me the amount in ml or mg.
And how many times per month did you pick up your prescription for (^drug prescribed) to begin with?
Are you still being prescribed (^drug) now?
1: Yes  
2: No

What is your current daily dose of (^drug)? Please give me the amount in ml. or mg.
How many times per month do you pick up your prescription for (^drug prescribed) now?

Have you been subject to supervised consumption for (^drug prescribed)?
1: Yes  
2: No

(^Did you/Do you) have a keyworker associated with your prescribing based elsewhere, such as in a drug service?
1: Yes  
2: No

How often do you see or speak with this person?
1: Four or more times a week  
2: Two or three times a week  
3: About once per week  
4: About once per fortnight  
5: About once per month  
6: Less than once per month

How would you describe your relationship with your keyworker?
1: Excellent  
2: Good  
3: OK  
4: Not very good  
5: Bad

Please look at this calendar. As a reminder, you presented at (^agency name) on (^date of triage interview) and we conducted our first interview with you on (^last interview date)

Can you tell me in which week you began to attend counselling?

Which of these drugs were you attending counselling for?
1: Heroin  
2: Methadone (not prescribed to you)  
3: Other Opiates (eg. morphine, diamorphine, Subutex, codeine, dihydrocodeine (DF1 18s), Opium)  
4: Crack cocaine  
5: Cocaine powder  
6: Amphetamines (not prescribed to you)  
7: Cannabis (Hash, resin, solids, grass, weed, skunk etc)  
8: Ecstasy  
9: Hallucinogens (e.g. mushrooms, LSD, ketamine)  
10: Alcohol  
11: Benzos ('Tranquillizers or sleeping pills) NOT prescribed to you  
12: Solvents (e.g. glue, aerosols)  
13: Any other drugs (not already listed)  
14: SPONTANEOUS: Was not getting (^type of treatment) for any drugs

Have you stopped attending counselling for any reason since you started it?
1: Yes  
2: No

So why did you stop attending counselling?
1: Treatment complete, drug free  
2: Treatment complete, not drug free  
3: Treatment withdrawn/kicked out  
4: No appropriate treatment available  
5: Referred on  
6: Dropped out  
7: Moved away  
8: Went to prison  
97: Other

When did you first stop attending counselling?
INTERVIEWER: ASK OR CODE ‘So are you still attending counselling for your drug use?’

1: Yes
2: No

And have you started attending structured counselling for your drug use again since (^Bcousp)?

1: Yes
2: No

When you (^first) started counselling after your last interview, how often did you see your individual counsellor or key worker for a one-to-one session? (This does not include brief sessions that took less than 15 mins, or sessions that were offered but that you didn’t go to.)

1: Four or more times per week
2: Two or three times per week
3: About once per week
4: About once per fortnight
5: About once per month
6: Less than once per month
7: Never

How would you describe your relationship with your counsellor?

1: Excellent
2: Good
3: OK
4: Not very good
5: Bad

Did the frequency of the one-to-one sessions decrease or increase during the course?

1: Decrease
2: Increase
3: Neither (stayed the same)

Did the frequency of the group sessions decrease or increase during the course?

1: Decrease
2: Increase
3: Neither (stayed the same)

Please look at this calendar. As a reminder, you presented at (^agency name) on (^date of triage interview) and we conducted our first interview with you on (^last interview date).

Can you tell me in which week you started attending structured daycare?

Which of these drugs were you attending daycare for?

1: Heroin
2: Methadone (not prescribed to you)
3: Other Opiates (eg. morphine, diamorphine, Subutex, codeine, dihydrocodeine (DF118s), Opium)
4: Crack cocaine
5: Cocaine powder
6: Amphetamines (not prescribed to you)
7: Cannabis (Hash, resin, solids, grass, weed, skunk etc)
8: Ecstasy
9: Hallucinogens (e.g. mushrooms, LSD, ketamine)
10: Alcohol
11: Benzos (‘Tranquillizers or sleeping pills) NOT prescribed to you
12: Solvents (e.g. glue, aerosols)
13: Any other drugs (not already listed)
14: SPONTANEOUS: Was not getting (^type of treatment) for any drugs

Have you stopped attending daycare for any reason since you started it?

1: Yes
2: No

So why did you stop attending daycare?

1: Treatment complete, drug free
2: Treatment complete, not drug free
3: Treatment withdrawn/kicked out
4: No appropriate treatment available
5: Referred on
6: Dropped out
7: Moved away
8: Went to prison
97: Other
When did you stop attending structured daycare?

INTERVIEWER: ASK OR CODE ‘So are you still attending structured daycare?’

1: Yes
2: No

And have you started attending structured daycare for your drug use again since (last Bacousp)?

1: Yes
2: No

Please look at this calendar. As a reminder, you presented at (agency name) on (date of triage interview) and we conducted our first interview with you on (last interview date).

Can you tell me in which week you started attending residential rehab?

Which of these drugs were you attending residential rehab for?

1: Heroin
2: Methadone (not prescribed to you)
3: Other Opiates (eg. morphine, diamorphine, Subutex, codeine, dihydrocodeine (DF118s), Opium)
4: Crack cocaine
5: Cocaine powder
6: Amphetamines (not prescribed to you)
7: Cannabis (Hash, resin, solids, grass, weed, skunk etc)
8: Ecstasy
9: Hallucinogens (e.g. mushrooms, LSD, ketamine)
10: Alcohol
11: Benzos (‘Tranquillizers or sleeping pills) NOT prescribed to you
12: Solvents (e.g glue, aerosols)
13: Any other drugs (not already listed)
14: SPONTANEOUS: Was not getting (~type of treatment) for any drugs

Have you stopped left residential rehab for any reason since you started it?

1: Yes
2: No

So why did you leave residential rehab?

1: Treatment complete, drug free
2: Treatment complete, not drug free
3: Treatment withdrawn/kicked out
4: No appropriate treatment available
5: Referred on
6: Dropped out
7: Moved away
8: Went to prison
97: Other

When did you first leave residential rehab?

INTERVIEWER: ASK OR CODE ‘So are you still attending residential rehab?’

1: Yes
2: No

And have you started attending residential rehab for your drug use again since (last Bacousp)?

1: Yes
2: No

When you first started residential rehab since your last interview, how long was your planned stay (~in residential rehab)?

Have you been formally discharged from all treatment?

1: Yes
2: No

What was the reason for discharge?

1: Treatment complete, drug free
2: Treatment complete, not drug free
3: Treatment withdrawn/kicked out
4: Referred on
5: Dropped out
6: Moved away
7: Went to prison
97: Other

I am now going to ask you whether you have received or used some other drug treatment related services since we last interviewed you on (~last interview date).
Have you used a needle exchange since we last interviewed you? These provide a supply of clean injecting equipment, and dispose of used equipment.

1: Yes  
2: No

Have you received safer injecting advice, that is, advice on injecting techniques to avoid injury and spread of infection?

1: Yes  
2: No

Have you received overdose advice, that is, advice on safer use of drugs to avoid the risk of overdose?

1: Yes  
2: No

As part of any treatment you have received since your last interview, have you received an alcohol-specific intervention, that is, any form of treatment or intervention focused entirely on use of alcohol?

1: Yes  
2: No

And have you received a stimulant-specific or crack-specific intervention? That is any form of treatment or intervention aimed purely at use of stimulants like amphetamines (or speed), powder cocaine or crack?

IF YES: Was it for crack, powder cocaine or amphetamines?

1: Yes – amphetamines (speed) or powder cocaine  
2: Yes – crack cocaine  
3: No

INTERVIEWER: ASK WHAT TYPE OF TREATMENT OR INTERVENTION WAS AIMED SOLELY AT USE OF CRACK AND RECORD VERBATIM

So you have received the following since we last spoke to you:

(^Was this received/Which of these were received) as part of a care plan?

0: None of them  
1: Needle exchange  
2: Safer injecting advice

3: Overdose advice  
4: Alcohol-specific intervention  
5: Stimulant-specific intervention (amphetamines or powder cocaine)  
6: Crack-specific intervention

I would like to know if you have received any of the following services since your last interview on (^Qsample. Fintdate), either as a part of drug treatment or elsewhere.

Have you received any advice on your personal or household finances, including advice on managing benefits?

1: Yes  
2: No

Have you used any NHS or other services focused on your mental health?

1: Yes  
2: No

Have you had any advice or support related to your accommodation or housing?

1: Yes  
2: No

Have you attended a peer support or service user group?

1: Yes  
2: No

Have you been provided with assisted access to any sport or leisure facilities, for example, trips to sports centres, gym facilities or climbing walls?

1: Yes  
2: No

Have you had any support with education or training initiatives, for example help with organising training courses or access to further education colleges?

1: Yes  
2: No

Have you received family support?

1: Yes  
2: No
Have you received any employment support, including assistance with applying for jobs and preparing for interviews?

1: Yes
2: No

Have you received maternity support services?

1: Yes
2: No

So you have received the following support services since we last spoke to you:

(Has this received/Which of these were received) as part of your agreed care plan?

0: None of them
1: Advice with personal finances/benefits
2: NHS or other mental health services
3: Advice/support on accommodation or housing
4: Peer support/service user group
5: Assisted access to sport/leisure activities
6: Education/training initiatives
7: Employment support
8: Support with family situation
9: Maternity support

When we first spoke to you, you told us that you first received structured or residential treatment for your drug use at the age of (qsample.faftreat).

Since that age, have you had any breaks of 3 months or more when you were not attending any of structured or residential services? You should include any such breaks caused by being in prison or another form of custody.

1: Yes
2: No

So how many times have you had a break of 3 months or more when you did not attend any structured or residential treatment services?

During that break from structured treatment, how long were you drug free for?

1: None of the time
2: A quarter of the time
3: Half the time
4: Three-quarters of the time
5: Nearly all of the time

At the last interview you told us that (the following drugs were a problem to you/or if no problem drugs) you had taken the following drug(s) in the last 4 weeks:

Were there any periods of at least one week where you stopped using (ALL these drugs/it) since your last interview on (last interview date)?

1: Yes
2: No

When did that start?

Have you used any (ProbDrgs) since?

1: Yes
2: No

Which ones did you use? Was it... (Probdrugs)

When did you use (it/either of them/any of them) again?

Did you take any other drugs during the time that you were not using ProbDrgs?

1: Yes
2: No
What drugs were you using?

1: Heroin
2: Methadone (not prescribed to you)
3: Other Opiates (eg. morphine, diamorphine, Subutex, codeine, dihydrocodeine (DFI 18s), Opium)
4: Crack cocaine
5: Cocaine powder
6: Amphetamines (not prescribed to you)
7: Cannabis (Hash, resin, solids, grass, weed, skunk etc)
8: Ecstasy
9: Hallucinogens (e.g. mushrooms, LSD, ketamine)
10: Alcohol
11: Benzos (‘Tranquillizers or sleeping pills) NOT prescribed to you
12: Solvents (e.g. glue, aerosols)
13: Any other drugs (not already listed)
14: Have not taken any of these drugs

Have you been arrested?

1: Yes
2: No

Have you had a restriction of bail imposed, or are you now attending any treatment services as a condition of bail?

1: Yes
2: No

Have you been told that you would be charged with an additional offence if you didn’t attend treatment?

1: Yes
2: No

Have you now been made subject to a DTTO (Drug treatment and testing order) or DRR (Drug rehabilitation requirement)?

1: Yes
2: No

Are you now subject to any other probation orders (that is since we last interviewed you on [^last interview date])?

1: Yes (please specify)
2: No

Since you were last interviewed on (^last interview date) have you been imprisoned or held in custody for a week or more?

1: Yes
2: No

Please tell me the dates that you were imprisoned.

When did it start?

When did that end?

Were there any other times you were imprisoned since your last interview?

1: Yes
2: No

Since you were last interviewed on (^last interview date)...
### AIMS/GOALS OF TREATMENT

What do you now hope to gain or achieve by being in treatment?

<table>
<thead>
<tr>
<th></th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No clear goals</td>
</tr>
<tr>
<td>1</td>
<td>Stop taking all drugs</td>
</tr>
<tr>
<td>2</td>
<td>Stop taking specific drug(s)</td>
</tr>
<tr>
<td>3</td>
<td>Reduce all drug use</td>
</tr>
<tr>
<td>4</td>
<td>Reduce use of specific drugs</td>
</tr>
<tr>
<td>5</td>
<td>Improve health</td>
</tr>
<tr>
<td>6</td>
<td>Improve employment chances</td>
</tr>
<tr>
<td>7</td>
<td>Improve education</td>
</tr>
<tr>
<td>8</td>
<td>Improve relationships</td>
</tr>
<tr>
<td>9</td>
<td>Sort life out/get it together</td>
</tr>
<tr>
<td>10</td>
<td>Get kids back/contact with kids</td>
</tr>
<tr>
<td>11</td>
<td>Keep someone happy (family, partner etc)</td>
</tr>
<tr>
<td>12</td>
<td>Sort out other family issues</td>
</tr>
<tr>
<td>13</td>
<td>Sort out finances</td>
</tr>
<tr>
<td>14</td>
<td>Sort out accommodation</td>
</tr>
<tr>
<td>15</td>
<td>Receive script/prescription</td>
</tr>
<tr>
<td>16</td>
<td>Referral to another drug service</td>
</tr>
<tr>
<td>17</td>
<td>Avoid a sentence</td>
</tr>
<tr>
<td>18</td>
<td>Look better in court</td>
</tr>
<tr>
<td>19</td>
<td>Get out of crime/stop getting in legal trouble</td>
</tr>
<tr>
<td>20</td>
<td>Just see what happens/what's available</td>
</tr>
<tr>
<td>21</td>
<td>Get a care worker/someone to talk to</td>
</tr>
<tr>
<td>97</td>
<td>Other specific goal</td>
</tr>
</tbody>
</table>

How likely do you think it is that any treatment you are now receiving will have helped you to achieve your most important goal/goals in **3 months time**?

<table>
<thead>
<tr>
<th></th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very likely</td>
</tr>
<tr>
<td>2</td>
<td>Quite likely</td>
</tr>
<tr>
<td>3</td>
<td>Neither likely nor unlikely</td>
</tr>
<tr>
<td>4</td>
<td>Quite unlikely</td>
</tr>
<tr>
<td>5</td>
<td>Very unlikely</td>
</tr>
</tbody>
</table>

Please say how much you agree or disagree with the following statements:

**Basically, I feel that my drug use is a very serious problem in my life.**

<table>
<thead>
<tr>
<th></th>
<th>Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strongly disagree</td>
</tr>
<tr>
<td>2</td>
<td>Disagree</td>
</tr>
<tr>
<td>3</td>
<td>Neither agree nor disagree</td>
</tr>
<tr>
<td>4</td>
<td>Agree</td>
</tr>
<tr>
<td>5</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

**Often I don’t like myself because of my drug use.**

<table>
<thead>
<tr>
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</thead>
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<tr>
<td>4</td>
<td>Agree</td>
</tr>
<tr>
<td>5</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

**Lately, I feel if I don’t change, my life will keep getting worse.**

<table>
<thead>
<tr>
<th></th>
<th>Agreement</th>
</tr>
</thead>
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</tr>
<tr>
<td>4</td>
<td>Agree</td>
</tr>
<tr>
<td>5</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>
I really feel bad that my drug use and the way I've been living has hurt a lot of people.

1: Strongly disagree
2: Disagree
3: Neither agree nor disagree
4: Agree
5: Strongly agree

It is more important to me than anything else that I stop using drugs.

1: Strongly disagree
2: Disagree
3: Neither agree nor disagree
4: Agree
5: Strongly agree

C. Drug behaviour

I am now going to ask you some questions about your use of drugs since our last interview. As before, the questions are mainly about non-prescribed drugs. It's important to us that you answer these questions as honestly and accurately as you can. Remember, all your answers are treated confidentially, and won't affect your treatment or legal status, either at the moment or in the future.

Which of the drugs on the card have you taken in the last 4 weeks?

1: Heroin
2: Methadone (not prescribed to you)
3: Other Opiates (eg. morphine, diamorphine, Subutex, codeine, dihydrocodeine (DF118s), Opium)
4: Crack cocaine
5: Cocaine powder
6: Amphetamines (not prescribed to you)
7: Cannabis (Hash, resin, solids, grass, weed, skunk etc)
8: Ecstasy
9: Hallucinogens (e.g. mushrooms, LSD, ketamine)
10: Alcohol
11: Benzos ('Tranquillizers or sleeping pills) NOT prescribed to you
12: Solvents (e.g. glue, aerosols)
13: Any other drugs (not already listed)
14: Have not taken any of these drugs

And does (this drug/any of these drugs) cause you problems at the moment?

1: Heroin
2: Methadone (not prescribed to you)
3: Other Opiates (eg. morphine, diamorphine, Subutex, codeine, dihydrocodeine (DF118s), Opium)
4: Crack cocaine
5: Cocaine powder
6: Amphetamines (not prescribed to you)
7: Cannabis (Hash, resin, solids, grass, weed, skunk etc)
8: Ecstasy
9: Hallucinogens (e.g. mushrooms, LSD, ketamine)
10: Alcohol
11: Benzos ('Tranquillizers or sleeping pills) NOT prescribed to you
12: Solvents (e.g. glue, aerosols)
13: Any other drugs (not already listed)
14: Respondent does not classify any drugs as a problem

Which (^other) drugs on the card have you taken since your last interview on (^last interview date)?

1: Heroin
2: Methadone (not prescribed to you)
3: Other Opiates (eg. morphine, diamorphine, Subutex, codeine, dihydrocodeine (DF118s), Opium)
4: Crack cocaine
5: Cocaine powder
6: Amphetamines (not prescribed to you)
7: Cannabis (Hash, resin, solids, grass, weed, skunk etc)
8: Ecstasy
9: Hallucinogens (e.g. mushrooms, LSD, ketamine)
10: Alcohol
11: Benzos ('Tranquillizers or sleeping pills) NOT prescribed to you
12: Solvents (e.g. glue, aerosols)
13: Any other drugs (not already listed)
14: Respondent does not classify any drugs as a problem
You have said that you have problems with (^drugs that are a problem to respondent). Which of these drugs causes you the most problems at the moment?

1: Heroin
2: Methadone
3: Other opiates
4: Crack cocaine
5: Cocaine
6: Amphetamines
7: Cannabis
8: Ecstasy
9: Hallucinogens
10: Alcohol
11: Benzos
12: Solvents
13: Other drugs
14: They all cause me equal problems/none of them (exclusive code)
15: Other drug(s) are biggest problem at the moment

Are you receiving a prescription specifically for your drug use at the moment?

1: Yes
2: No

Which drugs are you currently being prescribed for your drug use?

1: Methadone
2: Subutex
3: Lofexadine
4: Naltrexone
5: Naloxone
6: Ritalin
7: Zopiclone
8: Beta Blockers
9: Anti-depressants (Prozac, Seroxat, Lustral, Faverin, Cipramil, MAOI’s)
10: Anti-psychotics (e.g. Largactil)
11: Other (please specify)

I am now going to ask you some questions about each of the drugs that you’ve used in the last four weeks. These questions are mainly about drugs that have not been prescribed to you.

First of all, have you injected any drugs in the past 4 weeks?

1: Yes
2: No

**Heroin**

How often have you used Heroin in the last 4 weeks?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week

On how many days in the last 4 weeks, that is in the last 28 days, did you use heroin?

On the days when you took heroin during the last 4 weeks, how much heroin in grams would you say you normally used?

So on the days when you took heroin during the last 4 weeks, how many £10 bags did you use on a normal day?

On the days that you used heroin in the last 4 weeks, what would you say was the value in pounds of heroin you normally used?

Not including any heroin you may have bought for someone else or to sell, what, in total, what was the value in pounds of the heroin you personally used in the last week?

And can I just check, have you taken heroin in the last 48 hours?

1: Yes
2: No

How often in the last 4 weeks did you inject heroin?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week
6: Not injected heroin in the last 4 weeks

For the following questions, I would like you to think about your use of heroin in the last 4 weeks.
Please select the option on the card that best describes your use of heroin in the last 4 weeks

1: Never out of control
2: Almost never out of control
3: Sometimes out of control
4: Nearly always out of control
5: Always out of control

Unprescribed methadone

The following questions are about methadone you have taken in the last 4 weeks that was not prescribed to you.

How often have you used unprescribed methadone in the last 4 weeks?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week
6: Only used prescribed methadone in last 4 weeks

On how many days in the last 4 weeks, that is, in the last 28 days, did you use unprescribed methadone?

On the days when you used unprescribed methadone in the last 4 weeks, would what would you say was the value in pounds of the unprescribed methadone you normally used?

What in total was the value in pounds of the unprescribed methadone you personally used in the last week?

How often in the last 4 weeks did you inject unprescribed methadone?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week
6: Not injected unprescribed methadone in the last 4 weeks

For the following questions, I would like you to think about your use of methadone in general, whether prescribed or unprescribed, in the last 4 weeks. Please select the option on the card that best describes your use of methadone in the last 4 weeks.

1: Never out of control
2: Almost never out of control
3: Sometimes out of control
4: Nearly always out of control
5: Always out of control

Please select the option on the card that best describes how you felt about the prospect of missing a hit of heroin during the last 4 weeks?

1: Never worried or anxious
2: Almost never worried or anxious
3: Sometimes worried or anxious
4: Nearly always worried or anxious
5: Always worried or anxious

Which answer on the card best describes how you felt about the prospect of missing a hit of heroin during the last 4 weeks?

1: Never
2: Almost never
3: Sometimes
4: Nearly always
5: Always

Thinking about your use of heroin during the last 4 weeks, how often did you worry about it?

1: Never
2: Almost never
3: Sometimes
4: Nearly always
5: Always

And during the last 4 weeks, how often did you wish you could stop using heroin?

1: Never
2: Almost never
3: Sometimes
4: Nearly always
5: Always

How difficult do you find it to stop or go without heroin?

1: Not difficult
2: Quite difficult
3: Very difficult
4: Impossible
Which answer best describes how you felt at the prospect of missing a hit of methadone during the last 4 weeks?

1: Never worried or anxious
2: Almost never worried or anxious
3: Sometimes worried or anxious
4: Nearly always worried or anxious
5: Always worried or anxious

Thinking about your use of methadone during the last 4 weeks, how often did you worry about it?

1: Never
2: Almost never
3: Sometimes
4: Nearly always
5: Always

And during the last 4 weeks, how often did you wish you could stop using methadone?

1: Never
2: Almost never
3: Sometimes
4: Nearly always
5: Always

How difficult do you find it to stop or go without methadone?

1: Not difficult
2: Quite difficult
3: Very difficult
4: Impossible

On how many days in the last 4 weeks, that is, in the last 28 days did you use any of these other opiates?

So on the days when you used any of these other opiates (not heroin and methadone) in the last 4 weeks, what was the value in pounds of the other opiates you normally used?

Not including other opiates you bought for someone else or to sell, what, in total, what was the value in pounds of the other opiates you personally used in the last week?

How often in the last 4 weeks did you inject other opiates?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week
6: Not injected other opiates in the last 4 weeks

Crack

How often have you used crack in the last 4 weeks?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week

And on how many days in the last 4 weeks, that is, in the last 28 days did you use crack?

So on the days when you used crack in the last 4 weeks, what was the value in pounds of the crack that you normally used?

Not including any crack you bought for someone else or to sell, what, in total, was the value in pounds of the crack you personally used in the last week?

And can I just check, have you taken crack in the last 48 hours?

1: Yes
2: No

Other opiates

You told me that you have taken opiates other than heroin or methadone in the last 4 weeks. This could have been one or more from morphine, Subutex, Codeine, Dydrocodeine (DF118s), Opium, Diamorphine, or other painkillers. How often have you used any of these other opiates in the last 4 weeks?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week

Not including other opiates you bought for someone else or to sell, what, in total, was the value in pounds of the other opiates you personally used in the last week?

And can I just check, have you taken crack in the last 48 hours?
How often in the **last 4 weeks** did you inject crack?

1: Daily  
2: Most days  
3: 3 or 4 days a week  
4: 1 or 2 days a week  
5: Less than once a week  
6: Not injected crack in the last 4 weeks

For the following questions, I would like you to think about your use of crack in the **last 4 weeks**.

Please select the option on the card that best describes your use of crack in the last 4 weeks

1: Never out of control  
2: Almost never out of control  
3: Sometimes out of control  
4: Nearly always out of control  
5: Always out of control

Which answer on the card best describes how you felt at the prospect of missing a hit of crack during the last 4 weeks?

1: Never worried or anxious  
2: Almost never worried or anxious  
3: Sometimes worried or anxious  
4: Nearly always worried or anxious  
5: Always worried or anxious

Thinking about your use of crack during the last 4 weeks, how often did you worry about it?

1: Never  
2: Almost never  
3: Sometimes  
4: Nearly always  
5: Always

And during the last 4 weeks, how often did you wish you could stop using crack?

1: Never  
2: Almost never  
3: Sometimes  
4: Nearly always  
5: Always

How difficult do you find it to stop or go without crack?

1: Not difficult  
2: Quite difficult  
3: Very difficult  
4: Impossible

**Powder cocaine**

How often have you used powder cocaine in the **last 4 weeks**?

1: Daily  
2: Most days  
3: 3 or 4 days a week  
4: 1 or 2 days a week  
5: Less than once a week

And on how many days in the **last 4 weeks**, that is, in the last 28 days did you use powder cocaine?

On the days when you used powder cocaine in the last 4 weeks, how much powder cocaine in grams would you say you normally used?

So on the days when you used powder cocaine in the last 4 weeks, how many wraps did you use on a normal day?

So on the days when you used powder cocaine in the last 4 weeks, what was the value in pounds of the powder cocaine you normally used?

Not including any you bought for someone else or to sell, what, in total, was the value of the powder cocaine you personally used in the **last week**?

And can I just check, have you taken powder cocaine in the last 48 hours?

1: Yes  
2: No

How often in the **last 4 weeks** did you inject powder cocaine?

1: Daily  
2: Most days  
3: 3 or 4 days a week  
4: 1 or 2 days a week  
5: Less than once a week  
6: Not injected powder cocaine in last 4 weeks
For the following questions, I would like you to think about your use of powder cocaine in the last 4 weeks. Please select the option on the card that best describes your use of powder cocaine in the last 4 weeks.

1: Never out of control
2: Almost never out of control
3: Sometimes out of control
4: Nearly always out of control
5: Always out of control

Which answer on the card best describes how you felt about the prospect of missing a hit of (powder) cocaine during the last 4 weeks?

1: Never worried or anxious
2: Almost never worried or anxious
3: Sometimes worried or anxious
4: Nearly always worried or anxious
5: Always worried or anxious

Thinking about your use of powder cocaine during the last 4 weeks, how often did you worry about it?

1: Never
2: Almost never
3: Sometimes
4: Nearly always
5: Always

And during the last 4 weeks, how often did you wish you could stop using powder cocaine?

1: Never
2: Almost never
3: Sometimes
4: Nearly always
5: Always

How difficult do you find it to stop or go without powder cocaine?

1: Not difficult
2: Quite difficult
3: Very difficult
4: Impossible

For the following questions, I would like you to think about your use of unprescribed amphetamines (Speed) in the last 4 weeks.

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week

And on how many days in the last 4 weeks, that is, in the last 28 days did you use unprescribed amphetamines?

On the days you used unprescribed amphetamines in the last 4 weeks, how much unprescribed amphetamine in grams would you say you normally used?

So on the days that you used unprescribed amphetamines in the last 4 weeks, how many wraps did you use on a normal day?

On the days when you used unprescribed amphetamines in the last 4 weeks, what would you say was the value in pounds of the unprescribed amphetamines you normally used?

Not including any amphetamines you bought for someone else or to sell, what in total was the value in pounds of the unprescribed amphetamines you personally used in the last week?

And can I just check, have you taken amphetamines in the last 48 hours?

1: Yes
2: No

How often in the last 4 weeks did you inject unprescribed amphetamines?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week
6: Not injected unprescribed amphetamines in last 4 weeks
For the following questions, I would like you to think about your use of amphetamines, whether prescribed or unprescribed, in the last 4 weeks. Please select the option on the card that best describes your use of amphetamines in the last 4 weeks.

1: Never out of control
2: Almost never out of control
3: Sometimes out of control
4: Nearly always out of control
5: Always out of control

Which answer on the card best describes how you felt about the prospect of missing a hit of amphetamines during the last 4 weeks?

1: Never worried or anxious
2: Almost never worried or anxious
3: Sometimes worried or anxious
4: Nearly always worried or anxious
5: Always worried or anxious

And thinking about your use of amphetamines during the last 4 weeks, how often did you worry about it?

1: Never
2: Almost never
3: Sometimes
4: Nearly always
5: Always

And during the last 4 weeks, how often did you wish you could stop using amphetamines?

1: Never
2: Almost never
3: Sometimes
4: Nearly always
5: Always

How difficult do you find it to stop or go without amphetamines?

1: Not difficult
2: Quite difficult
3: Very difficult
4: Impossible

Cannabis

How often have you used cannabis in the last 4 weeks?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week

And on how many days in the last 4 weeks, that is, in the last 28 days did you use cannabis?

On the days when you used cannabis in the last 4 weeks, how much cannabis in ounces or grams did you normally use?

1: Answer given in ounces
2: Answer given in grams

So on the days when you used cannabis in the last 4 weeks, what was the value in pounds of the cannabis you personally used in the last week?

Not including any cannabis you bought for someone else or to sell, what, in total, what was the value in pounds of the cannabis you personally used in the last week?

Alcohol

How often did you drink alcohol in the last 4 weeks?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week

And on how many days in the last 4 weeks, that is, in the last 28 days did you drink alcohol?

On the days on which you drank alcohol in the last 4 weeks, how many units of alcohol did you normally drink?

So on the days when you drank alcohol in the last 4 weeks, what was the value in pounds of the alcohol you normally drank?

Not including any alcohol you bought for someone else or to sell, what in total was the value in pounds of the alcohol you personally drank in the last week?
Looking at the drinks measures on the first card, can you tell me how often you would have (If respondent is male, 'eight', if respondent is female, 'six') or more drinks of this size on a single occasion?

1: Never
2: A few times a year
3: Every month
4: Every week
5: 2 or 3 times a week
6: Every day

How often during the last year have you been unable to remember what happened the night before when you had been drinking?

1: Never
2: A few times a year
3: Every month
4: Every week
5: 2 or 3 times a week
6: Every day

How often during the last year have you failed to do what was normally expected of you because of drinking alcohol?

1: Never
2: A few times a year
3: Every month
4: Every week
5: 2 or 3 times a week
6: Every day

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking and suggested you cut down?

1: No,
2: Yes, on one occasion
3: Yes, on more than one occasion

Benzos

How often did you take benzos ('Tranquillizers, sleeping pills etc) that were NOT prescribed to you in the last 4 weeks?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week

And on how many days in the last 4 weeks, that is, in the last 28 days did you take benzos?

So on the days when you used benzos in the last 4 weeks, what was the value in pounds of the benzos you normally used?

Not including any benzos you bought for someone else or to sell, what, in total, what was the value in pounds of the benzos you personally used in the last week?

How often in the last 4 weeks did you inject Benzos?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week
6: Not injected benzos in last 4 weeks

Ecstasy

How often did you take ecstasy in the last 4 weeks?

1: Daily
2: Most days
3: 3 or 4 days a week
4: 1 or 2 days a week
5: Less than once a week

And on how many days in the last 4 weeks, that is, in the last 28 days did you take ecstasy?

So on the days when you took ecstasy in the last 4 weeks, what was the value in pounds of the Ecstasy you normally used?
Not including any ecstasy you bought for someone else or to sell, what, in total, was the value in pounds of the Ecstasy you personally used in the last week?

Hallucinogens

How often have you used Hallucinogens in the last 4 weeks?

1: Daily  
2: Most days  
3: 3 or 4 days a week  
4: 1 or 2 days a week  
5: Less than once a week  

And on how many days in the last 4 weeks, that is, in the last 28 days did you take hallucinogens?

So on the days when you used hallucinogens in the last 4 weeks, what was the value in pounds of the hallucinogens you normally used?

Not including any hallucinogens you bought for someone else or to sell, what, in total, was the value in pounds of the hallucinogens you personally used in the last week?

Solvents

How often did you take solvents in the last 4 weeks?

1: Daily  
2: Most days  
3: 3 or 4 days a week  
4: 1 or 2 days a week  
5: Less than once a week  

And on how many days in the last 4 weeks, that is, in the last 28 days did you take solvents?

So on the days when you used solvents in the last 4 weeks, what was the value in pounds of the solvents you normally used?

Not including any solvents you bought for someone else or to sell, what, in total, was the value in pounds of the solvents you personally used in the last week?

Other drugs

And on how many days in the last 4 weeks, that is, in the last 28 days did you take other drugs?

So on the days when you used other drugs in the last 4 weeks, what was the value in pounds of the other drugs you normally used?

Not including any other drugs you bought for someone else or to sell, what, in total, was the value of the other drugs you personally used in the last week?

Normal use

You’ve told me that you’ve used the following drugs in the last 4 weeks...

Is this more, less or about the same as you usually use?

1: Used more drugs than usual in last 4 weeks  
2: Used less drugs than usual in last 4 weeks  
3: Used about the same amount of drugs in last 4 weeks  

When did you start using (^more/less) drugs?

1: Within the last 7 days  
2: 1 to 2 weeks ago  
3: 2 to 3 weeks ago  
4: 3 to 4 weeks ago  
5: 4 to 5 weeks ago  
6: 5 to 6 weeks ago  
7: 6 weeks ago or more  
8: SPONTANEOUS: It was a gradual change  
9: SPONTANEOUS: I can’t remember when  

From what you’ve told me so far, it seems that you’ve used drugs to the approximate value of £^CValdrug in the last week. Does this sound about right?

1: Yes  
2: No  

Could you estimate the correct value of the drugs you have used in the last 7 days?

Can I check, is this also the amount you have actually spent on drugs for yourself in the last 7 days?

1: Yes  
2: No
How much did you actually spend on drugs for yourself in the last 7 days?

**D. RISK BEHAVIOUR: Self Completion**

**Practice questions**

If you need help ask the interviewer.

The 3 following questions introduce the types of question that will be asked to you. To continue, press the number 1, and then the key with the red sticker in it.

Have you used a computer since your last interview?
Choose one answer: Press the number shown next to the answer you want to give, then press the key with the red sticker.

1: Yes
2: No

This time you will be given a choice of answers.

In the last 4 weeks, how often have you been to the pub?
Choose one answer. To move on please press the key with the red sticker.

1: Frequently
2: Sometimes
3: Hardly ever
4: Never

This time you can select a number by pressing the number keys.

How old are you?

You have now finished the practice questions. The next questions are about how you take drugs.

Questions start from here

The following questions are about your use of injecting equipment with other people. These questions refer to everybody, including friends and/or your sexual partner and/or strangers.

In the past 4 weeks, how often have you given or lent used needles/syringes to anyone?

1: Frequently
2: Sometimes
3: Hardly ever
4: Never

In the past 4 weeks, how often have you injected with needles/syringes that have already been used by somebody else?

1: Frequently
2: Sometimes
3: Hardly ever
4: Never

In the past 4 weeks, how often have you filled your syringe from a syringe already used by someone else?

1: Frequently
2: Sometimes
3: Hardly ever
4: Never

In the past 4 weeks, how often have you let someone else fill their syringe with a syringe you had already used?

1: Frequently
2: Sometimes
3: Hardly ever
4: Never

In the past 4 weeks, how often have you drawn up from a container or spoon or used a filter into which someone else had put a used syringe?

1: Frequently
2: Sometimes
3: Hardly ever
4: Never
In the past 4 weeks, how often have you put a used needle into a container, spoon or filter that was then used by somebody else?

1: Frequently
2: Sometimes
3: Hardly ever
4: Never

In the past 4 weeks, how often have you used the same water or bleach as someone else for flushing out/cleaning?

1: Frequently
2: Sometimes
3: Hardly ever
4: Never

During the last 4 weeks, with how many different people have you done any of these things?

In the past 4 weeks, have you taken two (or more) opiates together (e.g. heroin, methadone, DF118s, codeine)?

1: Yes
2: No

Did you inject any of these?

1: None
2: One
3: Two or more together or at the same time

In the past 4 weeks, have you taken opiates with benzos (e.g. valium, temazepam etc)?

1: Yes
2: No

Did you inject any of these?

1: None
2: One
3: Two or more together or at the same time

In the past 4 weeks, have you taken opiates with alcohol?

1: Yes
2: No

Did you inject the opiates?

1: Yes
2: No

Have you taken drugs after a break (a week or more) without cutting down from your usual amount?

1: Yes
2: No

Have you overdosed on any drug you have taken in the past 3 months?

1: Yes
2: No

In the past 3 months, have you had penetrative sex (vaginal or anal) without using a condom?

1: Yes
2: No

How many people have you had penetrative sex with, without using a condom?

In the past 3 months, who did you have penetrative sex with, without using a condom (please choose one)

1: With my regular partner only
2: With my regular partner and with someone else/other people
3: Only with people who were not my regular partner
4: I don’t know
5: I don’t want to answer

What is your current hepatitis A status?

1: Positive
2: Negative
3: I don’t know/not been tested
4: I don’t want to answer

What is your current hepatitis B status?

1: Positive
2: Negative
3: I don’t know/not been tested
4: I don’t want to answer
What is your current hepatitis C status?

1: Positive
2: Negative
3: I don’t know/not been tested
4: I don’t want to answer

What is your current HIV status?

1: Positive
2: Negative
3: I don’t know/not been tested
4: I don’t want to answer

E. OFFENDING BEHAVIOUR – self completion

The next questions are about things you may have done since your last interview on (*last interview date).

Shoplifting

Since your last interview, have you gone into a shop and taken one or more things and then deliberately left the shop without paying?

1: Yes
2: No

And have you done this in the last 4 weeks?

1: Yes
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.

Buying and selling stolen goods

Apart from anything you have already told us about, have you sold anything to someone else that you knew was stolen, or have you bought anything that you knew or thought was stolen, since your last interview?

1: Yes
2: No

And have you done this in the last 4 weeks?

1: Yes
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.

Selling drugs

Since your last interview, have you sold illegal drugs, such as heroin, cocaine, crack, ecstasy or cannabis to anyone, including friends?

1: Yes
2: No

And have you done this in the last 4 weeks?

1: Yes
2: No

How many times have you done this in the last 4 weeks?

And how much profit did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.
Prostitution

Since your last interview, have you offered sex for money, drugs or something else?

1: Yes  
2: No

And have you done this in the last 4 weeks?

1: Yes  
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.

Vehicle crime

Since your last interview, have you stolen or driven away a car, van, motorbike or other vehicle without permission?

1: Yes  
2: No

And have you done this in the last 4 weeks?

1: Yes  
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.

Home burglary

Since you last interview, have you gone into someone’s home without their permission because you wanted to steal or damage something?

1: Yes  
2: No

And have you done this in the last 4 weeks?

1: Yes  
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.

Business burglary

Since you last interview, have you gone into other types of buildings, such as a factory, office, shop, warehouse, school, garage or shed, without permission because you wanted to steal or damage something? DO NOT include shoplifting.

1: Yes  
2: No

And have you done this in the last 4 weeks?

1: Yes  
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.
Violent acquisitive crime

Since your last interview, have you used force, violence or threats against anyone in order to steal something from them, or a shop, petrol station, bank or any other business?

1: Yes
2: No

And have you done this in the last 4 weeks?

1: Yes
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.

Back to non-violent acquisitive crime

Bag snatching

Since your last interview, have you stolen anything from someone’s hand, pocket, bag or anything else that they were carrying or wearing without the use of force, violence or threats?

1: Yes
2: No

And have you done this in the last 4 weeks?

1: Yes
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.

Other stealing

Apart from anything you have already mentioned, have you stolen anything since your last interview?

1: Yes
2: No

And have you done this in the last 4 weeks?

1: Yes
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.

Card Fraud

Since your last interview, have you used a cheque book, credit card, store card or cash point card belonging to someone else without their permission?

1: Yes
2: No

And have you done this in the last 4 weeks?

1: Yes
2: No

How many times have you done this in the last 4 weeks?

And how much money did you make from this, including the cash value of any goods obtained? The cash value of goods is the value that you could sell or trade them for.

Benefit fraud

Since your last interview, have you falsely claimed social security benefits, housing benefits, or tax credits that you were NOT entitled to?

1: Yes
2: No
And have you done this in the last 4 weeks?

1: Yes
2: No

And how much money did you make from this?

Apart from anything you’ve already told us about, have you used force or violence on anyone on purpose (for example scratching, hitting, kicking, throwing things) since your last interview?

1: Yes
2: No

And have you done this in the last 4 weeks?

1: Yes
2: No

And how many times have you done this in the last 4 weeks?

In the last 4 weeks, have you committed any crimes in order to buy or get hold of drugs?

1: Yes
2: No

In the last 4 weeks, have you committed any crimes because you were drunk at the time?

1: Yes
2: No

In the last 4 weeks, have you committed any crimes because you were under the influence of drugs (not including alcohol) at the time?

1: Yes
2: No

You have told us that you have done these things in the last 4 weeks: ^Crime1^Crime2^crime3

Is this more, less or about the same as you usually do? Please choose one answer

1: I have done more of these things than usual this month
2: I have done fewer of these things than usual this month
3: I have done about the same as usual this month

F. Mental/physical health – interviewer administered

How is your health in general?

1: Excellent
2: Very good
3: Good
4: Fair
5: Poor

These questions are about activities you might do during a typical day. Does your health now limit you in moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

1: Yes
2: No

And how much does your health now limit you with these activities?

1: A lot
2: A little
3: Not at all

And does your health now limit you in climbing several flights of stairs?

1: Yes
2: No

And how much does your health now limit you with this activity?

1: A lot
2: A little
3: Not at all

During the past 4 weeks, have you accomplished less than you would like with your work or other regular daily activities as a result of your physical health?

1: Yes
2: No

And during the past 4 weeks, were you limited in the kind of work or other activities you could do as a result of your physical health?

1: Yes
2: No
During the past 4 weeks, have you accomplished less than you would like with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

1: Yes  
2: No  

And during the past 4 weeks, did you not do work or other activities as carefully as usual as a result of your emotional health?

1: Yes  
2: No  

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

1: Not at all  
2: A little bit  
3: Moderately  
4: Quite a bit  
5: Extremely  

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please look at this card and give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks have you felt calm and peaceful?

1: All of the time  
2: Most of the time  
3: A good bit of the time  
4: Some of the time  
5: A little of the time  
6: None of the time  

And how much of the time during the past 4 weeks have you felt downhearted and low?

1: All of the time  
2: Most of the time  
3: A good bit of the time  
4: Some of the time  
5: A little of the time  
6: None of the time  

During the past 4 weeks how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends or relatives etc.)?

1: All of the time  
2: Most of the time  
3: A good bit of the time  
4: Some of the time  
5: A little of the time  
6: None of the time  

Have you been referred to a psychiatrist/psychologist or any other mental health worker for an issue other than your drug or alcohol use since your last interview?

1: Yes  
2: No  

Have you received any treatment or help for your psychiatric/mental health needs (other than your drug or alcohol use) since your last interview?

1: Yes  
2: No  

Have you been diagnosed with a psychiatric/mental health condition (other than your drug or alcohol use) since your last interview?

1: Yes  
2: No  

We're now going to look at your physical health in the past month.

How often have you had poor appetite in the past month?

1: Never  
2: Rarely  
3: Sometimes  
4: Often  
5: Always
How often have you had **tiredness/fatigue** in the past month?

1: Never  
2: Rarely  
3: Sometimes  
4: Often  
5: Always

How often have you had **nausea** in the past month?

1: Never  
2: Rarely  
3: Sometimes  
4: Often  
5: Always

How often have you had **stomach pains** in the past month?

1: Never  
2: Rarely  
3: Sometimes  
4: Often  
5: Always

How often have you had **difficulty breathing** in the past month?

1: Never  
2: Rarely  
3: Sometimes  
4: Often  
5: Always

How often have you had **chest pains** in the past month?

1: Never  
2: Rarely  
3: Sometimes  
4: Often  
5: Always

How often have you had **muscle pains** in the past month?

1: Never  
2: Rarely  
3: Sometimes  
4: Often  
5: Always

How often have you had **numbness/tingling** in the past month?

1: Never  
2: Rarely  
3: Sometimes  
4: Often  
5: Always

How often have you had **tremors (shakes)** in the past month?

1: Never  
2: Rarely  
3: Sometimes  
4: Often  
5: Always

**G. SOCIAL CIRCUMSTANCES (2)**

– Interviewer administered

Can you tell me whether you receive any of the state benefits or tax credits on this card at the moment?

0: Receive no state benefits or tax credits  
1: Incapacity Benefit  
2: Income Support  
3: Pension Credit/Minimum income guarantee/Guarantee credit  
4: Housing Benefit/Local Housing Allowance  
5: Council Tax Benefit  
6: Child Benefit/Guardians Allowance  
7: Jobseeker’s Allowance  
8: Severe Disablement Allowance  
9: Disability Living Allowance  
10: Working Tax Credit  
11: Child Tax Credit  
12: Savings credit  
13: Social Fund Loan or Community Care Grant  
14: Statutory Sick Pay  
15: National Insurance credits  
16: Some other state benefit or tax credit
What would you say is your total gross income from all the possible sources of earnings shown on the card?

1: Paid employment (before any deductions e.g. for income tax and National Insurance)
2: Tax credits
3: State benefits
4: Grants
5: Maintenance from an ex-partner
6: Interests from savings
7: Dividends from investments

And what period of time does that cover?

1: Weekly
2: Fortnightly
3: Four weekly
4: Calendar month
5: Annual
6: Some other period (PLEASE SPECIFY)

During the past 3 months have you attended any training or education course?

1: Yes part-time
2: Yes full-time
3: No

Can you tell me which of the following apply to you in the last 4 weeks?

1: I was in prison some or all of the time
2: I was in custody at a police station some or all of the time
3: I had an electronic tag
4: I had a curfew
5: I was in hospital some or all of the time
6: I was ill at home some or all of the time
7: None of these

G. Saliva testing – interviewer administered

(If not selected for a saliva test) Just to let you know, you have not been selected by the computer to provide a saliva test for this study.

(If selected for a saliva test) RESPONDENT SELECTED TO PROVIDE SALIVA SAMPLE. EXPLAIN PURPOSE OF TAKING SAMPLE AND ASK FOR WRITTEN CONSENT

HAS THE RESPONDENT GIVEN WRITTEN CONSENT FOR COLLECTING SALIVA SAMPLE?

1: Yes
2: No

Can I just check, are you currently on antibiotics?

1: Yes
2: No

And have you taken any prescribed or unprescribed medication in the last 48 hours?

1: Yes
2: No

What medication have you taken?

EXPLAIN PROCEDURE FOR COLLECTING SALIVA SAMPLE TO THE RESPONDENT.

Did the collection pad turn blue, or did respondent remove it before it turned blue?

1: Turned blue
2: Didn’t turn blue

How many collection pads did you use?

RECORD REASON(S) FOR NOT OBTAINING SALIVA SAMPLE/COLLECTION PAD NOT TURNING BLUE.

I. Recontact and stable address – interviewer administered

We would like to interview you again in about nine months time to see how you are getting on. We would write to you before any interviewer called, so you could decide then if you would like to be interviewed again. Is that okay?

1: Permission to re-contact given
2: Permission given but qualified
3: Permission to re-contact refused
In case you move, or change your phone number, can you give us the name and address of one or two people who will be able to find you in about 9 months time? IF NECESSARY: We will only contact them if we can’t get in touch with you, we won’t contact them for any other reason.

1: Yes  
2: No

Last time we interviewed you, you gave us the contact details of one or two people who could find you in the future. We are aiming to make contact with you again in about 9 months time. Can I just check, is there anyone else who would be more likely to know where you are after that period of time? IF NO, Are the details we have at the moment all correct?

1: All stable address information correct  
2: Amend stable address 1  
3: Don’t use stable address 1 at next wave  
4: (If we have one) Amend stable address 2  
5: Don’t use stable address 2 at next wave  
6: Add a new stable address (RECORD ON FACT SHEET)

References


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