Crew drug counselling service: evaluation study. Final Report

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Final Report

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Summary of Contents

Detailed Contents

Notes on Terminology

eSUS refers to a number of services provided within Edinburgh Stimulant Users' Service, including Support Work, Therapy, Complementary Therapy, Immediate Support and Parent Support first developed in 2002. In 2004 eSUS became eSUS@crew and in 2006 it became crew drug counselling. In this report the current name "crew drug counselling" is used interchangeably with eSUS.

crew refers to the service, within which eSUS/crew drug counselling sits and is managed. Until recently crew was known as crew2000. In this report crew and crew2000 are used interchangeably reflecting the use of both names during the evaluation period.

Psycho-stimulant drug users refers to the target client group for crew services. Psycho-stimulant drugs include: ecstasy, mushrooms, LSD, cannabis, crack, cocaine and amphetamines.

Service-users refers to those accessing any of the services within crew drug counselling, including both current service-users and former service-users, who are differentiated where appropriate.

eSUS database refers to the database containing all the eSUS/crew drug counselling service-user records.

Support work refers to the drug counselling service provided by crew drug counselling. This is the term used in the eSUS database and is used in this report when referring to these data.

Therapy refers to reality and art therapy as specified in the eSUS database.

Drug counselling refers to the professional counselling service provided by crew and includes both 'therapy' and 'support work'.

Complementary therapy refers to the ear acupuncture service provided by crew.

Executive Summary

1. The crew drug counselling service has evolved out of a service for psycho-stimulant drug users that began in 2002 and which developed in response to the report of the Psycho-stimulant Working Group set up by the Scottish Advisory Committee on Drug Misuse. Since then it has developed a range of interventions delivered within the framework of a distinctive philosophy and ethos. Crew does not condemn or condone drug use but is committed to working with those who wish to reduce the potential harm associated with drug use. It aims to support drug users to define and work towards their own their own goals. It offers a highly respectful, flexible, responsive, person-centred and holistic approach to service-users. In keeping with its commitment to continual review and improvement, crew commissioned an independent evaluation, which began in 2007, the findings of which are presented in this report.

2. The evaluation gathered and analysed data from published research, service-users, referrers, practitioners and crew's service records. Approximately 40 service-users participated together with eight referrers and four practitioners. Service records related to 651 service-users.

3. Published research indicates that a variety of psychosocial approaches are helpful for at least some service-users with no single intervention proving consistently more successful than others. The swift establishment of a strong therapeutic relationship appears to have a positive effective on both retention and outcome. Evidence regarding the impact of complementary therapies is inconclusive with auricular acupuncture widely perceived as a useful addition to psychosocial approaches. The design and delivery of services is crucial for the successful recruitment and engagement of psycho-stimulant drug-users. Services need to be specialist, flexible, responsive, empathic, persistent, and clear and open in their communications.

4. The crew drug counselling service works with a diverse range of service-users including men and women from across the age spectrum (mainly young adults), drawn from across Edinburgh and its environs and reflecting the ethnic mix of the area. Many contact crew on a one-off basis only. Those who engage over a period of time use the counselling service, auricular acupuncture or both. Assessment appointments are offered swiftly, sometimes on the same day and usually within a week. Most service-users who use the counselling service attend for a small number of sessions and leave without planned endings. A very small number continue for 20 sessions (the normal maximum) or more. Some service-users refer themselves to crew drug counselling while others are referred by intermediaries include health professionals and other drug agencies. Crew drug counselling works in close partnership with the Community Drug Problems Service. When service-users leave the service they may cease to engage with any support services or they may be referred on elsewhere.

5. Most of the small number service-users for whom data are available wish to stop using drugs altogether. Some succeed, with others successfully reducing their drug use. Most of those for whom data are available report improvements in mental and physical feelings as a result of service use. The small number of service-users for whom data are available demonstrate high levels of psychological distress when they arrive at crew drug

counselling – much greater than the general population and comparable to those referred to specialist mental health services.

6. Service-users report contacting crew at a time of significant personal crisis. They experience intense anxiety, with powerful feelings of shame and low self-esteem. Consequently, it requires considerable courage to seek help. Some do not overcome their fears sufficiently to engage. However, those that do, report being very well-received by the organisation, which they experience as approachable, non-judgemental, friendly, informative, trustworthy, responsive, flexible and respectful. Their accounts illustrate the importance of patience and persistence in working with this service-user group who may struggle to sustain their motivation for change and who often experience cycles of relapse and re-engagement. Some have complex needs arising from extreme trauma and loss. Those who attend ear acupuncture generally find it relaxing and calming. Those who attend counselling face the challenging task of addressing the factors underlying their use of drugs. They value the empathy, respect, genuineness, patience, persistence and flexibility of their counsellors together with the person-centred, holistic and integrated ethos of the service.

7. Referrers hold crew drug counselling in very high regard as a specialist service with a very high level of expertise in working with a challenging service-user-group. They value the unique place of the service in the wider network of provision and view crew as an excellent example of an organisation that successful embodies an accessible, holistic, person-centred, flexible and innovative approach to the empowerment of its service-users.

8. Practitioners working at crew drug counselling are well-qualified, professional counsellors committed to working with crew's service-users. They report high levels of job satisfaction notwithstanding the considerable challenges of their work. They report that an increasing proportion of service-users have complex needs, heavier drug use and more chaotic lives.

9. Overall, crew drug counselling is a highly successful service with a very good reputation. Its philosophical approach and ethos is effective and consistently embodied in its work.

10. The evaluators offer the following recommendations:

    - that the crew philosophy and ethos be sustained, protected and preserved through any changes in service provision
    - that crew drug counselling considers the implications for service provision and delivery of current trends in the psycho-stimulant drug use of service-users
    - that crew drug counselling redesigns and simplifies its database and arrangements for data entry
    - that crew drug counselling selects and uses a measure of therapeutic change
    - that crew drug counselling considers enhancing arrangements for waiting list management

- that crew drug counselling engages in continual improvement in advertising, publicity and networking
- that crew drug counselling considers expanding the range of service offered
- that crew drug counselling considers allowing greater flexibility regarding the maximum number of counselling sessions
- that crew drug counselling considers ways of supporting service-users after completion of counselling sessions
- that crew drug counselling reviews its advance information about counselling
- that crew drug counselling considers following-up non-attenders more actively

List of Figures

Chapter 1

Introduction

Since its inception, eSUS and its successor services have monitored their service provision using in-house methods. In addition, the original partnership project worked with Partners in Evaluation to assess its effectiveness. As eSUS@crew developed and evolved into crew drug counselling, the service began to explore the possibility of an external evaluation that would assess its effectiveness in wider terms. When funding for the evaluation became available tenders for this evaluation were invited and a team from the University of Edinburgh were awarded the contract.

Key questions for the evaluation were:

1. is the existing model of service provision working for the service-users?
2. could the existing model of service provision be changed in any way to make it more effective?

In order to address these questions, the evaluation examined:

- the organisational framework for service provision by crew drug counselling
- existing evidence of interventions designed to assist psycho-stimulant drug users to address their own goals for change
- who contacts and uses the services offered (including socio-demographic attributes and referral routes)
- waiting times and patterns of service use
- quantitative and qualitative evidence of therapeutic change including changes in drug use
- experiences of accessing and using crew drug counselling services and levels of satisfaction of service-users
- perceptions and opinions of service-users of the needs of psycho-stimulant drug-users, the challenges of reaching and supporting them, the quality and appropriateness of services provided by crew drug counselling and other organisations
- perceptions and opinions of referrers, partner organisations and other key stakeholders of strengths and weaknesses of provision
- the perspectives, understandings, professional standing and orientation of service practitioners

The findings reported are drawn from a range of data sets:

- a literature review of existing evidence of interventions designed to assist psycho-stimulant drug users to address their own goals change and of research led guidance on providing an effective service for psycho-stimulant drug users

- 651 service-user records for all those who were in contact with eSUS/crew drug counselling between the middle of November 2004 and the beginning of March 2008
- eight semi-structured interviews with former and current service-users
- 18 service evaluation questionnaires completed when service-users exit the service, ten questionnaires completed by current service-users and three questionnaires completed by people who contacted the service but did not attend the appointment they were offered
- 32 CORE therapy assessment forms and 27 CORE assessment outcome measures

Chapter two of this report explains the context and development of eSUS and crew drug counselling.

Chapter three outlines the methods used in the evaluation.

Chapter four summarises key findings from existing evidence about interventions and services for psycho-stimulant drug users.

Chapter five draws on the eSUS database and CORE forms to present a quantitative analysis of data about service-users, service use and the therapeutic change.

Chapter six draws on interviews and written comments by service-users to examine their experiences and perceptions of the service.

Chapter seven presents the views of referrers and partner agencies.

Chapter eight discusses the professional standing and perspectives of practitioners.

Chapter nine summarises and synthesises the evidence presented in the preceding chapters.

Chapter ten presents recommendations flowing from the evaluation.

Chapter 2

The Context and Development of eSUS and Crew Drug Counselling

2.1 Introduction

This chapter explains the background and development of the Edinburgh Stimulant Users' Service and crew drug counselling. It also explains the rationale for the evaluation presented in this report.

2.2 The Scottish policy context

By 2001 there was increasing anecdotal evidence of rising levels of psycho-stimulant drug use in Scotland. In this context, the Scottish Advisory Committee on Drug Misuse (SACDM), set up by the Scottish Executive Substance Misuse Division, commissioned a Psycho-stimulant Working Group (PSWG) to look at the drug treatment offered to people using psycho-stimulant drugs. In PSWG findings were reported in 2002 (see http://www.scotland.gov.uk/Publications/2002/08/15141/9082). crew2000 was represented on the PSWG and had already set up a pilot project designed to support young people experiencing problems associated with their use of psycho-stimulant drugs.

2.3 The origins and development of eSUS and crew drug counselling

2.3.1 Crew2000 and WEST partnership: 2002-2004

Following the PSWG report, crew2000 and West Edinburgh Support Team (WEST) joined forces to set up a partnership project called Edinburgh Stimulant Users' Service (eSUS). The partnership project began in October 2002 and established a range of low threshold, non-medical, community-based services targeted at some of the "hardest to reach" young people using psycho-stimulant drugs. At this time the funding made available (from the Scottish Government and Lloyds TSB Foundation Partnership Drugs Initiative) was targeted on work with those aged 16-25. The remit of the project was to "enable young people to take more positive action and reduce the physical and mental health problems associated with the use of psycho-stimulant drugs". The partnership built on the experience of both agencies: crew2000 had developed a pilot service offering a low threshold, informal service to young people experiencing problems associated with their use of psycho-stimulant drugs and WEST had developed a more formal support service in the form of Cognitive Behavioural Therapy (CBT) for the same client group.

The partnership project worked to provide support services for 18 months. These services included information and advice, one-off support sessions, complementary therapies, ongoing support sessions and cognitive therapies. By mutual agreement the partnership was dissolved in spring 2004. With support from their main funder and the local drug action team crew2000 put together a successful proposal to run the whole service as a project within crew, and the eSUS project became eSUS@crew, and then, in 2006, crew drug counselling.

2.3.2 eSUS@crew and crew drug counselling: 2004-2008

Working with Partners in Evaluation, crew2000 identified three main areas in which the work of eSUS could be improved. Firstly, there were difficulties in engaging young people under 21 in CBT: most people accessed this service only after a lengthy period of drug use and tended to be in their late 20s. Younger people preferred shorter interventions. To address this, more flexibility was built into the counselling service with a continuing emphasis on making access as low threshold as possible. Secondly, there were disappointing low referral rates from other drug agencies, youth organisations and health services, which were often unsure of the services and support on offer at eSUS. To address this marketing was improved; referral networks enhanced and the profile of the service was strengthened through training events and agency visits. Thirdly, retention of clients was low, with many "Did Not Attend" appointments (DNAs): people were showing an initial interest in seeking help but were finding it hard to commit, one factor being the lack of any effective substitute prescribing. To address this other methods were needed to support people reducing their drug use or experiencing withdrawal symptoms. An ear acupuncture service was developed to help combat cravings, aid in relaxation and reduce anxiety. Other complementary therapies including Reiki and Indian Head Massage were also introduced.

eSUS services developed alongside crew2000's outreach and peer support to meet the needs of people experiencing problems related to their use of psycho-stimulant drugs. The following services were offered by eSUS@crew and continue to be offered by crew drug counselling: support work through immediate and ongoing support, in-house therapeutic interventions and complementary therapy.

Although crew drug counselling offers the same interventions as eSUS@crew there has been a shift in the way their main service "ongoing support" is conceptualised and practiced. Since 2005-6 it has been recognised as 'drug counselling' to reflect the professionalisation of the service and its providers. The staff and service have developed within a counselling model. The service is an organisational member of the British Association of Counselling & Psychotherapy and adheres to its code of ethics. Conforming to this standard, practitioners receive clinical supervision for their client work. The practitioners also undertake continued professional development to ensure that their practice remains up to date and relevant.

2.4 Existing service provision

2.4.1 The crew context

Crew drug counselling is part of crew, which provides services to young people around psycho-stimulant drug use, sexual and emotional health and other related lifestyle issues. Crew also provides advice, information and training to a wide range of public and voluntary sector organisations.

Crew approaches drug taking as a public health issue and works within an explicit philosophy that

- does not condemn or condone drug use, but recognises that it is widespread and that measures can be taken to reduce the potential harm
- aims to make sure that people have access to realistic and relevant information about drugs and the risks involved in using them, so that they can make their own decisions

- aims to encourage public debate and influence decision-makers to deal with drug related issues constructively and pragmatically
- aims to provide a professional service in all of their work.

In the context of this philosophy, crew offers an integrated model of service provision for the full spectrum of those using psycho-stimulant drugs, including experimenters, recreational users, those for whom drug use is experienced as problematic and those concerned about the drug use of others. Following the integrated service model set out in the PWSG report, crew provides a stepped care approach offering a wide range of services of which crew drug counselling is one. Through outreach services in clubs and at festivals, together with its shop in central Edinburgh, crew makes available unbiased information for people using psycho-stimulant drugs experimentally or recreationally as well as to others with concerns about drug use. For the next step in service provision crew provides one-off support to recreational and experimental drug users as and when they seek it. The crew drug counselling service is aimed at the smaller number of people for whom drug use has become problematic.

The crew drug counselling service is open to people aged 16 and over who are experiencing problems related to their use of psycho-stimulant drugs. They work with people who are still using and those who have stopped and are seeking support to make this change more permanent. People can self-refer or are referred by another agency or service.

Crew drug counselling is centrally located in the city of Edinburgh, in a traditional tenement building where crew has its shop front. The drug counselling service is based in the crew offices located behind and above the shop front. The service has a separate entrance located discreetly on a side alley. The premises have been subject to internal reconfiguration to create therapy rooms where the drug counselling takes place as well as larger spaces for the ear acupuncture sessions. Upstairs are the offices, where the day-to-day management of the project is undertaken

2.4.2 Therapeutic approaches

People contacting the service are offered an initial appointment the aim of which is to explore how best they can be helped. Information is provided and service-users are supported to make their own decisions about what to do next. For some, the initial session is all that they use. However, those who are looking for ongoing support are offered drug counselling, reality therapy and/or complementary therapy.

Drug counselling

The main service offered is one-to-one drug counselling. Drug counselling aims to help the person explore their current situation, set goals and evaluate what they want from life and to see how drugs fit into the equation. The service-user is viewed as leading the process of working out if they want to reduce, stabilise or stop altogether.

Appointments are offered in the day time and early evening with the frequency and number of appointments varying according to the service-user's needs. The service-user may have a one off session, a short-term intervention (3-6 sessions) or relatively longer intervention (usually up to 20 sessions). Appointments are normally weekly but may be less frequent if preferred.

The approach taken is person-centred based on the belief that all people are capable of positive change when they are given the right support and remain in control of the process. The drug counselling is based on Egan's Three Stage Helping Model. This model gives structure to finding out

- where the service-user is now,
- where they want to go and
- how they can get there.

Reality therapy

The Reality Therapy offered is a cognitive behavioural intervention. It is based on the idea that everyone has five basic needs: survival, belonging, power, freedom and fun. Everything we do is an attempt to meet our needs, and anything we chose will be the best choice we are able to make at that time. The practitioner builds a relationship with the service-user and through this relationship explores what the person wants and what they are doing to get it. Practitioner and service-user look at how effective current behaviour patterns are and what could change in order for the person to get more of what they want in life. Together they develop a plan and continue to work together and evaluate as the plan is carried out. This cognitive behavioural approach is perceived to benefit people whose drug use is stable rather than chaotic, and someone who is motivated to change something in their lives. This approach is also deemed to be appropriate for anyone who is drug free and working on remaining drug free.

Complementary therapy

Reiki and Auricular Acupuncture are the complementary therapies offered in conjunction with crew drug counselling. At the time of writing only auricular acupuncture is available. This is based upon the National Acu-Detox Association (NADA) protocol. The NADA protocol consists of the insertion of five small, fine, sterile, disposable stainless steel needles under the surface of the skin on specific sites in the outer ear. These points are standard points for the treatment of substance misuse and anxiety management. The recipients sit quietly in a group setting for up to 40 minutes relaxing, during which they are taken through a guided relaxation programme called Qi Gong. This is not a talking session and participants are asked not to talk to others. These sessions are held twice weekly and are free, confidential and open to all without needing to make an appointment.

2.4.3 Management

Crew drug counselling is managed as an integral part of crew, which is a limited company and a registered charity. Crew employs several staff, including a director, an operations manager (who manages the crew drug counselling service), an outreach worker, several practitioners and support workers, and a project worker, many of whom began their association with crew as volunteers. Originally founded by a coalition of youth workers and volunteers, crew retains is voluntary ethos, with much of its work delivered by trained volunteers. However, the work evaluated in this report is primarily that undertaken by paid, professional workers. The development and direction of crew is overseen by a volunteer Board of Trustees.

Chapter 3

Methodology

3.1 Introduction

Crew drug counselling offers services to people who want to reduce, stabilise or stop their drug use. It supports service-users to identify and fulfil their own goals: it does not set aims for them. Consequently, evaluation of service provision requires a broad conception of what constitutes effectiveness. Much of the existing evidence about psychosocial interventions treats abstinence from drugs as the only successful outcome. This evaluation takes a broader approach, drawing on a variety of measures of outcomes and effectiveness, using a combination of quantitative and qualitative methods.

In collaboration with crew staff, the research team identified a multi-method approach to evaluate crew drug counselling:

1. Review of existing evidence about interventions designed to assist psycho-stimulant drug users to address their own goals for change, within which the work of crew drug counselling can be situated.

2. Review of existing service records. Data from these records provides information about client attributes, service use and the effectiveness of interventions.

3. Pre- and post- intervention CORE questionnaires. Data from these questionnaires provide a means to measure effectiveness of the service and to compare crew drug counselling service-users with other users of counselling and therapeutic services.

4. Consultation with service-users via individual interviews, focus groups and questionnaires. Data from service-users take the form of personal accounts of the impacts of the service provided by crew drug counselling.

5. Consultation with practitioners though individual interviews. Data from these people provide reflections on the strengths and weaknesses of service provision from a service-provider perspective.

6. Consultation with referral and partner agencies via telephone interviews. Data from these people provide a means to evaluate the role and standing of crew drug counselling within the wider community of service providers.

3.2 Ethics

The evaluation study was granted ethical approved by the Research Ethics Subcommittee of the School of Health in Social Science, the University of Edinburgh. Clear ethical protocols were followed throughout the research process.

Although an external evaluation, the research team depended upon the active assistance of those involved with the service provision for access to and recruitment of current and former service-users. The evaluation study is therefore also strongly guided by the processes and protocols in place at crew drug counselling.

In all contact between interviewees and researchers, the voluntary nature of participation was stressed and informed consent was negotiated formally before proceeding with any interviews and informally throughout the interviews. A careful balance was maintained between encouraging service-users to participate and ensuring they had the space to refuse.

The researchers who conducted the interviews with service-users had professional experience in counselling or related professions. The interviews were held on crew premises so that further support could be accessed if needed. In one instance, it was necessary to draw on this support.

3.3 Review of existing evidence

Using bibliographic and internet searches, studies of existing psychosocial interventions and complementary therapy for psycho-stimulant drug users was identified and reviewed. Protocols for delivering a service for psycho-stimulant drug users are also included.

The evidence reviewed is limited to the English language articles. The research on which it draws includes quantifiable evidence from clinical trials and surveys together with qualitative evidence. The literature is drawn from studies conducted in the UK, USA and Australia (but consideration of protocols is limited to the UK). These different locations have varying drug cultures/scenes. In addition, the contexts in which the research took place vary, including, for example, outpatient clinics, residential programmes, private treatment and free treatment. These widely varying contexts need to be borne in mind in considering the comparability and relevance of the evidence in relation to crew drug counselling.

The evidence was reviewed, collated and a summary of the findings is presented.

3.4 Service records

All service-users who come into contact with crew drug counselling generate a client ID on an Access database. Data about the service-user and his/her progression through crew drug counselling are recorded and maintained in this database.

Data are analysed for 651 service-users who had contact with eSUS/crew drug counselling between the start of the database in November 2004 and the 7th March 2008. Some contacted crew drug counselling but did not access any services; others accessed a full course of drug counselling together with ear acupuncture.

The data include:

- demographic information about service-users
- drug use
- referral routes and onward referral arrangements
- self rated scores for physical and mental well-being at the first assessment, during counselling and at the end of counselling
- service-user goals for change
- waiting times, uptake rates, contract lengths and non-attendance rates

Data were imported into Excel, which enabled identification of inputting errors and missing data, which were excluded from the analysis. Indeed the most striking feature of the

database is the extent of missing data. The evaluation includes consideration of arrangements for service monitoring and record-keeping.

3.5 Pre- and post-intervention CORE questionnaires

In addition to existing monitoring, the evaluation included the introduction of a standardised tool for assessing psychological distress before and after service use. In discussion with practitioners, the CORE (Clinical Outcome and Routine Evaluation) system was selected for this purpose (see appendix 1). The data generated enable the evaluation to compare objective measures of psychological distress experienced by the service-users at crew drug counselling with those accessing other services and has the potential to provide a standardised measure of therapeutic change. The introduction of the CORE questionnaire system as part of the evaluation was treated as a pilot within crew drug counselling and is evaluated accordingly.

3.6 Consultation with service-users

To solicit the personal views and experiences of service-users, multiple methods were used, which evolved as the evaluation continued.

- Existing evaluation sheets from 18 service-users are included in the analysis.
- Questionnaires for current service-users (approximately 30) were designed and distributed, generating ten returns.
- All current and former service-users (approximately 250 in total) were invited to attend semi-structured interviews, generating eight interviews in total (five with former service-users and three with current service-users).
- All current service-users (approximately 30) were invited to participate in focus groups but this generated no response.
- Questionnaires were designed and distributed to all those who contacted crew drug counselling and were offered an appointment, which they did not attend (approximately 50). Three completed questionnaires were returned.

Together these data provide evidence of the experience and impact of using the services provided at crew drug counselling, which are analysed and discussed in relation to three broad themes:

- experiences of contacting, accessing and using the services at crew drug counselling (both counselling and complementary therapy)
- helpfulness and effectiveness of the service in relation to drug use and well-being
- strengths, weaknesses and overall satisfaction with crew drug counselling

The recruitment of service-users for the evaluation was undertaken jointly by the researchers and staff at crew. Individual interviews were offered to all former service-users on the eSUS database. In September 2007 250 former service-users were sent information leaflets and invitations to participate in the research together with a covering letter from crew drug counselling. This led to seven responses and five completed interviews (contact was lost with the two other respondents). This recruitment strategy was repeated in April 2008 but did not yield any further responses.

A focus group to gather current service-user views was arranged and advertised extensively at crew drug counselling, through posters on the office walls and leaflets handed out in counselling and acupuncture sessions. This recruitment strategy generated no response. This disappointing response probably reflects intense concerns about confidentiality among crew drug counselling service-users. Following the failure of the focus group approach, all current service-users were invited to participate in individual interviews with a researcher. In addition questionnaires were distributed to all current service-users. To encourage response rates, these were given out in person by practitioners at the end of counselling sessions, with a drop-off box on the premises for completed questionnaires. Ten questionnaires were returned. Current service-uses were also invited to participate in face-to-face interviews on the same day as their counselling session. Ten current users agreed to participate in these interviews but several did not attend so a total of three interviews with current service-users were conducted.

In April 2008, short questionnaires with pre-paid return envelopes were sent to 50 potential service-users who had arranged a first counselling appointment, which they then did not attend. Three questionnaires were returned.

Copies of all questionnaires and interview schedules are included in appendix 1.

3.7 Consultation with practitioners

Interviews with the two full-time practitioners and the two part-time practitioners were conducted. The interview schedule is included in appendix 1.

3.8 Consultation with referrers

To gather evidence about the role and standing of crew drug counselling in the wider community of service providers, the views of partner agencies were collected using a short (10-15 minute) telephone interview (with one interview conducted face-to-face). All agencies that had referred three or more service-users were approached namely:

- Mid and East Lothian Drugs (MELD)
- Aberlour Outreach Edinburgh
- Community Psychiatric Nurse Manager (who passed the information onto the team of nurses)
- SACRO
- Turning Point
- Community Drug Problem Service (CDPS)
- Edinburgh Castle Drug Project
- Six GPs

A total of eight interviews were conducted with a mixture of service co-ordinators and frontline practitioners. Referrers were asked for their views of service provision and delivery at crew drug counselling and on the service needs of psycho-stimulant drug users. The interview schedule is included in appendix 1.

Chapter 4

Review of Existing Published Evidence

4.1 Introduction

This chapter reviews existing evidence of therapeutic interventions designed to assist psycho-stimulant drug users to address their own goals for change. The discussion is divided into two main sections, the first concerned with the effectiveness of specific interventions and the second concerned with questions of service design and delivery.

4.2 Specific interventions

A wide range of specific interventions designed to assist psycho-stimulant drug users are reported and reviewed in the literature. Many studies were conducted in North America, with some conducted in Europe. Many were conducted in psychiatric settings. The great majority of these involve the use of some kind of talking therapy or incentives to change behaviour or forms of social support. They are referred to collectively as psychosocial approaches and include the following studies.

- Cognitive behavioural therapy, which is an overarching approach that includes many of the other more specific interventions listed below (Baker et al, 2001, Epstein et al, 2003, Hoffman et al, 1996, Knapp et al, 2007, Rounsaville, 2004 and Woody 2003)
- Motivational interviewing (Baker et al, 2001 and Rohsenow et al, 2004)
- Coping skills training (Baker et al, 2001, Knapp et al, 2007 and Rohsenow et al, 2004)
- Contingency management (Epstein et al, 2003, Higgins et al, 2003, and Knapp et al, 2007)
- Individual and group drug counselling/therapy (Hoffman et al, 1996, Knapp et al, 2007 and Woody, 2003)
- Network therapy (Galanter et al, 2002)
- Community reinforcement therapy (Higgins, 2003 and Knapp et al 2007)
- Relapse prevention (Baker et al 2001, Hoffman et al, 1996 and Knapp et al, 2007
- Substitution therapy (Shearer et al, 2002)
- Supportive expressive therapy (SE) (Knapp et al, 2007 and Woody, 2003)
- Reinforcement base therapy (Knapp et al, 2007)
- Interpersonal therapy (Knapp et al, 2007)
- Service outreach and recovery (Knapp et al, 2007)

A smaller number of studies have been conducted on interventions that use of complementary and alternative medicines, notably auricular acupuncture (Bullock et al, 1999, Lipton et al, 1994 and Margolin et al, 1998).

The majority of this literature focuses on cocaine use (Bullock et al, 1999, Epstein et al, 2003, Galanter et al, 2002, Hoffman et al, 1994, Lipton et al, 1994, Margolin et al, 2002,

Rohsenow et al, 2004, Rounsaville, 2004). A few studies consider amphetamines (Baker et al, 2001 and Shearer et al, 2002) and others cover a range of psycho-stimulant drugs (Knapp et al, 2007, Shearer, 2007 and Woody, 2003).

The studies reported in the literature consist of trials, which may be randomised controlled trials or variants of this approach. Trials conceptualise interventions within the terms of the medical model, comparing the effects of a specific treatment with giving no treatment (or a placebo), or comparing the effects of more than one treatment. The most commonly used measure of success is abstinence assessed using urine tests. In some studies, extent of drug use is assessed with measurable reduction amounting to success. Some trials also measure the effect of an intervention on service-user behaviour through self- or practitioner-rated change.

4.2.1 Psychosocial approaches

No overarching meta-analysis has been published on the efficacy or effectiveness of psychosocial interventions designed to reduce the use of psycho-stimulant drugs (Shearer, 2007: 48). However, Knapp et al (2007), Shearer (2007) and Woody (2003) all review the findings of several clinical studies involving psychosocial approaches to psycho-stimulant drug use. These reviews agree that psychosocial treatments are consistently found to help psycho-stimulant users reduce their drug consumption and associated problems (Knapp et al, 2007:13, Woody, 2003: S25). However, there is not enough evidence available to support one intervention over another, partly due to the complex nature of addiction, which makes it difficult to design trials that compare impacts of different forms of treatment on identical groups of patients (Knapp et al, 2007: 13; Shearer 2007: 48).

Knapp et al (2007) conducted a systematic review of twenty-seven randomised controlled studies on psychosocial interventions for treating psycho-stimulant drug use disorders. There was a wide heterogeneity in the interventions which they evaluated, which prevented them summarising estimate of effects and results in a clear cut way. Their comparisons between different types of behavioural interventions showed results in favour of treatments with some form of contingency management in respect to both reducing drop outs and lowering drug use. This Cochrane systematic review concluded there was no data supporting a single treatment approach that is able to comprise the multidimensional facets of drug addiction patterns and to significantly yield better outcomes to resolve the chronic, relapsing nature of drug addiction, with all its correlates and consequences (Knapp et al 2007).

Other studies support the view that several psychosocial interventions have beneficial effects. Although no single treatment can be recommended over all others across a range of circumstances, there is evidence to support specific approaches in specific circumstances.

- Motivational interviewing is valuable at the beginning of treatment for cocaine abuse, and is more beneficial for less motivated service-users rather than more motivated ones (Rohsenow et al, 2004: 872).
- Brief cognitive behavioural therapy, consisting of motivational interviewing and skills training to avoid high risk situations, appears to be feasible and moderately effective among regular amphetamine users in reducing use and abstinence, and in recruiting, treating and retaining those who are ambivalent about changing their drug use (Baker et al, 2001: 1285).

- Network therapy, which entails supporting the service-user's natural social network, was found to facilitate abstinence from cocaine use, when introduced alongside individual therapy sessions (Gallanter et al, 2002: 164-166).

- Contingency management in the right therapeutic setting has been shown to be effective, provided that the patient's motivation to change is effectively managed (Knapp et al, 2007: 49 and Higgins 2003: 1049-51).

- Although not statistical significant, contingency management combined with cognitive behavioural therapy has been found to lead to a gradual and enduring reduction of cocaine use (Epstein et al, 2003: 9).

- Contingency management combined with community reinforcement therapy has therapeutic effects on substance abuse and psychosocial functioning during treatment but the effects on cocaine use might be limited to the treatment period (Higgins, 2003: 1049-51).

Studies have found some systematic differences in the effectiveness of specific interventions between different groups of psycho-stimulant drug users:

- Experiencing cocaine abuse and depression together can make it more likely that a person will seek treatment but makes it more difficult to have a positive outcome for either (Rounsaville, 2004: 807).

- There are some fairly consistent gender differences in the success of coping skills training for cocaine abuse, with women benefiting more than men (Rohsenow et al, 2004: 872). However, in a different study female clients were more likely than male clients to be using cocaine a year after group therapy that had focused on relapse prevention skills (Hoffman, 1996: 10).

The intensity of, and length for which, interventions are available can influence outcomes:

- Providing more intensive group therapy (five days a week as compared to two days a week), with an emphasis on relapse prevention training skills, can lead to significant increases in the rate of service-user participation in cocaine service (Hoffman 1996).

- Time in psychosocial treatment for psycho-stimulant dependence is strongly related to better outcomes (Hoffman et al, 1996: 10 and Shearer, 2007: 48).

Echoing findings from studies of counselling more generally, there are indications that a strong therapeutic relationship between counsellor and service-user as viewed by the service-user early on appears to have a positive influence on retention and treatment outcome (Barber et al, 1999: 70).

Since no single intervention is conclusively better than another but most are better than no intervention, offering some form of psychosocial approach that is flexible and responsive to the needs of individual service-users and with which they wish to engage is well-supported by existing research.

4.2.2 Approaches using complementary and alternative medicine

The use of complementary and alternative medicines (CAM) in westernised nations has risen sharply in the last two decades. Several CAM therapies are widely used within Drug and Alcohol services in the UK and are increasingly popular with substance users. Treatments such as acupuncture, Reiki and hypnotherapy have been used to help psycho-stimulant drug users. At present there hasn't yet been enough rigorous research to prove the effectiveness of CAM therapies in the management of drug users. One reason for this relates to the difficulties in applying the methods of conventional medical research to CAM treatments.

Auricular acupuncture, is one CAM therapy, which is becoming increasingly popular in the treatment of psycho-stimulant drug addiction. This form of treatment is widely thought to have a calming effect on psych-stimulant drug users, to decrease cravings (Margolin et al, 2002: 56), and to alleviate withdrawal symptoms associated with cessation of cocaine use (Lipton et al, 1994: 205). It is also thought to be popular because it is a “low tech” therapy, which is inexpensive to administer, can be used to treat many service-users simultaneously, can help retain service-users in therapy, has few side effects and because service-users enjoy it (Margolin et al, 1998: 406).

Few trials have investigated the effectiveness of auricular acupuncture. Those that have (Bullock et al, 1999, Lipton et al, 199; Margolin et al, 2002) have found many challenges with implementing well-designed and reliable trials, which do not allow for the individualisation of treatment (Bullock et al, 1999: 37). The results therefore need to be read with caution (Bullock et al, 1999: 38).

There is little clinical evidence supporting the claim that auricular acupuncture is an effective intervention. For patients also receiving psychosocial interventions, Bullock et al (1999: 36) and Margolin et al (2002: 61) found no significant differences in outcomes who received auricular acupuncture and those in the control group. Margolin et al (2002: 61) also found no differences in treatment retention between the groups.

Lipton et al (1994) evaluated auricular acupuncture without psychosocial interventions. Compared to placebo treatment they found that it did reduce cocaine usage and promote short-term abstinence (Lipton et al, 1994: 211). They reported that it helps with the general symptoms of withdrawal and abstinence, but argued that counselling would be needed as well to facilitate lasting changes.

4.3 Service design and delivery

Interventions for psycho-stimulant drug users are offered and delivered in specific contexts. The design of services has important impacts on uptake, retention and outcomes. This section reviews studies and policy documents that address issues of service design and delivery focussing on the British and especially Scottish experience.

4.3.1 Accessing and using services successfully

Recruiting service-users can be challenging. Both cocaine and amphetamine users are most likely to seek help when their drug use is heavy and/or at some kind of crisis point whether financial or personal (Morris, 1998: 1290; Wright et al, 1999: 82). Studies have found that amphetamine users are particularly reluctant to access services because they do not classify themselves as drug addicts, are concerned about the stigma and stereo-typing of identifying themselves as drug users, are worried about having to confide in someone and about issues

of confidentiality, and because they doubt that the treatment would work (Wright et al, 1999: 75-79). These findings have been replicated in studies of psycho-stimulant drug users in Scotland (Scottish Advisory Committee on Drug Misuse, 2008).

There is a high drop-out rate among those who access psycho-stimulant user services. In an English study, Wright and Klee (1999) found that amphetamine users who left treatment early were more likely than those who stayed to be younger, living with parents, be using less amphetamine, have been using amphetamine for a shorter period of time, report aggressive interpersonal episodes, be using other drugs as well, and have a history of criminal activity (Wright and Klee, 1999). The authors suggest that amphetamine users' motivation to continue coming to the service are undermined by unrealistic expectations of the ease of abstaining from amphetamine and the ability of treatment services to alleviate the discomfort of withdrawal and by lack of conviction that they need the treatment. The quality of their experience of the service is crucial to successful engagement, as is good informal support from partners and family members, whose encouragement to them to continue using the service may be critically important (Wright and Klee, 1999).

In a US study, Agosti et al (1996) found that those who left cocaine treatment early were most likely to be an ethnic minority and to have had an earlier onset of substance abuse. Like Wright and Klee (1999) they found that drop-out rates were higher for younger than older service-users. Agosti et al (1996: 37) argue for high intensity approaches to keep service-users engaged, such as multiple sessions per week, a multi-disciplinary approach and routinely following up missed appointments. In another US study on retention rates, the authors concluded that rather than looking at client variables, it may be more important to consider therapist and service variables (Kleinman et al, 1992: 30).

The quality of the relationship between the practitioner delivering an intervention and the service-user emerged as a key factor facilitating change according to a scoping study of psycho-stimulant drug user service providers in Scotland (Effective Interventions Unit 2004: 9). Respondents in this study rated this factor above professional qualifications and their training in the delivery of specific interventions. This view accords with the finding note above of the positive influence of the service-user's perception of the strength of their relationship with their counsellor (Barber et al, 1999).

4.3.2 Service-user views on service provision

Ten years ago, Bottomley et al (1997) reviewed the dearth of appropriate services for crack and cocaine users in Manchester. The drug users they spoke with wanted services that provided counselling, information, residential facilities, substitute prescribing, an informal "drop in" and where a proportion of staff are themselves former drug users.

Neale (1998) found that service-users value drug services that offer specialist drug knowledge, a broad range of services, are accessible, have a positive attitude towards drug users, encourage open and honest relationships, and are willing to listen, be supportive and understanding. The study found that service-users do not like being grouped together in waiting rooms where they report that violence and drug-dealing may take place. The service-users thought that the best counsellors were ex-drug users. Of all services, specialist drug agencies were seen as the most helpful (Neale, 1998).

Similarly, the Scottish Drugs Forum (2002) reported on the service provision needs of Scottish psycho-stimulant users, finding that they wanted a variety of treatment approaches to be available, including alternative therapies and counselling to explore the reasons behind drug use. They also emphasised the importance of access to confidential advice and information without referral via a GP and provided evidence of the need for health care professionals to have more training and information about psycho-stimulants and psycho-stimulant drug users.

McKeganey et al (2005:432) investigated whether drug users contacting treatment services in Scotland were looking for harm reduction or abstinence. They found that, on the whole people, wanted to achieve abstinence. They argue that drug treatment services need to spend more time explaining harm reduction strategies and linking them to abstinence.

In 2007, an evaluation of the Incite Project, a pilot psycho-stimulant project in Aberdeen, found that service-users valued the central location, the open door policy, use of text messages to communicate, the quick initial appointments, the informal assessment process, the general relaxed atmosphere, the privacy provided by the building and set-up, the positive effect of the acupuncture on calmness and relaxation, and that the staff were non-judgemental, supportive, approachable, trustworthy and treated them as equals (Human Factors Analysts Limited, 2007: 12-13). Some service-users found the week-day day-time opening hours inconvenient and welcomed the addition of weekend and evening opening hours (Human Factors Analysts Limited, 2007:12).

4.3.3 Service provision ideals

Service evaluations have led to the development of recommendations for service provision, some of which have been incorporated into Scottish policy documents.

The evaluation of the Incite project provided the following key lessons for the development of psycho-stimulant services:

- being flexible and responsive
- having friendly, fast and informal processes
- engaging in frequent, effective, unobtrusive communications (such as text messaging)
- providing an extensive choice of interventions (harm reduction to crisis intervention to acupuncture)
- having professional, credible and well-informed staff
- having a robust infrastructure and information management services (for monitoring and development)
- doing targeted outreach (such as promotion at night clubs/dance events and providing drop-in facilities) (Human Factors Analysts Limited, 2007: 23-24).

To increase the relevance, accessibility and effectiveness of a service for psycho-stimulant drug users, Wright et al (1999: 84) suggest that providers should:

- make sure information about the service is widely advertised with clear confidentiality policies

- form partnerships with non-specialist agencies
- a recognition of the impact of psycho-stimulant drugs on individuals and their relationships
- raise the credibility of the service through training and education
- provide a specialist service for this client group

The National Institute on Health and Clinical Excellence (NICE) (2007) recommends that

- treatment and care should take into account the individual's needs and preferences
- families and carers should be provided with information and support, and, with the service-users agreement, they should be directly involved in treatment
- services should include contingency management programmes

Drawing on national guidance documents on commissioning and providing services for crack users produced by the National Treatment Agency and COCA (Conference on Crack and Cocaine) Turning Point and COCA (2005:4-6) outline some key principles for responding to the needs of psycho-stimulant users.

- Evidence demonstrates that engaging potential service-users is an important factor.
- Crack users are most likely to engage with informal, open access services.
- Services need to respond quickly to ensure that service-user motivation is not lost. Because many seek help at a significant crisis point, the provision of immediate support is important.
- Some groups may require more pro-active approaches to engage them, for example black and ethnic minority people, middle-class users, unemployed and heavy users.
- Research suggests that client-centred approaches in which the key worker demonstrates empathy and understanding, and can respond positively to the service-user's needs, are important.
- Staff working with crack users need effective support. The work can be intensive and energy consuming, and the chaotic nature of crack use can lead to high levels of crisis intervention work.
- Assessment information should be gathered gradually rather than all at one.
- Confidentiality policies (and their limits) should be explained clearly to reduce anxiety.
- Those who do not attend appointments should be followed up with letters and telephone calls. Text message reminders of appointments may be useful.

The Effective Interventions Unit (2002:14) suggests that services for psycho-stimulant users must be:

- responsive
- accessible
- credible

- develop clear assessment procedures
- employ staff with specific competencies

The Scottish Advisory Committee On Drug Misuse (2002) recommends that services are:

- available via multiple points of entry
- person-centred and timely
- use shared assessments procedure

The report also advises that there is a need to improve training for health care and other professionals about psycho-stimulant drugs and the needs of their users. A subsequent report (Scottish Advisory Committee on Drug Misuse, 2008) recommends the use of:

- open access, walk-in services
- a stepped-care approach and outreach in order to provide flexible and immediate service

4.4 Summary

In summary, studies of specific interventions suggest that:

- psychosocial approaches are well-supported by existing research and there is no reliable evidence to choose one particular approach over another
- the relationship between service-user and practitioner is probably an important factor in retention and in the impact of psychosocial interventions
- evidence for the effectiveness of auricular acupuncture is limited but service-users report beneficial impacts and it is therefore a useful adjunct to psychosocial interventions
- offering a range of treatment options is likely to increase engagement and retention rates

With respect to service design and delivery, services for psycho-stimulant drug users need to be:

- specialist
- flexible
- responsive
- empathic
- persistent
- clear and open in their communications

The approach to service development at crew aligns closely with the recommendations emerging from existing research as well as the Scottish policy context. The remainder of the evaluation examines how crew drug counselling's approach impacts upon and is viewed by service-users and those seeking to support them.

Chapter 5

Service-Users and Service Delivery

5.1 Introduction

This chapter draws on data available in the eSUS database about 651 service-users who contacted crew drug counselling between November 2004 when the database was set up and the beginning of March 2008. As noted in chapter 3, although the database has the potential to record a great deal of information about every service-user, beyond the allocation of an identification number and basic demographic data, data are more likely to be missing than entered. Furthermore some of the data that are available are ambiguous and in other cases seem likely to have been entered incorrectly or there is a possibility of incorrect entry. The analysis presented in this chapter uses the data that are available where they can be considered reliable and draws attention to limitations where caution is advisable.

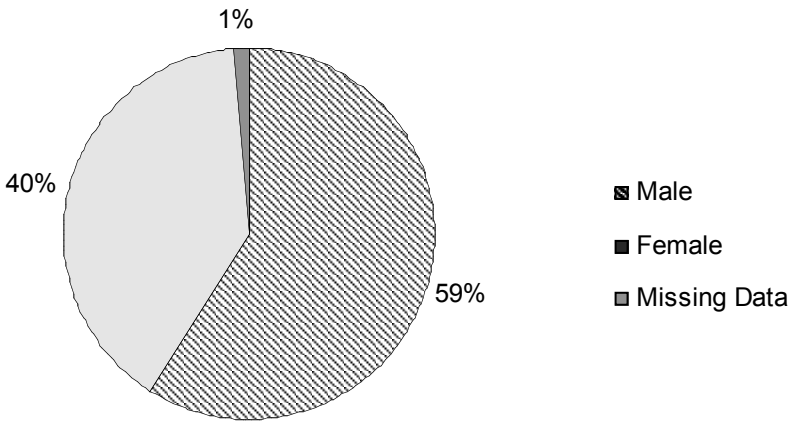
In addition to the service records held in the eSUS database, the evaluation included the introduction of CORE questionnaires, which provide a standardised tool for assessing psychological distress before, during and after service use. These provide quantitative evidence of the level of distress of people entering the service compared to other service and compared to the population in general. They also have the potential to provide quantitative evidence of therapeutic change. Section 5.4 presents the initial findings available from this data source.

5.2 Demographic characteristics of service-users

5.2.1 Gender

Crew drug counselling services are accessed by both men and women, with men making about 60 per cent of the total (figure 5.1).

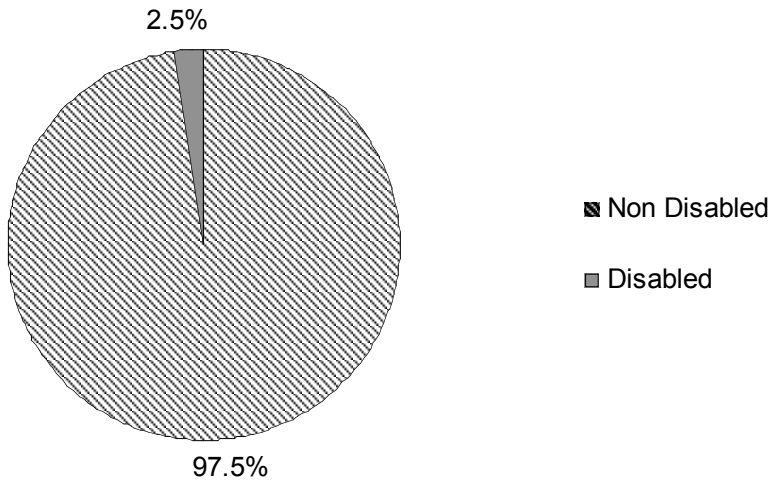
Figure 5.1: Gender of service-users



5.2.2 Disability

The service-users at crew drug counselling are predominantly non-disabled, with only 16 of 651 service-users (2.5 per cent) identifying as having a disability (figure 5.2).

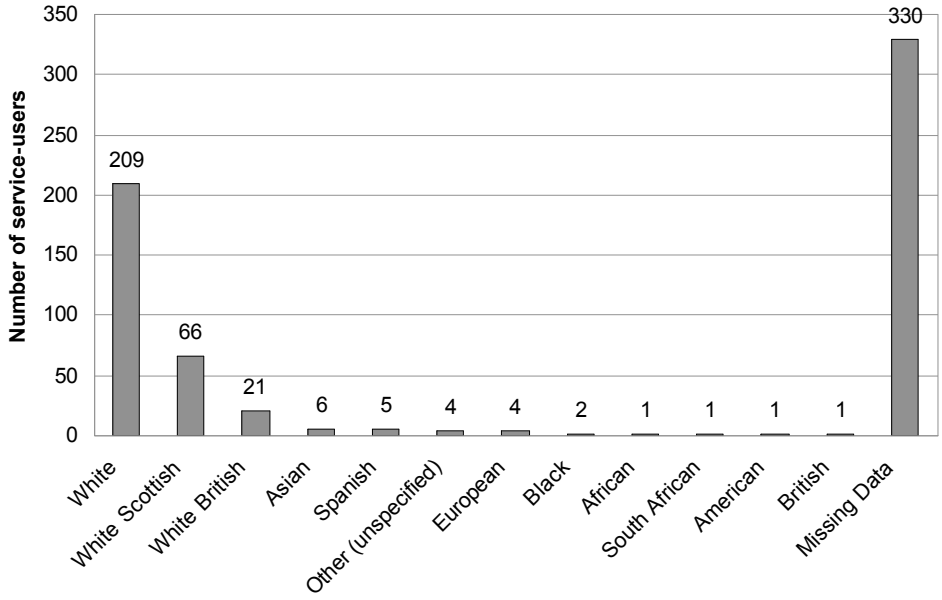
Figure 5.2: Disability status of service-users



5.2.3 Ethnicity

Half of the service-user records do not record ethnicity. Of those for whom data are available, the great majority identify themselves as white, white Scottish or white British with small numbers identifying themselves as belonging to other ethnic groups (figure 5.3)

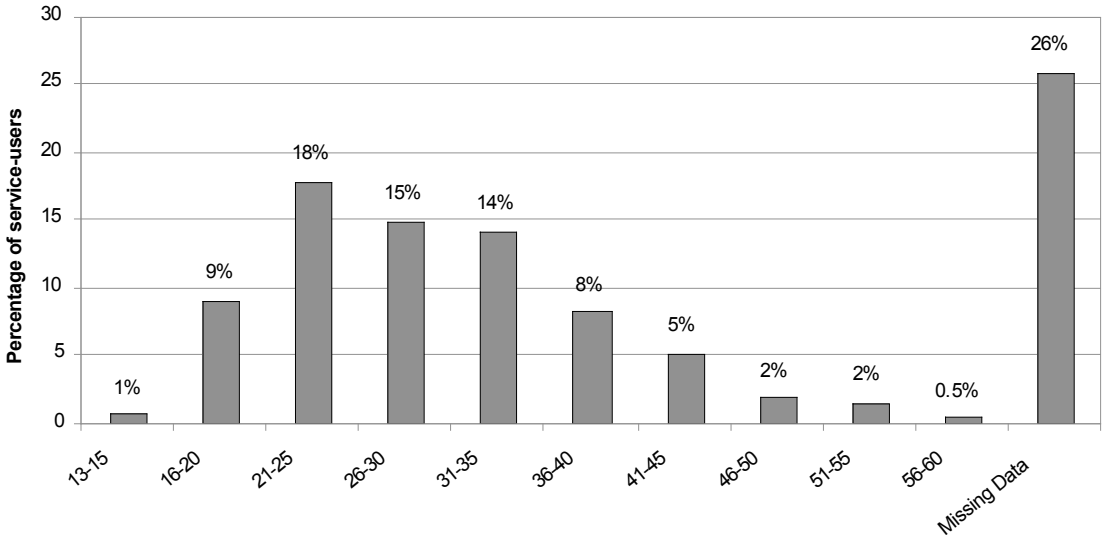
Figure 5.3: Ethnicity of service-users



5.2.4 Age

Service-users vary in age from 13 to 59, with most service-users being young adults between 21 and 35 (see figure 5.4). (Service-users aged under 16 are offered immediate support only and are referred elsewhere for specialist services.)

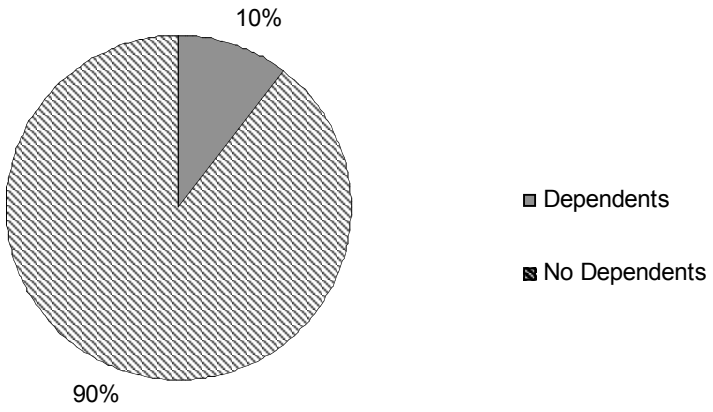
Figure 5.4: Age of service-user at first contact



5.2.5 Dependents

A relatively small but significant number of service-users have dependents (67 or 10.3 per cent) (figure 5.5). Most of these dependents are children under 16 who may be living at home with the service-user or living elsewhere with an ex-partner.

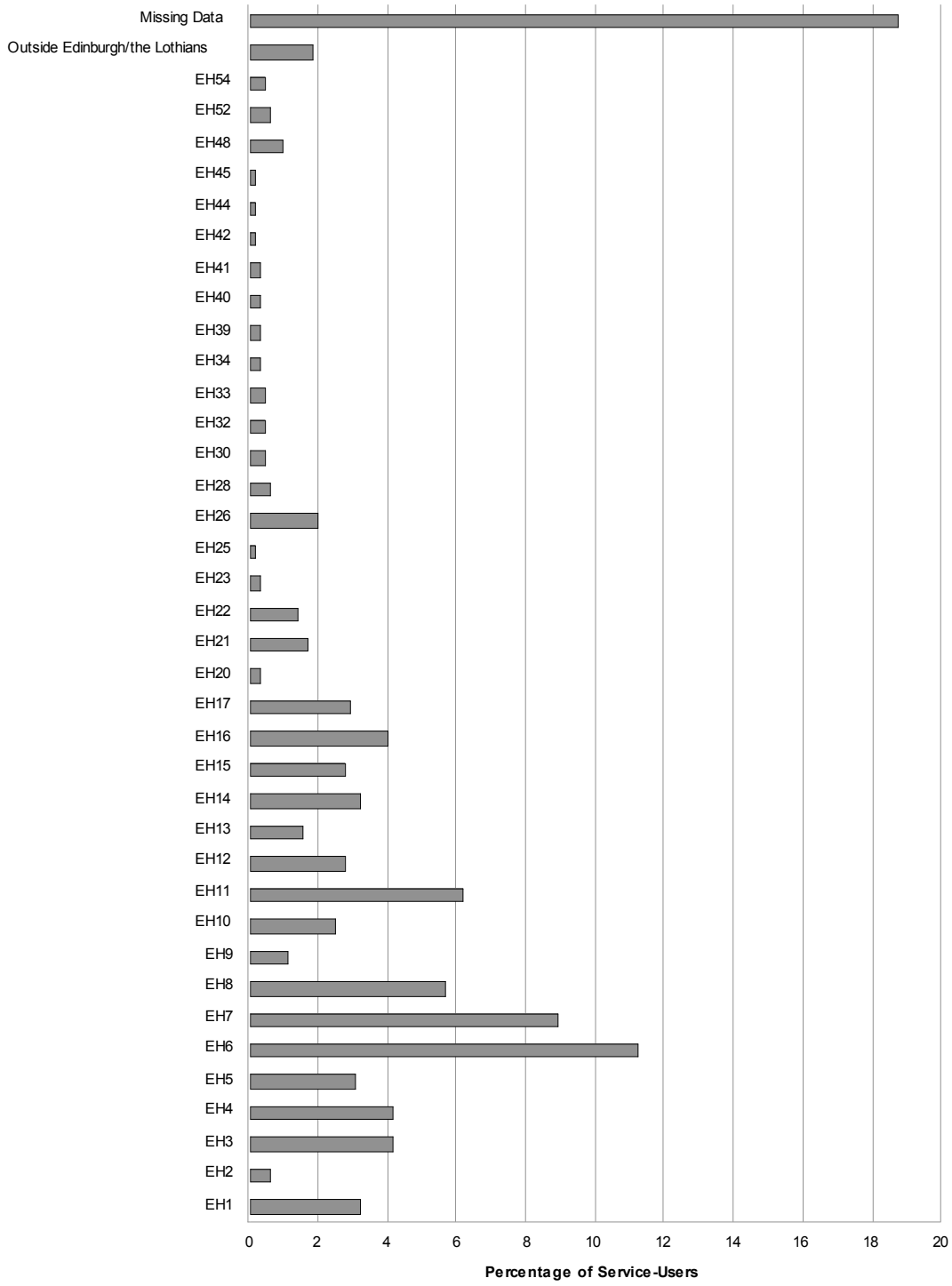
Figure 5.5: Service-users with dependents



5.2.6 Locality

The great majority of service-users (79.5 per cent) live in Edinburgh and its environs (figure 5.6). Service-users are most likely to be drawn from addresses in Leith (EH6), Restalrig (EH7), EH8 (Holyrood Park/Northfield) and E11 (Dalry/Sighthill/Stenhouse), with other City of Edinburgh postcodes (those up to EH17) accounting for the majority of other service-users.

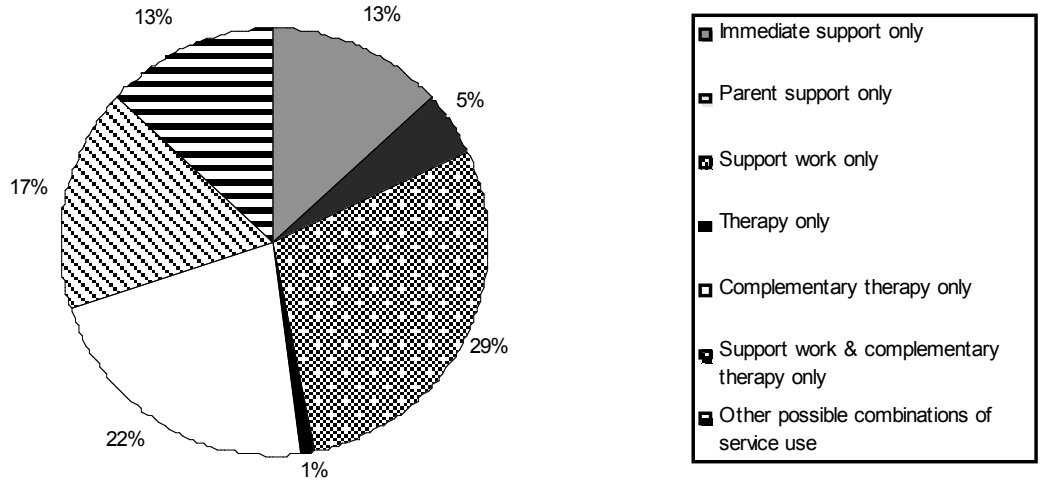
Figure 5.6: Locality of service-users



5.3 Use of different services

There are five services available within crew drug counselling of which two are single-contact only (immediate support and parental support) and three invite service-users to continue over multiple contacts (support work (drug counselling), therapy and complementary therapy). As figure 5.7 shows, 18 per cent of service-users are access single contact services only. Of those accessing other services, the majority make use of drug counselling either alone or in combination with complementary therapy, while many others use the complementary therapy alone. The database indicates that approximately 13 per cent of all service-users use a combination of single-contact and multiple-contact services. These data are difficult to interpret. In many cases it is likely to be that a service-user came for one session and did not make a commitment to return to use another service and was recorded as immediate support, but then swiftly re-contacted the service having decided to take up the offer of drug counselling and/or complementary therapy, with the data base being updated accordingly. However it may also be that the type of service use was simply mis-recorded.

Figure 5.7: Use of different crew drug counselling services



5.4 Service-user pathways

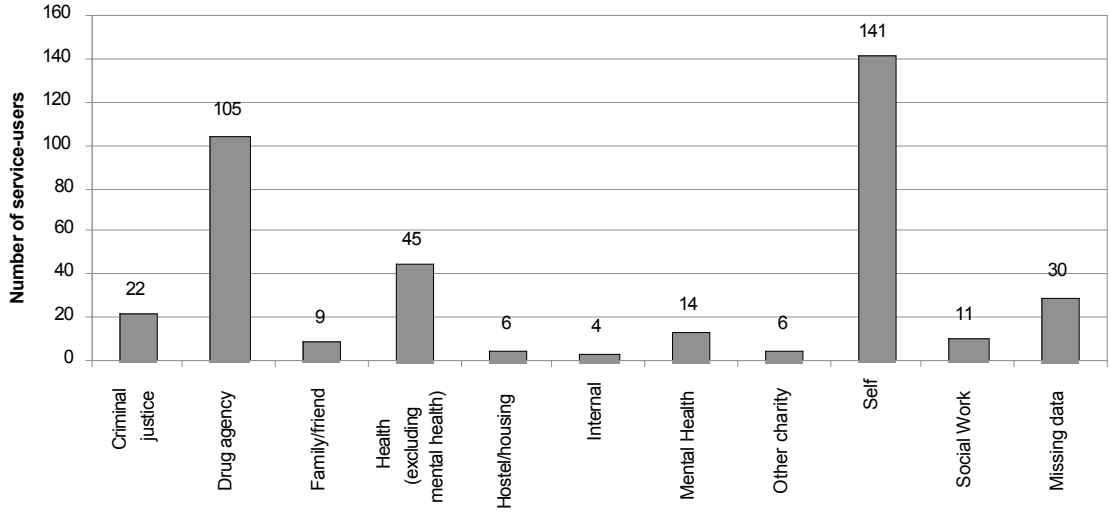
This section summarises the data available on how service-users enter, proceed through and exit the service. Of the 651 service-users entered in the eSUS database there is no information about service-user pathways for 308. The analysis in this section is based on 343 cases where some data about service use is available. However, for these service-users the data record is often incomplete.

5.4.1 Referral routes

While some service-users refer themselves to the service, many are encouraged to make contact by intermediaries. In some cases more than one such intermediary is involved. For the 343 service-users included in this analysis, 14.5 per cent have two referrers listed in the database. As figure 5.8 shows, of the 394 referrers recorded, the largest single category is self-referral (36 per cent). Other drug agencies account for 25 per cent of cases and health

services (including GPs, hospitals and mental health practitioners) account for a further 14.5 per cent.

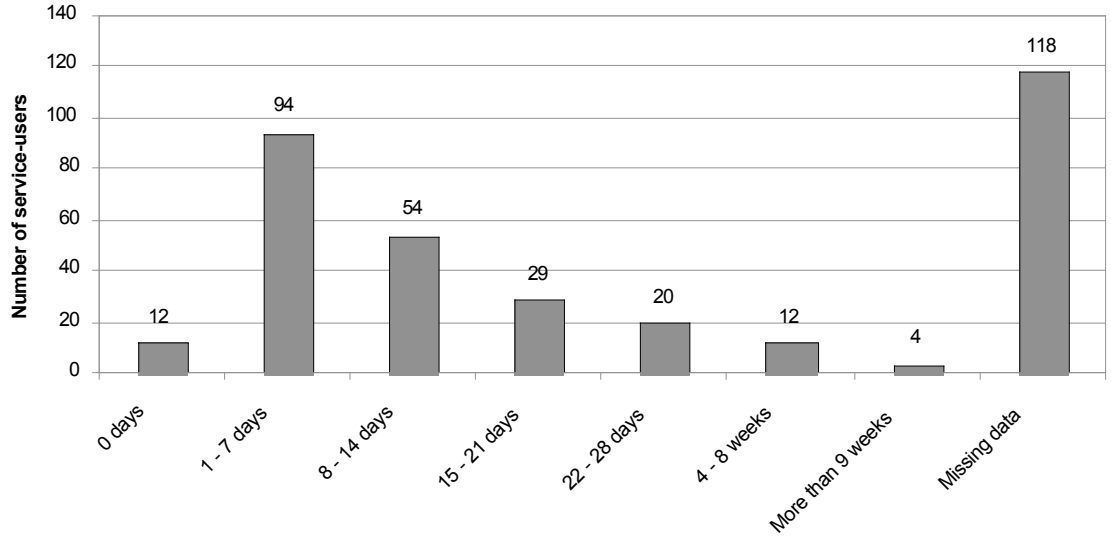
Figure 5.8: Sources of referral



5.4.2 Waiting times

The time between date of referral – when the service-user first contacts the service – and the date of assessment – the date on which they are first seen by a practitioner – was recorded for 227 cases, although in two cases the dates were considered unreliable because they exceeded 12 months. Of the 225 service-users for whom reliable data are available, waiting times varied between 0 (i.e. same day) and 324 days. As figure 5.9 shows, nearly half of those for whom data are available were seen within a week, and over 90 per cent were seen within a month.

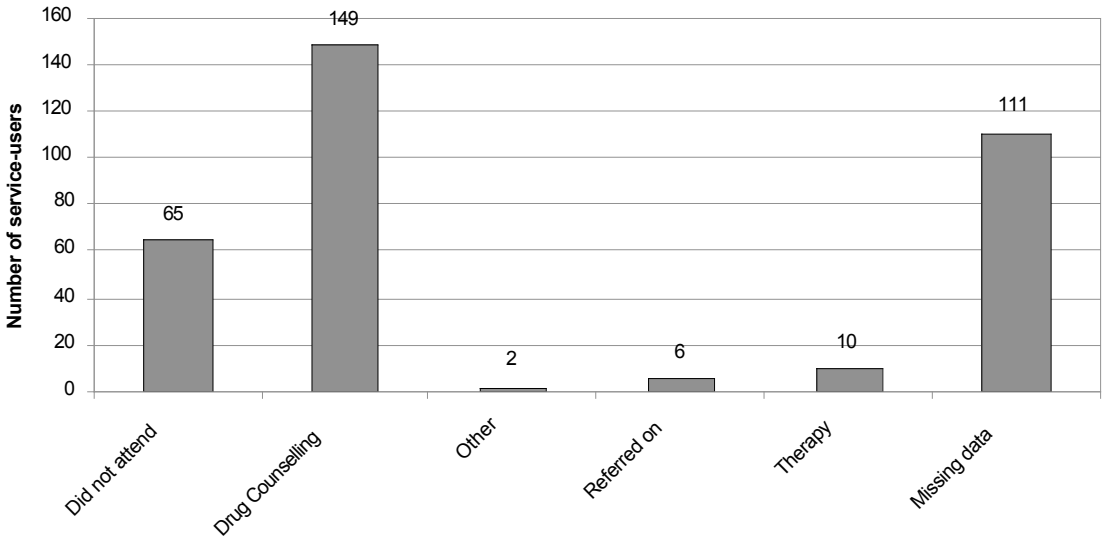
Figure 5.9: Waiting times



5.4.3 Assessment outcome

In a third of the 343 cases analysed in this section, no assessment outcome is recorded. It is not know if some or all of these did not attend their assessment interview or if they did attend but not outcome was recorded. Of the remaining 232 service-users, 89 per cent were referred into the drug counselling service (see figure 10).

Figure 5.10: Assessment outcome



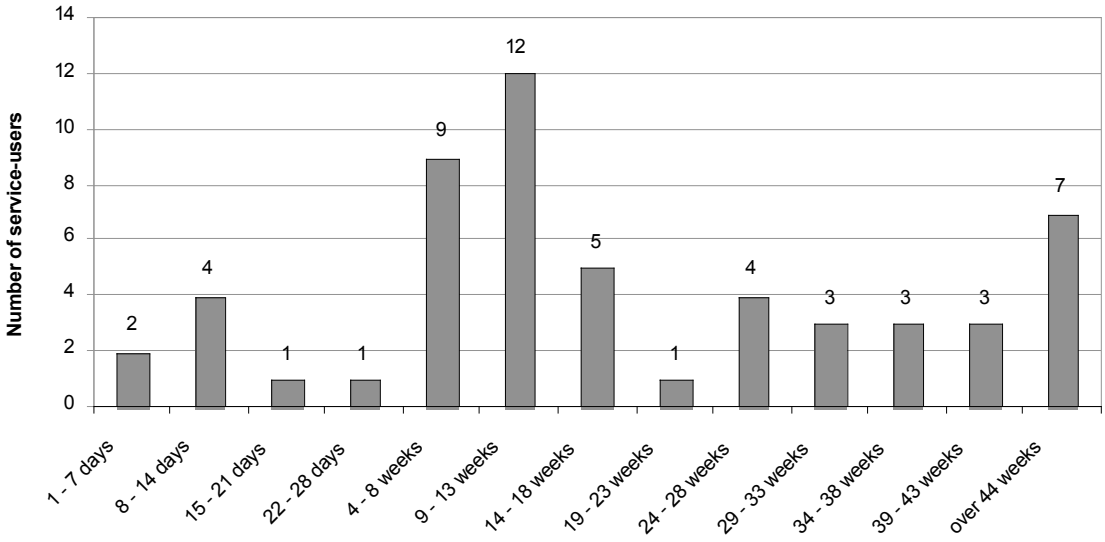
5.4.4 Appointments and length of engagement

The database includes records of appointments for 323 service-users, who were offered a total of 1397 appointments in total, of which 860 (62 per cent) were actually attended. This means that 38 per cent of the appointments offered were not attended.

The 323 individual service-users for whom data about appointments are available, were each offered between one and 38 appointments and actually attended between 1 and 30. The mean number of sessions attended is 5. Women were slightly more likely to attend their appointments than men while men actually attended slightly more sessions than females (5.2 on average compared to 4.5).

For 55 service-users dates of first and final appointments are available indicating the length of time during which they engaged with crew drug counselling, which varied from 1 to 519 days with a mean duration of 149.3 days (see figure 5.11).

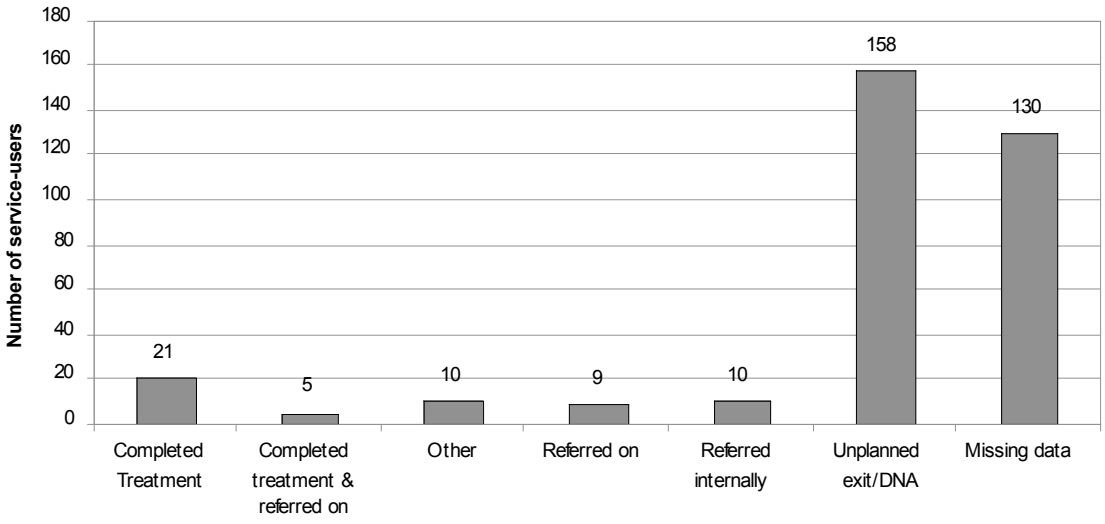
Figure 5.11: Length of engagement



5.4.5 Exit routes

Data about the completion of service use is available for 213 service-users out of the 343 considered in this section. Drug counsellors offer a planned series of sessions coming to a negotiated ending in which service-user and practitioner know when their meeting is the final one of a series. These final sessions often involve discussion of how the service-user will continue to support themselves after the ending of the counselling. However, many service-users do not choose to end in this way and simply stop attending when they have decided that they have had enough counselling for the moment or simply do not wish to return for another appointment. Consequently, as shown in figure 5.12, the great majority of the 213 service-users for whom data are available exited the service in an unplanned way.

Figure 5.12: Exit routes



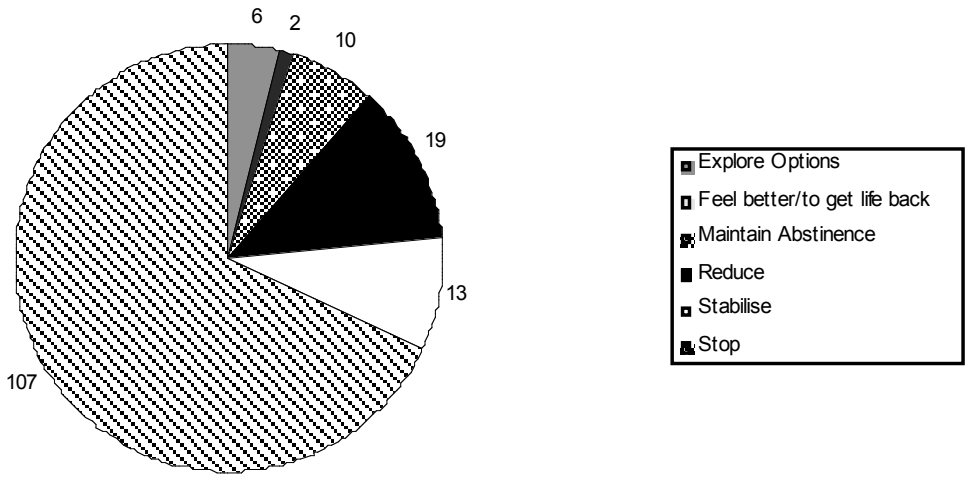
5.5 Therapeutic goals and change

This section summarises the data on therapeutic change and effectiveness available in the eSUS database.

5.5.1 Service-users goals

As described in chapter 2, crew drug counselling invites service-users to establish their own goals in relation to drug use and other aspects of their lives. Some data about these goals are available for 157 service-users. As shown in figure 5.13, the majority (68 per cent) said they wanted to stop taking drugs, with small numbers aiming to reduce or stabilise their drug use, to maintain abstinence or to explore their options

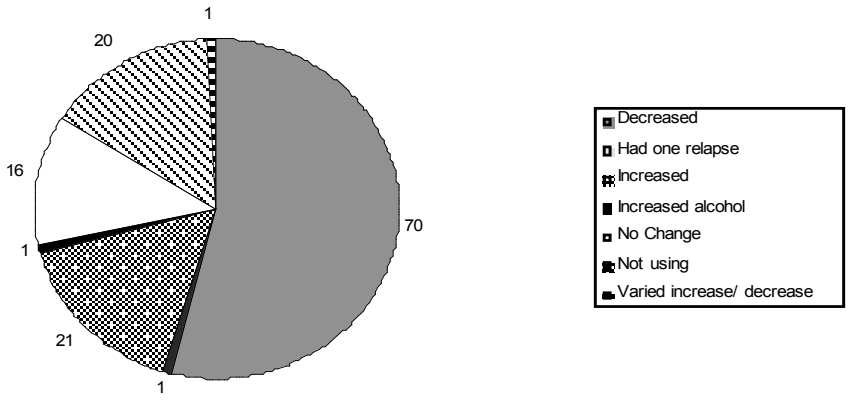
Figure 5.13: Goals of service-users



5.5.2 Change in drug use

During a series of drug counselling sessions, service-users are invited to review the extent to which they are moving towards their goals and whether their goals have changed. In this context, some data have been collected about changes in drug use for a total of 60 service-users, often at more than one review. For these service-users, drug use was recorded at 130 reviews and the results are shown in Figure 5.14. The great majority of reviews recorded decrease in drug use or continued abstinence. A minority (16 per cent) of reviews indicated an increase in drug use.

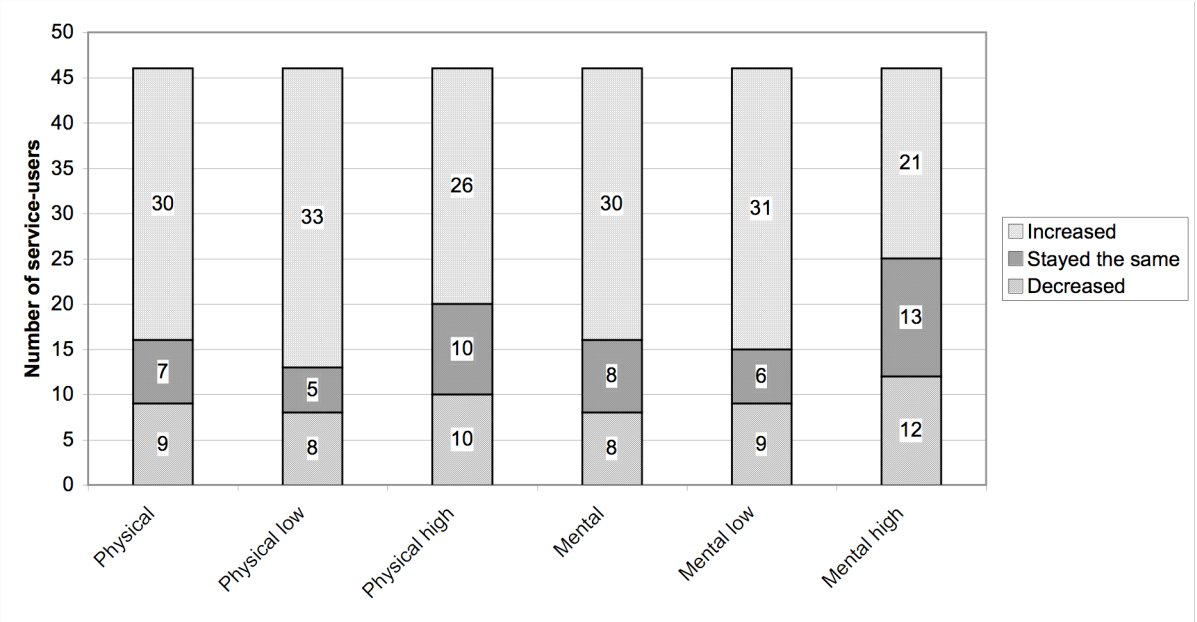
Figure 5.14: Change in drug use



5.5.3 Change in physical and mental feelings

In counselling sessions, service-users may be asked to rate their average, highest and lowest physical and mental feelings over the preceding week on a scale of 0 (very bad) to 10 (very good). Only 46 service-users had scores recorded on two or more occasions. Figure 5.15 shows that scores improved for most service-users but worsened for up to 25 per cent.

Figure 5.15: Change in physical and mental feelings



5.6 Clinical distress and therapeutic change

Two CORE tools were used in the evaluation: the CORE therapy assessment form and the CORE outcome measure (see appendix 1). The CORE therapy assessment form collects important contextual information including service-user support; previous/concurrent attendance for psychological therapy; medication; and a categorisation system to record presenting difficulties, their impact on day-to-day functioning and any associated risk. The CORE outcome measure consists of 34 items which assess the service-user' well-being (4 items), symptoms (12 items), functioning (12 items) and risk (6 items). Each item is scored on five-point scale ranging from 0 (not at all) to four (most of the time). The total score is calculated by adding the response values for all 34 items (minimum score = 0, maximum score = 136) and the total mean is calculated by dividing the total score by 34.

The use of CORE forms began towards the end of 2007 with new service-users. Consequently only a small amount of data was generated for this evaluation. A total of thirty-two assessment forms were completed, of which four were follow-up assessments. Some forms were only partially completed. The very low number of completed follow-up assessment forms provides insufficient date for evaluation of the value of this form as a measure of change in the evaluation of crew drug counselling services. However the assessment forms do provide useful indicative data about the levels of distress experienced by service-users, which can be compared with the levels of distress reported by the general population and by people presented at other kinds of services.

Of service-users who completed therapy assessment forms, 19 were male, eight were female and one did not specify. Their ages ranged from 17 to 50 with a mean age of 29. Comparing these demographic attributes to data for all service-users presented in section 5.2, the service-users completing CORE forms are fairly typical. Of these service-users, 40.6 per cent lived alone; 28.1 per cent lived with their parents; 21.9 per cent lived with a partner and 6.3 per cent lived with others. Three respondents had children, two under five and one over five. Nearly half (46.9 per cent) were being treated by their GP at the time they presented for their initial assessment and three (9.4 per cent) were hospital in-patients. Nearly one-third (31.3 per cent) were currently prescribed anti-depressants. Not surprisingly, all service-users reported difficulties with addictions. Most also reported suffering from anxiety problems of self esteem (89 per cent each) and over half (64 per cent) reported depression. Several also reported suffering psychosis, eating disorders, trauma, relationship difficulties and/or difficulties at work. These service-users also reported very high levels of risk in the form of suicide, self-harm, ham to others and/or legal risk.

The CORE outcome measure provides a way of comparing the distress of service-users with two other groups namely the general (or non-clinical) population and a large number of users of a wide range of mental health services offering psychological therapies immediately before their treatment starts (termed the clinical population). On average, the distress of those in the clinical population is substantially higher than for the non-clinical population. The crew drug counselling service-users who completed CORE forms showed much higher levels of distress than the non-clinical population. Their levels of distress are similar to the clinical population completing CORE assessments. This means that the distress experienced by crew drug counselling service-users is likely to be broadly similar to those presented at psychiatric outpatient services and other specialist mental health services offering psychological therapies. Examining scores under the sub-headings well-being, symptoms,

functions and risk, the crew sample are similar to the clinical population in general except in relation to risk where their scores are rather higher indicating greater risk of harm to self and/or others when first presenting for help than among psychiatric outpatients and other specialist mental health service-users. Full details of the results are presented in appendix 2.

The CORE outcome measure has the potential to assess therapeutic change for service-users in a way that can be compared to the improvements achieved by other services. To date there is insufficient CORE data to be able to make any meaningful conclusion about therapeutic change in relation to crew drug counselling services. To realise this potential it is essential that as many service-users as possible complete the CORE outcome measure at (or before) the end of their service-use as well as at the start.

5.7 Summary

There is no “typical” service-user at crew drug counselling: the service reaches a very diverse group of people, in terms of age, gender age range and locality. Compared to many counselling services, but similar to alcohol counselling services, men outnumber women among service-users. The demographic characteristic with the least variance is ethnicity, which reflects the relative lack of ethnic diversity in Edinburgh.

Crew drug counselling sits within a network of services and many of its service-users are referred by health professionals and people working in other drug agencies. A substantial proportion of those contacting crew drug counselling do so on a one-off basis. The service succeeds in offering initial assessment appointments swiftly to those who want them, usually within a week. Most of those that engage for longer than a single contact undertake drug counselling, many of them also using the complementary therapy service. A minority use complementary therapy only. Those using the drug counselling and for whom data are available see their counsellor for an average of five sessions. Missed appointments are very common, which is to be expected in work with service-users struggling with issues to do with psycho-stimulant drug use. This is reflected in the way in which service-users leave the service, which is more likely to be unplanned than planned.

Chapter 6

Service-User Accounts and Perceptions

6.1 Introduction

A variety of evaluation methods were undertaken to explore the views and experiences of current, past and potential service users. These included:

1. In-depth interviews with current and past service users: eight
2. Questionnaires completed by current service users: ten
3. Questionnaires completed by people who made an appointment but who did not attend: three
4. Analysis of agency's standard evaluation forms completed by service users at the end of their counselling: eighteen

The variety of methods used generated a rich range of data and enabled a comprehensive picture of service users' experiences to be established. In total, 39 service users have contributed to this section of the evaluation.

To explore the views and experiences of service-users in greater depth, all current and former service-users were invited to take part in a research interview with a member of the research team who has previous experience of counselling or related professions. The interviews were carried between December 2007 and May 2008. Of 250 potential former service-users, seven offered to be interviewed. Two were not able to attend so a total of five interviews were conducted representing a 3 per cent response rate. Of 30 potential current service-users, seven offered to be interviewed. One cancelled in advance, one cancelled on the day, two did not arrive so a total of three interviews were conducted representing a 10 per cent response rate. The interviews explored service-users' experiences of accessing crew drug counselling, their expectations and experiences of counselling, descriptions of therapeutic change and their satisfaction with the Service. In the following discussion, the pseudonyms used for the five former service users are: Dave, Margaret, Paul, Angus and Tom and the three current service users are: James, Douglas and Helen.

In addition, questionnaires examining similar themes were distributed to all current service users and ten completed responses were received. Excerpts from these questionnaires are coded Q1 to Q10. Adapted questionnaires were sent to a sample of 50 people who had contacted the service but who failed to attend the initial arranged appointment and did not subsequently come into the service. Three completed questionnaires were received from this group: excerpts from these are coded dnaQ1 to dnaQ3. Finally, the research team analysed 18 agency evaluation forms completed by service-users at the end of the counselling. These are coded: ID1 to ID18. Invitations to contribute to the evaluation through interview and questionnaire explicitly stated the independent status of the research team and the confidentiality of the data generated.

6.2 Making contact with the service

Many interviewees described approaching the service when their lives had reached a significant crisis point. For example, Tom described himself as completely suicidal and desperate while Dave described himself as being completely out of control. Angus was more ambivalent, finding himself in two minds: one part of him knew that his drug use had "taken over" and was out of control, while another part of him was in denial, minimising the drug use and just wanting to "keep on partying". For others the crisis took a different form. For example, Margaret had been diagnosed as suffering from bi-polar disorder, while Paul did not convey any sense of urgency or desperation but was aware that his drug use was becoming an issue between him and his partner.

Interviewees approached the service in different ways. Some were referred by other agencies: Douglas was referred by his GP, James was referred by Turning Point and the Service was recommended to Margaret whilst she was an in-patient in hospital. Some interviewees made contact via crew's own outreach services. For example Angus came across a crew stall at a nightclub and this triggered the realisation that his drug use was becoming a problem and that he needed to go to the service. Friends and family were important for several interviewees, sometimes being the people who trawled the Yellow Pages to find an appropriate service. For example both Dave and Tom were encouraged to access crew by family members, while Helen was encouraged by a friend. Others already knew about the service through their own work. For example one had previously been a sessional worker on a drug and alcohol project.

6.3 Facing anxieties and getting started

Most people contacting the service are offered an initial appointment within a few days, and in some cases on the same day, for example, when people walk into the shop and ask to speak to someone (see chapter 5, section 5.4.2). Margaret walked in to the shop explained why she was there and was seen immediately. If the initial appointment leads to a decision to beginning drug counselling, there may be a wait before a regular appointment becomes available. For some this wait is short and not experienced as a problem. For example Margaret recounted

> *It was very quick. I don't know exactly how long but I wouldn't be surprised if it had been a maximum of three weeks. Yeah, it was really soon, which was brilliant.*

However for others, the initial waiting time, whether for an initial appointment or for ongoing sessions was a period of heightened anxiety. Interviewees described worrying about feeling judged, whether information would remain confidential and feeling embarrassed about admitting they were having problems with drugs. Questionnaire respondents illustrated these feelings very clearly in their comments after indicating "yes" to the question "Were you worried about coming to use the services at eSUS/crew2000?":

> *In case it wouldn't help. (Q1)*
>
> *Being treated in an unsympathetic manner and also the thought of failure. (Q2)*
>
> *Wasn't really but just didn't know what to expect. (Q3)*

Just embarrassed about talking about my problems and ashamed. (Q4)

Admitting I had a problem. (Q8)

For Angus, accessing the service was an admission of failure and it therefore took a great deal of courage "to come through the door"

> *It seemed insignificant, you know, but when you think back]… you know, coming through the front door and saying basically admitting you've got a problem – there's a sorta bit embarrassment thing about it, 'cos you're admitting; - it's like a defeat thing.*

Quite a few of those who make contact and are offered an initial appointment do not get past such feelings. One such person returned a questionnaire explaining why s/he had not gone:

> *I was a bit ashamed and knew I needed help but was very depressed and did not want to speak about it. (dnaQ1)*

Another offered a comment that suggests a paralysing cycle of shame:

> *eSUS done nothing wrong and that is what makes me feel worse that someone is willing to help me and I wasted their time. (dnaQ3)*

For those who find the courage to attend their first appointment confidentiality was a significant issue. For example, Dave said:

> *The worry for me at the time was somebody might see me walking in here that maybe knew me and go, 'oh that's crew2000, they deal with drugs', cos that was it – I was in denial and hiding everything that I did.*

Those who had become service-users indicated that the service had been able to provide them with the reassurance and safety they needed to understand and make good use of what was offered. The clarity of information provided, the '"feel" of the environment and especially the qualities of staff they interacted with were all-important.

6.3.1 Staff

The approachability and non-judgementalism of staff was mentioned repeatedly:

> *I phoned up [and] they were very approachable. I was made to feel relaxed. (Angus)*

> *Very positive experience, staff were friendly and very supportive. (Q3)*

> *Open and friendly, approachable and non-judgemental. (Q8)*

While some emphasised friendliness as in the comment from Tom that *"they're just a nice bunch – just a nice bunch o' folk"*, this sense of the staff being open and warm co-exists with them being respectful and professional:

> *Even the first day I came in, I was treated well and I always am treated very well when I think back, yeah. (Dave)*

> *I felt relaxed and in a non judgemental, professional environment. (Q1)*

Margaret, who stopped taking drugs after her first appointment clearly felt a tremendous sense of acceptance and support from the very start:

> *You were able to speak to somebody that was obviously, you know, completely, impartial and wasnae a doctor, wasnae a psychiatrist, wasnae really there to give you a ticking off or whatever, you could actually say, 'well I've been using drugs' or 'I did this at the weekend' or whatever. So it's great just to have that chance to speak to someone and – you know it's confidential.*

6.3.2 Information

For many people contacting the service, the first need is for information. This was evaluated highly be the majority of service users who provided feedback. Questionnaire respondents commented that the received *"very friendly helpful advice"* (Q2) that *"gave me a decent bit of insight about what it [drug counselling] was"* (Q4). Paul offered similar feedback:

> *I would say that I've always found – the sort of front line staff – the first people you meet to be very welcoming, friendly, knowledgeable, pretty open and honest actually about things that they might not know, not that you'd find questions that they didn't exactly have answers to. I certainly got the impression that they wouldn't pretend to know stuff that they didn't know or whatever, which I found really refreshing and quite useful.*

Most interviewees conveyed a sense of feeling that they had received the kind of information they needed when they needed at, as in Dave's comment that

> *I was told what would happen – I would be seen again and how often and how often they could see me and it would only be for a set period of time and there was literature out there on the table and also that I could phone and speak to one of the counsellors.*

6.4 Personal experiences and impacts of the complementary therapy

Not all of the service-users who were interviewed had used complementary therapy but those who had were positive about it, emphasising how it complemented their counselling sessions and how hey found the therapy very relaxing. Some referred to significant problems with sleeping and reported sleeping better on the day they received ear acupuncture treatment.

> *The second time that I had it, it was in this room, I had my friend with me, it was a totally different kinda experience. I still haven't tried it again 'cos I'm no really sure it's for me but I did really feel that it did help, even just that once I felt more relaxed and calm after the session and, you know, I'm sure my sleeping was better as well. (Margaret)*

> *You get five needles in each ear and they put music and you just chill out, and it's relaxed […] My problem is I used to get a bit erratic thinking – just get speedy like I had a bit stuff and that was a danger to me that I needed to slow down and I would come here and it would certainly help. Take time out, I used to call it. (Dave)*

These comments were echoed in questionnaire comments, which included remarks about how ear acupuncture helped reduce cravings and provided a non-drug means of working on bodily sensations:

It can help craving and other problems e.g. sleep anxiety. (Q6)

Creates a mind and body reaction/sensation - and not from drug. (Q1)

Others commented on how it might be experienced as an easier way to start addressing issues than through counselling:

It's important as it is an alternative to people who may not be ready for counselling. (Q3)

Others recognised the benefit of the acupuncture, but were unable to explain how:

I've still not worked it out yet. I feel something but I've not worked it out. (Tom)

Several interviewees had slight reservations about the acupuncture therapy being conducted in groups. They would have preferred to have individual treatment. For some, entering a group was a daunting experience and came as a surprise. They would have preferred more preparation for that. The issue of confidentiality in the group setting was raised by some who were concerned that confidentiality cannot be guaranteed in a group because the participants might disclose information about other group members. This had an impact on feelings of safety and trust. But they also spoke of how they became used to the group setting.

I said I'd tried the acupuncture but it was in a group setting which just wasnae appropriate for me at the time but they had offered to say that they could try and get a counsellor to do it one-to-one, but I actually ended up coming with my friend to the group session, which was fine a while later. (Margaret)

Only Helen had accessed the Reiki service. She described the one session she had attended as "*interesting, it was good*" and commented that she'd like to have more sessions.

6.5 Personal experiences and impacts of drug counselling

Interviewees and questionnaire respondents described very positive experiences of drug counselling. Throughout interviews and questionnaires, there is a dominant and recurrent theme of the depth and quality of the work undertaken in the counselling service, namely, how the counselling addressed underlying problems, difficulties or issues which were causing or contributing to the drug use, rather than simply focusing on the drug use itself. Interviewees and respondents reported consequent significant positive impact on their lives in general, in addition to their drug use. Many service users commented on the important function of the counselling in providing them with a calm and contained space to think, as illustrated by Dave's statement:

The counselling was – 'cos I needed somebody to help me, know what I mean, and to speak to, somebody outwith my normal circle, and cos when you're on drugs, you miss a lot. You think you know everything but you miss that much and they help you to think more. Because they'd opened doors here with my therapy and that, 'cos it is therapy here.

Examples from the current service-user questionnaires in response to the question "do you think drug counselling is helping you" are:

Helps me sort out what is important and what isn't instead of it going round and round in my mind. (Q1)

Found that the root of why I was using. Mental condition was found out then dealt with. (Q4)

It's helping me address my problems and admit there is a problem. (Q6)

Assist in helping understanding your addiction/behaviours and alternative ways to look at dealing with them. (Q8)

Helped me address a major problematic period in my life and chronic addiction. (Q9)

This theme is also recurrent in the completed service user evaluation forms as illustrated by the following examples:

eSUS offers a truly excellent support service to any individual fighting substance issues. The service is both caring and challenging. Out of all support and therapies I have tried over the years, this is the one that has truly helped me make progress regarding my substance abuse issues. (ID5)

I would like to thank eSUS and especially [name of practitioner] for letting me come in and discuss my problems. It has helped me a lot being able to talk about how and why I am having a few problems with substances. (ID7)

Words can't describe the positive effect. Totally changed my life for the better. (ID8)

Been really helpful to unravel the mess in my head, which in turn helped my drug control. (ID14)

Interviews allowed fuller exploration of comments of this kind and reiterated the sense that a key impact of counselling is in enabling people to face the reality of their lives, whether or not major transformations follow. This point was made poignantly by Dave:

My hopes were that I would get myself back together, I wouldnae touch any drugs again and I could get myself the old Dave back. The old me. And I was told that I maybe never ever be that same guy or have that same guy back but that guy'll be there and there'll probably be other things – a new me, which I – like I accept now, know what I mean, for good or bad but, I accept that, and there is a lot of positive things that was said to me.

For others, counselling did lead to major changes. For example, Tom reported that his life was completely transformed and: "*It helped me a lot, saved my life really".* He had stopped using drugs, developed greater openness with his partner and begun to deal openly with important identity issues that he had previously been concealing from everyone.

Interviewees emphasised that a key feature of drug counselling is that it is the service-user who has to the work, with the counsellor acting in the role of facilitator or guide in that process rather than problem-solver, adviser or expert authority. Paul spoke eloquently about how enabling he found this approach.

> *I was being allowed space to explore what were quite deep and significant issues but I did find the lack of pressure was helpful I think. [The counsellor] was - seemed like or played the role of a facilitator, she was an enabler, she was helping to create the conditions where that the learning or the change or the thinking could happen. I did find that a very useful approach I think.*

For others this approach was very challenging. For example Angus stressed the personal commitment required, and throughout the interview he kept challenging the potential fallacious assumption that some clients might have, and which he himself had held at the beginning, that the counsellor will sort things out for them.

For many service-users the challenging work required of them meant being open about their feelings, both to themselves and with the counsellor. Paul described this as both hardest thing about the counselling and the source of the most significant learning:

> *The hardest thing was being able to speak to someone about the deeply felt emotional things. I would say that's more to do with me than with the service but, I mean, it's probably a bit of a guy thing as well that, men find it difficult to talk about their emotions and what not. I did find that quite hard but, in a sense, that was probably the useful bit actually because that's where the learning and the change happened, when I was able to open up and to look at whatever.*

Through such openness interviewees reported finding deeper self-understanding. For example Douglas commented that

> *My counsellor can see things in me that I don't see myself and that is great because it helps bring out realisations in myself of things that I haven't been aware of […] I've come to know myself.*

Others described how drug counselling had helped them build their self-confidence. For example Helen had a history of very difficult relationships with medical professionals, which had left her feeling "*completely destroyed*" and "*quite worthless*". Counselling felt very different to her and was helping her build up her sense of self worth.

Improved relationships with others was another theme that came through a number of accounts. For Paul this was a key issue and he described how counselling had provided an opportunity to gain perspective, to see issues from his partner's point of view and to see himself more clearly and fully. He came to appreciate that his drug use was jeopardising his relationship with his partner, and that he had been acting both defensively, and, to some extent, selfishly in relation to his drug use. The counselling helped him to express his feelings and to communicate more openly with his partner, an achievement he reported he had sustained after he had left the counselling service.

> *I was concerned that my drug use was hurting my relationship. […] I got the opportunity to sort of see that from someone else's eyes - from someone else's point of view. It doesn't have to be complicated, it doesn't have to be rocket science or something like but it was just really useful for me to maybe pause for a minute and say, well hang on a minute what's happening here, let me try and look at it, more in the round, rather than just from my personal and narrow, perspective. I think it did help to see how my attitudes or speech or behaviour might be perceived by someone else – a little bit like a mirror in a sense that you get a good look at yourself but in a non threatening sort of way.*

For some service-users, drug counselling enabled them to address links between drug use and past life experiences which they had never addressed before. For example, Tom had a history of childhood abuse and neglect, as well as issues of sexual and gender identity. By the time he came for counselling his drug use was having side effects, which left him feeling desperate. The counselling service allowed for all of this to come out:

> *I was at the stage where I just needed to talk, I needed to release some of the shit inside. I was at the end of my tether. Well, I was just ready to jump off a cliff.*

In answer to the question, what impact the counselling had for him, Tom said simply *"It freed me*". Dave had a history of multiple family losses and bereavements which he had not been able to confront. Through counselling, he came to recognise that he was using drugs "to numb the pain" of these experiences and he learned that he could allow himself to get in touch with these emotions with the help of the counsellor and without recourse to drugs.

While some service-users find the service at the moment at which they are ready to engage in the challenging work of counselling, others start and stop, either returning to crew when they recognise they are more ready or going on to other services to do the work they need to do on their drug use. For example, Angus who attended five sessions and then stopped coming. He said:

> *I was treated fine. I was made to feel really welcome and I wasn't pressured in any way whatsoever. I didn't have a bad experience or anything like that. That's what I'm saying. It's nothing to do with anybody here that I didn't come back. […] I just lost the momentum.*

Although he didn't work through key issues in counselling he explained that his sessions nevertheless set him on the road to recovery. He reflected that the service enabled him to access other services subsequently, to admit to himself and others that he had a major problem with his drug use, that a harm reduction or moderation approach would not work for him, and to begin to recognise the role that drugs played in his life in distracting him from boredom and an inner sense of loneliness. He went on to undertake longer-term work with an NHS Psychology service and, at time of interview, was abstaining completely from drug use.

Another service-user had similarly come for just five sessions initially and "didn't find the counselling service particularly useful" because of her own limited insight into her drug use at that time. She returned to the service later and re-engaged, reflecting that

> *[when I first came] I wasnae really discussing difficult times when I was trying not to use cocaine but ended up doing it, which would [have been] really useful, but when I stopped accessing the service and I got better, I then started using drugs again and that's why a few months ago I came back and said, God, I really need help, I actually need it now. (Margaret)*

6.6 Impact of drug counselling on drug use

The impact of the counselling service on clients' drug use is complex and variable, with some stabilising, some reducing, some managing to stop completely and others still struggling, despite the increased understanding and perspective gained through the counselling.

For some heavier users, the counselling hour is the only hour of the waking day when they are not using drugs:

> *I come up here for that hour and I don't touch cannabis. The hour when I'm with my counsellor. (James)*

> *I never touched cocaine when I came here. I never had a line when I came here. I used to go with maybe other things an' I would take something. I didnae but I admit I smoked a bit hash when I came in an' then I stopped smoking it but … ye can be told things an' that but unless you're really shown an' that, ye can … if you willnae listen, it'll just fly over your shoulders and I felt, ye know, they were getting some place with me but then it just kinda … I never stopped smoking' till I sorta, you know, left counselling, know what I mean. That's when I sorta … but I was told it could cause paranoia and the rest of it but I don't know if you'd maybe be able to show examples or show a film or a movie or something of it, just examples. You could have dug a wee bit deeper in it rather than just telling you. (Dave)*

For some, the aim of attending the service is not so much to change or stop using drugs but to address the consequences of drug use or other factors relating to drug use.

> *I would say that yes, coming to the service did change some of my behaviours around drug use. I'm not sure how much it changed the kind of amount of use. I'm not sure that I started sort of using much less or more or anything like that but in different ways and maybe in different contexts or, you know, at different times and also I think it changed a little bit how I spoke to my partner about it or related to her about it or whatever – that kind of thing. (Paul)*

While all respondents and interviewees reported significant positive benefits of the counselling in relation to self-awareness, understanding and insight, the work of either reducing or stopping drug use was for some a very long-term task, which was not always achieved during their time at crew drug counselling.

> *I dinnae ken why I'm going really. I'm going round in circles actually. (James)*

Others experience cycles of gain and loss, managing to reduce or stop for a time and then starting again when stressed or when there is a break in the service or when there service ends.

> *It didn't to start with and then I did try because I realised that I suppose I was still under the influence of it. I would try and keep it to a minimum, just have one before I came if I had to have any. […] Aye. I'm back on it again, aye. […] I'm back at the stage that I was at before I came here in the first place. (Tom)*

> *Right, this is a wee challenge here, I'm gonna have to stay off drugs 'cos I dinnae want to be coming in here the next time and telling him, oh I've had a relapse and feel a prat, ye know. So I was a bit … and of course I cancelled a couple of times because I had relapsed and I didnae want to admit that I relapsed. (Angus)*

Several interviewees noted the understanding and supportive approach which crew staff took towards relapse, which helped them to return to the service despite the shame of having taken drugs again when they had promised themselves and their counsellor that they would never do so again.

For several of the interviewees, although there had been changes over time with both the nature and quantity of drugs, there did not appear to be any great overall reduction at this stage, yet there has been an increase in capacity to engage with and monitor drug use.

> *My time with the counselling has been – it's been fluctuating. The review again has been flexible to reflect that. […] The overall goal setting hasn't changed but smaller parts within have. Again, back to that flexibility – to adapt to what I find most useful for myself and the input from the counsellor with the suggestions and ideas of how to do that have been invaluable to me. I wouldn't have thought of any of the ideas of monitoring some of the things I do, and they've been very helpful, very helpful indeed. (Douglas)*

For others, the very first contact with the service, and the knowledge that there was someone there to help and listen, provided the confidence to stop using drugs entirely.

> *I came back, possibly the very beginning of November, and spoke to someone for an assessment, which went really well, but they said there is a waiting list, and I'm obviously still waiting to hear, but it was great to have a chat with the person and, as I said, whatever it was they talked about or whatever, which was really, really helpful. I havenae actually used drugs since. (Margaret)*

For Helen, the previous acupuncture sessions had a positive impact on her drug use.

> *I stopped smoking cannabis after I had the acupuncture here and I stopped smoking tobacco as well.*

However, she subsequently started smoking cannabis again, which led her to return to the service.

Some clients began counselling with the aim of "getting their drug use under control", i.e. either stabilising or reducing, but found through the work that they were able to achieve the more significant step of abstinence.

In addition to the interviews, current service user questionnaire responses illustrate the impact that the counselling is having on their drug use, as exemplified by the following excerpts:

> *Counselling is helping me to face the difficult situation I find myself in – in a safer way. And more as time goes on. I can see that talking things through is better than covering them up, i.e. smoking cannabis. (Q1)*

> *Found out what it was aggravating so I kinda had to limit it… Treat them with more respect, even softer ones and more open to herbal drugs. (Q4)*

> *Am trying to stop altogether and counselling should help. (Q6)*

> *Think more about taking drugs. (Q8*

> *Helped me to cut down my use and dependency … That the dangers you are exposed to through drugs. (Q9)*

6.7 Specific aspects of the drug counselling service that facilitated change

6.7.1 The counselling relationship

Interviewees described the primary task of the counsellor as to create a space in which they could undertake the important and painful personal work of confronting and expressing their problems and emotions and working towards change. The interviewees recognised that the counsellor facilitated this through:

- taking the client and their issues seriously

  I think it was the person that runs the place that saw me initially for the assessment, but as I was speaking to her, I was expecting her to say piss off, you've got no problems or you're no worth it, ken. I was still very low. I felt kinda sheepish and actually stupid saying to people ... Asking for help's not easy. Never had it before. (Tom)

- creating a safe space for these issues to be discussed

  What helped that trust? The people are all very friendly and quite down to earth and stuff like that. [ ] There's a far more realness about people at crew. (Margaret)

  I feel like lucky because from immediately meeting my counsellor, I felt at ease and relaxed. I felt comfortable and I felt I was able to trust, which was the biggest thing and I couldn't tell you why but I felt that almost within the first couple of minutes. (Douglas)

  I trust her because we have built a relationship of trust and openness where I can talk about anything. (Q9)

- respecting confidentiality

  It's your own space. You're getting a bit of space for yourself […] I trust them like because what I say is not gonna go anywhere else, it's only my counselling – the hour she deals with me. (James)

  Totally separate, and everythings on my terms. Like I'm no worried that you're gonna go and phone my missus and say … you need to start checking. (Tom)

  I appreciate that she doesn't write things down. (Q1)

- not speaking, giving opinions or advice,

  The biggest asset I think is she knew when to not speak. From my experience, sometimes they're trying to tell you what you're saying; they're trying to tell you how you're feeling or 'I believe this out of what you're saying' which then in turn can make the subject believe that when they didnae really mean that. Ken what I mean? It's like almost influencing the person and it can be their guess and what if their guess is wrong? A lot of people speak too much whereas they should actually just let the person get it off their chest, listen to them babbling on. There's a computer happening up there, and it's starting to fix itself out a bit, ken… You can only help yourself really. The person's just there to … keep you on the straight run. (Tom)

- not being critical or judgemental,

  They were quite good as well a couple of times when I had to cancel, there wasnae … I think they know people cancel […] they weren't hard about it, they weren't like nippy or anything like that. I don't like letting people down, you know. 'Cos you're letting people down, made an appointment […] but they weren't. (Angus)

- being real, genuine and not seeking to be an expert

  That feeling or that approach applies to pretty much all people I've met at crew even at the front desk or whatever if I need to ask some advice about any technical aspect. I never felt that I was being talked down to or anything like that, even though obviously that they had specialist knowledge that I didn't have, it didn't feel like an unequal relationship at all. (Paul)

- not applying pressure to speak or change,

  We seem to progress at my speed. (Q1)

  She would be a bit positive and that, know what I mean, and she does … she would pick up things I'd done during the week or done in my life that were good things rather than negative things and I suppose that's a feel good factor. (Dave)

- being flexible

  I'd say the best thing was the attitude and being open and being welcoming, treating you as an equal, being flexible and willing to come and go a little bit. Yeah, I think that was the best. (Paul)

- not setting an agenda

  They asked me, did I want to talk about stopping all together or did I want to talk about controlled use, and that still fascinates me because at the time, I felt I had to stop all together but I think now maybe it's not really a good time to stop anything all together right now. (Helen)

- being caring and believing in the client

  Just the manner and the way they speak. […] and it was believing that somebody was trying to help you and they had good intentions 'cos you were in the drug scene and all the rest of it, you get a lot of people that's misguided and their intentions are totally different and it's trying to get back on that road again and believing that there is somebody there that is trying to help ye. An' that made me feel good. (Dave)

6.7.2 Counselling plus

For many respondents, crew acted as more than simply a one-hour-per-week counselling service. Their sense of being known, cared for and helped extended beyond the counselling hour/counsellor to their whole experience of the service, to all the staff they had contact with, to the extra support they received on the phone or at times when they simply walked in needing to speak to someone. They also really appreciated the acupuncture service being offered in addition to the counselling. In this sense, crew offers a place and a community of people to which these service users, some of whom are very vulnerable, can turn at times of

need. Many service users, both current and past, experienced crew as a lifeline without which they reported they might not have survived.

> *I have found this service excellent and feel that without it I would still be going down a path to destruction. (ID4)*

The flexibility, approachability, accessibility, reliability and consistency of the services offered offered by crew drug counselling were all noted as invaluable by the service-users.

6.7.3 Location of service and quality of accommodation

Most interviewees like the central location. This was mentioned in several questionnaire responses. For example, one service user liked that the service is "c*entral, easy to reach. Anonymous. Small. Friendly old building"* (Q1) Similarly, Tom very much appreciated that the service was city-centre based and separate from all areas of his life so that he could be confident that nothing shared with the counsellor would be communicated in any way to anyone else.

> *I don't know what it is that made me trust them. Obviously how they've reacted though … Nothing about them that's distrust … distrusting. And again, because it's out of my area, they're not gonna ken my next door neighbour.*

The central location together with the discreet entrance was very helpful in enabling service-users to maintain their privacy:

> *Well, I come here, there could be people out there I know that come here like. I don't know. I've never seen anybody I know. When you come here, it's like, you dinnae see anybody else's that's coming here, like you maybe pass somebody but you come and that's it. You dinnae ken anybody. (James)*

One service-user found the location inconvenient because his journey was quite lengthy:

> *It would have been nice if the service was a wee bit more closer to home. It was a bit of a trek to have to come to it and it was only available at this one place. […] I mean, sort of 45 minutes away on the bus. (Paul)*

Interviewees commented that the entrance area within the building met their need for privacy. The rooms were considered to be comfortable and light, although the rooms were noted to be sometimes cold in the winter and some interviewees had experienced intrusive noise from outside the building.

6.7.4 Timing, flexibility and availability of sessions

Interviewees valued the reliable framework and flexibility of a once a week model. The hour-long counselling sessions, mainly once a week, were felt to be of about the right duration and gap between sessions, interviewees were aware that the service was open to offering occasionally more frequent sessions if the client was in need of them and moving to fortnightly sessions if that felt appropriate. The interviewees appreciated that any changes were made in consultation with them. Mention was made of the flexibility of staff to find times that fitted client's needs, whether to do with employment or times of day that the client felt most able to come.

My counsellor was really flexible on what time of day was best for me. So I was able to see her in the afternoon, which was good and sometimes an hour was too long, so we cut it short and I think we ended up having half hour sessions or something like that, which was great. She was really flexible. (Margaret)

6.8 Comparison with other agencies

All interviewees spoke very positively about their experience of crew drug counselling in relation to other services they had accessed for their drug problems.

I've been to Wellspring, I've been to my doctor's, I've been to Cocaine Anonymous and crew's the one that's helped me the most. (Dave).

Margaret notes the importance of having a specialist services and issues of disclosure of drug use and knowing she would not be judged. Dave describes crew drug counselling as much more than a counselling service: it is a whole package of services of support, guidance, offering holding and containment at points of crisis and chaos, which accounts for the powerful attachment he formed with it.

Prior to accessing crew drug counselling, Paul had spoken to his GP about his drug use and his GP had referred him for a psychiatric assessment which Paul attended. Reflecting on his experience of these two NHS consultations allowed him to identify the particular qualities and features of the service he received at crew which enabled him to make personal progress and change.

"I mentioned to my GP that I was taking Ecstasy and the GP kind of freaked out really. I felt over-reacted and made an appointment for me to see a psychiatrist. It felt a bit heavy and over-bearing. I suppose it was also to do with where I was at that time but I don't think I took very kindly to that and don't think I really got any benefit from that conversation I must say. I went to see [the psychiatrist]. I don't think I found that very useful. Just in terms of comparing the two – having spoken to the psychiatrist or the sort of clinicians and medical people, I didn't really feel that I wanted to speak with them some more. Whereas speaking to the counsellor here, I did feel very much that I'd like to come back and sort of explore some of these issues a bit further – back to do some more of that kinda thing. I don't really want to get into jargon here but to me, it's like a different philosophy and it comes from probably I would say a kind of understanding of what health and ill-health is or are, and the GPs to me seem to take a very clinical view and seemed very unwarm, more cold, more cut and dried, kind of scientific. Whereas here at creew there was perhaps a more social model of good health and ill-health and illness and wellness and it did seem like here at crew [the counsellor] was much more able and willing and skilled at looking at the issues in a wider context and more holistically perhaps.

Paul also appreciated the sense of equality between him and the counsellor, which contrasted with his other experiences of seeking help.

The sense was that the service was identified as different to what might be on offer elsewhere and that, in working with a very specific group, it freed the interviewee to be more open about their drug use. Margaret felt that it was important that it was specialist service having had unhelpful experiences of generic counselling in the past. She felt that this would encourage service users to be honest because "*they're not gonna be judged*".

Service-users reported that they often felt wary or uncertain about disclosing their drug use to either NHS services or other voluntary sector services. Anxieties included worrying that they might be judged or criticised, that the practitioners in these other services might not really understand them, that they might not know anything about drugs or the drug scene, that information about their use of drugs might be recorded in official records, such as medical notes, and that services might break confidentiality and pass on reports to other services, including the police. In contrast, the image, ethos and environment at crew alleviated such anxieties for most service users almost immediately. They recognised that this was a service that knew about drugs and the drug scene, would not judge or criticise, would respect confidentiality and not record information or pass information onto third parties. In short, they felt that this was a place where they could talk openly and honestly about their use of drugs. The "realness" or "genuineness" of all crew staff was a recurrent theme in responses on this topic.

> *It was the combination of an open counselling where I felt very comfortable and free to discuss drug issues and the combination of the two that seemed to me a sort of unique service available and that was the biggest appeal if you like as opposed to other counselling where I would be free to discuss that and when I say that I mean talking about drug misuse. I didn't feel comfortable doing it elsewhere and here I do. (Douglas)*

Helen also highlighted the importance of feeling that the counsellors had a "*real world take*" on drugs.

> *I've mentioned to the doctor in the past that I've smoked dope and I think the doctors had me down as some kind of heroin addict or something and I don't feel the doctors knew the difference between smoking dope and injecting yourself with powdered drugs. I wouldn't tell the doctor in the future [… they] don't realise what a common thing dope-smoking is. I think they do here though – people in here are more kind of street-wise.*

The flexibility of the service provided by crew compared to other service providers was a recurrent theme. Helen recalled the support she received when she spoke to a counsellor on the telephone.

> *I thought it was really valuable that somebody had half an hour to spend with me, with my breathing and my fear and everything 'cos you don't get that from a doctor – they probably just give you tablets and tell you take them and go away. [Here it's] not like other experiences where you felt pushed away a bit and people in a hurry.*

One questionnaire respondent noted their particular appreciation for being able to receive immediate telephone support when they were experiencing a panic attack:

> *When I first came last year I was having panic attacks and got help with my breathing for about half an hour on the phone I was at home and found that very helpful because it was happening there and then. (Q1)*

For Paul, the counsellor's flexibility in agreeing to work with him and his partner together was also immensely helpful.

6.9 Suggestions for change

While these current and ex-service-users were generally satisfied with their experience of the crew drug counselling service, they did have suggestions for changes to the service.

6.9.1 Greater outreach and community presence

Margaret felt that crew would benefit from greater funding to allow them to have a bigger community presence and allow them to attend events, such as, music festivals etc.

> *Well, I know that they go to festivals which is just brilliant 'cos obviously I go to festivals myself and if was taking Ecstasy or anything like that or any mad drugs, LSD or anything, it would be good if I freaked out, it'd be a good place to go. So if I had the magic wand, then they would go to all the festivals and they would have loads of staff and they would access all areas.*

Paul also felt it would be good if the service could undertake more community outreach and provide services in people's communities rather than in a single city-centre location

> *I do recognise it's not terribly likely and it's to do with money and resources and all of that … maybe a kind of small pilot outreach service or one day a week in the community somewhere might be a good idea.*

6.9.2 Early intervention approach

Paul also suggested that the service promote a more 'early intervention' message, encouraging people to come and talk about their drug use before it actually becomes a major problem or difficulty in their life. He suggested more publicity and awareness-raising and a greater public presence at relevant events to facilitate this.

> *It just seems so much more sensible to spend some time and energy on the kind of so called low level or early intervention before the person's really stressed and freaking out and not really coping.*

6.9.3 Increasing public and professional awareness

Margaret raised the importance of providing information for potential service-users and for potential referrers.

> *Go round the bars and stuff like that at night the same as like the Homeless Project street work and go round the streets, they maybe do some sorta outreach work. If they could access where young people are actually at, sorta festivals or clubs or stuff like that and had cards, leaflets and fliers and stuff like that, it might be quite good. […] People in education or doctors or medical service or something like that might – it might not be their kinda take on it or whatever. But I think people that – your first point of contact is, maybe your GP or whatever, it'd be good if they did pass on crew's details.*

6.9.4 Managing the ending of counselling sessions

Dave felt strongly about the management of the ending of counselling sessions. He felt extremely let down when his counselling ended after a set number of sessions. He felt very vulnerable at this time and was very disappointed by the lack of support at that moment

26 sessions and I believe that's all I could get. Or it was 21. But I felt that at the end of that, it was just … bye now, that's the most that we can do for you – and I had maybe … with abusing cocaine, I felt then I was vulnerable and I voiced my opinion.

Tom also felt quite let down when his counselling ended after a set number of sessions. He felt he had made a great deal of progress and needed a little longer, but the service was inflexible in applying a definite cut-off rather than allowing him and his counsellor to negotiate an ending that was right for him.

Like, for me, it wasnae enough. […] I was like three-quarters of the way through and then there was no more. It was like I'm back to where I was in the first place. I've nobody to talk to but now it's private and I'll not tell anybody. So for me, it could have … if there was no restrictions on the time […]. I mean, some people might not need 20 sessions, other people might need 60. So why was there a cut off? There was the 20 and then the extension of 10 and that was definitely over. That was it. Nothing more they could do.

These examples illustrate the significant attachment that a subgroup of service-users, those who may have limited support in their families or communities, may form to both their crew drug counsellor and to the service as a whole. Given the power and value of the service they receive from crew drug counselling, such service-users may experience the ending of crew's service provision as particularly challenging, especially when they may be referred on to services which may have long waiting lists or where they do not feel as welcome or as supported as they have felt at crew.

6.9.5 Out-of-hours support

Dave also felt strongly that more support should be available at the weekend. He thought that the help-line service should be extended beyond Monday to Friday.

A couple of times it got to the weekend and I did need help and there was nobody I could speak to 'cos one time I did phone twice and it was the answering machine at the weekend and it was a Sunday morning. It would have been helpful now that I think about that. I mean, I'm just thinking back now. Maybe if I'd been able to speak to somebody cos what actually happened was I did have a relapse and touched drugs that time, that weekend. I'm not sure if it was because I never got in touch with them. It was just … it was my choice but I took the easy option rather than deal with the pain that weekend.

Another service-user acknowledged that there were sources of emergency support but that their preferred service would be one from crew, because the crew staff had detailed and intimate knowledge of them unlike the people on the emergency help-lines.

Out of hours service. Whilst I appreciate resources/funding etc are limited, I have been in situations where it would have been more helpful to contact my counsellor rather than another agency who don't really know my history/problem. (Q8)

6.9.6 Managing length of counselling sessions

Three interviewees raised the issue of the possibility of counsellors being a little bit more flexible with their time and extending a session if necessary.

The hour was OK but I think maybe you should have a choice of – if you're getting into a session, maybe an hour and a half or two hours because if that's touching on things, you have to stop. I sometimes found that - it was just – you were getting a bit clock looking. (Douglas)

Sometimes I wish it was longer but most of the time it's OK. I suppose an hour and a half would be better but then, no, an hour's probably alright 'cos sometimes if it's really bad, an hour's a long time if you're somewhere that you don't really want to be emotionally. (Helen)

I've found it hard in here but I've found it maybe it's time wise, so I don't know if maybe they're pushed for their hours. Like I said, you get an hour o' clocks and it's bang on your hour. So I don't know, maybe a wee bit leeway wit time, maybe have more rooms. (Dave)

6.9.7 Managing expectations of counselling

Angus' main suggestion was that the service find some way of helping people to have more realistic expectations about what counselling is and what the service can achieve. He is aware that both he and other people he knew entered the counselling expecting to "be sorted" simply though turning up and it came as a rude awakening to discover that it's not that simple.

I had a perception about – you know, if I come along and see a counsellor, it was gonna be like waving a magic wand and I would all of a sudden get my act together.

6.9.8 Managing the impact of counselling sessions

Paul was taken aback by the emotional impact of his counselling sessions and the difficulty he felt adjusting to going back to his everyday activities afterwards. He suggested that this possibility is raised with new counselling clients at the beginning so that they can make suitable post-session arrangements.

The one thing that was a bit unsettling was because I hadn't had any experience of counselling before, I maybe initially thought, oh that's just like – that's a meeting, I'll go to the meeting and then I'll, you know, once I'm finished with that hour, then I'll go off and get back to my normal day kind of thing. But I found that wasn't so easy, that it wasn't just like going into a meeting, you know, where it's like work and you're not really engaged. I did feel that I needed space to kind of – not recover but to kind of – I needed a little space around me after the session just so that I could be comfortable with it. So that was something that I was maybe a bit surprised about, but I don't want to say that someone's just told me that this is gonna be like heavy-duty or whatever.

6.9.9 Greater range of complementary therapies

Some service-users reported that they would have liked to have access to a wider range of complementary therapies, such as aromatherapy, hypnotherapy, Indian head massage or Reiki, recognising that acupuncture and talking therapies are not the right fit for everyone.

6.9.10 Improvement to the building

Some service users noted that the waiting area could be improved and that the rooms were often cold in the winter.

6.9.11 Information about drugs

For one interviewee it would have been helpful if the staff were up -o-date with good quality information about the newer drugs. In another area of questioning, the posters are felt to need to be more direct about what is on offer.

6.10 Composite case studies

The preceding sections analyse the accounts and responses of different service-users by identifying common themes. This section offers another perspective by drawing on service-user accounts to construct to "composite case studies. The case studies are created by drawing on elements of individual account, assembling them in stories that do not correspond directly to any real individual but which nevertheless represent in a personal form the kinds of experiences recounted by individual service-users.

6.10.1 Jake: from lines of coke to lines of meaning

Jake walked off the street one day into the crew shop having seen a crew stall at a nightclub that Saturday. He let the person in the shop know that he wanted to talk to someone about his drug use. The crew worker phoned upstairs and Jake was seen immediately by the manager of the counselling service. She conducted a brief assessment, explained how the service operated and Jake began weekly counselling three weeks later.

Jake was thirty-four years old. He had his own small business but this was now in serious difficulty as were his finances, with a number of credit cards maxed out. He had divorced in his late twenties after a six-year marriage. His recent long-term relationship of three years had also just split up. He recognised that his cocaine use was now, in his own words, "completely out of control", as was his weekend party life which had begun stretching from Thursday evening to Monday morning. He was also using ecstasy at the weekend and using cannabis to relax and unwind, to "try to sleep", not usually successfully, after his use of stimulants. He was very sexually active when under the influence of alcohol and drugs, often without using protection, and he had a recent scare in relation to a sexually transmitted infection. He realised that he was on a "self-destructive rollercoaster" and he did not feel he had the resources to get off by himself. He had seen his GP, but had not disclosed the full extent of his drug use and personal difficulties, as he felt that his GP had overreacted somewhat at Jake's first mention of "sweeties" and Jake found himself uncomfortable talking about these issues. His GP had referred him for a psychiatric appointment but Jake had not gone.

Jake was very nervous on first beginning at crew drug counselling. He was anxious that other people might recognise him. He knew some people who were crew volunteers and he was anxious that they might hear about him and what he said through the counsellor. However, his first session with the manager and later with the counsellor helped reassure him regarding the strict confidentiality rules and procedures in the service.

From the start, Jake felt comfortable talking about his drug use. He reported that there was "something about the place and the people" that allowed this: that the service was upfront about their philosophy that drugs are there, that many people use them and that it is up to each person to define for themselves what drugs mean for them, weighing up the advantages and disadvantages. He knew from the start that he would not be judged or lectured or "ticked off". Later he realised that sometimes he would have liked someone at

crew to give him “a right telling off”, but he knew that he would probably have used this as an excuse to walk out, never come back and go right back into heavy drug use.

Jake was surprised that the counsellor asked him about his life, his feelings, his relationships and his past, as he had assumed that the service would just want to know about what he was taking and what it was doing to him. He summed this up by saying: “you see they were there to help me with my problems, not just my symptoms”. By the second session with the counsellor, he realised that he had just begun on a “long, long road” and although the counsellor was there to help, support and guide, “keep him on the straight run”, as he called it, he came to the conclusion that the biggest part of the work was work he would have to do for and by himself: the painful personal work of looking at all that had gone wrong that had led to him wanting to lose himself in drugs, alcohol, parties and sex. Jake acknowledged that he had never before spoken about deeper feelings to anyone. He said, “Maybe it’s a guy thing. You just get on and say you’re fine, let’s have a line, let’s smoke a spliff. Talking about your feelings… well, that wasn’t really my kinda thing.”

He attended 25 sessions in all, over the course of nine months. Beginning with a focus on drug use, Jake traced the actual function that coke was serving in his life: it was dulling the pain of losses and hurts that stemmed from early childhood bereavement (his premature loss of his father) right up to his marriage break-up, his recent relationship split, estrangement from his family and his deep-rooted sense of failure as a man, a partner, a son, a businessman and a friend.

While cutting down his drug use, and virtually completely stopping his wild nightlife after his first few counselling sessions, three months into his counselling, Jake relapsed and “went on a binge”. He disappeared from the counselling service and was so overwhelmed by feelings of guilt and shame that he felt he could not go back. He imagined that his counsellor would feel so disappointed in him and would not want to continue working with him. However, suspecting what had happened, the counsellor got in touch with Jake, and left a phone message, gently indicating as much, and offering another session. Jake returned and worked through all that had happened and the counselling deepened as a result.

By the end of his counselling at crew, Jake was completely drug free, had changed his leisure time completely, had taken up sport for the first time, and moved on to a different set of friends. He had made tentative moves towards reconciliation with his family and was working well with a debt adviser in sorting out his financial troubles. He noted the paradox of the counselling service philosophy: “You know they don’t tell you to stop or cut down or that drugs are bad. They just keep asking you to think about yourself and what you want in your life and come to your own conclusions about your drug use. And here I am at the end of it, completely drug free, although at the start, all I wanted was to get the cocaine use under control. It’s like by not telling you what to do, but just being there to help you in any way they can, you get to do things you never imagined you could.”

6.10.2 Shelley: somebody was there for me

Shelley was referred to crew drug counselling on discharge from hospital following an overdose. The overdose was precipitated by her partner discovering that Shelley was secretly using drugs and had been doing so for some years. Feeling deeply betrayed, he had threatened to leave her.

There were a significant number of other undisclosed aspects of Shelley's life, stemming back to childhood sexual abuse by her stepfather, which had contributed to her sense of desperation at the time of the overdose. Secrecy, fear and "living a lie" characterised her sense of her life, further exacerbated by her stepfather's recent death and funeral, and her partner's increasing frustration at her unwillingness to consider having children. As a result, Shelley's drug use had escalated and she had begun self-harming again, through cutting, which she had used intermittently since her teenage years at time of stress.

Although a frightening experience at the time, Shelley appreciated the "straight-talking" she received from the hospital psychiatrist who warned her of the potential severe damage to her physical and mental health if she kept using drugs. While it "scared the wits" out of her, this admonition served to motivate her to do something about her drug use so that, when she heard about crew drug counselling during her discharge planning, she decided "to give it a go".

With her experience of clinical services, Shelley was very surprised at first that the crew counsellor did not seem to want to focus on her drug use. She felt wary as the counsellor seemed more interested in finding out about her life, family relationships and feelings than which drugs she was using, how often etc. After a couple of sessions when she acknowledged she had been "keeping her cards close to her chest", she decided to trust her counsellor and to disclose her childhood history and its ongoing impact on her life. She couldn't really explain how she came to this significant turning point: "I don't know what it was. There was just something about her. I knew it would be OK".

While she acknowledged the support she had received from her GP and hospital staff, Shelley recognised that it was crew's distinctive image and ethos, and its separateness from other services, which helped her feel that it was a "safe place" for her to disclose and begin to work on her early experiences of abuse and neglect and how that led to her drug use. For the first time in her life, Shelley was able to talk about her early childhood experience, to access the painful emotions associated with these, and to grieve for the loss of her childhood. As this became the focus of her work, her drug use decreased as did her need to bring it as a theme to her counselling sessions. Doing this difficult personal work, she went through a period of several months feeling extremely vulnerable. During this time she experienced her counsellor as the major source of support in her life: "She was my lifeline, really. Without her, I don't know if I'd have got through it". Crew drug counselling recognised her extreme vulnerability at this time and offered both extra counselling sessions and regular telephone support. However, the temptation to turn again to drugs and to self-harm continued and, on one occasion, when her counsellor was on holiday, she relapsed into both drugs and self-harming. While deeply ashamed, she was able to raise this when she recommenced counselling and to stop again.

Recognising Shelley's continued vulnerability and the powerful attachment she had formed to the counsellor, and the service as a whole, Shelley's counsellor negotiated an extension of service beyond the standard 20 sessions. While appreciating this, Shelley still found the end of the counselling very difficult and was not ready to leave when the extended period came to a close. She recognised that she could not stay at crew drug counselling forever, but also did not feel ready to "face the world alone" after the profoundly valuable experience of this relationship. "It was like the first time in my life somebody was really there for me and really

cared about me and believed in me and then suddenly it was like, your time's up, off you go, time to get on with things by yourself".

The service arranged for Shelley to access a mainstream counselling service, which offered long-term counselling. After a long wait, and a few setbacks, Shelley has engaged with that service. While she feels that "they're just not the same" she recognises that her experience at crew has enabled her to trust in this new service and begin with someone new. She remains free from drugs and not self-harming.

6.11 Summary

Service-users all have unique lives and each has their own story to tell about the events and experiences that led up to making contact with crew drug counselling as well as the impact of their service use. Nevertheless common patterns emerge from their various stories. For the majority, making contact with crew occurs at a significant point of crisis and is associated with considerable levels of anxiety. The way staff at crew respond to them at this point is very important. Interviewees and questionnaire respondents reported finding the staff very helpful, accepting, non-judgemental and supportive. Those who used the acupuncture service generally found it helpful in reducing cravings and helping them to sleep. Those using the drug counselling service were very positive about the service if they were ready to engage with the personal challenges it entailed. Qualities of the relationship with their counsellor were especially important, key aspects including respect, safety, confidentiality, non-judgementalism, genuineness, flexibility together with a sustained focusing on what the service-user wants, feels, believes and needs. The availability of more than counselling within the context of the crew philosophy was also much appreciated. Service-users report varied impacts on their drug use with many but by no means all finding it possible to reduce their drug use or to give up completely. Service-users compare crew drug counselling very favourably with other services they have used, emphasising the importance of being the knowledgeability of crew as well as the person-centred philosophy. They also have suggestion for improvement, which would make the service more accessible to more people, provide a wider range of services, and make longer-term counselling available to those feeling in need of it and able to benefit from it.

Chapter 7

Referrer Views

7.1 Introduction

In this chapter views from eight interviews with people at partner and/or referral agencies are presented. Three of these interviews were with healthcare professionals and five were with other drug-related services. Themes emerging from these interviews include contact and partnership work, reputation, referrals, changes to the service provision and key issues for any psycho-stimulant use service provider.

7.2 Contact and partnership work

Contact with and knowledge about crew drug counselling varied. Six interviewees had contacted crew directly about a service-user and two interviewees were aware of crew but had not had direct contact with them. Most of the interviewees had a clear idea about the services provided at crew, and those who where less confident about the accuracy of their knowledge had had less contact with crew.

The interviewees knew about and had contact with crew drug counselling through:

- agency visits from and to crew
- promotional literature
- training events
- networking events
- inter-agency work
- colleagues
- other agencies
- former crew service-users
- making and receiving referrals
- getting advice about psycho-stimulant drug use generally or a service-user they are working with

The agency visits, in particular, promote a good understanding of the work of crew.

7.3 Reputation

The services provided by crew have a very good reputation in Edinburgh. This reputation was referred to by those working in related services and by the health professionals interviewed. The interviewees had received positive feedback about crew drug counselling from: their direct experience, colleagues and related professionals, and former service-users.

eSUS, crew and crew2000 tend to be used synonymously by interviewees. This suggests that the re-branding of eSUS@crew as crew drug counselling is appropriate.

Interviewees who were knowledgeable about the work of crew attributed this reputation to their service delivery, making specific reference to

- out-of-hours work
- the provision of complementary therapies
- a discreet location but with an eye-catching shop front
- outreach work
- good promotion and awareness raising
- good management

Interviewees also attributed crew's reputation to features of its philosophy including its

- holistic and person centred approach
- empowerment of service-users
- flexibility and ability to tailor their service to the individual
- vibrancy, innovation, forward thinking and pro-activeness
- openness to suggestions and change
- dedication

Other agencies seek to emulate this philosophy but on their own admission are less able to do so than crew. One interviewee attributed this to the work and dedication of individual practitioners at crew.

7.4 Referrals

The six interviewees who had had direct contact with crew about a service-user experienced no problems and identified the staff team as helpful, available and approachable. One interviewee pointed out that if he did have any concerns he could easily speak directly to the staff at crew. Referrals to crew drug counselling were not always successful, in that the service-users did not always engage. This was viewed as a problem characteristic of work with this particular group of service-users rather than anything to do with crew. To encourage service-users to contact crew, referrers do one or more of the following:

- send promotional literature about crew
- go through the promotional literature about crew with the service-users
- contact crew by phone or letter
- attempt to engage the service-user with the acupuncture service if they are not ready for drug counselling

- arrange to visit crew with the service-user

One interviewee could not remember what the referral process was and felt that this might indicate that crew could advertise this more.

Interviewees indicated that they would refer to crew drug counselling if they have a service-user they felt would benefit from the service. Interviewees working within other drug-related services worked with service-users across the whole range of drug use, but they recognised that the majority of their work is around opiate use. They viewed crew as having important expertise and training for work with psycho-stimulant drug users. There are situations when Interviewees indicated that they would not necessarily refer a psycho-stimulant drug user experiencing problems to crew if the drug user was also using other drugs. In these cases, the Community Drug Problem Service (CDPS) (a statutory organisation in Edinburgh) would be the first point of contact. The CDPS would assess the situation and then make the most appropriate referral. The CDPS report working in close partnership with crew drug counselling and would refer to them those poly-drug users assessed as suitable for the crew service. However this double referral process results in considerable delay for the service-user. Interviewees also cite geographical accessibility as a reason for referring to crew drug counselling: its central location and their city wide work means drug services located in local areas or outwith Edinburgh may refer to them.

Apart from the CDPS, interviewees identified two other drug counselling services to which they could refer psycho-stimulant users: Simpson House and WEST. These were both viewed as less flexible and more intensive than the crew drug counselling and likely to be appropriate only for those definitely ready to commit themselves to weekly counselling.

7.5 Changes to service provision

Many interviewees struggled to suggest ways in which crew drug counselling could improve their services. The changes that were suggested were often about extending what they already provide and therefore depend on accessing more resources. Examples include undertaking more outreach work and more publicity, plus expanding the number of service-users that can be seen. One interviewee suggested that crew drug counselling could increase the font size on some of the promotional literature to make it more accessible to potential service-users. Another interviewee felt that it would help their service development if they had feedback on what happened to those that they referred to crew drug counselling. Whilst they recognise that this probably does not happen due to issues of confidentiality and the person-centred way of working, they would find it useful to know if the service-users they referred attended the service or not, and if they did attend, for how long.

7.6 Key issues in psycho-stimulant service provision

To contextualise the work of crew drug counselling, interviewees were asked to describe what they considered to be key issues in providing services for psycho-stimulant drug users.

Interviewees identified the motivation of the service-user as crucial for engagement with any service. This motivation is perceived to change rapidly. Consequently, services need to engage service-users when they are sufficiently stable to sustain attendance and also need to with those in crisis as this is when people are most likely to seek support. Any service must treat the service-users with respect, be non-judgemental, be confidential (within the accepted limits) and be open and honest. The development of trust is seen as important in

any relationship between service-user and service-provider. Services need to be accessible in terms of location, opening hours (weekends and evenings are essential) and the range of services available (for example, one-to-one, group work, ear acupuncture). Services must not be punitive when it comes to attendance or drug use. One interviewee emphasised the importance of good assessment and referral procedures to ensure that those not motivated to change do not absorb resources inappropriately.

A number of interviewees identified partnership and joined-up working as important because of the relationship between different addictions, as well as the high number of dual diagnosis and poly-substance-use cases. The "chaotic" nature of psycho-stimulant use was frequently mentioned and the problem of retaining service-users in a service was accepted as inevitable. Suggestions to maintain user engagement included having individual client case loads, always "leaving the door open" for re-engagement, following up non-attendees with letters and phone-calls and offering incentives like acupuncture.

Some of the interviewees argued for more investment in services for psycho-stimulant drug users to enable the expansion of existing services and the development of new ones with a view to offering service-users more choice. Others felt that more training about psycho-stimulant drug use would be helpful for their agencies.

7.7 Summary

Crew drug counselling is a highly valued and highly respected service within the network of provision for drug users in Edinburgh. It is valued because of its expertise in a specialist area that other drug services and health professionals find particularly challenging. Crew's model of service provision and delivery is also highly valued, as its role in the training and education of other providers on issues of psycho-stimulant drug use. Crew has a particularly strong relationship with CDPS and this facilitates referrals from a wide range of sources including GPs.

Feedback about crew's service provision is consistently and strongly positive. The organisation as a whole and individuals are respected for their capacity to meet the needs of individual service-users and for their innovative working practices.

Chapter 8

Practitioner Views

8.1 Introduction

This chapter presents the findings from interviews with four practitioners at crew drug counselling. The purpose of the practitioner interviews was to deepen and extend the knowledge of the service and how it works, including its strengths and areas for development, by communicating directly with the practitioners who are delivering the front-line service. Many of the questions put to practitioners reflected the topics raised with current and former service-users, with additional questions that focused on the worker's experience, including support and supervision, motivation, rewards and satisfaction in the work. Staff were reassured that their contributions would be anonymised in so far as it was possible to do so, given the small numbers of staff employed and who participated in the research.

8.2 Background details

Interviews were conducted with four counsellors/therapists: two full-time, one part-time (two days per week) and one sessional (four hours per week). Two of these were also trained in auricular acupuncture and deliver that service at crew. Length of service at crew varied from six years to nine months. While they had different trainings, all four described themselves as person-centred therapists. Two were trained or completing their training as person-centred counsellors, one had trained as a reality therapist and one had trained as a clinical associate psychologist. The level of professional qualifications was high, including masters programmes at higher education institutions. The four practitioners also came to crew drug counselling with a significant level of prior professional experience in a variety of settings. The part-time and sessional practitioners continued to work in other services in addition to their work for crew drug counselling.

8.3 Motivation

All interviewees reported high levels of motivation to work with people using psycho-stimulant drugs. Some recognised psycho-stimulant drug use in general as a significant and increasing social problem and they wished to offer their services in ameliorating its effects; others spoke of being motivated by being more personally affected by these issues in their friendship circle.

> *I'm from quite a clubby background, I've got a lot of friends that use drugs and I'm from Edinburgh … very sort of important in Edinburgh and it just felt right for me.*

Interviewees also reported being particularly interested in working for crew because of its specialist status as a drugs service and its ethos and approach to people using drugs, which was summed up in words such as person-centred, non-judgemental and holistic. One practitioner spoke several times of the crew ethos as deliberately not adopting any expert role in relation to their client or their life. Interviewees were clear that the agency's orientation to practice with service-users matched well with their own philosophy of practice and therefore offered the opportunity to practise with integrity in relation to their own personal and

professional values and convictions. Staff's commitment to both service-users and the service was evident to both interviewers throughout these interviews.

8.4 Service-user characteristics

Longer-serving practitioners recognised that service-users had changed over the years with greater prevalence of cocaine use and particularly stronger and more addictive forms of cocaine, and greater prevalence of psycho-stimulant drug use in general. One practitioner identified two different groups of service-users: those who were managing their lives reasonably well, holding down jobs, sustaining relationships etcetera, but for whom their drug use was causing them concern; and those with greater and more complex needs, who may be using drugs heavily, may not able to work or sustain relationships, and who may be accessing a range of professional help, including primary and secondary health services. One practitioner summed up this group as "increasingly chaotic clients". In relation to their capacity to use the counselling service, the latter group both presents and faces particular challenges, practically and emotionally. Practically, the service relies on service-users managing to attend regular weekly appointments – without this, the benefits of counselling will necessarily be very limited. Counselling, however, also requires service-users to undertake personal work, often of an emotionally painful nature: for people with limited social support and whose capacity for self-care may be compromised, engaging beneficially in a counselling process may thus prove difficult.

Practitioners identified that one prerequisite for successful engagement is that service-users must be motivated to consider their drug use. For those who were not yet able or willing to think about their use of drugs, its role or function in their lives, and the needs that may be being met through it, the counselling service was not the appropriate resource. One therapist noted that some of the service-users who realised at the initial appointment that they were not sufficiently motivated to engage in the counselling service did in fact return at a later date when they recognised that they were more ready.

Practitioners identified that many crew drug counselling service-users may be less informed about, and prepared for, counselling or therapy than service-users accessing mainstream counselling or psychology services. As it is a behavioural problem that brings them into the service, service-users may expect to be on the receiving end of behaviour-focused interventions, and can be surprised when their counsellor encourages them to think about their feelings, their relationships, their personal history, and sources of stress in their life.

> *They're quite surprised that we don't home in straight away on the drug use, that we try and see where the drug use ties in and what needs they are having met from that and you do a sort of exploration. I think they can expect to be met by a set of behavioural responses in terms of like okay, well, take the numbers of your dealers off your phone.*

Some service-users may also expect to be given solutions or direct instruction or guidance and may thus experience the person-centred approach to counselling as confusing and mysterious.

These accounts highlighted the importance of good contracting and clear information, in both written and verbal form, about the service's approach to counselling.

8.5 Nature of the work

All practitioners interviewed identified the core purpose of the counselling service as increasing the service-user's understanding of the use of drugs within their life. They recognised that they achieved this through establishing a supportive, containing and trusting relationship in which personal issues could be disclosed and worked through. As service-users began to reduce or come off drugs, the painful issues or emotions which the drug use may have been masking or obviating can begin to come to the surface and leave service-users feeling vulnerable or distressed. The work therefore also required the ability to work with the emergence of such painful feelings. This may involve holding on to hope and faith in the service-user's capacity to change and to manage such change when the service-user may be feeling despairing and hopeless. Practitioners reported that such a process required a non-judgemental approach and the capacity to work at the service-user's pace on the goals and aims they have set for themselves.

One practitioner spoke of how the service-user's aims may change over time: they may enter counselling hoping but hardly believing that they could alter their drug use, but in time find the strength and capacity to come off drugs entirely. She acknowledged the almost paradoxical nature of the service: that in not emphasising or requiring service-users to aim for abstinence, service-users themselves often found this capacity within themselves.

Practitioners emphasised that their work involves going deeper than focusing on symptom management or coping, but aiming for personal transformation and life change on the service-user's terms. They were also aware that for some service-users with more complex needs and/or chaotic life circumstances a more realistic goal may be to help them stabilise their drug use and begin to gain some psychological insight into their behaviour so that they may undertake their more longer term personal work in another service.

The provision of complementary therapies in conjunction with counselling was viewed very positively by the practitioners. One stated that she noticed that the auricular acupuncture had a real impact on service-users' physical symptoms:

> *But it's actually something that happens in the process of using the acupuncture, so physically in relation to being able to sleep better, to be able to deal with cravings, particularly in the initial stages of cutting down.*

8.6 Strengths of the crew drug counselling service

While practitioners identified the need for a range of services, both clinic-based and community-based, to meet the needs of psycho-stimulant drug users, they also identified the particular characteristics of the crew service provision that allowed it to reach service-users who might otherwise not be able or willing to access other relevant services. These include:

1. Accessibility: the fact that service-users can walk in and speak to someone and often receive an initial appointment straight away without having to go through systems of referral and waiting lists was viewed as extremely useful

2. City centre shop-front location: this improves both visibility and access and reduces anxieties about being identified within one's community as a drug user.

3. Separateness from health/statutory services: crew's identity as a standalone service completely separate from health, social work and criminal justice services reduces service users' anxieties about the potential consequences of disclosing drug use in relation to statutory interventions, recording and information-sharing

4. Non-medicalised, person-centred approach: the service's status as a community rather than a clinical resource is attractive to people using drugs who may be concerned that they might be regarded as having a disease or disorder, whether physical or psychological. Similarly, crew's emphasis that the service-user defines what may or may not be a problem in their lives and sets the goals for their therapy in collaboration with their therapist is acknowledged as particularly helpful for people who may be reluctant to engage ion the more traditional health service processes of being assessed, diagnosed and expected to comply with a prescribed treatment plan

5. Drug scene awareness/credibility: associated with its non-medicalised approach, crew's image as a service which knows about the reality of the drugs scene and does not ascribe to a zero tolerance "drugs are always bad" philosophy enables service-users to feel that they will be met with understanding and acceptance, which they are not so confident of when contemplating accessing either health services or mainstream counselling/support services

Having recounted these particular qualities, practitioners were also clear that some service-users require other approaches, which crew does not offer and that crew's is only one service on a spectrum of related interventions. For some people using drugs, a service that upholds a zero tolerance, total abstinence approach may be required. Similarly, some service-users may benefit from a more behavioural treatment service, involving rewards for abstinence and sanctions for relapse. Some service-users also regard their drug use from an addiction-disease perspective and are therefore more eager to engage in an explicitly medicalised assessment and treatment service model.

8.7 Relations with other services

While acknowledging the value of being an independent standalone service, practitioners also highlighted the importance of good links with referring bodies, including the NHS.

> *We've got a good relationship with our referrers, which we work very, very hard on because when you have street cred, it doesn't necessarily mean that you have credibility with other agencies. […] I mean, we are in a really good position now and I suppose, having been in eSUS, because that was part of [… partnership] in some ways that was beneficial because as a service then we were part of crew but was possibly seen as, something more slightly more professional in relation to drug counselling. […] We did a lot of liaison work and we worked well with the CDPS, which is an NHS community drug and psychiatric services and they refer quite frequently to us. We can use [Dr X] as a psychiatrist and as a consultant and he's happy to help us out particularly [with] dual diagnosis cases.*

8.8 Rewards and job satisfaction

All four interviewees reported high levels of job satisfaction and rewards, with statements such as: "*very rewarding", "learn so much working with clients"* and *"learn about myself also"*. One practitioner emphasised how rewarding it is to establish a level of intimacy with service-users:

I think, for me, the most rewarding thing, the thing that gives me the biggest buzz is just having a job where I have that level of psychological contact with people. It's like in your daily life you strive to kind of meet with people and that kind of deep contact level but you don't always get that.

There was also the acknowledgement that seeing people grow, change and develop, reduce or come off drugs entirely, and walk out the door a changed person was both "*very humbling*" and deeply gratifying.

The support of the agency and in particular of the service manager was identified as a major contributor to job satisfaction for these practitioners, but they were also realistic that it wasn't always harmonious and at times required significant mutual commitment to work on interpersonal communication and managing change.

In general, a very good employer … yeah, not wanting to portray this, oh they're so fantastic and beautiful. Everything is also … because it certainly is not … at times difficult and we struggle to work alongside each other and we struggle but also struggle with the workload and communication we struggle with, and there's a lot of changes but we try so hard to do something about that and maybe that's my role within the team to push for that as well … well, not singularly, you know, with other people as well but as an organisation, I'm really … yeah, I'm quite proud of working here.

Practitioners also praised the agency's commitment to promoting their personal and professional development through funding further training and through providing them with external supervision in addition to line management supervision. One member of staff described crew as a "*fantastic employer*".

In general, practitioners recounted a person-centred approach to the management, support and development of staff in keeping with the agency's philosophy of practice in relation to their service-users.

8.9 Frustrations of the work

One practitioner noted that the work also held significant frustrations on account of the service-user profile becoming increasingly more chaotic, which leads to a higher DNA rate for both initial and follow-up appointments and to discontinuity in session attendance. A further challenge was the increasing number of service-users with a combination of alcohol and drug problems. As noted above, the increasing use of cocaine was raised by all three interviewees.

Three of the four practitioners also highlighted issues relating to the service's set number of 20 counselling sessions, which proved very challenging for both counsellor and service-user when the service-user had formed a good working alliance, or even a significant attachment, and clearly required longer-term work. This was summed up by one interviewee as follows:

For me personally, I don't like the kind of…you work with somebody who's got quite complex issues, just getting them to a certain point and then sort of refer somebody on. I would like to be able to offer more sessions…to see that through or to take somebody a little bit further along that road. Because quite often 20 sessions will just get the person to the point where they've kind of stopped their drug use or whatever

so I'd like the flexibility to … we have a small bit of flexibility, a couple of sessions more or less, but I would like a bit more flexibility in that.

Other sources of frustration raised were the wider agency's tendency, on occasion, to move quickly to grasp a new funding opportunity without necessarily thinking through the implications for staff or service users; the service's patchy implementation of basic auditing and more recently of the CORE assessment tool, which has necessarily inhibited service monitoring and evaluation; the agency's tendency to regard people with mental health diagnoses, such as bipolar disorder, as needing to be seen by mental health services rather than being seen as appropriate for crew drug counselling.

8.10 CORE: Clinical Outcome Routine Evaluation

Practitioners were asked about their use of CORE and those who had used it, two of the four, found that it was valuable, especially in identifying problem areas and potential risk at the initial appointment. However, both acknowledged that it took time, found that it could feel intrusive and that they had not yet found a way of making it feel seamless and fitting in their sessions with service-users:

As an assessment tool, it's been amazing, … it's a bit intrusive, I have to say because it does take a bit of time… I feel in some ways that it's an interruption to the work… It's (CORE) not my favourite part as much as I know that it's bloody important and really beneficial but that's my resistance and it's … and it's something that I would like to be better at and I think it's something that I think we need to be better at.

8.11 Possible areas for development

The four practitioners interviewed identified the following potential areas for development for the drug counselling service:

1. Development of outreach activities such as in prisons and work with women involved in the sex industry.
2. A full-time administration person for the drug counselling service:
   If we could get an administration person for … only for drug counselling, that would be my dream, because a lot of my time is taken up by, you know, letters and letters to referrers, letters to clients and maybe that … I'm not trying to excuse myself but it does again take all your time from contact with people seems always more important
3. Further expansion of the complementary therapy service, to include other therapies and possibly other approaches to well-being
4. Openness to working with people who meet diagnostic criteria for specific psychiatric issues
5. Openness to incorporating other therapeutic approaches within an overarching person-centred ethos, for example, CBT tools and techniques
6. Improvements in advertising, publicity campaigns and marketing including the service's web presence
7. Establishment of branches throughout Scotland
8. More counselling rooms

Chapter 9

Summary and Synthesis of Findings

9.1 Introduction

This chapter summarises and synthesises evidence presented in the preceding chapters of this evaluation to assess whether the model of service provision embodied by crew drug counselling is working for its service-users. Feedback from service-users and potential service-users is central to this, but so too is wider research evidence and feedback from referrers and practitioners.

9.2 How does the crew approach compare to existing research evidence?

As noted in chapter 4, the approach to providing services for psycho-stimulant drug users adopted by crew drug counselling aligns well with existing published research. Research evidence makes clear that there are no simple, straightforward, foolproof treatments available to enable people to stop using psycho-stimulant drugs. No effective medications are available to drug-users to overcome cravings or side-effects of withdrawal. Research has been conducted on a wide variety of psychosocial approaches, including psychological therapies and other forms of support. Many such approaches are helpful with at least some service-users, and research findings indicate that there is little to choose between different approaches in terms of effectiveness across the spectrum of psycho-stimulant drug-users. Ideally, service-users are offered a range of interventions from which to choose. There is good evidence that, regardless of the particular therapeutic approach, the swift establishment of a strong therapeutic relationship between practitioner and service-user is important in maximising the chances of service-users engaging successfully. This is understood well by crew drug counselling practitioners.

Research on the effectiveness of complementary and alternative therapies is inconclusive. Auricular acupuncture is a promising approach but decisive evidence to demonstrate its effectiveness is not available. However, anecdotal reports of its value continue to accrue and offering it appears to be an effective way of engaging at least some psycho-stimulant drug users who might not otherwise come forward. Since service-user motivation and readiness is critical for successful engagement with psychosocial approaches, it is very useful to have additional options available that drug users appreciate and which therefore keep them in touch with services, even if they are not actually ready to address their drug use. This point is underscored by the insights of crew drug counselling practitioners who observe that service-users can engage with drug counselling successfully only if they are ready and willing to explore and reflect on their drug use and the factors underlying it (see chapter 8).

Research evidence indicates that the way in which services are designed, offered and delivered is at least as important as the specific interventions or treatments that are offered. Psycho-stimulant drug users are difficult to reach, harder still to engage and very likely to experience cycles of change, with periods of relapse as well as periods of motivation to change. Successful services need to be able to work with service-users through these cycles, ensuring that relapse is not confused with failure and maintaining a respectful, no-

judgemental stance through the most testing of circumstances. Patience, persistence and constancy are essential. So too is flexibility and responsiveness in relation to individual service-users whose circumstances and experiences are necessarily unique. In addition, for services to secure the trust and respect of psycho-stimulant users it is essential that the workers and volunteers with whom potential service-users come into contact are highly knowledgeable about psycho-stimulant drugs and the local drug scenes. Crew's approach is informed by all this evidence about services for psycho-stimulant drug users and is regarded by referrers as being particularly successful in embodying these characteristics in its service provision. The importance and impacts of such attributes as expert knowledge, non-judgemental attitudes, respectfulness, patience, persistence, empathy and profound understanding are illustrated in the accounts of service-users (chapter 6).

9.3 Who uses crew drug counselling, how and with what effects?

There is no "typical" psycho-stimulant drug user who contacts crew drug counselling. As shown in chapter 5, people approaching the service include men and women across the age spectrum (mainly young adults), drawn from across Edinburgh and its environs and reflecting the ethnic mix of the area. Practitioners perceive distinct trends in the kind of service-users coming forward, with an increasing proportion presenting with greater and more complex needs, more chaotic lives and therefore more challenging to engage and work with.

Of those contacting crew drug counselling, some find the service themselves. However the majority are referred by others, including health professionals (GPs and mental health specialists), other drug agencies, and a range of others. For some the referral process involves more than one organisation before the person reaches crew. This can cause delays. For some potential service-users this results in a loss of motivation and readiness to engage when they finally do reach crew.

Some of those contacting the service are looking for information and advice only, which is delivered through single-contact support. This includes parents of drug users as well as drug users themselves. Others are offered an assessment session to explore options and refer people into the most appropriate form of support, including counselling, ear acupuncture and reality therapy. Limitations in data recording make it impossible to give precise figures about the ensuing pathways. However, a substantial number of those offered an assessment appointment do not attend it. Given the challenges of working with psycho-stimulant drug users, this is not surprising. However, more consistent data recording might enable useful analysis of those likely to be at most risk of not attending. Of those who do attend, most are offered drug counselling. Many are also invited to use the ear acupuncture service, either alongside counselling or on its own as they wish.

Most of those entering the drug counselling service attend for no more than a few sessions, the average being about 5 according to the available data. A small number attend 20 (the normal maximum) or more sessions. The majority of service-users end counselling sessions on their own decision and without discussion with their counsellor. Again, this is not surprising for a service working with psycho-stimulant drug users. Of those who begin counselling, the majority wish to stop taking drugs completely. For the small number for whom follow-up data are available, most succeed in reducing their drug use or stopping completely. They also experience improvement in how they feel both physically and mentally. For a small number of service-users, data from the standardised measure CORE are available. These service-users present with a high degree of distress (in terms of their self-

reported well-being, symptoms, functioning and risk to self and others) of an intensity much greater than the general population and directly comparable to clinical populations entering specialist mental health services such as psychiatric outpatients services. Data are not yet available to assess therapeutic change using the CORE system.

Interviews with current and former service-users provide vivid accounts of the distress that brought them to crew, their experiences and the impact on them of their service use (chapter 6). The people offering these accounts are limited to those who have engaged for at least a few sessions and do not include people who made but did not sustain contact with crew. It is impossible to know in what ways these groups of people differ. It may be that they are broadly similar, differing only in their readiness to engage at a particular moment in time. Thus, those contacting crew but not engaging with the service beyond a single contact may return in the future. If this is the case, the experiences of those who were interviewed provide examples that are illustrative of possibilities relevant to many others.

Service-users tend to contact crew at a point of personal crisis. They need a swift and appropriate response at the moment they make contact and benefit considerably if an assessment appointment can be offered quickly, which is the case for most people. Their fears and anxieties are such that a sensitive, informative, respectful, encouraging, non-judgemental reception is crucial to the chances of successful engagement. Service-users indicate that this is exactly what they find. Most of those who use the ear acupuncture service find it useful and they overcome their trepidation of the group setting relatively easily. Drug counselling presents substantial challenges and brings important benefits to service-users. For some, finding a safe space to talk is an enormous relief, but talking about themselves, their drug use and their feelings may be immensely difficult. Only through this are they able to better understand the factors underlying their use of drugs. This is generally a crucial step in finding alternative ways of coping with the personal difficulties that often turn out to underlie their drug use.

Service-user accounts illustrate how their use if crew drug counselling forms part of varied trajectories through the wide landscape of service provision. Some come directly to crew and it is they only service that they use. However, others come to crew from other services in the voluntary or statutory sectors. For some, crew drug counselling is the service that enables them to return to “normal life”. For others, crew drug counselling is one stage from which they move into other kinds of services in voluntary or statutory sector.

9.4 What do service-users think of crew drug counselling?

It is very difficult to garner evidence from people who approach crew but do not engage beyond a single phone call. Moreover, among those who do engage, feedback is patchy. Former service-users who volunteered to be interviewed include some of the relatively small number who have attended over a period of months. Those who completed questionnaires tended to be highly satisfied. Feedback is therefore weighted towards those for whom crew was especially successful. This provides good evidence of the potential for the service to have beneficial impacts but provides less reliable insight into how more service-users might be enabled to realise that potential. Nevertheless service-user feedback provides some useful evidence of their views of the strengths of and suggestions for improving the service.

Key strengths include:

- the ease of access to the service and the approachability, non-judgementalism, friendliness and supportiveness of all crew staff
- the quality of information provided
- the trustworthiness and confidentiality of the service including its complete independence from statutory health services
- the responsiveness and flexibility of the service
- the empathy, respect, genuineness, patience, persistence and flexibility of practitioners
- the person-centred, holistic and integrated character of the service, including out-of-hours support, an the availability of complementary therapy as well as counselling

Suggestions for improvement include:

- greater outreach and community presence to reach more drug-users sooner
- activities to enable the earliest possible intervention
- increasing public and professional awareness of the crew service
- more flexibility on the number of sessions and the management of endings
- more extensive out-of-hours support (especially at weekends and during holiday periods)
- more flexibility with the length of sessions to allow sessions to run beyond an hour
- more information about what counselling entails
- more attention to post-session arrangements for service-users
- greater range of complementary therapies including individual acupuncture sessions
- improvements to the building
- further improvements to the information available and its presentation

9.5 What do referrers think of crew drug counselling?

Crew drug counselling is part of a network of voluntary and statutory sector provision. It has a close working relationship with the Community Drug Problems Service and with a wide range of other referrers. Those who refer people to crew drug counselling hold it in very high regard: it has an excellent reputation as a specialist service with a very high level of expertise in working with a challenging service-user group. It is recognised as exceptional in its practical implementation of an accessible, holistic, person-centred, flexible, innovative service that empowers service-users. Referrers would like crew to secure additional resources to expand its work. They would like to strengthen their links with crew through more knowledge exchange, agency visits and information about the outcome of referrals

9.6 What do practitioners think about working at crew?

Practitioners are well-qualified professionals who are deeply committed to working with crew's service-users and feel well-supported by the organisation. Despite the challenges and frustrations of the work they do, they report a high level of job satisfaction. They are aware of the unique place of crew drug counselling within the wider network of voluntary and statutory sector services. Developments practitioners would like to see include:

- more extensive outreach work
- more administrative support and to be relieved of paperwork
- more scope to work with service-users over longer periods rather than referring them on to other services
- scope to work with people who meet diagnostic criteria for specific psychiatric issues
- expansion of complementary therapies
- improvements to advertising and publicity
- more counselling rooms
- branches throughout Scotland

9.7 Conclusion

Overall, crew drug counselling is a highly valued, successful and respected service. It occupies a unique place in the network of services and successfully offers a service that is both specialist and highly accessible. Located in central Edinburgh with a discreet side entrance, it offers a low threshold, non-medical, community-based service open to service-users who walk in or self-refer as well as being drawn upon by a wide range of referrers. The nature and organisation of the service is well-aligned with existing research evidence. It works in close collaboration with other agencies with a view to offering a holistic, person-centred service to a particular service-user group who are challenging to reach and engage. In so far as data about service-users is available, it is performing very well. However there is also scope for improvements, which are addressed in the next chapter.

Chapter 10

Recommendations

1. The crew philosophy and ethos

The philosophy and ethos of crew are core strengths, which successfully permeate the whole organisation. They are crucial to crew drug counselling's capacity to realise its purpose and to engage psycho-stimulant drug users. *The evaluators recommend that the crew ensures that its philosophy and ethos sustained, protected and preserved whatever other changes are introduced.*

2. Responding to changes in drug use

Patterns of psycho-stimulant drug use are subject to change and it is crucial to crew drug counselling's continuing success that it keeps abreast of such trends. *The evaluators recommend that crew consider the implications of changes in drug use for service provision and delivery.*

3. Redesign and simplify the service database

Although crew drug counselling endeavours to monitor its services effectively, the existing database is unduly complex. Data entry is far from consistent and this undermines the organisation's capacity to analyse its own service records. Decisions need to be made about the data that is *essential* to capture for all service-users and about how to ensure that the essential data are recorded for *each and every* service-user. *The evaluators recommend that the database and arrangements for data entry be redesigned according to these principles.*

4. Select and use a measure of therapeutic change

Monitoring the impact on service-users of their engagement with the service in a systematic way will provide useful feedback to practitioners. This might mean continuing to use the CORE outcome measure, or a variant of it, or another standardised measure of therapeutic change. *The evaluators recommend that crew drug counselling considers adopting and fully implementing a simple, well-focussed and standardised measure for assessing therapeutic change.*

5. Waiting list management

Responding swiftly to motivated service-users is crucial in maximising the chances for engagement. Prioritising service-users at particular risk is also very important. It is therefore essential to ensure that waiting lists do not build up, and that assessment allows the service to gather information relevant to the effective prioritisation of service-users. This needs to attend to risk, needs and motivation, with which the CORE system is helpful. *The evaluators recommend that crew drug counselling manages waiting times to minimise the risk of loss of motivation and to ensure that service-users are tracked into the most appropriate support systems as swiftly as possible.*

6. Continual improvement in advertising, publicity and networking

Crew drug counselling has a very good reputation among the organisations with which it works most closely. However, raising awareness of its services with potential service-users and referrers requires continual effort. This is particularly important in order to maximise the chances of drug users making contact when their motivation for change is at its highest. Potential referrers, such as a wider range of GPs, need to be informed and encouraged to refer directly rather than always relying on the CDPS. *The evaluators recommend continual improvement in advertising, publicity and networking is integrated into the routine work of the organisation.*

7. Expanding the range of services

Existing evidence indicates that different psycho-stimulant drug users will benefit from different therapies and support services. Crew is therefore encouraged to consider expanding the range of services it offers to include:

- a wider range of complementary therapies
- additional formats such as drop-in support and individual ear acupuncture
- extended hours for telephone support
- educational and CBT-based interventions
- an open-ended drug counselling service

The evaluators recommend that crew seeks to secure additional resources to enable the expansion of the range of services offered to service-users.

8. Greater flexibility in terms of the maximum number of sessions

The flexibility of the service is greatly prized by service-users, referrers and service staff. However the application of set maximum number of sessions does not accord well with this flexibility. The great majority of service-users seek fewer than 10 sessions and so the normal maximum of 20 affects only a small number of service-users. Within the framework of a limited-term service, it may be possible to offer such service-users greater flexibility, including the opportunity to engage more actively in determining the number of sessions they need in order to complete their drug counselling work. However it is important that this does not jeopardise the capacity of crew drug counselling to offer a swift response to new service-users. *The evaluators recommend that crew drug counselling considers relaxing the upper limit of 20 sessions and ensuring that longer-term service-users are invited to play an active part in determining the number of sessions they require subject to the availability of resources.*

9. Supporting service-users beyond the end of counselling

A minority of service-users attend counselling sessions over a period many months. Some of these form a strong attachment to the service and these include individuals who have complex and ongoing needs, who have often experienced extreme trauma and loss, and who may have continuing problems with daily living, even after they have succeeded in ending their drug use. *The evaluators recommend that crew drug counselling considers the*

possibility of providing ongoing flexible support to this service-user group, after formal counselling has ended.

10. Information about counselling

While crew's information is generally highly regarded, some service-users are nevertheless surprised by the personal demands of undertaking drug counselling. This could be more fully addressed in advance information about the counselling service, both written and verbal, which needs to emphasise the personal commitment required to change drug use and the need for personal motivation to change. *The evaluators recommend that crew drug counselling reviews its advance information about counselling to maximise the chances that the personal demands are understood by service-users.*

11. Following up non-attenders

A substantial number of service-users make assessment appointments or appointments for first counselling sessions but do not attend. The evidence gathered in the evaluation highlights how feelings of shame, anxiety and low self-esteem are often at the root of people's inability to engage with the service and that considerable personal courage is required to commence counselling. *The evaluators recommend that crew drug counselling considers following-up early non-attenders more positively with a view to further supporting their motivation for change.*

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Appendix 1

Questionnaires and Interview Guides

A1.1 Current Service-User Questionnaire

eSUS Evaluation: Questionnaire

We are trying to find out what how to make the services at eSUS/Crew2000 better for the people who use them. To do this, we need to speak to people who have seen a counsellor here. We are from the University of Edinburgh and we have been asked to do this by the staff at crew2000 so that they will know what things they do well and what things they should change.

We would like to offer you the chance to fill in this questionnaire for us. You do not have to answer any questions you do not want to but any answers you give will be helpful to us You do not have to put your name on this sheet so no-one will know that these are your views. Whether you fill in the questionnaire or not will have no effect on the service you get at eSUS.

You can return this questionnaire to us by post in the pre-paid envelope or drop it into the box by the door as you leave the eSUS offices. If you have any questions about the evaluation project or this questionnaire please contact Vicky Plows, research assistant, on 0131 650 3929 or V.Plows@sms.ed.ac.uk

A. Coming to eSUS/crew 2000

1. How did you first hear about the services at eSUS/Crew2000?
Please tick one box

Friend/Family	☐	Through another service/agency (e.g. healthcare)	☐
Saw a leaflet/poster	☐	Met a member of the eSUS/Crew 2000 staff	☐
On the internet	☐	Other (please name here)	☐
Don't know	☐		

2. How did you first make contact with eSUS/Crew 2000?
Please tick one box

Phone-call	☐	Text message	☐
Face-to-face	☐	By email	☐
By letter	☐	Someone else contacted them for me	☐
They contacted me	☐	Other (please name here)	☐

3. How happy were you with this first contact with eSUS/Crew 2000?
Please tick one box

Not happy ☐ Quite Happy ☐ Very Happy ☐ Not Sure ☐

Can you tell us what was good and/or bad about your first contact with eSUS/Crew 2000?

4. Were you worried about coming to use the services at eSUS/Crew 2000?
Please tick one box

No, not at all ☐ Yes, a little ☐ Yes, a lot ☐ Not sure ☐

If yes, please tell us what these concerns were here

5. What encouraged you to use and continue to use the services at eSUS/Crew 2000?
Please tick as many boxes as apply

The eSUS staff	☐	Friends/Family supported me	☐
The eSUS information I was given	☐	I feel like I have no other choice	☐
I am finding it helpful	☐	I like coming	☐
It feels safe	☐	I trust the counsellor	☐
Other	☐	Not sure	☐

If other please tell us what _____

6. Roughly, how many times have you met with a counsellor? **…….. times**

B. Experiences of the drug counselling service
Please tick one box for each question in section B

7. What do you think about the amount of time you have during a counselling appointment?

It is just right ☐ It is too long ☐ It is too short ☐ Not sure ☐

8. What do you think about the length of time between each counselling appointment?

It is just right ☐ It is too long ☐ It is too short ☐ Not sure ☐

9. How important is the personality of the counsellor to you?

Not important ☐ Quite important ☐ Very important ☐ Not sure ☐

Please describe what you think the counsellor should be like:

10. How important is the location of the service to you?

Not important ☐ Quite important ☐ Very important ☐ Not sure ☐

Please describe a good location for this kind of service:

11. How important is it for counselling appointments to be available outside of usual working hours?

Not important ☐ Quite important ☐ Very important ☐ Not sure ☐

12. How confident do you feel about letting your counsellor know about your drug use?

Not very confident ☐ Quite confident ☐ Very confident ☐ Not sure ☐

13. How confident do you feel about talking to your counsellor about things that trouble you most?

Not very confident ☐ Quite confident ☐ Very confident ☐ Not sure ☐

If you feel able to, can you tell us what does, or what would help you, to trust your counsellor?

14. How important is it to offer services like the ear acupuncture as well as the drug counselling?

Not important ☐ Quite important ☐ Very important ☐ Not sure ☐

If you can, please tell us why you think it is important/not important?

15. Is there anything you would change about the drug counselling service?

Yes ☐ No ☐ Not sure ☐

If yes, please tell us what you would change and why

C. Helpfulness of the drug counselling service
Please tick one box for each question in section D

16. Do you think the drug counselling is helping you?

Yes, a lot ☐ Yes, a little ☐ Not very much ☐ Not at all ☐ Not sure ☐

If the counselling is helping you, are you able to tell us in what way is it helpful?

17. Do you think the drug counselling is having an influence on your attitude to drugs?

Yes, a lot ☐ Yes, a little ☐ Not very much ☐ Not at all ☐ Not sure ☐

If counselling is influencing your attitude to drugs, are you able to tell us why here?

18. Do you think the drug counselling is having an influence on your drug use?

Yes, a lot ☐ Yes, a little ☐ Not very much ☐ Not at all ☐ Not sure ☐

If counselling is influencing your drug use, are you able to tell us why here?

19. Would you recommend drug counselling at eSUS/Crew 2000 to a friend?

Yes ☐ No ☐ Not sure ☐

If no, please tell us why. If yes, please tell us what you might say to them.

20. If you have used other services, that you have found useful, please tell us about them here

21. Please write any other comments you have about the drug counselling service at eSUS here.

D. We would like to know a little bit about you to help us to see any patterns in people's experiences of drug counselling. *Please tick the boxes that best describe you. You can tick as many as you need to.*

Gender: male ☐ female ☐ trans-gendered ☐

Employment: working full-time ☐ working part-time ☐ studying full-time ☐
studying part-time ☐ parent/carer ☐ not working ☐

Age: 16 – 20 ☐ 21 – 25 ☐ 26 – 30 ☐ 31 – 35 ☐ 35 plus ☐

Drug use: ecstasy ☐ mushrooms ☐ LSD ☐ cannabis ☐ crack ☐
benzodiazepine ☐ anti-depressants ☐ alcohol ☐ cocaine ☐
opiates ☐ amphetamines ☐

Thank-you for your time

If you want to speak to a researcher face-to-face about your views on using the services at eSUS/Crew we would very much like to hear from you. Please contact Vicky Plows, research assistant, on 0131 650 3929 or at V.Plows@sms.ed.ac.uk to find out more.

A1.2 'Did Not Attend' Questionnaire

eSUS Evaluation: Questionnaire

We are trying to find out what how to make the services at eSUS/crew2000 better for the people that they are trying to help. We are from the University of Edinburgh and we have been asked to do find out these things by the staff at crew2000.

We are trying to find out why people, who have set up a meeting with a counsellor, do not turn up to see the counsellor. We need to know this so that eSUS/crew2000 can change what they do to help more people to come and use their service.

We are writing to you as someone who has at some point been in touch with the staff at eSUS/crew2000. We do not know your name or address - this questionnaire has been forwarded to you through the staff at crew2000. You do not have to put your name on this sheet so no-one will know that these are your responses.

We would be grateful **if you could fill in this short questionnaire for us**. You do not have to answer any questions you do not want to but anything you can tell us will be helpful to us. When you have finished please post the questionnaire back to us in the pre-paid and addressed envelope**.**

With many thanks, the research team: Liz Bondi, Vicky Plows, Seamus Prior & Graeme Smith

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1. Which sentence best describes why you did you not come to your counselling appointment at eSUS/crew2000? *Please tick one box*

I forgot about the appointment ☐

I did not know I had an appointment ☐

I no longer felt I needed an appointment ☐

I had never wanted the appointment ☐

I could not make the appointment because of work commitments ☐

I could not make the appointment because of family/care commitments ☐

I could not make the appointment because of a medical reason ☐

I could not get transport to the appointment ☐

I cannot remember why I did not come to the appointment ☐

I had another reason for not going to the appointment ☐

Please tell us in more detail about why you did not to go to your counselling appointment**:**

2. Would anything listed below have helped you to come to your counselling appointment? Please tick one box for each question

	Yes	No	Maybe	Not Sure
If there were different opening hours	☐	☐	☐	☐
If I could drop in without a fixed appointment	☐	☐	☐	☐
If I could have the option of counselling in my home	☐	☐	☐	☐
If the place of the counselling had been somewhere else	☐	☐	☐	☐
If I had got more reminders about the appointment	☐	☐	☐	☐
If I had the opportunity to meet the counsellor informally first	☐	☐	☐	☐
If I had more information about what the counselling is like	☐	☐	☐	☐

Please tell us what, if anything that might have helped you to come to your counselling appointment?

If there is nothing eSUS could have done to help you to come to your counselling appointment, please can you tell us why not here?

3. We would like to know a little bit about you to see if there are any patterns in the reasons people do not come to drug counselling. *Please tick the boxes that best describe you when you were in contact with eSUS/Crew2000. You can tick as many as you need to.*

Gender: male ☐ female ☐ trans-gendered ☐

Employment: working full-time ☐ working part-time ☐ studying full-time ☐
studying part-time ☐ parent/carer ☐ not working ☐

Age: 16 – 20 ☐ 21 – 25 ☐ 26 – 30 ☐ 31 – 35 ☐ 35 plus ☐

Drug use: ecstasy ☐ mushrooms ☐ LSD ☐ cannabis ☐ crack ☐
benzodiazepine ☐ anti-depressants ☐ alcohol ☐ cocaine ☐
opiates ☐ amphetamines ☐

Thank-you for your time

If you have any questions about this questionnaire or the evaluation project Vicky Plows from the research team is happy to speak with you. You can contact Vicky on 0131 650 3929 or V.Plows@sms.ed.ac.uk. If you think that you would like to speak to someone from the drug counselling service at eSUS/Crew 2000, you can contact them on 0131 220 3404.

A1.3 Current Service-user Interview Guide

1. Contacting eSUS about their support services

Can you tell me how you first heard about eSUS?

Where? How?

How did you first contact eSUS?

Was it yourself or someone else on your behalf?

How did you feel about contacting eSUS?

Why?

Anything that helped you make the decision to contact them? Anything that would have helped make it easier?

What kind of information did you get from eSUS about their support services?

Was it easy to understand? Why/Why not?

Did you have enough information? (too little, too much…)

2. Visiting eSUS for a counselling session

Can you remember how you felt about coming in to see the counsellor for the first time?

Would you change anything about this first meeting?

Anything that was making you feel like you did not want to come?

Anything that encouraged you to come?

Can you remember roughly how long you had to wait between contacting eSUS and coming in for your first counselling session?

Was this wait okay for you? (better less, more, no difference…)

3. Your experience eSUS

What do you think about the timing of the counselling sessions that you have had so far?

Too short, too long? Why?

Good time of day, bad time of day? Why?

Would you change anything about the timing?

Time in between sessions? How long? Does that work for you? Why/why not?

What do you think about where the counselling sessions are held?

The location of the eSUS offices? Ease to access, privacy…

The room that you have the counselling sessions in? Comfort, privacy…

What do you think about the way your counselling sessions are run?

Filling in forms, setting your own goals, relationship with counsellor…

Do you feel that you can say what you want to in your counselling session?

Why/why not?

Is there anything that has led you to trust or distrust the counsellor?

If you feel you want to, can you tell me if you found the counselling sessions you have been to helpful?

Why, why not? How are they helpful?

Was anything really helpful? Not helpful at all?

Specific examples? e.g. has it helped to address any concerns had around drug use/behaviour? In what way helped?

Are you accessing any other services at eSUS?

Ear acupuncture? What is that like? How helpful and why?

Is there anything you would change about the way eSUS do things to make their service better?

How and why would you change it?

Is there anything that you think eSUS is doing really well, that you think they should continue to do? *Why?*

4. Other services

Have you been in touch with any other services in relation to drug use?

How compare to service at eSUS? Was it NHS?

5. eSUS wants to encourage more people who need their support service to use it…

What kind of things do you think might put people off from coming to a service like eSUS?

Is there anything you think eSUS could do differently to help overcome these issues and encourage more people to come to them?

Places and ways advertise?

Change the way people can contact them?

Change the type of services they offer?

6. End of my questions

Is there anything else you want to tell me about eSUS that we have not talked about?

Is there anything you want to ask me about the project?

*** **Thanks** for all your help with this.

A1.4 Former Service-user Interview Guide

1. Background Details

I would like to start with some background questions about the services you went to at eSUS.

Can you tell me which services you used at eSUS?

- Reiki
- Ear Acupuncture
- Counselling

Can you tell me when it was that you used these services/drug counselling?

Can you tell me how long you used these services for?

Can you remember how many times you went to see the counsellor?

(Optional: Can you tell me the name of the counsellor that you saw?)

2. First contact with the service

These questions are about how you heard about the service, your experience of contacting them and your first visit there.

Can you tell me how you first heard about the drug counselling service?

When you heard about the counselling service, what did you think?

- Did any other service provider, such as your GP put you in touch with the counselling service? Was that okay with you?
- Had you heard of or being in contact with eSUS or crew 2000 before this for something other than the counselling service?

Thinking back to when you made the decision to use the drug counselling service, what helped you decide to go?

- Was there anything that was putting you off going?
- Did anyone or anything at the counselling service itself help you to make the decision?

Can you tell me what, if any, information you got about the service beforehand?

- What did you think about this information?
- Is there any thing else you would like to have known beforehand?

How easy was it for you to get the information you needed about the counselling service?

Once you got in touch with the counselling service, can you remember how long you had to wait before you met someone from the service?

- Was the timing okay for you?

After that first meeting can you remember how long it was before you started the counselling sessions?

Was the time you waited okay for you?

Do you remember what the first meeting was like? How did you feel afterwards?

3. Evidence of therapeutic change

The next questions are to find out how effective you found the drug counselling service to be for you. We can talk about what you think worked well and not so well.

Experience of this model of therapeutic intervention

Overall, do you think going to see the drug counsellor at eSUS was helpful for you?

- In what ways was it helpful?
- In what ways was it not helpful?

Can you describe to me what the overall experience of drug counselling was like for you?

- How did you feel before your first session with the counsellor?
- How did you feel when you had been to a few meetings with the counsellor?
- What did you think about the drug counselling when you were going to it?
- What did you think about the counselling after you had stopped going?
- [Explore aspects like fear, feelings of control, empowerment]

Do you think your experience of drug counselling was what you needed at the time?

- In so, what ways, was the counselling what you needed?
- If not, what would have made it more suitable for you?

Can you think of anything specific about the drug counselling service that you found helpful?

- Was there anything about the counsellor as a person?
- What kind of approach did the counsellor take?
- Can you think of anything that the counsellor said or did that you found helpful?
- Was there anything about the way the service is run that was helpful?

Thinking about the different sessions you went to:
Can you give me an example of something that happened that worked well?
And an example of something that didn't work so well?
Would you want the counselling sessions to have been done differently in any way?
Looking back over all your sessions, which one is the one that stands out the most for you?
And what was it that made that session the most memorable?
Are there other moments that stand out for you? Why?
Are there any aspects of using the drug counselling service that stand out as particularly good for you?
And are there any aspects that were particularly bad/hard for you?
Can you tell me how you felt before your final session with the counsellor?
Were you ready to stop?
Did you feel able to contact the service again in the future?
Was there any support you received or that would have been helpful to have at this point?
What do you think about the length of time you had during an individual counselling session?
Was this the right length for you?
During some of your counselling sessions you may have filled in forms like these ones with the counsellor [show blank copies of the monitoring and evaluation sheets used by eSUS].
Can you remember filling these in?
If so, did you find them useful? Which parts were most useful? Were any parts not all that useful?

Changes to drug use and behaviour

Before you went, what did you hope to get out of the drug counselling?
Did these hopes involve changing your drug use?
Did your experience of the counselling match up with these hopes? What, if anything, was different?
Did your drug use change when you went to the counselling?
If there has been any change, what do you think may have led to that change?
Have these remained after you finished the counselling?
If there was no change to your drug use, can you think why that was?
Did you feel that you changed in other ways when you went to the counselling?
[Could explore personal change, work, relationships, lifestyle]
If there has been any change, what do you think may have led to that change? Have these changes remained after you finished the counselling?
If there has been no change, why do you think that was?
How might the counselling have made a difference?
Do you think those around you, who know you well, would say that you changed after using the counselling service at eSUS?
In what way might they say you have changed?
Was there any impact on your relationships with those around you?

4. Opinions on the service provided

These next questions are to find out what you think about some specific aspects of the way that the drug counselling service is currently provided.

Location and room

Did you like the location of the counselling sessions in the crew 2000 building?
If yes, what did you like? Was there anything you did not like about it?
Was it easy for you to find and get to?
Would you change anything about the location?
What did you think about the room that the counselling session took place in?
Was it the right size, was it comfortable, was it private enough?
Is there anything you would change about the room?

Trust in the service

Were you able to open up and be honest when talking with the counsellor?
What helped with this?
Was there anything that did not help with this?
Did you feel that issues of confidentiality were explained well to you?
How was this done?
Could this have been done any better?

Contact between client and service

Sometimes people using drug counselling services do not make it to all of their meetings with the counsellor

and some do not continue with the counselling at all. Did you find that you needed encouragement to continue with the counselling?
Was there anything that service at eSUS did/could do to encourage people to keep on coming to the counselling?
Did you ever receive a text message, phone call, letter to remind you about a session or to find out why you had missed a session?
Do you think contact like that from the service is useful?
Have you had any contact with the service since you stopped going to counselling sessions?
    What kind of contact? Was this helpful?
Overall, were you satisfied with the way that the service contacted you whilst you were going to meet with the counsellor?
    Is there anything you would change about it?

Timing of sessions

Can you remember the number of sessions you had with the counsellor?
    Was this the right number for you?
How often were these sessions?
    Was this often enough/not often enough for you?
How long did the sessions last?
    Was it always the same?
    What do you think about the length of the sessions?

Recommendation

Would you recommend the eSUS drug counselling service to others?
    Why would you/why would you not?
What would you tell them about the service?

5. Satisfaction and improvements

To finish up, I would like to ask you some questions about your overall satisfaction with the service at eSUS and if you have any thoughts on how the service could be improved.

If you were to give the drug counselling service a mark between 0 and 10, where 0 means totally unhappy with the service and 10 means you were totally pleased and happy with everything about the service. What would you give to them?
If you were able to make any changes to the drug counselling service to, what would you change about it?
    Why would you want to do this?
    Can you suggest how the service might do this?
If you have accessed any other services for support around drug use, can you tell me how they compare to the drug counselling at eSUS?
    What was helpful about the other services?
    What was unhelpful about the other services?
It can sometimes be quite difficult for a drug counselling service to make sure that those who might need the service know about it and feel able to contact the service:
    Can you think of anything the counselling service could do to so that more people using psycho-stimulant drugs hear about them?
    Is there anything you think that eSUS could do to encourage those who might need drug counselling to contact them?

Debriefing

That is the end of the questions that I wanted to ask you.
Thanks a lot for speaking with me, it was really helpful.
Is there anything else you would like to add or any questions you would like to ask?
Is there anything you said that you do not wish to be included in the evaluation? If you are happy for us to use the audio recording anonymously in the evaluation report can you look at and sign this consent form?
When the report for the evaluation is written, would you like to receive a copy of it?

A1.5 Referrer Interview Guide

Clarify role in organisation.

1. Your experience of contacting and referring to eSUS

In what circumstances have you made referrals to eSUS?

Were you satisfied with the referral procedure? (Why/Why not?)

Do you expect to make referrals to eSUS in the future? (Why/Why not?)

Have you had contact with eSUS for purposes other than making referrals? (If so… what for?)

What do you think about the service provided by eSUS? *Their approach, their strengths, anything you think they could improve on…?*

2. Your view on provision for psycho-stimulant drug users

What do you think about the provision that is available for psycho-stimulant drug users in and around Edinburgh? *Approaches like to see more of, less of?*

Do you refer psycho-stimulant drug users to services, other than eSUS? *When would you refer to these services? View of these services?*

What do you consider to be the key issues to consider when developing a service for psycho-stimulant drug users? *Any comment about getting psycho-stimulant drug users to access, and then continue to come to a service?*

Thank you – is there anything else you would like to add or comment on?

Your name is not going to be in the evaluation report, but is there anything you have said that you would not like to be included in the evaluation?

A1.6 Practitioner Interview Guide

Introduction
Thank you for agreeing to talk with me today.

As you will know we are undertaking an evaluation of the psycho-stimulant drug user services at crew and interviews with counsellors here forms an important part of this evaluation.

This will help us to understand if the services provided by eSUS are working for the people who are using them and if they could be changed in any way to make them better.

What you say will be treated as confidential and your name will not appear on any research findings. (Need to clarify how many practitioners are being interviewed as, if number is very small, then realistically speaking the data will not be confidential!)

If you do not wish to answer any questions please say so and if you want to stop the interview at anytime that is fine as well.

The interview will last about 1 hour.

I would like to record the interview, is that okay? Can you fill in this consent form with me to say that you have agreed to this?

We will come back to this consent form after the interview to check that you are still happy for the interview to be used in the evaluation.

Background Details
I would like to start with some background questions about your work here.

Can you tell me when you began working for crew?
And when you began counselling here?
Other work you have done here or continue to do here?
Could you estimate how many clients you have seen altogether in the counselling service?

Motivation

Could you tell me a bit about what has drawn you to this work?
What your motivation is/where it comes from?
And your motivation for working with this client group in particular?

Ways of working

Could you describe your orientation as a counselling practitioner?
How would you describe yourself as a practitioner?
What is fundamental or core to your practice as a counsellor in this service?
If I were to ask a client how they experience you working with them, what do you think they might say?

Processes of Change and Growth

How do you feel people using psycho-stimulant drugs benefit from counselling?
While retaining client confidentiality, could you give some brief examples of how clients you have worked with have benefited?
What do you feel the counselling service offers these clients in order to facilitate these beneficial effects?

Can you describe the therapeutic process for clients in this service?
In what ways is it similar or different to clients in other counselling services?
Or: what specifically do crew counselling clients need and get from this service?

Drug use change

To what extent would you say that clients' use of psycho-stimulant drugs is affected by their experience of accessing the counselling service?
While retaining client confidentiality, could you give some brief examples of how clients' drug use may have been influenced?
How do you understand these changes in terms of the therapeutic factors of counselling?

Client characteristics

Can you specify from your experience what kinds of clients are most able or likely to benefit from the counselling service?
Do you have a sense of particular client characteristics or situations predisposing clients to a better outcome from counselling?
Examples: clients who are highly motivated/have prior experience of counselling/ have reasonable stability or support structures in their lives etc

Or perhaps you can more easily specify what kinds of clients are less likely or able to benefit from the counselling service?
What could the service do, if anything, to work more effectively with such clients?

How the crew counselling service may differ from other counselling services.

Have you experience of working in other counselling services?

If so, what kinds of services?
How do these compare with the counselling service at crew?
In what ways is the work similar or different?
For example: Client group characteristics,
use of service,
counsellors' experience of work.
In what ways are the systems/procedures similar or different?

If not, what do you imagine might be the main differences between the counselling service at crew and other counselling services?
On what would you base your judgement?

How crew may differ from other drugs-focused services.

Have you experience of working in other drugs-related services?

If so, what kinds of services?
How do these compare with the services at crew?
In what ways is the work similar or different?
For example: organisational culture, kinds of services offered, organisational approach to drug use – ie basic philosophy
In what ways are crew's services similar or different?

If not, what do you imagine might be the main differences between the services at crew and other drugs-related services?
On what would you base your judgement?

Personal experience of the work

What would you say are the main rewards of the work?
And what are the main challenges?
What kind of impact does the work have on you personally?

What are the particular strains and stresses of this kind of counselling work?
What keeps you going, keeps you motivated?
Do you see yourself working here for some time?
Or do you think this kind of work has a time limit to it?

Working context/sources of support

Thinking of the organisational context of the work, how do you find working here?
Ask about: organisation and team culture, sources of support and supervision, what kind of employer crew is, satisfaction with pay and conditions and job security.

Summarising

In summary, what would you say are the main strengths of crew's services for psycho-stimulant drug users?
And what are the main weaknesses or areas to change?
In an ideal world, what changes would you want to introduce to the service?

Debriefing
That is the end of the questions that I wanted to ask you.

Thanks a lot for speaking with me, it was really helpful.

Is there anything else you would like to add or any questions you would like to ask?

Is there anything you said that you do not wish to be included in the evaluation? If you are happy for us to use the audio recording anonymously in the evaluation report can you look at and sign this consent form?

CLINICAL OUTCOMES in ROUTINE EVALUATION

THERAPY ASSESSMENT FORM v.2

Site ID (letters) (numbers)

Client ID

Sub Codes TH ID number; SC2 numbers; SC3 numbers

Referrer(s)

Age

Male ☐ **Female** ☐

Employment

Ethnic Origin

Referral date D D / M M / Y Y Y Y

First assessment date attended D D / M M / Y Y Y Y

Last assessment date D D / M M / Y Y Y Y

Total number of assessments

Previously seen for therapy in this service? Yes ☐ No ☐ Episode

Months since last episode

Is this a follow-up/review appointment? Yes ☐ No ☐

Relationships/support *Please tick as many boxes as appropriate*

- Living alone (not including dependents) ☐
- Living with partner ☐
- Caring for children under 5 years ☐
- Caring for children over 5 years ☐
- Living with parents/guardian ☐
- Living with other relatives/friends ☐
- Full time carer (of disabled/elderly etc) ☐
- Living in shared accommodation (eg lodgings) ☐
- Living in temporary accommodation (eg hostel) ☐
- Living in institution/hospital ☐
- Other ☐

Current/previous use of services for psychological problems?
Please tick as many boxes as appropriate

		Concurrent	< 12 mths	> 12 mths
Primary	GP or other member of primary care team (eg practice nurse, counsellor)	☐	☐	☐
Secondary	In primary care setting	☐	☐	☐
	In community setting	☐	☐	☐
	In hospital setting on sessional basis	☐	☐	☐
	Day care services (eg day hospital)	☐	☐	☐
	Hospital admission < = 10 days	☐	☐	☐
	Hospital admission > = 11 days	☐	☐	☐
Specialist	Psychotherapy/psychological treatments from specialist team (sessional)	☐	☐	☐
	Attendance at day therapeutic programme	☐	☐	☐
	Inpatient treatment	☐	☐	☐
Other	Counsellor in eg voluntary, religious, work, educational setting	☐	☐	☐

Is the client currently prescribed medication to help with their psychological problem(s)? Yes ☐ No ☐

If yes, please indicate type of medication:

- Anti-psychotics (neuroleptics/major tranquillizers) ☐
- Anti-depressants ☐
- Anxiolytics/Hypnotics (minor tranquillizers) ☐
- Other ☐

Brief description of reason for referral

Identified Problems/Concerns

Severity		< 6 months	6-12 months	> 12 months	Recurring/ continuous
	Depression				
	Anxiety/Stress				
	Psychosis				
	Personality Problems				
	Cognitive/Learning				
	Eating Disorder				
	Physical Problems				
	Addictions				

Severity		< 6 months	6-12 months	> 12 months	Recurring contin.
	Trauma/abuse				
	Bereavement/loss				
	Self esteem				
	Interpersonal/relationship				
	Living/Welfare				
	Work/Academic				
	Other *(specify below)*				

Risk

	None	Mild	Mod	Sev
Suicide				
Self Harm				
Harm to others				
Legal/Forensic				

ICD-10 CODES

	F/Z	Main code	Sub-code		F/Z	Main Code	Sub-code
1			.	3			.
2			.	4			.

What has the client done to cope with/avoid their problems? *Please tick, and then specify actions*

Positive actions ☐

Negative actions ☐

Assessment outcome *(tick one box only)*

- Assessment/one session only ☐
- Accepted for therapy ☐
- Accepted for trial period of therapy ☐
- Long consultation ☐
- * Referred to other service ☐
- * Unsuitable for therapy at this time ☐

***If the client is not entering therapy give brief reason**

CLINICAL OUTCOMES in ROUTINE EVALUATION

OUTCOME MEASURE

Site ID

letters only | numbers only

Client ID

Therapist ID | numbers only (1) | numbers only (2)

Sub codes

D D / M M / Y Y Y Y

Date form given

Age

Male

Female

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

		Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1	I have felt terribly alone and isolated	0	1	2	3	4	F
2	I have felt tense, anxious or nervous	0	1	2	3	4	P
3	I have felt I have someone to turn to for support when needed	4	3	2	1	0	F
4	I have felt O.K. about myself	4	3	2	1	0	W
5	I have felt totally lacking in energy and enthusiasm	0	1	2	3	4	P
6	I have been physically violent to others	0	1	2	3	4	R
7	I have felt able to cope when things go wrong	4	3	2	1	0	F
8	I have been troubled by aches, pains or other physical problems	0	1	2	3	4	P
9	I have thought of hurting myself	0	1	2	3	4	R
10	Talking to people has felt too much for me	0	1	2	3	4	F
11	Tension and anxiety have prevented me doing important things	0	1	2	3	4	P
12	I have been happy with the things I have done.	4	3	2	1	0	F
13	I have been disturbed by unwanted thoughts and feelings	0	1	2	3	4	P
14	I have felt like crying	0	1	2	3	4	W

Please turn over

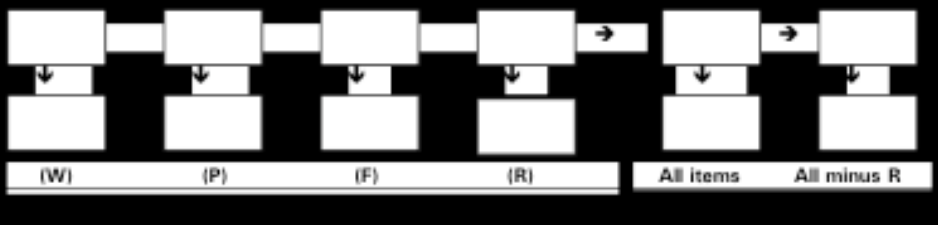
Over the last week

		Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
15	I have felt panic or terror	0	1	2	3	4	P
16	I made plans to end my life	0	1	2	3	4	R
17	I have felt overwhelmed by my problems	0	1	2	3	4	W
18	I have had difficulty getting to sleep or staying asleep	0	1	2	3	4	P
19	I have felt warmth or affection for someone	4	3	2	1	0	F
20	My problems have been impossible to put to one side	0	1	2	3	4	P
21	I have been able to do most things I needed to	4	3	2	1	0	F
22	I have threatened or intimidated another person	0	1	2	3	4	R
23	I have felt despairing or hopeless	0	1	2	3	4	P
24	I have thought it would be better if I were dead	0	1	2	3	4	R
25	I have felt criticised by other people	0	1	2	3	4	F
26	I have thought I have no friends	0	1	2	3	4	F
27	I have felt unhappy	0	1	2	3	4	P
28	Unwanted images or memories have been distressing me	0	1	2	3	4	P
29	I have been irritable when with other people	0	1	2	3	4	F
30	I have thought I am to blame for my problems and difficulties	0	1	2	3	4	P
31	I have felt optimistic about my future	4	3	2	1	0	W
32	I have achieved the things I wanted to	4	3	2	1	0	F
33	I have felt humiliated or shamed by other people	0	1	2	3	4	F
34	I have hurt myself physically or taken dangerous risks with my health	0	1	2	3	4	R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores

Mean Scores
(Total score for each dimension divided by number of items completed in that dimension)



Appendix 2

CORE data analysis

Table A2.1: Means and standard deviations for clinical, non-clinical & crew samples

	Non clinical		Clinical		eSUS CORE		eSUS=n
Dimension	Mean	sd	Mean	sd	Mean	Sd	
Total mean	0.76	0.59	1.86	0.75	1.90	0.70	22
Wellbeing	0.91	0.83	2.37	0.96	2.29	0.80	27
Symptoms	0.90	0.72	2.31	0.88	2.23	0.76	24
Function	0.85	0.65	1.86	0.84	1.97	0.85	26
Risk	0.20	0.45	0.63	0.75	0.96	0.73	26
	n=1084		n= 863				

Table A2.2 Means and standard deviations for non-clinical & eSUS sample

	Non clinical		eSUS CORE		Difference		eSUS
Dimension	Mean	Mean	Mean	sd	95% C.I	p*	
Total mean	0.76	1.90	1.90	0.70	0.83 to 1.45	<0.005	22
Wellbeing	0.91	2.29	2.29	0.80	1.07 to 1.70	<0.005	27
Symptoms	0.90	2.23	2.23	0.76	1.01 to 1.66	<0.005	24
Function	0.85	1.97	1.97	0.85	0.79 to 1.45	<0.005	26
Risk	0.20	0.96	0.96	0.73	0.46 to 1.06	<0.005	26
	n=1084						

*p values for one sample t-test