Evaluation of the Independence Initiative 1-2-1 Detox programme pilot

April 2009

Claire Shaw

Centre for Public Health
Research Directorate
Faculty of Health and Applied Social Sciences
Liverpool John Moores University
Castle House
North Street
L3 2AY

Tel: 0151 904 6003
www.cph.org.uk
c.shaw@ljmu.ac.uk

Centre for Public Health

SEFTON DRUG ACTION TEAM

Acknowledgements

I would like to thank a number of people for assistance provided during the production of this report. Thank you to the participants who were open and enthusiastic throughout the evaluation. Thank you to the staff from Independence Initiative and Lighthouse Project who fully supported the research. Thanks to Sefton DAT for their funding support. Thank you to the staff at Centre for Public Health in particular Dave Seddon, Layla English, Sian Connolly, Lee Tisdall and Dr Caryl Beynon.

Contents

Executive Summary

Background

The Independence Initiative (II) is an aftercare service located in Bootle, Merseyside that supports the long term rehabilitation of drug users and their re-integration into society. Demand for new and extended services emerged due to the continued success of II since establishment in 1996, in particular II noted an anecdotal demand for a detoxification programme based on the one-to-one model.

In 2007, II began planning for a pilot programme, named *1-2-1 Detox.* The aim of *1-2-1 Detox* was to provide each client with a safe '*house*' environment where they could undertake an opiate detoxification with 24 hour support and supervision. It was anticipated that with the group element and peer pressure associated with traditional detoxification services removed, the *1-2-1 Detox* would achieve higher rates of successful completion than other detoxification models.

The *1-2-1 Detox*

Lighthouse Project (LHP) was commissioned to provide the clinical elements of the detoxification and was the sole referral agency. In order to be accepted to the *1-2-1 Detox* clients had to meet the referral criteria. The criteria stated that clients must be receiving less than 40 mgs methadone mixture daily (or street heroin equivalent), compliant with their medication regime if diagnosed with mental health issues, committed to the detoxification process and resident in the Sefton DAT area.

Clients who engaged with *1-2-1 Detox* were titrated from methadone (<=40mgs) or low levels of street heroin to Subutex® (sublingual buprenorphine tablets) and were placed on a structured dose-reduction regime. Each client was offered a stay of 14 days for Subutex® dose-reduction and an additional five days where clients could be prescribed Naltrexone (an opioid antagonist) if desired. The length of engagement with the *1-2-1 Detox* was assessed jointly by keyworkers and the clients, the stay timetable was flexible and changed according to clients needs.

In keeping with the model of community detoxification, clients were responsible for the administration of their own medication. A dose-reduction plan was supplied by the clinical staff at LHP. Each client was responsible for following the plan with support from both II and LHP staff.

During their time engaged with the *1-2-1 Detox*, each client was invited to participate in the II structured day programme. Participation with the structured day programme was entirely voluntary and each client could access activities or lessons that suited them.

The Evaluation

In January 2008 the Centre for Public Heath (CPH) at Liverpool John Moores University (LJMU) was commissioned to conduct an independent, formative evaluation of *1-2-1 Detox*. The evaluation investigated the effectiveness of *1-2-1 Detox* as an alternative to conventional models of detoxification and assessed the treatment outcomes for those who engaged with the detoxification programme.

Key Findings

Seventeen clients (15 male and 2 female) engaged with *1-2-1 Detox* during the pilot programme timeframe (March 2008-Januray 2009). In the pilot time period 20 episodes of treatment were undertaken as three clients engaged with the *1-2-1 Detox* on two occasions. The average length of clients' first detoxification programme was 18.1 days (range 9-35 days). Prior to detoxification 35.3% (n=6) of clients reported that they were stabilised on an opiate substitute (i.e. methadone or Subutex®) and the remaining 64.7% (n=11) reported using heroin.

Follow-up interviews were completed by nine clients after completion of their first episode of detoxification (52.9%). The average length of time between discharge and *follow-up* was 52.4 days (range 26-77 days). The majority of those who completed *follow-up* interviews were male (88.9%, n=8).

Rates of successful completion

Approximately two-thirds of clients who engaged with the *1-2-1 Detox* successfully completed the detoxification programme and exited drug-free (64.7%, n=11). Comparison of the rates of drug-free completion indicate that the detoxification programme was considerably more effective than traditional community detoxification (with rates of 20% successful completion cited) and as effective as inpatient detoxification (with successful completion rates of 65-75% cited).

The term 'successful completion' used in this study refers to completion of the detoxification programme and achievement of a drug-free status. One-third of clients did not achieve this drug-free status before disengaging from the detoxification programme and exited stabilised on a low dose of Subutex® (35.3%, n=6). However, when put in perspective, of the high rates of relapse typically found during community detoxification and drop-out from inpatient detoxification, it can be concluded that 100% of clients completed their detoxification programme and did not return to illicit drug use whilst engaged in the detoxification programme. This finding is in stark contrast to the rates of relapse/drop-out from other models of opiate detoxification.

Differences in drug use before and after detoxification

The lifetime prevalence of illicit drug use was high amongst clients, with at least 50% reporting use of illicit drugs except solvents. In the month prior to

engagement with the *1-2-1 Detox,* at least half of clients indicated that they had used heroin (58.8%, n=10) and crack cocaine (52.9%, n=9); the majority of these clients stated they used these substances frequently in the previous month. Post-detoxification, proportionately lower rates of heroin and crack cocaine were reported by clients (44.4% [n=4] and 33.3% [n=3] respectively). Frequent heroin use was reported by two clients and frequent crack cocaine use by one client at this stage.

In addition to the differences in illicit drug use before and after detoxification, there was a reduction in client's use of prescription drugs. The findings suggested that this difference may be associated with the change in attitude regarding clients' health.

The findings from *follow-up* interviews indicated a low level of drug use amongst the majority of clients, and clients were more likely to 'lapse' into drug use than 'relapse'. This finding is important as it shows that, after returning to the community, many clients were able to return to a drug-free status after a small amount of drug use and that they were able to understand that a lapse did not signal a complete return to drug use.

Changes in drug withdrawal

Statistical analysis indicated that, overall, there was a significant change in client's reported symptoms of drug withdrawal across the three stages of interview. Evidence indicates that withdrawal from Subutex® is less severe than from heroin or methadone (West, O'Neal & Graham, 2000), but this drug induces withdrawal symptoms in some users. A number of clients reported during the *post-detox* and *follow-up* interviews that they had experienced withdrawal symptoms when on a low dose of Subutex®, and one client reported '*I didn't expect the cold turkey feelings when I left*'. This finding was supported by the statistical increase in reported withdrawal severity between *pre-detox* and *post-detox* interviews. Experience of withdrawal symptoms on low dosages of Subutex® may also have contributed to failure of some clients to achieve a drug-free status prior to disengaging with the *1-2-1 Detox*.

Analysis of the clients' severity of withdrawal across the three interview stages indicated that there was a significant decrease in clients reported withdrawal severity between *post-detox* and *follow-up*. This finding indicated that the withdrawal symptoms experienced on low doses of Subutex® did not persist approximately four weeks after disengagement with the *1-2-1 Detox*.

Desires for drugs

There were no significant differences in clients' desires for drugs as measured on the three subscales (desires and intentions, negative reinforcement and control) between the interview stages. The lack of significant differences may be due to a low desire for drugs amongst clients at the beginning of the detoxification process, potentially influenced by the proportion of clients stabilised on opiate substitute prior to detoxification. Another potential explanation for this finding may be due to the lack of cessation of

psychological opiate dependence after completion of physical detoxification (Ghodse, 1995; O'Brien & McLellan, 1996).

Changes in depression, anxiety and arousal

There were significant decreases in clients' levels of depression and anxiety between *pre-detox* and *post-detox,* and significant increases in arousal between *pre*-detox and *post-detox*. However, there were no significant differences between depression, anxiety or arousal across all three interview stages suggesting that there may have been a return to *pre-detox* levels at *follow-up*.

These findings suggest that the positive effects on clients levels of depression, anxiety and arousal that occurred whilst present at the *1-2-1 Detox* diminished after a period of time (approximately one month) post-engagement. During the *follow-up* interview many clients were thriving in the community, however, there were a number who reported low levels of motivation, high levels of boredom and anxiety, and difficulties coping with '*normality*'.

Acceptability of the 1-2-1 Detox

Clients had high levels of praise for the *1-2-1 Detox*, the one-to-one model and the staff who had supported them throughout their detoxification programme. The qualitative analysis indicated that clients felt that the staff had provided a support package which could respond quickly to their individual needs, within a calm, relaxed and flexible environment. A key theme that was identified during the qualitative analysis was related to the level of choice and unregimented manner in which the detoxification programme was run. Clients indicated that this was an aspect that they particularly liked and that had enhanced their overall experience of the detoxification programme. Furthermore, clients indicated their level of personal responsibility within the programme facilitated their preparation for the future and enhanced their feelings of personal control.

The one-to-one aspect of the detoxification programme was considered as a positive aspect of the service by the majority of clients, and provided a rare opportunity for clients to focus solely on themselves and their drug problem. None of the clients reported feeling isolated or lonely, suggesting that the high level of interaction between client and staff/mentors was sufficient. The model facilitated more client:staff contact time than other models of detoxification. Evidence indicates that, when an individual undertakes community opiate detoxification, they are vulnerable to drug related cues and triggers including contact with other drug users, being offered drugs or asked to acquire drugs (Gossop, Johns & Green, 1986; Unnithan, Gossop & Strang, 1992). Clients reported feeling less vulnerable to outside influences and protected whilst resident at the *1-2-1 Detox*, and as there was no contact with other drug users, clients were not exposed to drug related cues and triggers commonly associated with community detoxification. However, a small number of clients

felt that the additional support of contact with another client going through a similar experience could have been useful.

Effectiveness

The findings of the evaluation, as discussed above, indicate that, overall, the *1-2-1 Detox* has provided an effective alternative to traditional models of detoxification. In addition to a physical opiate detoxification service, the *1-2-1 Detox* has made significant differences to the clients quality of life, health, social relationships and educational/employment prospects. Additionally, the pilot programme has provided a response to the UK Drug Strategy and NICE guidance through the provision of individualised, personalised and outcome focussed treatment.

Recommendations

A number of recommendations for the future development and expansion of the *1-2-1 Detox* were made. A summary of the recommendations is detailed below. The summary recommendations should be read in combination with the full report.

1. Continued monitoring of clients exit status and treatment outcomes to facilitate longer term evaluation of effectiveness of the *1-2-1 Detox*.
2. Promotion of the drug-free period of residence at the *1-2-1 Detox*.
3. Preparation of clients for lapse and relapse through interventions focussed on coping strategies, drug related triggers and cues.
4. Ensure each client completes a full structured induction.
5. Consider each clients general mental health and seek to ensure that positive changes in clients' levels of depression, anxiety and arousal are maintained.
6. Decrease the number of clients who did not engage post-detoxification for negative reasons.
7. Offer sessions which aim to increase clients' self-confidence and self-esteem.
8. Encourage attendance at psychosocial interventions post-detoxification.
9. Continue to operate the *1-2-1 Detox* in its current facility at the three bedroom capacity.
10. Continue close partnership between II and LHP and maintain the use of gatekeepers at each agency.
11. Continue to utilise the LHP outreach team to re-engage clients.
12. Develop II governance framework.
13. Continue monthly meetings of steering group.
14. Clarify legislation regarding smoking.
15. Make available additional evening/weekend activities or sources of entertainment.
16. Expand the *1-2-1 Detox* into other Merseyside areas in a staged manner.
17. Seek to secure long-term funding for the *1-2-1 Detox*.
18. Consider the requirement of additional staffing capacity.
19. Assess the evidence of detoxification effectiveness for other types of drug users (i.e. stimulant users) prior to accepting them into the *1-2-1 Detox*.

1. Introduction

1.1 Background

Opiate detoxification

There is no universal cure for drug addiction and typically a range of interventions are required. In the case of opiate addiction, one of the most important and common treatment steps towards abstinence involves cessation of the physical dependence through withdrawal from the drug.

Opiate detoxification typically takes place in one of a number of settings; inpatient (i.e. in hospital or a specialised drug dependency unit), in prison, in a residential drug treatment facility or in the community (i.e. in the individual's home or another safe location). The effectiveness of a programme of detoxification is typically measured on rates of clients successfully completing the programme drug-free (McCambridge et al., 2007).

Community detoxification is more widely available than inpatient detoxification, and it is estimated that approximately 90% of opiate detoxifications take place in the community (National Collaborating Centre for Mental Health, 2008). However, detoxification effectiveness without simultaneous or additional interventions to respond to the psychological drug addiction has been questioned (Katz et al., 2004; O'Brien & McLellan, 1996). Rates of successful completion of community detoxification have been cited at approximately 20% (Gossop, Johns & Green, 1986; Littlewood, 2007; Wright et al., 2007). Luty (2004) reported that inpatient detoxification was amongst the most preferential treatment modalities for opiate-dependent individuals. Rates of successful completion of inpatient opiate detoxification have been reported between 65%-75% (Broers, Giner, Dumont & Mino, 2000; Gossop, Johns & Green, 1986; Keen, Oliver, Rowse & Mathers, 2001). Inpatient detoxification is significantly more expensive than outpatient/community treatment (24:1 ratio), but, inpatient treatment yields almost double successful completions (1.9:1 ratio) (Gossop & Strang, 2000).

The National Institute for Health and Clinical Excellence (NICE) (2007) recommend that in the first instance opioid dependent individuals wishing to undergo detoxification should be offered community detoxification. The NICE (2007) guidance states that residential/inpatient detoxification should only be offered to those with comorbid physical and mental health issues, those who have not previously benefited from community detoxification or those requiring detoxification from more than one substance. The number of bed spaces available for inpatient detoxification has been on the decline in recent years (Day, Ison & Strang, 2005) and NICE (2007) recommend that inpatient detoxification should only be considered for those who require a significant level of nursing and/or medical care for physical, medical or polydrug issues.

Factors affecting successful detoxification completion

Whilst pharmacological approaches to detoxification should be the primary method of treatment for those dependent on opiates, NICE (2007) assert that psychosocial interventions and good quality keyworking are also essential to achieving positive outcomes for those undergoing detoxification. Furthermore, the NICE guidance (2007) states that opioid detoxification should be undertaken using a *'person-centred'* (p.6) approach where the specific needs, desires and opinions of the service user should be priority, ensuring informed consent from the individual and a partnership between the service user and the staff involved. In addition, it has been noted that treatment success can be improved by matching an individual's treatment needs to the drug treatment service provided (Gossop, 1992; McCaffrey, 1996; NTA, 2006).

Research has shown that those who under-go community detoxification are more likely to be vulnerable to relapse as a result of drug-related triggers and interpersonal factors, than the physical effects of withdrawal (Unnithan, Gossop & Strang, 1992). Individuals who undertake detoxification in a community setting are more vulnerable to situations such as encountering other drug users, being offered drugs or asked to obtain drugs for others, all of which create temptation to use drugs (Gossop, Johns & Green, 1986; Unnithan, Gossop & Strang, 1992).

The detoxification setting and the extent of non-pharmacological interventions (i.e. psychosocial interventions) offered during withdrawal have been reported as significant treatment outcome factors (Amato, Davoli, Ferri, Gowing & Perucci, 2004; Joe, Simpson & Broome, 1999). Research has found that detoxification programmes, without other treatment or psychological interventions, can serve as powerful harm-reduction initiatives (Chuntuape, Jasinski, Fingerhood & Stitzer, 2001). However, detoxification alone is not enough to ensure individuals maintain drug-free status and relapse is frequent and effectiveness can be poor (Amato, Davoli, Ferri, Gowing & Perucci, 2004; Gossop, 1992; Luty, 2003; O'Brien & McLellan, 1996). Other interventions such as methadone maintenance, relapse prevention therapy, reinforcement-based therapy, structured aftercare and counselling have been found to enhance abstinence rates amongst opiate users (Jones, Wong, Tuten & Stitzer, 2005; McCambridge et al., 2007). Social support was found to have potential negative effects on detoxification completion in an inpatient setting, with those with secure housing and strong family support more likely to disengage with treatment before completion (Westreich, Heitner, Cooper, Galanter & Guedj, 1997).

It has been reported that detoxification services closely linked to aftercare services produce higher rates of positive outcomes than those without links (Day, 2005). Confidence to remain opiate-free has also been shown to be an important predictor of post-discharge abstinence (Murphy, Bentall, Ryley & Ralley, 2003).

Lapse and relapse

Regardless of the detoxification setting, relapse into drug use after detoxification is frequent and a significant problem in drug treatment (Broers, Giner, Dumont & Mino, 2000; Unithan, Gossop & Strang, 1992; Wilson, Elms & Thomson, 1975). The psychological dependence of opiates does not cease when withdrawal is complete and detoxification is not a cure to opiate dependence, but one stage in an individual achieving a drug-free status (Ghodse, 1995; O'Brien & McLellan, 1996). Relapse not only has a profound effect on the individual but it also has wider social and economic consequences. Unithan, Gossop and Strang (1992) found that among opiate users undertaking an outpatient detoxification programme 40% had relapsed by the second week and regular interaction with other drug users was a high-risk factor associated with relapse. Evidence suggests that inpatient opiate detoxification yields better rates of abstinence compared to community detoxification. Research in Geneva found that 33% of those who had been resident in a specialist detoxification facility were dependent on drugs after one month and 50% after six months (Broers, Giner, Dumont & Mino, 2000). Whilst the rates of dependence reported by Broers et al. (2000) were less than that reported with individuals undertaking outpatient detoxification (Unithan, Gossop and Strang, 1992), 65% of those who had been resident in the specialist detoxification facility relapsed into at least occasional drug use in the month post-detoxification.

Evidence suggests that an initial lapse into opiate use post-detoxification does not necessarily predict regular future use (Bradley et al., 1992; Ghodse et al., 1997). A UK study reported relapse amongst 71% of a sample of individuals in the first six weeks post opiate detoxification and 55% at six month follow-up (Gossop, Green, Phillips & Bradley, 1989). This study also indicated that opiate use may fluctuate from relapse to abstinence post-detoxification and there may be a critical period post-treatment of up to one week where initial relapse is most likely (Gossop, Green, Phillips & Bradley, 1989). A similar pattern was observed in a study conducted by Ghodse et al. (1997) where the authors also suggested that the fluctuations in opiate use post-detoxification could encourage those who relapse to focus on the very real possibility of reducing their drug use again. However, the authors also warned that drug treatment professionals should be very aware of these patterns and should not become complacent when an individual leaves detoxification drug-free as there is a very real possibility that they will relapse.

Due to the high rates of relapse associated with detoxification from opiates the role of aftercare and support post-detoxification is vital and a poorer prognosis is expected for those who do not receive it (Ghodse et al., 1997; Haug, Sorensen, Gruber & Song, 2005). NICE (2007) recommend continued support for those who have undergone an opioid detoxification for at least six months post-detoxification. Although it is recognised that relapse after detoxification is frequent, this should not detract from the fact that even small periods of abstinence are a positive outcome for someone who is drug dependent and a number of detoxifications may be necessary to achieve abstinence (Ghodse, 1995). In order to address the issue of relapse in the

initial weeks post-detoxification Ghodse et al. (1997) suggested that a three stage model of detoxification should be adopted. The three stages were described as (1) detoxification and in-depth assessment of needs, (2) a drug-free period pre-discharge (approximately 5 days) and, (3) relapse prevention and social re-integration via a day programme. The second stage suggested by Ghodse et al. (1997) allows the individual to adjust to their drug-free status and prepare for discharge back into the community allowing the individual to focus on their finances and social care issues.

UK clinical guidelines on opiate detoxification

The Department of Health's (DH) guidelines on clinical management of drug misuse and dependence recommend that for the management of opiate addiction substitute prescribing should not be undertaken in isolation and should be accompanied by psychosocial interventions (DH, 2007). Specifically, DH recommend that psychosocial interventions should be utilised to enhance motivation, prevent relapse and respond to social, family and employment issues. In addition, the DH clinical guidelines indicate that a multi-disciplinary approach to addiction should be undertaken, and where possible a shared care model should be implemented. DH (2007) recommends that opiate withdrawal should only be undertaken after the individual has gone through a period of stabilisation, after which a dose reduction regime should be used until the individual has become drug-free.

1.2 Independence Initiative

The Independence Initiative (II) is an aftercare service located in Bootle, Merseyside that supports the long term rehabilitation of drug users and their re-integration into society. Currently II utilises a model of one-to-one guidance and counselling, action planning, core/basic skills, pre-vocational training and ongoing support to achieve its aims. II offer clients, who show a commitment to changing their drug use, a structured day programme timetable of one-to-one support and pre-vocational training.

The 1-2-1 Detox pilot

Demand for new and extended services emerged due to the continued success of II since establishment in 1996, in particular II noted an anecdotal demand for a detoxification programme based on the one-to-one model. Structured day programme clients who had flourished in the one-to-one structured day programme indicated that they did not wish to undergo detoxification in a group setting. In order to provide evidence for the requirement of a one-to-one model of detoxification the II commissioned a feasibility study. This study investigated the potential demand for a one-to-one detoxification service and indicated that the service would be beneficial to a wide variety of clients and particularly advantageous as there would be little or no opportunity for the client to interact with other drug users (Wareing & Sumnall, 2006).

Twenty-four hour nursing care was not considered economically viable and therefore II developed the detoxification model in likeness to a structured community detoxification in a safe, homely environment. It was recognised that as there would be no clinical staff on site 24/7 there was a requirement to utilise a partner agency to deliver the clinical aspects of the detoxification. Lighthouse Project (LHP) at Oriel Road in Bootle was chosen as the preferred partner organisation to provide the clinical components, guidance and support.

In 2007 II began planning for a pilot programme, named *1-2-1 Detox.* The aim of *1-2-1 Detox* was to provide each client with a safe '*house*' environment where they could undertake opiate detoxification with 24 hour support and supervision. It was anticipated that with the group element and peer pressure associated with traditional detoxification services removed (Unithan, Gossop & Strang, 1992) the *1-2-1 Detox* would achieve higher rates of successful completion than other models of detoxification. In addition, the model has sought to incorporate the principles of the new national strategy *Drugs: protecting families and communities, the 2008 drug strategy* (Home Office, 2008) through provision of '*personalised and outcome focussed treatment*' (p.27). The service aimed to facilitate and support each client who completed the *1-2-1 Detox* to engage with aftercare and relapse prevention agencies, re-integrate into mainstream society or attend another appropriate/preferred programme.

Currently there are no public funded one-to-one detoxification facilities with constant supervision in the UK and the *1-2-1 Detox* is a unique service. Due to the unique model of one-to-one detoxification, there is no research which directly assesses its effectiveness or outcomes with opiate users. However, other available research indicated that improved outcomes in residential treatment programmes have been associated with single rooms, respect of client privacy, lower counsellor caseloads, individual counselling and a lower requirement for the individual to engage in domestic duties (Meier & Best, 2006).

Early in 2008 renovations were completed and two ensuite bedrooms and a staff bedroom/office were ready for commencement of *1-2-1 Detox*. In March 2008 the first client was accepted into *1-2-1 Detox*. In September 2008 work began to develop a wheelchair-friendly third bedroom in the *1-2-1 Detox* which has since been completed.

Funding for the pilot *1-2-1 Detox* was provided by grants from two ESF Pathways Partnerships in South Sefton and the South Sefton Development Trust. The funding was available until the end of June 2008 and ring-fenced to the inclusion of clients from the South Sefton area only, this included Bootle, Seaforth, Orrell, Litherland and Netherton.

In June 2008 an interim evaluation report produced by the Centre for Public Health (CPH) at Liverpool John Moores University (LJMU) recommended that a steering group be established to help guide the future of the *1-2-1 Detox*, and that further funding be sourced to continue the pilot programme for approximately another six months (Shaw, 2008). In July 2008 the steering

group was established (consisting of members of II, LHP, Sefton Drug Action Team (DAT) and CPH, and funding was secured from Sefton DAT to continue the pilot programme until the end of January 2009. At this stage it was also decided that the catchment area for admission to the *1-2-1 Detox* should be expanded to include the entire Sefton DAT area.

The pilot programme fitted neatly with one of the key strategy actions on treatment in the most recent national drug strategy *Drugs: protecting families and communities, the 2008 drug strategy* (Home Office, 2008) which focuses on pilot programmes to test new treatment approaches with improved '*end-to-end management*' (p.27) of a clients treatment journey.

Criteria for referral and admission to 1-2-1 Detox

All referrals to the *1-2-1 Detox* were made through LHP as the sole referral agency.

The minutes from a project initiation meeting attended by II, LHP and Sefton DAT staff members in February 2008 state that the criteria for referral to the *1-2-1 Detox* was:

- Client receiving low dose of Subutex® or methadone.
- Client in planning stages of detoxification.

During the early stages of the pilot programme (i.e March-June 2008) clients were referred to the *1-2-1 Detox* on the basis of the open criteria described above. However, feedback from the interim report (Shaw, 2008) indicated that there was confusion about the referral criteria and a requirement to tighten it, and include further detail. The steering group developed the following criteria.

Post-June 2008, in order to engage with the *1-2-1 Detox* clients' were required to undergo an initial assessment at LHP and to satisfy the criteria outlined below:

- Client receiving less than 40 mgs of methadone mixture daily, or the street heroin equivalent.
- Client with mild to moderate mental health issues were accepted providing that their condition was stable and they were compliant to their medication regime.
- Client must show a commitment to detoxification and a desire to become drug-free.
- Client must be resident in Sefton DAT area.

Only once a client satisfied the criteria as set out above, was a referral to II made. To ensure the appropriateness of referrals, clients underwent a further assessment at II with the intended keyworker.

Furthermore, post-June 2008 more robust referral protocols were developed jointly between II and LHP. The referral protocol included:

- The completion of an assessment of each potential client at LHP (including completion of appropriate paperwork);

- A joint agreement of client suitability between II and LHP prior to admission;
- A three-way meeting between II, LHP and each client upon admittance.

All clients received a robust aftercare plan prior to disengagement from the *1-2-1 Detox*. This plan was developed by the client in conjunction with their keyworker at II.

The referral pathway and client journey is illustrated by Figure 1. This diagram illustrates the assessments undertaken prior to admittance to the detoxification programme, at both LHP and II, and the pathways for re-assessment for those considered unsuitable at either assessment stage. The diagram also illustrates the pathway for re-engagement for those individuals who relapse into drug use post-detoxification and for those wishing to access relapse prevention or mainstream re-integration post-detoxification.

The detoxification process

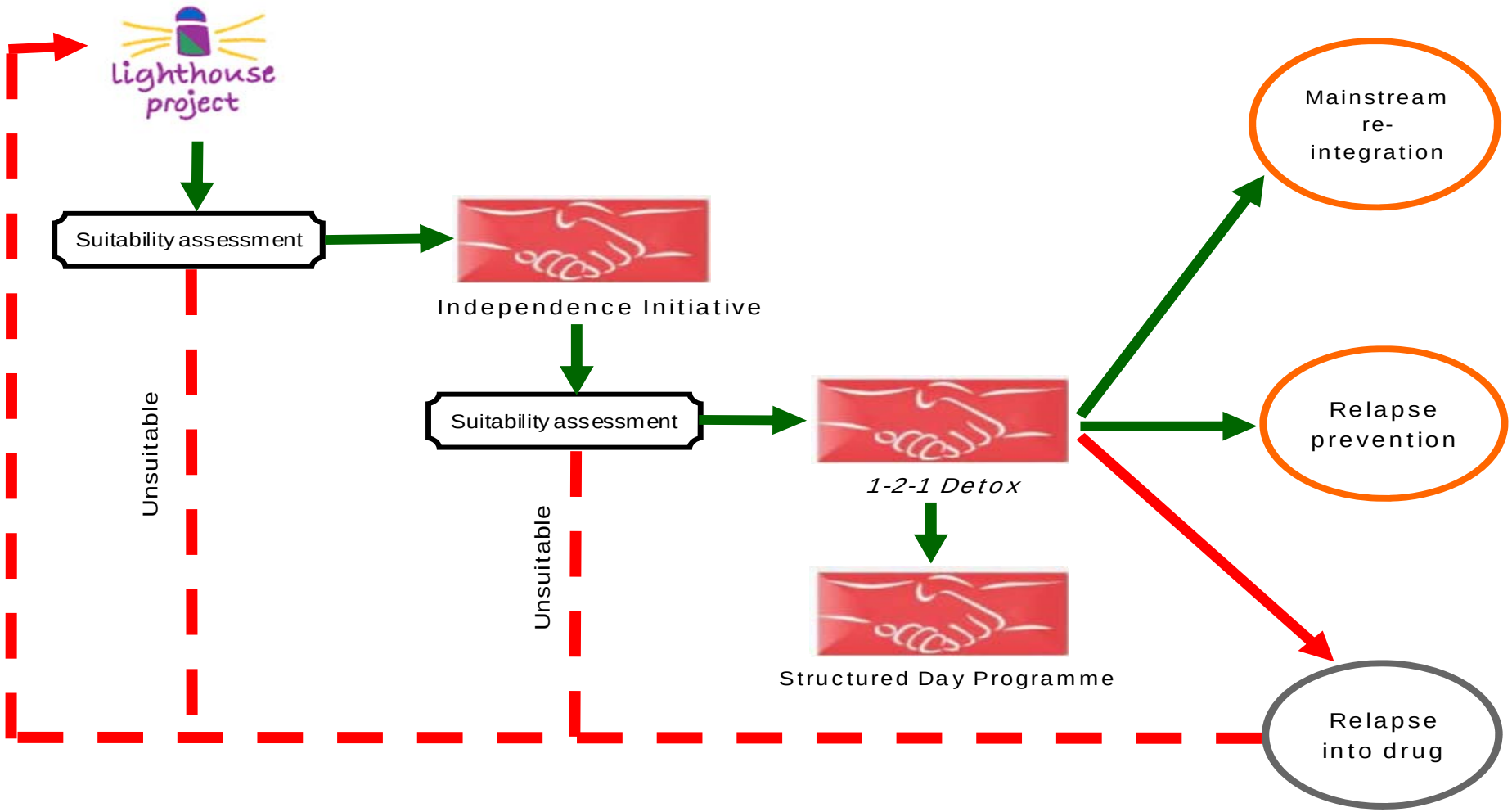
Clients who engaged with *1-2-1 Detox* were titrated from methadone (<=40mgs) or low levels of street heroin to Subutex® (sublingual buprenorphine tablets) and were placed on a structured dose-reduction regime. Each client was offered a stay of 14 days for Subutex® dose-reduction and an additional five days where clients could be prescribed Naltrexone (an opioid antagonist) if desired. The length of engagement with the *1-2-1 Detox* was assessed jointly by keyworkers and the clients, the stay timetable was flexible and changed according to clients needs.

In keeping with the model of community detoxification, clients were responsible for the administration of their own medication. A dose-reduction plan was supplied by the clinical staff at LHP. Each client was responsible for following the plan with support from both II and LHP staff.

During their time engaged with the *1-2-1 Detox*, each client was invited to participate in the II structured day programme. Participation with the structured day programme was entirely voluntary and each client could access activities or lessons that suited them.

Each client had a dedicated keyworker at II. The role of this key worker was to provide one-to-one support throughout the detoxification process, provide guidance and action planning, arrange structured day programme activities, and facilitate aftercare support and/or mainstream re-integration.

Figure 1: The detoxification journey



1.3 The Evaluation

Independent evaluation, a form of applied social research, should be utilised to assess the value and impact of new or novel interventions, projects or services and assess their suitability for future use in combination with recommendations for improvements (Clarke, 1999; Robson, 2000). All new programmes of drug treatment should be subjected to a formal, independent evaluation to ensure appropriate use of public funds and evidence-based practice (EMCDDA, 2007).

In January 2008 CPH at LJMU was commissioned to conduct an independent, formative evaluation of *1-2-1 Detox* pilot programme. The evaluation investigated the effectiveness of *1-2-1 Detox* as an alternative to conventional models of detoxification and assessed the treatment outcomes for those who engaged with the detoxification programme.

Specifically, the success of the *1-2-1 Detox* pilot programme was measured against a number of objectives, including:

- Rates of successful completion of detoxification;
- Analysis of differences in quantity and frequency of drug use among clients prior to and after detoxification;
- Differences in self-reported measures of drug craving and withdrawal prior to and post detoxification;
- Changes in clients levels of depression, anxiety and arousal before and after detoxification;
- Analysis of the strengths and weaknesses of the service as reported by the clients;
- Examination of the staffs' opinions about the service and suggestions for development.

Based on the findings, recommendations for the future development of the *1-2-1 Detox* were developed.

1.4 This Report

This report details findings from the evaluation and includes analysis of all clients who attended the *1-2-1 Detox* during the pilot period from March 2008 to January 2009.

In June 2008, an unpublished interim report was produced as part of the formative evaluation to provide an interim assessment of the detoxification programme's effectiveness and highlight areas for improvement (Shaw, 2008). This report includes an evaluation of the complete pilot programme and supersedes the previous report.

1.5 Ethical Approval

As the clients involved in this research were vulnerable drug users and furthermore undergoing a particularly difficult period in drug treatment, detoxification, it was imperative that ethical approval was sought from an appropriate independent body before the research was initiated.

Ethical approval was granted by LJMU Research and Ethics Committee in March 2008 prior to initiation of the fieldwork, and the research was undertaken in accordance with the British Psychological Society's ethical guidelines (BPS, 2006). All clients were provided with participant information sheets and requested to sign consent form (copies available on request).

2. Methodology

In order to assess the effectiveness of the *1-2-1 Detox* the methodology focussed not only on the clients but also on the Independence Initiative (II) staff and partners at Lighthouse Project (LHP). The evaluation was undertaken with a mixed methodology (i.e. semi-structured interviews and focus group).

2.1 Client Interviews

A semi-structured interview guide was developed for use with the *1-2-1 Detox* clients. Each client was invited to be interviewed three times, at the beginning of their detoxification (*pre-detox*), during the last few days of their detoxification (*post-detox*) and approximately one month after detoxification completion (*follow-up*).

After initial engagement with the detoxification programme each client was informed of the evaluation research by a member of the detoxification staff. After giving an initial indication that they would be willing to participate in the research, the researcher met with each client on their second or third day of detoxification to complete the *pre-detox* interview. The *post-detox* interview took place at the end of the clients detoxification programme, typically one or two days before they disengaged with the detoxification programme. The *follow-up* interview took place approximately one month after the client left the detoxification programme. All interviews were conducted by the same researcher to ensure consistency in interview style and familiarity for the clients.

The length of each interview varied across the different interview stages, however, on average each lasted approximately 30 minutes. Contact details for each client and their permission for the subsequent meetings, including in the event of unsuccessful completion of the programme, were obtained during the first meeting.

A general set of questions were developed for use in the semi-structured interview and these were revised and asked as appropriate for each interview. The semi-structured interview included a mixture of researcher derived questions and validated scales. The topics discussed during each interview are detailed in Table 1.

A contingency plan was developed to ensure that the views of any clients who did not complete their detoxification programme were collected. At the *pre-detox* interview, permission was sought for the researcher to contact the clients in the event of unsuccessful completion. However, as all clients had a planned exit from the detoxification programme it was not necessary to implement the contingency plan.

Table 1: Topics included in the semi-structured interview at each interview stage.

Topics	*Pre-detox*	*Post-detox*	*Follow-up*
Demographic information	✓		
Drug using profile	✓		✓
Alcohol use	✓		✓
Injecting	✓		✓
Overdose	✓		✓
Treatment history	✓		✓
Housing situation	✓		✓
Post-treatment arrangements	✓	✓	
Health profile (including mental health)	✓		✓
Employment and education	✓		✓
Short Opiate Withdrawal Scale*	✓	✓	✓
Desires for Drug Questionnaire*	✓	✓	✓
Anxiety, Depression & Arousal Questionnaire*	✓	✓	✓
The Stages of Change Readiness and Treatment Eagerness Scale*	✓		
Assessment of and opinions about the *1-2-1 Detox*	✓	✓	✓

*Validated scales.

Copies of the semi-structured interview guides are available on request. Additional information relating to the validated scales included in the semi-structured interviews is included in Appendix 1.

2.2 Staff & Partner Focus Group

In order to assess the effectiveness of the *1-2-1 Detox* from all perspectives a focus group with staff from II and their partner organisation, LHP, was held. Six members of II staff and three members of LHP staff attended the focus group which lasted for two hours.

The focus group took place approximately four months after *1-2-1 Detox* received its first clients and after 10 clients had been admitted to *1-2-1 Detox*. All attendees at the focus group received a discussion guide to assist focus on relevant issues. The discussion guide listed topics including strengths and weaknesses of the *1-2-1 Detox*, effectiveness, partnership and the future.

Copies of the discussion guide are available on request.

3. Evaluation Findings

3.1 Evaluation of the Effectiveness of the *1-2-1 Detox*: quantitative findings

Seventeen clients engaged with *1-2-1 Detox* during the pilot programme timeframe. In the pilot timeframe 20 episodes of treatment were undertaken as three clients engaged with the *1-2-1 Detox* on two occasions.

The majority of the findings presented below refer to the first episode of treatment for each client as these interviews were conducted when each client was '*treatment naive*' (i.e. had no prior experience of the *1-2-1 Detox*), and thus the clients could give an accurate account of their first impressions and expectations. However, where the findings of all interviews and treatment episodes are relevant these have been included and the term 'episodes' used.

3.1.1 Client demographics

A total of 17 clients took part in the study, 15 males and two females. The mean age of the sample was 39.2 years (range 24-50 years). All clients described their ethnicity as White British. The majority of clients described themselves as single (58.8%, n=10) and 35.3% (n=6) reported that they had a partner who they did not live with. One client was married. Seven clients reported that their partner was also a drug user (41.2%).

All clients were primarily undergoing detoxification of opiates. The average length of clients' first detoxification programme was 18.1 days (range 9-35 days). When all episodes of engagement with the detoxification programme were included the average length of retention was 17.4 days. Prior to detoxification 35.3% (n=6) of clients reported that they were stabilised on an opiate substitute (i.e. methadone or Subutex®) and the remaining 64.7% (n=11) reported using heroin.

All clients completed a *post-detox* interview prior to disengagement with the detoxification programme for their first episode of engagement. One client who had two episodes of engagement with the detoxification programme did not complete the *post-detox* interview for their second episode, and the researcher was unable to make contact.

Follow-up interviews were completed by nine clients after completion of their first episode of detoxification (52.9%). The average length of time between discharge and *follow-up* was 52.4 days (range 26-77 days). The majority of those who completed *follow-up* interviews were male (88.9%, n=8) and the mean age of the group was 38.9 years.

Comparison of the *follow-up* group and those not followed-up indicated no statistical differences in gender (p=0.73, Fishers Exact Test), previous month heroin use (p=0.22, Fishers Exact Test), lifetime use of benzodiazepines (p=0.55, Fishers Exact Test) or crack cocaine (p=0.53, Fishers Exact Test), lifetime injecting (p=0.67, Fishers Exact Test) or clinically significant CAGE

alcohol score (p=0.65, Fishers Exact Test). Additionally, no statistical differences were observed in the age[1] of those in each group (t(17)=-0.62, p>0.05)[2].

3.1.2 Previous treatment

All clients had previously received drug treatment prior to engagement with the detoxification programme. Most commonly clients had previously undergone opiate detoxification (88.2%, n=15) in a variety of settings including in the community, inpatient detoxification units, residential rehabilitation services and in prison. Two clients reported that they had attempted inpatient detoxification on at least three previous occasions (11.8%). Other forms of treatment reported by clients included methadone maintenance, structured psychosocial interventions and structured day programmes.

The majority of clients indicated that their previous attempts at detoxification had led to periods of abstinence. Reasons for returning to opiate use included feelings of vulnerability, inability to deal with drug cravings, pressure from other drug users and infrequent heroin that became regular use.

3.1.3 Readiness for change

During the *pre-detox* interview clients were asked to complete The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) (Miller & Tonigan, 1996). Clients rated how much they agreed or disagreed with each statement on a 5-point Likert Scale. SOCRATES has three sub-scales measuring recognition, ambivalence and taking steps. See Appendix 1 for more detail regarding this scale.

Clients' raw scores on each of the subscales were recoded into decile scores and the analysis is presented below as low, medium or high (Table 2)[3]. Prior to detoxification clients indicated high levels of motivation on the *taking steps* subscale. There was greater variance in the scores on the *recognition* and *ambivalence* subscales. Over half of clients had high levels of recognition of their drugs problems as measured by the *recognition* subscale (58.8%, n=10), however, two-fifths of clients scored in the low category on this subscale.

Table 2: Clients recoded ratings on SOCRATES Personal Drug Use Questionnaire subscales (n=17)

	Low		Medium		High	
	%	n	%	n	%	n
Recognition	41.2	7	0.0	0	58.8	10
Ambivalence	29.4	5	41.2	7	29.4	5
Taking steps	5.9	1	5.9	1	88.2	15

[1] This analysis was based on age at the beginning of the detoxification programme.
[2] The author is aware that using a parametric test on a small sample increases the risk of a Type I error.
[3] Note that the low category presented is a combination of responses of 'Low' and 'Very low' and the high category is a combination of responses of 'High' and 'Very high' decile scores.

3.1.4 Rates of successful completion

All clients left the detoxification programme with a planned discharge and aftercare plan in place. Eleven clients exited the detoxification unit drug-free (64.7%). Those who did not leave drug-free exited stabilised on a low dose of Subutex® and with a plan to complete the detoxification in the community supported by Lighthouse Project (LHP) (35.3%, n=6). Of those who left on a low dose of Subutex®, rather than drug-free, the reason for disengagement included experience of withdrawal symptoms (mainly attributed to the Subutex®) and pressure from outside influences (i.e. family and partners) to leave the detoxification now that they were '*better*'. Seven clients (41.2%) received a Naltrexone prescription before or shortly after discharge from the programme.

When all episodes of detoxification are considered the rate of detoxification programme completion drug-free is 70% (n=14) and 35% (n=7) of episodes were followed by a Naltrexone prescription. All clients who underwent the detoxification programme twice exited drug-free after their second episode.

3.1.5 Drug use

At the *pre-detox* interview clients were asked about their use of a range of drugs. Data were collected on lifetime[4] use of each drug, age of first use, use in the previous month, frequency of use in previous month and usual route of administration. No drug use questions were asked in the *post-detox* interview as clients had no access to drugs whilst engaged with the detoxification programme. At *follow-up* interview clients were asked about their drug use in the period since leaving the detoxification programme. Clients who responded positively to use of any drug in this period were asked further questions about frequency of use and usual route of administration.

Pre-detox drug use

Prior to engagement with the detoxification programme, all clients had used heroin (Table 3). High rates of lifetime use of other drugs were reported, with only lifetime solvent use reported by less than half of clients (41.2%, n=7). Considerably lower rates of previous month drug use[5] were reported. Heroin and crack cocaine use in the previous month were reported by at least half of clients at 58.8% (n=10) and 52.9% (n=9) respectively. Previous month cannabis use was reported by one-third of clients (35.3%, n=6).

[4] Lifetime drug use refers to any use of the drug, even if only once, in an individual's lifetime.
[5] Previous month use refers to drug use in the month prior to questioning and is considered a good indicator of recent drug use.

Table 3: Self-reported lifetime and previous month illicit drug use at *pre-detox* interview (n=17)

Drug	Ever		Previous month	
	%	n	%	n
Heroin	100.0	17	58.8	10
Amphetamine	64.7	11	5.9	1
Cocaine	88.2	15	23.5	4
Crack cocaine	94.1	16	52.9	9
Hallucinogens	76.5	13	5.9	1
Ecstasy	70.6	12	0.0	0
Cannabis	94.1	16	35.3	6
Solvents	41.2	7	0.0	0

In addition to illicit substances, clients were asked about their use of prescribed substances (in both a prescribed and non-prescribed manner). All clients reported lifetime use of prescribed methadone, with over half reporting use in the previous month (58.8%, n=10). Two clients reporting '*topping up*' their methadone prescription with non-prescribed (illicit) methadone bought from a dealer.

The majority of clients reported lifetime use of benzodiazepines (82.4%, n=14) and approximately one-third reported use in the month prior to engagement with the detoxification programme (35.3%, n=6). More than half of clients reported lifetime use of barbiturates (52.9%, n=9) and 17.6% of clients (n=3) indicated previous month use (two prescribed and one non-prescribed). Approximately one-third of clients reported lifetime use of tranquillisers (35.3%, n=6) and 17.6% (n=3) reported that they were currently prescribed tranquillisers. The majority of clients indicated that they had used anti-depressants in their lifetime (58.8%, n=10) and almost one-third reported that they were receiving prescribed anti-depressants on a daily basis in the previous month (29.4%, n=5).

The frequency of use of heroin and crack cocaine in the month prior to engaging with the detoxification programme is illustrated in Figure 2 and Figure 3 below. Note that this analysis is based only on those who reported use of these drugs in the previous month

.

Figure 2: Previous month frequency of heroin use (n=10)

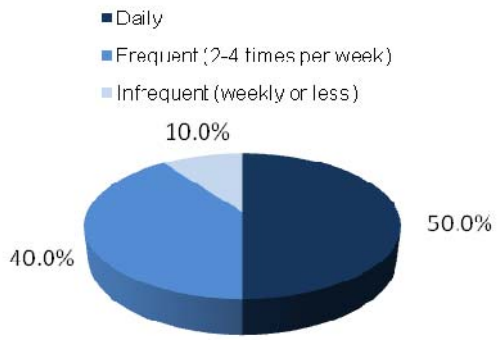
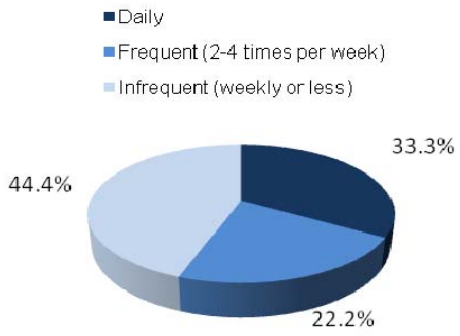


Figure 3: Previous month frequency of crack cocaine use (n=9)



Of those clients who indicated that they had used heroin in the month prior to engaging with the *1-2-1 Detox*, daily heroin use was reported by 50.0% of clients (n=5) and 40.0% reported frequent use, defined as use 2-4 times per week (n=4). One client reported infrequent use (defined as less than weekly) of heroin (10%). Of those using heroin smoking was the most common route of drug administration (80%, n=8), with two clients reporting usually injecting heroin in the previous month. Age of first use of heroin ranged from 12 to 42 years.

Of those clients who indicated that they had used crack cocaine in the month prior to engaging with the *1-2-1 Detox*, daily use was reported by one-third (33.3%, n=3) and two clients reported frequent use of this drug (22.2%). Four clients reported using crack cocaine infrequently (44.4%). Similarly to heroin use, the largest proportion of clients reported smoking crack cocaine in the previous month (77.8%, n=7) and two clients reported usually injecting the drug (22.2%). Age of first use of crack cocaine ranged from 17 to 46 years. Notably, all but one client who reported use of heroin in the previous month also reported last month crack cocaine use. Two clients reported injecting both drugs.

Frequent heroin and crack cocaine use in the previous month was reported by the three clients who had two episodes of engagement during their second *pre-detox* interview.

Follow-up drug use

Nine clients completed a follow-up interview. Two of the nine (22.2%) were drug-free (i.e. had not used any illicit substance since exiting the programme). The use of a range of drugs was reported by the other seven clients, including amphetamine, heroin, crack cocaine, cannabis and hallucinogens (Table 4). However, in the majority of the cases the reported usage was infrequent (i.e. once or a couple of times in the previous month). One client reported frequent crack cocaine use (11.1%) and two reported frequent heroin use at *follow-up*

(22.2%). Notably, four clients reported frequent use of cannabis at this stage (44.4%).

During the *follow-up* interview one client who reported a relapse into frequent heroin use since completing the detoxification programme had since become drug-free again and enrolled in a relapse prevention programme.

Table 4: Self-reported illicit drug use since disengaging with the *1-2-1 Detox* (n=9)

Drug	%	n
Heroin	44.4	4
Amphetamine	11.1	1
Cocaine	0.0	0
Crack	33.3	3
Hallucinogens	11.1	1
Ecstasy	0.0	0
Cannabis	44.4	4
Solvents	0.0	0

Clients who completed *follow-up* interviews reported use of a number of prescription drugs, most of which were legitimately prescribed. Legitimately prescribed drugs included DF118s (11.1%, n=1), benzodiazepines (11.1%, n=1), barbiturates (11.1%, n=1) and anti-depressants (11.1%, n=1). Non-prescribed use of benzodiazepines was also reported by one client (11.1%).

Comparison of drug use *pre-detox* and *follow-up*

Due to the differences in sample sizes of the number of clients who engaged with the detoxification programme and those who completed a *follow-up* interview it was not valid to produce comparisons of use for all drugs and therefore only heroin and crack cocaine use has been compared.

Figure 4: Comparison of clients self-reported drug use in the month prior to engaging with *1-2-1 Detox* (n=17) and since disengaging with *1-2-1 Detox* (n=9)

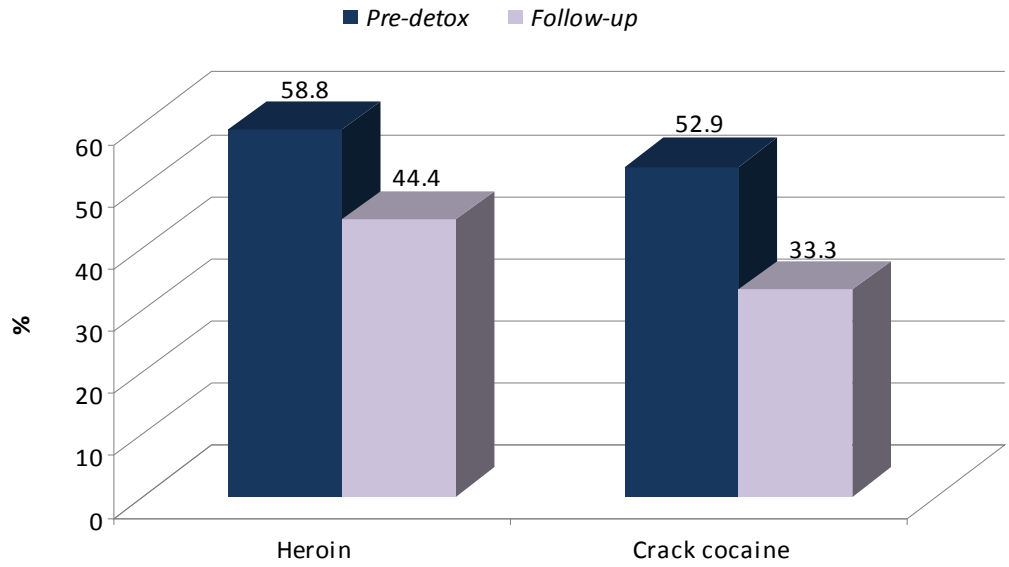


Figure 4 shows that a lower proportion of clients reported the use of heroin and crack cocaine in the previous month at *follow-up* than *pre-detox*.

The Fishers Test was used to examine the differences in drug use post-detoxification between those stabilised on methadone or Subutex® prior to engaging with the *1-2-1 Detox* and those using heroin. The analysis showed that there was no significant differences between the groups post-detoxification heroin use (χ^2=0.17, p<0.05) or crack cocaine use (χ^2=1.00, p<0.05).

Figure 5: Comparison of frequent[6] heroin and crack cocaine use in the month prior to engaging with *1-2-1 Detox* and since disengaging with *1-2-1 Detox*

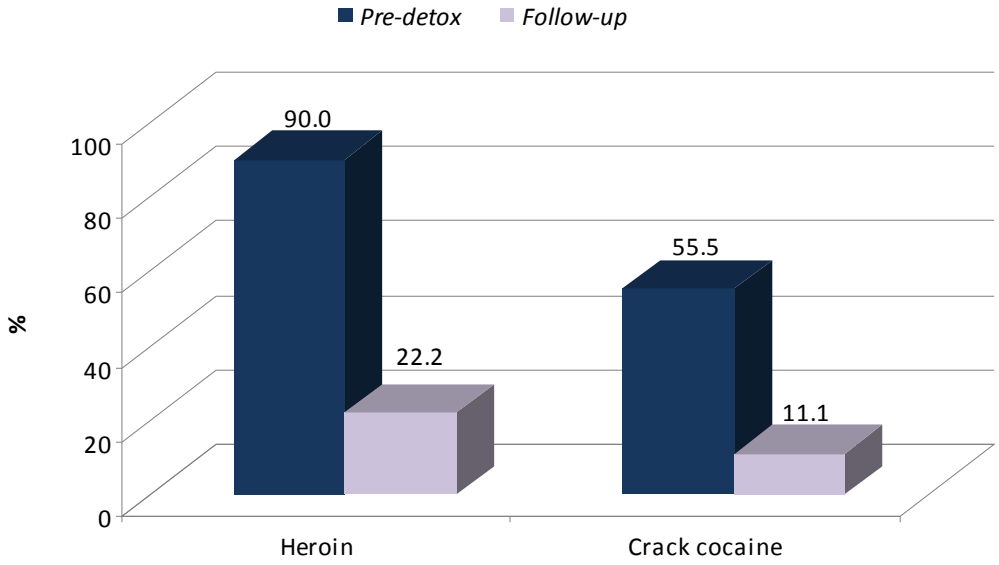


Figure 5 shows that there was considerable differences between the proportion of clients who reported frequent use of heroin and crack cocaine at *pre-detox* and at *follow-up*. There was a particular difference in frequent use of heroin with 22.2% reporting frequent heroin use at *follow-up* compared to 90.0% at *pre-detox*.

3.1.6 Injecting

Clients were asked about injecting in their lifetime and in the previous month. Clients who indicated that they had injected in their lifetime were also asked about sharing of injecting equipment and paraphernalia. In addition, at the *follow-up* interview data were collected on injecting and sharing behaviour since leaving the detoxification programme.

Pre-detox injecting and sharing

Three-quarters of clients reported injecting at least once in their lifetime (76.5%, n=13). The age of first injection ranged from 13 to 37 years. The length of time since client's last injection ranged from one week to 15 years. Three clients reported injecting in the previous month (17.6%). Arms and groin were reported as the place where clients usually injected, with the exception of one client who reported that they usually injected in their neck due to the collapse of veins elsewhere.

High levels of sharing of injecting equipment and paraphernalia were reported amongst clients (Table 5). Over half of clients reported sharing filters, water and spoons, indicating that clients were more likely to report sharing of paraphernalia than injecting equipment.

[6] 'Frequent' use refers to use more than twice a week.

Table 5: Self-reported lifetime sharing of injecting equipment and paraphernalia *pre-detox* (n=13)

Equipment/Paraphernalia	Reported sharing	
	%	n
Needle	30.8	4
Syringe	30.8	4
Filter	61.5	8
Water	69.2	9
Spoon	76.9	10

Notably, no sharing of injecting equipment or paraphernalia in the previous month was reported by the clients who had injected in the previous month.

Follow-up injecting and sharing

One client reported injecting in the time period since exiting the detoxification programme. The client further described that he had injected regularly for a few days during a lapse, and at the time of interview had not injected or used any illicit substances for three weeks. During this time the client reported that he had not shared any injecting equipment or paraphernalia.

3.1.7 Alcohol use

During both the *pre-detox* and *follow-up* interviews clients were asked about their alcohol consumption in the previous week. Although the detoxification programme was an opiate detoxification, alcohol use was not permitted during the detoxification and therefore questions on alcohol use were not included in the *post-detox* interview.

Pre-detox alcohol use

Approximately two-thirds of clients reported that they drank alcohol (64.7%, n=11) and 58.8% (n=10) reported drinking alcohol in the week prior to engagement with the detoxification programme. The majority of clients who reported alcohol use in the previous week were drinking sensibly (according to the Department of Health's (2005) guidelines) (70.0%, n=7). Two clients were drinking to hazardous levels (20.0%) and one to harmful levels (10.0%).

Two-fifths of clients who reported drinking in the week prior to interview indicated that their alcohol consumption in the previous week was more than usual (40.0%, n=4) and half of clients stated that it was the same as usual (50.0%, n=5). One client stated that their previous week alcohol consumption was less than usual (10.0%). Clients who indicated that their previous week alcohol consumption was more than usual were prompted for more information regarding why this was the case, a common theme of nervousness and anxiety about undergoing detoxification was recorded as a reason for the change in usual drinking habits.

Of those clients who reported that they drank alcohol (n=11), four had a CAGE score (Ewing, 1984) which was clinically significant indicating that they

were at risk of problem drinking and alcoholism (36.4%). Further information on the CAGE alcohol questionnaire can be found at Appendix 1.

Follow-up alcohol use

None of the clients who completed the *follow-up* interview reported alcohol use in the previous week.

3.1.8 Housing

At the *pre-detox* interview clients were asked about their current housing situation. Approximately half of clients had been living in their own home prior to engaging with the detoxification programme (52.9%, n=9). Six clients (35.3%) were living with family members, one client was living in supported hostel accommodation (5.9%) and another was '*sofa surfing*' (i.e. staying for short periods of time with family/friends and regularly moving accommodation) (5.9%).

The majority of clients indicated, at this stage, that they intended to return to their current living situation after detoxification. Two exceptions included one client who was moving into residential rehabilitation accommodation and the client who had been '*sofa surfing*' had arranged to stay with family.

At *follow-up*, two-thirds of clients interviewed were living in their own home (66.7%, n=6) and the remaining third were living with family (33.3%, n=3).

3.1.9 Clients' health

Clients were asked to rate their general health at the *pre-detox* and *follow-up* interviews. In addition to rating their general health, questions were also asked about specific illnesses and blood borne virus status.

Clients' health at *pre-detox*

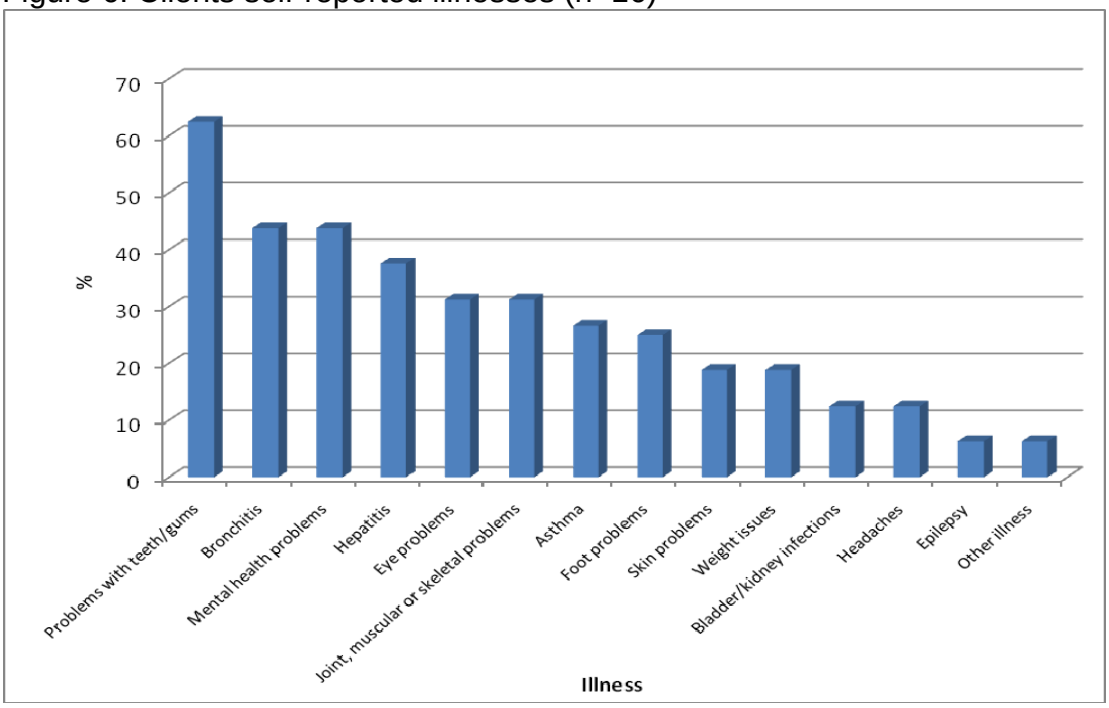
Six clients rated their health as bad (35.3%) and four rated their health as good (23.5%)[7]. The remaining clients rated their health as fair at this stage (41.2%, n=7).

When all episodes of engagement with the detoxification programme were considered, the proportion of clients who reported their health as bad was 35.0% (n=7) and one-quarter reported that their health was good (25.0%, n=5).

The analysis of illness questions presented below is based on each client's first occasion of engagement with the detoxification programme to prevent double counting of illnesses. One client refused to answer the illness questions, therefore the following analysis is based on 16 clients (Figure 6).

[7] Note that the bad category presented is a combination of responses of 'Bad and 'Very bad' and the good category is a combination of responses of 'Good and 'Very good'.

Figure 6: Clients self-reported illnesses (n=16)



Clients reported a variety of illnesses and health related issues. Figure 6 shows that the most commonly reported health problem at *pre-detox* was problems with teeth and gums (62.5%, n=10), followed by bronchitis (43.8%, n=7) and mental health problems (43.8%, n=7). Hepatitis was reported by more than one-third of clients (33.3%, n=6).

Clients were also asked at this stage if they were aware of their blood borne virus status. The vast majority (94.1%, n=16) were aware of their status for human immunodeficiency virus **(**HIV), hepatitis A and hepatitis B. A slightly lower proportion were aware of their hepatitis C status (88.2%, n=15). Clients who were aware of their blood borne virus status were invited to disclose it. Two clients who were aware of their status refused to disclose. Of those who did disclose all reported that they were HIV negative. One client disclosed that they were hepatitis A positive, two disclosed positive tests for hepatitis B and five for hepatitis C. Almost half of clients (47.1%, n=8) had been vaccinated for hepatitis B.

Clients' health at *follow-up*

Four clients who attended the *follow-up* interview rated their health as good (44.4%). One client rated their health as bad at this stage (11.1%). The Wilcoxon Test indicated that there were significant differences in clients assessment of their health between *pre-detox* and *follow-up* (z =-3.55, $p<0.01$). Examination of the client's responses indicated that there was a positive change in how clients rated their health between *pre-detox* and *follow-up*.

Few changes in health related illnesses were reported at the *follow-up* stage. However, one client reported that they had been diagnosed with hepatitis C since completing the detoxification programme. And one-third of clients (33.3%, n=3) stated that they had continuing mental health issues.

3.1.10 Post-detoxification challenges and support

At *pre-detox*, the majority of clients indicated that they intended to continue to engage with the structured day programme offered by Independence Initiative (II) once they completed their detoxification (94.1%, n=16). The one client who did not intend to stay engaged with the service was moving onto residential rehabilitation in another part of the country and therefore could not feasibly attend the structured day programme.

Clients who completed *follow-up* interviews were asked about their engagement with II after the detoxification programme. One-third of clients reported that they had attended the structured day programme or at the agency for one-to-one support since exiting the detoxification programme (33.3%, n=3). Reasons for non-engagement with II after detoxification included both positive and negative reasons. Positive reasons included a desire to '*go it alone*' after detoxification and lack of time due to commitments at other relapse prevention/aftercare agencies and with education and employment. Negative reasons included a lack of interest in the courses offered, feelings of isolation and de-motivation and embarrassment at lapsing/relapsing into drug use or continued Subutex® use.

3.1.11 Education and Employment

Education and employment status *pre-detox*

The majority of clients indicated at the *pre-detox* stage that they had no formal qualifications and had left school before the completion of their compulsory education (58.8%, n=10). Five clients had formal qualifications or training in the form of GCSE, NVQ or completed apprenticeship (29.4%). The remaining two clients held undergraduate degrees (11.8%, n=2).

Two clients were in employment at the time of the *pre-detox* interview (11.8%). One client stated that he had never been employed. All other clients had previously been employed and a range of previous jobs were stated including construction work, postman, care assistant, hotel porter, forklift truck driver and market trader.

Education and employment status at *follow-up*

At follow-up two clients reported that they were in paid employment (22.2%) and another was engaged in voluntary work (11.1%). One client was awaiting their start date at college (11.1%). Whilst the other clients who completed *follow-up* interviews were neither employed nor enrolled in an educational course at the time of interview, all clients indicated aspirations or intentions to work or attend college.

3.1.12 Drug withdrawal

At all three interview stages clients were presented with the Short Opiate Withdrawal Scale (SOWS) to measure drug withdrawal (Gossop, 1990). The SOWS assesses the severity of different conditions, experienced in the previous 24 hours, associated with opiate withdrawal on a four-point scale from *none* to *severe*. Further information on the SOWS can be found at Appendix 1.

Analysis of the client's categorised mean SOWS scores shows that at *follow-up* a larger proportion of clients had a mean score in the *mild* withdrawal symptoms compared to *pre-detox* and *post-detox* (Table 6). At *follow-up* none of the clients reported *severe* withdrawal symptoms. It is notable that the percentage of clients reporting *moderate* withdrawal symptoms increased between *pre-detox* and *post-detox*, and the proportion of clients who reported no drug withdrawal decreased.

This analysis is based on all episodes of engagement with the detoxification programme.

Table 6: Clients severity of drug withdrawal symptoms (n=20)

Interview stage	None		Mild		Moderate		Severe	
	%	n	%	n	%	n	%	n
Pre-detox	10.0	2	70.0	14	10.0	2	10.0	2
Post-detox	0.0	0	68.4	13	26.3	5	5.3	1
Follow-up	22.2	2	77.8	7	0.0	0	0.0	0

Due to the difference in the number of episodes of attendance at the detoxification programme and episodes where *follow-up* interviews were completed, the analysis of differences in the severity of drug withdrawal symptoms is presented as differences between *pre-detox* and *post-detox* and differences across all three interviews[8].

The Wilcoxon Signed Ranks Test indicated that there were significant differences in the severity of drug withdrawal between *pre-detox* and *post-detox* (Z =-4.28, p<0.01). The median of the severity of drug withdrawal score was higher at *post-detox* than *pre-detox* (0.7 and 0.8 respectively) indicating the significant difference relates to an increased severity of drug withdrawal symptoms amongst clients at *post-detox*. This difference may be explained by an onset of Subutex® withdrawal symptoms at low Subutex® dosages or after completing the detoxification programme as described by clients.

The Friedman Test indicated that there were significant differences in the severity of drug withdrawal experienced by clients across all three interview stages (χ^2=9.15, p<0.05). The median severity scores of the *pre-detox*, *post-detox* and *follow-up* interviews were 0.7, 0.8 and 0.2 respectively, therefore

[8] Clients scores for the drug withdrawal were not normally distributed and therefore non-parametric tests were employed ($D(48)$=0.16, p<0.05).

indicating that the significant difference across all three interviews related to a decrease in the severity of withdrawal symptoms experienced by clients.

These findings suggest that there is a significant increase in the client's experiences of withdrawal at the *post-detox* stage. This may be explained by the onset of Subutex® withdrawal symptoms or as a consequence of stabilisation or heroin use prior to engagement with the *1-2-1 Detox*. It is significant that the withdrawal symptoms do not persist approximately one month after disengagement from the detoxification programme.

3.1.13 Desires for drugs

Client's desires for drugs were measured at all stages using the Desires for Drugs Questionnaire (DDQ) (Franken, Hendriks & van den Brink, 2002). The DDQ contains three subscales measuring desire and intention, negative reinforcement and control.

The Wilcoxon Signed Ranks Test indicated that there were no significant differences between the clients mean scores on the desires and intention (z =-0.36, p>0.05), negative reinforcement (z =-1.56, p>0.05) and control (z =-1.14, p>0.05) subscales between *pre-detox* and *post-detox*.

Analysis of the differences in clients' desires for drug across all three interviews was undertaken using the Friedman Test. The findings indicated no significant differences between the clients mean scores on the desires and intention (χ^2=0.00, p>0.05), negative reinforcement (χ^2=2.17, p>0.05) and control (χ^2=0.86, p>0.05) subscales between all three interview stages.

The lack of significant differences in the clients' desires for drugs across the different interview stages may be attributed to a number of factors. The clients commitment to detoxification and wishes to become drug-free at the initial interview (*pre-detox*) may have contributed to a reduction in drug desire. Clients who were stabilised on methadone or Subutex® prior to engaging with the detoxification programme may have lower levels of desire for drugs than those who had been using heroin. Research suggests that changes in an individuals psychological and behavioural drug-related process take a considerably longer period to change after physical detoxification is complete, and therefore it is possible that the clients desires for drugs at this stage had not yet begun to change significantly.

3.1.14 Depression, anxiety and arousal

Clients level of depression, anxiety and arousal were measured at each interview stage (Fisk & Warr, 1996; Matthews, Jones & Chamberlain, 1990). Clients were presented with a list of adjectives and asked to identify the response which most described their current state from '*not at all*', to '*extremely*'. Mean scores for each subscale were calculated and further categorised as low or high. Low scores of depression and anxiety were favourable, whereas a high score of arousal was more favourable.

The percentage of client's episodes where high levels of depression was recorded at each interview stage is shown in Table 7 below. This analysis is based on all episodes of engagement with the detoxification programme. The proportion of client episodes with high levels of depression remained stable across the three interview stages. It is notable that the largest proportion of client episodes with high arousal levels was recorded at the *post-detox* stage.

Table 7: The proportion of episodes of engagement where high levels of depression, anxiety and arousal were recorded

Interview stage	Depression		Anxiety		Arousal	
	%	n	%	n	%	n
Pre-detox	20.0	4	40.0	8	60.0	12
Post-detox	21.1	4	26.3	5	78.9	15
Follow-up	22.2	2	22.2	2	55.6	5

*Unlike depression and anxiety, high levels of arousal are more favourable.

The Wilcoxon Signed Ranks Test indicated that there were significant differences in the clients scores for depression (Z =-5.44, p<0.01), anxiety (Z =-5.44, p<0.01) and arousal (Z =-5.44, p<0.01) between the *pre-detox* and *post-detox* interviews. Further investigation of the median scores on each subscale indicate clients had decreasing levels of depression (*pre-detox* median=13.5, *post-detox* median=12.0) and anxiety (*pre-detox* median=15.5, *post-detox* median=15.0). The clients level of arousal increased between the two interview stages (*pre-detox* median=19.5, *post-detox* median=24.0).

The Friedman Test indicated that there were no significant differences in clients scores across all three interviews on the depression scale (χ^2=0.65, p>0.05), anxiety scale (χ^2=0.17, p>0.05) or arousal scale (χ^2=0.67, p>0.05).

The lack of significant differences in the clients reported levels of depression, anxiety and arousal at *follow-up* suggests that the positive changes made during engagement with the *1-2-1 Detox* did not persist when clients re-engaged in their communities.

3.1.15 Client's ratings of the detoxification programme at post-detox

Clients were asked to rate how satisfied they were with a variety of aspects of the detoxification programme during the *post-detox* interview. Clients were presented with a Likert scale ranging from 1 'very dissatisfied' to 5 'very satisfied' on which to provide their response. At this stage of the interview process the majority of clients praised the detoxification programme and this is evidenced through the positive ratings as shown in Figure 7 below. Notably all clients rated each aspect of the detoxification programme at 3 or above on the Likert scale.

Figure 7 below illustrates the proportion of clients who were satisfied[9] with each aspect of the detoxification programme only. This analysis is based on

[9] The 'satisfied' category is a combination of clients who stated they were 'satisfied' or 'very satisfied'.

the 19 *post-detox* interviews which included two clients who had two episodes of engagement with the *1-2-1 Detox*.

Figure 7: The proportion of clients who were satisfied with each aspect of the detoxification programme.

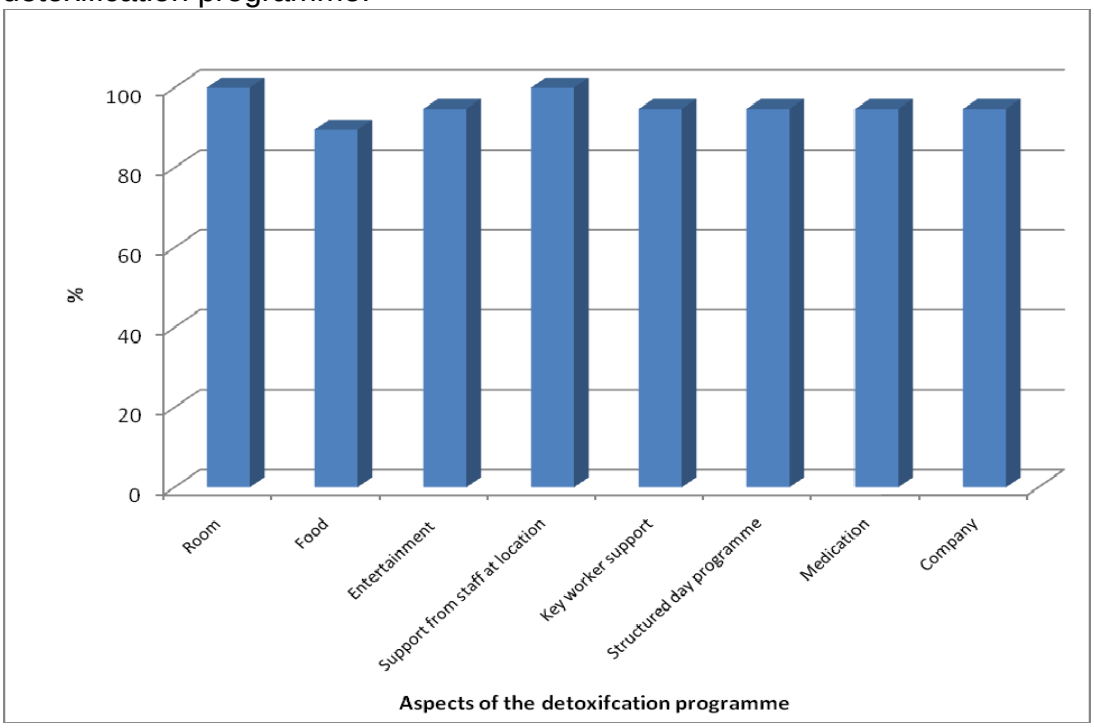


Figure 7 above clearly illustrates the high level of satisfaction amongst clients regarding the different aspects of the detoxification programme. Specifically, in all episodes of engagement 100% of clients reported that they were satisfied with their room and the support from staff at the detoxification programme. The aspect of the detoxification programme which received the lowest satisfaction rating was the food, in which 89.5% of episodes clients reported satisfaction.

3.2 View and experiences of clients: qualitative findings

To gain further information on client's motivations for undertaking the detoxification programme and to track the client's views and opinions regarding the detoxification programme, each structured interview included a number of time-relevant open ended questions. These questions were also used to assess changes in client's attitudes and behaviour during the detoxification process which were not addressed by the quantitative measures. The clients' responses to open ended questions in all interviews (i.e. for all episodes of engagement with the detoxification programme) are included in this section.

Qualitative analysis of the structured-interview questions led to the identification of eight themes: reasons for accessing the detoxification programme; pre-detoxification expectations and aspirations; opinions

regarding the one-to-one model; the service received; differences to other models of detoxification previously experienced; the detoxification environment; post-detoxification outcomes and client's assessment of the detoxification programme.

3.2.1 Reasons for accessing the detoxification programme

Clients were asked to explain their motivations for undertaking the detoxification programme at II, as opposed to undergoing detoxification in the community or at an inpatient or residential rehabilitation treatment agency. A variety of responses were provided including that the detoxification was convenient, no other choice was given, the one-to-one model was appealing and the clients had previous contact with II.

Convenience

Seven clients made reference to the convenience of access to the detoxification programme. For two clients the location was the most convenient factor associated with the detoxification as it was close to their homes and easily accessed by family and partners. It should be noted that this finding is influenced by the Sefton DAT catchment area for the pilot programme.

> *"It is local to where I live".*

> *"It is local to me and easy for my family to come in".*

The convenience of quick access to a detoxification was reported by five clients. Clients indicated that when they presented at LHP they were offered a place on the detoxification programme and took it without too much consideration for alternative options.

> *"Because it was offered".*

> *"Everything has got on top of me this week. I was kidding myself so I went to Lighthouse Project yesterday and they said that I could come here the next day. So mostly because it was convenient".*

No other choice

Two clients indicated that they were not given any other detoxification options by the referral agency. In one case, the client was happy to trust the judgement of his doctor at LHP and the other accepted his placement at the detoxification programme as an essential part of proving his commitment to treatment prior to being funded for residential rehabilitation.

> *"I wasn't offered any other options. I trust the judgement of the doctor who referred me here. I think it is a good idea after I failed to complete detox at home twice before".*

“I didn't have an option, Lighthouse Project sent me here to prove my commitment to change before they will fund me for residential rehabilitation”.

The one-to-one model

The most common reason for engaging with the detoxification programme was the model of one-to-one support. Ten clients indicated that the one-to-one model and the lack of interaction with other people undertaking detoxification was the biggest contributing factor to their reason for engagement with the detoxification programme.

“I didn't want to be in an environment with other addicts”.

“I am easily influenced by other people so I thought this type of detox might be better for me”.

“Past experience of residential detox in a group setting have taught me that despite a spectrum of commitment, drive to succeed etc. it is often the negatively orientated who dominate...This detox focuses on the most important thing, from my perspective, me. There are no distractions, temptations or other people’s issues. It is truly client centred whereas, by their nature other units need to be community centred i.e. the common good of the group”.

“I thought 121 would be the best way”.

Additionally, two clients reported negative comments about their experience of group-based specialised detoxification. Client’s previous experience of this model of opiate detoxification was negative and reinforced their desire to undergo detoxification in an alternative setting.

“I didn't want to go to the [name of another detoxification service] as there would be too much peer pressure”.

“The [name of another detoxification service] is like a conveyor belt”.

Previous contact with Independence Initiative

Any previous contact that clients had with II was described as a positive factor in their decision to undertake the detoxification programme with the agency.

“Because I know the people here (Independence Initiative)”.

“Because I have dealt with Independence Initiative before and have already had experience with this project”.

"I know people who work here (at Independence Initiative) who have recovered from drug use, this makes me motivated".

These findings suggest a variety of motivations for engaging with the *1-2-1 Detox*. The majority of clients based their decision to attend the detoxification programme on the unique detoxification model offered. Clients were aware of the effect that other drug users could have on their own willpower and determination to successfully complete detoxification, and chose the *1-2-1 Detox* to protect them from negative influences.

3.2.2 Pre-detoxification expectations and aspirations

Clients were asked during the first interview (*pre-detox*) to describe their expectations of the detoxification programme. In addition to responses relating to the actual process of the detoxification, many clients described what they expected to achieve personally and their aspirations for the future.

Expectations

Clients had numerous expectations about the detoxification programme which generally related to the rules and regulations of the programme. Personal responsibility for their recovery and withdrawal medication was mentioned by eight clients. Generally clients indicated that they were happy to be in control if this aspect of their detoxification.

"I expect to be encouraged to be responsible for my own recovery & medication".

"The self-control of medication is ok".

"I expect to be supplied with the right amount of medication and have a gradual withdrawal".

In addition, clients made reference to their expectation to become involved with the structured day programme and that it would provide entertainment or diversionary activities.

"Things to do during the day which will ensure I'm not bored and I have no excuse to use".

"To be given opportunities to be kept occupied".

Aspirations

Clients made reference to their personal aspirations at the early stage of the detoxification programme. Two clients mentioned a desire to obtain 'normality' in their lives.

"I want to get as much knowledge and normality back into my life".

"I want to get normality back in my life".

Clients also made reference to their aspirations to obtain a drug-free status.

> *"Here I can deal with the practicalities of cleansing my body of drugs, rest, recuperate and prepare for the real test i.e. living drug-free".*
>
> *"I want to become drug-free".*

One client discussed their future hopes at this stage and described their hope to volunteer with II after completing the detoxification programme.

> *"I would like to give something back as a volunteer in the future".*

Upon initial attendance at the *1-2-1 Detox* all clients were given instruction about the rules, procedures and their role in the detoxification programme during an induction. When asked at *pre-detox* about their expectations of the detoxification programme, many made reference to their responsibility for medication and the option to engage with the structured day programme. However, a number of clients expressed their future aspirations as expectations suggesting a level of positivism amongst clients at this early stage.

3.2.3 Opinions regarding the one-to-one model

Clients expressed both positive and negative opinions about the one-to-one model of detoxification and the rule that they were prohibited from interaction with the other clients (both in the structured day programme and the detoxification programme).

Seven clients discussed that the one-to-one model had ensured that they were not subject to the influence of other drug users or individuals undergoing treatment.

> *"I didn't want to be in an environment with other addicts...there were no outside influences here".*
>
> *"I liked the one-to-one element...there is nothing like that in (name of other detoxification agency). There is only one TV between 16 people in the (name of other detoxification agency) and there is too many people in there. I have never had a detox experience like I had in here. I have walked out of other detoxifications time and time again due to other people. The one-to-one worked".*
>
> *"I didn't want to go to the (name of other detoxification agency) as there would be too much peer pressure...The one-to-one model takes away the peer pressure".*

In addition, clients stated that the one-to-one model allowed them the opportunity to concentrate on themselves and their recovery without distraction.

> *"I am easily influenced by other people so I thought this type of detox might be better for me. During home detoxifications I was very stressed out due to the presence of my children. The one-to-one (detoxification programme) was well better because there were no distractions".*

> *"This detox focuses on the most important thing, from my perspective, me! There are no distractions, temptations or other people issues".*

> *"I also wanted to come here because it is your own detox i.e. your own space, staff and responsibility for medication".*

Whilst many of the clients felt that the one-to-one model was a positive aspect of the detoxification programme, four clients made negative comments about the model. Specifically, these clients felt that contact with the other detoxification programme resident could provide additional support beneficial and one client felt that ignoring the presence of the other person was difficult.

> *"I don't see how we could pressure each other. I think it would be nice to talk to someone else who is going through the same thing".*

> *"If your sensible enough you should be able to talk to the other person with a member of staff there".*

> *"It is difficult to ignore the fact that someone is living next door to you. I felt rude".*

One client indicated that they were not aware of the one-to-one model when they agreed to undergo the detoxification.

> *"I didn't think it would be like this. I thought there would be two of us together, but we weren't allowed to communicate. The staff are very strict on that. I would have preferred to have had more contact with the other person. It wasn't fully explained to me about the one-to-one".*

The majority of clients felt that the rule prohibiting contact with other clients was beneficial and easy to abide by, and provided a rare opportunity for them to fully focus on themselves, their needs and their recovery. However, a number of clients explained that whilst they understood the rule, there were times during the detoxification programme where they would have appreciated the contact with and support from the other client.

3.2.4 The service received

Clients discussed many aspects of the service that they received whilst undertaking the detoxification programme. Clients explained how the service that they received fitted with their expectations and praised the flexibility and informality of the *1-2-1 Detox*.

Service received

Clients explained that whilst resident in the detoxification programme they received a service which was personal, supportive and tailored to their individual needs and wants.

> *"I can't think of anything that I wanted that I didn't get".*
>
> *"You aren't made to feel that you are getting in the way. You don't have to ask for anything".*
>
> *"I have been motivated, given direction and support".*

The support and one-to-one time with staff was discussed by clients as an aspect of the service which was very positive and added to their overall comfort whilst undergoing the detoxification programme.

> *"Staff are going out of their way to offer support to me".*
>
> *"The staff give more time to you".*
>
> *"There are a lot more staff time for you and they sort out problems immediately".*

More specifically, the informal, personal and friendly manner in which the staff operated was praised by the clients. Clients indicated that they felt that the staff were genuine and had a vested interest in their recovery.

> *"The staff are very professional but not impersonal. They are all very approachable".*
>
> *"The staff are lovely, you can tell that they enjoy their job. You can tell that they are not just here for the money".*
>
> *"Staff are professional, informal, loving and caring".*

The structured day programme was discussed by clients as part of the service they received from II. Clients indicated that the structured day programme was useful for relieving boredom and providing distractions. The different day activities were utilised by clients for different reasons i.e. some use the massage and aromatherapy to relax, English and IT was used to enhance their skills and access to education or employment after completing

detoxification, and music and fitness sessions were used to relieve stress and boredom.

> *"It's good, been doing guitar lessons to fill time and going to the gym".*

> *"I think that the day programme helps to occupy the day as when you are bored during detox is when your mind starts to wander and think about drugs".*

> *"Brilliant, I have been doing music lessons, cookery, IT, maths and English. It keeps me occupied. This weekend I am going into Liverpool City centre".*

In addition to positive comments about the structured day programme, clients also explained that an important part of engagement with the structured day programme, from their perspective, was that it was optional. After initially settling into their room and the detoxification programme, each client was provided with detail about the structured day programme, however many clients chose not to participate immediately until they first got used to their new environment and settled into the dose-reduction detoxification regime.

> *"I think it is good that I have a few days to chill out first and get used to my surroundings".*

> *"I didn't always have to take part in lessons if I didn't want to. In here it is down to yourself and what you want to do".*

How service met expectations

In general, clients indicated that the service that they received at the *1-2-1 Detox* was much better than they had expected. Clients further explained that the level of comfort and support, and the respect with which they were treated was better than anything they had previously experienced. Additionally, the welcome that their families and partners were given was praised.

> *"I was blown away with it all. I couldn't believe that I could just come off the street and be treated like a normal person. I was really made to feel at home".*

> *"The experience was better than my expectations. I expected it to be more like a private hospital room but it was more like a welcoming hotel".*

> *"My partner came in and she was very relaxed and contented here. She was treated with respect".*

The findings suggest that clients had a very positive experience at the detoxification programme. Clients felt that the II staff went out of their way to offer comfort, support, advice, motivation and to provide anything that they

requested. The activities provided through the structured day programme and during evenings/weekends were praised by clients as useful, motivational and diversionary.

3.2.5 Differences to other models of detoxification previously experienced

Clients were asked to describe how the detoxification programme at II differed from other types of detoxification that they had experienced previously. Clients discussed how, compared with other detoxification experiences, they felt protected at II and that there was a relaxed, non-regimented atmosphere. Furthermore, five clients explained that they had more choice and control at the detoxification programme compared to others and that this was beneficial in their recovery process and contributed to their desire to complete the programme.

Clients indicated that, compared to other models of detoxification, at II they felt protected, supported and less vulnerable to outside influences.

> *"I felt more protected here than when doing a home detox. There were no outside influences".*
>
> *"It took away the temptation (to use drugs) by being here. I didn't have to rely on my own willpower as much because I was supported".*
>
> *"During home detox's I was very stressed out due to the presence of my children. The one to one was well better because there were no distractions".*

In comparison to other models of detoxification, clients felt that the programme at II was less regimented and more focussed on a relaxed, homely environment.

> *"It is less regimented here".*
>
> *"It is a much more relaxed environment at Independence Initiative compared with other inpatient detox's. There are less stringent rules and I felt like I was at home".*
>
> *"I didn't have to stick to a strict regime in here. I didn't have to take part in group discussions or confrontations, which is not always the best place to get things off your chest. Here I could do things in my own time".*

One client felt that a significant difference of the service he received at II was the wraparound care, and the focus on other aspects of his life other than simply physical withdrawal.

> *"This [detoxification programme] has opened doors to education and other things in respect of my addiction. I have been motivated, given direction and support. Being around people has been good. I have built my confidence. I feel more comfortable in the one-to-one day programme too, compared to just coming in from the outside. There are no barriers for me now".*

The level of choice about their own care and how they structured their days in the detoxification programme was praised by clients.

> *"I could lie down when I want and just go off on my own without having to explain why".*

> *"I think it was good as you need free reign when your body clock is messed up".*

> *"I had the option to do what I wanted to do. I could eat when I wanted".*

Additionally, the choice to engage with the structured day programme or not was considered by clients as a difference to other models of detoxification, where structured day programmes and group therapy sessions are often compulsory.

> *"I thought that there would be more pressure to take part (in day programme) but there wasn't".*

> *"I expected it to be much more strict and that things would be pushed on to me. It hasn't been like that at all. Things have been at my own pace".*

Clients described considerable differences between the *1-2-1 Detox* and other, previously experienced, models of detoxification. Clients described feeling less stressed and more protected at the detoxification programme compared to community detoxification. The relaxed and informal atmosphere was praised as very different to '*regimented*' inpatient detoxification.

3.2.6 The detoxification environment

The physical environment and the atmosphere of the detoxification programme were described by clients as a positive aspect of their detoxification experience. Specifically, clients described their room as much more homely and comfortable than they had expected and praised the standard of the food provided.

> *"I expected it to be more like a private hospital room but it was more like a welcoming hotel".*

> *"The room is like a hotel".*

"I was pleasantly surprised the whole place, my room is comfortable and the food is good".

"The actual rooms are light, airy and very comfortable. Everything I need is available and close to hand".

However, some clients made reference to negative aspects of the detoxification programme environment. Issues raised by clients included the disruption caused by the buzzers which sound when a bedroom door is opened.

"The buzzers are very loud and are particularly annoying at night, when your already struggling to sleep you hear a pin drop and they are very disruptive".

The majority of the clients who attended the detoxification programme smoked tobacco and many made reference to the fact that they were prohibited from smoking in their room. This rule was considered as a nuisance, particularly for those who were engaged with the detoxification programme during the winter months.

"Its hassle having a cigarette outside".

"It's a pain that you can't smoke in rooms".

Additionally, one client mentioned that ensuring they were smoking at different times to the other detoxification resident was an annoyance.

"Taking smoke breaks separately can be difficult".

Whilst many clients felt that the structured day programme and evening and weekend activities were plentiful, as one client stated: *"the entertainment and day programme have kept me active and busy"*. However, this was not the view shared by all clients. Two clients explained that they felt that additional methods of entertainment, particularly for the evenings and weekends, would be beneficial.

"More evening activities needed, like arts & crafts".

"I wasn't able to play x-box live as no internet connection in room. The weekends are a drag, it's a bit like being in prison at the weekend, except there is less happening. A better book & dvd library would be good".

Clients expressed high levels of satisfaction with their rooms at the *1-2-1 Detox*. However, clients indicated that prohibition of smoking in their rooms was an annoyance and ensuring that they took separate smoke breaks to the other clients was sometimes difficult. Additionally, a number of clients indicated that the availability of additional activities, particularly in the evenings and weekends, would have further been advantageous.

3.2.7 Post-detoxification outcomes

This section is based on responses from clients at the *post-detox* interview (n=17) and *follow-up* interview (n=9) where clients were asked about their feelings since completing the detoxification programme, the changes that had been made to their lives and their future plans.

Challenges post-detoxification

When asked to describe their post-detoxification challenges, the majority (n=9) of clients discussed difficulties that they had faced since completing the detoxification programme. Clients stated that contact with other drug users now that they have returned to their own home was a challenge and in some cases had even led to lapse into drug use.

> *"It is difficult living in the same area as when I was using drugs. I don't like being around old drug using acquaintances and it is frustrating when I see drug dealers".*
>
> *"When I left the detox, the accommodation that I was promised wasn't available. For a while I stayed with someone on prescribed morphine, that was a challenge as it made me crave the methadone".*
>
> *"Socialising with old acquaintances, it was with them that I smoked crack".*

One client described how their cannabis use was a barrier to accessing Narcotics Anonymous and the further support that he desired, he stated that: *"NA [Narcotics Anonymous], they want complete abstinence, but I can't give them that"*.

Four clients mentioned that motivation and boredom was an issue for them post-detoxification. An issue that was further confounded by mental health issues, particularly depression, in a number of clients. Notably, clients had different ways of responding to their lack of motivation and boredom, with some seeking diversionary activities to tackle the issues.

> *"Motivation has been a challenge. I have just signed on to the SPIDER programme (relapse prevention programme) to get involved in outdoor activities".*
>
> *"I am bored, but I am on the list for a work programme with Lighthouse Project".*
>
> *"Independence Initiative has helped with the challenge of boredom because it fills up my week".*

Whereas other clients substituted opiate use with other drugs and were very isolated and de-motivated.

> *"I am struggling with normality and smoking a lot of cannabis because I am home alone all day. It's hard when you have had 25 years of blocking out the pain of life".*

Positive changes in life post-detoxification

Although challenges were described by clients regarding their lives since completing the detoxification programme, many clients also made reference to the positive changes in their drug use, self-confidence, self-esteem and ability to re-integrate into society.

Two clients described how their outlook on life had changed since completing the detoxification.

> *"This experience has changed everything. The way I feel, the way I think. I am much happier than I have ever been in 25 years. I have never had a detox experience like I had in here. I have walked out of other detox's time and time again due to other people. The one-to-one worked".*

> *"I am made up I was talked into doing this. I feel like a different person altogether".*

One client explained that he had positive feelings towards the detoxification programme, which was not something that he would have previously associated with detoxification services.

> *"Independence Initiative one-to-one is a little gem of a project. I feel that it should continue, whereas I am all for objective evaluation, I came away from the unit feeling better for the experience and that I was better off for the experience too. I have positive and fond memories which for a problematic drug user to feel towards a detox is a rare thing indeed"*.

Another client felt that the detoxification programme had saved his life, he stated: *"I was suicidal when I came in here and [name of staff member]) got me another chance"*.

Four clients described how the detoxification programme had changed their drug use, not only opiate use, but also use of other drugs was mentioned.

> *"The one-to-one has taken me out of the daily grind of heroin and crack cocaine user lifestyle. I now feel that I have choices again and that can be anything as mundane as waking up at 8.40am and deciding to lie there for another half an hour. In a far wider stakes I can get up and go when I want, there is no chemical ball and chain around my ankle".*

> *“I feel like I'm me before I started using. Sometimes I think ‘how is this possible?’, but then I just do it (remain drug-free)”.*
>
> *“It has changed my life for the better because it gave me the space to get drug-free”.*
>
> *“I don't use benzos [benzodiazepines] on a large quantity or a daily basis anymore. I also don't use any sleeping tablets”.*

Post-detoxification plans

Clients were asked about their plans and priorities post-detoxification. A number of common themes emerged in client’s plans including addressing health issues, sourcing appropriate and long-term accommodation, and gaining employment or educational qualifications.

A number of health issues were mentioned by clients in their future plans, including a desire to get fitter, engage with treatment for hepatitis and seek dental treatment.

> *“In the short term I want to get motivated and get more active with running and going to the gym”.*
>
> *“I want to get my treatment for hep C sorted”.*
>
> *“My teeth are a big issue, I want to get treatment to have them fixed”.*

Two clients also made reference to their desire to remain drug-free and were engaging in initiatives to support them to retain this status.

> *“I want further stability regarding my drug use and to stay drug-free. I am trying to get enrolled with the SPIDER (relapse prevention programme) project”.*
>
> *“I want to complete the SHARP programme (12-step relapse prevention programme) to ensure I get support through the next few weeks and stay off the drugs”.*

Accommodation was a future priority of two clients, and one stated: “*I also want to get settled in my own accommodation*”.

Seven clients indicated that employment or education was part of their future plans. Whereas three clients simply indicated that they wanted some paid employment, and one stated: *“I want a career”*. Three clients had a desire to work or volunteer in the area of supporting people with drug or alcohol problems.

"I would like to come back to Independence Initiative detox when it expands and work as a volunteer. I would like to give a little bit back".

"I need to stay drug-free for 6 months then I can apply to Armistead (a project which works with street sex workers) as a volunteer, that's my goal currently".

"I would like to get some work or do some volunteering in a drug agency".

One client wanted to attend college or volunteer for an environmental cause.

"I would also like to attend college or do some volunteer work. I would like to do something to help the environment".

These findings indicate that post-detoxification clients encountered factors which have been identified as contributing to relapse into drug use, including; other drug users, use of other substances, de-motivation and boredom. However, many clients had experienced positive changes since completing the detoxification programme and had renewed confidence and enthusiasm. Clients also had a greater interest in their health and reducing their use of other substances. There was a desire amongst clients to work in the drug treatment field indicating that clients appreciated that sharing their experiences could help others.

3.2.8 Client's assessment of the detoxification programme

Clients were asked their views about the detoxification programme, specifically they were invited to identify the strengths and weaknesses of the programme and make suggestions for improvements.

Strengths of the detoxification programme

When describing strengths clients made reference to themes that have been previously discussed including the level of choice and freedom provided by the detoxification programme and the time and support provided by staff as a result of the one-to-one model. However, a number of additional strengths were discussed including the lack of peer pressure from others undergoing detoxification and the client's obligation to take responsibility for their own detoxification. The delivery of a whole package of support in one place and feelings of protection were also referred to by clients.

Clients indicated that the removal of peer pressure from others undertaking detoxification as a result of the one-to-one model and the rule prohibiting contact with others was a strength of the detoxification programme.

"The individual basis puts you in a position where the only person you can let down is yourself. You can't give yourself that alibi unless you've got someone to provide it".

> *"The one-to-one element. I liked having my own space and not feeling that I had to compete with anyone else or be influenced by them".*

The majority of clients indicated that responsibility for their own medication during the detoxification programme was a positive step for them, and was a step towards responsibility of their own lives.

> *"I liked being entrusted with my own medication and money".*

> *"Taking responsibility for my medication was important to me. It made me feel more like I was in control and like real life".*

> *"I felt like I was in control with things like my medication".*

The availability of a variety of activities at the structured day programme, and the willingness of the staff to fulfil client's requests was described by clients as a strength of the detoxification programme.

> *"The staff give more time to you. The day programmes were great. I can't think of anything that I wanted that I didn't get".*

> *"The support, environment, diversionary activities. If they haven't got something here which you want they will find it for you".*

> *"Three saunas a week, you don't get that at the Priory".*

Feelings of protection and comfort in the detoxification environment were also explained as a strength by clients.

> *"It was good being able to speak freely without being judged".*

> *"You aren't made to feel that you are getting in the way. You don't have to ask for anything".*

> *"I have felt very protected from outside influences in here".*

Weaknesses of the detoxification programme

Clients discussed a variety of perceived weaknesses, however, unlike the strengths, there was less consistency in responses. Two clients made reference to the noise from building work which took place whilst they were engaged with the detoxification programme. However, these clients recognised that there were limitations on what could be done to minimise building noise, and one stated: *"The workmen were here and were very noisy, but there is nothing that anyone really could have done about that*".

Another weaknesses described by clients related to the rules regarding tobacco smoking (n=2), and one stated: "*It's hassle having a cigarette outside*".

One client felt that the lack of a resident clinical staff member was a weakness when there were clinical issues as it could take several hours for a response to clinical issues.

> *"The only negative thing is that there is no doctor or nurse, because when you have a problem they have to contact Lighthouse Project and they [1-2-1 Detox staff] have to contact the doctor".*

Another client felt that the detoxification programme should have been more lengthy to take account of time required to stabilise after completing the Subutex® detoxification plan.

> *"The detox could have been longer as I didn't expect the cold turkey feelings when I left. Maybe I should have been told to expect the symptoms after using the subutex".*

Suggestions for improvements to the detoxification programme

Many of the clients' suggestions for improvements to the detoxification programme followed directly from the described weaknesses.

One client stated that he would like to be able to smoke indoors, and stated: "*A safe smoking area which is not outdoors is needed*".

Four clients made reference to improving the availability of activities onsite, particularly for the evenings and weekends when the structured day programme was unavailable. Availability of equipment to keep fit and physically exert themselves on site at the *1-2-1 Detox* was suggested by two clients. More access to multimedia or gaming equipment was also suggested.

> *"A punch bag or some type of equipment where I could use up my energy in the evenings would be good. Also, they need to get proper sky TV with the football".*

> *"Gym and punch bag".*

> *"Internet in the rooms and access to a DVD library".*

An extension of the detoxification programme was suggested by two clients as a way to improve the service.

> *"A few days extra to stay after finishing the detox".*

> *"My only suggestion is if you could stay longer it would be good, maybe for about 3 months".*

One client explained that a resident clinician would improve the detoxification programme and access to other medications, he stated: "*A nurse on site who had direct contact with a doctor 24 hours would be better or a nurse practitioner who can prescribe medication on site. You can't even get a headache tablet*".

These findings suggest that clients viewed the aspects of the detoxification programme that they most liked or got most out of as the programme strengths, i.e. choice, freedom and one-to-one support. Significantly, one of the main aims of the *1-2-1 Detox*, the removal of peer pressure and others influence, was cited as a strength of the detoxification programme. Clients' suggested improvements for the *1-2-1 Detox* which included an inside smoking area, additional entertainment activities and exercise equipment and round-the- clock medical support.

3.3 Findings from staff focus group

A focus group with members of II and LHP staff was conducted approximately four months after the first client was admitted to *1-2-1 Detox* to obtain information on the initial implementation of the programme. Six members of staff from II attended and represented management, key workers and night staff. Three members of LHP staff attended and represented clinical management and key workers.

The findings from the focus group are presented as themes below. As this session was conducted at an early stage of the pilot, where appropriate author observations regarding changes made during the remaining months of the pilot have been added in blue text to ensure the findings discussed here are placed in context of evaluation of the complete pilot programme.

3.3.1 Issues raised and how they have been resolved

The staff indicated that the pilot *1-2-1 Detox* had been a steep learning curve for both agencies. However, it was noted that as issues arose during the *1-2-1 Detox* they were dealt with in partnership with clients and the two agencies. Further details regarding challenges faced during the pilot which were discussed during the focus group are detailed below.

Referral to *1-2-1 Detox*

It was noted by staff that the referral process was not always as fluid as it should have been during the pilot. At the initial set-up of *1-2-1 Detox* staff accepted clients based on the perception of operating within an open and flexible criteria assessed on an individual client basis. However, after four months, it was recognised that some clients had been referred into the *1-2-1 Detox* whose mental health issues were more acute than considered manageable in a non-clinical environment. This issue was quickly acknowledged by both II and LHP and meetings held to discuss and resolve this particular issue.

It was further noted that the open and flexible criteria had allowed clients, who under stricter criteria may have been excluded from the *1-2-1 Detox*, to attend, successfully complete and flourish post-detoxification.

After the focus group II and LHP developed and put into place more robust referral protocols, and an agreed robust admission criteria was developed in conjunction with Sefton DAT. The agreed referral procedure is illustrated by Figure 1 and the criteria for admission are detailed in the introduction.

Family visits

II staff indicated that initially they were '*naïve*' regarding family visits and they found that families could not only be supportive, but could also cause *'chaos'* with a client's detoxification progress. In order to ensure control in relation to family visits the visiting arrangements were streamlined to certain hours (2-4pm on weekdays) and no weekend visits. However, if a client was considered vulnerable and at risk of leaving the detoxification, family or partner visits were allowed outside the normal times if it was deemed that the family or partner could be useful in convincing the client to remain at the *1-2-1 Detox*. The decision to allow family or partner visits outside normal visiting hours was made in consultation between II staff and the client. II staff reported that limiting the family contact actually '*relieved the pressure*' on clients in some cases as it allowed them to focus on their own needs, to take charge of the situation and progress through their detoxification.

A further issue that became apparent during family visits and discussed at the focus group was in relation to family members and partners who were under the influence of alcohol or drugs during visits. It was noted by the staff that this situation was stressful for the clients, could cause problems and was unsuitable in the safe detoxification environment. In order to resolve this issue both client and family members/partner were consulted by II staff and made aware that if they continued to attend visiting sessions under the influence they would be asked to leave.

Additional work loads

Staff from both agencies acknowledged that the pilot *1-2-1 Detox* had increased their workloads. This was particularly relevant in relation to challenging clients. However, all staff indicated that they felt they had managed this increase well and refined specific roles and responsibilities as the pilot had progressed.

The additional workload continued to be an issue throughout the pilot programme. However, the working partnership between II and LHP continued to be established and strengthened throughout the pilot and resulted in an effective partnership. The monthly steering group meetings were a valuable tool for regular and open communication between the two agencies ensuring consistent delivery of services to clients, and an appropriate distribution of tasks.

Professional boundaries

Staff representing II reported that they had faced new issues in relation professional and personal boundaries with clients living on site. At the early stage of the *1-2-1 Detox* these boundaries were set, yet staff acknowledged that there was a continuous learning process throughout the pilot in relation to these issues. Specific examples given at the focus group related to clients in their nightwear, clients privacy in their room and inappropriate clothing that clients wore (e.g. t-shirts referring to drugs or alcohol) and how to address the issue sensitively.

At the outset of engagement with the *1-2-1 Detox* all clients were given a brief of the programme rules and appropriate behaviour whilst engaged with the *1-2-1 Detox*. Interviews with clients and discussions with staff indicated that clients easily accepted these rules when they were clearly and openly presented. All staff were trained to sensitively address any issues of this nature.

Night time

It was acknowledged by II staff that night time brought a new set of issues for clients and the night time staff. Sleep deprivation and insomnia was an issue that most clients experienced. It was recognised by staff that in some cases clients may be having issues sleeping because of their expectation of what they should go through during a detoxification or because they were having trouble re-adjusting to normal sensations of discomfort. It was recognised by staff that it would be useful prior to detoxification to ask clients about their sleeping patterns and how they would deal with sleep deprivation or insomnia in order to pre-empt any potential problems during the detoxification and have pre-discussed solutions available.

After the focus group, information on clients sleeping patterns and strategies of coping with sleep deprivation were included as part of the LHP assessment. This information was shared with II and when clients presented with sleeping issues they were reminded of the strategies discussed at assessment and advised to implement them. Additionally, when clients were experiencing sleep deprivation they were given opportunities to meet with the LHP doctor to discuss these issues and receive appropriate medication if desired.

3.3.2 Strengths of 1-2-1 Detox

When asked about the strengths of the *1-2-1 Detox*, the staff highlighted a variety of positive aspects.

The one-to-one model was praised by the staff for its facilitation of individualised care packages that were flexible and tailored to suit the client's needs. The high level of focus on each client also allowed issues to be identified and resolved quickly. In addition, the flexibility of the detoxification enhanced the client's opportunities to interact with other agencies as the II staff kept track of internal and external appointments with the client's own

pharmacist, GP and optician. The opportunity to address additional health needs of clients during the detoxification was something that the staff felt they '*could never have foreseen*' but was positive and added to the overall effectiveness of the detoxification. It was recognised that client's proximity in their own local area enhanced this particular aspect of their progress and the positive contact with clients own health professionals was considered as an aspect of the detoxification that would have a lasting effect on the client. Staff stated that responding to additional health issues, other than the clients drug use, was something that would not have been picked up during typical client contact.

In addition to providing a detoxification, the staff indicated that the process also promoted normality, sensibility and responsibility amongst clients. The process provided a holistic approach to detoxification which considered other aspects of the client's life and their needs post-detoxification. For example, the promotion of a balanced diet and cookery skills, relaxation techniques, sleeping regulation and methods to aid and enhance sleep. Clients were encouraged to be responsible for themselves during the detoxification, this included responsibility for their own medication and decisions regarding family visits and structured day programme activities. Client's responsibility for their own medication, and in particular sleeping tablets, was further discussed by staff. It was recognised by staff that clients had successfully managed their sleeping medication with advice from LHP clinicians and with some clients it was clear that they wanted to ensure they did not develop a reliance on the medication so they self-regulated infrequent use.

The lack of a '*strict regime*' as found in 'traditional' inpatient detoxification units was noted as a particular strength of the *1-2-1 Detox* by the focus group. The openness and flexibility of the detoxification allowed clients to feel comfortable and at ease in their surroundings. The client's ability to make decisions for themselves, deal with other health and social issues and have a sense of normality was considered as a contributory factor in the client's successful detoxification completion and the preparation for and transition back into their life.

The staff noted the positive outcomes of the rules relating to use of other substances for clients whilst at *1-2-1 Detox*. Clients were only permitted to smoke tobacco and take prescribed medication whilst attending *1-2-1 Detox*, and were strictly forbidden from the use of any other substances. It was noted that, compared with a community detoxification, this rule ensured that clients did not develop a reliance on cannabis or alcohol during the detoxification. Furthermore, the rules relating to discussion of or reading about drugs at the *1-2-1 Detox* encouraged clients to change their thinking of and about drug use.

It was reported by the staff that the inability to interact with other clients whist at *1-2-1 Detox* had a powerful effect on reducing peer pressure and enhancing retention. There was no competition or comparisons between clients as they had no opportunity to swap stories or to use peer pressure to convince other residents to leave or use drugs. It was further discussed that

this experience was a protective factor for successful completion as it placed the responsibility of successful detoxification completion solely with the client.

The staff indicated that the one-to-one level of support was also beneficial to the II and LHP staff. Staff reported that they had found the *1-2-1 Detox* rewarding and challenging, and the model made it easier for staff to get to know a client and provide individualised support. The two-way support between the two agencies was seen as positive and both agencies reported that they would like to see that continue in the future.

The close relationships between staff and clients was viewed as a feature of the model of detoxification that made it easier to resolve misunderstandings and also '*convince*' clients to stay when they suggested they were going to leave.

The II staff indicated that their initial worries about client isolation were unfounded. It was noted that although clients were not able to interact with each other they utilised their opportunities to interact with the detoxification and structured day programme staff.

The strengths as described above continued to be strong themes throughout the pilot and are closely linked to the strengths described by clients.

3.3.3 Weaknesses of 1-2-1 Detox

The staff indicated that they felt that the positive outcomes of the pilot far outweighed the negative. The main issue that was discussed by staff as a potential negative issue was in relation to referrals and client preparation for detoxification. As aforementioned, it was noted during the focus group that the referral process into the *1-2-1 Detox* required refinement and that this process was already underway in partnership between the two agencies.

In addition to developing a robust referral plan it was noted by the staff that clients and staff would benefit from additional client information pre-detoxification and a personalised and detailed post-detoxification action plan. Staff agreed that further assessment of clients mental health issues, medication and previous detoxification history before admittance to detoxification would be useful. Staff also discussed how further information on previous withdrawal symptoms that clients had suffered and how they would deal with the symptoms would assist *1-2-1 Detox* staff to tackle issues during the detoxification. The staff recognised that post-detoxification arrangements required developing and that a joint post-detoxification action plan should be developed with each client, including aftercare and relapse prevention support and preparation for re-integration into family, relationships and community.

In order to address these issues more robust referral and information sharing procedures were developed and established between LHP and II. These procedures ensured more consistent information sharing and that II staff were better briefed on the individual needs of each client prior to, or at the early stages, of engagement with the *1-2-1 Detox*. A robust aftercare plan was

developed with each client detailing post-detoxification goals and outlining their desired contact schedule with II or LHP (or both).

3.3.4 Retention

The staff indicated that retention levels in the *1-2-1 Detox* were good at approximately 15 days for each client and that all clients left having successfully completed their detoxification or on the lowest dose of Subutex®. Flexibility with the time frame for each clients stay at the *1-2-1 Detox* was stated as a contributory factor to the positive outcomes for clients as they were not put under any pressure to leave and encouraged to leave only once they felt ready.

Post-detoxification it was reported by staff that all but two of the clients were still in contact with and receiving support from II or LHP. The staff were aware of clients who had relapsed and had offered these clients additional support.

The retention rates of clients at the *1-2-1 Detox* continued to be high and all clients had a post-detoxification care plan in place prior to disengagement with the *1-2-1 Detox*. The close partnership between II and LHP ensured that information relating to the relapse of clients post-detoxification was quickly conveyed between the agencies and the community outreach team at LHP were tasked with contacting those clients to re-engage them. In these cases clients either re-engaged with LHP for methadone stabilisation prior to undergoing detoxification, or if appropriate they could re-enter the *1-2-1 Detox*. This procedure worked effectively and three clients underwent two episodes of detoxification at the *1-2-1 Detox*.

3.3.5 Challenges facing client's post-detoxification and impact on post-detoxification engagement

As previously mentioned staff were aware of the specific challenges that clients faced post-detoxification and as the *1-2-1 Detox* developed they put into place post-detoxification plans to address these issues.

Staff recognised the need for a detailed individualised post-detoxification action plan detailing clients' short, medium and long-term goals. Specifically staff indicated that this plan should focus on aftercare and support, housing, relationship changes, family support, negative thinking, vulnerability and testing situations and post-detoxification concerns. It was acknowledged by staff that guiding the clients through addressing many of the post-detoxification issues whilst still in the safe environment of the *1-2-1 Detox* would enhance the client's ability to tackle these issues in the future.

This focus continued throughout the pilot and was effective in establishing clients in hepatitis C treatment, relapse prevention, education or employment post-detoxification.

3.3.6 Overall effectiveness of 1-2-1 Detox

When asked about the overall effectiveness of the *1-2-1 Detox*, the staff agreed that the success rates achieved so far were far greater than expected and of those achieved in traditional inpatient or community detoxification. In addition, it was recognised that the *1-2-1 Detox* overall had a wider scope than just detoxification and that the positive outcomes for clients were associated with all aspects of their life. The staff indicated that the *1-2-1 Detox* was a '*middle ground*' between inpatient and community detoxification models.

The views of the effectiveness of the *1-2-1 Detox* continued throughout the pilot. Staff from both agencies were enthusiastic and committed to the detoxification programme. The staff continually sought to improve and engage clients in the programme and maintain high levels of effectiveness.

3.3.7 Partnership between II and LHP

Staff from both agencies acknowledged that at times the partnership between II and LHP had worked well and at other times there was a breakdown in communication. However, the staff recognised that tackling issues of communication between the agencies had enhanced the partnership and support between the two agencies and therefore provision in the future would be more streamlined and effective. It was recognised that the new level of communication and protocols regarding referrals and partnership needed to be developed to ensure the future success of the *1-2-1 Detox*.

Recognition and discussion about the inconsistent communication at the focus group prompted changes in the communications strategies between the two agencies. After the focus group robust client referral procedures were developed and established. Additionally, key contacts were identified at both agencies and these individuals were given gatekeeper status to ensure the approval of all new clients and to act as first point of contact for any issues regarding a clients care at the detoxification programme. These changes improved the overall communication between II and LHP.

3.3.8 Contact with other relevant agencies

Whilst the participating agencies (II and LHP) were the two main agencies involved in the *1-2-1 Detox* there was a requirement for interaction with other agencies, including GP, optometrists, dentists, alcohol treatment agencies and other drug treatment agencies.

It was reported by the staff that there had been some issues relating to communication with pharmacies which had resulted in difficulties obtaining the required medication for clients. It was acknowledged that the partnerships between II and LHP had helped to resolve issues relating to prescriptions when necessary. It was noted that for development of the *1-2-1 Detox* the interaction with pharmacies should be addressed and medication issues assessed prior to each client's admittance to detoxification.

Staff recognised the support that they had received from other substance misuse treatment and aftercare agencies. In particular reference was made to Sharp and the Windsor Clinic who had been supportive of the project and communicated well for the overall benefit of the clients. It was noted that this was not only beneficial for clients but also for the service generally, as it was advantageous to ensure that other agencies were aware of the existence of the *1-2-1 Detox*.

Positive relationships with other substance misuse treatment and aftercare agencies continued throughout the pilot, with referrals for clients to a wide variety of agencies post-detoxification. Additionally, the issue relating to medication and daily client pick-up of Subutex® continued to be an issue after the focus group. However, in the later stages of the pilot programme II and LHP secured an agreement with a local pharmacy to provide all prescriptions. This agreement included a daily delivery service from the pharmacy, an awareness of the *1-2-1 Detox* and its functions amongst the pharmacy staff and an open line of communication which could quickly and easily resolve medication issues. The establishment of the links with this pharmacy improved the service provided to clients and reduced the number of medication related problems.

3.3.9 The future

When asked about the future of the *1-2-1 Detox*, all staff agreed that the service is beneficial to clients and that it should be commissioned to continue for the foreseeable future. Staff recognised that the focus group discussion had identified many positive areas of the model, and also areas where improvements or changes should be made. In addition, II and LHP agreed that the experience had brought the two agencies closer together and this had enhanced services in both agencies for the benefit of clients.

The staff agreed in principle that expansion of the service into other areas of Merseyside would open the service for the benefit of a greater number of clients, but, with that, new challenges may arise through the dilution of the service and the required partnership with other external agencies. However, in order to address these issues prior to expansion the staff suggested that a steering group with appropriate representatives should be developed to ensure that the expansion is controlled and maintains the service's uniqueness and effectiveness.

In July 2008 a steering group with representatives from II, LHP, CPH and Sefton DAT was established. The steering group met on a monthly basis to discuss the *1-2-1 Detox*, address issues and was a useful forum for partnership decision making.

4. Additional Observations

This section details additional observations which are relevant to the evaluation.

Partnership between Independence Initiative and Lighthouse Project

This partnership has grown and developed throughout the *1-2-1 Detox* pilot. In the initial stages of the pilot there were inconsistencies in the level of communication between the two agencies. However, since the focus group and the establishment of the steering group the partnership between these agencies has strengthened and been a driving force behind engaging new clients, ensuring relapsed clients were quickly contacted and offered appropriate treatment, the smooth widening of the catchment area of the pilot to include all Sefton DAT residents and the establishment of links with a local pharmacy. The appointment of an individual in each agency as the main liaison between the two agencies ensured more consistent management of clients and a reduction in communication issues.

Early, yet successful, completion

The length of stay for each individual at the *1-2-1 Detox* was decided jointly between clients, Independence Initiative (II) and Lighthouse Project (LHP) staff at the beginning of the detoxification, based on the individual's needs and the duration of the Subutex®-assisted withdrawal. At the outset of detoxification the majority of clients indicated their intention to stay with the *1-2-1 Detox* for a few days after they completed their medication. However, many clients did not complete their whole period of intended detoxification at the *1-2-1 Detox*. As clients neared the end of their course of Subutex® many made the decision to leave either as soon as they completed their course or whilst they were on the lowest Subutex® dose. All clients who left the detoxification early indicated that they felt that they had successfully completed their detoxification and were ready to leave (and where appropriate, completed their Subutex® course in the community).

As the staff at II became more experienced with the *1-2-1 Detox* they began to recognise the early warning signs that a client would not stay the whole period that they had indicated at the beginning. Recognition of the signs that a client would leave earlier than intended allowed staff to better prepare for a clients departure, ensuring that they left with the appropriate information and support required, and crucially with a robust aftercare plan in place.

Considering that clients set their own timetable for detoxification, a client leaving the *1-2-1 Detox* earlier than planned was not a 'failure' in the same sense of a client suddenly dropping out of detoxification and relapsing into drug use. All clients who left, did so within the last few days of their intended detoxification timeframe and feeling that they had successfully completed the detoxification. As the onus was on the client to set their own level of success, as it was the client's perspective of success and failure was more important than adhering to guidelines set out by others.

Responsibility

A significant difference between the *1-2-1 Detox* and 'traditional' residential detoxification was the level of responsibility that clients had for themselves. At the *1-2-1 Detox* clients were encouraged to make themselves at home and take control of their own detoxification. This included decisions regarding mobile phones, medication, contact with family and friends, cooking, participation in the structured day programme, evening and weekend activities and length of stay at *1-2-1 Detox*. Clients and staff alike noted that this element of the detoxification promoted confidence and personal growth amongst clients and better prepared them for life post-detoxification.

On one occasion when a client felt that the level of contact from family via mobile phone was too much and putting their chance of a successful detoxification at risk. The client decided, in conjunction with II staff, that the best course of action was to surrender the mobile phone to staff for the duration of the detoxification. During conversation with the client, they indicated that making that decision had been difficult but overall worthwhile. In addition, they felt that they had been supported to make the decision and not put under pressure to relinquish their mobile phone.

The structured day programme

In addition to the positive comments made during the client interviews about the structured day programme activities at II, observation of clients during interviews and throughout their stay at *1-2-1 Detox* further indicated its usefulness and overall benefit. The structured day programme aimed to develop natural talents and provide attendees with new skills with a view to education or employment. However, during the initial stages of detoxification each client reported that they had mostly attended relaxation sessions, including massage and aromatherapy. Staff at II purposely guided clients into relaxation sessions during the early stages of detoxification and built up to pre-vocational and skilled sessions, such as computing, cookery, art and crafts, English and maths, when the client felt that they were settled into the detoxification process and ready to engage.

The structured day programme sessions were praised by clients as useful diversionary activities which ensured that they were not bored or isolated. Staff at II strived to keep clients busy to relieve boredom, divert client's attention from feelings of withdrawal and enhance skills, but, if a client decided they did not wish to take part in sessions they were under no obligation to do so. Clients indicated during interviews that they were also given adequate time alone when they required or wanted it.

During interviews post-detoxification clients made some statements about the usefulness of the structured day programme which are detailed below.

'The day programme was good. I had low self-esteem and lazy intelligence before. I have enjoyed the classes and the encouragement. It has given me confidence and opened up to new opportunities. I have learnt to play the

drums in 2 weeks. The staff have been great and have let me practice on the drum kit in the evenings.'

'It (the structured day programme) *is definitely a good thing. Three saunas a week, you don't get that at the Priory! I couldn't have asked for more.'*

Engagement with the structured day programme post-detoxification

Upon discharge from the *1-2-1 Detox* each client was encouraged to continue to engage with II for relapse prevention and support, and the structured day programme to continue to enhance their learning and skills.

During client interviews at the end of the detoxification process, the majority indicated that they were interested in continuing their contact with II and the structured day programme. However, actual levels of engagement with the structured day programme post-detoxification were low. There were a variety of reasons for this low level of engagement, both positive and negative. These included clients desire to create a bit of space between themselves and II for a while post-detoxification and '*go it alone*', attendance at other support services, lack of time due to educational/work commitments, embarrassment because of continued Subutex® use and relapse into drug use.

Whilst the engagement with the structured day programme was low post-detoxification, the majority of clients had received contact from their keyworker at II or LHP and therefore were receiving support and advice. Staff at both II and LHP were proactive in making contact with clients post-detoxification (either face-to-face or by telephone) to ensure they were updated on the clients progress and offered additional support.

Attendance at other services

Clients were encouraged to continue to engage with II and the structured day programme post-detoxification, however, II did not solely promote their own service and did not utilise the *1-2-1 Detox* as a method of recruitment to the structured day programme. Where clients expressed an interest in attending a different aftercare service, agency or education/employment this was actively encouraged and facilitated by II staff. The general ethos of II regarding post-detoxification arrangements was on the client to choose the route that best suited them and staff supported clients to engage with their preferred service. Other relapse prevention services that clients attended post-detoxification included Sharp and Spider. Additionally, clients were given support from II to access education or employment post-detoxification if that was their preference.

The snowball effect

The positive experience of clients at the *1-2-1 Detox* had a snowball effect locally and played a significant role in encouraging other drug users to consider referral into *1-2-1 Detox*. On a number of occasions, clients who completed their detoxification were followed by other drug users that they

knew (i.e. family, partners, friends). Word of mouth and positive feedback from clients was an effective method of maintaining high levels of capacity at the *1-2-1 Detox*. In addition, the snowball effect had the potential to make significant changes in the lives of drug using families or partnerships by tackling the drug use of more than one member of a family or partnership.

Quality of life

At *post-detox* and *follow-up* interviews it was evident that the *1-2-1 Detox* had improved clients quality of life and aspirations for the future. In particular, at *follow-up* clients had re-established family relationships, found new accommodation, initiated hepatitis C treatment, signed up to relapse and aftercare services and enhanced self-esteem and self-belief. Although clients indicated that they had encountered difficulties and challenges since exiting the detoxification programme, they all felt that the *1-2-1 Detox* had had a positive impact upon their life and were glad that they had participated in the detoxification programme.

Service uniqueness

There was wide recognition of the uniqueness of the detoxification programme by both clients and the staff members involved with the service. Staff from both II and LHP indicated that they had received positive feedback about the *1-2-1 Detox* and how it differs from other available models of detoxification from clients and their families. Additionally, during the *post-detox* and *follow-up* interviews clients made reference to the uniqueness of the detoxification programme and many stated that it was an important resource. Specifically one client stated: "*I think the DAT have a very important resource here. Its unique and it's a little gem of a project*".

Governance

As LHP provided the clinical elements of the detoxification, II has operated with pilot under their clinical governance guidelines. However, as II is responsible for the safety of those who are engaged with the detoxification programme there is a requirement for the agency to create their own governance framework to ensure that clients are clinically safe and risk are managed.

Opiate-substitution medication

Whilst the II was the host organisation for the detoxification programme, all clinical aspects of care, clinical safety and medication were provided by LHP. Although clients were responsible for their own medication and dose reduction regime (as outlined by LHP), clients referred to problems with medication and their first point of contact for medication issues was staff at II. Specifically clients mentioned that because of the different roles and responsibilities of the two agencies clinical issues could not normally be addressed outside of LHP office hours. However, it should be noted that this issue is not different to that which clients would experience whilst undertaking a community detoxification.

This is an issue that was frequently raised at the steering group meetings and caused frustrations for clients when provided prescriptions were incorrect or missing. A number of changes were made by the steering group to reduce prescription related problems. These included the appointment of gatekeepers at II and LHP who were the main contact points for referrals, assessments and any issues raised. Additionally, an agreement was reached with a local pharmacy who became the only pharmacy that distributed the medication for the detoxification programme. This agreement ensured that the pharmacist was aware of the detoxification programme, its individual needs, the key points of contact at both II and LHP and a quick response to any prescription related issues. These two changes were significant in lessening prescription related issues for the duration of the pilot programme.

Cannabis use post-detoxification

Frequent cannabis use was reported by almost half of clients who completed *follow-up* interviews. Further exploration of this issue indicated that some clients were smoking cannabis regularly because they were bored and others did not view it as a drug and therefore did not consider their use as problematic. During the detoxification process clients could not use any other drugs, except tobacco, and therefore the detoxification also ensured detoxification from other non-opiate based substances. However, the high levels of cannabis use post-detoxification suggests that further drug awareness and focus on reasons for reliance on other substances post-detoxification during the *1-2-1 Detox* may be beneficial.

Relationship changes

Relationship changes are a frequent outcome upon exit from detoxification for clients. Better preparation for relationship changes post-detoxification was suggested as an area for improvement by staff at the focus group. This was further validated when a client reported post-detoxification that they had ended a relationship because their partner had a problem with alcohol n.

In addition to intimate relationship changes, clients should be prepared for potential changes in family relationships. Clients discussed improved relationships with children and siblings at *follow-up*. However, the responsibility of maintaining drug-free or opiate-free status was a source of anxiety for some clients as they did not want '*to let anyone down again'*.

Post-detoxification de-motivation

A number of clients reported feeling de-motivated and having low levels of self-confidence post-detoxification. This was reported by clients as a reason for lack of re-engagement with II and LHP after completion of the detoxification programme. A number of clients indicated that they had found the transition from the detoxification environment, where there was always someone to talk to, to returning home difficult. However, at *follow-up* all clients indicated that they were aware that they could attend the structured day

programme or drop into II or LHP. Two clients indicated that they felt embarrassed by their drug use post-detoxification and this had hindered their desire to seek aftercare and relapse prevention support. Keyworkers at both II and LHP made multiple attempts to contact clients post-detoxification and were particularly motivated to re-engage clients who had begun to use drugs again post-detoxification. Discussions with clients suggested that low levels of self-confidence and self-esteem were significant barriers to re-engagement of clients who had lapsed or relapsed post-detoxification.

Housing

Access to appropriate housing post-detoxification is a protective factor which aids client's recovery. A number of clients reported changes in their accommodation plans post-detoxification from staying on their own (*pre-detox*) to staying with family (*post-detox*). This finding indicated that whilst undergoing detoxification some clients recognised that they required, and would benefit from, additional support in the initial post-detoxification stages. At the *follow-up* interviews many of the clients who had stayed with family immediately after exit from the *1-2-1 Detox* were seeking independent accommodation indicating that the short period of family support post-detoxification may have enhanced the client's stability.

Gate keeping

As the pilot programme was a learning environment for all involved, amendments to how the *1-2-1 Detox* was organised and functioned were made as the pilot programme progressed. One significant change was the appointment of a gatekeeper at each agency. This change made the lines of communication between the two agencies clearer for all involved and also ensured a rigid and quality assured decision making process for referrals and assessments of potential clients.

Empty beds

During the pilot period there were several occasions when the *1-2-1 Detox* did not have both or either beds occupied. In June 2008, after the initial funding period was completed, the pilot programme catchment area was extended to include all residents of Sefton DAT. This decision was taken to expand the number of potential clients who were suitable to engage with the *1-2-1 Detox*. However, in practice there were still a number of occasions where the *1-2-1 Detox* was not operating at its full capacity. A number of factors influenced the unoccupied detoxification programme places including uncertainty about funding and a lack of clients who were 'ready' to engage (i.e. met the criteria for acceptance).

5. Conclusions & Recommendations

This section details the evaluation conclusions and makes recommendations for the future of the *1-2-1 Detox*.

5.1 Conclusions

5.1.1 Rates of successful completion

Approximately two-thirds of clients who engaged with the *1-2-1 Detox* successfully completed the detoxification programme and exited drug-free (64.7%, n=11). Comparison of the rates of drug-free completion indicate that the detoxification programme is considerably more effective than traditional community detoxification (with rates of 20% successful completion cited [Gossop, Johns & Green, 1986; Littlewood, 2007; Wright et al., 2007]) and as effective as inpatient detoxification (with successful completion rates of 65-75% cited [Broers, Giner, Dumont & Mino, 2000; Gossop, Johns & Green, 1986; Keen, Oliver, Rowse & Mathers, 2001]).

The term 'successful completion' used in this study refers to completion of the detoxification programme and achievement of a drug-free status. One-third of clients did not achieve this drug-free status before disengaging from the detoxification programme and exited stabilised on a low dose of Subutex® (35.3%, n=6). However, when put in perspective, of the high rates of relapse typically found during community detoxification and drop-out from inpatient detoxification, it can be concluded that 100% of clients completed their detoxification programme and did not return to illicit drug use whilst engaged in the detoxification programme. This finding is in stark contrast to the rates of relapse/drop-out from other models of opiate detoxification.

5.1.2 Disengagement whilst continuing to take Subutex®

The proportion of clients who disengaged from the detoxification programme whilst still taking a low dose of Subutex® may be attributed to a number of factors. It is possible that these clients were experiencing Subutex® withdrawal which contributed to their desire to remain on a low dosage rather than fully experience the withdrawal symptoms (West, O'Neal & Graham, 2000). Or, it is possible that the clients good social support and family networks negatively influenced their likelihood to achieve drug-free status at the *1-2-1 Detox*. Westreich et al. (1997) found that participants with better levels of social support were less likely to complete treatment and that the family *'pull'* (p.147) or family pressure to be 'better' or at home had a negative effect upon drug-free completion. During interviews in this study, a number of clients reported that they preferred to complete their detoxification at home in order to be with their family, most of whom had stated that they wanted the client to come home.

Whilst it is a positive outcome that none of the clients disengaged with the *1-2-1 Detox* unexpectedly, it is important for the service to maintain their focus as an abstinence based model. The second stage of Ghodse et al's (1997)

model is a drug-free period (of approximately five days) whilst still in attendance at the detoxification. During the pilot phase the *1-2-1 Detox* promoted and offered this drug-free period to all clients, however, one-third did not take advantage of it.

5.1.3 Disengagement with aftercare plan

At the point of exit from the *1-2-1 Detox*, all clients, in conjunction with their keyworker, developed an aftercare plan. This plan focussed on relapse prevention and future goals. An essential element of this plan included follow-up appointments with keyworkers at II, LHP or both services (as desired by the client). All clients developed an aftercare plan before exiting the *1-2-1 Detox* and left with a fixed follow-up appointment.

The follow-up appointments focussed on client motivation to maintain drug-free status (or methods to regain drug-free status), monitoring of clients progress against their goals and to provide support for any other areas of the clients life that they required. The aftercare process was shared between II and LHP, if the client wished to remain in contact with both agencies, and was a good example of the integration of treatment and recovery and provision of continuous care for the clients.

5.1.4 Differences in drug use before and after detoxification

In the month prior to engagement with the *1-2-1 Detox* at least half of clients indicated that they had used heroin (58.8%, n=10) and crack cocaine (52.9%, n=9); the majority of these clients stated they used these substances frequently in the previous month. Post-detoxification, proportionately lower rates of heroin and crack cocaine were reported by clients (44.4% [n=4] and 33.3% [n=3] respectively). Frequent heroin use was reported by two clients and frequent crack cocaine use by one client at this stage. The proportion of clients in this study reporting heroin use post-detoxification (44.4%) was lower than the 58% of participants reported by Murphy et al. (2003) one-month after completion of inpatient detoxification.

In addition to the differences in illicit drug use before and after detoxification, there were also differences in clients' use of prescription drugs. In the month prior to attending the *1-2-1 Detox* clients indicated use of a variety of prescriptions drugs (prescribed and non-prescribed) including methadone, benzodiazepines, barbiturates, tranquillisers and anti-depressants. Post-detoxification lower levels of prescription drug use were reported and considerably lower levels of non-prescribed use were reported. Analysis of the qualitative data indicates that this difference in use of prescription drugs may be associated with the change in attitude regarding clients' health. In addition to seeking treatment for health problems, clients discussed reductions in their prescription drug use.

The findings from *follow-up* interviews indicated a low level of drug use amongst the majority of clients, and clients were more likely to 'lapse' into drug use than 'relapse'. This finding is important as it shows that after

returning to the community many clients were able to return to a drug-free status after a small amount of drug use and that they were able to understand that a lapse did not signal failure. The findings support that of Ghodse et al. (1997) who found that an initial lapse into drug use did not predict a full relapse and individuals could return to and maintain abstinence after a lapse. The transference of regular use to another substance post-detoxification is not uncommon (Ghodse et al., 1997) and therefore the frequent cannabis use during this period by almost half of those who completed *follow-up* interviews is notable. The use of drugs regularly by a number of clients post-detoxification should not detract from the benefits of small periods of abstinence.

Research has reported that methadone stabilisation prior to detoxification is associated with better post-detoxification outcomes (Backmund, Meyer, Eichenlaub & Schutz, 2001; Gossop, Marsden & Stewart, 2006). However, this study found no significant differences in post-detoxification drug use between those stabilised on methadone or Subutex® prior to detoxification and those who reported use of heroin.

5.1.5 Changes in drug withdrawal

Statistical analysis indicated that overall there was a significant change in clients' reported symptoms of drug withdrawal across the three stages of interview. Evidence indicates that withdrawal from Subutex® is less severe than from heroin or methadone (West, O'Neal & Graham, 2000), but this drug induces withdrawal symptoms in some users. A number of clients reported during the *post-detox* and *follow-up* interviews that they had experienced withdrawal symptoms when on a low dose of Subutex® and one client reported that he '*didn't expect the cold turkey feelings when I left*'. This finding was supported by the statistical increase in reported withdrawal severity between *pre-detox* and *post-detox* interviews. Experience of withdrawal symptoms on low dosages of Subutex® may also have contributed to failure of some clients to achieve a drug-free status prior to disengaging with the *1-2-1 Detox*.

Analysis of the clients severity of withdrawal across the three interview stages indicated that there was a significant decrease in clients reported withdrawal severity between *post-detox* and *follow-up*. This finding indicated that the withdrawal symptoms experienced on low doses of Subutex® did not persist approximately four weeks after disengagement with the *1-2-1 Detox*.

5.1.6 Changes in depression, anxiety and arousal

There were significant decreases in clients' levels of depression and anxiety between *pre-detox* and *post-detox*. However, there were no significant differences between depression and anxiety across all three interview stages suggesting that there may have been a return to *pre-detox* levels at *follow-up*.

There was a similar pattern with the arousal subscale. Clients had a positive, significant increase in arousal between *pre-detox* and *post-detox*, however,

this effect was not present across all three interview stages. Again, suggesting a return to *pre-detox* arousal levels at *follow-up*.

These findings suggest that the positive effects on clients levels of depression, anxiety and arousal that occurred whilst present at the *1-2-1 Detox* diminished after a period of time (approximately one month) post-engagement. During the *follow-up* interview many clients were thriving in the community, however, there were a number who reported low levels of motivation, high levels of boredom and anxiety, and difficulties coping with '*normality*'. Martinotti, Cloninger and Janiri (2008) found an association between anhedonia (inability to derive pleasure from normal things i.e. eating, sex, social life etc) and drug use in non-psychiatric individuals and concluded that anhedonia should be considered in relapse prevention initiatives. This theory may be one explanation for the differences between clients who thrived post-detoxification and those who did not, and the differences in those regularly using cannabis and those who were not. However, a measure for anhedonia was not included in this study and therefore no conclusions can be drawn.

5.1.7 Desires for drugs

There were no significant differences in clients' desires for drugs as measured on the three subscales (desires and intentions, negative reinforcement and control) between the interview stages. The lack of significant differences may be due to a low desire for drugs amongst clients at the beginning of the detoxification process, potentially influenced by the proportion of clients stabilised on opiate substitute prior to detoxification. Another potential explanation for this finding may be due to the lack of cessation of psychological opiate dependence after completion of physical detoxification (Ghodse, 1995; O'Brien & McLellan, 1996).

5.1.8 Alcohol use

Over half of clients reported drinking alcohol in the week prior to engaging with the *1-2-1 Detox* (58.8%, n=10). Analysis of the units of alcohol consumed by clients at this stage indicated that the majority were drinking alcohol sensibly and within the Department of Health (2005) guidelines. Four clients had a CAGE score that was clinically significant indicating a possibility of problematic drinking or alcoholism. Further investigation to compare the client's previous alcohol consumption with their normal consumption indicated that a number of clients, who did not normally drink, did so in the week prior to engaging with the *1-2-1 Detox* because they were nervous or anxious about undertaking the detoxification. No alcohol consumption in the previous week was reported by clients who completed *follow-up*. This finding suggests that clients did not transfer to alcohol use post-detoxification.

5.1.9 Health

Clients had a wide variety of health problems, and three-quarters reported more than one problem (76.5%). At *pre-detox* the majority of clients were

aware of the blood borne virus status, and one-third reported positive diagnosis for hepatitis. The majority of those who reported positive hepatitis diagnosis were hepatitis C positive. At *follow-up* there was little changes in the number of health problems that clients reported, however, there was a significant decrease in the proportion of clients who rated their health as bad between *pre-detox* and *follow-up* from 35.3% to 11.1%. The qualitative analysis suggested that clients had a change in their attitude to their health, with many clients reporting placing higher importance on their health and making positive health-related changes. Specifically, clients indicated that they had a desire to become fitter, healthier, engage with hepatitis C treatment, address their dental health and use less prescription drugs.

5.1.10 Mainstream re-integration

Mainstream re-integration was the goal of the majority of clients as they exited the detoxification programme. Clients discussed education, employment and volunteering as part of their future goals and plans. Clients were aware that their experiences as a drug user and their knowledge of drug treatment services could be used in the future to help others and a number expressed an interest in following this path. Clients had admiration of staff at II who had previously been drug users and had since forged a career in the field and this inspired clients.

Clients chose different routes to achieve their mainstream re-integration and continue with their relapse prevention post-detoxification. Staff at II facilitated the contact between clients and educational establishments, employment agencies and a variety of specialist aftercare and relapse prevention providers. Whilst all clients were invited to re-engage with the II structured day programme after detoxification, the *1-2-1 Detox* was not considered a recruitment source for the structured day programme, and clients were facilitated and encouraged to pursue their own interests after detoxification.

5.1.11 Engagement with the structured day programme

II aimed to vertically integrate the *1-2-1 Detox* with their structured day programme which offered one-to-one support, relapse prevention and pre-vocational training. All clients utilised at least one of these functions during their time with the detoxification programme. The high detoxification programme retention rate and high level of engagement with the structured day programme supports Katz et al.'s (2004) questioning of the effectiveness of detoxification without simultaneous psychosocial interventions.

The staff at II guided clients into the most appropriate structured day programme activities at different stages of their detoxification. Specifically, in the early stages of the detoxification clients were encouraged to participate in relaxation-focussed session i.e. aromatherapy and massage. Once clients had settled into the detoxification programme and had adjusted to the Subutex® dose reduction regime, they were encouraged to participate in the pre-vocational training i.e. English, maths and IT sessions. Throughout the detoxification programme a number of clients attended the local leisure centre

(accompanied by a mentor) to use the gym, sauna and swimming pool. Clients discussed how they felt physically and psychologically better after attending the leisure centre as often they felt full of energy and the exhaustion felt afterwards facilitated sleep.

As previously mentioned, at the point of disengagement with the detoxification programme all clients were offered a pathway immediately into the structured day programme and appointments with their keyworker at II (these appointments did not necessarily form part of the structured day programme and could be used for support purposes only). However, post-detoxification there was a low rate of engagement with the structured day programme. There were both positive and negative reasons for the low rates of engagement with the structured day programme post-detoxification. Positive reasons included that clients were too busy with work/employment commitments. Negative reasons included apprehension amongst clients who had used drugs post-detoxification. Clients who felt apprehensive reported that they were aware that they could re-engage with II or LHP at any time, whether using drugs or not, but they did not want to let anyone down. It is evident from the clients responses and the multiple attempts to contact each client made by II and LHP staff, that clients lacked the self-confidence and self-esteem to return to the services after using drugs.

5.1.12 Relapse prevention

Post-detoxification clients were attending a variety of aftercare or relapse prevention services, including the structured day programme at II. II did not solely promote their own structured day programme for relapse prevention and facilitated referrals to other appropriate agencies. Clients who were involved with drug treatment services post-detoxification indicated that these services helped to motivate them and keep focused on their goal of abstinence. This finding supports the research of Day (2005), Ghodse et al. (1997) and Haug et al. (2005).

5.1.13 More than opiate detoxification

Whilst clients were engaged with the *1-2-1 Detox* the only substance that they were permitted to use was tobacco. Examination of the clients' drug use profile prior to engaging with the detoxification programme illustrates that clients were using a variety of substances in the month prior to detoxification. These included cocaine, crack cocaine, cannabis, illicit methadone, other illicit prescription drugs and alcohol. Whilst engaged with the detoxification programme clients could not use any of the other drugs listed above and therefore the time engaged with the detoxification programme provided a short detoxification or period of abstinence from all other substances (except tobacco).

5.1.14 More than physical detoxification

Evidence suggests that a multifaceted model of care which focuses on both physical dependence and an individual's psychological and behavioural

processes related to drug use achieve better outcomes than treatment which focuses on each aspect separately (Amato, Davoli, Ferri, Gowing & Perucci, 2004; Gossop, 1992; Luty, 2003; O'Brien & McLellan, 1996). The *1-2-1 Detox* did not solely focus on clients drug use, but also addressed their psychological and behavioural processes related to drug use through one-to-one support, the structured day programme and relapse prevention; the success of which is reflected in the rates of successful completion and the positive personal and social outcomes of clients. However, the findings from the desires for drugs scales suggest that there were no significant changes in clients drug craving and this is a point that should be considered further in the future.

5.1.15 Acceptability of the 1-2-1 Detox

Clients had high levels of praise for the *1-2-1 Detox*, the one-to-one model and the staff who had supported them throughout their detoxification programme. The qualitative analysis indicated that clients felt that the staff had provided a support package which could respond quickly to their individual needs, within a calm, relaxed and flexible environment. A key theme that was identified during the qualitative analysis was related to the level of choice and unregimented manner in which the detoxification programme was run. Clients indicated that this was an aspect that they particularly liked and that had enhanced their overall experience of the detoxification programme. Furthermore, clients indicated their level of personal responsibility within the programme facilitated their preparation for the future and enhanced their feelings of personal control.

The one-to-one aspect of the detoxification programme was considered as a positive aspect of the service by the majority of clients, and provided a rare opportunity for clients to focus solely on themselves and their drug problem. None of the clients reported feeling isolated or lonely suggesting that the high level of interaction between each clients and staff/mentors was sufficient. The model facilitated more client:staff contact time than other models of detoxification. Evidence indicates that when an individual undertakes community opiate detoxification they are vulnerable to drug related cues and triggers including contact with other drug users, being offered drugs or asked to acquire drugs (Gossop, Johns & Green, 1986; Unnithan, Gossop & Strang, 1992). Clients reported feeling less vulnerable to outside influences and protected whilst resident at the *1-2-1 Detox*, and as there was no contact with other drug users clients were not exposed to drug related cues and triggers commonly associated with community detoxification. However, a small number of clients felt that the additional support of contact with another client going through a similar experience could have been useful.

5.1.16 Response to policy

The findings suggest that the *1-2-1 Detox* is a good example of how a drug treatment service can respond to government policy. The current UK Drug Strategy (Home Office, 2008) states that drug treatment should be *'personalised and outcome focussed'* (p.27) and the NICE guidance (2007) on

opiate detoxification states it should be '*person-centred*' (p.6). The statement made in the UK Drug Strategy and NICE guidance is difficult for any service to deliver when responding to the needs of a group of drug users, and in clinical practice can be difficult (Gossop, 1992). However, a significant factor to the ability of II successfully providing a tailored and individual package of care was the focus on individuals and that they did not have to significantly consider how a decision made in relation to one client impacted upon a group of clients.

5.1.17 Client awareness of detoxification programme

The findings suggest that a small number of clients were unaware of the structure of the *1-2-1 Detox* and the rules they would have to abide by, prior to engaging with the detoxification programme. Specifically, a small number of clients indicated that they were unaware of the one-to-one model and that they would be responsible for their own dose-reduction regime. This is an area for concern as all clients should be briefed on the detoxification programme structure prior to engaging, particularly to ensure that they are prepared to take responsibility for their own dose-reduction regime.

5.1.18 Partnership with Lighthouse Project

The partnership with LHP was a vital element of the detoxification programme. Their provision of the clinical elements of detoxification, client referral, clinical advice and guidance to clients and staff, and clinical governance framework were significant contributors to the *1-2-1 Detox*. LHP were also present on the steering group that was formed in July 2008. Prior to July 2008 referrals and initial assessments were carried out by a number of LHP staff members, all of whom made direct contact with II. This method of referral was problematic and caused confusion. One of the key decisions of the steering group related to the appointment of gatekeepers at both II and LHP who were the main points of contact for referrals, assessments and problem solving. The appointments reduced communication issues and related problems significantly, ensured robust referral procedures and a structured pathway for client engagement. LHP were also instrumental in developing the agreement with a local pharmacy to be the dedicated provider of clients' medication.

5.1.19 Quick response to client relapse

The close partnership and regular communication between II and LHP facilitated a quick response to the relapse into drug use of clients. Staff at II and LHP became aware of the relapse of a number of clients through contact with the client or through information from other clients or staff members. In these cases the LHP outreach team was tasked with making contact with the client and inviting them to re-engage with LHP for drug treatment. On three occasions clients were re-assessed at LHP as suitable for the *1-2-1 Detox* and these clients agreed to undergo detoxification for the second time.

5.1.20 Governance

Throughout the pilot the *1-2-1 Detox* operated within the clinical governance framework of LHP. The majority of clinical issues raised during the pilot programme, such as prescription problems, were the responsibility of LHP. However, II encountered issues relating to the distribution of over the counter medications to clients. Whilst governance under LHP framework was sufficient for the pilot, there is a requirement for II to develop their own governance framework for the future.

5.1.21 The steering group

The initiation of the steering group in July 2008 was a significant point in the pilot programme. The steering group allowed decision making to be carried out in partnership between II, LHP and Sefton DAT and provided a forum for formative evaluation feedback. It also facilitated open and regular contact amongst the key members of staff from both agencies, and partnership decision making.

5.1.22 Empty beds

At various stages during the pilot there were rooms that were unoccupied. This impacted upon many functions of the *1-2-1 Detox* including staffing and economic viability. Additionally, clients who were undertaking their detoxification without a counterpart occupying the other room indicated that it was very quiet at night and weekends. Whilst all clients understood that they could have no interaction with the other clients, there was a suggestion that it was a support to know that someone else was going through the same experience at the same time.

5.1.23 Geography

There are a number of geographical implications of the pilot programme which should be considered. II, the LHP site who provided the clinical care, Sefton DAT who provided funding and the clients all came from or were situated in the Sefton DAT area. This contributed to a close knit management team who could easily meet or respond to clients needs when required. Additionally, the family and friends of clients undertaking the detoxification programme did not have to travel far to visit and could provide support from close by. The findings and success of the *1-2-1 Detox* should be considered in context of the locality of services and clients. Further investigation and expansion of the service is required to ensure that the success was not a local phenomenon influenced by the local links.

5.1.24 Methodological implications of the evaluation

The sample size of the pilot programme was influenced by a number of factors including the number of clients who engaged with the *1-2-1 Detox* during the pilot period and the number of clients who agreed to participate in the follow-up or were contactable by the researcher. However, there were no

statistical significant differences between those who completed follow-up and those who did not.

5.1.25 Effectiveness

The findings of the evaluation, as discussed above, indicate that, overall, the *1-2-1 Detox* has provided an effective alternative to traditional models of detoxification. In addition to a physical opiate detoxification service, the *1-2-1 Detox* has made significant differences to the clients quality of life, health, social relationships and educational/employment prospects. Additionally, the pilot programme has provided a response to the UK Drug Strategy and NICE guidance through the provision of individualised, personalised and outcome focussed treatment.

5.2 Recommendations

1. There is a requirement for continued monitoring of clients exit status and treatment outcomes. In addition to the information provided to the National Drug Treatment Monitoring System (NDTMS), detailed information on the long-term outcomes of clients who have engaged with the detoxification programme should be collected and regularly analysed. This will facilitate a longer term evaluation of effectiveness of the *1-2-1 Detox*.

2. In order to assist the achievement of a drug-free status amongst clients, II should continue to promote the drug-free period of stay at the *1-2-1 Detox* (i.e. the five drug-free days offered to each client) and the ensure clients are aware of the potential negative effects of family '*pull*' which is common when they reach the end stage of their detoxification and how it can affect their treatment journey.

3. Whilst engaged with the detoxification programme clients should be prepared for the possibility of lapse and relapse post-detoxification. Clients should be offered psychosocial interventions whilst engaged with the *1-2-1 Detox* which focuses on relapse, coping strategies, drug related triggers and cues. Clients should be made to feel confident about re-engaging with drug treatment agencies if they lapse or relapse after disengaging from the detoxification programme.

4. Each client should receive a structured induction upon their initial engagement with II at the *1-2-1 Detox*. This induction should cover a variety of important issues including, strategies for coping with sleep deprivation, information about the one-to-one model (including the rules and regulations) ensuring 'buy in' from the client, the potential for experiencing withdrawal effects at low doses of Subutex® and coping strategies and their personal responsibility for their detoxification (including responsibility for dose reduction regime). It is possible that at this stage of initial engagement that clients may not be completely focussed on the induction information and therefore each client should also be provided with a 1-*2-1 Detox* pack detailing information on all issues discussed at the induction which they can refer to during the detoxification process.

5. II and LHP should seek to maintain the positive change in clients levels of depression, anxiety and arousal which takes place whilst engaged with the *1-2-1 Detox*. Consideration should be given to the client's general mental health whilst engaged with the *1-2-1 Detox* and clients should be provided with the support to address any identified mental health issues post-detoxification. Additionally, II should continue to promote aftercare and relapse prevention services, and provide clients with details of their ethos and structure so assist clients to make an informed choice regarding post-detoxification contact with support services.

6. II should seek to decrease the number of clients who did not engage post-detoxification for negative reasons. Methods to identify clients who may struggle to cope when they return to the community should be employed and vulnerable clients should be offered additional sessions focussed on motivation techniques, coping with boredom, isolation and stress post-detoxification.

7. Clients levels of self-confidence and self-esteem should be assessed whilst they are engaged with the *1-2-1 Detox*, and where necessary, clients should be offered sessions which address low self-confidence and self-esteem levels.

8. Clients should be encouraged to continue to attend psychosocial interventions. This will engage clients in the longer term and actively seek to change their drug related behaviour therefore increasing the likelihood of long-term abstinence.

9. The *1-2-1 Detox* should continue to operate at its current volume (i.e. with three rooms) within its current facility. The current volume should be maintained to avoid dilution of the service and difficulties in maintaining the one-to-one model.

10. The partnership between II and LHP should continue in its current format. The use of gatekeepers at each service should be continued to ensure continuity in robust referral and assessment procedures, and useful information sharing. The gatekeepers should always be of a managerial level to ensure that they have the authority to make and implement decisions and changes as necessary is maintained.

11. The LHP outreach team should continue to be used as a method of contact with clients when they return to the community, particularly to establish contact with clients who are not engaging with any aftercare or mainstream services, or who have relapsed into drug use post-detoxification.

12. There is a requirement for II to develop their own governance framework. Specifically, the framework should outline the roles and responsibilities of LHP and II, the administration of over the counter medications and risk management. The governance framework should be developed for II by an

appropriately qualified person and independently validated. The governance framework document should be updated, as necessary, to reflect any changes to the *1-2-1 Detox* and its function.

13. The steering group should continue to meet regularly and be used as a forum for communication and decision making. The steering group membership should be expanded to include key individuals from any other agency that contributes to the *1-2-1 Detox*.

14. II should seek clarification regarding the legislation governing smoking in facilities such as the *1-2-1 Detox*. The provision of smoking areas within the *1-2-1 Detox* should be re-examined within this context.

15. Additional weekend and evening activities should be made available. Client's suggestions for additional sources of entertainment including a library, DVD library, games consoles and exercise equipment should be considered and if possible developed.

16. The *1-2-1 Detox* should expand the client catchment area into other Merseyside areas. This expansion should be staged and the outcomes of clients from other areas and any different or additional issues that this presents closely monitored. An expansion would address the periods where beds are unoccupied and ensure the *1-2-1 Detox* is operating in an economically viable and competitive manner. Where expansion is undertaken, it is essential to ensure that clients receive a comparative level of service and have similar outcomes as those from the Sefton area, with a full package of care made available for non-local clients. II should source the appropriate clinical support for other areas through a partner agency and it is recommended that in areas where LHP have a base that this agency should be approached first as the clinical provider to maintain this relationship and continuity in practice.

17. The *1-2-1 Detox* should seek to secure long-term funding. The expansion of the *1-2-1 Detox* into other areas and commissioning agreements with local DA(A)T areas should contribute to financial security of the service and job security, staff retention and continued professional development of the *1-2-1 Detox* staff members.

18. Should the expansion of the *1-2-1 Detox* be undertaken there will be a requirement for an additional staffing capacity to manage the *1-2-1 Detox* administrative duties and the general day to day running of the service (i.e. staff rotas, clients activity schedules, food provision etc). However, it is essential that the decisions to accept or refuse clients into the *1-2-1 Detox* remains at a managerial level.

19. The *1-2-1 Detox* should continue to accept clients who have a primary opiate problem. Any expansion to include clients with other primary drug problems (i.e. cocaine, amphetamine etc) should only be undertaken after a rigorous review of evidence of effective treatment for these groups of drug users. Should the review indicate that detoxification would be

effective and other types of drug using clients accepted into the *1-2-1 Detox*, there should be a pilot period and an in-depth evaluation to assess the effectiveness of their treatment.

References

Amato, L., Davoli, M., Ferri, M., Gowing, L. & Perucci, C.A. (2004). Effectiveness of interventions on opiate withdrawal treatment: an overview of systematic reviews. *Drug and Alcohol Dependence,* 73, 219-226.

Backmund, M., Meyer, K., Eichenlaub, D. & Schutz, C.G. (2001). Predictors for completing an inpatient detoxification program among intravenous heroin users, methadone substituted and codeine substituted patients. *Drug and Alcohol Dependence,* 64, 173-180.

Bradley, B.P., Gossop, M., Brewin, C.R., Phillips, G. & Green, L. (1992). Attributions and relapse in opiate addicts. *Journal of Consulting and Clinical Psychology,* 60(3), 470-472.

British Psychological Society (BPS). (2006). *Code of Ethics and Conduct.* Leicester: BPS.

Broers, B., Giner, F., Dumont, P. & Mino, A. (2000). Inpatient opiate detoxification in Geneva: follow-up at 1 and 6 months. *Drug and Alcohol Dependence,* 58, 85-92.

Chuntuape, M.A., Jasinski, D.R., Fingerhood, M.I. & Stitzer, M.L. (2001). One-, three-, and six-month outcomes after brief inpatient opioid detoxification. *American Journal of Drug Abuse,* 27(1), 19-44.

Clarke, A. (1999). *Evaluation Research. An Introduction to Principles, Methods and Practice.* London: Sage Publications.

Day, E. (2005). *Opiate detoxification in an inpatient setting. Research briefing: 9.* London: National Treatment Agency.

Day, E., Ison, J. & Strang, J. (2005). Inpatient versus others settings for detoxification for opioid dependence. *Cochrane Database of Systematic Reviews, 2*.

Department of Health (DH). (2005). *Alcohol Needs Assessment Research Project (ANARP). The 2004 national alcohol needs assessment for England.* London: The Department of Health.

Department of Health (England) and the devolved administrations. (2007). *Drug Misuse and Dependence – Guidelines of Clinical Management.* London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2007). Guidelines for the evaluation of treatment in the field of problem drug use. Lisbon: EMCDDA.

Ewing, J.A. (1984). Detecting Alcoholism: The CAGE Questionnaire. *Journal of the American Medical Association,* 252, 1905-1907.

Franken, I.H.A., Hendriks, V.M. & van den Brink, W. (2002). Initial validation of two opiate craving questionnaires The Obsessive Compulsive Drug Use Scale and the Desires for Drug Questionnaire. *Addictive Behaviors,* 27, 675-685.

Fisk, J. E. & Warr, P. (1996). Age-related impairment in associative learning: The role of anxiety, arousal and learning self-efficacy. *Personality and Individual Differences,* 21, 675-686.

Ghodse, A. (1995). *Drugs and Addictive Behaviour: A Guide to Treatment* (2nd ed.). Oxford: Blackwell Science.

Ghodse, A., Dunmore, E., Sedgwick, P.M., Howse, K., Gauntlett, N. & Clancy, C. (1997). Changing pattern of drug use in individuals with severe drug dependence following inpatient treatment. *International Journal of Psychiatry in Clinical Practice,* 1, 287-294.

Gossop, M. (1990). The development of a short opiate withdrawal scale (SOWS): Brief report. *Addictive Behaviors,* 15, 487-490.

Gossop, M. (1992). Addiction: treatment and outcome. *Journal of the Royal Society of Medicine,* 85, 469-472.

Gossop, M., Johns, A. & Green, L. (1986). Opiate withdrawal: inpatient versus outpatient programmes and preferred versus random assignment to treatment. *British Medical Journal,* 293, 103-104.

Gossop, M., Green, L., Phillips, G. & Bradley, B. (1989). Lapse, relapse and survival among opiate addicts after treatment. A prospective follow-up study. *The British Journal of Psychiatry,* 154, 348-353.

Gossop, M. & Strang, J. (2000). Price, cost and value of opiate detoxification. *British Journal of Psychiatry,* 177, 262-266.

Gossop, M., Stewart, D. & Marsden, J. (2006). Readiness for change and drug use outcomes after treatment. *Addiction,* 102, 301-308.

Haug, N.A., Sorensen, J.L., Gruber, V.A. & Song, Y.S. (2005) Relapse prevention for opioid dependence. In G.A. Marlatt & D.M. Donovan (Eds.), *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviours (2nd Edition).* New York: The Guilford Press.

Home Office. (2008). *Drugs: Protecting Families and Communities. The 2008 Drug Strategy.* London: Home Office.

Joe, G.W., Simpson, D.D. & Broome, K.M. (1999). Retention and patient engagement models for different treatment modalities in DATOS. *Drug and Alcohol Dependence,* 57, 113-125.

Jones, H.E., Wong, C.J., Tuten, M. & Stitzer, M.L. (2005). Reinforcement-based therapy: 12-month evaluation of an outpatient drug-free treatment for heroin abusers. *Drug and Alcohol Dependence,* 79, 119-128.

Katz, E.C., Chutuape, M.A., Jones, H., Jasinski, D., Fingerhood, M. & Stitzer, M. (2004). Abstinence incentive effects in a short-term outpatient detoxification program. *Experimental and Clinical Psychopharmacology,* 12(4), 262-268.

Keen, J., Oliver, P., Rowse, G. & Mathers, N. (2001). Residential rehabilitation for drug users: a review of 13 months intake to a therapeutic community. *Family Practice,* 18(5), 545-548.

Littlewood, C. (2007). A new buprenorphine prescribing service for opiate detoxification. *Psychiatric Bulletin,* 31, 91-93.

Luty, J. (2003). What works in drug addiction? *Advances in Psychiatric Treatment,* 9, 280-288.

Luty, J. (2004). Treatment preferences of opiate-dependent patients. *Psychiatric Bulletin,* 28, 47-50.

Martinotti, G., Cloninger, C.R. & Janiri, L. (2008). Temperament and character inventory dimensions and anhedonia in detoxified substance-dependent subjects. *The American Journal of Drug and Alcohol Abuse,* 34, 177-183.

Matthews, G., Jones, D.M. & Chamberlain, A.G. (1990). Refining the measurement of mood: The UWIST mood adjective checklist. *British Journal of Psychology,* 81, 17-42.

McCaffrey, B. R. (1996). *Treatment protocol effectiveness study.* Washington, DC: Office of National Drug Control Policy. Accessed October 26th, 2008, from http://www.ncjrs.org/ondcppubs/publications/treat/trmtprot.html

McCambridge, J., Gossop, M., Beswick, T., Best, D., Bearn, J., Rees, S. & Strang, J. (2007). In-patient detoxification procedures, treatment retention, and post-treatment opiate use: Comparison of lofexidine + naloxone, lofexidine + placebo, and methadone. *Drug and Alcohol Dependence,* 88, 91–95.

Meier, P.S. & Best, D. (2006). Programme factors that influence completion of residential treatment. *Drug and Alcohol Review,* 25, 349-355.

Miller, W. R. & Tonigan, J. S. (1996). Assessing drinkers' motivation to change. The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors,* 10**,** 81–89.

Murphy, P.N., Bentall, R.P., Ryley, L.D. & Ralley, R. (2003). Predicting postdischarge opiate abstinence from admission measures of motivation and confidence. *Psychology of Addictive Behaviours,* 17(2), 167-170.

National Collaborating Centre for Mental Health (NICE). (2008). *Drug misuse. Opioid detoxification*. The NICE Guideline. Leicester: The British Psychological Society.

National Institute for Health and Clinical Excellence (NICE). (2007). *Drug misuse. Opioid Detoxification*. London: NICE.

National Treatment Agency (NTA). (2006). *Models of care for treatment of adult drug misusers: Update 2006.* London: NTA.

O'Brien, C.P. & McLellan, A.T. (1996). Myths about the treatment of addiction. T*he Lancet,* 347, 237-40.

Robson, C. (2000). *Small-Scale Evaluation*. London: Sage Publications.

Shaw, C. (2008). *Evaluation of the 1-2-1 Detox pilot at Independence Initiative. Interim Report.* Unpublished report

Unithan, S., Gossop, M. & Strang, J. (1992). Factors associated with relapse among opiate addicts in an out-patient detoxification programme. *The British Journal of Psychiatry,* 161, 654-657.

Wareing, M. & Sumnall, H. (2006). *A feasibility study to establish a new model for inpatient detoxification at the Independence Initiative.* Liverpool: Liverpool John Moores University.

West, S.L., O'Neal, K.K. & Graham, C.W. (2000). A meta-analysis comparing the effectiveness of buprenorphine and methadone. *Journal of Substance Abuse*, 12, 405-414.

Westreich, L., Heitner, C., Cooper, M., Galanter, M. & Guedj, P. (1997). Perceived social support and treatment retention on an inpatient addiction treatment unit. *American Journal on Addictions,* 6(2), 144-149.

Wilson, B.K., Elms, R.R. & Thomson, C.P. (1975). Outpatient vs hospital methadone detoxification: An experimental comparison. *Substance Use & Misuse,* 10(1), 13-21.

Wright, N.M.J., Sheard, L., Tompkins, C.N.E, Adams, C.E., Allgar, V.L. & Oldham, N.S. (2007). Buprenorphine versus dihydrocodeine for opiate detoxification in primary care: a randomised controlled trial. *BMC Family Practice*, 8, 3.

Appendix 1

Additional Information on Validated Scales Included in Structured Interview Guides

Additional information on the validated scales utilised in the semi-structured interview guide is detailed below.

Short Opiate Withdrawal Scale (SOWS) (Gossop, 1990)

The SOWS assesses the severity of different conditions, experienced in the previous 24 hours, associated with opiate withdrawal on a 4-point scale from *none* (score=0) to *severe* (score=3). The mean score provides an indication of the respondent's severity of withdrawal in the previous 24 hours.

Desires for Drug Questionnaire (DDQ) (Franken, Hendriks & van den Brink, 2002)

The DDQ measures opiate craving at that moment i.e. immediate craving. It consists of 14 statements, the participant rates how much they agree or disagree with the statement of a 7-point Likert Scale. The DDQ has three subscales measuring desire and intention, negative reinforcement and control. The mean score on each subscale is calculated as an indication of level of desire for drugs.

Anxiety, Depression & Arousal Questionnaire (Fisk & Warr, 1996; Matthews, Jones & Chamberlain, 1990)

This questionnaire is comprised of an anxiety and arousal measure (Fisk & Warr, 1996) and a depression measure (Matthews, Jones & Chamberlain, 1990). For each adjective the participant is asked to identify the response which most described their current state from 'not at all', 'slightly', 'moderately', 'very' and 'extremely'. Total scores were calculated for each of the measures with certain items reversed scored so that the higher the score indicates a higher level of anxiety, arousal or depression. A mean score of 18 or above was considered *high*, a score of less than 18 was considered *low*. Low scores of depression and anxiety were favourable, whereas a high score of arousal was more favourable.

The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) – Personal Drug Use Questionnaire (Miller & Tonigan, 1996)

The Personal Drug Use SOCRATES Questionnaire Version 8 is a 19-item scale on which the participant rates how much they agree or disagree with statements on a 5-point Likert Scale. SOCRATES has three sub-scales measuring recognition, ambivalence and taking steps. The decile range for each subscale is determined by the total score on each subscale. Due to the small sample size, the decile ranges were further recoded as follows:

- Very low and low = Low
- Medium = Medium
- Very high and high - High

The CAGE Questionnaire (Ewing, 1984)

The CAGE questionnaire is a four-item psychological tool used to detect alcoholism. Participants can respond either yes or no to each item. Scoring is based on one point for ‘yes’ and zero points for ‘no’. A score of two or above is clinically significant, indicating that the respondent is at risk of problem drinking and alcoholism.