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What Are Drug Users Looking For When They Contact Drug Services: abstinence or harm reduction?

NEIL MCKEGANEY[1]*, ZOË MORRIS[2], JOANNE NEALE[3] & MICHELE ROBERTSON[4]

[1] *Centre for Drug Misuse Research, University of Glasgow, UK;*
[2] *Judge Institute of Management, University of Cambridge, Trumpington Street, Cambridge, UK;* [3] *Department of Social Policy and Social Work, University of York, UK;*
[4] *Robertson Centre for Biostatistics, University of Glasgow, UK*

ABSTRACT *Within the UK and in many other countries two of the most significant issues with regard to the development of health and social care services for drug users has been the growth of the consumer perspective and the philosophy of harm reduction. In this paper we look at drug users' aspirations from treatment and consider whether drug users are looking to treatment to reduce their risk behaviour or to become abstinent from their drug use. The paper is based on interviews using a core schedule with 1007 drug users starting a new episode of drug treatment in Scotland. Participants were recruited from a total of 33 drug treatment agencies located in rural, urban and inner-city areas across Scotland. Our research has identified widespread support for abstinence as a goal of treatment with 56.6% of drug users questioned identifying 'abstinence' as the only change they hoped to achieve on the basis of attending the drug treatment agency. By contrast relatively small proportions of drug users questioned identified harm reduction changes in terms of their aspiration from treatment, 7.1% cited 'reduced drug use', and 7.4% cited 'stabilization' only. Less than 1% of respondents identified 'safer drug use' or 'another goal', whilst just over 4% reported having 'no goals'. The prioritization of abstinence over harm reduction in drug users treatment aspirations was consistent across treatment setting (prison, residential and community) gender, treatment type (with the exception of those receiving methadone) and severity of dependence. On the basis of these results there would appear to be a need for harm reduction services to be assiduous in explaining to clients the reason for their focus and for ensuring that drug users have access to an array of services encompassing those that stress a harm reduction focus and those that are more oriented towards abstinence.*

Introduction

Over the last fifteen years, two important developments have in different ways influenced the provision of treatment and care to drug users within the UK. The first of these is an increasing focus on the consumer perspective in health and social care services (Forbes & Sashidharan, 1997; Lindow, 1999;

* Correspondence to: Neil McKeganey, Centre for Drug Misuse Research, University of Glasgow, UK. Tel: 0141 3303616. Fax: 0141 3302820. E-mail: N.McKeganey@socsci.gla.ac.uk

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Kemshall & Littlechild, 2000). The second is the increase in, and diversity of, harm reduction initiatives that have evolved as pragmatic approaches to the problem of drug addiction (Berridge, 1991; Stimson, 1995; Gossop, 1998).

In terms of the consumer perspective, it has become commonplace to obtain the views of service users in assessing virtually every aspect of service provision from development to delivery. Historically, though, this perspective has had rather less impact on the world of drug misuse treatment than other areas of health and social care (Neale, 1998). By and large, professionals and resource availability determine the planning and provision of drug treatment and this seems to hold true across the various available treatment options. Thus, decisions about whether individuals are offered methadone maintenance rather than methadone reduction, dihyrocodeine rather than diazepam, or a place in a residential rehabilitation unit rather than a residential detoxification service are seldom made by drug users themselves. Similarly, the particular mix of residential and community-based services within any given local area is invariably a function of provider perspectives and funding priorities, not the views of local people affected by addiction (Kennedy *et al.*, 2001).

The above does not, of course, mean that the views of drug users have been entirely ignored by service planners and providers. Indeed, the Scottish Executive has recently promoted the development of drug-user groups throughout Scotland in the expectation that service providers would consult their clients. In addition, the Scottish Drugs Forum has an active user and carer involvement team, which had been developing a distinctive model of practice across the country over the last four years. Despite this, it is still the case that hardly any drug action teams within Scotland or elsewhere in the UK, have allocated places specifically to members of drug-user groups (Kennedy *et al.*, 2001).

If the consumerist perspective has had only limited impact on the world of drug-use treatment and care within the UK, the situation is very much the opposite in respect of the harm-reduction perspective. In recent years, this approach has had an unparalleled impact on the world of drug-abuse treatment and care (Marlatt, 2002). Although there is no clear single definition of harm reduction within the drugs field, the International Harm Reduction Association has characterized it as a set of:

> . . .policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individuals, drug users, their families and their communities. (IHRA, 2002)

The harm-reduction perspective is thus very different from the abstinence approach, which encourages drug users to cease all use of illicit substances. A harm-reduction model of service delivery recognizes that abstinence can be an unrealistic goal for many. Accordingly, it is considered entirely appropriate to provide addicted individuals with the means to reduce the harm associated with their continued substance use. Within the UK, much of the impetus underpinning the development of harm-reduction approaches in the care and treatment of drug users was the statement by the Advisory Council for the Misuse of Drugs that the:

> threat to individual and public health posed by HIV and AIDS was much greater than the threat posed by drug misuse. (ACMD, 1988)

In light of the perceived public health threat of AIDS and HIV, the UK Government extended the use of harm-reduction measures, such as substitute drug prescribing, and authorized the development of needle and syringe exchange programmes. Whilst some people saw the provision of sterile injecting equipment as condoning an illegal activity, there was widespread agreement that this was at least one way in which drug users, as well as society in general, could be protected from a deadly new infection (Berridge, 1991; Gossop, 1998). Over time, harm reduction has acquired the status of a distinctive social movement with its own international organization and annual conference lobbying in favour of a wide range of pragmatic drug policies including the depenalization or legalization of illegal drug use, pill testing, and the development of safe injecting rooms.

In this article, we combine this focus on consumerism and harm reduction by asking whether drug users contacting treatment services are looking for help in reducing the harms associated with their continued drug use or for assistance in achieving abstinence. The data on which the paper is based have been collected in the course of an ongoing prospective study of drug users contacting drug-treatment services in Scotland. It will be helpful to provide some background information on this study before looking in detail at individuals' treatment aspirations.

Methods

Between 1 October 2001 and 30 June 2002, 1007 individuals beginning a new episode of drug treatment were interviewed as part of the Drug Outcome Research in Scotland (DORIS) study. DORIS is a prospective cohort research project that is designed to provide a wide-ranging evaluation of the main treatment services currently available to drug users in Scotland. The study has full ethical approval from the Scottish Multi Centre Research Ethics Committee and involves an intake interview (to collect baseline information on participants' circumstances) and interviews thereafter on an eight-monthly cycle to assess individuals' progress over time.

Drug users were recruited onto the study from 33 agencies located in rural, urban and inner-city areas across Scotland. Prior to joining the cohort, potential participants were given an information sheet about the research; fully apprised of the study requirements—including the need for subsequent interviews; reassured of the confidentiality of their responses; and asked to sign a consent form. After completing their first interview, each drug user was paid £10 for their inconvenience [1] and told when they would next be contacted.

Respondents were interviewed using a structured questionnaire administered by one of a team of trained interviewers from the Centre for Drug Misuse Research at Glasgow University. This structured questionnaire collected information on issues including current and recent drug use (legal, illegal and prescribed), previous use of drug-treatment services, employment status, housing circumstances, relationships with peers and family members, health, involvement in criminal activities, and contact with the criminal justice system. Interviews generally took between one and two hours to complete and 88% of the new treatment clients approached agreed to participate in the research. The figure of 1007 drug users included in this study represents approximately one in twelve

of all drug users contacting drug-treatment services in Scotland for a new episode of treatment over a twelve-month period.

Of the 1007 drug users interviewed, 695 (69%) were male and 312 (31%) were female. Their median age was 27 years (range 16–53) and 1000 (99%) were white. Women were generally younger than men, the median age of females being 24 years compared to 28 years for males. At the time of their first interview, respondents were starting to receive a range of treatments. These were substitute drugs excluding methadone [2] (29%); methadone (27%); non-clinical assistance [3] (20%); residential detoxification (12%); and residential rehabilitation (12%). In total, 560 individuals (56%) were recruited from a community setting (specialist drug service, GP practice or pharmacy) and 447 individuals (44%) were recruited from a prison. Although this paper is principally based upon data from the first sweep of DORIS interviews the paper also contains information on the proportion of drug users who were able to attain a period of abstinence eight months and sixteen months following their recruitment into the study. These data on abstinence are drawn from the second and third sweeps of the DORIS study.

Statistical Analysis

Analyses were carried out on the drug users' achievement hopes from the drug agency they were attending. Comparisons were made between the responses for treatment type (residential, non-clinical, etc.); treatment setting (community and prison); gender and finally severity of dependence scale (SDS) score for their main drug. As part of the DORIS questionnaire, the SDS was completed in respect of each individual's main drug (Gossop *et al.,* 1995). The SDS involves five questions (each scored from 0 to 3) that collectively quantify the degree of psychological dependence experienced by users. These five questions are: 'Did you ever think that your [main drug] use was out of control?'; 'Did the prospect of not taking any [main drug] make you anxious or worried?'; 'Did you worry about your [main drug] use?'; 'Did you wish you could stop using [main drug]?'; and 'How difficult would you find it to stop, or go without [main drug]?'. Total SDS scores range from 0 to 15, with higher scores indicating more problematic drug use. For the categorical variables analyses were carried out using chi-square test of association. For the SDS score an analysis of variance test (ANOVA) was carried out.

Results

The data in Figure 1 are based on responses to the question: 'What changes in your drug use do you hope to achieve by coming to this agency?' Drug users were then asked to tick all responses that applied to them from a list of options that included: 'abstinence/drug free'; 'reduced drug use'; 'stabilization'; 'safer drug use'; 'no goals'; and 'other goals'. Nine individuals indicated 'other goals' and in eight cases it was possible to categorize the response into one of the options 'abstinence/drug free', 'reduced drug use', 'stabilization' or 'safer drug use'.

In response to this question more than half of the drug users (56.6%) cited 'abstinence' as the only change they hoped to achieve from attending the drug agency, while nearly a quarter (24.0%) ticked more than one goal. Relatively small proportions of respondents cited 'stabilization' (7.4%) or 'reduced drug use' (7.1%) as the only change they wished to bring about while even fewer selected 'safer drug use' (0.7%). In addition, 4.1% had 'no goals'.

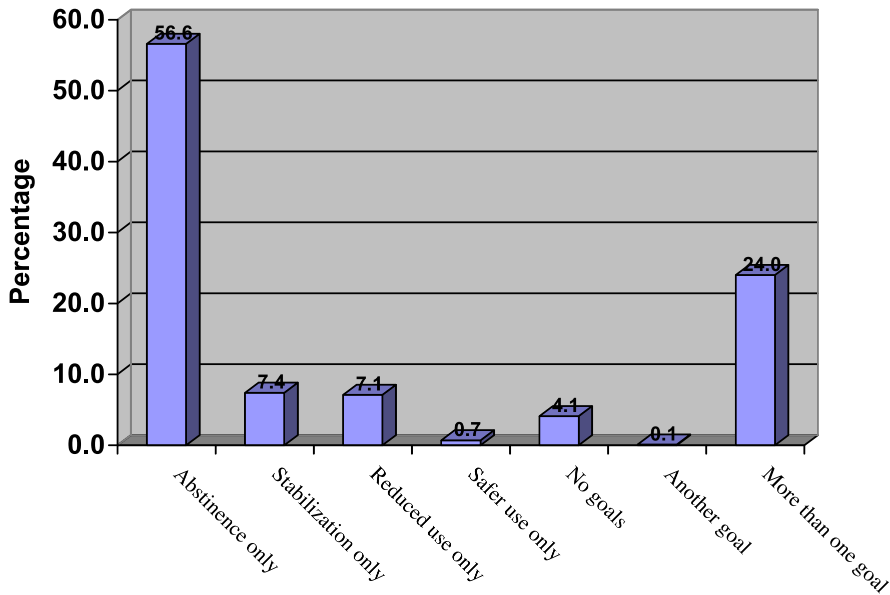

Figure 1. Treatment goals.

Figure 1 clearly shows that abstinence was the mostly commonly reported outcome desired from contact with a drug-treatment service. Nevertheless, the finding that nearly a quarter of drug users cited more than one goal seemed to merit closer investigation. Accordingly, the responses of individuals citing multiple goals were reviewed and reclassified with the responses evident in Table 1.

Table 1 shows that multiple responses subdivided into two main categories: 'abstinence plus one or more harm-reduction goals' ($n = 185$) and 'combinations of harm-reduction goals' ($n = 41$). The most frequent combination of outcomes was 'abstinence and stabilization' ($n = 82$). In addition, a small number of individuals ($n = 16$) reported other groupings such as 'abstinence, harm reduction and other' or 'harm-reduction goal(s) and other'. Table 1 thus reveals that respondents often desired a range of outcomes in tandem and frequently these involved abstinence in combination with one or more harm-reduction aims.

For subsequent analyses, it seemed most useful to focus on the three main groups of respondents: (1) those seeking abstinence only ($n = 570$); (2) those desiring harm-reduction goal(s) only ($n = 197$) [4]; and (3) those wanting both abstinence and harm-reduction goal(s) ($n = 199$). Respondents citing no goals ($n = 41$) were excluded from these analyses, as were responses which could not be included in one of the three groupings, such as wishing to be abstinent from a particular drug or those specifying particular treatment types. In addition, respondents who failed to answer the question were excluded from the analysis. Therefore 966 cases were included in the subsequent analyses.

Aspirations by Treatment Type

In the introduction to this paper, we noted that drug treatment providers have in recent years focused increasingly on harm reduction. Nonetheless, it

Table 1. Breakdown of respondents citing more than one goal

Goal	*n*
(1) *Abstinence plus harm-reduction goal(s)*	
Abstinence and stabilization	82
Abstinence, stabilization and reduced use	33
Abstinence and all 3 harm-reduction goals	32
Abstinence and reduced use	23
Abstinence and safer use	8
Abstinence, stabilization and safer use	5
Abstinence, reduced use and safer use	2
Total	185
(2) *Harm-reduction goal(s) only*	
Stabilization and reduced use	23
All 3 harm-reduction goals	10
Stabilization and safer use	4
Reduced use and safer use	4
Total	41
(3) Includes 'other'—14 with both abstinence and harm-reduction goal(s), and 2 with harm-reduction goal(s)	16

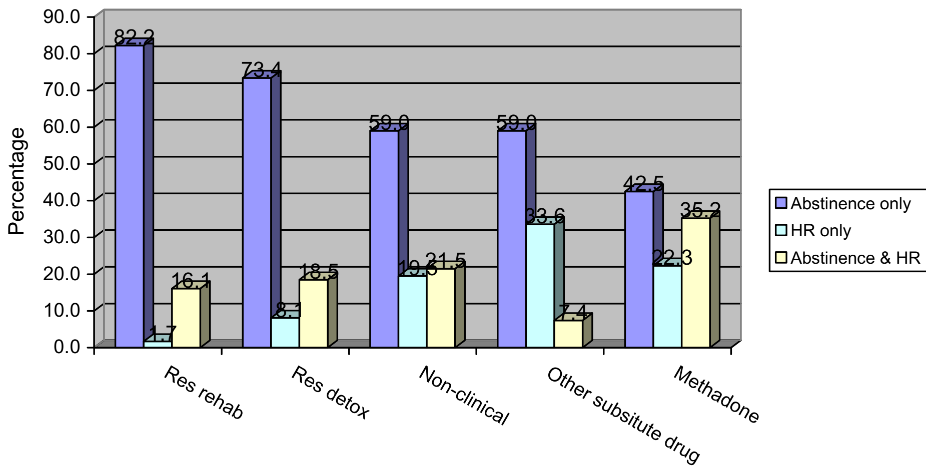

Figure 2. Aspirations by treatment type.

would not be accurate to state that all kinds of service provision have embraced this philosophy to the same extent. For example, residential detoxification and rehabilitation services obviously adhere to a more abstinence-orientated approach than substitute prescribing services. It therefore seemed valuable to consider the drug users' aspirations according to the different kinds of treatment that they were about to receive and the results of this analysis are depicted in Figure 2.

Although abstinence was clearly the predominant aspiration across each of the treatment categories, particularly high proportions of drug users in residential services were seeking to be completely drug free. Indeed, over 80% of residential rehabilitation clients and 73.4% of residential detoxification clients reported abstinence to be their only goal. Amongst those receiving non-clinical treatments and other substitute drugs, the percentages of individuals desiring

abstinence were also very high (nearly 60% in both cases). Meanwhile, 42.5% of respondents receiving methadone stated that they hoped to achieve abstinence alone.

Figure 2 also reveals that the most common treatment goal after abstinence only was abstinence in conjunction with a harm-reduction goal or goals. This was the case across all treatment types except other substitute drugs where harm reduction was preferred. These differences in aspirations across treatment types were highly statistically significant with a *p*-value of <0.0001.

Aspirations by Treatment Setting

As highlighted previously, nearly half of the DORIS sample was recruited from the Scottish Prison Service. Treatment options offered in this setting differ appreciably from those offered within the community. Specifically, there is a greater inclination to non-clinical interventions, non-methadone drugs tend to be preferred over methadone, and there is an absence of 'residential treatment provision' (as defined by 'a structured programme of therapeutic activities within a supportive residential environment'). In addition, drug users' motivations for participating in treatment within a prison are likely to differ from motivations within the community. In this regard, previous research has shown that prison and criminal-justice referred drug-treatment clients tend to be less motivated than other drug users (Farabee *et al.*, 1993; Kline, 1997; Brochu *et al.*, 1999). Accordingly, one might speculate that the prisoners would be less likely to aspire to being completely drug free.

Figure 3 compares respondents' aspirations for treatment across the prison and community drug-treatment settings and shows that 59.1% of drug users interviewed in prison reported 'abstinence' only as their desired goal, with 33.3% citing harm-reduction goal(s) and 7.6% reporting both abstinence and harm-reduction goals. Amongst those interviewed in community-based agencies, 59.0% cited 'abstinence' only, 10.9% reported harm-reduction goal(s), and 30.1% indicated combined goals. Counter intuitively, then, prison drug users were no less inclined towards abstinence or harm reduction goals, but seem much less likely to specific both types of goal. Nonetheless, they still expressed a very clear desire to be totally drug free. These differences in aspirations across treatment setting were highly statistically significant with a *p*-value of <0.0001.

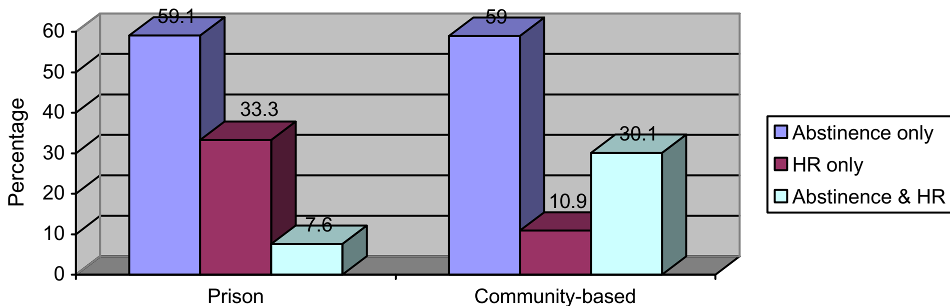

Figure 3. Aspirations by treatment setting.

Aspirations by Gender

Although there has been no previous research investigating gender differences in desired treatment outcomes, a number of studies have revealed significant differences in the drug careers and treatment trajectories of men and women (e.g. Callaghan & Cunnigham, 2002; Green *et al.*, 2002; Neale, 2004). In particular, there is widespread evidence that women encounter more barriers in accessing drug services and these include negative stereotyping; social stigma; ignorance about the range of treatment options available; concerns about childcare; transportation problems; and anxieties about the confrontational models used within some treatment programmes (Copeland, 1997; Fraser, 1997; Marsh *et al.,* 2000). It seemed likely, therefore, that those women who have actually begun the treatment process would be very determined to succeed and thus especially keen to achieve abstinence.

Figure 4 presents responses for the DORIS drug users' treatment goals by gender. As anticipated, women were more likely to report aspirations for abstinence. However, this should not detract from the finding that once again being drug free was the overwhelming desire of both male (57.1%) and female (63.4%) drug users. At the same time, very similar proportions of men and women desired harm reduction goal(s) (21.6% and 17.6% respectively) and combined abstinence and harm-reduction goal(s) (21.3% and 19.0%) respectively. These differences in aspirations across gender were not statistically significant with a *p*-value of 0.17.

Aspirations by Severity of Drug Dependence

Levels of drug dependence have been found to predict initiation of treatment (Weisner *et al.*, 2001) in some cases but not in others (Hser *et al.*, 1997). Despite this, there is some logic to the argument that individuals experiencing the most problematic forms of drug use are more likely to identify a need for complex multifaceted forms of treatment. In contrast, those with the least problematic use may be more likely to desire less radical and less interventionist forms of assistance because they do not yet feel ready for change. In the next analysis, we considered treatment aspirations by levels of dependence.

The 966 DORIS study participants included in the analysis had a mean total SDS score of 10.65 ($SD = 3.85$), thus indicating overall high levels of drug dependence compared with other studies (Gossop *et al.,* 1995). The breakdown of mean scores of the three respondent groups is depicted in Figure 5.

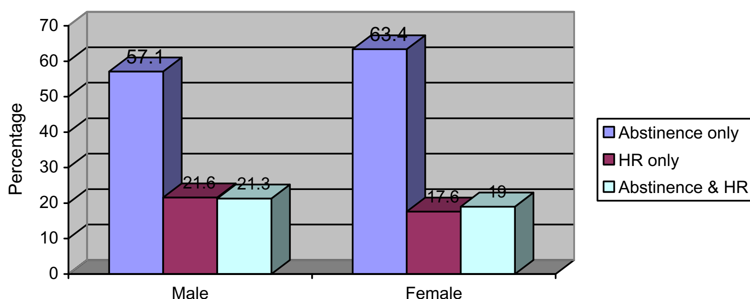

Figure 4. Aspirations by gender.

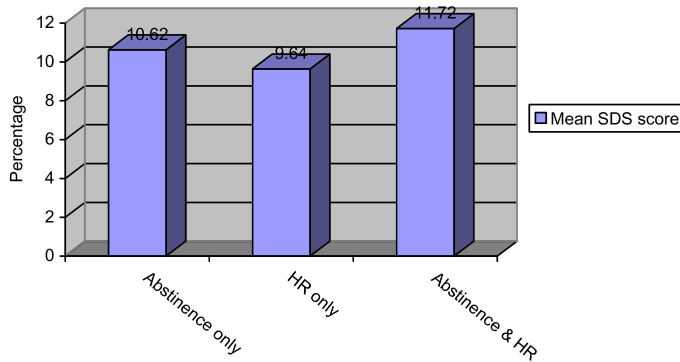

Figure 5. Aspirations by severity of dependence scale score for main drug.

As anticipated, those who said they had harm-reduction goals had the lowest mean SDS score ($M = 9.64$; $SD = 3.98$). Meanwhile, those who stated abstinence as their only goal had a slightly higher mean score ($M = 10.62$; $SD = 3.93$) and those identifying harm-reduction and abstinence goals reported the highest levels of dependency ($M = 11.72$; $SD = 3.17$). These differences in SDS score between the aspirations groups were highly statistically significant with a p-value of <0.0001.

Achieving Abstinence

Much of this paper has been about drug users' aspirations for abstinence. We have shown that the majority of drug users recruited into the DORIS research cited abstinence as the sole change that they wished to bring about on the basis of contacting the drug agency where they were interviewed. Because DORIS is a prospective study, with drug users being interviewed on an eight-monthly cycle, we have the opportunity of looking at what proportion of drug users were able to sustain a period of abstinence over successive sweeps of the DORIS interviews. In Figure 6 we have summarized the proportion of respondents who were abstinent of all drugs and those whose drug use was confined to cannabis at the time of their successive DORIS interviews. We have also looked at the proportions of DORIS respondents who had a period of abstinence of at least two weeks' duration *between* the DORIS interview sweeps. In the case of the second DORIS interviews, undertaken eight months after the first interview, we were able to interview 85% of the original 1007 cohort (859 respondents). In the case of the third interview (undertaken sixteen months after the first DORIS interview) we were able to interview 78% of the original 1007 cohort.

Between the first and second DORIS interviews 11% of respondents had a period of abstinence of at least two weeks' duration, where their drug use was confined to cannabis, and 30% had been completely abstinent over a similar period. However, at the actual point of the DORIS 2 interviews only 6% of drug users were abstinent apart from cannabis use. At the point of the DORIS 3 interviews 12% of drug users were abstinent from all drugs. These data show that a significant minority of drug users are able to achieve at least a period of abstinence within a relatively short period of having started drug-abuse treatment. It is evident, however, that sustaining abstinence is by no means a simple task.

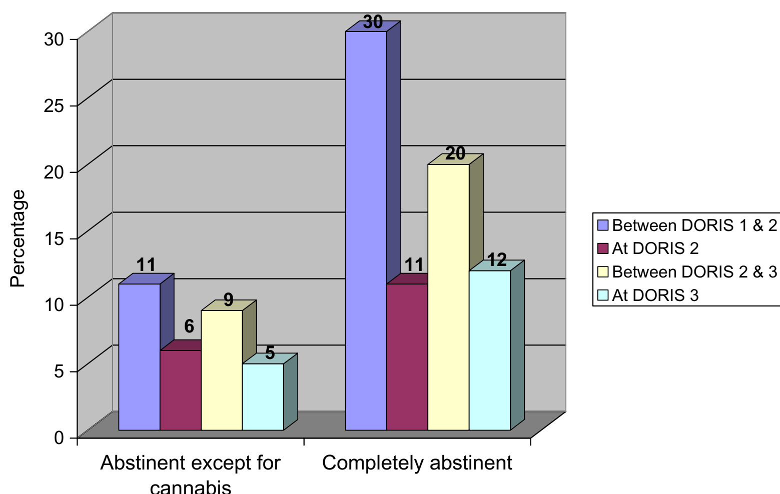

Figure 6. Abstinence periods between DORIS 1 and 2, and between DORIS 2 and 3 (% drug users).

Discussion

In this paper, we have looked at drug users' aspirations for change on first contact with a drug agency for a new episode of treatment. We have seen that when individuals contacting drug-treatment services were presented with a range of possible aims (from abstinence to harm reduction), almost 60% of individuals said that abstinence was the only goal that they were seeking to achieve. This finding was consistent across all treatments except methadone; all treatment settings, except community settings (where 70% of methadone prescribing took place); as well as gender. Whilst there were differences in level of dependence between the groups, those respondents with the highest levels were the most likely to cite abstinence as the desired goal of treatment.

In contrast, very few drug users cited harm-reduction outcomes (reduced use, stabilization or safer use) as the only change that they desired. This is a surprising finding since harm reduction and its associated goals have had an unparalleled influence on the world of drug-user treatment and care in the UK over the last ten years or so. On this basis one would have thought that the goals of harm reduction (reduced risk behaviour, stabilization, safer injection etc.) would have been more salient in terms of drug users' aspirations for treatment.

The data presented within this paper should not be interpreted simplistically as suggesting that one type of approach to service provision (abstinence) should be provided in preference to another (harm reduction). A number of other relevant factors need to be considered. Firstly, the views of drug users are only one of many relevant factors that should be considered when developing and delivering drug-treatment services. Harm-reduction approaches are a valuable public-health measure in protecting drug users, their families and the wider community from a range of harms. It is therefore arguable that even if no individuals cited harm-reduction as an aim, it would still be appropriate for services to provide a harm-reduction input. Secondly, few people make an immediate and once-only transition from drug use to abstinence, which means that harm-reduction measures are still relevant to them as long as they are using.

Thirdly, abstinence may not be a realistic goal for some drug users even though they may aspire to it. Thus, one might want to question whether persistent failed attempts at abstinence will ultimately be more damaging and demoralizing for drug-agency clients than success on at least one significant measure of harm reduction. We cannot answer this question with these data. What we can say, however, is that in principle the two things (harm reduction and abstinence) are not mutually exclusive and that if we conceive of recovery as a process, then harm reduction may form an essential element of transitional support, allowing that peoples' capacities for and commitment to change may vary over time, such that in due course abstinence may come to be perceived by drug-treatment agency staff as an achievable for many if not most drug users (McIntosh & McKeganey, 2002).

Finally, there may be some issues around the meaning of abstinence itself that might influence the findings. It is possible that drug users may have been providing what they thought would be the most socially acceptable response to the question about desired changes in drug use rather than the response which most accurately reflected their actual expectations for change, thus over-prioritizing abstinence. In addition, drug users' definitions of abstinence were not sought. In this regard, further examination of whether respondents really interpreted abstinence as meaning 'no illicit drugs at all' rather than only 'abstinence from their main problem drugs' seems to be required. It may also have been the case that in responding to the question about treatment goals, drug users were more inclined to cite what they saw as their long-term and ultimate objective, rather than any intermediate aims, within which harm reduction might have featured more prominently.

These uncertainties aside, a key message appears to be arising from the data, that is, that many drug users simply do not perceive harm reduction as treatment goals that they are seeking to bring about at the point of contacting agencies. Within the context of the growing value placed upon obtaining the views of consumers and service users, it is obviously important that service providers consider and address the changes that drug users themselves are hoping to achieve in coming forward for treatment and this would suggest much greater emphasis being given to abstinence than has been the case in the recent past within drug-treatment agencies. Certainly the finding that as may as 30% of drug users within the DORIS study had a period of complete abstinence of at least two weeks duration between their first and second interview suggests that abstinence as such is not an unrealistic goal for a significant minority of drug users even if they are likely to face difficulties in sustaining their non-drug use.

Conclusions

Over recent years, policy and practice within the drug-misuse field has tended to prioritize harm reduction over abstinence. The reasons for this are likely to be complex but may in part consist of a perception amongst workers in drug-treatment and care services that abstinence is a long-term goal that is difficult, if not impossible, to achieve and that their efforts will be more profitably directed at reducing some of the dangers associated with individuals' continued drug use. What emerges very clearly from our data is the fact that, on the whole, drug users contacting drug-treatment services in Scotland tend to be looking for abstinence rather than harm reduction as the change they are seeking to

bring about. In the light of this finding there is a need to ensure that services that have a harm-reduction focus are prepared to enable drug users to move over time from a concern with reducing the dangers of their continued to drug use towards a position where their drug use ceases. Equally, given that so few respondents articulated harm reduction as the change that they were seeking to bring about on the basis of having contacted drug-treatment services, it is clearly important that drug-agency staff (many of whom will be adopting a harm-reduction perspective in their work with clients) invest time in explaining to their clients the value of harm reduction as part of a broader strategy of ceasing all drug use. Finally on the basis of these results it is important to ensure that drug users have access to an array of services both those which have a harm-reduction focus and those that are more explicitly oriented towards abstinence.

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Notes

[1] Drug users interviewed within prisons were excluded from payments for legal reasons.
[2] Mostly, dihydrocodeine and diazepam.
[3] Counselling or group work.
[4] This comprised individuals desiring stabilization ($n = 75$), reduced drug use ($n = 71$), safer drug use ($n = 7$) and any combination of one or more harm-reduction goals ($n = 44$).

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