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# Executive Summary

## Barriers to the Effective Treatment of Injecting Drug Users

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# BARRIERS TO THE EFFECTIVE TREATMENT OF INJECTING DRUG USERS

## EXECUTIVE SUMMARY

### AIMS AND OBJECTIVES →

The aims of the study were to provide new UK information on how injecting drug users' (IDUs') engagement with services could be improved and the cost/ benefit implications of successfully increasing take-up. Qualitative and economic data were collected to investigate:

- the nature and extent of barriers to effective treatment encountered by IDUs
- the particular circumstances in which specific barriers do/do not prevent IDUs from accessing treatment
- how barriers may vary between sub-groups of IDUs
- how barriers may differ between service types and possible ways of removing barriers to the effective treatment of IDUs
- the costs to society of IDUs not entering treatment
- the costs of removing barriers to treatment encountered by IDUs.

### POLICY RELEVANCE →

Identifying factors that prevent IDUs from accessing treatment, whilst simultaneously suggesting ways of removing those barriers, will help to inform current UK drug policy and practice. Specifically, it will increase understanding of how best to engage some of the most problematic groups of drug users in treatment, potentially leading to reduced drug-related deaths, infectious diseases, and crime.

### BACKGROUND →

The provision of treatment services is known to be effective in reducing drug injecting, the sharing of injecting equipment, health risks, criminal activity, and drug misuse more generally. The UK government is consequently committed to ensuring that effective drug treatment is easily accessible to all who need it, and has advocated that each local region should offer a full range of services organised into four broad tiers. At the time this research was undertaken, these were:

- **Tier 1:** Non-substance misuse specific (or generic) services
- **Tier 2:** Low threshold open access drug misuse services
- **Tier 3:** Structured community-based specialist drug misuse services
- **Tier 4:** Residential substance misuse specific services

A preliminary review of the international literature found that drug injectors encounter many barriers when they try to access services. However, there was little UK research, few studies based on qualitative data, and limited information on the economic costs associated with treatment barriers.

### RESEARCH DESIGN AND METHODS →

The study was conducted in three geographical locations across West Yorkshire: a large city, a medium-sized town, and a small town within a rural area. Fieldwork took place between January 2006 and May 2006 and involved interviews with 75 current injectors. Recruitment was through three needle exchange programmes, with additional snowball sampling to ensure inclusivity of gender, ethnicity, and primary drug injected (opiates and stimulants).

Qualitative data were collected using a semi-structured interview schedule and then analysed thematically with the assistance of the software package MAXqda2.

Economic data were collected via a structured interviewer-led questionnaire on service use and the EQ-5D health status questionnaire. Cost profiles for each individual were calculated using unit cost estimates; regression methods explored whether these cost profiles could be predicted from particular individual characteristics; and the potential costs and benefits of reducing treatment barriers in the study areas were assessed.

### PARTICIPANTS →

Of the 75 injectors, 28 were recruited from the large city, 25 from the medium-sized town, and 22 from the small rural town. Fifty-one participants were male and 24 were female. Their ages ranged from 19-48 years and 9 were from a Black or Minority Ethnic (BME) group. Forty-eight were primarily heroin injectors, 15 were primarily stimulant injectors (crack cocaine or amphetamines), and 12 injected both opiates and stimulants equally.

## FINDINGS

Injectors reported improvements in the availability and accessibility of services in recent years - particularly needle exchange provision and criminal justice/ prison drug treatments. Nonetheless, they still identified a wide range of barriers. These were believed to be an overall lack of services, long waiting lists, inflexible appointment systems and opening times, bureaucracy, travel (particularly travel costs), poor confidentiality, and limited knowledge of what services were available. Other barriers related to the particular needs, expectations and psychological states of mind of individual injectors - such as disliking services, feeling ashamed or embarrassed about drug taking, not being motivated for treatment, or being afraid of the consequences of others finding out about an addiction.

Some aspects of treatment and service delivery (such as agency rules and urine testing) were 'disliked' by many participants, but did not function as major 'barriers' to service usage. Other aspects (such as judgemental staff attitudes and travel) were barriers to some injectors, but not to others. Contrary to the existing literature, there was little evidence that being female or from a BME group created particular access problems. In contrast, stimulant users, homeless drug users, injectors with parenting responsibilities, injectors with mental health problems, injectors with physical mobility problems, and injectors who did not have supporting family members encountered many difficulties.

Barriers varied between service types - for example, the main barriers in pharmacies differed from the main barriers in residential services. Additionally, there were some differences in barriers between service tiers. Thus, negative staff attitudes and restrictive appointments/ opening hours were particularly problematic in respect of Tier 1 services, whereas limited service availability/ poor knowledge of service availability was most often a problem amongst Tier 3 and 4 services. There was also variation at the individual agency level. For instance, negative staff attitudes were a problem in some pharmacies and not others, or even between some pharmacy staff in a particular outlet but not others.

On the whole, injectors tended to have realistic expectations about how much agencies could support them given resource constraints, and were generally quite satisfied with current service provision. Nevertheless, they still wanted more services and a broader range of support at individual agencies. Equally, they suggested changes to service provision that would improve access to support without necessarily increasing service costs (for example, more flexible service delivery and more sympathetic staff attitudes).

Economic data confirmed that the 75 injectors were very expensive in terms of societal resources. The mean cost per injector over the previous six-month period had been £931 in health care costs, £167 in social care costs, £693 in addiction service costs, and £4,145 in criminal justice service costs. Female injectors, those with mobility problems and those with high levels of anxiety had consumed disproportionate health costs. If it is assumed that successful treatment would reduce societal costs by 75%, then the financial benefits of providing treatment would exceed the

costs if a treatment episode cost less than £4,452. Using a more conservative estimate that successful treatment would reduce societal costs by 25%, positive savings would be generated if treatment cost less than £1,484.

## CONCLUSIONS

Injectors reported that services had improved and become easier for them to use in recent years. Despite this, there was still insufficient support - especially locally available services - and many barriers limited service use. These barriers related both to structural aspects of service provision and delivery (such as waiting lists and bureaucracy), but also to injectors' individual circumstances and psychological and emotional states of mind (such as their poor motivation for treatment and feelings of shame and embarrassment).

Whilst some aspects of service provision (such as agency rules or judgemental staff attitudes) were disliked by many injectors, they did not necessarily operate as barriers to treatment use. Indeed, whether or not a particular negative aspect of treatment became an actual barrier was contingent on a range of factors. These included the frequency with which the problem occurred, the service in which the problem occurred, and the personal characteristics of the person encountering the problem.

Although some groups of injectors experienced particular difficulties accessing services, barriers were often individual and context specific. Thus, the extent to which any single injector experienced a particular barrier reflected a complex interplay of their demographic characteristics, drug use, health, social situation, family support network, and emotional and psychological state of mind. Similarly, whilst particular barriers commonly clustered around specific service types, it was not possible to conclude that a particular agency would necessarily present a particular barrier.

Key strategies for reducing barriers to the effective treatment of IDUs identified by the qualitative data were: providing more services (particularly substitute prescribing, psychiatric & counselling services, and advice & information), as well as targeting provision at those groups currently encountering access problems; improving existing services (for example, by re-organising current provision, investing in staffing and staff training, and addressing the poor communication systems operating within some services); and capitalising on those factors which can facilitate help seeking (such as encouraging and enabling supportive relationships and recognising when life events and changes in injectors' emotional and psychological states of mind present positive opportunities for change).

The costs to society of IDUs not entering treatment included continued street drug use, high risk injecting practices, and on-going crime. The economic data indicated that the mean cost per injector over the previous six-month period had been £5,936. The provision of additional treatment places seemed very likely to yield positive net financial benefits given the savings that would be made in future health, social care, addiction service and criminal justice system costs.

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