National Treatment Agency for Substance Misuse

Summary of the NECTOS study of specialist crack services

Crack suite of documents

This document is part of a series of research projects commissioned following the launch of Tackling Crack: A National Plan (Home Office, 2002), which was implemented in 2003. This series was jointly funded by the NTA and the Home Office, to increase the knowledge base around crack treatment.

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The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:

- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

Reader information

Document purpose	To assess the effectiveness of specialist crack services and to compare differently configured services
Title	Summary of the NECTOS Study of Specialist Crack Services
Lead authors	Tim Weaver, Jozella Hart, Deborah Rutter, Nicky Metrebian and Khatidja Chantler
Publication date	April 2007
Target audience	Primarily providers and commissioners of drug treatment services in England.
Circulation list	Managers and commissioners of treatment services Co-ordinators and chairs of local partnerships (e.g. drug action teams and crime and disorder reduction partnerships). Service user and carer groups. Commissioners of pharmaceutical enhanced services local pharmaceutical committees. Regional government department leads on drugs. Central government department leads on drugs.
Description	This document summarises the National Evaluation of Crack Cocaine Treatment and Outcome Study (NECTOS). The study evaluated a number of specialist crack treatment services, with the aim of describing the interventions provided, and measuring their effectiveness in engaging and retaining clients and how well they helped clients reduce consumption.
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Gateway/ROCR approval	The NTA is a self-regulating agency in relation to the Department of Health Gateway

Disclaimer

This publication is not a journal publication and does not constitute National Treatment Agency or Department of Health guidance or recommendations. The views expressed by this study are not necessarily those of the Department of Health or the NTA, but are based on externally refereed research.

Introduction

The Government acknowledges that crack and cocaine use is a significant public health issue. It has attached a high priority to getting more crack users into treatment and retaining them, and commissioning new research into the effectiveness of different treatment methods.

Tackling Crack: A National Plan (Home Office, 2002) was implemented in 2003. There has been no independent assessment of existing crack and cocaine treatment services in this country to establish what interventions are delivered, how effective services are, and what lessons can be learned for future service planning. This evaluation aims to directly address this shortcoming.

The National Evaluation of Crack Cocaine Treatment and Outcome Study (NECTOS) (NTA, 2007, forthcoming) evaluated a number of well-established specialist crack treatment services. The intention was to describe the interventions they provided, to measure how effective the services were in engaging and retaining crack users, and to assess whether they helped users reduce their consumption.

Study aims and method

The main aims of the study were:

- To measure the how effective specialist services are in attracting and retaining clients, and achieving their stated outcomes
- To provide commissioners, managers and clinicians with comparisons of differently configured services.

We evaluated one Tier 4 service and four services offering Tier 3 interventions on the following measures:

- Processes – measurements of service activity and treatment processes
- Outcomes – assessments of crack use in the 30 days before referral, and 30 and 90 days after beginning treatment
- Qualitative measures – a qualitative investigation of service management, based on opinions of clients, staff and management.

The services

The evaluation focused on a core group of four Tier 3 services (evaluated using a common measure) and a single Tier 4 service that required separate evaluation. Services, staffing, target populations, referral and assessment procedures, and treatment programmes are detailed in the full NECTOS study. The characteristics of the services evaluated are outlined in Table 1.

Client characteristics

The study encompassed four specialist crack or stimulant drug treatment services. Client data was obtained in 447 of 477 cases that were referred during a recruitment period. Ninety-nine cases met our criteria for inclusion in the outcome study, which focused on crack users treated at a Tier 3 service.

Age, gender and ethnicity

The ratio of males to females was approximately 3:1, with average ages of 33 for men and 31 for women. Age and gender profiles were similar in all services, but there were significant variations in the ethnic mix. White British clients made up around 70 per cent of the client population, with Black British and Afro-Caribbean clients making up about 12 per cent.

Referral

Around one-third of referrals were self-referral, with drug services referring around 20 per cent and criminal justice agencies referring about 25 per cent.

Only half of the study group started treatment, with a significant minority of the referred population – around 40 per cent – failing to turn up for assessment. There were no significant differences in the age, sex and ethnicity profiles of the assessed and non-assessed populations, or between the assessed population and those who started treatment.

Clients referred by other drug services, GPs and criminal justice agencies appeared least likely to attend assessment. Referrals from arrest referral workers and DTTO clients were seen as potentially disruptive of more motivated clients.

Two-thirds of those assessed were referred because of problems relating to their use of crack and a slight majority of crack users were also reported to use other drugs.

Patterns of use

Around one-third of clients used crack and heroin, while one-fifth used non-opiates in addition to crack. There were large and statistically significant differences between the services in the pattern of drug use. On average, clients used crack in the ten days of the 30 days before referral, spending in the region of £60 on those days, totalling £600 a month. However, there was clinically significant variability between the four services in terms of these measures of consumption.

Most clients in the NECTOS population financed their crack use from state benefits, while one-quarter funded their use wholly or partly through criminal activity and around one-fifth used borrowed money or ran up debts.

Qualitative investigations

The qualitative study found that some clients reported spending less money on crack when it was used with opiates. However, this pattern of use could have a disinhibiting effect, reducing the determination to resist cravings from crack, thereby complicating and prolonging withdrawal. Moreover, crack and heroin lessen each other's worst effects (the lethargy of heroin and the paranoid and edgy aspect of crack as the high rapidly wears off), so the craving for one may entail the use of the other.

Services felt that the recruitment of black, minority and ethnic (BME) clients into treatment may be influenced by the location of the service. A view was expressed that services are ideally based on the geographical margins of areas with large BME populations, although some services felt geographically rather than culturally inaccessible to clients.

Ethnicity and gender

Services were aware of the pervasiveness of negative stereotypes about crack and violence, and the problems these presented in addressing crack use among Afro-Caribbean and Black British groups.

Services were concerned that disproportionately high representation of these groups on caseloads should not reinforce stereotypical associations between drug use and ethnicity.

Workers highlighted the benefits that having a diverse staff team brought in terms of the improved empathy between staff and Black clients. There was also an acknowledgement that counselling may rely on Euro-centric models.

No services had an explicit policy of matching clients to keyworkers on the basis of ethnicity. However, there was a desire to offer choice – if diversity within staff teams permitted it – where this could be consistent with therapeutic goals or empowerment of the client. The recognition of power relations, and how they may manifest themselves in particular relationships, is the central

	Service #1	Service #2	Service #3	Service #4
Casemix				
Inclusions	Primary crack cocaine users	Primary crack and cocaine users Other stimulant users	Primary crack and cocaine users Other polydrug users if "heavy" crack cocaine user	Primary crack and cocaine users Other polydrug users if "heavy" crack cocaine user
Exclusions	Primary opiate users	Primary opiate users	None, so long as client uses crack	None, so long as client uses crack
Age	18+	18+	No age restriction	18+
Interventions				
Structured day programme	Yes, core service	No, but under development	No	No
Treatment duration	12 weeks	Open-ended	Open-ended	Open-ended
Keywork or case management	Yes	Yes	Yes	Yes
Tier 2 drop-in	No	Yes, twice weekly	Yes, daily open access drop-in	No
Summary of intervention strategy	Care planning and keywork. Structured day programme. Alternative therapies	Care planning and keywork. Day programme. Group activities and drop-in Alternative therapies	Care planning and keywork. Drop-in Alternative therapies	Care planning and keywork. No day programme.or drop-in Alternative therapies

Table 1: Characteristics of the services evaluated

motive for matching in therapeutic relationships in these services, rather than client choice.

No services had found a satisfactory way of engaging non-English speakers. The interviews generated very little evidence of discrimination, tensions or conflict within services and these instances were dealt with promptly and appropriately.

Women who attend services may be subject to negative stereotyping. All service managers and many staff felt their inability to provide childcare was a barrier to engaging women. Women seen in services are often in exploitative or coercive relationships with men and fear retaliation, and stigmatisation may also deter some seeking contact with services. It was acknowledged that there were arguments for women-only services or sessions – only one of the services had successfully established a women-only afternoon. A shortage of units for women with young children was noted.

Treatment processes

Almost all clients were offered assessment, but less than two-thirds attended. Around one-fifth of clients who attended assessment did not subsequently start treatment.

There were significant differences in the speed with which the services were able to offer clients an assessment, and access to treatment. The lowest levels of pre-treatment dropout were observed at low-threshold services offering a mix of Tier 2 and 3 interventions, which permitted rapid assessment and access to treatment. Services that did not provide Tier 2 services effectively had to operate waiting lists for Tier 3 treatments.

A total of 221 clients started treatment at the four services, which was around 80 per cent of the assessed population, but only half the referred study population.

Retention

A total of 221 clients from the original sample started treatment at the four services. Over two-fifths of clients dropped out of treatment within 30 days and about ten per cent failed to enter treatment following a single contact or within seven days of their treatment start date. Only around one-third of the treatment population was still in treatment at 90 days or had completed the structured day programme offered by one service.

The highest levels of retention were observed among crack users receiving Tier 3 interventions. While there were large differences in retention of all stimulant drug users between services, there was no significant difference in the retention of clients in the more tightly defined crack-using population treated with Tier 3 interventions.

Keywork

There were large and significant differences in the frequency, duration and content of keywork contacts between the teams. The service with the most intensive contact with keyworkers saw clients every four days on average, with comparable figures for the other services varying between nine and thirteen days. The median length of individual keywork contacts was 60 minutes and keyworkers frequently reported that visits covered a number of topics and involved several interventions. More than one-fifth of all contacts take place within the clients' first ten days in treatment and about half of all contacts are recorded by day 30.

The treatment process – qualitative findings

The crack treatment services we evaluated deliver Tier 3 treatments, whether through keyworking or group programmes. These are diverse, adaptive to individual circumstances, and consciously focus on changing clients' awareness of their maladaptive behaviour in order to implement strategies for change.

The emphasis of treatment is on the client being supported to develop their own potential for change and treatment must therefore be client-centred. Care plans are tailored to individual circumstances and convey progression through treatment and progress on agreed goals. The motivational aspect of treatment is also ongoing.

The keyworker-client relationship is probably the key tool of most therapeutic Tier 3 services. Successful relationships between staff and clients in crack services appear to be generally characterised by respect and empathy, are non-judgmental and supportive but also challenging.

Key factors promoting engagement

Self-referral

The motivation of clients to contact services may be relatively short-lived and the use of crack is highly stigmatised. Self-referral provides a degree of confidentiality.

First impressions

Reception areas and the environment were important to clients attending services for the first time. Clients gave positive feedback on service environments they described as attractive, calm, relaxing and clean. Segregation, locked offices, obvious security devices, panic buttons and glass barriers at reception were identified as off-putting by staff and clients.

First contacts with staff

This contact may be the only opportunity to reinforce a client's motivation to be in treatment. Workers need to be welcoming, be seen as trustworthy, observe appropriate levels of confidentiality, and be pragmatic and flexible.

Responding to the client's motivation and ambivalence

Many clients are ambivalent about treatment, and early dropout may indicate they are not ready to access treatment. Clients should be made to feel they can re-establish contact and not feel rejected by overly formalised discharge or case closure.

Speed in initiating treatment

As client motivation is often fragile, all agreed it was desirable to get clients into treatment as soon as possible.

Open access Tier 2 services

Tier 2 drop-in services were seen as important in promoting engagement and retention. Clients could access Tier 2 informally from the point of referral, effectively accessing treatment immediately. Retention was enhanced because clients were more likely to be available for rapid assessment. Moreover, clients receiving Tier 3 keyworking were able to access the additional Tier 2 interventions they found valuable.

Safety and confidentiality

Because of the link between violence, crack dealing and acquisitive crime, clients need to feel confident that:

- Street issues such as drug debts cannot impinge on the service
- Staff can and will manage conflict
- Attendance at the service is not likely to be detrimental in other circumstances
- Disclosure to staff will be dealt with in confidence.

It is important that appropriate ethical practices in relation to confidentiality are made clear to clients.

Group therapy

Group programmes tended to have specific difficulties in engaging and retaining clients. Dropout can be high in the first days of attendance because the initial contrast between the "using" lifestyle and the group programme is too stark.

Workers felt that because opiate-based drug services are full of current users, they are not appropriate places for crack users struggling to be abstinent. For some clients, talking about crack use is a real threat to abstinence and some services promote rules to discourage talk about drug use except in keywork sessions.

The views of both staff and clients suggested that the appropriate length of treatment was something to be determined on an individual basis. Clients favoured open-ended treatment episodes and although they are very keen to move on and leave the crack-using periods of their lives behind (and sceptical about the value of aftercare in this context), many also felt that they could be susceptible to relapse even after lengthy periods of abstinence and might re-establish contact with services.

Treatment outcomes

Our analysis was conducted using data from keyworkers on crack use and criminal behaviour. We assessed the validity of this approach by comparing keyworker reported data with client self-reports where both sources were available. Our findings suggest that keyworker-reported data provides a reliable proxy measure for assessing crack use.

Among crack-using clients in the NECTOS population who remained in treatment at 30 and 90 days, there were large and statistically significant reductions in the frequency and amounts of crack consumed. There were significant reductions in the consumption of crack in the 30 days prior to each assessment point, although there were no statistically significant increases in abstinence.

Based on keyworker reported data on clients in treatment at 30 days, about 14 per cent were identified as involved in crime during that 30-day period – this is a reduction of around 25 per cent. However, keyworker-reported data about criminal activity needs to be used and interpreted with caution.

Qualitative findings

Clients and staff identified the following aspects of treatment as having an important influence on attaining their treatment goals.

Staff attitudes

People using crack do engage in antisocial behaviour and workers need to be non-judgmental while balancing this with approaches that encourage less self-destructive behaviour. Flexibility, both in terms of therapeutic approach and service delivery, appeared to be a key value for services

Relationships with keyworkers

In the absence of medication, service staff are the media through which most therapeutic interventions are delivered. Clients said therapeutic relationships were crucial to the success of treatment.

Support with practical problems often produced a dividend in terms of building trust between keyworker and client, and thereby promoting retention and improved treatment outcomes.

Support

Carers, if supportive, could be very helpful to clients encouraging clients into treatment and help sustain abstinence. Volunteers working within services (usually Tier 2) may act as positive role models.

There did not appear to be a high demand for aftercare groups among crack users. Clients interviewed said this was part of a desire to move on from crack use.

Empowering clients

Treatment is understood by keyworkers as a joint enterprise in which the client is empowered to lead. A common theme highlighted by workers during keywork is the examination of the link between actions and their consequences, where actions include relapse, drug use, offending behaviour and damage to relationships with significant others. Raising self-esteem without appearing to patronise the client, or excusing or colluding with bad behaviour, is one example of the fine balance that crack keyworkers have to achieve in their work.

Encouraging self-responsibility

Client-identified treatment goals and strategies promoted engagement and all of the crack workers described the importance of motivational interviewing. Developing self-confidence and accepting of personal responsibility were seen as key aspects of treatment.

Relapse prevention

Relapse prevention for those seeking abstinence, or harm reduction for those continuing to use, is a central feature of the treatment intervention.

Exit strategies

The end of treatment is an aspiration, but also a difficult transition. All services were ambivalent about discharging people who had not turned up for appointments, looking for ways to leave the door open to further approaches.

Findings from the crisis residential service

Clients attending this service showed a much higher rate of attendance for assessment (around 80 per cent). Of the population that were admitted, about one-third had discharged themselves before completing their planned admission period.

Around one-half of clients had referred themselves, one-quarter had been referred by criminal justice agencies and most of the remainder had come via drugs services.

The ethnic mix was: white British (40 per cent), Black British of Caribbean origin (20 per cent), Black British of African Origin (12.5 per cent) and mixed race (12.5 per cent).

Based on average measures, a "typical" client had the following characteristics:

- Male
- 31 years of age
- Had used in the 30 days prior to admission, on average for 25 days
- Had spent an average of £100 per day on crack when using, and £2,100 per month over the 30-day period prior to admission
- Financed their crack use through crime.

Compared to the period before admission, there were significant reductions in the frequency of clients' crack use. In addition, there were significant positive changes in clients' ratings of their physical and psychological health over the admission period.

Around two-thirds of clients reported that cravings for crack had decreased during their admission, nearly all reported being able to resist these cravings while at the residential unit, and most of this proportion expressed confidence that they would be able to do so in the community. Clients expressed positive views about the quality and appropriateness of the service.

Discussion

Services for crack users exhibit a variety of treatment models. There are common features between the services – a commitment to practical client-led and problem-solving casework, complementary therapies, and psychosocial interventions orientated towards abstinence as the primary treatment goal – but also important points of contrast (the extent to which treatment programmes were structured and the presence or absence of Tier 2 interventions).

Key findings

1 There appears to be a demand for all of the services that matches and in some cases exceeds capacity

2 Services are susceptible to shifts in the patterns of drug use and need to be adept at responding to referrals from clients using a range of stimulant drugs

3 There was a strong consensus on the need for specialist crack services (or at the very least for stimulant users generally) that were separate from those for primary opiate users

4 There are high rates of dropout among the referred population prior to assessment. Retention in the pre-treatment phase

appears to be increased by open access Tier 2 interventions and minimising times between referral and assessment

5 Clients beginning treatment show high rates of dropout. Higher rates of retention during treatment may be associated with higher threshold services offering more intensive casework. However, there is no known optimal period of treatment and our qualitative findings suggest that some clients may derive benefit from brief contact with services

6 Referral source appears to be a variable associated with differential rates of attrition. Clients referred by criminal justice agencies, GPs and other drug services were least likely to attend and engage with treatment

7 The proportion of female clients referred and in treatment was comparable to opiate-based services. Barriers to women accessing treatment were identified

8 The proportion of clients from Black and minority ethnic groups varied between services, but was relatively high compared with opiate-based services. There were no differences in rates of retention in treatment between Black, Asian and white clients.

9 Powerful and critical points were made in the accounts of staff and clients about the construction and categorisation of drugs, and the way in which these could become stereotyped by race and gender. Issues relating to ethnic monitoring and cultural matching require further careful consideration

10 The frequency, duration and content of keywork varied significantly between and within services. However, keywork could often be extremely intensive particularly in the early stage of treatment and workers appeared to require an eclectic range of generic skills to meet the presenting needs of clients

11 The pattern of engagement and keyworking with clients of crack treatment services may be quite different from those in opiate services. Clients can and do stay in treatment for several months and may also have a series of short treatment episodes spanning several years. Crack services therefore need to offer attractive, intensive and relatively brief interventions, which are client-led

12 Clients of Tier 2 and 3 services retained in treatment at 30 and 90 days achieved large and significant reductions in the frequency of crack use and the amount spent on crack. The outcomes for those who have brief contact with services are unknown and require further investigation

13 Most clients of the Tier 4 residential service complied with the treatment regime and reported benefits in terms of their self-rated health and motivation, and achieved abstinence during their admission.

Study limitations

Given available resources, we were unable to collect self-reported outcome data from clients. Process and crack use outcome data was therefore obtained from each client's keyworker, but this did not enable us to assess as wide a range of outcomes as we had intended, such as physical and mental health, and client satisfaction. We were also unable to assess the outcomes for clients who left treatment between our 30-day and 90-day assessment points. This problem was compounded by high levels of attrition and low levels of recruitment. We have not had the statistical power to undertake any analysis of the outcomes experienced by subgroups of crack users.

Conclusions

Specialist crack treatment services in the UK are relatively new and do not have an established evidence base. This evaluation provides new evidence, but raises as many new research questions.

Judged in terms of recruitment, engagement and measures of retention conventionally applied to opiate treatment, the Tier 2 and 3 services we evaluated did not appear to perform well. But it is debatable whether conventional measures of retention provide an appropriate basis to evaluate beneficial engagement with specialist crack treatment services. Unfortunately, our research is unable to provide any quantitative evidence to support or refute the hypothesis (which to some extent the qualitative work encourages) that a proportion of the clients who spend brief periods in treatment may also derive important benefits from contact with services. This needs to be investigated further.

Notwithstanding the need to interpret cautiously the retention data, the evaluation does suggest that retention may be improved when clients are able to access Tier 2 interventions at referral (or rapidly after), ensuring rapid assessment and initiation of treatment. This evidence should inform the future configuration of services and ensure that approaches with the potential to maximise early engagement are implemented, and that services have the resources to respond to increased demand. Although they were only a small proportion of the referred population, clients who were retained in treatment for 30 days were found to have significantly reduced their crack use. Although the increase in the proportion of clients that achieved complete abstinence was not statistically significant, the marked reductions in the frequency and quantity of crack use we observed is clearly a positive finding. If these reductions in crack use were shown to be associated with reductions in criminal activity (which our data suggests might be possible) then this outcome would undoubtedly have to be viewed as even more positive and important. Further research is needed to investigate the outcomes for clients on an intention-to-treat basis. This will

require the sufficient investment into studies that include intensive community follow-up.

While there is a need for enhanced treatment of polydrug users receiving opiate substitution therapy, clinics orientated to opiate substitution therapy may not be the appropriate setting in which to treat primary crack users and a twin-track approach to service development may be justified. This should ensure that interventions appropriate to the treatment of crack and other stimulant use, in the context of opiate substitution therapy, are implemented. This will be in parallel to the continued development of specialist stimulant treatment services, on the basis of emerging best practice and in accordance with the needs to achieve an evidence base on effectiveness.

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