

‘They can’t solve the problem without us’: a qualitative study of stakeholder perspectives on user involvement in drug treatment services in England

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Abstract

Providers of public health care are under pressure to involve service-users in service development. This pressure emanates from legislators and the public who promote user involvement (UI), as a ‘means to an end’ and/or ‘an end in itself’. Case studies in six English commissioning areas explored the process and purpose of UI in drug treatment services. In-depth interviews with 139 respondents who commission, manage, deliver or use services were conducted. We identified ‘non-’, ‘passive-’ and ‘active participant’ users. Active users were commonly motivated by a desire for social justice, a social conscience and personal development. UI was evidently influenced by multiple social organizational and personal factors. Some ‘generic’ factors have been reported in other settings. However, the illegality of drug use powerfully affects all stakeholders creating a context unique to drug treatment settings. Stigma and power imbalances were pervasive, and strong tensions concerning the goal and purpose of UI were apparent. Within the UK context, we identified five organizational approaches to UI. Based on rationale and objectives of UI, and the scope of influence accorded users, organizations could be characterised as protagonists, pragmatists, sceptics, abstainers or avoiders. We conclude that many tensions apparent in local level UI have roots in UI policy, which is ambiguous about: (1) benefit and rights, and (2) the promotion of healthcare objectives within a UK drug strategy driven by a crime reduction agenda. This duality must be resolved for UI to flourish at local level.

Keywords: drug misuse, qualitative research, service delivery and organization, service-user involvement, substance misuse, user involvement

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Introduction

Providers of publicly funded health care are under pressure to involve communities of interest in the planning and development of services (Department of Health 2001, 2002). Terms such as ‘empowerment’, ‘participation’ and ‘user involvement’ (UI) have become ubiquitous in healthcare discourse (Beresford 2002). However, the meaning and purpose of UI remain unclear (Thompson *et al.* 2002, Rutter *et al.* 2004), and providers and users

‘understand and practise UI in different ways according to individual ideologies, circumstances, and needs’ (Fudge *et al.* 2008). Furthermore, evidence that UI influences service development is, at best, equivocal (Crawford *et al.* 2002, 2004, Rutter *et al.* 2004). We note the potential for UI at multiple levels from individual care through to national policy. Our focus is exclusively on involvement in the local organization and delivery of services.

The UI imperative has roots in both the ‘consumerism’ of the political new and rights-based social activism

giving rise, respectively, to 'top-down' and 'bottom-up' involvement. While service improvement is central to each approach (Beresford 2002), it has been observed that motivation differs. Government is concerned with efficiency and accountability, whereas the public may be more concerned with service quality and citizens' rights (Buchanan *et al.* 2005). UI has thus been conceived as either a 'means to an end' seeking essentially to contain costs, and an 'end in itself' where it is valued irrespective of tangible outcomes (Mosquera *et al.* 2001).

In practice, the above distinction is not always clear-cut, however. For example, both US and UK healthcare policies explicitly promote UI as a 'means to an end', respectively, seeking to reduce health costs (Dougherty 2003) and enhance accountability and improve quality, thereby increasing satisfaction (Department of Health & Farrell 2004). These policies envisage users as discerning 'purchasers' of services and as community members, with a responsibility to contribute to the greater good through active participation in their own health care. Thus, UI is a function of citizenship and 'an end in itself'. Similarly, social movements drawing on 'rights' and social justice perspectives have been instrumental in encouraging service reform consistent with government 'consumerist' goals.

In the absence of specific guidance about implementation of UI, health services have employed diverse mechanisms, often unsystematically, to engage users (Crawford *et al.* 2003, Rutter *et al.* 2004). Organization-led consultative mechanisms predominate (Crawford *et al.* 2003, Rutter *et al.* 2004), and bottom-up involvement is limited.

A recent review in the UK concluded that not all UI mechanisms have been 'desirable or effective' (NHS 2004). Commentators have highlighted concern regarding power sharing, 'gesture politics' (Russell & Smith 2003) and potential health implications for users (Wallcraft *et al.* 2003). The considerable diversity evident in UI practice across and within health fields (Rhodes & Nocon 1998) reflects the complex influence of cultural, organizational, process and personal factors.

UI in the drug treatment context

Political support for UI in drug treatment has been attributed to the necessity of engaging with users to address the public health crises precipitated by AIDS and hepatitis C (Zibbell 2004). Internationally, drug user self-organizations have been instrumental in the development of harm minimization services and, acting as a conduit of users' views, have influenced public policy (Friedman *et al.* 2001, Kerr *et al.* 2004). Nonetheless, the level of involvement in UK drug treatment services is low (Schulte *et al.* 2007), and user influence

has been limited (Barnes *et al.* 1999, Bunce 2005). A best practice model is yet to emerge (Crawford *et al.* 2003).

Efforts to respond to problems associated with 'problematic drug users' are guided by the UK government's drug strategy. Although recently revised (Home Office 2008) at the time of the study the Updated Drug Strategy of 2002 was in force (Home Office 2002). Since 2002, the National Treatment Agency (NTA) has been charged with achieving the strategy's goal of increasing the availability, capacity and effectiveness of treatment. During the study period responsibility for local strategy implementation was delegated to 149 Drug Action Teams (DATs) across England. DATs are partnerships representing local authorities and health, justice and voluntary sector agencies, and have responsibility for commissioning treatment services.

The NTA's (2002) guidance to DATs on commissioning drug treatment services endorses involvement of users in the 'development of treatment services generally'. Guidelines indicate that drawing on the 'unique expertise and experience of users' may be central to achieving desired outcomes such as retention in treatment (NTA 2002), thus invoking 'means to an end' rationale for UI. However, rights-based arguments are also employed.

... The NTA wants to build an equal partnership with service users and drug users, because we recognise ... the right to become involved in activities that affect their health and well-being. (NTA 2002)

It has been argued that apparent discrepancies in stakeholder objectives and concepts of UI may be hampering progress (Schulte *et al.* 2007).

Method

Study aims

Our study aimed to develop a contextualised description of UI in drug treatment based upon an analysis of the experiences and perspectives of those commissioning, managing, providing and using services. Our study focused on UI in the planning, commissioning and management of publicly funded services offering specialist treatment to adults in need of structured and intensive intervention for opiate or stimulant misuse – referred to in the UK as Tier 3 services (NTA 2002). We used the term 'user' broadly to encompass potential, current and past service-users.

The specific study objectives were to: (1) describe stakeholder views regarding the rationale and objectives of UI; (2) explore contextual factors influencing implementation; and (3) explain the approach to UI in drug treatment services.

Study design

We completed qualitative case studies in six DAT areas. This work was undertaken in parallel with a national survey which assessed the extent and nature of UI in a representative sample of English DATs. Survey findings are reported elsewhere (Patterson *et al.* 2008).

Ethical approval for the study was obtained from the Central Office of Research Ethics Committee. National Health Service (NHS) Trust research and development governance requirements were met in each site. The study was guided throughout by a project advisory group (PAG) comprising service-users, academics, service providers and representatives of the Department of Health and the NTA.

Selection of sites

Seeking to explore UI in diverse contexts, we took a purposive approach to sampling, selecting sites on the basis of geographic and demographic characteristics (that influenced in service distribution) and self-reported progress with UI using NTA criteria (e.g. partnership with users and resource allocation). We created a sampling frame comprising six cells by separating London Boroughs, Metropolitan Authorities and English Counties, and then dichotomizing each geographically defined group of DATs into those reporting either advanced or limited UI progress. We selected one site from each cell ensuring that two served ethnically diverse populations. Two sites initially sampled declined to participate, and were replaced by reserves with similar characteristics.

Data collection

Data were collected between February and September 2006. Respondents were drawn from DATs and NHS ($n = 6$), and voluntary sector ($n = 10$) services across the sites. The 139 respondents included DAT coordinators and UI workers, service managers and workers and service-users. Fifty-nine individual interviews and 11 focus groups were completed. Service-users were contacted through referral by UI workers or key workers, contact with other users who had been interviewed and advertising within user groups. Written informed consent was obtained from each participant prior to interview. Service-user participants received a £15 honorarium. User respondents' ages ranged from under 20 to over 50. Approximately one-third were female. While the majority was white, our sample included users from BME groups.

Respondents included current and past service-users who reported varied patterns of substance use and diverse service and treatment experiences. The uneven distribution of respondents across sites evident in Table 1 which details site characteristics and data collection by site reflects the presence/absence of user group activity and the geographic distribution of services.

All interviews and focus groups were conducted by SP using topic guides informed by project aims, literature review and discussion within the PAG. Initial themes included the context, concept, rationale and objectives for UI, and factors perceived to influence UI. Guides were used flexibly to ensure coverage of key themes, while enabling exploration of respondents' areas of interest or expertise.

Data management and analysis

Interviews were audiotaped and professionally transcribed. Where permission was withheld or recording was not possible ($n = 3$), handwritten notes made by the interviewer were verified by respondents. Focus groups were audiotaped and professionally transcribed, with the exception of two large groups of service-users which were transcribed by the researcher.

Data collection and analysis were mutually informing. Transcripts were subject to thematic hand analysis as they were generated. A constant comparison process (Glaser & Strauss 1967) was employed to identify similarities and divergences in the data. The topic guide was continually revised to ensure that emergent themes were fully explored. Emerging themes and interpretations were 'checked' with the study team, and PAG as data collection progressed.

Thus, a thematic framework grounded in the data was developed. A two-level coding framework was used at this stage to code all transcripts. First, units of text were coded for content on the basis of their relationship to themes as expressed in the study aims. Data were disaggregated and compiled in a separate document for each theme. A complete copy of each transcript was retained to ensure maintenance of context. Second, constant comparison was used to develop conceptual categories under each theme, and relationships between categories were explored. The main aim of the analysis was to develop themes and networks of conceptual categories in relation to each of the study aims sufficient to enable understanding of stakeholders' experiences and multidimensional description. We also identified any divergent experiences and opinions that did not fit emergent patterns. These differing views are discussed where relevant.

Table 1 Case study sites: user involvement (UI), geography, demography and respondents

	Site A	Site B	Site C	Site D	Site E	Site F	Totals
Commissioned services	1 NHS	14 services	14 services	1 NHS	1 NHS	Multiple specialist	
CDP	2 VS	4 PCTs	1PCT, 1MHT	1 CDP	2 VS	1 CDP	
VS					BME service funded		
UI self-report	Green	Red	Green	Red	Green	Red	
Geography	County	County	Metro	Metro	London	London	
Population	190 000	500 000	500 000	192 000	190 000	210 000	
Individual interviews							
DAT management	1	2	1	1	2	1	8
DAT UI workers			1	1	1		3
NHS Trust UI leads	2						2
Service managers	3	2	4	1	2	3	15
Con. psychiatrist						1	1
Workers	2	1	3			2	8
Service-users	4	1	1	4			10
UI participants	1		6		5		12
Subtotal	13	6	16	7	10	7	59
Focus groups							
Workers							
Groups	1			1			2 Groups
<i>n</i>	7			5			12 Staff
Service-users							
Groups	4	1	1	1	1	1	9 Groups
<i>n</i>	30	6	4	16	5	7	68 Users
Subtotals							
Groups	5	1	1	2	1	1	11
Participants	37	6	4	21	5	7	80
Total participants	50	12	20	28	15	14	139

Findings

Rationale and objectives of UI

Respondents across stakeholder groups reported disparate exposure to UI. Their views about 'what UI is' and what UI might achieve were clearly affected by experiences. While some provided detailed descriptions of UI as full integration of users in organizational processes at multiple levels through identified mechanisms, others made cursory reference to 'getting or giving feedback' (manager, NHS service). Many users expressed confusion regarding the concept, and once it was explained declared that they had no knowledge of UI, in principle or practice.

Diverse opinions were expressed regarding the appropriate sphere(s) of influence of UI. A vocal minority across stakeholder groups was adamant that development of user-sensitive services was dependent upon decriminalization of drug use and reform of national prescribing policy. They therefore advocated focussing UI in the political arena. Others believed that this diverted energy from localised engagement where service improvement was the prime objective. With reference to local UI, respondents more readily identified

areas where participation was not appropriate (e.g. matters relating to care of other individuals, budget management) than where it was.

Despite identification of UI 'champions' among organizational and user respondents, we found an attitude of acceptance rather than enthusiasm for UI to be the norm. Frustration at the perceived failure of UI to achieve its potential and discrepancy between the current 'state of play' and an assumed 'ideal' was expressed by many. A minority of respondents (including service-users) questioned the worth of UI. Ambivalence among organizational respondents related either to the perception that UI complicated management processes and/or a view of providers as treatment experts. Some users who viewed themselves as passive care recipients shared this view. Across stakeholders, a minority questioned the legitimacy of involving people who 'choose' to use illicit substances and therefore have 'self-inflicted problems'. One voluntary sector manager steadfastly opposed UI, stating 'managers manage; users use'.

Across sites, respondents described perceived domination of the national UI agenda by a small number of high-profile users, closely associated with harm minimization movements, as undermining the

credibility of local UI. Described disparagingly by a voluntary sector manager as 'sort of VIP group' and one of their number as 'the cream of user involvement', these users were perceived to form a clique that alienated current service-users who felt undeserving of participation.

You see them at every conference, the same five or six people ... I've heard what they've got to say time and time again ... I'd like to hear somebody else, but they don't facilitate that ... the person who speaks the least is the person who needs to be heard the most. (Worker/Past user voluntary sector)

Government commitment to UI was questioned by many who perceived a disjunction between 'politically correct' UI policy and a primary focus on achieving and monitoring performance targets (e.g. numbers in treatment and retention). The absence of formal NTA guidelines and ring-fenced UI funding further undermined the credibility of commitment articulated in policy.

... we are hauled over coals if we haven't got enough people in treatment. I understand accountability and rationing resources, but that's the genuine culture, the bottom line, not genuine service-user involvement. (NHS worker)

DAT respondents identified legislative obligation as the primary driver for UI. Users, they proposed, ought to be involved to the extent that their views could enhance service acceptability, thereby contributing to effective use of limited resources. For UI workers (who all reported history of service use), expedience was secondary to entitlement to participate. UI was described as 'empowering' through engendering a sense of service ownership among user communities. UI workers described users as 'knowing best' in relation to service needs.

Managers and workers acknowledged that UI was a legislative and organizational obligation. However, they stressed that pressure to achieve performance targets detracted energy and resource commitment from UI. Managers viewed UI as potentially performing a quality control function; 'a reality check; to see if what we think we're doing is really what we're doing' (manager, voluntary sector). For the majority of workers, UI directives were perceived as irrelevant to service delivery roles. NHS and voluntary sector respondents expressed differing views regarding the rationale for UI.

Voluntary sector managers, with one notable exception, and workers expressed a rights-based philosophical commitment to having users 'at the heart of services'. UI was understood as a collaborative partnership in which users' expertise would complement formal management capabilities. UI was described as 'day-to-day business', and active engagement in individual care planning was integral to informing

service development. Challenging the status quo was the essence of UI for these respondents who acknowledged the potential incongruity inherent in partnership with 'the enemy, the person you're fighting against to get what you want' (worker, voluntary sector).

... there's a definite path to this, got to be involved in your own care ... , and that means personal responsibility to yourself before you can look wider, step out of your situation. (worker, voluntary sector)

NHS respondents viewed UI as primarily motivated by obligation, organization led and formal. Generally, they were reticent about its benefits. Although some posited that UI 'had potential' to improve service effectiveness through supporting informing decisions, the investment was perceived to outweigh.

When asked about UI practice, the majority of NHS workers focused on engagement in individual care planning or treatment evaluation. Generally, they were unaware of opportunities for organizational UI (where these existed). However, the capacity of users to 'think outside the existing box' (worker NHS) and not be impeded by the 'can't be done attitude' (worker NHS) that workers believed beleaguered bureaucratic services were viewed positively. There was a strong sense that UI could potentially lessen alienation between workers and users, and that an alliance may give credence to worker calls for service development. Thus, UI was viewed pragmatically with potential to improve services for the benefit of workers and users.

Users reported disparate experience with UI. We identified three distinct 'groups' among user respondents. 'Active participants' were those with roles in UI structures and processes (e.g. user group members or DAT committee members). Some reported extensive participation at DAT and service levels (and nationally, in a minority of cases). 'Passive participants' expressed support for UI, and while not formally involved described experience of UI initiatives (e.g. survey completion, attendance at consultation forums). 'Non-participants' included many current service-users, some reporting extensive treatment histories, who reported no awareness of UI either as a right or opportunities for participation where they existed. They frequently expressed surprise that services were obliged to involve them.

Users expressed divergent views regarding the rationale and objectives of UI. A minority believed that legislative obligation on services was the primary motivator for organization-led UI. For others, participation was a right attaching to a vested interest in service quality: 'it's our treatment' (service-user), or a responsibility 'to demonstrate to other users that we are important' (service-user). Active participants frequently emphasised

the capacity of people with shared experience to unite and exert collective influence. For some, UI was a means to public accountability and the promotion of integrity among those commissioning and delivering services. The majority described a pragmatic approach to UI. Users asserted that their expertise was fundamental to effective service development: 'they can't solve the problem without us' (service-user). In contrast to active participants who sought strategic influence, 'passive' and 'non-participant' users either acknowledged that as 'experts in drug use', they could propose relatively minor 'concrete' improvements or were so sceptical about their sphere of influence that they felt dropping out of services was the only feedback mechanism open to them.

Participating in UI

'Active participants', a minority among service-users, described complex motivations for their participation in UI. Many described a desire to contribute (e.g. 'wanting to give back' or 'do service') as their main motivation. This was particularly common among those who had undertaken abstinence-based programmes.

The NA [Narcotics Anonymous] philosophy is about doing service and this is how I do mine. (service-user)

A desire for social justice fuelled by a sense of inequity motivated participation for those users seeking to ensure that treatment was accessible and respectful, particularly for multiply disadvantaged client groups (e.g. homeless people, pregnant women). Participation was instrumental for those who undertook formal UI activities to access training and develop skills and confidence that may lead to paid work or enhanced self esteem. Short-term incentives such as cash, refreshments or alleviation of boredom were described as initially motivating participation of a minority of users but insufficient to sustain it. A large minority of users also viewed UI as an extension of therapeutic engagement or 'aftercare': 'a bridge to normal living' (user).

Across other stakeholder groups, respondents offered discordant and often negative views regarding the motivation of active users. 'Self-interest' was perceived as the primary motivator by many respondents (including users) even where they acknowledged the potential of individual contributions to benefit others. A minority viewed active users as vexatious and troublesome, and raised concerns about misuse of UI mechanisms to make 'frivolous' complaints or 'unrealistic' demands. Paradoxically, these respondents were no less likely to view UI as a 'good thing'.

[UI] ... can be used to avoid issues ... clients who come for treatment and go home are most successful; a very few users come to fill time and go to whatever meeting there is. Not

because they're interested in changing things but for something to do – they complain about this and then it's changed and then they complain in the opposite way – a very powerful position that can become rewarding. (manager, voluntary sector)

That few users were 'active participants' was attributed to organizational and user variables. Key among these were lack of awareness of the right to participate and absence of mechanisms to enable participation. Many respondents believed that the 'all-consuming' process of recovery involving rebuilding families, gaining employment and management of multiple health problems precluded participation. As one user said, 'It's all I can do to look after myself at the moment'. For some users and the majority of NHS workers, the ongoing association with other users and services necessitated by active participation ran counter to therapeutic paradigms that promote removal from that 'scene' and was therefore undesirable.

Influences on UI

Our respondents' accounts clearly demonstrated that UI was shaped by complex interrelated influences. Many of these including organizational complexity, funding, time, lack of organizational expertise and variable commitment appear to be generic. Issues related to transport and service distribution were discussed in rural sites, but not seen as a major influence on UI within the context of other challenges. Across sites, stakeholders emphasised the influence of factors specific to the drug treatment field.

Prejudice and stigma related to drug use were invidious and a pervasive influence on UI. Users reported experiencing discrimination in the community, within treatment services and as participants in UI activities. Commissioners and managers frequently confirmed this, describing colleagues' assumptions regarding the perceived inability of users to participate in 'sophisticated' forums and contribute to complex processes deemed to require specialist skills. These assumptions were said to create discomfort for those facilitating UI. The low self-esteem reported by many users who feared that their contribution would be inadequate or inappropriate compounded difficulties. For some, this was their direct experience.

... it was like our opinion didn't count but everyone else's did ... they didn't listen to us ... bit of a waste of time really. (user, NHS service)

... I'm a dirty junkie, the dregs of society haven't got a say ... it's a hopeless position. Whatever happens, it's down to 'it's because he's on drugs', but I held a job for 10 years. And you believe it's self inflicted, your own fault so you don't deserve help. (user, NHS service)

Countering stigma around drug use and users was seen as both an antecedent and a consequence of UI, linked to open acknowledgement of the 'expert' role of users and a philosophical commitment 'at the top' to UI as a right (rather than an obligation).

One worker's description of treatment providers as 'agents of social control' aptly summarised the perceived power imbalance and hints at its influence on UI. Managers often believed that the close association between 'statutory agencies' and authority in the mind of users limited their capacity to engage users. However, users attributed the distrust to the *experience* of services as punitive and authoritarian in nature with potential to exercise coercive power (e.g. through medication restriction or service exclusion) over them if they complained. Indeed, a minority of workers reported finding clinical reasons to discharge 'troublesome' users.

Many NHS workers described a sense of powerlessness emphasizing their own minimal influence on service development and were pessimistic about the potential for influencing change. Some expressed reluctance to encourage users in what they perceived as an essentially futile quest; others held the view that if workers had no say, users should similarly be denied. These views add credence to the view expressed by various stakeholders that organizations may feel threatened by power sharing, fearing exposure of systemic weaknesses and ineffective treatment.

Approaches to UI in drug treatment

We found that approaches to UI in the drug treatment arena at the individual and organizational level reflected views regarding rationale and objectives of UI combined with beliefs about the capacity of people who use drugs to contribute meaningfully. Within a context characterised by multiple tensions, we identified five distinct organizational approaches to UI: 'protagonists' express a philosophical and practical commitment to collaboration with users. While positive service development is valued, the intangible benefits such as improvements in user self-esteem and challenging stigma through joint working are equally important. For 'pragmatists', UI is obligation based and outcome oriented. Expedience is primary, and user views are valued to the extent that they aid in achieving organizational goals. 'Sceptics' are ambivalent about UI, view involvement as a privilege and seek user input only in specific limited areas. 'Abstainers' adopt a position derived from a belief in organizational expertise in designing and delivering treatment and views of users as incapacitated. A conscious decision to exclude users beyond the level of individual care has been taken.

'Avoiders' are characterised by apparent lack of knowledge of the UI agenda and avoidance of the debate.

Discussion

Our exploration of UI in drug treatment in the UK has revealed a complex entanglement of influences and a multitude of tensions. Our findings provide strong empirical support for existing commentary regarding the influence of stigma and users' health and social circumstances on UI. Importantly, we provide new understanding regarding various organizational approaches to UI and the motivations of active participants.

Our findings need to be considered in light of certain study limitations. Data collection was restricted to six DAT areas and a sample of services within those DATs. While we purposively selected dissimilar DATs, we cannot be certain that we were able to access the full spectrum of experiences of UI. It is possible that additional or differing influences on UI may be operant in other sites. Further, as with all qualitative research based on purposive sampling designs, the frequency with which any given case characteristic, process or experience was observed in our sample should not be seen as a measure of its frequency in other settings.

Our findings demonstrate the multiple contextual influences on UI. Some, including limited organizational expertise, competing management priorities and funding difficulties, may be described as generic in that they are common across health sectors (Crawford *et al.* 2003). However, UI in drug treatment services is sought within a complex cultural context imbued with stigma evidenced by discriminatory behaviour. Factors related to the social status of drug users were profoundly impacting UI. For example, mistrust of 'authority' and government systems, prejudice, social exclusion and the stigma associated with illegal drug use described by commentators (Polley 1995, Barnes *et al.* 1999, Efthimou-Mordaunt 2005, Foster *et al.* 2005) were found to perpetuate power imbalances, thereby inhibiting involvement. Further, it is likely that the stigma associated with using illicit drugs has a direct impact on the willingness of some service-users to become involved where that involvement entails public disclosure. Consistent with commentary, we found professional hostility to UI and some reluctance to engage people perceived as disabled by drug use and therefore incapable of participation (O'Neill 2003). However, this was not widespread and rather than being reluctant to share power as has been suggested, we were struck by the sense of powerlessness expressed by workers and managers within the NHS.

The mixed messages regarding rationale for UI contained in policy were evident in our respondents'

views. We found a mixture of rights-based commitment and expediency to be underpinning UI within organizations, and users reflected these positions. Disturbingly, we found little evidence that policy was adequately supporting UI and a lack of belief in high-level commitment to UI. The absence of clear objectives for UI, disjunction between UI and policy goals related to the social imperative to address drug-related crime that underpins policy (numbers in treatment and retention) and monitoring those targets undermined stakeholders' confidence and devalued local-level commitment to UI.

That limited numbers of users were seeking to participate is consistent with other health settings (Thompson *et al.* 2002, Crawford *et al.* 2003). However, the degree to which service-user respondents were unaware of UI in principle or practice is particularly concerning. Our findings in relation to the motivation of users who actively participate provide a foundation for further development of UI.

Conclusions and implications for policy and practice

Power imbalance is inherent in UI in the drugs field. Given the lack of clarity our respondents reported about ethos and objectives of UI, it seems that policy and guidelines must declare not only the rationale for UI but also articulate clear goals and link UI with other policy objectives. Guidance must enable development of frameworks that are sufficiently flexible to allow for local variation in service configuration, thus enabling local 'ownership' of the processes. While policy and practice must embody clear objectives, they ought not be so prescriptive or define UI so specifically that development is stifled. It would appear that there is a reciprocal relationship between power imbalance inherent in the drug treatment arena and UI process and outcome: UI has the potential to challenge that imbalance, and is unlikely to develop without a willingness to do so. UI it appears can be both a means to an end and an end in itself; the challenge is to bring the agendas together and seek complementarity rather than conflict.

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