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Out-of-treatment dependent drinkers and people who use opiates or crack: the perceptions of professionals working in two locations in England

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Abstract

Background

Following the influential Black Review, engaging out-of-treatment people who use drugs in structured provision was a particular priority in England. There is little known, however, about professionals' perceptions of people who use opiates and/or crack, and dependent drinkers, who are not in structured treatment (OOT-PWUD).

Methods

Semi-structured interviews with 34 professionals who work with OOT-PWUD (defined as those who had not been in structured treatment for the past year) in two case-study sites that have high rates of drug and alcohol use.

Results

Professionals said that most OOT-PWUD they saw had previously been in structured treatment at some point in the past. Crack use was seen as an emerging problem. Professionals said the physical location and nature of services was an important barrier and that safe and non-stigmatising spaces for all users and staff were needed. Professionals stressed the importance of education to reduce societal stigma and long-term investment in treatment services and staff.

Conclusion

Professionals said that most OOT-PWUD needed support with all the challenges they faced in their lives, most notably their housing needs, rather than just their substance use. Consistent long-term funding in both services and staff is critical if this is to be achieved.

Introduction

Worldwide, around 2.6 million deaths were caused by alcohol consumption in 2019 (World Health Organization, 2024), and around 80% of the 600,000 deaths attributable to drug use the same year were related to opioids (World Health Organization, 2025). The use of crack cocaine has increased across Europe in recent years, which has led to considerable health and social costs(EUDA, 2024, 2025). Dependent drinkers and people who use opiates and/or crack collectively cause considerable harm to themselves and others (Chen et al., 2022; Gladstone et al., 2016; Nutt et al., 2010; Smart, 1991; World Health Organization, 2023).

In England, there were an estimated 608,000 people who were alcohol dependent (OHID, 2024b), 294,000 people using opiates and 177,000 using crack cocaine in 2019/20 (OHID, 2023). The harms from alcohol use included an estimated 1.3 million hospital admissions where the primary reason for hospital admission or a secondary diagnosis was linked to alcohol (NHS England, 2020). The economic consequences of alcohol use in the UK are estimated at between £21 and £52 billion a year (Burton et al., 2017). Evidence suggests people who use opiates and/or crack incur high levels of mortality and morbidity (including poor mental health), crime, homelessness and associated economic costs (Black, 2020a, 2021a, 2021b; Nutt et al., 2010). Approximately 86% of the £19 billion cost of illicit drug use is associated with opiates and crack (Black, 2020b).

The evidence has shown that treatment can mitigate the harms associated with problematic heroin, crack and alcohol use (Bennett & Holloway, 2004; Black, 2020a; Gossop et al., 2003). If people who use these substances were to receive treatment, this could yield substantial reductions in mortality, morbidity, crime, and social and economic costs (Burton et al., 2017; McSweeney et al., 2008).

In England, treatment can be separated into 'structured' and 'unstructured' treatment. Structured treatment can be defined as: '...a comprehensive package of concurrent or sequential specialist drug- and alcohol-focused interventions. It aims to address multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone' (PHE, 2019, p. 42). Structured treatment should follow a comprehensive assessment of an individual's needs and all service users should receive information and advocacy, crisis and risk management support, as well as appropriate support for their healthcare, education, training and employment, and family support needs (OHID, 2020). There will be, however, considerable variability around the country in the extent to which structured treatment services are able to provide wraparound support. Professionals who might contribute towards structured treatment in England include clinicians, case workers, social workers, pharmacists, employment and training professionals, and those working for local councils and charities. Some professionals working on structured treatment provision have Lived Experience of substance and/or alcohol misuse.

People in structured treatment appear in the National Drug Monitoring Treatment System (NDTMS) database, which collects identifiable, person-level data from drug and alcohol treatment services about their clients (NHS Digital, 2024). In England, those who are receiving Opioid Substitution Therapy (OST) appear in this database. Evidence from the NDTMS suggests that approximately 83% of dependent drinkers, 47% of people who use opiates and 58% of people who use crack are not currently in structured treatment for these substances (PHE, 2020). As these data are cross-

sectional, those not in structured treatment could include those who have just dropped out of treatment, those who have been consistently in and out of treatment for a long period of time, and those who have decided not to access treatment.

Due partly to the perceived 'unmet need' for treatment (Bhardwa et al., Forthcoming), and the increasing rate of deaths related to all drug poisoning and alcohol-specific deaths (ONS, 2021, 2024), in 2019 the UK Home Office and Department for Health and Social Care commissioned Dame Carol Black to report on what could be done to tackle these harms (DHSC & Home Office, 2021). The resulting *Review of Drugs* identified several key problems, including a shortage of workforce training and a shortfall of c. £500 million in funding over five years. The report also highlighted the existence of a sizeable, hidden cohort of people using crack, many of whom are unlikely to be in treatment (Black, 2020a, 2020b, 2021a). The Government responded to the findings by guaranteeing in excess of £500 million of funding to prioritise the (re-)engagement of problem drug users into structured treatment (OHID, 2022a).

The Current Evidence

Research has identified several barriers to accessing treatment for dependent drinkers and/or people who use drugs (collectively, PWUD). PWUD may not feel ready to abstain or would prefer to reduce their substance use without help (Apsley et al., 2023; Gilbert et al., 2019). Others may avoid treatment because it has not worked for them in the past or because their local service provision has a religious element (Jayne & Williams, 2020; Livingston et al., 2012; Wallhed Finn et al., 2014). For people who use crack cocaine, there is no 'gold standard' treatment available—the most comprehensive study of drug treatment in England showed that no form of treatment had any effect on levels of crack use after 4-5 years (Gossop et al., 2003).

Those PWUD who are ready to take action related to their substance use may not do so because they are unaware what services are available to them, because the services in their region are not suitable for their preferences, or because local services have stringent entry requirements. Other similar barriers include: having to navigate long waiting times for treatment (Alderson et al., 2021; Houghton & Taylor, 2021; Notley et al., 2012); the location, and distance to treatment services (Apsley et al., 2023; Frazer et al., 2019); and the incompatibility of treatment services with the lives of many PWUD (Briggs, 2010; Coulson et al., 2009). Those with a dual diagnosis of both a substance misuse disorder and a mental health disorder may find themselves passed backwards and forwards between substance treatment services and mental health services (Houghton & Taylor, 2021).

One overarching barrier to treatment is stigma. Many PWUD may be too embarrassed to seek help (Houghton & Taylor, 2021), or fear the consequences of it being known that they are seeking treatment (Apsley et al., 2023; Houghton & Taylor, 2021; Page & McCormack, 2023). Some research has highlighted how some PWUD are put off entering treatment because of the attitudes of professionals working in treatment services (Briggs, 2010; Neale et al., 2007; Salamat et al., 2019).

Research has shown how barriers to treatment can be experienced differently between different populations. For example, women and LGBTQ+ populations were found to be more likely to report stigma as a barrier to treatment when compared to men and cisgendered populations (Dimova, Elliott, et al., 2022; Dimova, O'Brien, et al., 2022; Stringer & Baker, 2018), and that women's needs have historically been failed by male-oriented services (Becker & Duffy, 2001; Whitehead et al., 2023; With You, 2021). Research has also shown differences in abstention levels and treatment-

seeking attitudes between different demographics (Bayley & Hurcombe, 2011; Coulson et al., 2009; Eastwood & Schlossenberg, 2023; Gleeson et al., 2019; Hurcombe & Goodman, 2010; Naughton et al., 2013; Raleigh & Holmes, 2021; UK Government, 2018), and the attitudes of staff working in services have been found to differ between PWUD from different racial and ethnic backgrounds (Beynon et al., 2008; UKDPC, 2010).

Most of the research about barriers to treatment, however, has focused on PWUD who were in treatment at the time of their participation. This likely skews the evidence towards the experiences of those who ultimately have been able to access treatment. There is still very limited research based on people who use opiates and/or crack, and/or who are dependent drinkers, but who are not in structured treatment (collectively, out-of-treatment people who use drugs, or OOT-PWUD).

A qualitative study by Notley et al. (2012) canvassed the opinions of 43 OOT-PWUD, and outlined the personal, interpersonal and systemic barriers they faced when seeking to access treatment. The data collection for the study was conducted in 2008, however, and there have been fundamental changes in the UK drug market and treatment landscape since then, including large cuts in public spending and changes to the nature of drug treatment and criminal justice budgets (Black, 2021b; Duke, 2013). Briggs (2013), Naughton et al. (2013), and Neale et al. (2007) did include OOT-PWUD amongst their participants, but the data included in these studies were collected around 20 years ago and the results were not disaggregated by treatment engagement level, so it is difficult to determine the treatment barriers identified that were particular to OOT-PWUD. It is important, therefore, to gain further, contemporary insight from and about OOT-PWUD. In addition, very little is known about the barriers faced by OOT-PWUD from the perspectives of professionals who work for or alongside treatment services. This paper seeks to address this evidence gap.

Research questions

This paper is focused on the following three research questions:

1. Which populations of PWUD are more likely to not be in structured treatment?
2. What are the barriers to engaging OOT-PWUD in structured treatment?
3. How could these barriers be meaningfully addressed?

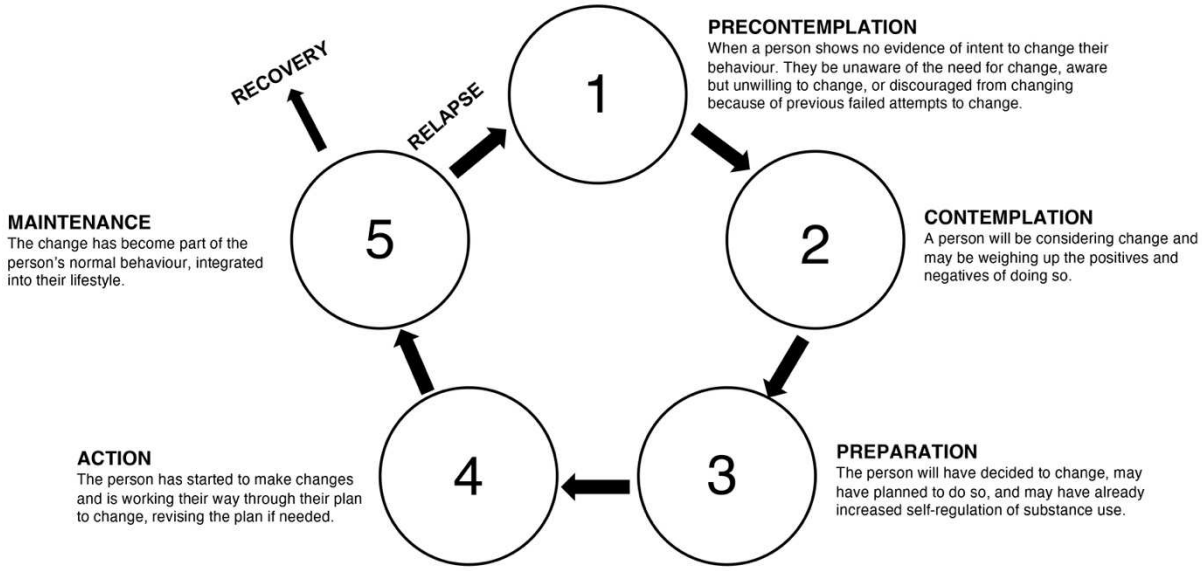
Theoretical Framework: Stages of Change

The theoretical framework adopted for the paper was Prochaska and Diclemente's (1983) transtheoretical model (TTM). Rooted in work on smoking cessation, the model was developed to cross disciplinary boundaries in psychotherapy (hence 'transtheoretical') to explain the processes involved in moving towards – and securing – lasting behavioural change. The model has been very widely adopted in both research and practice because of the evidence of its validity and clinical utility and its use in a wide range of research (Connors et al., 2013). Its roots in smoking cessation have supported its application to other fields of substance use research. In its foundational form, the TTM proposed five Stages of Change: Precontemplation; Contemplation; Preparation; Action; and Maintenance (Prochaska & DiClemente, 1983). These were conceived initially as existing in a fairly linear fashion: people begin at Precontemplation and (with timely professional intervention) pass through successive stages to a point of relative stability (Maintenance). Those in Precontemplation are not quite ready for structured intervention; whilst those in Maintenance are less likely to need structured intervention. The middle stages are thus most likely to reflect the trajectories of most

PWUD into and out of structured treatment. At the same time, professionals in less structured services (drop-ins, assertive outreach, homelessness) may be more likely to encounter PWUD who have not yet reached the Action stage.

Whilst never a part of Prochaska and DiClemente's TTM, some authors have suggested that the notion of a linear journey may mischaracterise the treatment trajectories of many PWUD. As a result, the concepts of Relapse and Recycling were meaningfully added (Raihan & Cogburn, 2023) to describe when Maintenance fails to become securely established, and people revert to old behaviours. This, in turn, reframes a linear model of behavioural change (stages) to one in which cycles may become more relevant – with people perhaps progressing through one or two (or more) stages, before relapsing (and possibly recycling) to an earlier stage – perhaps Precontemplation, or Contemplation (Kennedy & Gregoire, 2009)(see Figure 1 for details).

Figure 1: The Stages of Change model



Adapted from: (McDonnell & Regan, 2019; Opsal et al., 2019)

The movement of people across the Stages of Change will, however, inevitably be impacted by wider influences, such as age, gender, socioeconomic position, interpersonal relationships, and the nature and availability of the services available to them. Much addiction research has suggested that these factors can be critical in leading to an individual seeking to change (Kushnir et al., 2016), but the TTM is (deliberately) only focused on the influences of personal motivation (or psychological factors) on behaviour change (Velicer et al., 1998). In contrast, self-determination theory (SDT) is designed to address all influences on motivation for behaviour change (Sharma & Smith, 2011). The application of SDT to addiction studies, however, has been quite limited, and professionals tend to be more familiar with TTM (Herchenroeder et al., 2024; Kennedy & Gregoire, 2009). We sought, therefore, to use the TTM instead, but only as a structural aid for the paper—ie. each section in the results aims to encompass all of the barriers (personal, interpersonal and systemic) that professionals mentioned relating to OOT-PWUD when they can be said to be in a particular Stage.

Methods

This paper presents a key part of the results from a wider study looking at unmet treatment needs for OOT-PWUD. We defined someone as being out of treatment if they had not been in structured treatment during the past year. The study focused on two sites: one of which, 'Exborough', is a large city in the South of England; and the other, 'Northton', is a large town in the north of England. Both sites had high levels of Class A drug use and dependent drinking, and associated mortality.

The data presented in this paper come from interviews with professionals in the two sites who work for or have a connection to structured treatment services, or who work in a role that means they regularly encounter OOT-PWUD. This included housing outreach workers, NHS clinicians, commissioners, and substance misuse and homelessness professionals (see Table 1). Professionals were purposively sampled with the aim of gaining rich, broad insights into diverse groups of OOT-PWUD. The research team contacted relevant agencies directly and then worked with organisational gatekeepers to identify and approach potential professionals. Individuals were invited to participate via an email with an attached participant information sheet. The research team comprised three men and two women, one of whom had Lived Experience of substance misuse.

Table 1: Study participants

	Northton	Exborough	Totals
Outreach workers	4	2	6
NHS clinicians	1	2	3
Service commissioners	2	1	3
Substance misuse professionals	5	5	10
Homelessness professionals	1	6	7
Other	3	2	5
Totals	16	18	34

We asked professionals what they knew about OOT-PWUD (those who had not been in structured treatment for the past year) in their area, including the numbers of OOT-PWUD, the nature of their substance use and the barriers to treatment they felt OOT-PWUD faced.

Data collection took place between November 2022 and April 2024, with five interviews conducted face-to-face and all others conducted online via Zoom or MS Teams. Informed consent was recorded by all professionals before the interview started. These data were supplemented with observations taken over 47 days spent in the two sites between February and December 2024. Observations were based on the principle of "hanging out" (Browne & McBride, 2015; Gusterson, 2008), and involved activities including going out with outreach workers, and observing and talking to treatment professionals who were not interviewed about their work. These data helped contextualise the findings from the interviews, including providing information about how the various services (both treatment and non-treatment) worked together to engage OOT-PWUD. Detailed contemporaneous notes were taken.

Analysis

Recordings of all the interviews were transcribed and then imported, along with all observation notes, into NVivo, which was used to facilitate the analysis. Initially, the research team coded 19 transcripts using inductive open coding alongside broader deductive coding guided partly by the study research questions (Bingham, 2023; Saldaña, 2021). The research team then met and agreed on a coding structure that could be applied to all the remaining transcripts.

Patient and Public Involvement groups with People with Lived Experience (PWLE) of substance misuse also informed the analysis. We met twice with a group of people consisting of both those who were still using substances and those who were in recovery. We also held an open meeting after the data collection period had ended with seven OOT-PWUD who had not participated in the research, but who would have been eligible to take part in the wider study. These meetings helped us to refine our focus for the analysis and refine our understanding of the local context. We shared preliminary findings with the study's academic Advisory Group who suggested findings that they felt we should emphasise.

During the course of analysis, it became clear that professionals believed many OOT-PWUD had been in treatment at some point in the past. As a result, professionals' work frequently involved trying to engage OOT-PWUD who had previously made some (perhaps significant) progress in their recovery before disengaging from treatment.

In this sense, some barriers that prevented individuals from continuing in treatment became future barriers to treatment. Seeing engagement and re-engagement as a circular process also matched different parts of the professionals' work and shed light on how their interactions with OOT-PWUD fit together. Moreover, the initial coding framework we used tracked barriers to engagement as treatment journeys progressed and so fit well with the transtheoretical model (Prochaska & DiClemente, 1983). As a result of realising this, the coding structure we had at that point was integrated with the Stages of Change for final analysis. The results, therefore, include some in-treatment barriers, reflecting professionals' views that barriers encountered during past experiences of treatment become 'new' barriers to treatment for OOT-PWUD.

Results

We interviewed 34 professionals (18 in Exborough and 16 in Northton). The majority (n=21) were women and almost half had management responsibilities (n=16). Quotations from Exborough professionals are identified by 'E#' and quotations from Northton professionals are identified by 'N#'. Four themes linked to the TTM were identified through the analysis (see Table 2).

Table 2: Theme Overview

Theme 1	Precontemplation. Who is missing from services?
Theme 2	Contemplation to Preparation. First treatment contact.
Theme 3	Action. Supporting continued engagement.
Theme 4	Maintenance. Avoiding relapse.

Theme 1: Precontemplation. Who is missing from services?

This theme outlines professionals' views on the characteristics of OOT-PWUD and the interpersonal, social and system barriers to treatment they may face when they can said to be in the Precontemplation stage. Professionals said most OOT-PWUD they saw had been in treatment at some point in the past. This matches data on access to structured treatment, which indicates that, amongst new presentations, 74.7% have accessed services previously, and 31% have had more than four previous treatment episodes (OHID, 2024a).

Many treatment professionals said that many OOT-PWUD they see have a deeply-ingrained distrust of any type of service. They said that the OOT-PWUD they met were often not interested in seeking treatment because they had had what professionals described as a 'bad experience' with treatment services in the past. Examples of 'bad experiences' included when OOT-PWUD found that the treatment didn't meet their needs or the staff had not treated them well, or because of the generally negative impressions of treatment they had formed during that time.

> *'If they haven't had a great experience in the past that would probably stop someone from coming back again.' N8*

> *Our drop-outs tend to re-present. It tends to be our more chaotic, high-risk clients who will drop out [and] come back in.' N11*

A pattern of complex needs is also apparent in nationwide treatment data with 71% of people presenting to treatment having an assessed mental health need, and 21% being homeless (OHID, 2024a). Some professionals noted the importance of stable housing as a prerequisite to even considering treatment. Neither Northton nor Exborough had robust access to social housing, and sustaining engagement with homeless clients was a very real problem:

> *'Without somewhere to lay your head […] how can you even contemplate trying to change your substance misuse?' N9*

> *'[How are you] meant to reach self-actualisation when you can't even have your basic needs met, like housing, like any sense of security?' E15*

Professionals said that OOT-PWUD who did not feel they needed treatment were unlikely to attend services, and this was particularly the case for younger dependent drinkers:

> *'The younger ones will say that they don't want to just completely stop drinking because it's part of their socialisation and [they] can't imagine life without […] alcohol.' N7*

Other OOT-PWUD might have different reasons to avoid commissioned services. One professional (E13) noted that those who were 'financially well off [...] might go private,' in preference to attending local providers.

Patterns of drug use amongst OOT-PWUD were also discussed by professionals. Whilst increasing the number of people who use opiates in treatment has been a specific, recent policy objective (Black, 2021a, 2021b; HM Government, 2022), the availability of heroin has recently declined greatly

(Royal College of Psychiatrists, 2022; UNODC, 2023a, 2023b). Consequently, some professionals said they were seeing fewer heroin users in the course of their work.

> *'You seem to be hearing about [heroin] less and less and less.' N8*

Crack and cocaine, however, were widespread, with usage crossing class boundaries:

> *'The number of people using crack and cocaine is massive. That's ranging from your well-off middle-class working professionals to your construction scaffolders to the homeless clients.' E13*

For those OOT-PWUD who can maintain employment and relationships, the barriers to moving on from Precontemplation are likely to be higher (SAMHSA, 2014).

Whilst not a focus of the research, there was a related challenge with counterfeit and diverted medication in Northton where illicit tablets were cheap and abundantly available. Though marketed as zopiclone, gabapentin and benzodiazepines, it was not always clear what these illicit tablets contained:

> *'[Urine drug screens] have actually come back positive for opioids, and [...] clients are insistent that they've only had […] non-opioid-based tablets.' N3*

Because of this, it was hard for the professionals to assess local patterns of usage for all substances, particularly opiates, and target their engagement activities accordingly.

Professionals also felt that services were struggling to engage women, and sexual and global majority populations. Women comprise 31.8% of those in structured treatment (OHID, 2024a); research has long highlighted gendered barriers that prevent women's engagement (Becker & Duffy, 2001; Galvani et al., 2013; Page & McCormack, 2023). Many professionals talked about the importance of tailored training and engagement strategies that recognised key demographic needs:

> *'Women's pathways into drugs [are] often very different. What we don't often see is a specific pathway in substance misuse provision for women.' N16*

In line with previous literature engagement on treatment services (Becker & Duffy, 2001; Page & McCormack, 2023), professionals also noted that some women equated accessing treatment with social services intervention:

> *'Some women have the idea that if they access treatment […] they will get their children removed. That is absolutely a barrier.' N8*

Professionals also thought that mainstream services could not respond as effectively as dedicated services to the late working hours and complex needs of women who are sex workers.

Data collated on those who are in structured treatment also suggest ethnic disparities in treatment engagement, with 86% (non-opiates) to 90% (opiates; alcohol) of people in structured treatment being white (NDTMS, 2024)—much higher than the 81.7% of white residents in England and Wales

(ONS, 2022). Professionals felt that treatment services were missing some OOT-PWUD because of language barriers.

> *'They'll talk to me [but] some of them have got limited English. It is extremely rare for that cohort of people to then turn up.' N4*

Professionals also noted numerous, specific cultural and community barriers, with the example below relating to the South Asian community:

> *'There's quite high drug use within that area, but we're unable to necessarily target that particular cohort because of […] cultural beliefs and actually how that reflects on their family.' N3*

Finally, there was a sense from some professionals that LGBTQ+ groups were being missed. No data appeared to be being gathered on trans people in either location, making it hard to assess levels of unmet need amongst that community:

> *'So, we can't talk about the T in LGBT because there is no information on individuals who have transitioned gender.' E13*

This reflects national practice: data on those who are in structured treatment does not include information on 'client stated sex,' defined as '[t]he sex as stated by the client on their birth certificate or gender recognition certificate' (NDTMS, UNDATED; OHID, 2020).

Professionals suggested some ways for improving engagement across all these domains. First and foremost, visibility was seen as a key pathway to improved engagement.

> *'[For] LGBTQ [people] that's a huge barrier that I see people face [when] they're actually being supported by someone who they feel like doesn't have the same Lived Experience as them.' E15*

Similarly with respect to ethnicity:

> *'One of the things that supported my recovery was I saw another person who looked like me achieve recovery for the first time […] I trusted him, and actually, that particular individual was responsible for bringing about five of us into recovery.' E4*

Such calls for change were driven by the principle of 'You can't be what you can't see', and this was underscored by broader recommendations that 'Lived Experience needs to be right the way through the model' (N8).

Raising awareness of structured treatment was a key part of the work done by many of the professionals to break down some barriers to treatment; and is an important aspect of the Precontemplation and Contemplation stages (Prochaska & DiClemente, 1983). Patterns of outreach and referral have long been considered key to this. For example, before drug misuse treatment oversight was taken over by public health structures in England in 2013, criminal justice workers and

schemes such as arrest referrals[1] were seen as core pathways for treatment engagement (HM Government, 2022; Skodbo et al., 2007).

Some pathways for engagement in the case-study sites were substance specific: both sites had hospital-based alcohol intervention nurses who provided brief interventions to patients who scored highly on the AUDIT-C alcohol assessment tool (as per: Baker et al., 2014; Kaner et al., 2017; Papworth et al., 2017). Other approaches were more broadly aimed at engaging highly marginalised drug users. Outreach was one key strategy, particularly for people who used opiates. For example, harm reduction workers walked networks of streets and conducted occasional home visits in both sites, often carrying clean needles, naloxone and wound dressings to mitigate harm. This and other outreach work also built relationships that might support further engagement one day:

> *'We get emails or texts [...] saying, 'I didn't want to engage with you, but it was great that you were there. If I wanted anything, I know you're there'.' N3*

The research team saw the success of this in soup kitchens and drop-ins attended, with several OOT-PWUD entering structured treatment thanks to relationships they established with outreach workers.

Historically, beyond direct outreach, shared funding has been a key vector for improving joined-up work. Criminal justice and treatment agencies have tended to work to distinct agendas (Barton & Quinn, 2002), although the 2002 inception of a Home Office and Department of Health 'pooled budget' for drug treatment improved partnership work until its abolition in 2013 (Page, 2021, p. 103). Post-Black funding brought a patchwork of criminal justice partnerships back; and in our case study sites there were signs of varying relationships. For example, arrest referral appeared to be working well in Northton:

> *'If a young person gets taken into custody during the day we get notified and we go straight over.' N15*

However, there was a broader sense that prison referrals were being missed, often due to staff turnover (see Theme 4), presenting a barrier for an important section of the OOT-PWUD population:

> *'[Prison services] get excited that there's somewhere to refer on to when people are leaving prison [...] Then you get no referrals [for a period] so you chase it up and no one knows about you.' N8*

This is a widespread challenge, with data on structured treatment use showing that just 53% of people leaving prison treatment access community services within 3 weeks (OHID, 2025). Beyond outreach and criminal justice referrals, local partnerships varied. Exborough's services had strong links with a local GP, supported by their proximity to one another:

> *'[It's a] GP surgery for people who are rough sleeping. They are just across the street from us so they refer a lot of people.' E14*

[1] The identification of drug users who have been arrested and whose offences may be linked to their drug use, and their referral into drug treatment, diverting them from the criminal justice system.

We heard few other accounts of strong and consistent referral pathways from external partners, and some local frustrations about particular barriers (for example, a desire for improved referrals from the ambulance service).

Theme 2: Contemplation to Preparation. First treatment contact.

This theme outlines professionals' views on the personal, interpersonal and system barriers OOT-PWUD might experience when they are beginning to approach, or are actively in Prochaska and Diclemente's Contemplation and Preparation stages (1983). As noted previously, many OOT-PWUD at this point will have already experienced a 'cycle' of change, having engaged with treatment before, and this experience could have been a major barrier to re-engagement.

Within this context, lowering barriers to and within structured treatment was seen as essential. A first key priority centred on ensuring treatment was proximate to OOT-PWUD in both space and time. Firstly, the 'walkability' of treatment locations formed a key consideration:

> *'If you can't very quickly walk to a treatment service [then there's] a problem with getting people through the door, and we've got some geographical data that suggests that.' E13*

There are several possible solutions to improving walking distance access to treatment, including 'shared care' – partnerships in which service users' GPs provide prescribing services in their own surgeries, whilst drug services provide psychosocial support (Department of Health et al., 2017). However, a decade of austerity has reduced access to shared care (Grace et al., 2025), and the most direct response we encountered was a plan in one of the sites to open an additional treatment hub.

Secondly, even when treatment services were proximate to OOT-PWUD, not all services could be delivered immediately. The risks of alcohol withdrawal, for example, include death; and rigorous pre-treatment assessment is essential:

> *'Alcohol detox […] can't be a same-day thing. A lot of checks need to be done.' N8*

However, the same is not true for OST for people who use opiates, and swift responses and timely engagement can greatly reduce attrition (Department of Health et al., 2017). Northton operated a same-day OST prescribing service:

> *'There's no waiting time. We have an open-door policy where people can come in and be assessed on the same day that they walk in and ask for help.' N14*

The contrast with Exborough was striking:

> *'[Someone] might ring in a crisis and think, 'Right, today, I'm going to refer myself,' and if [they're] sitting on a phone for too long, sometimes that opportunity is gone. [Or they] sit in a room for an hour and a half, get given an appointment card: 'Come back [another day] for your clinical appointment…' That's enough to put people off treatment.' E13*

Northton was thus much better positioned to capitalise on brief windows of opportunity, maximising the engagement of people who use opiates.

Other features of service environments were also seen as potential problems. Page and McCormack (2023) note that mixed-gender waiting rooms can create an unsafe environment and expose vulnerable women to 'predatory' men, and this was echoed by the professionals:

> *'If you, as a woman, enter a very male-heavy environment, it can feel very threatening, especially if you have a history of trauma or abuse.' E1*

All professionals talked about trying to reduce the stigmatisation of potential clients, but this was often hindered by practical considerations. In Northton, the lack of a suitable building that would permit harm reduction services to operate on the premises meant that service users received treatment in a public space.

> *'We're not allowed to do a needle exchange [at our centre] so we have to […] do it in a back alley, which is just so stigmatising.' N5*

Finding the right balance between staff safety and the open stigmatisation of people presenting to treatment could also hit the wrong note:

> *'[When] you go into reception, the receptionist is behind a pane of glass, and she asks you a lot of questions in a public setting [and that] feeds into the stigma of it.' N1*

The difficulty of creating a space that felt warm and welcoming – not chaotic and clinical – was thus a significant concern. Professionals wanted to prioritise the personal over the clinical, to create services that people wanted to go to, such as support hubs 'like the old drop-ins [...] where there's a cup of tea and there's food, and you're not judged [...] and you can talk to somebody about things if you want, and there's a bit of help there' (E8). They felt these could help boost awareness of treatment, assist with meeting the other needs of OOT-PWUD, provide support whilst they were on waiting lists, reduce treatment dropouts, and support those who had finished treatment.

This was, however, intrinsically tied to questions about available services and treatment ethos. People who use opiates have fundamentally different patterns of need to those using some other substances (including alcohol and crack); are much more likely to enter long-term pharmacological treatment; and may take many more years to successfully leave treatment (ACMD, 2013; OHID, 2024a; PHE, 2013). Creating universally welcoming services is consequently hard: those OOT-PWUD that don't use opiates may be deterred by visible harm reduction services; whilst those who use opiates might feel stigmatised by their absence.

Equally, ambitious abstinence-focused provision might be inspiring for OOT-PWUD approaching Prochaska and Diclemente's (1983) Preparation or Action stage, but could feel excluding for marginalised OOT-PWUD:

> *'Going to a building which is very heavy on abstinence-based recovery […] That's too big of an ask for some.' N12*

Some OOT-PWUD – most notably people who use crack – were hit by both problems. Although they were often afflicted by the same patterns of complex need as people who use heroin (See also: Bennett & Holloway, 2004; Gossop et al., 2006), there is no pharmacological maintenance therapy

for people who use crack, and structured treatment primarily comprised abstinence-focused psychosocial interventions:

> *'A big barrier for our crack cocaine users is managing their expectations around what treatment will look like with no clinical intervention.' N1*

Where professionals saw potential solutions to this, they centred on embedding more Lived Experience within treatment services to make change appear more achievable.

Theme 3: Action. Supporting continued engagement.

This theme outlines professionals' views of the personal, interpersonal and systemic barriers experienced by OOT-PWUD after they have decided that they want to engage in structured treatment – most likely in the Action stage of the Stages of Change (Prochaska & DiClemente, 1983). These factors are important to include in a consideration of barriers for OOT-PWUD because, as noted, many of the barriers that exist at this stage may result in OOT-PWUD not wanting to engage with treatment providers in the future, therefore becoming a long-term barrier preventing future engagement in treatment.

A central theme here was the availability of partnership work, including the capacity of other agencies to provide timely collaborative support. Shortfalls in dual diagnosis support were also widely flagged. Local commissioners are expected to develop local pathways, ensuring that there is no wrong door for people to arrive at, but reflecting concerns that dual diagnosis has remained a leading concern for commissioners and professionals (Black, 2020a, 2020b, 2021a), professionals were clear that dual diagnosis pathways were broken:

> *'[The] mental health team might say, 'We can't work with them until they stop using.' Then we might say, 'They're too unwell to come and work with us'.' E13*

Historically, mental health services have been reluctant to engage OOT-PWUD due to concerns that symptoms may be attributable to intoxication or withdrawal rather than an underlying disorder (HM Government, 2022). However, even when service users had achieved sustained abstinence, referrals (regardless of substance) could take so long that symptoms became unmanageable, and people relapsed.

> *'[A client was] six months alcohol-free, home detox, doing really well, and there was a really long waiting list for mental health services [and then they] lapsed because obviously [they were] using the alcohol to support the mental health need.' N7*

One professional was keen to stress that a person-centred approach was required:

> *'If all of a sudden somebody who's presented with psychosis over the years has started adhering to antipsychotic medication, and it's working, and they're not doing things as dangerously before, then you lean into that [but] if somebody's really struggling to engage in mental health services, but they're loving life with their drug treatment team, and they're adhering to scripts if that's what they're on, and they're dropping the amount they're using, then you lean into that.' A9*

Improving treatment for people with a dual diagnosis in this way was another example given by professionals as to why it was important for services to consider each individual's wider needs when seeking to provide drug treatment.

This point was also reflected in discussions about people who were using more than one substance, with one notable example being that the alcohol treatment service in one of the case-study locations catered for those who were also using both alcohol and opiates.

Finally, there was a sense that a bit more 'give' in structured treatment models could be invaluable, both for the most marginal and for the most ambitious treatment entrants. For people who used heroin who had complex needs and, therefore, disengaged briefly, it seemed plausible that 'services should […] go to them' (N4), with brief outreach aiming to sustain engagement before they fully dropped out of treatment. Contrastingly, in both sites, professionals described frustrations that non-opiate and alcohol users found it immensely difficult to access residential treatment:

> *'We don't have enough money for residential rehab […] That is a major barrier. I don't know how they're ever going to get over [that] because there just aren't enough rehabs, and [funders] aren't prepared to put enough money into it.' E13*

Clinical guidance for the management of drug use (Department of Health et al., 2017) identifies that access to residential treatment should be a matter for clinical judgment; and that varying residential programmes may be suitable for those with complex needs, and for people who have not previously accessed treatment. Despite this, access remains very rare: just 2% of people in treatment access residential provision each year (OHID, 2024a).

Theme 4: Maintenance. Avoiding relapse.

This theme is focused on professionals' views on sustaining the engagement of service users. Ideally, this involves progressing towards Maintenance in Prochaska and Diclemente's Stages of Change (1983), embedding sustainable patterns of behavioural change. As noted previously, this is relevant to the study aims because many OOT-PWUD will have had previous experiences of engaging in treatment—if they have a 'bad experience', it may result in them not wanting to engage with treatment providers in the future. In effect, barriers to treatment maintenance could become long-term barriers preventing future engagement in treatment.

Most of the key concerns raised by the professionals centred on the pragmatics of service delivery. The Black Review noted that a decade of austerity had reduced workforce training and development, and that workers had faced increasing precarity and unsustainably large caseloads presenting with more complex needs (Black, 2020a). The additional funding that followed the Black Review mitigated this to an extent, but a reliance on undesirable fixed-term contracts made it impossible for providers to fill many new posts (Grace et al., 2025). This created serious challenges for providers:

> *'The pay's not that great […] so, they go to look somewhere else [because they have] high caseloads and high demands.' E3*

Supporting the development of secure, trusting relationships is an essential basis for trauma informed care (OHID, 2022b), particularly for those who may have significant historic trauma, and

who may have cycled through services repeatedly over a decade or more. However, staff shortages and turnover meant that this could not be guaranteed in the two sites:

> *'He would establish a rapport, he would start to divulge traumatic events that have led to his substance misuse [and then the service worker would change].' N9*

The pattern of re-traumatisation described here is precisely what trauma-informed work seeks to avoid. Each instance is likely to make re-engagement, the development of trusting relationships and sustained therapeutic change progressively harder. Professionals recognised this and offered a pragmatic suggestion for change:

> *'The drug services really should be funded for ten years, so there's massive amounts of continuity there, and people don't have to start again.' N14*

Some local authorities have deployed eight- to ten-year recommissioning cycles because of the benefits of long-term stability for providers and service users (Grace et al., 2025). However, the additional post-Black funding was only ever guaranteed for one year at a time. Moving to a more secure long-term footing could do a lot to increase workforce stability.

Whilst socialisation is often seen as a cornerstone of recovery from dependence, the benefits rest on having a critical mass of people who are relatively stable. Contrastingly, forced association could be disastrous when treatment groups hit difficult times:

> *'They just put all of our clients in that one building, which is absolutely a recipe for disaster [...] They're all using and chaotic and committing crime and involved in all kinds of things.' N14*

For people who did make it to the end of treatment, there was an additional sense that enhanced aftercare programmes were needed. These generally involve the continued availability of support at a reduced intensity (for example, following the end of full-time day treatment with a weekly meeting). Guidance and research suggest these interventions should change and evolve over time in line with the individual's needs and motivations (Addaction, 2006; McKay, 2021). The need for improved aftercare was clear, as some treatment graduates had relapsed after encountering profoundly difficult situations:

> *'Two lads have been put in this high-rise building [with] crack dealers over the road. You've just done six months in a rehab, you're pristine, you're full of motivation and willingness to change, and then you get put in that. It's tough.' N5*

Providers in Northton had started a programme that offered treatment leavers access to social activities and 'that short bit of intervention' (N3) when they needed it, but there was still a feeling that sustained recovery could be very reliant on systemic factors.

Some professionals felt that the way routine pharmacological treatment is delivered could have an impact on treatment retention.

> *'They have to do urine tests and mouth swabs and attend risk reviews and attend care plan reviews and attend appointments, go to a pharmacy every day to collect their dose and walk in*

there [with] a member of the public […] stood there waiting for their prescription for migraine tablets […] It must be really hard for people.' N14

It seemed as if there was a key paradox here – that people with few resources, just able to engage with provision, were expected to take on a great deal in return for nothing in the way of status or reward.

Discussion

Summary of findings

Professionals said that most OOT-PWUD they saw had been in treatment at some point in the past, and may have had a previous 'bad experience' with treatment services. This meant that barriers for those said to be in Prochanska and DiClemente's Action and/or Maintenance stages could become long-term barriers preventing OOT-PWUD's future engagement in treatment during the earlier stages of another 'cycle'. Professionals talked about the importance of building relationships over time, so that OOT-PWUD knew there was someone they could trust when they were ready to take the next step. Professionals noted that many OOT-PWUD needed support with all the challenges they face in their lives, not just their substance use, and that support hubs providing access to multiple services might offer a potential solution.

In terms of the profiles of OOT-PWUD, professionals said crack use was an emerging problem in both study locations, with people who use crack viewed as being much more likely to be out of treatment than people who use heroin. Professionals also said there were specific barriers that affected women, global majority populations, and those who did not speak English as a first language. Professionals identified a number of ways barriers to treatment services could be lowered for those in the Precontemplation and Preparation stages. They talked about the physical location and nature of services, including the effectiveness of same-day services and the importance of safe and non-stigmatising spaces for all users and staff.

Professionals said that more partnership working and greater flexibility, notably for those individuals with a dual diagnosis, would help OOT-PWUD in the Action stage. Professionals said that the long-term impact of austerity on caseloads and employment precarity was a key barrier affecting the ability of services to support OOT-PWUD in the Maintenance stage. Post-treatment support was important to ensure that clients did not have to start the 'cycle' of change again. Professionals also stressed the importance of Lived Experience, long-term investment in services and staff, and substance-specific training for staff.

Contribution to the literature

This study has contributed an important perspective on the nature of OOT-PWUD in England and the barriers that are preventing them from engaging with structured treatment.

Precontemplation

Professionals in both sites highlighted an increase in the number of people who use crack. This is particularly concerning as there is a less clear service offer for people who use crack than there is for people who use opiates or dependent drinkers (Gossop et al., 2003).

Two differences in the findings between our research and the wider literature is that the professionals we interviewed did not comment widely about those OOT-PWUD who are homeless

and/or sex workers and out of treatment (Hyshka et al., 2017; Jeal et al., 2018; Stuart & Grenfell, 2021). This may be because both case-study sites had projects specifically focused on engaging either homeless people and/or sex workers who use drugs in structured treatment.

The involvement of PWLE of substance use was seen as vital by the professionals. Although less was said about the importance of matching OOT-PWUD with professionals of the same gender, ethnicity or sexual identity, the evidence suggests this can be very important (Beynon et al., 2008; Whitehead et al., 2023), and was noted as an issue by one professional. Despite research showing how collaborative, assertive outreach work is effective at engaging out-of-treatment populations, much capacity was lost from this type of work in England over 2010 to 2020 (Black, 2020b). Professionals talked extensively about the impact of the more than £500 million worth of funding put into outreach work following the Black Review, and its critical importance on building lasting relationships with individuals who may later engage in structured treatment. These relationships could well be very important in ensuring that OOT-PWUD do not reject treatment in the future because of a previous 'bad experience' with treatment services.

Contemplation to preparation

Previous research supports the importance of the physical spaces of treatment services for those likely to be in the contemplation and preparation stages. As noted, women may come into contact with former abusive partners in services (Perri et al., 2022; With You, 2021); and a study of older drug users found some wished to avoid the 'chaos' of active and younger drug users (Ayres et al., 2012). Perri et al. (2022) noted that service shifts due to Covid-19 may have helped mitigate this barrier, with service users able to use virtual and remote services privately and confidentially. Changing towards more hybrid services may also have the additional advantage for some OOT-PWUD in helping them to circumnavigate physical access difficulties and inflexible opening hours. That said, despite the advantages of technology, many OOT-PWUD may not have a device capable of joining an online meeting (May et al., 2022).

In Northton, the same-day prescribing service was universally seen as a positive by the professionals, who believed it helped to get people who use opiates quickly into structured treatment. The wider evidence on the difference it makes, however, is unclear (Jakubowski et al., 2020). In contrast, the services for OOT-PWUD who were not using opiates in both sites were thought to be much less accessible and this view was reflected by treatment professionals across England (Lloyd et al., 2025). This is especially concerning given the recent increase in crack and powder cocaine use (Black, 2020b), which has contributed towards an increase in drug-related deaths (Home Office & PHE, 2019). Stigma and shame were noted as being important barriers by nearly all the professionals. The need for people who use opiates in Northton to move to an alley to receive harm reduction treatment was of particular note.

Action

An important finding from this study is that professionals were clear there needed to be more wraparound support for OOT-PWUD. As shown through other data collected for the wider study (Lloyd et al., 2025), ensuring the primary needs of OOT-PWUD – including housing, clothing and food – are met is crucial if they are to engage in treatment. This is supported by other research, such as that by Fountain et al. (2003, p. 389), who noted that services responding to immediate pragmatic needs were far more popular than drug treatment, with homelessness services accessed 'in far greater numbers than […] drug and alcohol services.' Fountain, et al. (2003) argued that multi-agency approaches could, therefore, have success in improving access to treatment for OOT-PWUD.

Whilst ensuring that OOT-PWUD' basic needs are met, being entirely focused on these might mean, however, that structured interventions are delayed. Better coordination between treatment and non-treatment services could ensure a more integrated approach.

Maintenance

Finally, the evidence presented here suggests that consistent and long-term funding is critical in ensuring both the success of treatment services, and the effective coordination of treatment and non-treatment services. The lack of consistent funding contributes both to client loss of confidence and trust in treatment services, and the loss of experienced and capable treatment professionals (Riley et al., 2023). As noted, the professionals said that many of the OOT-PWUD they saw did not want to engage in treatment because they had had a previous 'bad experience' with services. Previous research has noted mistrust of services as a barrier, but the literature up to now has tended to link this to stigma (Dimova, O'Brien, et al., 2022; Neale et al., 2007). The findings presented here, however, emphasise the importance of each and every contact with someone who is not in structured treatment: unsurprisingly, it seems that OOT-PWUD are more likely to engage with treatment services if they have had previous positive experiences with these or similar services.

Strengths and limitations

The primary strength of this study is the use of qualitative methods to gain rich data on the perspectives of professionals who work for, or closely alongside treatment services. It is important to note, however, that the data were only collected from two case-study locations, so some of the findings may be less applicable to services in other parts of England and elsewhere. Whilst the study was able to include the views of a wide range of professionals who frequently come into contact with OOT-PWUD, no professionals working for the police or in the criminal justice system were included. To achieve a more extensive understanding of the barriers to structured treatment for OOT-PWUD, future research should seek to incorporate these perspectives. In most cases, the professionals interviewed had worked in the sector for many years and were able to provide both a picture of the current state of affairs and a comprehensive view of past and present arrangements for structured treatment. As a result, the research was able to include many challenges and opportunities that were not temporally defined.

Conclusion

The professionals said a significant proportion of OOT-PWUD had been in treatment at some point in the past. Many will have gone through some, or all of the Stages of Change before relapsing. The professionals' views on who the OOT-PWUD are – in terms of their demographic and other characteristics – shows the importance of considering both how services can designed to better serve 'hard-to-reach' groups from a structural point of view as well as focusing on the individual needs and motivations of each person wanting to access treatment. Professionals in both sites were clear that the use of crack cocaine has increased, and that there was a lack of treatment provision for people who use crack, relative to the support for dependent drinkers and people who use opiates. Common structural barriers for OOT-PWUD included stigma and the failure of services to cater for those who had a dual diagnosis, which mirrors much of the research on PWUD based on those who are in treatment. Finally, ensuring services employ people with Lived Experience of substance use and providing wraparound support for OOT-PWUD that meets their treatment and basic needs were both thought to be very important influences on individual behaviour. Consistent long-term funding is critical to ensure that this can be achieved.

Ethics

The study was approved on 15 September 2022 by the SPSW Ethics Committee in the School for Business and Society, University of York (Ref: SPSW/S/22/12).

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The authors report there are no competing interests to declare

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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