QCT - EUROPE

FINAL REPORT

CONSTRUCTING, PRODUCING & ANALYSING THE QUALITATIVE EVIDENCE

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5. NVivo*: Types of documents received from each site during research period document:
6. NVivo* List clients by site
7. NVivo* List professionals by site

* Generated NVivo list converted to Word format

Part I

Construction of the qualitative priorities

1. Overview

The construction, production and analysis of the qualitative evidence were elements of an on-going activity throughout the research period. Broadly speaking, during the first year, priorities centred on the preliminary shaping of the issues at stake as well as the choice of the principal methodological strategies and the elaboration of the first qualitative instruments. Three separate but complementary activities permitted to the qualitative axe to clarify options and define the specific qualitative orientation: the international review of literature pertaining to QCT, a comparative QCT systems description, qualitative exploratory interviews on all sites. From the second year, data collection and ongoing analysis, sharing between partners and comparisons between qualitative and quantitative tendencies allowed both the progressive elaboration of the qualitative instruments and elaboration and the shaping of the final results.

The focus of the qualitative axe of the QCT Europe project became thus to understand *how* court ordered treatments work. Much emphasis was placed upon what was seen as an intrinsic tension or paradox consisting of "pushing" individuals into treatments whereas, according to much accumulated evidence from previous studies, treatments for drug offenders will be compromised if clients are not willing or motivated. The tension was also expressed in terms of motivational types, notably extrinsic and intrinsic motivation. At the same time, seeking to understand how court ordered treatments work implies attempting to grasp the implementation process itself. It was here that another tension, commonly referred to as the care – control dichotomy, entered the qualitative design. In practical terms, we needed to take into consideration the fact that the implementation of each court ordered treatment could not be reduced to a single treatment program but had to be considered as covering both judicial and treatment sectors. At a more fundamental level, we needed to conceptualize QCT implementation in a way that would include the complexities and the contradictions faced by professionals in both sectors, obliged nonetheless to find workable solutions. We therefore conceptualized the implementation process in terms of the progressive actions and interactions of *key actors*: clients and professionals from both the judicial and the treatment sectors. In order to give emphasis to the dynamic characteristic of all implementation processes, we used in parallel a chronological *phase* approach (entering, monitoring and persisting, leaving) and a *trajectory* approach (case histories of clients moving through QCT). Both inductive (identifying actors' issues and themes) and deductive (confirming on-going explications) methods were used.

Complimentary to the quantitative axe, which used large scale standardised methods in order to determine *if* or to *what extent* these treatments work, the qualitative axe attempted, hence, to open the QCT *black box*, the implementation process itself. Data collection followed the phase and, more

pragmatically, the quantitative data collection calendar. All the clients in the qualitative sample were chosen from the larger quantitative sample. They were selected according to theoretical pertinence criteria chosen by each site.

With the beginning of the data collection, on-going analysis obliged us to question a number of our fundamental concepts. The concept of *motivation*, for example, was replaced with what emerged as the more pertinent concepts of *commitment* and *commitment enabling conditions*. We were thus able to re-centre the analysis on the relationship between the QCT client and the specificities that QCT proffers to treatment situation. At the same time, in clarifying the commitment enabling conditions, we were confronted with the difficulty of extracting the quasi-compulsory attribute from "normal" treatment processes, or, put another way, QCT implementation concerns, also, the larger issue of the quality of services and service delivery across the social and judicial sectors. Similarly, our large "inclusive" model, bridging the care and the control sectors, appeared wanting as we came to realize that the efficacy of some court ordered treatments depended, also, on background welfare systems and regional administrative practices.

Other difficulties came to light. While an important characteristic of the overall project was to follow in real time QCT orders, we knew that our trajectory logic could not depend on clients being "available" throughout the research period. And, effectively, some sites were faced with the few of the original in-take "qualitative" clients still being in the treatment settings. Fortunately, the alternative strategy functioned. Clients who left the sample were replaced, thus in most cases ensuring a sizeable number of partial trajectories to add to the complete trajectories.

A final difficulty, seemingly practical but probably indicative of more important issues, needs to be highlighted. Independent of whether clients were original intake clients or replaced clients, general information about the last phase or the order was often difficult to pinpoint. We became convinced, however, that the difficulty in ascertaining *how clients do in fact leave QCT* is part of the QCT question itself. It would merit further studies.

2. Identification of key issues from the project literature revue

The attention of the qualitative axe was particularly focused on studies pertaining to QCT implementation, that is, those studies providing information about the processes characterising QCT and the conditions which promote or hamper satisfactory results for particular client groups (DUMONT, F.*, et al.*, 1995, SIMMAT-DURAND, L. & ROUAULT, T., 1997, LEMIRE, G. & NOREAU, P., 2000, SETBON, M., 2000, CRÉTÉ, R., 1997, BROCHU, S. & SCHNEEBERGER, P., 1999, SIMMAT-DURAND, L., 1998, SIMMAT-DURAND, L., 1999, KELLERHALS, C.*, et al.*, 2002, ERNST, M.-L.*, et al.*, 2000, JAMOULLE, P., 2000). It became apparent that implementation processes could not be confined to individual treatments programs. As pointed out by Brochu and Schneeberger, 1999, compulsory treatments push the limits of both social control and therapeutic support and as such will invite challenges and demand substantial contributions from both legal system and socio-medical structures. Michel Setbon (2000) in particular showed that QCT implementation cannot be separated from organisational considerations, since the co-operation between judicial and health authorities will not only be strongly involved but also decisive in defining the very form that court ordered treatments take.

Such studies can be grouped together according to their interest in QCT *feasibility*. Broadly speaking, they adopt the following perspectives:

- QCT implementation is defined as a specific type of intervention activity due to its dual status covering both the control and care area. As such, the range and type of interactions between the key players will be critical (user, carer, judge, police, lawyer, etc.).
- The implementation of compulsory measures will include many different types of client trajectories occurring within the obligation period itself and which will exceed the boundaries of a specific treatment project.

The professional or organisational factors identified by these studies as intervening in a decisive way in QCT implementation include:

a) Professional commitment

Success of the compulsory measures involves willpower and conviction on the part of the principal players. Certain professionals show mistrust regarding the central features of such measures, in other words the provision of treatment supported by legal compulsion SETBON, M., 2000.

b) Strategic implementation timings

Timing arrangements do not always favour positive outcomes. Potential candidates may wait months or even years for judicial and or implementation decisions. Such delays promote a feeling of insecurity and mistrust regarding all official proceedings JAMOULLE, P., 2000. On the other hand, understanding how the system works brings out the different types of stakes involved, explaining, for example, differences in motivation, demands and mobilization between pre and post sentence periods. CRÉTÉ, R., 1997.

c) Collaboration between professionals from judicial and health systems

Almost all authors consider this type of collaboration to be essential. However, they also note the considerable confusion concerning the roles that each professional is expected to exercise. Inevitably, this leads to feelings of mistrust and frustration CRÉTÉ, R., 1997, BROCHU, S. & SCHNEEBERGER, P., 1999. Examples include:

- A judge can order a course of methadone without even being an expert in this type of treatment and without checking the availability for such a ruling. CRÉTÉ, R., 1997.

- Lawyers submit clear and logical demands to try to obtain a lesser sentence. But there is not necessarily any assessment in terms of treatment requirements BROCHU, S. & SCHNEEBERGER, P., 1999.
- Police are obliged to enforce the law, but the policy on drugs is "in advance of legislation" ERNST, M.-L.*, et al.*, 2000. Hence, the feelings of discouragement amongst members of the police force unable de reconcile expectations and duties associated with their role and the belief that their views are rarely taken into consideration, despite their frontline position.
- During therapy the client will sometimes have difficulty in distinguishing between legal restrictions and therapy requirements BROCHU, S. & SCHNEEBERGER, P., 1999

d) The critical issue of entry and ongoing assessment

- An assessment of needs and the selection of appropriate services is a focal point in the collaboration between key actors. However, this crucial step is not always appreciated to a sufficient extent SETBON, M., 2000, CRÉTÉ, R., 1997, BROCHU, S. & SCHNEEBERGER, P., 1999.
- With regards to ongoing assessments during the implementation of the measures, BROCHU, S. & SCHNEEBERGER, P., 1999 note the fundamental differences in "dependence theories" used by actors. One typical example concerns actions that should be taken following a subsequent incident of drug use. A positive test may be interpreted as an example of a *recurrence* which should lead to the cessation of treatment and a return to imprisonment. Alternatively, a drug use incident can be interpreted as a foreseeable relapse and even a component of the healing process

e) Inequalities and disparities

Several studies provide evidence of disparities which, in turn, cause feelings of unease and frustration:

- In the offer which lacks alternative treatments SIMMAT-DURAND, L., 1997, SOTTET, F., 1996
- Between the practices of public prosecutor's departments SOTTET, F., 1996, SETBON, M., 2000
- Between regions, towns and rural areas SETBON, M., 2000, ERNST, M.-L.*, et al.*, 2000
- Between the way policies are interpreted and applied ERNST, M.-L.*, et al.*, 2000, KELLERHALS, C.*, et al.*, 2002, SETBON, M., 2000, MOREL, A., 1997.

Whilst focused on system functioning, such factors should be considered also in relation with more general findings about drug treatments. Two issues stand out.

1) Commitment and motivation: Motivation is generally studied in relation to clients. Indeed, the types and role of client motivation for entering and staying in treatments has been a constant theme in drug treatment research, maintaining, as do for example, LERT, F. & FOMBONNE, E., 1989 that the decisive element to explain the success of any treatment is motivation. However, motivation itself is a complex concept. The well known approach developed by PROCHASKA, J. O. & DICLEMENTE, C. C., 1982 identifies different types of motivations according to the perception that the individual has of the "problem". Other studies point out that motivation is not freely accorded. Debourg reveals, for example, the ambiguity of the majority of treatment demands which include pressure from friends, parents, colleagues, etc DEBOURG, A., 1997. Other authors recognise this difference by distinguishing between extrinsic or intrinsic motivation whilst then noting that in the majority of QCT cases, motivation appears to be exclusively *extrinsic* at the beginning of a QCT BROCHU, S. & SCHNEEBERGER, P., 1999. However, feasibility studies extend the motivation and commitment questions to the implementation systems themselves.

2) Treatment choice: the critical issue of treatment entry and ongoing assessment relates to the importance of finding the best possible "fit" between client needs and available services. Referred to as The concept of "pairing", when employed to the problem of drug dependency, relates to the awareness of dependence as a multidimensional problem which takes various forms depending on the individual (GOTTHEIL, E., *et al.*, 1981, LANDRY, M., *et al.*, 1995, MILLER, W. R. M., 1989). However, if pairing can already be problematic in the case of voluntary treatments, it would seem to be even more delicate in the case of QCT. For SIMMAT-DURAND, L. & ROUAULT, T., 1997 the selection process consisting of deciding between the various possibilities offered by legal texts is an "obscure areas if QCT which needs to be clarified. Brochu and Schneeberger take another angle. In the case of compulsory clients, does the obligation in itself constitute a specific profile requiring services which are better adapted to their needs? For example, to take up again the issue of motivation, how should the fact that in the majority of cases, motivation appears to be exclusively *extrinsic* motivation be integrated into treatment procedures? BROCHU, S. & SCHNEEBERGER, P., 1999

Given the large range of difficulties, frustrations and limitations that their own studies have contributed in bringing to light, Brochu and Schneeberger point out, however, that being overwhelmed by the difficulties inherent to QCT can engender a risk of refusing this type of client or leading to a situation whereby programs offer QCT "whilst disregarding essential communication with the judicial system, necessary for clarifying expectations and needs of individuals as well as co-ordinating the intended rehabilitation" BROCHU, S. & SCHNEEBERGER, P., 1999.

From this perspective, success would thus depend in being able to affront the essential contradictions that the care-control dichotomy presents. Hence, different authors recommend further studies on the relations between the judicial and public health systems and particularly with regards to the forms of "collaboration or competition between several agencies which are granted greater or lesser powers of intervention…" AUBUSSON DE CAVARLAY, B., 1997. The same authors recommend also that researchers clarify the meaning to be given to the "process" concept which can be a "portmanteau" or carryall concept. Setbon insist also on the need to clarify and identify processes and circumstances as well as the conditions promoting or hampering the correct execution of judicial measures SETBON, M., 2000.

3. Identification of key issues from the exploratory interviews

Parallel to the work involved in reviewing relevant literature review, all sites undertook exploratory qualitative interviews during December 2002 and January 2003. The focus of the interviews was firmly fixed on the clients as expressed by what was seen at that time as the general question of the qualitative axe: *For whom does QCT work (or not work), in what circumstances, and why?*

More specifically, the exploratory interviews aimed at identifying and clarifying the themes that the qualitative axe would need to explore. Certainly, previous studies on QCTs helped anticipate many pertinent themes (such as commitment and motivation issues, difficulties in role definition and differentiation, inadequate resources, etc.). However, the exploratory interviews not only sought to confirm the importance of these known and eventually new themes, but also to identify the different aspects they covered. At a more general level, the exploratory interviews allowed all researchers to get a feeling of the area, to identify the principal actors and their principle concerns.

Priority was given to interviewing “experienced” QCT clients. In addition, interviews were undertaken with professionals coming from the judicial and the treatment systems. The broad thrust of the interviews searched to understand how actors conceived “best possible practice” and conditions enhancing or hampering it (see appendix).

Taken together, more than 20 clients/patients/prisoners were interviewed, either alone or in a group situation and of course coming from the various cities represented in the project: Kent, London, Berlin, Padua, Vienna, and Fribourg. At least 15 professionals, largely coming from the treatment sector of QCTs, were also consulted. The interviews thus covered a wide variety of QCT situations, notably, residential treatments (women only, mixed groups), day treatments incorporating different types of multidisciplinary offers and a “Dependence Unit” situated within prison grounds

3.1. Consensus and challenges: the key issues

Added to the conclusions and interrogations noted in previous studies, the information and perspectives presented in the exploratory interviews confirmed the idea of QCT as an activity area of a "particular" kind, due to its double status of control and treatment. While the different institutional forms of QCT are already an indication of the range of contrasting configurations possible, the central questions always come back to the potentially conflicting *reasoning* and *practices* between judicial and treatment sectors.

Paradoxically, it is this very recognition of potential conflicts that probably provides a kind of *unity* to the QCT area itself and which seems to be founded on two fundamental and related perceptions that seem to characterise and define the area QCT itself:

1) *Inclusiveness*: While formal QCT definitions may refer to a specific treatment programme, clients under QCT orders as well as professionals, (both those mandated to decide orders or to apply them) talk about both penal *and* treatment areas when talking about QCT. Clients, for example, will typically refer to the period leading up to the court decision as well as that leading up to the placement itself. While some care professionals will actually attempt "*to forget about the order so as to concentrate on the treatment itself*", they admit that they cannot do so. They are faced, on the one hand, with clients who will frequently bring up their concerns about the order during therapeutic or work sessions. On the other, judges demand progress reports and specific actions in case of (for example) a relapse. A suitable definition of QCT context and boundaries would need to include the double areas associated with control and

treatment. Actors therefore would need to be considered in their relation to a QCT *system* rather than a QCT programme or project.

However, defining QCT in a large, inclusive way confirms and even reinforces a second fundamental characteristic.

2) *Ambiguity*. Both clients and professionals repeatedly expressed ambiguous feelings about QCT "systems". While not entirely belonging to the penal sector, QCT can not be considered just like any other treatments. While expressing hope that QCT is a (last) worthwhile chance, the same professionals will also express the inevitability of relapses and more criminal acts. For others, while being well intentioned, QCT places (impossible) strain on the therapeutic relation, so necessary for the treatment itself. For some care professionals, even enforcing the usual treatment rules becomes a problem, knowing that the consequences could mean that the client returns to prison.

In contrast therefore to formal definitions of a QCT which could limit analyses to specific treatment programmes, a "working definition" of QCTs' context and boundaries take in both control and treatment sectors, thus obliging clients and professionals to affront conflicting representations, reasoning and practices.

3.2. The underlying problematic dimensions of QCT

Whilst constituting and underlying QCT "unity", four problematic and interrelated dimensions were identified as decisive for shaping both QCT context and treatment processes.

1) Degree of agreement by judicial and treatment sectors on key issues

Some social care professionals put it in terms of *boundaries*, evoking at the same time the question of professional identity, risk of role confusion and maintaining coherence. Others put forward the very practical aspects: what actions need to be taken after a relapse, a missed appointment, an insufficient effort, knowing that reporting such *mishaps* could entail the revocation of the order and the return to prison?

Such concerns seem to reflect at least four issues:

- *conflicting views on drug dependence treatment:* time necessary, "constructive" relapses vs. reduction (absence) of substance use
- *conflicting views on acceptable success criteria*: outcomes oriented vs. progress; professional integration vs. social integration
- *composition of eventual and even changing alliances between the three types of actors:* clients, professional care workers, judges and the penal administration
- *worker confidence and commitment:* with regards to the capacity to intervene effectively in therapeutic relationship

2) Choices within obligations: the *quasi* that makes all the difference?

There were no examples in these exploratory interviews of compulsory (taken in its literal sense) treatments. Even the "Dependence Unit", situated within prison grounds, insisted on the "voluntary" nature of admission. However, the *choice* element in the QCT process was particularly

important for some clients, some of whom, for example, had not chosen a QCT order on a previous occasion. Even admitting that there had been indeed little manoeuvring space, one group of clients insisted that *choice there was!* The group went on to argue that they were therefore *"no different from the voluntary residents"* (who also had prison records and important drug problems). The fact that they *did* choose QCT was also used to highlight what they saw as the (favourable) difference between themselves and those persons "*not yet ready or not capable enough to see the advantages"* of QCT compared to prison.

Their reasoning would seem particularly pertinent with regards to the process consisting of developing *commitment* towards the treatment programme and thus encouraging retention and increased possibility of a positive outcome. At the same time, another signification is suggested. The symbolic importance these clients gave to the *choice*, (admittedly slim but perceived by them as *real*) suggests that the difference between, on the one hand, Type 1 and Type 2 orders and, on the other hand, Type 3 orders, would seem to represent far more than simply a difference in *degree*.

However, the choice theme covers other issues, too. During what appears to be a *transition period*, (starting with an acceptance to consider a QCT order and the actual placement following the order) one client was confronted with immediate restrictions linked to social insurance and political decisions concerning financial covers. From deception to deception, the final "choice", whilst still seen as a “chance”, seemed little more than the “only choice" available. Interestingly, the centre who did finally accept the client, argued that a successful transition period (availability of suitable institutions, adequate information concerning the functioning of the chosen institution, clarification of motivation and objectives…) was decisive for the rest of the treatment process. In another setting, QCT requests were adapted to the choices and the preferences of the… judge. Known to prefer residential treatments to outpatient methadone clinics, QCT reports addressed to this particular judge recommend residential treatments.

Of course, the question of "limited choice" raises the “best-fit” issue. Many professionals echoed known findings concerning the necessity to *match client needs to treatment offers*. Limiting effective choices would seem thus to reduce the chances of achieving positive results whilst at the same time negatively affecting the chances of individuals to adhere to a treatment considered as inappropriate. The additional question which emerges is that of the commitment of the professionals themselves, obliged to intervene after what could well be, inappropriate placement decisions.

3) Sifting through motivation: how is "not so good" motivation turned into "good" motivation? Or, how does “pushed” motivation relate to retention

After linking choice with commitment, it is not surprising that another dimension emerging from the interviews evokes the issue of *motivation*. The basic dilemma for treatment providers is recognised as needing to encourage or provoke the transformation from what can be called *extrinsic* motivation (being pushed) to *intrinsic* motivation (pulling oneself or adhering freely). The interviews suggested a number of leads to be explored. Admitting that the principal motivation at the beginning was to *avoid prison* seems almost an obligation in itself. However, the importance of this “confession” is perhaps overplayed. For some clients, not only was this motivation considered legitimate, it also seemed to exist in harmony with other "higher order" motivations such as *wanting to do something else with my life*. However, the central issue, put forward by almost all those who brought up this theme, was the capacity (or not) of the client to clarify, specify and probably diversify the forms this motivation could take (for example, being able to identify *what* else to do with the life ahead and seeing treatment as a means of achieving it).

Of course the essential dilemma is still there although the exploratory interviews helped to clarify the questions still to be explored. How do treatments attempt to assist this *motivational conversion/diversification* process considered so necessary for QCT clients? Are specific offers developed? Or are QCT clients mixed in with voluntary clients? If special offers are developed, which needs or priorities are addressed? How and by whom are priorities and utilities established? If or when discordance is present concerning the supposed utility, how is this dealt with? In other words, who convinces whom? (The latter questions are inspired by an apparent discordance between client preferences for projects aiming at *professional* insertion, as opposed to worker preferences for projects seeking *social* insertion).

However, in focusing on formal treatment elements, we should not forget the day-to-day interactions, the informal messages, the actual *doing* part of *being in a programme*. As one QCT client put it: "At first, most clients are doing it just to stay out of prison but eventually you'll find that once they start getting negatives (drug test results) they start to feel more positive, the staff make you feel more positive and you start actually wanting a better life" *(our underlining).*

4) The time dimension: the adequate strategies and capacities for the right moment

QCT is seen as evolving in time, suggesting differing issues according to treatment and order stages, not least of which is being sure that the order itself will end. To a certain extent, this final dimension cuts through the three previous dimensions. However, its specific focus is to identify significant phases of QCT in an attempt to understand what may be at stake at each one as well as how each phase leads into the next. Some interviews suggested that the period leading up to the QCT order could be considered as a *transition* phase. Referring to the same period, one professional pointed out that the client's focus was so much on obtaining the order (in order to avoid prison) that once the order was granted, a period more or less long of *de*-motivation followed. Research findings concur. However, certain clients, (also motivated to avoid prison) relate this period as a *success*: They were able to *seize their chance* which for them meant convincing the judge of their (politically correct) motivation, convincing their lawyer to argue for them, convincing a programme to accept them. However, not all clients appear to be able to mobilise such capacities. How will they fare during this phase?

The anticipation of the *final* phase of the QCT process also seems to be decisive. Some clients worried about what would become of them, whether they would find a job, how they would explain the past years to an employer. In a way, they "only" seem to share the same problems as any other dependent person during or towards the end of a treatment. With one exception: they also worried whether the order would in fact be lifted. Who would decide? What say would they have? It seemed to us that the final credibility of QCT is played out here.

Between the *transition* and the *final* phases, will be the *treatment* itself. Examining this phase will be the occasion to link together project characteristics, client and professional commitments with the day-to-day running of the QCT programme. How does client commitment evolve? Over and above programme routines, what events are perceived as significant? How is progress recognised within the programme itself, but also by the juridical sector? How is lack of progress dealt with? How, and by whom, are sanctions decided?

3.3. Bringing it all together…

The exploratory interviews proved decisive for the subsequent qualitative axe priorities.

The QCT system: The working definition of QCT context and boundaries used by the actors themselves was seen as the most pertinent and productive for understanding the processes involved. QCT was to be therefore considered as been *shaped by the judicial and treatment areas in interaction*, and, more specifically, by the ways these areas *attempt to find minimum agreement* on such issues as what constitutes a drug dependence treatment, what can be expected as progress, what can be considered as criteria to appreciate success. Whilst this conception of QCT includes the evaluation of specific treatment programmes, it also includes expressly the period preceding placement (considered as critical) and so extends analysis to those interactions which, whilst occurring "outside" the treatment programme itself, are an inherent part of the QCT process.

QCT over time: The apparently different "periods" or "stages" making up a QCT underlies the fact that issues and problems are both *punctual* (intake, best-fit, treatment choice) and *ongoing* (developing commitment, assessing progress). By following in "real time" the designation and the execution of QCT orders, the overall research design of QCT-EU (both qualitative and quantitative axes) should be able to pick up the specific problems and solutions at key moments.

QCT from the client perspective: The exploratory interviews confirmed (if need there be) that the clients submitted to QCT are capable of contributing greatly to understanding QCT processes and logics.

Questioning QCT: Broadly speaking, the QCT process can be conceptualised as the interactions occurring in the QCT system throughout a given court ordered treatment. From the qualitative axe perspective, the real issue at stake would seem therefore to be that of identifying the on-going and resulting processes that "make up" as well as impinge upon a programme and ultimately lead to the outcomes that that programme will have. Hence, the general question formulated by the qualitative axe - For whom does QCT work, in what circumstances and why? – needs to be modified in order to emphasise this larger context and at the same time capture the essential dilemma of actors obliged to work across habitual boundaries. Thus, the central question of the qualitative axe becomes:

How do programmes obtain the results they do?

4. System description: Pertinence for qualitative axe

The extensive comparative description of QCT systems in Europe confirms the core characteristics shared by European countries: treatments are encouraged, very rarely imposed whilst always controlled; orders can be revoked if conditions are not met and re-sentencing or additional orders made; in some countries, treatment orders can be prolonged. Differences do exist with regards to qualifying conditions, the degree and organisation of controls, the extent to which an order can be extended.

QCT systems are similar with regards to another fundamental aspect. In all countries, judicial systems delegate the actual treatment to the social and medical sectors, or more precisely to individual treatment centres. Whilst this may appear as self evident (although example of prison based treatment were noted), the *modes of cooperation between treatment providers and legal authorities* are not always specified. Generally speaking, they are not defined legally and, if they are, they do not go beyond written reports at, not always, defined moments. In all cases, the ultimate decisional responsibility will stay with the judicial sector. However, on a practical level, responsibilities seemed to be shared with the treatment sector. Probably, coordination between the systems fit into existing structures (probation, for example) or professional networks rather than being specifically codified. The overall picture which comes through, however, is that *intentions* and *structures* are in place. Judicial systems seize the occasion created by the criminal offence in order to create a strong, although external, motivation for clients to follow treatments. Treatment systems accept constrained clients in their structures and so work towards enabling clients to commit themselves freely and effectively to treatment aims.

However, whilst legal frames and even operational frames appear relatively clearly, many of the issues raised by previous studies or the exploratory interviews remain. QCT descriptions cannot, alone, indicate *how the QCT concept itself works*. Whilst decisive in defining possibilities, legal and organisational frameworks cannot explain what how key actors make (or break) QCT or how QCT is experienced, confronted and used by clients and treatment personnel to ensure “free” treatment retention and ultimately commitment to change. On the other hand, the system description enabled pinpointing and confirming key areas where the qualitative axe should concentrate.

1) *Entering phase*: apart from “ability and willingness” to undergo treatment, no information is yet available concerning how clients end up with the particular treatments they do. Whilst the range of treatment possibilities may give the impression that “all is possible” (residential, out-patient, community), the exploratory interviews suggest that choices can be limited by financial considerations, magisterial preferences, or by privileged networks between magistrates and specific centres. Such factors can take on a new meaning when compared with the importance given to “best fit” that is the importance for treatment success to have the best possible correspondence between client needs and treatment offers.

2) *Finishing phase*: over and above the differing regulations about lengths of treatments mandates, over and above the official assessments when these are indicated, what happens towards and at the end of the QCT period? If treatment commitment did occur, how is the link with voluntary treatment made?

It should finally be noted that a strong consensus exists about the importance of these issues as revealed by the exploratory interviews with experienced QCT clients and personnel, or in the literature under the generic term of QCT process. The descriptions of the different European legal frameworks show that these issues are embedded in the flexible character of QCT implementation. However let it be said that in noting the important flexibility left to actors in these key area, we are by no means

suggesting that codifying cooperation is necessarily indicated. Rather the qualitative axe assumes that legal and treatment systems ***do*** work together, that they ***do*** collaborate and coordinate their activities. The research priority becomes more than ever that of discovering ***how*** they do so.

Part II

Methodological strategies

1. General orientation

The focus of the qualitative axe of QCT-EU revolved around the central question:

How do programmes obtain the results they do?

The question assumes that all programmes do obtain results and that the comparative efficacy of these results will be more than amply served by the extensive on-going quantitative enquiry. The relevance of this particular qualitative question is the importance it implies on the actor-context situation. In other words, QCT is conceptualised as an essentially problematic cross-boundary and ambiguous situation which obliges both clients and professionals to search common meanings and solutions. The aim then of the qualitative axe becomes the understanding of the diverse processes involved. Complimentary to the quantitative axe, which used large scale standardised methods in order to determine *if* or to *what extent* these treatments work, the qualitative axe hence invited itself into the intimacy, so to speak, of the QCT implementation process itself.

Certainly, the importance of understanding how any treatment program is implemented has become a generally accepted objective in evidence seeking studies. Nonetheless, opening the QCT "black box" is particularly challenging. Whereas the implementation of a particular treatment program can be evaluated within its "own" boundaries, QCT implementation overflows these boundaries. Rather than being just "another" treatment program to be appreciated for its specialized therapeutic or social concepts, QCT requires that these programs be, also, answerable to criteria developed by the criminal justice system. Similarly, QCT requires of the criminal justice system, that it integrates another way of dealing with these particular convicted offenders. The essential complexity of QCT comes then from the fact that both social control systems and therapeutic support systems are pushed beyond their traditional limits and, what's more, find themselves in a situation of enforced "against nature" proximity. As for those involved in the day-to-day implementation of QCT, previous studies confirm that, indeed, the challenges will be considerable (BROCHU, S. & SCHNEEBERGER, P., 1999).

In very practical terms, key actors will need to overcome differences in drug dependency theories (medical or delinquency explanations). They will definitely need to agree on the "signification" of relapses and be able to decide what actions to take should a QCT client relapse during the order. They will also need to negotiate how they intend to monitor the client's progress (tests, reports, periodic court hearings) and what to do if progress is considered as insufficient. They may need to consider how an original court-decided decision could be modified in order to adjust to rapidly changing situations. They may even have to decide when, exactly, the order will finish. A vast French study went so far as to conclude that, not only the implementation of court ordered treatments depended on this kind of

continued co-operation between judicial and health authorities, but that the type of co-operation (affirmed, minimal, institutionally organized, left to individual actors) was decisive in defining the very form that court ordered treatments take (SETBON, M., 2000). In other words, opening the QCT "black box" is seen not only as *challenging* because of QCT's inherent contradictions and complexity but also as *essential* because the specific forms QCT takes depends on the working solutions that key actors develop in answer to these contradictions.

Interviewing the *key actors* became thus the *substance* of the qualitative axe. In contrast with a restrictive definition that would have limited a court ordered treatment to the treatment programme itself, we used a "working definition" of QCT as a *de facto* system taking in both control and care sectors. The key actors – clients and professionals – were thus considered as being placed in an essentially ambiguous context and obliged to affront potentially conflicting representations, reasoning and practices. Seeking to understand *how QCT works* required, therefore, that we understand how *clients* use constraints and possibilities throughout the order to (eventually) develop commitment to change; and that we understand how and why *professionals* implement QCT orders the way they do. The implementation of court ordered treatments can thus be conceptualised as a *dynamic process,* evolving over time. The order itself can then be described in terms of *chronological phases*; and the idea of *trajectories* can be used to capture the individual histories of clients as they move through QCT.

2. Qualitative tools

A set of *semi-directive, theme centred, actor-specific interview guides* and accompanying protocols were developed for each of the three *chronological phases* of QCT implementation (see Annexe nos 2- 4[1]). Whilst English was used as the working language for both the interview guide and the interview report, interviews were carried out by native speakers in the interviewee's language. The second and third phase guides took into consideration the on-going results of both the qualitative and the quantitative analyses[2]

Briefly the three ***phases*** covered:

Phase I	Pronouncing the QCT order.
Phase II	QCT in practice: monitoring treating, coordinating
Phase III	Terminating QCT: persisting, anticipating, contemplating

Themes explored the actors' QCT direct activities (client or worker) related as well as indirect activities (inter-sector coordination). Decisions about placements, relapses, progress were "unravelled"; day-to-day concerns were described; reactions and reflections were shared. The timing of the interviews was chosen to correspond with the quantitative protocol: intake, follow-after 6 months, follow-up after 12 months.

The ***trajectory*** logic directed efforts towards interviewing the *same* clients during each phase. In addition to responding to phase specific questions, clients were also asked to compare their first impressions with their present experiences, to review the time already spent as well as to anticipate what was to come, to identify eventual significant events that "made a difference" in either a positive or a

[1] The complete set of qualitative instruments is also presented in a separate document.

[2] One example concerned the continuity of supposedly on-going treatment support and/or control systems. In other words, who or which service/institution retained an overall view of the QCT measure? Preliminary analyses suggested that for some key actors (clients and professionals) this was an important issue. On the other hand, we noticed that responsibility during the QCT implementation tended to be spit and non continuous.

negative sense. From the purely methods point of view, we knew that constructing trajectories could not be guaranteed in advance. If a client did prove to be no longer available (left the treatment, returned to prison), all efforts were made to interview the person concerning the reasons of the QCT rupture. Exited clients were then replaced with other clients so as to assure continued information for all the three phases.

All sites (Berlin, Fribourg, Kent, London, Padua, Vienna), used the same interview set and had the possibility to add site specific themes. For each phase, sites attempted to interview 8 clients and 6 professionals. Each site identified its own key actors although professionals had to include decisional or managerial levels and worker intervention levels. Clients were chosen from the larger quantitative sample according to theoretically significant criteria with most sites choosing to privilege the type of treatment centre or client gender.

Each site's analysis was built into the data collection process itself as the interviewers' own interpretations and understandings of the principal points were included in the thematic report, made for each qualitative interview and progressively These first hand interpretations were indispensable for the more "removed", cross-site analysis.

3. Analysis process and strategies

The ultimate objective was to identify the underlying logics, processes and mechanisms shaping and being shaped by actors in QCT situations. A general interpretative orientation was broadly followed. While this privileges the "actor in situation" as the departure point, encouraging at the same time a predominantly inductive approach, the situation itself was narrowed to a *constraining and goal oriented* one in which actors were confronted with overall extraneous program objectives, suggestive then of more deductive approach. In fact the two approaches (inductive and deductive) were used according to the needs of the analytic process itself. Broadly speaking, during the early phases of the analytic sequences (for example, at the beginning or a QCT phase), analyzing tended to be inductive in order to identify the particular and eventually unanticipated themes. However as patterns and sequences emerged, allowing in turn "generality leaps" towards data reduction and model building, a deductive approach was used. The priority then became verifying and adjusting the model by returning to the data set, as well as confronting the model for *pertinence* with regards to the overall QCT system's objectives[3].

Concretely, the analysis process included the following repeatable and repeated steps:

- Interviewers completed a structured, thematic report on each interview (See appendices 2-4). So that these first-hand contacts were built into the analysis process itself, interviewers' own interpretations and understandings were included in the thematic report Reports were then progressively centralised at the Fribourg site.

[3] An example: During the analysis of the Phase II material, the inductive approach revealed different types of useful or helpful (or unhelpful) situations or interactions: *Being tested helped because I could see my progress; I tried to tell him what was wrong, but he didn't care, he didn't care at all; It was a regular job….* These examples contributed to a larger on-going discussion between research partners about the limits of the concept of *motivation* as a central concept in understanding QCT change processes. The examples then served to suggest a conceptual re-centering around the idea of *commitment*. From there, those particular examples could be conceptualized as being indicative of what we then termed "commitment enabling or hindering conditions" with regards to successfully (or not) completing the court ordered treatment. A deductive approach was then used in order to examine other situations indicative of enabling or hindering condition, allowing thus to test and clarify the pertinence of concept for the overall understanding of QCT implementation.

- Themes were examined by groups of actors and, by phase, by site. Trajectory data was used when possible to clarify particular issues.

- Whilst inter-site comparisons were therefore not the finalised objective of the centralised qualitative analysis, they provided the "raw materials" which, in turn, enabled the identification and clarification of the dimensions used in the cross-site models.

- The strategy of the *cross-site analysis* was to use the material from the different sites in order to construct models and typologies that *cut across national differences*. In a way, this means that individual sites, contributed to constructing and clarifying overall QCT process logics and operational styles which, in definitive, no longer correspond "exactly" to its own specificities! On the other hand, identifying the differences, both inter and intra site, as well as constructing the overall typologies that derive from these differences, sought to provide the means by which many of the defining characteristics of particular sites come to light.

- Interpretations were tested and clarified via email discussions between research partners, as well as by the presentation of on-going results during the more formal research team meetings.

- Team meetings also facilitated the inevitable adjustments to the data collection modalities based on each site's experience. Thus, a specific interview guide was added to the phase documents for "non-continuing clients", that is, those who had left the treatment program or who had been breached. Discussions about saturation fears led to a clarification of the differing issues presenting at each phase as well as a diversification of data collection modalities. Some sites, for example, chose to replace some individual interviews (especially when clients were no longer available) with group interviews.

- The process itself was undertaken with the support of a computer assisted qualitative analysis program (QSR NVivo). All the documents received (interviews, observations, notes), were introduced, thus creating a *comprehensive qualitative data bank*. The program also served as a *data management tool*. It was thus possible throughout the research period to generate lists of input documents by site and according to basic document attributes (subject, type of treatment setting, professional position…).

- Team meetings also provided the occasion for challenging comparisons between quantitative and qualitative findings. Strategies included searching for triangulation evidence, attempting to explain inter-site differences or anomalies occurring in either dataset, identifying common themes and cumulating the different types of evidence concerning specific themes

4. Description of sample

Across the different research sites, a total of 236 qualitative data reports were received from the Berlin, Fribourg, Kent, London, Padua and Vienna sites[4] and constituted progressively the qualitative data bank of QCT EU[5].

4.1. The qualitative data bank

The very large majority of the documents were interview reports of predominately individual interviews undertaken with key QCT actors. However, as the following table shows, a small number of reports concerned targeted observations (detailed account of a court review proceedings), diverse observations and information collected during quantitative interviews, spontaneous or structured discussions about general QCT themes, individual researcher's reflections or site clarifications.

Table 1: Number and type of documents received by site: N = 236

	Documents received	Individu or group Interviews according to protocol N1	Observations General discussions with individuals or groups	Site notes Reflections
Berlin	28	28		
Fribourg	37	37		
Kent	50	38*	9	3
London	47	46		1
Padua	42	42		
Vienna	31	31*		1
	236	222		

* including 2 group interviews

All documents were thus introduced into the data bank and became part of the ongoing analysis. We made nevertheless a distinction between data produced by the qualitative instruments themselves (i.e. interviews within the defined protocol), and the "other" documents. We were able thus to monitor the data intake in relation to both phase and trajectory logics as well as the distribution of key actors. The other documents however introduced novel elements into the overall analysis as well as adding clarity to site or cross-site issues.

The 222 documents produced within the protocol became thus N1.

4.2. Phase logic

The following table details the protocol data received from each site for each *phase*.

[4] The Zurich site did not collect qualitative data according to an agreement between the two Swiss sites. Hence, Fribourg constituted the qualitative sample within the French and Italian speaking cantons. In addition, Fribourg collected and transmitted to Zurich quantitative data from the clients of the qualitative sample. In this way, the qualitative subjects became part of the overall Swiss quantitative population, analysed by the. Zurich site.

[5] Appendix no 5 shows a generated NVivo list (converted to Word format) showing the types of documents received from each site throughout the research period.

Table 2: Protocol interviews by phase and by site: N1 = 222

	No protocol interviews	Phase 1	Phase 2	Phase 3 & 4	Overall
Berlin	28	11	10	5	
Fribourg	37	16	10	11	
Kent	38	17	9	7	5
London	46	14	11	21°	
Padua	42	14	14	14	
Vienna	31	14	14	3	
	222	86	68	61	5

° includes 6 phase 4 interviews

Phase 4 interviews, undertaken by the London site, followed the Phase 3 (finishing QCT) protocol. Faced as we were with an overall deficit of "finishing details", the London team undertook an additional 6 interviews. Without these additional interviews, the diminution of specific Phase 3 data would have been more marked. The Kent site faced another problem altogether. To a large extent (as trajectory data will show below), clients from the original input sample were no longer available. Input clients were then replaced with clients, some of whom were chosen for the specificity of their QCT experience or for the pertinence of their overall perspective of QCT processes.

4.3. Key Actors

Interviews produced within the protocol included both clients and professionals[6].

Table 3: Key actors interviewed with protocol interviews by site N = 222

	No protocol interviews	Clients*	professionals
Berlin	28	17	11
Fribourg	37	29	8
Kent	38	22	16
London	46	28	18
Padua	42	24	18
Vienna	31	18	13
	222	138	84

*The 4 group interviews were counted here, and in all following tables, each time as 1 client, corresponding for each to the single report received.

The proportions between the two groups corresponded to the priority given to the client group.

As presented in Appendix 8, the judicial and treatment personnel included judges, prosecutors, lawyers, prison workers, probation officers, treatment administrators, health and social workers, psychologists.... As well as representing a large range of professionals intervening at different phases or

[6] See Appendix 6 and 7 for full lists of clients and professionals

moments the professional group included a variety of different levels of responsability: intervention, policy, administrative, directional…

4.4. QCT Trajectories

The 138 interviews completed with clients, indicated in Table 3 above, covered 76 individuals, of whom 50 were chosen at intake and 26 were replacements. We there had to remark that achieving "complete" trajectories – a string of 3 interviews with the same client – was not always easy.

Indeed, of the original intake client sample of 50 clients, only 17 were interviewed 3 times, and in some cases even 4 times[7]. It can be noted that a small number of interviews included clients having acquired the status of "*not continuing*" client. However, when such interviews were able to be undertaken, they entered fully into the trajectory logic.

The following table summarises the number of complete and partial trajectories constituted by each site.

Table 4: Trajectory strings of intake clients by site N = 50

	Number of clients at intake	No clients interviewed on 4 or 3 occasions	No clients interviewed on 2 occasions	No clients interviewed on 1 occasions
Berlin	6	2	4	
Fribourg	12	7	3	2
Kent	8	2		6
London	8	5	3	
Padua	8	1	2	5
Vienna	8		8	
	50	17	20	13

Nevertheless, we were able to obtain a sizeable number of strings of at least 2 interviews. The following table shows trajectories of the 26 replacement clients.

Table 5: Trajectory strings of replacement clients by site N = 26

	Number of replacement clients*	No clients interviewed on 3 occasions*	No clients interviewed on 2 occasions	No clients interviewed on 1 occasion
Berlin	3			3
Fribourg	0			
Kent	12			12
London	4		2	2
Padua	5		5	
Vienna	2			2
	26		7	19
Total: All clients interviewed	76	17	27	32

[7] As explained above, the London site interviewed additional clients as extended Phase 3 or Phase 4 clients.

* Replaced clients entered at phase 2 or 3, so could not be interviewed three times[8].

Finally, the trajectory strings for the 76 clients interviewed is recapitulated in the following table.

Table 6: Trajectory strings for all clients interviewed N = 76

	Number of replacement clients*	No clients interviewed on 3 occasions*	No clients interviewed on 2 occasions	No clients interviewed on 1 occasion
Intake clients	50	17	20	13
Replacement clients	26		7	19
All clients interviewed	76	17	27	32

Of the 76 clients (intake and replacements), 44 clients were interviewed at least twice. What is more, the twice interviewed clients covered the range of possibilities: phases 1 & 3, 2 & 3, 3 & 4, 2 & 4.

[8] Theoretically, a replacement client from London could have been interviewed 3 times but this did occur.

Part III

Unravelling the QCT processes

1. Entering QCT: contradictions and issues

Whilst repeatedly identified by researchers as a key moment in the QCT process (SETBON, M., 2000, CRÉTÉ, R., 1997, BROCHU, S. & SCHNEEBERGER, P., 1999), analyses of court ordered treatment tend to take the entry itself as simply defining the boundaries of the research object itself (TAPLIN, S., 2002). In other words, in the studies we consulted, the idea of "entry" is methodologically marked by the judicial decision and represents, from then on, the beginning of a QCT time sequence. Although this does not in itself prevent reconstructing the motivations, pressures and justifications having influenced the decision[9], it proved to be a framework too restrictive with regards to the way that key actors refer to the period leading up to the decision. Moreover, whilst the "European QCT systems description"[10], had already suggested, no standardized road into QCT could be expected, we were surprised to find that, even within the same criminal and treatment system, "entry" needed to be grasped as a "multiform" concept. We were thus led to expand the phase perspective (already chosen as a methodological strategy) and consider entering a court ordered treatment as a *phase* in itself, that is, as a period of time constituted by key actors as they engage in a variety of activities and practices reflecting sometimes competing issues and logics that will, in turn, be susceptible to influence the context and the way that the order will be ultimately implemented.

Considering "entering court ordered treatments" in this more complex way still depended on the more concrete tasks of identifying and cataloguing the different types of activities involved: identifying potential candidates, defining responsibilities, applying procedures, evaluating suitability, deciding to accept, attempting to refuse, convincing, resisting… However, the approach allowed going further than the list itself in order to grasp the conditions and the underlying processes enabling and forming the way these activities were carried out as well as then identifying the central issues at stake for the different groups of key actors. It thus became possible to differentiate between three distinct processes – *eligibility*, *opportunity diagnostic* – each one of which has its own logic and specific challenges. However, it is ultimately the way that these processes combine or interact during the QCT entry phase that will allow differentiating between "best case" and "worst case" practices.

[9] As a number of our standardised questionnaires indeed were able to do.
[10] "European QCT systems description": a product of the QCT EU research project

1.1. The eligibility process

The eligibility process answers the question about whether, with regards to a particular case, QCT can be considered as a possibility, or from a practical point of view, whether a QCT file will be opened and a procedure begun. From a strictly administrative perspective, eligibility reflects the formal dispositions as defined in legal or organisational practice. As already described in the "European QCT systems description", criteria detail may vary but all systems combine in some way or another considerations about the type of crime that was committed, the severity and duration of dependence and, eventually, drug treatment history which may, or specifically not, include a previous QCT experience. Nonetheless, even these codified criteria could be open to interpretation by actors. Examples were found in one site of professionals who disagreed about which offenders were eligible, those esteemed as *more serious* offenders or those as *less serious* offenders[11]. Complementary dispositions in some systems may define conditions *excluding* not only otherwise potential QCT candidates but also any discretionary actions by actors attempting to extend possibilities For example, in one site, eligibility depended on the type of permit held, so some migrants were excluded from any eligibility considerations[12]. Similarly, insufficient health insurance would also exclude any further eligibility examination[13]. Moreover, eligibility margins can be moveable. Examples from one site showed that eligibility criteria was linked to pre-established quotas defined by government agencies in conformity with local political or welfare decisions and measured, in one case at least, by a computer questionnaire assessment of the likelihood of re-offending[14]. Taken together, inclusion and exclusion dispositions will thus define, formally and interpretatively, *who* amongst drug using offenders will be accepted as a potential player of the QCT game[15].

Policy issues will also define the institutional means that are allocated to this primary level of QCT intervention influencing the practical organisation of, notably, information diffusion but also the wider question of inter sector coordination between prison, judicial and treatment personnel. In practical terms, eligibility information will need to be transmitted to potential QCT clients[16]; and individuals who consider they may be eligible will need to communicate their "eligibility candidature" or, eventually, communicate their "*in*eligibility" if they feel they are being pressured. Yet, besides some examples of concerted actions, all sites also indicated that QCT clients are just as likely to have obtained the necessary information from fellow prisoners rather than from official sources. Other examples suggested that professionals themselves lacked information or that coordination procedures were not in place: some judges left the initiative to determine eligibility to probation officers or treatment personnel; some

[11] Kent
[12] Berlin
[13] Berlin
[14] Kent
[15] Recognizing exclusion criteria adds a twist to evidence which differentiates treatment types (voluntary or court ordered) on the one hand and class or status differences on the other. Cooper argues lower class or low status individuals are more likely to be recruited into court ordered treatments whilst higher status individuals are more likely to be present in voluntary treatments COOPER, H., "Medical Theories of Opiate Addictions' Etiology and their Relationship to Addicts' Perceived Social Position in the United States: An Historical Analysis" (paper presented at the International Conference on the Reduction of Drug Related Harm, Melbourne, 2004). Gerstein made a similar analyse linking larger social resources to short term, residential treatments and lesser resources to long term methadone treatments GERSTEIN, D. R., "The effectiveness of Drug Treatment," in *Addictive States*, ed. O'BRIEN, C. P. & JAFFE, J. H. New York: Raven Press, 1992. However QCT exclusion criteria could suggest that particularly low status individuals could find themselves outside the treatment hierarchy itself, and or out of the game, so to speak, with the only option being staying in prison for drug related crimes. game itself. not even qualify for excluded no treatment even lower status (under class) reserved for some lower status individuals will even lower status ; the opposite also being indicated.
[16] No evidence was offered that could suggest that eligibility information could be intentionally withheld. Theoretically, however, the question could be asked.

probation officers complained that judges seemed to ignore the prerogatives they nonetheless disposed of; at least one judge had to inform the defence lawyer that the treatment possibility existed.

Finally, these different policy and practical concerns should not hide the more fundamental symbolic issue that both professional and clients will need to face. For, in deciding *eligibility* for another or for oneself, both clients and professionals will be drawn into identity and status defining reflections and negotiations that will continue throughout not only the entry phase itself, but also all the way through the overall process of QCT implementation[17].

1.2. The opportunity process

The opportunity process describes a different type of questioning aimed as determining for one-self or with regards to the eligible client if it is the "right" moment for a QCT.

Eligible candidates ask questions about their own capacities to start a treatment. The fear of "*failing again*" may be particularly strong with drug users having already attempted multiple treatments in the past and whose "multiple failures have induced a sense of hopelessness, helplessness and harmful apathy" SAUNDERS, B. & ALLSOP, S., 1989, 253. But eligible clients also ask question about treatment efficacy and admit to having had, at times, little confidence after having seen other users "*go into*" treatments and then seeing them a few weeks later "*on the streets again*".

A decision about opportunity is also the result of an openly strategic calculation: getting out of prison, avoiding prison, preferring treatment given the respective times involved. Appreciating costs and benefits was never as explicitly expressed as by one man who goes to some length to explain not only the advantages but also the necessary conditions to ensure the success of a treatment order obtained after having served a part of his sentence:

> "*In September, that will make 10 months since I was put in (jail). As I got 16 months, that means that I could already get out. But I prefer to do a therapy… I was condemned to 16 months. I know that the therapy lasts around a year and a half, two years. There was a person who left recently and he did 32 months (of therapy). I wouldn't agree to that. One year, ok, even if that's already too much. In fact, I'm planning a few months, six months, no longer. When I will have done these six months, the sentence, the 16 months will be over. And there, the Judge, if I leave the therapy in good health, not having made a relapse, then he's not going to put me back into prison*" (male, 31 yrs, Fribourg).

There will be also other seemingly practical issues will concern the possibility of reconciling QCT with interests relating to family (keeping contact with partner) or professional life (being able to keep a job or to search for one)[18]). More largely, but perhaps more importantly because they engage clients in reflective processes having potentially life changing implications, eligible clients ask questions about the opportunity to change one's overall style of life. Even the strategic calculator above also talked about "*giving abstinence a try*".

[17] Serge Paugam explored this perspective during his evaluation of the work contract for the long term unemployed PAUGAM, S., *La Disqualification sociale. Essai sur la nouvelle pauvreté* Paris: Presses Universitaires de France, 1991.

[18] It should be mentioned however that such wishes seemed almost totally unrealistic. In our sample (with the notable exception of Padua during the latter treatment phases) there were very few examples of clients combining a treatment with employment. Whilst for clients in residential treatments, the possibility simply did not arise. As for clients in community or ambulatory treatments, programme conditions (number of hours per week) effectively rendered the clients unattractive for potential employers. We would have liked to pursue not only the utilisation by clients of the work-treatment dichotomy but of its wider signification as a potentially mutually exclusive dichotomy.

Professionals also ask whether QCT would be opportune for an eligible client. Indeed, deciding opportunity represents a major concern for professionals called upon to give an expert opinion about the readiness and the capacities of eligible clients to benefit from QCT (psychologists, prison social workers, probation officers, etc., working alone or regrouped in mono or multi disciplinary bodies). For professionals, the opportunity process is largely about the task of evaluating clients. Whilst priorities from may differ (inter and intra-site), evaluations seem to routinely include a selection of criteria representing positive indications (*motivation, responsibility, social competencies, stable social relations, personality, probable benefits, homelessness…*), recognition of "risk factors" (*homelessness*[19]*, concurrent mental health problems, history of violence or sex crimes*…) and finally a judgement or an informed opinion in the form or a "pre-sentence" report susceptible to contribute to a legal binding decision.

Deciding opportunity thus involves both individual reflective activities and negotiations between key actors. For eligible clients, the underlying issue of the opportunity process seems that of being able to *seize one's chance*, to convince the significant professionals treating his or her procedure that the moment is truly "opportune". From the professionals' point of view, the opportunity process requires that they do indeed express a judgement with regards to the probability that QCT does represent at this time an appropriate proposition. Of all the different aspects to be "decided, the most litigious one would surely be the motivation issue because the contrasting practices reflect effectively very different ways to conceptualize the concept itself of motivation. Professionals' practices reveal two contrasting approaches or tendencies.

- Professionals require a form of demonstrable motivation, if possible by the formulation of credible treatment objectives indicating the client's engagement to follow treatment and to undertake a life style modification without drugs or crime. Evidence suggesting the absence of this type of motivation would be the presence of "*inconclusive motivation*" corresponding (say) to a client merely wanting to get out of prison. Much value is placed thus on the necessity for clients to have a sufficient and appropriate motivation in order to be prepared for the difficulties to come; and for professionals to be able to assess the appropriate form[20].

- Professionals accept as a form of motivation, a "willingness" to give treatment a go. This approach downplays both the capacity to formalised acceptable objectives (clients know the language, know what they're expected to say) as well as the "wanting to get out of prison" argument (motivation will develop with the treatment process itself). These professionals will then *take the chance* to recommend QCT even if all the guaranties are not necessarily present, in order to "*give a last chance*" to drug users to benefit from treatments.

In both cases, professionals seem thus to be playing their professional credibility with regards to their capacity to make "*quality"* decisions. On the one hand they try to "*distinguish* those *genuinely committed to addressing their drug problem, from someone who is just seeking a community punishment to avoid jail"*. On the other, they argue for "flexibility" in order to include those whose willingness in not yet tangible (continuation of drug use) but which could well develop into a more acceptable form once treatment structures are in place.

[19] Homelessness can indeed be used as both an indication for readiness (because the client has reached the proverbial "rock bottom") or as a risk or non-readiness (because indicative of insufficient social structure in life style)

[20] How to asses, who should assess, what aspects should be assessed… some actors show much concern for such questions and debate, for example, the advantages and disadvantages of mono or multi disciplinary evaluations.

1.3. The diagnostic process

The diagnostic process regroups all those activities which seek to transform a potentially opportune QCT into a *concrete proposition* to be submitted to the court system. Implicitly, at least, actors seem to be concerned with respecting traditional best practice principles which argue that treatment efficacy is linked to an acceptable *pairing* or "best fit" between treatment needs and treatment offers (GOTTHEIL, E., *et al.*, 1981, MILLER, W. R. M., 1989). Both clients and professionals will thus typically consider the advantages and disadvantages of residential or stationary treatments *versus* ambulatory, day or community treatments; of abstinence *versus* substitution treatments (particularly if a substitution treatment is already in place) or they will consider specialised treatment concepts: residential with methadone, foyers accepting children, foyers specialising gender issues. Other considerations will concern even more specifically the compatibility between treatment choices and life situations (*being close to children, not being separated from children, partner or friends, possibilities to work during day*). Hence, the idea of treatment *needs* would seem to cover not only diagnostic needs (type of therapy) but also client preferences which, if respected, would be susceptible to facilitate the treatment and increase the likelihood of client cooperation and commitment.

Choice issues will also involve both *choice availability* (some foyers have waiting lists), *funding restrictions* (according to practices in at least two sites, residential treatments may be considered as too expensive in relation to pre-established regional budgets) and *accessibility to information* permitting "best-choices". With regards to the latter point, pre-sentence periods are predictably used by clients to obtain information about potential centres and even to contact them in order to organise an intake appointment. Interestingly, many clients dispose of their own knowledge of treatment possibilities either having already followed various programs or having "*heard about*" them from significant others.

However, what we could call *diagnostic idealism*, that is, an optional fit between needs, preferences and offers, may well be obliged to leave its place to a form of diagnostic realism. In all sites there were effectively, examples of potential clients adjusting choices to fit judicial preferences ("*asking for what the judge wants*"). A social worker intervening within prison contexts explains the counselling work involved:

> *It is necessary to be realistic with their abilities, their chances, their hopes. In some cases the prosecutor will not provide the service the client chooses. And I know that by looking at the whole situation. In this case there should not be a loss of energy obtaining an approval on something which will never conceded by the juridical system and will not really work for the client himself… Mostly the clients want to do out-patient treatment, but I also can tell them, that this will never work for them as a realistic chance to get rid of drugs, and will also not satisfy the prosecutor* (Social worker, Berlin)

At the same time that this particular counsellor attempts to equate *best fit* with the prosecutor predetermined choice, he also confirms the need for both professionals and clients to elaborate reasoning schema in order to render the link satisfactory[21].

1.4. Overall entry processes: cumulative, interactive, sequential and juggled

The following table summarizes the principal logics of the three processes and identifies some of the issues at stake.

[21] Of course, from a clinical point of view, the prosecutor and the judge's preference could well correspond to "best fit" diagnostic criteria. However, most sites also had examples suggesting that other criteria, notably or treatment ideologies financial constraints play an important role in the judicial decision making process.

Table 7: ENTERING QCT: IDEALISED PROCESSES

Process	Questions & criteria	Issues at stake
ELIGIBILITY	*Is QCT a possibility?* Legal dispositions: Crime & Dependence (type, severity, duration…) Contra-indications? Politico-admin decisions: Status & Means (immigrant, insufficient health insurance)	Inclusion-exclusion Availability of information Identity negotiations and labelling
OPPORTUNITY	*Would eligible person benefit from QCT?* Contact persons questions: Dependence history, co-morbidity, life situation, motivation… *Would I benefit from QCT? Do I want QCT?* Eligible person questions : Self-confidence, confidence in treatment, time calculations, willingness…	Professional credibility Professional (in)credibility (taking chance) Commitment-willingness Social skills & capacities: seize one's chance, convince others…)
DIAGNOSTIC	*What type of treatment corresponds to client's (my) needs & preferences?* Both question: Abstinence – substitution; Residential – ambulatory; Concept… Realistic chances to succeed Client also questions: Treatment in relation with life situation	Ideal–realistic diagnostics Optimal matching between offers & needs Resources to support best-choice Capacity to "choose" acceptable propositions

From an "ideal type" perspective, the three processes would tend to follow in a *sequential*, linear order. And, in some sites, this seemed in fact to be the case. It was particularly so when social workers, psychologists or probation officers had access to potential QCT clients in prison. These professionals (whatever intervention sector they came from) could thus intervene during the *crisis* or *shock*[22] period, caused by the arrest and impending trial, in order to give information to clients, to encourage them to examine the QCT options and to examine treatment possibilities. Not only do key actors present and intervening during the entry phase thus open the way for a well argued consensual proposition for a court ordered treatment, they are also creating the very conditions enabling clients to develop and express willingness to enter treatment programs, or even to begin committing to change. Whilst satisfactory coordination between sectors does indeed assure "best examples", local practices also suggest that agreeing on "who does what" is more important than the actual choice of *which* sector should assume particular responsibilities, for example, providing information to potential clients.

However, the tension between *ideal* diagnostics (best fit, preferences) and *realist* diagnostics ("choosing" according to what will be accepted) have already suggested that the processes are also *interactive*. In other words, actors will anticipate possible consequences before "deciding" and no doubt potential clients considered the treatment possibilities before deciding that the time was indeed opportune to seize the QCT chance. Nevertheless, examples of what can be called "sequential juggling"

[22] Expression used by the German research reporter.

need to be examined from the angle of whether they enable action or whether they impose or change conditions to an extent that they "denature" the logics of one or another of the processes itself.

The Swiss system provides an example of *enabling juggling*. Whilst in other systems, treatment placement occurred after the official QCT judicial decision, pre trial agreements between judicial and treatment personnel can anticipate the decision and allow the placements to *precede* the formal judicial decision authorising the same placement[23], Without going into the legal status of these clients during the "waiting for the judgement" period, we can retain the effectively enabling condition in the sense that these *potential-whilst-practising* clients do increase their chances before the judicial system to demonstrate not only motivation but also commitment and changed behaviours.

However, other examples suggested *inhibitive juggling*.

- Informing potential candidates of QCT possibilities and procedures is not systematically guaranteed by local practices which do not always assure adequate coordination between professions with regards to "who does what"[24], or even that all professionals have the necessary information themselves. Whilst some potential clients either had acquired some information from previous treatment or penal contacts, or received information from fellow inmates, knowledge about procedures is often laborious to put into place.

- Treatment preferences are adjusted to what the judge will accept. Already amply mentioned above, this example seems part and parcel of all QCT systems although the preferences themselves can be different from system to system or from region to region[25].

- Client treatment choices may be overly influenced by "exterior" factors rather than treatment needs: staying with partner, preferring an "easier" treatment form.

- An assessment is deemed as being demonstrated if the client is "accepted" by a treatment programme. Assessment responsibility is thus delegated to treatment centres who may (though not necessarily) be more concerned by their own criteria than by the more global questions suggested by opportunity and diagnostic assessments.

- An assessment is undertaken in view of a "one only" placement possibility. That will happen when a particular treatment service receives a contract to accept all court ordered treatments for a particular region. Assessments for *opportunity* will thus be "tailored" to the entry requirements of this one service. For example: one centre insisted that clients group work capacities be part of a probation assessment which would have the effect of deciding whether or not a QCT order could be pronounced or not for a person nonetheless potentially eligible.

[23] The Swiss national report discusses particular cases in more detail.

[24] All sites had examples of professionals "passing the buck" with regards to clients being not or insufficiently informed. Interestingly enough the criticisms went in all directions: prosecuter accuses defence lawyer, ambulatory drug counsellor accuses prison personnel, prison personnel accuses prison health worker, probation worker and judges accuse each other.

[25] Judges in mainland European countries would seem to prefer residential treatments. The evidence from the two English sites was more ambiguous with some indications that budget considerations play their role in treatment "choices" made by judges. It should also be remembered that our own sampling strategies favoured a distinction between residential treatments (mainland Europe) and ambulatory or community treatments (England). On the other hand, interviews in all sites with judicial and treatment personnel should have counter balanced the cleavage between the residential and ambulatory treatments.

- As well as arbitrarily modifying eligibility criteria, regional quotas may encourage "inopportune" or even coercive QCT decisions. As well increasing the ambiguity of the "quasi" characteristic of court ordered treatments, such practices also question whether procedures exist for quota included clients to contest the decision.

The following table summarises types of juggling activities emerging from the interviews.

Table 8: ENTERING QCT: USING OR ABUSING CRITERIA FLEXIBILITY

Process	Process juggling	
	Worst cases	*Best cases*
ELIGIBILITY	Disaccord or absence of clarity Arbitrary diffusion of information Means selected (health insurance, housing…) Determined by quotas…	Acceleration to placement (although legal status unclear)
OPPORTUNITY	Choices adapted to judicial preferences Assessment delegated to individual treatment centres	"Reading" the system Seizing one's chance Convincing others Using networks
DIAGNOSTIC	Assessment according to only option available Decisions outside quasi scope	

1.5. Leaving the entry phase: overriding continuing issues

Throughout the entry phase, potential clients and professionals will thus be faced with the particular challenges that each entry process poses. Rather than just passively submitting to exterior pressure, potential clients can generally be seen to be relatively active, even if this is expressed as little more than vaguely hoping for a positive outcome. However, the way they are able to use the possibilities, such as seizing their chance to overcome drug dependence, seems to depend to a large extent on their capacity to effectively *seize* the chance. Yet, within the group itself, potential clients showed important differences with regards to this capacity which, while linked to systems' knowledge and "know how" developed during previous treatment experiences, is also derived from general "social capital" including the way one presents oneself or how one attempts to convince significant and strategic others. Although one obvious question that arises will be the possible exclusion of those potential clients[26] not having the social resources or social capacities allowing them to "play the game", other questions concern the ways that clients' social resources and skills intervene in the treatment processes themselves. Professionals too face their own challenges and, like the potential clients, need to read the system. The particular task consisting of evaluating motivation suggests, however, that important differences exist even between professional working within a same sector. As well as acting within their own logics, potential clients and professionals are, of course, obliged to interact and in so doing they will not only be involved in the early stages of a therapeutic or helping processes. In the

[26] Other potential clients could be considered to be those individuals having comparable criminal and drug dependences histories but who are administratively excluded because of their status or financial resources or who were not able to have made themselves known as potentially interested, either by lack of knowledge or by the absence of a relay person.

broader sociological sense, they will also be drawn into negotiating identities and statuses (seeing oneself/the other as eligible, as suitable for QCT) as well as negotiating, or imposing, shared meanings about the way QCT should be implemented (client needs are interpreted in a way that corresponds to judges' preferences[27]).

Examining entering QCT as a *phase* has thus brought to light at least some of the complexities surrounding the *starting point* of a very particular type of treatment sequence and, at the same time, adds credence to arguments that entry into QCT signifies a crucial "moment" in the overall implementation process. Indeed, the day-to-day treatment and monitoring realities will need to take into account the "heritage" of the entry phase some of which will be adjusting to (perhaps) lesser than "best fit" treatment choices, differing forms of motivation as well as different approaches towards motivation itself, the wider issue of commitment, the development of meaningfulness and the conditions for fostering them.

[27] Of course, this is not to say that, in particular cases, a judge's preferences will not correspond to particular clients' needs. Rather, we are underlying that the social relationships in question are hierarchical.

2. Complying and committing: enabling and hindering conditions

2.1. Re-centring the concepts

Broadly defined, the second phase of court ordered treatment concerns the day-to-day functioning of treatments and their monitoring by the justice system. In a way, it could seem to be defined as the implementation process itself with the exception of the entry and the leaving phases: putting new routines into place, complying with testing controls, interpreting relapses, understanding product use, organising housing, acquiring new competencies, (re)appropriating non-drug relationships and activities, imagining new futures… Put another way, the second phase can appear as resulting more of the priority accorded to entering and leaving QCT, than because of any internal coherence. However, whilst apparently less "dramatic" than the opening phase which had, at stake, social status and life direction changes, less dramatic too than anticipating closure and emancipation, this *in between phase* corresponds to a sort of ***feasibility test*** both for clients and professionals, and ultimately for the QCT concept itself[28]. Indeed, the capacity of actors and services to establish some form of adequacy between *intentions* and *means* will underline, but also at times, dominate the day-to-day, and the month-after-month implementation of QCT. So it is the challenge faced by actors consisting of linking intentions and means which confers the *unity* of this second "phase". For, over and above the diversity of the activities, actors will be concerned with *mobilising, using and organising conditions* that will supposedly enable a satisfactory implementation of QCT.

The pragmatic linear ordering of the original phase divisions of the QCT implementation process (entering, doing, leaving) seems thus to have been confirmed[29]. It should not however be forgotten that alternative divisions can be surmised if more attention is given to client trajectories data[30]. Moreover, the trajectory perspective is a powerful reminder that social action is necessarily dynamic and that, in relation to a given "enabling condition", actors may seek to modify the condition itself or adapt it according to their evolving needs. So, whilst staying within the frame of this vast second phase of the implementation process, we will incorporate particular intra-phase dynamics when these are indicative of the ways clients "traverse" the phase.

[28] Given that QCT programmes are both judicially and politically sanctioned, the question of adequacy between intentions and means can even be particularly sensitive.

[29] It can be argued that linear divisions of social action are always "only" pragmatic and, as such, overly suggest that action, too, is to be analysed according to a linear past-present-future model. In stark contrast, trajectory perspectives and more largely life history and life course studies, support a dynamic looking back, forward and around in a movement of continual and reciprocal adjusting of contingencies, possibilities and interpretations. Concretely, an individual's actions in the "present" will be shaped not only of what "really" happened, but also by the way the individual "interprets" the past. Similarly, present actions are formed by the understandings that individuals have of the range of "options" that are open to them. However, even within the QCT phase logic, a non-linear perspective directs attention towards (yet again) the actor-in-situation and, notably, the *range and type of resources* that could contribute to the way QCT clients (re)interpret drug use and envisage alternative ways of life.

[30] Supplementary analyses could concentrate more on the "moving through QCT" opening new perspectives not with regards to breaking down the second phase into other more meaningful segments, but, eventually by letting emerge a different kind of order altogether. For example, many clients mention a kind of "turning point" signifying that, from then on, they understood *what the treatment was all about*, and which has as an effect to create a "before" and a "since". We hope to further our analyses in this area in order to strengthen the dynamic understanding of the particular constellation of conditions likely to provoke this type of significant change during the implementation process.

The second phase of QCT implementation takes as its starting point the inherent tensions between intentions and means and the challenges that this poses for professionals and clients. It will thus involve using actors' accounts of their QCT practices as well as program descriptions in order to highlight both tensions and conditions for coping with them. The orientation that the analysis of this second phase takes should also be seen as both continuing and re-centring the analysis of the entry phase. We were hence led to clarify three issues.

2.1.1. Constraints and flexibility: overarching tension or new combinations?

The analysis of QCT entry processes, and in particular the practices concerned with the assessment and the appreciation of motivation, allowed us to schematically identify two operational tendencies.

1) QCT is rigorously defined in terms of conditions, service accreditation, professional responsibilities and roles. Suitable and demonstrable motivation is required of potential clients. Placements are decided by professionals or administrators and adapted to judicial preferences. Although boundaries may be (arbitrarily[31]) modified, professionals value clarity, rigor and expertise. Hierarchical relations maintain role division between professionals and status difference between professionals and clients.

2) QCT is appreciated as a possible framework which is then "flexibly" interpreted according to specific cases. Professionals' own networks are amply used to secure wanted decisions (placements before measures, fluid role definition). A "willingness" to start treatment could be accepted as sufficient motivation. Professionals value capacity to find solutions at the risk of advantaging clients capable of negotiating with them and disadvantaging those who lack them.

Taken broadly, one could expect that similar versions of these tendencies will be present throughout QCT treatments. However, rather than pitting one tendency against the other, it would seem more pertinent to clarify how and under what conditions each tendency could be encouraged, or constrained, to go towards the other. More specifically, *how* and *with regards to which issues* do professionals adopt rigor or flexibility? In what circumstances could flexibility be considered as a "rigorous" intervention practice? How, and according to what conditions can constraints enable action?

However, before speculating how each of the two tendencies would interpret typical Phase II issues (for example, relapses), one issue potentially "left over" from the entry phase could well become problematic. Having noticed that administrative decisions restricted placement possibilities, we postulated that the risk of not achieving a "best-fit" placement would certainly increase. What subsequent adjustments will be necessary? How could they be negotiated within one or the other operational tendencies?

2.1.2. Everyday practices? Extracting the QC from the treatment

One advantage that could be counted on when analysing QCT entries is that they were "visible": court hearings, reports, appointments, decisions. Certainly, there were also reminders that "ordinary" treatment issues were also present, for example, clients and treatment centres deciding on entry suitability. However, in this second phase, now that every-day treatment plans are organised and being followed, the specificity of court ordered treatments may be more difficult to ascertain. Effectively, submitting to a QCT programme overlaps the more general issue of following any voluntarily entered

[31] Although, paradoxically, conditions may be adjusted to order to "widen the net" and so increase QCT entries.

treatment programme as indeed the formal objectives of any programme will illustrate[32]. In other words, examining the activities in court ordered programmes can leave an impression of "sameness" with the long standing programs and practices of the drug intervention area.

To cite just two examples:

- Professionals and clients in all sites mention the positive *structuring* effects of court ordered treatments (*putting order into the day, having a reason to get up in the morning*).
- Professionals and clients in all sites mention the importance of being able to depend on some form of *helping* relationship (caseworker, key worker, referent, *my* assistant…).

However, the need to develop *structure* and *routines* in one's daily life, as also the importance of the *helping other* can also be considered as being part and parcel of long-time accepted treatment principles (COPPEL, A., 1997). In other words, whilst certainly being examples of conditions which will enable commitment to treatments and commitment to change, neither can be considered as being, in itself, a QCT characteristic.

At the same time, the "sameness", the proximity with ordinary service structures is an important reminder that QCT quality cannot be separated from *ordinary service delivery and quality*. Indeed, we have already remarked that clients form judgements about treatment qualities which, in turn, influence the confidence they have in treatment processes[33]. To some extent, then, the quality of the treatment process itself cannot be ignored whilst being outside our own specific research frame. Our own challenge will thus be to identify in what ways QCT enhances, or hinders, commitment to change both in ordinary treatment situations as well as with regards to the more specific QCT characteristics, notably those concerning the controls ordered by the judicial sectors.

2.1.3. From motivation *to* enabling commitment conditions

If, when and how clients are developing motivation and what kind of motivation they are developing (in opposition to feeling coerced), could seem to be the principal, if not the *only*, implementation issue. As already argued by other authors, motivation or, more specifically, the transition from an "extrinsic" motivation (*avoiding prison*) to an "intrinsic" motivation (*overcoming drug dependency*), is estimated as essential for treatment success (BROCHU, S. & SCHNEEBERGER, P., 1999, LERT, F. & FOMBONNE, E., 1989). Indeed, our preliminary analyses recognized the importance of understanding motivation, not only the transition from one form of motivation to another but also the opposition between motivation and coercion (STEVENS, A.*, et al.*, *accepted for publication*). Amongst the findings we highlighted in that article, we can recall the following elements:

- *Offenders were motivated to accept a court ordered treatment for "mixed" reasons.* Clients' accounts indicate that, rather than being mutually exclusive, extrinsic motivation (*avoiding prison*) and intrinsic motivation (*trying abstinence*) can exist side by side.

- *Motivation was dynamic and takes time to emerge*. Following on from the idea that motivations can be mixed, this finding underlined the possibility that the priority between existing motivations can be modified, as well as the possibility that new or other motivations could emerge. Indeed, repeated interviews with the same subjects revealed sometimes major motivational re-positioning. In some cases, extrinsic motivation (*avoiding prison,*) faded in

[32] For example: understanding own drug use, learning relapse prevention strategies, developing vocational skills.

[33] We have already cited one client's judgement that "*treatments don't work*". Similar remarks include: *the worker had no idea what to do; he was hopeless, a real text book worker*. On the other hand, the glowing praise given to intervention workers in all sites can indicate precisely the confidence that it is hoped that clients will have with regards to treatments.

relation to the importance given to exploring the reasons of one's drug use. Of course, this was not always so. In other cases, initial motivation (*seizing chance*) was not confirmed and even appeared to decline, leading sometimes to clients abandoning the treatment or being excluded or breached. In yet other cases, "nothing" seemed to happen, leaving an impression that clients were simply biding their time.

- *Being motivated (or not) was related to treatment contexts*. To some extent, at least, motivation was closely linked to both the general perception that clients had of treatments (*treatments don't – or do – work*) and on the pertinence of specific treatment elements (*I learnt new skills; that part was a waste of time*) Even without pronouncing on the adequacy of the reactions and judgements themselves, these do recall the fact that clients do not just "receive" treatment. They continually form opinions and judgements which in turn can impinge on their continued involvement or motivation.

Taken together, these findings suggest that motivation is a dynamic, plural, interactive, responsive, and complex concept[34]. However, even a dynamic transactional view of motivation begs the question of how, in some cases, the transition from extrinsic motivation or even "coerced" motivation to the desirable, intrinsic motivation does in fact happen, whereas in other cases, it does not. Nevertheless, conceptualizing motivation as being *context linked* (expectation and experiences of service delivery) does open the (qualitative) way towards thinking *less* in terms of identifying, then categorising different types of motivation at particular points in time[35], and thinking *more* in terms of the broader idea of *commitment* and the conditions likely to enable its emergence.

It would be naïve however to imagine that the *commitment* concept is less complex than the motivation concept! At its simplest level, commitment can be considered as an implied "mechanism producing consistent behaviour" (BECKER, H. S., 1960, 32). In this sense, clients' continued compliance to QCT rules could be interpreted as indicative that compliance to following the rules indicates that clients are indeed appropriating treatment goals and committed to maintaining the changes already achieved, as well as pursuing new life objectives. While this may, in fact, be the case, compliance could also indicate a very simple idea of commitment. Perhaps the commitment is limited to the QCT period itself. Or, perhaps, the compliance itself represents little more than the fear of the negative consequences in case of non-compliance, for example, being sent to prison. For compliance to be indicative not only of consistent action but also of commitment to maintaining desirable changes or to continue pursuing them, *something else* would seem to be necessary. Becker argues that commitment comes into being when an individual "links a consistent line of activity" (for example, controlling drug use, following treatment prescriptions, investment in professional activities) with an "extraneous" interest or value (for example, satisfactory relations with significant others, social status, material advantages, conformity with image of oneself).

Searching then for indications that an individual is indeed committed to continuing a given line of activity, calls for recognising the link that an individual makes between continued behaviour (say, staying in a QCT programme, following particular treatment elements) and the advantages that this continuity signifies for that person (social recognition, material comfort, ideal of oneself). Interestingly, in Becker's theory, the extraneous values, interests or advantages are either already present or at least

[34] In contrast to a fixed, although not necessarily enduring, state.

[35] We make therefore a distinction between, on the one hand, a quantitative perspective that uses measurable and standardised motivation at fixed intervals of time and which can be considered as a powerful comparative indicator if motivational differences between groups as well as measuring change in the same groups at different points in time; and on the other hand, the concept of commitment which attempts to grasp how situated actors mobilise resources in order to "secure" behavioural changes for the time to come.

feasibly attainable, thus *enabling the link to be made*. Commitment, then, can be differentiated from long term goals. Whilst long term goals, for example, "being a drug free person", could also engender a commitment, an absence of signs that some progress is being made could well lead to the discouragement that some authors notice with regards to clients who have a long history of treatment failures behind them (SAUNDERS, B., *et al.*, 1995).

There would seem to be, therefore, at least three advantages in following the *commitment thread* (rather than the motivational thread) throughout this central phase of QCT implementation.

- *Commitment* incorporates our findings on motivation as being dynamic and contextually linked, but goes further by giving a higher priority to understanding these contexts and, notably, the ways QCT contexts can enable the emergence not only of the targeted consistent behaviour, (diminution of substance abuse, diminution de la criminality) but also how these contexts enable clients to develop *meaningful* consistent behaviour, as well as to what extent these meanings contribute to program retention.

- *Commitment* includes the idea of compliance as a way of *experiencing* targeted behaviours, but goes further in suggesting that the "carrot", or the last chance, must be linked with other more concrete and meaningful advantages or values, rather than (only) depending on the "stick" in form of prison avoidance.

- *Commitment enabling conditions* suggest their opposite, that is commitment *hindering* conditions, and could provide information about conditions that seem to hinder commitment and, in turn, lead to QCT ruptures.

2.2. Enabling commitment conditions

In order, then, to tease out the broad range of conditions and reasoning which appear to *enable (or hinder) clients to commit to targeted behaviours* in ways that were *meaningful* for them, we examined contrasting examples within and across sites. It should be noted that these *enabling conditions* exist in all sites, although in varying degrees. Similarly, no one site could boast of having *only* enabling and *no* hindering conditions. However, with regards to some conditions, some sites did seem to do "better"[36], and so we also tried to understand the particular configurations explaining these differences.

Thus, four non-mutually exclusive conditions can be identified as *commitment enabling* conditions, or as contributing to commitment emergence. At the same time, when particular conditions are not present, their absence seems to hinder commitment emergence.

2.2.1. Broad-based security structures

Recognized in all sites, by both clients and professionals, the *structuring argument* seems to have become a QCT truism. To a large extent, it assumes that, for QCT clients, substance dependence has engendered an *un*structured and stressful situation during which material and symbolic resources have been dilapidated[37]. With less stress and more structure, (the argument continues) clients will be

[36] In the sense that examples of the enabling or hindering conditions were concentrated in particular sites.

[37] While such examples do exist and were even spontaneously recalled by some interviewees as being the case for them, different studies have during the past years confirmed that the large variety of product use situations cannot be reduced to

encouraged in their compliance attempts, experience thus greater security, and, in turn, develop other (worthwhile) extraneous interests, or develop behaviours conforming to a positive image of him/herself. The structuring argument also "structures" treatment concepts: clients even take largely for granted that residential treatments impose full day and week schedules including "supervised" free time (shared leisure activities) or restricted to stipulated spaces (own room), or again, limits visits from the "exterior"[38]. Similarly, in ambulatory or community programs, rules will be laid down (punctuality, number of hours of presence, periodic tests) and be strictly controlled, particularly during the early days or weeks:

"[T]hey said to me at the time: 'it's very hard, very strict, if you miss 1 appointment you're going to get breached and put in prison'. And I said to them 'well good'…" (London).

One site gave examples of police controlled curfews: clients living outside residential care had to be "inside" by stipulated hours, including weekends[39]. Other examples of structuring concerned the periodic testing for drug use as well as less frequent court reviews. Important *initial* structuring also goes with the idea that autonomy will be developed – or earned – gradually, and that constraints will loosen as treatment progresses[40]. Some forms of structuring constraints will nevertheless continue in most programs in the form of periodic controls (notably testing and court reviews) in order to ensure that the desired behaviour is indeed continuing[41]. The underlying belief then would seem to be that constraints impose structuring in the form of routines which in turn enables security. The importance of routines and the link that is made with "security feelings" is of course well founded (GIDDENS, A., 1987, BOURDIEU, P., 1994), supporting, thus, the "enabling commitment" potentiality of such structuring efforts as well as the potential for the now more *disposed* individuals to link the routines with extraneous interests. Indeed, the best confirmation came from clients themselves:

> *The programme "stopped me…it took up a lot of my time. I wasn't bored all the time, sitting there with nothing to do and it gave me a lot of things to help me sort myself out". (London)*
>
> *"I don't think perhaps I would be as stable as I am had I not had the testing, because testing does kind of like, you know no-one wants to get a positive, even if you're using you still don't to get a positive so you want to try…Basically the testing was an incentive not to use" (London)*

"I actually liked going there, it was a routine for me. The more I went there the less I used. So it stood me in good stead".

Nevertheless, this potentiality seems diminished in many QCT situations for two contrasting reasons.

- First, the "*structuring enabling security*" argument can be limited to structuring time and ensuring social control, provoking thus, paradoxically insufficiently structured situations.

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the familiar "junkie" image. See SOULET, M.-H. *et al.*, *Gérer sa consommation. Drogues dures et enjeu de conventionnalité*, *Res Socialis* Fribourg: Editions Universitaires Fribourg, 2002., and more recently WARBURTON, H. *et al.*, *Occasional and controlled heroin use. Not a problem?* London: Joseph Rowntree Foundation, 2005. Nevertheless the issue would seem to be less the "exactness" of the disorganised junkie image than the apparently shared belief that the image does indeed correspond to users and that treatment programs are designed in consequence.

[38] These are all standard practices in residential care reported by Vienna, Berlin, Padua and Fribourg and which solicited few negative judgements.

[39] Padua was the only site mentioning this very specific collaboration between judicial and treatment sectors and executed by the local police.

[40] More than just being a "*reward*", a group of Austrian clients pointed out that having lesser constraints was an indication of being "*advanced*" in the treatment process, hence suggesting that a "status" change has occurred.

[41] Although there are notable cross-site differences: in Fribourg, controls were almost inexistent towards the end of the orders and in Vienna they were significantly reduced; whereas in London and Padua controls and testing were still active treatment elements.

In spite of the recognized importance of constraining daily or weekly routines, these efforts could well be counterproductive if the *security base* itself is not ***broad-based***. Surprisingly, it is during the early phases of the treatment process, that is, when structuring and security needs are considered as being particularly important, that other conditions intervene (or do not intervene) which seem to *hinder* the development of feeling "in security". The most striking examples of *insecurity* came from the English sites, in spite of the very rigorous efforts of these sites to encourage time structuring[42]. Some of the insecurity examples seemed to have been engendered by *coordination difficulties* between the "QCT system" and other "neighbouring" services that were responsible for medical or social benefits. The more general problem of waiting lists used for methadone prescriptions can be particularly acute for QCT clients and even jeopardize their engagement in a QCT programme[43]. Other examples concern the loss of certain benefit payments, notably unemployment benefits, for QCT clients, as the number of required hours for treatment rendered them inapt for job opportunities. Yet others concerned accommodation difficulties (inappropriate or no accommodation at all). Not only did these clients express feelings of insecurity, they also felt that neither their needs, nor they, were recognized. In signalling in particular the English examples, it should be remembered that these sites were concerned with ambulatory treatments[44]. Homelessness or absence of social benefits could not help but *be* visible! Nevertheless, it could also be expected that initial difficulties would be reabsorbed during the first weeks of a QCT duration. It was therefore surprising to notice that at the end of orders some clients still had housing and benefits problems.

- Secondly, the "*structuring enabling security*" argument becomes an end in itself and can paradoxically hinder not only committed behaviour but also compliance.

It appeared that sometimes professionals were themselves "locked into" the need to show and defend authoritarian stances. It certainly appeared that way to this client:

> *"I said 'how come you can't say nothing nice? Downstairs everyone's got nothing but praise for me, they're all saying, all the key workers down there are saying how well I've done, how much I've changed, how my attitude's changed, my appearance has changed and the way I think has changed. It would be a good thing for me to build that relationship with my daughter'…and he said 'well I'm not here to tell you you're doing good, I'm here to see the legal side of it and to breach you if I need to, and I'm the one who can breach you, not them…I'm not here to praise you or anything like that'. I said 'I don't want you to praise me, I just want you to be fair with me', you know, and then he starts going on 'well I can breach you…" (London)*[45]

At the same time, such examples recall that structuring occurs also in the (already) hierarchical relations between professionals and clients. Or they can be "*humiliated*" in front of others for being late for an appointment. Or they may feel they "*must go down on their knees*" when making the case that they are ready for the following phase in a residential treatment.

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[42] For example, being on time for appointments, stipulating the number of hours to be present in programmes..

[43] Setbon identified the coordination or absence of coordination in the hours following the pronouncement of a court ordered treatment as being particularly critique SETBON, M., *L'Injonction thérapeutique. Evaluation du dispositif légal de prise en charge sanitarie des usagers de drogues interpellés* Paris: CNRS - GAPP, 2000.

[44] However, there were examples of insufficient coordination between sectors in other sites too. In Berlin, for example, one client was discharged from prison a day earlier than his supposedly coordinated entry into a treatment institution.

[45] Admittedly, the example seems extreme. However, there were numerous certainly less extreme examples converging around the impression of being constantly put in one's place, being coupled with feelings of humiliation, apathy, revolt and feeling victimised. These examples take on yet more sense besides the opposing reactions of feeling encouraged.

Overly structured relationships and roles would seem therefore to *hinder confidence building situations* whilst generating feelings of *in*security. In other situation, clients from one residential centre lied about relapses even when they knew that the anticipated consequences would be confined to the treatment programme. One of them explained that he lied *not* because he contested the right for treatment professionals to "*know*" that he had relapsed but because he contested the interpretation that would be made of the event[46]. Without needing to know whose interpretation was the more adequate, the example does reveal that underlying "meanings" about drug use and acceptable behaviours are also at stake within these relationships. When little or no leeway appears to be possible, some clients will lie rather than comply[47].

More generally, some structures seemed to take insufficient account the QCT duration period as a dynamic evolving time sequence. Indication: Towards the end of some programmes, clients felt they were "*going over old ground*"; they had "*seen it all before*; they were "*bored*"[48]. Feeling bored could well be an extreme example of a more general critique concerning the difficulty for some clients to identify indications that they were indeed progressing and that the order, too, was progressing. Certainly, some programmes have their own "built in" markers (being able to leave the treatment centre, being allowed to take methadone doses home for the weekend, being able to work outside the resident centre, being able to live in an independent studio) and which gave opportunities for clients to appropriate more valued statuses[49]. When such markers were absent, or the programmes were predictably the same throughout the order, clients appeared to have lesser possibilities to experience statuses other than the one acquired with the QCT order.

2.2. Having an ally

Committing to treatment goals and developing non drug or criminal related life styles is difficult to do alone. Program descriptions and professional practices predictably and frequently refer to one of the founding principles of therapeutic and social work interventions – a meaningful helping relationship – as being part and parcel of the treatment process. In all sites, professionals seek to encourage clients to undertake the necessary reflective work in order to understand the meaning of their drug use as well as developing positive feelings about themselves and formulating new life objectives. In all sites, clients, too, confirmed again and again the importance of having a person who listened (*she really*[50] *listened),* who counselled, who took them seriously, who dialogued and, at least as important, who responded in concrete ways (*he took my situation into count*). Other equally strong but contrasting remarks (*he didn't care one bit)* would seem to reinforce the importance of having the "caring" person. Indeed, Serge Brochu recently even identified the "helping relationship" as probably the most important element explaining QCT success (BROCHU, S., 2005) Interestingly, the significant person could come from the full range of QCT situations. Whilst predictably social workers, psychologists, drug counsellors, treatment referents were often accorded the status of significant professional, so also were probation officers. Sometimes, a significant person's intervention was punctual: a policeman, a prison worker or even a judge during a review hearing.

The helping or therapeutic relationship is thus confirmed as an integral part of treatment or *care* processes and can even be integrated, at least to some extent, into the *control* sector. However, at the same time that QCT professionals recognize and practice the helping relationship, in some form or

[46] Examples from a residential centre in Fribourg site. We'll be examining this example further when discussing relapse management.
[47] In this particular case, the client actually left the treatment structure.
[48] All examples from London site.
[49] The Austrian group interview confirmed the feeling of valorised "*difference*" with regards to incoming clients.
[50] The "really" would seem to differentiate passive or functional listening from the *significant* listening.

other, the specificity itself of QCT can hinder its effectiveness. The confidentiality issue is particularly problematic in that it will inhibit the extent to which clients will "*share*" information. In one site, clients were told by probation workers that incriminating information could not be withheld from judicial authorities, suggesting that probation workers are themselves constrained with regards to what may be confidential or not in "helping" relationships. Serge Brochu, too, identified the same difficulty (BROCHU, S., 2005). And, as the judicial sector mandates the treatment sector, one can suppose that treatment personal could also be held accountable to communicate incriminating information[51]. Another hindering condition, frequently mentioned by both professional *and* clients in one site, was the *lack of time* (*He's always busy*) that probation officers had, due apparently to staff shortages[52]. In other site, the health worker was always "*on the phone*".

In spite of these real limits, interviews with clients and professionals confirmed that meaningful helping relationships are the tools of the treatment trade. This said, the complexity of QCT (defining roles between two sectors), could suggest that the *helper* will be called on to assume a more "overall" role than that of the traditional therapist or health worker. In fact, this same need was already anticipated during the QCT entry phase. We noticed that some clients were encouraged to engage in the QCT option after intensive interactions with designated workers, be they from the judicial or the treatment sectors[53]. However, more often than not, the QCT placement signified the end of this particular helping relation. In other words, the relay had been passed on, or, rather, it appears to be shared between a plural number of "key" workers, each with his or her own accountability constraints. However, some workers did position themselves as an *ally*. An ally, then, would be someone who is "*willing to go the extra distance*"[54], with regards to interventions in favour of his or her clients. Significantly, the interventions may not be confined to particular sector but could include selected interventions to (say) local housing authorities. Surprisingly though, allies seemed to "self-made" rather than depend on institutional or service professional culture or policy. Clients even explained their changing situations by the chance they had to have been allocated a different key worker within the same service[55].

Having an ally, relying on a meaningful helping relationship, can thus be understood as providing both practical and therapeutic assistance, conducive, notably to the development of practical knowledge, introspective skills and general *reflexive* processes. All these advantages would seem to be involved in clients' capacity to gain some distance from the QCT system itself. Clients, who came to develop a positive view of the court ordered treatment, showed that, in gaining distance, they also gained understanding "*of what it was all about*". Rules became, if not desired, at least "*understood*". In addition to what can be recognized as a part of an appropriation process, the understanding the system was sometimes accompanied by a sense of being able to use the possibilities that the system offered and even to adapt them to one's own objectives[56]. Having a sense of being an actor, of having some control over the paradoxically constraining QCT context cannot, of course, develop without some form of reciprocal recognition from professionals willing to consider with some flexibility the relationship between clients and professionals[57].

[51] In the Padua site, for example, residential workers were obliged to inform the district judge in case of positive drug tests. They did dispose however of the possibility to contextualise the relapse in their written report.
[52]Example from London site.
[53] Network arrangements differed from site to site.
[54] Tim McSweeny used this expression in an interview report.
[55] Example from London site.
[56] A noticeable example is provided by a Swiss client whose motivation at entry was essentially to avoid prison. However, after some time passed in the treatment institution, he was able to negotiate a therapy according to what he considered would be useful and which, notably included educational and community activities.
[57] As we discussed above.

Identifying *having an ally* as a commitment enabling condition, recalls an issue already identified during the QCT entry phase. We noticed that some clients were encouraged to engage in the QCT option after intensive interactions with designated workers, be they from the judicial or the treatment sectors[58]. However, more often than not, the QCT placement signified the end of this particular helping relation. In other words, the relay had been passed on, or, rather, it appears to be shared between a plural number of "key" workers, each with his or her own accountability constraints.

More generally, clients engaging in the reflective process find the means to produce a coherent "life story" (LINDE, C., 1993). One challenge that QCT clients face is to find ways of inserting the QCT experience into their overall life narratives. The court ordered experience not only would become acceptable to themselves but the narrative could then be used in interactions with significant others. Some indications that clients were indeed doing so included the way they appropriated the court-ordered treatment as their *own*, in explaining that it was *already planned*. Others used the "last straw" or the "rock bottom" to explain their directional change. Others again, as suggested by Charlotte Linde, used the QCT period as proof of their changed ways and as means to reassure parents and significant others ("*they see the efforts I'm making"*).

2.2.3. Relapsing positively

Relapses are foreseeable within drug dependence theories and expected by all key actor groups. Talking about relapses, testing for relapses, analysing relapses, preventing relapses, resisting relapses, using relapses to understand using drugs, reacting to relapses or defending relapses… the relapse issue is, predictably, a theme within helping relationships as well as the focus of specific therapies and programmes. However, if having to cope with relapses is accepted as inevitable[59], there are differences between the approaches used to do so. Although differences within the treatment sector are hardly surprising and reflect logically the large range of therapeutic references founding drug dependence theories[60], much more has been made of the differences between the judicial and treatment sector. Indeed, the potential that has the relapse issue to become an area of conflict between the two sectors has been largely documented for some years (CRÉTÉ, R., 1997, BROCHU, S. & SCHNEEBERGER, P., 1999). Given, then, the inevitability both of the relapses themselves and the differences about how to cope with relapses, it was hardly surprising to find examples of established practices and protocols about how, in a QCT context, relapses should be handled. In other words, the predictability of the relapse issue obliges some form, at least, of institutional preparation or positioning by actors called on to deal with it.

Of course, at the centre of the relapse issue, is the fact that relapses provide the "proof" that individuals are still using drugs. Certainly, within larger treatment models, relapses provide *exactly* the means by which clients may be led to understand the reasons and the circumstances surrounding the relapse and so progress toward treatment goals. Nevertheless, even in these larger treatment models, the diminution or elimination of relapses will, sooner or later, ultimately reflect the client's progress towards non problematic use or a drug free way of life. Within the more specific QCT framework, relapses become not only an indicator of changing behaviours; they become *the* indicator[61] *par*

[58] Network arrangements differed from site to site.

[59] We noticed in fact that occasional or recreational using is not a theme on the QCT agenda.

[60] Even within the same site, different approaches are easy to identify. Moreover, they will even be accentuated in order to convey the specificity of a particular programme. In Switzerland, for example, a national register, accessible on the Internet, details each institution or service intervening in the dependence area and details the therapeutic approach, the pedagogic concept, the size, the locality, etc.

[61] One can even have the impression that the indicator is confounded with the objective….

excellence of the extent to which clients are complying with the order itself. Testing for relapses can even be considered as the crux of the QCT matter.

For clients, the relapse issue thus involves decisions (at the very least) about *compliance* and (potentially) about *commitment* towards non problematic or drug free lives. In coining (with just a little provocation) the expression of "relapsing positively", we sought, certainly, to describe how some clients in some QCT contexts do indeed seem to use relapses in order to affirm commitment as so be able to identify at least some of the practices and contexts which enable or hinder positive relapsing. In addition however, the idea of relapsing positively refers to a specific *activity*, shared by the client and the worker, consisting of searching for an acceptable shared meaning to give to the relapse as well as the implications or consequences that will logically follow. Two areas, each in its own way, provided information to and about relapsing individuals as well as the relapsing activity in QCT settings.

Relations between sectors. Broadly speaking, most sites suggested that lessons have been learned from previous studies and that cross-sector consensus about monitoring and implementing QCT are established. Put another way, differences between sites and even between intra-site differences seemed to come more from the *type* of consensus elaborated (more of less constraining) rather than the suggesting conflicts about the issue itself[62]. More important, clients in most sites "*knew*" what would happen if they relapsed, that is, they knew if there will be an automatic notification by the treatment centre to the judge, or whether the incident will figure in the 6 monthly written report. Some will also have a fairly good idea as how much leeway they to influence the consequences, for example, if they can count on treatment professionals' support. Of course, in all sites the consequences were not necessarily appreciated (increase in the duration of the order after a positive cannabis test; transfer from one residential centre to another, augmentation of methadone dose against client's wish). Nonetheless, procedures were *known* or became to be known with the relapse incident. At the very least, relapses incidents facilitated *knowledge* diffusion about the *compliance ground rules*. In the relatively consensual systems, professionals from both sectors seemed to put up a common front with regards to relapse procedures, although in one site, judges were seen by treatment professionals as showing *partiality*[63]. The counter example came (again) from the English sites, less for their comparatively higher attrition rates (suggesting a lower tolerance to relapses) than from indications that, at least sometimes, professionals from one sector are seen by clients as explicitly disregarding the opinions of the other[64]. Although we cannot specifically make the link between, on the one hand, a divided front, nor a contentious one (with one sector demonstrating its ascendance on the other), and on the other, the ways that clients will comply or commit, we can surmise that *ground rules* are more difficult to read.

Clients and the programme concept: Whilst cross sector relations between professionals define the rules and so set the scene with regards to relapse controls, clients' face to face interactions take place in the daily programmes, group sessions and face to face appointments with key workers. Without attempting to construct an inclusive "relapse-response" inventory, a number of standard reactions appear in all sites such as specific relapse prevention techniques or adjustment of substitution treatments. Apparently independently of these particular techniques, two broad *approaches* can be distinguished:

- *Compliance oriented approach*. Testing is widely used. *To breach or not to breach* is the issue and above all a menace to all potentially relapsing clients.

[62] Certainly the types of consensus seem in turn to reflect the *balance of power* between the sectors. On-going analyses suggest that systems can be differentiated according to which partner claims and obtains the status of QCT expertise. We will pursue these typological efforts further on.

[63] As reported by Padua's interviewers.

[64] See the "extreme" example we cited above.

- *Therapeutic or education oriented approach*. The relapsing client is encouraged to analyse and understand the "meaning" of the relapse; may be encouraged;

Before concluding too rapidly that the therapeutic or education oriented approach would be more likely to enable commitment emergence, contrasting results suggest that this is not necessarily so[65]. In some programmes, the relapse signified an immediate break in all treatment activities other than the *reflective process* itself. One client was excluded from the treatment structure and sent to another centre with the understanding that the relapse signified a need to "*go back*" to the first stage of the treatment process. Whilst this particular client did indeed continue the therapy, his "commitment" appeared guarded. Significantly, he hid future relapses, specifically in order to avoid the repercussions. More dramatically, another client left the institution altogether as his relapse (occurring during the final stage of the programme and of the court measure[66]) would have entailed leaving his employment and returning to a "closed" treatment situation. Pursuing the latter example, we can in fact identify both the relapse reaction and the relapsing activity. Behind the more or less automatic sanction that the centre applied after relapses, there was the more fundamental activity of deciding what the relapse should signify. *Relapse defining* thus became the activity during which conflicting definitions were at odds. Whilst not "*excusing it*", the client persisted in seeing the relapse as a *"stupid incident*" rather than a "*sign that* (he) was *returning*" to his previous drug dependant way of life. Whilst the centre was (apparently) ready to not necessarily *over*-interpret the "incident", it did require that it be examined according to the "closed" treatment modalities. In leaving, it would seem that the client abandoned the possibility to commit to the treatment objectives. At the same time, one could also argue that the client followed his own commitment schema rather than the schema proposed by the institution[67].

In other programmes, too, relapses were considered as an issue to be faced, and were also required to be the object of analysis by the client himself and within the client – worker relationship. However, the implications were markedly different from the previous example. Instead of provoking a break with other treatment elements, clients in another residential institution were required to continue the elements *in spite of* the relapse. Indeed, according to one client, it was the continuation of the treatment routines that enabled him to "*realise what he had already achieved*" and that he "*didn't want to lose*".

Interestingly, in two of the examples, the treatment elements at stake were similar. The client who ultimately left the treatment was, at the time of the relapse-incident, employed "outside" the residential structure. As for the client who was obliged to continue in spite of the relapse, he too was involved in a supervised "work experience" outside the internal workshop concepts used by most residential treatment centres. The two clients had indeed something to lose; and both used their relapses to link together the *commitment* towards drug free behaviours to that of valued employment opportunity. From another perspective, the examples also point to contrasting ways of conceptualising the reflective process itself. In the first approach the reflective process seems strangely *disembodied*

[65] We examined the Fribourg sample because Swiss practices generally follow a therapeutic interpretation of relapses, that is, relapses are considered as interpretable and thus controllable events during the treatment process. One would expect therefore a high potential for commitment emergence. However, this did not necessarily seem to be the case.

[66] Although he theoretically ran the risk of returning to prison, he counted on being considered as having sufficiently fulfilled the obligations. This turned out to be the case.

[67] We are not attempting to legitimate one or the other actors with regards to the specific "incident". Rather, we see the example's pertinence as being two-fold. First, it can be considered as illustrative of the type of definitional processes well documented in sociological theories. In the QCT context, the example becomes a reminder that definitional processes not only occur throughout the treatment process but their outcome can depend on other factors, such as the client's social capital and resources. However, it is the second level of pertinence that we find enlightening and which allows the comparison with the example that follows in the text.

from any kind of activity whereas, in the second approach, the "other" activities were seen, to the contrary, as *enabling* the reflective process. In other sites, a similar difference could be seen in treatment programmes organised exclusively around drug-related themes in spite of clients experiencing important and sometimes overwhelming housing and basic benefits problems.

2.3. Linking to non-drug and non-treatment community spaces

The final enabling condition pushes even further the idea of extraneous interests by making them an objective in their own right. It uses material exclusively coming from QCT clients initially placed in residential centres, although some of the centres had treatment concepts which included different forms of out-client structures (supervised housing, independent housing combined with curfew controls).

A general characteristic of residential centres, in which the QCT clients of the qualitative sample were placed, is that they all included treatment elements pertaining to some form of "work" or "workshop" activity. Admittedly, whilst recognizing their utility in structuring day-to-day organisation and routines, clients appreciated differently the purported "therapeutic" value of the activities themselves. We could not help but notice, for example, that urban clients do not necessarily appreciate gardening activities or farm work with cows!

However, as already glimpsed in the examples above, in some centres the "work activity" elements of the treatment programme were particularly appreciated in that they were seen as "*giving real meaning*" to relatively new drug free lives. The difference was not so much to with the activity itself[68], but, as one client explained, he was being integrated into a "*real*" enterprise, with "*normal*" colleagues[69]. In addition to the "real-life" aspect, this client was sure that the experience would facilitate finding an employment after the end of the measure, another 18 months from then. Other clients[70] were able to use similar opportunities to do supervised work or, even, to have "*regular*" jobs. We also came across two clients, in two different sites, who were attending classes leading to professional diplomas. Whether in work or study contexts, all shared the preoccupation about being prepared to obtain employment after the measure and, at the same time, all expressed similar satisfactions with their treatment programmes[71]. In other words, rather than representing an escape from treatment obligations, all three clients linked these "*normal*" professionally oriented activities with the utility of the treatment programme itself. The essential point for them, however, was the *normal*, the *regular*, the *being seen as a normal person*, and not the *drug user*.

Linking to the normal becomes thus a powerful commitment enabling condition because it favours clients' attempts to develop social and professional identities which contrast with the marginal and deviant identities associated with drug dependence. At the same time, the value given to the *normal* and the *regular* provides a powerful incentive to clients to maintain their (new) non problematic behaviours. Clients recruited by the Padua site had additional possibilities to develop valorised identities[72]. Undertaking "*obliged voluntary*" work put clients into contact with different, usually

[68] The manual semi-skilled activity was finally not so different to what was proposed in the residential workshops.

[69] Contracts were made between the treatment centre and local enterprises. Clients were integrated into the enterprises for a certain number of hours per day, depending on their individual capacities.

[70] More particularly from the Padua and Fribourg sites.

[71] Even the client who left on relatively bad terms from the centre (see above) insisted that he had gained much from the programme itself.

[72] The Padua site was indeed the most advanced in the way the local community became a part of the treatment concept. However, as with all the sites, Padua had its share of "best cases" (appropriation of treatment goals and commitment to non problematic life styles) and its "worst cases" (minimum compliance, biding time). We will have other occasions to come back to other characteristics of Italian model.

institutionalised groups (handicapped, aged). Some clients developed affinities and competencies that were, apparently, recognised and which were to provide training and working options at the end of the QCT order. Hence, the after-QCT was being explicitly planned during this general QCT *doing* phase.

To what extent, however, are these favourable conditions associated with the comparatively large scope of action that each of these institutions seem to have? Apparently following the *one-stop* concept, these programmes contrast starkly with specialised drug services which stay within strictly defined mandates. Of course, insofar as specialised services are integrated into larger service networks, other advantages again could emerge. However this seemed not always to be the case.

3. Enabling client commitment and service feasibility: what makes the difference?

After having sifted through the multitude of examples and indications of *this* or *another* aspect of QCT implementation, we thus identified four sets of conditions that can be considered as commitment enabling conditions, each of which regroups its own tensions and provisos

Enabling…	*Hindering…*
Broad-based structuring enables security, which in turn favours self confidence and the practice of new capacities as one works through QCT	Whilst structuring logics characterise the essence of all QCT systems and practices, some practices are: - not sufficiently structuring because they concentrate on structuring daily time and leave aside fundamental security needs such as housing or benefits - too structured because they prioritize social control to the exclusion of progressive change within the QCT time frame
Having an ally enables developing an overall understanding of QCT; ideas can shared and tested, limits are more easily accepted to the extent that one's own progress is accepted;. reflexive skills are practices which may favour the development of acceptable life stories	Whilst being attached to the helping relationship concept, some professions are themselves subjected to institutional constraints (confidentiality) or pressures (understaffing) which could weaken the very base of the helping relationship.
Relapsing positively enables taking responsibility for one own actions and clarifying other values and advantages to which one is attached	On the condition that possibilities and options allow the emergence of other values and advantages
Linking to non-drug and non-treatment spaces provides opportunities for developing valued social identities and social competencies	However, providing work programmes or other community options may be out of the scope of some services. Some services may not have the means nor the mandate to use service networks

What then makes the difference between programmes? Is the answer in the accumulation of enabling elements? Are *all* the conditions necessary or do *key* conditions exist without which clients will probably neither comply nor commit to QCT's broad objectives? If the conditions are not mutually exclusive, how do they interact? Or, how do they enable each other?

Amongst the multiple combinations possible, and again referring to both convincing and less convincing practices in all the sites, three combinations appear to be particularly *enabling*:

- a mixture of practical and symbolic or relational aid
- a mixture of QCT spaces and non QCT spaces
- a mixture of structure and services

The mixture of *structure* and *services* merits an additional explanation. When comparing sites, two stood out as being more constraining than the others. The English sites and the Padua site displayed practices not seen elsewhere:

- In Padua: curfews and territorial restrictions, compulsory reporting of positive tests to the judge
- In London: a "breaching cloud" seemed to be constantly present
- In Kent: clients simply disappeared, apparently breached or gone elsewhere

However Padua and the English sites also differed. Along with the constraints, Padua offered services and real integration possibilities, for those who lasted the distance. Even admitting that the English sites included services having less scope in the actions they could develop, these same services also, apparently, lacked the means to connect to welfare and general services networks.

3. Leaving QCT: you said leaving?

3.1. Confronting absent data:

Generally, compared to the abundant details concerning the QCT entry phase (arguments, procedures, criteria, options, choices, reactions…), material collected concerning the end, or the ending phase, of a court ordered treatment seemed to be relatively "light" or less specific with regards to the order itself. Interpreting the absence of data is, of course, hazardous and generally indicates the need for further data collection. The particular challenge here comes from the impression that the relative absence of data could, in itself, indicate part of the response to the question of *how QCT works*! We therefore attempted reasoning in terms of propositions. The following propositions suggest contrasting explanations.

- *The battle is over theory:* Given that the entry phase includes the major decision of whether and under what conditions the order will be pronounced, actors are mobilised a maximum around key issues affecting as much the practical procedures and organisation of the order as the underlying symbolic stakes around status and social identity. Once the decision is made, the "battle is over", so to speak, leaving its place to the day-to-day treatment realities

- *The successful transition theory*: Compared to the entry phase, during which statuses and identities are at stake, the comparative demobilisation can be seen as being an indication that the transition from a quasi compulsory treatment to voluntary treatment has, indeed, taken place. Rather than being an issue, the end of the "compulsory" aspect of the order is thus relegated to the level of an administrative detail.

- *The non recognition theory*: The comparative absence of specific exit phase activities is an indication that any eventual difficulties related to finishing the order are not recognised and therefore are not translated into particular procedures or services.

Re-examining the available data does accord some feasibility to each proposition. We also remarked that professionals seemed to play down the signification of the end of an order, concentrating more on clients finishing or continuing the *treatment*, whereas clients expected or counted on some sort of official or symbolic recognition that the *judicial period* had indeed come to an end. Also, the fact that evidence does exists for each of these conjecture underlines, yet again, the large diversity of QCT practices. Interestingly, evidence can even be found in particular sites for each conjecture, suggesting that at least to some extent, practices develop independently of the codified systems in place.

From the interview evidence itself, analysis to date[73] can suggests three exit "ideal types", each one comporting its own advantages, disadvantages and implications for the *after-QCT* period.

3.2. Tentative conceptualisations:

Concentrating on the available material, three exit "ideal type" styles could be tentatively developed[74]:

- *Treatment oriented*: The end of a court ordered treatment is *oriented by treatment success*: The judicial sector awaits treatment sector reports before signifying the end of the court order by means of a letter, sometimes transmitted by the treatment personnel. Sometimes, favourable treatment reports can shorten the initially judicially defined period. Closure can be signified by a ceremony or celebration, organised by the treatment programme. However, if a successful treatment duration is significantly shorter that the initially defined period, clients may be required to report to a probation service[75].

- *Sentence oriented*: As with a traditional penal sentences, the end of a court ordered treatment signifies that the *fixed duration* of the judicial order has come to term. Specific financial benefits of services directly linked to the fixed duration will consequently be withdrawn. If initial problems are still present (dependence, criminal behaviour) a new procedure could be instigated[76].

- *Integration oriented:* In this exit style, *endings and continuities overlap*. Although the end of the order itself is negotiated within a quasi fixed duration, an exit phase ensures that the after-QCT is already in organised *as if* clients have already completed the order. Exits organised as an exiting phase explicitly overlaps constraints and judicial status with integrative activities and symbols such as independent housing and regular employment. Closure signified at the same time the end of the judicial status and the continuity of integrative activities[77]. Padua's "best examples" fitted here.

The following table summarizes the key characteristics of each style and examines further comparisons and contrasts according to a number of selected issues.

[73] We intend to extend data collection on the QCT ending phase in order to confirm or complete the emerging styles

[74] It must be remembered that developing "ideal types" involves exaggerating certain properties and dimensions so as to bring out the defining characteristics. It therefore follows that the individual site practices will approach one or the other styles without necessarily conforming to it completely. In the same way, whilst sites can be seen to favour one or another style, no one site can be reduced to one style.

[75] Some data from Berlin, Padua, Fribourg, and Vienna support this model

[76] Some data from London support this model

[77] Padua's "best examples" fitted here.

Table 9: Cross site "exit styles

Exit Styles			
	Treatment oriented	Sentence oriented	Integration oriented
Implicit logic	Recovery	Retribution	Rehabilitation
Duration a) Who decides b) Criteria c) Client input	Negotiated a) Judge after recommendation from social professionals b) Readiness c) Encouraged	Fixed a) Judge follows original decision Time up b) Not pertinent c) Not pertinent	Negotiated a) Judge after recommendation Integration b) Encouraged c) Encouraged
Confidence in anticipating end	Degree of incertitude	Maximal clarity	Degree of incertitude
Symbolic signification	Exit considered as event	No Eventually at individual level: achievement	Final exit considered as event
Specific exit activities	organised according to "phase" treatment models	Discretionary: depends on initiative of individual professionals	"Phase" treatment model conceived to overlap with an "after-treatment" time
Prevision of after-QCT voluntary treatment Transition to other structures	Probable if needed Transition assured	Discretionary: depends on initiative of individual professionals Transition not assured	Probable if needed Transition assured
Social integration after QCT	Eventually	Not assured	Probable

It should not be forgotten that all exit types can include both "best" and "worst" and "mixed" examples.

- Whilst the "integration oriented" model appears to be the most attractive, it depends largely on local employment possibilities. When these are not assured, exit procedures may be drawn out.

- Both the treatment oriented" and the "integration oriented" tend to conceptualize QCT exits as an exit phase, particularly in residential settings. Therapeutic closure can take the form of a final evaluation session. Social closure can be marked by a diner or a "party".

- In both the "treatment oriented" and the "integration oriented" types, formal exit decisions can also be delayed for a variety of reasons (administrative backlog, by security) and thus provoke

frustration and feeling of injustice in clients. For example, in one site[78], two QCT clients had already finished their respective treatment programmes and both had even left the two centres concerned. However at the last interview, both were still waiting for a "*signal*" from either the Judge or the regional probation service. Whilst each in own way attempted to "*move on*", neither were being monitored nor receiving support, although both "*knew where to go in case of…*" The problem, as they explained it, was at another level. While the measure is "*there*", they "*cannot move on*". One of the men felt particularly insecure or "*not at peace*". The least problem with the law could put him back to where he was 18 months ago, that is, having to return to prison to serve the original sentence[79]. Neither man felt that it could find *closure*.

- The status of the relay between treatment centres and probation services is not clear. During a group interview in Vienna, clients presented themselves as "*finishing QCT*" and "*finishing the treatment*" programme. Well into the interview, it almost incidentally came up that some would be reporting to the local probation service. The judicial status that these clients retained, however, was not clear.

- Whilst the "sentence oriented" model is not necessarily accompanied by any guarantees with regards to integration, individual actors can work around service possibilities so as to insure not only official closure but also necessary on-going benefits. Even so, the initiatives in this direction suggested that, for some clients, administrative processes (finding funding for voluntary treatment) would have to start from "scratch".

- The question of the benefits themselves was probably the most surprising element of the "sentence oriented" exit model. Fringe benefits (bus passes) were simply withdrawn. Clients appeared to be in disarray in learning, only days before, that social supported would be terminated. A general demobilisation was also noted: fewer appointments, less engagement from some professionals.

Together, the above glimpses of exit modalities convey an impression of exit inequalities. Whilst some clients can achieve closure, others seem suspended. Those transferring to regional probation services seem to know little about what this may entail from the point of view of their legal status, their responsibilities, or with regards to eventual benefits. The most disturbing cases, however, were those for whom, apparently suddenly, QCT ended. Some found themselves without closure and (in some cases) without the means of continuing towards voluntary treatments.

[78] Fribourg

[79] In fact, this is extremely improbable, and he probably knows it. However, the feeling of general absence of closure seemed very real.

Part IV

Conclusions and perspectives

Well, how does QCT work?

In a way, QCT puts actors together and summons them to cooperate for a period of time going from a few months to up to, maybe, 24 months. In spite of being deliberately simple, the description captures three defining QCT characteristics:

- The initial injunction will in itself be a defining moment as well as the culmination of intense activity
- In sharp contrast, the period of order may certainly (and will) provide new possibilities, but it may also represent a "drawn out" period where some clients and professionals may bide their time.
- And then it ends.

The starting point of our specific approach was, in a way, similar to this simplest approach. We understood that QCT implementation could not be reduced to a "sameness" and that a phase combined with a client trajectory approach would enable us to grasp the specificities and the issues at stake at key moments of the order. Following the QCT orders in "real time" proved decisive as we were able to focus data collection on three separate "here-and-now" interview situations.

- Entering QCT was thus analysed in terms of *three interactive process*es and which ultimately have at stake the quality of the QCT placement. We were able to show that for a variety of reasons, best fit between client needs and treatment offers are not always guaranteed.
- Doing QCT was analysed as a feasibility test in that another type of best fit this time between the key actors intentions and means. During this phase, it is the emergence of client commitment which is at stake. We were able to identify four enabling commitment conditions as well as their negative "hindering" version. Amongst the findings relating to this phase, we emphasised the necessity for services to create links between treatment services and the local communities.
- Finishing QCT proved to be a major surprise. After the intense mobilisation that characterised the first phase, after the admittedly sometimes tedious but nevertheless fruitful day-to-day activities, the finishing phase appeared at times like a arbitrary rupture which nonetheless did not allow, at least for some, satisfactory closure. We also made the point that further data collection would be necessary in order to understand this final, non event which paradoxically *was* an event.

The qualitative data bank is far from having being exploited. Work will be continuing in the following directions:

- Previous studies have underlined the sometimes difficult relationship between the two care and control sectors. We remarked that the relationships they foster and maintain cover implicit forms of power distribution, based probably around which partner claims expertise status. We hope to clarify the different types of expertise (including client expertise), and how these contribute to shape recognisable QCT operational styles.

- Although we used the client trajectory data to clarify and to enrich the overall analysis, we consider that the concept could take on a more central status. Identity negotiations appear to intervene at all times throughout QCT implementation: form potential prison in-mate to potential integrated citizen or, potential return to prison… the trajectory approach, especially if it could include the period after the order, should increase our understanding of the key transitional phases within a QCT duration.

- We intend to delve more into the links between the qualitative and the quantitative axes and to practice, more than we were able to during the research period, the reciprocal questioning and understanding of the two.

The final note should and will be a *thank you note* to the 76 QCT clients and the 84 QCT professionals who consented to share their experiences with this project.

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APPENDICE 1

QCT
QUALITATIVE METHODOLOGICAL APPROACH

Phase 1:

EXPLORATORY INTERVIEWS

with
professionals involved in QCT programmes
and
experienced QCT clients

Marc-Henry SOULET / Kerrie OEUVRAY

December 2002

Phase 1: Exploratory Interviews

with professionals involved in QCT programmes and experienced QCT clients

1. Reminder of the general qualitative question

- For whom does QCT work (or not work), in what circumstances, and why?

Implications: processes analyses (opening the treatment "black box"), linking context, mechanisms, outcomes understanding personal action theories, understanding interactions between professional and client systems…

2. Aims of the exploratory interviews

Use a small number of interviews to:

- Identify specific themes to be included in the draft qualitative research protocol (to be distributed 31.01.03)
- Identify pertinent arguments and reasoning

As far as possible, the interviews should remain *exploratory*; that is they should aim at identifying the *types* of themes that need to be explored rather than necessarily going into all the details of the interviewee own story (although themes can also be teased out of the details). The point we wish to make is that we see these exploratory interviews as having a specific function, that of opening up ideas rather than just providing a "practice" or "testing" session for later, modified use:

- Certainly, previous studies on QCTs allow much anticipation of the likely pertinent themes to be explored (such as difficulties in role definition and differentiation, inadequate resources, etc.). However, the exploratory interviews should allow us, not only to eventually confirm the importance of known themes, but also identify the different aspects of these same themes. For example, what makes role definition difficult? Is it essentially a problem about different professional cultures having to work together in a new intervention sector artificially created by the QCT measure? Or is it more about an inappropriate match between the needs of a QCT client and what is actually offered in a programme based originally on voluntary treatments?

- However, previous studies also indicate areas that have not yet been systematically examined. The lack of data about the perspectives of those who are actually submitted to QCTs is often cited. This would certainly be more than a sufficient reason for preferring to interview *experienced clients/patients* rather than professionals during this early phase of the study. On the other hand (even at this stage), you may wish to include people from both groups so as to enhance a *global picture* of the field.

- As the people interviewed will be experienced in treating, or in being treated, their insights should allow us not only to confirm and identify themes but also to appreciate how these themes are *prioritised*. Perhaps, for a professional, the role problem definition is, after all, just an on-going problem that will always need to be addressed in any

multidisciplinary settings whereas, other concerns (to be identified) could be estimated as being far more important.

At a more general level:

- The interviews should also give us an idea of differences between sites, as well as highlighting common concerns.
- Exploratory interviews allow a first "confrontation" between the researcher and the field. In asking ourselves if those interviewed said what we expected to hear, we should be able to start identifying new ways of looking at what is going on.
- In much the same way, the interviews allow first contacts to be made, although not necessarily with people who will later be interviewed (the clients will definitely **not** be the same people). However, they do give a chance to get a feeling of the area, who the principal actors are and how they define their main concerns.

3. Choosing the persons to be interviewed

While giving priority to experienced QCT clients, we suggest you also include persons coming from the judicial and treatment systems. For a total of **five** exploratory interviews by site, a suitable mix would be three interviews with clients and the other two coming from the judicial and the treatment systems. However you may prefer to bring (say) five or six clients together in a focus group.

Use your own networks to find suitable people. However, please note the **criteria** you use to choose the QCT programmes and the professionals. For example: Are they representative of a point of view that seems to be the most (or the least) expressed? Were you curious to discover more about a particular aspect of QCT? Are the professionals the official spokespersons for their sector?

Concerning the experienced QCT clients you will need to be guided by the programme personnel. Make sure those to be interviewed are "willing" and that they have been in the programme sufficiently long to be able to know how it works. Ideally, they should be towards the end of the obligation period. Try to explicit with the personnel what criteria were used to choose *this* or *these* clients and not others. Perhaps he/she is "typical" of a particular type of client?

4. Suggestion for an exploratory interview

The approach is the usual semi-directed exchange. With only minor adaptations, it should work for professionals and patient/clients. The indicated questions should allow the interviewee enough scope to answer according to his/her own experiences and knowledge. The interview is divided into five topics or themes, each one of which has its own objective while contributing to an overall progressive movement. Of course, language should be

adapted according to the style of communication used by the interviewer and the interviewee. Not all the *questions* need to be asked. However, if possible, all the *themes* should be covered. The average duration should be around sixty minutes.

Themes	Questions / *information*
1. Introduce context & the idea of expert knowledge - Information - Recognition of their expert status - Valorisation of their contribution - Naming the expertise areas (knowing the system, how to use it, how to influence it, etc)	**1. About what can a QCT expert?** *European research programme is seeking to analyse the overall efficacy of QCT programmes and how particular programmes work. At this stage of the study, we wish to use their experience in order to identify what we need to ask, what we need to explore, what must we imperatively concentrate on to avoid the risk of missing the point…His/her suggestions will be completed by those of other people involved in QCTs and then incorporated in the research protocol* - Can a "forced" client be an expert of QCT? About what can one be an expert? (clients) - At what stage of the QCT process does he/she intervene? What does this activity require? (profess.)
2. Extract the type of "best possible" elements	**2. What sorts of things work and for whom?** - What, in his/her opinion, should we consider as reasonable (or average) results to expect in a QCT programme? - What should we look at in order to understand how some programmes do (or could) obtain good results? - What should we look at in order to understand why a person is not doing well in what seems to be a good programme? - What, in his/her opinion, should we look at to know if a QCT programme is working well?
3. Extract the type of elements which hamper average or best results - Follow up on the "missing" categories	**3. What sorts of factors work against good results?** - What types of factors or reasons explain, or help understand, why a programme does not give good overall results? - What could be wrong about the organisation? Or the way people work together? Or the way services work together? Or the type of services being offered?
4. Situate his/her experience	**4. How do experiences contribute to personal evaluations?** - What does he/she particularly appreciate about being involved in a QCT programme? (profess) - What does he/she particularly appreciate about being in a QCT programme? (client/patient) - What does he/she **not** appreciate? - What would be needed to change what he/she does not appreciate?
5. Identify the most	**5. On which priorities should the research concentrate?**

important themes

- What in his/her opinion is the most important aspect about QCT programmes that we (the research team) need to understand before arriving in the programmes themselves?
- What in his/her opinion needs to be looked into (because it is not clear)?
- Any final recommendations?

The suggested order of the questions follows the idea that people usually need to "warm up" to a topic as well as "warm to" the interviewer.

Theme 1: Communicates the seriousness and the value of the answers as well as letting the person know that his/her contribution will no doubt be compared with that of others. Encourages identifying significant areas and mechanisms about which expert knowledge can be developed.

Themes 2 & 3: Continue in the professional or experienced registrar. However, while soliciting the expert knowledge, they could also tend to encourage the person to stay on "safe", conventional ground or respond according to what he/she expects we want. Follow up questions can however hone in on eventual undercurrents or suggestions by the person that he or she wishes to say more. Follow up questions would also be useful in order to widen a person's perspective. For example, if all the answers given by a professional tend to concentrate on client characteristics, ask a question about the programme itself. If a client concentrates only on a programme's restrictions, get him to talk about the advantages (or vice versa[80]).

Theme 4: After having appealed to the "expert", this theme should allow the person to express opinions over and above the usual evaluative categories.

Theme 5: Seeks priorities and closure.

5. Suggestions for an exploratory focus group with a group of experienced clients

While the objectives and general approach will be essentially the same as for the individual interviews, the time element here can be crucial. As is also keeping the discussion *focused*. Comparing global experiences, for example, could be fatal from this point of view. Be therefore particularly careful with the fourth theme. However, give ample time to the first question concerning their expertise. While seeking to convey recognition of their experiences and impressions, it also encourages thinking in more abstract terms. Once again, language

[80] We have often remarked that clients and patients (especially if they have been in a structure for some time) will often be reluctant to "criticise" the structure or the people who work in it to someone from the "exterior". Loyalty reflex? Suspicion of repercussions? Fear that it could be worse elsewhere? Whatever the reason, some people may need to be reminded of confidentiality issues and the project's need for constructive criticism in order to be effective.

should be adapted to the circumstances. Depending on the number of participants, the average duration will certainly be longer than for an individual interview[81].

[81] Many focus group guides exist and probably you have your favourite. We particularly like: Morgan D.L. & Krueger, R.A., *The Focus Group Kit*, Sage, London, 1998.

Themes	Questions / *information*
1. Introduce context & the idea of expert knowledge: - Information: - Recognition of their expert status: - Valorisation of their contribution: - Naming the expertise areas (knowing the system, how to use it, how to influence it, etc)	**1. About what is one an expert?** *European research programme is seeking to analyse the overall efficacy of QCT programmes and how particular programmes work.* ***At this stage of the study, we wish to use their experience in order to identify what we need to ask, what we need to explore, what must we imperatively concentrate on to avoid the risk of missing the point…*** *Their suggestions will be completed by clients coming from other QCT programmes as well as by professionals involved in QCTs, and then incorporated in the research protocol.* Can a "forced" client be an expert of QCT? About what do they consider to be expert?
2. Extract the type of "best possible" elements	**2. What sorts of things work and for whom?** What, in their opinion, should we consider as reasonable (or average) results to expect in a QCT programme? What should we look at in order to understand how some programmes do (or could) obtain good results? What should we look at in order to understand why a person is not doing well in what seems to be a good programme? What, in their opinion, should we look at to know if a QCT programme is working well?
3. Extract the type of elements which hamper average or best results - Follow up on the "missing" categories:	**3. What sorts of factors work against good results?** What types of factors or reasons explain, or help understand, why a programme does not give good overall results? What could be wrong about the organisation? Or the way people work together? Or the way services work together? Or the type of services being offered?
4. Situate his/her experience	**4. How do experiences contribute to personal evaluations?** What do they particularly appreciate about being in a QCT programme? (client/patient) What does they **not** appreciate? What would be needed to change what they do not appreciate?
5. Identify the most important themes	**5. What priorities should the research concentrate on?** What in their opinion is the most important aspect about QCT programmes that we (the research team) need to understand before arriving in the programmes themselves? What in their opinion needs to be looked into (because it is not clear)? Any final recommendations?

6. Summarising

At this stage, we're only after the interviewees ideas and suggestions. In other words, you will not need to do an in-depth content analyse! However, we do invite you to share with us your impressions and observations about particular points that may have struck you. To facilitate merging all the information, partners are asked to organise their reports as follows:

Part I: Background information
How were the interviewees chosen?

Part II: Interview information

Very often, the answers do not follow the questions. And just as often, the most interesting information was not even asked for! To cover both possibilities we ask you to organise the various points according to the suggested interview plan. That is, for each person interviewed:

Theme 1: Identify areas of expertise
Theme 2: Extract the type of "best possible" elements
Theme 3: Extract the type of elements which hamper average or best results
Theme 4: Situate the interviewee's experience
Theme 5: Identify the most important themes

and

Theme 6: Additional points/themes/ideas

Part III: Your impressions

- To what extent did the interview confirm what you already knew from your own previous studies, reading or other professional experiences?
- Did anything (content, attitude, contradictions…) surprise you? Please explain what and why.
- Taking into consideration all the exploratory interviews you conducted, what do you consider to be the three most important themes or areas that should be explored? How would you justify them?

6. Sending it on

- If possible (please; s'il vous plaît) in English or French!
- Document Word sent to Kerralie.Oeuvray@unifr.ch

Marc-Henry Soulet / Kerrie Oeuvray, 22.11.2002

APPENDICE 2

QCT
QUALITATIVE APROACH

HOW DO QCT PROGRAMMES OBTAIN THE RESULTS THEY DO?

PROTOCOL & INTERVIEW GUIDE

PHASE 1:

PRONOUNCING THE QCT ORDER

Marc-Henry SOULET / Kerrie OEUVRAY

Mai 2003

CONTENTS

PHASE 1 : PRONOUNCING THE QCT MEASURE

A. GENERAL PROTOCOL

1. Data collection

The data collection will broadly follow the same schedule as that of the quantitative collection: at entry, 6 months, 12 months, 18 months. The schedule will thus follow the phases of a QCT order

Phase 1 – QCT entry
Phase 2 – QCT treatment
Phase 3 – QCT exit

To which can be added:

Phase 4 – Overview: overall treatment process interpretation and elaboration of propositions.

Throughout all these phases, client and professional commitment will be a key issue as will also be systems cooperation. Some flexibility is to be expected with regards to the inclusion of other themes arising from the on-going analysis.

With regards to methods, both individual (or group) interviews and focus groups will be used. For *Phase 1*, only individual interviews will be used with clients and professionals. For the subsequent phases, individual interviews will continue with clients and some professionals. However, group interviews and focus groups with selected professional groups will also be used. Phase 4 will most likely exclusively use focus groups with professionals although, according to pertinence, a focus client-group could also be included.

2. Sampling strategy

The aim is to follow the QCT clients through the process and to interview them at three stages; entry, participation (after six months in QCT) and exit. If these interviewees drop out, we will aim to interview them once after drop out and then to replace them in the qualitative sample by people from the quantitative sample who are at the same stage of treatment.

In order to reveal how the system actually does work, rather than how it is supposed to work, professionals, coming from the judicial system, will be asked to consider a specific case (which will be kept anonymous) to describe how the system worked in ***that*** case.

Selection of clients:

- All clients will be "theoretically" selected from the population constituted by the quantitative sample.
- As overall numbers are small, it is decided to use no more than two criteria, one of which will be gender. Hence, if possible, at least half of each country's sample should be constituted by women. Partners can choose a second criterion according to their specific contextual concerns.
- Overall sampling intentions and justifications should be sent to Fribourg when they are known.

Selection of professionals:

- Professionals will come from both the judicial and treatment systems
- Judicial personnel will include those making QCT decisions (e.g. judge, prosecutor) and those monitoring the orders (e.g. probation officer)
- Treatment personnel will include both the directional and the worker levels
- Other key informants can be chosen according to site specificity (e.g. a police officer in Kent).

Sample size:
In the first phase of the qualitative research (June – December 2003), each partner doing qualitative work will interview:

- 8 people who have recently entered QCT (within four weeks of entry).
- 6 professionals in the QCT system:
    - 3 from the judicial system (decisional and monitoring);
    - 2 from treatment system (direction and client-involved);
    - 1 "other" according to partner's (justified) choice

3. Interviews guides

The same interview guides will be used by all partners. The guides will be regularly revised according to remarks concerning their continued pertinence and according to new questions deriving from the on-going analysis.

Partners may wish to add themes that suit their national situation. For the interview with the "other" professional (see above), partners can adapt an existing guide or develop their own. The report on this interview should follow the principal themes covered.

4. Reporting and analysing the qualitative data

In order to analyse data, Fribourg will need detailed descriptions of interviewees' responses – with quotes – as well as each partner's first interpretations and impressions. The following procedure (a variant of the Delphi method) should be used:

- After each interview, the partners will write a report, in English, divided into two sections. The *first* section concerns the data itself. As detailed as possible, it should be organised according to the pre-defined interview themes, background and contextual information. The *second* section will give partners the possibility to detail their own interpretations and to indicate pertinent directions to explore. These reports will be sent to Fribourg (Kerrie) as soon as possible after each interview.
- Fribourg will analyse the material according to a progressive and interactive process, led with each partner. Using memos exchanged by email, Kerrie will regularly instigate and maintain dialogue with partners on issues pertaining to country-specific and transversal analyses.
- Interim and final transversal analysis reports will be prepared by Fribourg at the end of each phase and at the end of the project. Hence, all reports concerning the entry phase of treatment must be sent to Fribourg by mid January 2004.
- Partners will write the qualitative sections of their national interim and final reports, using the interpretations that have been developed in dialogue with Fribourg and other partners

To facilitate handling, all reports sent to Kerrie must include a header (with source and date of interview) on every, numbered page. Individual templates (Word format) will be available for each interview guide. After assuring anonymity, these reports will be collated and form the basis of the dataset that will be delivered to the European Commission.

B. INTERVIEW GUIDES

1. THE JUDICIAL PROFESSIONALS INTERVENING DURING THE DECISION MAKING PROCESS

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own interventions and reflections with regards to a particular (anonymous) case***.

The information to be collected should thus concern:

- The interlocutor's own knowledge, understanding and evaluation of how the QCT system functions and where his/her activity fits into the overall system
- How he or she intervened with regards to a particular client
- How he or she coordinated and collaborated with colleagues working within either the judicial or the treatment systems

Whilst interlocutors should thus be steered away from giving only general information about system organisation, they will not, however, necessarily be able to contribute information about all aspects of the system in which they work. The judicial system particularly appears to involve many different professionals: prison personnel, social workers, psychologists, police, judges, probation officers…. each of whom will intervene at different stages of this first phase. Rather than drawing up a guide for each one (with the risk of forgetting other site-specific functions) the interview guide is *general* in its design whilst staying (hopefully) adaptable to all these different functions. Hence, general terms describing contacts or activities could be about:

- assessing clients
- motivating undecided clients
- finding a suitable treatment centre
- "passing" information between clients and other professionals
- organising the judicial coordination with treatment systems

As the particular activity of the interlocutor becomes clear, each interviewer should try to solicit specific information about the activity itself:, difficulties, resources, reasons for actions…

Explications to be given to interviewee:

1. Concerning the "pronouncing phase" of QCT

We have arbitrarily defined this period as:

- *starting* with the recognition by "someone" of a potential candidate,
- *continuing on* with the various assessment and organisational activities,
- *including* the decision itself,
- *ending* with the placement in a treatment centre.

2. Concerning the use of an anonymous example of a case with which s/he was personally involved

Without divulging names or other identifying factors, the interviewee should choose a case amongst the last 3-5 with which s/he was involved. Throughout the interview, all questions should be discussed with regards to ***this*** case. At the end of the interview, s/he will have the possibility to explain how, eventually, this case was different from others s/he has dealt with.

PHASE 1: PRONOUNCING THE QCT ORDER

INTERVIEW GUIDE
WITH
PROFESSIONAL FROM JUDICIAL SYSTEM

OVERALL OBJECTIVE:
Capture first indications of QCT system understanding, expectations and commitment process

THEMES	QUESTIONS SUCH AS…
1. Client contacts	
What type of intervention precedes the QCT decision and placement?	How did s/he have knowledge of this case as one potentially leading to a QCT order? Client request? Own initiative? Recommendation par other? What were the circumstances of the first contact? How was it initiated: client demand? Professional suggestion? What were the circumstances of any following contacts?
What contacts were established with client leading up to the QCT decision and placement	To what extent was the decision to request (or to accept) a QCT order "easy" to make with client? What questions, issues had to be dealt with? How were they dealt with? What changes occurred during this period? How were decisions arrived at concerning treatment choice? How was the court appearance prepared?
What are the eventual anticipated future contacts with client?	What will be the circumstances of any future contacts with this client? What will be the principal issues to be looked at during the future contacts?
2. Coordination with professionals of own system How does QCT fit into the broader judicial practice?	What information did s/he receive about this client from judicial system colleagues? Prior to first meeting? After intervention of other professionals? Who gave this information? How is information given? File, written rapport, oral? What information did s/he give about this client to other members of the judicial system? How was this information given? File, written rapport, oral? Was s/he present during the judicial proceedings? If so, what was his/her specific role? What information and criteria did s/he privilege? Did s/he participate in any decisions concerning this client (assessment, suitability, placement…)? With whom? What arguments did s/he put forward? What doubts did s/he express? What criteria were finally privileged? What responsibility will he have with regards to any future contacts with colleagues about this client?

3. Contact with professionals of treatment system How do the systems collaborate?	What were the circumstances of any contacts with treatment professionals? Decisions, assessing, planning? What type of information was exchanged? How was this information given? File, written rapport, oral? Will s/he continue to have contacts with treatment professionals concerning this client? If so, what responsibility will s/he have? Which priorities or issues will need to be examined? What information will he seek, will he give? How will these contacts be organised? Programmed, informal, according to need…?
4. Comparing case with standard procedure and general practice To what extent is this example typical?	To what extent is this case "typical" of usual QCT cases s/he deals with? How is it different? (type of problem, client; type of dependence, drug and treatment history, needs…). To what extent the contacts with own colleagues and those of treatment system are "typical" or different to what usually happens?
5. Evaluation of system adequacy from his/her perspective for the period leading up to the decision and first weeks of placement What is his/her own evaluation?	Considering overall period leading up to decision and placement: With regards to his/her work with the client, what "worked", did not work, could have worked better? Why? What will be the most difficult problem to be overcome? What was the time period between first contact and placement of this client? Typical? With regards to the QCT "system": what worked well, did not work, could have worked better? Why? To what extent a codified procedure was used? Or is a more "informal" professional network used? If so, how does it work? According to personal affinity? Organisation traditions? How did intervention responsibility for this case fit in with general professional practice? Time, support, resources, information, commitment, conviction…? Concerning the application of the order: what does s/he see as the main problems to be faced by the client? By the QCT system?
6. And lastly… Any final thoughts?	If just one aspect could be changed or improved…?

2. THE TREATMENT PROFESSIONALS INTERVENING DURING THE DECISION MAKING & PLACEMENT PHASE

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own interventions and reflections with regards to a particular case***.

The information sought for should thus concern:

- The interlocutor's own knowledge, understanding and evaluation of how the QCT system functions and where his/her activity fits into the overall system
- How he or she intervened with regards to a particular client
- How he or she coordinated and collaborated with colleagues working within either the judicial or the treatment systems

Whilst interlocutors should thus be steered away from giving only general information about system organisation, they will not however necessarily be able to contribute information about all aspects. Within the treatment system, different types of professionals will intervene: doctors, social workers, nurses, psychologists. Some will have direct contact with clients, whilst others will have only occasional, indirect or administrative contact. Rather than drawing up a guide for each possibility, the interview guide is *general* in its design whilst staying (hopefully) adaptable to all these different functions. Hence, general terms describing contacts or activities could be about:

- assessing clients
- planning and implementing treatment plans
- controlling progress
- "passing" information between clients and other professionals
- organising the coordination with judicial systems

As the particular activity of the interlocutor becomes clear, each interviewer should try to solicit specific information about the activity itself: reasons, difficulties, resources, criteria…

Explications to be given to interviewee

1. Concerning the "pronouncing phase" of QCT

We have arbitrarily defined this period as:

- *starting* with the recognition by "someone" of a potential candidate,
- *continuing* on with the various assessment and organisational activities,
- *including* eventually a "pre-placement" period
- *including* the decision itself,
- *ending* with the placement period in a treatment centre.

NB: Treatment intervention will vary according to local practices. Some centres receive QCT clients only after the court decision whilst others accept them for well before the official decision.

2. Concerning the use of an example of a case with which s/he was personally involved

As clients used in the quantitative sample have given permission for their situation to be discussed, there should be no difficulties in discussing the various themes. Throughout the interview, all questions should be discussed with regards to *one* case.

PHASE 1: PRONOUNCING THE QCT ORDER:

INTERVIEW GUIDE
WITH
Professional from treatment system

OVERALL OBJECTIVE:
Capture first indications of QCT system understanding, expectations and commitment process

THEMES	QUESTIONS SUCH AS…
1. Client contacts What contacts were established with client in the period leading up to the QCT decision and placement? What responsibility was assumed for intake procedures? Which intervention strategies are being planned or are already in place? What are the perceived problems and priorities?	What were the circumstances of the first contact with client? Client request? Professional suggestion? To what extent was the decision to request (or to accept) a QCT linked with the treatment centre? Place, type of offer… ? What treatment elements were offered doing the period prior to the decision? What questions, issues had to be dealt with? How were they dealt with? How was the court appearance prepared? Was s/he present during the judicial proceedings? If so, what was his/her specific role? What information and criteria did s/he privilege? Since the QCT decision, how did the intake procedure take place? What needs were perceived? What issues were raised? Were priorities defined? If so, by whom? To what extent was a consensus possible with client? If non-QCT clients also use this programme, to what extent does this client reply to "normal" entry requirements? How are judicial requirements discussed with client? Were any measures needed in order to facilitate entry of client in existing client group? How will judicial requirements work in with treatment elements during the following months? What problems could be expected with this client?
2. Coordination with professionals of own system How does QCT fit into the broader treatment practice?	What information did s/he receive about this client prior to first meeting? Who gave this information? How was the information given? File, written rapport, oral? What information does s/he give (or will be expected to give) about this client to other members of the treatment system? How is this information given? File, written rapport, oral? Did s/he participate in any decisions concerning this client (assessment, placement, treatment goals and/or modalities…)? With whom? What arguments did s/he put forward? What doubts did s/he express? What criteria were finally privileged? What responsibility does s/he have with regards to future contacts with colleagues about this client? What are his/her expectations about colleagues' responsibilities?

3. Contact with professionals of judicial system How do the systems collaborate?	What were the circumstances of any contacts with judicial professionals? Decisions, assessing, treatment planning? What type of information was exchanged? How was this information given? File, written rapport, oral? Will s/he continue to have contacts with the judicial professionals concerning this client? If so, what responsibility will s/he have? Which priorities or issues will need to be examined? What information will he seek, will he give? How will these contacts be organised? Programmed, informal, according to need…?
4. Comparing case with standard procedure and general practice To what extent is this example typical?	To what extent is this case "typical" of usual QCT cases s/he deals with? How is it different? (type of problem, client; type of dependence, drug and treatment history, needs… ?). To what extent the contacts with own colleagues and those of treatment system are "typical" or different to what usually happens with regards to QCT clients? With regards to voluntary clients?
5. Evaluation of system adequacy from his/her perspective for the period leading up to the decision and placement What is his/her own evaluation?	Considering overall period leading up to decision and first weeks of placement: With regards to his/her work with the client, what "worked", did not work, could have worked better? Why? What will be the most difficult problem to be overcome? With regards to the QCT "system": what worked well, did not work, could have worked better? Why? To what extent a codified procedure was used? Or is a more "informal" professional network used? Is QCT as a system in itself a discussion them between colleagues? How is it considered? How did intervention responsibility for this case fit in with general professional practice? Time, support, resources, information, commitment, conviction…? Concerning the application of the order: what does s/he see as the main problems to be faced by the client? By the QCT system?
6. And lastly... Any final thoughts?	If just one aspect could be changed or modified…?

3. CLIENTS
DURING EARLY PHASE OF QCT ORDER

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own interventions and reflections with regards to his own experience***.

The information sought for should thus concern:

- The interlocutor's own knowledge, understanding and evaluation of how the QCT system functions
- How his or her needs and demands are met

The challenge shared by all the actors would seem to be that of being able to develop a sufficiently "comfortable" commitment towards QCTs. The professionals may have to continue an activity in spite of not necessarily being convinced about the QCT efficacy. As for the clients, the stakes are much higher and concern the capacity to ultimately commit *voluntarily* to a treatment having started in what could be interpreted as highly unfavourable and quasi-obligatory, circumstances.

As clients used in the quantitative sample have given permission for their situation to be discussed, there should be no difficulties in discussing the various themes.

Explications to be given to interviewee:

Concerning the "pronouncing phase" of QCT :

We have arbitrarily defined this period as:

- *starting* with the recognition by "someone" of a potential candidate,
- *continuing* on with the various assessment and organisational activities,
- *including* eventually a "pre-placement" period
- *including* the decision itself,
- *ending* with the placement period in a treatment centre.

NB: Treatment experiences will vary according to local practices. Some clients will already be in treatment centres for many months before the official QCT court decision. If this is so, then the *before* and *after* experiences should be separated, as suggested in the first theme.

PHASE 1 : PRONOUNCING THE QCT MEASURE:

INTERVIEW GUIDE
WITH
CLIENTS IN EARLY PHASE OF QCT ORDER

OVERALL OBJECTIVE:
Capture first indications of QCT system understanding, expectations and commitment process

THEMES	QUESTIONS SUCH AS…
1. Process leading up to decision to accept QCT order - knowledge about system: availability of information, obligations, rights … - basis of decision: arguments, influence of others… - expectations…	How did he/she learn about the QCT possibility? What information was given? With whom did he/she clarify particular questions? Was written information available? If so, to what extent was is useful? With whom did he/she discuss the possibility? Professionals, important others? In-mates? Other users? Were QCT advantages generally recognized by all those with whom he/she spoke with? What disadvantages were mentioned? How long did he/she need to decide? Which argument was finally the most important in the decision to accept QCT? What role does he/she now see for the judiciary procedure? What contacts/controls are already planned? What obligations does he/she have?
2. Understanding how the decision was made to come to this particular treatment centre. *Type*: substitution vs abstinence, residential vs outpatient *Centre* : orientation, programme, previous contacts, reputation…	What choices were available about the *type* of treatment that would satisfy the court system? What information was available about specific *centres*? With whom was he/she able to discuss these alternatives? What were the advantages and disadvantages put forward? Was there a "formal" assessment about his/her treatment needs by a health or social professional? If so, to what extent did it help him/her in the decision about which centre to choose? Who made the necessary contacts to be accepted as a client in this programme? If he/she was involved, what arguments did he/she put forward? What made him/her finally decide on this type of treatment and this centre?

3. Concentrating on the treatment itself First impressions Verification and adjusting of objectives and expectations. Main problems at this time: drug or otherwise	Since arriving in the programme, are things going as he/she expected? Were there any good, or not so good, surprises about offers, possibilities, rules, atmosphere…? How are things going with the staff, other QCT clients, other clients? How are significant others (partner, friends, parents, children…) reacting? To what extent have objectives changed? Which offers now seem the most important? What does he/she see as the main problems (drug or otherwise) at this time?
4. Overall evaluation	What time period was involved: - when was he/she arrested? - When did he/she learn about QCT? - When did he/she arrive at the programme? If he/she had to go through this period again, that is, the period leading up to: - the QCT choice in itself - the decision to come to this particular centre or programme,
5. And lastly...	What would he/she change to make the system work better?

REPORT GUIDES

To facilitate handling:

- Without actually sending the transcripts, please give as much detail as possible. Some reorganising will no doubt be needed as information about one question often arises in replies from another.

- For each interview, there should be one report.

- A separate Word document containing templates for each interview guide will be sent separately. Report guides can then just be copied and "filled in".

- Please do not forget to substitute your own information in the header which will appear on each numbered page.

Top page header should be:

Month, year of interview Name of partner page no

Bottom page header should be:

Interview with (type of actor, function)

A JUDICIAL PROFESSIONAL
INTERVENING DURING THE DECISION MAKING PROCESS

REPORT

SECTION A: THEMES AND INTERPRETATIONS

A1: The interview data

1. Client contacts.

2. Coordination with professionals of own system

3. Contact with professionals of treatment system

4. Comparing case with standard procedure and general practice

5. Evaluation of system adequacy

6. Final thoughts

A2: Contextual information

1. Type of QCT

2. Short description of function exercised by interviewee

SECTION B: IMPRESSIONS AND INTERPRETATIONS

1. What do you see as the essential points?

2. What is your understanding of the interview?

A TREATMENT PROFESSIONAL
INTERVENING DURING THE DECISION MAKING & PLACEMENT PHASE

REPORT

SECTION A: THEMES AND INTERPRETATIONS

A1: The interview data

1. Client contacts.

2. Coordination with professionals of own system

3. Contact with professionals of judicial system

4. Comparing case with standard procedure and general practice

5. Evaluation of system adequacy

6. Final thoughts

A2: Contextual information

1. Type of QCT

2. Short description of treatment centre

3. Short description of function exercised by interviewee

SECTION B: Impressions and interpretations

1. What do you see as the essential points?

2. What is your understanding of the interview?

A CLIENT
DURING EARLY PHASE OF QCT ORDER

REPORT

SECTION A: THEMES AND INTERPRETATIONS

A1: The interview data

1. Process leading up to decision to accept QCT order.

2. Making decision about treatment centre

3. Verification and adjustments of objectives

4. Overall evaluation

A2: Contextual information

1. Type of QCT

2. Client characteristics: age, gender, brief information: treatment history,

SECTION B: Impressions and interpretations

1. What do you see as the essential points?

2. What is your understanding of the interview?

APPENDICE 3

QCT
QUALITATIVE AXE

HOW DO QCT PROGRAMMES OBTAIN THE RESULTS THEY DO?

PROTOCOL & INTERVIEW GUIDE

PHASE 2:

QCT IN PRACTICE:
MONITORING, TREATING, COORDINATING

Marc-Henry SOULET / Kerrie OEUVRAY

mars 2004

CONTENTS

A.: SECOND PHASE PROTOCOL

1. Guidelines

The data collection will broadly follow the same schedule as that of the quantitative collection: at entry, 6 months, 12 months, 18 months. The schedule will thus follow the phases of a QCT order

Phase 1 – QCT entry
Phase 2 – QCT treatment
Phase 3 – QCT exit

To which can be added:

Phase 4 – Overview: overall treatment process interpretation and elaboration of propositions.

Phase 2 will cover the period from March to June 2004.

Throughout all these phases, client and professional commitment will be a key issue as will also be systems cooperation. Phase 2 is particularly organised around these issues. After the initial period during which the measure was pronounced and treatment arrangements organised, Phase 2 will concentrate on the way QCT is "made to function" or put into practice, in spite of the inevitable difficulties. For client too, the commitment stakes are high. Now, six months into treatment, the initial, and official, reasons for preferring treatment to prison are being confronted with the day-to-day reality of treatment and judicial requirements.

Implicitly, a difference is made between the legal and organisational requirements (obligatory framework) and the way that actors actually do, or are able, to implement the measure (interpretative framework). Inevitably, overall system efficacy will be an issue during this phase but it is important to realise that the various strategies used by actors can either increase or diminish legal requirements. Over and above such differences however the underlying idea of the "qualitative axe" remains: to understand the results obtained by QCT, we must understand how it is implemented (made to work). This is the central concern of Phase 2.

Specifically the data should develop the following axes:

(a) Treating and being in treatment

Data will concentrate on how the existence of the order supports or impinges on treatment procedures and client and professional commitment. This will complement the quantitative data which focus more directly on the degree of success in reaching treatment goals.
Concerning clients having dropped out since the first qualitative interviews and who can still be contacted, a final interview will attempt to reconstitute the reasons and the circumstances leading to the QCT abandon.

(b) Monitoring

Data will concentrate on the on-going policing of the measure from the judicial and administrative perspectives. Whilst probation officers will be primarily concerned, judges (or the representatives) should also be included. If appropriate, funding bodies could also be approached.
The following aspect of the monitoring process will, in particular, be looked at:

- Does the judge who decides a QCT order in favour of a particular client, continue to be involved in case reviews concerning this client? The question concerns the overall "continuity" or "thread" of an order. Who assumes in fact this overall responsibility? What importance could "continuity" have for client commitment, for example?

(c) Coordinating

Data will concentrate on how professionals from the justice, probation, treatment (eventually funding) systems coordinate their on-going respective responsibilities and efforts.

The following aspect, in particular, should be examined:

- How is "non-compliance" handled practically and administratively? Quantitatively speaking, what are the usual time delays between examples of non-compliance with QCT (ex: non-attendance at treatment session) and the decision made about how to respond to this non-compliance (ex return to prison)? "Qualitatively", what influences the type of decisions taken?

2. Sampling and interview strategies

(a) Selection of clients:

The same clients already interviewed during the first phase will be interviewed during this phase. If any have dropped out, they should be replaced by clients from the quantitative sample who are at the same stage of treatment.

If possible, the clients interviewed during Phase 1 but who have since abandoned QCT, or who were sent back to prison, should also be interviewed.

(b) Selection of professionals:

- Professionals will come from both the judicial and treatment systems
- Judicial personnel will include those making QCT decisions (e.g. judge, prosecutor) and those monitoring the orders (e.g. probation officer)
- Treatment personnel can include both directional and worker levels
- Other key informants can be chosen according to site specificity.

Professionals already interviewed during Phase 1 may be re-interviewed.

(c) Sample size and method modalities:

As with the previous phase, Interviews will be held with clients and professionals.

Both individual and group interviews can be used according to partners' preferences. For a group interview, we highly recommend *two* research assistants

Clients

- 8 clients: that is, those already interviewed during Phase 1. If necessary, clients no longer available will be replaced by others at a similar treatment stage and chosen from the wider quantitative sample
- if possible, any client having dropped out since the Phase 1 interviews

Professionals:

- 6 professionals interviewed separately
    - 3 from the judicial system (decisional and monitoring);
    - 2 from treatment system (direction and/or client-involved);
    - 1 "other" according to partner's (justified) choice

or

- 4 group interviews
  - 1 with judicial personnel representing the decisional system
  - 1 with judicial personnel representing monitoring responsibilities (ex probation officers)
  - 1 from treatment system (direction and/or client-involved)
  - 1 "other" (ex: a "mixed" group) according to partner's (justified) choice

or, a combination, for example

- 2-3 group interviews
- 1-2 individual interviews

(d) Interviews guides

The same interview guides will be used by all partners. The structure of each interview is provided by the themes. Opposite these, "typical", indicative questions are suggested in order to give the main ideas that the theme should be developing. Obviously not all the questions will apply for each situation. Also, according to the way the interview develops, other directions could well be developed. And of course, the style itself of the question should correspond to each interviewers own style and the context of the interview situation itself.

In addition to the standard themes, partners may wish to add others that suit their national situation. For the interview with the "other" professional (see above), partners can adapt an existing guide or develop their own. The report on this interview should follow the principal themes covered.

4. Reporting and analysing the qualitative data

With the exception of file naming, the same procedure as that used during the first phase should be followed. Reports should be sent to Fribourg as they are available and, if possible, no later than:

31 August 2004.

To facilitate handling, all reports must include a header (with source, date of interview, file name) on every, numbered page. Individual templates (Word format) will be available for each interview guide. To avoid multiple documents having the same name, please use the following guide to name the files you send my email.

Phase+City Status-of-subject+No

That is:

phase 2	= 2
City	= KentA, KentN, Lond, Berl, Vien, Pad, Frib
Status subject	= Client Jud Treat Other
Number	= 1, 2, 3 etc

Examples:

2KentN Client4	= 2nd phase document by Neil about 4th Client
2Pad Treat3	= 2nd phase document by Daniele about 3rd Treatment professional

B. INTERVIEW GUIDES

1. THE JUDICIAL PROFESSIONALS MONITORING AND COORDINATING THE QCT ORDER

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own interventions and reflections with regards to a particular (anonymous) case***.

The information collected from these professionals during the first phase was retrospective in the sense that the decisions had already been taken. This time, it is the ongoing monitoring process that we want to capture. Specifically we need to know how the system actually does work, rather than how it is supposed to work. The implication is that in all systems, professionals are faced with unanticipated problems or less than ideal means to carry out obligations. They will certainly need to make choices, use strategies and "invent" ways of coping with the problems that arise. Compared to the official, legal and organisational requirements, the accumulation of these various practices should reflect more clearly the way the QCT system actually do work. It is therefore particularly important to focus the subjects being interviewed towards particular examples of what actually was, or is, done.

Explications to be given to interviewee:

3. Concerning the "monitoring and coordinating phase" of QCT

We have arbitrarily defined this period as:

- *starting* with the placement in a treatment centre
- *continuing on* at this time

4. Concerning the use of an anonymous example of a case with which s/he was personally involved

We suppose that the interviewee has continued responsibility and knowledge of at least one case, that is, he or she has already seen the client since the decision and will see the client again in the future. Eventually, knowledge will be obtained through delegates reports. If so, this should clearly be stated.

Without divulging names or other identifying factors, the interviewee should therefore choose a case amongst the last 3-5 with which s/he was involved. Throughout the interview, all questions should be discussed with regards to ***this*** case. At the end of the interview, s/he will have the possibility to explain how, eventually, this case was different from others s/he has dealt with

INTERVIEW GUIDE
PROFESSIONAL FROM JUDICIAL SYSTEM
(DECISIONNEL OR MONITORING RESPONSABILITIES)

OVERALL OBJECTIVES:
Capture how judicial professionals monitor the progress of QCT clients
Capture how judicial professionals coordinate their own activities (ie with other judicial personal) as well as with professionals associated with treatment system

THEMES	QUESTIONS SUCH AS…
7. Client contacts Types : face to face, telephone, letters, messages… Rhythm & frequency: planned, according to need, limited to crises, etc Content: routine, unanticipated, etc Evaluation: satisfactory, etc Decisions: criteria?	How does monitoring fit into the QCT process? Since the beginning of the prescribed treatment, what types of contacts has this professional had with the client? Were these contacts expected, programmed? If so, how were they planned (predefined rhythm, availability…)? According to whose initiative were the contacts programmed? Did the client seek contact? Concerning any unplanned contacts. What were the circumstances provoking these contacts? What issues were examined during these contacts? To what extent were these particular issues expected ones? How were they dealt with? What decisions are made? According to which criteria? What unexpected problems turned up? How were these dealt with? What decisions were made? According to which criteria? How is non-compliance handled? Generally speaking, what is considered non-compliance? How is non-compliance reported? How long does it take for non-compliance to be examined? Who examines non-compliance issues? Was non-compliance an issue with this client? How is the client included in this process? Were any "extenuating circumstances considered? Were any modifications made to the QCT order? How satisfactory were these various contacts? What made them satisfactory or unsatisfactory? What future contacts are planned for /with this client? What will be the principal issues to be looked at?
8. Contacts with client via reports Written traces Reports, discussions *about* client:	To what extent is progress communicated by written reports? How do reports (official progress reports, case notes…) fit into the monitoring process as exercised by this professional? What impact does an individual report have? What issues do the reports treat? What decisions are made? According to what criteria?
9. Coordination with professionals of own system How does QCT fit into the broader judicial practice? How is continuity assured?	Which judicial professionals are involved with the same case? What specific role has the Judge who pronounced the original order? How and what information is transmitted between colleagues? What type of information is passed on from judicial system colleagues? How is information transmitted? File, written rapport, oral? What type of information does s/he receive about this client from judicial system colleagues? Who gives this information? How is information transmitted? File, written rapport, oral? To what extent is collaboration and consensus between judicial professionals satisfactory with regards to this client? What problems (if any) have had to be confronted? What responsibility will s/he have with regards to any future contacts with colleagues about this client?

10. Contacts with professionals of treatment system How do the systems collaborate? To what extent do they coordinate their efforts in order to present a "united front" to the client? To what extent do they accord a priority to maintaining a difference with the treatment system?	How do the systems collaborate? Since the beginning of the prescribed treatment, what types of direct and indirect contacts took place with the professionals of the treatment system concerning this client but in his/her absence? Were these contacts expected, programmed? If so, how were they planned (predefined rhythm, availability…)? According to whose initiative were the contacts programmed? Was the client informed of these contacts? Since the beginning of the prescribed treatment, what types of direct and indirect contacts took place with the professionals of the treatment system in the presence of this client? Were these contacts expected, programmed? If so, how were they planned (predefined rhythm, availability…)? According to whose initiative were the contacts programmed? Concerning any unplanned contacts with professionals of the treatment system: What were the circumstances provoking these contacts? Was the client present? What issues were examined during these contacts? To what extent were these particular issues expected ones? How were they dealt with? What decisions are made? According to which criteria? Were modifications made to QCT order? How satisfactory were these various contacts? What made them satisfactory or unsatisfactory? What unexpected problems turned up with regards to collaboration and coordination efforts? What about ongoing contacts? Will s/he continue to have contacts with treatment professionals concerning this client? If so, what responsibility will s/he have? Which priorities or issues will need to be examined? What information will he seek, will he give? How will these contacts be organised? Programmed, informal, according to need…?
11. Comparing case with standard procedure and general practice To what extent is this example typical?	To what extent is this case "typical" of usual QCT cases s/he deals with? How is it different? (type of problem, client; type of dependence, drug and treatment history, needs…). To what extent are the contacts with own colleagues and those of treatment system "typical" or different to what usually happens?
12. Evaluation of system adequacy as it applies to this client What is his/her own evaluation?	Considering the overall ongoing functioning of QCT as it relates to this client: What works well, does not work, could work better? Why? To what extent is a codified procedure used? Or is a more "informal" professional network used? If so, how does it work? According to personal affinity? Organisation traditions? Funding obligations? How did intervention responsibility for this case fit in with general professional practice? Time, support, resources, information, commitment, conviction…? Concerning the ongoing application of the order: what does s/he see as the main problems to be faced by the client? By the QCT system?
13. And lastly… Any final thoughts?	If just one aspect could be changed or improved…?

B. INTERVIEW GUIDES
QCT IN PRACTICE: TREATING AND COORDINATING

2. THE TREATMENT PROFESSIONALS

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own interventions and reflections with regards to a particular case***.

The information collected from these professionals during the first phase was retrospective in the sense that the decisions had already been taken. This time, it is the ongoing monitoring process that we want to capture. Specifically we need to know how the system actually does work, rather than how it is supposed to work. In other words, we take it for granted that, in all systems, professionals are faced with unanticipated problems or less than ideal means to carry out obligations. Compared to the official, legal and organisational requirements, the accumulation of these various practices should reflect more clearly the way the QCT system actually do work. It is therefore particularly important to focus the subjects being interviewed towards particular examples of what actually was, or is, done.

In addition, treatment professionals are faced with the need to "fit" QCT clients within a programme structure which may, for example, use contrasting criteria to assess clients coming from the judicial system. The particular emphasis with regards to the treatment personal is therefore *how QCT impinges on their daily work with mandated clients*. Certainly individual progress issues will be discussed. However, as mentioned in the protocol, success in reaching treatment goals will be analysed in greater depth with the quantitative data.

Explications to be given to interviewee:

1. Concerning the "monitoring and coordinating phase" of QCT

We have arbitrarily defined this period as:

- *starting* with the placement in a treatment centre
- *continuing on* at this time

2. Concerning the use of an example of a case with which s/he was personally involved

As clients have given permission for their situation to be discussed, there should be no difficulties in discussing the various themes. Throughout the interview, all questions should be discussed with regards to ***one*** case. At the end of the interview, s/he will have the possibility to explain how, eventually, this case is different from others s/he has dealt with.

INTERVIEW GUIDE
Professionals from treatment system

OVERALL OBJECTIVE:

- Capture how treatment professionals integrate QCT requirements into their professional practices
- Capture how treatment professionals coordinate their own activities (ie with other treatment personal) as well as with professionals associated with judicial system

THEMES	QUESTIONS SUCH AS…
7. Client contacts How does QCT impinge on the treatment process? Types of contact: - appointments - day-to-day - according to need - etc QCT requirements: - drug use - compliance to treatment Treatment requirements? How are eventual discrepancies handled?	Is QCT treatment similar to voluntary treatment? What treatment does this QCT client receive? Does it differ in any way from what voluntary clients are receiving? If additional benefits or treatment elements are available, could the QCT client choose to follow them? Could such a reason be related to the payment of QCT treatments? Does the QCT client contribute to the cost of his/her treatment? To what extent does QCT imposes the "treatment agenda"? Concerning contact rhythm and frequency: What types of contacts take place with this client? Are these contacts generally programmed? If so, how were they planned (predefined rhythm, availability…)? According to whose initiative were the contacts programmed? Concerning any unplanned contacts. What were the circumstances provoking these contacts? Concerning the issues examined during these contacts? To what extent were these particular issues linked, or not linked, to QCT requirements? Concerning treatment progress and compliance: Generally, in this treatment programme, how is non-compliance estimated? How do criteria correspond to those regulating the QCT order? Concerning this client, has any eventual difference between the two sets of criteria been a problem? In other words, what leeway exists for workers to deal with (for example) relapse according to treatment criteria? Concerning periodic requirements: For example, progress reports, type of benefits, testing, restrictions… Overall… In what ways does the QCT order facilitate this client's treatment? In what ways does the order complicate his/her treatment?
8. Coordination with professionals of own system How does QCT fit into the broader treatment practice?	How are team efforts coordinated within the treatment team? How and what information about this client does this professional transmitted to his/her colleagues? How is information transmitted? File, written rapport, oral, case discussions? What type of information does s/he receive about this client from treatment system colleagues? Who gives this information? How is information transmitted? File, written rapport, oral, case discussions? To what extent is collaboration and consensus between treatment professionals satisfactory with regards to this client? What problems (if any) have had to be confronted? What responsibility will s/he have with regards to any future collaboration with treatment colleagues about this client?

9. Contact with professionals of judicial system For example, with: - Probation officers - Judges - Lawyers - Funding officials What about non-compliance? How is it handled?	How do the systems collaborate? Since the beginning of the prescribed treatment, what types of direct and indirect contacts took place with the professionals of the judicial system concerning this client but in his/her absence? Were these contacts expected, programmed? If so, how were they planned (predefined rhythm, availability…)? According to whose initiative were the contacts programmed? Was the client informed of these contacts? Since the beginning of the prescribed treatment, what types of direct and indirect contacts took place with the professionals of the judicial system in the presence of this client? Were these contacts expected, programmed? If so, how were they planned (predefined rhythm, availability…)? According to whose initiative were the contacts programmed? Concerning any unplanned contacts with professionals of the judicial system: What were the circumstances provoking these contacts? Was the client present? What issues were examined during these contacts? To what extent were these particular issues expected ones? How were they dealt with? What decisions are made? According to which criteria? Were modifications made to QCT order? How is non-compliance dealt with? Was this an issue for this client? If so, how was it handled? If not, how is non-compliance generally handled between the two systems? What delays typically occur between the non-compliance occurring itself and the decision taken about the non-compliance? What types of decisions are made about what types of examples of non-compliance? What can influence the decision? Who finally decides? Globally, how satisfactory were these various contacts? What made them satisfactory or unsatisfactory? What unexpected problems turned up with regards to collaboration and coordination efforts? What about ongoing contacts? Will s/he continue to have contacts with judicial professionals concerning this client? If so, what responsibility will s/he have? Which priorities or issues will need to be examined? How will these contacts be organised? Programmed, informal, according to need…?
10. Comparing case with standard procedure and general practice To what extent is this example typical?	To what extent is this case "typical" of usual QCT cases s/he deals with? How is it different? (type of problem, client; type of dependence, drug and treatment history, needs… ?). To what extent the contacts with own colleagues and those of treatment system are "typical" or different to what usually happens with regards to QCT clients? With regards to voluntary clients?
11. Evaluation of system adequacy from his/her perspective for the period leading up to the decision and placement What is his/her own evaluation?	Considering the overall ongoing functioning of QCT as it relates to this client: With regards to the QCT "system": What works well, does not work, could work better? Why? To what extent a codified procedure was used? Or is a more "informal" professional network used? If so, how does it work? According to personal affinity? Organisation traditions? How did responsibility for this case fit in with general professional practice? Time, support, resources, information, commitment, conviction…? Concerning the application of the order: what does s/he see as the main problems to be faced by the client? By the QCT system?
12. And lastly… Any final thoughts?	If just one aspect could be changed or modified…?

INTERVIEW GUIDE
QCT IN PRACTICE: FOLLOWING TREATMENTS ET OBLIGATIONS

CONTINUING CLIENTS

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own actions and reflections with regards to his own experience***.

During the decision making period, clients generally proffered a mixture of reasons for "preferring" treatment to prison. Hopes and resolutions were expressed, objectives announced, offers and treatment possibilities considered. Now, six months later, these initial and official, reasons for preferring treatment to prison are now being confronted with the of day-to-day reality of treatment requirements.

Of course, QCT clients are similar to voluntary clients to the extent that voluntary clients will also need to "prove their initial motivation" and accept the various restrictions and efforts deemed necessary. However, we want to understand how compulsory clients "use" the QCT framework throughout this period in relation to the treatment process.

Explications to be given to interviewee:

1. Concerning the "monitoring and coordinating phase" of QCT
We have arbitrarily defined this period as:
- *starting* with the placement in a treatment centre
- *continuing on* at this time

2. Concerning ethnical and confidential issues
As clients have given permission for their situation to be discussed, there should be no difficulties in discussing the various themes.

INTERVIEW GUIDE
CONTINUING CLIENTS

OVERALL OBJECTIVE:
Capture how clients situate and use the QCT system.

THEMES	QUESTIONS SUCH AS…
1. Being a QCT client in this particular treatment centre	What is a typical day in this centre? Taking "yesterday" as an example, what did the client actually do in the centre? What treatment did he follow? What activities were involved? Are additional offers available? Could such offers be interesting later on? Generally, since arriving in the programme, are things going as he/she expected? How are things going with other QCT clients, other clients? What's the "atmosphere" like? How are problems with drug use evolving? Have there (or are there) ongoing problems? How are significant others (partner, friends, parents, children…) reacting? Have any particular (out of the ordinary) events marked this period? Concerning contacts with treatment staff With which treatment professionals is s/he in contact? How are these contacts organised? Can additional contacts be arranged if desired? Concerning rules, conditions and requirements: What are the rules of the centre itself, that is, which apply to everyone, voluntary or QCT, only QCT? For example: attendance, drug use, behaviour, payment… What happens about drug use controls? How frequent is testing? Reactions to positive results? If client has had a positive test, or any other example of non-compliance, how was this dealt with by the staff? Did centre notify his/her probation officer? If so, Was he able to "plead his/her case? What decisions were taken? To what extent are these decisions considered by the client as "appropriate"?
2. Contacts with judicial system - "exclusive" contacts : ie without treatment staff - mixed contacts: ie in presence of treatment staff - formal contacts: court appearance, convocation before judge or representative *Type*: planned, rhythm and frequency *With whom* : probation judge, lawyer,	How does the juridical system control his/her progress? Since the beginning of the prescribed treatment, with who has the client had contact? Judge? Probation officer? Lawyer? Others? Were there any particular persons with which the client did not have any contacts but with whom who would have liked to? Why? Are differences made between formal reports (eventually before the judge) and ongoing progress? If appearances before the judge have taken place, was it the same judge who pronounced the order? Does it make a difference? Are contacts continued with the lawyer who was present during the decision phase? Were the various contacts this client had, those that were expected, programmed? If so, how were they planned (predefined rhythm, availability, need…)? According to whose initiative were the contacts programmed? Was there an occasion when the client him/herself requested an appointment? What were the circumstances?

Cf expectations, Cf utilité	How satisfactory (useful) were these various contacts? What made them satisfactory or unsatisfactory? What issues were examined during these contacts? To what extent were these particular issues expected ones? How were they dealt with? Or has the client been surprised? What unexpected problems turned up? How were these dealt with? What decisions were made? According to which criteria? Were modifications made to order? How does the client perceive links between treatment and judicial systems? Do contacts occur where representatives from both systems are present? Where? Under what circumstances? What place did the client have? What was at stake each time for the client? Does client know if written reports are made about his/her progress? Are such reports discussed with him/her?
3. Commitment Verification and adjusting of objectives and expectations. Main problems at this time: drug or otherwise	How are first decisions holding up? Now after 6 months, to what extent have objectives changed? Which offers now seem the most important? What does he/she see as the main problems (drug or otherwise) at this time? If he/she had to go through this 6 month period again, what about: - the QCT choice itself? - arguments used at the time: same or have they changed? - the decision to come to this particular centre: confirmation?
4. Overall evaluation The continuity issue… is it an issue for the client?	From this client's perspective… What are the main advantages of QCT? What are the inconveniences (acceptable or not)? Looking at all the professionals with whom this client has contact, which one(s) have been since the beginning of the QCT order? Which ones should still be there at the end of the order? To what extent is having the same people important? Looking at the system as a whole: - what works well? - what does not work well at all? What would he/she change to make the system work better?
5. And lastly…	What are expectations for the rest of the programmed treatment? What would he/she change to make his own situation better?

INTERVIEW GUIDE

QCT IN PRACTICE

"NON-CONTINUING" CLIENTS

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own actions and reflections with regards to his own experience***.

During the decision making period, clients generally proffered a mixture of reasons for "preferring" treatment to prison. Hopes and resolutions were expressed, objectives announced, offers and treatment possibilities considered and begun.

Amongst those who consented to a qualitative interview during Phase 1, some are no longer in the treatment program. They may have returned to prison or have been placed in another structure. Or they may have "disappeared" from the legal system.

To the extent that contact can be made with these persons, a final interview is recommended. We are particularly interested in understanding to what extent the decision not to continue is related to the way QCT functions.

Explications to be given to interviewee:

1. Concerning the QCT research
   The general aims of the research include understanding for whom QCT can be an advantage and for whom it is not; what conditions are necessary so that QCT can be useful and why, in other circumstances, QCT is not appropriate. Interviewing persons, who for various reasons did not continue with a QCT possibility, will help us have as complete a picture as possible of QCT.

2. Concerning being a "drop-out"
   We have simply created a category of persons who, after having agreed to participate in the research, decided after a time (or were obliged to) no longer continue the treatment programme approved by the QCT order.

2. Concerning ethnical and confidential issues
   As client initially gave permission for their situation to be discussed, there should be no difficulties in talking about the various themes. The same confidentiality guarantees apply.

INTERVIEW GUIDE
CLIENTS NO LONGER ON QCT ORDERS

OVERALL OBJECTIVE:

Review QCT trajectory before rupture (depending on length of time in treatment)
Capture circumstances surrounding the departure from QCT
Understand how these circumstances could relate to the QCT system itself or the way it functions.

THEMES	QUESTIONS SUCH AS…
1. QCT trajectory before rupture *Note: the importance of this theme will depend on how long the person actually stayed in treatment or whether there even was a period during which progress seemed promising.*	What expectations did s/he have when the QCT decision was made? What treatment did he follow? Why was this treatment chosen rather than another? What did the treatment involve? What contacts did he have with the judicial system during this time (probation, judge, lawyer, others). Did things generally go as expected? Or was the person surprised by certain aspects? During the time he was in the programme, did things go reasonably well at first? What specific contacts did he have with treatment staff? With probation officers? How were contacts with other QCT clients, other clients? How are problems with drug use evolving? Were there continuing issues with the police or the Justice system? How were significant others (partner, friends, parents, children…) reacting? Overall: Even if some problems were no doubt still present, what seemed nonetheless promising during that period?
2. Circumstances around rupture	How does the person explain what happened? Did problems get out of hand? Did circumstances change? Was there a gradual build-up or did an "event" occur? How did person attempt to find solutions? To what extent was s/he able to find support? Which professional aide was he able to solicit: treatment staff, probation officer, judge, lawyer, others? Were they helpful up to a point? How were significant others (partner, friends, parents, children…) reacting during this time? Were there any particular persons with which the client did not have any contacts during this time, but with whom who would have liked to? What could this person (eventually) have done? What were the circumstances of the rupture? Was it provoked, for example, by the person leaving? Or was it provoked by the judicial system, or by the treatment centre? How was the decision taken to stop the QCT order? What part did s/he have in the final decision? How was the decision legalised? Before the same judge who pronounced the original order?

3. Evaluation	Looking back, what could have made the difference? How could s/he have reacted differently? How could the various people who were involved have reacted differently? Looking at the system as a whole: - what generally does work well? - what does not work well at all? What would he/she change to make the system work better?
4. Present situation and perspectives	What is person doing now? Did QCT rupture imply a return to prison? If not, is the person's situation "legal"? What support can the person rely on? Can s/he rely on professional or other help? How are significant others (partner, friends, parents, children…) reacting during this time? QCT in the future? Could the person imagine accepting another QCT order? What would need to be different the next time?
5. And lastly...	What does person retain from his/her QCT experience?

REPORT GUIDES

To facilitate handling:

- Without actually sending the transcripts, please give as much detail as possible. Some reorganising will no doubt be needed as information about one question often arises in replies from another.

- For each interview, there should be one report.

- A separate Word document containing templates for each interview guide will be sent separately. Report guides can then just be copied and "filled in".

- Please do not forget to substitute your own information in the header which will appear on each numbered page.

Top page header should be:

Month, year of interview | Name of partner | page no

Bottom page header should be:

Interview with (type of actor, function) | Own file name (see protocol)

A JUDICIAL PROFESSIONAL
PHASE 2: MONITORING AND COORDINATING

REPORT

SECTION A: THEMES AND INTERPRETATIONS

A1: THE INTERVIEW DATA

1. Direct client contacts.

2. Contacts with client via reports

3. Coordination with professionals of own system

4. Contact with professionals of treatment system

5. Comparing case with standard procedure and general practice

6. Evaluation of system adequacy

7. Final thoughts

A2: SPECIFIC THEMATIC DATA

1. Continued responsibility of the order / continued responsibility for the client
a) Is the judge who decided the QCT order involved in subsequent reviews of this case (yes or no)? If so, does this involvement concern ***direct*** contacts (eg court hearing, appointment etc.)? Or is the on-going involvement ***indirect*** (ex reviewing through written reports by probation service)?

b) Does anyone else exercise a continued, personalised responsibility with regards to this client?

2. Non-compliance
a) When an example of non-compliance occurs (e.g. non-attendance, negative test, new crime etc), and when this non-compliance is submitted for consideration to the appropriate authorities, what is the usual time delay between the occurrence of the non-compliance and the decision about how to respond to this non-compliance (e.g. suspension of QCT, imprisonment, warning, extension of order, etc)?

b) What is the usual time delay between drug tests and their results? To whom and how are the results (positive or negative) communicated? How is a positive-test result treated?

A3: CONTEXTUAL INFORMATION

1. Type of QCT
2. Short description of function exercised by interviewee

SECTION B: IMPRESSIONS AND INTERPRETATIONS

1. What do you see as the essential points?
2. What is your understanding of the interview?

A TREATMENT PROFESSIONAL
PHASE 2: QCT IN PRACTICE: TREATING ET COORDINATING

REPORT

SECTION A: THEMES AND INTERPRETATIONS

A1: THE INTERVIEW DATA

1. Client contacts.

2. Coordination with professionals of own system

3. Contact with professionals of judicial system

4. Comparing case with standard procedure and general practice

5. Evaluation of system adequacy

6. Final thoughts

A2: SPECIFIC THEMATIC DATA

1. Continued responsibility of the order / continued responsibility for the client
a) Is the judge who decided the QCT order involved in subsequent reviews of this case (yes or no)? If so, does this involvement concern ***direct*** contacts (eg court hearing, appointment etc.)? Or is the on-going involvement ***indirect*** (ex reviewing through written reports by probation service)?

b) Does anyone else exercise a continued, personalised responsibility with regards to this client?

2. Non-compliance
a) When an example of non-compliance occurs (e.g. non-attendance, negative test, new crime etc), and when this non-compliance is submitted for consideration to the appropriate authorities, what is the usual time delay between the occurrence of the non-compliance and the decision about how to respond to this non-compliance (e.g. suspension of QCT, imprisonment, warning, extension of order, etc)?

b) What is the usual time delay between drug tests and their results? To whom and how are the results (positive or negative) communicated? How is a positive-test result treated?

A3: CONTEXTUAL INFORMATION
1. Type of QCT
2. Short description of treatment centre
3. Short description of function exercised by interviewee

SECTION B: IMPRESSIONS AND INTERPRETATIONS

1. What do you see as the essential points?
2. What is your understanding of the interview?

A CLIENT
PHASE 2: QCT IN PRACTICE: FOLLOWING TREATMENTS

REPORT

SECTION A: THEMES AND INTERPRETATIONS

A1: THE INTERVIEW DATA

1. Being a QCT client.

2. Contacts with judicial system

3. Commitment issues

4. Overall evaluation

5. Final thoughts

A2: SPECIFIC THEMATIC DATA

1. Continued responsibility of the order / continued responsibility for the client
a) Is the judge who decided the QCT order involved in subsequent reviews of this case (yes or no)? If so, does this involvement concern ***direct*** contacts (eg court hearing, appointment etc.)? Or is the on-going involvement ***indirect*** (ex reviewing through written reports by probation service)?

b) Does anyone else exercise a continued, personalised responsibility with regards to this client?

2. Non-compliance
a) When an example of non-compliance occurs (e.g. non-attendance, negative test, new crime etc), and when this non-compliance is submitted for consideration to the appropriate authorities, what is the usual time delay between the occurrence of the non-compliance and the decision about how to respond to this non-compliance (e.g. suspension of QCT, imprisonment, warning, extension of order, etc)?

b) What is the usual time delay between drug tests and their results? To whom and how are the results (positive or negative) communicated? How is a positive-test result treated?

A3: CONTEXTUAL INFORMATION

1. Type of QCT
2. Client characteristics: age, gender, brief information: treatment history,

SECTION B: IMPRESSIONS AND INTERPRETATIONS

1. What do you see as the essential points?
2. What is your understanding of the interview?

A NON-PARTICIPATING CLIENT
PHASE 2: QCT IN PRACTICE

REPORT

SECTION A: THEMES AND INTERPRETATIONS

A1: THE INTERVIEW DATA

1. QCT trajectory before rupture.

2. Circumstances around rupture

3. Evaluation

4. Present situation and perspectives

5. Final thoughts

A2: SPECIFIC THEMATIC DATA

1. Continued responsibility of the order / continued responsibility for the client
a) Was the judge who decided the QCT order involved in subsequent reviews of this case (yes or no)? If so, was this involvement ***direct***, (eg contact with client in court situation, by convocation etc.) Or was his on-going involvement ***indirect***?: ex deciding after written report by probation service)?

b) Did anyone else exercise a continued, personalised responsibility with regards to this client?

2. Non-compliance
a) When an example of non-compliance occurred (e.g. non-attendance, negative test, new crime etc), and when this non-compliance was submitted for consideration to the appropriate authorities, what was the usual time delay between the occurrence of the non-compliance and the decision about how to respond to this non-compliance (e.g. suspension of QCT, imprisonment, warning, extension of order, etc)?

b) What was the usual time delay between drug tests and their results? To whom and how were the results (positive or negative) communicated? How was a positive-test result treated?

A3: CONTEXTUAL INFORMATION
1. Type of QCT
2. Client characteristics: age, gender, brief information about treatment or crime history

SECTION B: IMPRESSIONS AND INTERPRETATIONS
1. What do you see as the essential points?

2. What is your understanding of the interview?

APPENDICE 4

QCT
QUALITATIVE AXE

HOW DO QCT PROGRAMMES OBTAIN THE RESULTS THEY DO?

PROTOCOL & INTERVIEW GUIDE

PHASE 3:

TERMINATING QCT

PERSISTING, ANTICIPATING, CONTEMPLATING

Marc-Henry SOULET / Kerrie OEUVRAY

October 2004

CONTENTS

A: THIRD PHASE PROTOCOL

1. Guidelines

Overview

The data collection will broadly follow the same schedule as that of the quantitative collection: at entry, 6 months, 12 months, 18 months. The schedule will thus follow the phases of a QCT order

Phase 1 – QCT entry
Phase II – QCT treatment
Phase III – QCT exit

To which can be added:

Phase IV – Overview: overall treatment process interpretation and elaboration of propositions.

Taken together, Phases I, II and III follow, in "real time", a number of QCT clients. During the same time frame, professionals are also being asked about the characteristics and issues of each phase. Whilst not excluding continued contacts with "real time" QCTs, Phase IV will also include more "detached" information. It should thus allow us to "test" our own analyses with experienced and decisional actors as well as widening the discussion to cover such issues as "system effects"[82] and, finally, to elaborate "usable" propositions

General Thrust

Phase III will roughly cover the period from September to January 2004.

Clients have now been following QCT for over a year. For some, the formal, that is, the penal and administrative end of the QCT order may already be programmed. This interview may well then be the ***final*** contact we will have with them although some of these clients could still be interviewed in Phase 4 as a "QCT expert consultant".

However, due to the very large variability of QCT practices, some of these "12 month" clients may still be in an ***on-going treatment*** situation, more similar to an advanced Phase II situation than to a ***Phase III Exit situation***. These clients should, however, continue to provide precious data that could well be more oriented towards ***treatment issues*** rather than (strictly speaking) QCT issues. Preliminary consultation of Phase II data do suggest that some QCT clients are more concerned about problems arising from the treatment than with the penal order as such. Perhaps, after all, QCT clients are just becoming "ordinary" clients and, as such, are obliged to confront the reality of having to make fundamental decisions about drugs, general behaviour or existential issues. The "advanced Phase II" clients should be able to provide information about ***how*** such issues are being resolved, and to what extent the compulsory aspect of the treatment contributes or complicates the ***way*** these "ordinary" issues are being resolved.

In both situations (terminating clients, advanced on-going clients), we will need to distinguish between the time period represented by:

- the compulsory and penal aspect of the treatment
- the treatment itself

[82] See Neil Hunt's excellent "après-Berlin" proposition « Optional 'professional' interviews to include within qualitative axe ».

Concretely, do the two time frames correspond? To what extent are they dependant on each other? If they are related, ***how*** are they related? How do key actors "adjust" or manage the relation between the two? Just one of the related questions is, of course, whether clients continue with the present or with another treatment after the order, that is, on a voluntary basis.

Dimensions
Specifically the Phase III interviews should solicit data according to the following dimensions:

(1) Persisting in treatment
Information sought from both advanced and final phase clients concerns the "day-to-day" situation of these, now, experienced clients. We are therefore assuming that the routines, problems, resources and, above all, the issues faced by these clients will have changed compared to what they were six months previously and, of course, at entry. Life styles, relation with illegal products, attitude towards present treatment will figure amongst the themes to be developed. Such "normal" treatment issues will then need to be understood in relation to the continuing penal obligations and monitoring.
Information sought from professionals should concern how treatment offers are adapted to these more "advanced" clients.

(2) Anticipating and preparing for the end of the penal order
This dimension addresses both the formal aspects of how QCTs finish and, more importantly, how actors (both clients and professionals) anticipate, plan for and perhaps attempt to influence the *way* (or even *when*) the order will finish. Essential themes will thus include the understanding that the different actors have about criteria, timing, and conditions surrounding termination. The significance given to the finish as an "event" should also be examined. To what extent does the ***finish*** mirror the ***beginning***? Does one pass before the (same) judge or is it more of an "administrative" finish, symbolised by some sort of notification (a letter, for example)?
More specifically from the client's perspective, anticipating the end of the penal constraint will probably be linked to anticipating the period ***after*** QCT. Perceived options and eventual means for choosing will also need to be explored.

(3) Contemplating and assessing the time passed in QCT
Anticipating the end of QCT also brings to the foreground, implicitly and explicitly, a retrospective look as the events and the changes that occurred since the order was pronounced. This dimension addresses notably the clients' retrospective appraisal of what has changed and (just as more important) how they attempt to explain these changes, that is, how they see the particular configuration between events, conditions and their own understandings. The central theme here to be explored is that of the different types and expressions of motivation and adherence to drug treatments.
Professionals' appraisals of terminated and terminating orders should give pertinent information about the different types of conditions (social benefits, types of services…) which seem to explain at least some of the differences between the QCTs that "work" and those that are not deemed as satisfactory.

2. Sampling and interview strategies

Selection of clients:
The same clients already interviewed during the first and/or second phases will be interviewed during this phase. If any have dropped out, they should be replaced by clients from the quantitative sample who are at the same stage of treatment.

If possible, the clients interviewed during Phases I and/or II but who have since abandoned QCT, or who were sent back to prison, should also be interviewed.

Selection of professionals:
The priority should be given to professionals implicated in final phase QCT coming from both the judicial and treatment systems. Other key informants can be chosen according to site specificity. Professionals already interviewed during Phase I or II may be re-interviewed

Sample size and method modalities:
As with the previous phases, iInterviews will be held with clients and professionals.
Both individual and group interviews can be used according to partners' preferences. For a group interview, we highly recommend *two* research assistants

Clients
- 8 clients: that is, those already interviewed during Phase I. If necessary, clients no longer available will be replaced by others at a similar treatment stage and chosen from the wider quantitative sample
- If new clients are chosen, a short contextual note should be included in the report
- if possible, any client having dropped out since the Phase I or Phase II interviews

Professionals:
- 6 professionals interviewed separately
    - 3 from the judicial system (decisional and monitoring);
    - 2 from treatment system (direction and/or client-involved);
    - 1 "other" according to partner's (justified) choice

or

- 3-4 group interviews
    - 1 with judicial personnel representing the decisional system
    - 1 with judicial personnel representing monitoring responsibilities (ex probation officers)
    - 1 from treatment system (direction and/or client-involved)
    - 1 "other" (ex: a "mixed" group) according to partner's (justified) choice

or, a combination, for example
- 2-3 group interviews
- 1-2 individual interviews

Interviews guides
The same interview guides will be used by all partners. The structure of each interview is provided by the themes. Opposite these, "typical", indicative questions are suggested in order to give the main ideas that the theme should be developing. Obviously not all the questions will apply for each situation. Also, according to the way the interview develops, other directions could well be developed. And of course, the style itself of the question should correspond to each interviewers own style and the context of the interview situation itself.

To some extent, the themes to develop with the professionals are similar to those used in the Phase II interviews. However, ***the time frame is not the same*** and we should expect that the ***issues are not the same***. If professionals stay on what appear to be generalities, it should be possible to bring them

back to examples of particular situations (which rarely follow exactly the "general model"). As for the "how does the system work" type question, such questions attempt to establish the "knowledge base" that the professionals being interviewed use in order to justify their own actions. In other words, these questions concern more the real functioning of QCT than the formal generalities about how systems are "supposed to" function.

In addition to the standard themes, partners may wish to add others that suit their national situation. For the interview with the "other" professional, partners can adapt an existing guide or develop their own. The report on this interview should follow the principal themes covered.

3. Reporting and analysing the qualitative data

Reports should be sent to Fribourg as they are available and, if possible, no later than:

31 January 2005

To facilitate handling, all reports must include a header (with source, date of interview, file name) on every, numbered page. Individual templates (Word format) will be available for each interview guide. To avoid multiple documents having the same name, please use the following guide to name the files you send by email.

Phase+City Status-of-subject+No

That is:
phase III = 3
City = KentA, KentN, Lond, Berl, Vien, Pad, Frib
Status subject = Client Jud Treat Other
Number = 1, 2, 3 etc

Examples:
3KentN Client4 = 3nd phase document by Neil about 4th Client
3Pad Treat3 = 3nd phase document by Daniele about 3rd Treatment professional

B. INTERVIEW GUIDES

1. THE JUDICIAL PROFESSIONALS MONITORING AND COORDINATING THE QCT ORDER

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own interventions and reflections with regards to a particular (anonymous) case***.

The information collected from these professionals during the first phase was retrospective in the sense that the decisions had already been taken. Interviews during the second phase concentrated on the ongoing monitoring process and the choices and strategies used by professionals to cope with the various official, legal and organisational requirements. The accent of Phase III will be ***anticipative*** because we seek to capture how judicial personnel are planning the foreseeable finish of QCT orders. However, we are assuming that the "ending period" does in fact constitute a "phase" in itself. So we will also be seeking information about monitoring "advanced" clients.

Explications to be given to interviewee:

5. Concerning the "ending" phase" of QCT

We have arbitrarily defined this period as:

- *continuing* at this time
- *probably finishing* (or being programmed to finish) within the following weeks

6. Concerning the use of an anonymous example of a case with which s/he was personally involved

We suppose that the interviewee has continued responsibility and knowledge of at least one case, that is, he or she has already seen the client who will or should benefit from the conclusion of a QCT order. Eventually, knowledge will be obtained through delegates reports. If so, this should clearly be stated.

Without divulging names or other identifying factors, the interviewee should therefore choose a case amongst the last 3-5 with which s/he was involved. Throughout the interview, all questions should be discussed with regards to ***this*** case. At the end of the interview, s/he will have the possibility to explain how, eventually, this case was different from others s/he has dealt with

INTERVIEW GUIDE
PROFESSIONAL FROM JUDICIAL SYSTEM
(DECISIONNEL OR MONITORING RESPONSABILITIES)

OVERALL OBJECTIVES:

- Capture how judicial professional monitor advanced clients and prepare the foreseeable finish of QCT orders
- Capture how judicial professionals coordinate this final stage (ie with other judicial personal) as well as with professionals associated with treatment system

THEMES	QUESTIONS SUCH AS…
14. Contacts with "advanced" and terminating clients *What is an advanced client?* *How are advanced clients "different" from other client groups?* *Reports, assessments? Decisions: criteria? Time frames?* *From the practical and from the symbolic points of view, how do we "know" that the QCT has ended?*	What type of monitoring is used with advanced clients? During the last 2 months, what type of contacts has this professional had with an "advanced" client? Were these contacts expected, or programmed in function of the foreseeable termination of the order? Concerning any unplanned contacts, what were the circumstances provoking these contacts? What issues were examined during these contacts? In what way are the issues and problems different than those this professional usually faces with QCT clients *entering* or *getting used* to treatments? What types of non-compliance arise with advanced clients? How is non-compliance managed with a client arriving towards the end of the legal order? What is being anticipated with regards to this client? Are reports and / or assessments required? On what will the reports and the assessments be focusing? Or was the QCT duration defined at the start? Will the contents of eventual reports or assessments be discussed with the client? Concerning the time frames: what is the relation between the legal constraining period of QCT and the "still-needing" treatment period? Does one define the other? How are the respective time frames coordinated in this case? Specifically, how will the "end of the QCT" actually happen? Will the client be summoned to go before a judge? Will it be the same judge who pronounced the order? Or, is finishing QCT more an administrative matter? If so, how and by whom is the decision made that the QCT will be terminated? Or, was the duration specifically defined at the beginning of the order? If so, is the finish of the order confirmed, for example, by some sort of official communication? What role does this professional have in the general "finishing" procedure? With regards to the particular case, how is it conform or not to the "usual" procedure?
15. Anticipating the "after" QCT	What will probably happen with this client after QCT? Will some form of treatment continue? What options will be available? What options have been discussed? To what extent social security benefits enhance or inhibit the range of options available? Will there be any contacts with this client after the end of the order? If so, what form and what level of constraint will be present? If not, will any other judicial, treatment or welfare service be involved? Will this professional have any contacts with any such service (written or oral reports)?

16. Contacts with terminating clients via reports :	To what extent is the end of a QCT managed by written reports? How do reports (official progress reports, case notes…) fit into the decision to end the QCT of this client? What impact does an individual report have? What issues do the reports treat? What decisions are made? According to which criteria?
17. Coordination with professionals of own system	Which other judicial professionals are involved with the same case? What specific role has the Judge who pronounced the original order? How and what information is transmitted between colleagues? What type of information is passed on from judicial system colleagues? How is information transmitted? File, written rapport, oral? To what extent is collaboration and consensus between judicial professionals satisfactory with regards to this client? What problems (if any) have had to be confronted? What responsibility will s/he have with regards to any future contacts with colleagues about this client?
18. Contacts with professionals of treatment system *How do the systems collaborate?* *To what extent do they coordinate their efforts in order to present a "united front" to the client?*	In view of the anticipated end of the order, how do the systems collaborate? What types of direct and indirect contacts have taken place with the professionals of the treatment system concerning this client? Who initiated these contacts? Was the client informed of these contacts? How satisfactory were these various contacts? What made them satisfactory or unsatisfactory? What unexpected problems turned up with regards to collaboration and coordination efforts concerning the QCT exit decision? To what extent does this professional accord a priority in maintaining a difference with the treatment system about decisions to be taken during this final stage?
19. Comparing case with standard procedure and general practice	To what extent is this case "typical" of usual QCT cases s/he deals with? How is it different? (type of problem, client; type of dependence, drug and treatment history, needs…). If this case is typical, what aspects can be "not typical" in other examples seen by this person? To what extent are the contacts with own colleagues and those of treatment system "typical" or different to what usually happens?
20. Evaluation of system adequacy as it applies to this client *What is his/her own evaluation?*	Considering the overall ongoing functioning of QCT as it relates to this client in the finishing phases of the order: What works well, does not work, could work better? Why? To what extent is a codified procedure used? Or is a more "informal" professional network used? If so, how does it work? According to personal affinity? Organisation traditions? Funding obligations? How did intervention responsibility for this case fit in with general professional practice? Time, support, resources, information, commitment, conviction…? Concerning the ongoing application of the order: what does s/he see as the main problems to be faced by the client? By the QCT system?
21. And lastly… *Any final thoughts?*	If just one aspect could be changed or improved…?

B. INTERVIEW GUIDES
QCT IN PRACTICE: TREATING AND COORDINATING

2. THE TREATMENT PROFESSIONALS

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own interventions and reflections with regards to a particular case***.

The information collected from these professionals during the first phase was retrospective in the sense that the decisions had already been taken. Interviews during the second phase concentrated on the ongoing monitoring process and the choices and strategies used by professionals to cope with the various official, legal and organisational requirements. The accent of Phase III will be ***anticipative*** because we seek to capture how judicial personnel are planning the foreseeable finish of QCT orders. However, we are assuming that the "ending period" does in fact constitute a "phase" in itself. So we will also be seeking information about treatment professionals' work with clients who, from the penal point of view would be considered as "advanced" clients. The correspondence between a legal definition of "advanced" and a treatment definition will certainly be a issue. We could imagine that some advanced clients have no longer needed any particular treatment for awhile now, whilst others could well indicate the need for more extensive services.

Explications to be given to interviewee:

1. Concerning the "ending" phase" of QCT

We have arbitrarily defined this period as:

- *continuing* at this time
- *probably finishing* (or being programmed to finish) within the following weeks

2. Concerning the use of an example of a case with which s/he was personally involved

As clients have given permission for their situation to be discussed, there should be no difficulties in discussing the various themes. However, if preferred, the same procedure as with the judicial professional can be used. That is, an interviewee could choose a case amongst the last 3-5 with which s/he was involved. Throughout the interview, all questions should be discussed with regards to ***this*** case. At the end of the interview, s/he will have the possibility to explain how, eventually, this case was different from others with which s/he has dealt.

INTERVIEW GUIDE
Professionals from treatment system

OVERALL OBJECTIVE:

- Capture how treatment professionals integrate QCT requirements into their professional practices
- Capture how treatment professionals coordinate their own activities (ie with other treatment personal) as well as with professionals associated with judicial system

THEMES	QUESTIONS SUCH AS…
13. Client contacts *What is an advanced QCT client?* *How are advanced clients "different" from other client groups?* *Reports, assessments?* *Decisions: criteria?* *Time frames?* *From the practical and the symbolic points of view, how do we "know" that the QCT has ended?*	Is treatment with advanced QCT clients similar to treatment with voluntary clients? To what extent is it possible to describe an advanced QCT client? In what way are the issues and problems different than those this professional usually faces with QCT clients *entering* or *getting used* to treatments? Or different that those faced with voluntary clients? What types of non-compliance arise with advanced clients? How is non-compliance managed with a client arriving towards the end of the legal order? What is being anticipated with regards to this advanced client? Are reports and / or assessments required? On what will the reports and the assessments be focusing? Or was the QCT duration defined at the start? Will the contents of eventual reports or assessments be discussed with the client? How are the respective time frames coordinated in this case? Concerning the time frames: what is the relation between the legal constraining period of QCT and an eventual "still-needing" treatment period? Does one define the other? Specifically, how does the treatment system contribute to decisions about the end of a QCT? What role does this professional have in the general "finishing" procedure? With regards to the particular case, how is it conform or not to the "usual" procedure? In other words, to what extent does QCT impose the "treatment agenda" and treatment possibilities? Overall… In what ways does the QCT order facilitate this client's treatment? In what ways does the order complicate his/her treatment? What would have been handled differently had this client been a voluntary client?
14. Anticipating the "after" QCT	What will probably happen with this client after QCT? Will some form of treatment continue? What options will be available? What options have been discussed? To what extent social security benefits enhance or inhibit the range of options available? What propositions can be made to a client concerning voluntary treatments? Would financial concerns be an issue?
15. Coordination with professionals of own system *How does QCT fit into the broader treatment practice?*	How are team efforts coordinated within the treatment team? To what extent the foreseeable finish of a QCT is considered a collective team decision? What criteria are used to decide or to recommend the finish or eventually the continuation of a treatment? Are there similar discussions about "continuing or not" voluntary treatments? Who ultimately decides the treatment point of view?

16. Contact with professionals of judicial system *For example, with:* - *Probation officers* - *Judges* - *Lawyers* - *Funding officials*	In view of the anticipated end of the order, how do the systems collaborate? What types of direct and indirect contacts have taken place with the professionals of the judicial system concerning this client? Who initiated these contacts? Was the client informed of these contacts? How satisfactory were these various contacts? What made them satisfactory or unsatisfactory? What unexpected problems turned up with regards to collaboration and coordination efforts concerning the QCT exit decision? To what extent does this professional accord a priority in maintaining independence with the judicial system about decisions to be taken during this final stage?
17. Comparing case with standard procedure and general practice	To what extent is this case "typical" of usual QCT cases s/he deals with? How is it different? (type of problem, client; type of dependence, drug and treatment history, needs… ?). If this case is typical, what aspects can be "not typical" in other examples seen by this person? To what extent the contacts with own colleagues and those of treatment system are "typical" or different to what usually happens with regards to QCT clients? With regards to voluntary clients?
18. Evaluation of system adequacy as it applies to clients in the finishing phase of a QCT *What is his/her own evaluation?*	Considering the overall ongoing functioning of QCT as it relates to this client in the finishing phases of the order: What works well, does not work, could work better? Why? To what extent is a codified procedure used? Or is a more "informal" professional network used? If so, how does it work? According to personal affinity? Organisation traditions? Funding obligations? How did intervention responsibility for this case fit in with general professional practice? Time, support, resources, information, commitment, conviction…? Concerning the ongoing application of the order: what does s/he see as the main problems to be faced by the client? By the QCT system?
19. And lastly…	If just one aspect could be changed or improved…?

INTERVIEW GUIDE
QCT IN PRACTICE: FOLLOWING TREATMENTS ET OBLIGATIONS

CONTINUING CLIENTS

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own actions and reflections with regards to his own experience***.

During the decision making period, clients generally proffered a mixture of reasons for "preferring" treatment to prison. Hopes and resolutions were expressed, objectives announced, offers and treatment possibilities considered. Six months later, those initial and official, reasons for preferring treatment to prison were confronted with the of day-to-day reality of treatment requirements. Of course, QCT clients are similar to voluntary clients to the extent that voluntary clients also needed to "prove their initial motivation" and accept the various restrictions and efforts deemed necessary. Preliminary consultation of Phase II data do suggest that some QCT clients are more concerned about problems arising from the treatment than with the penal order as such. Perhaps, after all, QCT clients are just becoming "ordinary" clients and, as such, are obliged to confront the reality of having to make fundamental decisions about drugs, general behaviour or existential issues. The "advanced Phase II" clients should be able to provide information about ***how*** such issues are being resolved, and to what extent the compulsory aspect of the treatment contributes or complicates the ***way*** these issues are being resolved.

However, the main concern of the interviews with these clients is the ***approaching end of QCT.*** According to the themes being explored, interviewers will need to juggle with on-going concerns, prospective and retrospective dimensions.

Explications to be given to interviewee:

1. Concerning the "ending" phase" of QCT

We have arbitrarily defined this period as:

- *continuing* at this time
- *probably finishing* (or being programmed to finish) within the following weeks

2. Concerning ethnical and confidential issues

As clients have given permission for their situation to be discussed, there should be no difficulties in discussing the various themes.

INTERVIEW GUIDE
CONTINUING CLIENTS

Remember: For some clients, this may be the last contact with QCT-EU!

OVERALL OBJECTIVES:

- Capture the "substance" of the final phase of QCT from the client's perspective?
- Capture how clients anticipate the actual end of the order and any associated conditions
- Capture the client's appraisal of QCT systems

THEMES	QUESTIONS SUCH AS…
1. Persisting as a QCT client in this particular treatment centre *On-going monitoring*	What is an *advanced* client? How would this client distinguish between "advanced", "settling in" clients and "new" QCT clients? How would s/he fit into this description? Concerning monitoring: do advanced clients have any formal or informal privileges or specific benefits? Do exactly the same rules apply to clients irrespective of time passed in QCT? Are there differences in this respect between QCT clients and voluntary clients? For example, concerning attendance hours, testing, participating in activities. At this stage of the treatment, what would happen if this person had a positive drug test? How would any other example of non-compliance be handled? Concerning notably the previous six months, what significant events have occurred? Have there been any important changes in his/her treatment, general way of life, relations with significant others? How are problems with drug use evolving? Do other priorities exist, for example, related to work, training, family or social life? Have there (or are there) ongoing problems? To what extent (if any) do on-going issues about product use continue to impinge on these other areas? Concerning other professionals: Irrespective of their attachment institutional, which professionals have been consistently (or potentially) present throughout the order? What has been (is still) their importance for this client? Who was important at some stages but less so now?
Anticipating and preparing the end of the penal order *What does the client know about the procedure?* *What does he expect to happen?* *What "control" will the client have over the "finishing events"?*	How does this client anticipate the end of the QCT order? Is the "end" already programmed? If the client does not know, does s/he know where, or from whom, this information can be obtained? How will the end of the treatment be notified? Will it involve a court hearing? Concerning time frames: Does the end of the legal order correspond with the end of treatment? How does the client perceive links between treatment and judicial systems with regards this "finishing stage"? Do contacts occur where representatives from both systems are present? Does finishing with QCT depend on an assessment? If so, who will have the responsibility? What criteria will be used? How does this client anticipate the "after" QCT period?

*Client's **prospective** look*	What will happen after the order? How does this client see him/herself in the months following the end of QCT? With which professionals will s/he still be in contact? Who will continue to be part of significant others? What are the options that appear possible? Are available or likely means a problem with regards to some of these options? If the client decided to continue this treatment, how would he pay any eventual costs? To what extent continuing treatment in another centre (as a voluntary client) is an option? Concerning general social security issues: how will the end of the order modify benefits? Will new benefit rights open up? Will others terminate?
4. Contemplating the time since the beginning of QCT *What is this client's **retrospective** appraisal of "what has changed"?* *How does the client explain or understand this change?*	How does this client look back at the overall QCT period? What differences does this client see in his/her overall situation now compared to the beginning of QCT? How has it changed? What is better? What has been less satisfactory? What complications has QCT occasioned? What eventually new possibilities have been opened? Concerning particular issues: What about being ***motivated*** to follow a treatment? Have reasons changed during the order? How does the client explain possible shifts? Were there any significant events that contributed to the change? What about his/her ***knowledge about benefits and services***? What does the client know now that wasn't known before concerning seeking useful help? What about ***significant others***? What role have they played throughout the last year? Looking at the system as a whole: Finally, what works well? What does not work well at all? What would he/she change to make the system work better? Concerning this client's position towards the QCT system: If he/she knew at the beginning of QCT what s/he knows know, what would be done, thought, believed differently? Concerning: - the QCT choice itself? - the decision to come to this particular centre?
5. And finally... *What should QCT-EU know about QCT…*	What is the most important aspect that this client considers that QCT-EU need to know?

INTERVIEW GUIDE

QCT IN PRACTICE

"NON-CONTINUING" CLIENTS

GENERAL CONSIDERATIONS

The general aim of the qualitative axe is to capture and analyse what key actors actually do during the different phases of QCT. The focus of the interviews is thus on the ***interlocutor's own actions and reflections with regards to his own experience***.

During the decision making period, clients generally proffered a mixture of reasons for "preferring" treatment to prison. Hopes and resolutions were expressed, objectives announced, offers and treatment possibilities considered and begun.

Amongst those who consented to a qualitative interview during Phase I or Phase II, some are no longer in the treatment program. They may have returned to prison or have been placed in another structure. Or they may have "disappeared" from the legal system.

To the extent that contact can be made with these persons, a final interview is recommended. We are particularly interested in understanding to what extent the decision not to continue is related to the way QCT functions.

Explications to be given to interviewee:

1. Concerning the QCT research
   The general aims of the research include understanding for whom QCT can be an advantage and for whom it is not; what conditions are necessary so that QCT can be useful and why, in other circumstances, QCT is not appropriate. Interviewing persons, who for various reasons did not continue with a QCT possibility, will help us have as complete a picture as possible of QCT.

2. Concerning being a "drop-out"
   We have simply created a category of persons who, after having agreed to participate in the research, decided after a time (or were obliged to) no longer continue the treatment programme approved by the QCT order.

2. Concerning ethnical and confidential issues
   As client initially gave permission for their situation to be discussed, there should be no difficulties in talking about the various themes. The same confidentiality guarantees apply.

INTERVIEW GUIDE
CLIENTS NO LONGER ON QCT ORDERS

OVERALL OBJECTIVE:

Review QCT trajectory before rupture (depending on length of time in treatment)
Capture circumstances surrounding the departure from QCT
Understand how these circumstances could relate to the QCT system itself or the way it functions.

THEMES	QUESTIONS SUCH AS…
1. QCT trajectory before rupture *Note: the importance of this theme will depend on how long the person actually stayed in treatment or whether there even was a period during which progress seemed promising.*	What expectations did s/he have when the QCT decision was made? What treatment did he follow? Why was this treatment chosen rather than another? What did the treatment involve? What contacts did he have with the judicial system during this time (probation, judge, lawyer, others). Did things generally go as expected? Or was the person surprised by certain aspects? During the time he was in the programme, did things go reasonably well at first? What specific contacts did he have with treatment staff? With probation officers? How were contacts with other QCT clients, other clients? How are problems with drug use evolving? Were there continuing issues with the police or the Justice system? How were significant others (partner, friends, parents, children…) reacting? Overall: Even if some problems were no doubt still present, what seemed nonetheless promising during that period?
2. Circumstances around rupture	How does the person explain what happened? Did problems get out of hand? Did circumstances change? Was there a gradual build-up or did an "event" occur? How did person attempt to find solutions? To what extent was s/he able to find support? Which professional aide was he able to solicit: treatment staff, probation officer, judge, lawyer, others? Were they helpful up to a point? How were significant others (partner, friends, parents, children…) reacting during this time? Were there any particular persons with which the client did not have any contacts during this time, but with whom who would have liked to? What could this person (eventually) have done? What were the circumstances of the rupture? Was it provoked, for example, by the person leaving? Or was it provoked by the judicial system, or by the treatment centre? How was the decision taken to stop the QCT order? What part did s/he have in the final decision? How was the decision legalised? Before the same judge who pronounced the original order?

3. Evaluation	Looking back, what could have made the difference? How could s/he have reacted differently? How could the various people who were involved have reacted differently? Looking at the system as a whole: - what generally does work well? - what does not work well at all? What would he/she change to make the system work better?
4. Present situation and perspectives	What is person doing now? Did QCT rupture imply a return to prison? If not, is the person's situation "legal"? What support can the person rely on? Can s/he rely on professional or other help? How are significant others (partner, friends, parents, children…) reacting during this time? QCT in the future? Could the person imagine accepting another QCT order? What would need to be different the next time?
5. And lastly...	What does person retain from his/her QCT experience?

REPORT GUIDES

To facilitate handling:

- Without actually sending the transcripts, please give as much detail as possible. Some reorganising will no doubt be needed as information about one question often arises in replies from another.

- For each interview, there should be one report.

- For subsequent interviews with the same client, please indicate in the report the file name you used for previous reports (Phase I and II) about this person.

- A separate Word document containing templates for each interview guide will be sent separately. Report guides can then just be copied and "filled in".

- Please do not forget to substitute your own information in the header which will appear on each numbered page.

Top page header should be:

Month, year of interview	Name of partner	page no

Bottom page header should be:

Interview with (type of actor, function)	Own file name (see protocol)

A JUDICIAL PROFESSIONAL
PHASE 3: MONITORING AND COORDINATING

REPORT

SECTION A: THEMES AND INTERPRETATIONS

A1: THE INTERVIEW DATA

1. Direct client contacts with “advanced” and terminating clients

2. Anticipating the “after” QCT

3. Contacts with terminating client via reports

4. Coordination with professionals of own system

5. Contact with professionals of treatment system

6. Comparing case with standard procedure and general practice

7. Evaluation of system adequacy

8. Final thoughts

A2: CONTEXTUAL INFORMATION

1. Type of QCT

2. Short description of function exercised by interviewee

SECTION B: IMPRESSIONS AND INTERPRETATIONS

1. What do you see as the essential points?

2. What is your understanding of the interview?

A TREATMENT PROFESSIONAL
PHASE 3: QCT IN PRACTICE: TREATING ET COORDINATING

REPORT

SECTION A: THEMES AND INTERPRETATIONS

A1: THE INTERVIEW DATA

1. Client contacts.

2. Anticipating the "after" QCT

3. Coordination with professionals of own system

4. Contact with professionals of judicial system

5. Comparing case with standard procedure and general practice

6. Evaluation of system adequacy

7. Final thoughts

A2: CONTEXTUAL INFORMATION

1. Type of QCT

2. Short description of treatment centre

3. Short description of function exercised by interviewee

SECTION B: IMPRESSIONS AND INTERPRETATIONS

1. What do you see as the essential points?

2. What is your understanding of the interview?

A CLIENT
PHASE 3: QCT IN PRACTICE: FOLLOWING TREATMENTS

REPORT

CODE OR FILE NAME USED FOR THIS CLIENT:

In Phase I File name (eventually code used):

In Phase II File name (eventually code used):

SECTION A: THEMES AND INTERPRETATIONS

A1: THE INTERVIEW DATA

1. Persisting as a QCT client

2. Anticipating and preparing the end of QCT

3. Retrospective look at QCT

5. Final thoughts

A2: CONTEXTUAL INFORMATION

1. Type of QCT

2. Client characteristics: age, gender, brief information: treatment history,

SECTION B: IMPRESSIONS AND INTERPRETATIONS

1. What do you see as the essential points?

2. What is your understanding of the interview?

A NON-PARTICIPATING CLIENT
PHASE 3: QCT IN PRACTICE

REPORT

CODE OR FILE NAME USED FOR THIS CLIENT:

In Phase I File name (eventually code used):

In Phase II File name (eventually code used):

SECTION A: THEMES AND INTERPRETATIONS

A1: THE INTERVIEW DATA

1. QCT trajectory before rupture.

2. Circumstances around rupture

3. Evaluation

4. Present situation and perspectives

5. Final thoughts

A2: CONTEXTUAL INFORMATION

1. Type of QCT

2. Client characteristics: age, gender, brief information about treatment or crime history

SECTION B: IMPRESSIONS AND INTERPRETATIONS

1. What do you see as the essential points?

2. What is your understanding of the interview?

Attributs 25 11 05 : Population totale

APPENDICE 5

Doc	1 Actor	C1 Site	C2 Doc received	C3 Doc Type
B 01	Client	Berlin	2003.9.3	Report interv indiv
B 02	Professional	Berlin	2003.12.3	Report interv indiv
B 03	Professional	Berlin	2004.2.2	Report interv indiv
B 04	Professional	Berlin	2004.2.4	Report interv indiv
B 05	Professional	Berlin	2004.2.4	Report interv indiv
B 06	Client	Berlin	2004.2.6	Report interv indiv
B 07	Client	Berlin	2004.2.11	Report interv indiv
B 08	Professional	Berlin	2004.2.24	Report interv indiv
B 09	Client	Berlin	2004.3.2	Report interv indiv
B 10	Client	Berlin	2004.3.5	Report interv indiv
B 11	Client	Berlin	2004.2.10	Report interv indiv
B 20	Professional	Berlin	2004.9.7	Report interv indiv
B 21	Professional	Berlin	2004.9.8	Report interv indiv
B 22	Professional	Berlin	2005.4.13	Report interv indiv
B 23	Professional	Berlin	2005.4.13	Report interv indiv
B 24	Client	Berlin	2005.4.14	Report interv indiv
B 25	Client	Berlin	2005.4.15	Report interv indiv
B 26	Client	Berlin	2005.4.18	Report interv indiv
B 27	Client	Berlin	2005.4.18	Report interv indiv
B 28	Client	Berlin	2005.4.20	Report interv indiv
B 29	Client	Berlin	2005.4.25	Report interv indiv
B 30	Client	Berlin	2005.4.25	Report interv indiv
B 31	Professional	Berlin	2005.10.14	Report interv indiv
B 32	Client	Berlin	2005.10.14	Report interv indiv
B 33	Client	Berlin	2005.10.14	Report interv indiv
B 34	Client non participant	Berlin	2005.10.14	Report interv indiv
B 35	Client	Berlin	2005.10.30	Report interv group
B 36	Professional	Berlin	2005.11.6	Report interv indiv
F 01	Client	Fribourg	2004.3.11	Report interv indiv
F 02	Client	Fribourg	2004.3.4	Report interv indiv
F 03	zzz	Fribourg	2003.12.12	Transcript
F 04	Client	Fribourg	2004.6.3	Report interv indiv
F 05	Client	Fribourg	2004.6.3	Report interv indiv
F 06	Client	Fribourg	2004.10.12	Summary
F 07	Client	Fribourg	2004.10.12	Summary
F 08	Client	Fribourg	2004.10.12	Summary
F 09	Client	Fribourg	2004.10.12	Summary
F 10	Client	Fribourg	2004.10.12	Summary
F 11	Client	Fribourg	2004.9.30	Report interv indiv
F 12	Client	Fribourg	2004.9.30	Report interv indiv
F 13	Professional	Fribourg	2004.8.30	Report interv indiv
F 14	Professional	Fribourg	2004.8.30	Report interv indiv
F 15	Professional	Fribourg	2004.8.30	Report interv indiv
F 16	Client	Fribourg	2004.9.30	Report interv indiv
F 17	Professional	Fribourg	2004.8.30	Report interv indiv
F 20	Client	Fribourg	2004.10.12	Report interv indiv
F 21	Client	Fribourg	2004.10.12	Report interv indiv
F 22	Client	Fribourg	2004.10.12	Report interv indiv
F 23	Client	Fribourg	2004.10.12	Report interv indiv
F 24	Client	Fribourg	2004.10.12	Report interv indiv
F 25	Client	Fribourg	2004.10.12	Report interv indiv
F 26	Client	Fribourg	2004.10.12	Report interv indiv
F 27	Client	Fribourg	2004.10.12	Report interv indiv
F 28	Professional	Fribourg	2005.2.21	Report interv indiv
F 29	Professional	Fribourg	2005.2.21	Report interv indiv
F 30	Client	Fribourg	2005.5.18	Report interv indiv
F 31	Client non continuing	Fribourg	2005.5.18	Report interv indiv
F 32	Client	Fribourg	2005.5.18	Report interv indiv
F 33	Client	Fribourg	2005.5.18	Report interv indiv
F 34	Client	Fribourg	2005.5.18	Report interv indiv

F 35	Client	Fribourg	2005.5.18	Report interv indiv
F 36	Professional	Fribourg	2005.5.29	Report interv indiv
F 37	Client	Fribourg	2005.5.29	Report interv indiv
F 38	Client	Fribourg	2005.5.29	Report interv indiv
F 39	Client	Fribourg	2005.5.29	Report interv indiv
F 40	Professional	Fribourg	2005.5.29	Report interv indiv
Ka 01	profs + clients	Kent-A	2003.7.14	Report interv group
Ka 02	Professional	Kent-A	2003.7.14	Discussion with prof
Ka 03	Professional	Kent-A	2003.7.14	Report interv indivi & observations
Ka 04	Professional	Kent-A	2003.7.15	Report interv group
Ka 05	NA	Kent-A	2003.8.12	Reflexion
Ka 06	NA	Kent-A	2003.9.8	Field note
Ka 07	NA	Kent-A	2003.9.8	Field note
Ka 08	Professional	Kent-A	2003.9.23	Report interv group
Ka 09	Professional	Kent-A	2003.10.16	Report interv group
Ka 10	NA	Kent-A	2003.12.8	Email discussion
Ka 11	Professional	Kent-A	2003.12.17	Discussion with prof
Ka 12	Client	Kent-A	2004.1.8	Discussion with client
Ka 13	Professional	Kent-A	2004.1.16	Discussion with prof
Ka 14	Professional	Kent-A	2004.2.13	Discussion with prof
Ka 15	Client	Kent-A	2004.2.25	Discussion with client
Kn 01	Client	Kent-N	2004.1.26	Report interv indiv
Kn 02	Client	Kent-N	2004.1.27	Report interv indiv
Kn 03	Client	Kent-N	2004.2.2	Report interv indiv
Kn 04	Client	Kent-N	2004.2.16	Report interv indiv
Kn 05	Professional	Kent-N	2004.3.9	Report interv indiv
Kn 06	Professional	Kent-N	2004.2.2	Report interv indiv
Kn 07	Client	Kent-N	2005.8.1	Report interv indiv
Kn 08	Client	Kent-N	2005.8.1	Report interv indiv
Kn 09	Client	Kent-N	2005.8.1	Report interv indiv
Kn 10	Client	Kent-N	2005.8.1	Report interv indiv
Kn 11	Professional	Kent-N	2005.8.15	Report interv indiv
Kn 12	Professional	Kent-N	2005.8.15	Report interv indiv
Kn 13	Professional	Kent-N	2005.8.15	Report interv indiv
Kn 14	Professional	Kent-N	2005.8.15	Report interv indiv
Kn 15	Professional	Kent-N	2005.8.15	Report interv indiv
Kn 16	Professional	Kent-N	2005.10.5	Report interv indiv
Kn 17	Client	Kent-N	2005.10.5	Report interv indiv
Kn 18	Client	Kent-N	2005.10.7	Report interv indiv
L 01	Professional	London	2003.11.3	Report interv indiv
L 02	zzz	London	2003.11.3	Report continued
L 03	zzz	London	2003.11.3	Transcript
L 04	NA	London	NA	Email discussion
L 05	Professional	London	2003.12.16	Report interv indiv
L 06	zzz	London	2003.12.16	Report continued
L 07	zzz	London	2003.12.16	Transcript
L 08	Professional	London	2004.1.12	Report interv indiv
L 09	zzz	London	2004.1.12	Report continued
L 10	zzz	London	2004.1.12	Report continued
L 11	Professional	London	2004.2.3	Report interv indiv
L 12	zzz	London	2004.2.3	Report continued
L 13	zzz	London	2004.2.3	Transcript
L 14	Client	London	2004.3.26	Report interv indiv
L 15	zzz	London	2004.3.26	Report continued
L 16	zzz	London	2004.3.26	Transcript
L 17	Professional	London	2004.9.24	Report interv indiv
L 18	Professional	London	2004.9.24	Report interv indiv
L 19	Client	London	2004.10.1	Report interv indiv
L 20	Client	London	2004.10.1	Report interv indiv
L 21	Client	London	2004.10.1	Report interv indiv
L 22	yyy	London	2004.10.5	Methodology
L 23	Client	London	2004.10.4	Report interv indiv
L 24	Client	London	2004.10.4	Report interv indiv

L 25	Client	London	2004.10.4	Report interv indiv
L 26	Client	London	2004.10.4	Report interv indiv
L 27	Clients : diverses	London	2005.5.5	Field note
L 28	Client	London	2005.6.10	Report interv indiv
L 29	Client	London	2005.6.10	Report interv indiv
L 30	Client	London	2005.6.10	Report interv indiv
L 31	Client	London	2005.7.26	Report interv indiv
L 32	Client non continuing	London	2005.7.26	Report interv indiv
L 33	Clients - not continuing	London	2005.7.26	Report interv indiv
L 34	Professional	London	2005.7.29	Report interv indiv
L 35	Professional	London	2005.7.29	Report interv indiv
L 36	Professional	London	2005.8.2	Report interv indiv
L 37	Professional	London	2005.8.3	Report interv indiv
L 38	Professional	London	2005.8.3	Report interv indiv
L 39	Professional	London	2005.8.24	Report interv indiv
L 40	Professional	London	2005.9.2	Report interv indiv
L 41	Professional	London	2005.9.5	Report interv indiv
L 42	Professional	London	2005.9.6	Report interv indiv
L 43	Professional	London	2005.9.9	Report interv indiv
L 44	Professional	London	2005.9.13	Report interv indiv
L 45	Professional	London	2005.9.14	Report interv indiv
L 46	Client	London	2005.9.23	Report interv indiv
L 47	Client	London	2005.9.26	Report interv indiv
L 48	Client	London	2005.9.28	Report interv indiv
L 49	Client	London	2005.9.28	Report interv indiv
L 50	Client	London	2005.10.14	Report interv indiv
L 51	Client non continuing	London	2005.10.21	Report interv indiv
L 52	Client	London	2005.10.21	Report interv indiv
L 53	Client	London	2005.10.24	Report interv indiv
L 54	Client completed	London	2005.10.28	Report interv indiv
L 55	Client non continuing	London	2005.11.1	Report interv indiv
L 56	Client non continuing	London	2005.11.2	Report interv indiv
L 57	Client	London	2005.11.3	Report interv indiv
L 58	Client completed	London	2005.11.5	Report interv indiv
L 59	Client completed	London	2005.11.10	Report interv indiv
Motivation	-	-	-	-
P 01	Client	Padua	2003.12.15	Report interv indiv
P 02	Client	Padua	2003.12.15	Report interv indiv
P 03	Client	Padua	2004.1.12	Report interv indiv
P 04	Client	Padua	2004.1.12	Report interv indiv
P 05	Client	Padua	2004.1.21	Report interv indiv
P 06	Client	Padua	2004.1.21	Report interv indiv
P 07	Client	Padua	2004.1.27	Report interv indiv
P 08	Client	Padua	2004.2.2	Report interv indiv
P 09	Professional	Padua	2004.6.15	Report interv indiv
P 10	Professional	Padua	2004.6.15	Report interv indiv
P 11	Professional	Padua	2004.6.15	Report interv indiv
P 12	Professional	Padua	2004.2.2	Report interv indiv
P 13	Professional	Padua	2004.6.15	Report interv indiv
P 14	Professional	Padua	2004.6.15	Report interv indiv
P 20	Client	Padua	2004.9.29	Report interv indiv
P 21	Client	Padua	2004.9.29	Report interv indiv
P 22	Client	Padua	2004.9.29	Report interv indiv
P 23	Client	Padua	2004.9.29	Report interv indiv
P 24	Client	Padua	2004.9.29	Report interv indiv
P 25	Client	Padua	2004.10.5	Report interv indiv
P 26	Client	Padua	2004.10.5	Report interv indiv
P 27	Professional	Padua	2004.10.5	Report interv indiv
P 28	Professional	Padua	2004.10.5	Report interv indiv
P 29	Professional	Padua	2004.10.19	Report interv indiv
P 30	Professional	Padua	2004.10.25	Report interv indiv
P 31	Professional	Padua	2004.10.25	Report interv indiv

P 32	Professional	Padua	2004.10.25	Report interv indiv
P 33	Client	Padua	2004.12.21	Report interv indiv
P 34	Client	Padua	2005.2.16	Report interv indiv
P 35	Client	Padua	2005.2.16	Report interv indiv
P 36	Client	Padua	2005.3.1	Report interv indiv
P 37	Professional	Padua	2005.3.1	Report interv indiv
P 38	Professional	Padua	2005.3.1	Report interv indiv
P 39	Professional	Padua	2005.3.1	Report interv indiv
P 40	Professional	Padua	2005.3.8	Report interv indiv
P 41	Professional	Padua	2005.3.17	Report interv indiv
P 42	Professional	Padua	2005.6.21	Report interv indiv
P 43	Client	Padua	2005.7.4	Report interv indiv
P 44	Client	Padua	2005.7.4	Report interv indiv
P 45	Client	Padua	2005.7.11	Report interv indiv
P 46	Client	Padua	2005.7.11	Report interv indiv
P 47	Client	Padua	2005.7.21	Report interv indiv
V 01	Professional	Vienna	2003.11.3	Report interv indiv
V 02	Client	Vienna	2003.11.3	Report interv indiv
V 03	Client	Vienna	2003.11.3	Report interv indiv
V 04	Client	Vienna	2003.11.3	Report interv indiv
V 05	Client	Vienna	2003.11.3	Report interv indiv
V 06	Professional	Vienna	2003.11.3	Report interv indiv
V 07	Professional	Vienna	2003.11.3	Report interv indiv
V 08	Professional	Vienna	2003.11.3	Report interv indiv
V 09	Professional	Vienna	2003.11.3	Report interv indiv
V 10	Professional	Vienna	2003.11.3	Report interv indiv
V 11	Client	Vienna	2004.1.24	Report interv indiv
V 12	Client	Vienna	2004.1.24	Report interv indiv
V 13	Client	Vienna	2004.1.24	Report interv indiv
V 14	Client	Vienna	2004.1.24	Report interv indiv
V 15	yyy	Vienna	2004.4.2	Site information
V 20	Professional	Vienna	2004.8.21	Report interv indiv
V 21	Professional	Vienna	2004.8.21	Report interv indiv
V 22	Professional	Vienna	2004.8.21	Report interv indiv
V 23	Professional	Vienna	2004.8.21	Report interv indiv
V 24	Professional	Vienna	2004.8.21	Report interv indiv
V 25	Professional	Vienna	2004.8.21	Report interv indiv
V 26	Client	Vienna	2004.8.21	Report interv indiv
V 27	Client	Vienna	2004.8.21	Report interv indiv
V 28	Client	Vienna	2004.8.21	Report interv indiv
V 29	Client	Vienna	2004.8.21	Report interv indiv
V 30	Client	Vienna	2004.8.21	Report interv indiv
V 31	Client	Vienna	2004.8.21	Report interv indiv
V 32	Client	Vienna	2004.8.21	Report interv indiv
V 33	Client	Vienna	2004.9.3	Report interv indiv
V 34	yyy	Vienna	2004.9.3	Reflexion
V 35	Clients - not continuing	Vienna	2005.4.6	Report interv group
V 36	Clients continuing	Vienna	2005.4.6	Report interv group
V 37	Professional	Vienna	2005.4.6	Report interv indiv

NVIVO Attributs 25 11 05 : Clients **APPENDICE No 6**

Doc	1 Actor	2 Age	3 Gender	5 Sector	A1 Phase	A2 Same Actor	A3 See Actor Ph I	A4 See Actor Ph II	A5 See Actor Ph III
B 01	Client	26	Male	Trait Stationary	I	-	-	-	-
B 06	Client	26	Male	Trait Stationary	I	-	-	-	-
B 07	Client	34	Male	Trait Stationary	I	-	-	-	-
B 09	Client	26	Male	Trait Stationary	I	-	-	-	-
B 10	Client	36	Female	Trait Stationary	I	-	-	-	-
B 11	Client	23	Female	Trait Stationary	I	-	-	-	-
B 24	Client	26	Male	Trait Stationary	II	same	B 01	-	-
B 25	Client	27	Male	Trait Stationary	II	same	B 06	-	-
B 26	Client	24	Female	Trait Stationary	II	same	B 11	-	-
B 27	Client	34	Male	Trait Stationary	II	same	B 07	-	-
B 28	Client	26	Male	Trait Stat & Ambu	II	same	B 09	-	-
B 29	Client	37	Female	Trait Stationary	II	same	B 10	-	-
B 30	Client	33	Female	Trait Stationary	II	new	-	-	-
B 32	Client	35	Male	Trait Stationary	III	same	B 07	B 27	-
B 33	Client	27	Male	Trait Ambulatory	III	same	B 09	B 33	-
B 35	Client	29	Female	Trait Ambulatory	III	new	-	-	-
F 01	Client	33	Male	Trait Stationary	I	-	-	-	-
F 02	Client	30	Male	Trait Stationary	I	-	-	-	-
F 04	Client	33	Male	Trait Stationary	I	-	-	-	-
F 05	Client	24	Male	Trait Stationary	I	-	-	-	-
F 06	Client	33	Male	Trait Stationary Substit	I	-	-	-	-
F 07	Client	25	Male	Trait Stationary	I	-	-	-	-
F 08	Client	41	Male	Trait Stationary	I	-	-	-	-
F 09	Client	33	Male	Trait Stationary Substit	I	-	-	-	-
F 10	Client	21	Male	Trait Stationary	I	-	-	-	-
F 11	Client	31	Male	Trait Stationary Substit	I	-	-	-	-
F 12	Client	31	Female	Trait Stationary Substit	I	-	-	-	-
F 16	Client	30	Male	Trait Stationary	I	-	-	-	-
F 20	Client	30	Male	Trait Stationary	II	same	F 02	-	-
F 21	Client	33	Male	Trait Stationary	II	same	F 01	-	-
F 22	Client	33	Male	Trait Stationary	II	same	F 04	-	-
F 23	Client	33	Male	Trait Stationary	II	same	F 06	-	-
F 24	Client	25	Male	Trait Stationary	II	same	F 07	-	-
F 25	Client	41	Male	Trait Stationary	II	same	F 08	-	-
F 26	Client	33	Male	Trait Stationary	II	same	F 09	-	-
F 27	Client	21	Male	Trait Stationary	II	same	F 10	-	-
F 30	Client	26	Male	Trait Stationary	III	same	F 07	F 24	-
F 32	Client	42	Male	Trait Stationary	III	same	F 08	F 25	-
F 33	Client	34	Male	Trait Stationary	III	same	F 01	F 21	-
F 34	Client	34	Male	Trait Stationary	III	same	F 04	F 22	-
F 35	Client	32	Female	Trait Ambulatory	III	same	F 12	absent	-
F 37	Client	22	Male	Trait Stationary	III	same	F 10	F 27	-
F 38	Client	34	Male	Trait Stationary	III	same	F 06	F 23	-
F 39	Client	30	Male	Trait Stationary	III	same	F 16	absent	-
Ka 12	Client	44	Male	Trait Stationary	I	-	-	-	-
Ka 15	Client	48	Male	Trait Ambulatory	I	-	-	-	-
Kn 01	Client	30	Male	Trait Day program	I	-	-	-	-
Kn 02	Client	40	Male	Trait Day program	I	-	-	-	-
Kn 03	Client	27	Male	Trait Day program	I	-	-	-	-
Kn 04	Client	23	Male	Trait Day program	I	-	-	-	-
Kn 07	Client	42	Male	Trait Day program	I	-	-	-	-
Kn 08	Client	23	Female	Trait Day program	I	-	-	-	-
Kn 09	Client	31	Male	Trait Day program	I	-	-	-	-
Kn 10	Client	21	Female	Trait Day program	I	-	-	-	-
Kn 17	Client	27	Male	Trait Day program	II	same	Kn 03	-	-
Kn 18	Client	27	Male	Trait Day program	III	same	Kn 03	Kn 17	-
L 14	Client	30	Male	Trait Day program	I	-	-	-	-
L 19	Client	34	Male	Community support	I	-	-	-	-
L 20	Client	25	Male	Trait Ambulatory	I	-	-	-	-
L 21	Client	39	Male	Trait Day program	I	-	-	-	-
L 23	Client	24	Male	Trait Day program	I	-	-	-	-
L 24	Client	39	Male	Trait Day program	I	-	-	-	-

L 25	Client	38	Male	Trait Day program	I	-	-	-	-
L 26	Client	18	Female	Trait Day program	I	-	-	-	-
L 28	Client	39	Male	Trait Stationary	II	same	L 24	-	-
L 29	Client	30	Male	Trait Ambulatory	II	same	L 14	-	-
L 30	Client	39	Male	Trait Ambulatory	II	same	L 21	-	-
L 31	Client	19	Female	Trait Ambulatory	II	same	L 26	-	-
L 46	Client	29	Male	Trait Ambulatory	III	new	-	-	-
L 47	Client	39	Male	Trait Day program	III	same	L 25	absent	-
L 48	Client	39	Male	Other	III	same	L 24	L 28	-
L 49	Client	40	Male	Trait Ambulatory	III	same	L 21	L 30	-
L 50	Client	36	Male	Trait Day program	III	new	-	-	-
L 52	Client	25	Male	Trait Ambulatory	III	new	-	-	-
L 53	Client	31	Male	Other	III	same	L 14	L 29	-
L 57	Client	39	Male	Other	IV	same	L 24	L 28	L 48
P 01	Client	38	Male	Trait Stationary	I	-	-	-	-
P 02	Client	31	Female	Trait Stationary	I	-	-	-	-
P 03	Client	39	Male	Trait Stationary	I	-	-	-	-
P 04	Client	30	Male	Trait Stationary	I	-	-	-	-
P 05	Client	26	Female	Trait Stationary	I	-	-	-	-
P 06	Client	32	Male	Trait Stationary	I	-	-	-	-
P 07	Client	34	Female	Trait Stationary	I	-	-	-	-
P 08	Client	22	Male	Trait Stationary	I	-	-	-	-
P 20	Client	36	Male	Trait Ambulatory	II	new	-	-	-
P 21	Client	42	Male	Trait Ambulatory	II	new	-	-	-
P 22	Client	32	Female	Trait Ambulatory	II	new	-	-	-
P 23	Client	22	Male	Trait Ambulatory	II	same	P 08	-	-
P 24	Client	34	Female	Trait Stationary	II	same	P 07	-	-
P 25	Client	26	Female	Trait Stationary	II	same	P 05	-	-
P 26	Client	32	Male	Trait Ambulatory	II	new	-	-	-
P 33	Client	26	Male	Trait Ambulatory	II	new	-	-	-
P 34	Client	32	Female	Trait Ambulatory	III	same	-	P 22	-
P 35	Client	26	Female	Trait Stationary	III	same	P 05	P 25	-
P 36	Client	30	Female	Trait Ambulatory	III	new	-	-	-
P 43	Client	42	Male	Trait Ambulatory	III	same	-	P 21	-
P 44	Client	36	Male	Trait Ambulatory	III	same	-	P 20	-
P 45	Client	50	Male	Trait Ambulatory	III	new	-	-	-
P 46	Client	32	Male	Trait Ambulatory	III	same	-	P 26	-
P 47	Client	26	Male	Trait Ambulatory	III	same	-	P 33	-
V 02	Client	30	Male	Trait Stationary	I	-	-	-	-
V 03	Client	27	Female	Trait Stationary	I	-	-	-	-
V 04	Client	25	Female	Trait Stationary	I	-	-	-	-
V 05	Client	17	Male	Trait Ambulatory	I	-	-	-	-
V 11	Client	35	Female	Trait Ambulatory	I	-	-	-	-
V 12	Client	36	Male	Trait Stationary	I	-	-	-	-
V 13	Client	24	Female	Trait Stationary	I	-	-	-	-
V 14	Client	16	Male	Trait Ambulatory	I	-	-	-	-
V 26	Client	28	Female	Trait Ambulatory	II	same	V 03	-	-
V 27	Client	30	Male	Treatment	II	same	V 02	-	-
V 28	Client	17	Male	Treatment	II	same	V 05	-	-
V 29	Client	35	Female	Treatment	II	same	V 11	-	-
V 30	Client	25	Female	Trait Stationary	II	same	V 04	-	-
V 31	Client	16	Male	Trait Stationary	II	same	V 14	-	-
V 32	Client	24	Female	Trait Stationary	II	same	V 13	-	-
V 33	Client	36	Male	Trait Stationary	II	same	V 12	-	-
L 54	Client comp	36	Male	completed	IV	same	-	-	L 50
L 58	Client comp	25	Male	Trait Ambulatory	IV	same	-	-	L 52
L 59	Client comp	33	Male	Trait Ambulatory	IV	new	-	-	-
F 31	Client non cont	31	Male	Trait Stationary	III	same	F 02	F 20	-
L 32	Client non cont	25	Male	Trait Ambulatory	II	same	L 20	-	-
L 51	Client non cont	34	Male	Left	III	same	L 19	absent	-
L 55	Client non cont	-	Male	Prison	IV	same	L 14	L 29	L 53
L 56	Client non cont	39	Male	Other	IV	same	L 25	absent	L 47
B 34	Client non parti	29	Male	Trait Ambulatory	III	new	-	-	-
L 33	Clients - not cont	24	Male	Trait Ambulatory	II	same	L 23	-	-
V 35	Clients - not cont	-	mixed	Trait Stationary	III	new	-	-	-
L 27	Clients : diverses	-	-	-	III	-	-	-	-
V 36	Clients continu	-	mixed	Trait Stationary	III	new	-	-	-
Ka 05	NA	NA	NA	NA	I	-	-	-	-
Ka 06	NA	NA	NA	Trait Stationary	I	-	-	-	-
Ka 07	NA	NA	NA	Trait Stationary	I	-	-	-	-
Ka 10	NA	NA	NA	Judic Decision	I	-	-	-	-
L 04	NA	NA	-	-	I	-	-	-	-

Attributs 25 11 05 : Population totale

APPENDICE 7

Doc	1 Actor	4 Prof position	5 Sector	C1 Site
B 02	Professional	-	Trait Ambulatory	Berlin
B 03	Professional	-	Judic Decision	Berlin
B 04	Professional	-	Trait Stationary	Berlin
B 05	Professional	-	Trait Stationary	Berlin
B 08	Professional	-	Judic Decision	Berlin
B 20	Professional	Therapeutical director	Trait Stationary	Berlin
B 21	Professional	High civil servant	Political adminstration	Berlin
B 22	Professional	Therapeutical director	Trait Stationary	Berlin
B 23	Professional	prosecutor	Judic Decision	Berlin
B 31	Professional	drug treatment counsellor	Trait Stationary	Berlin
B 36	Professional	drug treatment counsellor	Trait Stationary	Berlin
F 13	Professional	-	Medical execution	Fribourg
F 14	Professional	-	Trait Stationary	Fribourg
F 15	Professional	-	Trait Stationary	Fribourg
F 17	Professional	-	Medical decisional	Fribourg
F 28	Professional	probation officer	Judic Execution	Fribourg
F 29	Professional	social worker	Prison	Fribourg
F 36	Professional	institution director	Trait Stationary	Fribourg
F 40	Professional	institution director	Trait Stationary	Fribourg
Ka 01	profs + clients	-	Trait Ambulatory	Kent-A
Ka 02	Professional	-	Judic Decision	Kent-A
Ka 03	Professional	-	Judic Decision	Kent-A
Ka 04	Professional	-	Trait Ambulatory	Kent-A
Ka 08	Professional	-	Trait Ambulatory	Kent-A
Ka 09	Professional	-	Trait Ambulatory	Kent-A
Ka 11	Professional	-	Trait Stationary	Kent-A
Ka 13	Professional	-	Trait Ambulatory	Kent-A
Ka 14	Professional	-	Trait Ambulatory	Kent-A
Kn 05	Professional	-	Trait Day program	Kent-N
Kn 06	Professional	-	Judic Execution	Kent-N
Kn 11	Professional	Police - drug liaison	Police	Kent-N
Kn 12	Professional	Police - drug liaison	Police	Kent-N
Kn 13	Professional	drug treatment counsellor	Trait Ambulatory	Kent-N
Kn 14	Professional	judge	Judic Decision	Kent-N
Kn 15	Professional	magistrate	Judic Decision	Kent-N
Kn 16	Professional	lawyer	Judic Decision	Kent-N
L 01	Professional	-	Traitmt Decision	London
L 05	Professional	-	Judic Decision	London
L 08	Professional	-	Judic Decision	London
L 11	Professional	-	Judic Execution	London
L 17	Professional	drug treatment counsellor	Trait Day program	London
L 18	Professional	Service manager	Trait Ambulatory	London
L 34	Professional	magistrate	Judic Decision	London
L 35	Professional	probation officer	Judic Execution	London
L 36	Professional	probation officer	Judic Execution	London
L 37	Professional	drug treatment counsellor	Community support	London
L 38	Professional	-	Trait Day program	London
L 39	Professional	Chief Executive Officer	Regional Health organisation	London
L 40	Professional	Service manager	Trait Ambulatory	London
L 41	Professional	treatment & coord	Trait Ambulatory	London
L 42	Professional	treatment & coord	Traitment ambulat & community sup	London
L 43	Professional	Area manager	Regional Health organisation	London
L 44	Professional	Service manager	Judic Execution	London
L 45	Professional	Service manager	Judic Execution	London
P 09	Professional	-	Traitmt Decision	Padua
P 10	Professional	-	Traitmt Decision	Padua
P 11	Professional	-	Judic Decision	Padua
P 12	Professional	-	Lawyer	Padua
P 13	Professional	-	Other	Padua

P 14	Professional	-	Judic Execution	Padua
P 27	Professional	-	Lawyer	Padua
P 28	Professional	-	Lawyer	Padua
P 29	Professional	social worker	Judic Execution	Padua
P 30	Professional	educator	Trait Ambulatory	Padua
P 31	Professional	psychologist	Prison	Padua
P 32	Professional	educator	Trait Ambulatory	Padua
P 37	Professional	drug treatment counsellor	Treatment	Padua
P 38	Professional	social worker	Judic Execution	Padua
P 39	Professional	educator	Trait Ambulatory	Padua
P 40	Professional	lawyer	Judic Decision	Padua
P 41	Professional	lawyer	Judic Decision	Padua
P 42	Professional	psychologist	Prison	Padua
V 01	Professional	-	Judic Decision	Vienna
V 06	Professional	-	Judic Decision	Vienna
V 07	Professional	-	Trait Ambulatory	Vienna
V 08	Professional	-	Judic Decision	Vienna
V 09	Professional	-	Judic Decision	Vienna
V 10	Professional	-	Judic Decision	Vienna
V 20	Professional	judge	Judic Decision	Vienna
V 21	Professional	lawyer	Lawyer	Vienna
V 22	Professional	prosecutor	Judic Decision	Vienna
V 23	Professional	treatment & coord	Treatment	Vienna
V 24	Professional	social worker	Trait Ambulatory	Vienna
V 25	Professional	psychotherapist	Trait Ambulatory	Vienna
V 37	Professional	judge	Judic Execution	Vienna