Qualitative Evidence in Addictions

12

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12.1 Introduction

In this chapter the contribution of qualitative evidence to what is known about addictions is critically examined. It is argued that there is bias against publishing qualitative research in and for addictions and that there are ideological reasons for why qualitative research is not valued as *evidence*. A critical point in such discussions is the epistemology of method. The way qualitative research is used to inform and critique aspects of the addictions field is explored in relation to drug consumption (focussing on drug use by young people as an exemplar) and distribution (focusing on qualitative research on drug markets). The production of knowledge about drugs is scrutinised in terms of the processes of problem construction and the often taken-for-granted knowledge that informs or shapes them. Broader questions about the science and ideology underlying drug use related interventions (using harm reduction as an exemplar) are also considered. Examples of quantitative, qualitative, and mixed methods research questions are compared and contrasted in the chapter and the notion of transdisciplinary research is examined as a possible solution to the ontological and epistemological differences between researchers. It is demonstrated that the addictions field has been slow to implement evidence to inform best clinical practice and that qualitative research provides an insight into why this might be the case. Suggestions for future research, policy, and practice in defined evidence-based addictions interventions are made.

Throughout the chapter, the question of what is meant by *evidence* in general and *qualitative evidence* in particular in the addictions is alluded to. *Evidence* is especially difficult to define and has been characterised by theorists in a number of ways, e.g. the truth or falsity of something, or its *probability*, *likelihood*, or *warrantability* (Miller and Fredericks 2003). As is discussed later on in the chapter, these different characterisations mean that the concept of evidence is contested by different users of it. Additionally, it is not immediately obvious how qualitative data becomes evidence for a claim and there are several models in existence to explain the process (Miller and Fredericks 2003). Detailed discussion of these issues is beyond the scope of this chapter, but it is important to note that these theoretical concerns are not merely academic as they impinge on the credibility of the qualitative research paradigm and underpin some of the problems explored in relation to evidence based practice in the addictions field that are discussed below.

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12.2 Evidence in the Addictions Field

12.2.1 Historical Background

Most historiographers of addictions research agree that Lindesmith's (1947) study of opiate dependence and withdrawal is the start of modern qualitative research in the field (Feldman and Aldrich 1990). In this study, Lindesmith adopted a symbolic interactionist perspective and demonstrated that the experience of addiction had a social rather than a merely physiological basis. Following Lindesmith's seminal work, the concealed nature of many drug use behaviours and subcultures was further developed through a series of what are now considered classic ethnographies of addictions (Agar 1973; Becker 1953; Jackson 1978; Preble and Casey 1969; Preble and Miller 1977; Spradley 1970; Sutter 1966). The focus of such research was to *make sense* of the social world of drug use from the perspectives of drug users. Popular perceptions of drug users as passive or deviant were challenged through these studies and purposeful and active meanings in drug use within the context of the drug user's lifestyle were established (Becker 1963; Feldman et al. 1979; Hughes 1961).

Since the early qualitative studies in the addictions field there has been an increasing acceptance of the use of qualitative methods as a means of understanding and responding to drug use and misuse. Ethnographic analyses of populations marginalised on the basis of race/ethnicity, gender, and/or social class have emerged in recent decades (Bourgois 1995; Bourgois and Schonberg 2009; Maher 1997; Maher and Dixon 1999; Moore 2004). For example, early methadone treatment programmes for opiate-addicted women were shown to be characterised by limited space, inadequate facilities, overt voyeurism and sexism, and lack of gender-specific services in qualitative research undertaken by Rosenbaum (1981). More recently, Moore (1993) highlighted the manner in which drug use and related harms are influenced by historical and structural factors such as economic and class distinctions. Adler (1985) and Pearson's (1987) research on neighbourhoods in the north of England suggested a close local relationship between heroin abuse and neighbourhood levels of social deprivation and unemployment. Epidemics of HIV/AIDS infection among injecting drug users during the 1980s created the need to better understand the social contexts of risk behaviour so as to control HIV transmission. In addition to these studies, qualitative research began to be used to inform the development of policy and community interventions during the 1980s and 1990s (Atkins and Beschner 1980; Brooks 1994; Feldman and Aldrich 1990; Hughes 1977).

In recent years, there has been recognition of the importance of qualitative methods in the addictions field, particularly in relation to mixed methods research (Bourgois et al. 2006; Clatts et al. 1999; Grund 1993; Koester 1994). This new interest in qualitative research reflects awareness of the need for methodological and analytical research approaches capable of untangling the complex environments in which actions, diseases, and policies interact (Rhodes and Moore 2001a, b). Such approaches have also opened the way to the production of more reflexive accounts of the relationship between qualitative researchers and their subjects. Reflexivity entails focussing on the politics inherent in the representation of research data and in being interested in how wider social forces (whether historical, social or economic) shape the everyday realities lived by drug users.

The topics investigated using qualitative research in the last 67 years are almost limitless, and the range of methodologies employed is increasing all the time. For example, Coombes and Wratten (2007) used phenomenology to illuminate the experiences of mental health professionals working with people who have a dual diagnosis. Oksanen (2012) has used narrative analysis to examine rock autobiographies describing a wide variety of legal and illegal substances and risky behaviour used by rock artists. Martin and Stenner (2004) and Fraser (2006) have used discourse analysis to how participants first came to use heroin and how methadone treatment is reported in newspapers respectively. Murphy et al. (2010) employed grounded theory

to explore the experiences of racially and culturally diverse young mothers whose own mothers' misused substances two decades ago in inner city, urban neighbourhoods in the USA. It will be interesting to see how qualitative research continues to develop over the next seven decades.

12.2.2 Qualitative Evidence in the Addictions Field

This brief historical discussion has illustrated the gradual acceptance of qualitative research as a valid form of evidence in the addictions field. In a recent influential book on drug policy, Babor et al. (2010) mention qualitative research in relation to the production of evidence. They say "[…] a variety of methodological approaches have been used to assess the impact of drug policies as well as the effectiveness of policy-relevant prevention programmes, treatment strategies, and related efforts" (p. 98). They go on to add that qualitative research is an appropriate methodological approach. However, it is interesting to note that, perhaps unconsciously, qualitative research is placed at the end of a list of research methodologies starting with experimental studies.

There is much debate about the concept of *evidence* and *the evidence base* in the addictions field. As well as the conceptual problems mentioned in the introduction, the usefulness and relevance of such terms to both policymaking and practice has been questioned. The term *evidence-based practice* is used frequently in the literature, yet largely relates to only one type of evidence, namely research. In reality, a variety of distinct pieces of evidence and sources of knowledge inform policy and practice, such as histories and experience, beliefs, values, competency/skills, legislation, politics and politicians, protocols, and research results (Elliot and Popay 2000; Sibbald and Roland 1997). Because of this, the term *evidence-influenced* or *evidence-informed* practice or policy has been introduced in the addictions field and elsewhere to reflect the need to be context sensitive and to consider use of the best available evidence when dealing with everyday circumstances (Hayward et al. 1996; Nutbeam 1996; Sackett et al. 1996). A key challenge to those working in the addictions field is to better contextualise evidence for more effective policymaking and practice.

Consensus regarding the best procedures for identifying practices with sufficient empirical foundation to be considered *evidence based* has not yet been reached in the addictions field. For example, some have argued that evidentiary value should be based on a hierarchical model of research evidence (Lohr 2004). An alternative view is based on systematic reviews and meta-analyses as exemplified by the Cochrane Collaboration (Clarke 2007; Walshe and Rundall 2001). Yet others have proposed highly specified criteria that reflect the number and types of trials required to establish a treatment as *evidence based*, e.g. the American Psychological Association's Division of Clinical Psychology 1995 (Chambless and Hollon 1998). Critics of these approaches to selecting interventions for use in practice have argued that interventions established through efficacy research are unlikely to generalise to "real world" settings (Garfield 1996; Seligman 1995). Also, for reasons considered next, such approaches tend to exclude data obtained through qualitative research in the addictions field.

Taken as a whole, the addictions field is dominated by quantitative research (Neale et al. 2005). In a recent survey of the top eight ranked journals in the social science category of the Thomson ISI impact factor (IF) ratings, supplemented by journals of relative high impact in the field of drug use or known to attract social research submissions, it was estimated that 7 % of published papers were qualitative research (Rhodes et al. 2010). But it is not just the quantity of qualitative research studies that are published that is the issue. How is the research that is published *valued* by those in the addictions community?

Whilst it is difficult to generalise across groups as diverse as make up the addictions field, it is possible to discern some messages about how qualitative research is regarded. For example, Babor et al. (2010) comment:

> Researchers can complement quantitative research methods such as social surveys with qualitative studies, such as ethnographic interviewing, participant observation, case studies, and focus group

> discussions. As long as researchers apply standard scientific principles of confirmation, refutation, causal inference, and generalizability, qualitative research can provide an additional different form of evidence that can inform drug policy development. (pp. 99–100)

Qualitative researchers working in the addictions field would have no difficulty in accepting the proposition that qualitative research delivers evidence that can edify health providers, societal stakeholders and drug users in the addiction policy field. What is more contentious though is the inference that the proper place of qualitative research is secondary to quantitative research and that it should be appraised using quantitative criteria.

12.3 The Epistemology of Method and the Addictions Field

A critical point in this discussion concerns what is often referred to as the *epistemology of method*. Often, researchers' choice of a method will be between quantitative or qualitative or mixed, without any reference to our assumptions regarding the way of understanding and interpreting how we know what we know. A detailed analysis of the epistemological debates that have taken place regarding the correct approach to knowledge production is not possible here, but one effort to resolve what has been called *paradigm wars* is worth consideration, namely the call for *pragmatism* (Hammersley 1992; Johnson and Onwuegbuzie 2004). The pragmatist position, which sits comfortably inside narratives of evidence-based medicine, implies that differences in the epistemology of method are exaggerated as well as unconstructive. In the field of addictions, McKeganey (1995), for example, has argued for reconciling differences between quantitative and qualitative methods in addictions research, suggesting that *divides* are *unhelpful*, and that *methodological identity* should not be preserved at *the cost of greater understanding*.

Many qualitative researchers would contest this view and would argue that pragmatism as a solution to differences in epistemological method is insufficient. Qualitative research approaches are a commitment to illuminating how power, context, and objectification shape knowledge in relation to addiction (Bourgois 1999). Qualitative researchers should not have to quash their attachment to interpretivist theory, disguise their epistemological beliefs, or dumb down their analyses. Addiction and addiction science are essentially social and historical constructions (Courtwright 2001; Reinarman 1995), and a key role of qualitative research, through theoretically informed, systematic analyses, is to explore and demonstrate how particular constructions of knowledge, practice, and subjectivity come to be taken as real.

12.4 Use of Evidence by Addiction Workers

So far it has been suggested that traditional evidence based practice has tended to exclude qualitative research in relation to knowledge production in policy and practice. Nonetheless, in spite of these attempts to discount qualitative research, the approach has made several significant contributions in the addictions field. These are briefly discussed under the headings of: drug consumption and distribution (using drug use by young people as an exemplar); production of knowledge about drugs; and the science and ideology underlying drug use related interventions.

12.4.1 Drug Consumption and Distribution

For 2010–2011, the annual Crime Survey for England and Wales data for younger people aged 16–24 showed 19 % saying they had used an illicit drug in the past year—the lowest level since the survey began in 1996. For this age group, cannabis use has fallen sharply from 26 % in 1996 to 15.7 % in 2011, followed by a drop in powder cocaine use from 5.5 % at its peak in 2009–2010 to 4.2 % in 2011. Despite the current media focus on ecstasy, its use among young people has also experienced a recent decline,

down from 4.4 % in 2008–2009 to 3.3 % in the latest figures. Legal highs remain as popular as ecstasy among young people, with 3.3 % of 16-to-24-year-olds using them in the past year, but this is a decline since the previous survey showed 4.4 % trying it.

How should these statistics be interpreted? Trends such as those above signal a shift in the use of a drug. But why does the shift occur? Some commentators have claimed that the recent cannabis statistics in England and Wales are evidence that drug policy in the UK is working. The problem with this argument is that, for many critics, it is factors such as the legal reclassification of cannabis, changes in prices, availability of other substances, improvement in living standards, employment status, and changing family structure that are the causes of shifts in drugs trends, rather than drug policy. Yet other critics point to the contradictions and unintended harmful side effects of UK drug policy, which are not seen in headline official statistics (Transformhttp://www.tdpf.org.uk/).

In order to answer the two questions posed at the beginning of the preceding paragraph and to throw light on the issues touched upon in the rest of the paragraph, it is not simply a matter of referring to the facts produced by quantitative research. As Agar (2000) has pointed out, drug trends are the engines that drive planning, intervention and evaluation in the addictions field, whether one thinks of prevention, treatment, or law enforcement. Typically trends are monitored with a *number trail* from the institutions that deal with drug users but, useful as such data may be, well-known problems exist in reading trends from the quantitative record. One such problem is that indicators are typically lagging rather than leading. Another is that institutions that maintain records usually over-represent long-term users from impoverished groups and, in practice, their institutional processes may change the numbers (e.g. arrest statistics fluctuate with policy and shifting police priorities). The final issue is that the numbers do not reveal the changing worlds of use that are needed to interpret them: who is using what drugs, in what ways, in what circumstances—the world of use—plays no role in the indicator data. To account for a statistical trend in drug consumption, information about the lived world of user and use is needed, information that is best provided by qualitative research.

These points are well illustrated in a recent overview of drug research in the UK commissioned by the Joseph Rowntree Foundation regarding cannabis use by young people. Lloyd and McKeganey (2010) reported on five qualitative research studies of cannabis use by young people that focused on: the policing of cannabis as a Class B drug; the impact of change of legal classification of the drug; the domestic cultivation of cannabis; the social impacts of heavy cannabis use and; how young people access cannabis.

Lloyd and Mckeganey (2010) drew a number of interesting conclusions about the trend in cannabis use by young people in the UK. Firstly, they noted that there are some very significant gaps in knowledge of the most commonly used of the illicit drugs in the UK such as skunk and home-grown herbal cannabis, and that the growing fears over the new potency of cannabis have therefore been based largely on anecdote and conjecture. Secondly, they found that there were wide variations in practice in the policing of cannabis that cannot be accounted for merely on the basis of operational or strategic needs, particularly in relation to black and minority ethnic groups and the very different way that young offenders are dealt with. Thirdly, in relation to the domestic cultivation of cannabis, their research showed that there is considerable variation and confusion on the question of enforcement regarding young people's cannabis use. Fourthly, while an increasing proportion of cannabis is grown in the UK, the large majority of young people still have to obtain their cannabis from the illicit market—a market that seems to be able to reach people anywhere in the country. However, young users do not tend to buy their cannabis from a stereotypical older, unscrupulous and unknown "pusher"—they are far more likely to obtain it through friends. Fifthly, a somewhat surprising finding was the number of young people who reported taking cannabis into school and smoking the drug on school premises.

Sixthly, findings suggested that young people with troubled pasts may be more likely to smoke cannabis heavily, and that this heavy use can amplify their problems. Relatedly, there is also the suggestion that professionals working with vulnerable young people may not recognise the potential seriousness of heavy cannabis use. This may relate to their own, very different, experience of smoking cannabis during their youth.

As well as drug consumption, qualitative research has also made important contributions to the understanding of drug distribution. One of the earliest studies of drug distribution focused on the heroin market in New York and described the levels and hierarchies to the market (Preble and Casey 1969). This early qualitative study of the structure of drug markets was built upon by Dorn et al. (1992) in the UK, who identified seven different types of drug trafficking firms. They made two central claims about the structure of the drug market: firstly, they argued that there was no evidence for the large scale organised, top-down hierarchies controlled by "Mr Big"; secondly, the researchers found that the drug markets are constantly fluid and changing. Dorn et al. (1992) did not subscribe to the view of a simple hierarchical organisation, with levels of distribution characterised by the weights, price, and purity of the drugs traded.

From the USA, qualitative research by Natarajan and Belanger (1998) described a number of typologies of the drug market identifying five tasks/roles in drug trafficking organisations: (1) grower/producer; (2) manufacturer; (3) importer/smuggler; (4) wholesale distributor; and (5) regional distributor. As regards organisational structure, they identified four types: freelance, family businesses, communal business, and corporations. In the UK, qualitative research by May and Hough (2004) noted the change in the market from an open street-based market to a closed market, and associated this with the widespread introduction of mobile phones, coupled with community concern about public space. They used the term "retail market" to describe this segment, and distinguish it from the "middle-level" drug markets. Above this retail level, May and Hough (2004) documented two types of distributions systems: the more traditional pyramidal market (prevalent in the 1980s and characterised by highly disciplined and hierarchical organisation); and the fragmented, non-hierarchical entrepreneurial market (characterised by little structure, fluidity, and free enterprise). They noted that they cannot determine which of these two structures predominates. Aspects of the low-level market are described in South (2004) through two qualitative case studies of heavy recreational drug users. The daily lives of these users blur the line between the legal and the illegal and their drug trading is generally as a consumer and "friend of a friend" small dealer.

So far we have considered what Moore (2011) describes qualitative research *in*, or *fo*r, the drug field. That is qualitative research aimed at improving understandings of the addiction field, in this case, drug markets. However, qualitative research *on* the drug field and its underlying theories, methods, assumptions, and ideological bases, has also become the object of critical inquiry. An example of this kind of qualitative research is provided by Dwyer and Moore (2010) through a detailed critical analysis of surveillance and criminological research on illicit drug markets in Australia. They argue that conventional surveillance and criminological research on illicit drug markets is limited in terms of its inadequate methods, limited theoretical models, neglect of sociocultural and political processes, and narrow conception of those participating in drug markets. Given that drug markets and street-based drug marketplaces in particular, have emerged as central public policy concerns internationally, it is important to question whether quantitative approaches provide adequate understandings of these sites.

12.4.2 Production of Knowledge About Drugs

It was suggested in the previous section that knowledge production relating to drugs, drug use and addiction has been dominated by quantitative research and, because of this, many would argue that it is on this knowledge that drug policies and

practice is (and should be) based. While this approach has several strategic benefits, it also has two weaknesses. Firstly, it is self-contradictory—according to the advocates of evidence based drugs policy, policy should be based on independence and rationality, yet these are the characteristics that are said to be lacking in drug use and addiction. Secondly, it is epistemologically naive—it tends to take for granted that value-free, objective knowledge about the world can be produced. The quantitative approach to knowledge production assumes that social problems are constituted from concretely real damaging or threatening conditions. In this view, any condition that causes death or disease, shortens life expectancy or significantly reduces quality of life for many people should be defined as a "social problem" (Goode and Ben-Yahude 2009). An example of this is the disease model of addiction, which describes an addiction as a lifelong disease involving biological and environmental sources of origin. Within this model a genetic predisposition is believed to be present.

An alternative perspective to this is the social constructionist position, which argues that what makes a given condition a problem is the process of collective definition of that condition as a problem. Definitions of social problems emerge out of specific sociocultural conditions and structures, operate within particular historical eras, and are subject to the influence of particular individuals, social classes, and so on. Derrida (1993) has asserted:

> There are no drugs in 'nature' […]. As with addiction, the concept of drugs supposes an instituted and an institutional definition: a history is required, and a culture, conventions, evaluations, norms, an entire network of intertwining discourses, a rhetoric, whether explicit or elliptical […]. The concept of drugs is not a scientific concept, but is rather instituted on the basis of moral or political evaluations; it carries in itself both norm and prohibition, allowing no possibility of description of certification—it is a decree, a buzzword. Usually the decree is of a prohibitive nature. (p. 2)

Derrida is pointing to the intrinsically political nature of "drugs". He argues that the term does not refer simply or reliably to certain substances with clear-cut attributes or effects. Instead "drugs" is a political category that includes some substances and excludes others, depending on the politics of the day. For example, until very recently, tobacco was not commonly referred to as a drug.

12.4.3 Ideology Underlying Drug Use Related Interventions

One of the main preoccupations of qualitative research is with the question, "what really going on here?" What is really going on with this substance misuser, with this family affected by substance misuse, with this community where substance use and misuse is occurring? This initial question leads to further questions, for example, how do substance misusers and others in contact with them view their situation? By contrasting different viewpoints of the same situation the qualitative researcher demonstrates that there is not just one reality, one truth, but different and conflicting definitions of reality.

Following on from this, it becomes important to ask what people believe they are doing compared to what they are actually doing. This raises questions about ideologies. Beliefs may be ideological not because they are inherently untrue—often there is a strong element of truth in them—but because they are exaggerations of the truth, or they do not accord with the facts, or they are based principally on belief rather than careful observation and evidence, or they are used to justify the position of the powerful. One of the main tasks of the qualitative researcher is to criticise ideologies by demonstrating how they distort reality and how they serve the interests of the powerful. A good illustration of this kind of qualitative research is Bourgois and Schonberg's (2009) work with homeless injecting drug users.

Bourgois and Schonberg (2009) argue that epidemiologists identified injecting drug users as a potential threat in the spread of HIV in the 1980s. One response to this threat was the emergence of a worldwide health movement known as *harm reduction*, modelled on earlier hepatitis A prevention initiatives for heroin injectors in the Netherlands (Marlatt et al. 2012). The movement

advocated non-judgmental engagement with active drug users and hoped to lower the cultural and institutional barriers to medical services. Harm reduction outreach initiatives such as needle exchanges were not based on an abstinence model; rather they were designed to be pragmatic and inclusive (Marlatt et al. 2012).

Despite the radical, user-friendly intentions of harm reduction activists, Bourgois and Schonberg (2009) point out that the movement operated within what they call the *logic of governmentality*. Drawing on Foucauldian theory, they assert that harm reduction functions within the limits of middle class public health discourse committed to educating "rational clients […] free to choose health" (Moore 2004 p. 1549). In short, according to Bourgois and Schonberg, harm reduction became the gentle strand in the disciplinary web that seeks to rehabilitate the poor. Knowledge may be empowering to the middle class, but prevention and outreach messages that target the decision making processes of drug users fail to address the constraints on choice that shape need, desire, and personal priorities among the poor and homeless.

To illustrate this point, Bourgois and Schonberg (2009) described how healthcare providers and outreach workers routinely advised the homeless injecting heroin users in their study never to use injection paraphernalia. Practice at the time of the study regarding injecting drug users in the USA was to provide individuals with bottles of bleach to clean their equipment. But, as Bourgois and Schonberg point out, it is impossible to rinse a used cotton (a filter for drugs like heroin) or cooker (a container used for mixing and heating a drug) with bleach if these are used to inject leftover residues of heroin. Furthermore, they suggest that hypersanitary messages ignore the moral economy on the street. From the perspective of the homeless injecting drug user, sharing injection paraphernalia actually promotes health rather than damaging it. Their top priority is to avoid withdrawal symptoms and that requires them to share publicly and frequently in order to build a generous reputation.

What Bourgois and Schonberg (2009) seek to show in their analysis is that the harm reduction movement's well-intentioned initiative is based on an ideology inadvertently created by a dynamic of unproductive self-blame, which contributed to conventional misrecognition of the relationship between power and individual self-control.

12.5 Kinds of Questions that Can Be Answered in the Addictions Field Through Qualitative and Mixed Methods Research in Contrast to Quantitative Methods

A research question is a statement of the specific query the researcher wants to answer, to address a research problem. They can be expressed in declarative forms, for example, "The purpose of this study is to target co-occurring problems of substance use and intimate partner violence (IPV) using a computer-based intervention, B-SAFER" (Choo 2012 p. 1), or interrogative forms, such as "Which individuals and groups have the most input in decisions about substance use prevention curricula?" (Rohrbach et al. 2005 p. 516). Research questions serve two purposes: (1) they determine where and what kind of research will be carried out, and (2) they identify the specific objectives the study will address. Quantitative, qualitative, and mixed methods research questions in the addictions field are discussed below.

12.5.1 Quantitative Research Questions in the Addictions Field

A quantitative study seeks to learn the what, where, or when, of the research topic. For example, Haddock et al. (2003) stated the following quantitative research question in relation to their RCT of cognitive behavioural therapy and motivational intervention for schizophrenia and substance misuse: "To investigate symptom, substance use, functioning and health economy

outcomes for patients with schizophrenia and their carers 18 months after a cognitive-behavioural treatment (CBT) programme" (p. 418). Often quantitative researchers may not state the research question in this form, but instead present a statement of purpose and then one or more hypotheses, for example, "We tested the hypothesis that cigarette smoking would increase the risk for subsequent alcohol and drug use disorders by the young adult years and that the magnitude of this association will be stronger in youth with ADHD" (Biederman et al. 2012).

12.5.2 Qualitative Research Questions in the Addictions Field

In contrast, qualitative research questions need to articulate what a researcher wants to know about the intentions and perspectives of those involved in social interactions. Creswell (2007) noted another aspect of qualitative research that, "Our questions change during the process of research to reflect an increased understanding of the problem" (p. 43). Recent qualitative inquiry has moved toward involving the researcher and participants in the process of inquiry (Flick 2008; Griffiths et al. 1993). In the field of qualitative addiction research, Neale et al. (2007) conducted a study of injecting drug users (IDUs), and used the following qualitative research question: "To examine the nature and extent of barriers to effective treatment encountered by IDUs".

12.5.3 Mixed Methods Research Questions in the Addictions Field

A mixed methods study integrates both qualitative and quantitative studies, so the researcher must be directed at determining the why or how and the what, where, or when of the research topic. Redman (2010) conducted a mixed methods study of a community engagement orientation among people with a history of substance misuse and incarceration with the following research questions:

> The aim of this study was to identify contributors to a community engagement oriented purpose in life among people with a history of substance misuse and incarceration. The theme of community engagement was distilled from the qualitative data using an inductive process of constant comparisons […]. Themes were then aggregated for use in a series of quantitative analyses. Initially, bivariate analyses were conducted to explore the relationships of variables that previous research has associated with community engagement (e.g. demographics, substance use, treatment, socioeconomic status, education, self-esteem, previous civic involvement). (Redman 2010, pp. 249–250)

12.6 Research Designs, Protocols and Techniques that Can Produce Trustworthy and Rigorous Qualitative Research in the Addictions Field

During the 1980s and 1990s, there was increasing recognition within addictions research of the limitations of quantitative approaches (Rhodes and Moore 2001a, b). One consequence was the development of various forms of mixed methods research on addictions in which qualitative research was given increased prominence. These approaches emphasised cross-disciplinary research involving "cross-methodological and analytical dialogue" across research teams (Bourgois et al. 2006). Proceeding in this way, it was hoped that some of the limitations of quantitative and qualitative research could be minimised (e.g. the limited generalizability of qualitative research and the limited depth of quantitative research), and some of their strengths could be reinforced (e.g. the richness of qualitative data and the large samples of quantitative research). According to Rosenfield (1992), transdisciplinary research is the strongest form of cross-disciplinary research since it involves integrating two or more disciplines to produce novel, integrated hybrids of ideas, theories, and methods.

A recent example of the transdisciplinary approach to addiction research is the Addiction and Lifestyles in Contemporary Europe Reframing Addictions Project (ALICE RAP 2013http://www.alicerap.eu/). ALICE RAP aims to help policy makers "re-think and re-shape" current and future approaches to the human and economic costs of addictions and lifestyles in Europe. The initiative will investigate addiction in its broadest sense, including all types of substance problems and internet gaming and gambling. Over 100 scientists from 67 institutions in 25 countries are bringing together cross-disciplinary work into an integrated evidence base for informed policy action. The research programme includes a wide range of different quantitative and qualitative scientific disciplines.

Whilst the aims of cross-disciplinary research are laudable and its rationale is compelling, less attention has been paid to the politics of the approach and in particular how questions of theoretical and epistemological differences between disciplines might be managed and possibly reconciled. This issue has been encountered in earlier sections of the chapter. To achieve Fuqua el al.'s (2004) "[…] higher levels of convergent and discriminant validity […] through the triangulation of multiple methodologies" (p. 146) either the qualitative or quantitative researchers have to "suspend" some of their theoretical and epistemological commitments (Mckeganey 1995). Many qualitative researchers would argue that this usually means discarding their beliefs: such as there is no direct, unmediated access to the objective world; that qualitative data is created intersubjectively; and that there are multiple interpretations of data.

Differences in the epistemology of method discussed above can make truly cross-disciplinary research in the addictions field challenging (Moore 2002). But differences in approach are helpful too. There is increasing acceptance of post-positivism in quantitative research, as well as recognition of pragmatism in much applied qualitative research, and a growing respect for the need to reflect on how research questions and methods relate to epistemological assumptions. Collaborations between ethnography, epidemiology, and mathematical modelling provide examples in the addictions field (Agar 2003; Bourgois et al. 2006; Ciccarone and Bourgois 2003; Moore et al. 2009).

12.7 A Critical Evaluation of Current Qualitative Evidence for Addictions to Inform Best Clinical Practices

In recent years, health and social care organisations and agencies in the developed world have been exploring and adopting best practices (evidence based/informed practices) when delivering services. For example, in the USA, the Institute of Medicine issued the landmark report, *Bridging the Gap Between Research and Practice*: *Forging Partnerships with Community-Based Drug and Alcohol Treatment* (Institute of Medicine 1998). Several tasks were charged to this committee, including the identification of promising research strategies that would help lessen the disparity between research and practice within the field of substance abuse treatment. Among the committee's recommendations to improve implementation of research-based interventions in practice was the development of an infrastructure to facilitate research within a network of community-based treatment programmes and the suggestion for states and federal agencies to develop financial incentives to encourage the inclusion of evidence-based treatments (EBTs) in community-based programmes.

The National Institute on Drug Abuse (NIDA) responded to these needs in a number of ways. One method of promoting greater diffusion of EBTs was publishing treatment manuals for several different approaches including: cognitive behavioural treatment (Carroll 1998), the community reinforcement approach plus vouchers (Budney and Higgins 1998), and individual drug counselling (Mercer and Woody 1999). In 1999, NIDA established the Clinical Trials Network (CTN), which has produced several articles demonstrating the effectiveness of different substance misuse treatments in community-based treatment

settings (e.g. Petry et al. 2005). In 2001, NIDA worked with the Substance Abuse and Mental Health Services Administration (SAMHSA) to create the NIDA/SAMHSA Blending Initiative. The general technology transfer strategy used as part of the Blending Initiative includes: identification of promising CTN and/or other NIDA-funded findings that address gaps in the treatment field and formation of blending teams (composed of representatives of the NIDA research and representatives from the ATTCs), which work closely together to develop training curricula, supervisory manuals, and strategic dissemination plans.

Over the past decade, a great deal of effort has been invested into ensuring that evidence-based practice (EBP) is being utilised in the treatment of addiction. But even with this concerted effort, the implementation of effective addictions treatment interventions into the "every day" clinical setting has been minimal (Amodeo et al. 2011; Bradley et al. 2004; National Institute on Drug Abuse 2004; Rawson 2006; Sloboda and Schildhaus 2002). It has been shown that evidence-based programmes and practices take time to develop and mature. Some researchers have suggested that implementation of even the most successful interventions rarely exceeds 1 % of the target populations (Ginexi and Hilton 2006). Others have found that it takes at least a year for a new programme to be imbedded into an organisation (Bradley et al. 2004; Orwin 2000). The Institute of Medicine estimated that it may require about 17 years for a new technology to make its way into widespread clinical use in medicine (Chaffin and Friedrich 2004). Although the Institute of Medicine was referring to the field of medicine, the timeframe estimated for a substance abuse treatment organisation to adopt a new programme or practice needs to go well beyond a few months of training that may often be considered sufficient by implementers to transfer a new intervention into practice (Amodeo et al. 2006).

Why are frontline workers in the field of addiction treatment so slow to implement evidence-based practice? Qualitative research on the topic provides some clues. In a recent study from the Center for Addictions Research and Services of the Boston University School of Social Work, Amodeo et al. (2011) carried out 172 qualitative interviews of frontline addiction workers from community-based organisations that had received funding from the Center for Substance Abuse Treatment (CSAT)/SAMHSA to implement EBPs. She focused on four common EBPs in the substance abuse treatment field. Two were individually oriented approaches: *Motivational Interviewing* (*MI*), a brief approach that targets and builds on client motivation to change; and *Cognitive-Behavioural Therapy* (*CBT*), a theoretical approach that uses a variety of present-focused techniques to identify and modify triggers for substance abuse, especially clients' thought patterns, and to reinforce sobriety-related activities

The other interventions focused on the broader environmental level. These were: (1) *Adolescent Community Reinforcement Approach* (*A-CRA*), a behavioural approach that aims to replace reinforcers for substance abuse with environmental contingencies (particularly those applied by family members) that are supportive of recovery, (2) *Assertive Community Treatment* (*ACT*), a team treatment approach that delivers comprehensive, individually tailored case management services for clients who suffer both from severe mental illness, as well as substance-use disorders.

The authors of this study found that different barriers to implementation accompanied each type of EBP. Firstly, some evidence-based practices were perceived as burdensome in order to practice. Secondly, some practitioners complained of not receiving sufficient training in order to implement the model well. Thirdly, some practitioners felt there was a conflict between the approach of the EBP and their own philosophy, or the philosophy of the organisation they worked for. Thirdly, practitioners felt that the EBP was inflexible in meeting client needs. Fourthly, necessary resources were not always provided to implement the EBP.

This study identified specific, real-world barriers that have to do with the difficulty of implementing evidence-based practice in community-based agencies through qualitative

research. Those responsible for promoting evidence-based/informed practice and for executing it need to be aware of barriers to implementation and find ways to dispel them. Qualitative research has an important role to play in this.

12.8 Direction and Recommendations for Future Research, Policy and Practice in Defined Evidence-Based Addictions Interventions

Qualitative research has added to our understanding of issues in the field of addictions, especially from the perspectives of users and our awareness of how wider social, historical, or economic forces shape the everyday realities lived by drug and alcohol users. It has made major contributions to the addictions field as regards research for, or in, drug consumption and distribution, and strategies and interventions to tackle drug and alcohol use and misuse. In contrast, quantitative research can provide data to describe the illicit drug market, but is less amenable to answer questions of "how" and "why", the raison d'etre of qualitative research. However, more important than this, qualitative research in addictions provides insight into the nature of evidence, knowledge production, and ideology in field.

Based on the discussions presented in this chapter, a number of recommendations for future research, policy and practice in defined evidence-based addictions interventions can be proposed. Firstly, if practitioners are expected to utilise evidence-based interventions, then it should be accepted that addiction journal publishing should not contribute to the marginalisation of qualitative research for, or on, addiction. Secondly, the qualitative researchers in the addictions cannot, and should not, have to suppress their attachment to theory, camouflage their epistemological stance, or diminish the intellectual content of their analyses. Thirdly, policy makers, researchers and practitioners in the addiction field should recognise the key role of qualitative research, through theoretically informed, systematic and grounded analyses, in exploring and demonstrating how particular knowledge production, practice, and subjectivity come to be taken as *real*. Fourthly, cross-disciplinary and transdisciplinary approaches to knowledge production aim to synthesise and integrate different disciplinary approaches leading to new methods or new concepts and ideas and attempt to go beyond the use of multiple approaches to transcend disciplinary boundaries in search of new knowledge. Nonetheless, the integrity of qualitative approaches is also important. Fifthly, evaluation of implementation of evidence based/informed interventions in addictions should include qualitative research and this research should be part of explicit strategies to address barriers to implementation.

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