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APPENDIX

Full data from pilot study

The pilot ran from January to October 2013 and involved 11 TRP seminars; 9 seminars for community clients.

2 of the CDT clients were already abstinent but were concerned that they would relapse.

Clients

Age range 22-55

20 male, 2 female

Primary drugs: heroin, crack cocaine, cocaine, alcohol, cannabis or ketamine

Secondary drugs: crack cocaine, cocaine, alcohol, cannabis or benzodiazepines

Range of housing from homeless and 'sleeping rough', 'sofa surfing', living with parents/family, rented or owned accommodation

Length of treatment ranged from having just started treatment to up to 7 years (some continuous and some in and out of treatment)

Education varied from no or very little formal education to university degrees

Employment data varied from having never worked to currently working full time

The only criteria for being accepted to train in TRP was the willingness to do something different.

Data collected

All had Treatment Outcomes Profile (TOP) forms completed every 12 weeks. In addition subjective data was collected from the clients through discussions and follow up conversations and focus groups.

Data was also collected with regards to employment status, drugs of choice and change in usage patterns.

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Prior to attending TRP the drug of choice for clients was:

n=22	Pre TRP
Methadone	5
Buprenorphine	1
Heroin	3
Cannabis, cocaine and alcohol	9
Ketamine	2
Abstinent	2
Totals	22

Table 1: community clients' drugs of choice

Results

Out of 20 clients using, the TOP forms showed that 55% had reduced and 35% had stopped their drug/alcohol use (90% in total) and improved scores on their psychological and physical health and also their overall quality of life.

The clients' outcomes following TRP were:

Clients n=22	Reduced use	Abstinent	Unknown
Using pre TRP n=20	11	7	2
Abstinent pre TRP n=2		2	

Table 2: TRP clients' outcomes after TRP

Changes identified following TRP:

	Made no change in usage	Made change in usage	Remained abstinent	Unknown
Numbers	0	18	2	2

Table 3: TRP clients' changes made in drug usage following TRP

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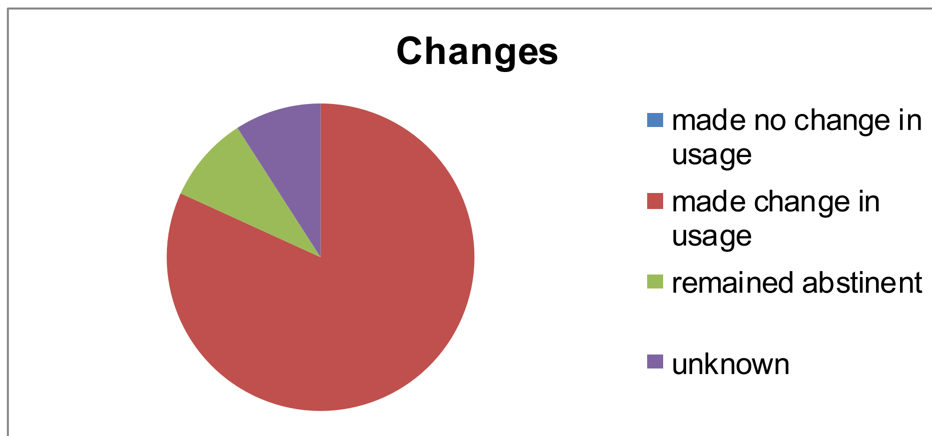

Figure 3: TRP clients' changes made in drug usage following TRP

Change in drug usage was identified by all except the 2 participants that remained abstinent. The change identified was either reduction of the usage of the participants' drug of choice or abstinence from using.

By drug this was:

N=22	Pre TRP	Reduced after TRP	Abstinent after TRP	Unknown after TRP
Methadone	5	3	1	1
Buprenorphine	1	1	0	0
Heroin	3	1	2	0
Cannabis, cocaine and alcohol	9	5	4	0
Ketamine	2	1	0	1
Abstinent	2	0	2	0
Totals	22	11	9	2

Table 4: clients by drug of choice

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Employment data from the clients:

Occupation	Pre TRP	Post TRP
Unemployed	19	6
Working full time	3	6
Working part time	0	4
At college	0	3
Volunteering	0	1
Unknown	0	1
Actively looking for work	0	1

Table 5: employment data before and after TRP

1 client that took up a part time job after TRP also started a college course and undertook volunteering (his college course and volunteering are not reflected in these figures).

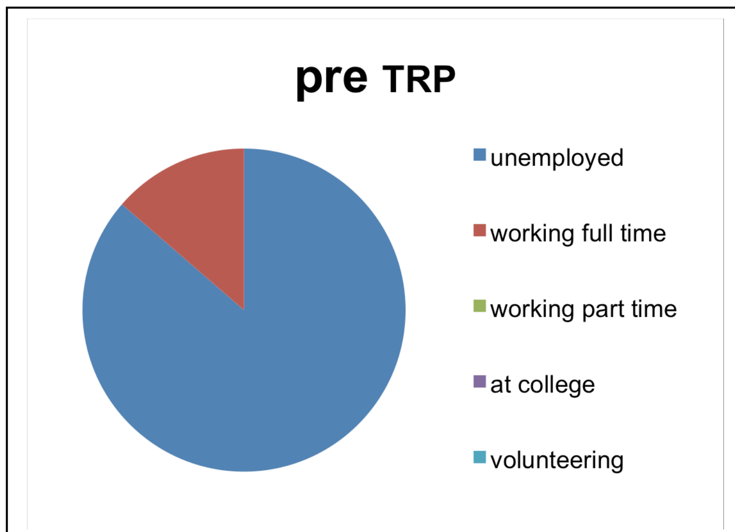

Figure 4: employment status pre TRP

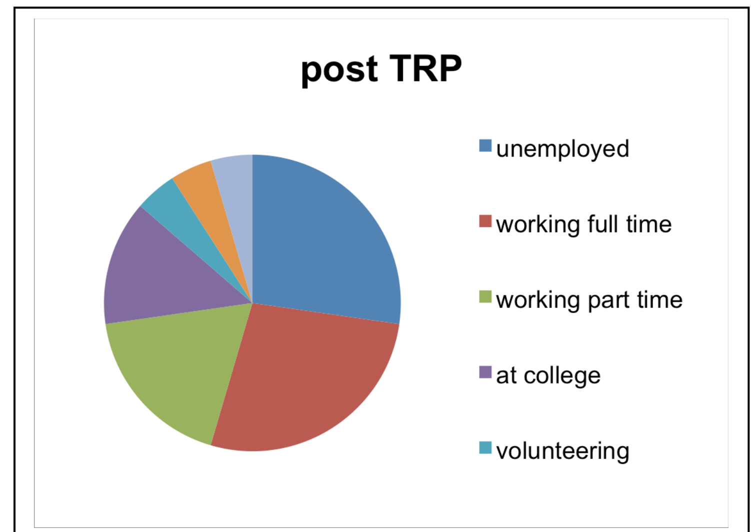

Figure 5: employment status after TRP

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During the follow up sessions the clients reported additional benefits of taking TRP:

More self-esteem

Calmer

More confident

Better relationships

Back to work or starting work

Starting college

Housing situation improved

Excited about the future

Sleeping better

Increased motivation

Improved physical health

Increased energy

Summary

All the clients that took TRP and were followed up made changes in their drug usage and in their lives. The vast majority sought and gained employment, enrolled as students or took on volunteering positions; they also reported positive changes in their interpersonal relationships and self-esteem levels.

These kinds of changes are relatively rare in drug treatment, and especially over such a short time frame of intervention. However they demonstrate the intention of TRP well: that through teaching self-empowerment strategies that are effective, simple to apply and help rebuild internal and external recovery capital, sustainable change in drug usage is possible and deliverable.