ITERATIVE CATEGORIZATION (IC): A SYSTEMATIC TECHNIQUE FOR ANALYSING QUALITATIVE DATA

Jo Neale

Professor of Addictions Qualitative Research

National Addiction Centre

Institute of Psychiatry, Psychology & Neuroscience (IoPPN)

King's College London (KCL), UK

November 2017

Iterative categorization (IC): a systematic technique for analysing qualitative data

Joanne Neale[1,2]

Reader in Qualitative and Mixed Methods Research, National Addiction Centre, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK[1] and Conjoint Professor, Centre for Social Research in Health, University of New South Wales, Sydney, Australia[2]

ABSTRACT

The processes of analysing qualitative data, particularly the stage between coding and publication, are often vague and/or poorly explained within addiction science and research more broadly. A simple but rigorous and transparent technique for analysing qualitative textual data, developed within the field of addiction, is described. The technique, iterative categorization (IC), is suitable for use with inductive and deductive codes and can support a range of common analytical approaches, e.g. thematic analysis, Framework, constant comparison, analytical induction, content analysis, conversational analysis, discourse analysis, interpretative phenomenological analysis and narrative analysis. Once the data have been coded, the only software required is a standard word processing package. Worked examples are provided.

Keywords   Coding, inductive analysis, iterative categorization, qualitative data analysis, qualitative research, research methods.

Correspondence to: Joanne Neale, Reader in Qualitative and Mixed Methods Research, National Addiction Centre, Institute of Psychiatry, Psychology and Neuroscience, King's College London, 4 Windsor Walk, London SE5 8BB, UK. E-mail: joanne.neale@kcl.ac.uk

Workshop outline

- Part 1 (presentation):
    1. Some general reflections on analysing qualitative data
    2. Coding and analysing qualitative textual data using Iterative Categorization (IC)
    3. Tips on publishing qualitative research
- Part 2 (live experiment):
    1. Analysing our own data

PART 1:

Some general reflections on analysing qualitative data

Common analytical approaches

- Techniques include:
  - Thematic analysis; Constant Comparative Method; Analytic Induction; IPA; Narrative Analysis; Grounded Theory; Content Analysis; Conversation Analysis; Framework; Discourse Analysis
- Common key processes of analysis include:
  - Identifying important phrases, patterns & themes
  - Isolating emergent patterns, commonalities & differences
  - Looking for consistencies in the data
  - Testing those consistencies against a formalised body of knowledge:
    - e.g. existing literature, policies, practices, concepts, constructs, theories

Concepts, constructs & theories

| Psychological	Sociological
Dependence, health belief model, theory of planned behaviour, theory of reasoned action, PRIME theory, attachment, attribution, cognitive dissonance, desensitzation, discounting, self-actualization, motivation, affordance, Maslow's hierarchy of needs, emotional intelligence, dissociation, cravings, actor network theory, identity, habituation, behaviour change techniques, nudging, gateway theory, maturation, risk, anxiety, trait, state, conformity, diffusion	Feminist theory, symbolic interactionism, identity, impression management, habitus, power, presentation of self, role conflict, role strain, structural violence, stigma, structure, agency, structuration, social capital, recovery capital, normalisation, downward comparision, othering, embodiment, trust, postmodernism, post-structuralism, retreatism, career models, deviance, subjectivity, intersectionality, discourse, performativity, pleasure

What is the problem?

- Long tradition of qualitative research within the Addictions, but…
  - Qualitative papers account for only a minority of addiction journal output
  - The proportion of qualitative research published in any given addiction journal seems to be inversely proportional to that journal's Impact Factor

  - Rhodes T., Stimson G. V., Moore D., Bourgois P. (2010) Qualitative social research in addictions publishing: creating an enabling journal environment. *International Journal of Drug Policy*, 21: 441-4.

An open letter to the BMJ editors on qualitative research

- **Seventy six senior academics from 11 countries invite *The BMJ*'s editors to reconsider their policy of rejecting qualitative research on the grounds of low priority. They challenge the journal to develop a proactive, scholarly, and pluralist approach to research that aligns with its stated mission**

- We are concerned that *The BMJ* seems to have developed a policy of rejecting qualitative research on the grounds that such studies are "low priority", "unlikely to be highly cited", "lacking practical value", or "not of interest to our readers". Here, we argue that *The BMJ* should develop and publish a formal policy on qualitative and mixed method research and that this should include appropriate and explicit criteria for judging the relevance of submissions. We acknowledge that (as with all methods) some qualitative research is poor quality, badly written, inaccessible, or irrelevant to the journal's readership. We also acknowledge that many of *The BMJ*'s readers (not to mention its reviewers and editors) may not have been formally trained to read, conduct, or evaluate qualitative studies. We see these caveats as opportunities not threats.

- Greenhalgh et al. (2016) An open letter to The BMJ editors on qualitative research. *BMJ*, 352: i563.
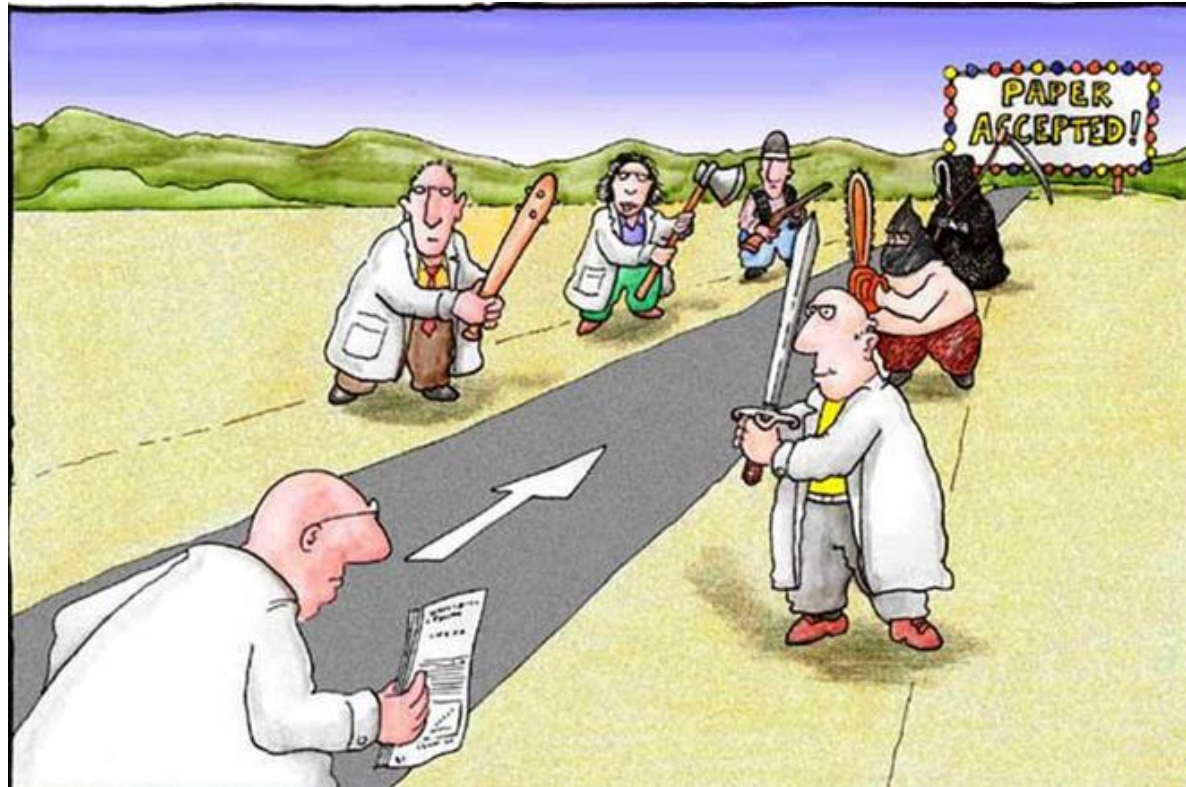
Ten misconceptions about qualitative analyses

1. It is simple, quick & easy to do
2. It requires no particular training or expertise; you just need a software programme
3. Double coding with a co-researcher increases the validity of your findings
4. Findings 'emerge' from the data
5. If findings don't 'emerge', report a few themes
6. If you can't find any themes, add a reference to 'grounded theory' or 'IPA'
7. If team members see different things in the data, just resolve your differences by discussion
8. Reporting numbers and percentages increases the validity of your findings
9. Never report numbers or percentages because it's qualitative
10. Use lots (and lots AND LOTS) of quotations

Characteristics of 'good' quantitative analyses

- Validity
- Reliability
- Falsifiability
- Generalizability
- Replication

- And a qualitative researcher's response…

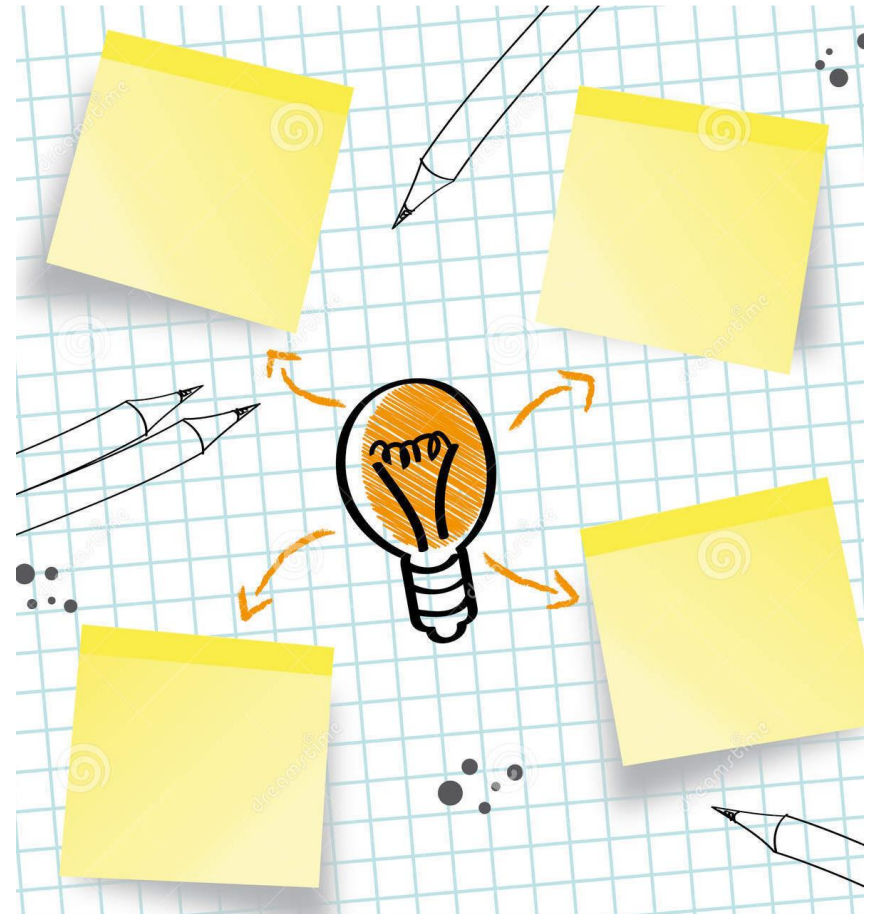# Characteristics of 'good' qualitative analyses

- Reflective
- Creative
- Transparent
- Rigorous
- Systematic
- Transferable
- Recognisable

- More than description

More than description…

- Identify themes, patterns, consistencies and inconsistencies in the data
- Link findings to concepts, constructs, theory, policy, practice or previous research/ literature
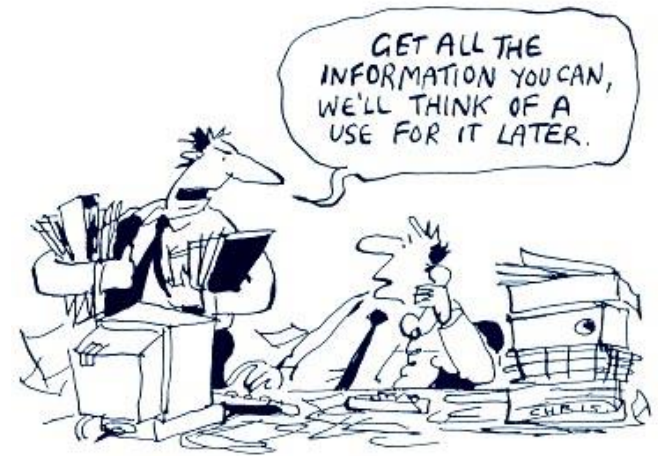
PART 2:

Iterative Categorization (IC) explained

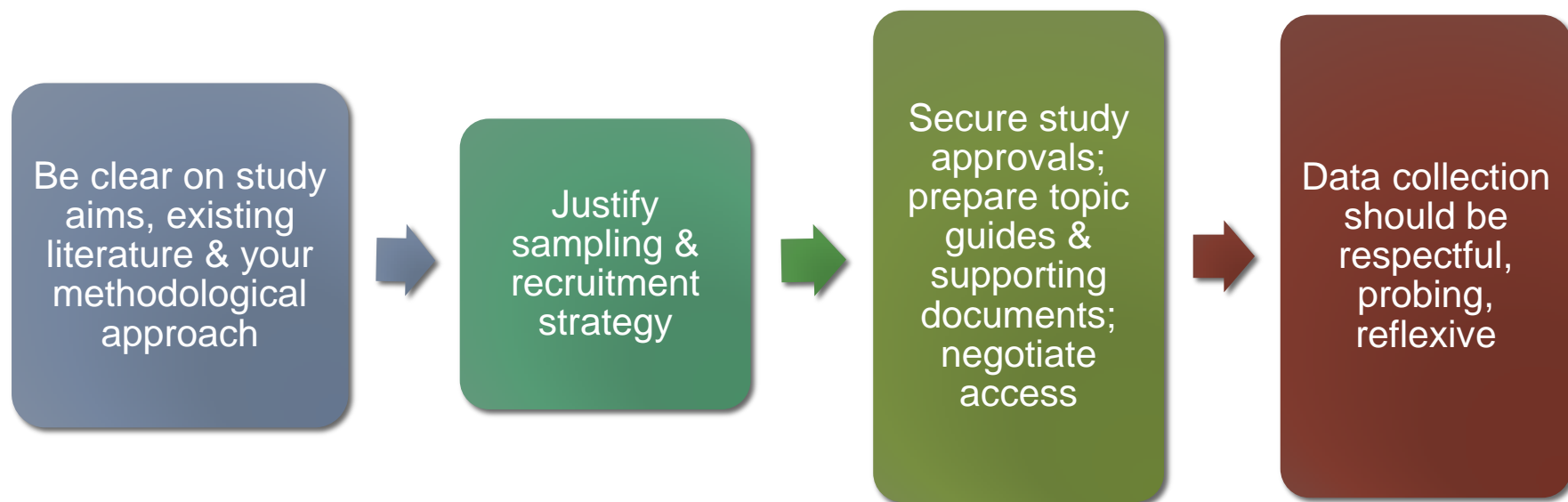# What is Iterative Categorization (IC)?

- A systematic technique to 'assist with' qualitative data analysis:
  - has been developed within Addiction science
  - is compatible with, and can support, common qualitative analytical approaches
  - provides a set of standardized procedures to guide researchers through qualitative data analysis to publication
- But it
  - is not the only technique
  - is not necessarily the best technique
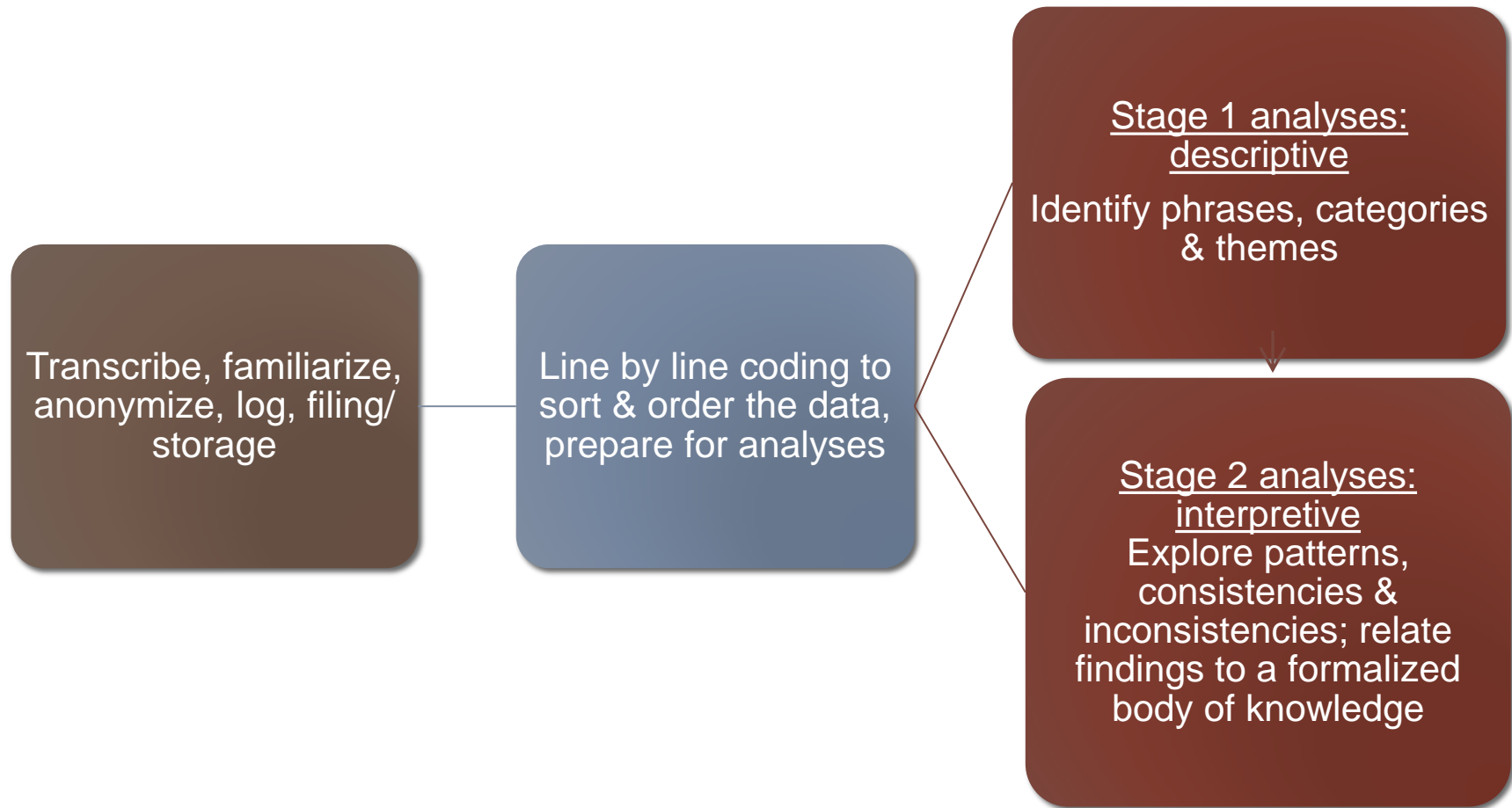 - is not meant to be prescriptive

IC assumptions

- The study for which the data are being analysed has clear aims and objectives (or an appropriate research question)
- Any interview or observation guides used for data generation were informed by both those aims/objectives and the relevant literature
- The data will be analysed thoroughly & systematically
- The researcher is willing to be open and transparent so others can see how they have handled and analysed their data

Good practice in data collection

Be clear on study aims, existing literature & your methodological approach

→

Justify sampling & recruitment strategy

→

Secure study approvals; prepare topic guides & supporting documents; negotiate access

→

Data collection should be respectful, probing, reflexive

Good practice in data handling & analyses

Transcribe, familiarize, anonymize, log, filing/ storage

Line by line coding to sort & order the data, prepare for analyses

Stage 1 analyses: descriptive
Identify phrases, categories & themes

Stage 2 analyses: interpretive
Explore patterns, consistencies & inconsistencies; relate findings to a formalized body of knowledge

IC Stages

1. Transcription (& collation of any other textual data)
2. Familiarisation
3. Anonymisation
4. Logging & filing/ storage
5. Data coding
6. Preparation for analyses
7. Descriptive analyses
   - identify important phrases, categories & themes
8. Interpretative analyses
   - isolate emergent patterns, commonalities & differences
   - explain consistencies/ inconsistencies
   - relate any consistencies/ inconsistencies to a formalised body of knowledge

1. Transcription & collation of other textual data

- **FIELDNOTES.......**

- **Interviewer:** So to start off, would you be able to tell me a bit about your use, about your drug use and um…a bit about your life in general?
- **Participant:** Uh…where do you want me to start?
- **Interviewer:** From the beginning if you like.
- **Participant:** I started using drugs like…I started smoking cannabis when I was thirteen and I gradually moved on to heavier drugs with the crowd I used to hang around with.
- **Interviewer:** Yeah.
- **Participant**: I jut got deeper and deeper into it. I tried to get help but the only way I got off it is going to prison.
- **Interviewer:** Right.
- **Participant:** I tried to get maintained and things like that and you have got to wait like six or seven weeks, you have still got to be using until you get maintained. I don't want to keep using. I have been trying to stop for ages. I have been taking drugs for…like I have just said since I was thirteen years old.

2 - 4. Familiarisation; Anonymisation; Logging & storage

- Read & re-read transcriptions & textual material/ listen to audio recordings
- Each document to be coded needs a meaningful identifier (ID)
- Ensure there is a secure system of logging and storing study documents

IDENTIFIERS
01afi
01afii
01afiii
02bfi
03cmii
04cfi
05amii
06bfiii

5. Coding

- Code (index) the transcribed data, usually with a software package (e.g. Nvivo, Atlas/ti, MAXQDA)
- 4 common stages
  1. Upload interview transcripts
  2. Devise coding frame (coding tree), with on-going refinements
  3. Tag (index) interview text segments to codes
  4. Retrieve text segments/ output/ codings

Coding

Coding

- Coding is primarily to sort & order the data systematically
- IC favours relatively substantive codes grouped under general headings
- Begin with deductive codes (derived from any instruments used for data generation)
- Supplement deductive codes with more inductive ('in vivo') codes
- Data should be coded comprehensively

6. Prepare for analyses

- Export the coded data from the specialist qualitative software into Word files
- Establish a good electronic filing system so that files relating to the same code are stored together

Enablers codings

Enablers analyses

Enablers folder

7. Descriptive analyses

- Systematic line-by-line 'inductive' analyses
  - Split screen with coding extracts at the bottom & blank space at the top
  - Read the coding extracts at the bottom, summarise the key points made at the top (include participant ID), then delete the extract
  - Each new point should be written on a new line, with the participant ID
  - If another participant repeats an existing point, add their ID and any supplementary details
  - Periodically, review and rationalise points at the top of the screen, grouping similar points together
  - Once all coding extracts have been deleted, all points should be reviewed, rationalised and re-grouped to generate a logical order or emerging narrative
  - Summarize the findings from each analysis file in a new 'summary' document

Text: C01
Code: 07. Enablers
So what's encouraged you in the past to not use on top of your script?
Just, erm, a matter of getting me family back. I mean I lost all me family and just a different circle of friends I wanted back. Like when I stop using, I've a different circle of friends have accepted me again, you know, like I used to knock about with. And me family and things have accepted me again and it's, do you know what I mean, it feels good, it's felt good. So I kept it going and then either I've gone to prison and got out and started again or I've just messed up through me own doing or through it being there all time or mainly it's having to live somewhere 'cos I've got nowhere to live, having to stop somewhere where there's smack everywhere.

Text: C01
Code: 07. Enablers
Right so they fast tracked you for a script because you tried…
I tried committing suicide.

Text: C01
Code: 07. Enablers

ENABLERS ANALYSES

Desire to get family back (C01)
Desire to get friends back (has a different circle of friends when not using, C01)
Being accepted by others again (feels good and is re-inforcing, C01)
Having somewhere to live (i.e. not being surrounded by smack all the time, C01)
Was fast-tracked into treatment because tried to commit suicide (C01)

Text: **C01**
Code: 07. Enablers
So what's encouraged you in the past to not use on top of your script?
Just, erm, a matter of getting me family back. I mean I lost all me family and just a different circle of friends I wanted back. Like when I stop using, I've a different circle of friends have accepted me again, you know, like I used to knock about with. And me family and things have accepted me again and it's, do you know what I mean, it feels good, it's felt good. So I kept it going and then either I've gone to prison and got out and started again or I've just messed up through me own doing or through it being there all time or mainly it's having to live somewhere 'cos I've got nowhere to live, having to stop somewhere where there's smack everywhere.

Text: **C01**
Code: 07. Enablers
Right so they fast tracked you for a script because you tried…
I tried committing suicide.

ENABLERS ANALYSES

PEOPLE

Family/friends/neighbours who provide practical and emotional support [family can help you stay drug free, give you money for drugs to save you committing crime, C01; went to stay with mum so was able to come off amphetamine as mum helped with looking after the children, C01; you can borrow money from family so you don't have to steal, her neighbour (whose mother had been a heroin user) helped her to come off heroin by being with her, talking to her, making sure she had something to eat, C10; mum phoned the agency to get an appoint, C04; friends who are users tell you about services that you didn't know existed, C10; parents have helped out a lot, C13; brother is helping with everything, neighbour helps by cooking and caring, C16; mother gives money and phones up the drug agency, C19; gets counseling off mother, mother reads leaflets and books and passes on information, mother is proud and encouraging for getting on methadone, C22; mother them took to drug service, and got them to register with mum's doctor, mum drives around, takes to appointments etc, K01; being with family helps prevent use, K03; wife & mum persuaded him to 'get on with it', K06; mother helped with taking take-home methadone – because going to the pharmacy daily was too far and too expensive, family helped sort out methadone after lost leg and mum died, K08; partner provides support as knows what he's going through due to own use, K13; mother helped come off, you can't do anything without family, K14; support from mother at home, mother or partner will take them to appointments, or would talk to grandmother, K17; needs partner to accompany them to town to pick up methadone, K18; mum will buy clothes or food but not give them money in case spends on drugs, mum trying to help find a flat, mum is now willing to put up a bond, K21; mum pushed the surgeon to operate on him despite only 20% chance of survival, K22; getting help so will have better contact with family and get children from care, L01; husband helps her get up on a morning, L02; previously didn't have anyone to accompany to medical appointments so didn't go as needed support, but now dad is going along, L04; wants to prove to mum can stay off drugs, wants to get mum's trust back, used to scrounge off mum for money for drugs but mother does not give now, needs to be someone younger brother and sister can look up to, being on methadone with friend offers mutual support and helps them both stay away from drugs,L05; family support is very important, L09; family has given money, scored drugs for them, looked after them when poorly, is looking after son now, family show tough love which is part of the incentive, but mother is there at the end of the day, L10; father taxis them about everywhere due to mobility problems, L13; family put them in touch with counselor, L15; trying to come off drugs with girlfriend and friend together, L18; getting lots of help now from partner, cousin told them where to get clean needles, L19; cousin helps because speaks English, L20; need to come off drugs with partner, they need each other, L23]

Having a good drug worker or workers [knowing the staff at an agency, staff being flexible and working with you, staff being ex-users making it easier to bond with them, C03; worker who helped build confidence up, K23; who fights her corner & attends appointments with her, gets things done, and stops her mouthing off, and with whom she feels comfortable and can talk, L02; ex-users who understand, L03; went to hospital appoints, L04; understanding worker, esp ex-users, L08; ex-users understand and you can relate to them, L09; ex-users as staff, L15; having a drug worker who was there all the time, could see at any time, would visit the house, phone everyday, proper help, L17; upfront and honest, L18; ex-users have a better insight, but some can look down at you, L22; needle exchange staff are nice, friendly, approachable, can talk to them, has been going there for years, get a key worker, help with accommodation, and methadone, L27]

A good doctor [who's helped out over the years, C01; who prescribed something to help her sleep, C10; who listens to you, K04]

A carer [neighbour was *de facto* carer, C16; who took him to the drug agency by car to sort out methadone, got self off streets, act as a witness for methadone, L07]

Being away from other drug users [C01; in a rehab, living in a new area, C03]
A helpful pharmacist [K10]
Support from a non-drug agency [dial – a service for sight impaired, C16]

PERSONAL CIRCUMSTANCES

Children [having a son, K14; having a baby makes you want help more, K11; wants children back from care or at least to see them at weekends, L01; doesn't want to die – has son, L10; having children (and girlfriend) is keeping him going & out of prison, L18; sick of never having any money to spend on the children, L19; did a methadone detox when found was pregnant with daughter, L28]

Having transport [a car to get to DIP, C03; access to mum's car, K01; mother or partner who will take them to appointments, K17]

Bereavements [mother died so got back onto a prescription despite 'double scripting', K08; of friends, wants to sort self, K14; not coping at all with death of girlfriend so needs help, L01]

Mother is very unwell [so staff more inclined to help, C19]

Attempted suicide [fast-tracked for treatment, C01]
Losing leg [got back onto a prescription despite 'double scripting', K08]
Going abroad [to Bangladesh to 'do rattle', K15]
Being a vulnerable female [young, female, domestic violence, C03; with children would make you priority for a house, K21]
Being caught up with the CJ system [lucky to have charges as quick access to a script, C01; being in prison helped although wouldn't want to go back because of family, L18]
Having a house [C10; a house would help to get life sorted, L01]

EMOTIONAL CIRCUMSTANCES

Confidence [won't go for job because of state of teeth, having daughter and getting married and help from a nurse persuaded to sort teeth, now can sort job, K12; drug worker helped build confidence up, K23]
Not feeling inadequate [or different, C09]
Getting over depression [K10]
Having something to work towards [K23]
Embarrassment or shame [incentive to get help, L11]

DRUG USE-RELATED

Wanting to be drug free [C03; can't go on taking heroin forever, C21; be able to drive again, stop shoplifting, K07; realising there are other possibilities, K23; whether or not you would be put off going to a service depends on how badly you want to be drug free, L08; had enough of using, fear of dying, L10; no buzz left, need heroin to feel normal, L22]
Deteriorating health [injecting getting worse, sites getting bad and started injecting into the groin, afraid of losing a leg, C03; needed a dentist, K12; no veins, what if had an accident, can't carry on like this, K23]
Having the will power [C03, C04]
Knows need help [and has heard from mates can get help, L05]
Keeping a paper diary of use [K03]

AGENCY - ORGANISATIONAL

Shorter waiting times [getting people straight onto 'a script', C01; waiting is wasted time, you should be able to prescribe something straight away to help people, C06; you need the medication, C10; for medication, L09; L17]
Being treated alongside a drug-using partner [C09; never really had a problem, they've always been able to see the doctor together, L23]
Local services [so don't have to travel, C09; local needle exchange, L04]
Someone kept ringing up to see how they were doing and would take them to appointments and help them to fill out forms [K16]
Depends whether the agency like the look of you [K01]
Being given another chance [if you fail a urine test, C03]
Knowing a particular agency [knowing the staff and not wanting to know other drug users, C03]
A rehab with choices and medication [K16]
A rehab that takes children [K11]
Employers being flexible to allow pick ups from chemist [L05]
Supervised daily pick up [is safer, stops you taking it all at once if having a bad day and overdosing, L27]
Private place to take methadone [L27]

AGENCY - TYPES OF SERVICE

Help with various issues [accommodation, methadone, L27]
Getting methadone [C21; K11]
Getting diazepam [K23]
Having blockers set up for when came out of prison [L18]
Being able to get a naltrexone implant [so could stop thinking about drugs, C04]
Complementary therapies [acupuncture etc, C06]
Knowing that 'the script' is going to be stopped at some point [an incentive not to use on top, K11]
Help with transport [bus passes so don't have to pay for travel to agencies, C09; help with transport, L09]
House visits [as pregnant and had a new baby, L19]
Activities to take your mind off drugs [including help in finding work, C09; gym, cinema, swimming, K11; to replace drugs, L22]
Information [leaflets to explain things, L04; more information and leaflets about what help/ services are available, L09]
English language courses [for non-english speakers, L21]

Rationale for the analyses

Participants identified a range of factors that they felt had helped, or would help, them to address their drug problem and/ or seek treatment. These factors are, in many respects, the opposite of treatment barriers, i.e. it is the absence of these factors that potentially constitutes barriers to help-seeking. That said, it seemed likely that asking a slightly different question – "What kinds of things have made it possible/ helped you to get treatment?" rather than "What kinds of things have made it difficult for you to get help?" – might generate some new insights whilst potentially confirming the barriers identified elsewhere in the dataset.

Findings

People

By far, the most important 'enabler' of addressing a drug problem/ seeking treatment was the informal practical and emotional support provided by family (and to a lesser extent friends and neighbours) – identified by about 30 participants. Overwhelmingly, the major source of support was mothers, but partners, siblings, fathers, grandparents, drug-using friends, non-drug using friends, and neighbours were also discussed. The kinds of support provided by family members were diverse but included:

- *Emotional:* talking/ listening/ counselling/ being with them/ encouragement &
- *Practical:* phoning agencies and sorting out appointments (including providing language support for the non-english speaker); transport to agencies and appointments; giving money (including for drugs so that crime does not have to be committed); providing somewhere to live; providing somewhere safe to stay whilst attempting to self-detox; providing food; child care, including fostering; and scoring drugs.

Some participants also reported that winning back the trust of family members or being a family member to be proud of/ looked up to (rather than ashamed of) was an important incentive for getting help/ addressing a drug problem.

The only examples of partners being identified as enablers were when couples wanted to be treated/ come off drugs together (although one woman talked about how she and her partner provided physical care for each other). Drug-using friends were mentioned in respect of providing information on what services are available locally and in terms of friends embarking upon treatment/ detoxification together as a form of mutual support. One individual felt that re-establishing contact with non-drug using friends was an important incentive to addressing his drug problem.

Drug workers were also often identified as making treatment seeking much easier. The kinds of factors that made drug workers especially helpful included:

- their personal characteristics (being nice, friendly, approachable, making you feel comfortable so you can talk, being understanding, being upfront and honest)
- their ex-user status (ex-users were often seen as easier to understand, relate to and bond with, and as having a better insight into the problems faced – although it was recognized that some can look down on you and a balance of ex-users and non-users within agencies is best)
- their method of working (being flexible, working with you, being always available to talk or pop in to see)
- their activities/ what they did for service users (fighting their corner; accompanying them to appointments; sorting out their problems; building up their confidence; visiting them at home; phoning them every day; and helping them with a range of issues, including accommodation and organizing prescribed drugs) and
- the length of time they had been known to the drug user (a number of participants reported long-standing good relationships with particular agency staff).

Interestingly, one participant drew attention to the converse of these points by pointing out that the extent to which you were helped by an agency would depend on whether or not the agency staff liked the look of you. In other words, establishing a good relationship with a particular staff member and reaping the benefits thereof was not something all service users could achieve.

Other individuals identified as enablers were 'good doctors' (who have helped out over the years; who have prescribed drugs to aid sleep; and who listen); a helpful pharmacist; and carers (in one case a neighbour who had become a *de facto* carer; in another case, an individual who had helped them off the street by providing

accommodation and helped to sort out a prescription). One individual also referred to the support they had received from a service for people with sight problems. Finally, two participants said that being away from other drug users, particularly living in a new area, was an important treatment enabler.

Personal circumstances & life events

In addition to reporting particular people as enablers, participants also stated that particular personal circumstances & life events had been instrumental in their decision to do something about their drug use and seek help. One of the most important of these was being a parent, and especially a new parent. Key aspects of being a parent that prompted individuals to address their drug problem were wanting to make sure children were not sent into care or getting children back from care; wanting to see more of their children; not wanting to leave a child 'orphaned'; and being tired of having no money to spend on children. Other life events that prompted help seeking were experiencing a bereavement, and usually not coping with that bereavement; a family illness; a suicide attempt; and losing a leg. All of these difficult events appeared to make drug agency staff more sympathetic, willing to help more quickly, and perhaps willing to forget about previous treatment lapses.

Other personal circumstances that facilitated help seeking included having transport so that they could more easily attend appointments (usually access to someone else's car or a family member willing to drive them); being a vulnerable individual (e.g. young, female, having children, experience of domestic violence) which made them more of a treatment priority; being caught up with the criminal justice system (which provided quicker access to a prescription); having a house, which gave some stability in terms of getting other aspects of life sorted; and in one case going abroad to stay with family in order to be able to detoxify away from drugs. A number of participants also reported that worsening physical health, particularly associated with injecting and fear of doing themselves irrevocable damage, had prompted them to do something constructive about their drug taking.

Relatedly, several participants explained how their emotional state of mind or well-being had been instrumental in their help-seeking. The most important of these was wanting to be drug free (being tired of using, fear of dying, needing drugs to feel normal, realizing that there are other things in life, wanting to drive again, wanting to stop shoplifting). In respect of this, a couple of participants highlighted the importance of having the willpower to stop using. Others stressed needing or having sufficient confidence to address their problems, not feeling embarrassed or ashamed of themselves, feeling less depressed, and having some goals/ purpose to work towards. One participant also discussed the value of keeping a paper diary of their drug use as a method of regulating consumption.

Agency/ service

Finally, many participants suggested particular services or aspects of service delivery that could encourage them into treatment. These included being able to obtain particular drugs (methadone; diazepam; blockers on release from prison; a naltrexone implant); particular types of rehabilitation services (that take children, that offer choices rather than regimentation and medication); information and leaflets about what help/ services are available; and a range of wrap-around services (including help with job-seeking), diversionary leisure activities, complementary therapies, and English language courses for non-english speakers.

Other aspects of service delivery that could encourage/ facilitate treatment uptake included short waiting times (especially for prescribed medication) and flexibility around service provision (being flexible with pick-ups from the pharmacy; employers being flexible to allow pick-ups from the pharmacy; being given a second chance if you lapse). Other factors relating to service delivery were only mentioned by one or two individuals, but included having local services so that travel is reduced; being given help with transport, such as bus passes to reduce the costs incurred; being offered home visits as it's difficult to get to the agency, especially with a new baby; being treated alongside a drug-using partner; having someone who would keep ringing up to see how they were doing, take them to appointments and help with form filling; and having a private place to take methadone. In addition, a few participants highlighted the benefits of more structured, inflexible aspects of service delivery, such as having supervised daily methadone to stop them from taking too much if they were having a bad day and knowing that a prescription would be time-limited to discourage using on top.

Enablers codings

Enablers analyses

Enablers summary

Enablers folder

8. Interpretive analyses

- Read all completed analyses and summary files to:
  - Identify themes that recur within and across the files
  - Explore whether themes can be categorized into higher order concepts, constructs or typologies
  - Assess the extent to which points, issues or themes apply to particular subgroups of study participants
  - Test specific hunches or theories about the data
  - Relate the findings to broader literature, theories, policies, practice

Writing up the findings

- After completing IC, the researcher will appreciate which summary file(s) may on their own, or in combination, form the basis of a journal article
- Summary documents can be linked to form the basis of a report or thesis
- Illustrative quotations can be selected from the codings, analyses or summary file

Aims	⟷	Topic guide	⟷	Codings	⟷	Analyses	⟷	Write up

Weaknesses and strengths of IC

- **Weaknesses:**
- Time consuming
- Requires the researcher's analytical skills and topic specific knowledge
- Not suited to studies with a very unstructured approach
- **Strengths:**
- Rigorous and transparent
- Provides a clear audit trail (with raw data, analyses and findings linked)
- Can demonstrate trustworthiness and potential repeatability of the analyses
- Is compatible with, and can support, most common analytical approaches
- Helps to move the findings beyond simple local description, demonstrating relevance to the wider world
- Pragmatic technique so others can develop and adapt it

Reference:

- Neale, J. (2016) Iterative categorisation (IC): a systematic technique for analysing qualitative data. *Addiction,* 111, 1096-1106.

PART 3:

Tips on publishing qualitative research

Tips for publishing qualitative research 1/4

- **Introduction**
  - Concisely refer to, and engage with, key relevant literature
  - Clearly specify the research question(s), aim(s), or objective(s)
  - Define any core concepts and specify any relevant theory or conceptual framework used

Tips for publishing qualitative research 2/4

- **Methods**
  - Describe and justify the dataset, including its size and any selection criteria
  - Report relevant contextual information on the setting and participants
  - Document the data collection processes
  - Provide brief details of any formal ethical approval granted and procedures for securing informed consent
  - Justify the analytic approach (e.g. Framework Analysis, Narrative Analysis, Content Analysis, Grounded Theory, Discourse Analysis, Interpretative Phenomenological Analysis etc.)
  - Describe the data coding process (including the use of any software, double coding, and whether codes were derived inductively or deductively)
  - Clarify how themes and concepts were identified from the data and whether any deviant or negative cases were explored

Tips for publishing qualitative research 3/4

- **Findings**
  - Anonymise people and places appropriately
  - Present quotations and fieldnotes within the main text
  - Present any quotations or fieldnotes in a way that enables the reader to assess the range of views expressed by the participants (e.g. give participants unique identifiers and provide basic demographic information, such as gender and age)
  - Do not use quotations as a substitution for analysis
  - Ensure distinctions between the data and the researchers' interpretation of the data are evident

- **Discussion & Conclusions**
  - Ensure consistency between the aims identified, data presented, the findings documented and the conclusions articulated
  - Relate findings to formal constructs, relevant theories, or broader policies, processes or treatment practices (i.e. ensure the findings extend beyond simple local description)
  - Ensure the manuscript conveys something original about processes, dynamics, concepts or phenomena that enhance understanding
  - Discuss any noteworthy limitations or idiosyncrasies in the research setting, data or methods that has (or could have) influenced its findings

Acknowledgements