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rehabilitation services in Ireland

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## **ACKNOWLEDGEMENTS**

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Gerry Mc Aleenan has been Head of Services in Soilse, the HSE daytime drug rehabilitation programme since 1992. He has expertise in organisational development and was instrumental in establishing the Soilse programme which innovatively took a holistic approach to drug recovery. He was also involved in setting up the first community drug team in Ireland and the first women's drugs rehabilitation project and the first youth drugs rehabilitation project in the country. He is an advocate of service users being fully involved in the services they receive. He has worked and built sustainable partnerships at an interagency level with local drug task forces, the community and voluntary sector, employment, education, training, housing and mental health services as well as at management, research, strategic and policy levels. Importantly, he is part of the HSE Dublin North Continuum which combines stabilisation, detoxification, residential and daytime programme provisions and supports. He has also been involved with European projects since the early 1990s on addiction, education and recovery themes. He is presently involved in a lifelong learning Grundtvig project which aims to develop knowledge on access to further education and learning opportunities for adults in addiction recovery, addressing issues of low educational attainment, employment and social integration.

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## **ABOUT SOILSE**

Soilse is the HSE daytime drug rehabilitation service. It supports people in recovery to move towards a drug-free lifestyle. The programme operates from two facilities. Henrietta Place is focused on preparation for detoxification. Green Street is for people who are recently drug free who wish to pursue a successful drug-free lifestyle. The programme is heavily experiential in addressing recovery and educational needs. Care planning around psycho-social needs underpins the learning process and is facilitated by key workers.

The model is eclectic (bio-psychosocial) with the emphasis on moving from dependence to independence, along a continuum of care. Essentially, Soilse is at the forefront of reorienting drug services and drug users into a recovery paradigm which is now emerging as the organisational construct for drug services in the US and UK.

Soilse was piloted in 1992 and following evaluation was mainstreamed in 1994. The overarching vision of Soilse is to break the spiral of addiction, dependency and social isolation and to motivate recovering drug users to realise their potential. Since its inception Soilse has established itself as a model of best practice and was recognised as such in the 1996 First Report of the Ministerial Task Force to Reduce Demand for Drugs. In 1994, Soilse represented Ireland as a Model of Excellence in the European Social Fund (ESF) Horizon conference in Barcelona. In 1999, the HYPHER magazine which was pioneered and published by participants in Soilse won an international award for innovation and design (1999). Soilse has always been dedicated to working with participants to improve their educational capital and assist them to enjoy the benefits of a full education. As part of this work, Soilse joined forces with the City of Dublin Vocational Educational Committee (CDVEC) in 2001 to establish a dedicated career guidance service. In recognition of its efforts to improve the educational opportunities for participants, in 2008 Soilse received the Dublin and region STAR award from Aontas, the Irish National Adult Learning Organisation, for both innovation in practice and teamwork in adult education (2008). Further recognition was bestowed on Soilse in 2009 when its Return to Learning project was selected as a finalist in the EBS/NALA Adult Continuing Education (ACE) Awards. The project supports recovering drug users in their progression to further education. Soilse's Career Guidance Service won the Dublin Regional STAR Award from Aontas and in 2011 Aontas again awarded Soilse the Dublin Regional STAR award for its Service User

Involvement initiative. In 2014 Soilse was a finalist in the Irish Healthcare Awards for the Rehabilitation Centre of the Year. Soilse is currently collaborating with international colleagues from the UK, Cyprus, Italy and Romania in a trans-European research project under the EU's Grundtvig Programme. The aim of this work with our European partners is to develop an evidence-based programme facilitating access to further adult education for people in recovery from addiction.

## Executive summary

Rehabilitation, or recovery as it more appropriately should be termed, has been the poor relation of Ireland's response to illicit drug use, particularly opiate addiction, where most of the resources have been directed over the past 20 years. This paper – *Addiction Recovery: A contagious paradigm!* – makes the case to correct this. The initiative grew out of Soilse's 20<sup>th</sup> anniversary symposium in the summer of 2012. There are three components to the paper: a review of the literature, a critique of Irish policy in relation to recovery/rehabilitation and the outputs of the Soilse symposium (workshops and personal narratives of people in recovery). The three components point in the same direction: it is time to prioritise recovery.

Addiction recovery is becoming the guiding principle for substance use treatment in a number of jurisdictions. The latest EU Action Plan on Drugs (2013-2016) calls on member states to implement recovery and social reintegration services as part of a wider demand reduction pillar. Policy on drugs in the USA is increasingly promoting recovery and recovery support services. A conceptual framework for promoting recovery and a detailed discussion of recovery principles is given in this paper.

A reading of Irish drug policy documents from the past 20 years demonstrates a strong and consistent advocacy for recovery which would lead one to wonder why there hasn't been more action. Non-implementation of policy is an area we can improve on. Coupling treatment and rehabilitation in our current strategy has been detrimental to recovery initiatives and now is the time to have a genuine fifth pillar – recovery – as part of Ireland's response to substance use. Stakeholder consultations as part of the development of previous strategies has shown wide support for the responses advocated by best international research and practice in the field of recovery.

There are increasing calls in the literature to draw on the experiences of people in recovery as a means of building effective policy and practice. This paper draws on the outputs of a symposium on recovery held in the North Inner City in the summer of 2012. Over 100 people attended the symposium, the vast majority living with or working in communities deeply stigmatized by opiate addiction. The four workshop themes were: recovery and research, clients and their recovery, recovery and services, and, finally, recovery and communities. The recommendations from the workshops, adopted in this paper, are grounded in experiences of people in recovery. The

symposium also heard detailed testimony from four individuals in recovery. The individuals highlighted what worked for them and what did not.

Chapter 8 of this paper charts a way forward. The recommendations are not radical: indeed, many are already policy but not practice. This paper is being published as a call to action to adopt recovery principles and practices in Ireland's substance use services.

## Chapter 1: Introduction

This report presents a case for the re-orientation of drug treatment to a recovery-focused paradigm. The impetus for this argument primarily arose from a symposium on addiction recovery undertaken by the Soilse Drug Rehabilitation programme in 2012. During this three-day event which included workshops and personal testimonies of numerous individuals in recovery from drug addiction, a consensus emerged from service providers and participants that there was a need to expand the discourse on drug treatment in Ireland to include and develop a greater understanding of what constitutes addiction recovery.

In addition to the outputs from this symposium, this report also highlights the current expansion in the international discourse on drug treatment which has become increasingly informed by the promotion of addiction recovery. For example, policy and practice in the USA and the UK are now promoting recovery as the central organising principle of treatment for drug dependence. This report will make a case for Ireland to proceed in a similar direction.

We also draw attention to the emerging body of evidence that is available on what constitutes recovery and what appears to be effective in initiating and sustaining recovery journeys. However, unlike identifying and evaluating the outcomes from compact interventions such as methadone or cognitive behaviour therapies, measuring and evaluating recovery is more complex and more work is needed to identify and establish reliable benchmarks.

Related to the complexity of measuring and evaluating recovery is the lack of consensus on what defines 'recovery'. To some, it is the pursuit of abstinence while for others it is about improving quality of life and removing the dependence on the primary drug of dependence. This report does not engage in this debate, rather it sets out what have become the agreed and accepted principles of recovery as the cornerstone of our argument. These principles reflect the findings from research and extensive consultations with key stakeholders and are the expressed desire from people in recovery for a life filled with hope, meaning and belonging.

The main objectives in compiling this report are to:

- contribute to and inform the on-going debate about the direction of drug treatment in Ireland;

- present the evidence for a re-orientation of policy and practice in Ireland towards a recovery-focused paradigm;
- reflect the views of people in recovery in Ireland; and
- present some ideas on how we might improve our services to achieve meaningful outcomes for people in recovery.

Chapter 2 describes the international trends in policy towards a recovery-focused approach and highlights the dimensions of policy in Ireland since the 1970s up to the present which have been a close fit to the recovery paradigm. Chapter 3 presents the key ideas that emerged from consultations with stakeholders in Ireland which demonstrate that there is a desire for a recovery-focused paradigm. Chapter 4 outlines the conceptual framework of recovery capital which is grounded in the philosophical tradition of social capital. Recovery capital can act as an anchoring concept for a recovery-focused treatment system where the assets of individuals are optimised.

Chapter 5, which is the cornerstone of this report, outlines the principles of recovery and illustrates how these principles are underpinned by an emerging body of research evidence. Where feasible, research undertaken in Ireland has been included to demonstrate how we might use our research to inform our promotion of recovery. Chapter 6 introduces the main outputs from the symposium workshops undertaken with Soilse participants in 2012 and Chapter 7 presents four personal narratives from Soilse participants on their experiences of recovery. Chapter 8 concludes by revisiting the main points in this report and outlines some recommendations for promoting and implementing recovery-orientated actions.

## Chapter 2: The policy context

This chapter will trace the development of drug policy in Ireland from 1971 to the present, with particular focus on the dimensions of policy which speak to the broader needs of people in treatment. These include housing, education, vocational training and employment which are key to the recovery aspirations and needs of people in treatment. In following these developments, we can see that the basic ideas around what individuals need to recover from dependence on drugs have been mentioned throughout the policy development process. However, to what extent these ideas have been acted on in an effective manner is open to debate.

The chapter will also review some of the key ideas of stakeholders on what constitutes recovery. These views have been put forward through public consultations, a mechanism that policy-makers have become increasingly reliant on in drawing up policy proposals to tackle social problems such as drug abuse. The expression of these ideas by stakeholders reflects the aspirations of people in recovery regarding how policy and practice can move towards meeting their needs in a holistic way.

Addiction recovery is becoming the guiding principle for substance use treatment in a number of jurisdictions. For example, Laudet and Humphreys (2013) document how policy on substance use in the USA is increasingly promoting recovery and recovery support services. Closer to home, current drug policies in England and Wales<sup>1</sup>, and Scotland<sup>2</sup>, have given recovery a prominent role.

Recently, the Council of the European Union (2013), under the presidency of Ireland, published the latest EU Action Plan on Drugs (2013-2016). This plan calls on member states to implement recovery and social re-integration services as part of a wider demand reduction pillar.

According to Pike (2012), the British-Irish Council (BIC) during its 17th summit meeting hosted by the Irish government in Dublin Castle, welcomed a discussion paper on recovery from problem drug use. Ministers discussed drug treatment measures and strategies that have been put in place in each administration to facilitate the path of recovery. The Council noted that a more ambitious approach was needed involving individual care plans and inter-agency working to better address the holistic needs of clients. The Council also noted the misuse of drugs workstream's commitment to include a renewed focus on recovery from drug dependence in any future drug strategies, with a view to maximizing the potential for individuals to access the social, economic and cultural benefits

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<sup>1</sup> Her Majesty's Government (2010)  
<sup>2</sup> Scottish Government (2008)

of life. Indeed, the sentiments expressed by the British-Irish Council are echoed in a number of drug policy pronouncements from the 1970s to the present.

*The Report of the Working Party on Drug Abuse* (1971) proposed a drug rehabilitation programme including measures to address accommodation, education, self-development and vocational guidance be put in place as part of the response to drug addiction. The 1991 Government Strategy to Prevent Drug Misuse (National Co-ordinating Committee on Drug Abuse, 1991) acknowledged that treatment programmes for drug misuse must be linked to the provision of adequate social and employment skills. The strategy noted the lack of co-ordination between drug treatment, rehabilitation and welfare services, and proposed to develop improved formal liaison between the relevant bodies. In particular, the strategy proposed that the Drug Treatment Centre Board (DTCB) play a major role in the social and occupational rehabilitation of drug misusers.

*The First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (1996) noted that the priority of the health service up to that time had been to provide access to treatment facilities for drug users. The report concluded that more emphasis should be placed on providing occupational and social skills training for recovering drug users. Following consultation with FÁS, the national agency charged with providing vocational training opportunities for unemployed people at the time, a policy statement was agreed with the following recommendations:

- priority status to be given to all Community Employment [CE] applications offering work experience/training for recovering addicts that are integrated with other support services;
- FÁS and the Local Employment Services to work closely and establish special links with the sponsors of CE projects providing opportunities for former drug addicts who are employment-ready, with a view to providing every assistance to the participants to progress to a mainstream job (p. 42).

The *National Drugs Strategy 2001–2008* noted the progress made on foot of these recommendations, in particular the action by FÁS to set aside 1,000 places for recovering drug users on the Special Drugs Community Employment Programme (Department of Tourism, Sport and Recreation, 2001). The strategy also pointed to the need for FÁS to work in partnership with employer organisations, trade unions and key government agencies to develop mechanisms to increase employment opportunities for former drug misusers. Of the 100 actions outlined in the National Drugs Strategy, three related directly to the provision of vocational rehabilitation measures.



The *Report of the Steering Group for the Mid-term Review of the National Drugs Strategy (2005)* recommended including rehabilitation as a fifth pillar of the strategy, as it was seen as a critical issue and was a recurring theme throughout the consultation stage (Steering Group for the Mid-term Review of the National Drugs Strategy, 2005). The strategy already included the four pillars of prevention, treatment, supply reduction and research. The view was expressed during the public consultation stage that drug users should not be kept on methadone indefinitely, but should be assisted in 'moving on' towards recovery and social re-integration.

The Steering Group noted the many different views and definitions of 'rehabilitation', ranging from therapeutic approaches on the one hand to training and social re-integration on the other. However, the group agreed that, in general, rehabilitation includes personal development, training, community integration, access to housing and employment. The mid-term review recommended that a working group be established to examine this area comprehensively and to develop an integrated rehabilitation policy as part of the National Drugs Strategy.

*The Report of the Working Group on Drugs Rehabilitation* was launched in June 2007 (Working Group on Drugs Rehabilitation, 2007). It set out the structural arrangements that were required to deliver on a number of key recommendations. The overall goal was to provide an integrated rehabilitation service to current, stabilised and former drug users. The Working Group recommended that the vocational training, employment, education and accommodation needs of recovering drug users be addressed as part of an overall rehabilitation policy.

In line with the recommendations outlined in the *Report of the Working Group on Drugs Rehabilitation*, a National Drugs Rehabilitation Framework was published (Doyle and Ivanovic, 2010). Approved by the National Drugs Rehabilitation Implementation Committee (NDRIC), the framework was constructed to enhance the provision of rehabilitation services to current and former drug users by creating integrated care pathways (ICPs) with the co-operation of different service providers.

It is recognised that service users may present with diverse needs, including treatment, education, vocational training, employment support and accommodation, and that no single agency can cater for all possible needs. It was proposed to develop an individual care plan for each service user, with the care plan being delivered by a multi-disciplinary team comprising the necessary range of disciplines and skills drawn from a variety of service providers. Where a service user has complex

and multi-faceted needs, a more intensive case management approach may be used. The recommendations in this report have been endorsed by successive governments and Action 32 of the National Drugs Strategy calls for implementation of the working group's recommendations. The current Programme for Government includes a commitment 'to assist drug users in rehabilitation...' (Fine Gael and the Labour Party, 2011:50).

Currently, there is a lack of information and data available on the implementation of the recommendations of the working party. However, data gleaned from available sources suggest that the challenge of getting people into employment remains complex. The *Report of the Working Group on Drugs Rehabilitation* recommends that measures to improve the employability of current, former and recovering drug users should form a key part of rehabilitation care plans, with the overall aim 'to maximise the quality of life, re-engagement in independent living and employability of the recovering problem drug user, in line with their aspirations' (p.21).

However, the most up-to-date report on the employment status of people presenting for treatment for drug misuse shows a steady trend downwards (Bellerose et al. 2011). There was a drop in the proportion of all cases in employment, from 22% in 2005 to 9% in 2010 (See Table 1). According to the authors, 'this is most likely a reflection of the current economic climate, and highlights the continued importance of social and occupational re-integration interventions as part of the drug treatment process' (p.2).

**Table 1: Number and percentage of treatment population in employment,**

	2005		2006		2007		2008		2005-2010 2009		2010	
	N	%	N	%	N	%	N	%	N	%	N	%
<b>All cases</b>	1025	(21.8)	1071	(21.0)	1059	(18.9)	921	(15.0)	689	(10.9)	670	(9.1)

Source: Bellerose *et al.* 2011

There was an even greater drop in the proportion of new cases (those presenting for treatment for the first time) who were in employment, from 29.7% in 2005 to 11.7% in 2010.

**Table 2: Number and percentage of treatment population in employment,**

	2005		2006		2007		2008		2005-2010 2009		2010	
	N	%	N	%	N	%	N	%	N	%	N	%
<b>New cases</b>	542	(29.7)	590	(28.0)	592	(25.6)	524	(20.8)	386	(13.9)	357	(11.7)

Source: (Bellerose *et al.* 2011)

A recent review of addiction services in North Dublin by Pilling and Hardy (2013) recommends that 'addiction services should be delivered around clinical care pathways for drugs and alcohol with a focus on recovery defined as...an individual, person-centred journey, enabling people to gain a sense of control over their own problems, the services they receive, and their lives and providing opportunities to participate in wider society' (p.6).

The definition of recovery cited by Pilling and Hardy derives from work by Strang (2011) who chaired an expert group in the UK on behalf of the National Treatment Agency for the purpose of designing guidelines on the role of opiate substitution therapy (OST) in a recovery-orientated treatment system. The definition of recovery employed by these authors is not wholly different from the definition of rehabilitation employed in Irish drug policy. The key properties of both include putting the person and their needs and aspirations at the centre, creating the conditions whereby the person in recovery derives some advantage from the services. For example, they become enabled and empowered to take control of their problems and the social distance they may have experienced from participating in mainstream society is reduced, for instance through employment, education and sustainable accommodation. These needs and aspirations on the part of people using addiction services are also reflected in the views of key stakeholders in the addiction sector in Ireland, which the next chapter will take up and develop.

## **Chapter 3: The views of stakeholders**

Public consultations with stakeholders in the substance misuse sector in Ireland have to some extent helped to shape drug policy. These include, in particular, consultations that took place prior to the national drugs strategy that was launched in 2001, consultations that arose during the mid-term review of that strategy and consultations that helped shape the final report from the working groups on drugs rehabilitation. These consultations were undertaken to document the views and experiences of stakeholders from the statutory, voluntary and community sectors regarding the nature of substance misuse and how best to respond. The purpose of this chapter is to show that the views expressed via these consultations are supportive of a recovery-orientated approach for people recovering from drug addiction.

When the first comprehensive national drugs strategy was being developed in 2001 public consultations took place with around 600 stakeholders through eight regional fora. In addition, 189 written submissions from individuals and organisations and 34 group presentations were received. An analysis of these submissions revealed that stakeholders were in favour of including a comprehensive range of drug treatment options in the strategy and promoting holistic patient care by access to a range of ancillary services. The continuum of care model was identified as the favoured approach to assisting people in treatment to eventually attain a drug-free lifestyle.

Some stakeholders were in favour of providing methadone as part of a range of treatment options as methadone was seen as effective in reducing some of the personal and social harms related to drug use. However, there was criticism from others that methadone maintenance provision kept people too close to the drug-using environments and did not encourage the pursuit of abstinence.

Stakeholders were also in favour of including community employment (CE) schemes to promote vocational training and some highlighted the need for extra residential treatment places and for aftercare facilities such as half-way houses. The final strategy which included 100 specific actions across the four pillars of prevention, treatment, supply reduction and research did reflect to some extent the views of stakeholders in providing for the implementation of measures that would assist people to recover from substance misuse.

The mid-term review of the national drug strategy occurred 4-5 years later. Public consultations included written submissions from individuals (n=18) and organisations (n=103), oral presentations (n=26) and five regional public fora with young people aged 12-20. By this stage, it appeared that stakeholders were thinking 'beyond treatment' and suggested ways to address the holistic needs of people in recovery. What distinguished these submissions was the recurring theme that the strategy needed to focus on rehabilitation to ensure that people in recovery were not kept on methadone indefinitely. There were strong and consistent calls for rehabilitation to be made the 'fifth' pillar of the strategy, to assist people in recovery in 'moving on' and, ultimately, re-integrating them into society.

Stakeholders expressed the view that treatment should focus on the person – and not on the drug – and that rehabilitation services needed to be tailored to meet the client's needs and to flow seamlessly from treatment, as part of the continuum of care. Stakeholders identified a number of key components that rehabilitation services needed to deliver on including access to employment, sheltered and appropriate housing, and relapse prevention to break the cycle of substance dependence.

The steering group that led the mid-term review recommended that rehabilitation should be the fifth pillar of the National Drugs Strategy and, to develop this pillar, they recommended that a working group be set up. The Working Group on Drugs Rehabilitation held 32 focussed meetings with various service providers, service users and their families, and experts in the field of rehabilitation. Subsequently, the Report of the Working Group on Drugs Rehabilitation was launched on 7 June 2007.

In setting the scene for the inclusion of rehabilitation as the fifth pillar of the National Drugs Strategy the working group endorsed the view that 'problem drug use is a chronic, often recurring, condition' (p.7). This endorsement represents an important underpinning of the rehabilitation pillar and is consistent with the views expressed by O'Brien and McLellan (1986) who argued that addiction should be viewed through a similar lens as other enduring conditions such as asthma and diabetes. By seeing addiction as a long-term condition, it becomes clear that short-term treatments, for example, detoxification, used to respond to more acute conditions are not effective approaches on their own.

## Chapter 4: A conceptual framework for promoting recovery

Granfield and Cloud (1999) introduced the construct of recovery capital to explain how 46 individuals overcame substance dependence without the aid of formal treatment or recourse to self-help groups. This type of recovery journey is often called 'natural recovery'. In developing the construct of recovery capital, Granfield and Cloud drew on the earlier work of Pierre Bourdieu who developed the construct of social capital. According to Bourdieu (1986:51), 'social capital is the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition, or in other words, to membership in a group...'

According to Cloud and Granfield (2008) recovery capital is the sum of resources necessary to initiate and sustain recovery from substance misuse. There are four dimensions to recovery capital: social, physical, human and cultural (See Figure 1).

**Figure 1: A model of recovery capital**

<b>Dimension of capital</b>	
Social capital	The sum of resources that each person has as a result of their relationships with, support from and obligations to groups to which they belong
Physical capital	Tangible assets such as property and money that may increase recovery options
Human capital	Personal skills and education, positive health, aspirations and hopes
Cultural capital	Values, beliefs and attitudes that link the individual to social attachment and the ability to fit into mainstream social behaviour

Source: Cloud and Granfield 2008

Granfield and Cloud (1999) are credited with introducing to the literature the construct of recovery capital. The construct was developed to explain how 46 individuals were able to overcome dependence on various substances, including alcohol, cocaine powder, crack cocaine, methamphetamines and heroin, without the aid of formal treatment or recourse to self-help groups. The 46 individuals were recruited through newspaper advertisements and chain-referral. In-depth interviews revealed they shared similar characteristics which constituted a form of pre-existing recovery capital.

For example, before they experienced substance dependence, most of the sample attended college and several had obtained degrees. Most of the sample was in regular employment, before, during and after their addiction experiences, some in professional occupations and others as self-employed business people. None of the sample displayed major mental health problems and according to the authors, none were embedded in the 'street' subculture that surrounds substance use. In addition, many feared their substance use would be revealed to their work colleagues, thus jeopardising their job, career and the status and respect bestowed by colleagues. They also reported membership of professional societies. According to Granfield and Cloud (1999), these personal and social assets enabled these people to initiate and sustain their attempts to overcome substance dependence without recourse to formal treatment or mutual-aid support. In effect, these assets represented a form of recovery capital.

The concept of recovery capital has been given centre stage in a recent report by the Recovery Orientated Drug Treatment Expert Group (2012). In their view, the re-orientation of drug treatment services in the UK should be based around the concept of recovery capital. In their suggestions on how practices may operationalize the concept, they state that 'assessment and recovery care-planning should identify the key resources that will help support recovery for each individual, and help them build up, and hopefully, draw on such resources [of recovery capital] during their recovery journey', (p.11).

This approach, often referred to as the 'assets-based approach', calls on services to focus on developing the personal and social assets that individuals have or need to initiate and sustain their recovery. This focus is in contrast to the deficits-based approach which puts primary emphasis on reducing the problems and harms related to substance dependence. Daddow and Broome (2010:1) have suggested that recovery capital can fulfil the function of an anchoring concept around which the recovery from substance addiction can be pursued by services and clients. In their introduction to a recent report which seeks to place the recovering person at the centre of the response system, they argue for 'a fundamental change to our collective response [to problematic drug and alcohol use]: a shift away from focusing on the traditional harms, to one that recognises the hidden wealth and untapped strength of individuals and communities...'

According to Best and Laudet (2010:2), '...there is an increasing awareness that people do recover, but we have limited knowledge or science of what enables recovery or at what point in the journey recovery is sparked and made sustainable...'. However, there are a number of studies and technical

reports available on recovery which is contributing to a better understanding of the importance of recovery capital to the recovery journey.

A good example of how individuals can be helped to build recovery capital is the work by Keane (2011) who interviewed 20 clients in the Soilse Drug Rehabilitation programme to explore what education meant to them while in recovery. All of the 20 people interviewed self-reported to be in recovery for substance dependence and all claimed to be abstinent and not using any mind-altering substances. For most interviewees in this study, their family upbringing and early school experience was set within a social context of poverty and disadvantage. Most were early school-leavers and some had poor literacy and numeracy skills and modest formal educational achievements. Nearly all the people interviewed had experienced repeated episodes of family conflict in the home, often against a background of alcohol abuse among their parents. Their narratives suggest that they drifted into addiction from various experimental episodes with drugs. Official treatment programmes such as methadone, detoxification and residential rehabilitation played a modest part in their recovery. They were caught in the dilemma of 'multiple recoveries'; they were not just recovering from addiction but also from a lifetime of exclusion, emotional turmoil and a 'fractured identity'. All of the people interviewed had progressed through the Soilse rehabilitation programme.

Education improved their social capital by opening up opportunities to develop new networks of friends. Education improved their physical capital by providing qualifications (tangible certificates of achievement) which improved career options and job opportunities. Education also improved cultural capital by exposing people to new values, beliefs and attitudes. Finally, participating in education improved their human capital by empowering them to take care of their health, develop achievable goals and help with the day-to-day problem solving that is part of the process of addiction recovery. In effect, education played a pivotal role in providing these people with the recovery capital that enabled them to reproduce their recovery on a daily basis.

Cloud and Granfield (2001) suggest that treatment services could benefit from having some awareness of the degree of recovery capital available to people with addictions. They suggest that people with little recovery capital availing of out-patient treatment services may benefit from a combined approach of case management and cognitive behavioural therapy or counselling and people with smaller amounts of recovery capital and availing of in-patient treatment could benefit from protracted aftercare. Clients with large amounts of recovery capital may be suitable candidates for less-intrusive interventions such as brief interventions.



White and Cloud (2008) reiterate the points raised by Cloud and Granfield and urge policy-makers and practitioners working in the field of addiction recovery to consider a shift in emphasis from pathology to a renewed focus on resilience and recovery. They argue that addiction treatment programmes can benefit from increasing their involvement with the families and communities that recovering individuals are embedded within. This approach recognises the assets that can facilitate recovery from addiction.

Lyons and Lurigio (2010) suggest that substance abuse treatment programmes in the criminal justice system should recognise the important relationship between abstinence and recovery capital. Their paper discusses the concept of recovery capital and the dimension of social capital and suggests that ex-prisoners appear to benefit from initiatives in the criminal justice system that promote the development of recovery capital by linking them with mentors and supports to ease the transition to re-integration. They view recovery capital as both an incentive for recovery and a means of sustaining addiction recovery. They argue that 'recovery capital is both a cause and a consequence of abstinence from alcohol and substance use: recovery capital fosters sobriety and sobriety generates more recovery capital...' (p. 446).

Lyons and Lurigio (2010:448) distinguish between bridging social capital among dissimilar people and bonding social capital among similar people in the context of drug treatment. This is a useful distinction and draws attention to the supportive role that can be played by people who are more advanced in their recovery journey and can assist the newcomer.

'a relationship between an individual new to sobriety and one in long-term sobriety is bridging; the latter person has experiences, resources and personal connections that the former does not. Indeed, people in long-term sobriety typically combine bridging and bonding social capital. They empathize with newly recovering individuals but are further along in their own recovery process. Therefore, they have substantial bridging social capital to extend to fledglings in the recovery process...'

## Chapter 5: Definition and discussion of the principles of recovery

This chapter sets out a benchmark discussion for the re-orientation of services and supports towards a recovery paradigm to tackle substance abuse including illicit drugs and alcohol in Ireland. The chapter draws on the 12 principles of addiction recovery as set out by Sheedy and Whitter (2009) and endorsed by Best (2010) which appear more accessible and inclusive than a formal definition of recovery. The principles of recovery are based on 20 years of research reviewed by Sheedy and Whitter and extensive consultations with stakeholders in the addiction recovery field.

### Figure 2: Principles of addiction recovery

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-redefinition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

### There are many pathways to recovery

There is an emerging consensus in the literature that individuals recovering from substance misuse are unique and their pathways into, and through, recovery can be highly personal. For some, natural recovery without the aid of formal treatment or mutual-aid groups is the chosen pathway which, according to Sheedy and Whitter (2009:15), is 'believed to be the most common recovery pathway'. Granfield and Cloud (1999) in their research with 46 individuals, who overcame their substance dependence without the aid of formal treatment or recourse to self-help groups, identified the

important and supportive role that social capital, that is, education, employment and supportive social networks played in their recovery.

For other individuals, perhaps those with less social and recovery capital, recourse to formal treatment and mutual aid groups can be beneficial. For example, in what has become known as the ROSIE study, Comiskey and colleagues (2008) collected data from a cohort of opiate users when they entered treatment (at baseline), one year later and again at three years from baseline. Reported benefits included reductions in drug and alcohol use and drug-related crime, and improvements in employment and vocational training. The authors note that outcomes are not only comparable with other international outcome studies, but in some cases are better, particularly in terms of drug abstinence rates; 29% reported abstinence from all illegal drugs at the 3-year follow-up in contrast to 9% at baseline. According to the authors, these rates of abstinence compare favourably with rates detected in similar studies in England and Wales (Gossop et al: 2000) and Scotland (McKeganey et al: 2006). However, abstinence was defined differently across the three studies so comparability is not straightforward. Nonetheless, the data shows that individuals engaging with formal treatment can make positive changes in their lives.

Retrospective cohort studies of treatment samples are useful in establishing the potential effectiveness of treatment interventions in delivering short-term outcomes but, as Laudet et al. (2002) point out, 'while there is a large body of empirical data on the short-term effectiveness (1-3) years of various treatment modalities, very little is known about the process of recovery over time... [Formal] treatment represents only one of the paths to recovery'.

White and Mojer-Torres (2010:4) in their comprehensive monograph on the role of methadone in recovery point out that:

'There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration. The [methadone maintenance person] who is stabilized on his/her optimal dose of methadone, abstains from the use of alcohol and other intoxicating drugs, and shows evidence of improving global health and social functioning is in recovery or recovering...'

However, research undertaken by Saris and O'Reilly (2010) in the Canal Communities area of South Dublin revealed that for some people, methadone is merely perceived to be another 'street

drug' among many that were used by the participants. According to Saris and O'Reilly, '...most users are ambivalent about both [methadone] and the treatment regime. The majority of users with whom we spoke, for example, do not consider methadone 'treatment' as such. Some talk about replacing 'one addiction with another' or even more severely, being 'a government junkie'....' (p. 19). For example, 59% of those who had taken prescribed methadone in the last 3 months also reported using heroin during this time.

Drawing on a re-analysis of data collected in both the North and South of Ireland with people on prescribed methadone, Harris and McElrath (2012) conclude that 'methadone provision in both jurisdictions was characterised by social control and institutional stigma, which served to reinforce spoiled identities, expose undeserving customers to the public gaze, and create barriers to re-integration'.

### **Recovery is self-directed and empowering**

According to Sheedy and Whitter (2009:16), 'While the pathway to recovery may involve one or more periods of time when activities are directed or guided to a substantial degree by others, recovery is fundamentally a self-directed process. The person in recovery is the "agent of recovery" and has the authority to exercise choices and make decisions based on his or her recovery goals that have an impact on the process...'

Motivational Interviewing (MI) is a recognised evidence-based intervention to promote self-efficacy. Motivational interviewing is acknowledged in the National Drugs Strategy (NDS) as an effective evidence-based intervention in the treatment of alcohol and stimulant abuse. The NDS also promotes the training and up-skilling of addiction counsellors to deliver MI to clients. Smedslund and colleagues (2011) undertook a systematic review of randomised controlled trials that assessed the effectiveness of MI in reducing drug use, improving retention in treatment and readiness to change, and reducing the number of repeat criminal convictions. The authors provide a useful description of how MI is intended to work, and describe four key strategies that addiction counsellors employ: empathy towards the client, building self-efficacy in the client, rolling with resistance and developing discrepancy.

According to Smedslund et al. (2011), fifty-nine trials undertaken between 1993 and 2010 covering 13,342 participants were included in the review. Of these, 57 were randomised control trials (RCTs) and two were quasi-RCTs. People who received MI reduced their use of alcohol and drugs more

than people who did not receive any treatment. The effect was strongest immediately following treatment and became progressively weaker at short-term (up to five months), medium-term (6–11 months) and long-term follow-up (12 months or more). The authors conclude that delivering MI to reduce substance abuse is more effective than doing nothing.

**Vignette: Soilse graduate recounts how recovery has unleashed a yearning for travel**

In recovery I found a passion and lust for life. I am blessed to have travelled the world every winter for the last seven years for three to four months each time. I mainly travel to developing countries such as Mexico, Costa Rica, Honduras, India and Vietnam, the list goes on and on. This is because of my yearning to learn more about different cultures and ways of life. The freedom I have received from recovery is immense and I remain forever teachable. I am like a sponge travelling our beautiful and diverse planet, soaking up all the wonders it has to offer.

**Recovery involves a personal recognition of the need for change and transformation**

Research has shown that for most people entering drug treatment, there is strong motivation to change their substance use. For example, when McKeganey and colleagues (2004) asked a cohort of 1007 drug users entering treatment in Scotland ‘what changes in your drug use do you hope to achieve by coming to this agency?’ 56.6% identified abstinence as their main aspiration. Laudet (2008) cites two studies she led with persons in recovery. In the USA 86.5% of participants and in Australia 73.5% endorsed total abstinence from both illicit drugs and alcohol as their personal definition of recovery. This expressed motivation for sustained change needs to be recognised and harnessed.

**Vignette: Soilse graduate recalls making changes in their life to help their recovery**

I saw the good life of those in recovery, began to buy into the process. Stopped going to Ma’s slowly, always got fucked up going there (used on resentments). Started to put on iPod and had a watch the time going to clinic and avoid speaking to others who were using drugs. I started seeing a counsellor, talking about self, stuff and family (once per week). Started going out walking to mountains with non-using friends, every fortnight for full day. I also played soccer every Monday night. Began to write, keeping a diary. Soilse was key

intervention, they would say would you like to leave methadone behind, make new friends, fellowships, daily meetings, I was benefiting big time.

**Vignette: Former soilese graduate talks about changes made in recovery**

I emerged as a role model from town at fellowship meetings. Got a counsellor and began to challenge irrational thoughts of how I saw myself. Put out all things that were holding me back. Also did aftercare – worked all options for recovery as suggested. Could see previous life was a life of misery. Simple things were now good.

**Recovery is holistic**

Laudet, 2007 argued that there is no clear definition of what is meant by the term ‘recovery’. Laudet examined how recovery was defined and experienced among persons who self-identified as ‘in recovery’. Data were collected from 289 individuals at two-year intervals from baseline using a semi-structured interview questionnaire which included closed and open-ended questions.

Most of the participants defined recovery as total abstinence from drugs. However, the researchers note that this may be explained through their exposure to the 12-step fellowships which pursue abstinence as the main goal of treatment. In addition, for most of the interviewees, recovery meant more than just being abstinent from drugs; it meant a ‘holistic’ way of living. Recovery was seen as a process of change with abstinence viewed as a necessary pre-requisite to recovery.

The holistic approach treats the whole person. This means that successful recovery consists of attending to the physical, emotional, mental, spiritual and social needs. Research is now emerging which shows the effectiveness of holistic interventions in reducing substance misuse. For example, Chiesa and Serretti (2013) undertook a systematic review of the literature on the effectiveness of mindfulness-based interventions (MBIs) to reduce the use of substances and their misuse. The review included 24 studies that compared an MBI with a control condition. The authors concluded that ‘current evidence suggests that MBIs can reduce the consumption of several substances of misuse including alcohol, cocaine, methamphetamines, marijuana, tobacco and opiates to a significantly higher extent than active and inactive controls. [In addition] MBIs can improve several psychological outcomes associated with drug consumption...’ (p. 17).

### **Recovery has cultural dimensions**

Each person's recovery is unique and likely to be shaped to some extent by their cultural beliefs and traditions. Their recovery is also likely to be affected by the cultural beliefs and traditions of the services and providers that they may interact with.

Research has demonstrated that individuals and families from the Travelling community, from new communities and from the lesbian, gay, bi-sexual and transgender (LGBT) community in Ireland are affected by substance misuse and often use services to seek help. For example, research by Fountain (2006), Van Hout (2009), Walsh (2010) and Cafferty (2011) has documented various accounts of substance use within the Traveller community and research by Merchants Quay Ireland (2004) and Kelly et al. (2009) explores substance use among new communities in Ireland. These accounts suggest that substance use and efforts to address the use and abuse of various substances are often shaped by cultural beliefs and traditions. For example, members of the Traveller community were reluctant to admit using drugs as it was not seen as part of the 'Traveller culture'. They were also reluctant to present for treatment as they anticipated a 'cultural bias' from the settled community. Participants from new communities in Ireland did not understand what harm reduction meant as it was not part of their 'culture' back home.

Cultural dimensions of addiction recovery can also include the learning and adoption of new beliefs and values. Research by Keane (2011) shows that participation in adult education can improve cultural capital by exposing people to new values, beliefs and attitudes and instilling a revised work ethic grounded in the demands of educational pursuits as distinct from the sub-cultural demands of the street drug-using lifestyle.

### **Recovery exists on a continuum of improved health and wellness**

Recovery is not a linear process. It is based on continual growth and improved functioning. It may involve relapse and other setbacks, which are a natural part of the continuum but not inevitable outcomes. Wellness is the result of improved care and balance of mind, body and spirit. It is a product of the recovery process.

Research is beginning to emerge that documents and measures the quality of life for people in addiction recovery. As Laudet (2011:44) acknowledges, 'the addiction field has come late to the chronic disease perspective, and the concept of quality of life [QOL] in addiction is relatively underdeveloped...' Traditionally, attempts to measure QOL in addiction have used the standard

Health-Related Quality of Life (HRQOL) instruments. These instruments tend to be designed for use on different populations. In an attempt to construct a QOL instrument based on the self-reported components of people in addiction recovery, DeMaeyer et al. (2011) have provided a useful starting point from their research with people in addiction recovery in the Netherlands. In this qualitative study, five components of a good quality of life among people on methadone were identified: (i) having social relationships, (ii) holding an occupation, (iii) feeling good about oneself, (iv) being independent and (v) having a meaningful life.

Best et al. (2011) assessed recovery and quality of life outcomes among 107 individuals recovering from alcohol addiction and 98 from heroin addiction. None of the participants had used their primary substance in the preceding 12 months of the research. Participants were recruited through recovery groups and advertisements in the local press and the sample was built up using 'snowballing' techniques. Data was collected using a structured questionnaire and a semi-structured interview. Longer time since last use of main substance was associated with significantly better quality of life at time of interview. On-going engagement with meaningful activities was associated with better day-to-day functioning and was the single most powerful predictor of overall quality of life. Those engaged in employment, training, volunteering and household duties were happier and functioning better than those not engaged in these activities. The second most powerful predictor of quality of life was being involved in supportive recovery networks embedded in local communities which included 12-step groups. Laudet et al. (2006) also reported that social supports, spirituality/religiousness, life meaning and 12-step affiliation enhanced quality of life among 353 individuals in recovery who were recruited in New York whose primary substances of use were crack cocaine and heroin.

Research by Van Hout and Bingham (2011) in the north east of Dublin with 26 individuals engaged in treatment and vocational training provides some insight into how recovery and quality of life is understood. The meaning of recovery and rehabilitation differed among participants: for some it meant being on methadone and not using their main problem drug, that is, heroin, while for others it meant the cessation of all substance use. The improvement in quality of life and the pursuit of mainstream norms such as employment and a settled family life were also cited as meaningful components of recovery.



### **Recovery emerges from hope and gratitude**

Individuals in recovery often gain hope from those who share their search for or experience of recovery. They see that people can and do overcome the obstacles that confront them and they cultivate gratitude for the opportunities that each day of recovery offers. It is key that individuals in recovery are in contact with what the literature refers to as 'models of success' – people who have overcome their dependence on substances and have regained the capacity for meaningful life activities. This means that services need to provide mechanisms for people to exit the 'drug scene' and support people to put distance between themselves and active drug users.

Best and Lubman (2012:595) point out that 'one of the most important things we know about recovery is that other people matter. The resolution of severe alcohol and other drug problems is mediated by processes of social and cultural support. Both general and abstinence-specific social support influence recovery outcomes, but abstinence-specific support appears to be most critical to long-term recovery.'

### **Recovery involves a process of healing and self-redefinition**

Research by Vigilant (2005; 2008) in the US with methadone patients that explored their meaning of recovery illustrates the complex nature of recovery as being more than becoming abstinent. In-depth interviews with 45 individuals identified the presence of 'multiple recoveries' concerning (i) addiction, (ii) associational disruptions, (iii) self-identity and actualization, (iv) drug induced diseases (HIV/AIDS, HCV, and so on), and (v) catalysing event(s). An important theme among individuals was that recovery was seen as caring for the self and taking time to heal from the emotions behind the heroin use and physical effects of the dependence on heroin.

Research with people in addiction recovery has identified the important role that identity transformation plays. For example, McIntosh and McKeganey (2000) interviewed 70 people in addiction recovery and reported that efforts to repair what the authors called the 'spoilt identity' were central to the recovery process. The three key areas identified by McIntosh and McKeganey (2000) in which the narratives of recovery could be seen to be constructing a non-addict identity were (i) reinterpreting the addict lifestyle, (ii) reconstructing the sense of self, and (iii) providing explanations for recovery.

**Vignette: Soilse graduate talks about repairing identity and healing self**

In recovery I began to see and accept myself, get honest about self and begin to like self. I had access to cousins, friends who were all drug free. Also group in Soilse were so strong – amazing – looked after each other. Phoned each other, went to some meetings with others, socially going out in Soilse (Howth etc.), coffee. Also support from aunt and grandparents; took time to get on side with parents as needed time to heal self before rekindling relationship.

**Vignette: Soilse graduate recalls how recovery helped construct a new identity with obligations to the community**

I got a house a day before going into treatment in Finglas facilitated by Soilse. Changed for partner as away from other negative influences – began to feel accepted, belonged to community in Finglas. I felt wholly reaffirmed by support from locals. Had chances to rob but wouldn't as didn't want to let community down, have cops knocking at door, lose house. People saw something we couldn't see – it was recovery, given a new identity.

**Recovery involves addressing discrimination and transcending shame and stigma**

The narratives of methadone clients in a number of studies speak of their frustrations of being unable to repair their spoilt identity and how their energies are directed towards performing concealing work regarding their use of methadone. The persistent belief among methadone clients that in the eyes of society they possess a discredited identity means they are reluctant to share with non-addicted members of society the modest changes that they have achieved. Reductions in heroin use and criminal activities and a shift in social functioning towards the pursuit of mainstream normal activities remain obscured beneath the discredited identity of being a methadone client and do not constitute legitimate entry points into mainstream society, Murphy and Irwin (1992), O'Connor and Rosen (2008), Vigilant (2004).

According to Lloyd (2010:12), '...there needs to be a consideration of the role of stigmatisation in preventing the social re-integration of problem drug users. If recovery really is to be the ambitious 'new' goal of drug treatment, then politicians and policymakers will have to look carefully at the question of stigma and how they and others can shift society towards a more compassionate approach to this deeply stigmatised group'.

### **Recovery is supported by peers and allies**

An individual's recovery is often influenced by the nature and extent of their social interactions, specifically the interpersonal relations they experience on an on-going basis with like-minded people. Laudet and White (2008) recruited 312 individuals and divided the sample at baseline into those under 6 months in recovery (28%), 6-18 months in recovery (26%), 18-36 months in recovery (20%) and over 3 years in recovery (26%). 'In recovery' was defined as length of time from the last time that any illicit drug was used. The study tested the following hypothesis: Do higher levels of recovery capital at baseline – that is social supports, spirituality, meaning of life, religiousness and 12-step affiliation – prospectively predict sustained recovery, higher quality of life and lower stress one year later? The authors (2008:9) concluded that:

'the main hypothesis that greater levels of baseline recovery capital prospectively predict better outcomes was generally supported: for the full sample, recovery capital added a significant percentage of explained variance in all three outcome domains after controlling for baseline level of the domains under study, and the full model reached statistical significance for each of the outcomes'.

Families can also play an important role in supporting individuals to recover from substance abuse and, indeed, families are in an good position to do this given their close proximity to people on a regular basis. Recent data reported by Bellerose and colleagues (2011) on trends in treated problem drug use in Ireland 2005 to 2010 found that between 48% and 52% of all cases and between 54% and 60% of new cases reporting for treatment over the six-year period were living with parents and/or family. This means that families have an opportunity to contribute a positive role to recovery.

Research by Duggan (2007) with 30 families in Ireland who were adversely impacted by heroin use identified both the difficulties experienced by families seeking to cope with heroin use and access services and the positive role that families can play in the treatment of the heroin user. Duggan reported that families need better information and support when confronted with heroin use in their family. Also, specialist drug treatment providers, including general practitioners, need to consider the role that families can play in the treatment plans of clients.

**Vignette: Soilse graduate talks about 'being shown how to live' by peers in recovery**

In Soilse, I found support of my fellow addicts trying to find a better way to live and interact with the world. I had no belief in myself but thankfully the staff in Soilse seen something in me that took years of recovery for me to discover for myself. I was a worthwhile human being with the capacity to change and grow into the person I had always dreamed of being, a normal productive member of society. This all took time and it was a process of baby steps, learning to grow up and to let go of my addiction. It took me nearly a full year to become totally drug free through the intervention of the Soilse programme. I just needed to be shown how to live, how to deal with the misery of my past and of my addiction, how to cope with life, how to have true friends, how to be a true friend, how to love, how to eat properly, how to maintain personal hygiene, how to have a routine, how to interact with my family, how to interact with society, how to have ethics, morals and values. Through the support of the staff and clients I actually found some self-belief and meaning to my life other than being a useless drug addict. I no longer felt alone.

**Vignette: Soilse graduate talks about how allies in recovery helped him reconnect**

In recovery I began to feel a part of something. For the first time in life I moved around with people who were happy. Felt comfortable and safe and wanted to hold onto it. I got structure into my life for the first time. Up to then had lost job, no prospects, drinking in house, no light in the tunnel, no way out.

**Recovery involves (re)joining and (re)building a life in the community**

Buchanan (2004) provides a useful model of the steps a recovering drug user must climb to overcome the 'wall of exclusion' and move towards social re-integration which involves re-joining and re-building a life in the community. Buchanan adapted the Prochaska et al. (1992) model of the stages of change to identify the different phases that individuals go through as they seek to overcome problematic drug use. He identified six phases that individuals moving from problematic drug use to social re-integration are likely to experience. The first four phases in Buchanan's model signal changes in the individual and in their use of drugs as they move from chaos to eventual control. The later three phases suggest that, while recovering drug users move towards 'normal living', individuals and agencies in the wider society need to change their attitudes and behaviour towards recovering drug users. The model provides a useful framework to conceptualise the

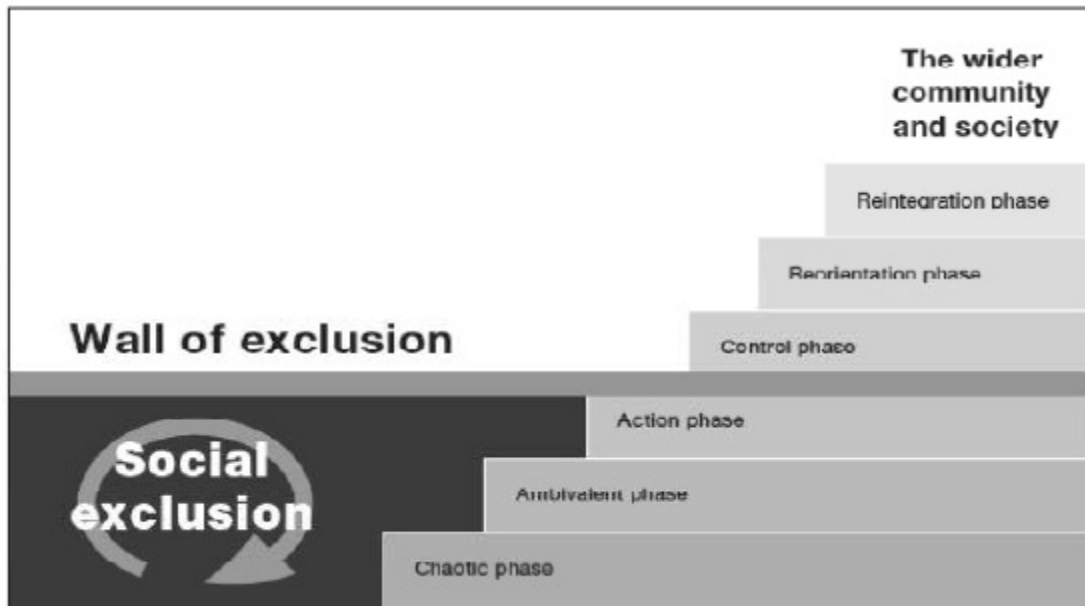
sympiotic changes that must take place on the part of the drug user and the wider society, if the vision of social re-integration is to be realised.

According to Buchanan (2004:395), 'The final phase is to begin social re-integration within the wider society. This may involve: finding accommodation, employment, securing a place in further education or establishing basic daily social routines....'

*The Report of the Working Group on Drugs Rehabilitation* (2007:21) recommends that 'employment, access to education and housing form a key part of rehabilitation care plans, with the overall aim to maximise the quality of life, re-engagement in independent living and employability of the recovering problem drug user, in line with their aspirations'.

Just as is the case with non-drug-users, having stable accommodation and the chance of employment serve both personal and social functions for recovering drug users. On a personal level, recovering drug users in stable accommodation feel secure and this can contribute to prevention of relapse into drug use. On a social level, stable accommodation removes the homeless drug user from the isolation of the street and the insecurity of hostel life and can contribute to a feeling of being part of society as opposed to feeling socially excluded.

Employment brings a sense of self-worth and self-respect to recovering drug users and challenges them to move beyond the negative experiences associated with using drugs. On a social level, employment gives recovering drug users a social status that can bring respect from their fellow citizens and opens up for them the opportunity to pursue mainstream social goals such as maintaining a home, owning a car or going on holiday. To the rest of society, these are fairly normative goals that are pursued by legitimate means. Social re-integration is about creating the conditions that allow recovering drug users to pursue and achieve these goals by the same legitimate means. Failure to create these conditions for the recovering drug user may contribute to relapse into further episodes of problematic drug use. According to Buchanan (2004:395), 'for many problem drug users relapse is not simply the result of a physical craving or a lack of motivation, but it is a direct consequence of a frustration and inability to secure a position in normal community life and establish everyday routines'.



Central to re-joining and re-building a sustainable life in the community is securing employment. Being employed is an established social norm in contemporary society and something that the majority aspire to for financial benefits and social status. As Berg (2003: 205) points out, 'the idea that one's job is the most central component of one's life is a norm that most people defend and practice'. Recovering drug users, too, aspire to the norm of employment and are aware of its benefits. Neale (2002) reported that drug users in Scotland believed that having a job was central to the process of recovery since working provided a distraction and, often, an alternative structure to their days. Klee et al. (2002) reported that over half believed that getting a job would make it easier to get off and stay off drugs, primarily because their time would be occupied. In Ireland, Van Hout and Bingham (2011) reported that among people in recovery, the improvement in quality of life and the pursuit of mainstream norms such as employment and a settled family life were cited as meaningful components of recovery.

However, the barriers to employment for recovering drug users are well documented. For example, a recent study by Bauld et al. (2010) which included semi-structured interviews with 75 individuals (54 male and 21 female) who were current or recent users of drug treatment services in the UK, corroborated earlier studies which have identified the salient barriers to employment for recovering drug users. Interviewees were lacking in self-confidence and coping with poor mental health, including depression and anxiety. Related to their lack of self-confidence was a fear of relapse if they returned to work before they felt ready. They felt incapable of meeting the demands of

returning to work and, for some, the idea of job-hunting was a daunting prospect. Some were daunted by the prospect of putting together a CV and attending interviews and trying to account for long gaps in their CV and a lack of references. They also feared stigmatization from potential employers because of their history of using drugs. Related to this was uncertainty about how employers would deal with their receiving treatment while being employed. Other respondents worried about the side effects of medication compromising their ability to work properly.

The barriers to employment articulated by the people interviewed in this study are also to be found in a review of the literature by Cebulla and colleagues (2004). According to a recent report by Drugscope (2010), these barriers are consistently mentioned throughout the literature. In a number of evaluations of vocational training interventions published in Ireland that included the views of service users, similar findings emerged (Lawless and Cox 2000; Bruce 2004; Lawless 2006). This type of consistent coverage of the salient barriers to employment for drug users signals a degree of consensus on what needs to be tackled by interventions if the employability of drug users is to improve.

A comprehensive review of the literature by Henkel (2011) on unemployment and substance use spanning the period 1990-2010 found that (i) problematic substance use increases the likelihood of unemployment and decreases the chances of finding and retaining a job; (ii) unemployment is a significant risk-factor for substance use and the subsequent development of substance use disorders; and (iii) unemployment increases the risk of relapse after treatment.

As already noted on page 33, employment brings a sense of self-worth and self-respect to recovering drug users and challenges them to move beyond the negative experiences associated with using drugs. On a social level, employment gives recovering drug users a social status that can bring respect from their fellow citizens and opens up for them the opportunity to pursue mainstream social goals such as maintaining a home, owning a car or going on holiday. To the rest of society, these are fairly normative goals that are pursued by legitimate means. Social re-integration is about creating the conditions that allow recovering drug users to pursue and achieve these goals by the same legitimate means. Failure to create these conditions for the recovering drug user may contribute to relapse into further episodes of problematic drug use. According to Granfield and Cloud (2001), interviewees who experienced 'natural recovery' were also assisted to locate and sustain meaningful employment through their relations with friends who provided a network of contacts and opportunities that opened occupational doors and facilitated the pursuit of career

aspirations; 'being embedded in structures of social relationships that were capable of providing resources such as access to meaningful employment was critical to respondents' eventual recoveries...[and]...facilitated their re-commitment to the conventional world of work...'

**Vignette: Soilse graduate recalls receiving support to return to adult education**

Since becoming drug free I never again committed any crimes and became a productive member of society. I was encouraged by staff to return to education. I received support with my third level education through their education support worker. I was given practical support on how to complete assignments but, more importantly, I was given emotional support. Being told you can do it goes a long way to people who are only beginning to build some self-belief.

**Recovery is a reality**

People do recover from addiction to substances and this message needs to be disseminated more frequently and more widely. According to Sheedy and Whitter (2009), around 58% of individuals with substance addictions will eventually achieve lasting recovery. Official treatment programmes can play a vital role in halting addiction and promoting recovery and can benefit people on a number of therapeutic levels. However, when people emerge from treatment, they need to transfer these benefits into day-to-day living and also navigate their way into and through real-life situations. Returning to adult education, securing employment and accommodation, developing networks with non-drug using friends and family and developing new and sustained meaning to their lives can enable people in recovery to build sufficient recovery capital to assist them on this journey and help them to reproduce their recovery on a day-to-day basis.

The importance of these components of sustained recovery is neatly encapsulated by Neale (2002: 218-219):

'Recovery will only occur if drug users believe that abstinence has more to offer than addiction. Accordingly, recovering drug users must find a purpose for their drug-free lives. To this end, they need meaningful roles and activities that offer them self-respect and pride, and daily routines that do not involve criminal or drug-using activities. ...the conditions that seem likely to facilitate successful rehabilitation are the same kinds of conditions that probably prevent drug misuse in the first place. That is, access to a decent income; adequate



housing; employment opportunities; family relationships; and being connected to community networks. ...These are also key factors motivating most non-addicted members of society...'.

## Chapter 6: Impressions from the Soilse workshops

In 2012, Soilse held a series of recovery workshops over three days to highlight the possibilities of a recovery-based approach. To a certain extent, interpreting the outcomes of the workshops was difficult. Whereas there were a lot of similarities in the stories of the four people in recovery (see chapter 7), the workshops were populated by a more diverse group with a range of views and experiences. Notwithstanding that, themes emerged. The most important was stigma – that is, stigmatising of drug users by their own communities and by services. This may have been unconscious but it felt like stigma to those on the receiving end.

What is most required of service providers is to understand and value the recovery journey that people want to embark on. There needs to be ambition and a self-led care plan that is enabled by the service. What is needed from communities is elimination of stigma and establishment of role models within the community. An ethos of recovery has to be nurtured in communities. This could be facilitated by locally-based recovery fora, supported at national and institutional level. There is also a role for traditional and social media. A national conference would help.

Barriers fell into three categories: existing attitudes, lack of information and organisational problems. Attitudes can change and a more precise definition and understanding of recovery will help that process. Organisational changes can follow but hearts and minds have to be won over first. The recommendations in relation to research are succinct – do more qualitative research and include the voices of drug users.

The main themes from each workshop are outlined below.

### Workshop 1: Recovery and research

#### **What lessons have been learnt from research in Ireland about barriers to pursuing addiction recovery objectives?**

The symposium heard the research agenda needs to change from the dominant focus on treatment and harm reduction. However, this should not precipitate a re-run of obsolete wars of harm reduction versus abstinence. It was suggested that a shift should occur in research approaches to look at how drug users remain drug free.

## **How can future research inform our understanding of what works in pursuing and achieving addiction recovery objectives?**

Recovery was seen as happening when the individual took responsibility for their own lives. However, it was acknowledged that there were many variations and meanings attached to recovery and that this complexity in definition could cloud effective research.

Some attendees felt people could be stuck on methadone maintenance long term as the attendees themselves had been. This was a disempowering experience. It was recognised that more Soilse-type programmes were needed to generate recovery capital. It was stated that problematic drug use was not solely a preserve of the disadvantaged. The Soilse ethos where the drug user was heard – a bottom-up, person-centred model – was recommended as a research approach.

It was suggested that research should be culture-specific – to determine how those who had progressed from drug use and services had achieved this progression. A barrier to conducting research on individuals' recovery journeys was deep-rooted stigma and prejudice. It was stated that people in Ireland who had recovered choose to remain anonymous. This highlighted the prevailing need to challenge stigma.

Counter-pointing this was the genuine need to see how hope was generated in services, as addiction was often manifest by resignation and fatalism. Soilse was cited for role modelling recovery, where people could be motivated and inspired by their peers and see effective progression and consolidation in their recovery. The result was real, personal, sustainable change. This is a subject matter for research.

Support was recognised as an effective tool for change. It was recommended that research should focus on what addicts in recovery are saying worked for them and that research into peer support would be invaluable in identifying resource capital.

While agreeing that all addicts may not want to be drug free, there was concurrence that for some, there is a small window of opportunity for change. Service interventions must be in place to take advantage of this opportunity.

## Conclusion

This workshop recommends that there is a need in Ireland to research what recovery is and how it works. Recovery is an overarching concept which threatens no one but benefits everyone. There is a strong evidence base established internationally of recovery-orientated practices resulting in personal progression and social inclusion.

## Workshop 2: Clients and their recovery

### What barriers face clients who want to pursue and achieve addiction recovery objectives?

Significant structural barriers facing those in drug services were outlined. These were: legal issues; childcare; housing and accommodation; accessing services; plight of foreign nationals; roles of doctors and clinics; and lack of residential treatment centres.

A list of personal and practical barriers was named in this workshop which recovering drug users must negotiate in their recovery journey.

<b>Cultural</b> Feeling of inequality Need to become assertive Agencies and professionals not promoting recovery No trust in the system	<b>Social</b> Need new residence area – fear of old ones Need access to their children Need family support
<b>Physical</b> Welfare entitlements Childcare Driving licence Medical card Dental access	<b>Human</b> Overcoming previous criminal charges Requiring structure Proper access to doctors for detox Need more support from doctors Better communication ability to overcome

Passport / ID	anxiety and anger
Bank account	Being properly care planned and case managed through the system
Housing	
Day-time programmes	Overcoming fear, for example of education
Women's programmes	
Teenagers' programmes	
Employment with a criminal record?	
Dealing with bureaucracy	
Little access to information	
No promotion of recovery services –don't know what's available	

Many of these items are normal attainments for most individuals and families. The deficits listed above are evidence of what constitutes recovery capital and normal quality of life indicators, essentially what people who come into services seek to acquire.

**How can barriers be reduced or removed to support clients when they want to pursue and achieve addiction recovery objectives?**

It was suggested that service users become honest regarding their circumstances. Stigma attached to addiction and recovery must be challenged and overcome. Stigma depicts drug users as untreatable, engendering fear and ignorance, resulting in avoidance and exclusion. Service users need hope, support and affirmation, empathetic engagement and understanding of their needs and aspirations. Therefore, the roles of those with power, status and influence, be they doctors or counsellors, should be proactive and progressive, not reductionist and disempowering. The stories of positive engagement and outcomes, both by doctors and counsellors should be amplified. Examples of these positive experiences were cited but it is the negative expression – hardly seeing doctors and failing to get support for change – that dominates. Therefore, an awareness of recovery and the potential for the needs of service users to inform both staff and services are needed. Pride in recovery will take stigma away.

Information barriers are substantial, for example around housing, addiction and medical services. The means to recovery needs to be promoted and supported locally and on an ongoing basis by the HSE through staff and the media.

Basic organisational requirements like good care planning and case management need to be properly and consistently applied to facilitate service user continuity through the system. There is a requirement here for staff and services to be properly trained and co-ordinated to support clients in recovery.

Service users in recovery need to be more assertive, both individually and collectively. As they become educated about recovery, they in turn will educate others in addiction and recovery.

### **What are the addiction recovery objectives that clients can pursue and achieve?**

There are many new obtainable goals that service users can pursue when they get into recovery. Feeling connected, belonging, becoming a part of the community or society brings acceptance and respect. Opportunities for work and education emerge. Personal qualities develop such as reliability, persistence and discipline. Family relationships improve. Health is enhanced. The opportunity to help others and give back to one's community arises.

### **Conclusion**

The variety and complexity of barriers facing service users is well researched and documented. Information and advocacy are required to articulate and attain service users' needs and aspirations. Service user involvement is critical. Barriers can be reduced if service users are genuinely put at the centre of the process. This means professionals must engage in a process based on parity of esteem. Robust care planning will also benefit how the recovery process is delivered on behalf of the service user. Their goals are modest and personally affirming – accessing opportunities lost by addiction such as improved family relationships, health, accommodation and education, simple rewards which give real purpose in life.

### **Workshop 3: Recovery and services**

#### **What barriers do services face in pursuing and achieving addiction recovery objectives?**

Services must be clear on what service users want for themselves. There is often a knowledge barrier here. It is not just methadone but other needs that makes life meaningful. The workshop heard harm reduction services were seen as too narrow. Services need to understand the recovery journey, the continuum of care that embraces stabilisation, detox, therapeutic treatment and aftercare. It takes little steps on a long journey, marked by obtainable goals, recognising everyone has different needs and rates of progress. Services must acknowledge their own limitations, that they are not and cannot meet a service user's needs on their own. There is an imperative to work with secondary services to secure the holistic range of needs of service users. Methadone plays a part but is not the whole.

#### **How can barriers be reduced or removed to support services to pursue and achieve addiction recovery objectives?**

Services can set goals for service users which are obtainable. For example, SMART (specific, measurable, attainable, realistic and timely) goals or self-graded care planning is motivational. The possibility of exiting services should be promoted rather than having service users in treatment forever. More information on recovery should be evident. Programmes should be better calibrated to meet the needs of service users, with better assessments and options, overarched by encouragement rather than discouragement for progression. Services as presently constituted are lazy and unambitious for their clients. Services should also acknowledge that part of the recovery journey is occasional failure and that is where best learning could obtain. There should be no fear of this.

#### **What are the addiction recovery objectives that services can pursue and achieve?**

Staff and service education is a core necessity to facilitate recovery. There are role models such as former service users in recovery who could be shown to people in clinics. This is a missed opportunity to recycle recovery. The language and culture of recovery should be embraced and promoted by professionals. Services should be motivational with information, education and support apparent. Talks on recovery, peer support and the options that exist will all help services break the cycle of addiction for service users. Drug-free options should be promoted.

## **Conclusion**

It is important that services embrace an agreed and understood conceptual framework on recovery. This will facilitate methodological clarity in the work of services. There should be a skills framework, holistic, multi-agency care planning and relevant training on recovery to meet the needs of service users.

## **Workshop 4: Recovery and communities**

### **What are the barriers facing communities when they want to support clients and to pursue and achieve addiction recovery objectives?**

It was agreed that there was a lack of recognition of recovery in communities. There was no facilitated detox or access to treatment. Stigma was still a major inhibitor and vested interests ensured little progress occurred.

### **How can communities be supported to reduce or remove barriers that may prevent them from supporting clients and services to pursue and achieve addiction recovery objectives?**

Communities must recognise the limitations of the medical model. Local centres must have all the necessary information regarding recovery and service options. Doctors must liaise with other workers. Services and service users must have key workers to care plan progression. Methadone often becomes chemical handcuffs. People never initially went onto clinics for long-term methadone – they should be encouraged to get into recovery when they are motivated. Role modelling recovery in communities will create an awareness of real options for individual development and fulfilment, inspiring others. Social inclusion options in communities must be discussed with, and should be available to, all service users, fully supporting them in their re-integration which is a central tenet of community development and health policy.

The role of doctors was cited often as being obstructionist and inflexible, having immense power and often socially controlling people's care. Doctors have vested financial interests in maintaining the status quo and ignoring options in the community. Advocacy on behalf of



service users to GPs was needed. People working in services also need professional development around recovery. There is a discernible shift to the psycho-social model which will facilitate communities in more equitably addressing addiction. Literature must be circulated in local communities and the use of social and mainstream media will help promote recovery.

A recovery forum was suggested as a start. This could grow into a national recovery movement, building awareness, publicising recovery and pulling communities together. A network of stakeholder groups, addiction professionals and GPs should also be promoted. TV and social media are also avenues to activate recovery in communities. A national conference could act as a flagship to highlight the lessons communities can apply to building the recovery movement in Ireland.

**What are the addiction recovery objectives that communities can promote to support clients and services to pursue and achieve addiction recovery?**

The minister with responsibility for drugs needs to be fully aware of what recovery entails and give substance to it at a policy level. Recovery gives service users the chance for a better quality of life and the possibility of exiting services. People in communities can influence here. Recovery needs to be defined and understood in communities. Stigma needs to be challenged, especially by service providers. Service users need to be consulted, supported and given the chance to try recovery. They should not be ridiculed for wanting this. Drugs are also becoming more complex with ignorance around the damage poly-drug abuse can do. Countering this at community level is vital for a better future.

## Chapter 7: Stories of four people in recovery

As Neale and colleagues (2012:14) point out in their recent research on the day to day lives of recovering heroin users,

‘Treatment and recovery from heroin use continue to be high profile topics in local and national media, and in political debate. There is also no shortage of academic textbooks and policy documents relating to problem drug use. Despite this, heroin users still seldom have the chance to tell their own stories to a broader audience. This is both surprising and disappointing given that one of the best ways of understanding an issue is to listen to those with first-hand experience. Personal accounts are very good for generating debate, highlighting common concerns, and combating unhelpful myths and stereotypes. They can also reassure, inspire and motivate others...By reporting the actual words of [people in recovery] we [can] produce an accessible resource for those who want to understand how recovery is really experienced from the perspectives of drug users themselves...’.

This chapter presents verbatim narratives from four former Soilse participants on their experiences of being in recovery from drug dependence. These narratives were presented as personal abridged testimonies during the Soilse symposium in 2012 and followed up with face-to-face interviews which are presented below.

### **Bill from Ballymun (pseudonym)**

I was born 32 years ago and reared in Ballymun. I have 3 sisters. I remember changing schools at age 6 or 7 and I set the flat on fire. We were relocated to a house and I became a bit wild. I was showing signs of dysfunctional behaviour. My parents were both alcoholics with destructive behaviours, they were chaotic and violent. I tried to stay in school but I was causing havoc. I became a tyrant to the community from age 9 to 10. I remember robbing the principal’s office in school and then I got expelled in 6<sup>th</sup> class for being unmanageable. Went to secondary school for about 2 months and then got referred to Geraldstown House, an after-school project. All the kids there were chaotic. Most took the same route in life – death or prison. I was sleeping rough from age 13 and went into care at age 14. I personally deteriorated after. I would often go to the Garda station in Ballymun when I was homeless and they put me in a side room and called the social worker. .

My mother spent time in the women's refuge in Rathmines. When my parents split up I moved in with my mother. From age 9 I was often supervised by the Juvenile Liaison Officers, but I accumulated a lot of criminal charges without realising the amount. I moved in with Peter McVerry to his homeless shelter. Before that I often slept in the pipe box in the tower in Ballymun. I spent some time moving between Peter's homeless shelters and spent some time in St. Michael's in Finglas when I was age 13. I also spent time in Trinity House in Lusk. I was using every drug around bar crack at this stage. I could read and write and did a bit of education in Trinity House.

I remember I kept a diary and it was full of horror stories, like I was seeing a psychologist as a kid. I was put on anti-depressants for 6 months and 7 years later I was still taking them, I was suffering from depression and had no outlet for it. I was prescribed physeptone (methadone) around age 15 and I stayed on this drug for about 11 years.

In my 20s I got an opportunity to train racehorses (part of a FÁS intervention). But I was strung out at this stage and got removed from the project as I still taking gear. I was delighted to get removed as this reinforced my idea of having no hope and gave me a chance to whip myself. I spent time going in and out of most of the prisons – St Pat's, Wheatfield, Mountjoy and Cork. I was using drugs for most of the time during my 20s. I was clean for a short period when in Soilse during my 20s. I had an operation on my arm due to injecting and then tried to stop using drugs through going to Christian Fellowships and Keltoi treatment centre but always went back using more drugs. I felt like I was hitting walls from around age 16 but I hadn't hit rock bottom. Then I got hooked on crack and felt I was at the gates of torment; also got a few bad beatings in Ballymun. I began to realise that death was slowly beckoning.

### **Recovery**

I suppose my recovery started when I met 2 Soilse staff by chance in town and they invited me to drop in. I started to reach out again. I went back to live in my Ma's for about 2 months. I was still in a negative state and still taking the phy, just sitting around watching the TV and then I said to my Ma that 'I can't do this any longer' so I left the house and I didn't want to go back.

I went back to live in the Peter McVerry shelter. Although I was still using drugs I knew I had had enough and I was really looking to open a new chapter in my life. I was moving between Ravenswood in Finglas and still using crack and started to become psychotic. Then I stopped using crack and moved to Cabra, still using other drugs and selling some. Then I went to the stabilisation clinic in Parkgate Street as I had an idea that I wanted to get stable. I was told to stop using heroin and just stay on the phy. Then I started going to the NA meetings. I was taking 80mls of phy a day. My sponsor and the lads in the meetings were very helpful.

I saw the good life of those in recovery and began to buy into the process. I stopped going to my Ma's. I always got fucked up going there and I think I used drugs [because of] the resentments I felt. I started to put on my iPod and had to watch the time going to the clinic to avoid speaking to others who were using. I was seeing a counsellor in Ballymun and began to talk about self, stuff and family. I started going out walking to the mountains every fortnight for a full day. I also started to play soccer every Monday night. I began to write and did ABC worksheets for CBT therapy. I started keeping a diary.

At this time, Soilse was a key intervention. The people in Soilse encouraged me to leave methadone behind. I was making new friends, I was attending daily NA meetings, I felt I was benefiting big time. I moved from the stabilisation clinic but I was still on the phy. Then I went to the Lantern Centre and then to the Rutland Centre. I started to go to the gym and do personal training and boxing and I disconnected from my old friends and got out of Ballymun completely. Progress was slow but I began to build new relationships with others. I continued to attend Soilse and then I did Rutland Aftercare for 18 months and got my medallion. Then I moved to a drug-free house in Cabra. I joined a soccer team and started interacting with normal people. I went to Soilse in Green Street for 6 months and achieved FETAC accreditation. I was also attending the ACRG which helped me consolidate my recovery. I continued my interest in boxing and got involved in boxercise classes doing some mentoring for others. Then I moved into a shared house with a recovery community where we provided mutual aid and support to each other.

During my time in the fellowship, I was doing the chair at meetings and also was the secretary. Then I moved into my own apartment. I was also doing some voluntary work in the recovery house that I used to live in and also in drug projects, helping with cooking and

music classes and training a soccer team in another community. I am currently drug free 2 years next week and I am off the cigarettes five months. I am still involved with the NA fellowship and I feel a major commitment to others who need help and support. I also have a good life beyond the recovery circles and have made new friends. I had to work hard to make changes to my life but it was all worth it today.

### **Dermot from Donaghmede (pseudonym)**

I am the eldest of 5 children and I was born in Ringsend where we lived in a bedsit for about five years. My father worked and we survived ok and then we moved to Donaghmede. When we moved I felt uncomfortable and was unable to settle there. I was sent to school in Clontarf and didn't really fit in there. I did well in sports at school and generally I was outgoing and motivated and made friends gradually.

I began experimenting with drugs about age 10 and started to act out, not coming home when expected. I felt that expectations on me were high as I was the eldest. I was drinking cans of alcohol and smoking cigarettes at a young age. Then I got a summer job on the ferries at age 14 and I found that drugs were easily accessible. I went to secondary school but I didn't want to go, I hated it. When I returned home from the job on the ferries I expected to be treated more maturely, but was disappointed this did not happen.

When I was working I was drinking every weekend and earning £200 per week. To go back to school at 14 was a disincentive. However, I went back to school but my behaviour became a big problem and I was often missing classes. Despite this I did well in the Inter Cert. Then I went back to work on the boats and I tried heroin. This drug gave me self-belief. Then I was earning less on the boats and wanted to leave there. I started going to raves and started to smoke hash and kept on drinking, I was also taking acid, ecstasy and speed. I was around aged 17 then and I was also using heroin when working on the ferries, I seen this as a treat. When I was age 18, my son was born but I continued to drink and use drugs to excess. I felt I didn't have a lot of self-esteem and I was very self-conscious. My use of acid gave me heightened feelings of despair.

I was now using heroin and other drugs to fit in and drinking to be accepted. I got strung out on heroin and I felt I had two separate lives. During the day I was quasi-normal and at night I was scoring drugs and using. I broke up with my child's mother and wandered into other

relationships where I met someone who was using recreational drugs. During this time I did contemplate change but always rebounded to use more drugs. When I was age 23, I became a father again. However, I felt my life was unravelling and it was harder to survive as my dependency on drugs was massive.

I attempted suicide one night and was found in bed by my mother. I ended up in hospital in a coma. I awoke to feelings about how to keep people happy. Then my brother was diagnosed with cancer. During this time I was feeling really bad within myself and I ended up on phy at age 22 following an intervention by my work. I wanted to kill my boss after he sent me to a psychiatrist and from there I was referred to a private GP. Then I went back to work and continued to take the phy. I was getting encouragement from my GP to address my addiction as I had been on tablets for 5 years. I always had enough money to keep going without resorting to crime.

In 2002 my ex-partner's fella died from a brain tumour. My child was devastated as this fella had been good to him. I personally felt that I was on my own and I realised I was going to die if I continued to use drugs.

I went to Greece with 1,000mls of phy and loads of tablets. I thought I was drug free as I was not using heroin. I felt I was cured. Then I returned to work in Ireland and shortly after relapsed back onto the heroin with another former user. This was around Christmas 2003. By the middle of January 2004 I was strung out again and went back to the GP and went back on the phy. Around March 2005 I had a nervous breakdown from the pressure of concealing my drug use. Then my friend got me an appointment with Soilse and I also wrote an application for me to High Park. I was attending Soilse in Henrietta Place for 5 months before I went to High Park. Everyone thought I was grand and happy but I was just trying to keep all those people happy.

### **Recovery**

Having spent 5 months in Soilse and 18 weeks in High Park, I began to see and accept myself, get honest about myself and begin to like myself. I now had access to cousins, friends who were all drug free. Also the group in Soilse were so strong, amazing, we looked after each other. We phoned each other. I went to some meetings with others, and began socially going out for coffee with people from Soilse. I also got support from my aunt and

grandparents. It took time to get on side with parents as [I] needed time to heal [my] self before rekindling the relationship. After High Park I attended Soilse in North Frederick Street and mixed with drug-free friends and the network got big. I started to put in positive time, moving around town, visiting bookshops, reading spiritual books. During the summer I worked in Henrietta Place, did a bit of cooking, did a mentoring course around recovery. I applied for Trinity Addiction Studies Course [in] 2007. I did some preparation for a year in Coláiste Dhúlaigh in 2006.

I began to notice changes on a physical level and my confidence improved. I felt self-worth, part of a process and saw the recovery process as a job. I put a lot of effort into not being late for Soilse, complying with full attendance and having the right attitudes. I was putting the effort in and I was experiencing the results. I felt alive and was enjoying doing things like playing golf. I also stepped up to take responsibility as a father with 2 kids.

In 2008, I was working at weekends doing relief work. I got a house in Clúid Housing, the social housing project. I became a father again in recovery and this was a massive development for me. I was able to look after my family when my partner became sick and previously I would have run away from this responsibility. I now had skills around relationships and was enjoying my hobbies. My relationship with my Da and my family improved and we enjoyed playing golf together. I continued to work on myself and do personal development courses. I also tried to make amends for all failures of the past. I had been out of control on alcohol since 18. I didn't use NA or fellowships long-term but worked very hard on myself and realised I don't need to go back on to drink.

### **Frank from the flats (pseudonym)**

I was abusing alcohol at age 10 and graduated to hash at age 14. I came from a community where addiction was widespread. I came from a family of nine where alcohol consumption was a big issue but went unrecognised. I was the only one in the family that used illicit drugs and from age 15 I used heroin.

I left school around age 12 and started to hang around the flats, getting into mischief, scuttling lorries, doing petty crime. I was attracted to heroin as I seen the older lads in the flats using it. It took hold of me in about two years and I was using it daily and using tablets

as well. I spent time in Mountjoy prison when I was age 15. This was my first sentence and they didn't want to keep me in St. Pat's. I got six months.

While in Mountjoy I made contact with people who were using drugs and this may not have happened if I had gone to St. Pat's. In Mountjoy I put on a false persona, acting like I was mad, just to fit in. I used a lot of drugs in prison, including injecting heroin and when I came out I continued to use drugs. I then spent the next 15 Christmases in a row in prison doing small to bigger sentences as I was not in the drugs groove totally. I kept using drug while in prison. My father died when I was in prison and I had 3 months left on my sentence. When I got out I got money from a claim and continued to use a lot of drugs. When in prison I got through the sentence by buying and using heroin inside and so was stoned the whole time.

I was diagnosed with HIV and I tried suicide but was found. I then met my partner in 1993 and wobbled on the drink until around 2000. I knew I needed help and to get onto a clinic but I started using tablets to numb myself and felt worse. I was literally at the point of dying, in a bad way in the house so I chanced asking to go to an NA meeting with my partner and brother-in-law. For the first time, I saw recovery was possible and shortly after this I joined Soilse.

### **Recovery**

Slowly I began to feel a part of something. For [the] first time in life I moved around people who were happy and I drew into this process. I felt comfortable and safe and wanted to hold onto it. I got structure into my life for the first time. Up to then I had lost my job and had no prospects. I was drinking in the house and felt there was no light in the tunnel, no way out. Only by going to Soilse, where I knew a few from town, I could get out of the house and have a laugh. Also, I was going to NA meetings and got a sponsor. My daughter was now four years of age. My partner started going to college but was still drinking and doing cocaine, I was finding the situation very tough. I survived because of the support I received in Soilse. I also went for treatment to the Rutland Centre. Then my partner came into Soilse and prepared to attend a CP [Concerned Person's] day in Rutland. She thought she would be in the eye of the storm but the CP day had a huge, life-affirming effect.

We were living in a drug-infested area but got a house a day before going into treatment in Finglas. This was facilitated by Soilse. This was a good change for my partner as we were



away from negative influences. I began to feel accepted and that I belonged to a community in Finglas. This was wholly reaffirmed by the support from locals in our community. I had chances to rob but wouldn't as I didn't want to let [the] community down, have cops knocking at the door, lose the house. People saw something we couldn't see – it was recovery. We were given a new identity. Neighbours could see we were different by what we were doing. We could now handle difficult times as we had support from the group in Soilse. I could also talk about my HIV and now began to live with it. Slowly I was getting in touch with my emotions and could cry with happiness when I did get good news.

I emerged as a role model from the fellowship meetings. I got a counsellor and began to challenge irrational thoughts of how I saw myself. I put out on the table all the things that were holding me back. I also did aftercare – worked all options for recovery as suggested. I could see my previous life was a life of misery. Simple things were now good. I did Tai Chi, painting and decorating, did a certificate in Addiction Studies, went back to adult education in Mountjoy Square, ACRG. I focused on getting involved in my community, involved in soccer club, now helping others. My partner and children were all doing well – going to school meetings, linking to other parents, feeling a part of it. Reports were excellent and I was putting time into my kids. I even paid for a child psychologist to video interactions between my children and myself. For me, it was all about becoming a father in recovery – not to react but to look first. I also became very health conscious and I use a journal to plan food, diet and personal reflection (nightly). Currently, I have a couple of part-time jobs and I'm doing a Diploma in Addiction Studies. I aim to go to university.

My relationship with my family of origin is good and I got a new house in Finglas. I now have deep friendships with a few people – I never had this before. My neighbours leave their keys with me when they are going on holidays and ask me to look after their house and put out the rubbish bins. I get Christmas cards from all my neighbours and I get invited to weddings. Prior to this, I only ever attended funerals. My partner has completed college and is now working with kids in need. I also do voluntary work and have done some for the local drug task force. I now try to bring people into recovery through meetings and local services and get them playing soccer. I have also met the President! I sometimes think that all the information I got when I was a child was useless. In a way, I had to re-programme when I came into recovery.

### **Teresa who loves to travel (pseudonym)**

At the age of twelve I became addicted to using solvents – glue, shoe polish, petrol, anything that would get me away from my insecure thinking and the deep emotional pain I was feeling. This was all due to a series of traumatic events in my early life. I lost a brother when I was ten years of age with whom I was very close. Unfortunately, I was not shown how to cope and how to express this grief in a positive way. At first, this grief channelled itself through self-destructive negative behaviour, such as getting into trouble in school, rebellion from my parents and from any form of authority. Thus, this began a hopeless perception on the meaning of life and all it entails. The older I grew the greater the hopelessness became and I reached for more and more drugs to fill the deep loneliness, pain and inadequacies that I felt each day. By the age of twelve I had lost my childhood, by fifteen I left school and by the age of seventeen I was addicted to intravenously using heroin and benzodiazepines. Not a day went by where I did not have some form of chemical in body. I also drank, used cocaine, smoked hash and took any pharmaceuticals I could get my hands on, anything to escape the inner turmoil I felt on a daily basis. Overdoses and arrests were regular occurrences and the older I got, the more crimes I needed to commit to pay for my addiction. The more crimes I committed, the more drugs I needed to take to mask the shame I was feeling for behaving in such a way.

Deep down I knew this was not the way to live. I was going against my true spirit. My addiction had isolated me from my friends, my family and from society as a whole. I would have given anything to be able to live a normal life, go to work, have a family. It was all just out of my reach. I couldn't go on living the way I was. I tried suicide several times to no avail. I was trapped, stuck in a paradox. However, I knew no other way of living. I was stuck between the pain of continuing to live life this way and the fear of living life without my emotional crutch which was destroying me and everything around me. I was lost and deprived of all hope.

At 23, I came close to doing a few years in prison. The judge was giving me a chance to change or go to prison. I had prayed to god to help me, that I could not go on living the way I was, that I was a prisoner of my addiction. I first found some hope when I began the Soilse programme back in November 2003. Here is where my journey of recovery first began.

## **Recovery**

In this programme I found the support of my fellow addicts trying to find a better way to live and interact with the world. I had no belief in myself but thankfully the staff in Solise seen something in me that took years of recovery for me to discover for myself. I was a worthwhile human being with the capacity to change and grow into the person I had always dreamed of being, a normal productive member of society.

This all took time and was a process of baby steps, learning to grow up and to let go of my addiction. It took me nearly a full year to become totally drug free through the intervention of the Solise programme. I received a holistic approach which really helped provide for all of my needs. I just needed to be shown how to live, how to deal with the misery of my past and of my addiction, how to cope with life, how to have true friends, how to be a true friend, how to love, how to eat properly, how to maintain personal hygiene, how to have a routine, how to interact with my family, how to interact with society, how to have ethics, morals and values.

Like a child beginning school, the Solise programme taught me how to adapt to society in the hope that I might someday finally feel a part of it. Through the support of the staff and clients I actually found some self-belief and meaning to my life other than being a useless drug addict. I no longer felt alone and so began my process of my restoration back to my humanity.

The holistic care plan in Solise continued even when I left the programme. Since becoming drug free I never again committed any crimes and became a productive member of society. I was encouraged by staff to return to education. I received support within my third level education through their education support worker. I was given practical support on how to complete assignments but more importantly I was given emotional support. Being told you can do it goes a long way to people who are only beginning to build some self-belief.

After I got my education I started my career. I've been incredibly lucky to develop my career in diverse aspects of social care, from homelessness to mental health and from autistic children to women's refuges. I have discovered that I have a great talent and passion for

working with people who are suffering from the traumas of life which I once faced. Now I can provide support and identification to those who need it most.

In recovery I found a passion and lust for life. I am blessed to have travelled the world every winter for the last seven years for three to four months each time. I mainly travel to developing countries such as Mexico, Costa Rica, Honduras, India, and Vietnam the list goes on and on. This is because of my yearning to learn more about different cultures and ways of life. The freedom I have received from recovery is immense and I remain forever teachable. I am like a sponge travelling our beautiful and diverse planet, soaking up all the wonders it has to offer.

Recovery has not been easy. I have had many challenges to face both internally and externally. I had to go back to prison in recovery due to fines I could not pay. I lost friends due to addiction. I discovered I was gay and had to face all the stigma that was attached. My career was tested a few times when I lost jobs over convictions that were eight and ten years old. Ireland has no rehabilitation act and therefore every job I have got, I've had to go through my whole past and explain my recovery. Luckily, some employers have been a great support, however, the HSE who funded one of the private child care companies I worked for, insisted to the company that they remove me straightaway, that the HSE does not allow people with a background such as mine to work with vulnerable children. This is ironic really because I got clean in an HSE hospital who promoted recovery and rehabilitation. This also happened with Focus Ireland who also utilise an ethos of change and rehabilitation. Throughout all these challenges I've remained proud to be in recovery and I'm always prepared to challenge the misperceptions and stigma that Irish society has about drug addicts. I believe my past is my greatest gift as it gives me the ability to help people and to pass on the message that anyone can recover, not only from addiction but from any form of traumatic experience. Nine years on I maintain my recovery through fellowships and developing my spirituality. Recovery from drug addiction has connected me back with my mind, body, soul and life in general.

## **Chapter 8: Conclusions and next steps**

This report has set out a case for the re-orientation of drug treatment services to promote a recovery-focused paradigm. We have shown that from the 1970s up to the present, successive policy pronouncements have acknowledged that the provision of drug treatment in the form of medical services is insufficient to cater for the social and cultural needs of people affected by drug addiction. We have also shown that stakeholders, when consulted, have argued for a response to drug addiction that promotes and responds to the broader needs of people in treatment. It is our contention that, when taken together, these pronouncements speak to the need for policy and practice to focus on a recovery paradigm where these broader needs can be addressed in a holistic way.

The framework of recovery capital has been embraced by policy makers in the UK and beyond as the key anchor upon which to build policy and practice. The framework speaks to the social, human, cultural and physical resources that individuals need to initiate and sustain recovery from dependence on drugs. We have described the research background where this framework was developed to understand how individuals with recovery capital can recover without accessing formal treatment. We have outlined the key principles of recovery and we have shown how these principles are supported by research evidence on what promotes and supports recovery. Finally, we have presented the main outputs to emerge from a symposium on recovery that revealed a strong desire from participants to promote the goals of recovery.

We believe the time is right to increase the visibility and give more prominence to recovery in the next phase of our strategic response to drug addiction by commencing the conversation now. We believe a major contribution can be achieved by reorienting existing resources within the recovery framework. Much work is currently being done in isolation. Inter-agency work through a recovery continuum with a focus on a community-up, assets-based approach will accrue recovery capital, responsibility and inclusion.

Theoretically, everybody is in favour of recovery – it threatens no one and embraces everyone. What is needed now is a stimulus to move from theory to action. Structures put in place over the last five years offer hope: NDRIC, a national rehabilitation co-ordinator, expanded regional and local

drug task forces, a pilot NDRIC framework and enhanced drug user involvement are positive. We must build on this.

There are still significant challenges ahead. It must be acknowledged that the State has shrunk and austerity has adversely affected services and morale. Stigma is also pervasive. Indeed, many service users are resigned and fatalistic as to their futures.

Yet the varied voices for and of recovery are rising and must be heard. The view from this paper is their view – that people do come through traumatic human experiences and out the other end where change is possible and many people do obtain fulfilling lifestyles and lasting recovery. As the workshop on Recovery and Service Users states: ‘their goals are modest and personally affirming, accessing opportunities lost by addiction such as improved family relationships, health, accommodation and education, simple rewards which give real purpose in life’.

The triple lock of research, case studies and workshops cited here endorses this. Recovery capital is now the emerging international construct for the addiction field. It can translate across the various spheres of addiction influence and delivery. It is the way forward.

## **Recommendations**

### **Policy**

- Put the framework of recovery capital and the principles of addiction recovery at the centre of our policy response to substance use.
- Make recovery the fifth pillar in the National Drugs Strategy, replacing rehabilitation.

### **Recovery and research**

- Establish a recovery academy of researchers, policy makers, practitioners and service users to promote recovery through research, education and advocacy.
- Develop an evidence base on the operation, process and outcomes of recovery.
- Give priority in research to the narratives of people in recovery.
- Disseminate evidence-based bulletins on recovery to inform stakeholders.

## **Recovery and service users**

- Promote the active engagement of all service users in the design, delivery and evaluation of their treatment and recovery plans.
- Pilot a recovery module for service users and make it widely available in a virtual learning environment (VLE).
- Encourage service users in recovery to train as recovery coaches to mentor and support other service users.
- Help service users in recovery to take on the role of recovery champions in their local communities.
- Mobilise service users, their families and their communities to become involved in the building of a recovery movement.
- Increase advocacy and awareness to ensure service users are treated with equality and respect, and mentored and supported through their anxiety and fears to progress their recovery.
- Make fellowship meetings attractive and accessible for service users.

## **Recovery and services**

- Encourage services to undertake ongoing needs assessment among service users to determine priority goals.
- Enable services at each stage of the continuum of care (stabilisation, detoxification, therapeutic treatment and aftercare) to develop sufficient capacity to meet demand and be part of the recovery journey.
- Encourage services to set SMART (specific, measurable, attainable, realistic and timely) goals for service users.
- Promote the development of professional key working, holistic care planning and case management practices across the statutory, voluntary and community services.
- Encourage services to develop an outcome orientated focus for service users.
- Encourage services to provide information and support for families on recovery issues as well as childcare, parenting and family support options for all.
- Encourage services to identify and respond to the specific needs of women in recovery.
- Encourage services to develop culturally-sensitive responses to the recovery goals of minority groups.

- Encourage services to promote recovery options among people imprisoned for addiction-related issues.
- Advocate for the implementation of the Spent Convictions Bill.
- Encourage services to use recovery coaches to support prisoners following their release.
- Work with national stakeholders to develop the capacity to challenge public stigma around addiction recovery.

### **Recovery and communities**

- Undertake work with local communities to inform them that people do recover from addiction.
- Undertake work with local communities to address the stigma that people in addiction recovery perceive and experience.
- Support communities to develop recovery forums to build awareness of recovery.
- Support communities to develop networks with relevant stakeholder groups, for example medical professionals, to promote recovery.
- Promote the role modelling of recovery in communities to motivate and inspire others towards recovery.
- Promote the development of recovery sub-committees in local and regional drugs task forces.
- Promote the development of social inclusion and social economy options to facilitate recovery.



## **Overarching issues – workforce plan**

NDRIC should take the lead on implementing these recommendations by ensuring key stakeholders – providers such as the Health Service Executive, Solas/DSP, Education Training Boards, Homeless Executive and Probation and Welfare – combine, co-ordinate and integrate their interagency service responses around recovery into a ‘whole system’ approach.

- Implement a system level of change embracing the Health Service Executive, Solas/DSP, Education Training Boards, Homeless Executive and Probation and Welfare to combine, co-ordinate and integrate their interagency responses.
- Establish a small technical leadership team drawn from the Health Service Executive, Solas/DSP, Education Training Boards, Homeless Executive and Probation and Welfare at senior level to facilitate, monitor and measure the changes to services proposed.
- Develop a cross-sectoral workforce training plan based on recovery principles and practices spanning the statutory, community and voluntary sectors.
- Set up a skills consortium for service workers and providers drawn from existing specialists currently working in the field.
- Set competency baselines for all areas of staff and service delivery.
- Nominate recovery day programmes and residential centres as models of best practice and use these as learning hubs for other service providers.
- Use audits to ensure that best practice and consistent practice standards occur across sectors.

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## **A recovery reflection**

'...the process of self-resolution, as illustrated by our respondents, rarely occurs in isolation. Instead, personal transformation is a social product that is greatly influenced by the situational social context in which an individual is located...their motivations, cessation strategies, opportunities to change, and their ultimate success at recovery were largely a product of their social interactions with others and the related social capital derived from these relationships...(Cloud and Granfield 2004: 194)





