

THE UNIVERSITY OF HULL

An exploration of the process of recovery from heroin dependence

Being a Thesis submitted for the Degree of Doctor of Clinical Psychology

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by

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## Overview

There are several models which emphasise the importance of psychological and sociological processes in recovery from heroin dependence. However, there is still some uncertainty surrounding the definition of 'recovery'. This research portfolio explores the concept of recovery from heroin dependence and how different psycho-social factors, methadone maintenance and drug treatment services may play a role in the recovery process.

The research portfolio consists of three sections. The first is a systematic review of the British literature, investigating the association between psycho-social factors and recovery from heroin dependence. The main themes from the literature are collated and discussed, with reference to the quality of the studies included in the review. The literature review ends with a discussion of the potential for further research.

Part two details an empirical study in which the experiences of clients receiving methadone maintenance treatment (MMT) are explored using a qualitative methodology. The study focuses on how clients perceive their recovery process and the role of MMT and drug services. The results of the interpretative phenomenological analysis are stated and the main themes discussed. The apparent split between the positive and negative aspects of the clients own identities, methadone and drug services is emphasised as one of the main themes.

The final section of the research portfolio contains the appendices which contribute towards sections one and two. These appendices include a reflective statement from the perspective of the author regarding the research process and a brief justification for the journal chosen for the publication of this research.

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## **Part One**

Psycho-social Factors Associated with Recovery from Heroin Dependence:

A Review of the British Literature.

This paper is written in the format ready for submission to *Addiction Research and Theory*. Appendix A contains the guidelines for authors.

# **Psycho-social Factors Associated with Recovery from Heroin**

## **Dependence: A Review of the British Literature**

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## ABSTRACT

This review aimed to collate information regarding the psychological and sociological factors that contribute to recovery from heroin dependence. Systematic searches (manual and electronic) using the databases PsychInfo, PsychArticles, Medline, CINAHL, Scopus and Web of Science were undertaken. Six themes were identified: the role of social factors in the engagement of heroin users with services, psycho-social factors associated with motivation to stop heroin use, the role of motivation in achieving abstinence from heroin, the role of confidence/self-efficacy in reduction of heroin consumption, coping strategies and heroin abstinence and the theme of how social factors aid the transition from addict to non-addict identity. The development of non-drug using relationships and coping strategies was associated with abstinence from heroin, identifying points for intervention by drug treatment services. Self-confidence for remaining abstinent from heroin at admission to treatment was found to be unrelated to heroin use following treatment. Confidence surrounding cessation of heroin use was dependent on receiving substitution medication. Drug services may play an important role in increasing past heroin users' self-efficacy with regard to living without heroin and substitution treatment. Throughout the literature, 'recovery' was viewed as engagement with services and abstinence from heroin use. It seemed that this conceptualization of recovery was inconsistent with that provided by the latest government policy and that more research is required to discover how people receiving MMT and people working in drug services view recovery from heroin dependence.

Key words: heroin dependence, psychological, sociological, psycho-social, recovery.

## INTRODUCTION

### Prevalence of heroin dependence within the United Kingdom

Opiate dependence has been associated with unemployment, homelessness and increased criminal activity (Carroll, 1997). For opiate users themselves, dependence has been linked to poorer physical and mental health. Users report higher levels of anxiety and depression and lower self-esteem (Flynn, Joe, Broome, Simpson & Brown, 2003) and the effects of heroin use on families and communities can be devastating. In 2007, the number of people with an opiate addiction within the United Kingdom was estimated to be 8 people per 1000 of the population (DOH<sup>1</sup>, 2007). Within England, this translated to approximately 270,000 people who were using heroin from 2006 to 2007 (Hay, Gannon, Casey & Miller, 2010 In HM Government, 2010).

However, it appears that the number of people using heroin has declined in recent years. The NTA<sup>2</sup> compared the number of people taking heroin and/or crack cocaine in the mid-2000's versus 2009 and discovered that there were 11,000 fewer heroin users within the British population in 2009 (NTA, 2010). The NTA also found that there were fewer young people using heroin, as indicated by a decline in numbers first seeking treatment for heroin dependence. The most common age group seeking treatment for heroin dependence for the first time are people over forty years of age, suggesting an aging heroin using population (NTA, 2010). Alternatively, it could signify the age at which heroin users first present to services, as they have decided that they no longer wish to be part of the drug using lifestyle and want to change.

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<sup>1</sup> Department of Health

<sup>2</sup> National Treatment Agency

## Treatment of heroin dependence in the United Kingdom

The 1926 Rolleston Report<sup>3</sup> gave British medical practitioners permission to prescribe opiate drugs to people dependent on opiates (Carson-Dewitt & Gale, 2001). The conditions for this were that the opiate users should be capable of maintaining a 'useful and normal life' whilst on a minimum dose, a lifestyle which proved impossible when the drug was withdrawn. The practitioners themselves also had to have the intention of encouraging patients to participate in a gradual withdrawal from the drug (Strang & Gossop, 1994). This suggests the British system from the 1920s onwards viewed the prescription of opiate to addicts from a medical viewpoint, construing opiate addiction as a disease that should be treated.

However, in the 1960s, opiate users from abroad moved to London to exploit the British prescribing system and use prescribed opiates for hedonistic purposes. To contain the spread of such opiate use and the associated rise in crime, drug clinics were set up. These clinics aimed to provide heroin free of charge in sufficient dose to reduce the cravings of the addict. Over time, the prescription of heroin was replaced by methadone. The importance of retaining opiate users in treatment, through prescription of substitute medication and increased access to other services e.g. needle exchange, social support e.t.c. was emphasised in British drug services over the next forty years. Engagement with services beyond 1 year was associated with reduced crime and unemployment within local communities. With respect to the opiate users themselves, increased engagement with services was associated with reductions in injecting and illicit drug use (NTA, 2004)

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<sup>3</sup> The report published by the committee commissioned by the Home Office to consider whether prescription of opiates to opiate dependent individual was advisable, and if so, to recommend any precautions necessary to prevent abuse of the system. The committee was chaired by Sir Humphrey Rolleston and consisted of medical personnel representing government agencies and physician-interest groups.

## Current policy for treating heroin dependence in the United Kingdom

In 2010, a new drug treatment strategy was released by the government. Instead of focusing on retaining individuals in treatment, the strategy aimed to provide a person-centred approach with the ultimate goal of enabling opiate (and other drug) dependent individuals to be able to lead a drug free life. As well as being independent of illicit drugs, the drug strategy suggests that recovery also includes two other principles: wellbeing and citizenship. This states that in addition to previously existing goals of reducing drug-related deaths and the prevalence of crime and blood borne viruses, the new strategy emphasises other dimensions of recovery. These include: sustained employment, improvement in mental and physical health, improved relationships with family members and friends as well as the ability to be a caring and effective parent (HM Government, 2010). Whilst this policy represents an attempt to conceptualize recovery, a consensus of what recovery from drug use actually consists of is still in the early stages of development (UKDPCG<sup>4</sup>, 2008)

## Models of recovery from drug dependence

One of the most well-known models of recovery from drug dependence is “The Trans-theoretical Model of Change” (DiClemente, 2003). This model suggests that the process of recovery from drug dependence is characterised by several stages: 1) Pre-contemplation, where the individual can see no reason to change, 2) Contemplation, where the individual has recognised that there may be some benefits to changing their drug taking behaviour but may feel they are not ready to start the change process, 3) Preparation, where the person takes steps towards starting to change, 4) Action where the person starts the process of change, for example, entering a treatment programme and 5) Maintenance, where the person tries to maintain the changes they have made

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<sup>4</sup> The United Kingdom Drug Policy Commission Recovery Consensus Group

within their life. The model states that change can be supported by the environmental context the person is experiencing, with factors such as their current life situation, interpersonal relationships, social systems and personal characteristics all influencing the change process.

The Trans-theoretical model states that for change to occur, drug-dependent individuals need to experience changes in their cognitive and experiential processes. These processes include those of consciousness raising, self-revaluation, emotional arousal/dramatic belief and social liberation. These cognitive changes are necessary to allow for the behavioural changes that are, as suggested by the 2010 Drug Strategy (HM Government, 2010), associated with recovery from drug abuse. However, the model proposes that these cognitive changes can be affected by several inter-related psychological and environmental factors, for example: an increase in the drug-users self-efficacy, supportive relationships and severing ties with the former drug-using lifestyle.

Why is a review of the literature necessary?

Recent policy changes within British Drug Treatment Services suggest that views on what constitutes recovery from heroin abuse are changing. Recovery now appears as a broader concept and is conceived as being more than retention in substitution treatment. Outcomes now encompass behavioural, emotional and relationship changes within heroin users lives. The Trans-theoretical Model of recovery from drug addiction proposed by DiClemente (2003) suggests that there are several inter-related cognitive and environmental changes associated with recovery from drug dependence. It seems that to achieve the desired outcomes proposed by the 2010 Drug Strategy, a thorough understanding of the psychological and sociological factors which may contribute to the

recovery process is required so that drug services can target these factors in person-centred treatment plans. Thus, this review aims to examine existing evidence within the British literature of the psychological and sociological factors associated with recovery from heroin dependence.

## METHOD

### Search Strategy

#### Identification of search terms

Search terms were informed by the question: “What are the psycho-social factors associated with recovery from heroin dependence?” Several different search terms were identified, using synonym’s from different components of the review question (Table 1).

*Table 1: Search terms based upon the literature review question “What are the psycho-social factors associated with recovery from heroin addiction?”*

<b>Search Term</b>	<b>Psycho-social</b>	<b>Recovery</b>	<b>Heroin</b>
<b>Search Term</b>	Psych*Social	Recovery	Heroin
<b>Variations</b>	Psych*social	Rehab* or rehab*	heroin
	psych*social	Detox* or detox*	
	Psych*		
	psych*		
	Soci*		
	soci*		

Search terms were “Psycho-social”, “Recovery” and “Heroin”. The number of synonyms for each search term was deliberately limited in number and kept quite broad. This had two aims. Firstly, to ensure that the authors’ assumptions on what could/should be included under each search term could be controlled for as much as possible, to ensure a comprehensive literature search. Secondly, identified search terms needed to be kept to a realistically manageable number to facilitate clarity of the review.

#### Data sources

Identified search terms were entered into PsychInfo, PsychArticles, CINAHL, Medline, Web of Science and Scopus databases on 13<sup>th</sup> February 2011. These were chosen to provide access to journals whose content reflected the psychological, sociological and medical subjects topics necessary for this literature review.

Publications were also acquired through hand searches of the bibliographic review of studies obtained through the online searches. Eminent authors within the recovery from heroin dependence field, identified by previous literature searches, were contacted via email to request details of other potentially relevant papers, which may not already have been identified by the systematic search. One reply was received, identifying material published by the author that they believed may be relevant to the current literature review.

#### Inclusion and exclusion criteria

To ensure that the literature review was based upon as homogeneous sample of studies as possible the inclusion and exclusion criteria, as outlined in Table 2 were used.

Figure 1 outlines the process of study selection for inclusion in the review. Studies were initially screened according to title and abstract and were only excluded if they clearly met the exclusion criteria outlined in Table 2. The full text was then obtained from the relevant online database, or by requesting a hard copy from a public library. Inclusion and exclusion criteria were then applied to the full text, which was accepted into the literature review if criteria were satisfied. In total, 14 studies met the inclusion/exclusion criteria. Eleven of these were quantitative in design, and 3 were qualitative. Table 3 indicates the number of papers that were excluded due to not meeting inclusion criteria.



Table 2: Inclusion/Exclusion criteria and rationale

Inclusion	Exclusion
<p>Heroin as primary drug of abuse*. To ensure the results of the review could be applied to as homogenous a population as possible.</p>	<p>Papers focusing on participant relapse. Inclusion of these papers would have meant assuming that the psycho-social factors linked to recovery were the “opposite” of those associated with relapse.</p>
<p>Peer reviewed paper and Journal to ensure scientific rigour of studies included in the review.</p>	<p>Studies evaluating the effectiveness of treatment /comparing treatments. These studies did not include any link between Psycho-social factors and an aspect of recovery.</p>
<p>Clear link between psychosocial and recovery factors. This was to exclude articles with a purely medical focus.</p>	<p>Non-British Studies. Literature from other areas of the world may have been influenced by cultural variations in how heroin dependence is perceived and treated which may have affected the variables under consideration in this review.</p>
<p>Studies published from 1977 onwards.*<sup>1</sup></p> <p>Participants over 18 years of age. To preserve homogeneity of studies included in review and to increase confidence in conclusions drawn from data.</p>	<p>Non-English papers. No time, funding or expertise available for translation purposes.</p> <p>Proceedings papers, Notes, Editorial Material Document Types; letters, non-clinically based discussion articles/review papers or papers conducted with prison population. This was to maintain homogeneity of review</p>

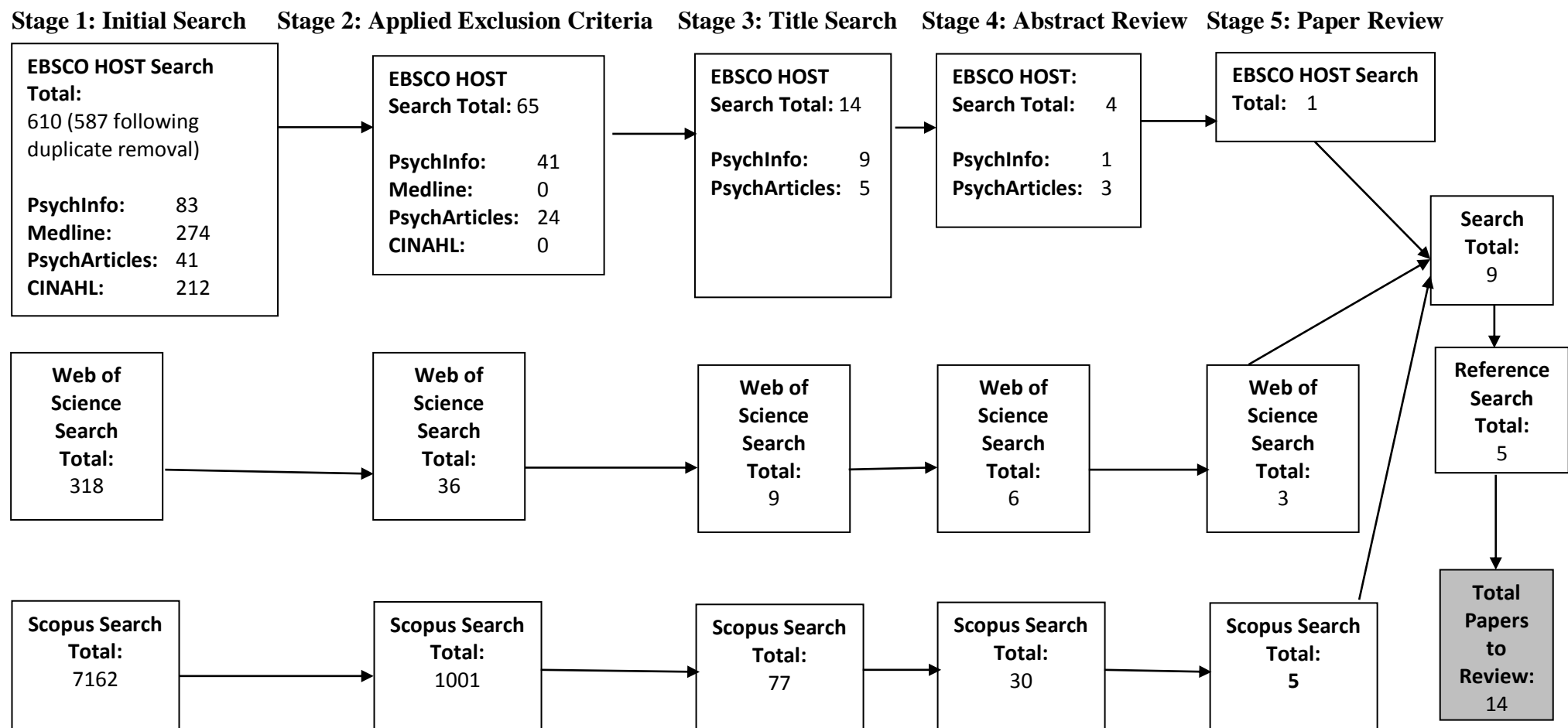
if:

- There was a clear link between a psycho-social factor and a recovery factor.
- If heroin was the main choice of drug for 80% of the participants' in the study.

This was to encourage a broad range of topics were included in the review, whilst making sure the results of the review could be applied to a heroin using population.

\*<sup>1</sup> Engel's (1977) Bio-psych-social Model of Health and Illness considers psychological and social aspects to health problems. Any literature pertaining to the psychosocial and sociological factors contributing to recovery from heroin dependence seemed more likely to occur following the publication of this model. This was confirmed following a preliminary literature review in December 2009.

Figure 1: Process of Identification of Studies for Inclusion in Review



## Study quality assessment

The methodological quality of included qualitative papers was assessed via guidelines provided by the National Institute for Health and Clinical Excellence (NICE, 2007).

This measure was chosen because its direct applicability to the papers included in this review (See Appendix B.1). Scores on this checklist ranged from 0 to 16, with 16 indicated a good study.

The quality of the quantitative papers was assessed through a modified version of the Down and Black (1998) checklist. This checklist was chosen due to its reported ease of application to papers on healthcare subjects and its high reliability testing scores (Cronbach alpha > 0.69 on all subscales, except for the external validity subscale) (National Collaborating Centre for Methods and Tools, 2011). Because many of the studies selected for the current literature review were not intervention studies, some items on the Down and Black (1998) checklist were not useful for this review. As a result, it was adapted, incorporating questions from the CONSORT 2010 statement to create the finalized checklist. (Schulz, Altman & Moher, 2010), (See Appendix B.2). Scores ranged from 0 to 54, with 54 indicating a study of excellent quality.

Checklist scores were converted into percentages to allow for integration of scores from the quantitative and qualitative papers. The mean quality score for the studies included in the review was 52% (range from 31% to 72%). This suggests that there was a large variability in the quality of the studies included in this review and that overall, the quality of the studies was quite low. A number of methodological flaws were identified in these studies, which are considered in the results section of this review. A Pearson's product-moment correlation coefficient test of inter-rater reliability, based on a sample of 50 per cent of the studies, was calculated. A high level of agreement ( $r =$

0.81) was reached between the author and an independent rater (Cohen, 1988). No studies were excluded from the review on the basis of receiving a poor quality rating.

#### Data extraction and synthesis

Following identification and quality rating of studies to include in the literature review, the main themes were extracted and grouped thematically using the data extraction form detailed in Appendix B.3. Due to the heterogeneity of the data, no statistical analysis was attempted. The main themes found from the studies are discussed in a narrative format in the results section (see Table 4 for detailed results of individual studies).

## RESULTS

*Table 3: Description of included studies (with quality ratings and key abbreviations)*

<b>Authors</b> (Quality Rating)	<b>Study Aims</b>	<b>Participants</b>	<b>Method</b>	<b>Findings</b>	<b>Research Limitations</b>
Best, D.W., Ghufuran, S., Day, E., Ray, R., & Loaring, J. (2008) (Rater1: 25/54) (Rater 2: 23/54)	To measure factors associated with "desistence" of heroin use and identify what enables heroin users to achieve and sustain abstinence from heroin.	107 former heroin users, recruited through former users in addiction field. Mean age 42, 79% male, 88% white.	Quantitative: participants asked to complete questionnaire about their heroin careers and desistence. Qualitative: some qualitative questions about how they had become drug free and maintained this. Some participants had "in-depth" interviews. Qualitative descriptive statistics used e.g. percentages.	Common reasons for stopping heroin use (motivation)* :tired of lifestyle, psychological/physical problems, criminal justice, family pressures, work, support from partner/friends. Factors related to sustained abstinence were: prescribed methadone, alternate substance use, support from friends, moving away from drug using friends, place to live and religious/ spiritual beliefs. Other things that supported last quit attempt: insight, feeling psych. prepared, family reasons.	Retrospective study: possible recall bias. Participants were often working in drug services, possible impact on results generalizability. Questions more perhaps suited to qualitative method and analysis, as seems more exploratory and used a non-validated data collection instrument.

<b>Authors</b>	<b>Study Aims</b>	<b>Participants</b>	<b>Method</b>	<b>Findings</b>	<b>Research Limitations</b>
Gossop, M., Green, L., Phillips, G., & Bradley, B. (1990)  (Rater 1: 24/54)  (Rater 2: 26/54)	To examine psychosocial factors that may be predictive of outcome among opiate users. Recovery defined as abstinent from all opiate drugs.	80 former opiate users in an inpatient unit for withdrawal treatment of drug problems.	Quantitative. Structured interviews at admission, immediate post discharge and six months post discharge. Measures used: basic demographic variables, drug history, protective factors, coping strategies, CRS. Analysis used: Backward stepwise multiple regression analysis.	Number of protective factors ( $p < 0.001$ ) time in treatment ( $p < 0.05$ ), confidence in abstaining from opiate use ( $p < 0.05$ ) were found to predict outcome at six months following treatment. Protective factors ( $p < 0.01$ ), coping strategies ( $p < 0.05$ ) and confidence ( $p < 0.05$ ) were found to be negatively associated with frequency of opiate use in two months following discharge. Protective factors ( $p < 0.01$ ) and confidence ( $p < 0.05$ ) also positively associated with improvement in opiate six months post discharge (improvement = reduction in opiate use).	Didn't indicate which protective factors associated with outcome. Non-validated outcome measures. Limited follow up period.

<b>Authors</b>	<b>Study Aims</b>	<b>Participants</b>	<b>Method</b>	<b>Findings</b>	<b>Research Limitations</b>
Gossop, M., Stewart, D., & Marsden, J. (2006) (30/54)	To investigate the hypotheses that higher "taking steps to overcome opiate use" scores should be related to less frequent opiate use and less illicit drug use at follow up. Recovery = changes in substance abuse behaviours, health problems and personal and sociological functioning.	1075 people seeking treatment for opiate use (heroin) recruited through NTORS. Mean age 29.3, range 16-58. 74% men 91% white. 753 in follow up group	Qualitative. Longitudinal, prospective cohort study. Structured interviews at treatment intake and one year follow up. Measured motivation/readiness for change using SOCRATES, SDS, depression/anxiety scales from BSI. Analysis = Multiple Regression.	At intake: recognition scores were positively associated with more frequent use of heroin ( $p < 0.001$ ), and higher anxiety/depression scores ( $p < 0.01$ and $p < 0.001$ respectively). Taking steps was negatively associated with heroin use ( $p < 0.01$ ). At follow up: None of the SOCRATES (motivation) scales associated with heroin use. Higher scores on taking steps scale associated with less use of unprescribed benzodiazepines ( $p < 0.001$ ).	Follow up sample not compared to sample at intake. Perhaps useful to see if SOCRATES scores had changed at follow up, and whether these scores were linked to drug use?



<b>Authors</b>	<b>Study Aims</b>	<b>Participants</b>	<b>Method</b>	<b>Findings</b>	<b>Research Limitations</b>
Gossop, M., Stewart, D., Browne, N., & Marsden, J. (2002).  (28/54)	To investigate factors related to relapse to heroin use and use of coping responses by heroin users (specifically to which different types of coping responses were related to heroin use). Recovery = non-heroin use/prevention of relapse.	242 heroin users on admission to residential treatment programmes.  Mean age = 29.4 years, S.D. = 6.2. 78% = male, 91% = white, UK.	Quantitative. Structured interview at intake/ follow up. Separated into relapsed, lapse and abstinent groups.  <i>Measures used</i> ; SDS, alcohol units/day, OTI, BSI, PCQ, duration in treatment.  <i>Analysis</i> ; One way analysis of variance and post-hoc differences by Tukeys HSD for continuous data. X <sup>2</sup> tests for categorical data.  Repeated measures analysis of variance for coping score changes.	At intake: no difference between 3 relapse groups in terms of cognitive, avoidance or distraction coping strategies. At follow up, clients in abstinent group reported greater use of all three coping responses than at intake (p<0.05).	Large variation in time between intake interview and follow up (mean = 19.3 weeks, s.d. = 17.3) which may have introduced bias

<b>Authors</b>	<b>Study Aims</b>	<b>Participants</b>	<b>Method</b>	<b>Findings</b>	<b>Research Limitations</b>
Hughes, K. (2007)  (6/16)	To develop a "social conceptualization" of addiction. Explored how migration from addict to non-addict involves more than identity work and how this can be applied to recovery process.  Recovery = stopping heroin use.	10 current and ex heroin users.	Qualitative. Data collected using repeated semi-structured interviews.  Participants asked about periods in lives when they had felt health/unhealthy and about their heroin use and addiction. Analysed using discourse and content analysis.	The process of constructing a non-addict identity is not solely due to the behaviours of the individual.  Participation in relationships and behaviours (e.g. work) outside the drug-using lifestyle reinforces non-addict identity, which further increases non-drug using behaviours.	More than one interviewer - could be considered useful as can generate inter-rater discussion of themes.  Recovery is small focus of paper. Participant sample not adequately described. Small sample size

<b>Authors</b>	<b>Study Aims</b>	<b>Participants</b>	<b>Method</b>	<b>Findings</b>	<b>Research Limitations</b>
Ison, J., Day, E., Fisher, K., Pratt, M., Hull, M., & Copello, A. (2006) (31/54)	To explore process of self-detoxification from opioid drugs; (Part relevant to literature search; Which psychological and physical methods of detoxification did they employ and which were most helpful). Recovery defined as abstinence from opiates sustained without medical assistance for over 24 hours.	98 people presenting to outpatient opioid detoxification service. Mean age 27.4, range 18-63 years. 90 males.	Retrospective Quantitative study. Part 1: Semi structured interviews: description of previous attempts to self-detoxify. This informed Part 2: structured interview questionnaire, details on reasons for; self-detox and not to accessing services, psychological/ physical strategies employed, factors in relapse. <i>Analysis:</i> Chi-square for categorical data, 2-tailed independent t-tests/Mann Whitney-U tests for continuous data.	Reasons for trying to detoxify (motivation)*; no money, for self, physical/mental health, pressure from others, criminal justice, couldn't get help, work/studying, on waiting list. Methods used to aid detoxification =avoidance*; keep busy/take mind off, other drug use, exercise, work, stay at home, Other factors; avoid drug using friends, get support from others, counselling	No previously identified psychological/sociological factors. An exploratory study so perhaps qualitative methodology could have been more appropriate. Relied on retrospective accounts. Definition of recovery/ detoxification is limited?

<b>Authors</b>	<b>Study Aims</b>	<b>Participants</b>	<b>Method</b>	<b>Findings</b>	<b>Research Limitations</b>
Mullen, K., & Hammersley, R. (2006).  (Rater 1: 5/16)  (Rater 2: 8/16)	Analysing reasons for ceasing or continuing heroin use. Focus on processes involved in initial cessation and on those involved in episodes of relapse and in success in sustaining abstinence from heroin. Examines how cessation and relapse were related to managing social roles and identity.	26 male current and past heroin users, recruited through drug services. Mean age = 34	Qualitative. Data collected using semi-structured interviews. Analysed using grounded theory and analytical induction techniques.	Factors involved in choosing to cease heroin use; needing to be ready to quit, stopping when getting tired of "heroin blocking normal reality", the "right time to stop" (sub factors include: hitting rock bottom, quitting for self rather than for external pressures, growing out of it), Reasons for stopping (sub-factors include: major life changes, avoid prison, birth of child/loss of custody).  Factors involved in avoiding relapse: effective management of emotions, avoid high risk situations, readiness to quit (sub-factors include: maturation, personal low point, conscious preparation to quit), change of identity (processes involved in this: need to recognise some changes have occurred, trust from others, helping others, managing stigma)	All male participants; lack of generalizability to rest of heroin using population.  Only people over 28 years of age asked to participate

<b>Authors</b>	<b>Study Aims</b>	<b>Participants</b>	<b>Method</b>	<b>Findings</b>	<b>Research Limitations</b>
Murphy, P.N., & Bentall, R.P. (1997)  (Rater 1: 35/54)  (Rater 2: 27/54)	Test predictive value of motivation model proposed by Murphy and Bentall (1992) and the predictive value of self-efficacy and lifestyle stability ratings. Recovery defined as; still receiving withdrawal medication, with planned discharge.	57 patients admitted for detoxification from heroin at Mersey Regional Drug Dependency Unit. 47 male.	Quantitative. Prospective cohort study. Participants interviewed within 24 hours of admission and outcome at discharge recorded. Measures used: 16 item Motivation questionnaire devised by Murphy and Bentall (1992) and visual analogue scale for self-efficacy for withdrawal (from heroin) completion. Information on living circumstances, education, employment and past drug use via questionnaire. Analysis: stepwise multiple regression/logical regression.	Negative effects of heroin motivation factor negatively associated with length of stay, but only accounted for 5.8% of variance ( $F = 2.09$ , $P = 0.042$ ). External constraints motivation factor positively associated with premature ( $p < 0.045$ ) and planned discharges ( $p < 0.029$ ). Lifestyle stability was associated with drug free status at discharge ( $\chi^2 = 11.036$ , $d.f = 3$ , $p < 0.0115$ ). Whole model failed to predict discharge outcome or whether completed detox. Self-efficacy did not predict discharge outcome.	Variables chosen to represent lifestyle stability = number of jobs held in 2 years before admission, whether receiving methadone at admission, number of opiate drugs used at time of admission. Possible bias in results? ' Small sample

Authors	Study Aims	Participants	Method	Findings	Research Limitations
Murphy, P. N., Bentall, R. P., Ryley, L. D., & Ralley, R. (2003) (Rater 1: 32/54) (Rater 2: 27/54)	Examined predictive ability of model of motivation and confidence for post discharge outcomes. Recovery defined as abstinence from heroin 30 days after discharge and number of heroin free days in the three months following admission	Recruited from patients entering Mersey Regional Drug Dependency Unit for opiate detoxification. <i>Original Sample:</i> Mean Age = 25.7 years (S.D. = 3.53), 47 men, 10 women. <i>At follow up:</i> Mean Age = 25.9 years, (S.D. = 3.35). 36 men, 7 women.	Quantitative: Structured interview 24 hours after admission. Measures: MQ, CRPA, Demographic data. Participants followed up at 1/3 months post discharge. Data on re-use of heroin by interview, postal questionnaire or via telephone. Analysis: Admission scores of motivation/confidence and logical regression to predict heroin re-use. Logistic regression to test predictive ability for re-use within 30 days of discharge. Multiple linear regressions to test for no. of heroin free days within 3 months from admission.	Confidence rating significantly improved logical regression ability to predict heroin use after discharge ( $X^2(1, 39) = 8.915, p=0.003$ ). Motivation factors did not contribute significantly to the models ability to predict participants' heroin use following discharge. Both Confidence and External constraints motivation score contributed significantly to multiple linear regression ability to predict heroin use during 30 days following admission ( $p=0.01$ and $p = 0.03$ respectively). External Constraints motivation scores were inversely related to heroin use.	Recording of post-discharge opiate use was based on verbal reports of participants, thus may have been influenced by recall bias. Relatively small sample size, thus results may not be generalizable to the wider heroin using population. The total follow up period of three months was also of limited duration, which may limit the applicability of the results to more everyday settings.

Authors	Study Aims	Participants	Method	Findings	Research Limitations
Murphy, P.N., Bentall, R.P., &Owens, G. (1989)  (34/54)	To investigate relationship between users motivation, incentives and previous withdrawal experiences and their experiences unmodified opioid withdrawal. Recovery = abstinence from heroin	70 people referred from counselling centres, outpatient drug dependency clinics and inpatient drug dependency wards. Mean age = 23.6, range 15-45, 47 male.	Quantitative. Participants asked about motivation behind most recent experience of unmodified withdrawal. <i>Measures used:</i> 5 visual analogue scales, based upon previous literature (court case, new job, concern for well-being, keeping present job, for sake of relations with people close to them), Measure of withdrawal experiences = visual analogue scale of distress. <i>Analysis:</i> independent t-tests and principal components analysis.	No sig. relationship between any motivational scales and reported distress/duration of withdrawal. Successful people reported greater motivation with respect to relationships (t=2.00, p<0.05) but less motivation with respect to contact with the law (t=2.52, p<0.014). Two factors extracted from data. 1 = motivation for relationships and own well-being (private affairs) 2 = motivation for acquiring/ keeping job and contact with legal process (public affairs). No sig. relationship between motivation factors and drug use outcome. Subjects who reached abstinent showed sig higher factor 1 scores than unsuccessful subjects (t=2.25, p<0.03).	Retrospective, un-validated measure. Statistical tests used not clear.

Authors	Study Aims	Participants	Method	Findings	Research Limitations
Neale, J., Sheard, L., & Tomkins, C, N.E. (2007)  (Rater 1: 7/16) (Rater 2: 5/16)	Explores factors that enable heroin users to access and benefit from drug treatment services. Recovery = engagement with services.	75 illicit drug injectors (heroin) recruited through needle exchange programmes. Aged from 19-48 years. 52 Male, 9 Black/Ethnic minorities.	Qualitative: Semi-structured interviews asking about; general life circumstances, drug use, treatment history/service use, problems experienced in accessing drug treatment, changes that services could make, other factors that have made it easier for them to seek support. <i>Analysis;</i> Interviews transcribed and coding frame created. Text systematically analysed using framework. Framework updated until all theme's accounted for	3 factors associated with access to and benefit from services. 1) Supportive relationships (family members, friendly professionals) 2) Personal Circumstances and life events (being a parent, bereavements, poor mental health, family illness). 3) Injectors state of mind (feeling more positive about themselves, increased motivation); feeling less depressed about lives, growth in self-confidence, reduced feeling of shame. Reasons behind emotional and psychological changes; supportive drug worker, getting married, becoming parent. Those with better psych/emotional health had tended to have had previous treatment.	Engagement with services was small part of paper. Participants who were asked may still have been receiving some support through the needle exchange service: potential bias. Only 80% participants main drug of choice = heroin. 20% indicated that their drug of choice was cocaine or amphetamines. This may impact on generalizability of results to heroin using population.



<b>Authors</b>	<b>Study Aims</b>	<b>Participants</b>	<b>Method</b>	<b>Findings</b>	<b>Research Limitations</b>
Noble,A., Best, D., Man, L., Gossop, M., & Strang, J. (2002)  (28/54)	Investigate self- detoxification attempts in opiate users currently receiving MMT. To examine which factors influence decisions to attempt self-detox. Recovery = self- detoxification attempt: to achieve abstinence from opiates for at least 1 week without clinical assistance	115 patients attending methadone maintenance outpatient clinic. Mean age = 37 years (S.D. = 7.9) Range = 21- 55 years. 79 males, 89 = white.	Quantitative; Interview on admission. Participants asked about earlier self- detox. Attempts and experiences, illicit drug use, social functioning. Some qualitative questions. Measures used: MAP, Self-detox. Questionnaire (Gossop, et al., 1991). Analysis: Descriptive statistics - mainly percentages.	Reasons reported for self- detoxification (motivation*): Fed up with lifestyle (61%), For family (12%), Wanted to stop using (9%), Work reasons (3%), Court case (3%), Forced detoxification - prison (3%), Heroin bad for you (3%), For myself (2%), Other (availability/money/financial) (4%).	Retrospective; potential recall bias. Poor statistical analysis; perhaps qualitative method/analysis would have been more appropriate. Weak psycho-social recovery link.

Authors	Study Aims	Participants	Method	Findings	Research Limitations
Powell, J., Dawe, S., Richards, D., Gossop, M., Marks, I., Strange, J., & Gray, J. (1993)  (27/54)	To investigate if personality, cue-elicited craving, outcome expectancies for drug use, self-efficacy predict ability to resist drug use. Recovery = duration of abstinence from heroin	43 opiate users receiving inpatient detoxification treatment in either a specialist drug dependence unit or BPW. 36 men, mean age 29.7 (s.d. = 6.7).	Quantitative; RCT. Initial semi-structured interview at admission and completion of questionnaires; EPQ, TAS, IQ, CQ, CT. At follow up at 1 and 6 months, subjects asked about drug use in last month, and to describe circumstances around lapse to opiate use. <i>Analysis:</i> two-tailed t-tests and point- bi serial correlations between predictor variables and six month outcome measures.	Craving levels not related to opiate use at either first or second follow ups. No significant correlations between EPQ-N, Trait Anxiety or impulsivity and opiate use at two follow ups. Negative correlation at second follow up between pro's of opiate use score and days of opiate use (p<0.02). CQ scores predicted number of days opiate use at six months follow up (negative association, p<0.02 for DDU group only).	Query "data-dredging"?

Authors	Study Aims	Participants	Method	Findings	Research Limitations
Senbanjo, R., Wolff, K., Marshall, J., & Strang, J. (2009)  (Rater 1: 39/54) (Rater 2: 37/54)	To evaluate the confidence in ability to remain abstinent of methadone patients in high risk situations for heroin use. To identify moderators of heroin use outcomes during methadone treatment and main factors linked to continued heroin use. Recovery = abstinence from heroin in 14 days prior to assessment.	191 Methadone users in outpatient clinics. Mean Age =33 years old. 70% Male, 97% White European	Quantitative: Cross sectional survey. Users were separated into heroin using/non heroin (based on previous 14 days) using groups and compared. Measures used: DTCQ, Time spent socializing with other drug users, HADS, MAP, AUDIT, Analysis used: Means, SD. Groups compared using OR, mean differences, CI, X <sup>2</sup> or independent t-tests. Logical regression performed to assess impact of a number of factors on persistent heroin use.	Heroin users sig. more likely to spend 'some' or 'most' of their time with other drug users (p<0.05). Non users group had sig lower depression score ( p=0.002). Non users also reported sig. higher coping self-efficacy (p<0.001). Logistic regression model with co-variants; perceived self-efficacy, time in treatment, satisfaction with methadone dose, time with drug users, HADS scores provided best predictive power of heroin use (X <sup>2</sup> = 80.3, d.f. =7, p<0.001). Spending more time with drug users associated with sig. lower mean coping self-efficacy scores in certain situations (p - 0.029). Low mood also associated with lower scores on some self-efficacy scales.	Retrospective study thus may have been influenced by recall bias. Results merely express a relationship between heroin use and psycho-social factors, no implication of causality.

\*Label applied by Shaw (2011) not author of the paper included in this literature review

ANOVA = Analysis of Variance, AUDIT= Alcohol Use Disorders Identification Test, BPW = Behavioural Psychiatric Ward, BSI = Brief Symptom Inventory, CRS = Confidence Rating Scale, CQ = Confidence Questionnaire, CRPA = Confidence Ratings for Post-discharge Abstinence, CT= Craving Test, DTQC = Drug Taking Confidence Questionnaire, DDU = Drug dependence unit, EPQ = Eysenck Personality Questionnaire, Hospital Anxiety and Depression Scale, IQ = Impulsivity – 7 questionnaire, MAP = Maudsley Addiction Profile, MMT = Methadone Maintenance Treatment, MQ= motivation questionnaire, NTORS = National Treatment Outcome Research Study, OTI = Opiate Treatment Index (physical health items), PCQ = Process of Change Questionnaire, RCT = Randomized Control Trial, SDS = Severity of Dependence Scale, SOCRATES= Stages of Change and Treatment Eagerness Scale, TAS = Trait Anxiety Scale from State-Trait Anxiety Inventory.

The main themes extracted from the studies included in the review are now discussed and this is followed by an exploration of their methodological limitations.

#### Social factors and engagement with services

In a qualitative study by Neale (2007), injecting drug users stated that supportive relationships with friends, family and professionals enabled them to seek support from services. These relationships provided both practical and emotional support that provided heroin users with sufficient stability in their lives to enable them to seek professional help. In terms of practical support, the supporters phoned drug agencies to arrange appointments for the user, accompanied them to services, negotiated on their behalf and provided accommodation, clothes and meals. The users also felt that these supportive relationships provided them with someone to talk to, someone who would give them confidence and encouragement to seek treatment. They stated that it was important that someone believed that they could overcome their addiction and that these supportive relationships helped 'improve their state of mind', which also aided them in seeking help. These "improvements" included feeling more positive about themselves and being more motivated to seek treatment. Factors which were associated with this motivation to seek treatment included: feeling less depressed about their lives, growth in self-confidence/willpower and a reduced feeling of shame and embarrassment about themselves and behaviour. Participants also stated that personal circumstances and life events such as: being/becoming a parent, bereavements, poor mental health and family illness contributed to their decision to seek service support (Neale, Sheard, & Tomkins, 2007).

## Psycho-social factors associated with motivation to stop heroin use

In a quantitative study utilizing descriptive statistics, former heroin users working in the addiction field stated that common reasons for them stopping their heroin use included: being tired of the lifestyle, psychological problems, family problems and support from friends and family. Factors that the former users identified as being particularly important in helping them initiate their last quit attempt were: insight into their difficulties, feeling psychologically prepared and family reasons (Best, Ghufuran, Day, Ray, & Loaring, 2008). No additional descriptive information about these themes was provided; indeed this paper may have benefited from utilizing a qualitative methodology. This study found that social factors associated with sustained abstinence from heroin were: support from friends, moving away from drug-using friends and religious/spiritual beliefs. These findings are supported by quantitative research conducted by Ison et al (2006), again using descriptive statistics, where heroin users stated that factors behind previous attempts to self-detoxify included: doing it “for themselves”, mental health difficulties, pressure from others, being involved with the criminal justice system, or trying to quit to enable them to work/study.

In a qualitative study, Mullen and Hammersley (2006) interviewed both current and past heroin users about previous successful attempts to stop their heroin use. One factor involved in stopping was users getting tired of heroin blocking normal reality. One participant stated:

“...Years go by very quickly when you’re stoned you know and you just get into a rhythm like that, you just don’t notice that life’s going on and things aren’t changing much for you.” (Mullen et al., 2006 p 81).

Participants also reported that quitting heroin occurred after it was the “right time for them to quit”. Another participant stated: “Tried to come off of drugs through other

people's pressure but every opportunity I sneaked through the door. It was not my time. But when the time comes I believe you will know it" (Mullen et al., 2006 p 81).

Sub-factors that were related to it "being the right time" were: hitting rock bottom, quitting for self rather than external pressures and "growing out of it". Other reasons for stopping included: major life changes, to avoid prison and birth of a child/loss of custody. These findings are supported by another quantitative study utilizing descriptive statistics by Noble, Best, Man, Gossop and Strang (2002), who also found that factors influencing previous self-detoxification attempts included: being fed up with the lifestyle, family reasons, wanting to stop using, work reasons, court cases and doing it for themselves.

The role of motivation in achieving abstinence from heroin

In a study using independent t-tests and principal component analysis, it was found that successful abstinence from heroin was more likely to be achieved by drug users whose desire to quit was more motivated by improving relationships with other people and their own wellbeing, than by motivation by external factors such as acquiring/keeping a job or contact with the criminal justice system (Murphy, Bentall & Owens, 1989). In a later paper using regression analysis, Murphy and Bentall (1997) found that motivation for withdrawal that was based upon fear of the negative effects of heroin predicted earlier drop-out from detoxification treatment. As in the earlier study, motivation based upon external factors such as keeping jobs and the criminal justice system was associated with a shorter duration of stay in detoxification treatment. Increased heroin use was predicted by higher scores on a list of positive consequences from heroin use in users seeking heroin detoxification treatment (Powell et. al., 1993).

Conversely, another study using regression analysis has found that motivation (as defined by: fear of negative effects of heroin, internal factors, such as wanting to change for self, and external factors such as changing due to pressure from others) was not associated with participants heroin use at discharge (Murphy, Bentall, Ryley, & Ralley, 2003). This is supported by the finding that measures of motivation (defined by: recognition of drug problems and desire to change, perceived control over drug use and taking steps to change drug using behaviour) at intake to treatment, were not associated with heroin use at discharge. However, higher scores on the “taking steps” subscale of the Stages of Change and Treatment Eagerness (SOCRATES) questionnaire were associated with reduced heroin use at intake, and less use of un-prescribed benzodiazepines at follow up (Gossop, Stewart & Marsden, 2006).

#### Confidence/Self-efficacy and heroin reduction

Levels of confidence in abstaining from heroin use in heroin users being admitted for detoxification treatment was found to be positively related to levels of heroin use at six month follow up. Thus people who were more confident at abstaining from opiates upon admission to treatment were more likely to use heroin again at six months post-treatment. This was the reverse of findings at two months post-treatment, where pre-admission levels of confidence were found to be negatively associated with frequency of opiate use (Gossop, Green, Phillips, & Bradley, 1990).

Self-efficacy for remaining abstinent from heroin in high risk situations, measured at admission to detoxification treatment, was found to be negatively associated with heroin use at six month follow up (Powell, et al., 1993). However, self-efficacy for completing withdrawal from heroin whilst receiving detoxification treatment was found to be un-



related to planned or unplanned discharge from detoxification treatment (Murphy and Bentall, 1997)

A logistic regression model, with the variants: perceived self-efficacy for abstinence from heroin during high risk situations, time in treatment, satisfaction with methadone dose, time with other drug users and Hospital Anxiety and Depression sub-scales<sup>5</sup> were the strongest predictors of whether heroin users sought methadone treatment and whether they had been abstinent from heroin in the previous two weeks. Spending more time with other drug-users was found to be associated with lower self-efficacy for not using heroin (Senbanjo, Wolff, Marshall & Strang, 2009).

#### Coping strategies and heroin abstinence

The number of behaviours heroin users had for coping with high risk situations for using heroin, was found to be significantly associated with less heroin use two months following discharge from an inpatient detoxification unit (Gossop et al., 1990). A later quantitative study using inferential statistics, found that at intake for admission onto a residential treatment unit, there was no difference between users who lapsed back into heroin use or those that became abstinent in the number of cognitive (e.g. tell myself I can stop using drugs), avoidant (e.g. remove things that remind me of drugs from my home, stay away from drug using friends) or distraction (e.g. physical activity, think about something else) coping strategies. However, at six month follow up, clients in the abstinent group reported significantly greater use of all three of these coping strategies vs at intake ( $p < 0.05$ ). In contrast, in the relapsed group there was no significant change in the number or type of coping strategies used (Gossop, Stewart, Browne and Marsden,

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<sup>5</sup> (HADS): A self-report questionnaire that measures symptoms of depression and anxiety.

2002). Thus, abstinence from heroin appears to be associated with the development of different kinds of coping strategy.

In a retrospective quantitative study, Ison et al (2006) identified several different types of coping strategies used by people trying to self-detoxify, including: keeping busy/taking their mind off drug use, exercise, working, or staying at home to avoid other drug users and places associated with drug use. These coping strategies could be classified as avoidance, similar to the strategies described in Gossop et al's (2002) study. Participants in Ison's (2006) study also identified help-seeking coping strategies, which included: talking to non-drug users and going for counselling. No additional information was provided on how useful these coping strategies were to people trying to abstain from heroin or when particular coping strategies were utilized over the duration of the quit attempt.

Other strategies that were used to avoid relapse back into heroin use were found to be: effective management of emotions, avoidance of high risk situations and readiness to quit (Mullen et al., 2006). Common themes that participants reported affecting their readiness to quit included: maturing out of drug use or reaching a personal low point. Participants also reported the need to recognise that changes had occurred and the importance of trust from others in helping them to change their identity to that of a non-drug user. Another interviewee highlighted the importance of helping others as a way of changing their own identity:

“...What helped me through was that I was still working with people that were using, I would say maybe 90% of the people who came in (religious agency) were using, either alcohol or drugs. But I was on the other side of the counter.” (Mullen et al., 2006 p 86).

## Social factors and the transition from addict to non-addict identity

Another qualitative study suggested that as well as initiating the recovery process, heroin users' development of new relationships with non-drug users was a product of their recovery process, which further facilitated their recovery. People who were successful in detoxing from heroin described how they re-engaged with non-drug using relationships and participated in practices that maintained a non-using lifestyle and relationships (Hughes, 2007). These observations are supported by the finding from a quantitative study using descriptive and inferential analysis, which suggest that heroin users entering methadone treatment were significantly more likely to use heroin if they spent a lot of time with other drug users (Senbanjo et al., 2009).

Two themes were identified using qualitative methodology by past and current heroin users in the process of transition from user to non-user identity. These were: the importance of having belief in one's own ability to stop using heroin and, the importance of recognising the extent to which changes were needed in living practices and social relationships. Participants in Hughes (2007) study suggest that for shifts in the living practices of heroin users to occur, heroin users needed to develop and maintain close and emotional relationships with non-users, as they provided emotional support that helped enable these behavioural shifts, which in turn affect the formation of a new "non-addict" identity. As the non-drug use continued, it enabled new forms of engagement and participation in new non-drug using relationships and non-using lifestyle, which allowed for the non-addict identity to develop further. These findings support the view that the level of support received from people, activities or social structures (protective factors), as identified by heroin users entering detoxification treatment, predicted reduced heroin taking status at six-month follow up (Gossop et. al., 1990).

## Methodological considerations of studies included in review

The quality of the studies included in the review varied considerably and several methodological flaws were identified. These can be viewed in Table 4, however a summary of the main methodological weaknesses is provided below.

Firstly, five of the studies included in the review used retrospective methodology, which may have introduced recall bias into the results. A recruitment bias was also present in two studies, limiting the generalizability of results to the rest of the heroin using population. Three studies utilized a quantitative methodology where qualitative research may have been more appropriate. In these cases, the quantitative method appeared to limit the detail of the information that could be obtained. Some studies used a follow-up period as part of their data collection. For four of these studies, the duration of this period seemed of limited duration, varying from immediate post-discharge measurements, to follow up at five months post-treatment. Thus, results from these studies may not be generalizable in the longer-term.

Several studies also used non-validated outcome measures. Some of these outcome measures were based upon participants own experiences and thus useful to describe the experiences of participants. However, results may not be applicable to a broader population. Finally, two studies appeared to use “data-dredging” to inform their results section. This means that upon finding no significant results from the first round of analysis, the studies seem to continue to compare different aspects of their results, until a significant finding was discovered. However, it was difficult to determine this for certain as these studies did not state whether any post-hoc tests were used. If “data-dredging” were used, it may have affected the validity of the results obtained.

## Summary of results

It appears that non-drug using relationships are important at different stages of ‘recovery’ from heroin dependence; from the initial engagement of heroin users with services to the provision of positive feedback to encourage the formation of a non-drug using identity. Another factor associated with initial engagement of heroin users with services is motivation to change, with motivation based upon more external, less selfish reasons (such as improving relationships with others) being linked to abstinence from heroin and longer stay in treatment. However, other studies suggest that motivation to abstain from heroin upon admission to treatment is unrelated to heroin use at discharge.

The evidence for a link between self-efficacy and abstinence from heroin is also conflicted. One study found that confidence in ability to abstain from heroin upon admission to treatment predicted reduced heroin use at two months post-discharge, but increased heroin use at six months post-discharge, whilst another study found that self-efficacy predicted later abstinence from heroin post-treatment. Successful abstinence was also associated with an increased number of coping strategies.

There are a number of methodological flaws within these papers, including retrospective study designs, which may account for these inconsistencies. These methodological flaws may affect the extent to which the conclusions drawn from the studies included in the review can be applied to a broader population.

## DISCUSSION

Overall, it would appear that the studies included in this review reflect past government policy on the treatment of heroin dependence in Britain. Until recently, the government has encouraged the engagement of heroin users with drug treatment services and

promoted the importance of a stabilized lifestyle and reduction in illicit drug use, mainly through the use of methadone treatment (NTA, 2004). This emphasis on treatment engagement and reduction in illicit drug use was reflected in the literature and is discussed in relation to the broader literature and existing psychological models.

Exploration of main themes

#### Engagement in treatment

In terms of the initiation of an attempt to become abstinent from heroin, the literature appears to emphasise the importance of it being the right time for the individual heroin user and the idea that they are doing it for themselves, not because of pressures from others or due to the fear of negative effects of heroin (Ison et al., 2006; Noble et al., 2002). Many factors seem to contribute to heroin users seeking treatment (Neale, et al., 2007). Research suggests that increased recognition of the need for change at admission to detoxification treatment is related to increased heroin use and higher levels of depression and anxiety (Gossop et al., 2006).

The implication for drug treatment service is clear. Not only is it important that they are available to support heroin users when the time is right for that individual; it also seems important that services recognise that increased heroin use upon admission to treatment may not always be a sign that the heroin user is not ready to change/engage with services. Instead, their increased heroin use could indicate their increased recognition of their need to change or be a symptom of underlying mood difficulties, which using heroin helps them to manage. Services' may play an important role in helping heroin users understand the reasons behind their heroin use and support them, instead of reacting in a way that could be viewed as punitive by the service user e.g. withdrawal of service support.

### The role of self-efficacy

It is possible that mood difficulties and increased heroin use in heroin users who had recognised the need for change may be due to their fear that they may be unable to change their drug-using behaviour ( Gossop et al., 2006). An important factor which may mediate between intention to change and maintaining change is the drug users' confidence or self-efficacy for remaining abstinent from heroin. This idea is supported by the Trans-theoretical Model of Change (DiClemente, 2003) and the Cognitive-Behavioural Model of Relapse Prevention (Marlatt & Gordon, 1995). Both models suggest that a rise in drug-users self-efficacy towards remaining abstinent from drug-use is necessary in the 'recovery' process. In support of this, Gossop et al (1990) found that the higher the heroin user's confidence for achieving abstinence from heroin at admission to detoxification treatment, the less frequently they were likely to use heroin 2 months following discharge. However, at six months post admission, those with higher admission measures of confidence were likely to have higher levels of heroin consumption. It is uncertain why this change in direction of association between confidence in ability to maintain abstinence and heroin use occurred. Previous research has suggested that past experience of withdrawing from heroin can affect level of self-efficacy in maintaining abstinence. Reilly et al (1995) found that between admission and the start of a 120 day stabilisation programme where 74 opiate addicts received a stable dose of methadone, level of self-efficacy with regard to reducing drug taking increased and level of opiate consumption decreased. However, when dose of methadone was reduced, level of abstinence self-efficacy also fell and this was associated with a significant rise in opiate use.

This research suggests that it is perhaps easier for heroin users to feel confident in remaining abstinent from heroin when they are sure of receiving medicinal support.

However, this confidence may lead them to underestimated how difficult the detoxification experience would be, leading them to “relapse” during the critical period following discharge from hospital. This may have some implications for how drug treatment services present medicinal support (for example, methadone) to clients. Services may need to emphasize the role of the client themselves in developing coping strategies, other than drug use, to help them deal with the difficult experience of detoxifying from drugs. This may help prepare heroin users for the detoxification experience and foster a sense of hope that they will be able to overcome these difficulties and will not always be reliant on heroin and/or substitution treatment such as methadone.

In addition, Reilly et al (1995) found self-efficacy, when controlling for past behaviour, was only significantly related to future drug use at the beginning of the stabilization phase and at the beginning of the taper phase. At these times, clients had no experience of the extent to which methadone/being withdrawn from methadone could impact upon their drug taking and had to rely on their sense of self-efficacy. This suggests that opiate addicts abstinence self-efficacy ratings may to some extent be based on their past and present experience of withdrawing from heroin.

Thus, in Gossop et al (1990), high confidence in maintaining abstinence may only be related to actual heroin abstinence when heroin users have managed to abstain from using heroin, an experience they may have been more unlikely to achieve within the longer sixth month follow up period if their confidence at remaining abstinent was based on receiving substitution medication. This again emphasises the role of drug treatment services in increasing drug users’ abstinence self-efficacy and fostering a sense of hope that they will be able to maintain abstinence without substitution



treatment. It would have been useful if Gossop et al (1990) had controlled for previous experience of withdrawing from heroin, to investigate if the link between confidence in abstaining and heroin use was still significant at two months post-admission. The hypothesis is also based on the assumption that the heroin user's self-efficacy ratings for remaining abstinent did not change over the course of detoxification treatment. It would have been interesting if the study had investigated if heroin users' confidence in abstaining from heroin use had changed over time.

### Coping strategies

Individuals who were more likely to be abstinent from heroin following drug treatment were more likely to develop cognitive, avoidant and distractive coping strategies than individuals who relapsed into heroin use (Gossop et al., 2002). This supports the importance of the current role services have in encouraging heroin users to identify "high risk" situations for when they are most likely to want to use heroin and helping them plan how to cope with these situations.

The literature did not explore whether there was a possible link between self-efficacy of heroin users and type of coping strategy that they favoured. It could be hypothesized that individuals with higher self-efficacy for abstaining from heroin use would use more cognitive coping strategies, whilst those with lower self-efficacy may use more distraction or avoidant strategies. Based on this hypothesis, it may be that teaching past heroin users more sophisticated (cognitive) coping strategies may reduce the likelihood of them relapsing back into heroin use.

### Social support and identity

The theme of social support runs through most of the literature, whether it is social support that enables heroin users to seek treatment or social factors that contribute towards the decision to abstain from heroin (Best et al., 2008; Ison et al., 2006). It seems that support from non-drug users and participating in activities in the non-drug using world is important to allow past heroin users to develop a non-addict identity. The literature supports the idea that interaction with a non-drug using world supports cognitive and behavioural change, which further enables the past heroin user to interact with the non-drug using world, which further enforces the process of change (Hughes, 2007).

The positive feedback past heroin-users obtain from non-drug using relationships and activities (e.g. being able to hold down a job) in the form of being able to see a change in themselves and have it recognised by others, may increase their sense of self-efficacy and their motivation to continue/maintain the process of change. This process may be enhanced by the past heroin user distancing themselves from their heroin using lifestyle (Senbanjo et al., 2009).

### What is recovery?

The definition of recovery from heroin dependence within the British literature appears to focus on engagement with services and the decision to abstain from illicit drug use, which reflects recent governmental policy on the treatment of heroin dependence in Britain. However, the literature also reflects that there are processes involved in achieving abstinence. These seem to encompass the social and psychological factors underlying heroin users' decision to seek treatment and abstain from heroin and work towards the development of a non-addict identity.

The development of a non-addict identity as part of the recovery process is a theme that has been recognised in other countries. Avants, Margolin and McKee (2000) reported that, unlike with cocaine addiction, abstinence from opiates is not predicted by self-efficacy. Instead, abstinence can be predicted by how addicts relate to an “addict” schema. This study appears to have viewed the “addict identity” as separate from the “self-efficacy” of individual heroin users. However, it is possible that the transition from “addict” to “non-addict” as depicted by Avants et al (2000) and Hughes (2007) may both be based upon an increase in heroin users’ self-efficacy and also *cause* an increase in their self-efficacy for abstinence from heroin. It does not seem possible or even, perhaps, necessary to separate these two processes.

In Avants et al (2000) study, measures of self-efficacy were: goals for abstinence, desire to abstain, and confidence in ability to abstain from all illicit drugs. This again emphasizes the idea that “recovery” is abstinence from heroin use. However, other research suggests that the processes underlying the achievement of abstinence from illicit drug use can be considered a “recovery”. Vigilant (2005) interviewed people who had been receiving Methadone Maintenance Treatment (MMT) about their views of recovery. He found that they conceptualized recovery in a variety of ways, outlined below.

1. Recovery as being normal and recapturing lost time.
2. Recovery being an on-going process without a “recovered state”
3. Recovery 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.

4. Recovery as severing ties with the addict lifestyle by changing friends, places of residence and finding new support networks.

In a later paper, Vigilant (2008) expanded this idea of multiple recoveries to include:

1. Recovery from the addiction itself.
2. Recovery from heroin induced associational disruptions.
3. Recovery at self-actualizing levels: i.e. “who am I really?” including future plans and goals.
4. Recovery from heroin induced disease: e.g. hepatitis C, liver problems.
5. Recover from catalysing event: i.e. physical, emotional or psychological crisis precipitating heroin use (47% of responders).

It would appear that recovery from heroin dependence does not merely involve achieving abstinence. However, Vigilants’ (2005, 2008) studies were conducted in America and due to potential cultural differences in the way heroin dependence and the use of methadone are perceived, it is uncertain whether these findings can be generalized to a British heroin using population.

#### Summary of themes

The results of the literature review suggest that heroin users’ engagement with services is facilitated by supportive relationships and sociological factors which mark “a turning point” in their lives. It also appears that different sociological and psychological factors underlie a person’s motivation to enter treatment for heroin use. However, whilst motivation to enter treatment may give some indication of a heroin user’s intent to change, it is not a reliable predictor of whether they benefit from drug treatment. As Gossop et al (2006) highlight, “motivation and intentions do not translate directly into

outcomes” (p 306). This suggests that other factors play a role in who can achieve and maintain abstinence from heroin use. The literature suggests that heroin users’ confidence (self-efficacy) in abstaining from heroin use is linked to their actual abstinence, although their level of confidence may be mediated by their previous experiences/success in withdrawing from heroin as well as the feedback they gain from their social network. This literature is consistent with the proposals by the Trans-theoretical Model of Intentional Behavioural Change (DiClemente, 2003), which proposes that change process is mediated by several factors, including commitment to the decision to change and feeling able to make the sought after change. The model also suggests that social relationships influence the change process and this is supported by the results of this review. Social relationships experienced by heroin users were found to play an important role in aiding them to achieve abstinence and in mediating their transition from an “addict” to a “non-addict” identity. The development of a non-addict identity appears to be a process associated with the overall goal promoted by the British drug literature of achieving abstinence from heroin. However, literature from other countries suggests that recovery from heroin dependence does not merely consist of heroin abstinence.

#### Limitations of review

To avoid the possibility of cultural bias affecting the results, this literature review was deliberately limited to studies conducted in Britain. This was also to ensure that the psycho-social factors identified as being associated with recovery from heroin dependence were fully applicable to a British population. It is possible that the results of the review may be generalizable to a wider population, however to ascertain this, the review would need to be replicated so that studies from other countries were included.

The search terms used in this review were kept to a limited number. This was to minimize the extent to which any assumptions were made about what factors may contribute to the “psycho-social” and “recovery” search terms.. However, this may have meant that studies relevant to the review were unintentionally not identified by the search criteria. If the review were to be replicated it would perhaps be useful to include additional synonyms under the “psycho-social” and “recovery” search terms. It may also have been useful to broaden the review by including psycho-social factors associated with relapse to heroin use. However, this may have meant answering two questions within one review, thus making the review too broad. Alternatively, it may have meant assuming that the psycho-social factors associated with recovery from heroin dependence are not the same as those associated with relapse, which may not necessarily be the case.

The studies included in this reviewed varied in their methodological quality. Thus, the extent to which the results of this review can be applied to British heroin users who are in recovery is uncertain. In addition, the concept of recovery was sometimes only a small part of the overall study and, as previously stated, often focused on abstinence from heroin. This limited conceptualization of recovery seems to reflect past governmental policy in Britain, which has emphasised the importance of retaining heroin users in treatment and reducing their illicit drug use. This focus appears to have influenced the British literature surrounding recovery from heroin dependence in addition to how drug-treatment services are provided.

#### Implications for further research

Past government policies have encouraged the retention of heroin users in treatment, often through use of prescription of substitution medication such as methadone, with the

aim of helping service users achieve abstinence from heroin. However, recent policy changes mean that recovery from heroin dependence is now conceptualized as encapsulating other factors: such as achieving wellbeing and contributing to society, instead of purely focusing on maintaining abstinence (HM Government, 2010). Part of this new conceptualization of recovery seems to be to encourage people to come off of substitution treatment, due to the rapidly increasing number of people being maintained on substitution treatment (EMCDDA<sup>6</sup>, 2008).

It appears important to investigate to what extent the governments' "new" conceptualization of recovery from drug dependence matches the experiences of staff and service users within drug treatment services. This is because the messages service users and staff have received from past governmental policy may have an effect on how quickly the new government conceptualization of recovery can be integrated into the culture of existing drug-treatment services. Thus, it would be useful to explore the current understanding of staff and service users of government policy that emphasises the retention of heroin users within treatment using substitution treatment.

The perceived role of substitution medication within the recovery process should also be explored. If past drug users, who may have been receiving substitution treatment for a prolonged period of time, attribute changes to their everyday lives to substitution medication, they may find it difficult to stop taking it, thus potentially causing difficulties in the implication of the 2010 Drug Treatment Strategy. Thus, it also seems important to investigate whether substitute medication is associated with a change in identity or self-efficacy. Drug service staff views on the role of methadone in the

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<sup>6</sup> European Monitoring Centre for Drugs and Drug Addiction

recovery process should be explored, to investigate if their views on service users' requirements are consistent with recommendations made by new government policy.

Finally, based on the variable quality of the literature examined by this review, it appears that the field of recovery from heroin dependence would benefit from more rigorous research investigating the link between different psycho-social factors and recovery. This research should focus on addressing the methodological limitations of the existing British literature.

### Conclusion

This review of the literature suggests that increased self-efficacy, social support and the development of a non-drug using identity are associated with recovery from heroin dependence. However, due to methodological limitations and the narrow definition of recovery included in the studies included in this review, the results may not be generalizable to the recovery experiences of the broader heroin using population. Future research is needed to address these methodological flaws and explore staff and service users' conceptualization of recovery and how the role of substitution medication fits within this.



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## **Part Two**

Recovery in methadone users: Their experiences of methadone maintenance treatment  
and drug services

This paper is written in the format ready for submission to *Addiction Research and Theory*. Please see Appendix A for the guidelines for authors.

Word count (excluding abstract, tables and references):

Recovery in methadone users: Their experiences of methadone  
maintenance treatment and drug services

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## ABSTRACT

Due to a larger number of people receiving methadone maintenance treatment (MMT) in the UK, increased pressure has been placed on drug treatment services. Because of this, efforts have been made by government policies to address what recovery from drug dependence consists of. For people in recovery, there is currently a focus on achieving wellbeing and citizenship. However, it is uncertain to what extent government definitions of recovery apply to people receiving substitution medication such as methadone. This qualitative study aimed to explore methadone maintenance users' views of what recovery is and how they perceive the role of methadone within their own recovery. This study also aimed to investigate what messages service users may have received about recovery and methadone from services. Nine people were interviewed using a semi-structured questionnaire. Transcriptions of the interviews were analysed using Interpretative Phenomenological Analysis (IPA) methodology. Five superordinate themes were identified: "Recovery as a process", "products of the recovery process", "processes that enable changes", "a paradox in how people receiving MMT view themselves" and "messages received by people in MMT". To move beyond MMT, users may have to resolve the "split" in their identities. However, the idea that everyone should progress from MMT contradicts the idea that recovery is unique to each individual. It seems that the views society holds about methadone use need to change to allow recognition that for some people, being in MMT is their recovery. Implications for services and ideas for further research are also explored.

Keywords: Recovery, methadone maintenance treatment, MMT, services, client views.

## INTRODUCTION

### A British history of opiate dependence

In the nineteenth century, opiates such as opium and morphine were the only way to medicate many physical ailments. As a result, opiates were not illegal at this time and were freely available through the commercial market. Despite the easy availability of opiates, opiate dependence was considered a rare illness, confined to the middle classes and members of the medical profession. Few criminal addicts were then known, so criminalizing opiate dependence and associating it with jail sentences and other punishments was deemed inappropriate by the government. This contrasted with how opiate dependence was viewed elsewhere in the world, particularly in America where the 1914 Harrison Act<sup>7</sup> meant that both opiate users and opiate prescribers were threatened with prosecution (Carson-Dewitt & Gale 2001a).

### The British prescribing system

The 1926 Rolleston Report<sup>8</sup> concluded that opiate dependence was a manifestation of a disease, not a “vicious indulgence” as it was viewed in America. As a result of this, the report gave British medical practitioners permission to prescribe opiate drugs to people dependent on opiates. The conditions for this were that the opiate-dependent individuals should be capable of maintaining a productive and normal lifestyle whilst on a minimum dose, a lifestyle which proved impossible when the drug was withdrawn.

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<sup>7</sup> Commissioned by American Congress, the report was a product of the 1909 Shanghai drug control initiative, which encouraged representatives from countries to create legislation to manage narcotic use within their countries. New York’s representative, Francis Harrison, introduced two measures within the United States; one prohibiting the importation and non-medical use of opiates and one regulating the production of opiates in the United States.

<sup>8</sup> The report published by the committee commissioned by the Home Office to consider whether prescription of opiates to opiate dependent individual was advisable, and if so, to recommend any precautions necessary to prevent abuse of the system. The committee was chaired by Sir Humphrey Rolleston and consisted of medical personnel representing government agencies and physician-interest groups.

The practitioners' themselves also had to have the intention of encouraging patients to participate in a gradual withdrawal from the drug (Strang & Gossop, 1994).

This suggests the British system from the 1920's onwards viewed the prescription of opiates from a medical viewpoint, construing opiate dependence as a disease that should be medicated. Due to the low numbers of opiate dependent people at that time, this system initially worked well. However, the number of people dependent on opiates in Britain increased dramatically between 1960 and 1990. This was due to the expansion of drug dealing on an international scale and increased immigration to Britain by foreign drug users (Carson-Dewitt, 2001b). Many of the immigrants came to Britain to exploit its system of prescribing opiates to opiate dependent individuals. In 2007, the number of people dependent on opiates within the United Kingdom was estimated to be 8 per 1000 of the population (DOH<sup>9</sup>, 2007). Opiate dependence within society is associated with unemployment, homelessness and increased criminal activity (Carroll, 1997) and for the person taking opiates, dependence has been linked to poorer physical and mental health, for example, higher levels of anxiety, depression and lower self-esteem (Flynn, Joe, Broome, Simpson & Brown, 2003).

In a bid to contain the spread of opiate addiction and the associated rise in crime, drug clinics were set up. These clinics aimed to provide heroin of sufficient dose to reduce the cravings experienced by the opiate user. Over time, the prescription of heroin was replaced by methadone. By engaging the opiate dependent person with services, it was intended to reduce crime and establish a therapeutic relationship necessary to increase the person's motivation to withdraw from opiate use.

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<sup>9</sup> Department of Health.

## The role of methadone

Methadone is a synthetic opiate which can be taken in liquid (oral or injectable) or tablet form. The prescription of methadone to opiate dependent individuals aims to initiate the process of stabilization. This is a process involving a reduction in the chaotic lifestyle and negative consequences associated with opiate dependence. It includes: a reduction in illicit drug use, decreases in criminal activities that have previously been undertaken for heroin users to obtain drugs, finding regular employment and housing and improving relationships within families and communities (Dekel, Benbenishty & Amram, 2004).

Within the past forty years, the focus for drug services has been on engaging and retaining drug users in treatment. This was based upon the British Government's historical view of opiate dependence as an illness, and is supported by research which demonstrates that individuals retained in treatment for over a year show less illicit drug use and improved physical health (NTA<sup>10</sup>, 2004). As a result, there has been a large increase in the number of people receiving methadone treatment for opiate dependence. In 2006, 119,000 people were receiving support from MMT<sup>11</sup> programmes in England, an increase from 109,500 in 2005 (EMCDDA<sup>12</sup>, 2008).

Although British GPs have been encouraged to provide detoxification to people receiving methadone treatment using a gradually reducing methadone dose (MRT<sup>13</sup>) versus maintaining the methadone dose at a constant level (MMT) (DOH, 1991), research indicates that few opiate dependent individuals prescribed methadone treatment may be receiving MRT. Gossop, Marsden, Stewart and Treacy (2001)

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<sup>10</sup> National Treatment Agency.

<sup>11</sup> Methadone Maintenance Treatment

<sup>12</sup> European Monitoring Centre for Drugs and Drug Addiction.

<sup>13</sup> Methadone Reduction Treatment

conducted a study that demonstrated that of 111 clients' allocated to a UK MRT programme, only 36% received an overall reduction in the amount of methadone prescribed to them over an average of two years. This appears to be because the rate of reduction of the methadone dose was exceedingly slow. Seivewright (2000) describes this phenomenon as "methadone maintenance drift", where opiate users are stabilized using a set dose of methadone and this dose remains the same for years. Conversely, research shows that large reductions in levels of prescribed methadone over short periods of time are associated with high drop-out rates from MRT programmes and few people achieving abstinence from illicit drugs (Gossop, Johns & Green, 1986; Unnithan, Gossop & Strang, 1992; Dawe, Griffiths, Gossop & Strang, 2001: In Gossop et al., 2001). The National Treatment Agency (NTA) state that improved treatment outcomes, in terms of reduction in crime and heroin use, have been found in clients who remain in MMT for over one year (NTA, 2004), with higher doses of methadone being associated with greater treatment retention rates (Ward, Mattick & Hall, 1998).

This increased retention of people in MMT, without any concurrent increase in service capacity, has increased demand for drug treatment services. As a result, there is now a drive to reduce the number of people receiving MMT within the United Kingdom.

However, this drive does not seem to consider how clients receiving MMT view their own recovery and how they perceive the role of methadone within the recovery process.

Current drug treatment policy: what does recovery from drug dependence mean?

In 2010, a new drug treatment strategy was released by the government. Instead of focusing on retaining individuals in treatment, the strategy aimed to provide a person-centred approach with the ultimate goal of enabling opiate (and other drug) dependent

individuals to be able to lead a drug free life. As well as being independent of illicit drugs, the drug strategy suggests that recovery also includes two other principles: wellbeing and citizenship. This proposes that in addition to previously existing goals of reducing drug-related deaths and the prevalence of crime and blood borne viruses, the new strategy emphasises other dimensions of recovery. These include: sustained employment, improvement in mental and physical health, improved relationships with family members and friends as well as the ability to be a caring and effective parent (HM Government, 2010). However, it is uncertain whether this definition of recovery provided by the government represents the experiences and goals of people receiving MMT.

What is recovery?

There is currently a debate within the drug dependence field as to whether clients receiving methadone can be considered as being in recovery. White (2007) suggests that the term “medication assisted recovery” could help legitimize the status of people using medications such as methadone as being in recovery. However, he warns that this could create a sub-class within the definition of recovery itself, where people receiving MMT could be seen as being “less in recovery” than others. He also states that recovery should attempt to distinguish between people who resolve their alcohol/drug problems but their lives remain otherwise unchanged; and others who achieve alterations in their “personal character and identity” (White, 2007 p 234).

The UK Drug Policy Commission Recovery Consensus Group (2008 p 6), a collection of 16 individuals representing drug services and service users, defined recovery as “...characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of

society.” They stated that this definition should apply to individuals receiving MMT and that recovery could be viewed as both an outcome and a continual process. Although service users were included on the panel (2 individuals), it is uncertain to what extent this definition of recovery can be generalized to other service users.

### Models of Recovery

The Trans-theoretical Model of Change (DiClemente, 2003) suggests that recovery from drug dependence is a process that can be characterised by several, co-occurring stages: 1) Pre-contemplation, where the individual can see no reason to change; 2) Contemplation, where the individual has recognised that there may be some benefits to changing their drug taking behaviour but may feel they are not ready to start the change process; 3) Preparation, where the person takes steps towards starting to change; 4) Action, where the person starts the process of change, for example, entering a treatment programme and 5) Maintenance, where the person tries to maintain the changes they have made within their life. The model states that change can be supported by the environmental context the person is experiencing, with factors such as their current life situation, interpersonal relationships, social systems and personal characteristics all influencing the change process. This is supported by research which has found that personal motivation, religion, family, employment, and support from family/friends have helped drug-dependent individuals reduce their illicit drug use (Flynn et al., 2003).

The Trans-theoretical Model states that for change to occur, the person needs to experience changes in several behavioural processes, the first of which is ‘self-liberation’, where drug users start to believe in their ability to change and begin to act on this belief. The second behavioural process is ‘counter-conditioning’, where drug users learn alternate ways of thinking and behaving to drug use and the third process is

that of ‘stimulus control’, where drug users learn to use stimuli to cue healthy coping strategies and behaviour instead of drug using behaviour. The final two processes are called ‘reinforcement management’, which involves rewarding non-drug taking behaviour and helping relationships, which ensure that recovering drug users find people who are supportive of their wish to change.

The Trans-theoretical model also states that for change to occur, drug-dependent individuals need to experience changes in their cognitive and experiential processes. These processes include: ‘consciousness raising’, whereby drug users learn more about an alternative non-drug using lifestyle and ‘self-revaluation’, where they decide that being a non-drug user is who they would like to be. ‘Emotional arousal’ is where drug users feel anxiety or fear surrounding their drug using behaviour and/or hope about the possibility of change. The process of ‘social liberation’ occurs when drug users realise that society is supportive of their non-drug using behaviour.

These cognitive and behavioural processes are reflected in the findings of Vigilant’s (2005) American study. Vigilant (2005) interviewed 45 opiate users (21 of whom were female), who had been receiving MMT (between 3 months and 30 years) about their views on recovery. He found that methadone maintained clients viewed recovery in several different ways:

1. Recovery as being normal and recapturing lost time: regaining a sense of control over heroin addiction. In particular, a sense of routine, security and safety are of particular importance.
2. Recovery as a perpetual and on-going process without a “recovered state”.



3. Recovery as a state of caring for the self: a time to reflect upon emotional precursors that may have catalysed entrance into heroin use and heal the body from the effects of heroin addiction.
4. Recovery as associational change: Severing ties with the addict lifestyle, including changing friends, places of residence and finding new support networks.

Additionally, a further study by Vigilant (2008) supports the processes of recovery proposed by the trans-theoretical model. Transcripts from the 2005 study were re-examined and it was concluded that people receiving MMT undergo “multiple recoveries” over the course of treatment for opiate addiction. These recoveries are listed below:

1. Recovery from the addiction itself (reported by 100% of responders).
2. Recovery from heroin induced associational disruptions (reported by 73% of responders).
3. Recovery at self-actualizing levels: i.e. “who am I really?” including future plans and goals. (reported by 67% of responders).
4. Recovery from heroin induced disease: e.g. hepatitis C, liver problems (53% of responders)
5. Recover from catalyzing event: i.e. physical, emotional or psychological crisis precipitating heroin use (47% of responders).

Vigilant (2005, 2008) found that MMT clients placed a lot of emphasis on the role of methadone in helping them to achieve security through: routine, stability and risk reduction, biographical re-ordering, strategic life-planning and through having a care

network which utilizes empathy and clinical surveillance. It appears that on some levels, this security may include some aspects of recovery as suggested by the 2010 Drug Treatment Strategy (HM Government, 2010), which promotes the questions: does being in MMT mean that a person has recovered and to what extent is MMT essential to the recovery process?

To consider these questions further, research investigating the relapse back into drug use needs to be considered. The cognitive-behavioural model of relapse prevention (Marlatt and Gordon, 1985) supports this idea by suggesting that there needs to be improvements in drug users' self-esteem and self-efficacy in order to prevent relapse in a "high risk" situation. Indeed, Reilly et al (1995) found that between admission and the start of a 120 day stabilisation programme where 74 opiate addicts received a stable dose of methadone, their levels of self-efficacy with regard to reducing their drug taking increased and their level of opiate consumption decreased. However, when their dose of methadone was reduced, their levels of abstinence self-efficacy also fell and this was associated with a significant rise in opiate use. This suggests that clients viewed methadone as essential in aiding them in reducing their drug use and did not view their drug use as something they could control without it. To fully investigate what recovery from heroin dependence means for those receiving MMT, we need to consider the challenging question of what role MMT plays in the recovery from heroin dependence.

If we agree with Reilly et al (1995), then the extent to which opiate dependent individuals attribute changes in their lives to the methadone treatment they receive over the longer term may influence the length of time they receive MMT. If people who were dependent on opiates believed the changes in their lives were wholly due to the

stabilizing effects of methadone, there would be little motivation for them to stop taking their methadone and to cease receiving support from drug services.

Another issue highlighted by the Trans-theoretical model is the fact that people do not recover in isolation. The model highlights the importance of environmental change and supportive relationships in the recovery process (DiClemente, 2003). Given the apparent importance of the environment on the recovery process, it is surprising that little research has been conducted on how involvement with services affects methadone users' views of recovery. Given the history of using the prescription of methadone to retain clients in drug services in Britain, it would seem prudent to investigate how interaction with services has affected clients' views of recovery and the role of methadone within this. Past emphasis on the retention of clients within MMT by the British government may have affected service users' views on their ability to maintain their recovery without methadone.

### Summary

The Trans-theoretical model suggests that for recovery to occur, various cognitive and behavioural processes need to take place, within the context of a supportive environment. Marlatt and Gordon (1985) highlighted the particular importance of increased self-esteem and self-efficacy in preventing relapse back into drug use. Research suggests that many of these processes occur during MMT (Vigilant, 2005, 2008); however, a study by Reilly et al (1995) suggests that any increase in former drug-users' self-efficacy may be entirely dependent on methadone use. It is also possible that the previous emphasis by the British government on retaining people in MMT has reduced service users' self-efficacy with regard to living without MMT. It is

clear that several questions remain unanswered and further research is required in this area.

This study aimed to understand how clients receiving MMT in Britain view the recovery process and what they perceive the role of methadone within their recovery to be. The study also aimed to explore how previous government policy and involvement with services may have impacted on their views of what recovery consists of and the role of methadone. Based upon these aims, the following research questions were identified:

- 1) How do MMT clients in a British sample view the recovery process?
- 2) How do methadone maintenance users perceive the reasons behind any changes in their lifestyle?
- 3) What are the experiences of methadone maintenance users of the impact of MMT on the way they view themselves?
- 4) What are MMT clients' experiences of the impact of interaction with drug services on their recovery process?

These questions were explored using a qualitative methodology, outlined in the method section below.

## METHOD

### Design

A qualitative design allowed for exploration of clients experiences in relation to the stated research questions. This design was based upon the assumption that participants' experiences are not objective phenomenon that are examples of an independent reality that could be objectively measured, but are instead constructed by individual people

based upon their own unique experience. Interviews were conducted and then analysed using Interpretative Phenomenological Analysis. For a rationale of the decision to use IPA, see Appendix C.

### Measures

Participants were invited to take part in a semi-structured interview (appendix D). The interview schedule was designed to ask specific, yet open questions specifically related to the study research questions. The average length of each interview was 40 minutes (range 32 to 50 minutes). The interview schedule was developed over time in response to participant feedback (Appendix M) to ensure that participants' experiences were adequately explored.

Participants were also asked to complete a questionnaire (Appendix E) to obtain additional contextual information with regards to: duration of MMT, number of phases of MMT and demographic information such as participants' age and level of education.

### Procedures

Ethical approval for the study was obtained from the local ethics committee in April 2010. Permission for the study to proceed was then granted by the appropriate trusts' Research and Development (R & D) Department. Copies of Ethical and R & D approval are provided in Appendices F and G.

### Participant Identification

Service users eligible to take part in the study were identified by staff from Community Drug and Alcohol Teams (CDAT's) in the north of England using a computerised patient management system and individual case reviews. Service users who were

identified as being potentially eligible for the study were discussed in the multi-disciplinary team meeting to ensure their suitability. To be eligible for inclusion in the study, service users had to meet the inclusion and exclusion criteria outlined in Table 1.

During a routine appointment with a CDAT team member, information about the study (Appendix H) was given to suitable service users. If the client was interested in knowing more about the research, an appointment was made for them to discuss the study in more detail with the researcher.

*Table 1: Participant Inclusion/Exclusion Criteria*

<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
Past heroin users.	Receiving type of substitution treatment other than methadone.
18 years old or over	Client severely intoxicated at the time of interview (client will be asked to return when not under the influence of drugs and/or alcohol).
Receiving MMT for 1 year or over.	Person is “in crisis”: This includes MMT clients who are experiencing stressful life events and clients who are still using opiates/other illicit drugs heavily, to the extent to which these difficulties are interfering with their ability to remain in MMT.
Oral MMT only.	Clients receiving other forms of substitution treatment in addition to MMT.

Because poly-drug use is common in this client group, participants who were abusing other licit/illicit drugs, for example cocaine or alcohol, and/or were receiving treatment for abuse of other substances were included in this study. However, it was ensured that the focus of treatment for each participant was for heroin dependence. Only people who had been receiving oral MMT for over a year were allowed to participate. This was to ensure that participants' experience of prolonged retention in MMT, as recommended by the NTA (NTA, 2004), could be fully explored. Individuals who had received MMT for a shorter period of time may have been less stable and/or have less experience of recovery.

#### Data collection

Following consenting to meet with the researcher, the Information Sheet (Appendix I) was reviewed and discussed with each service user and any questions about the study were answered. If the service user decided they would like to participate, they were asked if they wished to complete the research during that appointment or at a later date. Participants were informed that they could leave the study and/or request that their data be destroyed at any time up until publication and that this would not affect the standard of care they received from the CDAT.

Before the interview, participants were asked to sign a consent form (Appendix J) indicating that they understood the purpose of the study and how their data would be used. At this stage, participants were also asked if they would like to comment on the results of the study when they were available, and to indicate their preference on their consent form. Participants were informed that their anonymity would only be broken if any issues arose which caused concern that the client or others were at risk of harm. If the researcher judged that a person was at risk of immediate harm, the risk assessment

procedure outlined in Appendix K was followed. No risks were identified during the interview procedure and no participants were excluded as a result.

After signing the consent form, prior to the interview, participants completed the questionnaire shown in Appendix E. Following the interview, participants were given the opportunity to ask questions and to reflect on how they had found the interview process. If the client felt they required additional support, or an opportunity to discuss their treatment, a clear pathway to accessing support through their key-worker and other agencies (both statutory and voluntary) was provided (Appendix K). Participants were then provided with a £10 Boots voucher or chocolates of an equivalent value to thank them for taking part in the study. This value was chosen to minimize the extent to which clients felt pressurized to take part in the study but was deemed to be of sufficient value to provide an incentive for people to participate. The vouchers could not be exchanged for alcohol or cash, thus minimizing the potential risk of harm to the participants.

Recorded interviews were stored securely on encrypted and password protected computer software and destroyed after they had been transcribed. The transcribed interviews were anonymized so that no personally identifiable data was included.

#### Data analysis

Data analysis utilized IPA. This allowed for the main themes within the data to be identified without deliberately imposing presumptions based upon existing literature that could then limit information extracted from the data. The methodology was consistent with that recommended by Smith, Flowers and Larkin (2009). The content of each segment of data was summarized in the left hand margin of each transcript, then the overall themes emerging from this data were recorded in the right hand margin of



each transcript. The themes that emerged from the data were compared across all transcripts and each transcript was re-analysed when a “new” theme was identified.

Thematically similar themes were then grouped to form subordinate themes, which were then examined for similarities. This enabled identification of superordinate themes. The original data was then re-examined to ensure that both subthemes and superordinate themes were consistent with original data. This was an iterative process during which new or alternative layers of interpretation were added during each refinement. See Appendix L for a worked example of the analysis.

#### Validation of themes

Extracts from each interview were analysed by an independent psychologist for identification of alternate interpretations which could then be incorporated into the analysis. Potential super and subordinate themes were discussed again in research supervision and alternative arrangements of themes were explored to ensure “best fit” to the data. Participants who had indicated that they wished to comment on the results of the study were contacted approximately 5-9 months after initial data collection by a member of the Community Drug and Alcohol Team. Initially 7 participants indicated that they wanted to know the results of the research, and wanted the opportunity to comment on results. Two participants (1 male, 1 female) attended a feedback meeting with the researcher and were given the opportunity to comment on identified themes. Their feedback was incorporated into overall results.

## RESULTS

### Profile of participants

Nine people receiving MMT were interviewed, representing 75% of those who initially agreed to participate. Of the three participants who did not participate, one did not attend the initial meeting with the researcher and two declined to participate upon receiving further information about the study. The average age of participants was 35.56 years, (range 28 - 44). The male to female ratio was 5:4. Eighty-eight per cent of participants (n = 8) were White British, with one participant stating their ethnicity as “White European”. Table 2 provides a summary of contextual information.

*Table 2: Description of participant*

<b>Duration of past heroin use</b>	<b>n</b>	<b>Number of phases of MMT</b>	<b>n</b>
1-5 years	2	1 phase	1
6-10 years	1	2 phases	2
11-15 years	3	3 phases	5
16-20 years	2	4 phases	1
21-25 years	0	<b>Length of time on MMT (years)</b>	<b>n</b>
26-30 years	1	1-5	6
<b>Current occupation</b>		6-10	1
Unemployed	4	11-15	1
Disability living allowance	2	16-20	1
Working part time	2	<b>Level of Qualification</b>	<b>n</b>
Education part time	1	GCSE's	8

Subordinate themes emerging from the analysis were grouped to form superordinate themes, as shown in Table 3. In presenting the results, a narrative and exploratory position is maintained, consistent with an IPA approach.

*Table 3: Superordinate themes and associated subordinate themes*

<b>Superordinate Themes</b>				
<b>Recovery as a process</b>	<b>Signposts of recovery</b>	<b>Factors enabling change</b>	<b>Paradox</b>	<b>Messages received by people in MMT</b>
Initial point of change	Acceptance	Validation of changes	Perception of services	Expectations about coming off MMT
Learning to live without heroin	Changing thought patterns	Role of past success	Identity	Using heroin on MMT viewed negatively
Repairing relationships	Improved relationships	Internalization of control	The role of methadone	Not belonging
Progression from a drug-user to a non-drug user identity	Recovery on methadone	Hope		Acceptability of methadone to society
	Coming off heroin and MMT	Sense of security/ support		Recovery unique to individual
		Services as responsive parent		

Participants in the study viewed recovery in two ways. Firstly, recovery was described using more abstract concepts, which alluded to it being more of a process. Alternatively, recovery also seemed to be conceptualized as a series of more concrete “goals” or “outcomes” which seemed to act as indicators that the process of recovery was occurring. These two conceptualizations of recovery are explored further below.

Superordinate theme: Recovery as a Process

Sub-ordinate themes are described as a series of potentially co-occurring stages to be completed during the recovery process. These “stages” are explored below.

#### Initial point of change

Participants described a “changing point” where they appeared to experience a shock realisation that their lives, and heroin use, had to change. This point was often precipitated by a personal low point or difficult life event, as illustrated by P8: *“Fireworks going off for the millennium and I just thought that was my lowest point...I’d only just got there, I had a few clothes, I thought ‘my life’s gotta change now, it has to change.’* Here it seems that it was the sense of isolation that was the motivation for P8 to change their drug use. For others, the point of change followed a near death experience: P3: *“...I nearly died like, so it sort of like opened my eyes a little bit. That’s when I first started thinking, ‘ahh, I’m gonna have to pack this in now.’* P4 emphasised the importance of making the decision to stop using heroin for themselves, an opinion shared by other participants; *“You won’t do it if you’re not committed to yourself. It’s more of a selfish thing as well. Just sort of selfish doing it. But you’ve got to be selfish to get yourself better.”*

It appeared important that MMT users recognised the role that they have in deciding to stop using heroin. The idea of being committed to this chosen course of action was also expressed and this theme was duplicated throughout multiple participant interviews. Participants stated that the decision to stop using heroin, even whilst receiving MMT required a lot of work and required the heroin user to take control and demonstrate commitment to overcoming the temptation to lapse back into heroin use; P8: *“I’m doing it my way and if it takes five years it takes another five years, you know, but I will make that recovery.”* Here the participant is stating the need to take responsibility for their recovery process and recognises that the process may be a long and slow one.

This active decision approach to recovery where methadone users take control of their recovery process contrasted with another, more passive, conceptualization of the decision to change. P1: *“It just got to the stage with me where I couldn’t have any injections.”*

P2: *“But there comes a time when you just decide it’s not worth it anymore. It’s too much hassle running around and looking for drugs and stuff.”*

It appears that that heroin use is still something that was enjoyed by these participants at the time they decided to stop using heroin and that their decision to stop was made because further heroin use was not possible or because the sacrifice made to continue using heroin was not worth it. Interestingly, this passive approach to ceasing heroin use was made by the participants with the longest heroin careers, supporting the idea that to cease heroin use, it requires a definite decision to quit.

### Learning to live without heroin

Throughout interviews, heroin was described as a method of coping with: physical pain, negative life events and the difficult emotions associated with these. Participants also believed it was important to learn to live without heroin. For some people this was a huge challenge as heroin had been a part of their everyday life for a long time; P9:

*“...it’s just like rehab for a bad leg. It’s just the same. You’ve got to learn to live life without heroin and if you can live life without heroin...”* For some, the cessation of their heroin use was like losing a friend and a source of certainty and stability in their lives; P8: *“...coz heroin’s been a part of my life for so long that...through all the good and bad times I could always, heroin’s always been there when my family have been having a go at me, when everyone’s disowned me.”* It seemed that by ‘losing’ heroin, some people felt that they had lost a part of themselves, as well as a familiar coping strategy.

### Repairing relationships

Part of finding alternate sources of support seemed to be the repairing of relationships with family and friends. This involved people apologizing and proving their trustworthiness, a process which people admitted could take a long time. P4 also talked about how part of their making amends involved them explaining to their parents why they had started to use heroin: *“...having to explain it to them, who, like I say they’ve never drunk or anything like that. It was hard to explain to them how you get addicted to things”*. This suggests that “coming clean” involves more than the cessation of heroin use.

### Progression from a drug user identity to a non-drug user identity

Participants talked how they felt separate from “normal reality” whilst on heroin; P6: *“...You seem to think that you’re the only person in the whole world that matters. And*

*you're completely not. Are you? It's like you don't care what you're doing to people around you.*" At this stage, heroin appears to provide a "separate reality" that enables users to block out the emotional pain of societies' "normal" reality and the shame/stigma of being dependent on heroin. In other words, heroin provided them with a 'protected state', where they felt secure and loved.

The development of an identity *not* associated with heroin use seems to be important. The development of this 'non-drug user' identity seemed to happen through regaining the life lost due to heroin use; P3: "*Since I've stopped taking heroin now, I've just come back off holiday, I've got myself a car...had to move back in with mum and dad, but, its...they wouldn't have had me three, four years ago*" as well as through experiencing roles and activities outside of drug use. This is illustrated by P1: "*...I've told them, you know, what I've told you. It's a ritual thing...I said you don't need it when you're on methadone...*". Here P1 shows that part of their non-drug user identity is that of a "teacher" where they pass on knowledge and experience to heroin users.

Progression towards a 'non-drug user' identity also seems to involve planning for the future, as this seemed to encourage people in MMT to keep progressing and reinforce their development of a non-drug using identity. For example, P3 states : "*Yeah, I've got some very good plans, yeah, and this time I'm getting a full time job like, so...I've got all sorts of qualifications that I've done through learn direct and things like that...*"



Superordinate theme: Signposts of recovery

The process of recovery seemed to give rise to several, more concrete conceptualisations or “products” of recovery. These are explored below.

### Acceptance

Participants described living with things they felt they could not change and finding alternative ways of coping with them. An example of this was the apparent recognition of self as always being an “addict” and needing to live with the knowledge they would never be able to use heroin again; P4: *“It’s like, it’s a bit like an alcoholic. Once you’re an alcoholic you’re a recovering alcoholic aren’t you...they say with an alcoholic they’re always an alcoholic.”* This suggests that the process of recovery is never ending and something that always needs work.

Another example of acceptance was that of living with the unalterable physical consequences of past drug use; P2: *“...every once in a blue moon, sort of, once every eight months to a year, I get a bad bout of septicaemia...”* This demonstrates an acceptance that borders on resignation of extremely challenging experiences and suggests that some people in MMT view themselves as continually being very close to death.

There was also recognition that methadone users were tempted to use heroin and part of the acceptance of this involved finding alternate ways of coping, such as that of avoiding stimuli that act as triggers for craving, illustrated by P9: *“...we had to walk literally through the back end of town to this cafe to get something to eat so we didn’t see anyone before to hit them triggers, coz we both got money and we both don’t want heroin, and er, but we also don’t want it in our face either.”* This use of alternate

coping strategies appears to be related to the process of learning to live without heroin. Another coping strategy identified by participants included distraction with new, non-drug using roles, such as caring for other family members.

### Changing thought patterns

One important part of recovery appeared to be the alteration that occurred to methadone users thought patterns which resulted in them “not wanting heroin anymore”. This seems to be something that takes a long time to occur; P6: *“So, if I’ve been on methadone for all that time (7 years), it’s only just, in this six, eight months that my thought patterns started to change drastically.”* Indeed, a sign of change appeared to be an increase in participants’ levels of confidence in their ability to not use heroin, as suggested by P7: *“...but now, I can refuse it (heroin), I can say ‘no, I don’t take it now’”*.

### Improved relationships

Another factor which may contribute to participants’ development of a non-drug using identity and help maintain the recovery process is improved relationships with family and friends. This theme focused on regaining trust with family members and feeling part of the family; P8: *“Their mum, she just like, drops them on me at any time she can get rid of them, if they’re, a bit too rowdy or whatever... she knows I’ll have em anytime, that’s the thing, you know.”* Here, improved relationships seem to be the product of the process of regaining trust from family members and friends. Participants talked about how they could now enjoy spending time with their families; something that was not possible whilst they were taking heroin; P3: *“...we do things together, like we might go out for a meal or something like that. Nothing could have happened like that until I was off of heroin.”*

### Recovery on methadone

Some participants viewed being on methadone as being either fully recovered or as an intermediate stage in the recovery process. For example, P1 stated: *“I’ve got on with my methadone and not touching heroin”*, whilst P3 said:

*“You could say I was recovering now coz I’m not using drugs, but I’m still using methadone.”* Again, it seems to be participants with longer heroin and MMT careers who viewed being on methadone as a state of recovery. These participants seemed to view any changes in their lives as being entirely dependent on methadone, a theme which may be linked to participants becoming “stuck” in MMT.

### Coming off MMT and heroin

Overall, 7 out of the 9 participants said that they were working towards coming off MMT. This theme contradicts the idea that recovery for some individuals may be receiving MMT. Only two of these participants seemed to have a clearly defined plan for coming off of methadone. For the remaining participants, the idea of stopping their MMT seemed ill defined, as if it was at some point in the future they were unable to determine as yet;

I: *“How long do you see yourself staying on methadone for?”*

P1: *“Not forever I know that. Um, I don’t know.”*

It appears that for most of the methadone users in this study, coming off methadone was an unobtainable, indistinct goal. The contradiction between being in recovery on methadone and yet wanting to stop their MMT may be interpreted as participants feeling ambivalent towards their MMT.

## Summary

Recovery from heroin use appears to involve a gradual transition from a drug user to a non-drug user identity. As an individual negotiates this process, it can result in various outcomes including an increased sense of self, improved relationships and reduced heroin use. These outcomes further reinforce the development of a non-drug using identity. Thus, once started, the recovery process could be self-reinforcing.

## Superordinate theme: factors enabling change

Various processes that enabled change to occur were identified. These factors were may support the overall recovery process and are described below.

## Validation of changes

The experience of recovery appeared to be reinforcing, further enabling the recovery process. Participants stated how important it was to receive validation, particularly from other people, regarding the changes they had made in their lives; P1: *“It’s nice when people who know me, know that I don’t (use heroin). You know, it’s like, you’ve done well...”* It seems that recognition from others acts as a reward for their hard work and may act encourage them to continue. For some people, achieving a goal they had worked towards seemed provide the same sense of validation; P3: *“It’s just nice to know that I’d worked really hard and saved that money up, to pay for it (holiday). No one paid for it for me, do you know what I mean? I’ve, I’ve er. It took a good while to save up, I needed to save up nearly a thousand pounds and er, never saved that before in my life.”*

### Role of past success

The role of past success appears to be important in the development of participant's self-belief and sense of self. This is illustrated by P1 and P6 who talked about stopping their heroin use; P1: *"...i'm gonna be honest, the reason it had to happen (stopping heroin use) was because I couldn't have a dig. But then afterwards, I found out if I leave it alone I can..."*;

P6: *"...the first couple of times it's a bit harder to say no, but, when you do, it kind of like boosts you a little bit as well, like, that you've kind of like got over the thing, where you can say no, if you want to..."*. Thus, the experience of saying no to heroin increases their confidence of doing so again in the future and increases confidence in ability to do so again and in turn, increases confidence in ability to stick to that decision. This is consistent with the Trans-theoretical model of change (DiClemente, 2003) and the model of relapse prevention (Marlatt & Gordon, 1985) which state that an increase in self-efficacy is necessary for behaviour change.

### Internalization of control

This subordinate theme suggests that over time, people receiving MMT internalize a sense of being in control of their recovery process; P3: *"But to me, I'm off heroin now and I'm recovering being on methadone. I'm keeping away from that, been and got help and that..."*;

P7: *"Well, it's just pure will power ain't it coz, there's that much about, or there seems to be."* Here both P3 and P7 take responsibility for their decision to stop their heroin use, and in P7's case, apparently disregard the role of MMT. This internalization of control could play an important role in helping make the transition to a non-drug using identity.

## Hope

The theme of hope seems important in enabling the recovery process. Participants talked about hope in the context of coming off methadone and looking forward to a life without heroin; P9: “...if you can live life without heroin, which is quite possible, a lot of people do it, but it ain't easy, but people do it.” Hope may aid people in MMT to continue with the recovery process; however this subordinate theme was present in only three participant interviews. The possible role of hope in people receiving MMT is explored further in the discussion.

## Sense of security and support

In order to make changes, people receiving MMT may need to feel safe and secure in their everyday lives. Throughout their interviews, participants talked about the role of methadone and services in providing them with support and a sense of certainty for the future. P4 talked about the role of methadone in supporting her to break her routine surrounding her heroin use: “I used to go score when I finished work and then I'd be asleep and then I'd start work again at ten o'clock. But, um, with me not doing that...it's (methadone) sort of helped me get out of that...” Alternatively, P4 also talks about the role of services in helping her to cope with her emotions: “...knowing that I have somebody there, if different sort of situations crop up in your life...you take heroin and it like numbs, you don't feel it...just knowing there's summat there you can fall back on if you know what I mean. It sort of helps you to get over it and go forwards again.” It seems that MMT and drug services play an important role in helping manage MMT users' anxiety and difficult emotions as well as teaching them new skills. This perhaps enables them to reach the point conceptualized by the “internalized sense of control” subordinate theme.

### Services as responsive parent

A role ascribed to drug treatment services was that of a “responsive parent”. Participants appeared to view services as both a source of motivation and as a carer who provides a sense of positive regard; P9: *“She (keyworker) pats you on the back when you do a good job and she kicks you up the arse when you don’t”*;

P6: *“...you have to go into ‘oh, why did you use, what made you use?’ It’s like, it upsets you more because people are actually asking...rather than just like going mad and falling out like ‘Oh, you fucking druggie bastard, why did you have to do that?’”* Here, P6 appeared upset as services make her feel worthy of care. Perhaps part of the role of services is to help MMT users internalize this sense of positive regard, aiding in the formation of a non-drug using identity.

Another factor that contributes to this theme is that of people in MMT being ‘looked after by others’. P3 talks about how services control his drug use: *“I’m not using drugs, but I’m still using methadone, which to me is, is, it’s not as bad because it’s not heroin, you know, it’s supervised.”* Here it appears P3 has an external locus of control and relies upon services to manage his behaviour.

### Summary

Several factors may need to be in place to enable the recovery process to occur. Drug treatment services and MMT may play a role in encouraging methadone users to internalize sense of control over their future and provide feelings of positive regard, thus potentially enabling service users to work towards achieving a non-drug using identity.

Superordinate theme: a paradox

Throughout the interviews, the way in which participants viewed drugs services, their own identity and methadone was often split into “entirely good” or “entirely bad”, creating several interesting paradox’s.

### Perception of services

For some participants, their current drug treatment service was perceived as entirely “good” and experienced as either a “responsive parent”, as discussed above or as a saviour. For example, P5 stated: *“Oh, I adore this service, coz of what it’s done for me and that. If it weren’t for these I wouldn’t be anything. I’d be down in the gutter still and probably, I’d probably be dead by now.”*

In complete contrast, some participants gave negative reports of drug treatment services. People reported that services could be unreliable and punitive, with some participants reporting past experiences of services being unresponsive and unable to provide what they need; P5: *“and you’d have some heroin, they’d kick you straight off methadone. So, they’re not really helping you if you know what I mean? They’re like sending you back on the streets to get it again. Coz they don’t really understand. They see it as “oh a positive, they’re not interested in getting off it”*

Here there is a sense that services are perceived as not caring about the individual person, but are more interested in people stopping their heroin use, as if individuals are “statistics” (P2). This view of drug treatment services may contribute towards MMT clients feeling that they can only rely on methadone, and becoming “stuck” in MMT.

A negative case analysis indicated that one participant was able to recognise the “good” and “bad” aspects of drug services. P9 discussed how services both supported and



motivated him (see previous quote p 95) but also appeared frustrated that sometimes services could not provide the support that they felt they needed; P9: *“Sometimes it’s their only answer isn’t it? “Let’s go up”. Going up is not the answer.”*. However, the majority of participants talked about “good” and “bad” experiences of services in terms of those services which had provided them with methadone and those which had not. For P6 in particular, it appeared that the “good” service she was currently receiving was mainly due to them giving her methadone. P6: *“I did used to go to (drug treatment service), but, them over there, they don’t really know much, they see if that you’re on methadone over there until you like, say like you do have a, mishap, and you’d have some heroin, they’d kick you straight off methadone. So, they’re not really helping you...They’re like sending you back on the streets to get it again. Coz they don’t really understand...they don’t offer you good help over there, that’s why I came over here. And I find it’s a lot better over here, a lot more helpful.”*

### Identity

Participants appeared to view themselves as both “non-drug users” and “druggies” on MMT, although most people did not appear to hold both of these views of themselves at the same time.

In the “non-drug user” position, participants agreed that their level of confidence to stop using heroin had increased during their time in MMT and reported that they had also gained a sense of pride in themselves. This was both in terms of their appearance and in terms of their non-drug using behaviour:

P5: *“I feel that I’m beautiful now coz I look after myself and on a morning I just didn’t, I just looked like a tramp when I were on heroin. I just didn’t give a monkeys whether*

*my hair were done, I'd just go out looking like a tramp. Honest it were horrible. But now I take pride in myself. I look after myself now";*

P1: *"...well I know in my own mind I don't take drugs. You know what I mean?"*

It seems that whilst on MMT, participants experienced an increase in their sense of value and worth both to themselves and society, making the transition from a "repulsive drug user" to someone who is "straight". Participants also talked about becoming more aware of others opinions of them and wanting to be thought well of by them, as illustrated by P2: *"I wanted to be somebody that she (mum) could rely on now. And I couldn't be like that before."* People who were interviewed also talked about gaining an increased awareness of their actions on other people, for example, P6 said:

*"...give him half the money towards the bills which is like something I'd like never even have thought of. Like, my money was for drugs and his money was for everything else..."*

This gives the impression of people in MMT leaving the "drug world" with its self-focus and restrictive routine behind to "re-join the non-drug using society", which provides opportunities for positive feedback and reinforcement of the non-drug using identity.

To protect this non-drug using identity, many of the people interviewed tried to distance themselves from being perceived as drug users. Strategies used to do this included: externalising the blame for the initial use of heroin as well as maintaining that they were never a "proper addict". For example, P3 stated:

*"...it's difficult coz I know a lot of friends who've done a lot of...bad things through drugs, I mean, this is the longest I've ever been without having a job...I've always had money coming in so I've never really gone down the burglary thing."*

Participants also compared themselves to people who used heroin whilst in MMT, suggesting that there is a perceived hierarchy within MMT, where some people are seen as “addicts”, whilst other people are not;

P7: *“For some people, yeah, coz they’ve got no intention of stopping and they just use it to, you know, at times that er, they end up with no heroin and they’ve got that to fall back on...”*

This appears to be related to the subordinate theme “internalization of control”. Here, P7 has internalized the positive step they have made of deciding not to use heroin and has distanced themselves from people who still do. Thus the “good” is internalized, whilst the “bad” appears to be projected onto external objects, such as methadone, the service or other drug users, as in the case of P8:

*“...it was, his auntie who actually was one of the dealers in in (place) and er, she don’t, she came here for six weeks holiday when I was thirteen...and when I went into the caravan and she were smoking it on foil, I was like, “What the hells that?” and she was like “Oh, I’m chasing the dragon” so I didn’t have none the first day, but, as I kept going round, he tried some and I tried some and I was like oh, still didn’t know it was heroin and then she was like, after five days she was like “oh, it’s smack, you know, you’ve used” and I was like “what’s smack?” you know?.”*

Alternatively, participants also appeared to identify with a drug-using identity, despite receiving MMT. Some participants talked about the craving of heroin, and how they perceived everyday as a “battle” to stay off of drugs; P8: *“If I saw him scoring, that would...I’d start rattling, even though I’m not rattling coz obviously my methadone holds me...”*

Here, P8 talks about how his mental craving for heroin can make him feel physically unwell and it appears he feels very reliant on methadone to maintain his stability. This

also appears to be another example of how fragile participants' users perceived this stability to be.

Some participants spoke about methadone in terms of the negative physical side effects, as if by using methadone they felt they were still continuing to put abusive substances into their body and were thus still drug users; P5: *"Because a lot of people's tell me that it rots your bones and that...and it's knackered, sorry for swearing, it's rotted all my teeth..."*

It appears that some participants saw little difference between heroin and methadone.

Indeed, some participants viewed methadone as being more harmful than heroin:

P2: *"But what they don't tell you is, yeah it changes your life, yeah. Ok you can sort yourself out, but methadone does you as much if not more harm than heroin does. Heroin in moderation will not harm you in the slightest. Methadone damages your internal organs. Hardens them"*

A negative-case analysis revealed that one participant had been able to integrate aspects of both their "drug user" and "non-drug user" identities. P3 states: *"...the doctor said to treat it like you're a...diabetic who needs insulin every day. Well that's rubbish really isn't it?...diabetics are diabetics because they've been born with it or they've got an illness that's caused it. I'm a heroin addict coz I started taking heroin...no one else did. It weren't nothing that's, it weren't the illness, it's summat I chose to do..."*. Here P3 appears to take ownership of their decision to start using heroin. Later, they demonstrate this internalization of responsibility for past crime, a process which appears uncomfortable and is thus minimized; P3: *"...when I went to jail, that was for drugs...I got trapped, if er, if it was America it would have been entrapment....But I went, I did*

*my time, I did do something wrong...apart from that I've never really been in trouble..."*

P3 also talks about methadone in terms of something that appears to have helped resolve some aspects of his drug using identity, but as something that also maintains it. For example, P3 talks about his difficulty with coming off of methadone, despite not wanting or needing the heroin anymore: *"...this reducing thing, it gets me every time. You know when you come down ten every so often. I get to a certain point and then I'll start (feeling I'm withdrawing)...whereas at least in jail, I know it was awful but they just chucked me in a cell and went "ah get on with it"...at the end of that three months I was off. So, if that had happened now, now I was as mentally stronger as I am now, I wouldn't have gone back on it (heroin)"*

Here P3 recognises themselves as someone who no longer wants heroin, but also as someone who is dependent on methadone. P3 also seems to doubt that they can cope with the gradual withdrawal process from methadone. This perhaps highlights how individuals receiving MMT can be "recovered" in the sense that they no longer mentally crave heroin, but are still mentally and physically dependent on methadone.

### The role of methadone

There also appears to be a contradiction in how people in MMT view methadone. On the one hand, as illustrated within the superordinate theme "enablers of change" methadone is viewed as something that acts as a support, aiding people to make changes in their lives. In contrast, methadone users appeared to also view themselves as still being dependent on a drug. This is illustrated by some participants, who felt that they owed their life to methadone:

P2: *“Well, if I didn’t have the methadone I’d be dead.”*

P9: *“At the moment? It’s (methadone) er, it gets me out of bed, it er, it makes me take the dog for a walk, you know, what I’m trying to say is its making me do normal things.”*

It appears that sometimes people on MMT view themselves as being entirely dependent on methadone. This sense of powerlessness can also be applied to a perceived lack of control over their methadone dose and their own future, where in some cases participants perceived an inevitable return to using heroin and/or MMT following an upsetting event, P4: *“Something will come along, something will happen. Maybe you’ll lose your job or you’ll have an argument with your mum and dad, or, you know, just summat trivial sort of thing. Next minute, back on it again.”*

Here, P4 appears to see herself as someone who is weak and who cannot cope with “trivial” things without resorting to heroin. Participants also doubted their ability to stop MMT and this seemed to be influenced by past experience of failure.

In contrast, MMT was seen by some individuals as restrictive. MMT was seen as both a means of control by services and as something that held them back and prevented them from living how they wanted to;

P3: *“It’s like a scent, it’s like a rope around my neck. Every time I start going that way it pulls me back coz I’ve gotta be there for it.”*

This appeared to be influenced by fear of withdrawal from MMT, which was described in terms that made it seem both unendurable and repulsive and something to be avoided at all costs.

An exception to methadone being perceived as either a saviour or a restrictive drug is P5, who appeared to view MMT as a tool to support them in achieving their goal in achieving abstinence from heroin. P5: “... *I’ve took heroin before and I’ve got off it before without methadone*’...

*I: ‘How’s it going this time round compared to last time?’*

*P5: ‘It’s obviously longer but, its, not as er, you don’t have the withdrawals and you know, you do without methadone...it’s like a crutch to lean on is methadone...’*”. Here, P5 appears to have faith in their own ability to stop using heroin based upon previous success and has chosen to use methadone to make the process of achieving abstinence from heroin a bit easier. Interestingly, P5 appears to view methadone as something that is part of their routine and as more of a medication than a drug, despite reporting a physical tolerance to the methadone: *“I: ‘How do you see the role of methadone in your life at the moment?’*

*P5: ‘I just take it daily so, I’ll have it in the morning and just carry on with life as normal...It don’t, it don’t affect me in any way really. Coz you get used to it...if somebody who weren’t on it took it, it’d probably kill them like, but, your body get’s used to it...You just take it and you just feel normal.’*”.

It seems that whilst methadone makes life easier for P5, they do not see themselves as being reliant on to maintain this ‘normal’ life.

### Summary

There appeared to be a split in how participants viewed services, themselves and the role of methadone. In one position, participants appeared to view themselves as a non-drug user. In this position, all the positive aspects of their recovery, such as reclaiming control over their lives are internalized, whilst the more negative aspects seem to be projected onto external things and the role of methadone and services in their lives

minimized. In the alternative position, participants viewed themselves as drug users, who were wholly bad, powerless and repulsive to others, whilst all the good things were put upon services and methadone, which were seen as saviours. There appeared to be only a little integration of the two positions, suggesting most individuals could only adopt one position at a time and alternate between them. Potentially, this alternation between the drug user and non-drug user identity could cause people to become “stuck” in MMT. Alternatively, the vacillation between these two positions may have represented where participants were in terms of their overall recovery process. This latter idea is supported by the fact that some participants appeared able to integrate their split views of themselves, services and methadone.

Superordinate theme: messages received by people in MMT

#### Expectations about stopping MMT

Service users seem to experience little expectation from services or from other clients/themselves that they will be able to stop receiving MMT:

P5: *“I wanna get off it soon time. But like, Dr. (person), keyworkers tell me I ain’t to rush into things, coz last time I rushed into it when I first ever got on it, I rushed into withdraw, like cutting down off it. And then coz I was feeling withdrawals and that, I started to dabble on heroin.”*

P6: *“I thought I’d probably always be on it, coz personally, I, erm, well I suppose even now, I can’t think of, I don’t interview everyone that I know that’s on drugs, but as far as I know, I don’t know many people that have been on methadone, reduced it and never taken drugs again. But like I say, I don’t ask people, but I don’t remember hearing anyone say “oh yeah, I was on methadone for three years and now I’m not on anything” I’m not saying that it can’t happen. But personally, I don’t know of anyone that has. And like I say, when I got off it too fast I went straight back onto it.”*



There seems to be the expectation from services that MMT clients will fail should they attempt to stop their MMT. This expectation may contribute towards people being afraid to come off MMT.

#### Using Heroin on MMT viewed negatively

MMT users in this study seem to have received the message that using heroin on top of their MMT was bad. Sometimes this message appeared to be viewed as services not caring about the individual person: P3: *“Or whether they genuinely think it’s, or whether it’s for the numbers, I don’t know. Maybe because, er, for everytime they get someone not using or negative tests it gets all measured up and it, and it makes it look good to the government.”* Alternatively, some service users viewed this message as useful advice, with the persons’ best interest at heart; P5: *“they always tell you not to use on top and that, because you could die and go over and that There’s useful things like that they always tell you good things.”* Again, this highlights how services are seen as either entirely “good” or entirely “bad”.

#### Not belonging

Despite receiving methadone, all participants appeared to feel that they did not belong with the rest of society, and that other people still viewed them as drug addicts;

P6: *“I always said that I’d never wanna go on methadone, coz you’re swapping one for the other and plus like, other people still think like, of methadone as like you’re still a druggie if you’re taking methadone.”* There was also a feeling that people are not “normal” on MMT. For example, P5 stated: *“I: ‘So recovery for you is coming off the methadone?’ P5: ‘Yeah, and you’re like recovering to get back to normal.’”*

This perceived message could be a projection of participants' negative view of themselves onto others, or it could be messages from society that reinforce participants' drug-user identity. In the researchers' opinion, it is probable these alternative explanations are not mutually exclusive.

#### Benefits of MMT to society.

Participants' appeared to view methadone in terms of its benefits to society, particularly in terms of reduced crime rates and ensuring a "calmer" world: P7: "*...it (methadone) prevents quite a lot of crime don't it, well in my view it does anyway. Prevents a lot of crime and er, keeps people stable and stops people doing irrational things, like, you know, like they would if they, if they couldn't get any money and couldn't get any methadone they'd be in a desperate situation they'd do anything to get that money to get the fix wouldn't they? And if there weren't places like this, well, this the users would be out of control or in jail wouldn't they...*". This appears to suggest that methadone enables people taking it to be more in keeping with societies' norms. This seems to be a perception service users' have, perhaps via interaction with services, but one which does not reflect their inner experience of what life is like as "an outsider" on methadone.

#### Recovery unique to individual

Participants appear to have received the message from services that recovery is unique to each individual. Participants talked about the flexibility of services in taking individual needs into account, not forcing people to adhere to strict treatment rules and by not imposing their own views on what recovery should consist of, for example P9 stated: "*I think er, I think she's very open minded. I don't think she's judgemental. I think she's very open minded...*". This contrasts' with previous themes which suggested that coming off MMT and "being clean" was a goal for some participants.

## Summary

Participants appear to have received the contradictory messages that methadone is more acceptable than heroin to both society and services, but that they still do not ‘belong’ with the rest of society and are seen as “druggies”. Perhaps these mixed messages may have contributed to how MMT clients either view themselves as “a druggie” or as a “non-drug user” whilst on MMT.

### Overall summary of results

Participants appeared to view recovery as a long, slow process which involved committing to a decision to change and learning to live life without heroin. This process had several indicators or “signposts” that the recovery process was occurring, including: an improved sense of self, better relationships with others and acceptance of things that could not be changed. Recovery appeared to be facilitated by a number of underlying processes including a sense of hope and internalization of control over the future.

Overall, recovery appears to be characterized by a transition from a drug-user to a non-drug user identity, which is facilitated by past experiences of success and positive feedback from others.

However, it seems that whilst receiving MMT, individuals perceived themselves as both a non-drug user and as a drug user. There appeared to be little integration between these two positions and this “good” and “bad” split was replicated in how participants viewed both methadone and services. Methadone was viewed as something that enabled freedom from the drug lifestyle, but at the same time was experienced as restrictive because it prevented people living the way they wanted to. Services were seen as “good parents”, as participants found them motivating and a source of emotional warmth. However, they were also seen as “bad parents” and perceived as untrustworthy,

uncaring and unreliable. This oscillation between good and bad gave a sense of participants being “stuck” on MMT

## DISCUSSION

The superordinate themes identified in this study which defines recovery by both its underlying processes and their concurrent “outcomes” are consistent with the findings of Vigilant’s (2005; 2008) American studies. These themes also support the conceptualization of recovery proposed by the Trans-theoretical Model of Change (DiClemente, 2003) which suggests that both behavioural and cognitive changes are required to enable recovery from drug dependence and that changes in the social network of former heroin users are necessary for the recovery process to occur. The results also suggest that several processes occur when former heroin users decide to change their social network, and the effects of these are self-reinforcing. The first of these seems to be that former heroin users make a decision not to use heroin in addition to their MMT and also make an effort to sever all associations with their drug using lifestyle. One function of this seems to be to enable the past heroin user to avoid temptation. However, this appears to leave a “gap” in lives that needs to be filled, as exemplified by one participant who talked about missing the social aspects of the heroin lifestyle.

Thus, an important part of the recovery process seems to be that of building up a part of the self not associated with using heroin, by taking part in non-drug using activities and re-forming social relationships with non-drug users. Participants in this study reported that the positive feedback they receive from others validates their recovery efforts. This supports the idea proposed by Hughes (2007) that former heroin users do not recover in isolation. The more non-drug using activities and relationships former heroin users are

involved in, the greater the positive reinforcement their non-drug using identity receives, which may further enable them to distance themselves from their former drug using lifestyle. These findings are supported by results of a study by McIntosh and McKeganey (2000a), who discuss the role of avoidance of former drug-networks and the development of non-drug related identities. McIntosh and McKeganey (2000b) suggest that development of a non-addict identity involved reinterpretation in three main areas: past drug using lifestyle, sense of self and providing an explanation for their recovery. Again, the findings of this study are consistent with this research.

It is interesting how even whilst receiving MMT, individuals perceive themselves as having made a transition from a drug-using to a non-drug using identity. Participants associated the drug-using identity with heroin use in addition to MMT and criminal activity and were keen to distance themselves from this lifestyle to preserve a positive, non-drug using identity. Methods they used to achieve this was to externalize the blame for their former drug using behaviour and internalize positive aspects of their behaviour associated with the recovery process, such as the decision to stop taking heroin and enter MMT. This is consistent with findings from a study by Radcliffe and Stevens (2008) who found that people who dropped out of drug treatment did not associate themselves with other drug users. Their study found that drug users tended to avoid entering drug treatment because they viewed the routine management of drug-dependence promoted by services as stigmatizing and confirming of the “addict” identity. This suggests that former drug users can see involvement with services as something which confirms the drug using identity and which may exclude them from society. This finding seems to be supported by this study, where participants perceived themselves as being outsiders or “not normal” despite receiving MMT.

However, this also contrasts with two other themes that emerged from this study; that is themes of participants “re-joining society” and “regaining a life” whilst in MMT.

Participants talked about how methadone had freed them from the drug using lifestyle and meant that they could repair relationships with family and friends. To some extent, it seemed that the people in MMT in this study were already making a recovery consistent with the recommendations made by the 2010 Drug Treatment Strategy (HM Government, 2010). If it is the case that people receiving MMT have already achieved some aspects of recovery, then why are they still receiving MMT?

One of the superordinate themes that emerged was that of “Paradox”. Whilst at times participants on MMT associated themselves with a non-drug using identity, most of them appeared to view their way of life as being dependent on MMT, and they seemed to view the future, and their ability to influence this future, as uncertain. This gave a sense of participants being “stuck” in MMT and suggested that participants had not experienced the increase in self-efficacy whilst receiving MMT which the cognitive-behavioural model of relapse prevention deems necessary to prevent relapse into drug use (Marlatt and Gordon, 1985). While it may be extremely positive that drug treatment services provide the opportunity for MMT users to control their treatment, if service users’ have low self-efficacy, they may not feel able to make use of this control and prefer that services and methadone take control for them, thus maintaining their “stuckness” in MMT.

Indeed, upon analysis of transcripts it appeared that most of the participants were living “day by day” with a fragile sense of stability which appeared entirely dependent on methadone. The evidence for “stuckness” appeared to far outweigh evidence for “enablers of change”, particularly aspects of change that involved hope for the future. It

seemed that some of the participants still viewed themselves as still being very close to death, despite receiving MMT. This was clearly illustrated during feedback of the study's results to P2. When the sub-ordinate theme of "The role of methadone" was explored with them, P2 spoke about their fear that their MMT would be stopped and stated that they would "kill themselves rather than start taking heroin again". Thus, for some people, it appears that methadone is the only thing between them and death.

Vigilant (2008) suggests that Maslow's (1970) hierarchy of needs conceptualizes the self-actualisation stage of recovery. Alternatively, the multiple recoveries proposed by Vigilant (2008) and the results from this study could perhaps be thought of in terms of the entire hierarchy of needs, with personal safety and meeting of basic needs (stabilization through methadone) being the start of the recovery process, with self-actualisation (working out a new identity) completing the recovery process. However, the results of this study suggest that for many people receiving MMT, each stage of the hierarchy, including the "self-actualization" or non-drug using identity phase, may be viewed as being dependent on MMT. Some people receiving MMT may doubt their ability to maintain their non-drug using lifestyle/identity without the use of methadone, thus preventing them from progressing beyond a maintenance dose of methadone.

This message appears to be reinforced by methadone users' involvement with services. Results from this study suggest that there is little expectation from drug treatment services that people receiving MMT will progress beyond receiving a MMT dose. This may be a reflection of the governments drive to ensure people who are receiving MMT maintain involvement with drug services. Alternatively, it may reflect the requirements of the recovery needs of the particular individuals from this study. Participants were only eligible for participation in the study if they had been receiving MMT for over one

year. It is possible that these individuals may have had more entrenched heroin dependence, and this influenced services expectations of their outcome. One message was clearly received by participants in this study: that recovery was unique to the individual and that drug treatment services generally responded to this in a flexible manner, without imposing their views on individual clients.

In contrast, MMT was also viewed as preventing people from living the lives that they wanted to. Participants talked about experiencing services (drug treatment and prison) as punitive, untrustworthy and unresponsive to their needs. It appears participants viewed MMT and services as both restrictive and as enablers of change. However, there may also be another factor involved in how methadone and services are perceived by MMT users. Many people who use heroin have experienced emotional and physical abuse and neglect during their childhoods and as a result have not had the experience of being consistently parented (Wieder & Kaplan, 1969). Thus, they may not have been able to internalize a positive sense of self and feeling of self-efficacy, and thus feel unable to make sense of their internal or external worlds or feel able to control their future (Ball & Legow, 1996). Potik, Adelson and Schreiber (2007) propose that both methadone and the counsellors involved with MMT users can be viewed as ‘transitional objects’, used by former heroin users to contain negative emotions and provide a sense of security when times are difficult, when they feel unable to cope alone. Thus MMT and drug services can be seen as the stable parental figure that many past heroin users may not have experienced. At the same time, MMT and drug services may be viewed as neglectful and unresponsive due to powerful projections of service users’ negative emotional experiences that are intolerable. Thus, people in MMT can maintain a non-drug user identity by internalizing the “good” such as their decision to enter recovery, and externalizing their negative experiences that they are unable to tolerate. For



example, services could be viewed as punitive rather than the methadone user taking ownership of difficult emotions and past mistakes.

It is possible that service users' perception of MMT and services is dependent on whether they see themselves as having a "drug-user" or "non-drug user" identity.

People within the powerless "drug user" position may view services as all powerful and positive, whilst they themselves are "all bad" whilst people in the "non-drug user position" may have internalized the positive aspects of their recovery experience and projected the negative parts of their identity onto services and MMT. Whilst in the non-drug user position, service users may minimize the role methadone and services are still playing in their lives. Perhaps recovery from heroin dependence using MMT could be conceptualized as a process of resolving this "split", where the service user is able to internalize both positive and negative aspects of their experience and develop their sense of self to encompass both their past drug-user identity and their current/prospective non-drug user identity. This may help them feel able to cope with their experiences without needing to rely on methadone or drug treatment services to manage the parts of their identity that they feel ashamed of/painful. This idea is supported by the negative case analysis, which found evidence that one participant (P3) who appeared able to bear the responsibility for crime they had committed in the past but also saw themselves as someone who did not want heroin and as someone with a non-addict lifestyle. P3 also saw MMT as something that had both aided and restricted them, indicating an integration of "good" and "bad" aspects of their identity and perception of MMT.

## An Alternate Conceptualization of Recovery

The viewpoint that recovery from heroin dependence means people coming out of MMT, as proposed by both the “Signposts of recovery” superordinate theme and governmental policy contrasts with the “Recovery is unique to each individual” message MMT users receive from services. It also contrasts with ideas from the mental health literature that recovery may not always mean being symptom (or in this case drug) free (Onken, Craig, Ridgeway, Ralph & Cronk, 1997). Some participants in this study held the viewpoint that recovery was different for every person and for some, recovery meant receiving MMT. Indeed, as stated earlier, people receiving MMT have already made changes in their lives which are consistent with recommendations made by the 2010 Drug Treatment Strategy (HM Government, 2010). Why is this not a “good enough” recovery? Why is there still a drive to make people stop using MMT? Part of this, undoubtedly, is the cost of maintaining people on MMT. Due to financial costs, there is the risk that MMT clients will be forced to make a “recovery” that is not best suited to their individual needs, and that the person-centred approach will be abandoned in order to meet cost-cutting goals.

Although in the current financial climate cost-cutting is certainly not merely restricted to drug-treatment services, the stance taken with clients receiving MMT seems particularly punitive. For some people, their lives appear to depend on methadone. Insulin would not be withheld from a diabetic, nor oxygen from someone who has had a lung removed. The non-drug using society appears to have an extremely negative view of people receiving MMT; we see the consequences of drug use in terms of crime and the “dirty” people walking the street, instead of the cause of it; early life-stressors, low levels of care and high levels of criticism (Wieder et al., 1969). There is an argument that not everyone with a difficult childhood turns to drug use. This is true, but there are

other symptoms; obesity caused by overeating, lung cancer due to smoking and liver disease due to alcoholism to name just a few. The National Health Service pays for the treatment of these symptoms also, yet it appears these are viewed less negatively by society. People receiving MMT report feeling like “outsiders” as if they are excluded from normal society. This can only keep them within their drug world, “stuck” on MMT. One clear finding from interviews with participants in this study is that recovery is a long and slow process. It takes time to heal from both the effects of drug use and its underlying causes. Perhaps MMT provides the time for people to do this and the opportunity for them to rebuild a more positive identity. This process could only be facilitated if the views of society could be encouraged to view MMT users as people and not “druggies”.

#### Implication for services

Two contrasting views of recovery have been discussed and it is probable that both are equally applicable. Indeed, these views in themselves may represent a “split” in how MMT users are viewed! The “truth” is probably somewhere between the two views. One thing seems clear; that MMT represents a chance for healing and regaining of things that have been lost. Often drug-dependent individuals may not have had the opportunity to develop a secure attachment style, or their secure attachment may have been disrupted through their drug-using lifestyle (Ball et al., 1996). This insecure attachment may have continued throughout their lives, contributing to relationship and emotional management difficulties, further perpetuating their drug use (Wieder et al., 1969).

### The provision of a secure base

Bowlby (1988) emphasised the role of the parental figure in providing a secure base to allow a child to explore the world and in helping the child make sense of their reactions to it. For some people, entering drug treatment services may be a rare source of stability in their lives and an opportunity for them to learn to cope with the world and their emotions, without relying upon heroin and/or methadone. Clearly, drug treatment services have a larger role than the provision and monitoring of methadone to their clients. It seems that one of their most important roles is that of providing a positive parental figure for people receiving MMT. Ideally, this would involve encouraging people receiving MMT to integrate both a positive, non-drug using identity and their past drug-user identity by offering a secure, stable and containing base that would help people explore and manage the emotions associated with their “drug user” and “non-drug user” identities.

Essentially, services would be “re-parenting” individuals receiving MMT by providing them with a secure base, from which they could explore the world and develop the skills to cope with their emotions and daily challenges that they would normally have developed in childhood. This is a process that is likely to take time and require patience.

### Encouraging the development of autonomy

If the service user decides that they would like to try to achieve abstinence from MMT, this could potentially be facilitated by encouraging them to take part in non-drug using activities and relationships, to build on their positive sense of self. However, to avoid these changes being attributed to methadone, it appears that self-esteem work may be necessary. Ultimately, people receiving MMT need to prove to themselves that they can maintain their lifestyle without methadone. This means stepping away from their source

of support (methadone) and risking potential failure. Drug treatment services would have the difficult task of working with each individual to identify when a quit attempt would be most appropriate and supporting them through this difficult time. It would be important for services to take a confident and encouraging stance and to remain calm should a service user “fail”. Perhaps services’ role in light of service users “failure” would be to encourage participants to internalize responsibility for their actions (i.e. negative experience) and enable them to learn from their experience to build a sense of hope for a MMT free future. At points of “failure” it appears important to remember that these present opportunities for individuals in MMT to test themselves and increase self-efficacy. If “failures” are conceptualized as learning points, it is important that the urge to protect individuals from failure does not result in their dose of methadone being increased after an unsuccessful quit attempt, or worse, that the quit attempt is never made.

Of course, if a service user experiences too many failures, it may have a detrimental effect on self-efficacy. The timing of a quit attempt should be at a time right for the individual, yet it appears it will always be a balance between risk of failure and success. People receiving MMT would have to face their fear of withdrawal and in some cases actually experience this. There is no doubt that this will be an incredibly difficult time for the service user, and the urge to return to taking methadone would understandably be huge. Increased support from services before and after this time point may be appropriate to enable the initial painful “separation” of the methadone user from their transitional object and encourage them to maintain this. It would be important that self-esteem and identity work is continued following a successful quit attempt, to allow service users to overcome any self-doubt by internalizing the sense of control they previously relied upon methadone and services to provide.

It is likely that reducing the number of people receiving MMT will take time. Service users have potentially been receiving the message that they “need” methadone for years and building their non-drug using identity, a sense of self-efficacy and reducing other factors associated with “stuckness” may be a long, slow and frustrating process. It is important that services maintain a person-centred approach, which recognises that the recovery process is unique to each individual. People receiving MMT may have different goals and aspirations and take different lengths of time to reach their goals.

Some people may not want to come off MMT and it is important to respect this decision, even whilst looking at why this may be the case (for example, low self-efficacy). Recent statistics have indicated that the number of older people entering drug treatment is rising, and that many of these have long, entrenched heroin careers. This suggests that people who are now entering MMT represent an aging population (NTA, 2010). It may be that a long period is required for heroin users to decide that they want to change and feel able to embark on the process of recovery. If this is the case, an alternative management response could be to encourage services to run out-reach programmes, aimed at encouraging heroin users to enter services and increasing their motivation and self-efficacy with regard to change. Due to their long heroin careers, some of the older treatment seekers may view methadone as being “in recovery”. This may require increased funding from the government to allow for the management of this population in MMT for the rest of their lives.

### Summary

This research has several possible implications for the development of services for people receiving MMT. However, there are several limitations to this research which

need to be considered before applying the results of this study to a broader population.

These limitations are discussed below.

### Limitations of Research

As with most qualitative research, the extent to which these findings can be generalized is limited. Only a small number of participants, recruited from two drug treatment services in the North of England took part in this study and all of them were White British, or White-European. However, the results of this study are consistent with other research on recovery from heroin dependence from Britain and America, which lends external validity to its findings.

Upon re-examining the interview schedule following data collection, one of the questions could be construed as making assumptions about participants' experiences on MMT. This question: "If you could compare how you saw yourself before you started on MMT with how you see yourself now, what would you notice?" may have influenced the direction the interview took and the content of narrative obtained.

Theme's that could have been potentially affected were the addict and non-drug user superordinate themes. This was primarily due to the author's inexperience using IPA methodology and future research may wish to explore this aspect of recovery more thoroughly. However, these themes were still present when participants were talking about other aspects of their experience and were also consistent with other, pre-existing literature.

Finally, this study was conducted with individuals who were still receiving MMT and do not consider the views of people who have already achieved long-term abstinence from both heroin and methadone. Thus, the extent to which the ideas and theories

presented in this study conceptualize the recovery process may be limited. It is important that this study is replicated with individuals who had already achieved abstinence from heroin and methadone to investigate the extent to which the results/ideas from this study can be applied to their experience.

#### Further research

This research has identified that the formation of a non-drug using identity, its integration with the more “negative” aspects of self and increased self-efficacy with regard to being “in control” of one’s life may be associated with change in MMT. It seems important to determine whether these factors really are associated with success in coming off MMT. A quantitative study examining the relationship between self-efficacy for maintaining the lifestyle achieved whilst on MMT, the development of a non-drug using identity and outcome following an attempt to withdraw from MMT could be conducted. If relationships were found, it may help services to develop ways of promoting these changes in MMT clients and reduce the number of people receiving MMT in the UK.

Alternatively, the development and trial of measures that identify aspects of self-efficacy and non-addict identity related to achieving abstinence from MMT would be of interest. These measures could then be used to help drug treatment services identify individuals who may be suitable to support in quitting their MMT. Alternatively, a qualitative study examining staff views of recovery in MMT users and the role of methadone would be exceedingly useful to identify how staff perceives the recovery process and what changes they would like to make to the service they work in. This could be very beneficial in terms of service development and add to the knowledge, understanding and conceptualization of recovery in the methadone using population.



## Conclusions

This research identified themes consistent with the wider literature around the concept of recovery being a process and the importance of the transition from a drug using to a non-drug using identity, which appears to be facilitated by MMT. Another important idea identified was that of “stuckness” which was characterized by participants’ self-doubt and reliance on MMT. It is proposed that for services to facilitate the transition from MMT to non-methadone use, services play an important role in “re-parenting” individuals on MMT, by encouraging them to internalize both a sense of self-efficacy and an integrated sense of self, including both positive and negative aspects of their experience. This may involve teaching them to tolerate both their negative and positive emotions. Alternatively, recovery may simply be recognising that some individuals may want to stay in MMT. There are many avenues for future research, including focusing on exploring a possible relationship between an integrated sense of self, self-efficacy and success in withdrawing from methadone, and developing measures that drug treatment services could use to assist service users with this transition. In order to aid development of drug treatment services, it is important to gather views from staff on how they conceptualize the recovery process and the role of methadone, as well as gathering information on what changes both they and service users would like to see in drug treatment services.

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## APPENDICES



Appendix A: Guidelines for authors submitting to the journal: *Addiction*  
Research and Theory

## **Instructions for Authors**

### **INTRODUCTION**

Submission of a paper to Addiction Research and Theory will be taken to imply that it represents original work not previously published, that it is not being considered elsewhere for publication, and that if accepted for publication it will not be published elsewhere in the same form, in any language, without the consent of editor and publisher. It is a condition of the acceptance by the editor of a typescript for publication that the publisher automatically acquires the copyright of the typescript throughout the world.

### **SUBMISSION OF MANUSCRIPTS**

All submissions should be made online at the Addiction Research and Theory's Manuscript Central site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

Each paper will be read by at least two referees.

### **FORMAT OF MANUSCRIPTS**

Manuscripts should be typed in double spacing with wide margins. Please upload an anonymous main document and a separate title page with author information.

**Title page:** This should contain the title of the paper, a short running title, the name and full postal address of each author and an indication of which author will be responsible for correspondence, reprints and proofs. Abbreviations in the title should be avoided.

**Abstract:** This should not exceed 250 words and should be presented on a separate sheet, summarising the significant coverage and findings.

**Key words:** Abstracts should be accompanied by up to six key words or phrases that between them characterise the contents of the paper. These will be used for indexing and data retrieval purposes.

### **TEXT HEADINGS**

All headings in the text should be set over to the left-hand margin, and the text should begin on the next line. Type first level (sectional) headings all in capitals. For second and third level headings, only the first letter of the first word should be a capital. Underline third level headings.

For example:

#### **FIRST LEVEL TEXT HEADINGS**

Second level text headings

Third level text headings

### **REFERENCES**

Style, statistical reporting, and reference citations should conform to the American Psychological Association's guidelines, from the APA Publication Manual, fifth edition.

To conform with the APA Publication Manual, fifth edition, references should be alphabetized at the end of the manuscript text, in the following formats:

Kozlowski, L. T., Henningfield, J. E., & Brigham, J. (2001). *Cigarettes, nicotine, and health*. Thousand Oaks, CA: Sage Publications.

Weinstein, N. (2001). Smokers' recognition of their vulnerability to harm. In P. Slovic (Ed.), *Smoking: Risk, perception, & policy* (pp. 81-96). Thousand Oaks, CA: Sage Publications.

Perkins, K. A., Donny, E., & Caggiula, A. R. (1999). Sex differences in nicotine effects and self-administration: review of human and animal evidence. *Nicotine & Tobacco Research, 1*, 301-315.

## **FIGURES**

All figures should be numbered with consecutive Arabic numerals, have descriptive captions and be mentioned in the text. Figures should be kept separate from the text but an approximate position for each should be indicated in the margin. It is the author's responsibility to obtain permission for any reproduction from other sources.

**Preparation:** Figures must be of a high enough standard for direct reproduction. They should be prepared in black (india) ink on white card or tracing paper, with all the lettering and symbols included. Axes of graphs should be properly labelled and appropriate units given. Photographs intended for halftone reproduction must be high quality glossy originals of maximum contrast. Redrawing or retouching of unsuitable figures will be charged to authors.

**Size:** Figures should be planned so that they reduce to 10.5cm column width. The preferred width of submitted drawings is 16-21cm, with capital lettering 4mm high, for reduction by one-half. Photographs for halftone reproduction should be approximately twice the desired size.

**Captions:** A list of figure captions should be typed on a separate sheet and included in the typescript.

## **TABLES**

Tables should be clearly typed with double spacing. Number tables with consecutive arabic numerals and give each a clear descriptive heading. Avoid the use of vertical rules in tables. Table footnotes should be typed below the table, designated by superior lower-case letters.

## **PROOFS**

Authors will receive proofs (including figures) by air mail for correction, which must be returned within 48 hours of receipt. Authors' alterations in excess of 10% of the original composition cost will be charged to authors.

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No stated word count.

Instructions for Authors (2011). *Addiction Theory and Research*. Retrieved on 22<sup>nd</sup> May 2011 from:  
<http://informahealthcare.com/userimages/ContentEditor/1271255276587/ARTIFAS.pdf>

## Appendix B: Information pertaining to part 1: systematic literature review

*B.1: Checklist of methodological quality for qualitative papers: based on NICE (2007)*

*B.2: Checklist of methodological quality for quantitative papers: Based on Downs and Black (1998) checklist and CONSORT (2010) statement.*

*B.3: Data extraction form*

*B.4: List of studies excluded from systematic literature review*

Appendix B.1: Checklist of methodological quality for qualitative

papers: based on NICE (2007)

(obtained <http://www.nice.org.uk/niceMedia/pdf/GuidelinesManualAppendixH.pdf>: 31<sup>st</sup> March 2011).

<b>1 Aims of the research</b>			
1.1	Are the aims and objectives of the research clearly stated?	Clearly described Unclear Not reported	Comments
1.2	Is a qualitative approach appropriate?	Appropriate Unclear Not appropriate	Comments
<b>2 Study design</b>			
2.1	Is (are) the research question(s) clearly defined and focused?	Clearly defined and focused Unclear Not focused Not defined	Comments

2.2	Are the methods used appropriate to the research question(s)?	Appropriate Unclear Inappropriate	Comments
<b>3 Recruitment and data collection</b>			
3.1	Is the recruitment or sampling strategy appropriate to the aims of the research?	Appropriate Unclear Not appropriate	
3.2	Are methods of data collection adequate to answer the research question?	Adequate Not adequate Not reported	Comments
3.3	Are the roles of researchers clearly	Clear	Comments
3.4	Have ethical issues been addressed adequately?	Adequate Unclear Not adequate	Comments
<b>4 Data analysis</b>			
4.1	Is the data analysis sufficiently rigorous?	Rigorous Not rigorous	Comments
<b>5 Findings/interpretation</b>			
5.1.	Are the findings internally coherent, credible (valid)?	Valid Unclear Potential bias	Comments
5.2	Are the findings relevant?	Relevant Unclear Limited relevance	Comments
<b>6 Implications of research</b>			

6.1	Are the implications of the study clearly reported?	Clearly reported Unclear	Comments
6.2	Is there adequate discussion of the study limitations?	Adequate Inadequate Not reported	Comments
<b>OVERALL ASSESSMENT OF THE STUDY</b>			
How well was the study conducted? <i>Code ++, + or –</i>			
Are the results of this study directly applicable to the patient group targeted by this guideline?			Yes No



## Appendix B.2: Checklist of methodological quality for quantitative papers

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### Quality Checklist Question

(Y =2, Partially = 1, N=0, Unable = 0)

---

1. Was there a structured summary of study design, methods, results, and conclusions?
  2. Were the background and objectives of research described?
  3. Is the hypothesis/aim/objective of the study clearly described?
  4. Are the main outcomes to be measured clearly described in the Introduction/Method
  5. Are the characteristics of the patients included in the study clearly described?
  6. Was the study design adequately described?
  7. Were the statistical methods used described?
  8. Was there a description of participants' who a) Were not eligible to take part in study, b) Dropped out, C) Lost to follow up (2 points available for each)
  9. Was comparison made between participants not included in study to those who were?
  10. Have the ethical issues been addressed adequately/explained to participants?
  11. Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?
  12. Are the main findings of the study clearly described?
  13. Does study provide estimates of the random variability in the data for the main outcomes?
  14. Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?
  15. Were the subjects asked to participate in the study representative of the entire population form which they were recruited?
  16. Were those subjects who were prepared to participate representative of the entire population from which they were recruited?
  17. If any of the results of the study were based on "data dredging" was this made clear?
  18. In trials and cohort studies, do the analyses adjust for different lengths of follow up of patients?
  19. Were the statistical tests used to assess the main outcomes appropriate?
  20. Were the main outcome measures used accurate (valid and reliable)?
  21. Was there adequate adjustment for confounding n the analyses from which the main findings were drawn?
  22. Were study limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses discussed?
  23. Was the generalizability (external validity, applicability) of the trial findings discussed?
  24. Was the interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence?
  25. Were implications of the study on services/policy discussed?
-

Appendix B.3: Data extraction form

**Pro-Forma for Data Extraction**

Paper number:
---------------

Journal Article Title: \_\_\_\_\_

Author (s): \_\_\_\_\_

Year: \_\_\_\_\_

Question				
Sample	N	Age Range	Population	Other relevant Demographics
Aim of the study				
What was the design of the study and basic methodology?				Statistical Tests used
What was the				

<b>psychological factor (s) under consideration?</b>	
<b>What was the sociological factor under consideration?</b>	
<b>How was Recovery defined?</b>	

<b>What were the key limitations of the study?</b>	
<b>Additional relevant results</b>  <b>e.g. Super/sub ordinate themes and brief description</b>	

Appendix B.4: List of Excluded Studies

<b>Database</b>	<b>Papers Excluded at Stage 4: Abstract Review</b>	<b>Stage 5: Paper Review</b>
<b>EBSCOHost</b>	<b>Non British Study:</b> 6	<b>Non British Study:</b> 1
<b>(PsychInfo,</b>	<b>No recovery element:</b> 2	<b>No Psychosocial-</b>
<b>Medline, Psych</b>	<b>Prison Population:</b> 1	<b>Recovery Link:</b> 1
<b>Articles,</b>	<b>Participants under 18:</b> 1	<b>Total:</b> 2
<b>CINAHL)</b>	<b>Total:</b> 10	
<b>Web of Science</b>	<b>Non British Study:</b> 1	<b>Weak Psychosocial-Recovery</b>
	<b>Treatment effectiveness study:</b> 1	<b>Link:</b> 2
	<b>No recovery element:</b> 1	<b>Mixed drug use:</b> 1
	<b>Total:</b> 3	<b>Total:</b> 3
<b>Scopus</b>	<b>Interest Only:</b> 5	<b>No recovery factor:</b> 1
	<b>Non-drug taking participants:</b> 7	<b>No psychosocial factor:</b> 2
	<b>Duplicate papers:</b> 3	<b>Prison population:</b> 1
	<b>Treatment effectiveness study:</b> 3	<b>Participants under 18:</b> 1
	<b>Discussion article/review:</b> 4	<b>Discussion Paper/review:</b> 5
	<b>Prison Population:</b> 2	<b>Study not in Britain:</b> 12
	<b>Non British Study:</b> 12	<b>Alcohol main drug</b> 1
	<b>Participants under 18:</b> 2	<b>Mixed-drug use sample:</b> 2
	<b>No psychosocial- Recovery link:</b> 2	<b>Total:</b> 24
	<b>Total:</b> 47	

Appendix C: Rational for interpretative phenomenological  
analysis (IPA) data analysis

As stated in methods section of the empirical paper, the research questions in this study best lend themselves to a relativist standpoint. That is, that “reality” is unique to each individual and thus based upon their own life experiences. Thus, these individual “realities” are unsuited to measures that are based on a more positivist viewpoint (i.e. that there is one shared “reality” that can be objectively measured) such as questionnaires. To best explore individual experiences, a qualitative methodology appeared to be the most appropriate. There are several types of qualitative analysis, the most common of which are explored below, with reference to their applicability to the research questions stated in part two of this thesis.

#### Content analysis

This technique involves analysing existing texts to produce inferences that can be reliably replicated (Krippendorf, 2004). This technique was not considered to analyse the data produced from this research. Firstly, because this research involved the generation of new and unique data. Secondly, because content analysis makes use of categories that are defined before data analysis begins (Willig, 2001). This would be inappropriate with respect to answering the research questions as it would have involved the researcher imposing some of their assumptions onto the data analysis process. This would not have aided the exploration of participants’ own views of recovery and methadone.

#### Grounded theory

Grounded theory analysis also involves the “identification and integration of categories of meaning” (Willig, 2001 p33) from the initial data. However, these categories are identified from the data itself, rather than being pre-defined. Once the initial categories of semantically similar information have been identified, additional data is analysed with reference to these categories, where the researcher tries to identify information that

does not fit with the categories identified. Throughout the process of category creation, different levels of interpretation are applied. For example, a category may begin as a descriptive label, but as more data is collection, increased levels of abstraction could be added. The aim of this method of data analysis is to achieve data saturation, whereby no more categories can be identified from the data. This method of data analysis appears to be suited towards answering the research questions and was considered for use in this research. However, the assumption that data collection should be continued until data saturation is achieved was deemed unfeasible by the researcher, due to the difficulty in recruiting participants from the target population.

#### Discourse analysis

This approach is concerned with the role of language in creating social reality (Willig, 2001 In: Smith, 2003). One of these forms of discourse analysis is that of ‘discursive psychology’, which focuses on how people use language and what its effects are. A second form of discourse analysis ‘Foucauldian Discourse Analysis’ explores how language is used in the construction of identity and the relationship between language, power and social practises. This form of discourse analysis is more concerned with how language is used to construct ideas and objects. Upon examination of participants’ transcripts, it was decided that this type of qualitative methodology was unsuitable. Some of the participants who took part in the study appeared to have difficulty in expressing themselves verbally. It seemed that a data analysis method which allowed for additional levels of interpretation to identify the meaning of what participants were saying was required. Whilst discourse analysis does allow for interpretation, it was felt that this interpretation (i.e. interpretations made in terms of constructions of identity, power e.t.c) would limit the type of information gained from the analysis and thus may not answer the research questions.



## Interpretative phenomenological analysis (IPA)

IPA examines how people interpret and make sense of their lived experiences, which appeared appropriate when considering the research questions in this study. IPA allows for additional interpretation by the researcher so that they can try to understand how an individual makes sense of their experiences. This methodology also encourages the researcher to be aware of their own pre-conceptions, so that they can minimize the extent to which these interfere with the data analysis. Data saturation is not the goal of IPA, which appears more consistent with the relativist opinion, that everyone has their own unique reality. As a result, IPA was deemed the methodology that “best fit” with the epistemological stance and research questions of this study.

## Summary

The data analysis methods of; content analysis, grounded theory and discourse analysis were considered for use in this research. However, they were not considered appropriate to answer the research questions. IPA was deemed to be the data analysis method most suited to the data obtained.

## References:

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## Appendix D: Interview Schedule

## Interview Schedule

1a) “Recovery” is a word that is sometimes used when people talk about coming off drugs. Can you tell me what “Recovery” means to you?

- Is there anything else?
- Recovery has been described as a process. What are your views on this?
- Do you see there being a particular endpoint to people’s recovery?
- Can you tell me more about that?
- Standard definition of recovery from The UK Drug Policy Commission Recovery Consensus Group (2008):  
Recovery“...characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.” If client does not have a clear one: not for everyone. Ask if client agrees with definition.
- 

1b) What is your experience of recovery?

- What has changed in your life?
- Is there anything you would say that is getting in the way of you making a recovery?
- What has helped?
- What do you think the most important experiences have been in helping to change?
- How was that for you?
- How did that make you feel about yourself?
- Can you tell me more about that?
- What changes do you think other people may have seen in you?

2) What are your views on the role of MMT in your life?

- Has it helped? If so, how? If not, why not/can you tell me a bit more about why you think that?
- Has anything changed in your life since starting MMT?
- Is there any area of your life/how you see yourself where you feel MMT has not helped?
- What makes you want to stay on MMT?
- Is there anything that makes you want to come off MMT?
- Is there anything that stops you coming off MMT?
- How long do you see yourself continuing on MMT?
- Can you tell me more about that?

3) You have been in contact with services for (*time period*). Has your view your recovery/methadone use changed over that time?

- If so, how?
- If not, tell me why you think this?
- What were your views on what recovery was at the start of your involvement with services? What are your views on what recovery is now?

- What were your views on the role of MMT for you at the start of your contact with services? What are your views on the role of MMT now?
  - What do you think has caused this?
  - Have services played a role in this? – If so, what/how?
  - Has your view on methadone/recovery changed? If so, how?
  - How have services been helpful?
  - Has there been anything that has not been so helpful with your involvement with services?
  - Can you tell me more about that?
- 4) If you could compare how you saw yourself before you started on MMT with how you see yourself now, what would you notice?
- What is the same?
  - What is different?
  - How did you view yourself then
  - How do you view yourself now.
  - What do you think other people may have noticed about you?
  - What words would you use to describe yourself then/now?
  - Can you tell me more about that?
- 5) Do you feel you have received any messages from services about what recovery is/the role of methadone
- How do you think services view recovery/use of methadone
  - Do you think different members of staff see recovery/role of methadone differently?
  - What do you feel the service view's the role of methadone to be?

## Appendix E: Participant Demographic Questionnaire



1. **How long have you been taking heroin/other opiates? .....**  
**What type? .....**
2. **What type of opiate use are you currently seeking treatment for?**  
.....
3. **How long have you been receiving Methadone Maintenance Treatment?**  
.....
4. **How long have you been receiving your current phase of Methadone Maintenance Treatment?**  
.....
5. **How many phases of Methadone Maintenance Treatment have you received before your current phase?**  
.....
6. **What dose of methadone are you currently receiving?**  
..... mg
7. **Are you currently in the process of reducing your methadone dose?**  
*YES/NO (please circle one)*
8. **Are you receiving any other substitution treatment? YES/NO (please circle one)**
9. **Is there anything happening in your life at the moment that is making it difficult for you to remain in methadone maintenance treatment?**  
.....  
.....

**Thank you for your participation.**

Appendix F: Confirmation of ethical approval from local ethics  
research committee





## National Research Ethics Service

### South Yorkshire Research Ethics Committee

1st Floor Vickers Corridor  
Northern General Hospital  
Herries Road  
Sheffield  
S5 7AU

Telephone: 0114 226 9153  
Facsimile: 0114 256 2469  
Joan.brown@sth.nhs.uk

10 May 2010

Miss Elizabeth Shaw  
75 Haworth Street  
Hull  
East Yorkshire  
HU6 7RQ

Dear Miss Shaw

**Study Title:** An Exploration of Methadone Users Views of Recovery:  
The Role of Methadone Maintenance Treatment and  
Drug Treatment Services

**REC reference number:** 10/H1310/31

**Protocol number:** 5

The Research Ethics Committee reviewed the above application at the meeting held on the 29 April 2010. Thank you for attending to discuss the study.

#### Discussion

You were asked to confirm how long you expected the interviews to last and you confirmed you thought they would take about an hour but it could be longer. The committee accepted this clarification.

It was queried whether the dictaphone that was being used had a removable memory in it and whether you would be able to remove it and permanently destroy the data and you confirmed that you would. The committee accepted this assurance.

It was queried why the methadone users had to have been on the programme for over a year and you explained that one of the guidelines from the National Treatment Agency was to retain patients in treatment for over a year and there was a massive drive to increase the number of people receiving the service. You felt that it was more appropriate to select patients who had been using for over a year and also, you felt that if they had just started on the methadone programme the concept of recovery might be quite alien to them. The committee accepted this explanation.

It was queried who would be completing the data sheet and you confirmed that you would be completing it with the participant present. The committee accepted this confirmation.

It was observed that the interview schedule was really thorough and the only comment regarding that was that it did not ask if the patient had been in recovery before and whether



this was a second or subsequent treatment programme. The data sheet asked the question "How long have you been receiving your current phase for" but it did not ask whether it was a subsequent treatment. You observed this may be something you could consider in your analysis or perhaps you could add it as a prompt. The committee felt it was possible that it might change the participant's opinion if they had previously been in treatment before and thought the information might be useful.

It was observed that participants would be informed of the study at a clinic appointment visit and then they would be given the participant information sheet and consent would be taken at the next visit when they would only be given about fifteen minutes to consider their inclusion. It was suggested that the information sheet could be given to potential participants at the first visit as it would give longer for them to consider their inclusion in the study. You agreed this was a good idea.

There was an additional statement that needed adding to the consent form, details of which are given below.

### **Ethical opinion**

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, **subject to the conditions specified below.**

### **Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

### **Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

**Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.**

*For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

### **Other conditions specified by the REC**

- 1. Submit amended Consent Form (with a new version number and date) as follows:**

- **Add an additional point as follows: "I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records."**

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES directorate within The National Patient Safety Agency and Research Ethics Committees in England



2. The committee recommend that you add an additional question to the data sheet as referred to above (recommendation only – not mandatory).

The REC nominated the Co-ordinator, Mrs Joan Brown to be the point of contact should further clarification be sought by the applicant upon receipt of the decision letter.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

### Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		
REC application		14 April 2010
Protocol	5	30 March 2010
Investigator CV		09 April 2010
Participant Information Sheet	3	21 March 2010
Supervisor CV - Sue Clement		
Participant Consent Form	2	31 March 2010
Referees or other scientific critique report		08 January 2010
Client Research Overview Sheet	2	31 March 2010
Interview Schedule	7	31 March 2010
Flow Chart	2	31 March 2010
Questionnaire: Non-validated - Participant Data Sheet	5	31 March 2010

### Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators

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- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

<b>10/H1310/31</b>	<b>Please quote this number on all correspondence</b>
--------------------	---

With the Committee's best wishes for the success of this project

Yours sincerely

J Brown

R  
**Miss Jo Abbott**  
**Chair**

**Enclosures:** List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers" SL-AR2

**Copy to:** Mr Stephen Walker, Humber NHS Foundation Trust, Clinical Governance Department, Trust Headquarters, Willerby Hill, Hull, HU10 6ED

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The National Research Ethics Service (NRES) represents the NRES directorate within  
The National Patient Safety Agency and Research Ethics Committees in England

Appendix G: Confirmation of approval from Research and  
Development department of the NHS

25/05/2010

Elizabeth Shaw  
Department of Psychology  
Hertford Building, University of  
Hull  
Cottingham Road, Hull  
HU6 7RX

Dear Elizabeth Shaw

**Re: R&D ID: 10/04/436 REC ID: 10/H1310/31**  
**An exploration of Methadone users views of recovery: the role of methadone maintenance treatment and drug treatment services**

I am please to notify you formally that this study has been approved by the Humber NHS Foundation Trust and may commence within the following locations:

- Bridlington and Goole Community Drug Teams

Humber NHS Foundation Trust conducts all research in accordance with the requirements of the Research Governance Framework, and the NHS Intellectual Property Guidance. In undertaking this study you agree to comply with all reporting requirements, systems and duties of action put in place by the trust to deliver research governance, and you must comply with the Trust information management and data protection policies. In addition, you agree to accept the responsibilities associated with your role that are outlined within the Research Governance Framework as follows:

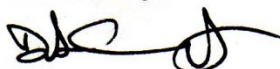
- The study follows the agreed protocol
- Participants should receive appropriate care while involved in the study
- The integrity and confidentiality of clinical, other records and data generated by the study will be maintained
- All adverse events must be reported to the Trust and other authorities specified in the protocol
- Any suspected misconduct by anyone involved in the study must be reported

You must ensure that the protocol is followed at all times. Should you need to amend the protocol, please follow the national research ethics service procedures. You should forward a copy of all amended versions of the protocol and/or documentation together with written confirmation that a favourable opinion has been given by the REC, to the R&D office at the trust.

You will be required to complete electronic progress reports and a final monitoring form on completion . As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum, however, if you fail to supply the information requested, the trust may withdraw approval.

I would like to wish you every success with this project

Yours sincerely



Duncan Courtney  
Clinical Governance Specialist

## Appendix H: Study overview sheet



## Would you like to take part in some research?

### *An Exploration of Methadone Users Views of Recovery: The Role of Methadone Maintenance Treatment and Drug Treatment Services*

*Over the next couple of months there will be a research study taking place within the Community Drug and Alcohol Team. At your next appointment, you may be asked whether you would like to take part in this research. This sheet is to give you some information on what this research is about.*

The research will explore how people who are currently receiving methadone maintenance treatment view their recovery. It is also interested in peoples' views on how methadone and drug services have influenced their recovery.

Because you have been receiving Methadone Maintenance Treatment for over a year, the Drug and Alcohol Service wondered if you would be interested in sharing your experiences of recovery, methadone use and involvement with drug services. The information from this research will be used to inform services whether any changes should be made to the way they are provided.

*It is up to you to decide to join the study. Your decision on whether or not to take part will not affect the quality of care that you receive.*

If you decide that you would like to take part in this research, you will be asked to take answer some questions on your experiences of recovery, methadone and services. This should take about 60 minutes. You will also be asked to provide some basic information about yourself, such as your age and ethnicity. All interviews shall take place in a private room and the information that you provide shall be anonymized and kept securely according to Humber NHS Foundation Trust Guidelines.

A £10 Boots voucher or a box of chocolates worth up to £10 will be provided to people who take part in the research.

**If you are interested in taking part in this study, please tell someone when you come to your next appointment at the Community Drug and Alcohol Service.**



## Appendix I: Study Information Sheet

# Participant Information Sheet

## *An Exploration of Methadone Users Views of Recovery: The Role of Methadone Maintenance Treatment and Drug Treatment Services*

*I am Liz Shaw, and I would like to invite you to take part in my research study. Before you finally decide to take part, I would like you to understand why the research is being done and what it would involve for you.*

*If you are interested in discussing what this research is about, I shall go through the information sheet with you and answer any questions you have. This should take about 5 minutes.*

### **Part 1: What is the purpose of this study and what will happen if I decide to take part?**

This study will explore how people who are currently receiving methadone maintenance treatment view their recovery. I am also interested in peoples' views on how methadone and drug services have influenced their recovery. I am hoping to recruit 12 participants and as you are a past heroin user, the Drug and Alcohol Service wondered if you would be interested in sharing your experiences of recovery, methadone use and involvement with drug services. The information from this study will be used to inform services whether any changes should be made to the way they are provided.

*It is up to you to decide to join the study. Your decision on whether or not to take part will not affect the quality of care that you receive.*

#### ***What are the possible advantages to taking part in this study?***

This research aims to provide you with the opportunity to talk about your experiences of recovery, methadone use and of services. By gathering this information, it is hoped to help services understand how people view their recovery and their use of methadone and whether services need to change the support they offer to their clients.

#### ***What are the possible disadvantages to taking part in this study?***

The interview will take approximately an hour. Some people may find talking about their experiences distressing. If this is the case, you will be able to talk to someone about this.

#### ***What will happen to me if I take part?***

- 1) You will be asked to sign a consent form to show that you agree to take part in the study.
- 2) You will then be asked to fill in a sheet providing a few basic personal details, such as age and your ethnic group.
- 3) Then I will ask you some questions about your experiences of recovery, methadone maintenance and services and your answers shall be recorded on a dictaphone. This should take about 60 minutes. Our conversation shall take

place in a private room and the information you give me shall be kept securely. Please see part 2 of this form for more details.

- 4) You will be given a chance to ask questions and comment on your experience of taking part in the study.

If you choose to take part in the study, you will be asked whether you would like to comment on the results of the study once it has been completed. You will be asked this when you sign your consent form. If you would like a chance to do comment on the results, a member of the community drug and alcohol team will contact you approximately 3 months after your initial interview. This will be to arrange an appointment with me so that we can talk about the results of the study.

*If you are interested in taking part in this study, please read the extra information in Part 2 before making a decision.*

## **Part 2: How is this study conducted?**

### ***What will happen to the information that I provide?***

You will only be asked to share information that you feel comfortable with. All information shall remain anonymous (Unless it is felt that you may be at risk of harming yourself or others). Your GP will not be informed if you decide to take part in the study.

All recordings of the interviews will be stored on secure password protected computer software. The interviews will be transcribed. After the transcription of the interview has taken place, the audio-recording will be deleted. The transcribed, anonymized information will be shared with my supervisors and anonymized extracts may be included in the final report that will be fed back to services.

All information that you provide on the patient information sheet shall be stored according to Humber Mental Health Foundation Trust policies, within a locked filing cabinet on Trust premises. There will be no personally identifiable information on this sheet. The consent forms and data sheets of the people who have taken part in the study shall be kept in a locked filing cabinet on Trust premises. This is so that the people who want to know the results of the study can be contacted by the Community Drug and Alcohol Team when the results have been analysed. The consent forms are also a record that people have agreed to take part in the study. These consent forms shall be after submission of the thesis. No one will have access to these apart from the research and their research supervisor.

### ***Withdrawal from the study***

You can withdraw from this study at any time before the research is submitted for publication, without giving a reason. This would not affect the standard of care you receive. You may request for any recorded information to be deleted and for the transcripts not to be included in the results of your study.

### ***What will happen to the results of the study?***

The results will be submitted as part of a doctoral research project in July 2011. The anonymized results shall also be fed back to the Drug and Alcohol Services. It is also hoped to publish this research. Anonymized quotes from the interviews shall be included in the published report. The information you provide will not be personally identifiable in any report or publication. You will be asked if you would like to

comment on the results of the study and/or receive a copy of the finished report when signing your consent form.

***Who is organising this research?***

The Humber NHS Foundation Trust is funding the research. The research is a requirement of the Clin.Psy.D course in Clinical Psychology at the University of Hull.

***Who has reviewed the study?***

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the South Yorkshire Research Ethics Committee.

***Complaints***

If you have a concern about any aspect of this study, you should ask to speak to the manager for your service. In Goole, this is [REDACTED] who can be contacted on: [REDACTED]. In [REDACTED], the service manager is [REDACTED] who can be contacted on [REDACTED].

*Alternatively, you could speak my supervisor, [REDACTED] who is based at the University of Hull. Her telephone number is [REDACTED]. Sue will do her best to answer your questions.*

If you remain unhappy and want to complain formally, you can do this by contacting the Patient Advice and Liaison Service on 01482 303966

***Further information and contact details:***

If you would like any further information or advice, please contact:

Liz Shaw  
Department of Clinical Psychology  
Hertford Building  
University of Hull  
Cottingham Road  
Hull  
HU6 7RX

Tel: 01482 464087 (office hours)

Email: E.H.Shaw@2008.hull.ac.uk **Many thanks for your time. If you have any other questions, please do not hesitate to ask.**

## Appendix J: Participants' consent form

## CONSENT FORM

**Title of Research:** An Exploration of Methadone Users Experiences of Recovery and Methadone: The Impact of Drugs Services

**Researcher:** Liz Shaw

**Patient Identification Number for this study:**

Please  
initial  
box

1. I confirm that I have read and understand the information sheet dated .....  
(version .....) for the above study.

2. I understand that my participation is voluntary and that I am free to withdraw at any  
time without giving any reason, without my medical care or legal rights being affected.

3. I have had the opportunity to consider the information and to ask questions. My questions  
have been answered satisfactorily.

4. I understand that the above study involves an interview which shall be audio-  
taped. I understand that this information shall be transcribed and anonymized and that  
the recording shall then be deleted.

5. I understand that the some of the anonymized transcribed interview data  
collected during the study will be looked at by the researchers' academic  
supervisor based at the University of Hull. I give permission for this individual to  
view my anonymized data.

6. I understand that some anonymized quotes will be included in the write up of  
this research and that these will not be personally identifiable.

7. I agree to take part in the above study.

8. I understand that any personally identifiable information (i.e. audio tapes) shall  
be destroyed after the completion of the research.

9. I would like to know the results of the study and give permission for a  
Community Drug and Alcohol team member to contact me by phone when the  
results of the study are ready.

10. I would like the opportunity to comment on the results of the study and give  
permission for a Community Drug and Alcohol team member to contact me by  
phone when the results of the study are ready.

11. I understand that data collected during the study may be looked at by  
individuals from regulatory authorities or from the NHS Trust, where it is  
relevant to my taking part in this research. I give permission for these  
individuals to have access to my research records.

\_\_\_\_\_  
Name of Client

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of person taking  
consent

\_\_\_\_\_  
Signature of person taking  
consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (if required)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

When completed: 1 for participant; 1 for researcher site file.

## Appendix K: Participants' pathway to further support

Following the interview, the participant has questions or issues with regard to the treatment they are receiving that cannot be resolved by the interviewer.

Is the client at risk of harming themselves or others? Information obtained through interview or direct questioning. Direct questioning appropriate if participant appears low in mood.

No

Yes

Do they have an appointment with their key-worker/GP in the future?

Yes

Agree that the participant will talk to their Key-worker/GP about these issues.

Interviewer to conduct a risk assessment and take participants GP/Key-worker details.

Participant safe to leave the room.

Participant unsafe to leave the room

No

If they would like an appointment with their key-worker, suggest they go to reception and ask for the next available appointment.  
  
If they would like an appointment with their GP, agree that the participant will contact their surgery.

If they do not want an appointment with their key-worker/GP, ensure they know how do this if they change their minds.

Remind participant of confidentiality agreement. Agree that interviewer will inform service manager/Key-worker / GP of participants' risk.

Interviewer to ask participant to remain in the room whilst they contact on-call GP for a risk assessment. If participant leaves room, Interviewer to inform participants GP and Key-worker of risk.

Ask if they would like their details and concerns passed on to the service manager

Yes

Pass on name and concerns to Service manager  
Goole:  
Bridlington:

No

Do not pass on details.

If participant at risk of harm to others, remind of confidentiality agreement and inform participants' key-worker and service manager. If vulnerable persons (e.g. children) at immediate risk of harm, interviewer to contact social services.

Ensure has information on services to contact in a crisis.  
Goole Samaritans:  
Goole Crisis Team:  
Bridlington Samaritans:  
Bridlington Crisis Team:



## Appendix L: IPA example

The initial analysis process began with making notes against the original transcript. The author decided to use the left-hand margin of each transcript to record their own thoughts and impressions relating to the text, as well as relating segments of text to other semantically similar segments or theories. The transcripts were then re-read and the authors' initial notes grouped in semantically related themes in the right hand margin (Smith et al., 2009). An extract from an analysed transcript is shown below.

I: Recovery is a word that is sometimes used when people talk about coming off of drugs, can you tell me what recovery means to you?

P4: Um, *getting yourself clean/sorting your mental health out* as well, you know, your thoughts right and everything in the family around yer, coz it's like a ripple effect ain't it really? You know, *the environment you're in.*

I: Oh yeah, can you tell me a bit more about that?

P4: What do you want to know? (laughs)

I: Um, I guess you're talking to me a bit about it being a ripple effect. I guess I'm curious about that.

P4: Yeah, it's with your family as well, *(coz they go through it as well)*, don't they? Coz I'm living with my mum and dad at the moment. So, recovery is *Parents take responsibility, can't do it without parents* gonna have to involve them as well, *keeping an eye on me*. Sort of *babysitting me really (for the first year)*. Yeah,

I: Hmmn, yeah. So I mean recovery's been described as a bit of a process, what do you make of that?

P4: Well recovery to me is like er, that word, its, more of an illness. And this isn't, if you know what I mean. So, I don't, I don't really know how to, how, I know what I want to say but I don't know how to put it into words, if you know what I mean?

I: That's ok, these things are hard to put into words. So, so, it's different

get clean  
mental health  
take thoughts  
right  
+ everything in  
family  
ripple effect

Recovery of  
Person affects  
their environment

Role of  
Person in  
doing these  
things

family linked  
to recovery  
- person not a  
solution

- more if  
needed  
- make sure don't  
- slip up  
- self doubt  
- needs water  
- supervision

recovery with  
family  
family go  
through recovery  
heavily  
- with parents  
- support her

"recovery" is  
more of an  
illness  
- more addiction  
- not illness  
- don't know how  
to say what  
prevents

The small themes from the right hand margin were then grouped semantically to produce larger, subordinate themes. At this stage the subordinate themes were then

examined and some similar themes were merged and renamed. The subordinate themes were then repeatedly checked against quotations from the original transcript data until a smaller number of clearly semantically diverse subordinate themes were identified. Finally, superordinate themes were identified from semantically grouping the subordinate themes. Again, these were validated by returning to the original interview data. The progression from interview data to subordinate themes and then superordinate themes was a repetitive, iterative process. This was necessary to ensure that the themes identified through the authors' interpretative analysis were semantically diverse, as much as possible and related to the original data.

#### External validations

During the cyclic process of identifying themes, external validation was sought from participants who took part in the research, and a psychologist experienced in IPA methodology. This consultation occurred from the initial analysis of the transcripts, through to the identification and refinement of themes.

During the initial analysis of the transcripts, an alternative perspective was sought. This was to ensure the interpretation of the results was not restricted by any interpretative bias of the author, related to their previous knowledge of the drug dependence literature. Care was taken that themes identified by the alternative perspective did not override alternative themes found in other transcripts. Validation of the initial themes was sought from two participants, who agreed with the themes presented and used the themes to talk again about their own experiences, strengthening and clarifying the initial interpretation. Finally, the supervisor of this research aided in the organisation, re-naming and validation of the themes, by relating some of them to existing health and drug-dependency literature.

## Appendix M: Reflective Statement

### Development of research idea

I knew that I was interested in the concept of recovery, and applying this to the drug dependence field, but found it difficult to focus my ideas to find a specific question. For this reason, it was useful to have the structure provided by the necessity of submitting a series of research proposals to the clinical psychology department, as it allowed me to focus my ideas.

The fact that I was not familiar with the drug abuse literature was both challenging and quite helpful. It was challenging because I felt that I did not know what I was looking for and felt I was missing out on the “bigger picture” when I was focusing in on only one specific issues/interest. It felt a bit like being a fish out of water, and that I was playing “catch-up”, especially as my supervisor at the time was very familiar with the context of this research. At the time I suspected she may have already had an idea in which direction she wanted the research to be taken in. Looking back, I can remember feeling quite frustrated that my supervisor did not just give me a research question! However, because I was not familiar with the drug dependence literature at all, I was more motivated to familiarize myself with existing research and the government context. This meant that it felt more natural when I found a “gap “in the literature to explore, like I was working alongside the existing data , rather than looking back over it at things I was already familiar with trying to identify a “new angle” which I could exploit.

Because the development of my research question was, like all research, quite messy, I found the feedback from my peers and supervisors invaluable. They helped me sort out the interweaved threads of different ideas and spin them together to form one, cohesive

idea. From the initial strands of different ideas and contrasting methodologies, their feedback helped me to compare the ideas I had currently, with my past work.

Sometimes this process highlighted amazing incongruences! For example, having a qualitative methodology but quantitative research questions based upon my previous and out-dated ideas. This was an example of my tendency to focus on what I feel needs to happen next, rather than taking my time to consider the process as a whole.

### Ethics and data collection

I found the process of gaining ethics and R&D approval quite easy and non-anxiety provoking. It made sense to the logical, step by step side of my nature. Having been supported to refine my research idea and ensure that the background literature was logically related to my research questions and methodology, it was easy to focus on what I needed to do next; fill in a form! However, I feel my focus on doing things correctly and in a logical manner, continued into the data collection process. This meant that I focused on how I was conducting the interviews, whether I was asking the “right” questions and whether the interview schedule needed to be changed, instead of focusing on what was said and how it was said. I found transcribing the interviews very useful in helping me to reflect on what was being said, whilst taking a non-judgemental stance. I think this was because transcribing helped me to get more involved with my data, as I had to really listen to what was being said, and thus the focus was not on myself but on the content of the participants’ experiences.

Data collection was, at times, exceedingly frustrating. It would sometimes take months for the drug and alcohol teams to identify potential participants, and then when I went along to interview them no-one would turn up! This was far more common with one team than another and there was a definite recruitment bias, with again one team being

more effective than the other. In a sense, I had a “reliable team” and a “chaotic” team, a split that is quite characteristic of the client group we were both working with. Another example of such a split is the difficulty I experienced during data analysis, when I became quite protective of the individual nuances contained in the data. I did not want to merge what ended up being very similar themes because I saw them as categorically distinct. I needed support from my colleagues to recognise that some themes were the same. Here I was perhaps mirroring participants’ difficulty with integrating different parts of themselves.

I found listening to the experiences of the people who took part very challenging at times. There was a sense of sadness and missed opportunities present in most interviews and often I received an “emotional punch in the gut” as people talked about their recovery journeys. As someone who, before my data collection, was wary about mixing with past heroin users, I am surprised that I did not have any difficulty in seeing the people behind the “druggie” identity with which they have been labelled by society. It makes me sad to think that these people, who have been through incredibly difficult experiences are in sense, victimized by society. It seems that I found it very easy to overlook (or split off) the damage some of the people have done to their own communities in return, in terms of crime, e.t.c.

#### The process of being reflective

After I had begun my data collection, the person who was supervising my research changed. Whilst slightly anxiety provoking, this change in supervisors was very useful, as because I now had a new research supervisor, it was necessary to take a step back and review the work I had been doing and reflect on the process. This reflective process is something that I would have needed to have done to inform my data analysis for my

empirical paper. However, I am not sure that this is a skill I would have developed as much without the firm encouragement I received from Dorothy, as I have a tendency to “carry on going” without looking back over what I have done, especially when I am anxious!

Over the course of this research, indeed I suppose over my entire time as a trainee, I feel my reflective skills have increased and this has definitely benefited both this piece of research and other areas of my clinical work. I feel that the process of completing this piece of research has interesting parallels with other areas of my life and that the increase in my self-reflection skills has been interlinked with the research process.

### Final thoughts

I have spent the majority of this statement reflecting on my empirical work and have not given any space to thinking about my literature review. To me this could be down to two things. Firstly, perhaps the space of this reflective statement relates best to the empirical work, which required reflection in the analysis of its results. I felt that I was less reflective in my literature review. The literature review felt like I was following a series of steps to ensure it was easily replicable. Even the analysis of the results, which involved identifying themes and links between data, felt more linear and straightforward. Perhaps, the systematic literature review reflects the “step by step” part of my personality!

Secondly, this may be due to the large amount of time invested in the analysis of the empirical papers results. I found this to be a repetitive, circular and exceedingly frustrating process. I began with streams of paper strewn across my living room floor, which slowly condensed down into more manageable theme. Then, after I had thought I



had finished, I would look at my themes again and realize that some of them were too similar, were named “wrongly” or did not belong where I had placed them, and things would descend again into chaos (both with paper across the floor and in terms of my level of confusion) as I would return to the original data to begin again. Although it felt like I was returning to the start each time, each “circle” through this process, from original quotations through to superordinate themes, was less chaotic and more condensed. Eventually, I had a series of themes which I could talk with people about, which I found very satisfying! However, I found that the process of writing up these themes difficult, because I felt constrained by the pressure I felt to answer my research questions. Thus, I feel I perhaps imposed a structure on my results section, which may have unconsciously affected how I interpreted my results. I feel that I invested a large part of myself in the process of completing my empirical piece of research. I am exceedingly proud of it.

#### Justification for journal choice

In what could be construed as a resolution of the split discussed above, I decided that the content of the systematic literature review and the empirical paper were too thematically similar to be divided up into separate journals. Addiction Theory and Research was chosen to submit both papers to because I felt it was open to alternative, more psychological conceptualizations of drug dependency and openly stated that it welcomed papers utilizing qualitative methodology. It seemed that this peer-reviewed journal would be open for two papers focusing on recovery instead of drug-dependency. Both parts of this thesis have implications for service and policy development and Addiction Theory and Research will facilitate access to this research by the multi-disciplinary professionals to whom this research is most relevant.