

**UNDERSTANDING THE
PROCESS OF RECOVERY
FROM HEROIN ADDICTION:
INITIATING AND
MAINTAINING FACTORS.**

Lucy James

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ABSTRACT

There is increasing recognition that recovery from heroin addiction is possible but there is limited understanding of the recovery process and of how services can support people in that process. At present, most of the research concerning recovery from heroin addiction comes from the United States where the treatment system is very different to that in the UK. This study aimed to gain a better understanding of the recovery process from the perspective of people who are in recovery from heroin addiction, with the aim of informing service development and delivery in the South Wales area.

This study employed a grounded theory qualitative methodology to analyse data collected from ten interviews with people in recovery from heroin addiction in the South Wales area. The results revealed four core categories: i) initiating recovery, including the triggers for recovery and what helps; ii) maintaining recovery, consisting of thought changes, lifestyle changes and the role of supportive networks; iii) the reality of recovery, encompassing the process of recovery and obstacles faced; and iv) service provision, encompassing current problems, how support needs can be met and how wider needs can be addressed. The findings highlighted some important considerations for the development of services specifically designed to meet the needs of this client group, thus facilitating long term stable recovery.

The findings are reviewed in relation to the wider literature regarding recovery from heroin addiction. Implications for clinical practice and service delivery are also reviewed, and suggestions provided for how services can incorporate recovery-orientated principles. Suggestions for future research are also considered.

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CHAPTER ONE - INTRODUCTION

1.1. OVERVIEW OF THESIS

The concept of recovery from heroin addiction has gained significant energy in recent years, largely driven by extensive research in the United States of America (USA), and reports by people who have overcome heroin addiction, promoting the idea that recovery is not only possible, but probable (e.g. Laudet, 2007; White, 2008a). Historically, the concept of recovery was predominantly associated with the 12-step fellowship, but in recent years the USA has demonstrated a successful shift from a focus on addiction to a focus on recovery, which has now been incorporated into government policies and research.

More recently, the UK has recognised the necessity for recovery to be a fundamental component of the services provided to those affected by substance misuse (White, 1998) and in Scotland and England government strategies for addressing substance misuse have demonstrated a noticeable shift towards recovery. Previous government targets centred on reducing the harm caused by addiction, in particular, reducing crime (Home Office, 1998), but in 2008 the government strategy shifted the treatment focus towards a person-centred approach and recognised the importance of life factors such as training and employment (HM Government, 2008). The Scottish Government strategy (2008) demonstrated a further shift in policy when publishing “The Road to Recovery” strategy which focused on an approach to tackling problem drug use based firmly on the concept of recovery.

Within this introductory section, the prevalence and consequences of heroin addiction will be considered, followed by a brief overview of how heroin addiction is currently addressed in the UK. In addition, the prevalence and definition of recovery, and current theories of recovery will be discussed followed by both an overview of what is known from the literature regarding the initiation and maintenance of recovery, and a critical review of the evidence base. The aims of this research are also presented.

1.2. HEROIN ADDICTION

1.2.1. Characteristics of addiction

1.2.1.1. Dependence/addiction

Initial use of heroin has been described as leading to an experience akin to that of being back in the womb, with a removal of all emotional and physical pain. However, these intensely positive experiences last only a short time, and repeated use inevitably leads to dependence, with the 'need' for heroin becoming all-consuming, and often necessary for the individual to just feel 'normal' (Kenny, 1999). The need to obtain heroin to stave off withdrawal symptoms often results in the individual having to prioritise their drug use over other aspects of their lifestyle (APA, 2000).

Addiction can be defined as "the continued use of a mood-altering substance despite adverse consequences" (Angres & Angres, 2008, p.696). Unlike most other recreational drugs, heroin is defined as being both physically and psychologically addictive (Kaplan, 1983; Robins *et al.*, 2010). People who have become dependent on heroin develop significant levels of tolerance to the drug, and normally experience physical and/or psychological withdrawal symptoms on cessation of use. These physical withdrawal symptoms differentiate dependence from abuse, and are normally evident within 6-12 hours of last use. Symptoms include pupil dilation, profuse perspiration, fatigue, depression, nausea, vomiting and diarrhoea. Without pharmacological intervention, these symptoms will last for 7-10 days, with a peak in symptomology on days 2-3. Other symptoms, such as anxiety, dysphoria, insomnia and drug craving can continue for months following cessation. Psychological dependence refers to the often pervasive need to obtain and use substances (Johnson, 2003).

The terms 'dependence' and 'addiction' will be used interchangeably throughout this thesis.

1.2.1.2. Relapse

'Relapse' refers to the return to heroin use following a period of abstinence. Heroin addiction is classified as a chronic relapsing condition (Hser, 2007), and evidence suggests that approximately 80% of people relapse following opiate addiction treatment (Broers *et*

al., 2000; Smyth *et al.*, 2010). Factors that are known to precipitate relapse include: craving or continued desire for drug; negative emotional states such as depression, boredom and loneliness; the experience of stressful or conflicting situations; and pressure from others to resume drug use (McIntosh & McKeganey, 2001).

Evidence suggests that relapse following a period of abstinence is a risk factor for overdose (Oliver & Keen, 2003) particularly for released prisoners (Bird & Hutchinson, 2003) and people leaving inpatient detoxification (Strang *et al.* 2003). Evidence suggests that the point at which the future risk of lifetime relapse drops below 15% occurs after 4-5 years of sustained abstinence (e.g. Jin *et al.*, 1998).

1.2.1.3. Co-morbidity

Epidemiological researchers have reported a high prevalence rate of co-occurring mental health problems in heroin users (Karam *et al.*, 2002; Rodrigues-Llera *et al.*, 2006; Vasile *et al.*, 2002) with an estimated 70-80% of heroin users experiencing co-occurring mental health problems (e.g. Health Canada, 2001; Weaver *et al.*, 2003). Similar to individuals with severe mental health problems, opiate dependence is associated with a 14-fold increased risk of suicide (Appleby, 2000; Neale, 2000). From 2006 to 2010, admissions for mental and behavioural disorders due to opioid use in Wales increased by 53.2% (WAG, 2011). Weaver and colleagues (2003) also reported that approximately 30% of the drug treatment population experienced co-occurrence of a number of psychiatric disorders, described as 'multiple' morbidity.

Co-morbidity is associated with negative and often complex factors including higher rates of relapse, increased risk of hospitalisation, higher rates of completed suicide, housing instability, less compliance with treatment, greater service utilisation, higher costs to services, and poorer levels of social functioning as indicated by such factors as poverty, violence, criminality and marginalisation, (Department of Health, 2007).

1.2.1.4. Consequences of heroin addiction

Heroin addiction is associated with many adverse consequences which occur as a result of the drug use itself and the lifestyle that often accompanies heroin addiction. There are

numerous physical implications of heroin use including risk of overdose, with the mortality rate for heroin users in London being reported as 17 times higher than for non-heroin users (Hickman *et al.*, 2003). In the year 2000, the World Health Organisation reported an estimated 69,152 deaths attributed to opiate overdose (Degenhardt *et al.*, 2005). However, there is some debate over the accuracy of worldwide figures, as some evidence suggests that opiate overdoses are underestimated and increasing worldwide (Coffin, 2008). In Wales during 2010 there were 152 drug misuse related deaths, representing a 15.2% increase since 2009 (WAG, 2011).

A further health risk associated with heroin use is the spread of blood-borne viruses, particularly amongst injecting drug users (IDU's). In the UK, the incidence of HIV among IDU's peaked in 1986, but by 2005 only 5.6% of all UK HIV cases were attributed to IDU (HPA *et al.*, 2006). UK evidence suggests that over 90% of known hepatitis C cases involve IDU's (HPA *et al.*, 2006) and estimates of the prevalence of hepatitis C among IDU's has been reported at 64% in Scotland and 42% in England (HPA *et al.*, 2006). Blood borne viruses may also be spread through sexual contact, and evidence suggests that, in particular, young and single infected drug users are more likely to spread the virus through sexual contacts (Parry *et al.*, 2005).

In Wales it has been reported that, among IDU's, 20% had shared needles in the previous four weeks (WAG, 2011). Reported needle sharing was associated with injecting crack-cocaine, cocaine and amphetamine, and homelessness in the previous year (Health Protections Agency, 2010). There are estimated to be 14,000 hepatitis C sufferers in Wales, with 93% of those diagnosed with the illness reporting having contracted it from IDU. Craine and colleagues (2009) reported that 26% of Welsh IDU's are estimated to have hepatitis C, although this figure is much higher in Swansea (42%) and Cardiff (38%). In Wales in 2010, there were 1321 HIV infected individuals accessing treatment, of whom 2.3% reported becoming infected through injecting drug use (HPA, 2010).

There is also evidence that heroin addiction is closely associated with crime, often of an acquisitive nature to fund drug use (Budd *et al.*, 2005; Farabee *et al.*, 2001). Heroin use alone is rarely associated with violent crimes, unlike crack cocaine and alcohol use. Gordon and colleagues (2006) estimated the socio-economic cost of Class A drug use in the UK and

at £15.4 billion in 2003/4, although this may be an over-estimation as it was based on a small number of highly criminally active drug users.

Heroin addiction does not only impact on the individual, but also on their families, the communities they live in and society as a whole. Findings suggest that approximately 200,000-300,000 children in England and Wales have parents who are problematic drug users, accounting for 2-3% of all children under 16 (Advisory Council on the Misuse of Drugs, ACDM, 2003). These children face potential problems with their health, development, relationships and education (ACDM, 2003).

1.2.2. Prevalence

Obtaining accurate estimates of drug use is notoriously difficult and can be influenced by many methodological factors including the definitions used, the research population, the source of information and response rates. Furthermore, drug users may be less likely to complete nationwide questionnaires which calculate the prevalence of drug use, such as the British Crime Survey, due to their chaotic lives, lack of stable accommodation and literacy problems. These factors need to be considered when viewing the following figures.

1.2.2.1. Worldwide

The United Nations Office for Drugs and Crime (UNODC) World Drug Report (UNODC, 2007) estimated that approximately 16 million people worldwide abuse opiates, of whom about 71% are involved in heroin abuse. Over three quarters of the world heroin abuse occurs in Asia and Europe.

1.2.2.2. UK

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2011) estimated that there are approximately 380,000 problem drug users (defined as IDU's or long-term/regular users of opioids, cocaine and/or amphetamines) in the UK, and 133,000 IDU's (primarily of opiates or crack cocaine). There was a slight increase in the prevalence of opiate use reported in the UK from 262,428 in 2008/09 to 264,072 in 2009/10.

A study commissioned by the Home Office reported that there were 327, 466 problem drug users (defined as persons using heroin, methadone, other opiate drugs or crack cocaine) in England, of whom it was estimated 281,320 were opiate users and 192,999 were crack cocaine users, suggesting a high degree of poly-drug use with this population (Singleton *et al.*, 2008). These figures, which report for England only, suggest that the number of opiate users in the UK may be higher than the estimation provided by the EMCDDA.

1.2.2.3. *Wales*

The EMCDDA (2011) estimated there were 16,389 problematic opiate and/or crack cocaine/cocaine powder users in Wales in 2009-10. During 2010-11 there were 11,481 recorded referrals for drug treatment in Wales, of which 47% specified heroin as the main problem drug (Welsh Assembly Government (WAG), 2011). These figures represent 278 drug users in every 100,000 of the Welsh population, with males accounting for 73% of drugs referrals (WAG, 2011).

1.3. ADDRESSING HEROIN ADDICTION

Both pharmacological and psychosocial interventions have been shown to be effective in curtailing heroin addiction (Ball & Ross, 1991; Weisner *et al.*, 2003). A brief overview of these will now be considered.

1.3.1. Pharmacological intervention

There is evidence for the effectiveness of treatment for heroin addiction (Gossop *et al.*, 2003; Simpson & Sells, 1990) with outpatient methadone treatment reported to be effective in reducing opioid drug use, cocaine use, criminal activity, HIV risk behaviours and death from overdose (Avants *et al.*, 1999; Gossop *et al.*, 2001; Joe *et al.*, 1999; Sees *et al.*, 2000; Zanis & Woody, 1998), at least for the duration of treatment. However, the effectiveness of treatment varies greatly amongst studies which may be related to how 'treatment' is defined and what it entails. In the UK, studies have provided little evidence for a significant reduction in drug-related mortality or the spread of blood borne viruses amongst those treated for addiction (Health Protection Agency, 2008).

Amato and colleagues (2005) summarised the major findings of five Cochrane reviews on substitute maintenance treatment for opioid dependence and reported that methadone maintenance treatment was the most effective treatment for patient retention and reduction in heroin use, and was associated with reductions in criminal activity. Higher doses of methadone were shown to be most effective. However, the evidence strongly supports the role of treatment, which addresses psychosocial problems, alongside substitute prescribing (Mark *et al.*, 2003; McCusker *et al.*, 1995).

The NICE guidelines (2007) state that opioid detoxification should be readily available and service users should be offered the choice of methadone or buprenorphine. The guidelines also state that psychosocial interventions should be offered, irrespective of the setting in which opioid detoxification is delivered. Support and monitoring to help maintain abstinence should normally be available for at least six months.

Substitute prescribing offers an alternative to heroin use in combating some, if not all, of the physical dependency experienced by heroin addicts. However, for some time it has been recognised that substitute prescribing is not a cure in itself (e.g. Bewley & Ben-Ari, 1968). Between 2010-11, the National Treatment Agency in England estimated that of 306,150 opiate and crack cocaine users in England, 204,473 were in contact with treatment services, but only 27,969 successfully completed treatment free of dependency (NTA, 2011). Large multi-centre studies in the USA (Hser *et al.*, 1998) and Australia (Teesson *et al.*, 2006) suggest that approximately 20% of those who enter treatment, in the form of methadone maintenance programmes and residential treatment, remain opiate free for the respective observation periods of the study. Length of treatment and treatment adherence are positively related to outcomes.

Although the evidence base demonstrates that treatment can be effective in addressing substance use, it is most effective when combined with long-term support that addresses broader aspects of recovery such as quality of life, family functioning and active contribution to communities and society (Best *et al.*, 2010a). Recent UK research provided unfavourable evidence for how treatment services support people in achieving and maintaining recovery from addiction, with reports that treatment is primarily focused on substitute prescribing with little attention paid to psychosocial issues (Best *et al.*, 2009a).

1.3.2. Psychosocial interventions

The importance of holistic interventions continues to be demonstrated in the literature (Edwards, 2000; McIntosh & McKeganey, 2002), and it has been proposed that a variety of biopsychosocial interventions may support the process of natural recovery (Edwards, 2000).

Edwards, Marshall and Cook (1997) proposed that psychosocial interventions can play a role in recovery by helping people to view things in a more constructive manner and by enhancing self-efficacy. With regards to recovery from alcohol dependency, Edwards (2000) proposed that people have to believe that change is feasible, which can be facilitated by trained professionals using techniques such as motivational interviewing (Miller & Rollnick, 1991). Furthermore, professionals can play a role in helping clients to develop appropriate goal setting techniques, developing relapse prevention skills and discovering meaningful and fulfilling activities that can act as effective substitutes for drug use (Edwards, 2000).

The NICE guidelines (2007) promote the provision of person-centred care and enabling service users to make informed decisions about the care they receive. The guidelines state that psychosocial interventions should include brief interventions focusing on motivational enhancement, linkage with self-help groups and contingency management. Behavioural couples' therapy should be offered to those who have a non-drug using partner and who continue to use illicit drugs during or after treatment. The guidelines also state that cognitive behavioural therapy or, in some circumstances, psychodynamic therapy, should be offered to service users who achieve abstinence or are stabilised on an opioid maintenance programme and have comorbid depression or anxiety disorders.

Most drug treatment in the UK is accessed through the NHS and this generally consists of assessment and structured intervention (e.g. detox or substitute prescribing). Engagement with community groups or peer-support groups is not currently a measure of treatment delivery (NTA, 2006) so is not generally included within formal outcome measures, despite a strong evidence base for peer support (Humphreys, 2004). Although third sector and community recovery orientated services are becoming increasingly prevalent, the linkage between statutory care and third sector services is not well established (Best *et al.*, 2010b). Researchers have reported a 'suspicion' on the part of many professionals about the nature

of many community based approaches (Best *et al.*, 2010b; Day *et al.*, 2005), and although assertive linkage between statutory and community services has been shown to be necessary (Timko *et al.*, 2006), it does not regularly occur.

Despite the increase in recovery-directed policy activity, UK addiction services remain primarily focused on measuring numbers of clients in substitution treatment. The move towards recovery orientated services provides policymakers with the opportunity to incorporate recovery-oriented measures of service performance such as gains in recovery capital. There is an increasingly strong evidence base showing that engagement in recovery management check-ups (Dennis *et al.*, 2008) and peer support (Humphreys, 2004) significantly enhanced outcomes. Combining addiction treatment with recovery mutual aid groups is more predictive of long-term recovery than either activity alone (Moos & Moos, 2005; White, 2008b).

In the UK, the dearth of research on the recovery process has resulted in a lack of long-term recovery support for individuals (Best *et al.*, 2010a). Dennis and colleagues (2007) posited that the focus of treatment needs to shift from acute episodes of treatment to the management of recovery during longer periods of time including improving approaches to continuing care, linkage to mental health and wrap around services and sober activities.

1.4. RECOVERY FROM HEROIN ADDICTION

Recovery from heroin addiction has been described as a complex and dynamic process, with considerable variation across individuals (Hser & Anglin, 2011). In this section, the prevalence and definition of recovery will be considered.

1.4.1. Prevalence

Despite heroin addiction often being viewed as a chronic relapsing condition that often spans decades and requires several episodes of treatment and/or self-help (Anglin *et al.*, 2001; Dennis *et al.*, 2003), recovery from heroin has been shown to be possible for a significant proportion of heroin users (Best *et al.*, 2007). Evidence suggests that, of people with a lifetime substance use disorder, approximately 60% achieve sustained recovery (Cunningham, 1999a, 1999b; Dennis *et al.*, 2005). Gossop *et al.* (2005) reported that 48% of

the residential intake sample from the UK National Treatment Outcomes Research Study were abstinent from opiate use two years after they entered the study.

1.4.2. Definition

Despite the new focus on recovery, there is little understanding or consensus on what the term “recovery” means amongst professionals and researchers (BFICP, 2007), nor those who are in recovery (Laudet, 2007; Laudet *et al.*, 2006). Defining recovery could be beneficial for research purposes (Maddux & Desmond, 1986), thus informing the development and delivery of services in the addiction and recovery field, as well as informing families, professionals, the general public and policy makers about how best to facilitate the recovery process.

1.4.2.1. Is abstinence compulsory?

Viewing recovery solely in terms of the presence or absence of alcohol or drug use neglects the fact that addiction is often entwined with other problems which may have existed prior to the substance use or as a result of it. Worldwide, it has been recognised that recovery is not simply abstinence from substance use, and although abstinence may play a key role in recovery it is not sufficient alone (De Leon, 2000; Laudet, 2007; White, 2007). There is evidence that a small percentage of people who previously met the DSM-IV criteria for substance dependence can achieve moderate substance use which is not associated with any problems (e.g. Miller & Muñoz, 2005). Others may use alternative substances to help them maintain their recovery from their primary problematic substance, for example using marijuana to help with cessation of heroin (Bacchus *et al.*, 2000).

Some researchers suggest that the health and social aspects of recovery may be the components that are most attractive to people contemplating changing their substance use, and they may play a vital component in relapse prevention (BFICP, 2007). The WHO defines health as “...a state of complete physical, mental, and social well-being, not merely the absence of disease” (WHO, 1985, p.34), thus highlighting the importance of considering recovery within the context of improved quality of life.

There is also some contention over whether people stabilised on substitute drugs can be classed as in recovery (Murphy & Irwin, 1992; White, 2007). In the USA, there was initially some resistance to this, although this has reduced since the development of medication-assisted recovery communities (e.g. Pennsylvania Recovery Organisation- Achieving Community Together, 2006), and the inclusion of more varied pathways to recovery being highlighted and publicised (White & Coon, 2003). In the UK, empirical evidence suggests that those on substitute prescriptions are classed as being in recovery (Laudet, 2007).

Laudet (2007) reported that most people who had not used heroin in the past year considered themselves in recovery, and approximately half of those who had used in the past year also considered themselves as in recovery. Furthermore, the study suggested that the terms “abstinence” and “recovery” are related but distinct concepts, with 86.5% of participants included total abstinence from all drugs and alcohol as a criterion for recovery. In the qualitative part of the study, which asked participants to consider the definition of recovery, 40.3% defined recovery as ‘abstinence’, and 4% said ‘controlled use’. Some of the other concepts associated with recovery were a new life (22%), well-being (13%), a process of working on yourself (11.2%), living life on life’s terms (9.6%), self-improvement (9%), learning to live drug-free (8.3%), recognition of the problem (5.4%), and getting help (5.1%). This study provides a useful insight into the key components of recovery, but is limited as it primarily represented the views of minorities from an Urban setting in the USA who had long and severe histories of multiple substance misuse. In addition, most of the participants had had exposure to 12-step treatment which may have influenced their definition of recovery.

In summary, it is generally agreed that there are two important components of recovery; the removal of problematic alcohol and/or drug use, and life improvements (Centre for Substance Abuse Treatment (CSAT), 2006). Three definitions of recovery from drug and alcohol addiction will now be considered.

1.4.2.2. Betty Ford Institute Consensus Panel (BFICP)

An influential definition of recovery was produced by the BFICP (2007) in the USA which consisted of twelve individuals who represented treatment, policy and research, a number

of whom were in stable recovery themselves. The panel defined recovery as “a voluntarily maintained lifestyle [characterized] by sobriety, personal health and citizenship” (BFICP, p. 222). The panel also differentiated stages of recovery, classed as “early sobriety” during the 1st year, “sustained sobriety” for between 1 and 5 years, and “stable sobriety” of more than 5 years.

This definition has been praised for its recognition that recovery is not a static state (Scott, *et al.*, 2005; Simpson, 2004), as reflected in the common terminology of being “in recovery” or “recovering”, rather than being “recovered”. The panel also proposed that personal health and citizenship are often achieved through peer support groups. It is important to note that this definition was developed in the USA where the 12-step approach is dominant, and the Betty Ford treatment service is 12-step based.

1.4.2.3. *William White*

White (2007), a world-renowned expert on recovery from substance misuse, proposed that a definition of recovery should meet six criteria; (a) precision (captures the essential nature and elements of the recovery experience), (b) inclusiveness (encompasses diverse recovery experiences, frameworks, and styles), (c) exclusiveness (filters out phenomena lacking essential recovery ingredients), (d) measurability (facilitates self-assessment, professional evaluation, and scientific study), (e) acceptability (to multiple constituents), and (f) simplicity (elegant in its clarity and conciseness).

White (2007, p.236) proposed the following definition for recovery from alcohol and drug addiction:

‘Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.’

This definition has been praised for its inclusiveness and recognition of the multifaceted and individual nature of recovery.

1.4.2.4. *UK Drug Policy Commission (UKDCP)*

The UKDCP convened a meeting of senior UK practitioners and academics to develop a UK “vision” of recovery characterized as “voluntarily sustained control over substance use which maximizes health and [well-being] and participation in the rights, roles and responsibilities of society” (UKDCP Consensus Group, 2007, p.6.)

The above definitions of recovery have highlighted the importance of considering recovery not exclusively in terms of abstinence but also recognising improvements in physical and mental health, lifestyle changes and support systems (Laudet *et al.*, 2006; White, 2005).

1.5. THEORIES OF RECOVERY FROM HEROIN ADDICTION

1.5.1. Stages of recovery

It is commonly agreed in the literature that recovery is a process rather than an event (White, 2007). Prochaska and DiClemente (1992) proposed a popular five stage theory of change in recovery from all addictions which stated that people progress through a series of stages; ‘pre-contemplation’, prior to considering stopping heroin use; ‘contemplation’, considering addressing substance use; ‘preparation’, where the decision to stop using is made and preparations are made for stopping use; ‘action’, when specific steps are employed to reduce drug use; and ‘maintenance’, where non-using behaviour is consolidated. The authors posited that people can move back and forth between stages (relapse), and skip stages.

Frykolm (1985) proposed that recovery could be organised into phases of ‘de-addiction’. The first stage involves a period of ambivalence as a consequence of experiencing increased negativity related to their drug use, thus decreasing their desire to use substances. The second phase is when people experience a desire to become an ex-addict and seek help for their addiction whilst making attempts at detoxification, with drug-free periods growing in length. The final stage involves the individual continuing to abstain from substance use without external assistance. While Frykolm’s (1985) model of recovery does provide a useful framework for understanding recovery, it has been criticised for not accounting for natural recovery.

Margolis and colleagues (2000) reported findings from a small scale research project where participants described successive stages of recovery with changing focus, challenges and coping requirements. The beginning, commonly the first year, of recovery was focused on staying abstinent, followed by a focus on 'living a normal life', with abstinence no longer the main focus. The final stage was described as a time of individual growth and search for meaning.

In summary, although several researchers have suggested that there are a number of discreet stages in the recovery process, more research is required to better understand such progression.

1.5.2. Turning points

Although there is debate about the stages of recovery, there is a great deal of support and consensus about the importance of an identifiable 'turning point' in the drug-using career at which time the decision to stop using drugs is made (Prins, 1995; Simpson *et al.*, 1986). This turning point is characterised by reaching a low point in the drug-using career which signals a need to change. Such a development is often triggered by an event such as criminal justice system involvement, changes in family relations or adverse drug effects such as the experience of overdose in oneself or others (McIntosh & McKeganey, 2002; Prins, 1995; Shaffer & Jones, 1989).

Biernacki (1986) suggested that there are two main explanations for how and why people achieve abstinence following problematic heroin use. Approximately two thirds of Biernacki's sample reported that the idea of quitting heroin was developed rationally and stated explicitly. Approximately a third of the sample initiated recovery following a 'rock bottom' experience; a highly emotional and dramatic existential crisis which led them to reconsider their drug use. McIntosh and McKeganey (2001) supported Biernacki's findings, and although a number of their participants did experience 'hitting rock bottom', they did not believe it to be a universal or necessary component for initiating recovery.

1.5.3. The “Maturing out” hypothesis

Winick (1962) proposed the ‘maturing out’ hypothesis which suggested that heroin addiction is a self-limiting process, with many heroin users maturing out of their addiction by the time they reach their mid-thirties. Winick’s theory was based on the arrest records of 7,234 heroin dependent individuals in the USA, which demonstrated that drug-related offenses decreased as age increased. Winick proposed that this population used heroin to cope with the difficulties and challenges of early adulthood, but later in life they learned to regulate their emotions and the difficulties of life without the use of heroin.

Winick’s theory was supported by the research of McIntosh and McKeganey (2000) who posited that the physical maturation process, combined with a reduction in hedonistic pleasure from substance use, are key components in achieving recovery. This theory is supported by the literature on natural recovery from heroin addiction, where dependent heroin users become abstinent without formal treatment (Cunningham *et al.*, 1999a; Klingemann, 1991; Scharse, 1966).

Although Winick’s theory of recovery is widely quoted in the literature, and other researchers have reported that a high proportion of heroin users cease using in their thirties (e.g. Biernacki, 1986; Waldorf, 1983), the theory has been criticised for not providing a comprehensive understanding of the process of maturing out, and of the factors that may play an important role in this process. Alternative explanations for a reduction in drug-related crimes have also been proposed, including imprisonment, substitutive use of alcohol and more experience in concealing drugs or committing crime (dos Santos *et al.*, 2010). Vaillant (1973) reported that more than half of the men in his study were able to go for five or more years without being caught committing crime, despite continued active addiction and criminal activity. Furthermore, other studies have not found age to be related to drug abstinence (Anglin *et al.*, 1987; Levenson *et al.*, 1998).

1.5.4. Natural recovery

Although many heroin addicts report that treatment was a key component in their recovery, many also recover without any formal treatment (Klingemann, 1994). It has been suggested

that more addicts overcome their addiction without formal treatment than with treatment (Cunningham, 1999; Waldorf & Biernacki, 1979).

Vaillant (1983, 1996) conducted extensive research on the process of natural recovery from alcoholism and concluded that recovery was dependent on the severity of the addiction and encountering the right kind of natural healing experience. Vaillant proposed that the more severe the dependence, the more likely the individual will hit rock bottom or grow tired of using, thus initiating recovery. Furthermore, positive life experiences disrupt addiction and entrenched habits, thus facilitating the initiation and maintenance of recovery. These findings have been supported in relation to heroin addiction (Brownell *et al.*, 1986; Miller, 1993; Waldorf & Biernacki, 1981).

Biernacki (1986) posited several commonalities between the recovery experiences of those who had received formal treatment and those who had not, which included:

“(1) an attempt to destroy existing identities rooted in the drug world; (2) the common structuring of exclusionary group membership during the initial stage of abstinence, even if it means breaking up couples; (3) the establishment of social networks to support the new identities, corresponding perspectives, and vocabularies that are being shaped and developed in the program in lieu of those related to the addict world; and (4) the provision of some social-psychological techniques that can be used to neutralize drug cravings when they appear.” (p. 193).

There is evidence that the characteristics of people who resolve their substance misuse without formal help differ considerably from those who achieve recovery through formal treatment (Klingemann *et al.*, 2001). Those who achieve natural recovery often have no family history of substance abuse problems, later developmental onset of substance misuse, lower problem severity, less medical/psychiatric comorbidity and greater family and social supports (Finney & Moos, 1995; Ross, Lin & Cunningham, 1999).

1.5.5. Spoiled identity

The importance of identity change in the transition from addiction to recovery has been described using many different terms. The literature highlights the role of developing a new

identity, which contrasts with the addict identity, with awareness and dissatisfaction of the addict identity reported to be a crucial factor in initiating recovery (McIntosh & McKeganey, 2000; 2001; Radcliffe & Stevens, 2008; Waldorf & Biernacki, 1981).

Waldorf and Biernacki (1981; Biernacki, 1986; Waldorf, 1983) described the process of recovery from dependent drug use in terms of the management of a spoiled identity. Biernacki (1986) proposed that when the person's addict identity conflicts with other non-drug related identities, for example, being a parent or partner, the decision to cease drug use occurs. Biernacki suggested that the key process underlying recovery is the recognition of a damaged identity and the reawakening or establishment of a new identity. He proposed that the key to initiating the recovery process is the decision to restore a damaged sense of self by building upon and developing new positive identities. Recovery is maintained as the new, more positive identities are reinforced by positive life changes and damaged identities are de-emphasised (Hughs, 2007; Kellogg, 1993).

McIntosh and McKeganey (2002) built upon Biernacki's work and proposed that transforming a spoiled identity was a necessary component of the recovery process. They posited that recovery occurs as a result of recognising one's spoilt identity, either through acquiring a sense of responsibility through relationships with others (Schottenfield *et al.*, 1999) or through no longer viewing their drug use as a pleasurable activity. They suggested that the desire to change and pursue a new identity is, in itself, not sufficient to initiate and maintain recovery, but is a necessary condition for the recovery process to occur. The authors suggested that other important factors needed to occur simultaneously, including the belief that change was possible.

Following a qualitative analysis of 70 interviews with recovering heroin addicts (see Section 1.7.2 for more details), McIntosh and McKeganey reported that the recognition of a spoilt identity, and the subsequent decision to stop using heroin, was facilitated by single events, on-going experiences or a combination of both, that resulted in the individual reviewing their identity. The authors proposed that it is not these events in themselves that precipitate successful recovery, but the meaning which the individual ascribes to the events, and the impact this interpretation has on their sense of self. In essence, these events reveal their 'spoilt identities', forcing them to review themselves and what they had become. The

authors proposed that the recognition of a 'spoilt identity' is a gradual process which is resisted for as long as possible due to difficulties with accepting a negative view of oneself. Hughes (2007) proposed that enmeshment in non-using social networks facilitates this process.

In another aspect of their study, McIntosh and McKeganey proposed that unsuccessful attempts at recovery can be beneficial in clarifying the extent to which identities have been damaged, as the impact of heroin use can be examined from the perspective of a non-user. Furthermore, time spent in recovery can allow new, or old, non-using identities to emerge, which elicit comparisons between drug using and non-drug using identities. This research supported that of Kellogg (1993) who proposed that successful recovery was underpinned by the construction of a new identity incorporating values and perspectives of a non-using lifestyle.

1.6. IMPORTANT COMPONENTS OF RECOVERY

Humphreys and colleagues (1996) recognised that the factors important in initiating recovery differ from those that are important for maintaining recovery. Some of the key factors will now be considered.

1.6.1. Abstinence from heroin

Although some heroin users are able to return to controlled heroin use following dependence (Warburton *et al.*, 2005), research suggests that the majority require, or choose, abstinence from heroin due to inability to control drug use (Laudet, 2007).

The evidence base suggests that abstinence is associated with improvements in a variety of areas, including a reduction in physical and mental health problems (Mertens *et al.*, 2003; Weisner *et al.*, 2003), reductions in illegal activity, incarceration and poverty (Dismuke *et al.*, 2004; Scott *et al.*, 2003), less use of avoidant coping styles, and improvements in problem solving, seeking support, positive reappraisal (Holahan *et al.*, 2003; Moos & Moos, 2005), quality of life (Donovan *et al.*, 2005; Laudet *et al.*, 2006) and higher life satisfaction (Laudet *et al.*, 2009).

Dennis and colleagues (2007) conducted an eight year study considering the relationship between the duration of abstinence and other aspects of recovery. Yearly interviews using an augmented version (Scott et al. 1995) of the Addiction Severity Index (ASI; McLellan et al. 1992) and drug screenings were completed, and of the 1162 participants who completed the 8-year interview, 501 had been abstinent for at least one month. The data from the abstinent participants was compared to the data from those participants who were not abstinent.

A number of findings were reported from the data including: a peak in mental health problems during one to three years of abstinence, suggesting a need for early and on-going mental health support and treatment; a high use of coping strategies in early recovery which diminished with length of time abstinent, suggesting that coping strategies may be a characteristic of early recovery; the likelihood of sustaining abstinence increased dramatically during the first three years and then plateaued; abstinence for five years or more was associated with a 14% risk of relapse; women had improved likelihood of maintaining their abstinence earlier on than men; and women were more likely to enter and remain in recovery than men. As supported by other researchers (Laudet, 2007; White, 2005), the authors also reported that the longer a person was abstinent the greater their level of social and spiritual support, non-drug using friends and self-efficacy to resist relapse. This study had a number of strengths including using a number of standardised measures, a large sample size and long-term follow up. However, the study was limited as the participants were all from treatment services in one American location and were disproportionately female and African American. This may limit the generalizability of the findings.

1.6.2. Initiating recovery

Waldorf (1983) conducted research with heroin users that suggested there were a number of different routes into recovery including: 'drifting' out of substance misuse, substituting one drug with another, for example alcohol, becoming psychologically unwell, spiritual conversions and situation change. Powerful evidence for the role of situational change was reported by Robins (1974) who found that many American service men who had become addicted to heroin whilst in Vietnam were able to significantly reduce or cease their drug use on return to America. Robins posited that addiction was not necessarily a lifelong issue,

treatment was not a necessary component for recovery, and changes in social context could be a key component in recovery.

Many studies have highlighted the influence of significant others in the decision to stop using heroin (McIntosh & McKeganey, 2001). Simpson and colleagues (1986) reported that over half their sample cited family responsibilities, and one third reported pressure from family, as important in their decision to stop using drugs. It has also been reported that additional factors in the decision to stop using heroin including deterioration in health or the fear of health problems (Simpson *et al.*, 1986; Waldorf, 1983), periods in prison and the death of a drug-using friend (Shaffer, 1992).

McIntosh and McKeganey (2002) reported that an important component in successful recovery was giving up heroin for oneself, rather than for someone else. The authors interpreted this as a desire to make changes for the sake of one's own identity. They went on to describe how heroin can be more powerful than many other reasons for ceasing use, but by rejecting the drug-using identity, the power of the drug is diminished. The participants in this study described a powerful dislike of what they had become as a result of their heroin use, and this played an important role in their decision to stop using.

Research suggests that a decrease in the positive pharmacological effects of heroin, and the realisation that the drug no longer plays a positive role in one's life represents an important turning point in initiating recovery for many people (Stimson & Oppenheimer, 1982). McIntosh and McKeganey (2002) also reported that weariness with the routines and demands of maintaining heroin use played an important role in the decision to initiate recovery. Evidence suggests that for people with severe drug problems, stable recovery often follows multiple attempts at recovery initiation (Dennis *et al.*, 2005).

1.6.3. Maintaining recovery

Waldorf (1983) reported that the most important cited reason for maintaining recovery from heroin addiction in those who did and did not receive treatment was the establishment of new, important personal relationships. Both groups described the most

important sources of support as new and old friends, family and spouses. Less than 20% of the treated group described social support from agencies as important.

Klingermann & Efionayi-Mäder (1994) reported that the important factors in helping non-treated recovering heroin addicts to maintain their abstinence were social and family relationships, employment, vocational training and leisure activities/hobbies. The authors emphasised the importance of people in recovery having opportunities to experience a meaningful and fulfilling lifestyle which provides structure to daily life, especially during times of difficulty.

Research has proposed that those in recovery gain strength from support through friends and family, spirituality, inner strength and a desire to get better (Blomqvist, 2002; Flynn *et al.*, 2003a, 2003b). This may account for the success of the 12 step fellowship (Humphreys, 2004), which combines social, psychological, spiritual and theological ideologies. Scott and colleagues (2005) showed that having drug-free friends was a key predictor of maintaining abstinence over a one-two year period. Regarding alcohol addiction, Schutte and colleagues (2001) reported that the level of support an individual has in terms of self-perceived personal strengths, family and social peers mediates the effects of stress, thus reducing the risk of relapse. In the 12 year Drug Abuse Reporting Program (DARP) follow-up, the major reasons associated with sustained recovery after treatment included the adoption of more conventional lifestyles and better psychological support systems (Joe *et al.*, 1990).

Biernacki (1986) and Waldorf (1983) identified three important components of integration into non-addict social networks: 1) to remove the individual from the temptations and old behaviour patterns associated with drug-using networks, 2) to redefine drug use in a negative context and 3) to provide alternative behaviours and activities. Biernacki also highlighted the difficulties that can be faced in developing new non-addict social networks including fear of rejection, social disapproval or stigma.

Research has emphasised the importance of post treatment monitoring and support, actively linking clients to recovery mutual aid, stage-appropriate recovery education, and early re-intervention when necessary (Scott *et al.*, 2005; White *et al.*, 2002). Some studies have considered the factors associated with relapse and have suggested that negative

emotional states and involvement in criminal activities are risk factors for relapse (Vaillant, 1988), whilst supportive social networks and good self-efficacy have been shown to be protective against relapse (Weisner *et al.*, 2003).

Vaillant (1996) conducted a 12 year follow up of opioid users from New York which reported that the reasons for change and improvements included relocating to an area with limited drug availability, developing meaningful new relationships, becoming involved in positive activities (e.g. employment), and substituting other drugs (e.g. alcohol) for opioids. In other long-term studies, self-motivation, treatment (Bailey *et al.*, 1994), employment, fewer psychological problems and less illegal activity (Hser *et al.*, 2001) were further self-reported reasons for recovery.

1.7. SYSTEMATIC REVIEW

1.7.1. Identification of literature

A systematic literature review was conducted on February 15th 2012 using the Ovid database and included 'EMBASE', 'Ovid MEDLINE', 'PsycINFO,' and 'PsycARTICLES Full Text'. The following strand was searched: (heroin or opiate or opiates) in the title AND (addiction or addict or dependence or dependent or dependency or abuse or misuse) in the abstract, AND (recovery or overcome or overcoming or abstinence) in the abstract. The search was limited to those reported in English, studies using human participants and published between 1990 to the present. Duplicates from the search were removed.

The search generated 256 results. The titles, and where appropriate the abstracts, for these studies were reviewed using the following exclusion criteria: recovery focused studies only, no medical studies, no treatment focused studies and published research only. Of the 256 results, four studies met all of the inclusion criteria. Of those 251 articles that did not meet the inclusion criteria, 66 were not recovery focused, 102 focused on treatment, 79 were physiological studies and four were animal studies. The Cochrane Library, Google Scholar and citations of key papers were also reviewed (Chenail, 2011a) which generated a further three appropriate studies. The seven identified papers met the Critical Appraisal Skills Programme (CASP: Chenail, 2011b) criteria for quality research and will now be reviewed.

1.7.2. Critical review of literature

Best and colleagues (2008) conducted a retrospective analysis of cessation factors among 107 formerly problematic heroin users using questionnaires consisting primarily of quantitative questions with a small number of open-ended questions. Participants were recruited in the UK from an Addictions Symposium in Scotland, a Scottish residential rehabilitation centre and through a bimonthly magazine sent out to addiction services.

The authors reported that the most common reasons given for deciding to stop using heroin were: 'tired of the lifestyle' (89.5% stating 'a lot' or 'quite a lot') which supports Winicks (1962) maturing out hypothesis; and psychological health problems (58.5% stating 'a lot' or 'quite a lot'). The most common reasons given for successfully sustaining abstinence were: moving away from drug using friends (83.5% stating 'a lot' or 'quite a lot'), having reasonable accommodation (71.9% stating 'a lot' or 'quite a lot') and support from friends (64% stating 'a lot' or 'quite a lot'), which supports the findings of White and Kurtz (2006) who highlight the importance of recovery communities for developing positive social networks. The most common reasons given for why previous attempts had been unsuccessful (open-ended question) were: lack of support (30%), not 'ready' for abstinence (27%) and lack of awareness or insight about the nature of addiction (16%). The most common reasons given for what was different on the successful quit attempt, compared to unsuccessful attempts, (open-ended question) were: 12-Step affiliation (24%), good support (22%) and tired of the lifestyle (21%).

Although this study contributed to our knowledge of the factors involved in initiating recovery, it had several limitations, in particular the bias created by opportunistic sampling which resulted in the participants consisting largely (79%) of former heroin addicts now working in the addictions field. In addition, many of the participating organisations adhered to the 12-step approach which may have biased the results. The generalisability of these findings is therefore questionable. The questionnaire may have been biased by the authors' experiences and knowledge as it was not a standardised tool, and therefore the validity and reliability are unknown. Furthermore, as a retrospective study the results could be susceptible to recall and self-serving biases. No credibility checks were reported by the authors.

Hser (2007) conducted a prospective longitudinal study to identify predictors of long-term stable recovery among 242 male heroin addicts who were admitted to the California Civil Addict programme (a compulsory drug-treatment program), between 1962-1964. Participants engaged in three interviews which were adapted from an interview instrument developed by Nurco and colleagues (1975). Urine drug tests were also collected. The author reported a comparison of those who were in recovery with those who were not in recovery.

The recovered group were reported to have lower levels of psychological problems, greater non-drug-using social support networks, higher self-efficacy and less likelihood of having a spouse/partner who also abused drugs. The majority of the recovered group cited “tired of lifestyle” (87%), “tired of addiction” (80-86%), and “fear of incarceration” (45%) as the reason to stop using heroin. The most frequently cited methods for maintaining abstinence included: starting new relationships with friends, relatives, children and spouse/partner; receiving support from family, spouse/partner, new friends and church; and spending spare time in activities such as new interests, family activities, work and physical fitness. The author also reported that significant predictors of recovery status after ten years included high self-efficacy and low psychological distress.

This comprehensive study overcame a number of biases associated with retrospective studies by conducting a 33 year longitudinal study. However, the findings are limited in their generalisability as the sample consisted of males only, all of whom were offenders. Furthermore, these findings are based upon heroin users from the 1950-60’s whose experiences may not be generalisable to current heroin users. Although this study has enhanced the understanding of the predictors of recovery and important factors in maintaining recovery, it provides limited information about the initiation of recovery. Hser (2007) reported a high prevalence of continued heroin use in their aging sample, with 53% of participants continuing to use heroin into their late 50’s or 60’s, which challenges the maturing out hypothesis (Termorshuizen *et al.*, 2005).

From an initial sample of 10,010, Flynn and colleagues (2003) considered the views of 432 people who were considered to be in recovery five years after completing methadone programs in the USA. The study used the Recovery Perception Scales (De Leon & Kressel, 1996) and compared those who were in recovery to those who were not. Those in the

recovery group had no evidence of opioid or cocaine use or daily alcohol use and no self-reported criminality in the one year period prior to the five year follow up. Urine and hair specimen samples were also obtained and participants received monetary reward for their participation in the study.

The authors reported that at five year follow-up, 28% of the initial sample were in recovery. Compared to those not in recovery, those in recovery were significantly more likely to indicate that they had improved “very much” in their perceptions of socialisation, constructive lifestyle, healthy expression of feelings, health/appearance, maturity, ability to handle responsibilities and overall personal growth. They were also significantly more likely to believe that drugs had a negative impact on life. Those in recovery reported that personal motivation had the biggest influence on their overall improvements, as well as family, drug treatment experiences and religion/spirituality.

The study relied on retrospective recall so the participants’ perceptions about recovery may have been biased due to their positive behavioural changes. By comparing people in recovery to those not in recovery, this study increased understanding of the positive outcomes of maintaining recovery, but did not enhance our understanding of the processes involved in initiating and maintaining recovery from heroin addiction, or how services could be developed to support recovery. Furthermore, the criteria for being in the recovery group was very stringent, excluding cocaine users, those who had engaged in criminal activity in the previous year and daily alcohol drinkers. This may not be generalisable to other people in recovery who continue to use other substances in a controlled manner.

Watson and Parke (2011) conducted a qualitative analysis of five females’ experiences of recovery using interpretive phenomenological analysis (IPA). Participants were recruited from voluntary sector addiction counselling services in Lincolnshire, UK. Three super-ordinate themes were identified: childhood experiences, physiological and psychological symptoms and perceptions of recovery.

As this study did not solely focus on recovery, the findings were only partially relevant to recovery from heroin addiction. The authors focussed on reporting the childhood experiences of the participants, suggesting how services could be adapted to better meet

these needs, but little information was given regarding the recovery process and how services could support this. Furthermore, the sample consisted of females only who were recruited from counselling services and this may have impacted on their perception of the importance of psychological symptoms. To address the issue of subjectivity during data analysis, the second author assessed the proposed theoretical framework themes against the raw data to confirm representativeness of themes.

Dos Santos and Van Staden (2008) conducted a content analysis of 40 interviews with formerly heroin dependent participants who were recruited through a snowball technique in the Pretoria region of South Africa. This study design is similar to that of the study reported in this thesis.

This study reported four key themes. Firstly, the recognition of heroin misuse problems were often associated with a series of realisations. Some participants described a 'rock bottom' experience whilst others described a rational decision-making process of weighing up the pros and cons of continued heroin use. Secondly, during this realisation process, behaviour modifications occurred, primarily changes to control or stop heroin use. Barriers to change included: a lack of awareness/denial of problem; lack of access to services; fear of experiencing withdrawal symptoms; and a feeling of being unable to see a way out of addiction.

The third identified theme was that treatment was viewed as a crucial component of recovery (90% of participants had accessed residential rehab) in addressing physical dependence, physical health, confidence levels, isolation, coping methods, lifestyle changes, life perspectives, identity and understanding about heroin addiction. Key components of treatment were identified including; shared experience, meeting others at different stages of recovery (which provided hope and a reminder of where they had come from), education about addiction and available services, psychotherapy, having needs met holistically, development of support networks, and reintegration into society. Furthermore, important personal factors were identified including effort, hard-work, commitment and discipline.

The fourth theme identified by the authors reported the following factors as being important in recovery: being ready to make changes, being focused and committed to

recovery, abstinence, proficient support networks, post-treatment counselling, peer-support, neutralising reasons for using heroin, and preparing for cravings. Participants recognised changes in themselves since being in recovery in terms of their lifestyle, identity, self-esteem and perspective and had experienced rewards from relationships, spirituality, employment, leisure pursuits and education.

This study supported the findings of a number of other researchers including; learning from failed attempts at recovery (Hser *et al.*, 1997), the role of 'rock bottom' experiences (Prins, 1995) and rational decision making (Biernacki, 1986) in triggering the initiation of recovery, the positive role of treatment (Edwards, 2000; Granfield & Cloud, 2001), the positive role of psychotherapy (McIntosh & McKeganey, 2002), and the importance of proficient support networks, early intervention and long-term care (Darke *et al.*, 2007; Grey & Fraser, 2005; Hser, 2007).

This study is limited in that the sample was not representative of heroin dependent individuals in the area with regards to education (participants were on average more educated than peers) and employment status (higher employment rates in this study than amongst peers), which may have influenced the findings. Furthermore, the majority of the participants attended residential rehab, which may have influenced their perceived view of treatment. There may also have been bias from the participants due to the retrospective nature of the study, and from the researchers in terms of bias during analysis, although there was a peer review of the analysis and a sub-set of participants were asked to comment on the accuracy of their analysed transcripts, thus enhancing reliability. Overall, this study provides a detailed understanding of the process of recovery in a district of South Africa, but it is unknown if these findings can be generalised to people overcoming heroin addiction in other countries due to many cultural differences.

McIntosh and McKeganey produced two papers (2000; 2001) reporting the findings of interviews conducted with 70 recovering heroin addicts recruited from across Scotland using a variety of methods including newspaper advertising and snowball sampling. The interview data was analysed using analytic induction allowing a conceptual framework to emerge from the data.

In their 2000 paper, the authors identified two factors which were important for a successful decision to stop using drugs: a desire to restore a spoiled identity and a sense of a future that is potentially different from the present. The authors also suggested that the process of maturing out of addiction is closely associated to the process of recognising a spoilt identity and reawakening interest in the future. These findings supported those of Biernacki (1986) who identified two principal routes out of drug use: rock bottom experiences or rational decisions and the importance of restoring a spoiled identity.

In their 2001 paper, McIntosh and McKeganey built upon the work of Waldorf (1983) and Biernacki (1986) by identifying three key areas in which the participants' narratives could be seen to be constructing a new, non-addict identity: 1) *Re-interpreting the addict lifestyle* in a negative light, including a change in viewing the effects of heroin as something positive to having little or no pleasurable effects, and a recognition of the negative lifestyle associated with heroin use; 2) *Reconstructing the sense of self*, which required a differentiation of their sense of self before their drug use became central to their lives, the person they had become as a result of their drug use, and the person they aspired to be; 3) *Providing explanations for recovery*, which the authors suggested had to be convincing to others as claims of recovery are often challenged or disputed. The authors also proposed that significant others can play a key role in the construction of narratives of recovery (including those of professionals).

This research supported that of others (Klingemann, 1994; Prins, 1994) in reporting that drug users often make multiple unsuccessful attempts at recovery. The authors supported the findings of Biernacki (1986) who identified two principal routes out of drug use: rock bottom experiences or rational decisions, with the majority having made rational decisions to exit drug use as a gradual process of realisation of the negative consequences of their drug use. Consistent with Biernacki's work, this decision often followed prolonged exposure of negative experiences which lead to a decision to change their lives in order to restore a spoiled identity. The authors also reported that, although many addicts feel that they should stop using, they are only likely to succeed if they want to stop, as supported by Prins (1994).

This study allowed for participants to self-report their recovery status, with no urine tests provided or minimum period of drug-use specified. The findings, in the context of

developing a new identity, provide a useful insight into the initiation process of recovery from heroin addiction, but provide little information on the process of maintaining recovery.

1.7.3. Implications of existing research

Although there is ample evidence that recovery from heroin addiction does occur (e.g. Prins, 1994; Waldorf, 1983), the process by which it occurs is still not fully understood. Research has primarily focused on the initiation of recovery (e.g. Best et al, 2008; McIntosh & McKeganey, 2000), and there is still limited understanding of the processes people go through in maintaining their recovery, and the role that services can play in the recovery process (McIntosh & McKeganey, 2000).

The research conducted by dos Santos and Van Staden (2008) provided a good understanding of factors involved in initiating and maintaining recovery, as well as the role of residential treatment. However, although their research is very informative, it recruited participants solely from South Africa, where treatment services differ greatly from those in the UK, most notably with respect to the fact that treatment is primarily provided privately in residential rehabilitation.

A further difficulty with generalising the findings in the existing literature is that most of the current research emanates from areas where there are recovery-orientated services, such as the USA (e.g. Flynn *et al.*, 2003; Hser, 2007; White, 2007) and Scotland (Best *et al.*, 2008; McIntosh & McKeganey, 2000). This influences the experience of the recovery process and makes it difficult to generalise the findings to areas where recovery orientated support is in its infancy, such as South Wales.

A number of researchers (McIntosh & McKeganey, 2002; Terry, 2003) have highlighted how, compared to other areas of health and social care, the views and opinions of service users in the substance misuse field are less frequently obtained in order to shape the planning and delivery of services. Dennis and colleagues (2007) proposed that there needs to be more research into how long-term recovery is managed, to inform the development of effective and cost-efficient services. This reinforces the importance of gaining the views and

experiences of people in recovery from heroin addiction in developing and delivering appropriate services.

White (2005) proposed that we need to learn more from the lived experiences of those in recovery to gather information about the principles and practices that underlie the initiation and maintenance of recovery. Prins (1995) suggested that more qualitative research would provide a better understanding of the processes that people go through when initiating recovery. At present there is no published research regarding the recovery journeys of people in South Wales, so it is unknown whether their needs would be the same as populations in other areas. It is essential that delivery reflects the needs of those in the area, and qualitative research can provide an in-depth understanding of those needs and experiences which can inform accurate service development and delivery.

1.8. THE CURRENT STUDY

1.8.1. Rationale

Although there is a considerable volume of research published about recovery, the majority of this work has been carried out in the USA and much of it focuses on alcohol addiction. Recovery orientated research from the USA is beneficial in guiding the UK recovery movement, but it is limited, as the USA system for treating addiction differs greatly from the UK system.

In the UK, much of the evidence base around recovery comes from the mental health field (Forchuk *et al.*, 2005; Onken *et al.*, 2007), and there is limited evidence available on the typical recovery journeys of heroin users in the UK, or of the factors that are associated with initiating and maintaining recovery (McIntosh & McKeganey, 2000). UK research, to date, has primarily been conducted in Scotland, where the Scottish Government have embraced recovery at the core of their substance misuse policies, which is reflected in the availability of recovery orientated services, thus influencing the experiences of those overcoming heroin addiction. At present there is no known research available on the recovery experiences of people in the South Wales area, where recovery orientated support is minimal and in its infancy.

The author of this thesis proposes that a fundamental step in considering the development and delivery of recovery-orientated services is to consider the experiences and needs of those in recovery in a given location, so that the specific needs of that population can be considered and appropriate services put in place.

1.8.2. Research aims

This thesis will present the findings of a qualitative study considering the recovery experiences of ten formerly heroin dependent individuals from the South Wales area. The aim of the study is to gain a better understanding of the process of recovery, in particular the processes involved in initiating and maintaining recovery, and how services in South Wales can be developed and delivered to support the recovery process. The study will also consider how recovery is conceptualised by those with personal experience of overcoming heroin addiction.

CHAPTER TWO - METHODOLOGY

2.1. OVERVIEW OF CHAPTER

This chapter considers the design and procedure of the current study which explores the recovery process from heroin addiction. A qualitative methodology involving interviews, a focus group, and utilising a grounded theory approach for analysis was used. This chapter will consider the rationale for this approach, an overview of grounded theory and consideration of the researcher's theoretical stance. The procedures for participant recruitment, data collection and data analysis will also be outlined and ethical considerations discussed.

2.2. QUALITATIVE METHODOLOGY

2.2.1. Philosophy

Qualitative methodologies are non-statistical methods of inquiry and analysis of social phenomenon drawing upon inductive processes. In recent years there has been an increase in the use of qualitative research methods in psychology, as well as in other disciplines (Smith, 2003). This may reflect an increased acknowledgement of the social, historical and cultural factors that can be lost or minimised through quantitative approaches which test hypotheses that have derived from theory (Willig, 2008). Qualitative methodologies focus on people's perceptions of their own experiences thus capturing the richness of human experience (Ashworth, 2003). Such methods allow for theories to emerge from the analysis of verbal data acquired from a smaller number of participants than normally recruited for a statistical quantitative analysis.

2.2.2. Rationale

Fossey and colleagues (2002) proposed that qualitative methodologies are best suited to research where there is little existing evidence or theory. Although there has been a growth in recovery research from the USA over the past decade, in the UK there is still very little research considering the recovery process from heroin addiction, particularly in South

Wales. Furthermore, it has been suggested that a qualitative approach to research is appropriate when there is a broader research topic rather than a specific research question (Orona, 1997), as with this study.

The aim of the research was to gain a better understanding of the recovery process from the perspective of people in recovery, rather than to test out hypotheses based upon existing theories. Therefore a qualitative approach allowed the researcher to conduct an in-depth exploration of participants' experiences using semi-structured interviews. This allowed participants to shape the interviews, thus minimising the risk that data collection was influenced by the researcher's preconceived ideas (Willig, 2008). Based on the above factors, the researcher thought it appropriate to use a qualitative methodology in this study.

2.2.3. Ensuring quality

Qualitative methodologies have received a number of criticisms including lack of scientific rigour, researcher bias, over reliance on anecdotal evidence and lack of generalizability (Mays & Pope, 2000). One of the main criticisms of qualitative methodology is that the data can be prejudiced by the researcher as the interpretation is subjective, thus weakening the scientific validity of the analysis. Qualitative researchers acknowledge that their personal theoretical perspectives may influence how their data is collected and interpreted (Henwood & Pidgeon, 1995). Eriksson and Kovalainen (2008) highlight the importance of researcher *reflexivity*, where researchers continually and critically reflect on how they produce knowledge, and relate this knowledge to other knowledge. This helps to make meaning of their journey through their research, and brings rigour to the study, thus improving the quality of the research (Guillemin & Gillam, 2004).

Validity and reliability in qualitative methods cannot be tested in the same way as in quantitative methods. However, qualitative researchers have proposed alternative constructs for ensuring quality in qualitative research. Guba (1981) proposed four criteria for enhancing trustworthiness in qualitative research (see Shenton, 2004). These are credibility, transferability, dependability and confirmability. Each of these will be discussed and reflected upon in relation to the current study.

Credibility attempts to address how congruent the findings are with reality (Merriam, 1998). The literature proposes a number of ways in which credibility can be enhanced including ensuring that the most appropriate research methods are used (Yin, 1994), gaining an early familiarity with the culture being researched (Erlandson *et al.*, 1993), triangulation (Bogdan & Biklen, 2006), promoting honesty in participants (Shenton, 2004), frequent debriefing sessions between researcher and their supervisors, peer scrutiny of the research (Shenton, 2004), and researcher experience in qualitative methods (Patton, 1990).

A number of the above credibility checks were incorporated into the present study. The researcher had previous experience of using qualitative methodologies including grounded theory, and the research was monitored by a supervisor with extensive experience in qualitative methodologies. A reflective diary (see Appendix K) was also kept by the researcher to ensure continual evaluation of the methodology by the researcher and supervisors.

The researcher also took measures to become familiar with the culture being researched through visiting organisations and gathering feedback from those in recovery from heroin addiction about the design of the research project. Following analysis of results from the interview data, the findings were presented at a focus group consisting of both people working in the addictions field and those directly affected by heroin addiction, in order to gather their views on the findings, and to consider whether their experiences and perceptions were congruent with the outcomes of the study. This is thought to be an effective form of triangulation (Morgan, 1988) and enhances validity and credibility. Honesty in participants was enhanced through providing participants with ample opportunity to refuse involvement in the study, thus increasing the likelihood that participants were providing information freely. Participants were also reassured that there were no right or wrong answers and that they could withdraw from the study at any time without repercussions.

Transferability refers to the extent to which the findings of the study can be generalised to other situations (Merriam, 1998). In quantitative research this refers to external validity, and the generalisability of applying findings to the wider population. However, because qualitative methodologies explore the experiences and perceptions of a smaller number of

participants in a particular environment, there are clear limitations regarding generalising the findings. However, good practice suggests that the researcher should be explicit about the context in which the research took place, for example providing detailed information about the number of organisations taking part in the study and where they were based, the inclusion and exclusion criteria, the data collection methods employed, the number and length of data collections and the time period over which data was collected (Shenton, 2004). To address the issue of transferability the researcher adhered to these guidelines and provided extensive information regarding the setting and context in which the study took place (see sections 2.4 and 2.6).

Dependability refers to the issue of whether the results would be repeated if the same methodological techniques were repeated in the same context and with the same participants. To address dependability it is suggested that researchers are explicit about their research design and implementation including data collection and interpretation. In the current study the researcher was explicit about the procedures, methods and techniques utilised in the study, including providing numerous excerpts from the transcripts and examples of different stages of the analysis (see Appendix J). Gathering the views and opinions of a focus group consisting of participants who had not been involved at the individual interviews stage also helped to address the dependability of this study. The researcher also evaluated the study throughout, and all stages of the project were overseen by a supervisor.

Confirmability refers to the processes put in place to ensure that the research findings reflect the perceptions and experiences of the participants, rather than those of the researcher. Triangulation can help to address confirmability (Shenton, 2004), as does the researcher being explicit about their theoretical and personal orientation (Miles & Huberman, 1994). Both of these techniques have been used in this study. The reflective diary, supervision, and gathering feedback about the results in a focus group also help to maximise confirmability, as evidenced in this study.

2.3. GROUNDED THEORY

2.3.1. Overview

Grounded theory (GT) is a qualitative methodology originally developed by Glaser and Strauss (1967). GT was developed to facilitate the process of theory generation during a time where research methods were predominantly testing existing theories using quantitative techniques. GT was intended to conceptualise qualitative data, to reveal relationships between conceptual categories, and to identify the circumstances under which theoretical relationships emerge, change or are maintained (Charmaz, 2003).

Since its inception, GT has been further developed into two rather different forms: constructivist and objectivist (Charmaz, 2000). The constructivist approach sees both data collection and analysis as created from the shared experiences of researchers and participants, thus acknowledging the relationship between researchers and participants and the influence this may have on data collection and analysis (Charmaz & Mitchell, 2001).

Constructivists study how participants construct meanings and actions by getting as close to the experience as possible. From a constructivist viewpoint, the data is located within the time, place, culture and context of the participants' experiences, as well as reflecting the researcher's thinking. A constructivist approach provides an interpretive portrayal of the studied world, rather than claiming to portray an exact picture of it (Charmaz, 2000; Schwandt, 1994). The researcher aims to gain a better understanding of participants' implicit meanings of their experiences, and to develop a conceptual analysis of them. Constructivist researchers view GT as a method for learning about a phenomenon, rather than an end in itself.

Objectivist GT derives from positivism and proposes that meaning lies in the data and the grounded theorist discovers it (Strauss & Corbin, 1990). Therefore, researchers try to maintain "value-free neutrality" (Charmaz, 2006, p.132) by taking a position of distance and separation from the participants in order to remain an unbiased observer who discovers theory in the data.

2.3.2. Researcher's theoretical orientation

It is important that qualitative researchers consider the philosophical underpinnings of their methodology to avoid overly influencing the data collection and analysis with their own philosophical position (Eriksson & Kovalainen, 2008). The researcher recognised that a grounded theory approach could be influenced by a number of factors including participants' understanding of questions and the research in general, the researcher's own perspectives and the researcher's ability to make interpretations of the data within an appropriate context (Henwood *et al.*, 1995). The researcher therefore takes a constructivist approach to grounded theory, and acknowledges the influence that this may have on data collection and analysis.

In order to acknowledge the above factors, the researcher adopted a flexible interview guide underpinned by open-ended questions which allowed participants to take the lead on the interviews and to talk freely about their experiences. People in recovery were also consulted during the design of the interview guide to ensure that questions were valid and addressed the research question.

2.3.3. Rationale

The purpose of this study was to consider the experiences of people in South Wales who are in recovery from heroin addiction, with regard to the initiation and maintenance of their recovery. This is an area in which there is little research, especially in South Wales. The purpose of this study was to gain a better understanding of this area, and to consider theory that might emerge from the data, thus representing the experiences of the participants, which is in line with the central principle of GT (Strauss & Corbin, 1997). Such theory might then later be considered on a larger scale using quantitative methodologies to assess reliability and validity.

Alternative qualitative methodologies, such as interpretive phenomenological analysis (IPA) could have been used to analyse the interviews in this study. However, IPA focuses on individuals' perceptions of situations and experiences (Smith, 2003), rather than collating the experiences and ideas of a group of people within a social context and considering emerging theory, as with GT.

A further reason for using a GT methodology related to the data collection methods used in this study. GT is compatible with data collection in many forms including interviews and focus groups (Willig, 2001).

2.4. DESIGN

2.4.1. Research context

This study was conducted across the South Wales area and interview participants were recruited from a number of voluntary and statutory addiction services, as well as through word of mouth. Following analysis of the interviews, a focus group was arranged with people in recovery and professionals working within the addictions field, to elicit discussion of the findings.

At the time that the interviews were conducted, there were very few services available in the area specifically for people in recovery from heroin addiction.

2.4.2. Researcher's position

Reflexivity is an important component of qualitative research as it requires the researcher to acknowledge that it is impossible to remain impartial to the subject matter when conducting research. Therefore the researcher must consider their role in the construction of drawing meaning from the data (Willig, 2001). Elliott and colleagues (1999) suggested that researchers should 'own' their perspectives by disclosing their values and assumptions so that readers can take into consideration how the researcher may have influenced the data analysis.

The researcher is a white 29-year old unmarried female who grew up in a South Wales city. During the research process the researcher was completing her Doctorate in Clinical Psychology, and for part of the study the researcher was on placement at a NHS addictions service in South Wales. Prior to clinical psychology training, the researcher was employed at a charity which worked with people in recovery from substance misuse, primarily providing a channel for people to share their recovery experiences.

The researcher was aware that her previously experiences of working with people in recovery from substance misuse could potentially bias her perceptions and subsequently

the data analysis. The researcher, therefore, made efforts to detach from her previous perceptions of recovery from addiction and endeavoured to maintain an open-minded approach throughout data collection and analysis. The researcher also used supervision and reflexivity to further reduce potential biases.

2.5. ETHICAL APPROVAL

Prior to starting the study, ethical approval was obtained from the South East Wales Local Research Ethics Committee in February 2011 (see Appendix A). Prior to participating in the study, participants were provided with an information sheet (see Appendices E and F) and the opportunity to ask questions about the study and their involvement. The information sheet outlined confidentiality and explained that the interviews and focus group would be audiotaped, and the interviews transcribed, but that all identifiable information would be removed from the transcripts and the tape recordings would be destroyed after transcribing. Participants were reminded that they were free to withdraw from the study at any time, and that this would not affect the care they received, or their employment in the case of professionals attending the focus group. Once participants were satisfied they provided written consent (see Appendices G and H).

2.6. PARTICIPANTS

2.6.1. Participant recruitment

Participants were recruited via a number of statutory and voluntary addiction services in the South Wales area including Recovery Cymru, Inroads, Drug Aid and a South Wales Community Addictions Unit. Participants were also recruited by word of mouth. The researcher aimed to make the sample as heterogeneous as possible in terms of age, gender and recovery experiences. The final sample consisted of ten participants recruited from voluntary sector agencies and two participants recruited from word of mouth.

Participants were recruited through poster advertisements (see Appendices C and D) at local services and support groups. Potential participants were provided with a telephone number at which they could contact the researcher. The researcher also spoke to professionals in the field and asked that they help to recruit potential participants from the services in which they worked. Packs containing a participant invitation letter (see Appendix B), information

sheet (see Appendix E) and consent form (see Appendix G) were available for the researcher and other professionals to give or to send to potential participants.

Ten consent forms were returned to the researcher and interviews were arranged with these participants at local addictions service locations that were convenient for the participant.

2.6.2. Inclusion and exclusion criteria

2.6.2.1. Interviews

Participants were people in recovery from heroin addiction, who may have accessed formal treatment services, attended peer-support groups or achieved recovery without any formal or informal involvement.

When recruiting participants, the following inclusion and exclusion criteria were adhered to:

Inclusion criteria -

1. People in recovery from heroin addiction – as defined by ‘someone who believes that they were addicted to heroin, and now believes themselves to be either recovered or in recovery.’
2. People on prescribed substitute drugs could participate.

Exclusion criteria –

1. Those who were under the influence of alcohol or illegal drugs at the time of interview.
2. Those with current problematic drug/alcohol use.
3. Those who had used heroin (lapsed/relapsed) for more than 30 days in the past six months.

2.6.2.2. *Focus groups*

Participants were people in recovery and professionals working with people in recovery from heroin addiction.

When recruiting participants, the following inclusion and exclusion criteria were adhered to:

Inclusion criteria –

1. People with personal or professional experience of recovery from heroin addiction.
2. People on prescribed substitute drugs could participate.

Exclusion criteria –

1. People who had participated in an individual interview in this study.
2. Those who were under the influence of alcohol or illegal drugs at the time of focus group.

2.6.3. **Description of participants (situating the sample)**

The mean age of the participants was 43.2 years, with a range from 31 to 59 years. Eight participants were male and two were female. Brief information about each participant's heroin use and recovery journey is provided below. All names have been changed to protect the identity of the individuals.

Adrian is a 32 year old male who has been smoking heroin since the age of 16. Adrian was a heroin user for 12 years and last used heroin 4 years and 8 months prior to the interview. Since this time he has been on a substitute prescription of methadone. Adrian had reduced his daily methadone from 110ml to 35ml and hoped to continue with his reduction. He is also prescribed diazepam for a life-long pain disorder. Adrian has had 3 treatment episodes at residential rehabs which lasted 3 months, 8 weeks and 2 weeks. He currently smokes cannabis approximately 6 times per month, but does not use any other illegal drugs or alcohol. Adrian classed himself as being in recovery for 4 years and 8 months.

Kurt is a 59 year old male who first used heroin aged 20. He initially injected heroin and started smoking heroin at 22. During his 33 years of heroin use he would use both methods of administration, although he became more heavily reliant on injecting as his tolerance

grew. Kurt last used heroin 6 years ago, since which time he has been on a methadone reduction prescription. At the time of the interview Kurt had reduced his methadone from 120ml to 31ml and planned to continue with his reduction. He was also prescribed diazepam and was currently reducing this prescription. Kurt had had 4 treatment episodes, including 3 stays at residential rehab, each for 3 months. On one of those occasions he had remained in aftercare, and abstinent from heroin, for 3 years. He had also previously had a methadone maintenance prescription for 2 years but had not found this beneficial in addressing his heroin use. At the time of the interview Kurt had not use any illegal drugs or alcohol in the previous month. Kurt classed himself as having been in recovery for 6 years.

Gary is a 45 year old male who first used heroin aged 17. At the age of 18 he progressed from snorting heroin to smoking it, and then at the age of 24 he began injecting heroin. Gary used heroin for 24 years. At the time of the interview Gary had not used heroin for 2 years and 1 month and was not on any substitute prescription drugs. Gary had had 2 treatment experiences: a 6 month dihydrocodeine reduction programme and counselling, and a 1 year subutex maintenance programme. Gary drinks approximately 10 units of alcohol per week and does not use any illegal drugs. Gary classed himself as being in recovery for 2 years and 1 month.

Melanie is a 32 year old female who first smoked heroin at the age of 21 and then first injected heroin at the age of 25. She used heroin for 13 years and last used heroin 2 months ago. At the time of the interview Melanie was not prescribed any substitute prescriptions, however, she had previously completed a methadone maintenance programme and 2 subutex reduction programmes. Melanie currently smokes cannabis daily and drinks 1 unit of alcohol per week. Melanie classed herself as being in recovery for 6 months.

Rob is a 56 year old male who first used heroin at the age of 52. He injected heroin for 2 years. He last used heroin 18 months ago and is not on any substitute prescriptions. He had previously had 2 treatment episodes, both of which were suboxone reduction programmes, the first lasting 12 days and the second 9 months, which he found useful in enabling him to cease using heroin. At the time of the interview Rob had used cocaine 5 times and alcohol 8 times in the previous month, and had used cannabis daily. Rob classed himself as having been in recovery for 18 months.

Phillip is a 49 year old male who first smoked heroin at the age of 36, and injected at the age of 44. Phillip used heroin for 14 years and last used heroin 9 months ago. At the time of the interview he was not on any substitute drugs, but he had recently completed a subutex reduction programme over a period of 9 months. He had not had any prior treatment. In the month prior to the interview Phillip had not consumed any illegal drugs or alcohol. Phillip classed himself as having been in recovery for 2 years.

Don is a 34 year old male who first smoked heroin at the age of 23 and injected at the age of 25. He used heroin for 8 years but had not used for 3 years at the time of the interview. Don was on a subutex maintenance programme and was prescribed 28mg daily. He had previously been on a methadone programme for 4 years. At the time of the interview Don had not used any drugs or alcohol in the previous month, and classed himself as having been in recovery for 3 years.

Sally is a 31 year old female who first smoked heroin at the age of 18 and injected at the age of 20. Sally used heroin for 13 years but had not used heroin for 11 months at the time of the interview. Sally was on a methadone reduction programme and had reduced from 85ml to 34 ml. She planned to continue her reduction. Sally had not had any previous treatment experiences. In the past month Sally had smoked cannabis once and had drunk alcohol on 4 occasions. Sally classed herself as having been in recovery for 11 months.

Tommy is a 50 year old male who used heroin for 20 years. He first smoked heroin aged 21 and injected aged 22. He last used heroin 7 months ago and at the time of the interview he had reduced on a methadone prescription from 100ml to 14ml. Tommy had not had any previous treatment experiences. In the past month he had not used any illegal drugs and had drunk alcohol on 1 occasion. Tommy classed himself as having been in recovery for 2 years.

Daniel is a 44 year old male who first smoked heroin at the age of 37 and injected at the age of 39. He used heroin for 7 years until 6 months prior to the interview. Daniel was on a methadone reduction prescription and had reduced from 75ml to 60ml. He had previously spent 1 year and 4 months at a residential rehab. In the month prior to the interview Daniel had not used any illegal drugs and had consumed 4 units of alcohol. Daniel classed himself as having been in recovery for 6 months at the time of the interview.

2.7. PROCEDURE

2.7.1. Interview methodology

Semi-structured interviews are a flexible, emergent technique allowing ideas and issues to emerge during the interview which can be pursued by the researcher (Charmaz, 2003). Bernard (1988) proposed that semi-structured interviews are best utilised when the researcher only has one opportunity to interview a participant, as was the case in this study.

The semi-structured interview guide provided a clear set of topic areas for the researcher, which yielded reliable, comparable qualitative data. The researcher used open-ended questions which provided the opportunity for participants to shape the interviews and share their experiences and understanding of a variety of topics.

Semi-structured interviews enable participants to talk about their experiences and views in detail and depth. The researcher could explore areas suggested by the participants' answers, thus providing information that may not have occurred to the researcher or of which the researcher had no prior knowledge. Semi-structured interviews also help to minimise pre-judgements from the researcher about what information was important and what was not.

The researcher believed that semi-structured interviews were an appropriate data collection method for this study. All interviews were conducted in a private room at an addictions service that was convenient for the participant. Interviews lasted between 46 minutes and 90 minutes, with a mean length of 67 minutes.

2.7.2. Interview content

The researcher initially drew upon her own experiences of working with people in recovery from substance misuse to compile an interview guide. This was then shared with a number of professionals working in the field, and people in recovery from substance misuse and some minor amendments were made.

The main questions are in bold, and each of these was asked to each participant. Some examples of subsidiary questions are also given, which were asked in response to participants' answers in order to further explore their experiences and perceptions.

1. What led up to you entering recovery?

- What made you think about stopping using heroin?
- What type of social support/relationships did you have?
- What was your physical and mental health like?
- What were you expecting/hoping recovery to be like?

2. What did you find most helpful when you were starting your recovery?

- Did you receive any treatment or engage with any services? If so, what?
- What type of support was available to you?
- Did you notice any changes in your lifestyle? The way you thought? The way you behaved?

3. What helped you to maintain your recovery?

- Did you receive any treatment or engage with any services? If so, what?
- What type of support was available to you?
- Did you notice any changes in your lifestyle? The way you thought? The way you behaved?

4. Did you experience any difficulties in your recovery? If so, what happened when faced with these?

- What helped? Hindered?
- If relapsed, what if anything did you learnt from the relapse experience?
- At this stage, how would you have responded if someone offered you heroin?

5. What do you feel are the important factors in maintaining recovery in the long-term?

- What could help you to achieve this?
- Are there any potential obstacles to achieving this?

6. How could services meet the needs of those in recovery?

- What are the most pressing needs?

- Do any services meet the needs of those in recovery? Are there any needs that aren't met?
- Have you had any particularly good/bad experiences with services since being in recovery?
- Do you have any ideas for developing services?

7. How would you define recovery from substance misuse?

- What does it mean to you?
- When does recovery start?
- How would you describe recovery to someone with a substance misuse problem who was thinking about changing their lifestyle? Would you prepare them for anything? Recommend or discourage anything?

Some changes were made to the interview questions as the interviews progressed. For example, at the first interview, the researcher asked the participant to summarise their addiction experiences, however, this took time away from discussing the recovery process. From this experience, the researcher decided that participants would not be asked about their addiction experiences, and the interviews would focus solely on the recovery process.

As the interviews progressed the researcher tested out hypotheses that were emerging from the analysis. These included: the role of family members at different stages of recovery (e.g. 'Did your family play a role in your recovery?'); whether participants viewed recovery as a staged process (e.g. 'Do you think there are different stages in recovery? If so, what are they?'); and the role of substitute prescribing in recovery (e.g. 'Did substitute prescribing play a role in your recovery? If so, in what way? Could prescribing services/practices be improved').

2.7.3. Interview style

The interviews were recorded using a digital audio recorder. The tape recordings were then transcribed verbatim to assist a grounded theory analysis. All identifiable information was removed from the transcripts to protect the identities of the participants.

The interviews were designed to be sensitive and non-threatening, thus encouraging participants to talk freely about the issues they felt pertinent to their recovery journeys.

2.7.4. Focus group methodology

Focus groups have been shown to be an effective method of data collection and are commonly used in psychology research (Wilkinson, 2003). Focus groups can capture dynamic group discussions about a specific topic, and allow participants to discuss and debate topics, thus providing rich data (Bloor *et al.*, 2001). Wilkinson (2003) proposes that focus groups are an effective method when the intention is to elicit participants' own perceptions and understanding of a topic, as was the case in this study.

Goodacre (2006) proposed that focus groups are a good method of exploring the 'credibility' and validity of findings from qualitative research. In this study, a focus group was used to present the findings of the research to people affected by addiction and professionals working in the substance misuse field in order to obtain their views and opinions, both in agreement and disagreement, of the study outcomes. These individuals had not participated in the individual interviews.

2.7.5. Focus group content

A summary of the key findings from the study were presented to the focus group in a verbal format, with diagrams to aid understanding (see Figures 3.1-3.6). Participants were encouraged to openly debate the findings, including four testable propositions, and to contribute their own views and experiences from both a personal and professional perspective. The focus group was facilitated by the researcher.

2.7.6. Focus group style

The focus group was recorded using a digital audio recorder, and the researcher made some notes during the group to capture key themes. The tape recordings were then transcribed verbatim to assist a thematic analysis (Boyatzis, 1998). All identifiable information was removed from the transcripts to protect the identities of the participants.

The focus groups were designed to be sensitive and non-threatening, thus encouraging participants to talk freely about the issues they felt pertinent to recovery from heroin addiction and the findings of the study.

2.8. DATA ANALYSIS

2.8.1. Grounded Theory

The data collected from the interviews and focus group was transcribed verbatim. After each interview the researcher reflected on the process and noted any emerging themes or ideas that could then be explored in future interviews (see Appendix L). The researcher listened to the audio tapes and read through the transcripts a number of times to ensure immersion in the data. The researcher wanted to remain close to the data so did not use any computer packages to aid the analysis of the data (Goulding, 1999).

The analysis of the data was informed by a grounded theory approach which proposes a number of key strategies which should be adhered to when analysing data (Willig, 2008). These strategies help to identify '*categories of meaning*' (Willig, 2008, p. 35) which emerge from the data and group together data which share similar features or characteristics. Categories can be either descriptive in their nature or analytic, whereby they represent an interpretation of the data. These key strategies will now be considered in relation to this study.

Coding – This forms the fundamental process for the identification of categories. The researcher began coding with a line-by-line analysis which generated a considerable number of descriptive categories. As coding progressed, the researcher was able to identify analytic categories which grouped together descriptive categories to give them meaning. Where possible, categories were named using words or phrases taken from the data to ensure that the categories and subsequent theory emerged from the data (Willig, 2008).

Constant comparative analysis – This is the process by which the researcher continually linked and integrated categories to ensure that all instances of variation were encapsulated by the emerging theory (Willig, 2008). Constant comparative analysis required comparison between each piece of data to consider the similarities and differences, and resulted in the

emergence of core-categories, categories, sub-categories and concepts which linked and integrated the data.

Negative case analysis – Throughout the analysis the researcher searched for elements of the data that did not support, or appeared to contradict, patterns or explanations that were emerging from the data analysis. The identification of data that did not fit the emerging theory added depth and density to the theory, thus encapsulating the richness of the data.

Memo-writing – Throughout data collection and analysis the researcher wrote numerous memos to document the emerging categories and subsequent theory (see Appendix L). These memos enabled the researcher to trace how the relationships between codes and subsequent categories emerged, thus providing information on the iterative analysis process.

Theoretical saturation – The researcher aimed for theoretical saturation whereby data was collected until no new categories could be identified, thus ensuring that the categories and subcategories captured the majority of the data. However, it is acknowledged that theoretical saturation is a goal rather than a reality (Willig, 2008) as modifications and additions to categories are always possible.

The data analysis process was overseen by the researcher's supervisor to enhance reliability of the analysis through the method of triangulation.

CHAPTER THREE - RESULTS

3.1. OVERVIEW OF CHAPTER

This chapter presents the results of the grounded theory analysis of the interview data. The themes that emerged during the analysis have been organised into a hierarchical system consisting of **CORE CATEGORIES**, categories, sub-categories, and *concepts*.

A diagrammatic summary of the relationships between the four **CORE CATEGORIES**, 10 categories and 12 **subcategories** is presented in Figure 3.1. Furthermore, separate hierarchical diagrams for each of the **CORE CATEGORIES** including categories, subcategories and *concepts* are presented in Figures 3.2-3.5. Each *concept* will be described in this section, supported by quotations.

A grounded theory model of recovery from heroin addiction is then presented. This chapter concludes with the findings from the focus groups where Figures 3.1-3.6 were considered alongside a discussion of four testable propositions derived from the grounded theory model.

Figure 3.1. Overall view of hierarchical relationships between core categories, categories and sub-categories.

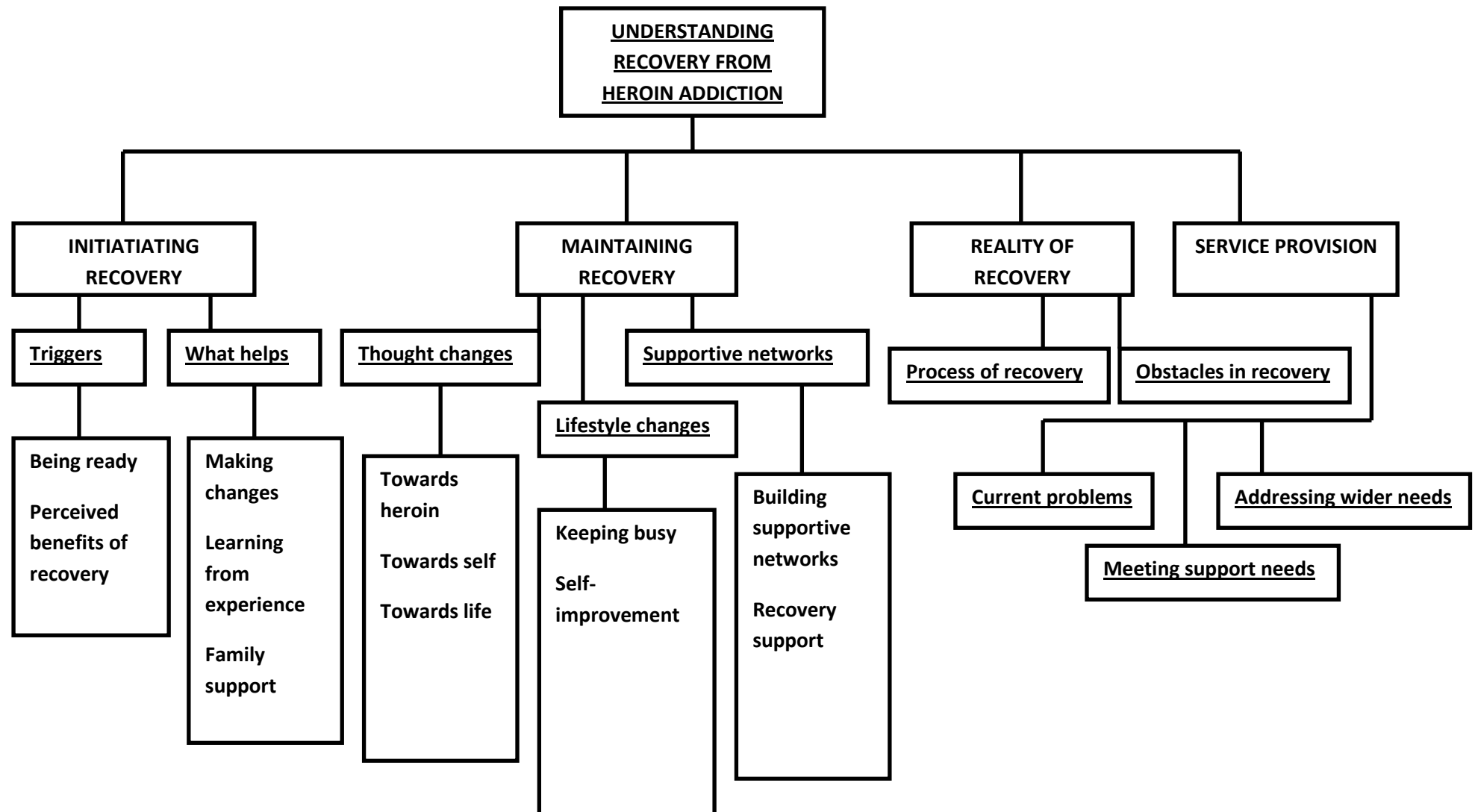
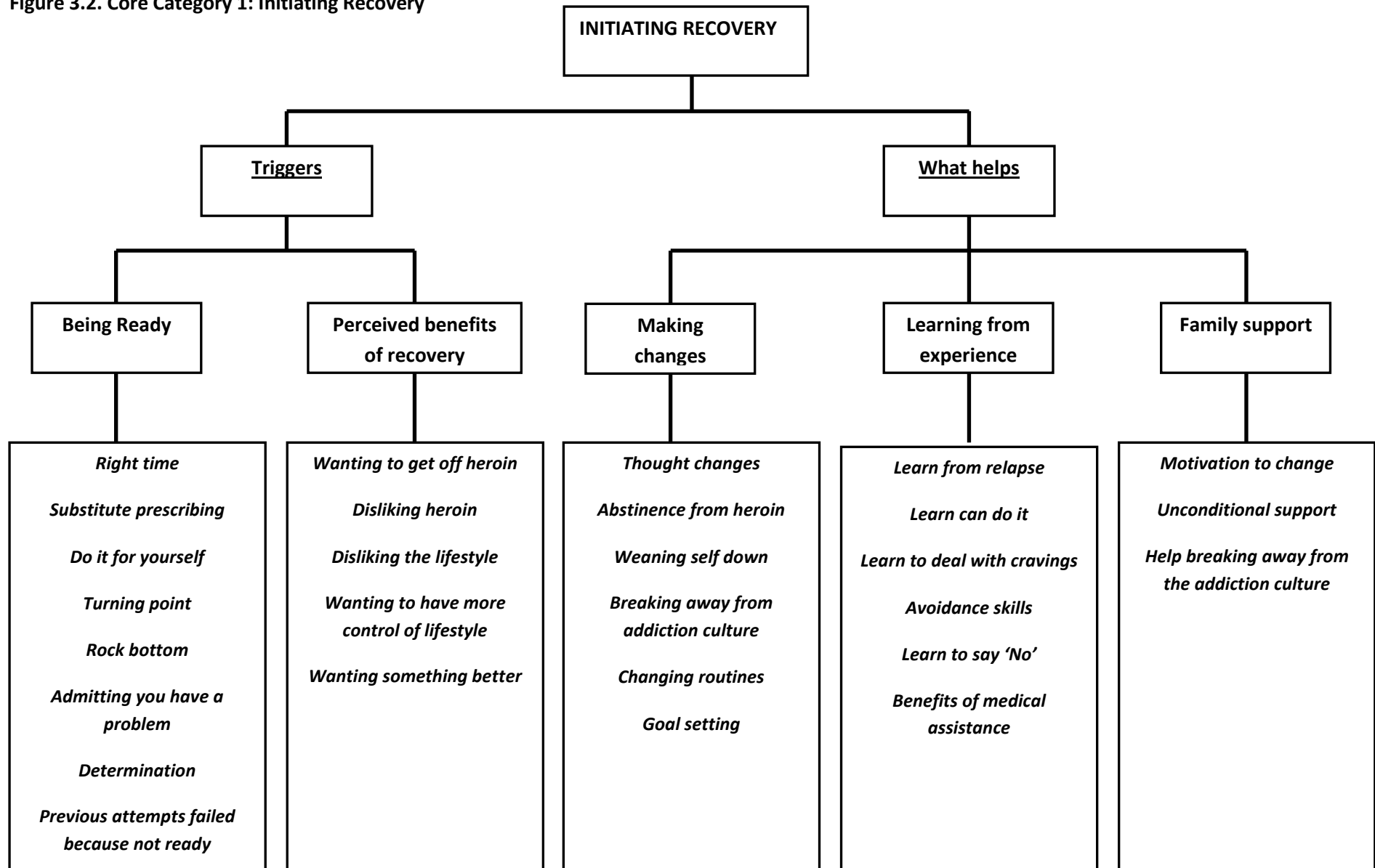


Figure 3.2. Core Category 1: Initiating Recovery



3.2. CORE CATEGORY 1: INITIATING RECOVERY

This core category considers participants' experiences and views on the process of initiating recovery from heroin addiction (see Figure 3.2). This core category comprises of two categories: triggers and what helps.

3.2.1 Triggers

The triggers category comprises of two sub-categories: **being ready** and **perceived benefits of recovery**. These sub-categories contained a number of concepts which will now be considered, with quotations to support them.

3.2.1.1 Being ready

All of the participants described the importance of 'being ready' for initiating recovery. Eight concepts were included in this subcategory: *right time, substitute prescribing, do it for yourself, turning point, rock bottom, admitting you have a problem, determination* and *previous attempts failed because not ready*.

Right time

This concept refers to the importance of choosing the right time to initiate recovery. All of the participants talked about the importance of choosing a time when they felt able to make the changes necessary to initiate recovery.

Sally: At the time I was feeling stronger as well, mentally stronger. I wouldn't have been able to do it if I was feeling low. At the time I knew that things were right for me to do it and I had to just go for it. 'Cos I was ready in myself. You just know you're ready. Now was the time.

For Tommy, who has schizophrenia, it was the voices he heard in his head that helped him to make the decision to stop using heroin.

Tommy: And if I went out and scored then I would have the voices saying, 'he's gone out and got the hurtful again', 'cos that's what they used to call it. And once they started to say they didn't like it as well it really helped me to make the decision to not go back.

Rob described how he had chosen to self-medicate with heroin to cope with his severe depression. He knew the time was right to initiate recovery when he felt that he had better control over his depression.

Rob: I had used heroin as medication to stop myself from killing myself and I knew it was time to give that up. Heroin saved my life. I've always been a depressive ... So I decided to self-medicate and I knew that eventually I would have to get off the addiction. Two years later I realised I had had enough of this, and I wanted to get off it. 'Cos I realised that I was handling my depression better.

Substitute prescribing

All of the participants who received substitute prescriptions described finding them beneficial in enabling them to initiate their recovery. For some, the substitute prescription enabled them to cope with the physical withdrawals from heroin

Don: knowing that I would have a prescription to take to make the physical symptoms less severe than they would have been if I had cold turkeyed it ... And then the subutex, that put me off it all together 'cos I know that if I use it won't work ... So for me it's easier using subutex compared to methadone 'cos if I was taking methadone I could still use heroin, but if you are on subutex it's sort of like there is no point.

For others, their prescriptions enabled them the opportunity to learn to live without heroin, although Tommy described the difficulty of learning to live without heroin and how services can sometimes be too quick to increase the amount of methadone prescribed.

Tommy: So they increased my methadone to 100ml and then I was able to not use for a month at a time. I could have done it on 60ml but the nurse wanted me to go on 100ml. The thing with the [prescribing service] is that if you don't present as clean they suggest you increase your methadone ... But they are so fixated on getting you to stop immediately that they don't give you the time to go through the process of getting used to not using and getting used to living without drugs. Don't forget you are always surrounded by people who are using, you know where all the dealers are, you have all their numbers on the phone and you have people coming to the door all the time. You have to build up strength to say no even when you don't want to say no. And it takes time to adjust and get used to it but they don't give you enough time before they start forcing you to increase your dose of methadone.

Do it for yourself

The majority of the participants described the importance of making the decision to initiate recovery for themselves, rather than having it forced upon them by others, for example family or the criminal justice system.

Melanie: Do it for yourself before you do it for someone else.

Daniel: I'm doing this for myself. My father doesn't even know. It's not to show anybody else; relatives, girlfriends anything. It's not for that. It's for me.

Some of the participants described how it can be an additional motivator to want to address their addiction for others, but it is fundamental that you do it for yourself, as other factors can change, thus potentially jeopardising recovery.

Phillip: If people only want to do it for their family then that's not enough. The drug can be bigger than anyone or anything else. Otherwise we all would have given up a long time ago. You have to want it for yourself. There's no other reason on this earth. You can't do it for someone else, your dad, mum or son. All that will help but you need to want it for yourself.

Tommy described how telling his father about his addiction gave him the extra push he needed to stop using heroin.

Tommy: I let my dad know the fact that I had a problem with heroin and he was obviously upset about it. And because I had let him know I decided that I had to do something about it. I knew that I had to do something about it anyway but that gave me an extra push. I had been trying to recover since I had got on the methadone but it was when I told my old man that was the point when I actually had to stop using.

Turning point

The majority of the participants described experiencing a turning point at which time they realised that they were ready to initiate recovery. For some of the participants, this turning point was an internal trigger, or a change in their thinking, that helped to motivate their decision to address their heroin use.

Don: The penny dropped I guess is the only way to describe it. Everything came to me at once I think and I just thought it's best to stop. Your life is going nowhere using and it's best to stop, you know, and that's when I decided.

For others, it was an external trigger that prompted their turning point.

Gary: At the time there was someone I shared a [prison] cell with and he pointed out how old I was and did I want to be back there again in 10 years time. Did I want to be 60 years old and still taking heroin? No, that's not how I'd ever seen my future ... Talking to him was just at the right time for me.

Adrian described a spiritual experience that triggered him to address his heroin use.

Adrian: And then on one bus journey something spoke to me and said, 'if you don't stop now you might lose your mother and she's going to die knowing that you're a drug addict'. That was my defining moment. That was when my thinking changed and I decided that I didn't want to be in it no more, I wanted to stop.

Rock bottom

Some of the participants described how they had 'rock bottom' experiences that triggered the start of their recovery. These rock bottom experiences were often as a consequence of their heroin use and the lifestyles they were engaged with.

Adrian: Then the police kicked my door through and I thought I've gotta stop and that was it. Full stop. I went and got my treatment sorted and that was it.

Gary: I ended up getting caught for driving under the influence of drugs. And that was it. Basically I had to resign from my job because the police took my license away and I was under an interim order and I was going to go to prison ... I was kicked out of my family home.

Admitting you have a problem

Some of the participants described how their heroin addiction had escalated, often without them explicitly noticing, to the degree where they were no longer in control of their heroin use or their lives. The realisation that they did have a problem helped some of the participants to make the decision to initiate recovery.

Phillip: But the position you are in at the moment means that every penny you've got goes to drugs to keep you going. You have to pay the devil everyday just to feel how other people feel, normal. Like you have to take it just to be normal when everyone else wakes up with a smile on their face you wake up worrying about where you are going to get the money to buy drugs. That's when you realise you have a problem and you need to do something about it.

Sally described how difficult it can be for people to admit that they have a problem when they are caught up in the lifestyle of heroin addiction.

Sally: I know a lot of people who think, there's nothing wrong with me. But I can see it happening 'cos I'm an outsider looking in. And you can tell them and tell them, but until they are ready to look at themselves and admit it, they can't make changes.

Determination

All of the participants described how their determination was a key factor in being ready and able to initiate recovery. This determination helped the participants to stay off heroin once they had made the decision to stop. Participants described how without this determination and willpower they would not have been able to stop using heroin.

Don: And determination. There were things I wanted to do ... I was just determined to stop so I just cut myself off. And I've stayed clean until now ... You have to want to do it. That's the main thing.

Adrian: I said never ever would I give a positive test again and that's what I've done, it was very hard to do but there's no excuse for it.

Previous attempts failed because not ready

A number of the participants described how previous attempts to initiate recovery had been unsuccessful, and with hindsight they realised this was because they were not ready.

Kurt: When I first went into recovery I wasn't ready. I stopped for my family. I think the person stops when they have had enough. You can give them everything and do everything for them, but that person will not stop until they are ready ... For me, I wish I had listened sooner but I wasn't ready. So that says it. That is the key. I was not ready.

Adrian: But I wasn't ready. I tried to say, and I told [family] that I loved them to bits but I just couldn't give it up. It was something that I just wasn't ready to do at the time ... I think because I wasn't ready, and that is a big thing, you have to be ready, because if you aren't ready, if you don't want it, then you just won't do it. No matter how many times you try, you won't unless you really want it.

3.2.1.2. Perceived benefits of recovery

All of the participants described a number of perceived benefits of recovery which helped to motivate them to initiate recovery. Five concepts were identified: **wanting to get off heroin, disliking heroin, disliking the lifestyle, wanting to have more stability in lifestyle, and wanting something better**. Each of these concepts will now be illustrated with quotations.

Wanting to get off heroin

The participants described how wanting to get off heroin was an important motivating factor in initiating recovery. Some described how the desire to get off heroin needed to be very strong to be able to withstand the cravings and temptations to use heroin.

Phillip: It doesn't matter what you've got, unless you really want to get off it in your head then nothing will work. You really have to want to be clean. You have to want to choose life ... You have to want to do it. You have to say to yourself, 'I want to be clean. I don't want to be where I am anymore. I want to see myself clean'.

Disliking heroin

The majority of the participants described how they had grown to dislike heroin towards the end of their addiction, and this dislike for heroin had helped to trigger the initiation of their recovery.

Adrian: I hated it. I was using half of it and throwing the rest away. As long as I wasn't hurting that was enough. I just hated it ... I don't like the taste, the smell. It came to the point where I actually hated the drug and what it's done to me.

Daniel: But the last time I done heroin it tasted out of date. That was it. Even the feeling of it, I don't even want that anymore. I don't think I could do a spell on heroin even if someone was paying me.

However, two of the participants described how they continued to like heroin throughout their addictions, even though they did not like the physical consequences of heroin use.

Melanie: My problem is, I like heroin. I just don't like the consequences of it. Physically I enjoy it. I just don't like the effects, how you physically hurt and everything.

Nearly all of the participants described how their tolerance to heroin had increased to the point where they needed to use it to stave off the withdrawals and feel 'normal', rather than experiencing pleasurable effects, which helped some of the participants to initiate recovery.

Tommy: Heroin users get to a point when they aren't happy with their lives. And the amount of grief they are getting doesn't make it worth it ... 'Cos when you are on heroin you wake up in the morning sick and rattling and you need a fix to feel normal.

Disliking the lifestyle

Some of the participants described how they came to dislike the lifestyle associated with heroin addiction, and this motivated them to stop using heroin.

Phillip: I don't like the heroin scene. I don't like the dirtiness of it all. The squalor, the stink of the flats.

Adrian: I could smell it and everyone was sat there in a mess. And I had to walk out. And that told me that day that it was never going to be for me.

Wanting to have more control of lifestyle

All of the participants described how their heroin use had taken over their lives, thus having a detrimental impact on numerous aspects of their lifestyle. Consequently, the desire to have more stability and control over their lives was a motivating factor for many of the participants initiating recovery.

Gary: I was in a very very dark place ... I was using £300 worth of heroin a week, spending a lot of money on it ... I was still getting in debt because even though I was earning very very good money I was managing to spend most of it on heroin. I was mounting debts everywhere using credit cards to buy everything so I could spend my wages on heroin. I was living day to day. I couldn't even think about the next day, let alone the next week ... I was very depressed and very stressed ... because I had the family pressures as well as work pressures and the pressure of keeping a habit running and keeping a double life which is an incredible pressure in itself.

Kurt: I stopped working, I was a brick layer, I'd been a foreman and I had a good reputation. But I got to the stage where it became unimportant. Drugs had become the most important thing to me - more important than family, my home, my job, everything. I was slowly but surely losing everything.

Melanie described her heroin addiction as a “full-time occupation” which meant that she was not able to attend to other areas of her life that needed addressing, for example accommodation and health care. This led her to address her heroin use in an attempt to achieve more control over her life.

Melanie: If you've got a habit and you're not on a script then you're chasing the drug to make yourself better. Once you're better you can't go to appointments 'cos then you're busy chasing drugs for later on ... When I was on heroin I used to look at it as a full time occupation. I used to get up in the morning, take my heroin. I would go out on a raise, until the afternoon. Then go and sell what I had stolen. Then hang around on street corners for about an hour waiting for the dealer to turn up, in rain, sunshine, lightning whatever. Score your bag, take it so you're better then go out

shoplifting, sell whatever you've got, stand on street corners again, score your shit and then go home. It's a full time occupation, heroin, and I don't have that full time occupation anymore.

Wanting something better

All of the participants described how achieving something better for themselves was a perceived benefit of recovery which helped to initiate their recovery.

Sally: I thought, 'I have to pull my finger out and stop it'. I was adamant then. I wanted better things for myself. And I wanted to get back into work. I wanted to have my own nice little home. Maybe a nice little car one day. I just wanted to be normal ... That's what made me want to get into recovery. I wanted to be like my friends and like everybody else.

Adrian: I'm doing it to better my life and better my health 'cos my health was suffering ... And I want to be something. I want to be an accountant or an engineer or a counsellor or a social worker ... I had nothing, nobody. And I thought there's got to be something better. I have to have been put here for a reason.

Daniel described how he registered himself on a college course as a motivator for stopping his heroin use.

Daniel: So I put myself into college last September. So it was in my head that I needed to be getting a career so I had to get into college. So I knew that I had to stop before I started college. And getting a place made me serious about giving up. 'Cos I wanted more from life.

3.2.2. What helps

The participants described a number of things that helped them to initiate their recovery, which fell into three sub-categories: **making changes**, **learning from previous experiences**, and **family support**. The concepts in each of these sub-categories will now be explored.

3.2.2.1 Making changes

All of the participants described a number of changes that they made which helped the initiation of their recovery. Six concepts emerged from the analysis: ***thought changes***, ***abstinence from heroin***, ***weaning self down***, ***breaking away from the addiction culture***, ***changing routines***, and ***goal setting***.

Thought changes

A number of the participants described changes in their thinking that they believed helped them to initiate recovery. These changes included positive thinking and having a more realistic view of their heroin use.

Sally: I started to give myself power talks in my mind. When I would be in the house and I would start to feel depressed I would say, 'come on Sally, you can do this, it's not so long now 'till you can move and it will all be OK'. And I kept reminding myself that until one day I just thought 'fuck it, I'm going'.

Adrian: But in the end I thought I can't even sleep when I'm on it. So if I can't sleep when I'm on it and I can't sleep when I'm off it I'm better off not to be on it and to be clean and to struggle with my sleep. Rather than struggling with keeping a habit and my sleep.

Gary: I had always been promising myself to stop, but would always be 'not today, I'll do it tomorrow'. I decided that needed to change.

Abstinence from heroin

Although only half of the participants explicitly mentioned abstinence from heroin, all of the participants had abstained from heroin during their recovery (excluding lapses and relapses). Participants described a number of factors pertinent to recovery from heroin addiction and although abstinence from heroin was one of them, it was not mentioned as regularly as some of the more psychological and social factors perceived to be important in recovery.

Gary: I think that once you've had a habit you can never use recreationally again. Once you have crossed that line you can never go back.

Kurt: One is too many and a thousand is never enough. I will be back on that merry go round again. And no, I'm not going there ... The only way for me is abstinence.

Weaning self down

The majority of the participants described how they had cut down their heroin use prior to abstaining from heroin. Some weaned their heroin use down before starting a substitute prescription. Others used their prescriptions to help them reduce the frequency of their heroin use.

Adrian: So I cut it down as low as I could go from maybe £100 a day to £20 a day, by myself, before the treatment started.

Tommy: I found it really difficult to stop using even when I was on the methadone. I could go for 5 days or 10 days, it slowly went up from three days to longer ... I had been building up to it slowly ... The periods between relapses had got longer and longer and I found that I could stay clean for a month at a time so I realised I could stay clean for good. Because my methadone was so high the physical battle was over so, it was more mental.

Daniel described how his dislike of using heroin helped him to wean himself down.

Daniel: Just before I gave up, my use was sporadic. It was, like, once every couple of days, then once a week. And the guilt, I felt sick. The heroin was working and trying to make me feel good but the guilt was working against that feeling and ruining it.

Breaking away from the addiction culture

The importance of breaking away from the addiction culture was one of the most referenced concepts from all of the participants. They all described how it is essential to break away from the people they had previously used drugs with in order to be able to address their heroin use.

Kurt: Staying away from people who are using is a major thing. Don't even go near them. Keep away from them. Don't even go there and show them how well you are doing. That's a no no ... You should stay away from them as much as possible.

Don: You have to cease contact with friends or acquaintances who are still using for obvious reasons otherwise you are just going to be tempted to use again and then you will just be back to square one.

Tommy: Moving house did help quite a lot 'cos I ended up living quietly on my own. I think it is quite important to move 'cos there's no good stopping and then going back to the same place with all the same people turning up. And they would knock on the door with bags [of heroin] and stuff.

Sally described how previously she and her ex-boyfriend had unsuccessfully tried stopping using heroin together.

Sally: And my boyfriend would stop as well. But then he would always start back up and make me start up again as well.

The majority of the participants described how hard it was to break away from the culture as they had little or no alternative social network.

Adrian: What you need to do is change all your friends, cut off all ties ... And to break that routine is the hard part, but once you break it you have lost all your friends, all your associates, so called friends shall we say. And that's really hard.

Changing routines

A number of the participants described how their daily routines had been dominated by their heroin use, so when they stopped using it was important for them to find alternative things to fill their time.

Sally: At the beginning, it was a bit difficult 'cos it's on your mind and you were stuck in a routine before. Like you would wake up, sort yourself out, jump on a bus, get your gear ... Not having those things to do and not doing all that running around was difficult at first. You have to get used to settling into a different lifestyle and that is hard at the beginning.

Melanie: When you come from taking drugs it's not as simple as thinking I'm going to stop taking drugs and that will change my life around. You've got to totally change everything in your life. That's your routine. People you associate with. People you speak to on the street. You have to change your whole lifestyle ... You can't keep any parts of that life. It's physically impossible ... But to get into a routine makes your life easier. It's a learning process and I'm still learning myself.

Goal setting

Some of the participants described the importance of setting themselves goals when they were initiating their recovery.

Sally: Set yourself little goals and stick to them because this is what you have to do. I found it really helpful to make smaller goals for myself because then I was achieving them and that gave me more strength in carrying on

3.2.2.2. Learning from experience

All of the participants described the importance of learning from experience in helping them to make the changes necessary for initiating recovery. Six concepts were identified in this sub-category: ***learn from relapse***, ***learn can do it***, ***learn to deal with cravings***, ***avoidance skills***, ***learn to say 'no'***, and the ***benefits of medical assistance***.

Learn from relapse

All of the participants had previous experience of relapse from which they had gained knowledge that helped them with initiating their recovery. A number of participants talked about the importance of learning from relapses.

Kurt: But addiction is such a cunning enemy that if I let me guard down it will get me. And I know that 'cos it happened in the past. I am living proof that addiction should

not be underestimated because it's so powerful. It's more powerful than anything ... I have to work 24 hours a day to keep this addict in check ... They say relapse isn't a bad thing. Sometimes it makes us stronger. And I certainly think that for me it has made me stronger. It has made me more aware of how strong and how cunning drugs can be.

A number of the participants described how their relapse experiences had reinforced the importance of breaking away from the addiction culture.

Rob: So I tried to do a 12 day detox but I didn't get out of the environment. So after 12 days it was great I was off the heroin, no withdrawals, nothing, until I went straight down my mate's house and got straight back on it again. So I knew that the next time I tried it I would have to change the way that I approached it ... I had learnt from my previous attempts. I knew I had to move away. I knew I should do a slower detox off the suboxone.

Gary described how he had learnt from a friend's relapse which had been fatal.

Gary: If it hadn't been a drug overdose, a drug related death, if he had walked under a bus for instance, then it might have been totally different. But because it was a lapse that killed him it had all the greater impact. Something saying, you're on the right path. Very, very hard and severe lesson in that sense, but that's what it said to me.

Learn can do it

Participants described how their previous attempts at addressing their heroin use had taught them that they could go periods of time without using, and this gave them strength in initiating recovery.

Sally: I did learn that I didn't have any problem stopping. I knew I could stop if I put my mind to it. That got me prepared for going into recovery 'cos I knew that I could do it. ... mentally and physically I knew that I could get off it.

Learn to deal with cravings

Some of the participants described having learnt coping mechanisms that enabled them to cope with the cravings they experienced in early recovery.

Adrian: And as soon as I got cravings and stuff like that I learnt that I had to get a piece of paper and write down the pros of taking it and the cons of taking it. And by the time I had done that the craving had gone. That was my tool for dealing with cravings.

Gary: And when I did think about it I would think about the consequences and how difficult my life had become, you know. I'd had a good job. Now I was on benefits.

Avoidance skills

Avoidance was regularly mentioned as an effective skill for use in early recovery. This avoidance related to old friends, to places that triggered cravings and to mental avoidance in overcoming cravings.

Sally: I think because I had tried so many times before to get myself off it, I knew that I couldn't let myself think about it. It would have been so easy for me to jump on a bus and get some, but I couldn't let myself think that.

Adrian: A lot of it was avoidance. Like avoiding certain people, avoiding certain places.

Learn to say 'no'

Some of the participants described how they had to learn to say 'no' when people offered them heroin, which for most participants was quite a regular occurrence. This skill was perceived as an important step for them in their recovery.

Gary: At that point I knew that the real test would be when I got back [home] and I was back around the people I knew ... the first time I said 'no' to someone was OK. The first time I was offered it, I just avoided the question ... Basically he asked if I wanted anything and I said I didn't have any money at the moment but I would take his number and call if I needed anything. So I put the number in but didn't save it. So I avoided the issue. And my probation officer quite rightly challenged me about that and asked me why I didn't just say that I didn't want it. So that's what I did with the next person.

Benefits of medical assistance

Some of the participants described how they had learnt from previous experiences that a substitute prescription was necessary to help them get through the physical withdrawals associated with abstaining from heroin.

Tommy: I couldn't have done this without methadone, I'm fairly sure.

Phillip described how he attributed a previous relapse to sleep deprivation caused by withdrawals, which he addressed through the use of valium.

Phillip: The main things I learnt from before are to get myself some valium and crash myself out. 'Cos that's what went wrong last time ... I wasn't getting any sleep so I couldn't function and I felt like a zombie. That was a massive part in my relapse.

3.2.2.3. Family support

For those participants who had contact with their families, the importance of family support was greatly emphasised. The three concepts that emerged were: ***motivation to change***, ***unconditional support***, and ***help breaking away from addiction culture***.

Motivation to change

Some of the participants described how their families had given them extra motivation to address their addiction and initiate recovery.

Phillip: My family are everything. They have motivated me.

Sally: I've always wanted to keep my dad happy because I'm a daddy's girl. And as soon as I saw that I was making him happy I thought, 'right, now is the right time', because of his support. And I knew I wouldn't be able to do it without his support. So I asked my dad 'will you help me?' and he said 'yes' and that was it.

Unconditional support

Some of the participants described how the unconditional support of their families had helped them feel able to initiate their recovery.

Don: Well my parents, they have gone through a lot of stuff with me. A lot of problems with my addictions before and they were still there for me to support me through it. I don't think they would ever turn their back on me.

Phillip: Me and my dad and my mum have always been really close. They have always understood me even when I've been really short tempered and moody and things like that.

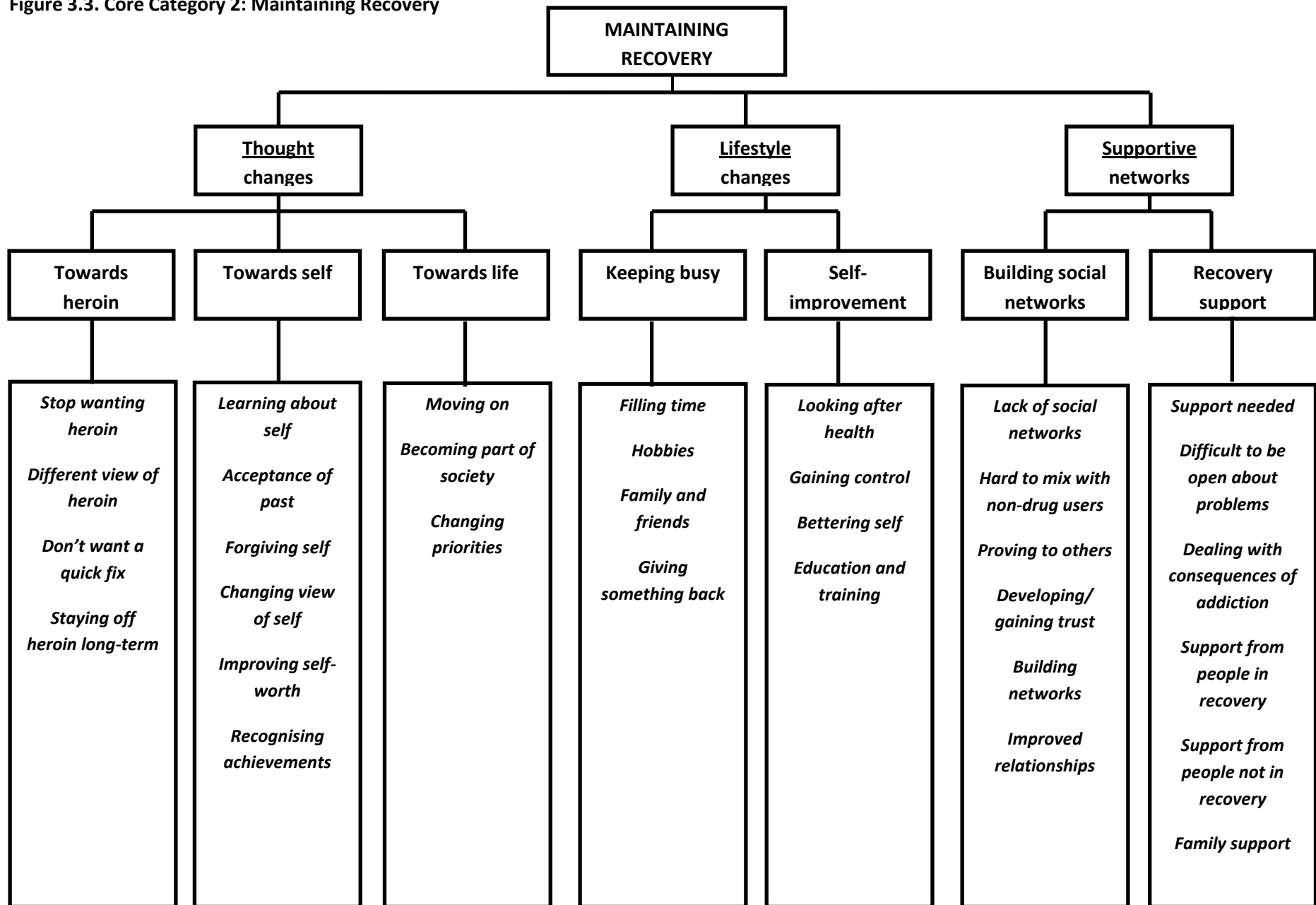
Help breaking away from addiction culture

The participants also described the role that their friends and family played in enabling them to break away from the addiction culture.

Sally: So I stayed with my dad for a few months until I got my house. And that helped me, being at my dad's, because he doesn't have anything to do with drugs so it helped to be away from all that and it helped to be around my family.

Rob: The person I stayed with was totally anti-heroin, anti-drugs really, so out of respect for her I wouldn't do anything around her. Maybe if it hadn't been for that then I would have used ... so I think that helped.

Figure 3.3. Core Category 2: Maintaining Recovery



3.3. CORE CATEGORY 2: MAINTAINING RECOVERY

This core category highlights the participants' views and experiences of maintaining their recovery from heroin addiction (see Figure 3.3). Three categories emerged from the analysis: thought changes, lifestyle changes and supportive networks.

3.3.1. Thought changes

This category considers the thought changes that participants described as important in maintaining their recovery. Three sub-categories of thought changes were identified: **towards heroin**, **towards self** and **towards life**.

3.3.1.1. Towards heroin

Participants described how they experienced thought changes towards heroin whilst in recovery, and how these helped them to maintain their abstinence. Four concepts were identified: ***stop wanting heroin***, ***different views of heroin***, ***don't want a quick fix*** and ***staying off heroin long-term***.

Stop wanting heroin

Many of the participants described how an important stage in their recovery was when they realised that they no longer wanted to use heroin, or that heroin no longer occupied their thoughts. This was described in stark contrast to active addiction when the participants described their lives as dictated by thoughts of heroin.

Don: But as time goes on it sort of gets easier and you begin to forget about it a little bit. So it gets easier in your mind if you know what I mean ... The main factor is that it has been so long now at the moment that I really don't miss it. As opposed to the first few months when you have just stopped and you really do miss it. But I think the longer you go without it the easier it gets.

Tommy: I think you get to a point when you have been clean for a certain amount of time that you want to stay clean. I don't want to go back on heroin.

Different view of heroin

The participants described how their view of heroin had changed, and they began to focus on the negatives of the drug. These thought changes helped them to maintain their recovery.

Kurt: Drugs will take everything from you. They take your dignity, everything. They strip you of everything. As well as your family, your home, your job, your self-esteem goes, everything. Everything that is right and nice. You become a horrid liar, cheat, dishonest, all the negative things in life. That's what drugs turn people into. I still see people using and ... I look at them and it reminds me why I'm doing this.

Sally: It ruins your life, it knackers your body up, its rubbish. Everything I've lost, the money that's gone is no one's business. I don't get emotional over it, though. If anything, I just feel anger towards it. I just don't want it anywhere near me ever again.

Don't want a quick fix

Some of the participants described how heroin had offered them a quick fix to some of their emotional and/or physical problems. However, since being in recovery their thought processes had changed and they realised that the quick fix of heroin was not helping them in the long run.

Adrian: I went through a lot of making excuses for taking it. Reasons why I could take it. Like I'm bad today so I need it to get rid of the pain but I won't need it tomorrow so it's OK just to have some today. And it was just an excuse. But then I thought, 'what am I going to gain tomorrow when I'm bad again?' 'Cos it's just going to be another excuse to go and use. So I had to fight that every time. That continued for the first 9-12 months ... But I didn't want the quick fix that was heroin. Now I don't look for a quick fix, I look for a permanent fix. This is what I'm trying to do now.

Staying off heroin long-term

All of the participants described how their thoughts towards the future required staying abstinent from heroin. Some described how they felt they had too much to lose now to ever turn back to using heroin.

Adrian: And then I think 'what about my future? What do I want to get from my future?' But then I just don't know. I just want to be clean and not have to worry about it.

Tommy: Now it's a matter of time. I should be off methadone by the summer and then I'll have been so used to being off heroin that it shouldn't be a risk for me. If things get difficult in the future I don't think I'll turn to heroin. I've got too much to lose now. I've got a nice place to live; I've collected all my books. I'm filling my life with other things and I don't want to lose them, so I won't use heroin again.

3.3.1.2. Towards self

The participants described a number of thought changes that they experienced towards themselves that they believed contributed to their ability to maintain their recovery from heroin addiction. Six concepts were identified in this sub-category: ***learning about self, acceptance of past, forgiving self, changing view of self, improving self-worth and recognising achievements.***

Learning about self

A number of the participants described how they learnt a great deal about themselves when they entered recovery, which helped them to continue with their recovery journeys.

Sally: Whereas before I didn't know myself. I didn't know what I wanted. I didn't know what I enjoyed. I didn't know what life I wanted. I didn't know anything. So now I am starting to get back in touch with myself. I think all those years on heroin I just lost track. I didn't know who I was.

Daniel: Recovery is when you find out about yourself. It's not what everyone else has been telling you, you find out who the real you is and what it's all about.

Acceptance of past

Some of the participants described how they had previously used their life experiences as a reason for using heroin, but they now realised that they had to accept the past to enable them to move on from addiction.

Adrian: I know getting ill wasn't good, but it's something that's happened. It destroyed my life and I couldn't cope with it. But now I cope with it because I have to. Because it's there and it's not going to go ... And it's kind of about understanding. Holding a grudge against someone doesn't affect them. It affects me. It was ruining my life, not theirs.

Others described how they had to accept some of the things they had done whilst addicted, and learn from them rather than letting them hold them back.

Kurt: It cost me so much. And I regret that, I made a lot of wrong choices and decisions. But I can't turn back the clock. What is done is done.

Forgiving self

Some of the participants described the difficulties they faced in forgiving themselves for some of their actions whilst they were using heroin. Forgiving yourself was portrayed as an important, but difficult, step in moving forward in your recovery.

Don: Like people forgiving me. At the beginning I found it really difficult to come to terms with it. It's got easier for me now, but still I get the feeling that I was bad and it's difficult to forgive myself. That gets easier. It started off being about the drug but then it's kind of become more about me and me forgiving myself and me moving on.

Changing view of self

A number of the participants described how their view of themselves had become more positive since being in recovery.

Sally: Recovery means a great deal to me, actually. I don't see myself as an addict anymore. I don't see myself as a junkie anymore. I see myself as a normal member of the community now and it's great. It means a lot to me to be at this stage. I thought I would never recover off it.

Melanie: In a way, the way that I view myself has changed ... It makes you a better person than what you are when you're on heroin.

Some of the participants described how they had noticed how their confidence had grown since being in recovery.

Phillip: I have started feeling more confident. More stronger. More strength in myself.

Improving self-worth

Many of the participants described how they had had low opinions of themselves as a result of childhood experiences, the consequences of addiction or a combination of both. Since being in recovery they had noticed that their self-worth had improved, which helped to motivate them to continue in their recoveries.

Adrian: Feeling as if I'm worth something is the hard part, 'cos I've always been told I'm useless and I would never amount to anything and that was drilled into me from when I was 6. That's a hard thing to beat ... It's [self-worth] getting more now that I've been in recovery a lot longer. I care about my health a lot more. And I care about my appearance a lot more. And I do my health properly. And I take my medication properly. And that's a good thing.

Don: I'm doing something. I have some sort of purpose even if it's not a lot but it's a vast improvement over what I used to be like. So it's a start. I've surprised myself really.

Recognising achievements

All of the participants described having times in recovery when they doubted themselves or their ability to sustain recovery. Some described not having expected to have to 'cope with so much' once in recovery, in particular the psychological and social difficulties that all participants described. At these times of self-doubt, participants described the importance of recognising their achievements.

Sally: And if you do get a day when you are feeling down, you just have to say to yourself, 'look, I might not have much now but remember a few months ago, it could be like that'. You have to keep building yourself up and reminding yourself how far you have come. And pat yourself on the back and say, 'yeah, I've done good'. Praise yourself 'cos no one else is going to. That's what I say!

Daniel: When I have a bad day I try and remind myself how much better things are and to give myself a break. My life is so much better and that's because I'm in recovery. When I have my self-doubt days I have to remind myself how much better things are. I remind myself where I would be if I hadn't put myself into college ... But you have to remind yourself that you are doing well and you have come far.

3.3.1.3. Towards life

All of the participants described changes in their thinking towards their life since being in recovery. Three concepts regarding thought changes towards life emerged: **moving on**, **becoming part of society** and **changing priorities**.

Moving on

Many of the participants described the importance of moving on from their life of addiction. Since being in recovery they were able to better understand what they wanted from life.

Kurt: 'Cos I think that when you're using you don't know what you're feeling, you don't know what you're thinking, you don't know what you're going to do, you don't know where you're going to end up, you don't know what your outcomes are going to be. But I do today. I have a fairly good idea of what I'm going to do and where I'm going to be and that.

Melanie described the importance of learning that there are ways of coping with life's problems other than using heroin.

Melanie: I've learnt that I just have to deal with things. I can't keep turning back to heroin every time I'm stressed ... I just have to deal with it. And every time I deal with something I get a bit stronger.

Daniel described how, in the longer term, he does not want his recovery to be the main focus of his life.

Daniel: I'll always be in recovery but I'm going to get to a point where I feel better and that will be different for me. I'll be in recovery but I will feel better. It won't be the main focus anymore. Life will take over and recovery will just be a part of it.

Becoming part of society

A number of the participants talked about how being in recovery had enabled them to feel like they could belong to 'normal' society.

Kurt: I'm beginning to feel human and part of society. Whereas when you use, you don't feel part of anything.

Sally described how initially it was very difficult to tell new people about her past. However, she learnt that she did not have to tell everybody, and that she could socialise with people from all walks of life.

Sally: You worry about whether you'll be accepted ... And then you learn from being around people that they can't tell just from looking at you. And then you realise that people don't need to know. That's your past. I was nervous at first, though. I thought I wouldn't fit in ... You do need to be around people if you can. Make a new group of friends, 'cos it will change your way of thinking as well. 'Cos it's not normal to be on drugs. But some people think it is. And when you've been in that lifestyle for so long it feels normal. So you have to relearn what normal is.

Changing priorities

A common thought change described by many of the participants was a shift in their priorities, in particular, putting other people first. This was often in stark contrast to their time in active addiction when obtaining heroin would often be their number one priority.

Melanie: But now, rather than spending £40-50 on drugs I would rather go out and spend it on my kids or the flat. So the way I think has changed ... my priorities have changed ... When I'm using I don't give a shit for no one. All I want to do is to be left alone to take my drugs. And now I have more time for people. And more time to sort out my life.

Gary: I used to just do what I wanted to do. It was all about me. But I prefer my life now because I'm connected with other people and I prefer having other people in my life.

3.3.2. Lifestyle changes

The participants described a number of lifestyle changes that they believed were pertinent in enabling them to maintain their recovery. These fell into two sub-categories: **keeping busy** and **self-improvements**.

3.3.2.1. Keeping busy

The participants described a number of lifestyle changes that helped them to keep busy, thus helping them to maintain their recovery. These fell into four concepts: ***filling time, hobbies, family and friends*** and ***giving something back***.

Filling time

All of the participants described the importance of filling their time in enabling them to maintain their recovery. They described how, previously, their addictions had consumed their daily lives, and how it was important for them to fill the gap left by their drug use.

Gary: So I was getting involved with things. That's what stopped me from using, really. I had a purpose. I had things to do day to day. Things to keep me occupied. So the times when I thought about drugs, I was already doing something ... Having something to do, especially early on, with other people, is very important, well it is to me anyway. It doesn't really matter what you are doing I don't think it's just the fact that you are there doing it.

Daniel: Its really helped me to cram a lot into the start of my recovery, like college and counselling. It keeps me busy and focussed and helps with my confidence. It's important for me to have my time filled and I'm going to keep on doing that.

Melanie described how she not only had to fill the time left by not using drugs, but also the void left since having her children taken into care due to her drug use.

Melanie: I'm so used to being a mum, so my time was devoted around my kids. Even though I was taking heroin, I was still looking after them and they wouldn't see any of that. They never came to no harm or anything. I'm so used to being around the kids, looking after them. Doing the housework. Cooking. So I was occupied. But now I have no kids with me, and obviously where my kids are is upsetting to me. I just have to keep strong and think of my kids. And hopefully I'll be doing the MILE project [a skills development course for ex-addicts] soon, so that will help.

Hobbies

The majority of participants described how spending time on old and new hobbies had helped them to maintain their recovery.

Gary: I realised when I was in prison how important music was to me ... I'd been straight for 2/3 weeks when I got my hands on some instruments in the chapel. And I couldn't believe how much I got out of playing it. I was on cloud nine for a couple of days after. I couldn't believe it. ... Music has been a really important part of my recovery.

Tommy: And I've got a hobby, well I've got lots of hobbies. But I bought a wooden model sailing boat which took about 8 months to do. So I was working on that 8-12 hours a day, 7 days a week. So I had that to do while I was staying clean, just to keep my mind occupied.

Family and friends

A number of the participants described how friends and family had helped them to keep busy and fill their time.

Sally: And it's helpful to have support from your family. And going out, maybe twice a week. Like me and my friend go swimming or go for a coffee and that really helps to have something to look forward to. Or going for a jog with a friend. Just trying to keep yourself motivated.

Adrian: I spent a lot of time with my brother and his wife. So I would go and visit them every day so I was busy. Have a chat. Have a cup of tea. So it was keeping my mind occupied.

Giving something back

Several of the participants described how they would like to use their experiences of addiction and recovery to help others affected by substance misuse. Many were currently engaging in volunteering activities to help them gain experience in the field of addictions. This not only helped to fill their time but provided meaningful and fulfilling opportunities that helped to maintain their recovery.

Don: And I volunteer with them once a week. I think it's given me a bit more confidence than I had. And it's obviously given me the opportunity to pass on some experience and knowledge and to share. You know, if I can help anyone through doing that, then I will be glad to do it. I think it has given me a purpose, whereas before I had limited myself to my bedroom and I was avoiding people. But now I have

the opportunity to go places and to meet people and to learn. Get some experience under my belt and hopefully work in that area in the future.

Phillip: But what I would like is to get involved with this service and to be someone who's been there and knows exactly what it's like and help others. 'Cos unless you have been there you will never understand ... And I'd like to try and help people who are in my position.

3.3.2.2. Self-improvement

The participants described a number of ways in which they have improved themselves since being in recovery. These were arranged into four concepts: ***looking after health, gaining control, bettering self*** and ***education and training***.

Looking after health

Some of the participants described how, since being in recovery, they had begun looking after their health. This had helped them gain strength and maintain their recoveries.

Sally: If you had seen me when I was flat out – it was sad. There's a hell of a difference. I would be covered in spots. I would only be six stone; I was skin and bones ... I was a mess. I used to think I looked alright – but nope! Hell of a difference now.

Adrian: So I need to keep going as I am. I'm sure the drugs didn't help at all [with ill health]. But if I keep on the straight and narrow now, then hopefully it will help my health.

Gaining control

Nearly all of the participants described how an important part of maintaining their recovery was gaining control over numerous aspects of their lives, as well as control over their drug use.

Melanie: 'Cos if I did use heroin, I wouldn't have got all the stuff that I needed to get sorted done today. 'Cos I would have other things that I had to do to get drugs rather than go to the meetings I had to attend. Now I've got organisation and control in my life. If I'm on heroin, I'm not going to go and attend the meeting you want me to go to, simple as. When I'm not on heroin I will attend it.

Tommy: It's got to the point where I feel more in control. I won't relapse. I don't want to relapse ... Heroin will ruin your life, but in recovery you can get control of your life.

Rob also described the importance of feeling in control of his suboxone reduction.

Rob: Being in control was a big thing. I controlled coming off the suboxone more so than the advice from the doctor. I did it how I wanted to do it – what suited me. I took it down when I wanted to take it down and if it didn't feel right I would go up a bit. I knew how I felt and what I needed.

Bettering self

All of the participants described how lifestyle changes had led to improvements in their lives, and this in turn helped to motivate them in maintaining their recovery.

Phillip: I can do things now. I've built my son an extension so he has his own room ... These are things I never would've been able to do before.

Daniel: And since I started college I have had something little every week to prove to me why I am doing this. Like passing my exam last week was a right ego boost and those are what keep me going.

Education and training

All of the participants talked about the education and/or training opportunities that they were pursuing. These opportunities helped to fill their time, boost their self-worth and led the way to self-improvement that would enable them to achieve the life goals that many of them had set themselves.

Don: And I think there has to be an end goal. Something you want to do, so you are focussed on it. Like getting into education, or getting back into work – whatever that person wants to do. I think it's important to have something to aim for. I really do think it is important to have something to aim for because that's what keeps you focused.

Adrian: I am trying to do a college course and get some education ... so I can do an access course and then I can study for a few years and I'll only be 35/36 and then maybe I can have a job. I want something out of my life ... I don't want my legacy to be that I'm disabled and sat on my arse all the time. I believe that I am worth more, and it's taken a long for that belief to come.

3.3.3. Supportive networks

All of the participants described the importance of having supportive networks to enable them to maintain their recoveries. Two sub-categories related to supportive networks were identified: **building social networks** and **recovery support**.

3.3.3.1. Building social networks

The development of social networks was identified by all of the participants as crucial in maintaining recovery. Six concepts were identified relating to building social networks: ***lack of social networks, hard to mix with non-drug-users, proving to others, developing trust, building networks*** and ***improved relationships***.

Lack of social networks

All of the participants described how they had to leave behind their drug using social networks when entering recovery, which left them with little or no social network, especially in early recovery. Many described how difficult this was for them, and at times it seemed to threaten their recovery.

Daniel: I don't bother with any of the friends I used to have and I don't know anyone round here who doesn't use drugs. I had to stop people coming round to my flat and that was hard 'cos I've been out of work for ages and I was just sat at home on my own. So it was hard saying no to people coming round when you haven't had company for ages. But if you say yes for the company you are pretty much going to use so you have to say no. But that means that you are on your own a lot of the time and that leads to a bit of loneliness, a bit of self-doubt, never mind the anxiety.

Adrian: I'd like to meet with people once or twice a week. As much to keep my mind busy as possible. And to have a social network. Someone to phone up and say "are you busy today, fancy meeting for a coffee", just something simple like that. Not going to a pub or anything. Just something simple. Anything that breaks the monotony of being sat there thinking, 'I'm recovering from drugs'.

Hard to mix with non-drug-users

Nearly all of the participants described how difficult they found it to mix with non-drug-users. Some felt desperate to hide the fact that they were in recovery, whilst others worried about what they would have in common with non-drug-users.

Adrian: I can't mix with normal people at the moment because I feel like I'm lying. Like when people say, 'have you done this? Have you done that?' and I feel like I have to say no, so I am always hiding things from people ... So it's very difficult to get a social network without drugs, 'cos I know you don't have to tell everybody, but I don't want to build any new relationships on a lie 'cos that's what I did when I was on drugs and I'm trying to change those ways and build on my recovery.

Sally: It's weird learning to do non-drug things. I didn't think I would be able to mix with people. I didn't think I would be able to sit with them and talk to them 'cos I

didn't think we would have anything in common. And what do you talk about? And I thought that they would look at me and know that I used to be on heroin. And I used to just worry.

Proving to others

Several of the participants described how they felt it was important and/or necessary to prove to others that they were maintaining their recovery.

Adrian: The first year was really difficult 'cos you have to prove to everyone else that you are doing the right thing. You have to prove it to people. And I still get judged to this very day and I still have to prove it to people, and this is five years on.

Daniel: My relationships with my family are still sour. They just don't believe ... But I'm going to go up there at Christmas and show them my papers [negative drug tests]. Just so that they don't worry.

Developing/gaining trust

Some of the participants described having experienced difficulties with learning to trust other people, whilst some described how they noticed that people have been placing more trust in them.

Sally: But then the friends you have when you are on the heroin are just using you anyway, they aren't really your friends. You can't trust them. So it's been weird for me to have proper friends. I'm expecting them to pinch off me and stuff like that. And they don't! And I'm shocked! I think it's part of the change that has to come. You have to realise that there are good people out there. They aren't all bad.

Don: People place a lot more trust in me than they ever did before.

Building networks

Despite the difficulties they experienced concerning being able to mix with non-drug users, several of the participants described how they had been able to build social networks.

Daniel: No one in college knows I used to be a junkie and when I'm talking to these people I sometimes realise that I'm having a normal conversation with a normal person and that's something that I haven't done for years and years. Stuff like that amazes me and makes me want to keep going.

Gary also described how he has found support from other people in recovery very valuable.

Gary: [groups have been important for] making some very important friendships, I suppose, and connections I have made with other people.

Improved relationships

The majority of the participants described how they had seen drastic improvements in relationships since being in recovery, and this gave them more strength in maintaining their recovery.

Sally: Oh, it's brightened up so much. I'm talking to my brother on Facebook now and that's the most me and my brother have ever spoken ... My dad's got his own set of keys and he comes and goes as he pleases. Me and him are great. We went out together last weekend and it was great. Me and my cousin meet up and go for lunch which is great, every Tuesday. I didn't have no relationships before. I would never have seen my cousins. But now I have all their phone numbers. And I'm seeing my cousin's kids. And they love me, they don't leave me alone.

Don: I'm rebuilding my relationships with my family. With my sister and with my brother which were like non-existent when I was using. And my sister would obviously never let me around her children 'cos I was always hammered or high or untrustworthy but now they visit me quite often ... So it's pretty good at the moment. Definitely. I'm glad I did it.

3.3.3.2. Recovery support

All of the participants talked in detail about the importance of having support in their recovery. Six concepts were identified: **support needed, difficult to be open about problems, dealing with the consequences of addiction, support from people in recovery, support from people not in recovery** and **family support**.

Support needed

The participants all highlighted the value of having support in their recovery.

Sally: I have my days when I think, 'I can't do this'. And I would think, 'am I doing the right thing?' If it wasn't for the help and support of [support worker] I don't know where I would be. She's only on the end of the phone if I get down days so I can always ring her up and talk to her.

Melanie: When I'm lost and feeling down I can come here [drug service] and get some support. That's really important.

Difficult to be open about problems

Some of the participants described how they found it difficult to be open about their problems, despite also recognising the importance of gaining support with their difficulties.

Kurt: And sometimes I don't tell others if I'm struggling. That's my pride, you're a man and you should be OK. I've always been the joker at a party. People can look at me and on the outside I might be OK, but on the inside I will be in bits. And I won't tell them that.

Gary described how helping a friend with difficulties also helped him to open up about his feelings.

Gary: I think I got through it [death of a friend] through supporting [a friend], because he really had a tough time. He was talking about his feelings with me and so I was able to talk through mine at the same time. So I think that really helped.

Melanie talked about the difficulties that parents can face in being open about their problems, for fear of having their children taken away from them.

Melanie: I know someone whose kids are in care. She uses heroin on and off but she can't go and get help for it 'cos if she goes to her doctor and asks for a methadone script social services won't give her back her kids. So it is harder for women, especially when they have kids involved. Rather than thinking it's good that you are getting support, social services use that against you. So you don't get many people coming forward saying 'I'm a heroin addict' when they've got kids, 'cos they are scared of social services. But we need the support. It makes it worse if we are hiding it.

Dealing with the consequences of addiction

The majority of the participants described the importance of having help with dealing with the consequences of their addictions, for example the activities they had engaged in to fund their habits.

Sally: Just 'cos you're in recovery doesn't mean you don't need help. You might need to see people more. You might have a lot of things come into your head that you need help dealing with. There's a lot of stuff that comes up that the heroin was blocking out. It's important to have help in recovery ... Doing the things you do when you're on that stuff is going to affect you.

Phillip: 'Cos out of all my friends I'm the only one left alive. I've buried 11 of my mates. A friend of mine died in my arms – things like that I had to deal with them all of a sudden ... Mainly emotions.

Support from people in recovery

Nearly all of the participants described the value of having support from other people in recovery, including having a shared experience, not being judged and learning from one another.

Rob: I found it helpful to read people's posts on the internet about what to expect when coming off suboxone – it was helpful as I didn't feel alone and I knew that what I was experiencing was normal.

Don: I guess there could be a disadvantage if other people are going through the same thing then you may get tempted by each other, but there's an obvious advantage as well 'cos you are all going through the same thing so you can all support each other. There's pros and cons but mostly it would be beneficial.

Support from people not in recovery

Some of the participants also described the importance of having support from people who were not in recovery. The opportunity to have relationships not associated with their recovery was perceived as a positive thing.

Gary: Then I started playing [music] with these other two guys and we've got a little band now. They are just guys who are musicians. They aren't anything to do with my old life, and they aren't anything to do with the recovery side of things. I think it's important to have a mixture in your life of people who are in recovery and those who aren't, otherwise you become ghettoised.

Phillip: I've got one or two friends who will call in, but they weren't users. They will call in for a coffee ... I don't mind them coming round. They don't sit down and talk about drugs. They will sit down and say, 'what did you think about Liverpool on Saturday?', you know, general things. 'Cos I like football, rugby, most sports. And it's nice to have those talks.

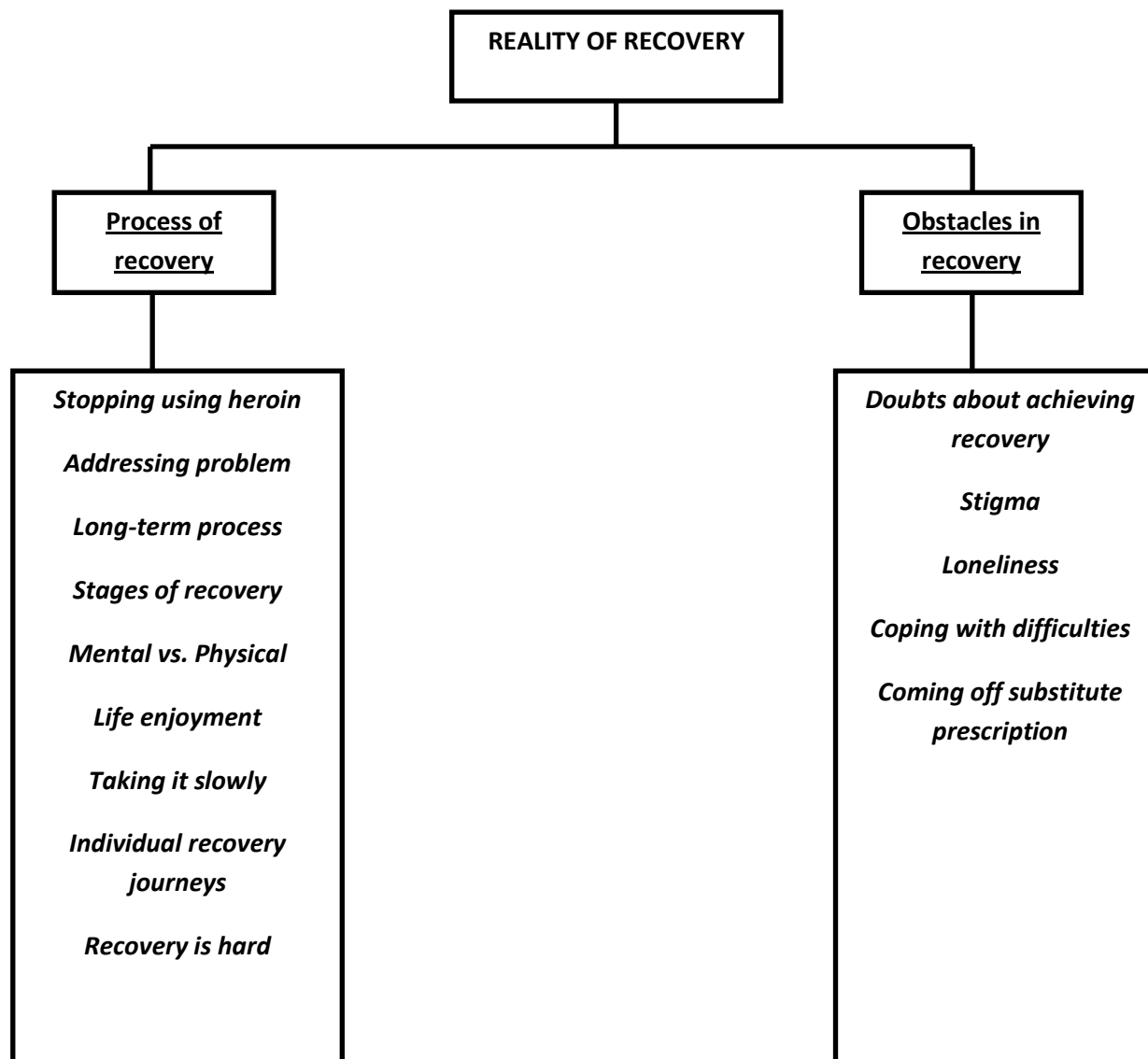
Family support

Those who had received support from their families perceived this as a valuable source of support.

Sally: Basically, I knew I needed my family's support. They aren't here all the time but I know they are only around the corner and I can get help from them anytime.

Don: People need family support. That's if they've got family, or concerned others. Definitely helps to have the support – it gives you extra motivation 'cos you want to change and be a better person for them as well ... Knowing that they are there. Talking to them. Having a place to live. Just support like that.

Figure 3.4. Core category 3: Reality of Recovery



3.4. CORE CATEGORY 3: REALITY OF RECOVERY

This core category describes the participants' general views and experiences of recovery from heroin addiction (see Figure 3.4). Two categories were identified from the analysis: **process of recovery** and **barriers to recovery**.

3.4.1. Process of recovery

This category considers the participants' views and experiences of the process of recovery from heroin addiction. Nine concepts were identified: ***stopping using heroin, addressing problems, long-term process, stages of recovery, mental vs. physical, life enjoyment, taking it slowly, individual recovery journeys*** and ***recovery is hard***.

Stopping using heroin

The majority of the participants described how their recovery started when they stopped using heroin. They described how stopping using was not just a physical process, but required a change in thinking as well.

Adrian: The day you wake up and tell yourself that you don't want to take drugs no more. That's when recovery starts. When people tell you that you should go to rehab, or when people force you to go to drug treatment, it means absolutely nothing. When you say 'I've had enough', that's when recovery starts.

Tommy: It's when you do your first day without using through personal choice ... it starts with that first day when you get through without using.

Addressing problems

Nearly all of the participants described the start of recovery as being defined by asking for help and/or making changes in their lives.

Gary: But I don't think it's just when you make the decision, because I decided loads of times and I wasn't in recovery before. It's when you actually go ahead and do something about it. You go and see someone ... When you do something, it starts. It's more of a mental thing than a physical thing. Some definite change has to have been made.

Adrian: Recovery starts when you first ask for help. Because that's a big step. A very big step.

Long-term process

All of the participants described recovery as being a long-term process. This was often in contrast to what they had been expecting. Many described having anticipated the physical battle of coming off heroin, but they had not expected the psychological and social impact. Furthermore, they had not expected the amount of time that it took them to deal with, or learn to cope with, the psychological effects of coming off heroin and having to make the necessary lifestyle changes and improvements.

Don: it's a long journey emotionally and physically.

Daniel: At the start, once you have not used for a week, it feels like you have been clean for about six months and then you start to think, 'whey, it's all behind me'. You're talking like its six months down the line but it's only very early. And then you realise that it's only been a short space of time and there are loads of other things you have to deal with, not just not using. And that can be hard.

Stages of recovery

All of the participants believed that there were different stages to the recovery process. Although the stages they described did differ somewhat, there were many similarities. In particular, at the start of recovery the participants described the greatest challenges being drug related, especially staying abstinent and breaking away from the addiction culture. Then, as their recoveries continued, they described more psychological and social challenges such as dealing with the consequences of addiction, or the reasons they had initially begun using drugs, and developing positive social networks.

Sally: You have to get used to settling into a different lifestyle and that is hard at the beginning. And then you get to the level where you are comfortable but sometimes it will trigger off, but you are at the stage where you think, 'I've done so well now I don't want to throw it all away by using'. Then after that comes the stage where you don't think about it. So I think there are three different stages ... I didn't look at it as stages but now looking back I can see that there probably was stages that I was going through.

Adrian: I define it as growing up. That's how I'd put it. You start with baby steps when you are focusing on not using and you have to slowly work towards adult steps where it's about sorting your life out and dealing with the consequences of the addiction and how you feel and stuff. You've got your toddler steps when you have a little bit more trust in yourself, then you have your junior steps and then your teenager steps. And at each stage you get a bit stronger and you have dealt with things a bit more and you have got your life sorted that bit more.

Most of the participants described how they saw an end point to recovery, where they would be recovered.

Rob: I class myself as over it. I'm recovered now. Absolutely recovered ... I would say I was recovered when I came off suboxone. Say a month after I took my last suboxone. I felt then that I had done it. I no longer felt any residual off the suboxone. There was no more withdrawal effects. Once they had gone, after a month, I felt that I didn't need it anymore. I was recovered.

Sally: I can't see myself being in recovery forever. Not for too much longer, really. I think I'll be recovered when I am totally off my methadone and I haven't touched anything. I will class myself as being recovered when I am off the methadone and I know what is going on in my life.

Mental vs. physical

All of the participants highlighted how the psychological and social aspects of recovery are often overlooked, and the main focus is usually on the physical aspects of recovery. However, in the participants' experiences, the psychological and social factors were just as important, and as difficult to overcome, as the physical factors.

Melanie: 'Cos once you have done the physical side of withdrawing you've got the psychological side and that's hard.

Phillip: At the beginning all you can think about is not using. But you are prepared for that 'cos you know it's going to be shit ... But then you get hit with all this other crap. And you're not expecting that. All of a sudden I was having all these emotions and I didn't know where they were coming from. It was like being on a rollercoaster. And on top of that I was all by myself ... I had no one to talk to. I couldn't leave my flat in case I bumped into someone and used. And the state I was in, with all those emotions flying round, I wouldn't have had the strength to say no. So yeah, it was really tough. Lots of things to deal with. Lots of things I hadn't expected.

Daniel: People used to talk about recovery and I didn't really listen. I just thought, when I'm clean I'm clean. But it's more of an issue than I ever thought it would be. I didn't realise all the other stuff I would have to deal with, not just getting clean ... I did need a lot more help for coming off the drugs. It's not just about stopping using. The heroin makes you feel invincible and when you haven't got it there anymore you have to deal with that yourself and all the negative thoughts that come in and the self-doubt. If it wasn't for the counselling, I would be a wreck now in college. In fact, I probably wouldn't have got this far.

Life enjoyment

All of the participants described the importance of life enjoyment in defining recovery. For some this was being able to do 'normal' life tasks and wanting more from life, rather than having their lives dominated by their drug addiction.

Phillip: It means everything to me. It means that I've got my life back. I can get up in the morning without feeling ill. I can help my dad. Do all the housework. I do everything now, the hoovering, polishing, dusting, getting everything sorted for my son like his packed lunch, getting him to college, washing his bedding, ironing his clothes. It sounds stupid for a man, but I wasn't able to do these things before and I want to do them now.

For some participants, recovery was defined as enjoying life more.

Gary: I wouldn't define it as anything to do with substance misuse. I would define it as improving your life and a general enjoyment of life without drugs. That's how I'd define recovery.

Taking it slowly

The majority of the participants talked about the importance of not rushing their recovery, and taking things at a slow and steady pace to minimise the potential for jeopardising their progress.

Phillip: Then I realised there's no point in rushing it, I just had to see it through 'till the end and that's what I've done.

Melanie: There's loads of things I'd like to change, but I can't change them over night ... don't expect any miracles, just take each day one at a time. You can't push things. It's like everything else in life you just have to go at the pace it's going.

Individual recovery journeys

Most of the participants talked about the importance of recognising that each person's recovery is an individual process, and although it may share some similarities with other people's journeys, each person will experience different things.

Adrian: And there are just different ways to find a route to recovery. You have to figure out what's going to be easiest for you.

Gary: I think lots of people have completely different recovery journeys to me ... You may be in what someone else would class as early recovery for a couple of years,

whereas someone else may already be in a later stage after a year. Everyone is different. It has to be individual.

Recovery is hard

All of the participants identified that recovery is a very hard process, filled with physical, psychological and social battles throughout the journey.

Adrian: I thought recovery was going to be like a magic wand. But it's not. It's a lot of hard work. Very hard work. With recovery you have to always find new ways ... It's sometimes like running up a hill and it's made of ice and you sometimes fall over but you have to get yourself back up and dust yourself down and keep going.

However, some of the participants noted that recovery was not as hard as they expected.

Don: I thought it would be hell to be honest. But with support it's not as bad as you think ... It was different, sort of easier than what I expected. I could never envisage a time when I would be free of heroin, but then when I was it was easier than what I thought it would be ... The first few months is difficult, physically and emotionally. But then it gets easier, a lot easier, I think.

All of the participants noted that although recovery is hard, it was worth it.

Melanie: Life's much better now than when I was using, 'cos I'm maintaining a normal life, whatever 'normal' is. This life is much easier, I'm not getting arrested every week, in and out of courts for shoplifting. This life is much easier. Much better ... It's hard, but it's positive. Being in recovery is better than being a heroin addict.

Kurt: You're worst day clean and sober is better than any day using ... Recovery is tough. It's a lot of hard work, but it's worthwhile. I wouldn't change what I have today for a pipe of pure Bolivian flake coke or top quality heroin.

3.4.2. Obstacles in recovery

The participants described a number of potential obstacles that they faced throughout their recovery. Five concepts were identified: **doubts about achieving recovery**, **stigma**, **loneliness**, **coping with difficulties**, and **coming off substitute prescriptions**.

Doubts about achieving recovery

Some of the participants described how they had had doubts about whether they would ever be able to stop using heroin and achieve recovery.

Sally: I thought I would never recover off it ... I thought I would go on for years stuck in a rut ... I also had my fears that it wouldn't happen and it would be something that I always wanted.

Tommy: I didn't see how I was going to get off it. I can't believe I have got to this point.

Don described how fears about being able to get through the physical withdrawals of abstinence from heroin made him doubt whether he would be able to address his addiction.

Don: I could see them going through withdrawals and stuff and I could see it was pretty difficult, pretty horrible ... The reason I kept on using was because I didn't want to go through the withdrawals without being medicated. So definitely that was a big factor. That's a huge reason why people continue to use. They don't want to get sick.

Stigma

All of the participants talked about the stigma that they had experienced since being in recovery.

Adrian: So it was kind of difficult for the first two years that I was on methadone, because I didn't want to mix with people because there's a stigma attached to that still. So for two years I just stayed in the house and only went out when I had to and got pretty depressed ... People want to get educated, but because of the stigma of drugs it's hard, even when you are in recovery or recovered.

Melanie described how she experienced the negative consequences of stigma from her mother.

Melanie: But you will always get labelled whether you've been clean five days, five months or five years. I was clean for three and a half years but I still got called a junkie by my mother. I was clean. I was living with her. She could see that I wasn't using. She used to pick my meth up for me. But she still thought I was a junkie.

A number of the participants had also experienced stigma from professionals, which they described as an obstacle in their recovery.

Phillip: It's frustrating when stigma continues with you into recovery. I was begging with my doctor to prescribe me valium [to cope with death of mother] and they wouldn't. I tried to kill myself that night and prayed to God that he would put me out of my misery.

Melanie: Social services don't look at us as people, they look at us as addicts. Just 'cos we have used heroin doesn't mean I'm not human.

Loneliness

As previously discussed, all of the participants described how they had distanced themselves from their drug using social networks, which often left them with little or no social support available. As a result, they all described struggling with feelings of loneliness during their recovery.

Adrian: The most difficult part at the start was just being so lonely 'cos you have to disconnect yourself from everybody ... that's the hardest part of recovery. Trying to build bridges. That takes a long while.

Phillip: All I have at the moment is my sons, my dad, my dogs and the gym pass. A big change to when I was using and I had loads of people in my life.

Kurt: But I do find sometimes that I get lonely. And the sadness can come through. I can shed a tear at night sometimes, thinking, 'God, I miss my family'.

Coping with difficulties

Most of the participants described life difficulties that they had faced during their recovery, and how they managed to get through them without turning to heroin.

Gary: I found it very difficult with my mother's death. I suppose that's been my main difficulty over the past two years, watching my mother die. But that again tells me what good would I be doing if I got myself a habit again? What good would that do for my mother? It wouldn't do her any good.

Sally: I had a miscarriage not so long ago ... And my dad and step mum were on holiday and I was really lonely. I had this girl's phone number in front of me, I could have rung her and she would have brought it [heroin] to me. I was that close but I thought I would ring [my support worker] first and I told her. I said, 'look, I'm really tempted to do it' and she understood because of everything I was going through at the time. But she talked some sense into me and told me, 'obviously you're upset but you don't want to be doing that 'cos it will mess up everything you have been doing so far'. And I knew she was right I just needed to calm down a bit I think.

Daniel described how getting mugged at knifepoint had led him to think about using heroin, however, he sought counselling and found that he was able to cope without turning to heroin.

Daniel: I was mugged by knifepoint just before I started college. That was really hard but it helped to talk to someone here to deal with the anxiety, 'cos I was in a hell of a mess ... I struggled with wanting to use but I kept on saying to myself, 'you've got college coming up don't ruin it'. That was a tough time. And having no one to talk to about it. That's what led me to get counselling.

For some of the participants, life difficulties led to relapse as they had not developed effective coping strategies at that point.

Phillip: If it hadn't been for my mum dying I would've stayed clean, 'cos I was only on 2ml of subutex ... I was suicidal when my mum died. I was going to end it all. I just wanted to give up ... I felt like the only thing I could do was use heroin ... It helped numb things, the guilt that I feel and the blame for my mum's death, it helped to numb that.

Coming off substitute prescriptions

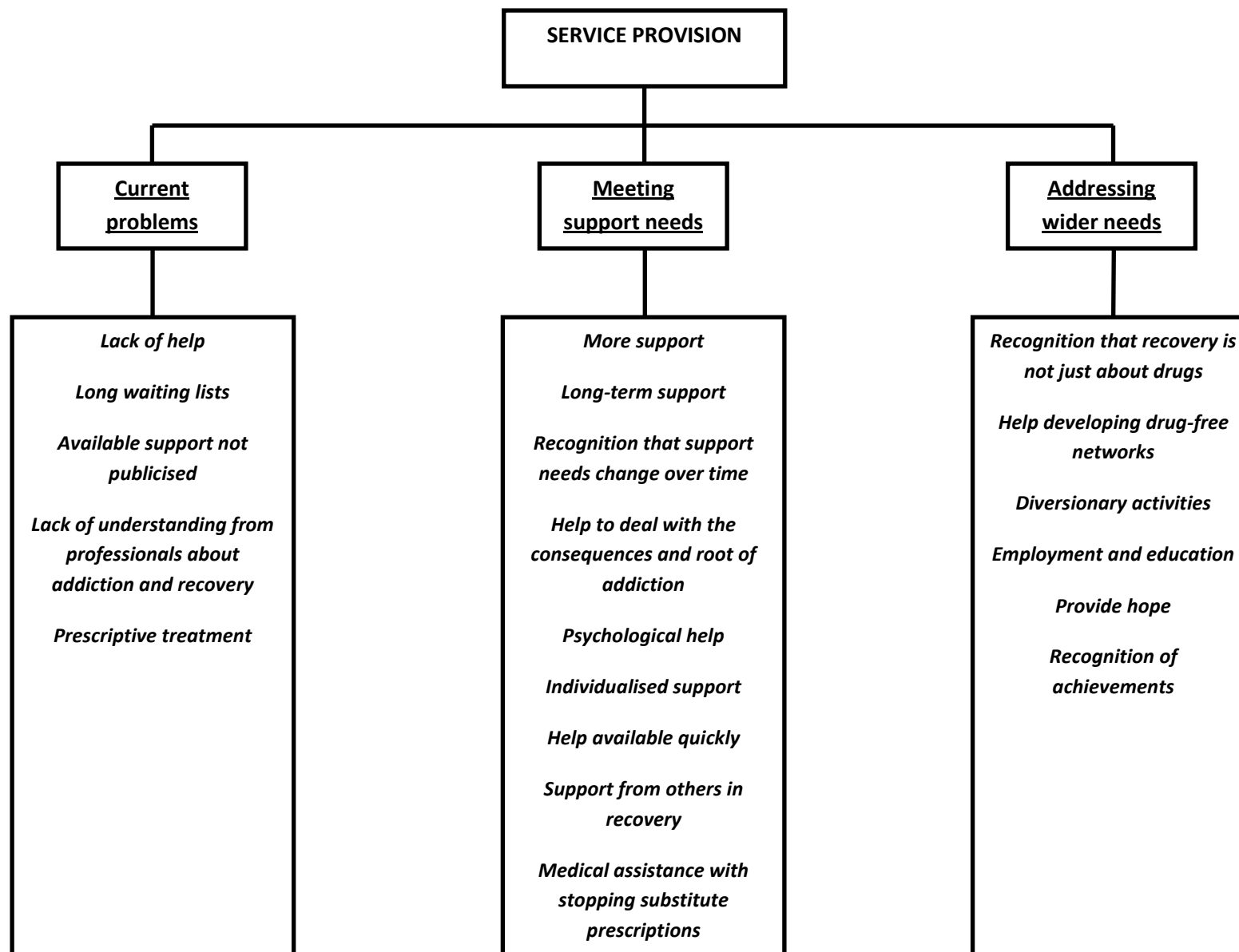
Some of the participants who had experienced reducing their substitute prescriptions described what a difficult time it was during their recovery.

Phillip: In the last couple of weeks when I have been coming off the subutex I have felt really weak and low. I haven't even been able to go to the gym. Slowly it is wearing off, but it has been really hard. But it's a bit like, you've been clean now for years, you're through the rest of it so people don't really realise how much you are struggling. It's OK to struggle when you come off the gear. But not really when you come off your script. But it is just as hard. In different ways really. But there's a bit less support and people don't seem to think it will be hard – when really it is.

A number of the participants described experiencing severe difficulties with their sleep when reducing their substitute prescriptions, in particular when on lower doses and when stopping.

Tommy: One thing that would have been helpful would have been being able to get hold of valium around the time I was reducing, 'cos your sleep patterns go haywire and that can be really difficult after five days or more ... But if there was something they could do to help, that would be great as it's a really risky time when you are reducing.

Figure 3.5. Core category 4: Service Provision



3.4. CORE CATEGORY 4: SERVICE PROVISION

This core category highlights the participants' views on the current services available for people in recovery, and how these could be further developed (see Figure 3.5). Three categories were identified: current problems, meeting support needs and addressing wider needs.

3.5.1. Current problems

All of the participants described a current lack of support available in the South Wales area for people in recovery from heroin addiction. Five concepts were identified: ***lack of help, long waiting lists, available support not publicised, lack of understanding about addiction and recovery, and lack of respect for service users.***

Lack of help

Each participant described the lack of support available for people in recovery. They also highlighted how people in recovery commonly need support to deal with the difficulties they are experiencing and to help them to move forward in their recoveries.

Adrian: I was desperate for someone to talk to. And I had no help and no one to talk to ... But if I could've got some support from somewhere – somewhere I could've gone to see someone or maybe even someone coming out to the house to talk to me – that would've been brilliant. But that help wasn't there ... I had support but the support at that time was every two months, and only getting that chance to speak to someone is really hard. Especially when so much is going through your head every day, to only talk to someone once every two months – well I wouldn't stop talking for the hour.

Melanie: They used to have staff there and you used to have to do group work and one-to-one. But now if you feel down or depressed, or you feel like using, they don't have the staff there for you to talk to. If you want to go and use they don't care. They are only there to prescribe your methadone and take your mouth swabs. They aren't there to provide you with any support ... they wonder why people are relapsing, but it's because they haven't got the support there for them.

Long waiting lists

All of the participants described how they had experienced long waiting lists for receiving help, which they believed had been detrimental on their addiction and recovery. Commonly,

the participants described how treatment needed to be readily available to capture the person at the right time when they are feeling ready and able to address their problems.

Adrian: It's really important that when people want help it needs to be there for them. There is no point making them wait for months and months – it's no good for them. Waiting hindered and slowed my recovery down. I could've been off all the drugs by now.

Tommy: It took me a year from when I got in touch with [prescribing service] before they actually did anything. If they had helped me straight away I could have been clean a lot earlier ... The trouble was, by the time I had spent an extra year of taking heroin I was more immersed in the life so it took a lot to leave that. During that time I did something wrong – I took out a bank loan 'cos I was so scared about getting ill. I shouldn't have done that, but I did and I'm still paying that off and will be for a long time. Perhaps if the help had been available I wouldn't have done that.

Rob noted that if you break the law you may get fast-track treatment, which he believed was sending a message out to heroin users that committing crime would help them to address their addiction.

Rob: It's crazy – you have to wait months and months for treatment unless you break the law and then you get treatment quickly. If I ever need treatment again, I will smash a window and hand myself into the police. It's crazy, but that's the only way you can get quick treatment.

Available support not publicised

Nearly all of the participants described how there was a lack of advertising about the services that are available for people in recovery. This meant that they often 'stumbled' upon recovery support, rather than being signposted to available help.

Phillip: I don't know if there is enough information available for people who are in recovery. 'Cos before I got involved in all this I didn't know any of it was here. But I think that what could help a lot is that if people go to their doctors instead of being looked down at and made to feel like scum, they could be pointed in this direction.

Kurt: They could advertise a bit more. 'Cos I don't see a lot of advertisements for recovery. You always see the bad things about it. Never any good about drugs, you know, about how, such and such is doing well, they've helped so and so change their life. So I think advertising could help ... They need to advertise that recovery is possible and let people know what services are out there ... They need to say, 'Listen, recovery is possible, let us help you to give it a try'.

Lack of understanding from professionals about addiction and recovery

Many of the participants had not encountered professionals who had a comprehensive understanding of recovery, including understanding how their needs differ from those in active addiction, and how to properly support people in their recovery.

Tommy: Then there's the period of learning to get through a day without using. And that's a big step and I'm not sure services realise what a big step that is. Then you need to build that up to two days, then three etc. and that takes time to get used to those extended periods of abstinence. Services seem to think that as soon as you start using methadone you can stay clean from that day on. But that's not the case. You have to change your lifestyle and you have to get used to not using it. Change your routines. Change everything. Because heroin is a real emotional crutch as well as a lifestyle thing.

Melanie described how difficult it is to have to regularly attend a service to undergo drug tests when current heroin users also attend.

Melanie: I don't see why they should put someone who is clean in the same place as loads of other people go who are still using. That's not good. I don't need to be around it when they are all talking about heroin and stuff. They shouldn't put that person in that predicament. 'Cos then you are interacting with the other clients who are still taking heroin and then they are putting you in a vulnerable position when they are meant to be helping you to maintain a drug free life ... It's like waving a bottle of vodka in front of an alcoholic. It makes it really difficult to stay clean. Especially if you are having a bad day – it's not good to be around that temptation.

Prescriptive treatment

The majority of the participants described how their treatment experiences had been very prescriptive since they had been in recovery. Some thought that this may be because professionals have more experience of working with active drug users than people in recovery. The participants described how people in recovery can be 'tarred with the same brush' as those in active addiction, and have treatment 'done to them' rather than being supported in taking responsibility for their recovery.

Gary: Finding out what the people who are using the services want from that service and actually giving them treatment appropriate to what they want rather than what the treatment service wants. Start to treat service users as adults rather than as naughty girls and boys.

Adrian: You need that bit of support to go in the right direction to do what you want to do. You don't need someone doing it for you, you need someone there to like hand

out the leaflets and say, 'here's your responsibility, here's the leaflets now you go and phone them up', like the teenager going into being an adult. And then people respond a lot better. That would've helped me a lot more.

Melanie described her positive experiences of receiving a respectful service.

Melanie: Just the staff, they don't judge you. They don't look down their noses at you. They don't look at me funny just 'cos I used to be a heroin addict ... they don't treat you like that here ... they keep an open mind and don't judge you for the mistakes you've made in life.

3.5.2. Meeting support needs

All of the participants described in depth how services could be developed to better meet the needs of people in recovery. This section will consider their views, which have been organised into nine concepts: ***more support, long-term support, recognition that support needs change over time, help to deal with consequences and root of addiction, psychological help, individualised support, help available quickly, support from others in recovery, and medical assistance when stopping substitute prescriptions.***

More support

All of the participants identified a need for more recovery focused support.

Sally: I think the services need to be more hands on with recovery clients. 'Cos a lot of the clients might think that they aren't having any attention paid to them, but when they were using they were having loads of attention ... It shouldn't be, 'oh you're in recovery now, great, see you in whenever' because that's not enough. Just 'cos you're in recovery doesn't mean you don't need help.

Adrian: I think the support is there but it is limited. I think once you have been in recovery for a certain length of time you are forgotten. Well, not forgotten, but rather than them seeing you every two weeks, they see you every eight weeks or every three months, but it feels like they are leaving pieces out that need to be dealt with. And that's what I think would be helpful is like groups, having something like after support for when you are clean and ready to move on. There should be someone or something that you can contact if you are having some problems and you just want to meet with someone for an hour and have a bit of contact, or get something off my chest, or just to tell someone that I'm craving and I don't know what to do. There could be a drop in centre or something.

Long-term support

All of the participants stated that recovery support should be available on a long-term basis.

Gary: Any service needs to get out of the mentality that treatment stops when the pills stop ... There should be a period of transition when you are handed over to an aftercare provider of some sort. There needs to be something. Someone who can say, 'you can do this, you can do that, there's this going on, tell them about [recovery support]'. There needs to be long term support which helps people with social, emotional and practical support ... There should be some period when they are still being monitored by the treatment service. To make sure that they have stabilised in their recovery.

Kurt: Services need to see the individual frequently, to talk, and keep in touch. That's a must. There's no point talking to someone and saying, 'yep, he's all right now', because it doesn't work like that. It's an on-going thing. We must keep that on-going until that person passes away.

Recognition that support needs change over time

All of the participants talked in depth about how the support needs of people in recovery change over time, and services need to be aware of this to ensure that they are providing the appropriate level and nature of support.

Sally: I think at the beginning they need to be more hands on. Seeing them more often to make sure everything is going OK. 'Cos that's when I think people are more vulnerable, is right at the beginning. Then start weaning off a bit and when they are feeling a bit stronger in themselves start introducing them to work or stuff, voluntary work or things to do, group work or sessions. Anything really, just to get them involved in stuff. Like making them feel like what they are doing is worth it. Making them feel a bit more worthwhile. I think at the beginning services need to be a bit more hands on but then wean off but don't totally phase them out. And then when they are in the third stage and really strong-minded, talk to them about proper work or training. Like they done with me.

Daniel: At the start of recovery, things need to be taken out of your hands a bit and you should be told that you are doing things like going on days out or meeting with other people in recovery. Then, as you get a bit stronger, it would be good for everyone to be offered counselling, when you are ready to start dealing with things and looking at ways of making things better. And then after that you need life skills when you can teach people how to get things for themselves like a job or education. And you need support 'cos if you get a 'no' it could be enough to turn you back 'cos you don't know how else to deal with it.

Some of the participants described how support needs to be intensified when an individual is coming off their substitute prescription, as this is a time when people's vulnerability to relapse increases.

Adrian: Your needs change as you go through recovery. You need intensive support to get you over the edge of getting off methadone, to get you over that edge of coming off it. You need it to be more intensive 'cos it's the end of the programme. But after that you still need to have a few back up appointments, or some support there – to give people a chance.

Phillip: It's OK to struggle when you come off the gear. But not really when you come off your script. But it is just as hard. In different ways, really. But there's a bit less support and people don't seem to think it will be hard – when really it is.

Help to deal with consequences and root of addiction

All of the participants described how they would have benefitted, or did benefit, from support in dealing with the consequences of their addiction.

Sally: 'Cos with women there are all sorts of things they do when they are using heroin and stuff. And I think that's the hard part that women have to deal with ... Just 'cos you're in recovery doesn't mean you don't need help. You might need to see people more. You might have a lot of things come into your head that you need help dealing with.

Don: I did some bad things, like stealing from my mother's purse and things. Which I would never do if I didn't have a problem. It's still hard. But it gets easier. 'Cos I used to beat myself up about it all the time. But knowing that they forgive you is a help. It sort of helps. But I still can't forgive myself fully.

Some of the participants described how they would like to have support to deal with the reasons why they initially started using drugs. Now that they were in recovery, and not using drugs to self-medicate or block out things, they found that issues had resurfaced that needed to be addressed.

Phillip: Then I started having panic attacks which I thought was from coming down off the methadone. But it wasn't, it was from the PTSD and reliving things which the heroin had been numbing. Like, for me I still see this girl's head on my lap and I'm trapped in the car and I can't get out. So I had terrible nightmares and you can't get things like that out of your head. I've never had any help for that.

Rob: It's understandable why a lot of people are on heroin. The stuff they have been through, being in care, horrible, horrible childhood, things like that. No wonder people turn to drugs. And then, when they stop, all of a sudden they have to deal with all that crap – all the reasons why they had started using originally and now

they are trying to cope with it when the only world they know is the drugs world and they have to keep away from that so they have no support, no one to help them deal with all those things. That's why counselling is so important. I can't image how people can stay in recovery without having good counselling.

Psychological help

All of the participants described how services need to provide psychological help for people who are in recovery. Some of the participants had benefitted from psychological help, whereas others felt that it was a service that was greatly needed but not available to them.

Daniel: I have been coming down here once a week for counselling. 'Cos it did leave me quite empty giving up the heroin ... I sometimes put myself down a lot, but with the counselling it's cutting out that negative thinking. It's hard to shake off the past. I'm clean and not using and doing well but it's the fact that I still feel bad about myself ... The counselling has been really useful 'cos I have had the chance to talk to someone ... So that's why I needed counselling. It's perfect. I see him every Friday which gears me up for the weekend – reminds me why I'm doing this and keeps me strong.

Rob: And I was going to a great counsellor. She was great ... She used to really lift my spirits. She was a huge help. She helped me to see that I had isolated myself too much and that I could address that...The best thing people need is a good counsellor – that was a real turning point for me. She got me through a lot ... I definitely needed the counselling in early recovery.

Individualised support

All of the participants suggested that support for people in recovery needs to be person-centred and individualised because their needs can vary greatly.

Adrian: There can't just be one format, there needs to be different formats for different people ... But those avenues need to be open. There needs to be a wide range of services available. You can't have one thing 'cos it won't work for everyone. There isn't a magic pill that will work for everyone. I'm different to, let's say, the next person. They might walk in and have a different opinion. I will have different things I need because I've got illness problems, compared to someone who hasn't got illness problems. So you need to have different, more of a flexible way of finding the best solutions for each person. That would be really good.

Help available quickly

All of the participants described the importance of having help available for people quickly, so that services can make the most of the person being ready to address their problems.

Adrian: When people come to you telling you they want recovery, there needs to be help for them quicker. Because, when you say to people 'I want to be in recovery', they have come in that day because they want help. They don't want help in four weeks, or four months time. They've gotten past those bad three-four days and they need help quickly so they don't go back to their bad ways. I'm not saying it needs to be there and then, but within two weeks, say. They could maybe come in each day or twice a week and give a sample and know that there is help there.

Rob: When someone wants to give it up, they want to give it up there and then, not nine months down the line. It's really important that when someone identifies that it is the right time for them to give it up that the treatment is there for them there and then.

Phillip described how he would like to have help available quickly if he relapsed in his recovery.

Phillip: I want to stay close and stay in contact with [services] so if anything does happen and I have a relapse then I can quickly do a two week detox. That's the way I look at it now.

Support from others in recovery

Nearly all of the participants described how they have, or would have, benefitted from support from other people who are in recovery. The participants thought that support from people with similar experiences would help them to feel less alone, increase supportive networks, and help promote the support that was available for people in recovery by sharing experiences and knowledge.

Sally: It would be good for people in recovery to have group sessions, 'cos then we can all sit down together and talk about what we are going through. Every person is going through something different, but perhaps we can get hints and tips off other people and swap things around and meet a different group of friends ... 'Cos I don't know anyone who's in recovery and I would like to know people in recovery, so maybe I could have a chat with them. Just so I don't feel like I'm on my own.

Don: Support from people like me. People who have been through the same or similar things as me. And they can tell you what they are doing to help get over it. Or if they have come across an agency or a technique that they have found useful - they can tell you about it and it doesn't mean that it would be helpful for everyone, but it might help. I think that would be a big help.

Medical assistance when stopping substitute prescriptions

Some of the participants who had experienced reducing their substitute prescriptions felt strongly that there should be medical assistance for coming off methadone.

Phillip: When you are coming off it, a short valium script would help. You could just lay in bed without all the fidgeting and then by the time that's over you're past the physical part of it. And it would also help with the mental part ... Because when you haven't slept for four-five days you feel just as bad as you do when you are coming off the gear.

Rob suggested that offering people the option of suboxone would be helpful as the physical withdrawal is less severe, and therefore the risk of relapse is reduced.

Rob: I think when someone has decided they need help for heroin, they tend to put you on methadone. But to me methadone is a silly drug 'cos it becomes more addictive than heroin. So how are you going to come off a drug that becomes more addictive? ... If they put people on suboxone I think it would be different – it would help people to not end up addicted to two drugs.

3.5.3. Addressing wider needs

All of the participants highlighted the importance of recovery support addressing wider needs, such as helping people to develop social networks and gain life satisfaction. Six concepts were identified: ***recognition that recovery is not just about drugs, help developing drug-free networks, diversionary activities, employment and education, provide hope, and recognition of achievements.***

Recognition that recovery is not just about drugs

All of the participants highlighted the importance of professionals recognising that recovery-orientated services need to address the emotional and social aspects of recovery as well as the physical aspects of stopping using heroin.

Gary: Be prepared for an emotional rollercoaster. Especially at the beginning. You go through all these emotions that you've failed to deal with for the past however many years.

Don: I thought that was the whole point of the service - that they help you with drugs and other problems you may have. But they just seem to do the drugs aspect and not the other. I need to go in-depth. Because I do get quite anxious and obviously I want to get rid of that 'cos that could hold me back in a big way.

Rob described how services should offer help for the physical, psychological and social components of recovery.

Rob: If I was designing a service I would be offering suboxone, counselling and diversionary activities. I think they are the key things for recovery.

Help developing drug-free networks

Having recognised that breaking away from the culture of addiction was a vital stage in their recovery journey, all of the participants described how recovery-orientated services could play an important role in helping people to develop drug-free social networks.

Adrian: But finding something like [recovery service] has given me an extra outlet, so hopefully I can make a drug free social network, which is what I want ... And the social networking is so hard that there should be something, I don't know what, but a group where you can meet people, have a chat about how your week's been. And that's really good. 'Cos you get to know people then and you can meet them outside of the groups. And you don't need to talk about drugs, 'How's you, how's your week been?' and if they need to get something off their chest then they can tell you and vice versa.

Kurt: 'Cos my life was spent around addicts and I'd had enough of that. 'Cos all they talk about was bullshit. And I'd had enough of that talk. It's nice to be sat around human beings who are talking about life, life in general. About their families, about the realities.

Diversiory activities

All of the participants said that offering diversionary activities would be a very positive step in helping to address the needs of people in recovery.

Don: Diversionary activities would have been a big help right from the start of my recovery ... [they] would have helped to take my mind off things, to get out instead of being stuck in. 'Cos if you are stuck in with nothing to do, you are just going to think about it a lot more.

Sally: We could all meet up and go on group activities and days out. Maybe a swimming group one day and going on trips and arranging things so that the people in recovery meet up once or twice a week and keep us occupied, keep our minds focussed. Show us the nicer things in life. Go on day trips to the beach, nice things, I think that would be really good for people who are in recovery.

Daniel described how, at the start of recovery, it would be beneficial if services could actively include people in diversionary activities.

Daniel: They say it's not about getting off the drugs, it's about staying off them and that's true. That's the hard part. It would be helpful if services arranged things for people to get them out of the house. At the start, you need people setting things up for you. Telling you you have to be somewhere and not giving them a chance to say no ... It's really hard in recovery 'cos even the small things seem really big and it takes so much for you to do them. People don't realise that, and you need a lot of support

at the start ... 'Cos we don't know what's out there. Our lives have been all about drugs for God knows how long. It feels massive having to think about doing other things and that can be overwhelming and can make you go back to it 'cos it's what you know.

Employment and education

The majority of the participants described how filling their time with meaningful and fulfilling activities, such as education or employment, is an important part of recovery, and an area where services could be providing assistance and enabling people to reach their goals.

Daniel: It would be great if services could help with things like interview practice and stuff, but I can't find it anywhere. That would really help, 'cos I had never had an interview before. It was a big thing for me and half way through the self doubt crept in and that was it from there. They could see it in my face. Normal people may be able to deal with that but I wasn't able to. When you're in recovery it's a bit harder 'cos you're not completely on your feet.

Rob: Volunteering has helped with my motivation. I volunteer to fill up my days, eventually with the view to getting a job in this field ... I think I've been looking for fulfilling things to fill my time.

Adrian described how engaging in education or employment would help him to move forward from his life as a drug user.

Adrian: People need different avenues. Like different groups they can go to, or help with getting into college, or help with getting a job ... things that they can try and build on so they can build a future separate from drugs. Their drug life can go in a box and go away. And then you can open a nice new bright box and everything starts to slowly come together.

Provide hope

The majority of the participants described how it would be beneficial if services helped people to realise that recovery is a possible and viable option, and provide hope for them to achieve the changes they want to make.

Daniel: People need to know about the possibilities. That recovery is possible. There are other options like going to college and getting a job. People need to realise they can do it. 'Cos they find it hard to believe in themselves. But people telling you that there are options and helping you to put things in place to grab your dreams would be really helpful.

Kurt described the powerful impact that seeing other people in recovery can have on people's beliefs that recovery is possible.

Kurt: This guy tells me that he stopped heroin because of me. And I say to him, 'no it's because of yourself', but what he's trying to say is that I showed him the way. With several people, they have said that I showed them that it is possible.

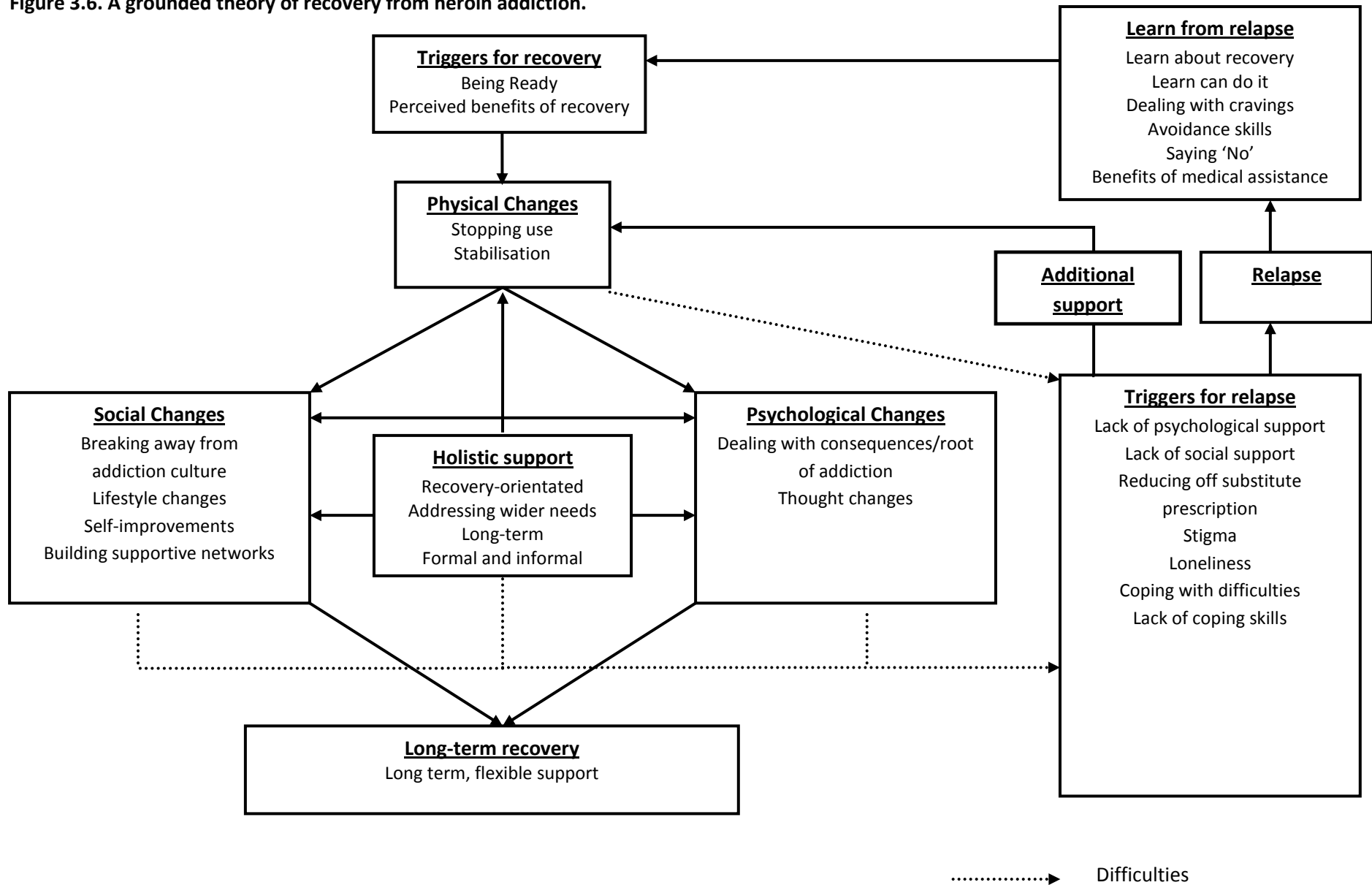
Recognition of achievements

Several of the participants also described the importance of services recognising the achievements that people in recovery have made, thus encouraging them to continue putting in the hard work needed to make the necessary life changes and achieve their goals. Furthermore, recognition from professionals would also help people in recovery to recognise in themselves the achievements they have made, which can sometimes be overlooked by people, especially during difficult times.

Sally: I think people need to realise how well they are doing. 'Cos I think they are feeling like they are on their own and they are just being left to it. I know you shouldn't get any rewards just for not taking drugs, but professionals have to realise that just saying, 'well done, you've been on heroin for years and now you are doing something about it' really helps us to see how well we are doing.

Kurt: I was giving urine tests and they were always clean. And they were saying, 'You're doing well' ... I had taken criticism for most of my life ... but being complimented about something I found really hard to accept. People would say, 'You're doing well' and I would be like, 'shut up'. Perhaps I was getting embarrassed about it. Like a lot of people in this establishment say you are doing so well and I find it really hard to hear ... but I guess I'm starting to see that I am doing well.

Figure 3.6. A grounded theory of recovery from heroin addiction.



3.6. MAKING SENSE OF HEROIN ADDICTION: A GROUNDED THEORY

Figure 3.6 represents a grounded theory of the participants' views and experiences regarding the process of recovery from heroin addiction. It is important to note that the proposed model is based upon the researcher's interpretation of the data and must therefore be treated with caution until subjected to further research.

Following analysis of the data, and organisation of the hierarchical systems within each core category, the researcher considered whether the findings could be brought together to produce a grounded theory model. One of the aims of this research was to consider how the participants' data could be used to inform the development and delivery of recovery orientated services in the South Wales area. The researcher immersed herself in the data, and drew upon knowledge of the literature and addictions system in the local area, in order to consider how the data could be organised into a model that would inform services delivery.

Using constant comparison and negative case analysis, the researcher continually linked and integrated categories to ensure that all instances of variation were encapsulated by the emerging theory (Willig, 2008). A number of possible models were trialled, and discussed with the researchers supervisor, and different components of these were drawn upon to develop the grounded theory model presented in Figure 3.6. The researcher and their supervisor believed that this model draws together a number of the key themes that emerged through the data analysis, and these will be discussed now in more detail.

This grounded theory incorporates a staged model of the process of recovery. The model suggests that the initial stage of recovery is predominantly focussed on the physical aspects of addiction, namely stopping heroin use and physical stabilisation. This initiation can be triggered by a number of factors as mentioned in Section 3.2.1.

The model then proposes that the next stage in recovery requires addressing the psychological and social needs of the individual. Some of the important social changes identified by the participants were lifestyle changes, self-improvements and building social networks. The important psychological changes identified by the participants included dealing with the root and consequences of their addiction and thought changes towards heroin, themselves and life. A key factor in enabling people to make the necessary physical,

social and psychological changes is holistic support, including support specifically regarding recovery from heroin addiction as well as support with addressing wider life issues such as help with achieving employment or education goals.

It is important to note that the recovery process varies for each person, and therefore the support required, and at what time, will vary considerably and services need to be person-centred in their approach. It is also important to note that the physical, psychological and social factors of recovery are very much interlinked, and therefore, where appropriate for the individual, need to be addressed simultaneously. Developing recovery plans with clients prior to them addressing their addiction, or as early in recovery as possible, can help to identify the areas that need to be addressed, and how the individual would like to go about making those changes.

The diagram also illustrates potential triggers for relapse, and how participants described the process of learning from relapse, should it occur, which they could draw upon in future attempts at addressing their heroin use. Furthermore, the participants in this study suggested that support can reduce the risks for relapse, suggesting that support should be made readily available to people in recovery.

From this grounded theory model of heroin addiction four testable propositions were developed which were discussed in a focus group consisting of people with personal and professional experience of recovery from heroin addiction.

3.7. FOCUS GROUP

A focus group was attended by five professionals who work with people in recovery from substance misuse including a clinical psychologist (Bronwen), a social worker (Amy), the Director of a recovery charity (Louise), an assistant psychologist (Danielle), and a recovery coach (Edward). The focus group was facilitated by the researcher and participants were asked to discuss four testable propositions derived from Figure 3.6. The following provides a summary of the focus group.

Proposition 1: People who have meaningful and fulfilling activities in their lives are more likely to maintain their recovery.

All of the participants agreed with this proposition.

Amy: Those people who have achieved recovery in the longer term have been the ones who have filled their time with other activities such as voluntary work, education, being parents, things like that. Unless they replace that drug use with something meaningful that gives them a sense of purpose and increases their confidence, then they are more likely to relapse. And their sense of identity, if you take the drugs away they struggle to know who they are, so if they engage in activities it can help them to find out who they are.

Louise: There's often a feeling of 'what's next?' Actually, if you are still quite unhappy and disconnected from the world you can wonder why you did this ... We find people getting involved in new activities makes them realise that it is worth it and they have taken something out of their lives but replaced it with something they get a lot from.

Proposition 2: People who receive psychological help to deal with the root causes and consequences of their addiction will be less likely to relapse.

All of the participants agreed with this proposition. When considering why there is a lack of psychological help currently available for people in recovery in the South Wales area, the participants suggested that psychological support is not currently prioritised within the medical model that dominates public sector services.

Bronwen: There is pressure from services to get people through the system and discharged when, really, people need time to be able to address those underlying issues. And the pressure to move people on means that those important things sometimes get lost. And, often, because it is those underlying issues that are firing the substance use problems in the first place, we find that people come back through our doors because they have not been offered the services to help them to deal with it.

All of the participants agreed that psychological support should be provided depending on what the individual needs, and wants, at different times in their recovery journey.

Louise: There needs to be different levels of psychological help. Help with dealing with the more day to day things like relapse prevention and coping skills and then the deeper level of helping people to deal with the root of their addiction ... And if we talk about return for investment, it is much better to provide those psychological services for people when they need them, and are ready for them, because that may help to stop the cycle of people going through services and then back again.

Proposition 3: People who are supported in developing positive social networks will be at reduced risk of relapse.

All of the participants strongly agreed with this proposition.

Edward: if you have made all the effort to make those changes you need to see the things around you get better as well – and that means doing things, and seeing people and getting enjoyment.

Louise: There's lots to learn about trust and being valued and having people who care about you. Those can all be new experiences that take time to learn and get used to. It's so powerful ... There's something about having a group of people who know you for who you are today, not for the bad times. So you are not always the bad one. Something about being who you are today rather than being the person you were in the past, who you might not be proud of.

Proposition 4: Developing services specifically aimed at supporting people in recovery to holistically address the impact of addiction and recovery will increase the number of people achieving long-term recovery.

The participants all agreed with this proposition. The group discussed how the system is currently disjointed, thus making accessing different services difficult.

Bronwen: Some services are very medicalised. They draw lines around addressing the medical side and nothing else. And because we don't have good links and understanding of what else is out there, we don't link them in very well ... there is some irony in the fact that we are trying to generate independence but everything we do in the system takes that control away from the person. And we work in a very disjointed manner where people get little or no say in what they are going to get.

All participants also highlighted the importance of professionals supporting people to address their addiction and recovery in a holistic way, from the initiation of their recovery.

Danielle: – I think it's about services, from day one, understanding that it's biological, social and psychological and bringing those things together. Not just targeting one thing. Formulating that with people from the beginning, so all the way through it's those things coming together, rather than doing it one thing at a time. It's about bringing it all together from the start ... you can't just take it all away and then replace it. It needs to be done on the journey. You take a little piece away but you replace it with something else, then you can take a little bit more away and find another thing to replace that. It can't just be about the drug addiction. It's about the whole life.

The importance of enabling individuals to have control over their recovery was also highlighted by all the participants.

Louise: And also for them to be actively involved in a [recovery] plan, rather than being told 'this is the process, this is what you are going to go through'. A collaborative approach, thinking about the physical, psychological and social aspects, could help people to feel clearer about what they have to do and have more hope.

Amy: It goes back to service users having control. There is currently a lot of imbalance. But it should be about having a partnership approach. If you have ownership over what is happening to you then you are going to put more into that rather than having things done to you and having things dictated to you.

The participants highlighted that many professionals assume that people who have experienced substance misuse problems will always be reliant on services.

Bronwen: I think there's something about moving on and not being a service user for the rest of your life. And I think sometimes there is a sense amongst workers that that is what you have to be and you are reliant upon a service. But for me it's about people getting out there and having the life that they want.

Edward: That stigma of being a service user stays with them. They go from being a drug user to a service user – you are still a user. You aren't putting anything back in.

All of the participants also recognised that there is a lack of knowledge, amongst professionals and people in recovery, regarding what services are available.

Danielle: I think the problem is making the services known. 'Cos there is plenty of stuff out there. People don't think there is anything out there for them.

Amy: And I think in addiction services there is not enough publicising of main stream services. And in my experience people don't want to be associated with addiction services. They would prefer to be using other services in the community.

The participants also discussed the necessity for service commissioners to recognise the importance of a biopsychosocial approach to recovery, and how the current pressure to 'get people through the door' results in the psychosocial aspects of recovery being overlooked.

Amy: we need to make changes so these issues are brought in from the top down. Commissioners need to understand we can't incorporate these approaches if we also have to see 40 people a week! And until there are changes at the top, the pressure on workers to get people off substances is too great for them to consider other aspects of the people's life. That's where the changes need to happen.

In summary, the professionals who attended the focus group supported the conclusions and analysis of the original interview-based research.

CHAPTER FOUR - DISCUSSION

4.1. OVERVIEW

This research explored recovery from heroin addiction from the view-point of those with personal experience. The study aimed to gain a better understanding of the process of recovery and the factors important in initiating and maintaining recovery, in order to consider how services can be developed to deliver support appropriate to the needs of those in recovery, or those seeking recovery.

This chapter summarises the key findings of the research and considers them within the context of the existing evidence base. The implications of the research will be considered with regards to clinical and service delivery implications, as well as the potential role that clinical psychologists can play in developing and improving the services available to people in recovery from heroin addiction. The limitations of this research will then be considered followed by suggestions for future research.

4.2. RESEARCH FINDINGS AND THE EXISTING LITERATURE

From the rich data collected through this research, four core-categories emerged, each with a number of categories, sub-categories and concepts. The main findings, and how they relate to the existing literature, will be considered in this section.

4.2.1. Initiating recovery

A number of the key factors that were identified in this study regarding the initiation of recovery supported the existing literature. These included developing a dislike of the lifestyle associated with heroin addiction (McIntosh & McKeganey, 2001), learning to cope with cravings (dos Santos & Van Staden, 2008) and the importance of feeling ready to address heroin use (Best *et al.*, 2008).

As supported by the existing literature (Prins, 1995; Simpson *et al.*, 1986), all of the participants in this study described an identifiable trigger in their addiction career when they made the decision to address their heroin use. Triggers varied considerably, but fell broadly into two sub-categories: 'being ready' and recognition of the 'perceived benefits of

recovery'. With regards to being ready, the participants described turning points, including rock bottom experiences and spiritual awakenings, as well as realising that it was the right time for them to make changes as a result of feeling strong in themselves, stabilising on a substitute prescription, or feeling supported by family. In support of previous research (Biernacki, 1986; McIntosh & McKeganey, 2001), this study found that rock bottom experiences were not a universal component of initiating recovery for all people, but for many did play an important role. The participants also described a more rational process of weighing up the perceived benefits of recovery, which was a powerful motivator for initiating recovery.

These findings partially support those of dos Santos and Van Staden (2008), Biernacki (1986), and McIntosh & McKeganey (2001), who reported that initiating recovery occurred as a result of either rock bottom experiences or a rational decision process of weighing up the pros and cons of addiction and recovery. However, the majority of the participants in this study described the importance of 'being ready', which was often triggered by a turning point or rock bottom experience, as well as having spent time weighing up the perceived benefits of recovery compared to their current life in active addiction. This may reflect the perceived lack of support in the local area for addressing heroin addiction, which may have delayed the initiation process until an existential crisis occurred whereby the current lifestyle could not be maintained.

Although the existing literature suggests that deteriorations in psychological health can be a common trigger for initiating recovery (Best *et al.*, 2008; Waldorf, 1983), the participants in this study did not report this. Much of the existing research focuses on individuals who have received intensive treatment such as residential rehab which has a psychological component that may help people to gain a better understanding of the psychological impact of their addiction. However, only three of the participants in this study had received residential rehabilitation, whereas the treatment experienced by the others had consisted of substitute prescribing only, and in one instance substitute prescribing alongside counselling. This lack of psychological treatment may have implications for psychological insight and may explain why psychological distress was not commonly mentioned as a trigger for recovery, despite many of the participants describing psychological difficulties in their lives.

Other key factors were identified by the participants in this study, including the importance of admitting that their heroin use was problematic, and gaining a determination to address their heroin use and associated difficulties. This research has highlighted a multitude of factors that influence the decision to initiate recovery, which can combine to make it the 'right time' to address those changes.

In support of the existing literature (e.g. McIntosh & McKeganey, 2002), all of the participants described the importance of deciding to address their heroin use for themselves, due to the powerful nature of the drug and the determination that is necessary to initiate and maintain recovery. As documented in other literature (Stimson & Oppenheimer, 1982), the participants in this study described how being ready to address heroin addiction was often triggered by a decrease in the positive pharmacological effects of heroin and the realisation that the drug no longer played a positive role in their life.

This research also supports the findings of McIntosh and McKeganey (2002), who highlighted the role of rejecting the drug-using identity, which can often occur when the person develops a powerful dislike of the person they have become due to heroin addiction. The participants described the recognition of a 'spoilt identity' in their thought changes, including a dislike of heroin, the associated lifestyle, and the activities they were engaging in to maintain their addiction. This was commonly exacerbated by rock bottom experiences.

This rejection of the drug-using identity combined with the desire to have a better life were described as key motivating factors in initiating recovery. For those still in contact with their family, the role of family members in providing additional motivation and supporting the recovery process was also highlighted, as supported by previous research (Simpson *et al.*, 1986; White, 2008a). Furthermore, the recognition of the spoilt identity appeared to be a gradual process, which could be exacerbated by existential crises, which supports the findings posited by McIntosh and McKeganey (2002).

The evidence suggests that many people experience multiple treatment episodes prior to achieving recovery (Scott *et al.*, 2005), and the cumulative effect of treatment episodes has been reported to help enhance the likelihood of achieving recovery (Dennis *et al.*, 2005). The participants in this study highlighted the importance of utilising previous experience of treatment and periods of abstinence to help them in initiating recovery and overcoming

some of the early obstacles, such as dealing with cravings, and avoiding high risk situations. These previous experiences also highlighted some of the lifestyle changes that would be necessary to overcome their addiction, in particular breaking away from the addiction culture and introducing new routines into their lives.

4.2.2. Maintaining recovery

Many of the key components identified in this study regarding the maintenance of recovery were supported by the literature, including developing new social networks (Best *et al.*, 2007; Best *et al.*, 2012¹; White & Kurtz, 2006), keeping busy with hobbies, employment, education and training (Klingermann & Efionayi-Mäder, 1994), and support from peers, families and professionals (Scott *et al.*, 2005; Weisner *et al.*, 2003).

The concept of developing a new identity in recovery, which contrasts to the addict identity, has been well documented in the literature (Radcliffe & Stevens, 2008; Waldorf & Biernacki, 1981), and is further confirmed in this research in a number of ways. The development of a new identity was achieved through breaking away from the addiction culture, developing positive social networks, learning about themselves, and consequently changing their view of themselves so that they increased their self-worth and engaged in meaningful and fulfilling activities. In support of McIntosh and McKeganey (2002), this research suggests that the desire for and development of a new identity is not, in itself, a necessary condition for the recovery process to occur, but can be extremely powerful in the process of initiating and maintaining recovery when combined with other factors such as the belief that recovery is possible.

There is persuasive evidence to suggest that lifestyle changes can play an important role in enabling people to address their heroin addiction (Robins *et al.*, 2010). This study supports this, as participants described the importance of breaking away from the addiction culture, developing non-drug related social networks and developing new routines which included engaging in fulfilling activities such as volunteering or education.

¹ This reference, which was published post-submission of the Doctoral thesis, was added to the Discussion section on the request of the external examiner.

Although much of the previous research has identified various social changes that appear to be important in maintaining recovery, the psychological changes are less well understood or documented. McIntosh and McKeganey (2002) described the process of reconstructing the sense of self in recovery, and this was evident in this study as participants differentiated between the person they had been and the person they aspired to be. However, the process by which that reconstruction occurred is not documented in the existing literature, and this research has provided a greater understanding of the thought changes that are experienced during the recovery process, in particular regarding the individuals' views of themselves and their future. This insight into the thought changes that occur in the recovery process can better equip professionals to support individuals in the recovery process.

Furthermore, although the existing literature highlights the importance of social support in the recovery process (Best *et al*, 2012; Bond *et al.*, 2003), it does not focus on the role of psychological support, which was identified by the participants in this study as a key component of recovery. The participants highlighted the importance of having psychological support in addressing the underlying causes that led to addiction, as well as the consequences of addiction and the associated lifestyle. Furthermore, psychological support could facilitate the development of skills that support the expansion of positive social networks, as the participants in this study highlighted how mixing with non-drug users can be a daunting prospect which may be exacerbated by under-developed relationship skills, as also reported by Biernacki (1986).

This study has highlighted the importance of receiving support from, and providing support to, others who have experienced similar difficulties. The value of such experiential knowledge and expertise has been recognised in the literature as a crucial source of support and hope for the recovery process (Jackson, 2001), and has been associated with positive recovery outcomes (Stahler, 2007). Enhancing links with other people who are in recovery could also address some of the issues identified by the participants such as having doubts about achieving recovery and loneliness.

4.2.3. The process of recovery

The participants all viewed recovery as being a long-term process, which supports the existing literature (e.g. White, 2007). This research strongly supported theories of stages of recovery, in particular the findings reported by Margolis and colleagues (2000) who posited that early recovery focuses on abstinence, followed by learning to 'live a normal life' and ending with a period of searching for individual growth and meaning. The participants in this study described initially focusing on abstinence, which was followed by gaining the strength and stability to address the underlying issues and consequences of their addiction and developing social networks, before moving on to a focus on life enjoyment and engaging in meaningful and fulfilling activities. Recognition of different stages in the recovery process is important as it provides vital information for the development of services and how support needs may change over time. This will be further considered in Section 4.3.1.

Although the participants all viewed recovery as a process, a number of the participants also described an end point to the process where they would be 'recovered'. Although there is only limited scientific literature regarding this, the available research suggests that most people in recovery do not assume that there will be an end point, but assume that they will always be 'in recovery' (Laudet, 2007). The disparity in findings between this research and published literature may be explained by the different cultures in which the research was conducted. The concept of there being no end point to recovery fits with both the disease model and the 12-step Fellowship, predominant models in the USA where much of the recovery literature is generated (Dennis *et al.*, 2005; Laudet & White, 2004). The current study was conducted in South Wales where there is little 12-step influence, and no dominant treatment approach, which may explain the difference in viewpoint.

This study has highlighted a number of obstacles to recovery experienced by the participants. These will be further explored in Section 4.3.2 where service implications are discussed.

4.2.3.1. *Definition of recovery*

This research supported a definition of recovery that encompasses improvements in quality of life as well as abstinence from heroin use, as proposed by other researchers (BFICP, 2007;

CSAT, 2006; White, 2007). The importance of viewing recovery in a more holistic manner was mentioned by all of the participants, although direct reference to abstinence was less commonly mentioned. This could suggest that at the stage the participants perceived themselves to be, at the time of the interviews, abstinence was not a focus of their recovery. Alternatively, it could reflect the greater importance of psychosocial changes in the participants' recovery journeys. However, all of the participants were abstaining from heroin use at the time of the interviews, suggesting that it was an important component in their recovery. This supports the literature regarding the difficulty with achieving controlled heroin use following heroin dependence (Laudet, 2007).

Those participants who were on substitute prescriptions still reported themselves as in recovery, which supports the evidence that, particularly in the UK, people on substitute prescriptions class themselves as in recovery (Laudet, 2007). The fact that abstinence was not directly named as a key component in recovery supports the literature which suggests that the concepts of 'abstinence' and 'recovery' are two distinct things (Laudet, 2007).

A number of the participants in this study reported using other substances (excluding heroin) at the time of the interview. Only three of the participants in this study were abstinent from all alcohol and illicit drugs, whilst the others described "controlled" use of other substances. This included one participant reporting cocaine use in the past month (on five occasions), two participants reporting daily cannabis use, one participant reporting weekly cannabis use, one reporting cannabis use once in the past month, and six participants reporting alcohol use ranging from two units per month to 10 units per week. These findings do not support the substitution theory, which proposes that heroin addicts replace heroin with an alternate substance once in recovery (White, 1998). In addition, this study does not support the findings of Laudet (2007), who reported that only 4% of her participants incorporated the controlled use of substances in their definition of recovery. However, it does support the findings of Bacchus and colleagues (2000) who reported that some people find that the controlled use of other substances helps them to maintain their recovery from their primary problematic substance.

This study therefore better supports the definitions of recovery proposed by the UKDCP (2007) and White (2007), who refer to gaining voluntary control over substance use rather

than the BFICP (2007) definition of recovery which refers to sobriety. However, this study also highlighted how the recovery journey is a very individual process, so caution should be taken when attempting to define it, to ensure that different and diverse recovery pathways are encapsulated in a definition.

4.2.4. Service Provision

Although heroin addiction is classified as a chronic relapsing disorder (Anglin *et al.*, 2001; Dennis *et al.*, 2003), it is often treated in an essentially acute-care model of treatment characterised by professionally led brief interventions with a focus on abstinence (White, 2008b). The importance of providing holistic interventions to people addressing their heroin dependence has been well documented in the literature (Edwards, 2000; McIntosh & McKeganey, 2002), and is strongly supported further by this study, as exemplified in Figure 3.6. Participants described how the provision of long-term flexible support that addressed the physical, psychological and social components of the recovery process is crucial, although currently not readily available in the South Wales area. Furthermore, the participants identified the importance of having rapid reintegration into treatment when relapse or difficulties occur, which is also supported by the literature (e.g. White, 2008b).

This study highlighted the importance for services and professionals working with people in recovery to recognise that support needs change over time. This is supported by the literature which suggests that during the initiation of recovery, support needs to focus on abstinence from the problem substance and enhancing stability in the individual's life. Later in the recovery process support can be utilised to develop a life in the community, and later again to enhance personal growth, life meaning and helping others (Laudet & White, 2008). The evidence also suggests that treatment can play a critical role in recovery initiation, but factors outside of treatment have a more critical role in the maintenance of recovery (Vaillant, 1983; White, 2008). The current study supports this as participants talked in depth about the importance of making changes in wider aspects of their lives, such as developing positive relationships and engaging in activities that enhance self-esteem and life enjoyment.

Edwards (2000) reported that, for alcohol dependent individuals, a key component of the recovery process was the belief that change was possible. This study has confirmed that this is also the case for individuals in recovery from heroin addiction. The participants identified the importance of having hope in recovery and recognising their achievements, and they believed that professionals could facilitate this process. Edwards suggested that professionals play an important role in facilitating skill development in techniques such as goal setting and relapse prevention, providing psychological support, and facilitating engagement in meaningful and fulfilling activities. This study highlighted a gap in the availability of such support, which could reflect higher rates of co-occurring mental health difficulties in heroin addicts compared to alcoholics (White, 2008), or could reflect a variation in the availability of psychological services in different areas, as Edwards' research was conducted in England.

The NICE guidelines promote a person-centred approach to addressing heroin addiction, which encourages clients to make informed decisions about the care they receive. However, such control over their treatment was not the general experience of the participants in the study, who described having treatment 'done to them', and not being given much information or choice regarding their treatment. This was particularly the case in statutory services, whereas the participants described more positive experiences from voluntary sector organisations. This may reflect the pressures on statutory services to achieve outcomes set by the government, especially with regards to numbers of service users on substitute prescriptions, a view expressed in the focus group. Participants in this study described how the focus on prescribing resulted in a lack of attention being paid to psychosocial difficulties, which may reduce awareness of risk factors in clients' lives, and leave professionals feeling disempowered and deskilled. Furthermore, the evidence suggests that engagement and retention rates in methadone programs are higher when psychosocial support services are offered in conjunction (Humphreys *et al.*, 2008), which was not the experience of the participants in this study. Although many of the participants in this study highlighted the benefits of substitute prescribing, they suggested that having more information about different options, and having more control over their prescription plan (e.g. increases and decreases to their prescription), would have been beneficial in their recovery.

The NICE guidelines also recommend linkage with self-help groups, which is supported by the literature (Best *et al.*, 2012; Humphreys *et al.*, 2004). The participants in this study highlighted the lack of communication between services and the lack of integration between formal services and self-help groups. This may reflect a lack of peer support in the area, or a lack of awareness of such support on the part of professionals. Furthermore, Best and colleagues (2012) reported that, in a sample of recovering heroin and alcohol users, engagement in meaningful activities and positive support networks was closely related to personal traits, such as self-esteem, and the development of social skills. This highlights the importance of services supporting clients in the development of interpersonal and social skills that can facilitate the development of supportive networks which is a predictor of stable recovery (Hser, 2007).

The NICE guidelines also state that CBT or psychodynamic therapy should be offered to clients who are abstinent or are maintained on a substitute prescription and have co-morbid depression or anxiety disorders. This study suggested that psychological services are not readily available, as a number of the participants experienced psychological difficulties for which they had unsuccessfully sought treatment. This is supported by literature from the USA, which reports that only 25% of people meeting the criteria for alcohol addiction will receive specialised treatment in their lifetime (Dawson *et al.*, 2005). Furthermore, from a study based in Scotland, Best and colleagues (2012) reported that ex-heroin users maintained on substitute prescriptions had lower levels of self-efficacy and quality of life, and higher levels of anxiety and depression, than ex-heroin users not on a substitute prescription. This is an important finding with regards to service provision as maintenance substitute prescribing is a widely available treatment option across the UK, and such clients are more likely to require psychosocial interventions.

4.3. IMPLICATIONS OF THIS RESEARCH

4.3.1. Clinical implications

This research provides evidence that recovery from heroin addiction is possible. This has important implications for clinical practice as many professionals rarely see service users successfully overcome heroin addiction, often because such individuals disengage from treatment services and the drug-related culture. This study has highlighted the role of

emphasising the positives of recovery and providing hope that recovery is possible. Professionals can play an important role in instilling hope and a positive outlook on recovery through the use of well evidenced techniques such as motivational interviewing (Miller & Rollnick, 1991) and motivational enhancement therapy (Ball *et al.*, 2007). It is therefore important that staff are trained in using motivational approaches, which are also promoted in the NICE guidelines (2007).

A number of the participants in this study described experiencing psychological problems at the time of the interviews, including low self-esteem, social anxiety, post-traumatic stress disorder and depression. The experiences of these participants suggest that adequate support was not available to enable them to address these difficulties whilst in active addiction or once in recovery. The evidence suggests that unresolved psychological difficulties are closely associated with increased risk of relapse (Joe *et al.*, 1990; Schutte *et al.*, 2001), thus highlighting the importance of providing services for people in recovery with psychological problems. These difficulties can be overlooked because addiction services often work primarily in a medical model, thus focusing on addressing substance misuse, and mental health services often will not work with clients with substance misuse problems. The importance of identifying psychological problems in people addressing their substance misuse, and making appropriate referrals to mental health services, needs to be highlighted to bridge this gap in service provision.

Although this study was unable to compare the psychological health of those in recovery with that of people not in recovery, psychological difficulties were very prevalent amongst the participants. This contrasts with the evidence base which suggests that people in recovery have better psychological health than those in active addiction (Hser, 2007). This may reflect the very limited psychological support available in South Wales for people during active addiction and recovery, for example there is only one NHS clinical psychologist working in the addiction field across the whole of Wales. This study highlights the demand for an increase in the availability of psychological support for people in recovery, which may result in a reduction in relapse and the 'revolving door syndrome' commonly occurring in treatment services (Broers *et al.*, 2000; Smyth *et al.*, 2010). Hser (2007) reported that low psychological distress and high self-efficacy were significant predictors of stable recovery, thus highlighting the importance of addressing psychological difficulties in recovery.

Furthermore, it is well documented that approximately 70-80% of heroin users have co-occurring mental health problems which, for many, may continue into recovery and increase the risk of relapse if not addressed (DoH, 2007).

This study highlighted the importance of 'being ready' to initiate recovery, including having support in place from professionals and family or friends. Many heroin users are marginalised from society, and often have little or no contact with non-drug related support systems. The participants in this study highlighted the importance of having professional support in their recovery, including support in developing positive social networks. Professionals can support the development of social networks through assertive linkage, promoting available services and helping people to overcome barriers to engaging in services such as low self-esteem or difficulties with developing relationships. Linkage between formal treatment services, the voluntary sector and peer-support is currently quite limited in the South Wales area, despite the evidence promoting the positive benefits of joint working (White, 2008). This research has highlighted the importance of supporting recovery journeys in a holistic manner, and multi-disciplinary working can help to draw upon the strengths of different services, whilst also providing a more diverse support network for clients. Furthermore, the critical nature of 'being ready' in initiating recovery highlights the importance of services and support being quickly available to support the individual when the time is right for them.

The primary treatments available in the South Wales area are substitute prescribing and brief interventions. This lack of available intensive treatment may have played a role in the psychological problems described by many of the participants, as they had received little or no psychological intervention in their recovery journey. However, despite not having received intensive treatment, many of the participants described similar processes to those reported in other studies with individuals who had received treatment, including increased confidence and coping skills, lifestyle changes and a different view of the future (e.g. dos Santos & Van Staden, 2008). Some of the participants attributed these changes to engagement in peer support and non-drug using social networks. This highlights the importance of linkage with mutual aid, in particular where there is a lack of psychological support available. When working with clients in recovery it is crucial that professionals provide impartial information about available avenues of support and, when necessary,

support people in accessing these service. This becomes especially important with clients who have low self-esteem, poor social skills or anxiety problems, for which engaging in new activities can be difficult.

It has been well documented in the mental health field (Wagner *et al.*, 1996), and increasingly so in the addictions field (Hser & Anglin, 2011), that client directed care is associated with improved empowerment, therapeutic alliance, treatment adherence and treatment outcomes. The participants in this study did not describe feeling in control of their treatment and referred to having experienced treatment in a prescriptive manner. Best and colleagues (2009) suggest that professionals working with substance misusers need to make more effort in working alongside their clients in coaching them to develop a recovery plan. Strong support for collaborative working has come from the USA (White, 2008) and is promoted in the NICE guidelines (2007).

This study has highlighted ways in which professionals can support people at different stages of their recovery journey. To support the initiation of recovery, services can ensure that people are aware of the different medical options available to them, including substitute prescriptions and detoxification. These medical options need to be delivered alongside psychosocial support, to better support individuals and enhance positive outcomes. Using techniques such those involved in the International Treatment Effectiveness Project (ITEP; NTA, 2009) can help to place well-evidenced psychosocial interventions at the heart of addiction treatment. This can help to facilitate thought and lifestyle changes whilst also helping to recognise and draw upon clients' strengths and resources (NTA, 2009). It is essential that people are supported in the lifestyle changes they need to make, and more intensive support is available during this difficult time where support is often minimal due to a lack of non-drug related support. It is also crucial that people are educated about addiction and recovery so that they have a better understanding of the process and are more aware of the different challenges they may face. In this way they can be better prepared and supported.

Services can support the maintenance of recovery by providing psychological support in facilitating the thought changes that underlie successfully addressing heroin addiction, as well as supporting social improvements in the individual's life, for example by actively

encouraging engagement in peer support or educational opportunities. The participants in this study highlighted the importance of recognising that recovery is more than just about drug use. However, such a view often means that when drug use has been addressed, this is often followed by discharge from services, at a time when there are difficulties with broader aspects of health and wellbeing. This again highlights the importance of providing longer term care for people in recovery, and linking clients to community recovery resources.

The participants in this study described having made numerous previous attempts to address their heroin use, supporting the literature which suggests that for people with severe substance misuse problems, multiple attempts at recovery are often required before stable recovery is achieved (Dennis *et al.*, 2005). This study highlighted how unsuccessful attempts at recovery can play an important role in helping people to better understand their relapse triggers, how to cope with cravings, and the importance of avoiding the addict culture, as well as providing evidence that periods of abstinence are achievable. Professionals can play an important role in helping clients to identify what they have learnt from a lapse or relapse and to build upon these skills. Furthermore, clients can be supported in identifying obstacles in their recovery so that these can be addressed.

4.3.2. Service implications

Developing recovery-orientated systems of care requires a systemic approach where services are designed to facilitate pathways to recovery that maximise intrapersonal, interpersonal, and community resources (Best *et al.*, 2010). In the USA, evidence of best practice comes from peer-based recovery support centres (White, 2008b), an approach which differs vastly from the majority of statutory treatment provision, including that in South Wales. Changes towards recovery-orientated systems of care may be viewed as a threat by current treatment providers who practice within a predominantly medical model (Kirk, 2005). These potential anxieties need to be addressed through highlighting the roles of different professionals and how this can be supported by those with personal expertise of addiction and recovery to better meet the needs of service users.

Historically, addiction has been viewed as a chronic relapsing disorder which needs to be managed, as demonstrated in many services which focus on the medical management of addiction (O'Brien & McLellan, 1996). This research has highlighted the importance of

having a biopsychosocial approach to addressing addiction which provides long-term support for people in recovery.

Best and colleagues (2010a) suggested that addiction should be viewed as a complex problem which is addressed through hope, dynamism and choice. At present in the UK, addiction services are predominantly delivered from hospitals or clinics, with professionals directing the course of treatment and focusing on managing symptoms, primarily through substitute prescribing. This research has shown that, although substitute prescribing and other forms of treatment often have a positive influence on the recovery process, they need to occur within a context of social and psychological changes and support. These findings support the literature on natural recovery, which shows that positive lifestyle changes and experiences disrupt the entrenched addiction habits, thus facilitating the recovery process (Miller, 1993; Vaillant, 1996). Better meeting the needs of people in recovery requires a shift in thinking at multiple levels of the system, from front-line staff through to management and up to commissioners and policy developers.

In line with other research, all of the participants in this study described improvements in many aspects of their lives including better quality of life (Donovan *et al.*, 2005; Laudet *et al.*, 2006), improvements in problem solving and positive relationships (Holahan *et al.*, 2003; Moos & Moos, 2005) and better physical health (Mertens *et al.*, 2003). However, all of the participants also stated that there was limited support available in helping them to address psychosocial problems, and this is an area where service development could be key. Research suggests that it is the health and social aspects of recovery which are most appealing to people who are contemplating addressing their addiction (BFICP, 2007). Thus, providing psychosocial support could help clients to recognise the positives associated with recovery, and facilitate the recovery process.

This study supports the literature (Best *et al.*, 2010a; Dennis *et al.*, 2007) in advocating long-term recovery support, including improving approaches to continuing care, access to mental health services and linkage to self-help support and meaningful and fulfilling activities. Evidence suggests that providing more holistic services drastically improves recovery outcomes (McLellan *et al.*, 1994), suggesting a cost-effective improvement to service delivery.

Treatment services need to re-evaluate the way in which they deliver services to ensure that they are addressing the factors most important to their clients. This can help to enhance motivation, engagement and improve outcomes (Hser & Anglin, 2011). For this to happen there needs to be a greater focus on multi-disciplinary working across health and social settings and active linkage with community engagement, in particular mutual aid resources and other forms of social support. Improving the links with third sector services and mutual-aid groups will enhance the long-term support available to people in recovery, thus facilitating stable recovery (Humphreys, 2004). At present in the South Wales area a number of services in the statutory and voluntary sectors offer a variety of interventions. As reported in this study, the communication between these services is often poor, which may hinder the potential for service users to receive holistic care by drawing upon the support of multiple services. However, this issue is potentially being addressed in the South Wales area where services are currently being redesigned to provide a single point of entry (SPOE) system, bringing together voluntary and statutory agencies thus enhancing communication routes.

To achieve these changes in the treatment system, it is essential to address professionals' understanding of addiction, recovery, and how people can be supported in achieving long term stable changes. As highlighted by the participants in this study, there appears to be a lack of understanding regarding recovery from people working in the addictions field. This could be addressed through providing training regarding the process of recovery, and how professionals can support that process, including having a more person-centred and collaborative approach to working. Furthermore, other changes could include being aware of the language used and ensuring that it provides hope and choice to clients, involving families and wider systems of support, and utilising psychosocial tools into their work such as ITEP (NTA, 2009). For such training to be available, the support of commissioners and service managers is essential. The participants in this study also highlighted the importance of training professionals about the physical and psychological difficulties associated with reducing substitute prescribing in order to enhance the level of appropriate support available at this time when risk of relapse is increased.

Based on extensive reviews of the literature, the NICE guidelines (2007) state that heroin users wishing to address their dependence should be offered substitute prescribing,

psychosocial interventions and support in maintaining abstinence for six months. This is supported by research from around the world (e.g. Barlow & Durand, 1995; Best *et al.*, 2010b). However, such treatment experiences were not described in the accounts of the participants in this study. This may reflect some ambiguity from services regarding what psychosocial support should entail, and the difficulty of measuring the outcomes of such interventions. Furthermore, many addiction services work within a medical model, with outcome measures primarily, or solely, based on numbers of service users receiving substitute prescriptions. The experiences of participants in this study suggest that local treatment interventions are focused on substitute prescribing, and offer little psychosocial support. This supports findings published elsewhere in the UK (Best *et al.*, 2009b) and may reflect the outcome priorities of services within the financial restraints they face. Listening to the views of service users in a given area can provide services with an insight into how they can better meet the needs of clients, thus reducing the cost of an individual unnecessarily engaging in multiple treatment episodes. Services need to consider the psychosocial support they offer and to consider providing further training to professionals to ensure that service users' needs are being addressed effectively and holistically. The necessity for recovery-orientated training was raised in the focus group in this study, and identified as a positive way for professionals to enhance their understanding of recovery, and how they can best meet the needs of clients.

There is evidence that people addressing their addiction problems will require the greatest amount of professional support between years one and three of their recovery (Dennis *et al.*, 2007), a time when the focus shifts from abstinence to psychosocial improvements. This highlights the importance of long-term service provision that looks beyond abstinence as the goal for treatment. This time in treatment could help prepare people to develop skills to progress from professional help to self-management.

The participants in this study identified a number of barriers to accessing services including a lack of support, long waiting lists, a lack of understanding from professionals, and a lack of understanding about recovery. Similar factors were identified by dos Santos and Van Staden (2008) in their study in South Africa. The participants provided numerous ideas for how services could better meet the needs of those in recovery. These included increasing the availability of medical support, psychological support and social support and encouraging

services to recognise that support needs to be provided in a more holistic manner, rather than being focussed on medication, as at present.

Unlike many other studies (dos Santos & Van Staden, 2008; Hser, 2007), the participants in this study did not regard treatment as a crucial factor in their recovery, and talked relatively little about the role of treatment in their recovery, despite direct questioning. This suggests that although treatment, in particular substitute prescribing, does have a role in the recovery process, it is other factors such as changes in thinking, improved social support and engagement in new activities which are most valued in the recovery process. This may reflect the limited treatment available in the area, as at present residential rehabilitation is primarily accessed “out of country” and there is limited funding for this resource. The primary treatment available in the area is substitute prescribing, with limited counselling services also available.

Further barriers to accessing treatment identified in this study included long waiting lists, a focus on medical assistance and a scarcity of psychosocial interventions. The evidence suggests that recovery outcomes are worse for people who do not receive the treatment they seek, or who experience a delay in their treatment (Moos & Moos, 2006), thus highlighting the importance of readily available and appropriate support. The evidence base, and the findings of this research, emphasise the necessity for proficient support networks, early intervention and long-term care (Darke *et al.*, 2007; Grey & Fraser, 2005; Hser, 2007).

There is strong evidence for the importance of linking people in recovery with supportive networks (Timko *et al.*, 2006), and this practice is promoted by the NICE guidelines (2007). However, such provision had not been experienced by the participants in this study. This therefore highlights an area for service improvement. Including engagement with self-help groups as a treatment outcome could highlight the importance of this resource, and enhance professionals’ awareness of available services in their local area, and the evidence base behind such assertive linkage. The experiences of the participants in this study echo those reported in other areas of Britain (Best *et al.*, 2010a).

4.3.2.1. *The way forward*

The evidence from the USA strongly supports the implementation of recovery orientated systems of care (ROSC) to replace the current acute care model primarily used in the UK. For this to occur, the whole structure of addiction treatment needs to be shifted towards a focus on recovery which requires the support of professionals at all levels of the system. The emerging evidence from Britain regarding the current medical-focused experiences of people engaged with addiction services (Best *et al.*, 2010a) has highlighted the need for a change to the system. This research provides ideas for how this change in addiction services can be implemented.

This research has highlighted the importance of simultaneously addressing the physical, psychological and social consequences of heroin addiction in a long term model of care. Furthermore, this research has highlighted how current service provision in the South Wales area is not adequately meeting the needs of people in recovery, suggesting that changes need to be made in the development and delivery of recovery orientated services.

A lot can be learnt from the USA where a radical shift in addressing addiction has been witnessed, from an acute care model to ROSC, which refers to formal and informal services that focus on long-term recovery support. A robust and ever-growing evidence base for ROSC has been developed which suggests that it is a more effective way, in terms of cost-effectiveness and treatment outcomes, of addressing drug and alcohol problems (White, 2008).

The benefits of a ROSC have been recognised at multiple levels, from service users and family members through to commissioners and policy makers. Some of the most significant treatment system changes that have been evident in the USA include: the growth of diverse mutual-aid organisations (Humphreys, 2004); the emergence of a grassroots recovery advocacy movement (White, 2007); the development of recovery communities that exist independently of treatment providers (Valentine *et al.*, 2007); and the creation of recovery institutions such as recovery homes and businesses (White, 2008b). The USA has seen recovery incorporated into national and state policies (Institute of Medicine, 2006) which have enabled the development of ROSC and a recovery management philosophy where

treatment and recovery support services enhance pre-recovery engagement, recovery initiation and maintenance support, and quality of life in long term recovery (Kaplan, 2008).

One of the benefits of an acute model is the ability to easily measure outcomes and to evidence positive effects of interventions compared to the absence of treatment (Moos, 2003; Simpson, 2004). With regard to measuring the performance of ROSC, White (2008b) proposed that three critical performance arenas should be considered: *infrastructure stability and adaptive capacity*, such as whether an organisation has a recovery-focused culture, close working partnerships with other services and sustainable funding; *recovery-focused service process measures*, such as access to care, assertive linkage to recovery communities and post treatment monitoring, support and early re-intervention; and *treatment/recovery outcomes*, such as abstinence, employment/education and positive relationships. White (2008) proposes a variety of formal and informal measures that should be incorporated into service delivery and development.

4.3.3. Societal implications

The participants in this study identified the negative impact of stigma, both from professionals working in the addictions field and from society as a whole. Evidence suggests that the greater the social stigma surrounding addiction, the later the onset of help seeking behaviour (White, 2008b). The implications of this are important as other evidence suggests that the earlier the age of first treatment episode, the greater the prognosis for recovery (Klingemann & Klingemann, 1999).

Actions to address the stigma surrounding addiction and accessing addiction treatment could include conducting public education strategies to enhance knowledge and understanding of addiction and recovery, or conducting research into the practices and policies that may contribute to stigma within services and identifying areas for change (Luoma *et al.*, 2007). Treatment services could also be offered through avenues that have less stigma attached to them, such as primary health services (Luoma *et al.*, 2007).

4.3.4. Implications for clinical psychology

The profession of clinical psychology can play a crucial role in ensuring that the needs of people in recovery from heroin addiction, and other addictions, are better met. This

research has highlighted the importance of changes in the way that services are delivered to people in recovery, particularly with regards to addressing psychosocial needs, and clinical psychologists have a unique skill set which enables them to exert an influence at multiple levels of the system. This will now be considered in more detail.

4.3.4.1. *Clinical practice*

The best predictor for retention in addiction treatment is the quality of the therapeutic alliance established between therapist and client (Barber *et al.*, 2001; Meir *et al.*, 2006). Evidence suggests that approximately 50% of people who start addictions treatment drop out in the first month (White, 2008b), and clients with co-occurring mental health problems have been reported to be twice as likely to drop out of treatment (Haller & Miles, 2004). Clinical psychologists can use their training and expertise in working with complex client groups to implement engagement strategies into their work, the work of other professionals and the services in which support is offered.

The assessment skills of clinical psychologists can also be drawn upon to encourage a more holistic assessment process in services which also identifies individuals' strengths and resources, rather than the focus being entirely on the primary problem. Conducting comprehensive assessments which consider personal, family and environmental strengths and difficulties can encourage professionals to consider interventions for different aspects of the person's life, which may have a positive influence on the stability of their recovery. This is particularly important for clients with co-occurring difficulties such as mental health problems, where addressing one problem is often contingent on the other (Hasin *et al.*, 1996). More global asset-based assessments have been endorsed by influential American researchers (e.g. White, 2008b), and addiction treatment in the USA has seen a vast improvement in the number of services conducting rigorous assessments (Alexander *et al.*, 2008) which has, in turn, been associated with positive outcomes.

People with co-occurring substance misuse and mental health problems have a significantly worse prognosis post-treatment than those with substance misuse problems alone (Ritscher *et al.*, 2002). This suggests that specialist services which utilise continuing care strategies may be required for individuals with more complex issues, and psychologists are highly trained to work with such clients.

The training of clinical psychologists also enables them to continually evaluate their work, using formal and informal measures, thus being adaptive to the changing needs of clients. As identified by the participants in this study, recovery is a very individual process, and the needs of individuals change throughout their recovery journey. When working with clients, it is essential that professionals are adaptive and flexible, and psychologists can model this approach and help redefine the approaches used in services. Psychologists can also provide training on the use of formal assessment and evaluation measures such as the Addiction Severity Index (McLellan *et al.*, 1992) and the Global Appraisal of Individual Needs (Dennis, 2010).

4.3.4.2. *Leadership*

Clinical psychologists could play an important role in changing attitudes towards substance misuse treatment at the service delivery level. Their leadership, teaching, training and consultancy skills can be utilised to enhance other professionals' understanding of the recovery process to encourage well-evidenced changes in service delivery such as: improving access to services; addressing engagement difficulties; encouraging longer term care addressing psychosocial difficulties as well as substance use; incorporating post-treatment monitoring and support; assertive linkage to mutual aid support; and the development of peer support meetings onsite at treatment agencies (Laudet & Sands, 2007).

The importance of multi-disciplinary working within the addictions field has been identified as key to ROSC (White, 2008b). This requires an infrastructure of partnership working, consistent communication and good knowledge and understanding of the different types of support available. Clinical psychologists are well placed to offer training and teaching across different services and to different professionals, encouraging the integration of psychological perspectives into client work, and offering consultation and supervision for complex cases.

4.3.4.3. *Research*

In the USA, a great debate about the quality of addiction services has highlighted the gap between clinical research and clinical practice (Miller *et al.*, 2003), resulting in a call for the

incorporation of more evidence-based practice (White, 2008b). Although a great deal of research is being conducted in the USA, the difference in treatment systems impacts on the generalisability of that data to the British treatment system.

To continue enhancing our understanding in the area of recovery from addiction, a systematic collection of long-term post-treatment recovery outcomes need to be established and evaluated to enhance our knowledge of the recovery process and improve long-term service delivery. Clinical psychologists can take a lead role in implementing this evaluation and enhancing the evidence base in the UK.

4.4. METHODOLOGICAL LIMITATIONS OF THE STUDY

4.4.1. Design

There are numerous methodological limitations associated with using a qualitative methodology, and therefore it is important to justify their use in research. Qualitative methodology was deemed most appropriate for this study due to the limited available evidence base in the UK regarding recovery from heroin addiction (Fossey *et al.*, 2002). In Wales, there is no published research regarding the recovery journeys of Welsh heroin users, and recovery orientated services are in their infancy. This suggests that the experiences of people in recovery in South Wales may well be different to those of people in other areas where recovery support is better established. It was believed that a qualitative design would allow a rich and in-depth exploration of the recovery experience in South Wales, allowing social and cultural influences to be captured (Willig, 2008), in order to inform the development and delivery of appropriate services.

A grounded theory approach was deemed most appropriate in order to represent the collective experiences of the participants within a social context, as opposed to other qualitative approaches such as IPA which focus in a case-based way on an individual's perception of their personal experiences (Smith, 2003). However, it is recognised that utilising alternative methods may have produced different results.

4.4.2. Quality of research

A number of principles were adhered to in order to ensure the quality of this research. Firstly, the researcher adopted a reflexive approach to data analysis, which was enhanced

by regular explorations of the meanings drawn from the data with supervisors and professionals in the field, thus enhancing the rigour of the research (Guillemin & Gillam, 2004). A reflective diary was also completed throughout the research (see Appendix K for an excerpt) and memos (see Appendix L for an excerpt) were kept to aid the development of themes and higher levels of data interpretation (Montgomery & Bailey, 2007).

Shenton (2004) proposed four criteria for ensuring trustworthy qualitative research: credibility, transferability, dependability and confirmability. Components of each of these were incorporated into the design and execution of this study to enhance the quality of the research.

Section 2c in Chapter Two provides a detailed discussion of the quality checks used. However, it is recognised that these could have been improved upon. Firstly, credibility and confirmability could have been enhanced by obtaining feedback from the participants about the themes that emerged through the analysis. Although these themes were validated by the focus group, directly validating them with the participants would have been advantageous to ensure that the true meaning of their views were captured. However, this was not possible due to time constraints.

Secondly, although the researcher attempted to avoid personal bias in the analysis of the data, it is possible that this was not wholly successful and that certain preconceptions and attitudes may have influenced the analysis, thus reducing the dependability. This was in some way addressed through providing numerous direct quotes and excerpts from the transcripts, as well as having a focus group to discuss how far the findings fitted with professionals' experiences of the recovery process. Furthermore, the dependability of the research could have been further enhanced by having a second person analysing the data, although this was not possible in the constraints of this research.

4.4.3. Sample size

A significant limitation of this study is the sample size of 10 participants, which may have impacted on the generalisability of the findings (Watson & Parke, 2011). However, a sample size of 10 is generally regarded to be appropriate for a grounded theory study, and it is argued that as long as sufficient contextualisation is provided, a smaller number of

participants can be sufficient for the emergence of common themes amongst the participants' data (Smith & Osborn, 2003).

The author set out to recruit a heterogeneous sample consisting of males and females of varying ages, with diverse addiction and recovery pathways. For example, some of the participants were still using substitute prescriptions at the time of interview whereas others had not used any such medication during their recovery process. The diversity of the participants may be viewed as a limitation of the study as it can dilute the data. However, the purpose of this research was to gain a better understanding of the process of recovery amongst individuals in South Wales. The author believed it was important to include participants with diverse experiences at this initial stage, when little is known about the recovery process in the locality.

4.4.4. Sample bias

Qualitative research is often criticised for using purposive sampling rather than random sampling (Shenton, 2004). This study may have benefitted from using random sampling as a number of the participants were contacted by their key workers to inform them about the study, so biases may have resulted from the way in which clients were recruited. This was in part addressed by advertising the study through a number of different channels. However, this was limited in that it relied on word of mouth to recruit participants not linked with services. Future studies could use media advertising to expand the recruitment process.

This research recruited participants who reported themselves to have once been addicted to heroin, but to now be in recovery and to have not used heroin for more than 30 days in the six months preceding the interview. No formal measures were used to ensure that the participants had previously been addicted to heroin, or to ensure that their self-reported drug use at the time of interview was accurate. The author's intention was not to determine whether the participants' recovery was genuine, but to better understand the views and experiences of those who class themselves as in recovery from heroin addiction. Due to the voluntary nature of this study, it was thought that participants would be honest about their previous and current drug use. However, the study's authenticity may be criticised on this basis, and future studies may incorporate more stringent tests for previous and current drug use.

4.5. AREAS FOR FUTURE RESEARCH

Research into addictions has been largely influenced by Cochrane-type evidence hierarchies (Best *et al.*, 2010b). However, as exemplified in the mental health field, researching and documenting the recovery process does not lend itself to studies using robust research methodologies, such as randomised clinical trials (Peyser, 2001). This is due to the individuality of the recovery process, and to the factors that are perceived as being important in recovery, for example quality of life and self-identity, being more difficult to capture and to measure using standardised tools. Research into recovery faces the challenge of utilising a range of methodologies which provides robust and measurable outcomes that account for the multifaceted nature of recovery (Best *et al.*, 2010a).

The individuality of the recovery experience can be influenced by many factors, one of which is gender (Ettorre 1992; Watson & Parke, 2011). This research suggests that females in recovery may be more likely to have some specific support needs in their recovery journeys, including psychological support in addressing the consequences of addiction, such as prostitution and the impact on relationships with children. Further research into the female experience of recovery could help to identify specific services that best suit women's needs, thus helping to engage a client group of those traditionally less likely to seek treatment (Greenfield *et al.*, 2007).

At present the literature on mutual aid is very limited. That which exists is primarily focused on the 12-Step model (Toumbourou *et al.*, 2002) and mostly originating from the USA where mutual aid is better established and supported than in the UK. Additional research on different mutual-aid approaches would enhance understanding of what is provided, how effective they are, and why they are effective, thus potentially improving linkage between formal and informal service providers. Furthermore, the majority of the research on mutual aid support is based around alcohol addiction and, although there are many parallels with heroin addiction, there are also some notable differences. Future research specifically considering mutual aid for heroin addicts would be likely to enhance our understanding of their role in the recovery process.

This study has highlighted the importance of helping people in recovery to develop positive social support networks and to engage in meaningful and fulfilling activities. Further

exploration into the reasons behind the lack of active linkage between treatment providers and self-help groups in the UK could help to address this problem, thus enhancing the support available to people in recovery and facilitating long term stable recovery. This collaborative approach to working would also help to best utilise the skills available from different organisations providing formal and informal support to help to address people's difficulties in a more holistic manner, as highlighted in this research.

Further research into the psychological processes involved in the recovery journey would help to identify how services can best meet the psychological needs of people in recovery. Although there is a wealth of literature regarding abstinence and the importance of positive social networks, the psychology of recovery is still not well understood, despite evidence from this study that it plays a key role in the recovery journey. This study provides some insight into the psychological aspects of recovery but the issue would certainly benefit from further investigation.

The increasing development of recovery orientated services in the UK provides an opportunity for enhancing our knowledge and our understanding of how to deliver effective holistic services for people in recovery. Research utilising qualitative and quantitative methodologies should be conducted with these services to better inform service development in other UK areas. This knowledge, in combination with that obtained from the USA, will enable Britain to develop ROSC which might well reduce the risk of relapse through utilising biopsychosocial approaches, improving quality of life, and providing cost-effective services.

4.6. CONCLUSIONS

This study aimed to explore the experiences of people in recovery from heroin addiction in order to better understand the process of recovery and how services can be delivered to best meet the needs of those in recovery.

The research provided numerous insights into the process of recovery from heroin addiction, factors that can facilitate and hinder the process, the role that services play, and how services can be developed to better meet the needs of people in recovery. One of the key findings of the research was the recognition that recovery is an individual process that

requires long term concurrent support in addressing the physical, psychological and social consequences of addiction. The study also highlighted how the current treatment system focuses on addressing the physical aspects of addiction, and a lack of psychosocial support was identified despite the recognition that such aspects play a vital role. However, ways of addressing this lack of psychosocial support have been identified, and numerous possibilities for enhancing the services available to people in recovery have been proposed, as identified by the participants in this study and supported by the existing evidence base.

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APPENDIX A

Letters regarding ethical approval

- i) Confirmation of ethical approval from South Wales Research Ethics Committee**
- ii) Research and Development Committee approval letter – Cardiff and the Vale NHS**

APPENDIX A

- i) Confirmation of ethical approval from South Wales Research Ethics Committee**



GIG
CYMRU
NHS
WALES

Canolfan Gwasanaethau
Busnes
Business Services
Centre

South East Wales Research Ethics Committee Panel C

Direct Line: 02920 376823/376822

Facsimile: 02920 376835

Email: Carl.phillips@wales.nhs.uk

Miss Lucy James
Trainee Clinical Psychologist
Cardiff and Vale UHB
1st Floor, Archway House
Llanishen, Cardiff
CF14 5DX

29 March 2011

Dear Miss James

Study title: Understanding the process of recovery from heroin
addiction: A qualitative analysis of initiating and
maintaining factors in early recovery.
REC reference: 11/WA/0048

Thank you for your letter of the 24 March 2011, responding to the Committee's request for further information on the above research, and for submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised], subject to the conditions specified below.

Ethical review of research sites

NHS 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).

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.

Canolfan Gwasanaethau Busnes
Ty Churchill
17 Ffordd Churchill
Caerdydd, CF10 2TW
Ffôn: 029 20 376820 WHTN: 1809
Ffacs: 029 20 376826

Business Services Centre
Churchill House
17 Churchill Way
Cardiff, CF10 2TW
Telephone: 029 20 376820 WHTN: 1809
Fax: 029 20 376826

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.
- Management permission ("R&D approval") should be sought from all NHS organisations involved in the study 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 a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.
- For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.
- Sponsors are not required to notify the Committee of approvals from host organisations
- It is the 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 final list of documents reviewed and approved by the Committee is as follows:

| Document | Version | Date |
|--|-------------------|------------------|
| Interview Schedules/Topic Guides | 1.3 | 08 February 2011 |
| Advertisement | 1.3 - Interviews | 08 February 2011 |
| Advertisement | 1.3 - Focus Group | 08 February 2011 |
| Response to Request for Further Information | L James | 24 March 2011 |
| Participant Information Sheet: Participant | 1.4 | 24 March 2011 |
| Letter of invitation to participant | 1.3 | 08 February 2011 |
| REC application | IRAS 3.1 | 08 February 2011 |
| Participant Consent Form: Interviews | 1.4 | 24 March 2011 |
| Protocol | 1.3 | 08 February 2011 |
| Participant Information Sheet: Focus Group - Professionals | 1.1 | 24 March 2011 |
| Investigator CV | L James | 22 February 2011 |
| Investigator CV | A Smith | 22 February 2011 |
| Investigator CV | N J Frude | 23 January 2011 |
| Participant Information Sheet: Interviews | 1.4 | 24 March 2011 |
| Participant Consent Form: Focus Group - Professionals | 1.1 | 24 March 2011 |
| Participant Consent Form: Focus Groups | 1.4 | 24 March 2011 |
| Letter from Sponsor | CaRRS | 08 February 2011 |

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
- 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.

11/WA/0048

Please quote this number on all correspondence

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

Yours sincerely



Mrs J Jenkins
Chair, Panel C
South East Wales Research Ethics Committees

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

R&D office for Cardiff & Vale University Health Board

luciejames82@gmail.com

APPENDIX A

- ii) **Research and Development Committee approval letter – Cardiff and the Vale
NHS**



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Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Ysbyty Athrofaol Cymru University Hospital of Wales

Heath Park,
Cardiff, CF14 4XW
Phone 029 2074 7747
Fax 029 2074 3838
Minicom 029 2074 3632

Parc Y Mynydd Bychan,
Caerdydd, CF14 4XW
Ffôn 029 2074 7747
Ffacs 029 2074 3838
Minicom 029 2074 3632

Eich cyf/Your ref
Ein cyf/Our ref
Welsh Health Telephone Network 1872
Direct line/Llinell uniongyrchol

Tel: 029 20746986
Fax: 029 20745311
CAV_Research.Development@wales.nhs.uk

From: Professor JI Bisson
R&D Director
R&D Office, 2nd Floor TB2
University Hospital of Wales
Cardiff
CF14 4XW

05 April 2011

Miss Lucy James
Trainee Clinical Psychologist
1st floor, Archway House
77 Ty Glas Avenue
Llanishen
Cardiff
CF14 5DX

Dear Miss James

Project ID : 11/MEH/5062 : Understanding The Process Of Recovery From Heroin Addiction: A Qualitative Analysis Of Initiating And Maintaining Factors In Early Recovery

Further to recent correspondence regarding the above project, I am now happy to confirm receipt of:

- Evidence of favourable opinion from the relevant NHS Research Ethics Committee
- Evidence of completion of Informed Consent training by the PI
- Revised documentation as required by the REC in order to obtain favourable opinion

The following amended documentation is approved for use with this study:

| Document | Version | Date |
|---|---------|----------|
| Participant Information Sheet: Interviews | 1.4 | 24/03/11 |
| Participant Information Sheet: Focus Groups | 1.4 | 24/03/11 |
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| Participant Consent Form: Focus Groups | 1.4 | 24/03/11 |
| Participant Consent Form: Focus Group –Professionals | 1.1 | 24/03/11 |

Please accept this letter as confirmation of sponsorship by Cardiff and Vale UHB and permission for the project to begin.

May I take this opportunity to wish you success with the project, and to remind you that as Principal Investigator you are required to:

- Ensure that all members of the research team undertake the project in accordance with ICH-GCP and adhere to the protocol as approved by the Research Ethics Committee
- Inform the R&D Office if any external or additional funding is awarded for this project in the future
- Inform the R&D Office of any amendments relating to the protocol, including personnel changes and amendments to the actual or anticipated start and end dates
- Complete any documentation sent to you by the R&D Office or University Research and Commercial Division regarding this project
- Ensure that adverse event reporting is in accordance with the UHB adopted Cardiff and Vale NHS Trust Policy and Procedure for Reporting Research-Related Adverse Events (refs 164 & 174) and Incident Reporting and Investigation (ref 108)
- Ensure that the research complies with the Data Protection Act 1998
- Ensure that arrangements for continued storage or use of human tissue samples at the end of the approved research project comply with the Human Tissue Act, 2004 (for further information please contact Sharon Orton, HTA Coordinator OrtonS@cf.ac.uk).

If you require any further information or assistance, please do not hesitate to contact staff in the R&D Office.

Yours sincerely,



Professor Jonathan I Bisson
Cardiff and Vale University Local Health Board R&D Director

CC R&D Lead Dr Pamela Roberts
Professor Neil Frude, Academic Supervisor

APPENDIX B

Participant invitation letter



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Dear Sir/Madam,

This letter has been sent to you on our behalf by a professional working within the substance misuse field. This letter has been sent to a number of people in the South Wales area who are thought to be in recovery, or have recovered, from heroin addiction.

I am writing to introduce myself and provide you with information regarding a research study I am conducting which looks at recovery from heroin addiction. I was hoping that you may be interested in participating.

I am a Trainee Clinical Psychologist with a keen interest in recovery from drug addiction which stems from working for a number of years with substance misusers and people in recovery. As part of my training to become a Clinical Psychologist I am conducting a research project considering the process of recovery from heroin addiction. I hope that this research will add to the knowledge about recovery, and help to inform the development and delivery of services for people in recovery.

I have enclosed some information about my research and I would be very grateful if you would take the time to read it. If you would like to participate in the study, please complete the consent form and return it to me in the enclosed stamped addressed envelope. If you would like to discuss the study with me in further detail, then please do not hesitate to contact me on 02920 206464 or 07527171206.

Many thanks

Lucy James
Trainee Clinical Psychologist

Supervised by Professor Neil Frude
Clinical Psychologist

APPENDIX C

Poster Advertisements – interviews



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

ARE YOU IN RECOVERY FROM HEROIN ADDICTION?

I am a trainee clinical psychologist conducting research into people's experiences of recovery from heroin addiction in the South Wales area.

I am looking for people who define themselves as 'in recovery from heroin addiction' to participate in 1 hour interviews.

In particular, I am interested in hearing your experiences about...

- how your recovery journey started
- how you have maintained your recovery
- any obstacles you experienced in your recovery and, if so, how you overcame these
- whether you received any professional or informal support and, if so, what was helpful and not so helpful
- how you would define recovery

People on prescribed substitute drugs (i.e. methadone, subutex) are welcome to participate in the study.

If you are interested in taking part in this study, or have any further questions, please contact Lucy James on 02920 206464 or 07527 171206.

Thanks ☺



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106
Email/Ebost deborah.robinson2@wales.nhs.uk



APPENDIX D

Poster Advertisements – focus group



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

WOULD YOU LIKE TO SHARE YOUR VIEWS AND EXPERIENCES ON RECOVERY FROM ADDICTION?

Are you a dependent drug user? Or do you work with people
with substance misuse problems?

If so, you could really help this study.

I am a trainee clinical psychologist conducting research into
people's experiences of recovery from heroin addiction in the South
Wales area.

I have conducted interviews with several people in recovery and I
would like to present the findings to you at a focus group. I would
like to hear your views and discuss whether the findings fit with
your professional and/or personal experiences.

I am holding a focus group at the Community Addiction Unit on
February 29th, 2012 at 3pm.

If you are interested in taking part in the focus group, or have any
further questions, please contact Lucy James on 02920 206464 or
07527 171206. The focus group is limited to 10 places so please
contact me to book your space if you are interested!

Thanks ☺



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106
Email/Ebost deborah.robinson2@wales.nhs.uk



APPENDIX E

Participant information sheet – interviews



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Participant Information Sheet - Interviews

Understanding the process of recovery from heroin addiction.

We would like to invite you to take part in our research study. Before you decide, we would like you to understand why the research is being done, and what it would involve for you. Please take some time to read the following information carefully and discuss it with others if you wish.

Purpose of the study.

This research aims to gain a better understanding of the process of recovery from heroin addiction. We are interested in people's recovery journeys including how they started and maintain their recovery, any obstacles they encountered and how they overcame them, and what services were, or could have been, helpful. This information will be used to improve understanding of the process of recovery, and to inform the development and delivery of services for people in recovery.

Who will be conducting the study?

This study is being carried out by Lucy James, a Trainee Clinical Psychologist. The research will be written up and submitted as part of her Doctorate in Clinical Psychology. The research is supervised by Professor Neil Frude (Clinical Psychologist) and Dr Alyson Smith (Clinical Psychologist).

Why have I been invited?

You have been invited to take part in this study because you are in recovery, or have recovered, from heroin addiction. This study is aiming to recruit 8-12 participants who are in recovery from heroin addiction.

Do I have to take part?

It is up to you to decide whether you would like to join the study. This information sheet will describe the study and help you to decide whether you would like to take part. If you agree to take part then you will be asked to sign a consent form and send it to us in the enclosed stamped addressed envelope. You are free to withdraw from the study at any time, without giving reason. This would not affect the standard of care you receive.



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY **CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL**

What will happen to me if I take part?

If you decide to take part you will be contacted by post or telephone (whichever is most convenient for you) by Lucy James who will arrange a time and place to conduct an interview. The interviews can be held at an addiction service in your area or at Lucy's workplace (Archway House, Llanishen). If you need to use public transport to attend the interview we can reimburse you on receipt of your travel ticket.

The interviews will be one-to-one and held in a private environment. They will last approximately one hour. The interviews will be tape-recorded so that they can be transcribed and analysed by Lucy. After the interview, you will not be expected to actively participate in any other way.

The interviews will consist of questions about your thoughts and experiences of addiction, treatment and recovery.

What are the possible disadvantages of taking part?

Other than having to give up some of your time for an interview, it is not anticipated that there will be any disadvantages to you taking part in this study. During the interview you may find that upsetting topics come up, in which case, the services of a clinical psychologist will be made available for you.

What are the possible advantages of taking part?

Although there are no direct benefits from taking part in this study, we hope that you will welcome the opportunity to share your experiences of recovery. You may also value the opportunity to contribute to an area where there is currently little research and which may benefit the development and delivery of services for people in recovery.

What if I have a problem with the study?

If you have a concern about any aspect of this study, you should speak to Lucy James who will do her best to answer your questions. If you remain unhappy and wish to complain formally, please contact Professor Neil Frude or Dr Alyson Smith (details below) who will deal with your complaint appropriately.



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY **CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL**

Will my taking part in this study be kept confidential?

The information discussed during the interviews will remain confidential unless information is disclosed that suggests that you or someone else is at risk of harm.

The interviews will be tape recorded and transcribed for the purpose of analysis. The tape recordings will be stored securely in a locked cabinet, and once the information has been transcribed (within 3 weeks), the tapes will be destroyed. The transcripts of the interviews will be anonymised, and all identifiable information removed. Consent forms will be kept separately from tape recordings and transcripts.

What will happen to the results of the research?

The information gained from the interviews will be written up into a thesis that will be submitted by Lucy James to the South Wales Centre for Training in Clinical Psychology. Direct quotations from the interviews will be included in the thesis, but all identifiable information will be removed. A shortened version may also be submitted for publication in a journal.

If you would like a copy of the final report you can ask for this and it will be sent to you once the research is completed.

Who has reviewed the study?

All research in the NHS is looked at by an 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 East Wales Local Research Ethics Committee.

What do I do if I would like to participate in this study?

Please complete and sign the enclosed consent form and return it to Lucy James in the attached stamped addressed envelope. Lucy will be in contact with you in the near future to arrange a convenient time and date for the interview.

Further information.

If you have any further questions about taking part in this study please contact Lucy James on 02920 206464 or 07527 171206. If Lucy is not available please leave a message with your details and your call will be returned as soon as possible.

Thank you for taking the time to read this information sheet.
Your help is greatly appreciated.



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106
Email/Ebost deborah.robinson2@wales.nhs.uk



APPENDIX F

Participant information sheet – focus group



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Participant Information Sheet – Focus group

Understanding the process of recovery from heroin addiction.

We would like to invite you to take part in our research study. Before you decide, we would like you to understand why the research is being done, and what it would involve for you. Please take some time to read the following information carefully and discuss it with others if you wish.

Purpose of the study.

This research aims to gain a better understanding of the process of recovery from heroin addiction. We are interested in people's recovery journeys including how they started and maintain their recovery, any obstacles they encountered and how they overcame them, and what services were, or could have been, helpful. This information will be used to improve understanding of the process of recovery, and to inform the development and delivery of services for people in recovery.

The results of the study will be presented to current substance misusers and professionals working in the field to gather their views which will then be analysed and written up to form part of the research project.

Who will be conducting the study?

This study is being carried out by Lucy James, a Trainee Clinical Psychologist. The research will be written up and submitted as part of her Doctorate in Clinical Psychology. The research is supervised by Professor Neil Frude (Clinical Psychologist) and Dr Alyson Smith (Clinical Psychologist).

Why have I been invited?

You have been invited to take part in this study because you are currently engaged with addiction services. This study is aiming to recruit 6-10 participants who will participate in a focus group considering the process of recovery from heroin addiction. The focus group will consist of professionals and service users.



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Do I have to take part?

It is up to you to decide whether you would like to join the study. This information sheet will describe the study and help you to decide whether you would like to take part. If you agree to take part then you will be asked to sign a consent form and send it to us in the attached stamped addressed envelope. You are free to withdraw from the study at any time, without giving reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

If you decide to take part you will be contacted by post or telephone (whichever is most convenient for you) by Lucy James who will arrange a time and place for you to attend a focus group. The focus group will be held at an addiction service in your area. If you need to use public transport to attend the focus group we can reimburse you on receipt of your travel ticket.

The focus group will last approximately one hour and will be tape-recorded so that it can be transcribed and analysed by Lucy. After the focus group, you will not be expected to actively participate in any other way. The focus group will consist of you considering the results of a study which looked at people's experiences of recovery, and providing your thoughts and opinions on the results.

What are the possible disadvantages of taking part?

Other than having to give up some of your time for the focus group, it is not anticipated that there will be any disadvantages to you taking part in this study. During the focus group you may find that upsetting topics come up, in which case, the services of a clinical psychologist will be made available for you.

What are the possible advantages of taking part?

Although there are no direct benefits from taking part in this study, you may value the opportunity to contribute to an area where there is currently little research, and which may benefit the development and delivery of services for people in recovery.

What if I have a problem with the study?

If you have a concern about any aspect of this study, you should speak to Lucy James who will do her best to answer your questions. If you remain unhappy and wish to complain formally, please contact Professor Neil Frude or Dr Alyson Smith (details below) who will deal with your complaint appropriately.



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Will my taking part in this study be kept confidential?

All participants will be informed that the information discussed during the focus group must remain confidential within the group, unless information is disclosed that suggests that you or someone else is at risk of harm.

The focus group will be tape recorded and transcribed for the purpose of analysis. The tape recordings will be stored securely in a locked cabinet, and once the information has been transcribed (within 3 weeks), the tapes will be destroyed. The transcript of the focus group will be anonymised, and all identifiable information removed. Consent forms will be kept separately from tape recordings and transcripts.

What will happen to the results of the research?

The information gained from the focus groups will be written up in a thesis that will be submitted by Lucy James to the South Wales Centre for Training in Clinical Psychology. Direct quotations from the interviews will be included in the thesis, but all identifiable information will be removed. A shortened version may also be submitted for publication in a journal.

If you would like a copy of the final report you can ask for this and it will be sent to you once the research is completed.

Who has reviewed the study?

All research in the NHS is looked at by an 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 East Wales Local Research Ethics Committee.

What do I do if I would like to participate in this study?

Please complete and sign the enclosed consent form and return it to Lucy James in the attached stamped addressed envelope. Lucy will be in contact with you in the near future to inform you of the time and date for the focus group.

Further information.

If you have any further questions about taking part in this study please contact Lucy James on 02920 206464 or 07527 171206. If Lucy is not available please leave a message with your details and your call will be returned as soon as possible.

**Thank you for taking the time to read this information sheet.
Your help is greatly appreciated.**



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106
Email/Ebost deborah.robinson2@wales.nhs.uk



APPENDIX G

Participant consent form – interviews



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Consent form - Interviews

Research title: Understanding the process of recovery from heroin addiction

Researcher: Lucy James

Please
initial
box

1. I confirm that I have read and understand the information sheet (Version 1.4, dated 24/03/11) for the above study. I have had the opportunity to consider the information, ask questions and have them answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my standard of healthcare or legal rights being affected.
3. I understand that the interviews are confidential unless I disclose information suggesting that I or someone else may be at risk of harm.
4. I understand that the interviews will be tape recorded, and the tapes will be kept securely.
5. I agree to take part in the above study.

Participant name

Date

Signature

Researcher name

Date

Signature



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106
Email/Ebost deborah.robinson2@wales.nhs.uk



APPENDIX H

Participant consent form – focus group (professionals)



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Consent form – Focus groups

Research title: Understanding the process of recovery from heroin addiction

Researcher: Lucy James

Please
initial
box

1. I confirm that I have read and understand the information sheet (Version 1.1, dated 24/03/11) for the above study. I have had the opportunity to consider the information, ask questions and have them answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my employment or legal rights being affected.
3. I understand that the focus groups are confidential within the group, unless I disclose information suggesting that I or someone else may be at risk of harm.
4. I understand that the focus groups will be tape recorded, and the tapes will be kept securely.
5. I agree to take part in the above study.

☐☐☐☐☐

Participant name

Date

Signature

Researcher name

Date

Signature



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106
Email/Ebost deborah.robinson2@wales.nhs.uk



APPENDIX I

Participant consent form – focus group (non-professionals)



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Consent form – Focus groups

Research title: Understanding the process of recovery from heroin addiction

Researcher: Lucy James

Please
initial
box

1. I confirm that I have read and understand the information sheet (Version 1.4, dated 24/03/11) for the above study. I have had the opportunity to consider the information, ask questions and have them answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my standard of healthcare or legal rights being affected.
3. I understand that the focus groups are confidential within the group, unless I disclose information suggesting that I or someone else may be at risk of harm.
4. I understand that the focus groups will be tape recorded, and the tapes will be kept securely.
5. I agree to take part in the above study.

☐☐☐☐☐

Participant name

Date

Signature

Researcher name

Date

Signature



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106
Email/Ebost deborah.robinson2@wales.nhs.uk



APPENDIX J

Extracts from interview transcripts

INTERVIEW 1:

LJ: What did you think recovery was going to be like?

I thought recovery was going to be like a magic wand. But it's not. It's a lot of hard work. Very hard work. With recovery you have to always find new ways. Like bumping into people you know and avoiding them. Like there was a code we learnt at one rehab where I stayed for 3 months. It was avoid, action, walk away, face up, make an excuse or avoid the situation. So that was the kind of thing I lived by for the year. But it was very hard, and still now, 4-5 years on I still have no social network. It is so hard to build a social network with people who aren't involved in drugs because it is everywhere. That is what actually makes me depressed. I get depressed now still. Because I can't mix with normal people at the moment because I feel like I'm lying. Like when people say have you done this have you done that and I feel like I have to say no so I am always hiding things from people. Because I'm an honest person, cos I've not got a good enough memory to be a liar. So it's very difficult to get a social network without drugs cos I know you don't have to tell everybody but I don't want to build a new relationships on a lie cos that's what I did when I was on drugs and I'm trying to change those ways and build on my recovery.

[18.50] Cos I'm not recovered, still after 5 years I'm not recovered. But I'm getting there. I just need to get out and get a bit more social. But it's very hard and I had to learn a lot of different avoidance techniques and different things like that and that was the hard part. But finding something like [recovery service] has given me an extra outlet so hopefully I can make a drug free social network which is what I want. I want that outlet.

Cardiff's a big city but you always walk into people and it's hard but I don't wanna be there so my choice is either I suffer for now, or go through maybe 2/3 years of not having friends that I had before, before something will come out the other side. And that's the hardest part. Really hard. And I feel really lonely sometimes. And that's the hardest part of recover. Trying to build bridges. That takes a long while. And trust. And family. That's a hard one. Cos my family is not a close knit family and because I've been in care and I've been the odd one out I was always the black sheep of the family. There are four of us kids and I'm the middle one. I don't know. My older brother smokes

cannabis and my younger brother and sister don't touch nothing. But I seemed to get on heroin like. And they say to me, we've all been through the same stuff as you, but they haven't cos they haven't seen the beatings I was getting and the stuff that happened in the house and when I was in care and stuff. They didn't see that. And it's kind of about understanding. Holding a grudge against someone doesn't affect them. It affects me. It was ruining my life, not theirs. And my stepfather put me through hell, in my words. I wasn't no angel but there were better ways you could've treated people. And going into care as well but, they get on with their lives and it leaves you stuck. I felt stuck for a lot of years where I couldn't do anything. It was a really tough time.

LJ: What could've helped you to get through that? [22.18]

More support and maybe some social networking, but it just wasn't there at the time. It's come a long way now since I first started recovery. There was maybe 2 groups you could go to back then but now there's maybe 10. But when I first wanted to give up it was so hard and the waiting lists were so long. But I wanted it so bad that I was phoning them every other day and I wanted it. I wanted off it. I hated it. I was using half of it and throwing the rest away. As long as I wasn't hurting that was enough. I just hated it. It just wasn't for me. And that's when I decided that I was never going to go down that road again. I never say never but this is a never.

LJ: What was that first day/ week like?

I spent a lot of time in bed. A lot of time feeling sorry for myself. And a lot of time looking for support and blame, or an excuse for why I was going through this and why I was trying to get clean. Having to tell myself and repeat to myself that I was doing it for the right reasons. I'm doing it for myself. I'm doing it to better my life and better my health cos my health was suffering and all I was doing was taking it to hide the fact that I had a health problem. Cos I'm 33 and I have the bones of a 55 year old man. And that's not a very nice feeling. It's a really difficult thing to deal with. And in the winter I can't get out of bed and stuff like that. And it puts you on a downer. But there are prescription drugs, which sometimes can be just as bad as heroin to take away the pain. But I would rather go through the pain than suffer the addiction again. It was so horrible, I didn't like it?

LJ: What helped you in early recovery? [25.20]

Avoidance, a lot of avoidance. I spent a lot of time with my brother and his wife cos they lived quite close at that point. So I would go and visit them every day so I was busy. Have a chat. Have a cup of tea. So it was keeping my mind occupied and that was the hardest point. Cos as soon as you think about it you are back on it. And as soon as I got cravings and stuff like that I learnt that I had to get a piece of paper and write down the pros of taking it and the cons of taking it. And by the time I had done that the craving had gone. That was my tool for dealing with cravings. And like now, I still get a craving every so often, like when I see people from before. But then I think, but I hate it so it would just be a waste of time. I don't like the taste, the smell. It's come to the point where I actually hate the drug and what it's done to me. Cos it's ruined my life.

LJ: Could services have done anything to help at this time?

Maybe offered me some support. But it just wasn't there. I couldn't ask my family for support because I had none. And what family I did have lived 400 miles away. So my support was me and talking to god. I know that sounds mad but I was talking to myself for 6 months. I would sit there in my bedroom and say "I need someone to talk to and I would just start talking. It was like praying and talking to someone to get things out of my mind and stop me repeating them in my own head. The most difficult part at the start was just being so lonely cos you have to disconnect yourself from everybody. I kept one friend and I went to see him twice in the first year of my recovery but I couldn't go in. I could smell it and everyone was sat there in a mess. And I had to walk out. And that told me that day that it was never going to be for me. But if I could've got some support from somewhere – somewhere I could've gone to see someone or maybe even someone coming out to the house to talk to me – that would've been brilliant. But that help wasn't there. And what help was there was a massive waiting list. It's really important that when people want help it needs to be there for them. There is no point making them wait for months and months –it's no good for them. Waiting hindered and slowed my recovery down. I could've been off all the drugs by now. I don't know if I blame myself for that still but I just think of more positive things. Like I am trying to do a college course and get some education. Cos with my mobility problems it's quite hard.

[30.20] It's sometimes like running up a hill and it's made of ice and you sometimes fall over but you have to get yourself back up and dust yourself down and keep going. And then you try again and then sometimes that fails as well. And then you get to the point where you have to think about whether you actually want to give up. I went through a lot of making excuses for taking it. Reasons why I could take it. Like I'm bad today so I need it to get rid of the pain but I won't need it tomorrow so it's ok just to have some today. And it was just an excuse. But then I thought, what am I going to gain tomorrow when I'm bad again? Cos it's just going to be another excuse to go and use. So I had to fight that every time. That continued for the first 9-12 months. Because I was so alone – I had support but the support at that time was every 2 months, and only getting that chance to speak to someone is really hard. Especially when so much is going through your head every day, to only talk to someone once every 2 months – well I wouldn't stop talking for the hour – I never shut up.

[32.00] And the sleep, the sleep has been the worst for me. I think that a lot of people need to realise that sleep does have a detrimental effect on your recovery. Cos if you can't sleep it tends to make you go backwards. That's from my experiences and from other people I know. They say that if they could've slept in the night then they could've handled the rattle through the day as long as they could sleep at night. But cos they can't sleep they go back to it. But in the end I thought I can't even sleep when I'm on it. So if I can't sleep when I'm on it and I can't sleep when I'm off it I'm better off not to be on it and to be clean and to struggle with my sleep. Rather than struggling with keeping a habit and my sleep cos keeping a habit is like a juggling act all the time.

I try and get up every day before 10am and I try and go to bed every night before 12 and I turn my TV off by one.

INTERVIEW 5:

LJ: If you could design a service what would it look like?

It would have to be comfortable. It would have to be relaxing for a start. Not too formal or too officy. It would have to be nice and colourful and nice and warm and fresh. An uplifting feeling when you walk in to the room. I would like everyone to be sat around together with the tea making stuff in the middle. I would like it to be like a little home really.

The service would offer group activities. So we can all meet up and go on group activities and days out. Maybe a swimming group one day and going on trips and arranging things so that the people in recovery meet up once or twice a week and keep us occupied, keep our minds focussed. Show us the nicer things in life. Go on day trips to the beach, nice things, I think that would be really good for people who are in recovery. Not like people who aren't in recovery cos I don't think they would appreciate it anyway. But for those people who are in recovery I think people need to realise how well they are doing. Cos I think they are feeling like they are on their own and they are just being left to it. I know you shouldn't get any rewards just for basically not taking drugs, but they have to realise that something just to say, 'well done, you've been on heroin for years and years and years and now you are doing something about it'. They are so focussed on the people that are on heroin and trying to get them on their scripts that they don't have the time to think about the people who have got to the stage that I have got to but we still need their help now and then. I think they do need to focus more on the people who are in recovery. Cos all those ones who are on the methadone scripts and have been with them for years, and are still on their scripts but aren't taking part in the activities, aren't going to their meetings, aren't interacting with the services, why should they be focussing on them when there are people out there who have been focussed and have been trying really hard and are doing really really well but are just being left to it. I understand that the people out there do still need the help cos I was one myself, but the ones that are just abusing the services as a methadone script and that's all they want out of them. If they aren't going to be willing to sort themselves out and interact then they should look at the ones who are sorting themselves out and interacting. Cos I don't know anyone who's in recovery and I would like to know people who are in recovery so maybe I could have a chat with them. Just so I don't feel like I'm on my own. Cos I'm sure I can't be the only one who has sorted myself out. There must be more of us out there? And I think if we could just meet up together that would be great. It would be nice if they tried a bit harder with the ones who are in recovery. Let them know how special they are and acknowledge that they realise how hard we have worked. To be appreciated I think.

LJ: what are the important factors in maintaining recovery?

I think you have to keep on reminding yourself about how far you have come. Like set yourself little goals and stick to them because this is what you have to do. I found it really helpful to make smaller goals for myself because then I was achieving them and that gave me more strength in carrying on. And it's helpful to have support from your family. And going out maybe twice a week. Like me and my friend go swimming or go for a coffee and that really helps to have something to look forward to. Or going for a jog with a friend. Just trying to keep yourself motivated. And if you do get a day when you are feeling down you just have to say to yourself, 'look, I might not have much now but remember a few months ago, it could be like that'. You have to keep building yourself up and reminding yourself how far you have come. And pat yourself on the back and say, 'yeah, I've done good'. Praise yourself cos no one else is going to. That's what I say!

LJ: Has the way you view yourself changed? [30.00]

Yeah. I'm more confident, definitely. I feel happier in myself now. I'm not down in the dumps now. There are some days when I wake up and I don't want to wake up and I think, 'crap, same day again, same ole same old'. But then other days I look forward to waking up. I love being clean now. It's amazing how it makes you feel better in yourself. 100% better. I don't feel lethargic. I don't feel moody. I don't crave crap. It's great. I feel in control of myself. I feel more independent. Whereas before I didn't know myself. I didn't know what I wanted. I didn't know what I enjoyed. I didn't know what life I wanted. I didn't know anything. So now I am starting to get back in touch with myself. I think all those years on heroin I just lost track. I didn't know who I was. You turn into that. And people can see it as well. Now I'm clean I just feel much better. I don't have days when I don't sort myself out. I'm always showering. Before I wouldn't bath that often. I wouldn't do my hair or my makeup. I just couldn't be bothered. But now I like to be on top of things. It's great. And that's why I feel better.

LJ: How have things been emotionally? [32.20]

I've been great. I know some people are different but I've been fine. But I think I wanted off it so bad that I just don't care. I won't let it get into my head and me getting depressed because it's not worth getting depressed over. You know, it ruins your life, it knackers your body up, it's rubbish. Everything I've lost, the moneys that's gone is no one's business. I don't get emotional over it though. If anything I just feel anger towards it. I just don't want it anywhere near me ever again. That's how I feel about it.

APPENDIX K

Excerpts from reflective diary

Reflective diary (typed excerpts)

9.6.11 (first interview)

Wow, I've just done my first interview and it went really well, I am so pleased! One thing that I have learnt is that asking people to sum up their addiction is really hard and it takes a long time which takes away from the time left to talk about the recovery process. I think for future interviews I will just ask a couple of questions at the start about their drug use so I have some background information but it won't be a main focus of what we talk about. I asked [the interviewee] if he thought this would be a good idea and he agreed.

Questions to ask...

Age first used heroin, length of time using heroin, how long been in recovery, treatment experiences, current drug/alcohol use, number of previous attempts at addressing addiction.

I can't wait to do the next interview now. It's also made me remember how much I enjoyed working in the addictions field. I am so glad that I chose to do my research on this topic!

1.7.11 (third interview)

Today I did my third interview and it was quite difficult. The [interviewees] mum died this week after a long time of illness. I asked on a number of occasions if he would like to delay the interview but he was certain he did not want to. It made it quite difficult to explore some of the topics I would have liked to explore, such as relationships with family and coping with difficulties in recovery. But it was a really interesting insight into how people do cope with difficulties without turning back to using heroin. He was so strong and from what he was saying there are so many positive things in his life now where he can get support to get through this difficult time that he does not even consider using. This has really helped my thinking as my previous work experience saw a number of people relapse when they had negative life events – it's also really highlighted the importance of positive social support – that is coming through so strongly in the interviews so far – but also how hard it is to find that support when everyone in your life is linked to drugs. Where do you even start. It really shows how strong and determined you have to be to get off heroin, especially in an area where there is such little recovery support. So many ideas for service development are coming from the interviews – it all seems to be linked to changing the ethos of services to more recovery-focused. I wonder why this isn't happening already – it seems very common sensical but still the needs of this population are not being met.

5.8.11 (fifth and sixth interviews)

Interview 5 and 6 done today and they went really well. It was great hearing the viewpoint of two people who are engaged with different services and in a different area in south wales. But also seeing how similar so many of their experiences are. It really hit me with one of them how important psychological support is, and this links into what others have been saying. He is so obviously struggling with his anxiety and is desperate for help, but he doesn't seem to be getting enough help.

He did say he attends a service that is set up to help with mental health as well as addiction but all they do is drug test him and have a quick chat with him – he has told them that he needs more but nothing has changed. This is so frustrating as he is trying so hard and has made so many changes in his life but his anxiety is really holding him back. If the help were there then he could really move forward and meet new people, do new things- he is desperate to work in the addictions field and help others but this is really holding him back.

All of the interviewees have talked about the stigma that stays with them in recovery. I wonder how this could be addressed. Is it about psycho education? The message that recovery is possible seems to be getting lost – how can these stories be told? There also seems to be a need for professionals to receive recovery focused training and education. It would be interesting to do some interviews with staff and see if they think they are working in a recovery orientated way?!?

22.12.11 (starting analysis)

Well, I had been really looking forward to today! Yesterday I went and bought lots of different colour pens, note pads, you name it. I even got out of bed with a spark of excitement this morning! But after the first couple of hours of coding I remembered what a mammoth task grounded theory analysis is!! I have spent the day coding and I don't really feel like I have got very far (other than having pages and pages of codes!). I have jotted down some possible themes but it feels a bit overwhelming at the moment. I'm aiming to code three interviews and then see what themes emerge across them!

2.2.12 (the end of analysis)

Well, it's starting to feel like I am coming out the other side and after a long slog I am getting some enjoyment out of the results again! Looking back through my diary I can see how overwhelmed I became by the data, and how immersed I was in it, which at times meant I couldn't see the woods for the trees. I think what helped was putting everything onto index cards and taking over my lounge with them. I began to see how everything could link together and rather than feeling overwhelming it actually helped in the organisation of my thoughts – I could actually see it taking shape before my eyes!

I have been worrying that my results are too simple – as it is all so common sense and it doesn't really make sense why services are not providing psychosocial support to people in recovery. But I have spoken to Neil and he has reassured me that it is obviously not happening so it is still worthwhile research! I think the focus of this thesis has become more about service development and delivery as I have gone along. There are so many benefits for providing recovery-orientated services, not just for the people in recovery but in terms of cost effectiveness as it would drastically cut the number of people who repeatedly come through services. The proof is in America – why aren't we doing that over here? It seems so unfair on the service users – like they are being failed for something that in essence is so simplistic. Hopefully this research will help to highlight some of the changes that can be made so we can better meet the needs of people in recovery and support them in the longer term to achieve stable recovery.

APPENDIX L

Excerpts from memo-writing

Appendix J: Excerpts from memo-writing

Interview 1

- Importance of distancing from drug-using culture and the difficulty with developing new relationships – impact of low self-esteem.
- Lack of support once in recovery, and the desire to have support – service gap?
- Thought changes towards how view heroin and addiction and how view life prior to addiction i.e. the reasons began using and having to come to terms with those in recovery
- Learning skills i.e. Avoidance and saying no to heroin. Learning from past experiences about how to do this – what things are learnt?
- Have to really want to make changes - helped by a combination of catalysts and wanting something better than addiction – future goals seem really important – but there's a lack of support to help people get there and there is a lot of stigma in the way.
- Learning new skills – ranging from money management to how to make friends.
- Importance of enjoyment in recovery but this can be difficult – barriers include lack of social networks, low self-esteem, lack of support and fear of people finding out about addiction

Interview 2

- Wanting more from life – seeing life improvements motivate maintenance of recovery. Having control over life, when did not have that before.
- Breaking away from addiction culture – finding support from others in recovery and not in recovery. Hard to do this – lack of support in developing new relationships – role of services?
- Need to want to stop using for yourself – others can help but you have to have strength and determination so must want it for yourself.
- Difficulty of recovery – lack of support, isolation, learning new skills, must take things slowly
- Support needs to be long term – need help with developing new social networks, learning about yourself, help with employment and education. Needs change over time. Changes needed to develop recovery orientated services.
- Changes in lifestyle, family relationships, way view future

Interview 7

- Gender related difficulties – dealing with actions whilst addicted e.g. prostitution.
- Distancing from drug users – moving, changing phone, no contact – this is what stopped her from achieving recovery in the past. Need to be supported in this .
- Lack of support – isolation – doesn't know anyone else who's in recovery – wants support from others in recovery –shared experience, wont judge. Difficulty making new relationships
- Viewing recovery in stages appears in all of the interviews – how do these stages differ between individuals?
- Lack of support in recovery – get forgotten by services. Need reassurance that doing well.
- Role of family in support – help with making changes and sticking to them. Motivation for sticking to goals and wanting a better life.
- Changes in way views self and abilities such as what can achieve in the future. Thought changes are key – common theme.
- Wants help with keeping occupied – ideas for service development.