Norwich Medical School, The University of East Anglia

‘Moving on’ towards ‘recovery’

An exploratory study of barriers for long term opiate maintenance clients

Dr Caitlin Notley
Professor Richard Holland
Ms Vivienne Maskrey
Ms Annie Blyth
Dr Hayley Pinto
Ms Rhonda Beggs

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FINAL REPORT TO NORFOLK DRUG AND ALCOHOL PARTNERSHIP

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Executive summary

This study aimed to explore the client experience of long term maintenance (continuous substitute opiate prescription of more than five years duration) and identify perceived barriers to recovery from both substitute prescribing and heroin addiction. The study consisted of a systematic literature review and qualitative study, recruiting from a rural community drug treatment service (Norfolk). Twenty seven clients on long term substitute prescriptions and ten staff were purposively recruited. Interview data were thematically analysed guided by grounded theory principles of open and axial coding, triangulation and cross case comparison.

Client views suggested that a continuous substitute prescription enabled stability and a sense of ‘normality’. Clients expressed relief at moving away from previous chaotic lifestyles and freedom from the persistent fear of opiate withdrawal. However, being on a script made some clients feel withdrawn, lethargic and unable to fully participate in mainstream society. This suggests that this sample of clients are in transition between illicit drug use and recovery. Some clients spoke positively about recent script reductions, but for others complex physical and mental health issues made the idea of prescription reduction or abstinence seem impossible. Perceived barriers to recovery included individual (intra and inter-personal), social and system barriers, with intrapersonal barriers (motivation and fear) perceived as the key barriers to recovery. This study found consensus between staff and clients that recovery is a process rather than a fixed goal. Findings suggest that there is a need for services to negotiate individualised recovery goals, working flexibly and slowly. A middle ground approach between harm minimisation and abstinence oriented treatment approaches may often be required. Conclusions suggest areas for further research, including evaluating the suggested expansion of volunteering or service user involvement to support recovery orientated services.
Background

For approximately the last twenty-five to thirty years, a harm minimisation approach to drug treatment has prevailed in the UK. Drug treatment, particularly opiate maintenance treatment for problem opiate users, has been consistently shown to reduce morbidity, mortality and acquisitive crime (Ward et al., 1997; Marsch, 1998). UN guidelines on psychosocially assisted pharmacological treatment of opioid dependence emphasised the importance of substitute prescribing, and stated that ‘in most cases treatment will be required in the long term or even throughout life’ (WHO, 2009). Thus, there was an apparent need to encourage more problem users into treatment. The previous ten year strategy (DH 1998) set a target of doubling the number of problematic drug users in treatment, which was achieved (NTA, 2010).

However recent (NTA) guidance suggested that a minority of problem opiate users have been excessively retained in treatment, and anecdotally there was a view that some clients may be ‘parked’ on long term maintenance scripts once stabilised. In Norfolk, there are a disproportionate number of long-term prescribed clients compared to the rest of the Eastern region (22% of clients prescribed opiate substitution therapy have been prescribed for five years or more compared to 17% for the Eastern region) (NDAP, 2011). Correspondingly, and in contrast to the harm minimisation approach, there has been in recent years a move to promote recovery from both illicit drug use and substitute prescribing, in order that individuals can move on from treatment services towards a life abstinent from illicit substance misuse and where reliance on substitute prescribing is no longer necessary. The recent ten year strategy (HM Government, 2008) put emphasis on treatment exit, social reintegration and recovery (NTA, 2009 & 2010). This was superceeded in 2010 by a new strategy, emphasising even more strongly the focus on recovery in terms of ‘supporting people to live a drug free life’ (HM Government, 2010). Whilst, there is little clarity regarding the concept of recovery (White & Cloud, 2008), evidence does suggest that substitution treatment is associated with prolongation of time required to achieve abstinence (Best et al., 2006). So, whilst between 30-50% of clients achieve stability on prescribed medication (Gossop et al., 2003), less than 10% exit treatment abstinent (NTA, 2010).

Anecdotally, clients in treatment may have differing views of what is perceived as ‘recovery’ and ‘moving on’, and these views may not coincide with either professional views and goals or recent NTA guidance. Thus defined ‘positive discharges’ from an NTA perspective may not match to client or professional views of positive treatment outcomes for individuals. Stability on substitute medication with no additional illicit opiate use may, for example, be perceived as ‘recovery’ for some, whilst for others recovery may only mean freedom from all illicit substance misuse and substitute medication. For others still, recovery goals may be much broader than considerations around either substitute medication or illicit drug use, encompassing feelings of societal engagement, meaningful activity and escaping the stigma which may be associated with illicit drug use and being in treatment for substance misuse. These non-drug related recovery goals may be seen as more important than whether or not someone is taking prescribed or illicit substances. In addition, clients views of recovery and treatment success may change over time, as hopes and aspirations on entering treatment may change after the process of stabilisation and following a period of maintenance. There appeared potentially to be a broad spectrum of understanding that
required further investigation in order to assist treatment services to focus on the diversity of needs of this particular client group, whilst attempting to adhere to NTA guidance.

Once subjective understandings of ‘recovery’ have been addressed, it is necessary to focus on barriers experienced by long term opiate maintenance clients, both ‘real’ and ‘perceived’. This particular group are likely to have complex psychosocial needs which require exploring and greater understanding, in order that services can be targeted at the appropriate point in a user’s recovery journey, to be maximally effective. Dual diagnosis for this client group is significant, and lower level anxiety disorders are also likely to be an issue for many. In terms of social reintegration, housing, employment and relationship issues may be important for many individuals.

**Research questions, aims and objectives**

This study has consisted of two separate studies over a period of six months – a systematic literature review and a qualitative research study seeking client and professional views of long term maintenance. The following aims of the linked studies were stated in the protocol:

**Study 1 (Literature review)**

1. We will undertake a literature review of existing evidence on clients views of long term maintenance in treatment

**Study 2 (Qualitative study)**

2a. We will conduct qualitative interviews with long term maintenance clients to increase understanding of the meaning of ‘recovery’ and ‘moving on’ from the subjective perspectives of clients. We will also explore perceived barriers to recovery and suggested mechanisms by which these barriers may be addressed

   2b. We will conduct qualitative interviews with service staff, managers and commissioners to gather views of ‘recovery’ and perceptions of barriers, and compare these views to those of clients.

**Definitions**

For the purposes of this study, a ‘long term opiate maintenance’ client was defined as any person who has been in contact with tier 2 and 3 services for a period of five years or more, who has been maintained on an opiate maintenance prescription for that period of time, and who appears to be ‘stable’ in treatment. Stability in this context refers to regular attendance for appointments and adherence to the substitute prescription.

 Throughout this report the term ‘recovery’ is used in different ways. Indeed, one of the key aims of this study, as defined above, is to understand the varying perspectives and subjective
understandings of this term from both a client and staff perspective. In reporting the qualitative data, the term ‘recovery’ is often used as being linked to abstinence, from either illicit substances, or substitute medication, or both. Wherever possible, these distinctions are clarified, in the context of client’s own interpretations of the term. The term ‘recovery’ may also encompass numerous other aspects of social and psychological wellbeing, and concepts such as ‘reintegration’. Where these wider aspects of the term ‘recovery’ are referred to in participant quotations or within the narrative of this report, these wider aspects are made clear.

In the context of service provision, this report refers to a recent ‘recovery focus’ or ‘recovery focused treatment’. These terms are taken from recent policy documents, which emphasise a longer terms view of treatment for substance misuse, with substitute prescribing playing a role in active treatment, but with an end-point for the majority of clients being reduction and eventual abstinence form substitute prescribing.

As part of the qualitative analysis of client data the terms ‘barriers’ and ‘enablers’ are used. These are terms to encompass a range of factors, from the subjective perspectives of clients, which may hinder progress in treatment, or movement towards reduction of substitute prescribing and eventual abstinence (‘barriers to recovery’). Similarly, ‘enablers’ are taken to mean factors perceived by clients as being particularly helpful in supporting recovery, in terms of progress in treatment, reduction of substitute medication, and eventual abstinence.

**Methods:**

**Study 1 – Literature review**

The aim of this review was to inform understanding of the nature of long term maintenance and the concept of ‘recovery’, identifying barriers to recovery for this group.

After completion of initial literature searches, it was decided to complete a full systematic review of the available qualitative literature, since such a review was not in existence and it was felt that a systematic approach to the literature search would more fully inform the study’s aims. The systematic review has been registered on the PROSPERO international prospective register of systematic reviews (Notley et al, 2011).

The systematic review aim was met by exploring the following primary objective:

**Objective 1:** What is the subjective experience of long term maintenance and what are the barriers to recovery for this group?

This objective was met by accessing qualitative studies focused on long term maintenance from either a:

a. Service user perspective or a

b. Clinician/ treatment services perspective
Broader review objectives:

As part of the preparation work for the systematic review, a broader objective to create a database of studies specifically focusing on the experience of recovery was also pursued.

**Objective 2:** What is the experience of recovery from opiate addiction?

This objective was met by accessing qualitative studies focused on long term maintenance from either a

a. Service user perspective or a

b. Clinician/ treatment services perspective

**Objective 3:** What is the current policy and practice guidance for treating those on long term maintenance?

Objectives 1-2 were met by undertaking a systematic literature search of key databases. Objective 3 was met by reviewing all recent policy documentation and practice guidance materials.

**Relevant study designs**

The review specifically searched for qualitative studies using the qualitative research filter within key databases (where available), or using search terms to limit the results to qualitative studies only. Initial scoping reviews did not limit the search by study design, but the number of hits returned proved unmanageable within the project timescale.

**Inclusion / Exclusion criteria**

- **EXCLUDE SCOPE:** To be included a study must have examined the issue of long term maintenance or recovery from addiction, plus one of the following:
  1. User views
  2. Clinician views

- **EXCLUDE STUDY DESIGN:** studies were eligible if they included qualitative methodologies.

Book chapters, reports, theses conference abstracts and details of ongoing studies were all included within the review where ever possible.

- **EXCLUDE POPULATION:** studies were included if they studied populations that included:
  1. Long term maintenance clients aged over 18
  2. ‘Recovered’ clients
  3. Clinicians reporting on providing long term maintenance services to those aged over 18
• EXCLUDE LOCATION: studies were included if they were carried out in the UK or internationally.
• EXCLUDE DATE OF PUBLICATION: no date limits were set.
• EXCLUDE LANGUAGE: NON-ENGLISH papers were excluded.
• INCLUDE UNCERTAIN: any studies where it was uncertain whether or not the study met inclusion criteria were re-screened and agreed by consensus between members of the study team.

Search strategy
Drawing on the above inclusion criteria, search strings were developed that were used to search the databases. For a full description of search terms and strategy, please see appendix 1.

The databases that were searched were:

Medline (Pubmed)
EMBASE (Ovid)
Cinahl (EBSCO)
PsycInfo (Ovid)

Initially, searches of the Cochrane and Campbell databases of registered systematic review were undertaken to determine that no review of a similar nature had been registered.

References from key articles identified by initial searches were also incorporated into the review.

Study selection
Appendix 2, the PRISMA study flow diagram, gives an overview of the systematic review process followed and the outcomes of the different search stages. The review was conducted in three phases. The first phase was to undertake a title screen for relevant articles. 3242 articles were reviewed independently by CN and AB, with results checked for consensus. 2835 studies were excluded at this stage. The second phase was to undertake a detailed abstract screen for relevant articles according to the above inclusion/exclusion criteria. This stage was undertaken independently by two researchers, CN and AB, and the results were compared. During phase 2 - abstract screens, the researchers involved met regularly to discuss eligibility criteria of included studies, and to refine inclusion criteria for the phase 3 screen. Anomalies in the abstract screen review across the two researchers were examined and discussed until consensus was reached.

The final, 3rd phase of abstract screening, focused on included studies identified from phase 2. This screening phase was again undertaken independently by CN and AB and focused specifically on objective 1, to screen included abstracts for a second time in order to extract studies focused specifically on the experience of long term maintenance. A total of 407 abstracts were screened, with 364 being excluded. Of these, a total of 201 studies were separately saved as being focused
specifically on the experience of recovery from drug use or substitute prescribing. These studies will be utilised separately for further analysis not reported here. Following completion of stage 3 (final abstract) screens, CN and AB met to compare results and to identify the final list of studies to obtain for data extraction and synthesis.

A flow chart of the study selection process was maintained (see appendix 2) detailing the numbers of articles returned by each search, and the numbers included/excluded from the review (as per the guidance in ‘Systematic Reviews: CRDS’ s guidance for undertaking reviews in health care’).

**Data extraction**

14 articles identified as being relevant for inclusion in the qualitative systematic review were accessed as full text documents. All references were stored using Endnote software. LTM, AB and LTM extracted key data from relevant articles and used tables in Microsoft excel to summarise key aspects of each.

**Quality assessment**

Critical appraisal of the quality of the articles reviewed was undertaken with reference to the ‘Cochrane handbook for systematic reviews of interventions’, with reference to the special topic of qualitative research/critical appraisal. The CASP tool for critical appraisal of qualitative studies was utilised, and the research team developed a scoring system to rate reviewed studies according to the quality criteria defined in the CASP document (CASP, 2001).

**Narrative synthesis**

Because a meta-analysis or statistical summary of relevant review articles was not appropriate for this review, due to the qualitative nature of the studies, a narrative synthesis of key research findings, organised around the literature review objectives defined above, is in preparation by CN. This narrative synthesis will be further reported on in a planned journal article. The narrative synthesis will be verified and added to by other members of the research team.

**Study 2**

**Phase a – client interviews**

This study identified clients retained in treatment on long term maintenance prescriptions. Identification of eligible study participants was kindly facilitated by the Trust Drug and Alcohol Service via the Carenotes record system, and directly via key-workers. Initial searches of the Carenotes system in late 2010 identified 317 clients who had been maintained on a substitute prescription for a period of 5 years or more.

Eligible clients were approached personally by key workers and asked for consent for their contact details to be passed to the UEA research team. This was an initial step to the informed consent process suggested by the Norfolk research ethics committee.

Direct contact with potential participants was then made by members of the research team following risk assessment and initial agreement gained through the key worker. Telephone or face to
face contact was made to discuss the study and to gain informed consent to participate. A convenient date and time was arranged for a face to face interview, to be conducted in treatment clinics or in clients’ own homes following adequate risk assessment procedures. This option was designed to ensure that those with dual diagnosis of anxiety disorders were not excluded from the study. Clients being interviewed in their own homes were introduced personally to the researcher by their key worker, with a second researcher being present if the risk assessment deemed this to be necessary. In no cases was it necessary for two researchers to attend an interview, however, and the majority of interviews were conducted in clients’ own homes, following the choice and expressed wishes of participants.

Interviews lasted approximately one hour and asked participants to talk about the background to their drug dependence and treatment history. The interview focused particularly on current treatment experiences to discuss long term maintenance from the subjective perspectives of clients. Views on what constitutes recovery from a personal perspective were sought, as well as perceived barriers to ‘moving on’ and suggestions for overcoming barriers.

An approximate sample size of twenty five to thirty participants was originally stated in the protocol as the expected sample size. In total, twenty seven clients were interviewed. Following identification of potential eligible candidates, a sampling frame was derived drawing on key constituencies to ensure maximum variation in the sample. Thus, participants will be purposefully sampled to ensure variation in:

- Length of time in treatment (5-9 years, 10 years plus)
- Age
- Gender
- Location (rural/urban mix)
- Substitute medication (methadone/subutex and variation of prescribed dose)
- Dual diagnosis of mental health problems

Appendix 3 depicts the sampling frame used, with ranges in black font suggesting the estimated numbers within each core constituency for recruitment. Figures in red show the actual recruitment achieved for each constituency.

Thirty five patients were referred to the research interviewers by seventeen individual key workers. Of these twenty seven were ultimately interviewed.

Of the eight who had initially said to their key workers that they would be interested, three declined due to concerns about confidentiality, and five for other reasons (busy, fed up, unspecified difficulties, no longer wished to talk).

Interviewees were reimbursed with a £10 supermarket gift voucher in recognition of their time commitment in undertaking the interview. All interviews were transcribed verbatim, and a proportion (approximately 10%) of the interview transcripts were shown to participants to seek verification of accuracy of the transcription. This was confirmed in all cases although minor transcription errors were adjusted.
Phase b – Professional interviews

Qualitative interviews were undertaken with ten professionals involved in the treatment and care of long term maintenance clients. The multidisciplinary sample was drawn from liaison nurses, therapist, doctors, social workers and support workers (7) service managers (2) and a commissioner (1). The service manager category included a consultant & a service manager with a nursing background. Qualitative interviews were conducted either face to face or over the telephone at the convenience of professionals consenting to participate.

Data analysis

For the participant interviews, an interview guide was followed (see appendix 4). Participants were asked to talk about the background and history of their drug dependence, before focusing on the current treatment episode. Clients were asked specifically about what ‘recovery’ meant to them, what it was like to be maintained on a long term substitute prescription, and what they felt were the barriers to achieving recovery. Although all participants were asked questions in these areas, the interview guide was flexible, allowing participants to discuss issues of importance to them in a manner which was deemed appropriate. Views, experiences, and feelings about the issues of long term maintenance and the concept of recovery were analysed for key themes arising from the data. A grounded theory approach to data analysis was taken, working inductively line by line through transcripts, coding for meaning. NVivo qualitative software was utilised to aid the qualitative analysis.

The analysis reported below summarises the key coding categories and attempts to establish a framework or hierarchy of themes for more in depth understanding of client views. The qualitative data analysis addresses reported issues around patients’ subjective experiences of being maintained on a long term substitute prescription. Although other issues of importance, such as participant’s histories of substance misuse and previous treatment episodes, were often discussed at length, analysis of these aspects is secondary to the primary research question focusing on the experience of long term maintenance and the understanding of recovery. Analysis of these secondary areas is nonetheless critical, as participant narratives were seen to be important, in that earlier drug using and treatment experiences were likely to impact upon the participant views of the current maintenance treatment. Thus reference to earlier experiences, reflecting the narrative flow of participant experiences, is captured within the example case studies included in this report.

Qualitative analysis was led by CN, with independent coding undertaken by VM and AB. Throughout the period of analysis, regular team meetings were held, on an approximately fortnightly basis, to discuss the emergent thematic analysis, and to share areas of commonality and difference in the analysis. Thus a consensus view was reached through independent coding by three experienced researchers. Immersion in the data was considered important in order to capture the essence and meaning of client interview data, thus each researcher undertook coding of the interviews that they had undertaken. As a validity check, a proportion of the transcripts were independently coded a second time by another member of the research team. Independent coding was discussed and compared at verification meetings until consensus of emergent themes was reached.
A process of member checking of the emergent qualitative analysis was undertaken. This comprised two approaches. Approximately 10% of the interview transcripts were taken back to the research participants for verification of accuracy. Initial thematic coding was presented at a separate service user group convened as part of the project steering group. This meeting verified the emergent analysis, and views and comments of the service users have also been directly incorporated into the presentation of analysis in this report, where applicable. Finally, CN undertook some in-depth personal communication with a service user participant, who again verified and offered further comment on the data analysis.

In summary, analysis of client data proceeded along five key stages, as depicted in appendix 5, the qualitative analysis process flow chart. These stages can be summarised as:

1. Identification of key themes (open coding)
2. Initial verification of emergent analysis
3. Development and verification of key themes across sites (axial coding and development of initial hierarchies)
4. Incorporation of variation between cases and outlying cases into established hierarchies.
5. Final verification and reporting.

Throughout this report quotations have been carefully chosen to exemplify key themes arising from the data, organised around hierarchies for each specific area of analysis. It should be noted that quotations were chosen to show best fit with the reported theme, but also to show variation and consistency (where appropriate) within the sample. Care has been taken to ensure that the selected quotations are representative of the majority view, unless otherwise stated. However, quotations represent the particular views of individuals interviewed as part of this study, and thus may not always represent the views of the larger population.

Participants names and potentially identifying information, such as the total length of prescribing episode, have been altered to ensure anonymity. Participants are therefore identified throughout by study coded identifiers. Participants ages have been stated in age bands, as per the ONS standard age ranges, defined in 5 year blocks, such as 20-24, 25-29, 30-34, etc. As the sampling frame specifically sought those on long term prescriptions of 5-9 years and 10+ years, the ranges for the length of substitute prescribing are stated in preference to the actual self-reported length of the prescribing episode, to ensure further anonymity of the sample. It should be emphasised that the length of prescription reported relates to the participants’ current prescribing episode, and does not encompass previous episodes of prescribing.

Analysis of professional interview data proceeded in the same way as participant data, although transcripts were more briefly coded for key points of verification or diversion with the participant data.
Findings - Study 2 – qualitative findings:
The sampling frame (see appendix 3) was designed to guide recruitment to the study to ensure that interviewees represented both the breadth of experience across the group and also the demographic variation. At the time the sampling frame was drawn up there were 317 TADS clients who had been in receipt of maintenance prescriptions for more than 5 years.

The mean age of study participants recruited was 46.63 (47) years. Figure 1 below shows a comparison by age band of all TADS long term maintenance clients and those recruited to the study. Whilst study participants were drawn from all age bands there was some over sampling of those in the older age bands, 50’s and 60’s. This may represent a study bias due to the method of recruitment, where key workers were asked to refer their more stable clients and thus may have selected the older clients as being those considered more stable.

Figure 1:

![Figure 1: Clients on long term prescriptions by age band](image)

Figure 2:
The gender ratio of all TADS drug clients including those on long term prescriptions is approx a 2:1 male to female ratio. This was represented in the study sample. See figure 2 above.

**Figure 3:**

![Clients on long term prescription by gender](chart)

![Clients on long term prescriptions by area](chart)
The study sample which included 48% from more rural areas, again broadly representing the split between city clients and those based either in the county towns or rural parts of the county. See figure 3.

5 out of 27 participants interviewed (18.5%) had a formal diagnosis of a psychiatric condition. However, a further 11 participants in the sample had self-diagnosed (including 6 who take anti-depressants). Combining those 6 prescribed anti-depressants with those 5 who had a formal psychiatric diagnosis, indicates that 40% of the total sample could be said to have dual diagnosis. Including all 11 participants with self diagnosis would indicate that 59% of the sample had dual diagnosis.

The mean length of time on the current script reported by the study participants was 8.3 years (range 4-21 years). This was representative of the whole group at TADS on long term maintenance where the mean length of time of current prescription was 8.4 years. See table 1 below.

Of the sample participating in the study twelve out of our twenty seven recruited clients (44%) were currently reducing.

Table 1:

<table>
<thead>
<tr>
<th>Length of time in treatment</th>
<th>All LTM clients</th>
<th>Self report of study participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>TADS list Feb 2011 &gt; 5 years</td>
<td>N = 317</td>
<td>N =25*</td>
</tr>
<tr>
<td>Mean</td>
<td>8.4 years</td>
<td>8.3 years</td>
</tr>
<tr>
<td>Median</td>
<td>7.8 years</td>
<td>8 years</td>
</tr>
<tr>
<td>SD</td>
<td>3 years</td>
<td>3.5 years</td>
</tr>
<tr>
<td>Min - Max</td>
<td>5 years – 24.1 years</td>
<td>4 years - 21 years</td>
</tr>
<tr>
<td>* 2 clients not sure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The meaning of recovery

A core aim of this study was to assist in defining, from the client perspective, the meaning of the term ‘recovery’. In recent years, this term has been increasingly utilised by treatment services (Home Office, 2010, NTA, 2011). Within this context the meaning of recovery has been recognised as being divergent, but broadly associated with abstinence. Following qualitative analysis of this study data set, what has become clear is that the term ‘recovery’ has many different meanings, both within individuals (over time) and between individuals. Thus what recovery might mean for one individual at a certain point in time might be different to what it means to another. Similarly, what recovery might mean to an individual at a given point in time may change within the same individual over the course of time.

No one definition

There was a recognition that recovery means different things to different people:

“I know recovery; a lot of people see it in a different ways” (LTM21, female, aged 45-49, prescribed for 10+ years)

Others suggested that there is more than one aspect to ‘recovery’. The participant below mentions an awareness of both physical and psychological aspects to recovery from addiction, in terms of achieving abstinence from substitute prescribing:

“Int Okay so for you then recovering will be coming off methadone completely, is that right?

M Yeah. Yeah, well yeah, but there is an addictive side of it, and there is the psychological side of methadone that I have heard of. So I don’t know until I have got that far, really do you know what I mean, I only know what other people have said, do you know what I mean, and I can’t really comment on that so.” (LTM28, male, aged 30-34, prescribed methadone for 10+ years)

Others turned the question around, seeing ‘recovery’ as synonymous with abstinence as being an unhelpful concept. So, for the participant below, who no longer associated himself with the ‘addict’ role, the long term script was seen instead as part of a medication regimen. In this sense, just as he was resigned to taking certain prescribed medications for the rest of his adult life, he also saw the methadone prescription as ongoing, and not something that it would be appropriate to aim to be ‘recovered’ from:
“Yeah, I would say that the whole thing (stopping illicit use and the substitute prescription) is recovered, do you know what I mean. But I don’t look at myself as an addict anyhow so, it is just part of me and that is it.” (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)

Other participants broadly fell into two groups – those who viewed recovery as being synonymous with abstinence, and those who saw recovery as being more about social and psychological functioning, regardless of the medication consumed.

**Abstinence view of recovery**

For some participants, ‘recovery’ meant abstinence, but views varied about whether abstinence from illicit use alone meant that one could be considered ‘recovered’, or whether ‘full’ recovery also included abstinence from the substitute prescription. A strong theme within the data set was that recovery would mean abstinence from illicit heroin and also substitute medication, but might not necessarily mean abstinence from all illicit drugs. In this sense, participants felt at odds with treatment services, who were perceived as being less lenient about other illicit drug use. Many participants continued to use cannabis, and indeed alcohol, on a regular basis, but saw this as separate to achieving ‘recovery’. For the participant below, continuing to use other drugs was perceived to be important, for her, and not synonymous with recovery:

“Recovery to me is being able to stop injecting drugs, to stop doing heroin, to stop, well it is lots of things, but it’s the stability, having the stability back in my life. I suppose (pause) I have recovered, and saying that I still want to do (other drugs). But in my mind it is not something that I went to them with as a problem.” (LTM21, female, aged 45-49, prescribed for 10+ years)

This presented a perceived mismatch with the views of treatment services, however, as this particular participant, just beginning a reducing script, saw herself as being in a positive position and thought that, for the first time in her life, abstinence from a substitute prescription might be a possibility. However, she also discussed the perception from treatment services that she presented ‘dirty’ samples due to her other substance misuse. This was potentially a barrier to recovery for this individual, as her own view of ‘recovery’ did not necessarily match with that of the treatment provider.

So for some participants, abstinence from illicit heroin represented ‘recovery’, whilst others suggested that abstinence from the substitute prescription was also a part of ‘recovery’. This is corroborated in the analysis below of the experience of long term maintenance, where it is shown
how some participants see being on a script as on a continuum with heroin addiction, and thus maintenance on a script represents a continued addiction:

“It would be nice not to be dependent on anything, that’s where I stand with it at the moment.” (LTM45, male, aged 55-59, prescribed methadone for 5-9 years)

Others still suggested that it was not simply abstinence from illicit heroin use and substitute medication that represented recovery, but being able to sustain that abstinence:

“I don’t want to be on the script forever, I do want to be completely clean, and I want to be able to sustain, you know, how I feel now” (LTM23, male, aged 30-34, prescribed methadone for 5-9 years)

Thus, in terms of an abstinence view of the meaning of recovery, the thematic analysis suggested that this is further delineated by participants, who saw recovery as either complete abstinence, from all illicit drugs and substitute medication, abstinence from illicit heroin and substitute medication, abstinence from illicit heroin only (implying continuance of a script and other illicit drug use was acceptable) or, finally, being able to sustain abstinence, in whatever form that may take.

**View of Recovery as’ achievable goals’ – not about the drugs**

For many participants within the sample, the concept of ‘recovery’ was discussed in realist terms. There was an acceptance and appreciation that people had had long histories of illicit drug use, and many years since of substitute prescribing, and thus achieving ‘recovery’ was about being realistic about what might actually be possible, or was perceived as being possible. Thus, for the participant below, achieving ‘recovery’ was about coming off subutex, but being realistic about other substance use:

“once I am off the subutex completely I think that will be me as recovered as I am ever likely to be really, realistically. Um, I don’t know, if you had asked me ten years ago ‘Would I be able to come off heroin?’ I would have said ‘No, sorry’. It is difficult to say isn’t it, but at the moment anyway, I think that finishing, you know, reducing the subutex is the last sort of step for me really. I would love to, love dearly to, stop smoking, I am still on about 2 cigarettes a day, and I cannot quite kill that, you know. I hate it, I really do I hate what it does to your body, I hate everything about it. And I suppose if you have an addictive personality it is just, you know, it does
break into other areas in your life.” (LTM21, female, aged 45-49, prescribed subutex for 10+ years)

For others, ‘recovery’ was less about the actual prescription, and more about ‘being stable’ and not being involved in crime:

“I am stable, you see, which is good, where I am in my mind I don’t have to worry about it and wake up in the morning and think ‘Oh my God, where can I get the next fix from?’ and all that bollocks. So it is just really good, and I don’t have to get involved with criminals or anything like that, so.” (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)

Some participants in the sample described extremely chaotic childhoods, and thus achieving ‘recovery’ was difficult to conceptualise given the context of an unstructured and chaotic life being the ‘norm’ thus far. For these people, ‘recovery’ meant achieving a sense of stability in proportion to their previous lives, i.e. being more stable than they ever had been before:

“And the last few years everything has been peaceful there have been no nothing untoward in my life has come to upset the situation too badly.” (LTM45, male, aged 55-59, prescribed methadone for 5-9 years)

Others within the sample discussed other aspects of life, and being able to cope with all the challenges that life throws at you. Coping with major life events, without turning to drugs as a means of coping, was what some people felt to be an indicator of ‘recovery’:

“It is not like I think about it every day now do you know what I mean but I do I can go weeks, months or whatever you know. The odd thoughts still come every now and again when I am having a crisis or whatever yeah I had one not so long ago but I actually dealt with that without actually doing any drugs so that was a bit of a bonus.” (LTM02, female, aged 50-54, prescribed methadone for 5-9 years)

For this participant, who had had many years of sexual, physical and emotional abuse, illicit drugs had been, by her own admission, a means of dealing with the emotional upset caused by this. Thus beginning to face life without turning to illicit drug use when a crisis hit was what defined recovery
for this person. Others discussed aspects of engaging with ‘normal’ society as being synonymous with recovery:

“I would say you are recovered when you can take a job and keep a job down that’s when I would say you have recovered totally, totally recovered, and also keep everything else going in your life.” (LTM24, male, aged 50-54, prescribed methadone for 5-9 years)

Thus for some participants within the sample, ‘recovery’ was viewed in realistic terms, balancing what was potentially achievable in individual cases with a sense of past historical means of coping. For these participants recovery was not necessarily synonymous with abstinence, from either illicit drug use or the substitute prescription, but might be achieved with or without abstinence, being defined more by the individual’s ability to cope and engage with life’s challenges and opportunities in a positive way.

The experience of Long Term Maintenance
This section covers the key research question of this project, seeking to understand, from a client perspective, what it is like to be on a long term opiate maintenance prescription. This data was elicited in different ways throughout the qualitative interviews. We asked clients directly what it felt like to have been on a long term script, but as many clients found this kind of direct questioning difficult to answer, we also illustrate this section with coding arising from other sections of the interview, where descriptions and thoughts about being on a script are covered. Finally, this section includes some case studies detailing individual client experiences, which serve to exemplify the variation as well as the shared experiences of clients who have been prescribed opiate maintenance therapy for five years or more.

Escape from chaos
The overarching theme conceptualising the experience of long term maintenance for this sample of clients was a feeling that a script offered them an ‘escape from chaos’. There was a huge expressed sense of relief at being able to escape the previous chaotic world of drug use. Here a female client describes how starting a script is almost like a revelation compared to life using illicit heroin:

“For the first time you don’t have to chase anything, you don’t have to, and your life has been so hectic it is kind of hard to come out of at first”. (LTM25, female, aged 30-34, prescribed methadone for 5-9 years)
The client here also suggests that first starting on a script can represent a huge transition, and it can be difficult to leave behind a life of chasing the next hit, which may have offered a structure for many years. Replacing this illicit and chaotic ‘structure’ with the routine of collecting a script and consuming substitute medication was a significant decision.

**Takes the worry away**

However, many participants continued to describe life on a script in terms of their previous life using illicit heroin – so being on a script was described as a ‘relief’, as the ‘worry’ of ensuring that heroin was available and therefore that one would not become ill and start withdrawing, was removed.

> “the methadone was still a safety net and it was still like being an addict in a way”
> (LTM43, male, aged 45-49, prescribed methadone for 10+ years)

The relief for clients of escaping the seemingly never ending cycle of scoring, thinking about the next hit and involvement with crime to finance drug use was palpable. Indeed, for many clients in this sample, who had an average age 47 years, the ability to move away from crime was particularly important. The same client also described how being on a script simply freed up time and ‘head-space’ to think about other aspects of life away from illicit drug use:

> “I have got focus on other things in life and I don’t have to worry about that all the time, which would consume 75 % of your day if I hadn’t got a script you know.”
> (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)

So for some people, the relief of being on a substitute prescription meant that they were free to move on with their lives and focus on other things. The case study below exemplifies this well within the context of the participant’s history of substance misuse:

**Case Study 1 - Male, aged 25-29**

This twenty six year old man had an unstable childhood; his mother was an ex-drug user and his father was addicted to heroin and spent much of the participant’s young life in prison. The participant started using alcohol and cannabis at a very young age, and took whatever drugs were available (apart from heroin) but favoured speed, which he injected and became addicted to. His father later introduced him to heroin and he soon became dependent on this.
He sought help from a treatment centre as he had had enough of his life; living on the streets and having the continual worry of how he would find the money for heroin, which involved crime, drug dealing and begging.

He’s been on a subutex script for about ten years. He believes that the help he’s received has kept him alive. The prescription has removed the worry about funding heroin and the associated lifestyle, including the threat of being beaten up or robbed. He’s much happier now, and the stability he has found on his prescription, has helped him to address other problem areas in his life. For example, he looks after himself and has nurtured himself back to good health, he now has a flat which he also looks after and he has a relationship which he values and offers him emotional stability.

He has goals in his life which, through being stable and determined, he now considers to be realistic. For example, alcohol was a significant problem, but he’s managed to deal with that. He smokes cannabis and takes prescribed Diazepam, and although he would one day like to be off subutex, he can’t imagine coping without Diazepam.

For other people the prescription and taking the substitute medication itself seemed to act as a replacement for the routine of illicit drug use, with the focus wholly shifted over to the substitute prescription:

“You see I have got myself into a routine. I take my subbi’s at six o’clock in the morning and then of course on Wednesday I have got no subutex throughout Thursday, as the script is not issued until half past nine. So you start to feel a little bit; you are going to rattle, and that gets you a bit angsti. And you are not sick, you are not, you know as bad as you can be, bed ridden, whatever but, so, if you like it is my crutch, it is something that I need because I can’t take gear”. (LTM12, female, aged 40-44, prescribed subutex for 5-9 years)

**Script something to fall back on**

For some clients within the sample, a maintenance script was seen as ‘something to fall back on’. Some continued to use illicit heroin, but would rely on the script to prevent them becoming ill and withdrawing during those times when they were unable to score illicit heroin:

“I suppose after a time you realise that maybe you have had enough, or you need that extra bit of help, and you need something to fall back on. Which I think - that is a point - that is a big thing as well, you think ‘Oh God, I think I had better make an
effort now', when you realise you haven’t got the money; you can’t get the money, and things are going to be harder. And then you think 'I had better go', and it is just something to just sort of fall back on really. I think that’s most people’s outlook to start with. Yeah, I suppose a lot of people find it is so hard to give up, that they just think - that’s just something, yeah - it is just something to fall back on. Just in case I can’t get drugs or at least I will have my script, sort of thing” (LTM05, female, aged 35-39, prescribed methadone for 5-9 years)

This was a significant theme, but was perhaps most relevant when discussing first starting on a prescription and in particular for those prescribed methadone, not subutex. When discussing maintenance on a prescription in the longer term, the emphasis shifted from seeing the medication as simply something to fall back on when illicit heroin was unavailable, towards less and less illicit use, and increased reliance on the substitute medication. This suggests that, for some clients at least, a long term script as opposed to a short term reducing script, may be appropriate, as the shift in behaviour away from illicit heroin use can be gradual. Changing habits, both behavioural and physical, as well as beliefs and aspirations, built up over many months and years, can be a long term and non-linear process.

“I have been able to still carry on and I have had clean samples a lot of the time. But I had that little crutch, and I have got that sort of 10mil, whatever I was taking at that time, and I knew if I took that I was going to be okay.” (LTM06, female, aged 45-49, prescribed methadone for 5-9 years)

The case study below illustrates well the long term experience of maintenance prescribing. In the context of his long term heroin use, this participant describes gradually moving over the years from seeing his prescription as a ‘crutch’ that allowed continued use of illicit heroin, towards currently reducing and aiming to become drug free. The gradual change in views can be understood as having occurred over a protracted length of time, following numerous previous detox and withdrawal attempts, suggesting that the long term experience of treatment is critical for impacting upon the current state of perception and motivation:

**Case study 2, Male, aged 45-49**

Married (though separated) man in his late 40s who lives with another adult family member.

He has been in treatment more than ten years and is now reducing with the aim of becoming drug free.
He described a twenty five year history of heroin use initially started with cannabis use which he liked and was satisfied with; family members introduced him to heroin use as part of their lifestyle. He was involved in criminality to fund his habit and spent some time in prison when he was younger.

He has experienced previous detoxs’ both in the community and as an inpatient, some completed, some not, family members (mother and wife) were always supportive.

He believes a methadone prescription is always a safety net, because of the option to use heroin on top, and that a methadone “habit” is worse to come off than heroin. He regrets years spent on heroin, especially the loss of time to do things with his children when they were young, and the effect on his relationship with his wife.

His motivation in the past for taking up treatment was to be able to engage in family life and to be employed. He has been successful with this at various points, having a script enabled him to go out to work and to do things with his family. However he dropped out of treatment and returned to heroin and criminality to fund his habit at various points due to reconnecting with those drug users that he knew locally.

The current episode of treatment started after a number of serious overdoses where he was close to death. Initially the current reducing regimen was instituted by the treatment provider due to his continued illicit use of minor tranquilizers, however at the time of the interview he felt this was a very good thing and had given him a “jolt”, a push to make some changes. He has decided he doesn’t want to be on a script when he is fifty or sixty years of age and is now very pleased with how he is doing in cutting down. He remains fearful of the final stage, but is reassured that his key worker has his best interests at heart and will ensure that he has the appropriate medications to help him through the final withdrawals.

**Keeps me off heroin**

For other clients, especially when discussing the latter years of a long term substitute prescription, reports were that the prescription kept them away from illicit drug use. Thus there was a shift away from continuing to use illicit heroin on top of the substitute prescription, when starting out in treatment, towards increased reliance on the prescription:

“You know if it’s not methadone it would be heroin and I wouldn’t be like here you know” (LTM10, male, aged 50-54, prescribed methadone for 10+ years)
Here, an older male client suggests that methadone has saved him from probable death had he continued using illicit heroin. He is unable to envisage life without the prescription, perhaps linked to the length of time that he has been prescribed methadone. This was viewed positively by many within the sample – the prescription was viewed as a ‘crutch’ that prevented illicit heroin use, and there was an acceptance that taking alternative medication was a long term, if not lifelong, necessity. Others expressed dissatisfaction with this situation, despite acknowledging that it was a given:

“I will say again, you do develop a distaste for the stuff. Although you need what it does for you, it’s still sort of slavery and all the rest of it, and I mean, being addicted is not pleasant” (LTM45, male, aged 55-59, prescribed methadone for 5-9 years)

Thus an acceptance of the importance of the substitute prescription in helping to prevent illicit heroin use was a positive acceptance for some, but bittersweet for others, who recognised their addiction to the substitute medication in the same way that they had been previously addicted to heroin.

**Normalisation**

An over-riding theme when discussing the experience of long term maintenance was the concept of ‘normalisation’. Clients discussed their substitute prescriptions as being a medication like any other. So although methadone has a particular status as a medication, being a controlled substance, and also perhaps having its own social meaning and stigma attached, clients on long term prescriptions attempted to downplay this status. This view of the substitute medication allowed clients to move towards achieving ‘normality’ and feeling that they were integrating and engaging with mainstream society.

**Normal part of life**

Below, a male client describes the routine of picking up his prescription and daily consumption as being ‘the norm’.

“To me - that is the norm, if you like, um, do you know? I just went down to the chemist yesterday, just picked up my week’s methadone, and it is funny really, I don’t think anything of it, you know? And it was Wednesday you know, and it is just like getting out of bed or making a cup of coffee, do you know what I mean?” (LTM27, male, aged 30-34, prescribed methadone for 5-9 years)
In a positive sense, this client has moved on from seeing himself as an illicit drug user, but instead describes stability and an unquestioned sense of routine connected to his substitute prescription. This assimilation of the substitute prescription into one’s own self-identity is summarised perfectly by the participant below:

“But I don’t look at myself as an addict anyhow so, it is just part of me and that is it”. (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)

**Pick up as normal part of routine**

As part of assimilating the substitute medication within a sense of normal life routines, clients discussed schedules of pick up from community pharmacies:

“No, I um - when I last went I picked up eleven days worth, but it was a holiday; but I normally pick up on Monday. I pick a load up on Monday and then the next pick up is on Friday - for Friday, Saturday, Sunday. And then I have to go back on the Monday. So, you know, they give me four days, then I go back on the Friday for over the weekend, and it goes like that. Unless I arrange to, you know, take more, or it is Bank Holidays or something, they give you more.” (LTM28, male aged 30-34, prescribed methadone for 5-9 years)

However, others discussed how, for long term prescriptions, pick up was less frequent, and therefore the routine of pick up was hardly even an issue to consider (*personal communication from service user at data verification meeting, 11th August 2011*).

**Taking medication as normal part of daily routine**

Clients within the sample discussed their daily routines and how taking their substitute medication was part of this. For some, the substitute prescription allowed them to feel fully engaged with leading a normal life, as the small fact of consuming the medication was not noteworthy in any way:

“and I am really lucky in the sense that the cards have fallen my way. And the great joy is the stuff doesn’t dominate, I don’t even notice. I just take it of a morning and I never think about it, and it has been that way for a couple of years.” (LTM45, male, aged 55-59, prescribed methadone for 5-9 years)
In this sense, the long term prescription might be considered to have achieved its goal, as clients reported stability, engagement with normal life routines, and the substitute prescription assisted them with achieving these outcomes. However, for others, the dosage and timing of the substitute medication is critical. Notably, some participants within the sample experienced chronic ill health and chronic pain, and for them balancing and juggling a range of medications was a permanent preoccupation which prevented engagement with other normal life routines and a sense of normality:

“I take the 80mils all in one go. I have tried to do all that before and it doesn’t suit well with me. So I have that, and one Diazepam in the morning, because I take it before I get out of bed; my methadone and the Diazepam because I feel really bad. And because I have really bad sciatica I only have to sleep funny on one side of the leg and I have shooting pains all the next day” (LTM23, male, aged 30-34, prescribed for 5-9 years)

It is difficult to disentangle chronic pain from addiction and see how one might successfully intervene in the cycle of illness/pain/withdrawal offset by relief from a range of medications, including the substitute opiate replacement therapy. For those clients with particular chronic health issues, it is thus perhaps inevitable that a preoccupation with medication becomes all consuming, and, in effect, becomes the reality and ‘normality’ of life for these particular individuals.

**Methadone is medication like any other**

There was a difference within the sample, therefore, between individuals who viewed their substitute prescription as a ‘medication like any other’. These participants would tend to be also prescribed other medications, perhaps for ongoing chronic health or mental health issues. For them, taking methadone, or subutex, was perhaps less about escaping addiction to illicit heroin, but a means of managing ongoing health:

“Yeah it is just like medication, like any other medication - it doesn’t make me high or anything like that.” (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)

Especially perhaps for these particular participants, identification with a drug addict stereotype was not an issue, as the substitute prescription was just one of a number of medications. For others, the script was viewed as very much connected to previous illicit heroin use though, and for these people methadone was viewed more on a continuum with heroin (i.e. they still saw themselves as ‘addicted’ but just to a different substance). Thus it was possible to distinguish two different groups
within the sample of long term opiate maintenance clients – those who saw the medication as one part of a medication regime, and did not identify with the world of illicit drug use any longer, and those who saw the substitute prescription as strongly connected to their previous illicit heroin use, as on a continuum, and thus continued to identify and feel the stigma attached to, the image of an ‘illicit drug user’. It is worth noting here though that the first group, who no longer identified personally with the world of illicit drug use, seeing the substitute prescription as part of their treatment for their ongoing psychical problems, may not be perceived similarly by other people, including hospital and primary care staff, who may continue to see them as ‘drug users in treatment’. Thus may mean that those no longer identifying as ‘drugs users’ themselves, may still be vulnerable to the effects of stigma.

**Normality**

In conclusion then, a group of participants within the sample saw themselves as still ‘addicted’ because they were maintained on a long term prescription. For these clients, it was not possible to see themselves as ‘recovered’. There was a sense of a continuum from previous illicit heroin use to the current state of addiction to prescribed methadone. For others, the sense of being stable and feeling ‘normal’ whilst maintained on a script was such a huge relief, that this was viewed as normality, and clients saw themselves as ‘recovered’ whilst being maintained in this way. This contrast is particularly stark when considering the positions of some within the sample who had severe mental health difficulties. This lady, diagnosed as bipolar and having experienced mania and severe depression, with previous suicide attempts, described how methadone makes her feel ‘normal’, and that without it she believe she would be far from ‘normal’:

“Methadone - that fills the hole, and I don’t know why, but it does. It is only medically, I don’t mean mentally, it is medically, because it is a warmth. When you take it, it gives you a warmth and I think because I have been with a hole like, something missing, it fills that gap, it does fill that gap, and it makes, and I am ready to cope, I am normal on it. I am not out of it, I am actually normal on it, and without it, I am really a screw loose.” (LTM25, female, aged 30-34, prescribed methadone for 5-9 years)

**In limbo**

The split within the sample between those who saw themselves as ‘normal’ when on substitute medication, and those who continued to identify with the addict role, is perhaps well exemplified by the overarching theme of being ‘in limbo’.

**Happy to coast along**

Thus for some clients, reports were that they were very happy to ‘coast along’ taking the substitute medication, without really questioning it. There was a sense that they felt stable and well in
themselves, and so why would it be seen as necessary to change that situation?

“And we sort of chugged along really, and I felt that as long as I had that methadone, even as it went down, it was like the crutch. And I knew that made me feel better and everything, and I just plodded along just taking it really and got used to doing it.” (LTM06, female, aged 45-49, prescribed methadone for 5-9 years)

There was almost an unquestioned acceptance of the permanence of the substitute prescription, and a sense of not wanting to ‘rock the boat’ and risk destabilisation. For some people this might be considered an adequate aim and a goal in itself, as engagement in society, particularly in the form of employment, was made possible by the substitute prescription:

“the longer you are taking it you are just taking for granted and I was working and all that and I was giving clean samples”. (LTM04, male, aged 40-44, prescribed methadone for approximately 10+ years)

Linking to the theme of normalisation then, some participants reported that they were happy to coast along, as the substitute prescription was working for them – they felt stable, ‘normal’, and able to engage in meaningful daily activity, made possible with the support of the substitute prescription. However, for others, the prescription itself and the effects of the medication seemed to impact on everyday life, thus some individuals were reportedly stable, yet remained ‘in limbo’ and unable to actually engage with normal life. This supports the wider definition of recovery, that recovery means first and foremost psycho-social recovery and may not necessarily be about the drug use itself.

**Withdrawal from the social world**

A minority of participants within the sample described how they felt disconnected with the social world. For some, this was a consequence of circumstance – having no family to support them. Most people within the sample also described how previous social networks had been built around the common shared social activity of illicit drug use, and thus moving away from this activity meant accepting that the previous social world in which one lived could no longer exist:

“No family, absolutely no family about, I don’t have, and all my old friends and that were drug related, so they had to go. I don’t really have a lot of company, no, not really”. (LTM44, male, aged 35-39, prescribed methadone for at least 10+ years)
“And like certain people that I know, if they don’t do anything, but then I think, well if they stopped the drugs they perhaps might get out there and do more, and that is hard to do - it is very hard to do. I don’t mean to stop the drugs, but to actually getting a social life back, because the past few years have just been me and (male partner) and drugs you know. Drugs are the need in us, drugs to actually going out and socializing, and you don’t even socialize with the other people really because they are just, they are just doing the same as you. Do you know what I mean? You all get together and go out because you just don’t do that, you just sit there and do drugs”. (LTM02, female, aged 50-54, prescribed methadone for 5-9 years)

In this sense, part of ‘recovery’ and moving away from illicit drug use necessitated a withdrawal from the previous social world. This can be very difficult and lonely. Participants described a sense of being at a loss with where to start attempting to rebuild new social networks, particularly if they had long histories of illicit drug use, and had accumulated long stretches of substitute prescribing.

**Numbness**

Others described a sense of being ‘in limbo’ connected to the effects and / or side effects of the actual substitute medication.

“And the um trouble was with 80 (mls), it was hard to live with, because I was so numb to the world. I would be quite happy to sit in this chair all day with nothing on, and with a smile on my face. So I wasn’t quite in reality anyway, and I could feel myself slowly coming down to reality, as I was dropping down even through the 5 mls, especially as the ratio changed when I got down lower, to a lower amount. I could feel myself coming back with the touch, and with my feelings and everything coming back, you see the numbness out of your body going. So that was quite nice and, um, but then with that you have got all the emotional upset coming back. And after walking around, with really a blanket over you for years, and not having to take any emotional bombardment on your life, on your brain, it is quite hard to deal with.” (LTM24, male, aged 50-54, prescribed methadone for 5-9 years)

This participant very eloquently describes feeling numb as an effect of a high dose of methadone, of feeling disconnected from reality. Interestingly, he describes a sense of reconnecting with the world as his dose of methadone decreased over time. This was in some senses positive, enabling connection and a sense of reintegration, but also in itself presented difficulties, as this participant describes a reawakening of emotion that was difficult to deal with. For this group of people, taking heroin in the first place often represented an attempt to cope with difficult emotions, perhaps as a result of childhood trauma or abuse. Coming off heroin, and in turn reducing substitute prescribing,
coincided with a difficult return of emotions that may not have ever been fully addressed. Indeed, guilt and a stark realisation of the mistakes that one may have made when using illicit drugs, such as involvement in crime, prostitution, or stealing from one’s own family, also had to be ‘faced up to’ and dealt with as illicit drug use was no longer able to mask the realisation of these mistakes that may have been made (personal communication with services user, 10th August 2011). Thus huge remorse and guilt could potentially rise to the surface as substitute medication was reduced, with the implication that emotional support and, for some, one to one counselling, were critical if further reduction of the script and eventual abstinence were to be fully achieved.

Others within the sample, being maintained on high doses of medication, were perhaps not at this point, but were fearful of the future and possibly reducing their medication, being well aware of this emotional awakening that was likely to occur as medication might be reduced:

“It is frightening because, you know what I mean, at the moment, I am sort of existing, sometimes I feel like I am not living.” (LTM12, female, aged 40-44, prescribed subutex for 5-9 years)

**Lethargy / dopiness**

Others in the sample described the experience of being on a long term maintenance script as making them feel lethargic or dopey:

“It’s a bit lethargic I suppose, but it is all right if you don’t take it, you feel a bit itchy and jumpy - it makes me feel lazy sometimes you know.” (LTM26, male, aged 45-49, prescribed methadone for 10+ years)

In this respect, it can be understood that a sense of being ‘in limbo’ and unable to fully connect with the social world was an almost inevitable side effect of being on a substitute prescription. This tendency seemed to lessen as the dosage lowered, but this brought with it the associated difficult emotional realisations as described above. If the aim of treatment is to enable reintegration and recovery, however, the judgement regarding the appropriate medication dose may be a fine balancing act between enabling stability and preventing illicit heroin use, yet not over-prescribing medication which may in itself prevent individuals from feeling a sense of engagement and purpose. Below, the participant discusses the medicated feeling of being ‘in limbo’, or caught between the world of illicit drug use and the world of abstinence, suspended ‘in between’ by the medication prescribed:
“It is a horrible thing actually to be suspended on a, um, on a prescription because you don’t feel, you don’t feel, like someone who wasn’t taking drugs you know? They wouldn’t be able to take the medication they take and obviously, if I didn’t, I would be really, really ill. So you know, obviously you must feel it, but it is really hard to be. I wake up in the morning and, um, I can’t get out of bed for like half an hour easily, and it is with depression. You just sit there and you feel - what do I want to get out of bed for? But I know, as long as I have got to get myself a cup of tea and my medication, and within twenty minutes / half an hour I am going to feel better and more positive. But it is still trying to get that into my head you know? Just get up and what have you, but I do really feel like I am kind of stuck in limbo sort of thing”. (LTM44, male, aged 35-39, prescribed methadone for 10+ years)

Prevention of societal reintegration
A minority of participants within the sample saw the substitute prescription itself as preventing, rather than enabling, societal reintegration. This was discussed in very practical terms – participants talked about the difficulties of going away for a holiday due to having to alter the script and pick up arrangements, for example:

“Some days, yeah, I think there’s a lot of times I think, you know, there’s a lot of restrictions in that, you know, like, you can’t do everything you want to do when you’re on methadone, so that holds you back. Yeah, for instance, like going on holiday, you know, stuff like that - um. I suppose having kids as well, I’d have to think about, urm, would you be like healthy enough to produce kids if you’ve been on methadone so many years?” (LTM07, male, aged 35-39, prescribed methadone for 5-9 years)

This participant also discusses the concern with long term health complications – would it be possible to conceive a healthy child having been prescribed methadone for so many years?

Interferes with daily life
Other participants talked about the limitations of ‘being tied’ to the same chemist and not being able to leave the geographical area:

“I mean, as it stands, I am content enough and obviously I am still on a leash from the hospital and my GP, and there is no two ways about it; people do think less of you.” (LTM45, male, aged 55-59, prescribed methadone for 5-9 years)
However, these themes should be expressed with caution and caveats, as other participants in the sample felt that their lives, in comparison to their previous lives of illicit heroin use, were very much more free and less ‘tied’. During data analysis verification meetings with service users, this coding theme was also criticised, as some service users felt that actually people should consider themselves fortunate to be receiving a substitute prescription that had enabled them to move away from illicit heroin use (personal communication with service user, 10th August 2011), and that others just needed ‘something to moan about’ and ‘didn’t know how lucky they were’ (feedback form service user meeting 27th June 2011).

In conclusion, the experience of being on a long term maintenance script, from the perspective of the participants in this study, was a varied one. For some people, the script was normalised as a medication like any other, and the routines of picking up and consuming the medication were integrated as a normal part of life. For these people, being on a script enabled a sense of normalisation and social reintegration. However, for some people, the script itself became all consuming, perhaps in much the same way as illicit heroin use had been all consuming in the past, with the focus on daily consumption, and ensuring that the medication was available to prevent withdrawal symptoms occurring, being a constant preoccupation.

Some participants reported a feeling of numbness and disengagement with society, perhaps being at least partly attributed to the effects of methadone. Others reported feeling ‘themselves’, and being able to actively engage with society, in some cases even securing employment and caring for a young family, due to the continued support of the substitute prescription. For others, ongoing enduring physical and mental health difficulties were extremely complex, and being able to disentangle the effects of the substitute prescription from the effects of other medications was difficult. Thus the emerging message drawn from a detailed focus on the experience of long term maintenance, is that it is an effective intervention to offer ongoing support and stability for some, yet for others may in time prevent social reintegration and being able to move on, since the medication itself symbolically represented a continuation of addiction, and thus individuals felt that identification with the ‘addict’ role continued.

**Barriers to recovery**

Barriers to recovery were both specifically asked about during interviews, and were also covered naturally as participants spoke about their experiences and views of being on a long term script and the possibility of reducing or becoming abstinent. Perceived barriers covered all aspects of participants’ lives, and can be categorised according to system, social, interpersonal and intrapersonal (individual) barriers. By far the most frequently focused upon barriers were intrapersonal.
Intrapersonal (individual) barriers

Can’t imagine life free from all substance misuse

For many participants in the sample, there was a sense that they had been using drugs for so long, that they simply couldn’t envisage life without some kind of substance use:

“I have taken drugs all my life; it has just escalated from C to B to A as I do, and you know, I probably will always use heroin. I hope I don’t, because I wouldn’t even smoke a joint now if someone passed it me - I don’t want that. No in fact, ugh, so, so, maybe one day to be able to say that to heroin, but at the moment I wouldn’t. It might change, it might change. (LTM24, male, aged 50-54, prescribed methadone for 5-9 years)

However, as the quotation above illustrates, even though individuals couldn’t envisage a life without substance misuse, there was often the distant possibility of change. So for many, even those who had been using drugs all their lives, and so might be considered to be the most ‘entrenched’ clients, the possibility of change is perhaps one worth raising.

Too old to stop now

Linked to the above themes, there was a sense for many participants that they simply felt that they were ‘too old’ to consider stopping the substitute prescription now. It had been a part of their lives for so long, that they couldn’t imagine life without it, and felt that it was pointless attempting or considering reducing or aiming for abstinence. For some people, as possibly the case for the participant below, there was a fear of what would happen if they were to withdraw from methadone, which had become a part of who they are:

“It would probably kill me if I came off now - I have been using for so long. I mean, it has been in my bloodstream, and it is all part of me now fifty or forty years – forty six years - something like that. It is a long time now. Um, I don’t know what would happen if I had to knock that on the head.” (LTM22, male, aged 55-59, prescribed methadone for 5 -9 years)

This sense of being too old may represent a generalised unwillingness to consider change, or may indeed to be linked to the themes of stability and normalisation as discussed above, that being on a long term script had bought. Thus there was a sense of not wanting to rock the boat and risk changing the current situation of stability.
Likes the effect of drugs / enjoys taking heroin

Others within the sample were candid in sharing their view of quite simply enjoying continuing to consume heroin, either regularly or on occasions. The participant below describes the effect of heroin as being an emotional blocker, of giving a feeling of warmth and not caring or worrying about things that might otherwise distract him:

“It’s a drug I would never have used as a young man; it is not a young man’s drug really. It is because it gives you that - it gives you that warm feeling and, you know all the concerns you have had in your life? You know all the failures and the things that didn’t work out, that you might turn over in your brain sometimes? You don’t think of those things.

Int So it is more useful as you get older you think?

M Definitely yeah - because it’s a blocker; it is an emotional blocker you know? You know a record might come on, and you might think: ‘I remember when I was in love with that girl and we split up’ and you get a little bit emotional and all that? That don’t come into it when you are on heroin you know? All them things.”

(LTM24, male, 50-54, prescribed methadone for 5-9 years)

So for this participant, the continued occasional use of heroin, in addition to his methadone prescription, was seen as useful, and indeed serving a purpose and a function in allowing him to ‘switch off’ from some painful memories. This was perceived as a positive effect of heroin, and presented a barrier to recovery, as the participant could not envisage leaving behind this positive experience. Similarly, the participant below confides his love of using methadone, such that he often buys illicit methadone to top up his prescribed dose. He enjoys the effect of the medication, and this in itself would represent a significant barrier to abstinence from a substitute prescription for this person:

“Int I think you said you still buy methadone on top - do you?

M Well, I do sometimes when someone comes around now. I haven’t had any extra for several weeks now; I am trying to be straight, but I don’t enjoy life when I am straight.

Int What is different about it?

M It’s not nice. It is cold; it’s dead. Life is dead and I may as well be dead with it.
Int And what is it like in the other way?
M Oh I love it - the other way. Oh love it; I just love it.” (LTM42, male, aged 65-69, prescribed methadone for 10+ years)

**Complex mental health issues**

5 out of 27 participants interviewed (18.5%) had a formal diagnosis of a psychiatric condition. However, a further 11 participants in the sample had self-diagnosed (including 6 who take anti-depressants). Combining those 6 prescribed anti-depressants with those 5 who had a formal psychiatric diagnosis, indicates that 40% of the total sample could be said to have dual diagnosis. For these clients, the risk of destablising their condition represented a very significant barrier to recovery from substitute prescribing, and there was fear around the possibility that reducing the script might be enforced upon them by treatment services. One female participant, caring as a single parent for young children, and dealing with chronic anxiety and depression, discusses here how her period of illicit drug use (illicit methadone) was actually very short compared to the length of her substitute prescription. She perceives this as being because methadone for her has a medicating effect beyond simply substituting illicit drug use. For this reason, reducing or attempting to detox from methadone would be very difficult, as she fears a return of her anxiety symptoms:

“I don’t think the years that I have been on it has been because of my drug use, I think it is because of other things and that is the way I think of it, if I am honest. Because I don’t think my illicit drug use wasn’t very long, compared to how long I have been on this. And every time I think of coming off, or start to wean down, that anxiety kicks in. But I would I love to be - I would love not to hide it from other people. So many people don’t know, and it is not nice. And my kids don’t know and they just know that I take tablets, and that is all they know; they know that I take something.” (LTM25, female, aged 30-34, prescribed methadone for 5-9 years)

Similarly, a participant with bipolar disorder demonstrated concern about the interaction of his prescribed methadone with other medications:

“I want to reduce it, but obviously, when I get quite low they may have to put my mood stabilizers up a bit because obviously my thoughts and feelings are going to be a bit different to other people” (LTM23, male, aged 30-34, prescribed methadone for 5-9 years)
For the participants that we spoke to with dual diagnosis, reducing scripts had, for the most part, not been discussed with key workers, probably due to a recognition by treatment services that this would not be appropriate. However, participants were nonetheless aware of the recent shift towards recovery in treatment services, and expressed worry and concern that it might only be a matter of time before reduction was discussed. For others though, even the participant above who had severe and enduring psychiatric problems, reduction had been actively discussed with treatment services, and this had prompted some level of fear and worry:

“I have had offers of rehab from the social workers there but I don’t think that that would be a good thing for me do you (Name: male carer/partner)? Because I don’t like being around people, I can’t be around a lot of people. Like if I go to the doctor’s surgery, and there is a lot of people waiting there, and then just go outside and stuff. And it is bad enough being outside. I don’t normally like coming out of the house, but I know I have got to for my own health and sanity. But I don’t mind it outdoors, but I don’t like crowded places, I prefer it when it is dark; I don’t like the light because people can see you.” (LTM23, male, aged 30-34, prescribed methadone for 5-9 years)

**Complex physical health issues**

As with those with complex mental health issues, those participants in the sample with complex physical health issues did not see that reducing the substitute prescription would be appropriate or relevant for them. In this sense, other physical health problems represented a barrier in themselves towards recovery from the substitute prescription. This participant, having recently suffered life-threatening illness, and still being in recovery, suggested that reducing was ‘bottom of the list’ at present, for both him and treatment services:

“because of the hospital thing and all that you see; I been through a lot in the last year, so I think that’s bottom of the list at the minute. You know I have just been having to sort out everything you know and with being readmitted into hospital and that you know I have kind of given my year up.” (LTM27, male, 30-34, prescribed methadone for 5-9 years)

**It’s the wrong time**

There was a strong sense throughout the participant interviews that the motivation to reduce a script and potentially achieve abstinence and recovery had to come, ultimately, from within. The view was that there was a critical point in one’s life, which might be different for different people, at which this internal motivation was right. Correspondingly, if one attempted to reduce or achieve abstinence when the time wasn’t right, i.e. when individual motivation wasn’t maximised, then the
likely outcome would be failure, and a relapse would occur. In this sense, the time at which reduction and abstinence was attempted could be seen to present a potential barrier to recovery. One participant, a female who was pregnant at the time of interview, discussed wanting to stop using methadone as she had had a previous child when using methadone and had watched it suffering from withdrawal. She felt guilt and upset that this might happen to another baby, yet recognised that to reduce methadone now would be ‘doing it for the wrong reasons’, i.e. not motivated by her own desire to stop, but motivated by a concern for her child. This, she felt, would be setting herself up for failure:

“I thought, you know I can’t do another - one there is no way I can have another one on this, it is just not right, you know. I know being on 60mils is a lot, but um, I had to say to myself this time ‘you could end up not being well if you come off’, because you are not doing it because you are ready, you are doing it for something else.” (LTM25, female, aged 30-34, prescribed methadone for 5-9 years)

Although the participant above makes the situation more stark by discussing how her pregnancy interacts with this view of the time in one’s life representing a barrier to recovery, she does also illustrate well the view held by many participants, that reduction and recovery had to happen at a time that is right for the individual. This will be different for different people, and it is difficult to determine the ‘right time’, but there was a definite sense that the right time would be one when the participant was prepared to reduce for internally motivated reasons, and that this internal motivation would be the most likely aspect that would prevent a relapse.

**Not doing it for yourself**

Linked to the above theme, was a sense that, not only did reduction have to be attempted at the right time, but it had to be ‘for yourself’ and not motivated by others:

“I think age as well; I think I was at the right age to actually want to do it because in the past I’ve like wanted to do it, but it’s been for other people, um, and me. But it’s not been strong enough, do you know what I mean? And, um, this time it was strong enough.” (LTM07, male, aged 35-39, prescribed methadone for 5-9 years)

This participant illustrates the view that it is the internal motivation and strength within oneself that is critical for achieving a successful reduction and sustaining abstinence.
“No, there is only one way anyone can be recovered from heroin addiction is to really want to do it for themselves. There is no good anyone trying to do it for other people, other reasons, you can only do it for yourself, otherwise it doesn’t work. I have seen it hundreds and hundreds of times, and it just doesn’t work. (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)

The participant below makes the link between physical and psychological aspects of addiction, suggesting that you can detox and become clean physically, but if you are not ‘doing it for yourself’ psychologically, then a relapse will be the most likely outcome of attempts to become clean. For this participant, this was starkly illustrated by a spell in residential rehab, followed by a swift relapse to illicit heroin use:

“I wasted £4,000 on detox that is supposed to be this quick fix, that they get the opiate out of your body all right. So I mean they can get any drug out of your body, but they can’t get it out of your head can they, you know, they can’t lobotomise you can they, at the end of the day?” (LTM27, male, aged 30-34, prescribed methadone for 5-9 years)

Guilt at previous harm caused

As has been discussed in relation to the effects of heroin and high doses of methadone acting as an ‘emotional block’, participants discussed the guilt that they felt as presenting a barrier to recovery from substitute prescribing. For some participants, the sense of guilt and shame about their past history of substance misuse, and the associated lifestyle, was so strong that there was a very real fear of being abstinent and having to deal with the reality of thinking about the mistakes one had made. For the participant below, the guilt was about the choices she had made around injecting, and the harm that she had caused herself:

“I think that is where a lot of people find recovery so hard because they don’t know how hard it is to come to terms of some of the things they have done of using. You know I am still having a big problem actually taking in to what I have actually done to my body, there is not a day that goes by when I don’t think, you know, ever whatever was I thinking.” (LTM21, Female, aged 45-49, prescribed subutex for 10+ years)

Others were ashamed at the amount of time and energy that had been devoted to illicit drug use:

“gear and drugs - that was the first thing on my mind from the time I went to bed
till the time I woke up in the morning for years and years and years and it saddens me so much, you know, that you know I’ve wasted twenty five years of my life, you know, literally that I can’t get back.” (LTM43, Male, aged 45-49, prescribed methadone for 10+ years)

**Boredom**

For other participants in the sample, a sense of the mundaneness of life represented a barrier to recovery. Despite the chaotic previous lives of this participant group, dominated by a cycle of illicit drug use, crime and instability, there was a sense that the alternative ‘straight’ life was boring and unexciting by comparison. For these participants, the thought of that boredom and ‘normality’ itself presented a barrier:

“It is hard, especially in the winter with the long cold horrible evenings, that is definitely because there is a boredom thing as well and I don’t care what anyone else says - it is a boredom thing. Oh I can’t go out, I can’t do that, so I will do some drugs; I am staying in - do you know what I mean? But it is just knowing what to do. I mean, we say about it quite regularly like - I am bored, what shall we go and do? I think - well we are not drinkers we are not into the pub scene, do you know what I mean? And yeah, we like doing this and we like doing that, and then we laugh and say: ‘Well when the weather is better; we can go fishing.’ So it is better we can go fishing; it is a big void, like you say, because suddenly you are not doing the drugs.” (LTM02, female, aged 50-54, prescribed methadone for 5-9 years)

For others, previous attempts at abstinence had led to boredom, and this has resulted in a relapse:

“As I said Charlie a few times use to come off and seriously tried, but it has always worked out that I have ended up getting back into it through boredom or loneliness, not knowing anyone other than the scene or the pressure of things that, but mainly because I enjoy it.” (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)

Thus for those who had tried on multiple occasions to detox, sustained recovery had been illusive, as boredom has crept in, and the world of illicit drug use had eventually been returned to as a means of alleviating this boredom.
Fear

Fear was a significant sub-theme that arose in many forms under the over-arching theme of intrapersonal barriers to recovery. Fear was expressed when attempting to think about the future and consider treatment goals, as we asked all participants to do during interview. There was a fear of the unknown, it seems, that was tangible and expressed in many ways by participants. This fear was particularly marked for this group, perhaps, who had been on substitute prescriptions for long periods of time, and found it hard to consider life without treatment, or illicit drug use of some kind.

Fear of instability

Linked tangibly to the relief expressed by participants when discussing the experience of long term maintenance, of the substitute prescription providing an ‘escape from chaos, was the fear expressed when discussing abstinence that life without a script might mean a return to chaos. Discussing recovery then, demonstrated that many participants feared instability in a life which had stabilised because of the substitute prescription.

“I hate to think about it (reduction) - I would be in such fear and trepidation as to what really could happen; the pitfalls where I could end up and back to square one. It is frightening, so I haven’t give it that much thought; it is really frightening.” (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)

This clearly expressed fear provides further evidence to support the experience of long term maintenance as being one of feeling ‘in limbo’, as the gap between the previous chaotic world of the illicit drug user and a move towards full recovery, or abstinence, was viewed as feeling insurmountable by some. The ‘middle ground’ position of maintenance on a long term script provided reassurance and security in escaping chaos, the thought of being off a script created a fear of a return to instability. For some, this fear, worry and anxiety connected to the possibility of reducing or being abstinent from the script possibly created difficulties for some participants in itself, due to the strength of the negative thoughts:

“Yeah I hate change. I know we have all got it in common, but I hate any type of change - a little change, big change. I hate when I have got to change a script because I worry. I worry about silly things and it will be on my mind for days you know um.” (LTM23, male, aged 30-34, prescribed methadone 5-9 years)

Others were dealing with this in the current climate by actively discussing the long term script situation with their key workers. There was a high level of awareness of the change in focus in treatment services towards a recovery orientated model, and a fear of how quickly these changes might be implemented:
“Well I spoke to her (key worker) last week about reducing it (actually the last time I saw her was last Friday) because of the government cut backs. And I am worried that I might get kicked off and that is a life’s line to me and that is more important than food to me. So I said to her: ‘Look, can we start reducing?’ and she asked why and I said: ‘Look, you know because I don’t want to just be cut down quickly because I will. It will just destroy me, you know I would be ill really ill.’ And I think it is a little bit harder as you get older as well you know the withdrawal symptoms and longer.” (LTM24, male, aged 50-54, prescribed methadone for 5-9 years)

The participant here demonstrates a proactive approach to dealing with the worry and anxiety that the thought of ‘recovery’ can bring. However, for others, particularly those with dual diagnosis, such as the participant below, the fear of a return to instability is extremely potent:

“I think that is why it is harder for me to come off. Because I know that that was something that was in me before and I think it is going to return and I think that is why I have always got the opportunity to come off. There always is in place that I can, but I think because I am very, very frightened of what might happen if I do. Do you know what I mean? I think it is a massive risk to take” (LTM25, female, aged 30-34, prescribed methadone for 5-9 years)

At the time of undertaking the interviews, there was a general misunderstanding of the new recovery focus of treatment services, with some with enduring mental health problems possibly thinking that they may be asked to reduce their medications, although treatment services being aware of the patient case history would actually be likely to take a much more cautious approach, as indicated by the staff interviews discussed below. The implications of this finding are around service communication and dissemination of the interpretation of new policy. Participants in this study, at the time of interview, perhaps saw the recovery focus as a blanket policy for all clients, although in reality the service interpretation of this may have been more measured. Communication of this from a service perspective may have perhaps helped to relieve some of the intense worry and anxiety expressed by participants in this study.

In summary, the fear of instability expressed as a dominant theme when considering recovery by this sample links closely to the experience of long term maintenance as being an ‘escape from chaos’ and as representing stability. The thought of moving on from long term maintenance caused fear and consternation due to the possibility of a ‘return to chaos’. Participants wanted to avoid destabilising their lives once again. The long term nature of the maintenance prescriptions for this client group also meant that many had enjoyed a number of years removed from the chaotic world of illicit drug
use and, although many couldn’t envisage going back to this, they also lacked confidence in their ability to maintain this without a prescription, and thus a fear of instability was a stronger motivator than moving on to lead an abstinent life, which was very difficult to envisage for the majority of the sample.

**Fear of difficulty of recovery or withdrawal**

A further dominant fear expressed by the participant group in this study when reflecting on recovery, was the fear of withdrawal. This is an extremely potent fear for this participant group, who talked about the length of their dependency to heroin, and then to a substitute prescription in turn. The belief was that the length of dependency would be likely to be linked to the experience of withdrawal:

“Yeah, obviously I want to get down to like 20mls, less say 15 mils, and then come off; I don’t know if they would let me go on subutex and come off subutex, because I have heard it is easier to come off, but the methadone has been in my system for so long now the withdrawal is going to be - and I know it is going to be really, really bad. You just got to think in ten years of putting in you, everyday high doses of it, even 40 mils is a high dose really - do you know what I mean? It is just got to come out at some end, hasn’t it after the withdrawals, and I might be quite bad” (LTM28, male, aged 30-34, prescribed methadone for 10+ years)

Here, the participant also touches on beliefs about methadone particularly as being a substance which is hard to withdraw from. Myths and beliefs about methadone are very strong amongst service users, such that it is often depicted as ‘worse’ than heroin. Lay understanding of the medication, and the discourses shared amongst service users serve to demonise the substance, and this has the effect of creating additional fear when the idea of withdrawal is considered. This may act as a significant barrier to recovery, as the expectation of a lengthy withdrawal process if reducing and becoming abstinent for methadone, seems too difficult to contemplate. Additionally, fear about methadone withdrawal may have built up over time, as recall of the memory of previous withdrawal experiences may be negatively distorted. The same participant demonstrates this belief, showing that he feels robust enough to deal with a short period of pain and withdrawal, but doubts his ability to handle this if prolonged:

“I just don’t want to be ill, like for two months. If it is like two or three weeks I might handle it but you know, and people say you get off methadone for like, for about four months, is like – no, I couldn’t do four months. I would end up bloody killing myself before then.” (LTM28, male, aged 30-34, prescribed methadone for 10+ years)
Others mention again the feeling of being ‘tapped’ or caught ‘in limbo’ by the substitute medication. Whilst being motivated and excited about the potential idea of recovery, the fear of withdrawal was over-riding and prevented, or acted as a barrier, to them actually initiating any moves towards recovery to date. Some participants had attempted reducing their own medications in the past, and had experience difficult side effects that they were fearful of repeating:

“And I am very worried about that, very worried, but there is something about this methadone script and the valium script. It is something that has done; it has made me focus quite badly on the medication side of things, I feel very trapped - extremely trapped. I mean, oh God the thoughts of, and when they told me, when they mentioned about the study, my instant thought, even though it could be the best thing that could happen to me, that I was going to start coming off. And you know in my (()) extremes would be amazing to come off, but it is such a frightening thing, really frightening. Really frightening because I have tried to get myself down off my Diazepam myself, and it was just 10mils a day, and I had some quite nasty like fits and seizures and stuff which really weren’t nice.” (LTM44, male, aged 35-39, prescribed methadone for 10+ years)

Previous experience of negative side effects of withdrawal obviously serve to create additional fear and anxiety about the possibility of withdrawal, creating a cumulative effect of fear when combined with the dominant discourses around methadone as being a nasty drug with associated difficult withdrawals.

**Fear of illness & fear of return to poor mental health**

Linked very much with the dominant themes discussed above of a fear of a return to instability, and a fear of difficulty of recovery or withdrawal, were two sub-themes more specifically around a fear of illness and a fear of return to poor mental health specifically. No one would choose to feel ill where the choice was available. In terms of the general population, it can be understood that there may be a normal tendency to put off something that is likely to be uncomfortable or make life harder for a while. For people who are struggling to manage their everyday lives anyway it is easy to see why it would be hard to develop motivation to go through withdrawal to stop taking a prescribed medication, which in itself may not be causing a problem. Once the worst chaos of drug use is over and the individual is only a drug user in the sense of taking substitute medication, the difficulties which drive motivation to change are weaker and likely to be easily overridden by competing motivators around improving ones life – which could themselves be placed at risk by making changes to the prescription. Therefore, for those considering or having experience of reducing their prescribed medication, accepting some level of discomfort may be par for the course:

“obviously it is not going to be painless to get it from 100ml down to 40. Obviously you have got to go through a bit of crappy night and stuff, but the insomnia is a
pain the arse and you end up sleeping all day”. (LTM28, male, aged 30-34, prescribed methadone for 10+ years)

Addressing this knowledge and dealing with the fear associated with it is thus critical for those considering a reduction in substitute medication, as the fear of illness itself prevented a barrier to recovery. Others discussed, more specifically, their fears of experiencing mental health symptoms, which had been medicated via the substitute prescription. For the participant below, recovery could only be considered in terms of an intense therapeutic environment to address the dual diagnosed anxiety that she felt would reappear as the substitute medication was reduced. This in itself presented a barrier linked to the system barriers discussed below, as provision of such intensive rehabilitation and psychological support services is extremely limited:

“the only way to do it is to go somewhere where there is care and be in 6 months. And be somewhere that you are away, and you get so that when the mental issues do crop up, I have got help.” (LTM25, female, aged 30-34, prescribed methadone for 5-9 years)

**Interpersonal barriers**

Secondary to intrapersonal (within the individual) barriers, participants discussed interpersonal barriers as being aspects related to other people, their relationships and social groups. By far the most dominant theme within this category of barriers than were inductively derived from the data gathered for this study was the barrier of ‘mixing with the same crowd’.

**Mixing with the same crowd**

Participants discussed at length their social embeddedness within particular groups. Many participants, considering the average age of the sample of 46.63 years, had lived in the same geographical area for many years, and were deeply embedded within particular social groups. For some, these groups remained organised around illicit drug use, and thus immersion within these groups itself, formed a barrier to the prospect of achieving recovery:

“It is everything; everywhere, everything, every call that comes in, everyone that walks through the door now, everyone I literally stop to talk to, I know takes drugs.

Int So you wouldn’t be able to get away from it.

M it would be really, really, really hard. It would be, I think, the only way I could do it, would be is to move, but then I would just be lonely and probably start
using for that reason. I least I have got a life here, I have got good friends around me and family around me” (LTM24, male, aged 50-54, prescribed methadone for 5-9 years)

The participant here demonstrates the complexity of this barrier. Remaining immersed within an area where ones friends and acquaintances are associated with illicit drug use represents a difficult barrier to recovery, yet the alternative and extreme position of considering moving away from a particular area would present new challenges, in losing the established networks of support built up over many years, and in having to face the prospect of attempting to make new friends. Others though, had past experiences of failed attempts at abstinence, and viewed their social circles as explaining the failure:

“There is no good just coming out (or rehab) and thinking I will get on with it, because you are in the same group of people. And I think you need to be away from that group of people.” (LTM04, male, aged 40-44, prescribed methadone for 10+ years)

“Really, really hard cos everybody I knew was all at it; everyone who I hung about with - they were all using drugs, either cocaine or heroin so every night there was a knock on the door, somebody would turn up with something. It just got so like I just couldn’t get away from the people and that”. (LTM09, male, aged 40-44, prescribed subutex for 5-9 years)

In this sense, knowing that one would be likely to be mixing with the same people post-detoxification represented a significant barrier to recovery, and one that some were at a loss with knowing how to address, aside from suggesting complete relocation. Even for those that had taken this extreme measure, it was impossible to fully escape others who might cause one to stray from the path of abstinence. The participant below describes a period of abstinence and geographical relocation, but remaining in contact with close friends had eventually resulted in a relapse:

“I ended up moving out to another village. And when my son was about a year old, me and his dad broke up. And then I did the most stupidest thing. I had a best friend who I went right through school with - well I say right through school; we met when she was about ten and I was about twelve. We went right through school together, and we had habits together, we had done everything like that together. Um, and I had stopped, but she hadn’t. And she had carried on, and she was my best friend, and she had nowhere to go for a little while, and she asked if she could
stay with me for a few weeks. And I said yes. And I was in with that for three weeks, and it was awful. I was finding myself around people’s houses waiting for her, to bring her home. And I just wanted to keep her safe. But I also had my son who was like you know, no more than a year old, and I mean that lasted about five weeks. But by that stage I had started doing it a little bit, not a lot, every so often. And once again, I was going out and getting it, and coming back” (LTM06, female, aged 45-49, prescribed methadone for 5-9 years)

The same participant, when describing other relapses experienced over the course of her relapsing-remitting history of heroin dependence, suggests that her strength and ability to remain abstinent was tested in the face of interactions with drug using friends:

“I wasn’t as strong as I probably thought I was you know, and when it is in front of you it is a totally different kettle of fish; it really is” (LTM06, female, aged 45-49, prescribed methadone for 5-9 years)

In this sense, the presence of others using illicit drugs represents a difficult barrier when considering recovery, and in some senses that barrier will always exist to varying extents for individuals, who may need to draw upon their own individual and other social support (e.g. treatment services) resources in order to address this particular barrier. Even for those able to comprehend the idea of complete relocation to escape previous drug using friendship circles, the omnipresence of illicit drug use is inescapable. This may be particularly so given the limited choices of housing available to those on low incomes, as was the case for many of the participant group sampled for this study:

“I moved away from my other flat and moved here and since I got here the area is full of addicts.” (LTM13, female, aged 50-54, prescribed methadone for 5-9 years)

Thus ‘mixing with the same crowd’ presented the most salient interpersonal barrier identified for this participant group. Awareness of this as a barrier to recovery was high, but hope about being able to address this barrier, and the past experiences of those suffering multiple relapses, made the barrier seem difficult to address.

Unhelpful relationships

Linked strongly to the above key theme of mixing with the same crowd as representing an interpersonal barrier, was discussion of close relationships as being a barrier to recovery in
themselves, in some cases. This female participant, below, discusses how a particular relationship had been associated with a period of chaotic drug use:

“I met this bloke, and that just went completely mad for two years. I found myself, I was using again by this stage, we moved to here to be near my mum and the crux of it all with bloke was, um, not only did he take, he took Vallium as well and other things. And half of the time it was like looking after two children, yeah, and I don’t even know why. Oh to this day I just think to myself what was I thinking? I really, to this day don’t know what I was thinking. I knew from the word go he was crap for me” (LTM06, female, aged 45-59, prescribed methadone 5-9 years)

For some participants then, involvement in ‘unhelpful relationships’ represented an almost complete barrier to recovery, or at least had done so in the past. Others suggested that being single was a barrier in itself, as they needed the support of a long term partnership in order to be able to comprehend the difficulty of moving towards recovery:

“for me, to come off what I have been, I need a partner - somebody is going to understand and be there, because I am a big baby when it comes to being ill and what have you.” (LTM44, male, aged 35-39, prescribed methadone for 10+ years)

However, in positive recognition of the importance of close personal relationships to ones recovery status, more positively, some participants also discussed the positive influence and supportiveness of a close relationship where both members of a couple were in treatment together (see section below on recovery enablers).

**Breaking up with partner**

Just as being in a difficult relationship presented a barrier to recovery for some participants, for others it was the breakdown in a relationship that had contributed to past relapses, and the lack of a supportive relationship was also considered as a barrier to recovery:

“I had a break down in my relationship, um, so I just started using again and I know it is a stupid thing to do but I started using again. And I split up from my partner and the children ended up living with him and I ended up living in a caravan and just carried on taking drugs.” (LTM11, female, aged 50-54, prescribed subutex 5-9 years)
The fragility of attempting to achieve abstinence and the association with close personal relationships is thus highlighted. Participants gave a sense that ‘recovery’ is a process and one that may be in jeopardy at particular trigger points in one’s life. Thus the loss of a close personal relationship can be understood as representing a particular trigger that would threaten recovery and present a barrier for individuals attempting to achieve abstinence. This may present itself in a range of ways. For example, the participant below demonstrates how he was able to maintain stability on his substitute prescription and stay clear of illicit drugs, but began to chaotically use alcohol as a way of coping with a long term relationship breakdown. Thus other substance misuse aside from opiates can, in itself, be seen to threaten stability and recovery:

“when she left me so, um, and because I had been with her since I was twenty five and I am now fifty do you know what I mean? I lost my home, everything I owned, you know and sort of, um, she sort of, um, she used my youngest child, like she was seventeen at the time, to um, get into me really, you know? She made me lose my temper, so they could call the police and I ended up slashing myself I will show you. That is when I had drink see, when I have drink I do stupid things you know, and that is why I don’t want to drink see” (LTM10, male, aged 50-54, prescribed methadone for 10+ years)

**Need to stay stable for children**

In a linked manner, the way in which close personal relationship breakdown can be seen to represent a threat or barrier to recovery, other relationships can be seen to encourage stability. Within the sample, those caring for resident children discussed how important it was for them to continue to remain stable on a script in order that they can continue to care for their children:

“If they (the prescription) do keep me right and keep my life going, and for the children I have got to be right, they don’t want to see their dad having like it once was (being chaotic). And at my age as well that would upset their lives. So I have got to keep right for them and they have got to keep right for me (treatment services) so it works for everyone.” (LTM24, male, aged 50-54, prescribed methadone 5-9 years)

In this sense, caring for children represented and enabled continued stability, although this was in the sense of remaining on a stable substitute prescription. So, in effect, resident children could be seen to represent a barrier to achieving abstinences, since considering reduction or withdrawal when one has caring responsibilities may be perceived as difficult, if not impossible, due to the risk of illness and destabilisation, which would have knock on implications for those being cared for. However, this situation was not necessarily permanent. The same participant discussed at length his
To summarise, interpersonal barriers were significant for the study participant group. Although discussed with less depth and frequency than intrapersonal (individual) barriers, when discussed the barriers of mixing with other drug users and unhelpful relationships seemed extremely significant and difficult to address. These barriers obviously applied more to some individuals than others, such that, whilst many of the participants discussed mixing with others as being an important barrier to recovery, only those who had experienced particularly difficult relationships currently, or in the past, discussed this as a barrier. Similarly, those participants with children discussed this situation as presenting a barrier towards achieving abstinence at the present time, although the stability of being on a long term script and simultaneously caring for children suggested that in the longer term, involvement in caring activities may also assist in enabling recovery. The importance of this being achieved at the right time in one’s life to support the needs of others being cared for was paramount.

Social barriers

Barriers that could be grouped as social barriers to recovery can be further sub-divided in terms of micro and macro social factors. Micro factors, otherwise understood as social factors that participants felt impacted upon them in a very direct manner, of note within the analysis of the data set for this project included issues around housing and unemployment. Marco factors included less directly felt, although nonetheless equally pervasive factors, such as perceptions of ‘normality’ and social acceptableness, and a difficulty with perceiving how one might fit in with these perceptions. Stigma is also a pervasive issue discussed at length in various ways by the participants in this study.

Housing

One participant within the sample indicated the difficulty in finding reliable and stable housing, and how temporary measures are often unacceptable. This in itself obviously presents a difficult barrier to recovery, as the interacting difficulties of being surrounded by other drug users and having the stress of unstable accommodation would be likely to facilitate further illicit drug use:

“so when the mother and me split up, yeah, or when she sort of got me slung out of the house really. I was living with my daughter for ten months until I got a room in a place where it wasn’t full of alcoholics and users you know. It is hard to find somewhere to live without sort of either foreigners or people who are drunk all the
Another participant, with dual diagnosis and complex physical and mental health problems, discussed the difficulties of being housed in a particular area, where he felt vulnerable not only to further illicit drug use, but also to bullying and coercion due to a history of prostitution. His fear of being located by others attempting to bully or take advantage of him was stark, and this interacted in a complex way with his need to find secure housing and the pressure he felt to accept what was offered to him:

“I did feel like I was being propelled into taking that place, when I didn’t really want to take it, and he (the housing officer) knew that how I wasn’t aware of things and I was close to tears and I just felt like if I said no that, you know he made it sound as if I couldn’t stay at the other place and I would be on the streets and stuff like this... if I got re-housed properly you know – no, if had to get that flat there will be a time where they (drug dealers / pimps) will come round there and there will be something to try and get me back on to (heroin) and that is the type of person he is, do you know what I mean?” (LTM23, male, aged 30-34, prescribed methadone for 5-9 years)

Thus this participant, although somewhat confused in his discussion, demonstrates the importance of safe, secure housing in attempting to work towards recovery. In this case, there was a need to escape particular people in particular areas, although a pervasive fear that he would be tracked down. Stable housing, then, for this individual, needed to be in a secure area close to his family. This need was offset by the structural constraints of available housing, where only certain areas might be available for re-housing.

**Employment**

In a similar way to housing, participants discussed in general terms how employment was important in facilitating recovery, and thus unemployment represented a barrier to recovery. Generally, the feeling was that unemployment would make recovery difficult, simply perhaps due to the time that one had available, and the resultant difficult in resisting further illicit drug use:

“Oh I mean the first thing, you know, is to make sure that people can get into work. If they can get a job fair enough, but if they are not in a job or some activity they just sit at home and vegetate and think: ‘Oh I could do with a hit.’ And then
someone will come round, and maybe got a smoke or something blah, blah, blah and before you know it you are back on it again” (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)

The links here between, available free time, and interacting with other drug users, i.e. the theme discussed above around ‘mixing with others’ are important. Having free, unstructured time due to unemployment left individuals especially vulnerable to the influence of others, and also vulnerable to loneliness and boredom. Thus unemployment could be seen to operate as a barrier to recovery on a number of levels, and in interaction with other intra and interpersonal barriers.

Unemployment was also discussed by some participants more specifically, and again links to other barriers, in this case wider system or structural barriers, were again apparent:

“And I came back from the Job Centre and a couple of weeks ago and I was, um, trying to get a job, and they asked me in the Job Centre I don’t sort of apply for this job work on fields. And I done half a day for free to tell them that I could work, and I went down to the Job Centre and they always ask the question: ‘Have you done any unpaid work?’ and I said: ‘Yes, I worked half a day for free.’ And they then proceed to give me a form that I had to fill out because I was going to have my money docked. Now this is a typical addict way of looking at things but it is like the world is against me. I am trying to do something with my life, you know, and someone is trying to give me a kick, you know, and I just cried the whole way home. I really did, and I was really, really upset” (LTM44, male, aged 35-39, prescribed methadone for 10+ years)

Here, the obvious frustration at trying to ‘do the right thing’ and make progress towards employment and engagement with society is evident, as this attempt to improve one’s own situation is thwarted. Structural and system barriers interact in a frustrating manner here. Such experiences may act as further barriers to recovery for some people, as the memory of the difficulty of trying to gain employment may make individuals less likely to attempt to tread this difficult path again. Perhaps the implications of this particular scenario are that support and encouragement to continue to attempt to ‘do the right thing’ even in the face of additional difficulties likely to be experienced along the way is important. A peer buddying, or additional support service, for those in recovery may be best placed to provide this kind of support.

Stigma
Stigma can be understood as a pervasive social issue that acts in both direct and indirect ways. Although not often directly discussed, many clients within this sample talked about experiencing stigma, in terms of, for example, employment or housing opportunities available to them, or in terms of expectations of others. The participant below, in discussing her desire to obtain a fulfilling career in which she could ‘give something back’ to others, demonstrates how this desire is squashed by employment services, who have an expectation of an ‘ex-addict’ as only being capable of particular kinds of work:

“I think sometimes when they look at a bit of paper they think - oh she is doing that she is not really up for doing anything else. So I feel that, and I feel once I am not taking medication, that is something that I am not going to have to even think about anymore. Do you know what I mean? And I think that is a bit of a stickly, even though people, say – ‘Oh it doesn’t matter you know you are coming on.’ I think if it is there, it is still that thing you know, sort of like that stigma.” (LTM06, female, aged 45-49, prescribed methadone for 5-9 years)

This quotation demonstrates the subtle ways in which participants experienced stigma. It was not often as a single comment or interaction, but more a general experience of stigma that was felt to influence ones chances. Stigma can thus be understood as working in complex and subtle ways. In addition, the concept of ‘multiple stigmas’ was apparent for this participant group, as stigma was experienced in terms of being an ex-addict, in terms of being in treatment for addiction and on a substitute prescription, and also in other social terms, being linked to the experience of aging, being unemployed or homeless and, for some, being a single parent.

Others, fully aware of the stigma experienced as a result of being on a substitute prescription, dealt with this by being secretive about their medication:

“I will definitely go back to work, I am not going to sit here like this, I am only fifty three and I have got twelve years of work left in me, and I will go back to work. But I will probably go back on methadone prescription but no one else needs to know about that do they that is my business you know”. (LTM24, male, aged 50-54, prescribed methadone for 5-9 years)

**System barriers**

System barriers were mentioned by participants within this sample, although less frequently occurring, and when they did occur, less weight was given to system barriers than intra or interpersonal barriers.
**Treatment services too lenient**

There was a mismatch apparent within the sample between those who thought treatment services were too lenient, and those who thought treatment services were too structured and not lenient enough! One participant describes a background of illicit heroin use on top of her substitute prescription, and suggests that had treatment services been stricter with her earlier, she may have started on the path to recovery that she was now following earlier:

> “one time when I was seeing a particular counsellor, and I mean she was lovely, and it was her, like I said, she said: ‘You know that’s it; you have given me enough dirty samples, I am going to stop your script.’ And I will be honest I thought, right okay you are given to, but she did and I think in all honesty, if they were a bit more tougher, then there might be a lot more people out there who perhaps actually got to the point where I am if you know what I mean.” (LTM02, female, aged 50-54, prescribed methadone for 5-9 years)

Others agreed with this view, suggesting that widespread introduction of reducing or time limited scripts might be a positive move, as many users saw a long term script as a ‘crutch’ and might become overly reliant on it, i.e. de-motivated in terms of thinking about recovery:

> “But as a service, you know, I think they should be looked after in but not for very long, you know on a script for not very long, I mean I would give them a year” (LTM04, male, aged 40-44, prescribed methadone for 10+ years)

However, this hard line approach suggested by some participants was certainly not shared by all, and therefore these suggestions should be interpreted with caution.

**Need to approach the problem differently**

Other participants within the sample suggested that there was a need for a fresh approach to the problem within treatment services. Some felt that there was an over-emphasis on prescribing, and that this couldn’t help tackle the underlying causes of addiction:

> “I do feel that the service tend to treat the symptoms not the cause hugely.” (LTM44, male, aged 35-39, prescribed methadone for 10+ years)
Others corroborated this view, suggesting that there was a need for more counselling or therapy support, aside from the substitute prescription. The lack of therapeutic support of this kind was seen to constitute a barrier to recovery. In this sense, a service user recommendation for improvements in substance misuse services drawn from this data set would be that additional resources and support be given for therapeutic interventions beyond substitute prescribing to support recovery.

**Recovery Enablers**

Participants in the qualitative sample discussed enabling factors that they felt were, or could potentially assist, with supporting them to move towards recovery. The data in this section is, naturally, drawn primarily from those participants who were in reducing scripts at the time of interview. This ‘currently reducing’ status was generally experienced positively by participants interviewed, who were able to reflect on aspects that had helped and supported their recovery thus far. As with expressed barriers to recovery, perceived enabling factors were organised around individual level (intra and inter-personal), social and system factors. In support of the findings on recovery barriers, the weight of coding focused around individual, and especially inter-personal factors as being potential recovery enablers. Thus factors that could potentially hold people back, or present a barrier to recovery, such as internal motivation, were also perceived as being potentially the most powerful ways in which recovery might be enabled. Social factors played a lesser role in participant views of receiver enablers, although of note, was the increased importance placed on system factors which might enable recovery. So, whilst system factors were seen as less important than intra-personal factors as barriers to receiver, they were seen to play an increasingly important role when perceived enablers to recovery were discussed.

**Intrapersonal enablers**

Intrapersonal factors were discussed at length in terms of aspects that may support an individual’s recovery journey. In this sense, intrapersonal, or within the individual factors, were felt subjectively to be key contributes to receiver outcomes.

**Sense of purpose**

A major coding theme within the intrapersonal domain was that having a strong sense of purpose would serve to enable recovery. This ‘sense of purpose’ can be understood as an internal motivation to recovery and to stay abstinent. For some people this might come from a weariness with the lifestyle of illicit drug use, or perhaps an awareness of the societal stigma attached to drug use, and a strong desire to finally move away from this. When asked what had helped him to start to think about recovery, once participant answered:

> “Just determination I just don’t want to be there, I don’t want to be a dirty old smack head anymore more” (LTM14, male, aged 25-29, prescribed subutex for 5-9 years)
Others suggested that close family and friends were influential, in helping them to reassess their priorities, and therefore contributing to an internal motivation towards recovery. This participant discussed how she felt she had missed out on her children’s upbringing due to taking drugs, and was so pleased to be given a ‘second chance’ with her grandchildren, that she was determined to change:

“I have got my granddaughter, so that even made me more determined, and I will try and make up for lost time and what happened to my kids. So now I have got a granddaughter, and I am being entrusted to look after my granddaughter.” (LTM11, female, aged 50-54, prescribed subutex for 5-9 years)

There was some divergence in the sample on this point of others influencing internal motivation, however. For some, the rhetoric around ‘doing it for yourself’ versus ‘doing it for others’ was strong. Some participants discussed past attempts at abstinence in terms of ‘doing it for others’, and reported that this approach had failed in the past:

“in the past I’ve like wanted to do it (become abstinent from illicit heroin use), but it’s been for other people, um and me, but I’ve not been strong enough, do you know what I mean? And um this time I was strong enough” (LTM07, male, aged 35-39, prescribed methadone for 5-9 years)

Thus there was a demonstrable split within the sample between those who felt the internal motivation to succeed in recovery should be for one’s own reasons, and those who felt that that internal motivation might be inspired by others. Regardless of the underlying cause of the internal motivation though, it seems that the internal motivation itself was perceived as a key aspect in enabling recovery.

**New positive personal identity**

Some participants, within the sample, particularly those who saw themselves very much as being on the pathway to recovery, discussed starting to feel a new sense of purpose and a positive identity, which acted to further reinforce recovery and acted as an enabler to support recovery. Here, a female reducing client discusses how engaging with a college course had bought a new sense of identity, which is separate from the world of illicit drug use, as well as other domestic roles. This is experienced extremely positively and serves to continually reinforce recovery:
“At the moment and I think if, I can grab something like, I cherish like that, just that little nugget. I mean I love my family, but I said to my husband and I said to my son as well, when I go to college I am female client, I am not my daughter’s mum or my husband's wife, I am not my son’s mum. (LTM06, female, aged 45-49, prescribed methadone for 5-9 years)

This sense of ‘I am me’, and being proud of achievements that participating in new challenges, in this case a college course, can bring, is extremely important. Thus the interaction of educational opportunities, or other ‘diversion’ activities, with a sense of positive identity which reinforces motivation towards recovery, can be understood as being a critical enabler of recovery.

Indeed, for reducing clients, the positive gains and steps towards recovery seem to interact with a sense of positive self identity, such that reducing in itself can be understood as being reinforcing and enabling further steps along the path towards recovery:

“I have proved myself and that has made me feel really good. (LTM11, female, aged 50-54, prescribed subutex for 5-9 years, currently reducing)

**Critical point**

In support of much of the recovery literature, many participants within the sample expressed in some way that hitting a ‘critical point’ was important in enabling recovery. This is a well known phenomenon within recovery circles, such as AA/NA, where the concept of ‘hitting rock bottom’ is stated as being a crucial point in one’s recovery journey. Although not always defined in these terms, participants within this sample discussed the idea of a ‘critical point’ as presenting an important stage that needed to be passed through to enable recovery. Therefore, the ‘critical point’ that made the decision to either enter treatment or start to move towards recovery, was seen as an important enabler. The participant below demonstrates the complexity of this ‘critical point’:

“Um, I suppose we have been together through everything really and I think it got to a point where we, I mean we, could have lost everything I suppose, when you think about it. Because no matter what, you find the money, whether you have got it or not, I mean I never ever, I mean, we worked for what we had. We never ever went out and done anything else to get the money, we actually worked. So I think, when you are working, you are working hard and you have got nothing to show for and it gets to a point where my partner was fed up. He basically said: ‘I am fed up with the whole scenario, with the drugs with everything. You know what I mean?’ And you do drugs because you enjoy them, it is the same as having a joint because
you enjoy them, but when it comes to a point where you no longer enjoy that and all you have got is grief, then it is not longer fun, I suppose. And like I say, the money situation, and because he is self employed as well, I mean I at the moment I don’t actually work I am on incapacity. But like I say, I did work until about, um it has got to be five years probably now yeah, it might six and I don’t know, like I said, I think the money we were arguing a lot more, and I thought: ‘For what?’ And like when you sit down and think about it really, you know, is the drug really worth all that? And no, it is not. But I sometimes think it had to get to a point where, and he got to a point perhaps before me, and I was using things as an excuse, like I said, I have dealt with those things. And since then, I suppose it has got easier. So I think, having dealt with those as well, it is perhaps, has helped me to get to where I am. (LTM02, female, aged 50-54, prescribed methadone for 5-9 years)

It can be understood then, that for this person, and differently for others, the culmination of particular events in reaching a ‘critical point’ is likely to vary. The participant here talks about the interaction of financial and relationship based factors in reaching a ‘critical point’, where as for others factors such as health and criminal convictions may have been important contributors. The point is that determining the ‘critical point’ is exceptionally individualised, although the importance of reaching this point was felt strongly by participants within the sample. For some this was related to age, or length of time in treatment:

“I am 60 this year, and things have got to change you know” (LTM41, male, aged 55-59, prescribed subutex for 10+ years)

For others the ‘critical point’ could almost be understood as being the opposite of ‘rock bottom – reaching a stage where one feels personally in possession of sufficient psychosocial capital and self-efficacy to feel able to act. Some participants’ had been given ultimatums from treatment services, the threat of aging and / or of treatment potentially being withdrawn served to act as the ‘critical point’ for some, who described a renewed sense of optimism in terms of the potential for recovery from this point onwards.

**Addressing difficult past issues**

Some participants within the sample discussed candidly problems that they had experienced earlier in life, perhaps in the context of explaining or attempting to understand their own pathways into illicit drug use initiation. For example, a few participants mentioned violent or sexual abuse suffered at a younger age, and used this in terms of discussing illicit drug use, perhaps as a means of coping with the feelings that this abuse had caused, or as a way of trying to block out what had happened.
Conversely then, it followed that participants discussed having to come to terms with these past events, or dealing with them head on, as being subsequent enablers of recovery:

“Like I said, I have dealt with those things *(a history of sexual abuse)*, and since then I suppose it has got easier. So I think having dealt with those as well, it is perhaps has helped me to get to where I am” (LTM02, female, aged 50-54, prescribed methadone for 5-9 years)

For the participant above, dealing with abuse, and coming to terms with having been a victim for many years, was a critical enabler of her subsequent moves towards recovery. She describes a sense of feeling in a positive place, and able to deal with the challenge of considering recovery, as dealing with difficult past issues meant that her own sense of self-esteem and ability to act was improved. However, others found that dealing with their own mistakes represented the important issues for them that had to be addressed. The participant below refers to guilt at previous illicit drug use:

“I have felt like I have really been bad to my kids by getting into drugs when they were little and that. So I fell out, you know, so I have made a little bit … so I have tried to clean myself up, and it has worked.” (LTM11, female, aged 50-54, prescribed subutex for 5-9 years)

There was a sense amongst participants, then, that reflecting on one’s own past, whatever negative aspects that may entail, was a crucial enabler of recovery. Many participants spoke about this in terms of acceptance of one’s past as being a personal journey – something that only oneself could address, and that it might take time to come to terms with. This aspect of self-reflection though is potentially an area where services might offer an increased support role.

**Interpersonal enablers to recovery**

Although interpersonal factors were dwelled on less so, as a generalisation, than intrapersonal factors enabling recovery, there was nonetheless an emphasis on significant others as impacting upon the potential for recovery, and for those currently reducing, other people were discussed as playing an important role in both inspiring and supporting this recovery. Interpersonal enabling factors were split between factors related to close personal relationships (partners) and factors related to extended close relationships, with one’s family in particular.

**Partner tells it like it is**

An important perceived factor enabling recovery from the subjective perspectives of this sample was having a partner who was open and honest, and not afraid to tell some ‘home truths’. Here, a
participant demonstrates how her partner, with whom she has been in a long term relationship, was instrumental in contributing to the decision to embark upon treatment for substance misuse initially:

“He basically said: ‘I am fed up with the whole scenario with the drugs with everything. You know what I mean?’ And you do drugs because you enjoy them it is the same as having a joint because you enjoy them, but when it comes to a point where you no longer enjoy that and all you have got is grief then it is not longer fun I suppose”. (LTM02, female, aged 50-54, prescribed methadone for 5-9 years, currently reducing)

Others had had partners who had been extremely firm about illicit drug use, and had elicited strict ultimatums, using the relationship itself as a means to an end to force individuals to realise the seriousness of the situation. The participant below was in the situation of living apart from his current partner until he had reached a point of abstinence:

“She still loves me and I still love her but there’s no contact um until I’m totally clean of everything” (LTM43, male, aged 45-49, prescribed methadone for 10+ years)

The situation of being in a relationship where treatment for substance misuse became a critical determinant for the relationship continuing, or not, was perhaps expressed most starkly by those who were in a relationship with a non-drug using partner. The participant below discusses how meeting his current partner, who does not use any drugs herself, has been a positive recovery enabler for him, coming at a time when he was ready to move towards recovery, and assisting him by supporting him in this decision, as well as additionally enabling him to begin to interact with a new social circle away from illicit drug use:

“I’d met me partner, now this was when I think things totally changed for me. She doesn’t drink or anything she just smokes cigarettes, she’s very, er, like straight headed, and that and that’s what I think I needed um at this point in time” (LTM07, male, aged 35-39, prescribed methadone for 5-9 years)

**Able to talk to partner**

Being able simply to talk honestly and openly with a partner about one’s substance misuse dependence was experienced positively, as an enabler to recovery, as having someone listen, and feeling a sense of ongoing support was important. For some participants in the sample, this support
was very involved, as they were in a relationship where both members of the couple were in treatment (reducing) together.

“Definitely we helped like each other for like, if we start talking about it, you know the other one would say: ‘Come on - we don’t want be down that road again’, because we both hit rock bottom so. Yeah we like gear each other up you know and you think about all the good things we have instead of taking drugs. Because my life has changed quite dramatically and I am really chuffed.” (LTM11, female, aged 50-54, prescribed subutex for 5-9 years)

This direct and personal experience of the issues and difficulties of going through treatment, that being in a relationship currently in treatment together brought, was thought to be very important by those in that position. The flipside was that, potentially (although no participant in this sample disclosed being in this situation currently), being in a relationship with another person with a history of substance misuse could leave one vulnerable to relapse should the partner continue with, or relapse themselves into, further drug use. This possibility was demonstrated in a less direct way by participants who discussed ‘escaping’ from chaotic substance misusing partners as being instrumental to supporting one’s own recovery:

“I think I left them (treatment services) because my partner got back out and, he went to jail for about a month, and then he got back out, so I think I just didn’t bother anymore picking up my prescription and I didn’t go in, and then I was referred again and I don’t remember when the next one was referred and that was the proper time. And I have been with them kind of ever since... because he went down and it was just ‘lets end it all’, and that’s when I ended it with him. And I found, because I had cut him out, it made it easier to kind of do everything properly.” (LTM25, female, aged 30-34, prescribed methadone for 5-9 years)

Thus the importance, in a relationship, of the partners as being able to discuss the substance misuse problem openly and honestly was emphasised. Having a partner in treatment at a similar point on the ‘recovery pathway’ was perceived as being a recovery enabler, as both parties could support each other. Conversely, having a partner who continued to use drugs or who relapsed, could exert a negative influence on individual, and was seen as much more of a barrier to recovery. In this sense, the importance of a primary close personal relationship was very strong, as being a factor which could hold significant sway over one’s own recovery status.

*Family as an incentive*
Linked to the analysis above where participants spoke about family as influencing or inspiring their own decisions to move towards recovery. Family were again discussed in a wider sense, as supporting or enabling recovery. The participant below describes how she was rejected by her family, who for a long time were unable to believe she might be moving towards recovery, due to a number of failed attempts in the past. Her own family’s rejection of her was experienced in some sense positively, as being a strong incentive to continue towards recovery:

“Yeah it gave me something like just to sort myself out, because I knew that if I didn’t sort myself out, then I wouldn’t have my family because my family didn’t want know me they just washed their hands with me because I was a mess. Do you know what I mean? So yeah, I don’t know, someone else could have I suppose everyone has got their own little (()). But I had to get myself quotes and sort them out for the first couple of years before anyone would talk to me and I tried to prove myself and I am clean now. So basically it was getting my family to trust me instead of – yeah, yeah I am coming off drugs – yeah, yeah and - of course you are. Do you know what I mean? And then I would fall off the wagon again, and I suppose people just get fed up of hearing it - yeah of course you are whatever. So I really had to prove myself and stick to my guns and do it.” (LTM1 1, female, aged 50-54, prescribed subutex for 5-9 years)

**Wider support in place**

For some participants in the sample, although by no means all, there was discussion of wider support that had been perceived as enabling recovery. For example, one participant spoke about attending NA meetings, and had found this helpful:

“I have only been to one like or two, but it is nice. When people get up and they will say their story and you always think I can relate to that. And it is nice when they say - it gives you a bit of hope, because all those people are just like you; they are your every day normal people and you think - well they have done it, I can do it. So it is nice and it is just the support - it is just extra support.” (LTM05, female, aged 35-39, prescribed methadone for 5-9 years)

Views on NA in particular though were polarised within the sample, with many others feeling that this approach was not for them. The particular philosophy of AA and NA meetings was sometimes referred to as being unsuited to some individuals. Others, although perhaps choosing not to access this form of wider support, were nonetheless appreciative that the support was available for them should they choose to do so in the future:
“I know that they are available if we should have wanted them, you know, if we wanted to take advantage of them.” (LTM21, female, aged 45-49, prescribed for 10+ years)

The availability and provision of wider support to enable recovery, beyond the substitute prescription, was also something that participants discussed in the context of system enablers of recovery

**System enablers**

System based recovery enablers were discussed in greater depth than system barriers, implying perhaps that treatment services, or systems, are playing an important role in enabling recovery, and that developing the support offered within treatment services may act to further support recovery in the longer term, and for increasing numbers of individuals.

**New focus on recovery**

At a macro political scale, and at a micro, within systems scale, clients interviewed for this project were very well aware of the ‘new focus on recovery’. They were not always able to articulate necessarily where this focus had come from or what the key drivers were, but the consistent rhetoric around recovery and abstinences as treatment goals had filtered through to individual clients. This was seen by some as being a positive enabler for one’s own individual recovery. Although not all participants within the sample received news of a focus on recovery positively, for some, the new ‘push’ towards recovery had been the instigator that perhaps they had needed to encourage them to consider the possibility of reducing the substitute prescription and eventually achieving abstinence.

The participant below discusses how recent conversations with her key worker, and even an awareness of this research project recruiting those on long terms substitute prescriptions, had made her realise her own situation and question her ability to consider reducing:

“When I went to see the counsellor, and I suppose that made me realise that - oh my God has it really been that long? That’s just something that is just part of our daily routine I suppose. And it weren’t until they said about this study, and everything else, I mean God it can’t be that long? And I think - well it is about time do you know what I mean? I should really, by now; I should be clean, as in clean as off everything. But like I said, now it has been mentioned, and that has been
brought up, then yes let’s really try and go for it”. (LTM02, female, aged 50-54, prescribed methadone for 5-9 years)

The implication here is that, for this participant on a long term prescription, she would have been happy to ‘coast along’ had the recovery agenda not become apparent, and had her key worker not mentioned this new agenda to her. Similarly, another participant discussed how her ‘currently reducing’ status may not have been initiated by her, but in fact the new drive towards recovery was working well for her, as she had embraced the reducing script and was actually feeling very positive about it:

“I don’t suppose I would have gone and checked in myself I have got to be reduced, simply because it is just something; it is more adjustment, and you know in your head, you are maybe making yourself, it is going to make you think it is going to be worse than it actually is. But um now I am actually going to be doing it, I am actually glad I am doing it.” (LTM21, female, aged 45-49, prescribed subutex for 10 years+)

In a similar way, others talked about being challenged by their key workers to attempt a reduction. While this approach may not be beneficial in all cases, some participants spoke positively about this challenge, as they felt it had come at an appropriate time and had given them the push they perhaps needed to consider reducing and moving towards recovery. Indeed, some participants took this one step further, and felt that it was helpful for treatment services to directly confront clients, and to follow through on threats to stop the substitute prescription if that were necessary. One participant demonstrates his very strong feelings here that treatment should be directed towards those who are serious about eventually achieving abstinence, and that services should challenge those who seem to be in treatment without any wish to actually abstain from illicit drug use in addition to the substitute prescription:

“There is a lot of people out there who are now even today is basically: ‘Oh, that’s okay if I can’t get whatever I have got my methadone so I won’t be ill’. And I do think there is also a lot people who want the help and they are not getting it because of people like that. Do you know what I mean?” (LTM02, aged 50-54, female, prescribed methadone for 5-9 years)

Here, the implication is that a firm, or even moving towards punitive approach, by treatment services may, in some instances, act as a recovery enabler. Perhaps especially for those on current reducing scripts, there was support for a strong stance towards recovery taken by treatment services, as there was much expressed disdain for those clients in treatment who appeared to be
unmotivated to recover, but simply used the substitute prescription to avoid withdrawals. Indeed, being offered a direct ultimatum by treatment services was a positive enabler of recovery for some participants:

“I think a big part of it comes down to the people, your key worker like at the treatment centre, telling you: ‘If you don’t sort it out, you will lose your script.’ I think then you think: ‘Oh yeah - okay’ and then you sort of look at it from a different way. Because a lot of people think it is just like I say - like it is just something there, in case you don’t have anything.” (LTM05, female, aged 35-39, prescribed methadone for 5-9 years)

“It was the kick up the arse I needed; it was the kick up the arse I needed and I’ll be forever thankful for him for it” (LTM43, male, aged 45-49, prescribed methadone for 10+ years)

However, this view of treatment services as enabling recovery by taking a punitive, or at least strict stance, should be caveated, as this view was not universal across the sample, and indeed, others who felt that being long term prescribed had bought them stability and normality, were much less willing to consider the potential benefits of reduction, especially with regards to the strongly expressed fears discussed as barriers to recovery earlier in this report.

**Something to fill the gap / other distractions**

Participants discussed the importance of having something else to fill up one’s time once abstinence from illicit drug use was achieved. This may also be particularly important to support recovery from long term prescribing:

“Oh I mean the first thing, you know, is to make sure that people can get into work. If they can get a job fair enough, but if they are not in a job, or some activity, they just sit at home and vegetate and think: ‘Oh I could do with a hit.’ And then someone will come round, and maybe got a smoke or something blah, blah, blah and before you know it you are back on it again. So there has got to be all the services if they really want to make sure that people are recovered they have got to support it, and with plenty of action and plenty of money unfortunately from Mr whatever his name is Cameron.” (LTM22, male, aged 55-59, prescribed methadone for 5-9 years)
Here, the participant shows an appreciation of the bigger political picture in constraining the amount of support and links to education and employment that can be offered by treatment services. Others also understood this pragmatic view, suggesting that ‘other distractions’ might be found to fill the void left by illicit drug use in other areas, away from service provision. Here, the participant demonstrates that finding peace within his own self, or searching for finding fulfilment from other things in life, was acting as a recovery enabler:

“I suppose everyone needs something to fill the void - gambling anything. Everyone’s got a vice and I think I, um, because of all the adrenaline I used to get as well it’s hard to replace that, and now I’m at but now I’m actually genuinely happy to sit in on a Friday night with girlfriend, and that, and just chill out really. You know what I mean? And I get a buzz out of doing that, whereas before, I wouldn’t have been able to do that. I used to get grief off girlfriends for not being able to sit there and just watch the tele; if I didn’t have money and drugs I would be quite restless so yeah there’s a lot of positives”. (LTM07, male, aged 35-39, prescribed methadone for 5-9 years)

There was a general consensus amongst the sample that those in recovery needed something to ‘fill the void’. This was experienced positively as something that may be provided by treatment services, although this need not necessarily be the case:

“You need something to fill that gap it is a huge gap in your life,” (LTM04, male, aged 40-44, prescribed methadone for 10+ years)

**Giving back to others**

One way in which participants discussed ‘filling the void’ left by illicit drug use during treatment, and which may be a potential enabler provided or facilitated by treatment services, was in terms of services user involvement – or ‘giving something back’ to others. The participant below shares during interview, her experience of involvement at a service user support group. She had found this fulfilling in terms of being able to possibly help others to move away from illicit drug use, and there was a sense in which this ‘giving back’ to others was also a helpful part of her own recovery journey:

“And the nice thing about it was, well the nice thing about it I found there was, people there and there was younger people there, and there was actually a young lad and he said to me he said: ‘No disrespect, but I don’t want to be like you.’ And I said like: ‘What do you mean, like me?’ he said, no I am not being funny, he said and I don’t mean it rudely, he said: ‘I didn’t know you was that age’, he said. But do
you know what I mean? He said: ‘I don’t want to be like you at that age’, and I said: ‘I don’t want you to be like me at that age, so take note now. Do you know what I mean? You are twenty one, and you are younger than my daughter, for Christ’s sake. Do you know what I mean? And know that this is all you think it is it might start as a laugh and a joke because your mates are doing it, but you are here and that is serious.’ And the last time I heard he had moved away and was working with his dad he had got in touch with his family again and he was doing okay.” (LTM02, female, aged 50-54, prescribed methadone for 5-9 years)

Others supported this position, discussing their own and others involvement in service user groups as being an important recovery enabler:

“there was one particular guy who was coming to the meetings and he was such a nervy, now he kind of found himself again but he was such a nervy jittery sort of bloke. And he started coming to various meetings and started to become a service user representative. And now six months down the line, you wouldn’t even recognise him as being the same person. For him it has really helped him to find some purpose in his life you know, and I think it can it can really heal some of the most sort of open wounds really.” (CN21, female, aged 45-49, prescribed subutex for 10+ years)

Volunteering, or service user support and input, was therefore seen as a potentially important recovery enabler by many within the sample. This was viewed as something that one must undertake as part of a personal recovery journey, but something that might very well be initiated and supported via the structures of treatment services. Another participant describes volunteering at a local night shelter as having been an important recovery enabler:

“I knew the people in Salvation Army people who serve up the, and I just hand out a few roll ups to anyone who wanted one. And just being there, and handing out brochures and leaflets for different drug services and that if they wanted any help you know. I was all unofficial I done it on my own bat you know I am not a mentor or nothing like that just an interested person who wants to see somebody get better and get off the bloody shit you know.” (LTM41, male, aged 55-59, prescribed for 10+ years)
Others suggested much less formal means of ‘volunteering’ or ‘giving something back’, which gave an increased sense of purpose and self esteem, and perhaps thus bolstered one’s own recovery journey:

“I find I get a lot of young friends who have kind of lost their way a little bit and I kind of get them back on track and I am quite good at that. And quite well known for it”. (LTM44, male, aged 35-39, prescribed methadone for 10+ years)

The positivity that volunteering, of whatever kind, and whether in a formal or much less formal sense, bought was seen as a strong enabler supporting recovery. This positive aspect to volunteering or service user involvement is something that could be supported by services, and built upon to further support recovery.

**Social recovery enablers**

Aspects of the social domain as enabling recovery were much less frequently discussed than social barriers to recovery. Although minor coding areas were noted, such as one’s financial situation or employment status as enabling recovery to different degrees, these were not core areas of coding. The key coding category under social enablers was the perceived importance of moving away from past social circles.

**Moving away from past social circles**

In a similar way to that in which barriers to recovery were discussed, in terms of mixing with the same crowd and being unable to escape drug use in the immediate geographical area, moving away, whether literally or metaphorically, from one’s past social groups who were associated with illicit drug use, was felt to be a critical recovery enabler. Here, a participant discusses how he managed to move away from his previous, drug related, social groups, and considered himself fortunate to have found the ‘gap’ that enabled him to do so:

“the people who want to know now not necessarily on drugs mostly of the people I know are now off if you know what I mean, and you don’t hang around in that circle. And you are in a circle, you are in a circle and you can’t get out of that circle until you get a gap. And I had that gap and I got through.” (LTM08, male, aged 60-64, prescribed subutex for 5-9 years)

Similarly, other participants discussed the importance of changing friendship groups as being a recovery enabler, as the alternative (remaining associated with previous drug using friendship groups) presented a possible temptation which may be potentially hard to resist:
“Oh yeah it is completely changing your lifestyle because that has got to be done and I mean and I have been around people who are like into drugs and I have felt really uncomfortable because I just didn’t want to fall back into doing it again. And I knew to change to completely change my whole life was to stay away from all of it because it is just temptation and I didn’t just didn’t want to be tempted. Yeah in my head you don’t hold in heroin, I just never ever want to go down that horrible dark road again and I feel really strong, yeah, I will never do that again.” (LTM11, female, aged 50-54, prescribed subutex for 5-9 years)

The reality of the alternative of staying in contact with drug using friendship groups is starkly illustrated by the participant here, who reflects on the alternative paths that his life may have taken:

“No I don’t frequent the town or anything. I drive through it. I drive through it and I will see some of the people I used to know years ago, and they are still in the same boat you know, looking like, well they look like they should be in the cemetery you know, six foot under. But then are not they are like the walking dead if you like, and I feel glad that I got out when I did know because, not only that you know, not only that aspect of it, I would probably be in jail now doing a lot of years - lot and lot of years.” (LTM27, male, aged 30-34, prescribed methadone for 5-9 years)

The downside of this social mobility as being a recovery enabler, or course, was the huge sacrifice this meant for participants. The participant above, for example, who lived in the same small town in which he had previously dealt heroin, described how he never walked through the town centre anymore, in an attempt to avoid any contact with previous associates. This extreme life change can be understood as being a difficult sacrifice to make, but one that was experienced as a positive recovery enabler.

**Staff interviews – overview of sample**

In turning now to analysis of the staff interview data, it should firstly be emphasised that analysis of this data set took a less inductive approach to coding, but instead aimed to purposively direct analysis towards staff interpretations and perceptions toward the primary study aims and objectives. Thus presentation of the analysis in the following sub-section gives an overview of staff views on recovery and clients barriers to recovery, by way of providing a critical contrast and comparative analysis of staff views alongside the client views focused upon thus far. As staff interview schedules were derived from the initial analysis of participant interviews, the areas of discussion and questioning naturally focused around specific service orientated practices, achievements and
suggestions. Thus the final sections of this analysis of staff views focuses on concrete examples of how services worked well, or not so well, currently, alongside some specific suggestions, from the staff perspective, for identified areas of service improvement.

The meaning of recovery

The important emphasis of staff views and understandings of the meaning or recovery was that views of recovery were communicated as being inclusive and not set. In this sense, staff views of the meaning of ‘recovery’ were very much in agreement with client views expressed by participants in this project, that recovery meant different things for different people. Some expressed a dislike of the term ‘recovery’, due to its potential to further stigmatise and take control away from clients:

“I mean, the word recovery has a multitude of meanings and I think that is probably the biggest issue, and I don’t know where it really comes from, and whether it was a benevolent word, that sometimes, ah that sounds like a nice comforting word, but in fact all it comes down to is, that nobody really gets it. And I suppose from a strategic clinical point of view it is a word that is spread into other areas, mental health for instance, is by saying that someone is recovered you are then implying that someone had a serious issue in the first place to recover from. Now and of course people have to understand that there is, there is, something going on there, and you know there is some kind of diagnosis. You wouldn’t be in service otherwise, without there being some sort of diagnosis, but I don’t know, I just feel like the term becomes a little bit of a label, like other terms that have been used in the past. And so for me, I think things like ‘self maintenance’, ‘self stabilization’, and although they are kind of a bit clinical perhaps a bit faceless they have far more meaning for what we are trying to achieve, which is people, clients taking control of their therapeutic journey and always being, having choice, always having input, and it not being just clinically labelled just clinically imposed on someone” (Commissioner)

Others expressed the understanding that ‘recovery’ means different things to different people, and that what might constitute recovery for one person could represent the continuance of addiction for another:

“I still think recovery’s just very different to each individual, and while I’m promoting that um, I’d, you know, um, I have to be aware of how the person themselves sees their what recovery is to them, so it’s really hard to be specific because everyone is just so different” (Multidisciplinary team member)
Here, the nurse interviewed advocates a patient centred view of recovery, referencing the client’s own understanding of recovery as being a crucial starting point to understanding how to approach this concept.

“Some, for some people, it would be coming, stopping their prescription it would be um, trying to find voluntary work, um, or full time work, or part time work, it would be trying to look at kind of hobbies, um, it would be trying to perhaps integrate people into NA or AA and other support networks, um, and it would be to improve relationships with families as well. See, that’s a key kind of factor and I’m trying to work more with families to try, um (acom) because that’s er important, um so that’s what I see as kind of recovery, but for other people their prescription, you know, stops them from using illicit substances, so um, and they, they you just they find it really difficult to obtain employment” (Multidisciplinary team member)

Another member of staff corroborates this individualised, client centred view of recovery, suggesting that recovery is a process, or a journey, starting with a particular point in a client’s life at which they decide to approach treatment services for help:

“recovery sort of starts with right at the beginning, I think, when people are in their mind set to do something about it, and have reached rock bottom whatever that might be for them. And they make a referral and they come to TADS and they are assessed, and I would like to see that whole sort of start up this being about recovery right from the beginning. Like you know you can engage with us, you have acknowledged you have got a problem, and you are here; that is recovery you start at the first step. That’s how I like to see it and then hopefully um you have individual care plan treatment drawn up from that. But very much work client focused on what recovery maybe means to them, because I could talk about recovery, you know, be drug free, alcohol free, better relationships, um being able to control your anger your anxiety, getting your depression treated, engaging you in local things in the community. Giving something back to society getting a job, whether it be voluntary or work unpaid work, and I could talk about recovery in those sort of terms. And then have a ripple effect then to society generally but often for the client that is too big of a concept, recovery for them is a about what their needs are and priorities are at the time. And often for a client it is, day by day, step by step, week by week so the recovery concept is very individual for people” (Multidisciplinary team member)

The staff member here mentions many if the important facets that are likely to contribute towards recovery, many of which were covered by participants within this study themselves, such as abstinence versus stabilisation, engagement with society, employment etc. Critically though, from the perspective of this member of staff, was that recovery is seen as a long term process, starting
when a client first engages with services, and working slowly towards small achievable steps along the way, constantly, perhaps, negotiating and renegotiating recovery goals from the client perspective over time.

**Mismatch between NTA definitions and staff/client expectations of recovery**

A possible area of discord identified within service delivery from the staff perspective, was the apparent mismatch, or at least potential for mismatch, between ‘official’ NTA imposed definitions of recovery (for instance for the purposes of reporting), and staff definitions. It was reassuring to note that client and staff views of recovery broadly converged, but concerning to note the mismatch with official definitions:

“How do you measure success? What is that about? And we all know, coming from the service side of things, that you have to, statistics, you have to have outcome measures and targets and the NTA have TOP forms for all that sort of, bureaucracy with it, and it sometimes doesn’t really measure on an individual basis what recovery means. So you could say, well depending on whose agenda it is, I suppose as to whose recovery we are talking about” (Multidisciplinary team member)

Here, the member of staff draws attention to the fact that ‘recovery’ might be defined in different ways and for different purposes, and hints at the underlying political agenda with which varying understanding of recovery are imbibed. The mismatch in understanding between ‘official’ and staff or client views of recovery is perhaps, therefore, of concern when considering future service provision, and the measurements against which services will be judged.

**Enabling clients to reach their full potential**

In contrast to a consideration of service targets and goals around ‘recovery’, which may force service delivery to attend to particular targets, many of the staff interviewed discussed a much more ‘human’ side to treatment, discussing ‘recovery goals’ in terms of enabling individual clients to reach their full potential in society. This much more individualised empathetic stance had very little to do with service targets, and certainly didn’t necessarily involve the concept of abstinence or service discharge, but was rather concerned strongly with taking a fully patient centred perspective:

“I think it is just enabling people to, you know, to achieve their full potential outside of our service.” (Multidisciplinary team member)

The important point here was that, for the staff interviewed as part of this project, abstinence from illicit drug use, and in time perhaps abstinence from a substitute prescription, might be seen as
important, but equally continued maintenance was not necessarily incompatible with the core ‘recovery’ goal of working individually with clients to enable them to reach their full potential. For others, this was expressed in terms of assisting clients in being able to contribute to society:

“The concept of recovery to me is for them to get back into society really, um to be drug free if at all possible. And actually put something back into society and that’s whether getting physically and mentally well, um doing some form of employment or if not um you know whether that is voluntary or you know in long term employment that would great. But it is actually giving them you know a focus of getting on with their life really and away from the addiction.” (Multidisciplinary team member)

**Distinction between ‘in recovery’ and ‘recovered’**

An important distinction was made by staff interviewed, between the dual processes for clients of being ‘in recovery’ and being ‘recovered’. Thus the term ‘recovery’ may be more orientated towards an abstinence based model, at least ultimately, but there was a recognition of recovery as a process, and that the process of being ‘in recovery’ was what might be different for different people. Thus some clients might be considered as being ‘recovered’ had they ceased using substitute medication, but other clients may always be considered as being ‘in recovery’ regardless of their medication status. Again, the understanding of whether a client was either ‘recovered’ or ‘in recovery’ was an individual phenomenon, and one that can be understood as being influenced by the ideology and beliefs of the client themselves:

“I guess you can be in recovery if you are stable on a prescription, but I think, and I think you will always be is some sort of recovery. But I think you know in the truest sort of sense of word I guess if you have recovered from a condition if you know when it is all done and dusted and you have left that part of your life behind” (Multidisciplinary team member)

**Realistic recovery**

For many staff, there was a recognition that ‘recovery’ should be approached with clients in a ‘realistic’, pragmatic manner. Thus what is achievable for some clients may never be achievable for others, nor would it be appropriate that this should be the case. In this sense, the concept of ‘recovery’ was approached from the standpoint of awareness and pragmatism:
“I think for some clients who come in and want help with perhaps with heroin use, they don’t perceive that the occasional crack use or alcohol use is a problem and whilst you are in service you do expect people to be free from all illicit substances, and you do encourage people not to drink alcohol on a regular basis. Um that is a difficult one really. I guess as a service expectation you would expect people to be free from everything and often is not a realistic expectation for people though they have to be aware that sometimes you know using the occasional crack and things can then prompt them into other sort of illicit use, so it is just you know educating people on what the potential consequences could be I suppose.” (Multidisciplinary team member)

Here, the member of staff interviewed discusses the difficult interacting influence of alcohol. Since many of the clients interviewed within this sample drank alcohol, either occasionally, regularly, heavily or in a problematic sense, either currently or in the past, there was a recognition that it would be ‘unrealistic’ to consider abstinence from alcohol to be an important factor in terms of defining ‘recovery’ from substance misuse. This view was also corroborated, although to a lesser extent, with regards to other class B and C drug use, although views on this additional substance misuse were much more divergent amongst staff.

Below, the staff member interviewed discusses the concept of ‘realistic recovery’ in terms of additional substance misuse, but also importantly in terms of the social situatedness of individuals, who socially and structurally had seemingly huge mountains to climb in order to move away from illicit drug use in particular, but also substitute prescribing:

“I think a lot more onus should be on the actual recovery because obviously, and I think our expectation is really high, you know because people have been quite entrenched in their addiction for many, many years and we need to be realistic I think, within our expectations of these guys, especially when their philosophy has been sort of maintaining and harm minimisation for such a long time within the drug services. To now suddenly say to a lot of the clients: ‘Now we would like you to be drug free’ and you know, off their maintenance doses of methadone if you like, which has been a huge crutch for clients for many, many years. And again a lot of the clients, and I can only talk for (town name), um, a lot of them have never worked, and they have got very poor literacy and numerously skills. And some of the families we are dealing with are second and third generations for drug and alcohol and the entrenchment is, you know, is massive”. (Multidisciplinary team member)
Similarly, a nurse interviewed below discusses the societal stigma associated with long term illicit drug use, and the difficulties with reintegration that arise due to this. There is, therefore, a suggestion that a shift in societal attitudes, as well as structural resources put in place to support those who are the most socially disadvantaged, would be necessary in order to enable client recovery:

“for some I think recovery is, I think it’s positive, I think we need to be realistic about it and not unrealistic and I think there are a lot of clients that um that we could move out of maintenance prescribing and I do think they would be more socially integrated into society from moving out of maintenance prescribing because of the views of employers the views of society as a whole um how they kind of view opiate replacement prescribing. So I think it is a positive thing, but I think we need to be realistic about that and um some people will find it very difficult to obtain work and their (schoolings) been very poor and they've lost confidence and so you need the resources to kind of support all that and that’s really difficult.” (Multidisciplinary team member)

**Recovery as a process**

In conclusion, it can be understood that the staff interviewed for this project corresponded with client views of recovery, as being diverse, individually specific, and as being a process rather than a fixed endpoint. With this in mind, it was reassuring to hear the views of the consultant interviewed as part of this study, who endorsed the recovery consensus statement (The UK Drug Policy Commission Recovery Consensus Group, 2008):

“I think I hold with the definition that was agreed across all agencies, um, a year or so ago that the recovery is a process, um, and can be looked at a lot of levels. And I certainly don’t see recovery as being synonymous with abstinence. So recovery might be a regaining of um physical and mental health social integration, a capacity to work, care for your children; if you like the flip side of that list of reasons why one might not choose abstinence, but never the less could achieve, with appropriate treatment, interventions, um and a lot of gain which might eventually become conducive to abstinence. So I think recovery and obviously recovery is a process and um recovery and abstinence are not synonymous, and neither is maintenance and recovery are a contradiction.” (Service Manager)

**Perceived barriers for clients**

*When long term maintenance is the most appropriate treatment option*
Staff interviewed were asked about the appropriateness of long term maintenance. Whilst many were of the view that it was appropriate to suggest and prompt clients to think about reduction and move towards recovery, there was also a strong advocacy for the important place that long term maintenance continued to play within the treatment system, for some clients. Thus, staff were eager to discuss the cases where they felt that long term maintenance, not a recovery focus for treatment, was most appropriate:

“The onus has changed and a lot of people that were, that you know we have taken over, that were on long term prescription, we have tried to reduce down. However for some people I think when all interventions have been tried, and all sorts of therapies and all sorts of different approaches have been tried, and they just cannot sort of move forward, I think, you know, you have got to be pragmatic, and for some people I think, you know, being on maintenance methadone is as good as it is going to get. People that have got quite complex physical health, or mental health needs, um, I think you know, the methadone can keep them remaining quite stable on the drug side of things, and I think for those clients, I think maintenance methadone is more than appropriate. (Multidisciplinary team member)

The staff member here discusses the way in which complex physical and mental health needs in particular meant that stabilisation on a maintenance prescription was a positive outcome in itself. This corroborated client views and experiences discussed earlier, and suggested that for these complex clients it may not be appropriate to encourage an abstinence based focus for treatment.

Other staff interviewed suggested that there was a danger that drug workers working within the previous ‘harm minimisation’ orientated service had started to see maintenance as the best option, without questioning the underlying logic. Recent audit work carried out by the trust had enabled clarity about when long term maintenance may or may not be appropriate is appropriate or not:

“for the most recent generation of drugs workers there is an assumption that maintenance is a good thing per say with certain clients although you might encourage some people to move towards abstinence - stabilization was often given as a goal without an underpinning specified reason. So we tried to shift that a bit so that we do have an underpinning specified reasons, and we had things like, um, major mental illness, um current physical illness which would make reduction too difficult. Um and that would also include people currently undergoing um treatment for hepatitis C.” (Service Manager)

Since completion of the audit work, defined service criteria had been developed to underpin the reasons for those remaining on long term maintenance:
“I think it is seven actually, so we have got major mental illness, um, significant physical illness, currently Hep C a decision to maintain during the pregnancy again for reasons of safety and engagement. Um maintenance treatment enabling stable child care, ditto work, and current social situation is not conducive to abstinence. People living in squats, hostels and you know they are surrounded by it or ... And from a work point of view, um, as you may know you can continue to drive if you are in stable treatment and when you are in reduction or a detox, um, it puts you at risk of having your licence withdrawn until you have had a year of abstinence. So all through the period of reduction, and the post withdrawal year, you may have your diving licence withdrawn. And that can have an impact, not just on the work, but on the child care and other things as well. Um, or people who’s treatment is very stable, and they are well and they have a demanding job, that they don’t feel that, they don’t feel that they can do if they were in the process of reduction. So that list seems to work quite well” (Service Manager)

The audit work had then, reportedly, been successful in assisting with defining when long term maintenance, rather than a reducing script, could be justified as the best treatment option for individual clients. Findings of the audit suggested that:

“The most frequent reasons were the mental illness, the physical illness, and current social circumstances that were making it difficult to move people even contemplating reduction and withdrawal." (Service Manager)

Being able to more clearly categorise cases where long term maintenance was acceptable and the most appropriate treatment option was clearly of benefit to certain individual patients, but was also judged to be a positive development in reassuring staff that recovery, or abstinence focused course of treatment, were not always appropriate or justified, despite the core treatment orientation towards recovery. The consultant interviewed for this study also suggested that defining the criteria for justifying cases where long term maintenance was the most appropriate treatment option, meant that staff were ‘less distressed’:

“From my point of view, knowing that there is good evidence that the value of maintenance for certain patients, I wanted it structured so that workers are not, um, misguidedly pushing the wrong people down this management path. And that they felt that there was a sound basis to what they were doing, and that there were other things that they could do rather than this sort of overwhelming drive to get everybody off. Because they are clearly distressed and feeling that they need to push people who they have a sense of setting them up to fail.” (Service Manager)
Individual motivation to change

Corroborating the views of clients interviewed for this study, staff placed some emphasis on individuals’, internally driven, motivation to change as being critical. In this sense, the lack of internal motivation was viewed as an important barrier to recovery:

“People who have been on prescriptions for many, many years I think the thought of actually managing without and reducing their prescription down - especially when they have been stable on it - it is quite a frightening concept. So I think it’s the main barriers is trying to overcome people’s sort of reluctance to sort of consider change, and then to sort of try and motivate them, and make them sort of, you know, contemplate their actually life without a prescription is possible. Um I think it is just that it is just trying to get over the fact that people have been on it for such a long time, and have been very stable, and you know their philosophy is often, well you know, why try and change something that is working very well for me.” (Multidisciplinary team member)

Here, the staff member interviewed discusses the concept of motivation particularly in the context of long term maintenance. Her view is that individuals who have been in treatment for long periods of time may be especially reluctant to address the potential for change that offering a reduction might bring. It follows then that a key role of treatment services may be to address and challenge individual motivation in order to support recovery and attempt to overcome the perceived significant barrier of (lack of) motivation.

Fear of destabilisation

Similar to the idea that clients’ lack of motivation represented a key barrier to recovery, and again corroborating the views of clients themselves, staff felt that fear on the part of clients was an important barrier to recovery. Specifically, client fear of destabilisation (expressed by clients as discussed earlier as being a fear of ‘return to chaos’), was seen to be critical:

“People are very scared about withdrawing and they’re very scared about coming off medication, and are, and they also see themselves as a certain identity. And then to try and kind of change that, can be very difficult, because you’re altering someone’s whole perception of themselves and, um and um, where as we might see that as a positive, the person themselves can see that quite as a negative, I think. People hear horror stories about coming off medication, and certainly a few years ago the prison used to detox people very badly, and there’s a, and so we get a
lot of comments that: ‘Oh no, we can’t lose the effect of that stuff because of the prison () two or three tablets not do it properly’. So I have to work really hard, in in um in, to people to understand that you know they will be more comfortable, um and um, I think people you know have tried and tried, perhaps they’ve fiddled around with their medication they haven’t done it properly. They’ve started to feel, you know, withdrawals and that really frightens them, so they kind of just keep - they just want kept the same, they just kind of, you know, really kind of get stuck there um yeah”. (Multidisciplinary team member)

Reference is also made by the nurse interviewed, above, to the fear of withdrawals – a further point of convergence between the views of staff and clients interviewed in this study.

**Client acceptance of recovery model**

There was a divergence apparent within the staff data between discussion of the past approach of treatment services and the current focus. One interviewee discussed the (previous) ‘culture of maintenance’ which had resulted, in some cases at least, in a kind of complacency and unwillingness, by both staff and clients, to ‘think big’, and consider different treatment options, of which reduction and abstinence might be one.

“This culture of maintenance, this culture of, perhaps not always, both clients and the clinicians not challenging the status quo. So there is a lot of work done early on in trying to reduce someone, and trying to stabilize them from coming into service, but there does seem to be a point, although it is difficult to put your finger on it. But there does seem to be a point where it levels off and there is just this plateaux and it can last for years and someone just actually living their life relatively normally and relatively in a sober way. But always having this prescription” (Commissioner)

It was apparent in the quotation above the ambivalence and uncertainty still surrounding the concept of recovery and its appropriateness when applied in practice. The interviewee discusses the difficulty in assessing stability as a positive outcome for clients in itself, in relation to a desire to move away from substitute prescribing. This dilemma, caused perhaps by the impasse of the previous harm minimisation orientated approach of services with the recent and current recovery orientation, was unresolved within staff interviews. There was a perceivable acceptance and engagement with the recovery agenda on the one hand, juxtaposed against an emphasis of the importance of long term maintenance, and the stability that this could bring to previously chaotic clients, on the other hand. In a positive sense however, staff converged on the view that the new recovery focus within services had been positively received by the majority of clients. This was a
surprise for some staff, who had found their own assumptions and experiences of long term prescribing challenged in the face of unexpected client positivity:

“I think the onus has certainly switched towards the more recovery mode, but it is surprising how many clients who you can then start to offer reductions and things, that are quite willing to do so.” (Multidisciplinary team member)

**Stigma**

Again in corroboration of client views, the perception of societal stigma towards both illicit drug users and those in treatment for drug use was seen as an important barrier to recovery:

“I think from a service point of view there are two big barriers, one is having sufficient resources to really address client motivation and the identification of, um, options from moving forward. And the other over arching is the stigma that clients experience from the rest of health, social care, work, housing, right across the board really. And it is actually very, it makes it additionally difficult, if you like to help people achieve social reintegration. And if they have learnt that over a long period, then that impacts on their motivation; if you felt marginalised for the last twenty years, then contemplating reintegration is a huge amount for some people to climb” (Service Manager)

However, others took a positive stance, suggesting that stigma may have begun to be addressed:

“I do think there is a big stigma attached to people, especially people who have drug dependency. But that is beginning to shift slowly.” (Multidisciplinary team member)

This positive stance was less frequently expressed by staff than a more negative perception though, as the impossibility of breaking out of social and cultural situations that contributed to multiple stigmas was commented upon. For example, the nurse interviewed below drew attention to the ‘culture’ of living in certain areas and being unemployed; suggesting that this ingrained ‘culture’ is incredibly hard to address:

“There’s a whole culture of, kind of not working, of being in receipt of benefits and a
kind of expectation that is what happens and, um, certain postcodes that you would live at would, um, prevent you from (stuttering) probably from getting a job because they are renowned to be problem areas.” (Multidisciplinary team member)

This linked to the perceived difficulties of attempting social reintegration for clients moving towards recovery. There was a perceptible disenchantment with the entrenched positions of some clients, making it very difficult to see how multiple stigmas and barriers might be addressed. Here the interviewee suggests that, even for those clients motivated towards recovery, the experience of trying to break free from deeply ingrained labels and stigmatisation was disheartening and seemingly impossible:

“Often these people are still isolated in the community; they are not involved in work or other social groups. They might mix with their own, they try breaking out of that, but find that society isn’t that caring or that accepting, once you have got a label. So the long term stigma of people prevents them from recovering and moving on in lots of areas. And that is reality, and that is what we come across when we run like the relapse and prevention groups.” (Multidisciplinary team member)

Service barriers
As with the client interviews, service barriers were much less frequently discussed by staff than individual (especially motivational) and social barriers. However, there was some suggestion that service opening times presented a barrier for some groups of clients:

“It’s often very difficult to, um, for females with children to access treatment and the kind of treatment times (nine till five) can be really difficult for them, um, services to support them in recovery so to access education; to access work and um so stuff like that really.” (Multidisciplinary team member)

What works and what doesn’t work currently in services
Staff were asked specifically at interview to describe examples of good working practice in services currently, and to also identify, if possible, areas for improvement, or where things weren’t operating quite as well as they might.

Recovery as a flexible process
Despite the recovery drive apparent within services, staff were keen to demonstrate the way in which this orientation had been flexibly applied, to the benefit of patients:
“It is not set in stone that once you start reduction, it is not just go ahead no matter what you know, it is open to discussion and we can, you know, freeze it when necessary.” (Multidisciplinary team member)

Recovery being viewed as a flexible process was thus demonstrably carried through into current practice, and this was felt to be a benefit of current service operation. As part of this flexibility, others discussed the fast referral and re-referral times for clients currently. This was perhaps seen as especially positive as, in the past, waiting times to access services had been far longer and highlighted as a problem for clients on occasion (Holland et al, 2008).

“At the moment, if we have someone who, um you know, has completed their prescription and sort of goes off - if they have relapsed, they just have to come back through. They can drop in and they are normally seen on the day that they attend our service in particular.” (Multidisciplinary team member)

**Patchy shared care provision**

A difficulty with current service provision highlighted by a number of staff was the uneven provision of shared care services across the county. Shared care involves working closely with GP practices; with the reasoning being that more stable clients could be prescribed by GPs, thus encouraging movement away from treatment services and reintegration back into society. Some hinted that the limited uptake by GPs of offering shared care service may be due to GPs reluctance to take on this service:

“It is pretty patchy; GP’s are suppose to, um, offer shared care, so for our clients once they are stable GP’s are, you know in theory, meant to take over the prescribing and we still see the clients. And if they go through a bit of a rocky time, and become unstable, we obviously take or prescribe him back etc. But, um, it is very patchy and I know a lot of my clients who I see on my case load, in fact none of my clients on my case load are prescribed by GP’s. Because they just don’t, you know they don’t, consider it their remit at all.” (Multidisciplinary team member)
This theme of patchy shared care provision linked strongly to the theme of stigma, with the further suggestion that limited uptake of the service by GPs was a reflection of stigmatised views towards this particular client group:

“I think it is just, I don’t know, I think it is just reluctance because they are notoriously a very problematic client group to work with.

Int Right okay - so what do you think are the benefits really for stable clients of being moved to care under their GP and away from special services?

F I think it just reduces, and I mean there is a stigma attached to coming down to a drug and alcohol service, and I think if it can be more mainstream it just makes it - it just lessens that stigma I think” (Multidisciplinary team member)

Stigma can be seen to act in a multitude of ways however, as depicted in the above quotation. Despite the difficulties of encouraging wider uptake of shared care, this was nevertheless perceived by staff as being a key way in which stigma of clients may be addressed, through enabling their prescription needs to be dealt with within the community, and thus removing the need to attend specialist services, which was often viewed as stigmatising in itself, both by clients and staff.

“With, some high end of opiate drug use, there’s a very public stigma. I was reading in the EDP this morning, and there was a letter to the editor talking about how people who use drugs and commit crime shouldn’t be allowed to have NHS treatment and that would save a lot of money, and you know there is obviously still this prevailing view that if you were a heroin addict, or if you take crack cocaine, you are some kind of lost case that you are simply a burden to society and that you are never going to recover, and that is very unfortunate. And unfortunately it is still with our GP’s. I think it is a lot better than it was, but that there is still that prevailing attitude in the GP world, of - we don’t really want these guys in our surgeries because they can be quite unpredictable sometimes and sometimes quite loud.” (Commissioner)

**Helpful to have defined service standards for when LTM is appropriate**

Staff discussed at interview how it had been extremely helpful that, only very recently, the results of the service audit had been disseminated, and they felt a stronger sense of when long term maintenance might be appropriate, and for which clients. This clarity in operating within the recovery focused service agenda gave a sense of purpose and security:
“I have to say that now that we have sort of designed the definition of those people that to remain on maintenance if you like, you know, and whatever that would be, that if it was dual diagnosis, or somebody that was pregnant. Or for whatever reason - I am delighted because I think it makes, I think it is helpful for the staff to obviously know what they are working towards as well. And I think that, that has been really blurred, um, but that is my personal view, and I think that they, you know, because a client has been in um maintenance if you like for so long, I think it has been quite difficult to disperse of the staff to actually challenge that. And the rationale as to why they are on maintenance, when you know in real hind sight to be fair a lot of you know, going through all the clients individually, and care planning etc etc. And having that clear definition that you can start questioning as to why, you know has this client been in service for five years.” (Multidisciplinary team member)

The clarity that dissemination of the service audit findings has bought is clearly discussed here by this member of staff, who further suggests that a clarity of reporting and care planning will be enabled:

“I know that our consultant psychiatrist has, um has, put together um the clients that she would class as those that are on long term maintenance, I mean not necessarily forever but certainly, you know, it would be very clearly written on the care plan now. For instance if somebody had, um was going through a mental health difficulty, for instance, that would be very clearly defined now, that due to their vulnerability at this time with their mental health, then they would be on a maintenance dose. Um for a period of time, they wouldn’t be indefinitely, but it is very clear then that we know the reason why there is no changes been made to that particular prescription, and when the next review is going to be. ” (Multidisciplinary team member)

Some staff talked about the move towards recovery being led by the government as being helpful in able to challenge some clients – there was a rationale and a clear basis behind attempting to address recovery:

“I think the rationale for those people I think is good, and I think it makes it easier to challenge as well. Because if somebody, for instance has been on a maintenance dosage because of harm minimisation reasons for instance, and you know, haven’t worked or haven’t gone to any community groups or you know, haven’t received counselling or whatever the case may be, then it is kind of, you know, you can then say, well, ‘We would like you to start doing these things’. You know, and ‘What is
the reason really that you feel that you haven’t been able to address these issues in the past? And I think now, and I think from, I think it has been a lot easier as well because it has actually come from government, if you like, the expectation of recovery.” (Multidisciplinary team member)

Here, the implication is that staff are actually better able to engage with the recovery agenda because it has come directly from policy. There are no ambiguities about the strength of the approach, and staff perhaps feel better able to implement this approach because it comes with a strong direct backing. However, others were less informed of the service audit that had recently taken place, and expressed more uncertainty around defining which clients might be justified as being maintained on long term substitute prescriptions:

“I think that process is still happening in terms of you know who meets the criteria for long term prescribing, and whatever that criteria is. But I am not too sure about it all you know, at the moment.” (Multidisciplinary team member)

The implication here was that further dissemination of the service audit, to inform and support the individual key working approach, and to better justify the reasons for long term maintenance within a recovery focused service, where this was appropriate, would be beneficial.

Relapse prevention and post discharge groups
Staff were proud of recent service developments around support groups, describing what seemed to be working well in terms of relapse prevention support:

“It is not a group, it is, is like a um - it is more of a support, like a drop in, if you like. So they are invited to that, to go there, but it is quite informal, um you don’t, you know have to go every week or whatever. It is quite informal thing that you can go in, you know, if you are struggling at that particular time, so that is very beneficial” (Multidisciplinary team member)

Resource / service capacity limited
However, positive developments recently within services were discussed against a background of knowledge of possible future funding cuts and limited resources. This was a continued frustration of staff, who unanimously thought that more support, both psychological, social and in a wellbeing sense, was needed, but at the same time recognised that what could be offered and developed was very much constrained by limited resources:
“From the service point of view with the sort of case loads that we currently run, and the individual energy that one needs to put into um motivation to change, it is quite problematic. I think that the group work we have done has been a huge step forward and I would very much like to see a greater capacity to train staff in structured interventions so that people are better equipped to do highly targeted, um, psychological work with clients. If you are managing a case load of eighty, really it is quite hard to do that in a thorough way with all your clients.” (Service Manager)

The issue of large caseloads is mentioned here. As services have expanded hugely in recent years this has become an increasing issue. As the staff member below points out, a potential disadvantage with working with a large case load is that longer term or less chaotic clients get side tracked, as new clients coming in to service or those presenting particular problems, come to the fore:

“Sometimes I think with large case loads, the priority is the new people coming in to service - they seem to get a lot of the focus and attention. And maybe the people that you see every three months or even longer, they don’t get that individual contact and the chance to re-motivate, or for someone to you know have that conversation with them, so that is a drawback” (Multidisciplinary team member)

The danger of having to manage large case loads, then, is that clients who are on long term prescriptions but possibly ready to move on to reducing, are not picked up in a timely manner. As the consultant interviewed suggested earlier, it takes a great deal of time and energy to work with a client on individual motivation, and it is simply not possible for one key worker to do this thoroughly with each individual, when managing a caseload of eighty clients at any one time.

**Lack of communication and joint working between services**

Some staff expressed frustration at the lack of communication between different services:

“It’s very difficult to work with mental health services, there’s a barrier still unfortunately between TADs and the generic mental health, to work together and um, the mental health team are very reluctant to work with people with drug and alcohol problems, and so you get kind of chucked around trying to, um, coordinate from psychiatrist to psychiatrist that have different views, so that’s been quite tough as well” (Multidisciplinary team member)
These difficulties led to staff suggesting a number of potential service improvements. This was an area in which staff views differed markedly from client views, as staff were much more able to pinpoint particular ways in which services might be improved.

**Suggestions for service improvement**

**Better links with other agencies**

A number of staff suggested that links between services might be improved, particularly with regards to improving support for recovery, or post-discharge support. Thus links to education and employment were thought to be important:

“I think, you know, having better links with like the Job Centre and training courses would be much better because, you know, once you are out of addiction sometimes you have got a massive sort of gap in your day that you need to try and fill something more constructive. And I think if we had better links with local employers etc, I think that would make a huge difference to our clients.” (Multidisciplinary team member)

Thus links with other agencies towards the end of a client’s treatment journey were thought to be especially important, linking with the need as discussed earlier, to provide distractions of alternative ways of occupying clients who were moving away from illicit drug use, and ultimately, substitute prescribing:

“I think it is going to be that that is going to be the big thing is that kind of looking towards the abstinence model and actually replacing their addiction with something else and that is where the difficulty has been so far. (Multidisciplinary team member)

Others suggested that there needed to be more ‘link up’ with services that a client might need at the start of a treatment episode, with ongoing support and services. There was suggestion that this might be provided via a central point of contact:

“The working together, that is the thing, it is not saying ‘Well, we will pass you on to ...’ It is actually, you know, there is always that trust, that one person, that someone can go back to and trust within the service they originally entered, that they can
feel relaxed enough to go off and see other services, but they can always come back to the person who they originally worked with” (Commissioner)

Long term support post-treatment

Many of the staff interviewed discussed how important it was that support be extended beyond what was currently available, to support clients post-treatment discharge for extended periods of time. This was due to the perception of recovery as being a process, and thus not ‘complete’ at the moment of treatment exit. High relapse rates were referred to. Staff also felt that, whilst the recovery agenda could be positive and appropriate, it was not acceptable to ‘set clients up to fail’ by assisting them in reducing and becoming abstinent from illicit drug use and then a substitute prescription, but then not providing longer term ongoing support to assist with sustaining recovery. One member of staff discussed again the perceived successfullness of support groups that had formed recently, but was also keen to emphasise that services were still accessible to discharged clients if they felt that they needed them – this was a point that perhaps was not always clear to clients, she felt:

“I think it is, you know, having the support group here is good because if people are having problems they tend to talk, you know, they can ask to see one of the members of staff so we can nip any problems, hopefully in the bud, before they become more problematic. Um, and I think it is just having that awareness for ex clients that, you know, just because they are ex clients it doesn’t mean that they can’t just drop in and seek advice from staff.” (Multidisciplinary team member)

Others suggested that the first few weeks post-treatment discharge was a critical time. There was a need for particular support at this time, although there was, as before, a recognition of the mismatch between what would ideally be offered as part of a support service, and the constraints of available resources:

“I would like to have the capacity to give really intensive support in the first few weeks. In NA for instance people, if there is access to it, will be encouraged to do a meeting a day. And we can’t offer that intense input, and I would very much like to be able to do that so that we could actually really support people psychologically, and um, work with them to access generic sources of activities and support to help them feel more able, or to move away from addiction services as a source of support to some other. It is just like a bit of a dessert out there really um, and certainly we can’t do as much as we would like to you know.” (Service Manager)
“It is frustrating at the end of a patient’s detox we have a care planning, and, you know, the key worker or care organiser comes to those meetings and will say, ‘Oh, I will see you next Tuesday’. And you just think, oh, tomorrow would be, you know, nicer, and to really be able to give lots of support at that stage. When people go home to an empty house, you know, and all the old cues of using, or drinking, or drugs, I would love to put in some more intensive work at that stage. Maybe have some specialist post detox support worker that could work right across the sector? I don’t think we have really brainstormed how we should do it, but I know that the model that they have at 12 Steps, where they do a meeting a day, with people who are like working at Steps, find that very powerful and very helpful. And the buddying system, so you know even in-between the meetings a day, they have got someone that they can ring 24-7 to say ‘I feel wobbly’, and we just don’t offer anything approaching that, which is a shame.“ (Service Manager)

Indeed, the concept of a peer support or ‘buddying’ type of support service was something that others picked up on, discussed below in terms of service user involvement. Others suggested that utilising wider family support, i.e. drawing upon informal mechanisms of support in a more formal manner, might be a useful approach:

“Round people do not fit into square holes and one size doesn’t fit all, and I think having a holistic approach to care has really brought on holistic approach to treatment. So we are talking about bringing in care and families as well into the mix in terms of long term recovery. “(Multidisciplinary team member)

**Increased GP involvement**

Linking to the discussion above about the lack of shared care, or at least a patchy operation of this service, others suggested that increasing this would be of benefit:

“People on maintenance methadone or subutex - there is no need for them to be perhaps in specialist services, because it is going to be a long standing thing, and our input is actually quite minimal. It’s getting the GP’s to be more involved in care as well; I think that would make a big difference.” (Multidisciplinary team member)

As previously discussed, greater GP involvement, or shared care arrangements, was possibly a way of tackling stigma associated with being in treatment for substance misuse. Moving toward reduction of substitute prescribing, and beginning to reintegrate in society, with more GP involvement rather than specialist services, was also seen to be positive.
Manage recovery process very slowly

Staff expressed a preference for tackling the recovery agenda in a slow and client centred manner. There was a concern with reductions being suggested to clients too early, or too quickly. This concern emanated from years of experience working with clients. There was a recognition that clients had to be at the ‘right time’ in their substance misusing careers to be amenable to treatment and reduction, and that attempting to move clients towards reduction and abstinence too quickly may be much more likely to result in failure, in terms of client disengagement or relapse post treatment discharge. Similarly, it was felt that the process of reduction with a recovery focus should be managed very, very slowly. The staff member below suggests that, from a client’s perspective, this makes the process seem much more manageable and achievable. So whilst results might be slow to produce (in terms of abstinence rates), the suggestion was that longer term success rates, or sustained recovery, would be greater:

“I think it is just asking people what their long term goals are, so ‘Where do you see yourself in ten years?’; and even if you have got someone perhaps on a 100mil of methadone, which is quite high sort of prescription, you just sort of say ‘You know, how about if we were to reduce one mil a month over the next ten years?’ You know, ‘You would then be potentially off your prescription’. And so get them to, sort of think about it in tiny little amounts, rather than you know we give them a deadline - you know this is when you have got to be off your prescription. I think it is trying to break it down and make it manageable for people that can actually think: ‘Yeah I could do that; I could manage that’.” (Multidisciplinary team member)

Focus on recovery from start of treatment journey

Other staff interviewed felt that, in the light of the newly embedded recovery culture, it was important to emphasise this focus right from the start of treatment initiation. This view could perhaps be seen to be at odds with other staff views about managing the process of reduction very slowly, as some felt that actually clients should be made aware of a ‘recovery culture’ within treatment services and should not enter treatment with an expectation of long term prescribing, but rather see this as a time limited intervention:

“This Start Up group is so important right at the beginning for the new culture, the new people coming in for the next ten years, so that people coming in know that there is an end to this. You come in, you receive your treatment, you go to the groups which is the first part of the treatment, and then you are discharged.” (Multidisciplinary team member)
More service user involvement

Supporting staff views about the need for longer term follow up and support of clients post-treatment discharge, was discussion about how service user involvement might be utilised to greater effect. Staffs views on service user involvement were that there was the potential for positive outcomes as a result of increased service user involvement, and that it was an underutilised available resource. Some staff thought that services users might be able to fulfil specific roles that currently were not able to be funded within treatment services, such as wellbeing interventions:

“Personally I think we could either use more volunteers within the organisation, um, that could come in and do more of the well being, you know the likes of Reiki, acupuncture, some, um relaxation techniques, you know, that sort of thing. Um and that would be lovely” (Multidisciplinary team member)

Others suggested that service user involvement was critical, in terms of involving those who had been through treatment and were now abstinent. Such people might be used as inspirational role models for clients:

“I think we need to have ex service users in the organisation. I think that that is very important for clients that are coming on board, that they actually see that people have gone through the cycle and are now in recovery. And that gives them a lot of inspiration and something to aspire to, which often they don’t have maybe anything to aspire to, so I think that that is very important, that people are seen around the unit that have gone through the recovery process. “ (Multidisciplinary team member)

This was a position corroborated by the participant data, as consistently when asked about the credibility of key workers and other staff, participants in this and other studies (e.g. Holland et al, 2008) have indicated that those who had been through treatment themselves were viewed as the most credible support workers. Others discussed the idea of ‘recovery champions, as being ex-service users who might work on a voluntary basis within services, again to inspire and act as role models for current clients:

“I think recovery (champions) I think that’s really important and um while I was working in rehab um ( ) that just happens and I think that’s really important to have in the community as well because they give hope to people and people often have lost hope in their addiction. They’ve just lost total hope in it, and I think it’s really (difficult). And it’s really positive for people to listen to people that, um you know,
have overcome addiction and they have positive experiences, and so that’s, so I think we need to integrate that more here” (Multidisciplinary team member)

The need for support and positive influence that might be provided by ex service-users was recognised as extending beyond the period of treatment itself though. As discussed, the critical time for potential relapse or difficulty was perceived to be immediately post-treatment discharge. However, it was also recognised that support needed to extend further beyond this, and that there was perhaps a very long term period of ‘vulnerability’ for abstinent clients (hence the recognition of the term ‘in recovery’ to denote that recovery from an addiction may be a lifelong, or at least long term, journey).

“I think there needs to be a far more widespread understanding that people can become abstinent from substances and have a really great time you know and a really good period of great success. And there are always going to be those pinch points where, you know that stressful point where there is a crisis point, and someone has just been taken out of their comfort zone a bit too much, which is the way life is. And there needs to be something available for these guys, and someone they trust, and we talked about some peer support, you know peer groups run by service users or ex service users - there is just not enough of that” (Commissioner)

Others suggested that service users, ex-service users, or carers themselves held their own potentially very beneficial skill sets, and this was an under-utilised resource. Indeed, the mutual benefits of service user involvement (or ‘mutual aid’) were alluded to, such that service user involvement need not be a one way volunteering proposition:

“Those carers have become a very knowledgeable, very skilled, and can be very motivated to enable recovery - the evidence that they (colleagues) have, um, demonstrated is that if you empower significant others in that way, their own well being improves. And if you engage them (carers) in helping the client to change, then it is a huge gain for them, and of course they get professional support inherent with that, and I would love to see it take off with a capacity to do more of that.” (Service Manager)

The implications then, of the suggestions made by staff for further service user involvement in service delivery, were threefold. Firstly, it was suggested that ex-service users could potentially play an integral role in clients’ active treatment, acting as role models and providing inspiration and hope for clients that achieving abstinence was a possibility. Secondly, it was suggested that ex-service users or carers might be utilised to participate in post-treatment discharge, or recovery, support
groups. This might entail a mentoring or peer-buddying type of arrangement, where individualised intensive support could be made available to those recently discharged from treatment, especially in the early weeks when abstinence might be most difficult to maintain, and clients at their most vulnerable. Support might also be longer term though, offering a buddy system such that individuals going through particularly difficult periods in their lives might have a friendly person to contact at those times. Finally, it was suggested that ‘mutual aid’ should be recognised, where ex-service users as volunteers, or indeed carers, might be seen to benefit positively themselves through their contributions to the recovery journeys of others.

**Discussion and Conclusion**

**Summary**

To summarise, this report has focused primarily upon client subjective perspectives of what ‘recovery’ means. The report has also focused in depth on client experiences of long term maintenance, considering pathways and histories of substitute prescribing, and treatment journeys. Client views of barriers to recovery were analysed, with key barriers seen to be organised around individual (intra and inter-personal), social and system barriers. Finally, from the client perspective, perceptions of key enabling factors to support recovery were discussed, and these were seen to broadly correspond to an organisation of understanding around individual, social and system based factors. The final section of the report has focused upon the views of staff in relation to perceptions of recovery, treatment barriers for clients, and suggestions for service improvements. Consensus between client and staff views was remarkable, with varying and flexible understandings of recovery being prominent. However, divergence was noted in client and staff views in terms of perceived barriers to recovery, with clients seeing intra-individual, and especially motivational, factors as being key, while staff perceived many more service barriers to be in operation and emphasised the impact of stigma.

**The meaning of recovery**

Findings from the qualitative data have shown that client and staff views of recovery are broadly consistent. Both clients and staff saw recovery as being a flexibly interpreted process. Recovery did not, therefore, mean one thing to all, and was not necessarily synonymous with abstinence. Rather, recovery was seen to mean different things to different people, and may or may not encompass abstinence from illicit drug use, or substitute prescribing. Similarly, recovery was likely to mean different things within the same individual over time, as participants discussed the concept of a ‘critical time’ for considering reduction and abstinence from substitute medication, indicating that a readiness and preparedness for this might come at different time points. This flexible and individually negotiated view of recovery was shown to be at odds with official definitions (e.g. NTA, 2009 & 2010), but corresponded with the consensus statement on recovery (The UK Drug Policy Commission Recovery Consensus Group (2008)).
The experience of long term maintenance

The client experience of long term maintenance was shown to be primarily understood in terms of perceptions of ‘normality’ and ‘stabilisation’. Clients described feelings of having ‘escaped from chaos’, in terms of escaping from their previous lives of chaotic substance misuse. For some this was described as a return to ‘normality’, i.e. re-engaging with life as it was before substance misuse had taken over. For others, however, who described extremely chaotic and dysfunctional childhoods, perhaps involving physical, or sexual abuse, or enduring mental health problems, long term maintenance in itself was described as bringing a previously unknown stability and peace. A sense of ‘normality’ was harder to define, since for these clients, who had never known ‘normality’, there was a sense that the long term prescription itself had served to create a normality for them. For these clients, it could be seen that a long term maintenance script might be viewed as a means to an end in itself, and that in these cases a long term script as opposed to a short term reducing script aimed at abstinence, was the most appropriate form of treatment as it would allow additional psychological support work to address other issues vital to sustaining abstinence prior to achieving this.

Feelings of actually what it is like to be on a long term substitute prescription were described by the sample. Some individuals, perhaps especially those on higher doses of methadone, described feeling disengaged from the social world and experienced the substitute prescription in terms of being ‘in limbo’ between illicit drug use and recovery. This marginalised position on the edges of society is discussed in sociological terms by others (see, for example, Andreson & Levy 2003). Findings from this study therefore suggest that, if the aim of treatment is to enable recovery and reintegration, the judgement regarding the appropriate medication dose may be a fine balancing act between enabling stability and preventing illicit heroin use, yet not over-prescribing medication which may in itself prevent individuals from feeling a sense of engagement and purpose.

There was divergence in the sample between those, on the one hand, who felt that the substitute medication itself symbolically represented a continuation of addiction, and thus individuals felt that identification with the ‘addict’ role continued. On the other hand, some participants, having achieved stability of a substitute prescription, saw themselves as very much ‘recovered’ and having moved away from the role of ‘addict’ and the associated additional stigma that was attached to this role. However, the concept of ‘multiple stigmas’ was apparent for this participant group, as stigma was perceived or directly experienced on multiple levels, in terms of being an ex-addict, in terms of being in treatment for addiction and on a substitute prescription, in terms of mental illness, and also in other social terms, being linked to the experience of aging, being unemployed or homeless (particularly perhaps within small rural communities), and for some, being a single parent. The divergent perception and experience of stigma and the implications for individual recovery journeys is well covered within the academic research literature, supporting this study’s findings that stigma may be experienced on many levels and acts in complex ways as a barrier to recovery (see, for example, Corrigan & Watson, 2002, Link & Phelan, 2006, Andreson & Levy, 2003 & Link et al., 2001).
Barriers to recovery

Barriers to recovery were defined by clients in terms of individual (encompassing intra and interpersonal), social and system barriers. For clients, individual barriers were thought to be key, with intrapersonal factors such as individual motivation, and fear of change (including relapse), or fear of illness, being perceived as the key barriers. This was in the most part corroborated by staff views, although staff placed far more emphasis than clients on possible service based barriers to recovery (including psychological treatments, and services to support employment or housing).

In terms of interpersonal barriers, ‘mixing with the same crowd’ presented the most salient barrier identified for this participant group. Awareness of this as a barrier to recovery was high, but hope about being able to address this barrier, and the past experiences of those suffering multiple relapses, made the barrier seem difficult to address. This might be understood as a particular issue for those in rural communities, as it is conceivably more difficult to find new friends in a small rural community than a larger urban area. Support and encouragement to continue to attempt to ‘do the right thing’ in terms of forming new friendship groups or gaining employment even in the face of additional difficulties likely to be experienced along the way is important.

Enabling factors and suggestions for service changes

Clients discussed the possibility of reducing their substitute medication, or in some cases, clients were actually on reducing scripts at the time of interview, and so were able to discuss candidly what this treatment course entailed and felt like. Clients described having to deal with remorse and guilt at their previous behaviour whilst addicted to illicit substances. These negative feelings were described as ‘rising to the surface’ as substitute medication was reduced. The implication here was that clients needed to be supported through the reduction process where difficult emotions would arise and have to be addressed if progress were to be made. Some clients liked the idea of engaging with recovery support groups to assist with dealing with the emotional aspects of reducing substitute medication, whilst other clients indicated that there was a need for increased capacity in terms of one to one support or counselling. When discussing the recent recovery agenda, staff, in some cases, had expressed surprise that some long term clients were engaging with the new focus on recovery and had recently been moved to reducing scripts. Indeed, some participants within this sample who were currently reducing also admitted surprise at the situation – suggesting that they had not necessarily ever considered this possibility before, but were presently surprised at themselves for attempting it. This suggests that raising the possibility of script reduction and moving towards abstinence may be a possibility for many, even the most seemingly entrenched clients.

However, direction towards the possibility of reduction and abstinence needs to be well considered in advance. For the participants that we spoke to with dual diagnosis, reducing scripts had, for the
most part, not been discussed with key workers, probably due to a recognition by treatment services that this would not be appropriate. However, participants were nonetheless aware of the recent shift towards recovery in treatment services, and expressed worry and concern that it might only be a matter of time before reduction was discussed. Others had the possibility of abstinence actively discussed with key workers, and gave feedback at interview that they were extremely concerned about this possibility. When viewed in the light of complex medication regimens to deal with a range of psychiatric symptoms, any discussions around medication change were potentially extremely anxiety provoking in their own right. The implications of this finding are around service communication and dissemination of the interpretation of the recovery agenda. Participants in this study, at the time of interview, perhaps saw the recovery focus as a blanket policy for all clients, although in reality the service interpretation of this has been shown to be more measured. Communication of the instances where long term maintenance might be the most appropriate treatment option may perhaps help to relieve some of the intense worry and anxiety expressed by participants in this study.

Clients felt strongly that intrapersonal (within the individual) factors were the most likely to support or enable recovery. More abstract concepts, such as a defined ‘sense of purpose’ were thought to be key, and there was a prevailing attitude that internal motivation towards abstinence was the single most predictive factor of eventual success. This internal sense of ‘it’s the right time’ may however be likely to depend on a combination of external factors, such as relationships, employment, or housing. However, staff views differed on this point as, although there was recognition of the importance of internal motivation, staff also felt that service improvements might play an important role in enabling, or assisting, with recovery goals. These differing views might be synthesised, perhaps, by considering any proposed service changes as likely to move clients to a point where they have developed an internal sense of purpose. Indeed, the recent NDAP adult needs assessment (2011) highlighted the fact that a large proportion of opiate maintenance clients in treatment prescribed long term were not recorded as receiving any psychosocial interventions. Thus it would appear that greater access to psychosocial interventions to support recovery is a key recommendation that can be drawn from client and staff views of this study, and is corroborated by recent needs assessment work drawing on NDTMS recorded data (NDAP, 2011).

Staff felt that there were a number of areas in which future services might be improved. There was great emphasis placed on a need for ongoing support post-treatment discharge. With the ‘new’ recovery agenda within treatment services, staff were concerned that clients might be moved quickly towards reduction and abstinence, and that important support post-treatment discharge was not in place. Staff views in this sense have been supported in the wider academic literature, where suggestions for the need for ongoing client support post-treatment discharge have been made (e.g. Best et al., 2010, Galvanni & Forrester, 2010). Staff suggested that it was especially important to provide intensive support to clients immediately post discharge, but that ongoing support to cover potential ‘crisis points’ in the up and coming months, or even years, of an ex-service users recovery journey would be needed. There was a suggestion that volunteers or ex-service users may be well
placed to provide this type of ongoing support. Ex-service-users were understood as being especially credible sources of information, and perhaps well placed to act as positive role models or mentors for those currently going through treatment. The ‘mutual aid’ aspect of service user involvement was also emphasised with one member of staff discussing how service user volunteers or carers should themselves be empowered, trained, and thus able to gain themselves from their volunteering activities.

Indeed, the positive benefits of volunteering, from the perspective of the volunteers themselves, were discussed by some participants within this sample who had themselves had experience of service user involvement activities. These participants viewed the volunteering in itself as being a strong enabling factor to support recovery, working on a number of levels. This Service user involvement had provided diversionary activities for those attempting to move away from illicit drug use – a way of filling time with meaningful activity, as well as empowering individuals by providing a sense of purpose and a feeling that they were ‘giving something back’ to others. Service user involvement also appeared to enhance a sense of positive self esteem, as participants who had had this experience reported feeling good that they were able to help others in some way, and this in turn helped them to feel positive about their own treatment and increased stability. This positive aspect to volunteering or service user involvement is something that could be further supported by services, and built upon to support recovery, both of current clients and of those involved in volunteering. This recommendation corresponds to the recommendations in the interim report on recovery orientated services (NTA, 2011), which suggests that families and carers should be encouraged to be involved in an individual’s treatment, but should be formally supported in their own right for this involvement. Recent review evidence (Best et al., 2010) also supports this recommendation to extent peer support services.

The issue of sustained recovery was addressed by staff participants in this study, who were concerned that there was a need to further develop services and support structures to support recovery, and the potential for abstinence from substitute medication, not just in the immediate post-treatment discharge short term, but also in the longer term. There was recognition that relapse could occur for individuals beyond the immediate ‘crisis’ period, and perhaps even a long way in to the future. However, this represented an unknown, and a potential gap in research understanding, as the long term risk of relapse from abstinence may well be triggered by key life events, and these may be hard to predict or foresee. Ideally, a longer term study tracking recovery journeys over a protracted period of time would be able to investigate this, and suggest potential service interventions that may provide appropriately focused longer term support for individuals ‘in recovery’ or abstinent from drug use.

From the staff perspective, it was highlighted that clients need to be aware that treatment is ‘recovery focussed’ but that ‘recovery’ is seen as an individual concept with goals co-created between the client and key worker. Goals may be short and long term. Abstinence may be
considered by treatment services as being a desirable option for all, but individual factors may mean that for some this is a very distant long term goal. Clarifying the recovery focus, yet flexible and individualised approach of treatment services, may assist in allaying some of the fears and anxieties expressed by clients within this study, particularly those for whom abstinence in the immediate future would not be seen as an appropriate goal (e.g. dual diagnosis clients). This suggestion is in line with recent review work, in which “the valuable role of prescribing continues to be recognised, though it is not an end in itself but a component of a phased, integrated package of treatment that minimises risk while being ambitious for each individual patient’s recovery” (NTA, 2011).

The current UK economic climate is problematic in relation to the findings of this study, as funding for support services, employment, education, and treatment services will reduce, although clients and staff in this study have indicated strongly that there is a need for improvement in these areas. Employment difficulties are particularly salient given the current economic climate, and may be particularly hard to address for those in rural communities, where unemployment amongst the general population is a current difficulty. It is suggested that a peer buddy or additional support service for those in recovery may be best placed to provide the kind of ongoing encouragement and support for those in treatment or recently discharged for treatment that may be required.

Cyclical service changes, such as the re-tendering process, may also create feelings of instability, for both clients and staff, which may impact in an indirect way on client feelings of stability and thus internal motivation to engage with the recovery agenda. These wider political and structural forces need to be considered in the light of current research findings, which also seek to inform future service improvements in the light of difficult economic circumstances.

**Strengths and weaknesses**

This project sought a purposive sample of those prescribed long term substitute medication for opiate dependence, defined as clients being prescribed continuously for a period of five years or more, and deemed by key workers to be ‘stable’ in treatment. This study has been successful in reaching this target population. Clients were identified initially by key workers according to the study inclusion criteria. Following identification, it was necessary for key workers to gain initial (written) informed consent for clients via an ‘agreement to be contacted’ form, prior to contact details being passed to the study team. This initial step to the process of gaining informed consent was suggested to the research team by an NHS research ethics committee. On reflection, this additional stage in the process of obtaining informed consent may have hindered the study sampling strategy, since initial consent was reliant upon key worker engagement and motivation with the research project. Thus, it was perhaps the case that those key workers who were less aware of the project, or less motivated, for whatever reasons, to mention the project to eligible clients, may have passed less client names to the research team for contact for inclusion in the project. Indeed, this might be seen as a weakness of the study sampling strategy, since there was some evidence of key worker bias, as some key workers did refer more participants to the research team than others. Ideally, this reliance on
key worker consent as a first stage in the consent process would have been avoided by the research team, who would have liked to have sought to minimise inconvenience to service staff by undertaking recruitment themselves. Direct consent between clients and the research team may also have meant that a wider spread of clients across key workers within the service may have been achieved. Despite this possible barrier to recruitment, it can be observed that the purposive sampling strategy employed by this project has achieved a remarkably representative reflection of the total number of clients on long term prescriptions, as demonstrated in the data drawn from carenotes records for the period of recruitment for this study (see methodology section of this report).

As part of the sampling strategy for this project, the study team sought to purposively recruit those living in rural areas, who are often excluded or under-represented in research. Considering the geographical characteristics of Norfolk, it was thought to be especially important to incorporate the views of rural clients. We recruited 48% of clients from rural areas (including semi-rural areas such as small market towns). Furthermore, clients with dual diagnosis of co-existing substance misuse and psychiatric conditions were purposively sampled. Again, during the planning stages of this project it was indicated to the study team that the views of those with dual diagnosis were under-represented, and that this client group in particular were likely to have specific views of what recovery might mean, and experiences of long term maintenance. The study team therefore specifically targeted those with dual diagnosis for inclusion in the interview study. This approach was successful, with a total of 18.5% of participants having a formal dual diagnosis, although this figure may have been slightly higher, as reliance on self report data meant that considerably more clients mentioned psychiatric or psychological symptoms, which may or may not have had a formal diagnosis attached (40% in total). It is possible to conclude, therefore, that this study has successfully targeted previously under-represented groups of clients in treatment, by specifically targeting clients defined as ‘stable’, especially those rurally based or with dual diagnosis of substance misuse and other psychiatric conditions.

It is apparent by reviewing client demographic data that clients accessed for this study were slightly older than the average age of long term maintenance clients in treatment in Norfolk. This can be perhaps understood as an artefact of the purposive sampling of those prescribed continuously for five years or more, and defined as stable, in the judgement of key workers. A reliance on key worker initial consent and referral to the research team was again perhaps a limiting factor here, as the emphasis on stability as inclusion criteria may have been interpreted overly literally and resulted in a slight age bias within the sample. A further limiting factor of the sample characteristics and approach to sampling was that the research team made attempts to purposively recruit long term maintained clients who were in stable employment. This was a key gap in our sample, as the majority of the sample were unemployed, or in irregular or voluntary work. It is well recognised in substance misuse research that accessing those in employment yet also involved in substance misuse is extremely difficult, due perhaps to the wish of individuals to disassociate or distance themselves from the stigma, labelling and stereotyping that are applied to drug users in treatment. Despite attempts to
specifically recruit this group, we were unfortunately unable to. This anomaly aside, the qualitative sample accessed for this study can be seen to adequately reflect the demographic characteristics of long term maintained clients currently in treatment in Norfolk.

Next steps
Further fruitful routes forward for research to address have been identified around the suggestions of increased service user involvement in treatment. A pilot peer support or buddying intervention could well provide evidence for the effectiveness of suggestions made in this report to extend this type of support service. It is critical that an expansion of this type of peer support be thoroughly evaluated, both quantitatively in terms of service targets, but also qualitatively in terms of how participants and volunteers themselves experience the intervention. Evaluation in this sense would ensure that suggested service changes are implemented in an evidence based manner, where alterations and modifications to the intervention can be suggested as necessary. Alternatively, other forms of community based ongoing support for recovery may be explored, for example within pharmacy or voluntary settings, or through extension of shared care provision, where clients may be supported within the community by outreach workers. A scoping study of potential wider support for recovery may be necessary in this case, to identify possible routes to increase support for those ‘in recovery’ or discharged from specialist services as abstinent, in order to continue to support sustained abstinence in the longer term.

Conclusion
In conclusion, this report has drawn together qualitative evidence from a purposive sample of clients on long term opiate substitute prescriptions, and a selected sample of staff, to consider perceptions of ‘recovery’, to understand the experience of long term maintenance, and to consider what may help or hinder recovery focused treatment, in terms of barriers and enablers. Findings have shown broad and varied understandings of recovery, with both clients and staff sharing a view that recovery is an individualised process, and thus ‘recovery goals’ should be considered within the context of individual pathways through treatment. Long term maintenance was shown to represent stability and ‘recovery’ in itself for some previously chaotic clients and especially those with dual diagnosis. For others, long term maintenance represented a state of being ‘in limbo’, caught between illicit drug use and recovery, in an abstinence sense. This suggested that a ‘middle ground’ approach of treatment services between the two contrasting approaches of harm minimisation and recovery focused treatment may be appropriate, fulfilling the recovery agenda, yet recognising divergent pathways through treatment and defining the most appropriate recovery goals for individuals.

Participants saw intrapersonal barriers and enablers as being key in considering recovery focused treatment. This suggests that greater psychological support during a treatment episode, but also post-treatment discharge to support sustained recovery, may be needed. This coincided with staff
views that more could be done to support a recovery focused agenda beyond substitute prescribing itself. Both staff and clients spoke positively about the potential for service user involvement and volunteering, suggesting that this may be a way forward for treatment services in offering increased support for clients, both during treatment and to assist with sustaining recovery if abstinence is achieved.

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**List of Appendices**

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Appendix 2 – Systematic review PRISMA flow diagram

Appendix 3 – Sampling Frame

Appendix 4 – Qualitative interview guide

Appendix 5 – Qualitative data analysis process flow chart

**References**


Critical Appraisal Skills Programme (CASP) 2001, Tool for assessing quality of qualitative research evidence


