# *A Grounded Theory of Detoxification-Seeking Among Heroin Users in South East Ireland*

August 2010

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Part-Funded by the South East Regional Drugs Task Force

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## Glossary of Abbreviations

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| ADRU | Alcohol and Drug Research Unit of the Health Research Board (Ireland) |
| CSAT | Centre for Substance Abuse Treatment (US) |
| EMCDDA | European Monitoring Centre for Drugs and Drug Addiction |
| HRB | Health Research Board (Ireland) |
| NCCMH | National Collaborating Centre for Mental Health (UK) |
| NIDA | National Institute for Drug Abuse (US) |
| WHO | World Health Organisation |

# **Publications**

To date, finding of this study have been published in the journal '*Drug and Alcohol Today*', cited as follows; McDonnell, Anne and Van Hout, Marie Claire, 2010, 'Maze and minefield: a grounded theory of opiate self-detoxification in rural Ireland'. *Drugs and Alcohol Today*, 10 (2).

In addition an article outlining findings of this study, entitled 'Heroin Detoxification-Seeking, a Grounded Theory of Process and Practicalities' has been submitted to, and is currently under review at, '*The Grounded Theory Review: An International Journal*'.

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# Acknowledgements

The individuals, who shared their stories of heroin use throughout this research study, were full of energy, trust and enthusiasm when sharing their insights, opinions and personal experiences with me. For this I am very grateful, and I have held it in high importance to portray their stories, and their lives, with respect and honesty. I thank the three local gatekeepers who connected me to the field, guided me through services and potential contacts on the ground, and offered me their insights into many heroin-related issues. I also thank the drug treatment service where I spent two days, and the workers there who helped so enthusiastically in explaining this study to clients, and in recruiting participants. To all drug service workers who participated in this study, and referred research participants, I am very grateful. Without the support of funding from the South East Drugs Task Force this research study would not have been initiated, and for that I am very appreciative. Finally I thank my academic supervisor at Waterford Institute of Technology, Marie Claire Van Hout, who has provided me with consistent support during the process of this research study, both personally and academically, and has succeeded in guiding me as a novice researcher, through the realm of academic study.

The research was funded by the South Eastern Regional Drugs Task Force, Ireland. The opinions expressed in this article are of the researchers and are not necessarily those of the South Eastern Regional Drugs Task Force.

# Abstract

The need for widespread increase of both community and residential detoxification services in Ireland has been clearly articulated at national and local level (Mannix, 2006; Corrigan & O'Gorman, 2007; Dept. Community, Rural and Gaeltacht Affairs, 2007; Doyle & Ivanovic, 2010). This study explores a central phenomenon of detoxification-seeking among heroin users in the South East of Ireland, through a grounded theory approach. The study conceptualises detoxification-seeking as a help-seeking behaviour, experienced by heroin users, but not all, in response to and as a consequence of the complex experience of being heroin dependent, and wanting to become abstinent. The core category, *'forging a pathway towards abstinence from heroin'*, provides an insight into challenges and tasks that research participants undertook when their aim was abstinence. Pathways towards abstinence involved collaboration with other heroin users, family and/or health and drug service professionals and were heavily influenced by internal factors such as perception of services and perception of need for help. The process of forging a pathway towards abstinence had three stages; recognising, help-seeking, and navigating. The three stages include actions related to information seeking, and treatment (including detoxification) seeking. Not all research participants experienced all of the stages. However, all of the research participants, at some point in their heroin-using careers experienced factors which blocked, or facilitated them, to seek detoxification. Such factors included the presence, or lack of; family support, a therapeutic alliance, personal knowledge (of heroin dependence and drug treatment) and access to treatment services. Such barriers and/or enabling factors, were found in the social and personal contexts of the individual, and were shown to inhibit or facilitate the individual to seek heroin detoxification. The study offers a clear theoretical framework for understanding the contextual factors that can lead heroin users to seek detoxification. The study has implications for development of low threshold services, development of community-based detoxification and facilitation of service user involvement.

## An Overview of the Study

This research study was funded by the South East Regional Drugs Task Force and was conducted as a postgraduate research project within Waterford Institute of Technology during 2007 – 2010, for submission of the award of MA by Research. The main aim of the study was to develop a greater understanding of heroin users' experiences of detoxification-seeking in South East Ireland. It is envisaged that the findings of this study will provide a framework for discussion, and usable knowledge, for all those who are involved in the development of services in response to heroin use in the research area. The need for the widespread increase of detoxification services at both community and in-patient level in Ireland has been clearly articulated at a national level (Corrigan & O'Gorman, 2007; Dept. Community, Rural and Gaeltacht Affairs, 2007; Doyle & Ivanovic, 2010). A report from the statutory Working Group on Rehabilitation states that, in relation to opiate users, "*clients often feel that they are not given adequate options regarding their treatment and care-plans.......this is particularly evident to detoxification*" (Dept. Community, Rural and Gaeltacht Affairs, 2007:35). It has been identified that an additional 104 dedicated beds are required in Ireland for medical detoxification and stabilisation; 50% for alcohol and 50% for other drugs (Corrigan & O'Gorman, 2007). In Ireland, major challenges can present in the development of services in response to heroin use, in relation to meeting treatment and rehabilitation needs for heroin users in areas which are outside the main urban population centres, and where numbers of heroin users are low and may also be dispersed across large rural geographic catchment areas (Dept. Community, Rural and Gaeltacht Affairs, 2007). This study was undertaken with the purpose of contributing evidence-based knowledge towards determining the best ways of meeting the needs of heroin users who require access to detoxification services. It is hoped that exploring the experience of detoxification-

seeking with people who have experienced heroin dependence, will contribute to a greater understanding of the '*who'*, '*what'*, '*why'*, '*how'* and '*when'* of this help-seeking experience, and as such support effective, evidence-based policy and intervention development.

The fieldwork for the research project was conducted within two counties in the South East of Ireland during a four month period in 2008, and within a context of compromised detoxification service provision in the localities. The research topic was defined based on the area of interest of the researcher and following heightened anecdotal reports, at that time, within the media of the impacts of lack of drug detoxification services in Ireland, particularly in rural areas, (Evening Herald, 2006; Irish Medical Times, 2006; Irish Times, 2006; Westmeath Independent, 2006). Anecdotal accounts from local drug service providers during the research design phase reinforced the validity and worthiness of the research topic, as their accounts described the negative impacts of the lack of detoxification services within the research situation, on people who use heroin, families of heroin users and communities. In order to increase detoxification access for heroin users within areas in Ireland typical to the research area, and minimise frequent relapse typical to heroin dependent users, it was considered to be important to consult and recognise the views of those attempting to detoxify from heroin, in order to yield timely and proactive evidence-based knowledge for contribution to national, regional and indeed local service provision for heroin users.

The study did not consider only those aspects of individuals' lives that relate directly to heroin detoxification-seeking, but rather sought to locate these experiences within the wider structural and agential context of heroin use and attempting to become abstinent. As research participants

were interviewed at varying stages of their drug-using careers, a wide spectrum of insights into heroin use, treatment-seeking and detoxification were explored. The study recruited 12 research participants within what will be referred to throughout the report as 'Group X'; namely people who have experienced heroin dependence, and 9 people within what will be referred to as 'Group Y'; representatives from local drug service providers who engage directly with heroin users as they seek detoxification or other treatment. The 12 respondents within Group X included both men and women, of varying age groups over 18. Research participants also represented a continuum of heroin using careers and trajectories in terms of long term dependencies, and more *'novice'* type users. Some of the research participants within Group X were abstinent from all drug use, some were participating in a methadone maintenance programme, some had never accessed formal drug treatment, others were currently participating in formal drug treatment (including residential rehabilitation, and drug counselling), while a further sample of research participants had been unable to access formal treatment or refused formal treatment themselves.

Research participants (both heroin users and service providers) provided a wealth of information that had not been anticipated at the outset of the study, but was generated due to the inductive nature of, and indeed the reflective processes contained within, the study. Research participants were free to discuss issues which they felt were important. Narratives provided by research participants within this study were collected and analysed using a grounded theory approach (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Originally developed by Glaser and Strauss (1967), a grounded theory approach is a method of inquiry which builds on the basic principles of symbolic interactionism, which studies how people define their own realities and, how peoples' beliefs are related to their actions and interactions (Glaser and Strauss, 1967; Strauss &

Corbin, 1990; Glaser, 2002; Corbin & Strauss, 2008; Black, 2009). Glaser and Strauss (1967) indicate that grounded theory is based on the systematic generation of theory from data. Narrative analysis in this study involved a systematic approach using the constant comparative method and an intricate coding paradigm. Narratives containing lay and dominant heroin discourses were sorted into many units of meaning; concepts, with descriptive codes, and compared inductively in order to identify further units of meaning; theoretical categories. The overall process of narrative analysis involved three principal kinds of coding; open coding, axial coding and selective coding (Glaser & Strauss, 1967; Patton, 1990; Strauss & Corbin, 1990; Charmaz, 2001). Open coding involved the process of line by line analysis, involving reading, re-reading, breaking down, and conceptualising each '*slice*' of the data (Glaser & Strauss 1967; Strauss & Corbin, 2008) using codes which represented reported events, happenings and instances, experiences and perceptions. This stage of coding produced over 172 lower level concepts (as outlined in Appendix D). Axial coding was then used to group the data after open coding, into categories which addressed the relationship between conditions, and consequences of behaviours, perceptions and interactions within the concepts. Categories which emerged from this process were as follows; experiencing the impact of heroin dependence; attempting to stop using heroin**;** coping with withdrawal; early experiences of cessation of heroin use; seeking information from other heroin users; seeking help from a General Practitioner; self-detoxifying with the use of prescribed medication; engaging with GP's; going '*cold turkey';* self-detoxifying with the use of methadone; challenges within self-detoxification; completing self-detoxification; seeking in-patient detoxification; accessing methadone maintenance; factors effecting relapse, and factors supporting abstinence. Identifying the categories was a complex process of inductive and deductive thinking and repetitive analysis of the concepts revealed in the open coding phase.

Finally, through a process of selective coding and integrating the categories, a core variable and hypotheses were discovered based on the relationships between the categories. A core category *'forging a path towards abstinence from heroin'* was identified to describe all the concepts and categories which had emerged from the data analysis, and in itself represents a hypotheses of the context of heroin detoxification-seeking. Further hypotheses were conceptualised within stages of the experience of forging a path towards abstinence. Theoretical constructs describe the context and process of heroin detoxification-seeking as being a struggle, with various challenges and tasks undertaken by the individual heroin user. The three stages are conceptualised as; recognising a problem; help-seeking, and navigating the journey. The core category and hypotheses are presented in this report as a running discussion with narratives. The next chapter shall present a brief background to the research study which places the findings within a wider context of extant policy and literature.

# **Section One – Background to the Research**

## Heroin Use in Ireland

In Ireland, during the 1980s, heroin use was located primarily within Dublin's inner-city, and was described at the time as epidemic (Dean et al., 1983). Since the 1980's, the overall number of people in Ireland using heroin has increased, and the specific geography of heroin use in Ireland has changed significantly. The first national prevalence estimate of opiate use in Ireland indicated that there are approximately 14,452 opiate users in Ireland; 12,456 in Dublin and 2,225 throughout the rest of the country (Kelly et al., 2003). A repeat study undertaken in 2006 suggests the national prevalence estimate of opiate users in 2006 was between 18,136 and 23,576, although it is also reported that this estimate is likely to be inflated (Kelly et al., 2009). In 2008, an opiate (mainly heroin) was the most common main problem drug reported by all casesentering treatment and the majority (70.0%) of cases treated in 2008 reported problem use of more than one substance, which increased the complexity of these cases, and is associated with poorer treatment outcomes (ADRU/HRB, 2009). Irish statistics indicate an increase in new opiate cases entering treatment since 2005, similar to over half of all EU countries, and increasing steadily since 2005 (EMCDDA, 2009; Kelly et al., 2009). In Ireland, problem opiate (mostly heroin) use accounts for 63% of those entering drug treatment compared with a European average of 47%, and treatment statistics continue to reflect frequent treatment '*re entry*' together with increased '*new treatment*' cases (Carew et al., 2009). Opiate use is regarded as no longer being confined to the greater urban context in Ireland, with heroin use prevalent, and increasing, in rural areas throughout the country (NACD, 2008; Carew et al., 2009). Indeed national prevalence and treatment data indicate '*new treatment*' cases are acting as indirect indicators of emerging problem opiate use outside of Dublin (Lyons et al., 2008; NACD, 2008;

Carew et al., 2009; Kelly et al., 2009). Poly drug use also remains a significant issue for those opiate dependent and particularly in the context of potential treatment success for opiate use (Cox et al., 2007; Cox et al., 2007b; Kelly et al., 2009). Here follows a short section on drug terminology relevant to heroin use.

**Drug Use – Dependence, Tolerance, Withdrawal**

The term '*drug use*' refers to any aspect of drug taking. '*Illicit drug use*' refers to both the use of illegal drugs, and the unacceptable use of drugs that may or may not be controlled (Corrigan, 2003). Problem drug use can lead to premature death, occurring as a result of overdose, actions taken under the influence of drugs, medical consequences and incidental causes (HRB, 2010). Problem drug use is widely accepted to be a relapsing and remitting condition which may involve numerous treatment episodes over a period of several years (Neale, 2001; McElrath, 2001; McElrath, 2001b; McElrath, 2002; McIntosh & McKeganey, 2002; Marsden et al., 2004). Repeated use of any drug can lead to the development of tolerance wherein an individual will require an increased dose of the drug to produce the same effect (NIDA, 1999; NCCMH, 2008). The World Health Organisation (2009) describe opioid (including heroin) dependence as being characterised by a cluster of cognitive, behavioural and physiological features such as; a strong desire or sense of compulsion to take opioids; difficulties in controlling opioid use; a physiological withdrawal state; tolerance; progressive neglect of alternative pleasures or interests because of opioid use, and persisting with opioid use despite clear evidence of overtly harmful consequences. Opioid dependence is defined as the *"presence of three of more of these features simultaneously at any one time in the preceding year*" (WHO, 2009:5). Once drug dependence is established, particularly with opiates, an individual may experience on-going cycles of

cessation and relapse of drug use, which may extend over decades (Neale 2001; McElrath 2001; McIntosh & McKeganey 2002; Hopkins & Clarke, 2005; NCCMH, 2008).

**Types of Drugs**

A '*drug'* can be described as a chemical that changes the way the human body functions on a mental, physical or emotional level (Corrigan, 2003). The three main types of drugs are hallucinogens, stimulants and depressants. Hallucinogens alter perceptions of reality, and include LSD, cannabis and magic mushrooms. Stimulants, including amphetamines, cocaine, caffeine, ecstasy and tobacco, increase the activity of the central nervous system. Depressants reduce the activity of the central nervous system and include alcohol, barbiturates, benzodiazepines, solvents, and opioids. Drugs within a particular type generally produce the same effects and withdrawal symptoms, and can be used as substitutes for one another. Opioids are psychoactive substances derived from the poppy plant. Opiates are the subset of opioids that are naturally occurring or semi-synthetic. Opiates include diamorphine, otherwise known as heroin, morphine, opium and codeine, but exclude synthetic opioids with similar properties, such as methadone and buprenorphine. Heroin is a semi-synthetic opiate, processed from morphine, a naturally occurring substance extracted from the seedpod of the Asian poppy plant. Use of heroin generally involves injecting, or inhaling the fumes produced by heating the drug. With regular heroin use, tolerance develops, and as higher doses of heroin are used by a person over time, dependence develops (NCCMH, 2008). According to the WHO (2009) opioid dependence can develop after a period of regular use of opioids, varying from individual to individual, related to the quantity and frequency of use, the route of administration, and factors of individual vulnerability and the drug-using context. With dependence to heroin, withdrawal symptoms may occur if use is reduced, or stopped and *s*udden withdrawal by heavily dependent heroin users is

occasionally fatal. People who use heroin, may present with a range of physical health problems, mental health problems, social difficulties, and criminal justice problems (Gowing et al, 2000; Fagan et al., 2008; NCCMH, 2008). Mortality in heroin-dependent users is high, with estimates of between 12 and 22 times that of the general population (Oppenheimer *et al.*, 1994; Frischer *et al.*, 1997). Opiate dependence continues to be a cause of morbidity and premature mortality in Ireland (HRB, 2010).

**Treatment for Heroin Dependence**

The EU Drug Strategy 2005–12 places a high priority on improving the availability of and access to drug treatment options and calls on member states to provide a comprehensive range of effective drug treatments. There are three broad approaches into which drug treatments can be placed; harm reduction, maintenance-oriented treatments and abstinence-oriented treatments. All treatments aim to prevent or reduce the harm associated with the use of drugs (NCCMH, 2008). Recent studies have highlighted the positive outcome for heroin users participating in treatment as being abstinence, reduction of illicit drug use, reduction of risk behaviours and improvement in health status (Gossop et al., 2001; McKeganey et al., 2006; Cox et al., 2007, Cox et al., 2007b). For opiate dependence, it is recommended that a range of potential treatment options be accessible to individuals, including medications as well as psycho-social therapies, through both residential and outpatient approaches (NCCMH, 2008;WHO, 2009). In 2007, 11,538 cases were treated for problem opiate use (mainly heroin) in Ireland, representing an increase of 31% since 2002 and an increase of just over 7% since 2006 (ADRU/HRB, 2009; Carew et al., 2009). Formal treatment provision for heroin use in Ireland includes both inpatient and outpatient services, characterised by a mainstay of methadone maintenance (ibid.). Research has recently

conveyed both the merits and risks of methadone maintenance as treatment for heroin use. Outcome focused studies have highlighted positive results for the majority of those who participate in methadone maintenance programmes in terms of reduction of illicit target drug use, and harm reduction (Gossop et al., 2001; Cox et al., 2007b). However, research studies have also highlighted potential problems of methadone maintenance, for example indefinite maintenance and the risk of diversion of methadone into illicit channels of use (Best et al., 1997; Kreek et al., 2002; WHO, 2004; White, 2007). In addition there is a wealth of research studies which advocate the benefits, for heroin users, of the development of alternative treatment approaches with potential for abstinence and harm reduction, such as prescribing heroin or buprenorphine (Metrebian et al., 1998; Perneger et al., 1998; Amass et al. 2000; Pani et al., 2000; Ahmadi et al., 2004; Auriacombe 2004; Mattick et al., 2009). Conversely, studies have shown that alternative opiate antagonist treatment, such as naltrexone, risks overdose, and intensive rehabilitation or substitute prescribing may be a better option for heroin users with a more entrenched problem (Drucker et al., 1998; Sees et al., 2000; Digiusto et al. 2004; Masson et al., 2004). Previous research has also shown that while heroin users are often satisfied with current access to services, there is often a need for more providers and more support within current treatment services. Research studies advocate an improvement in the operation of existing drug treatment services, including; improved communication systems, more flexibility around individual needs, less judgmental and more understanding staff attitudes, and more autonomy for clients specifically in terms of no longer treating continued drug use as a disciplinary issue, and accepting goals of short term abstinence from illegal drugs (Des Jarlais et al., 1995; Neale, 1999; Robles, 2001; Brands et. al, 2002; Brands et. al, 2003; Loughran & McCann, 2006; Neale et. al, 2007; Neale et. al, 2007b).

**Detoxification**

Definitions of detoxification vary within the systems they are used in (criminal justice, health care, drug treatment, mental health). However, in general, definitions point towards the concept that detoxification forms one part of the treatment process for drug dependence, and for some individuals represents their first step to recovery, and a point of first contact with the treatment system and (CSAT, 2006; CSAT, 2008). Detoxification, in the context of drug and alcohol treatment has recently been defined as follows;

> *Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. Supervised detoxification may prevent potentially life-threatening complications that might appear if the patient was left untreated. At the same time, detoxification is a form of palliative care (reducing the intensity of a disorder) for those who want to become abstinent or who must observe mandatory abstinence as a result of hospitalisation or legal involvement.* (CSAT,2006:4)

Similarly detoxification has been defined as *"a process which provides supervised withdrawal from a drug of dependence so that the severity of withdrawal symptoms and serious medical complications are reduced to a minimum"* (Mattick & Hall, 1996:2), and as a "*controlled withdrawal from a substance such as heroin..... ...a procedure that aims to alleviate withdrawal signs and subjective discomfort, and prevent the risks inherent to suddenly stopping use of a substance that has resulted in dependence"* (Hopkins & Clarke, 2005:18*)*. An effective treatment system for heroin dependence requires the availability of detoxification to individuals, in the context of provision of managed withdrawal (Gowing et al., 2000). Methods of detoxification from drugs have developed over time, to *"reflect a more humanitarian view of people with substance use disorders"* (CSAT, 2006:3). The basic models of detoxification can be described as the '*medical model'*, in which detoxification involves a physician and/or nursing staff

administering medication to help and support people through physical withdrawal from drugs such as opiates safely, and the '*social model*' which does not involve the use of medication and the need for medical supervision, but instead psycho-social support only. There is generally a mixture of these approaches found in detoxification programmes (Mattrick & Hall, 1996; Robertson & Wells 1998; Inkster & Matheson, 2001; Keen et al., 2001; Rae et al.. 2001; Ghodse et al., 2002; Gossop et al., 2003). The development of detoxification services reflects changing patterns of drug use and drug using behavior, as outlined in the excerpt below.

> *"Just as the treatment and the conceptualisation of addiction have changed, so too have the patterns of substance use and the accompanying detoxification needs. The popularity of cocaine, heroin, and other substances has led to the need for different kinds of detoxification services, and more recently, people with substance use disorders are more likely to abuse more than one drug simultaneously (i.e., polydrug use), as treatment regimens have become more sophisticated and polydrug abuse more common, detoxification has evolved into a compassionate science." (CSAT, 2006:5)*

It is widely accepted that detoxification, in itself, is not a treatment for heroin dependence (Mattick & Hall, 1996; Gowing et al., 2006). However, the effectiveness of detoxification can be located in providing a safe withdrawal from heroin, relatively high completions rates and potential to effect reduced drug use, reduced injecting, increased health and accessing long-term treatment (Mattick and Hall, 1996; Smyth et al., 2005; Gowing et al., 2006; Cox et al., 2007). In Ireland, the most commonly used method of heroin detoxification within the formal drug treatment sector comprises of methadone tapering over a period of time which varies from 4-12 weeks and is carried out in both in-patient and out-patient services. Studies indicate that detoxification pre-injecting heroin use, and completion of in-patient detoxification or detoxification followed by residential rehabilitation, can support successful completion of

detoxification and have the potential to delay relapse (Smyth et al., 2005; Mullen et. al, 2010; Smyth et al., 2010). A recent Irish study found that successful completion of detoxification programmes were high (68%), and facilitated illicit drug abstinence rates as well as participation further treatment at 1 year (Cox et. al, 2007). Research has shown that detoxification, rather than maintenance is among the treatments preferred by drug users, in preventing illicit heroin use, as well as widespread support among drug users for abstinence as a goal of treatment rather than reduced drug use or stabilisation (Luty, 2004; McKeganey et.al, 2004). Considering the positive outcomes of detoxification services for heroin users, and the concept that detoxification is a preferred treatment option for drug users, this research study presents a timely opportunity to further explore the perception of detoxification among heroin users in Ireland.

**Self-Detoxification**

Research highlights the frequency of self-detoxification attempts without medical assistance, and with the help of drugs and/or alcohol, and informal strategies for abstinence, among heroin users (Gossop et al. 1991; McElrath, 2001; Noble et al., 2002; Ison et. al, 2006; Peterson et al., 2010). Self-detoxification, has been defined as a deliberate attempt to become abstinent from drugs without medical detoxification or the supervised provision of medication, and '*successful'* in the case of abstinence being sustained for at least 24 hours (Gossop et al.,1991; Noble et al., 2002). In a recent study of heroin users, the sample had instigated on average, 2.5 self-detoxification episodes lasting more than 24 hours, with an average time to relapse of 10 days (Ison et. al, 2006). Research on self-detoxification remains focused on outcomes, with little attention dedicated to the individual experiences and perspectives of self-detoxification (ibid.). However, research on self-detoxification, particularly successful self-detoxification, may have the potential

to contribute to improvements within detoxification programmes (Noble et al., 2002; Ison et al., 2006). The next chapter presents the research methodologies employed in this stud

# Section Two – Methodology

> *The world of social phenomena is bafflingly complex. Complexity has fascinated and puzzled me much of my life. How to unravel some of that complexity, to order it, not to be dismayed or defeated by it? How not to avoid the complexity nor distort interpretation of it by oversimplifying it out of existence? This is of course an old problem:Abstraction (theory) inevitably simplifies, yet to comprehend deeply, to order, some degree of abstraction is necessary. How to keep a balance between distortion and conceptualization? (Strauss, 1993:12)*

## The Role of Qualitative Research Methods in Drug Epidemiology

Qualitative research, by it's nature, involves the application of methods which have the time and process that is necessary for research participants to focus on their own meanings, perceptions, experiences and contexts. With regard to qualitative research, Rhodes et al. (2001:11) describe that;

> *"There is probably no better way to understand people's experiences, and the meanings they derive from them, than to speak with them, observe and spend time with them. In this way, it becomes possible to describe what they are doing, how they are doing it, and why."*

The lived experience and meanings of drug use, and in the case of this study, help-seeking for drug dependence can be considered to be sensitive topics and delicate in data as individuals are describing their personal experiences. Rhodes highlights that "*at its most fundamental, qualitative research on drug use can be envisaged as a means of understanding the lived experiences and meanings of drug use from the perspectives of drug users themselves"* (2000:

22). Qualitative research methods are frequently used within illicit drug use epidemiology, as they are a means of collecting sensitive information from '*otherwise elusive populations'*, (Wiebel, 1990). The World Health Organisation (2000) highlights the role of qualitative research in exploring the lifestyles of '*hidden'* populations such as heroin users, who are not readily accessible within general population research because of both the stigmatised and illegal nature of such use, and the low prevalence of use of heroin. The role of qualitative research within drug epidemiology is also noted in it's ability to reveal evidence-based knowledge to improve the effectiveness of treatments for drug users (Gossop, 1998; Fountain & Griffiths, 1999). In particular, qualitative research methods have the capacity to generate knowledge for supporting the development of local responses to drug use and can promote evidence-based practice through; understanding drug users' perceived needs for, and experiences of, interventions; understanding service providers' perceptions of service need, organisation and effectiveness, and exploring the social and contextual processes influencing the effectiveness of intervention delivery and impact (Feldman & Aldrich, 1990;Wiebel, 1996; Rhodes et al., 2001).

The social meanings of drug use and drug using behaviours are context-dependent (Beck, 1963; Agar, 2000; MacDonald & Marsh, 2002; Gourley, 2004). Context is described as the structural conditions that shape the nature of situations, circumstances, or problems to which individuals respond through interaction, action, emotions, and can vary from micro to macro level (Strauss & Corbin, 2008). Neale (2007:209) highlights that "*new explanations of, and strategies for dealing with drug dependence will always be needed"* and that strategies responding to drug use must recognise context, they "*must vary according to local patterns of drug use and according to the diverse needs of the individuals at whom they are directed"*. Strategies then must be

informed by both the needs of drug users and reflect the changing broader social and cultural context which drug-taking and every day drug use behaviour takes place (Shildrick, 2008; Measham & Shiner, 2009; Fast et al., 2009; Van Hout, 2010 in press). This requires on-going exploration of drug use and drug using behaviour, particularly in contexts which are experiencing patterns of drug use, such as heroin use, as new or changing phenomenon. Hartnoll, (1992) concluded that studies of help-seeking by drug users need to '*unpack'* drug problems, differentiating dimensions of needs among individual drug users, to contact out-of treatment groups, assess the role of significant others, and to give further importance to studies of processes of help-seeking in terms of drug users' personal perceptions and ideologies relating to their drug use, of problems, of risks and of services within the wider context of their lifestyles. It has also been suggested that help-seeking pathways are not random, but rather structured by the meeting of both psychosocial and cultural factors which can be studied as unfolding processes (Rogler & Cortes, 1993).

Grounded Theory (Glaser & Strauss, 1967) was developed as a specific methodology for generating theory from data, but the term is also used more generically to refer to grounded theory approaches to specific methods of data collection and analysis, such as theoretical sampling and constant comparative analysis, and the theoretical constructs which are derived from the systematic analysis of data. Adopting a grounded theory approach to qualitative research enables a theoretical framework to emerge from the data collected and analysed. Such '*generative'* approach to qualitative research is concerned with producing ideas which may contribute to social theory and/or to change in policy solutions (Weiss, 1988; Rist, 2000; Ritchie, 2003). In generative qualitative research, the analysis and interpretation of the data is placed in a

broader theoretical perspective which is applicable to the '*real'* context from which it emerged (Ritchie, 2003). Agar highlights that research approaches such as grounded theory can "*comprehensively and continually answer questions that link drug/alcohol use, specific local communities and planning, intervention and evaluation needs"* (Agar, 2000:68). Within a grounded theory approach, which can be applied to qualitative or quantitative data collection and analysis, it is most important that the emergent theory '*fits'* the substantive area under study, addresses the problems and processes of importance to those experiencing a phenomenon, makes sense to people working in the area, and is a guide to action in response to a phenomenon, bridges theory and practice and is open to refinement (Glaser & Strauss 1967; Strauss & Corbin, 1990; Black, 2009). In this context, qualitative research and the development of grounded theory in relation to aspects of heroin use, and help-seeking, provide a framework for generating understanding of the aspects of the lives of heroin users which are under-explored or '*new'* to a specific social or cultural context. Such theoretical understanding can be used to develop policy solutions and service delivery to respond to the needs of heroin users.

This study is set within a specific local context. By exploring the lived world of heroin users there, the study generates new levels of substantive theory relative to the context specific environment of a small drug subculture within a largely rural area. Thus the grounded theory derived from the study offers a context specific substantive theory which can contribute to understanding of heroin use and help-seeking within the specific social and cultural context. Without such understanding of the way users experience and perceive heroin use, and are affected by it, it is likely that policy and service development will be derived from inadequate data and will not achieve desired targeted outcomes (Trotter & Medina-Mora, 2000).

## Research Aims

The aim of this study was to generate a greater understanding of how individuals, who are heroin dependent, experience the process of detoxification-seeking. The study aimed to explore the lived experience of detoxification-seeking from the perspective of individuals who have experienced heroin dependence, and from the perspective of key stakeholders who work within local drug service provision in the research area. As the study aimed to understand individualised experiences and contextualisations, it explores experiences as subjective phenomenon, and investigates the dynamic and reciprocal interaction between the individuals and their environment. Thereby, the descriptions and narratives will be used to situate and contextualise the process of heroin detoxification-seeking and trajectories. Although the researcher trusted in the inherent emergence of grounded theory from the systematic data collection and analysis, and the prospect that the research participants would in fact identify the research problem, the researcher did also envisage from the outset of the study that the research would possibly provide insights into research questions such as the following;

1 How do individuals who are heroin dependent experience detoxification-seeking?

2 What are the ways which heroin users seek opiate detoxification?

3 What would support heroin users as they seek opiate detoxification?

## Research Design

The study was underscored with the discovery of the participants' ideologies throughout the process of detoxification-seeking. The initial questions asked about heroin use and detoxification within the research situation were simply '*what is going on?*' and '*what is the main problem of*

*the participants and how are they trying to solve it?*'. The researcher assumed a second order researcher role and was aware of the potential of dominant drug discourses to affect perceptions of addiction and dependence among respondents and thus aimed to unpack the constructed nature of knowledge and talk within narratives (Martin & Stenner, 2004; Mills et al., 2006). A grounded theory approach to data collection and data analysis was employed to study this phenomenon (Glaser & Strauss 1967; Strauss & Corbin, 1990). Recognising the evolution in the development of grounded theory methods (Glaser & Strauss, 1967; Strauss & Corbin 1990; Charmaz, 2006), the researcher sought to situate the research within the grounded theory approach developed by Glaser and Strauss and subsequently built on by Strauss and Corbin. The grounded theory approaches advocated by Strauss and Corbin strongly reflect the epistemological and ontological premises of Symbolic Interaction and Pragmatism. Strauss and Corbin (1990) highlight the possibility to remove research bias as much as possible, through specific systematic data collection and an analytic coding paradigm, while also referring strongly to the role of reflexivity and sensitivity within data collection and data analysis.

**Research Situation**

Fieldwork for this study was undertaken in two counties situated in the South East of Ireland, during 2008. The fieldwork and sampling processes within this study were situated outside of the dominant urban heroin contexts in Ireland, and thereby the researcher feels it necessary to underscore problematic drug statistics of this predominantly rural research area. As of the 2006 census, the population of County A was 50,349, and County B's population was 87,558 (www.cso.ie). In 2008, 194 individuals entered treatment for problem drug use within the two

counties in the research area representing 3.1% of the total number of treated cases in Ireland in 2008 (ADRU/HRB, 2009). Of these individuals, 92 were previously treated cases while 98 were new cases, representing 3.7% of the total number of new cases in Ireland in 2008 (ibid). The average annual incidence of treated problem drug use within the two counties under study was reported in 2009 as being 108.6 per 100,000 (ibid). Figures from the National Drug Treatment Reporting System indicate change in heroin use patterns within the two counties under study, and within the wider context of the South East region of Ireland. In the research area, opiates are reported as being the main problem drug for 21% of new treatment cases (ADRU/HRB, 2009). In 2008, heroin was the second highest treated drug of misuse in the South East at 12.5% of all cases, rising from 10.3% in 2007, with overall clients treated in the region for heroin as a main problem substance increasing from 49 (3.5%) in year 2000 to 293 (12.3%) in 2008 (Kidd, 2009). In the particular counties under study 33.3% (55) and 11.6% (44) of the total number of treated cases for problem drug use involved heroin as the main problem drug in 2008 (ibid). Considering risk behavior, there is a significant increase in the number clients who have ever injected within both counties. In County A the percentage of clients who had ever injected increased from 29 (23%) in 2007 to 36 (31.8%) in 2008 and in County B a similar increase occurred between 2007 and 2008 with the percentage of clients who had ever injected rising from 15 (4.8%) in 2007 to 29 (7.6%) in 2008, almost doubling in a year (ibid). Significantly, in 2007 42.9% of all clients treated in the South East were treated for more than one substance or problem, with this figure increasing to 43.6% in 2008, indicating the growing phenomenon of polydrug use in the area (ibid). Also notable, is that within South Eastern Ireland, the number of females treated for problem drug use accounted for 24.5% in 2004, rising to 31.1% in 2007 and have since risen to 31.8% in 2008 (ibid). Within the South East region the average annual

incidence treated problem drug use among 15–64 year-olds is one of the highest in Ireland at , 125 per 100,000 of the population (ADRU, 2009). The majority of clients assessed and/or treated for problem drug use within the South East region are in the 20-24 year age group at 35.1%, followed by those in the 30-34 year age group at 27.7% then by those in the 25-29 year age group at 23.4% (Kidd, 2009).

To provide a context for the figures outlined above, Table One and Table Two below provide an insight into the level of residential drug treatment service provision available within, and to, the research area at the time of study.

## Table One - National Summary of Residential Drug and Alcohol Residential Services, 2007

| **National Summary of Residential Drug and Alcohol Residential Services, 2007**<br>(Population 4,234,925 - Census 2006) | | |
|---|---|---|
| **SERVICE TYPE (N)** | **NUMBER OF BEDS** | **ESTIMATED ANNUAL CAPACITY** |
| Stabilisation Service<br>(Note there are no stand alone units but beds reserved within the two MD Units) | 5.5 | 87 |
| Community-Based Residential Detoxification (2) | 15<br>53% (n=8) alcohol only | 170<br>69% (n=118) alcohol only |
| Medical Detoxification Unit (2) | 17.5 | 157 |
| Residential Rehabilitation (28) | 634.5<br>31% (n=197) alcohol only<br>12% (n=76) men only<br>0.04% (n=28) women only | 3652<br>36% (n=1310) alcohol only<br>3% (n=106) men only<br>1% (n=24) women only |
| Step-Down/Halfway House (14) | 155<br>76% (n=118) men only<br>10% (n=15) women only | 368<br>78% (n=286) men only<br>13% (n=47) women only |
| General and Psychiatric Hospitals HIPE and NPIRS databases) | 79<br>16% (n=13) illicit drugs<br>84% (n=66) alcohol via psychiatric services | 3,825 (NPIRS)<br>718 (HIPE)<br><br>(2005 data on cases not individuals) |

Source: Corrigan and O'Gorman (2008)

## Table Two - Summary of Residential Drug and Alcohol Residential Services within Research Area, 2007

| **Summary of Residential Drug and Alcohol Residential Services within Research Area, 2007**<br>(Population 4,234,925 - Census 2006) | | |
|---|---|---|
| **SERVICE TYPE (N)** | **NUMBER OF BEDS** | **ESTIMATED ANNUAL CAPACITY** |
| Stabilisation Service | None | None |
| Community-Based Residential Detoxification (0) | None | None |
| Medical Detoxification Unit (0) | None | None |
| Residential Rehabilitation (7) | 83 | 718 |
| Step-Down/Halfway House (3) | 28<br>36% (n=10) men only<br>32% (n=9) women only | 85<br>44% (n=37) men only<br>39% (n=33) women only |

Source: Corrigan and O'Gorman (2008)

**Data Collection**

Theoretical sampling was adopted as a main procedure within this study. This process of data collection involved the researcher collecting and analysing data at the same time, from the point of first entry into the field, deciding what data to collect next and where to find them, in order to further explore and build emerging concepts, categories and theory. As such, the research was an instrument of data collection, taking control of data collection and analysis. The inductive nature of adopting a grounded theory methodology required a flexibility of approach from the researcher, and this allowed the researcher to follow leads gained from the data collected throughout the process of the study (Charmaz, 2001). Data collection began with a number of gatekeeper discussions with a small group of local drug service providers (n=3), who provided vital information on current service delivery within the research area, and supported the researcher to identify initial concepts for exploration within the research, based on their experience of engaging with heroin users and or families of heroin users. The researcher was consistently aware of the potential for gatekeeper bias, and maintained on-going focus with gatekeepers for the necessity to facilitate access to stigmatised and vulnerable clients in a supportive and confidential manner. In order to recruit service provider stakeholders, research information sheets were forwarded to community, statutory and voluntary drug service providers. Information sheets outlined the aims and methods of the research project and what the study would entail, should they volunteer. Service providers were then contacted with a follow-up phone call to secure involvement and provide any further information necessary. Recruitment of heroin users was a combination of theoretical and snowball sampling. As concepts were identified and developed, the researcher contacted drug service provider stakeholders to recruit potential participants who could provide information to confirm/disconfirm the emerging

concepts. In practical terms this yielded a varied representation of research participants in terms of gender, and both current and previous level of engagement in treatment processes. As a result, the continuum of narratives confirmed and disproved emerging concepts from the triangulated data sources. Access to heroin users was facilitated by service providers in all but one case in which a research participant was recruited through another user, using snowball sampling. The researcher spent time on two days within a local drug treatment service to recruit and interview research participants, with the support of a worker within the treatment service, while further interviews were conducted with research participants on an appointment basis. In conducting the interviews, the researcher went to locations arranged either directly with the participant by telephone, or previously by a gatekeeper, based on ensuring confidentiality and safety for both researcher and participant.

The primary data collection method for this qualitative research study was in-depth interviews. The in-depth interviews aimed to understand the meaning of participants' experiences and realities pertaining to experiences of heroin detoxification-seeking. An interview guide was developed and modified from interview to interview, based on the aforementioned research questions and emerging concepts. Themes emerged from ongoing analysis of interviews, and explored in subsequent interviews. Participants could give a richer picture of seeking detoxification, based on their own identified issues of priority. The interview guide was designed to encourage participants to talk, and throughout each interview, questions were asked in a conversational tone. During the first part of the interview, the researcher firstly facilitated the opportunity to hear the participant talk about particular aspects of their life relating to their experiences of heroin use as they wished to provide, in order to provide context for subsequent

questions. The researcher then proceeded to enquire directly about the participants' experience of seeking opiate detoxification. On occasion, individuals indicated that they wanted to speak directly from the onset of the interview about their experience of seeking detoxification, and in these cases participant's were free to provide as much or as little context as were willing to share. The second part of the interview covered participants' experiences of seeking detoxification. Questions were directed toward the circumstances that led the participant into detoxification or other treatment services, how the participants perceived their experiences, and how the experiences affected their lives.

The researcher collected data through verbatim interview answers to questions, and participants' own exploration of the questions. The focus of the interviews was to derive data that described the experiences and perceptions of the participants in their own words. Interviews were conducted in an informal manner in order to obtain information from participants in a comfortable, conversational manner. Techniques were used in the interviews to encourage and establish rapport between the researcher and participants. These included repetition and clarification of questions, providing information, body language and eye contact. Each interview was audio-taped when permitted. However, two participants chose to not give their permission for audio-taping. Audio-taping interviews allowed the researcher to concentrate on what was being said by the participants. Furthermore, the audiotapes captured laughter, sighs, silences and participants' questions and exploration, all of which are considered aspects of an interview that are '*vivid'* and '*revealing'* (Padgett, 1998). Each participant was interviewed for approximately half hour to an hour. The reported personal experiences of heroin detoxification-seeking took place both within and outside of the research area, and over an extended period of years. In total

9 representatives from drug service provider stakeholders (community, statutory and voluntary) provided information on their professional experiences of engaging with heroin users during help-seeking, and their professional experiences of engaging with concerned persons who were help-seeking for a family member, and 12 individuals who had experienced heroin dependence participated in the study. The main criteria for individuals who experienced heroin dependence participating in this study were; to be over 18, and to have a history of heroin dependence while resident in the chose research area. In order to maintain a reflexive, sensitive approach to the data collection process, and thus reduce bias, field notes were written and maintained after each interview, in order to identify any challenges or areas for improvement within the data collection process. Also, regular meetings with academic supervisor and the group of local gatekeepers provided opportunity for reflection on practice.

**Data Analysis**

As stated previously, throughout this research study, collecting data, organising and analysing the data, and developing a theory occurred at the same time. As such, the interpretation of knowledge by the author was constant throughout the research process. Interview material was analysed using a grounded theory approach on an on-going basis, which allowed a theoretical framework to emerge from the data through a consistent process of inductive and deductive thinking. On a practical level, interviews were transcribed, and field notes ordered as soon as possible after each interview, usually within one day. Immediately following each interview, the researcher also digitally voice recorded any immediate thoughts, feelings or ideas which the researcher contemplated after the interview. Memoing was carried out with each transcript over a period of time, which involved the researcher reading and re-reading transcripts, so that the

researcher was able to become '*immersed*' again in the words and meanings that had been expressed by the research participants during interviews. Identifying concepts involved writing ideas and codes within the margins or interview transcripts, writing possible explanations for behaviour which were logged for later use, using MSWord and MSExcel. Sometimes data analysis involved the researcher creating diagrams manually to map behaviours and experiences of participants. Concepts emerged from each analysis of an interview, which were then also confirmed or disconfirmed by deliberate exploration in subsequent interviews. Pieces of data were copied and cut from transcripts and placed under a descriptive code, in order to visually see a concept develop, and be able to place coded excerpts within one or more concept, and later category.

Data analysis involved various specific methods, which were not altogether separate, but rather were carried out by the author in an integrated, inductive manner, together with, and after data collection. Open-coding involved the data being analysed by the author by '*breaking down'* data into concepts, that is, '*words that stand for ideas contained in the data'* (Corbin & Strauss, 2008:159). The author interpreted the data and developed concepts in terms of their properties, that is, the characteristics that define the concept, and also recognising the dimensions of the concepts, that is the variations within the properties of the concept. Concepts represented a collective of similar incidents, actions, perceptions and behaviours within the described experiences of the research participants. Constant comparative analysis was a key procedure within the open-coding phase of data analysis. Each incident, action, perception and behaviour was compared against others for both similarities and differences in properties, and those that were found to be similar were coded with the same conceptual label, until all data was coded

within at least one concept. Concepts were developed and defined by the author as either context or process, based on interpretation of the raw data; the narrative. Process is on-going action, interaction, action, emotion which is taken in response to '*something*' (the context); the issues, situations, goals, problems and events which are occurring in someone's life (Strauss & Corbin, 2008). Axial-coding involved the development of '*higher-level*' concepts, by which the concepts were grouped together into categories, according to their shared properties, until conceptual saturation was reached. Categories were developed largely based on a paradigm offered by Corbin & Strauss (2008) which was used by the researcher to identify concepts as being conditions, or actions, interactions and emotions, or consequences. Conceptual saturation of a category was reached when a category was developed fully in terms of its properties and dimensions, and all variation was accounted for. When the author considered that theoretical saturation was reached, that is that all categories were well developed in terms of properties, dimensions and variations, and it was deemed that further data gathering and analysis would not offer new knowledge to the conceptualisation of data, the process of data collection was over. This was considered to be achieved by the researcher following an extensive period of data collection including gatekeeper discussion, interviewing, extant literature analysis, and reflection on the meanings and symbols contained in the narratives, which occurred over a two year period. Throughout the process of data collection and data analysis, in order to raise findings to the level of theory, the researcher sought to discover a '*core category*', which would represent the main theme of the research, and to which all other categories could be related. The process is described as '*integration*'. Strauss & Corbin (2008) described integrations as follows;

> "*Integrating means choosing a core category, then retelling the story around that core category, using the other categories and concepts derived from the data*" (2008:107)

The process of integrating was lengthy, and in essence spanned the entirety of the data collection and data analysis phase of the research study. On a practical level the process of integration involved on-going '*rough*' note writing, and diagram development, in order to link the categories together in a theoretical construct which would explain the story of heroin-detoxification seeking in Ireland. As a tool, the researcher used a causal/conditional matrix (Strauss & Corbin, 2008), to identify the location of main processes within the categories. Categories were also analysed for links between the conditions, actions and interactions, and consequences within categories. Through on-going integration a core variable was discovered which explains the '*when*' and '*why*' of heroin detoxification-seeking; *'forging a pathways towards abstinence from heroin'*. Theoretical constructs explain the connections between the core variable and conditions, actions and interactions, and consequences of the experience of heroin detoxification-seeking. In essence they represent the '*who*', '*how*' and '*what*' of heroin detoxification-seeking. The theoretical constructs are effectively the three main processes which make up the experience of heroin-detoxification seeking in Ireland; namely *'recognising a problem', 'help-seeking'* and *'navigating the journey'*. The core category and the theoretical constructs are referred to together as a grounded theory of heroin detoxification-seeking.

**Ethics**

When commencing the study, the researcher was personally aware of ethical questions such as, '*what are the consequences of the study for the participants?'; 'and for the wider community?'; 'how can informed consent of participants be ensured?'; 'how might the researcher's role affect the study?'*. Several key steps were taken by the researcher in order to address such questions. To ensure voluntary participation, at the beginning of each interview, the interviewee was made

aware of their right to refuse to participate, and to withdraw from the interview and the study, without prejudice whenever and for whatever reason they wished. All details from the information sheet were repeated, in understandable terms to the interviewees, at the beginning of each interview. Participants were informed that they were allowed to ask for clarification on any aspect of the study during all stages of the interview. The methodology was conducted in accordance to standards set by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2005) and in accordance with the NACD's Guidelines on Good Research Practice – Research Ethics (2005). The researcher recognised that heroin users may be vulnerable for a multiple set of reasons, due to the nature of addiction, the potential for intoxication and of experiencing withdrawal during the research process and was also aware of the impact which these contexts may have on informed consent, voluntariness and decision-making capacity of research participants, and considered the importance of maintaining the confidentiality of participant's personal information (Kleber, 1989; Sugarman, 1994; Anderson & Dubois, 2000). The confidentiality of records and data generated by the research was protected at all times. The protection of informant's identities was a priority throughout the research. All identifiers were removed from transcript material and fictitious names substituted in all cases for the purpose of reporting study findings. Throughout the project, all material, including the notes and tape recordings from interviews, were securely stored and available only to the researcher. Great care was taken to prevent data being presented in a form which could identify the study's participants.

**Limitations of the Research**

There are a number of issues which can be considered limitations of this research and warrant recognition. This section is written in the context that the author is conscious of reflexivity and transparency in order to maximise understanding of the research findings and certain hidden contextualisations and limitations. Heroin users in this study are often not in contact with treatment services. Fountain (1999) describes how the majority of drug users remain hidden from treatment and drug services and that those in contact with services are often unrepresentative of the broader population of drug users, with regard to patterns of drug use, risk behaviour and health status. A limitation of this study is that although it managed to reach a number of heroin users who had never accessed formal treatment, it was not capable of targeting and reaching a larger number of such '*hidden'* individuals. Also, the study did not include drug users who are currently homeless, or in prison. A constructivist grounded theory approach (Mills et al., 2005; Charmaz, 2006) challenges a '*rethinking'* of the traditional role of grounded theory researcher as objective observer. The author agrees that conducting interviews as the method of data collection defines the role of the researcher as one which is consistently practical and influential and that in-depth interviewing could be conceptualized as a special type of partnership and cumulative performance (Marvasti, 2004; Miller & Crabtree, 2004). However, the traditional grounded theory approach recognizes researcher bias and seeks to work towards removing it while maintaining reflexivity and sensitivity throughout (Glaser & Strauss, 1967; Strauss and Corbin 1990). For example line-by-line data analysis ensured ongoing inductive analysis of the data and promoted the deterrence of the researcher's own beliefs and biases (Charmaz, 2000). Thereby this exploratory study offers a rich and unique insight into the rural experiences of those opiate users seeking detoxification.

**Research Design - A Reflection**

Strauss and Corbin (2008) suggest that all researchers, in designing and carrying out research studies, take what items from their '*menu of learning'* that makes sense to them at the time of the research. The methods which researchers choose refer to their own immediate work as well as the research aims. In this context, the community development and equality environment in which the research was employed at the time of the research study, and the researcher's qualifications, study and previous work in the area of social justice, emerged as central to the research contextualisation and effected the choice of a research design which recognised the importance of listening to those who are experiencing a social problem. At the time of the study, the researcher had experienced drug treatment provision in Ireland, as a concerned person, and in addition was living in an Irish town experiencing a rise in heroin use and a lack of local detoxification or stabilisation services. These factors underpinned the need for a systematic approach to the research in order to provide clear tools for data collection and analysis, and specific efforts to reduce subjective forms of bias which may be existent in second order research where the researcher is collecting and constructing stories based on constructions of reality by another person, the interviewee (Martin & Stenner, 2004; Mills et al., 2006). Table 3 and Table 4 below outline the detoxification experiences of the research participants interviewed within Group X, including self-detoxification from opiates and specialist in-patient opiate detoxification services. Pseudonyms have been allocated throughout the reporting of findings, and treatment status is not indicated as this may indicate identity.

**Table Three: Baseline Data for Group X Participants – People who have experienced heroin dependence**

| Heroin | Ever Injected Heroin | Ever Used Heroin | Ever Attempted 'Cold-Turkey' | Ever Attempted Self-Detoxification from heroin using Prescribed Medication | Ever Attempted Self-Detoxification from heroin using Methadone | Ever Completed Self-Detoxification from heroin | Ever Sought Access to In-Patient Detoxification | Ever Completed In-Patient Detoxification | Ever refused access to an inpatient detoxification service | Ever completed an outpatient methadone detoxification for heroin use |
|---|---|---|---|---|---|---|---|---|---|---|
| Total 'Yes' | 11 | 12 | 12 | 8 | 2 | 9 | 7 | 4 | 2 | 1 |

**Table Four: Baseline Data for Group X Participants – People who have experienced heroin dependence**

| Methadone | Ever participated in community based outpatient methadone maintenance | Ever sought access to community based outpatient methadone maintenance | Ever sought in-patient detoxification from methadone | Ever refused methadone due to relapse during maintenance programme | Ever participated in an outpatient methadone maintenance programme | Ever attempted 'cold turkey' or self-detoxification from methadone |
|---|---|---|---|---|---|---|
| Total 'Yes' | 7 | 8 | 2 | 5 | 2 | 2 |

# Section Three – Results

*Knowledge may not mirror the world, but it does help us understand it. (Corbin & Strauss, 2008: 11)*

## Forging A Path Towards Abstinence from Heroin

Heroin users who participated in this study had experienced periods of abstinence following voluntary cessation of using the drug in their past. A majority of the Group X cohort reported at least one period of being abstinent from heroin use which lasted at least twenty four hours. A smaller number of individuals reported experiencing at least one period of abstinence from heroin use which lasted at least one week, with overall reported lengths of periods of abstinence from heroin varying from twenty four hours to three years. Individuals reported achieving periods of abstinence from heroin use both while participating in, and remaining outside of, formal drug treatment provision. When trying to give up heroin use, research participants were active in shaping out, inventing, '*forging*' their own individual path to abstinence, the direction of which was influenced by both structural and agency factors. The category '*forging a path towards abstinence from heroin'* represents the inner experience of becoming abstinent from heroin, and the challenges and difficulties which research participants experienced in finding their way towards abstinence from heroin. Thereby this process of *'forging a pathway toward abstinence'* remained characteristic of a struggle for research participants, due to both the inherent internal difficulty to '*beat'* heroin addiction, and the lack of clear, accessible pathways within the treatment sector surrounding them.

However difficult it was to reach abstinence from heroin, research participants conversely spoke about several key factors which assisted them to forge a path towards abstinence which met their needs, hopes and goals. Individuals also spoke positively about the periods of abstinence from heroin use in their lives, regardless of the length of '*clean'* time, and despite relapse in many reported cases of abstinence. Research participants who achieved abstinence for a period of one week or longer reflected on the clarity of thought and opportunity to engage in a reflective process which a period of abstinence provided, and expressed pride in the fact that they had been able to stop using heroin at least on one occasion. For some, seeking heroin detoxification was part of the path they forged which lead them to abstinence, while others chose to remain outside of formal detoxification service provision. The context of a decision to seek, or to not seek detoxification changed over person, time and place. This perspective was mirrored in the accounts of service provider stakeholders who emphasised consistently that detoxification as a treatment option for heroin use is considered by individuals for varying reasons, and indeed is not an option considered by all heroin users that they engage with. Here follows an illustrative narrative by a service provider;

> *It's mainly detoxing with a view to getting treatment..........but the reality is like, ye know, sometimes it's not the goal, or it's not our goal to detox everybody. Well I suppose, it's important if the client thinks it's important. So, it needs to be client driven. Because like, if they can detox then they can attend a treatment centre or have a better quality of life even. Nobody can attend ye know rehab, or a treatment centre if they are not detoxed. My experience of it is that like normally when people are going down the level of detox, ye know, they may have it in their mind or may not have it in mind to go for treatment, they may just want to do it for themselves. (Drug Service Provider)*

Research participants expressed that when they ceased using heroin, an inherent step for them on the journey of achieving abstinence was coping with withdrawal from the drug. Heroin users in this study chose to cope with withdrawal from heroin by self-managing withdrawal outside of formal drug treatment, and/or by seeking detoxification within formal drug treatment. Both structural and agency factors influenced this decision. Many of the heroin users in this study chose to self-manage their withdrawal from heroin, using other drugs, or by going '*cold turkey'*. Individuals who did not attempt to self-manage withdrawal from heroin reported an individual decision process based on lack of knowledge of the process of withdrawal, a desire for formal treatment support, and/or awareness of the risk of relapse during self-detoxification. Such heroin users in this study were often however, unable to access a formal heroin detoxification service. In many of these cases an individual decision making process dictated an alternative means of completing withdrawal from heroin, such as approaching a General Practitioner for prescribed medication, or availing of methadone maintenance. Heroin users who did seek detoxification, sought detoxification from both regional and national in-patient services, and approached other heroin users and non-detoxification services at community level for information and support (General Practitioner, drugs counsellour, methadone clinic).

Thereby, the concept of '*forging a path towards abstinence from heroin'* portrays challenges, decisions and tasks which research participants faced in finding '*the*' way to abstinence, and the fact that in reality there was no one '*way*' found to seek and achieve abstinence. As in the case of detoxification-seeking, or not, research participants defined their own journey towards abstinence by creating a path using their experience, perception and knowledge of heroin dependence, withdrawal and relapse. The direction taken towards abstinence changed over person, time and place, and the journey was often repeated, and modified, following relapse to

heroin use. Below is an outline of the three conceptual processes within '*forging a path towards abstinence from heroin'*, which occurred concurrently for some research participants, and as a series of steps for others.

**Forging A Path Towards Abstinence: Recognising a Problem**

Research participants provided a wealth of information which described their experiences of '*recognising a problem'* that led them to began their journey of forging a path towards abstinence from heroin. The concepts (actions, interactions, emotions and behaviours) that are encompassed in recognising a problem related to heroin use, and wanting to be abstinent, provide insight into the context and conditions of heroin detoxification-seeking. All of the research participants who participated in this study, who experienced heroin dependence, reported that for the most part of their heroin-using career, they were aware of, and reflecting on, the negative effect of using heroin on themselves, and their lives. For the majority of research participants, the negative effect of using heroin was experienced almost on a daily basis, throughout their heroin-using career, as a sense of weariness of the reality of life '*on heroin'*. On-going challenges and risks inherent in living with a heroin addiction were highlighted by research participants, mainly in terms of social exclusion (facing stigma in the community and '*labelling'*), the heavy financial burden of the cost of heroin, effect on family and personal relationships (including having children taken into care), inability to work or get a job, lack of life opportunities, loss of control and physical, emotional and mental ill-health ('*paranoia', 'fear'*). The narratives below, provided by Lisa and Sarah, provide further insight into the impact of heroin dependence, and the *'control'* which the research participants felt heroin had

over their lives.

> *I've hit the point where I've had enough, I'm on it (heroin) a good few years now and I've just reached the point where I want to be normal…………just to be able to go to sleep at night and not have to worry what am I gonna do for tomorrow, who am I gonna borrow off. (Lisa)*

> *From the minute you wake up in the morning you're thinking about it (heroin), where am I going to get money for it. Or, you wake up in the morning, ye do it, then the minute you have that done then it's 'where am I going to get the money to have my next hit'. Like all day everyday it's on your mind, you're either doing it or you're thinking about where you're going to get the money to do it or you're thinking about how am I going to get off it or, you're whole life is took over by it........say at night time or ye know even you're sitting there and someone just walks by and yer thinking I'd love my life to be back to the way it was, I'd love to be in control of my life just the way that girl is…….. cos ye have no control over your life anymore. (Sarah)*

A majority of individuals reported that the impact of heroin dependence on themselves and their lives often prompted them to resolve to address the problem by attempting to stop using heroin and '*get clean'*, as they desired a '*better'*, drug-free life for themselves, or their family. A majority of research participants described their motivation to attempt to stop using heroin as being grounded in their prioritisation of factors such as having a family, caring for children, and gaining or maintaining employment. Mary provided the following description of when she first injected heroin, and subsequently realised that she wanted to give up heroin as she was aware of the conflict that existed between incurring the health risks of injecting drug use and her personal desire to have a family in the future.

> *I always thought about coming off it (heroin) and I knew that I needed to come off it if I wanted any kind of a normal life at all…………. I was always thinking about it so I was and then I*

> *actually kind of started really realising that I needed to come off it, and then I just realised how bad I was after getting (injecting), and I knew that I needed to cos I was gone so far, ye know, and actually cos I'm (age deleted) now and I wanted to, I want to, have a family. (Mary)*

Attempts to stop using heroin were also experienced by a number of research participants as being motivated by goals other than achieving long-term abstinence and a drug-free lifestyle. Two research participants recalled attempting to stop using heroin in order to have a '*breathing space'*, to recuperate physical and mental health at times in their lives when they felt their health had deteriorated significantly, consequential to their heroin use. Two further research participants reported their attempts to try to stop using heroin, in order to avoid a judicial sentence. The narrative below describes the experience of Joe, a male research participant in the study.

> *I've had court cases and that, where I'd have to give clean urines every week, so I'd just quieten up a bit for the 3 days, get clean, do the urine and go back using again, I was doing that nearly every two weeks. I didn't want to get clean, I was only doing it cos I didn't want to go to jail either. (Joe)*

Significantly, a majority of research participants who were participating in a methadone maintenance programme at interview also expressed that they were regularly reflecting on the negative effects of using methadone, on themselves and their lives. All research participants who were participating in a methadone maintenance programme at the time of interview expressed that they were participating in the methadone maintenance programme with a goal of being detoxed from methadone within a year, or under. Many of those who were participating in a methadone maintenance programme at interview, reported a desire to be methadone free due to factors such as an inability to maintain a job and at the same time meet the requirements of a

methadone programme based outside of their immediate locality (travel, appointments), a '*fear*' of becoming dependent on methadone long-term and thereby living with a similar loss of control and lack of autonomy in their lives, and a desire to be completely drug-free. The narratives below provide an insight into this process.

> *I've been on 60 (mls. of prescription methadone) now for a while, and like I don't want to be on methadone maintenance. (Lee)*

> *Well I want to be able to have a working life ye know. I physically wasn't able to do it, like I said I was working and have to be home every day for the methadone and then twice a week you'd miss for to go to a clinic ye know, so it was very hard work around it and it the end I just had to leave the job ye know, and basically found it too hard to work it. (Barry)*

> *Well I kind of gave myself a year, like I don't want to trade heroin for that (methadone) like, I don't want to get stuck on methadone either, like I went up to 80 and I'm on 60 now and I'm going to get down to 30. (Joe)*

**Forging A Path Towards Abstinence: Help-Seeking**

Individuals who participated in this study reported their varying formal and informal strategies for trying to achieve abstinence from heroin. Some research participants decided to seek formal help, while others did not. Service providers also spoke of their awareness that a significant number of heroin users in the research area remained outside of the formal treatment provision available to them. Significant to this study, heroin detoxification-seeking was but one among many potential strategies along the path towards abstinence, described by both heroin users and service providers who participated within this study. Within narratives provided by heroin users, deciding to seek help, or not, with becoming abstinent from heroin was relative to person, time

and place. Individual research participants expressed that their level of personal knowledge of heroin dependence, withdrawal and relapse when they decided to stop using heroin, and a variety of personal needs (psycho-social, health, family, work) were influential in inhibiting or facilitating them to seek formal help. In addition some research participants decided to stop using heroin aiming for both short-term breaks and long-term abstinence, as outlined in '*recognising a problem'*. There appeared to be a varied continuum of knowledge, perceptions and experiences of formal drug treatment when deciding to seek treatment or not.

Strategies for becoming abstinent from heroin varied between individuals, and were often situated among multiple experiences of attempting to stop heroin use within an individual's drug-using career. Based on the data provided by research participants '*deciding to seek treatment, or not'* can be conceptualised as a '*knowledge rich'*, or a '*knowledge poor'* experience for heroin users, depending on their experience and knowledge of heroin dependence, withdrawal and relapse. Whether or not research participants chose to seek treatment or not, was influenced by their own definitions of their needs, and their goals. For some heroin users, defining personal needs and goals towards abstinence was described as an ill-informed process, due to the fact that they were not sufficiently informed on the impact of heroin dependence, or withdrawal. In particular, ceasing heroin use, or abrupt cessation of prescribed methadone use, for the *first* time were described as significantly vulnerable, confusing and lonely experiences. Attempting to stop using heroin for the first time was characterised by personal lack of knowledge of the effects of heroin dependence and lack of knowledge of the process of withdrawal from heroin, in tandem with the subjective realisation that the individual was in fact '*strung out'* on heroin. Such reported experience is captured in the descriptions provided below

by two men, and a woman who participated in the study.

> *When I first had the sickness I thought it was the flu or I didn't understand what was wrong with me, I didn't know I was sick from I wanted more heroin like, but that's what one of the lads when I rang him up who I was getting it from and he explained it to me, 'you're stuck on heroin now you're going to have to come and get a bag to get rid of the sickness', like the dealer was saying to me on the phone. (John)*
>
> *Well I didn't even know that you could get them (withdrawal symptoms), cos I was only on it a short time, I didn't know that there was a sickness at the start. (Sarah)*
>
> *It just hit me, it hit me 6.30 of a Sunday morning, I just didn't know what hit me in the bed, I started screaming and my father ran in, I just didn't know what was going on really. (Lee)*

In some cases of forging a path towards abstinence from heroin, research participants also reported at least one experience of a lack of knowledge of detoxification services inhibiting them to seeking detoxification. This lack of knowledge was located within early experiences of trying to stop using heroin. Similarly, for many of the heroin users interviewed, the *perceived* lack of other treatment options was reported as a significant factor in influencing self-detoxification as a perceived '*only*' option during initial help-seeking. The accounts overleaf illustrate the impact of some of the barriers which research participants experienced to seeking in-patient detoxification.

> *'I think it's because I didn't have enough information, because it was all kind of new to me, because all the people I used with they were using a lot longer than me or they knew they knew all about it, I actually just didn't know where to go or where to start or what to do and I think that's why I did it (withdrawal) on my own, I just didn't know what to do' (Sarah)*

> *I was advised by them to go into residential but I didn't want to with work, I thought work would find out, I didn't want to take the time off work, I was being promoted, I didn't want this to come up. (Bob)*

It is not surprising then, that '*first'* and early experiences of attempting to stop using heroin were described by research participants as being characterised by self-management of withdrawal from heroin using other drugs, and/or attempting to go '*cold turkey'*, that is to attempt to self-manage withdrawal without the use of any other drugs, or alcohol. In the context of lack of awareness of heroin dependence and withdrawal, it can be theorised that deciding to not seek detoxification during early stages of drug using was centralised by inherent lack of awareness that processes such as self-detoxification or '*cold turkey'* often do not result in abstinence.

Conversely, during later and latter stages of their heroin using career, some individuals also decided to not seek detoxification, and consequently to self-manage their withdrawal from heroin (including by '*cold turkey'*), having defined their personal needs and goals within a '*knowledge rich'* context of strong awareness of heroin dependence, withdrawal and relapse. Research participants reported deciding to attempt cold turkey, and/or self-detoxification using '*black market'* methadone during various stages in their drug using career which could be described as later stages. In some cases, research participants reported experiencing '*cold turkey'* as they preferred to not manage their withdrawal from heroin with prescribed medication, or any other drugs, considering the risk of developing another dependency.

> *I did it that way (cold turkey) cos I'm not dependent on anything now, I don't need any medication, I don't need any doctor. (Mary)*

> *I could do me detoxification on valium and sleepers but that's not right either, you're getting strung out on other things then, you're getting strung out on valium. (Lee)*

A method of self-managing withdrawal from heroin which was described by research participants was using methadone over a number of weeks. Three participants reported ceasing heroin use and self-managing their withdrawal symptoms with the use of street methadone. In all cases the methadone was obtained on the '*black market*', and the research participants attempted the self-detoxification in areas outside of where they lived and used heroin. The narratives below provide an insight into the experience of using methadone to manage withdrawal from heroin.

> *I'd buy methadone on the street and I'd go down the country for a week or two, and I'd detoxification myself down to something really small, and then I'd start at it again (Bob)*

> *I can't go through the withdrawals without anything, not only is it dangerous, it's too painful, it's horrible, so I just kind of got the phy myself and just took it and then every 2 weeks reduced it gradually and then within a few weeks I wasn't on anything at all, back to normal, start again, my appetite started coming back and I was clean again for 2 years after that (Lisa)*

In most cases such as those outlined above, research participants described that attempting to self-manage their withdrawal symptoms as the most available and accessible method of detoxification which they felt met their needs and goals at that particular time. Such research participants who chose not to seek opiate detoxification when decided to they stop use of heroin concluded that they did not need '*residential*' treatment at the time, or could not in any case avail of in-patient detoxification due to a lack of childcare support, or a commitment to work. The factors which prevented individuals to seek in-patient detoxification included family and work related factors, such as lack of childcare and an inability to take an extended period of time off

work without facing job loss.

In forging a path towards abstinence from heroin, in most cases research participants had at least one experience of seeking help, from a General Practitioner. Research participants described seeking help from a GP as their *first* help-seeking step, within the service provision sector, towards becoming abstinent, and as an on-going action within their drug using career. Research participants approached GPs in two contexts; during '*knowledge poor'* early stages of drug using and looking for detoxification and/or guidance from a GP, and during '*knowledge rich'* later stages when looking for referral or prescribed medication to ease withdrawal symptoms during self-detoxification.

During first time help-seeking from a GP, in many cases research participants reported a fear and '*shame'*, in identifying themselves as a heroin addict. Many of the research participants felt very anxious, or nervous, prior to speaking with the GP, with regard to disclosing their addiction to heroin. Service users expressed a sense of fear due to the stigma which they are aware surrounds heroin use, and heroin users. Research participants reported a sense of fear in particular in speaking to their *family* GP, for the first time, about their heroin use. The narrative below provided by a drug service provider echoes the sentiment which research participants expressed.

> *It's a sensitive issue obviously in that some people don't want to be identified in particular with a drug problem, and they do have issues there, but more often than not they are willing to go to their GP. (Drug Service Provider)*

Drug service provider representatives who participated in this research study also reported referring individuals who approached them seeking help for giving up heroin use, and concerned

persons, to GP's in their locality. This concept is illustrated by the account below which indicates that in the case of being approached by a drug user who expressed a desire to cease heroin use, that referral to a general medical practitioner was the first step, and the perceived only immediate option available to the worker, in the context of lack of specialist detoxification services.

> *The best thing I can do for them is to refer though their GP, and I suppose it develops from that point onwards, the GP is the one service that is particularly available to the rural user. (Drug Service Provider)*

Seeking help from a GP was reported in the majority of cases as resulting in attempting and in some cases, completing, self-detoxification using prescribed medication to manage physical withdrawal symptoms, such as clonidine, loxefidine or valium. In most cases, research participants reported at least one experience of self-managing withdrawal from heroin, in a home environment, using medication prescribed by a GP. Seeking help from a GP to manage withdrawal from heroin was not isolated to early experiences of cessation of heroin use. A number of research participants reported that throughout an extended career of heroin use, over 3 years or more, that they attempted and/or completed a self-detoxification more than once, with the use of prescribed medication, accessed through a therapeutic relationship with a GP.

The overall experience of managing withdrawal from heroin through a self-detoxification in a home environment, either by '*cold turkey'*, or with the use of other drugs was described extensively by research participants. The majority of respondents indicated that self-detoxification is a very difficult process to endure, and that '*it's hard to get drug free on the outside'* (of detoxification service provision). The process of self-detoxification was largely described in harsh terms; '*impossible', 'constant agony'*. The experience of managing

withdrawal in a home environment was mainly reported as resulting in being '*back out there again'*, using heroin, as described in the narratives below provided by a female and a male research participant.

> *You're there 'aw I can't do this' and you're just gone off then and ye start using again like so you don't really think about. (Lisa)*

> *Ye'd be awake for 5/6 days if ye don't have any tablets like, trying to do a detoxification yourself without anything at all like. I've tried that loads of times. I just could not. (John)*

Research participants provided extensive narratives which described that they found self-managing withdrawal from heroin extremely difficult, not only physically, but mentally and emotionally. The narrative below was provided by a female user who described an early experience of cessation of heroin use and coping with withdrawal without any other drugs, prescribed or otherwise.

> *Well with me I was just an emotional wreck as well, I was in pain physically n' all but it was my head, the mental pain like, the emotional part n' all, that was the worse, it was really bad like things that ye wouldn't think about when you're on heroin like all at once going through your head, like everything like, and you're just crying and you're thinking of I mean say everything, things that you're never thinking of like, it's just so hard. (Sarah)*

Research participants reported the significance of the ease of access to heroin during self-detoxification, and the desire to use again as the most challenging factors to overcome during self-detoxification. The narrative below provided by a male who was participating in a methadone programme at the time of interview conveys the mental anguish which a heroin addict can experience during self-detoxification.

> *I think the hardest thing when you're going through (self) detox is ye know you can walk out the door and down the road you can score and all your pain and all your problems will go away, and that plays havoc with you, for just 20 (euro) you can feel on top of the world again. (Bob)*

The '*serious danger'*, of coping with withdrawal by going '*cold turkey',* or self-detoxification with the use of other drugs, in terms of health-related risks were recognised and reported by service providers involved in this study, as conveyed in the narrative below.

> *And then there's the amount of people detoxing and going back on, detoxing and going back on, and they're all doing it on their own, serious danger. (Drug Service Provider)*

However research participants who had attempted and/or completed self-detoxification described that during their first experiences of self-detoxification they did not seek information from service providers on the process of withdrawal, rather they relied on the messages they received within their peer group of other heroin users. The narrative below provides an insight into this concept.

> *I mean I seen them when they were getting their tablets like ye know so kind of, just hear say like, people going back and using their old dose and their eh tolerance is down, just like they're urban myths or whatever, well they're not urban myths because they're true like but just that kind of thing like if ye know. It would have just been hear'say, there was no solid information from any medical people of anything like that like. (Joe)*

It is clear from narratives provided by research participants that the majority of participants have, at least once, managed their withdrawal in a home environment, either '*cold turkey'*, or with the use of other drugs (including medication prescribed by a GP), and successfully completed a self-detoxification from heroin. One respondent reported a period of abstinence of 6 months (at the time of interview) following management of withdrawal by '*cold turkey'*, while two respondents

reported a period of abstinence of between 1 to 2 months following '*cold turkey*'. One participant reported a period of abstinence of 2 years following self-detoxification with the use of methadone. Other research participants who reported successfully completing self-detoxification using other drugs maintained abstinence from cessation of heroin for varying lengths between 24 hours to 3 weeks. Completing self-detoxification was generally described as a collaborative process with others, for example family, health professionals or other drug users, in an information, support or caring role. Key factors which were described by research participants as being supportive in their experience of successfully completing self-detoxification from heroin were a strong motivation to become abstinent, support from family prior to withdrawal with regard to planning, support from family during withdrawal, use of drugs to manage physical withdrawal symptoms and contact with a drug service provider prior to ceasing use of heroin with regard to aftercare. In all cases of completion of self-detoxification a strong motivation to become drug-free was reported by the research participants. Some respondents described the power of the mind in contributing to completion of self-detoxification;

> *(I)Never really had a bad detoxification cos I'm very headstrong so I just get it into my head that I'll get there and I just grin and bear it.' (Joe)*

The role of family in supporting a heroin user during withdrawal was described extensively by research participants. Respondents reported contemplation of self-detoxification being easier in contexts of family support being available; *"I knew I'd be alright in my sister's"*. Of those who completed self-detoxification, the majority had family members present, and reported the help which their family provided; '*a cup of tea', 'someone to talk to'* as being a vital aspect of successful completion of self-detoxification. In some cases family members were involved in the planning of the management of withdrawal, or in the support of easing physical withdrawal

symptoms. The narratives below illustrate this concept.

> *They (parents) would have rang a doctor and asked what could be expected (during withdrawal), I had to bring my mother over with me (to the surgery) and she had to explain that it wasn't just to get stoned, that they were for a reason. (Joe)*

> *He (father, present) hadn't a clue and I just told him, I was going through withdrawals and that…….he just started giving me sleeping tablet. (Lee)*

Conversely, a small number of participants described the fact that they did not have support from family who were present in their home during withdrawal from heroin.

> *Ye he (father) doesn't like understand what ye go through like ye know when I was saying to him that ye do be sick coming off it like he thinks "oh yeh have just a little bit of pain maybe, but ye can do it like ye know". (Sarah)*

Research participants chose not to seek opiate detoxification when they stopped use of heroin when they were within one or more of the following contexts; first or early cessation of heroin use, '*residential*' treatment was not needed or wanted, did not want to detoxification over a long-term period within a methadone maintenance programme, had strong family support for self-detoxification, had a '*safe'* environment to complete self-detoxification. However, in many cases research participants also had at least one experience of seeking in-patient heroin detoxification, with a regional, national or international specialist service provider. Two participants reported seeking (and subsequently accessing) specialist detoxification services outside of Ireland. Two research participants described their active attempts to secure a place in a residential detoxification service in order to complete a detoxification from methadone over a shorter length of time than was possible within the methadone maintenance programme they

were attending. One research participant reported a personal experience of trying to stop using methadone, outside of the formal treatment by abrupt cessation of use of oral methadone. This process of self tapering from methadone appeared to underscore the aforementioned individualised attempts to reach abstinence via self-detoxification.

Research participants reported their first experience of seeking in-patient opiate detoxification as being after at least one attempt of self-detoxification and/or one completed self-detoxification using which resulted in relapse. Seeking in-patient detoxification was chosen by research participants who were trying to stop using heroin, had previous experience of self-managing withdrawal from the drug *and* one or more of the following; had previous experience of participating in drug treatment (including specialist detoxification), desired to access a residential rehabilitation treatment service, were caring for children and had childcare support from family, had a therapeutic relationship with another (with a drug counsellour, with a GP), had active family support (who were also seeking information and access to services), and those who had a strong desire to abstain from opiate use for long-term goals. Significantly, seeking in-patient detoxification was chosen by research participants who were trying to stop using methadone, in cases where individuals had strong personal commitments which they deemed were not compatible with being on methadone, had a strong desire to be drug-free and were conscious of previous relapse to heroin while on a methadone maintenance programme.

**Forging A Path Towards Abstinence: Navigating the Journey**

'*Navigating*' describes fact that an emerging and fundamental concept which was congruent throughout all of the narratives provided by the research participants within the study, related to

forging a path towards abstinence from heroin, is that the heroin users and service providers in the study defined the experience of heroin detoxification-seeking as a complex struggle, and one of many challenges which heroin users face in becoming drug-free, should they choose to seek help within the treatment sector. Many barriers faced research participants when they were seeking detoxification from heroin. Conversely, a number of factors facilitated research participants when they were seeking opiate detoxification. Knowledge acquisition and responding to service provision were key behaviours within the process of navigating successfully towards heroin detoxification-seeking. A number of research participants reported that despite seeking information on detoxification options available to them, that they experienced it as '*difficult*' to access information on detoxification services available to them. In particular research participants and service providers described the confusion that is experienced within the context of seeking in-patient detoxification from heroin for the first time, as the lack of detoxification service provision is generally *'unexpected'*. The narratives below describe the confusion that is a common aspect of seeking in-patient detoxification or other treatment-seeking for heroin use.

> *It (seeking detoxification) can't just be simple, it's an obstacle course…….travelling here to get this info, travelling there, it's ridiculous, it's impossible honest to God, and then, there's not that many detoxification centre……(Kate)*

> *Well anybody would expect that if there's treatment centres and you need to go to be detoxed to go for treatment, then how do you get there?....and I know there is alcohol detoxification and stuff like that, and that might be available but there is no opiate detoxification, so that's where I'm at, so like ye do have parents coming all the time just looking, because they, looking for some support or information but sometimes we don't have information because there isn't services*

*(Drug Service Provider)*

*I don't think it's easy to access any of the services, I don't know if that's a policy they have for addicts like if you really want it then you'll go looking for it, I suppose ye really have to want it, you really have to look for it, I didn't find it easy at all. (Bob)*

The vulnerability of an individual who is seeking detoxification from heroin was also described by all heroin users and service providers who participated in this study, with regard to the desperation experienced by heroin users in the context of compromised detoxification service provision, and restricted resources available to the person seeking detoxification. These concepts are described further in the narratives below.

*Because the choice was so limited I would have gone to wherever I was told to go practically (Owen)*

*Some addicts don't even have the money to ring these places, you can have use of the phone to do all that stuff whatever money ye get ye spend on drugs, or you don't even have a phone for people to ring you back (Bob)*

Barriers to accessing in-patient opiate detoxification services were faced by research participants who did seek in-patient opiate detoxification. Of those research participants who sought access to specialist in-patient detoxification services only 50% (n=4) gained access to a specialist in-patient detoxification service, all of which were regional, national or international detoxification services. A significant barrier to accessing detoxification services was the length of waiting lists which the research participants experienced. The effect of waiting lists within regional or national in-patient detoxification services is below conveyed in the narrative of a service

provider stakeholder.

> *It's (seeking opiate detoxification) em a nightmare, and it's a nightmare for everyone concerned, it's a major ordeal and I think it's absolutely disgraceful.....there's nowhere to go, there's a waiting list, and while they're waiting in the meantime they still have to keep taking the drugs, it's a no win situation, it's very frustrating, it's annoying and it makes you very angry (Drug Service Provider)*

The issue of waiting lists as a barrier to accessing in-patient detoxification services, as well as methadone maintenance programmes, was described by all research participants who had sought access to treatment for heroin use. Such barriers inhibited the timeliness of recognising a problem and *'wanting to get clean'*, and the pivotal motivation which research participants experienced. Several individuals described their experiences of contacting a service and being refused access due to a waiting list, and consequently continuing to use heroin. This is not surprising given the addiction potential of heroin coupled with serious withdrawal symptoms. In addition female research participants conveyed their difficulty in accessing a treatment facility for women, as conveyed in the narrative overleaf.

> *To think like of well where can I , well where do I go from here, like will I go up to the clinic, and then you're thinking about sure the way it is up there, it's months like ye know what I mean or where else could I go, well if I go to (residential treatment centre), its only for lads and they detoxification ye in there, there's nowhere for girls ye know that ye get methadone in there and they detoxification ye in there and then they have a service after, there's nowhere for girls for that, d'ya know what I mean, its madness like. (Sarah)*

A number of participants also highlighted their negative perception of a service, due to their first

hand experience, and indirect messages which they had received from other drug users about the judgmental attitudes of staff, as being a barrier to seeking formal treatment for heroin use.

> *I'd sooner stay on the heroin or whatever. It's like in (methadone clinic) they're just like cattle going into a slaughter, it's just like get them in, get them out like ye know, there's no compassion there at all like, and I think that you have to show some compassion in that job like ye know. (Joe)*

Together with facing barriers to accessing detoxification services, the frequency and ease of relapse to heroin use meant that the experience of seeking detoxification was an often repeated aspect of the lives of those research participants who chose to seek help within the formal drug treatment sector. All research participants reported experiencing relapse to heroin use, whether in the context of relapse after a period of abstinence following completion of self-detoxification, completion of in-patient detoxification, or participating in a methadone maintenance programme.

> *I've tried home detoxification myself, not with a doctor, like I'd always get down but then I'd go back out there again. (Bob)*

> *You're habit gets back into you really quickly and I know it's a battle you can't win, it doesn't take long to get back into it. (David)*

Considering the dearth of practical information which was available for those participants who experienced seeking help, research participants expressed that they continuously learned about, and responded to each personal experience of becoming abstinent and relapsing which they had. Personalised learning processes relating to individual relapse, and responding to this form of knowledge acquisition by accessing appropriate treatment during subsequent attempts to become abstinent was described extensively by research participants. Such processes underpinned the

navigational processes of heroin detoxification-seeking. The lack of change in user social environments post detoxification completion coupled with strong heroin cravings remained central to frequent relapse experiences, as illustrated by the narratives below.

> *I actually done it once…I was 10 days clean like, I only had tablets off the doctor like, just for pains or getting sick like…….but the minute I got me dole like I got it straight into my head like to get a bag and there I was like strung out again like ye know. (John)*

> *I had to go to hospital that's what it was and I did my detoxification in there, in hospital, but with nothing like, yeh, I was only on a drip I think it was and I got a sleeper at night time, but em I got off it then and I was off it for 5-6 weeks and then I went back at it again, yeh surrounded by like the same people, the same temptation and everything cos my boyfriend was on it and I had to go back to him and he was doing it in front of me and everything like on the first night, em then after that I never tried it with tablets or anything again, em that was it yeh. (Sarah)*

Research participants also described their sense of well-being after detoxification (self or otherwise) from heroin, which was described as a lonely time, full of worry, change and ill-health. This is captured in the narrative below.

> *Like ye feel really bad when ye come off, when you're detoxed and then when you come off drugs completely, and you just need some time to get your health back and relax, and not be paranoid and learn to laugh again, cos when you get drugs out of your system you're very raw ye know, and when you're walking down the street or when you're back in social circles ye do find it difficult ye know and it does take a good few weeks before ye build up your confidence again. (Bob)*

The over whelming factor which was reported in supporting abstinence following self-detoxification or completion of in-patient detoxification was a strong motivation to remain free from heroin, coupled with the presence of a support system including further treatment. The

narratives below describes this sentiment which was expressed by several research participants and service provider stakeholders.

> *They're ready in the time, it's not the place. If the addicts not ready no place will work for them ye know. Em I think if the addict is ready to give up no matter where they are it will work, but they need the supports in place as well. (Bob)*

> *I need to go to counselling and I go to counselling ye know (Mary)*

Alliance-building which research participants engaged in was a significant factor which eased the navigational process of heroin detoxification-seeking, and assisted heroin users in knowledge acquisition and forging a pathway towards abstinence from heroin. When individuals in this study decided to try to stop using heroin, they were active in creating new relationships (with local GP, drugs counsellour, non-specialist drug service providers), or using and/or strengthening existing relationships with others (family, other drug users), in order to have external support which would support them to navigate the process of treatment-seeking. Alliance building was initiated in most cases by research participants, by both those who sought detoxification within the formal drug treatment sector, and those who chose to manage their withdrawal outside of formal treatment provision. Consistent, positive, basic human contact such as listening, information provision, and support with contacting services were identified as supportive factors for those research participants who required access to detoxification services, or those who attempted and/or completed self-detoxification. Family and peer support, and the presence of a therapeutic alliance with a drugs counsellor, or a GP, emerged in the data as a significant supports in overcoming some challenges within the navigational process of heroin

detoxification-seeking.

When help-seeking heroin users in this study were often in a position in which they had a lack of resources, and were in a state of physical and or mental ill health, and consequently reliant on the support and advocacy of others. Vulnerability was experienced by the heroin users in this study, within the experience of detoxification-seeking (due to the presence of coping with the impact of heroin dependence, coping with physical withdrawal and the desire to become drug-free). In the context of lack of available detoxification services, support and advocacy for research participants to access other treatment, or simply have someone to talk to, motivated them towards becoming abstinent, and/or resulted in positive feelings of being helped, and being cared for. For example, in order to balance out the lack of information which research participants had when they first began to forge a path towards abstinence, research participants reported seeking information from other heroin users on what was going to happen during withdrawal from heroin, and seeking advice on how to best manage withdrawal symptoms. One female, described how '*there's no one like out there like if you get strung out on heroin 'this is what is going to happen, if you're sick this is what is going to happen', the only people that tell ye are the junkies that are around ye, ye ask them what's going to happen'*. The process of seeking information from other drug users was reported as being positive, and helpful with regards to the ease of access of information from peers, and the willingness of drug users to share information with each other. A negative aspect of receiving information from other heroin users, revealed by research participants, was the occasional inaccuracy of information received, as portrayed by the narrative below.

> *They (other heroin users) tell ye the symptoms that you're going to go through. I used to ask people that are after going through it (cold turkey) already about it and they'd, they'd tell me 'aw it will only last 3 days and you'll be alright', but it doesn't actually take 3 days like, it took me 3 weeks so it did before I was alright .............em they actually give you a lot of information because they're after going through it. (Mary)*

For the most part, research participants also described that they received empathy and support from the GP from whom they sought help, and defined their engagement with GP's as being a therapeutic alliance, characterised by information provision, provision of prescriptions for medication which eased the symptoms of withdrawal and referral to local, regional and national services such as counselling, methadone maintenance provider and specialist detoxification services. The narrative below illustrates the positive experience which research participants reported when seeking help from a GP.

> *I hadn't used my GP a lot, I actually went to another GP when I was on the heroin………he was a family GP for years, but in the end I went to him and he was very good, he's after referring me to a lot of places (John)*

However it must be noted that a number of research participants described their experiences of seeking help from a GP, as being not as helpful as they would have hoped. The particular research participants described their perception that they did not receive adequate information on the process of managing withdrawal with prescribed medication, and the fact that they chose to manage withdrawal using prescribed medication only in the context of lack of knowledge of treatment options.

*I went in and I told him that I was a heroin addict, and that I wanted help, and he didn't like talk to me or anything, he just wrote out, like this is my 1st time ever asking for help and he em wrote out a prescription for tablets and then that was it like, so I just went to the chemist then, I got the prescription and had to like figure out how do I do this or what do I take because I never went through it before like, he (GP) just like said about DF's, they take the pain they ease the pain like, and he said like d'ya want to do that and I said yeh, I need to do something like and that was it then. At the time I thought that was the only option, I didn't know like about this clinic (methadone) or I didn't even know what methadone was at this time, I didn't know any of that like, I didn't even know that ye could take tablets, I didn't know anything really so then when he said yeh can do a detoxification with tablets I thought well that was my only option cos he didn't say about methadone or anything, so I just took that option. (Sarah)*

Research participants described a positive process that was experienced during inpatient detoxification-seeking as being the therapeutic alliance with another individual. Others described seeking in-patient opiate detoxification experienced in collaboration with a family member, or a drugs counsellour who were also active in seeking information on treatment options, with the drug user and supporting the drug user with their decisions on detoxification options, and in accessing detoxification. The narrative provided below provides an insight into the various means which Bob found out about treatment options for himself, in collaboration with others.

*Mixture of places, other addicts definitely, em, family when they found out yeh, my mother must have done a shitload of research like ye know what I mean, so family would have been a big one, well at the start………and when I did it myself it would have been through other addicts, and meeting my counsellours. (Bob)*

The account below illustrates the collaboration with family members which was experienced by

some heroin users who sought in-patient detoxification.

> *We (drug user and family member) rang a load of places like, to try and get in like and they were pawning us off like, we were talking to some woman and she'd say oh no you have to ring this number, then we'd ring that number, they wouldn't even know what we're ringing for, or then we'd ring her and she'd put us onto someone else, like we were just going around in circles, like we were getting no satisfaction at all (Sarah)*

Research participants highlighted that the navigational process of seeking-inpatient detoxification, and indeed other treatment, would be less difficult with easier access to accurate information on services available to them, and consequently less of a '*struggle'* to find out what options are available to them, as experienced by some of the research participants when they lived in areas which offered a range of low-threshold services with access to information and support. Research participants offered their views that low-threshold services would improve their access to information on treatment options available to them, including detoxification.

> *Ye need people with experience and you need to have access to them on a regular basis, I think if you had some kind of a drop-in centre like, and ye probably need a needle exchange down here to ye know, someplace where you could go I there and there's different supports available cos you don't know about half the stuff that's there either like ye know what I mean and if you're having a shitty day or you're having a problem , there is somebody you can go to, even if it's just to speak to someone for 10 or 15 minutes, you don't need to have an appointment each time ye know, ye could sit around and you could have a coffee, I think that's something really important, with counsellours on site, people really need to feel comfortable there and I think that people are more comfortable talking to their own peer group. (Bob)*

It is notable that a number of participants accessed methadone maintenance in order to navigate

towards detoxification, and abstinence. Two research participants described their respective experiences of attempting to become drug-free, and managing their withdrawal from heroin, by accessing a methadone maintenance programme, after they had attempted to become heroin-free through self-detoxification. These particular research participants perceived the methadone clinic as the '*only'* treatment option available to them at a local, community level which met their personal needs such as looking after their children, and an avoidance of residential facilities. The narrative below illustrates this concept.

> *There's nowhere else to go, this (methadone clinic) was the only easy option where ye didn't have to go into residential care, where ye didn't have to get someone to mind your kids ye know. (Lisa)*

Some research participants who were participating in a methadone maintenance programme at the time of interview reported a supportive, caring, non-judgmental attitude form their prescribing GP, an opportunity to negotiate with the prescribing GP with regard to their dosage of methadone, as being supportive factors in maintaining abstinence from heroin use, and in forging a pathway towards heroin abstinence. Others reported that they felt strongly that if an individual relapsed to heroin use while on a methadone maintenance programme that they should not be '*kicked off*', and that this is actually a time when more support is needed, and not a punitive measure which they felt reinforced negative perceptions of self and heightened risk of relapse to heroin. Heroin users in the study reported that reducing the risk of relapse was planned by creating conditions/change in their lives that would best support their *chances* of maintaining abstinence following detoxification, and not relapsing to heroin use. Seeking alternative treatment, such as methadone maintenance was thus reported in the context of reducing the risk of relapse. Similarly, research participants who were seeking opiate detoxification reported a therapeutic alliance with a drug service provider (drugs counsellour) in

which they felt supported, listened to and cared for as being supportive during the process of detoxification -seeking, and motivating them to stay focused on becoming abstinent from heroin use. The need for aftercare, following detoxification from heroin was expressed by research participants who were seeking heroin detoxification at the time of interview.

> *Ye know I know that for me cos I'll be so emotional then like I do I need to talk to people like my way of dealing with things is by taking drugs and then when the drugs are finished I need to deal with my own problems and I need to learn how to deal with like I am in this little world say and I'm coming out of this world I know that I'm going to need help adjusting to my new lifestyle like, adjusting to now it is without drugs say cos its so scary thinking about it like......you're on your own in this big world and it's just adjusting to life, like it's a big change. (Sarah)*

Overall, individual experiences of detoxification-seeking were described by heroin users in this study within a framework of a dynamic continuum of potential processes encompassed in forging a path towards abstinence from heroin. Research participants described their experiences of detoxification-seeking as consisting of various related, and not necessarily ordered, actions beginning initially with information-seeking (most often from other heroin users and GP's); and subsequently, continued heroin, or other drug/alcohol use in the context of lack of services, attempting self-detoxification; completing self-detoxification, accessing stabilisation (methadone maintenance), seeking access to residential detoxification, accessing residential detoxification. Experiences of detoxification-seeking varied and were based upon previous experience and additional knowledge of service provision. In addition, research participants perceived that their, and others continued attempts to stop using heroin were negatively impacted on, by a lack of detoxification service provision. Consequently heroin users, particularly those in recovery, were anxious to support others to access detoxification or other treatment, and participate in the

development of detoxification services, either directly or indirectly. The next chapter shall contextualise and discuss the findings outlined above, within the greater extant literature base.

# Section Four – Discussion

## The Research Context

Throughout the research process, several key themes relating to heroin detoxification-seeking have repeatedly emerged. It is important to note that it is clear from the findings that that the individuals involved in this study collectively were not a homogenous group, and rather that their accounts represent a diverse range of heroin using experiences, needs and goals which in reality changed from person to person, and indeed, over time varied per individual user and heroin using context. In addition, it must be noted that the research was contextualised within a rural setting experiencing a recent increase in heroin use with consequential lack of detoxification services. Therefore, it must be asserted that heroin detoxification-seeking in South East Ireland is a complex, dynamic help-seeking phenomenon which is heavily affected by both internal and external factors, and dependent per individual drug trajectory and circumstance. There are however several worthy generalisations which can be made for the substantive area, based on the similarities and differences between accounts of trying to stop using heroin, and heroin detoxification-seeking provided by the research participants.

## Agency and Structure in Heroin Detoxification-Seeking

Firstly the role of '*agency*' and '*structure*' within the experiences of detoxification-seeking recalled by the heroin users in this study is significant. '*Agency*' refers to an emphasis on individual choice and action as the main organising principle of behaviours and experiences, while '*structure*' refers to the role of social and environmental factors as the key determinants of social life. It is apparent from findings within this study that there are structural, but more

prevalent agency factors which influence heroin users to seek detoxification. Firstly, considering structure, being drug-free is most often a pre-requisite for accessing a residential drug rehabilitation service in Ireland, and as such, the heroin users in this study who were unable to complete a self-detoxification required immediate access to a detoxification service in order to complete withdrawal from heroin safely, and pursue their goal of participating in residential rehabilitation treatment. Similarly, the majority of service users currently participating in a methadone maintenance programme expressed that they did not regard methadone maintenance as '*detoxification*', but in some cases referred to their participation within methadone maintenance within their experience of seeking opiate detoxification, as a consequence of non-available detoxification services appropriate to their needs. Resulting narratives are overwhelmingly conclusive however in underpinning negative life events related to heroin use, personal awareness of vulnerability during withdrawal, prior relapse experiences (whether during or after self-detoxification from heroin), a strong desire to become abstinent from heroin use and a supportive relationship with family or health professional (GP/Drugs Counsellour) as primary factors in facilitating the onset of detoxification-seeking attempts. Similar internal factors were present for those heroin users in the study who accessed methadone maintenance in the context of lack of detoxification services available to them. Similar to these findings, previous research highlights that significant adverse life events prompting concern and need for help, feeling the negative effects of drug dependence and having supportive relationships are key factors which influence drug users to seek help (Power et al. 1992; McElrath, 2001; Neale et al., 2007).

Barriers to seeking detoxification, or other treatment were also described by the heroin users within this study being both related to agency and structure factors. Similar to previous studies,

the individuals within this study described their fear or distrust of current treatment services, their negative perception of current drug treatment service provision and their awareness or disillusionment of waiting lists, as being the main factors which prevented them to initiate detoxification-seeking within the formal treatment sector, on occasions when they ceased use of heroin (Brooke et al., 1992; Sheridan et al., 2005; Howerton et al., 2007; Peterson et al., 2008). Many of the heroin users within the study also reported that they did not seek detoxification as they were '*knowledge poor'* when they were initially motivated to cease heroin use. Such participants described that they were not aware of the significant effects of heroin dependence, the challenges that withdrawal would present them, or indeed the treatment options that were available to them at the time. Structure and agency also had an effect on the overall experience of heroin detoxification-seeking in the lives of heroin users within this study. Lack of detoxification service provision in the research area resulted in the experience of detoxification-seeking being unclear, frustrating, difficult, and resource (time and money) consuming. Structural factors which contributed positively to the process of detoxification-seeking, in terms of bringing clarity through information provision or referral, included informal contact with others (drug users, family members) and/or a therapeutic relationship (drugs counsellour, GP), who '*navigated'* the journey of seeking detoxification together with the individual seeking detoxification.

Neale (2002) introduces the concept that people who are opiate dependent sometimes refuse offers of support, or '*manipulate*' professionals or treatment regimes to suit their own needs when they perceive services to be inappropriate, and that opiate dependent people are '*never*' completely reliant on any professional or supporting other, since they '*always*' have drugs. As

such, Neale outlines that drug users could seldom be described as subordinate to professional assistance. However, for those attempting to cease opiate use, in this rural setting in south eastern Ireland, the findings indicate that such drug users can be considered subordinate to policy and service provision, as their choices and desires for becoming heroin-free and completing detoxification safely are often compromised by a lack of detoxification service provision. The study has shown that very often, when seeking detoxification, individual heroin users are in a vulnerable position physically, emotionally and mentally, and as such are heavily reliant on the support of others to navigate the unclear pathway to detoxification. Whether or not drug users accept the subordinate position in which they are placed is explored by the findings of this study. The relationship between agency and structure is further explored through the findings that indicate that the heroin users in this study have, and are willing to, become involved in changing the current drug treatment service provision within the research situation, through activities such as a service user forum, meeting with GP's and promoting change in the number of Level 2 GP's in the research situation. In this context, a community development model emerges in which those who are experiencing the problem (a lack of detoxification services) are willing to be supported, by service providers, to participate in responses to the problems they and their peers are experiencing.

## The Location and Context of Opiate Detoxification-Seeking

Research shows that help-seeking is more common during stages of drug-use which are a significant length from onset of dependence, and in which a greater number of problems relating to drug use are being experienced by the user (McElrath, 2001; Neale, 2002; Dennis et al, 2005;

Hopkins and Clarke, 2005; Grella et al., 2009). Similarly within this study, individuals reported that help-seeking within the formal drug treatment settings were related to stages of heroin use which were characterised by lengthy onset of dependence, injecting heroin use, lack of employment, involvement in crime, and severe phsycial ill-health. However, similar to previous studies on help-seeking by drug users, the study shows that during the early stages of heroin use, the research participants did seek help for the management of withdrawal from heroin, albeit with non-specialist health professionals, namely local GP's, and other heroin users (Hartnoll et al., 1992; McElrath, 2001; Neale, 2002; Hopkins and Clarke, 2005). This is significant as this help-seeking behavior offers an early opportunity to create a positive experience for individuals who are actively looking for support with achieving abstinence from heroin use, and who are likely to relapse (Hopkins and Clarke, 2005; McElrath, 2001; Neale, 2002; Ward et al., 1999). Significantly, the majority of service users reported seeking detoxification from heroin as being their *first* formal contact with service providers in the context of treatment-seeking, and as a motivated step towards becoming abstinent. Help-seeking at this stage was located primarily within the community, mainly from local GPs, indicating that for many opiate users a community-based treatment option is the initial preferred option for heroin users during early help-seeking.

It is evident from epidemiological research that some heroin users can become abstinent *without* accessing formal treatment (Friedman et al., 2004; Ison et al. 2006; Bobrova et al., 2006; 2007; Petersen et al., 2010). Some heroin users manage their withdrawal from heroin outside of formal treatment. Studies suggest that pathways to abstinence from heroin, other than specialist treatment, are achievable, due to findings of heroin-free status, and harm reduction behaviours

among people who do not access specialist drug treatment for heroin use (Strang et al.,1998; McElrath, 2001; Neale, 2002; McIntosh and McKeganey, 2002) This study highlights several facilitating aspects along the pathways to abstinence from heroin use which were experienced by research participants, other than those relating to formal drug treatment. Risk and protective factors influence drug user's behaviours. A protective factor can be described as a factor that reduces the impact of a risk behavior, helps individuals not to engage in potentially harmful behaviour and/or promotes an alternative pathway to drug use (Broome et al., 1997; 1996; Spooner et al., 2010). This study shows that there are several protective factors within the risk environment which can greatly influence heroin users to initially and consistently seek detoxification, and thus potentially reduce harm to themselves. It has been suggested that internal barriers to seeking treatment can be reduced by engaging constructively with drug users going through critical emotional/ psychological changes, harnessing the momentum from pivotal life events, and involving supportive relationships (Horvath & Symonds, 1991; Power, 1992; Joe et al., 2001; McElrath, 2005; Neale, 2006; Neale, 2007; Grella et al., 2009). Factors within the risk environment which supported heroin users in this study to seek detoxification, included; the presence of a supportive relationship with family and/or the presence of peer support and information and/or the presence of a therapeutic relationship within the drug-using context. Most significantly this study shows that drug users are generally not trying to resolve the problems inherent in heroin detoxification-seeking on their own. For the most part trying to stop using heroin, managing withdrawal from heroin, maintaining abstinence from heroin, and, overcoming challenges of help-seeking involve a therapeutic alliance between the drug user and a service provider, or at the very least, a minimum level of informal therapeutic alliance between the drug user and peers or family.

**Significant Factors of Self-Detoxification**

This study reveals that heroin users within the study were particularly vulnerable to managing their withdrawal from heroin unsafely, outside of the treatment system, through attempting self-detoxification when they wanted to harness their *pivotal* motivation when they are compelled to cease heroin consumption. Research suggests that even if clear access pathways are available, not all opiate dependent users would enter treatment if offered (Zule & Desmond, 2000; Booth et al., 2003; Petersen et al., 2010). This study reveals that self-detoxification was often carried out by participants not as a response to a lack of services, but as a pro-active effort to achieve abstinence when motivation to stop using heroin was high, and a home based detoxification, with the support of family, was the method of managing withdrawal which they were comfortable with. It is evident from this study that at times individuals who were trying to stop using heroin managed withdrawal outside of formal treatment, which is an unsafe experience for them. Research suggests that self-detoxification attempts by heroin users are frequent (Strang, 1998; McElrath, 2001; Noble et al., 2002; Hopkins and Clarke, 2005; Ison et al., 2006). There is evidence within this study to suggest that self-detoxification from opiates is increasingly a normal part of the lives of heroin users. A level of this normalisation of self-detoxification can be viewed as inevitable, however it must also be recognised that within a context of lack of detoxification service provision, the normalisation of self-detoxification increases, not only among drug users themselves but among others in their environment, family members and drug service providers, and health professionals. Adapting the framework of normalisation as developed in the UK in the 1990s as a way of understanding the increase of illicit drug use (Parker et. al, 1998; Measham et al., 2001; Measham and Shiner, 2009), the normalisation of

self-detoxification can be located in the following characteristics of self-detoxification. Self-detoxification within the research situation was socially accepted, prevalent, accommodated, facilitated and mediated by sub terranean heroin user normative group dynamics. Thereby the research underscores the development of frequent detoxification attempts whether self led or medically managed as an inherent part of the heroin trajectory, and thereby somewhat exacerbated by the dearth of rural services. There is such a level of attitudes among heroin users of the merits of self-detoxification in becoming abstinent from heroin use, and a high level of availability of and access to prescribed medication and illicit methadone, that self-detoxification has become in itself, normalised. In-patient detoxification is most often sought following failed self-detoxification attempts, and as a pro-active step by a heroin user to create the conditions which they perceive, based on learning from previous self-detoxification and relapse will reduce their risk of relapse.

The majority of the opiate user cohort described experiencing episodes of both attempting self-detoxification which were successful (achieving abstinence for 24 hours or more), and attempts which were not completed. Most had made several attempts to self-detoxify, as the desire to become abstinent was *'always there'*, during active using. Respondents also reported significant amount of consultation with, and information seeking from other drug users in relation to, and prior to completing self-detoxification, and highlighted the ease of access to information from other drug users, and valuing the experiences of other heroin users. All respondents described at least one subjective experience of completing self-detoxification as being followed by relapse to heroin use within the short term, 1 day to 1 month. Current treatment status indicated that completion of self-detoxification did not result in longer term abstinence. Significantly, all

reported cases of completed self-detoxification involved an element of planning and preparation, either with family (providing a comfortable, safe place) or with a general medical practitioner (prescribing benzodiazepines). From analysis of the data provided, reports from service users indicate that initially seeking a safe process of withdrawal was mainly characterised by seeking help to cope with the physical symptoms of withdrawal, located within a community context and following at least one previous attempt of self-detoxification. The majority of the service user cohort reported approaching a local GP in order to seek medication to manage the physical symptoms of withdrawal.

**Meeting the Needs of Heroin Users in the Research Area**

The study '*unpacks'* the experience of detoxification-seeking for heroin use, and provides insight into the differentiating dimensions of needs among individual heroin users, and out-of treatment individuals. The study has also assessed the role of significant others within the experience of detoxification-seeking, in terms of the role of significant others in facilitating help-seeking onset and related actions. Analysis of heroin users' personal perceptions and ideologies relating to their drug use, of problems, of risks and of services within the wider context of their lifestyles indicate that within the research area, heroin user's are frequently in active seeking information and services, primarily at community level and primarily with a view towards abstinence. Locations and settings pertaining to detoxification efforts change over time and appeared contextualised within the variant forms of detoxification experiences mentioned by heroin users in the study. The heroin users' expectations of detoxification-seeking were inherently based on previous experience of detoxification services, and subjective knowledge of what detoxification

is per se. During early help-seeking the majority of heroin users were vulnerable due to a lack of knowledge of the treatment sector. As well as seeking support with withdrawal from heroin, they were also seeking support with navigating the treatment sector. As such they required clear, supportive information on detoxification and other treatment options. The presence of information-seeking among peers during early heroin use points to a significant potential for peer involvement in increasing awareness of recognition of problems related to drug use, and development of opportunities for peer health promotion and harm reduction methods as well as low threshold services such as drop-in centres and groups (Wright et al., 2006; Grella et al., 2009).

From analysis of data generated throughout this study, from both the service user and service provider cohort, it is clear that heroin-detoxification seeking, as a consumer experience, was both complex and varied experience for each individual heroin user, considering the lack of a clear access route to opiate detoxification within the climate of compromised detoxification service provision in Ireland. Consequently, from the perspective of people who use heroin, seeking detoxification for the first time is reported collectively as '*difficult'* process. The experiences involved lengthy processes of initial information seeking, repeatedly contacting limited detoxification service providers, liaising with non-specialist drug service providers and attempting and/or completing self-detoxification. Of the 12 research participants interviewed only 4 had completed at least one detoxification programme, all of which were residential. Heroin-detoxification seeking from the perspective and experiences of the heroin user cohort included seeking information and treatment, within the immediate community context, on detoxification options available to them, seeking referral from a local drug service provider or

GP to '*a*' detoxification service. This is significant as a large number of the heroin users within this study conveyed their preference for community-based treatment, indicating that community based detoxification services are a viable option for development within the research area. It is clear that not all drug users seek treatment or, in the context of this study, seek heroin detoxification. However it remains that completing self-detoxification is unsafe with regard to medical consequences, and also the impact on emotional and social health of the individual. The risk environment therefore not only involves heroin use as primary risk, but also incurs these frequent (and unsuccessful) self-detoxification attempts supported by lay knowledge and lay drug discourses, thereby increasing the potential for harm (Rhodes, 2002; Miller, 2005; Bahora et al., 2009). The frequency of self-detoxification reported by research participants is a worrying phenomenon. Research shows that successful treatment pathways for heroin dependence whilst influenced by a myriad of individual, social and environmental factors, can reduce negative individual and public health outcomes relating to drug use such as HIV; HCV; overdoses and criminal activity (Sorensen and Copeland, 2000; Gossop et al., 2003; Appel et al., 2004; Peterson et al., 2010). However, research has shown that the majority of opiate dependents remain on the periphery of the drug treatment system, a fact which is supported in the qualitative findings of this study (Gossop et al, 1991; Guggenbuhl et al., 2000; Friedman et al., 2004; Bobrova et al., 2006; 2007; Petersen et al., 2010). The availability of managed withdrawal (detoxification) within the community is essential for the provision of an effective treatment system for heroin dependence (Gowing et al., 2000).

The study has implications for drug service delivery in Ireland in terms of response to heroin use, recognition of the various challenges within current detoxification-seeking for heroin users, and

the level of self-detoxification attempts. The development of, and further support for existing, low threshold services, community based detoxification services, with service user involvement emerge as the way forward to meet the psycho-social and health needs of opiate users who are trying to stop their use of heroin. Such service development requires service user involvement in order to yield valuable information from the experiences of heroin users on the factors effecting completion of self-detoxification, and the successful completion of residential detoxification programmes. In addition, for some heroin users in-patient detoxification is vital in order to reduce the risk of relapse and in this context increased access to in-patient detoxification is necessary. Collaborative relationships with other drug users, family members and medical practitioners were critical to supporting clients who embarked on self detoxification and critical in the completion of self-detoxification. As most heroin users had sought advice from other users and/or medical practitioners before embarking on self-detoxification, there is a clear opportunity for peer education and/or harm reduction programmes for disseminating information on risks and processes of self-detoxification. This study also echoes the findings of other research studies which show that individualised perceptions regarding potential opiate treatment are paramount as these perceptions influence, facilitate, mediate and inhibit treatment entry, compliance and eventual outcomes for the individual user (Nelson-Zlupko et al., 1996; Karasabada et al., 2002; Shen et al, 2002; Siqueland et al., 2004; Bobrova et al., 2007).

An outline of evaluation for detoxification recently provided by a consensus panel that have built on existing definitions of detoxification as a broad process and identified three essential components that may take place concurrently or as a series of steps, comprising of evaluation, stabilization, and fostering a patient's entry into treatment (CSAT, 2006). The authors emphasise

that all three components involve treating the patient with compassion, understanding, care and respect (ibid). This study, based on the empirical findings and theory presented recommends that this concept of compassion and understanding needs also to be transferred to the person who is *seeking* heroin detoxification, and is positive that these aspects of service delivery alone could support heroin users while they are seeking detoxification, and be used to promote detoxification-seeking among out of treatment heroin users who are aiming to become abstinent from heroin use. It is also significant to note that recent research suggests that outpatient, solution-oriented, family systems approach to detoxification from drugs is a viable option, and that traditional notions about detoxification being only a biomedical, pretreatment event are challenged by the effective outcomes of such detoxification approaches (Carrenjo et al., 2002;Bischof et. al, 2003). The aims of out-patient opiate detoxification have been located within providing a safe and effective supervised withdrawal to substance users who were at low risk of severe withdrawal, engaging with those with severe dependence in further treatment and increasing the involvement of general practitioners in the medical care of opiate-detoxification seeking clients (Sannibale et. al, 2005). Traditional notions of recovery as abstinence have also been challenged recently, with recovery being promoted as not only abstinence but growth, reclaiming self and self-change (Dennis et al., 2005; Laudet et al., 2007). This ideology is also evident within this study, within the narratives of heroin users who described their sense of achievement with maintaining abstinence for any and all lengths of time, their increased awareness of heroin dependence, knowledge of withdrawal and positive support gained through treatment contact and informal help-seeking, despite relapse. In this context and considering frequency of relapse to heroin use reported by the research participants, development of services which provide strategies for long-term management of heroin use, harm reduction, and personal

development appear viable and necessary.

# Section Five – Conclusion

Withdrawal from heroin is an inherent, and difficult, step towards abstinence. The study provides a theoretical framework, to understand the factors which can influence an individual heroin user to seek detoxification, including the identification of three processes that take place concurrently, or as a series of steps, and provide context for detoxification-seeking. These processes within the overall experience of forging a pathway towards abstinence have been conceptualised as recognising a problem, help-seeking and navigating the journey. Most significantly this study reveals that seeking detoxification was described by research participants as their *first* help-seeking step, with a service provider, in relation to giving up heroin use. This step was taken when motivation to give up heroin use was strong, whether for short-term break of use of heroin, or long-term abstinence. Making a decision to seek detoxification was heavily influenced by personal experience, and perception, of heroin withdrawal, detoxification and service provision. Not all of the heroin users in this study sought detoxification, or indeed any formal drug treatment when they were motivated to give up heroin use, and/or become abstinent. This is not surprising in the least considering that detoxification-seeking for those living in the South East of Ireland is identified by research participants as a struggle, defined by difficulty in accessing information on detoxification treatment options and services, un-clear pathways to existing detoxification services, extended waiting lists, an unmet need for local detoxification service provision and treatment alternatives to methadone maintenance, and scant detoxification services for methadone users and women. And so the high levels of self-detoxification and relapse outlined by research participants are also not surprising to the author considering the lack of detoxification services available within the research area. Despite the struggle which heroin

users in this study experienced in the cases when individuals did seek detoxification, the strong will which they described to keep searching for a service which would meet their needs and goals towards abstinence was significant. The desire for abstinence from heroin, coupled with a strong sense of social justice and expectation of equality of opportunity from services motivated a large number of heroin users in this study to fight for their right to access a detoxification service. Individuals in this study literally travelled far and wide, in some cases across country and continent, in order to avail of a detoxification service which would potentially support their goal of abstinence. Others consistently voiced their needs and rights to access a detoxification service, both within their own engagement with non-detoxification drug service providers, and throughout this research process. It is apparent to the researcher that there is an energy and willingness among the heroin users who participated in this study which presents an opportunity for their direct involvement in identifying needs of heroin users in the research area, and in developing responses.

The study has implications for continued service development for heroin users living in South East Ireland, specifically in terms of promoting access to detoxification, and reducing the risk of relapse during withdrawal from heroin. Recommendations are made for developing low threshold services, community-based detoxification and involving service users as partners in design and delivery of service provision. It has not been within the capacity of the research to point towards the numbers requiring detoxification in the region, or indeed precise recommendations for service delivery within the region. Rather the study has provided another slice of data for those all those in the research situation who wish to work towards the improvement of treatment services for heroin users. The study does not provide directions as to 'what' needs to be developed, but does recognise the context and factors which enable heroin

users to seek detoxification, and in essence seek help to give up heroin use. However, the researcher recognises the challenges that can present in transforming theory into practice. In reality, turning theory into practice is a process in itself, requiring the participation of all those involved in the research situation who are concerned with the research problem itself. What is in place to support this process however, is a large body of international literature on the effectiveness of detoxification, and the essential components of detoxification programmes. The researcher recognises that the wealth of international literature, research and guidelines can, together with evidence-based local knowledge, support the development of appropriate detoxification services for rural South East Ireland.

The concept of a continuum of care, a term used frequently within extant literature and policy to refer to what should happen to a drug user once they engage with services does not apply to seeking heroin detoxification in South East Ireland. It is a misnomer when considered to what happens for those involved in this research study. The term suggests a transition to treatment options along a defined and accessible route. However, the participants in this study were in a position such that they had to invent their own pathway towards abstinence, using the limited agency and structure resources available to them. Each of the stories presented to the researcher by both heroin users and service providers echoed the sentiment that seeking detoxification from heroin was in no way easy for an individual, and indeed the process of help-seeking with regard to detoxification was a frustrating process which angered and dismayed all those involved in the research study. It is true that heroin dependence is complex and for this reason alone, pathways to accessing treatment towards abstinence need to be flexible and innovative for each individual. However, flexible and innovative does not mean always completely new and invented. What is vital is that familiar, defined, clear accessible information and treatment options are consistently

and always available for heroin users when they are experiencing a strong desire to give up heroin use and do not have the personal resources to give up heroin on their own. Pathways towards abstinence need to be visible, understandable and clear, for those at a distance from abstinence and for those who are already on a journey towards becoming heroin-free. Being able to see a pathway towards abstinence, or simply hearing about a positive experience of another individual could be supportive in encouraging an individual to believe in themselves, believe that achieving abstinence is not only a possibility, but a reality and seek help. There will always be heroin users who choose to remain outside of the treatment sector, for their own valid reasons, but surely for those who chose to seek help within the treatment sector, this active decision needs to be respected and met with a service that is there to meet the needs of the individual. For this reason detoxification services need to be immediately available for those individuals who require detoxification as part of their journey to becoming heroin-free. Having completed this research piece the lasting sentiment which I hold is that which was expressed by all of the individuals who told me their stories. That sentiment was that in the context of a lack of adequate service provision for heroin users, people, and lives are not only forgotten but in a sense de-valued. There was an overwhelming urge and 'fight' among all those who participated in this research study to improve this situation, and ensure that on a basic level those who are experiencing heroin dependence are valued equally in our society, and equally in life.

> *"If I was to be really basic and simple about this, we actually need to start humanising the issue for people because ye know I know one young lad who did exactly that, detoxed and went back, used and died, ye know he had a pattern of detoxing ye know, that's a major worry……… junkie and drug user is what surrounds the person, it's not what the person is" (Drug Service Provider)*

The study is limited by the exploratory nature and small sample size, and generalisations beyond the study sample are not viable. Further research is necessary to explore further the process of heroin detoxification-seeking, and indeed other help-seeking for heroin use, within a series of contextualisation and emerging phenomenon.

## Bibliography

Agar M., (2000), Towards a trend theory, in Greenwood G. & Robertson K. eds. *Understanding and responding to drug use: the role of qualitative research*, Belgium: European Monitoring Centre for Drugs and Drug Addiction

Ahmadi J., Farrashbandi H., Moosavinasab M., Babaee M., Firoozabadi A., Mohagheghzadeh M., Porter J., Pridmore S., Dehbozorgi G., (2004), Treatment of Heroin Dependence., *German Journal of Psychiatry,* 7 (2):1-5

Alcohol and Drug Research Unit of the Health Research Board (2009) *Treated problem drug use in Ireland: figures for 2008 from the National Drug Treatment Reporting System,* Dublin: HRB

Allen J; Copello A; Orford J. (2005), Fear during alcohol detoxification: Views from the clients perspective. *Journal of Health Psychology* 10(4): 503-510.

Amass L., (2000), Efficacy of daily and alternate-day dosing regimens with the combination buprenorphine-nalaxone tablet, *Drug and Alcohol Dependence,* 60:143-152.

Anderson E.E., and Dubois J.M, (2007), The need for evidence-based research ethics: A review of the substance abuse literature, *Drug and Alcohol Dependence*, 86:95-105

Appel, RW., Ellison, A.A., Hadley, KJ. & Oldak, R., (2004). Barriers to enrollment in drug abuse treatment and suggestions for reducing them: stakeholders. *American Journal of Drug and Alcohol Abuse* 30, 129 153.

Auriacombe M., Fatseas, M., Dubernet J., (2004) French field experience with buprenorphine. *American Journal on Addiction*, **13** (1): S17 –S28;

Bahora M., Sterk C., Elifson K.W., (2009) Understanding recreational ecstasy use in the United States: A Qualitative inquiry, *International Journal Of Drug Policy,* 20 (1): 62-69

Bischof G.H., Richmond C.J., Case AR., (2003) Detoxification at home: A brief solutionoriented Family systems approach. *Contemporary Family Therapy* 25(1): 17-39.

Black A., (2009), Blood Money, A Grounded Theory of Corporate Citizenship. Myanmar (Burma) as a Case in Point, University of Waikato

Bobrova, N, Alcorn, R, Rhodes, T;Rughnikov, I Neifeld, E and Power, R (2007). Injection drug users' perceptions of drug treatment services and attitudes toward substitution therapy: A qualitative study in three Russian cities. *Journal of Substance Abuse Treatment* 33, 373– 378.

Bahora M., Claire ES., Elifson KW. (2009), Understanding recreational ecstasy use in the United States: A Qualitative Inquiry, *International Journal of Drug* Policy, 20:1, 62-69

Best D., Gossop M., Marsden J., Farrell M., Strang J., (1997), Time of day of methadone consumption and illicit heroin use, *Drug and Alcohol Dependence,* 49: 49-54

Bobrova, N., Rhodes, T., Power, R., Alcorn, R., Neifeld, E., & Krasiukov, N.(2006). Barriers to accessing drug treatment in Russia: A qualitative study among injecting drug users in two cities. *Drug and Alcohol Dependence*, 82, S57– S63.

Booth, R. E., Corsi, K. F., & Mikulich, S. K. (2003). Improving entry to methadone maintenance among out-of-treatment injection drug users. *Journal of Substance Abuse Treatment*, *24*, 305–311.

Brooke, D.; Fudala, P.J.; and Johnson, R.E. (1992), Weighing up the pros and cons: Help-seeking by drug misusers in Baltimore, USA. *Drug and Alcohol Dependence,* 31:37-43.

Broome, K. M., Knight, D. K., Knight, K., Hiller, M. L., & Simpson, D. D. (1997). Peer, family, and motivational influences on drug treatment process and recidivism for probationers. *Journal of Clinical Psychology,* 53, 387– 397.

Broome, K. M., Knight, K., Hiller, M. L., & Simpson, D. D. (1996). Drug treatment process indicators for probationers and prediction of recidivism. *Journal of Substance Abuse Treatment*, 13, 487– 491.

Carew AM, Bellerose D, Lyons S and Long J (2009). *Trends in treated problem opiate use in Ireland, 2002 to 2007.* HRB Trends Series 7. Dublin: HRB.

Carreno J.E. et al., (2002), "24-hour opiate detoxification and antagonist induction at home – the 'Asturian method': a report on 1368 procedures, *Addiction Biology*, 7:243-250

Centre for Substance Abuse Treatment, (2006). *Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol* (TIP) Series 45. Rockville, MD: Substance Abuse and Mental Health Services Administration

Centre for Substance Abuse Treatment, (2008). *Detoxification and Substance Abuse Treatment Training Manual.* Rockville, MD: Substance Abuse and Mental Health Services Administration

Charmaz, K. (2000). Grounded Theory: Objectivist and Constructivist Methods. In Norman K. Denzin & Yvonna S. Lincoln (Eds.), *Handbook of Qualitative Research*, 2nd edition (509-535). Thousand Oaks, Ca.: Sage.

Charmaz, K. (2001). Grounded theory. In J. Smith, R. Harre, and L. Van Lagenhove (eds.) *Rethinking Methods in Psychology*. Sage Publications.

Corbin J., & Strauss A., (2008), *Basics of Qualitative Research:Techniques and Procedures for Developing Grounded Theory*, Third Edition, USA: SAGE Publications

Corrigan, D. (2003) *Facts about drug misuse in Ireland*. Health Promotion Unit, Department of Health, Dublin.

Corrigan, D. and O'Gorman, A. (2008) *Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Users)*. Health Service Executive, Dublin

Cox G., Comiskey C. and Kelly P (2007). *ROSIE Findings 2: summary of 1-year outcomes: detoxification modality*. Dublin: National Advisory Committee on Drugs.

Cox, G., Comiskey, C., Kelly, P. (2007b) *ROSIE Findings 4: Summary of 1-year outcomes: Methadone Modality*. Dublin: National Advisory Committee on Drugs.

Crabtree B.F. and Miller W.L, (eds.), (1999), *Doing Qualitative Research*, 2nd edition, Thousand Oaks, CA: Sage.

Dean G., Kelly M., O'Hare A., Kelly G., (1987), The Opiate Epidemic in Dublin 1979-1983, *Irish Medical Journal*, 80 (5):139-142.

Dennis M., Scott CK., Funk R., Foss M., (2005), The duration and correlates of addiction and treatment careers, *Journal of Substance Abuse Treatment,* 28: S51 – S62

Department of Community, Rural and Gaeltacht Affairs (2007), *Report of the Working Group on Drugs Rehabilitation,* Dublin: Government Publication

Des Jarlais, D. C., Paone, D., Friedman, S. R., Peyser, N., & Newman, R. G. (1995). Regulating controversial programs for unpopular people: Methadone maintenance and syringe exchange programs. *American Journal of Public Health*, *85*, 1577–1584.

Digiusto E., et al. (2004), Serious adverse events in the Australian National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD), *Addiction*, 99:450-460.

Doyle J., Ivanovic J. (2010) *National Drugs Rehabilitation Framework Document*,
National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive

Drucker, E., Lurie, P.,Wodak, A., & Alcabes, P. (1998). Measuring harm reduction: the effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV. *AIDS*, *12*(Suppl A), S217–S230.

Effective Interventions Unit, (2002), *Integrated care for drug users: principles and practice.* Scotland: Scottish Executive Drug Misuse Research Programme.

European Monitoring Committee on Drugs and Drug Addiction, (2009) 1. *Annual report 2009: the state of the drugs problem in Europe.* Luxembourg: Office for Official Publications of the European Communities.

Fagan J., Naughton L., Smyth B., (2008), Opiate-dependent adolescents in Ireland: a descriptive study at treatment entry, *Irish Journal of Psychiatric Medicine*, 25 (2):46-51.

Fischer G., Gombas W., Eder, H., (1999) Buprenorphine versus methadone maintenance for the treatment of opioid dependence. *Addiction*, 94, 1337 –1347.

Fountain J., Griffiths P. (1999), *Synthesis of Qualitative Research on Drug Use in the European Union:Report on EMCDDA* Project, European Addiction Research, 5:4-20

Friedman, S. R., Tempalski, B., Perlis, T., Keem, M., Friedman, R., & Flom, P. (2004). Estimating numbers of injecting drugs users in metropolitan areas for structural analyses of community vulnerability and for assessing relative degrees of service provision for injection drug users. *Journal of Urban Health*, 81, 377–400.

Frischer, M. (1997). More complex capture-recapture models: An illustrative case study using data from Glasgow, Scotland. In *Estimating the Prevalence of Problem Drug Use in Europe*, pp. 103-108. EMCDDA Scientific Monograph Series. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

Ghodse AH, Reynolds M, Baldacchino A, Dunmore E, Byrne S, Oyefeso A, Clancy C, Crawford V (2002) Treating an opiate-dependent inpatient population: a one-year follow-up study of treatment completers and noncompleters. *Addictive Behaviors*, 27: 765-778.

Glaser B., and Strauss A.,(1967), *The Discovery of Grounded Theory:Strategies for Qualitative Research.* Chicago: Aldine Publishing Company

Glaser, Barney G. (2002). Constructivist Grounded Theory? [47 paragraphs]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *3*(3), Art. 12, http://nbnresolving. de/urn:nbn:de:0114-fqs0203125.

Gossop M., Battersby M. and Strang J, (1991). Self-detoxification by opiate addicts. A preliminary investigation, *The British Journal of Psychiatry,* 159, 208-212.

Gossop M, Marsden J, Stewart D, Kidd T (2003) The National Treatment Outcome Research Study (NTORS): 4-5 year follow-up results. *Addiction*, 98: 291-303.

Gossop M, Marsden J and Stewart D (1998) NTORS at One Year. Changes in substance use, health and criminal behaviour One Year after intake. Department of Health, London.

Gossop M, Marsden J, Stewart D, Rolfe A (1999) Treatment retention and 1 year outcomes for residential programmes in England. *Drug & Alcohol Dependence*, 57: 89-98.

Gossop M, Marsden J, Stewart D, Lehmann P and Strang J (1999). Methadone treatment practices and outcome for opiate addicts treated in drug clinics and in general practice: results from the National Treatment Outcome Research Study. *British Journal of General Practice*.49(438):31-4.

Gossop, M., Marsden, J., Stewart, D., Treacy, S. (2001) Outcomes after methadone maintenance and methadone reduction treatments: two-year follow-up results from the National Treatment Outcome Research Study. *Drugs and Alcohol Dependence* 62:3:255-64.

Gowing, LR. and Ali, R.L., (2006). The place of detoxification in treatment of opioid dependence, *Current Opinion in Psychiatry,* 19:3, 266-270 .

Gowing L.R; Ali R.L ;White J.M, (2000), The management of opioid withdrawal . *Drug and Alcohol Review*, 19:3, 309 - 318.

Gowing, L.R., Ali, R.L., White, J.M., (2000) Buprenorphine for the management of opioid withdrawal. *The Cochrane Library*, Issue 3, Oxford, 2000.

Grella C.E., Karno M.P., Warda U.S., Moore A.A., Niv N., (2009), Perceptions of need and help received for substance dependence in a national probability survey, *Psychiatric Services,* 60:1068-1074.

Guggenbuhl, L., Uchtenhagen, A., & Paris, D. (2000). *Adequacy in drug abuse treatment and care in Europe. Part II. Treatment and support needs of drug addicts*. Zurich, Switzerland: Addiction Research Institute, A project of theWorld Health Organization

Haasen C., Verthein U., Degkwitz P., (2007), Heroin-assisted treatment for opioid dependence, Randomised controlled trial, *The British Journal of Psychiatry* (2007) 191: 55-62.

Hartnoll, R. Research and the help-seeking process. (1992), *British Journal of Addiction* 87, 429-437

Health Research Board (2010). *Drug-related deaths and deaths among drug users in Ireland, 1998 to 2007. Data from the National Drug-Related Deaths Index.*, Dublin:HRB

Hopkins A. and Clark D., (2005), *Using heroin, trying to stop, and accessing treatment: A qualitative analysis of the experiences and vies of clients on the Peterborough Nene Drug Interventions Programme*, unpublished.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38, 139– 149.

Howerton A., Byng R., Campbell J., Hess D., Owens C., Aitken P., (2007), Understanding help-seeking behavior among male offenders: qualitative interview study, *British Medical Journal,* 334: 303.

Inkster K, Matheson C (2001) A qualitative evaluation of the process and outcomes of Grampian opiate / opioid dependent patients seeking in-patient rapid opiate detoxification (IROD). Aberdeen, University of Aberdeen.

Ison J., Day E., Fisher K., Pratt M., Hull M., Copello A., (2006) Self-detoxification from opioid drugs *Journal of Substance Use*, 11, 2, 81 – 88.

Joe, G. W., Simpson, D. D., Dansereau, D. F., & Rowan-Szal, G. A. (2001). Relationships between counseling rapport and drug abuse treatment outcomes. *Psychiatric Services*, 52, 1223– 1229.

Kasarabada, N. D., Hser, Y. I., Boles, S. M., & Huang, Y. C. (2002). Do patients' perceptions of their counselors influence outcomes of drug treatment? *Journal of Substance Abuse Treatment,* 23, 327– 334.

Keen J, Oliver P, Rowse G, Mathers N (2001) Residential rehabilitation for drug users: a review of 13 months' intake to a therapeutic community. *Family Practice*, 18: 545-548

Kelly A., Carvalho M., Teljeur C., (2003) *Prevalence of opiate use in Ireland 2000-2001: a 3-source capture recapture study.* National Advisory Committee on Drugs, Dublin.

Kelly A., Carvalho M., Teljeur C., (2003) *A 3-source capture recapture study of the prevalence of opiate use in Ireland 2000 to 2001: key findings summary tables.* Department of Community Health & General Practice, Trinity College Dublin, Dublin.

Kelly A, Carvalho M and Teljeur C (2009). *Prevalence of opiate use in Ireland 2006: a 3-source capture recapture study.* Dublin: National Advisory Committee on Drugs.

Kosten TR., George T., (2002), The Neurobiology of Opioid Dependence: Implications for Treatment, *Science and Practice Perspective*.

Kidd, M., (2007) *Data co-ordination overview of drug misuse 2006*. Health Service Executive South, Waterford.

Kidd, M., (2008) *Data co-ordination overview of drug misuse 2007*. Health Service Executive South, Waterford.

Kidd, M., (2009) *Data co-ordination overview of drug misuse 2008*. Health Service Executive South, Waterford

Kleber, H., (1989), Drug abuse liability testing: human subject issues. In Fischman M.W., Mello N., (eds.) Testing for Abuse Liability of Drugs in Humans, National Institute on Drug Abuse Monograph Series, 341-356, Washington DC.

Kreek M.J., La Forge K.S., Butelmann E., (2002) Pharmacacotherapy of addictions, Nat Rev Drug Discoveries, 1:10-26

Laudet, A. (2007), What does recovery mean to you? Lessons from the recovery experience for research and practice, *Journal of Substance Abuse Treatment,* 33:243 – 256

Luty J., (2004), Treatment preferences of opiate-dependent patients, *The Psychiatrist*, 28: 47-50

Luty J., (2003) What works in drug addiction? *Advances in Psychiatric Treatment*, **9**, 280 –288.

Luty J., O'Gara C, Sessay M., (2005) Is methadone too dangerous for opiate addiction? *British Medical Journal*, **331**, 1352 –1353.

Lyons S, Lynn E, Walsh S and Long J (2008) 5. Trends in drug-related deaths and deaths among drug users in Ireland, 1998 to 2005. *HRB Trends Series 4*, Dublin:HRB.

Marsden J and Farrell M (2002) Research on what works to reduce illegal drug misuse. Appendix 5 of *Changing Habits. The commissioning and management of community drug treatment services for adults.* Audit Commission, London.

Mattick R. , Hall W., (1996), Are detoxification programmes effective? *The Lancet*, 347:8994, 97-100

Metrebian N., Shanahan W., Wells B. and Stimson G.V, (1998), Feasibility of prescribing injectable heroin and methadone to opiate-dependent drug users: associated health gains and harm reductions, *Medical Journal of Australia,* 168: 596-600

McDonnell, A. and Van Hout, M. (2010), 'Maze and minefield: a grounded theory of opiate self-

detoxification in rural Ireland'. *Drugs and Alcohol Today*, 10 (2).

McDonnell, A. and Van Hout, M. (2010), 'Heroin detoxification-seeking, a grounded theory of process and practicalities. *Grounded Theory: An International Journal.* In press.

McElrath, K. (2001) *Heroin use in Northern Ireland: a qualitative study into heroin users' lifestyles, experiences, and risk behaviours* (1997-1999). Department of Health, Social Services and Public Safety, Belfast.

McElrath, K. (2001a) Risk behaviors among injecting drug users in Northern Ireland. *Substance Use & Misuse,* 36 (14). pp. 2137-2157.

McElrath, K. (2003) *Review of research on substitute prescribing for opiate dependence and implications for Northern Ireland*. Department of Health, Social Services and Public Safety, Belfast.

McElrath, K. (2002) *Prevalence of problem heroin use in Northern Ireland.* Drug & Alcohol Information & Research Unit, Department of Health, Social Services & Public Safety, Belfast.

McIntosh, J. and McKeganey, N. (2002). *Beating the Dragon: The recovery from dependent drug use*. Prentice Hall.

McKeganey N., Morris Z., Neale J., Robertson M., (2004), What are drug users looking for when they contact drug services: abstinence or harm reduction, *Drugs: education, prevention and policy,* 11:5 423-435

McKeganey, N., Bloor, M., Robertson, M., Neale, J., MacDougall, J. (2006) Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study. *Drugs: Education, prevention and policy*. 13:6:537-550.

Mannix M., (2006), *Drug and Alcohol Detoxification Services A Needs Assessment for Cork and Kerry* 2005, Dept. of Public Health HSE South.

Martin A. & Stenner P., (2004), Talking about drug use: what are we and our participants doing in qualitative research?, *International Journal of Drug Policy,* 15: 395-405

Masson C.L., (2004), Cost and cost-effectiveness of standard methadone maintenance treatment compared to enriched 180-day methadone detoxification, *Addiction*, 99:718-726

Mattick R.P., Ali R., Lintzeris N., (2009), *Pharmacotherapies for the treatment of opioid dependence: efficacy, cost-effectivness and implementation guidelines,* Informa Healthcare

Measham, F. and Michael Shiner (2009), The legacy of 'normalisation': The role of classical and

contemporary criminological theory in understanding young people's drug use, *International Journal of Drug Policy* 20:502–508

Measham, F. (2002). 'Doing gender'–'doing drugs': Conceptualising the gendering of drugs cultures. *Contemporary Drug Problems*, *29*(2), 335–373.

Measham, F., & Moore, K. (2008). The criminalisation of intoxication. In P. Squires (Ed.), *ASBO Nation: The criminalisation of nuisance* (pp. 273–288). Bristol: Policy.

Measham, F., Newcombe, R., & Parker, H. (1994). The normalisation of recreational drug use amongst young people in north west England. *British Journal of Sociology*, *45*(2), 287–312.

Measham, F., Parker, H.,&Aldridge, J. (1998). The teenage transition: From adolescent recreational drug use to the young adult dance culture in Britain in themid1990s.
*Journal of Drug Issues*, *28*(1), 9–32.

Measham, F., Aldridge, J., & Parker, H. (2001). Dancing on drugs: Risk, health. In *Hedonism in the British Club Scene*. London: Free Association Books.

Miller, W. (1983). Motivational Interviewing with problem drinkers. *Behavioural Psychotherapy*, 11, 147-72.

Miller, W. (1993). Behavioural treatments for drug problems: where do we go from here. In *Behavioural Treatments for Drug Abuse and Dependence*. NIDA Research Monograph, 137, 303-21. Rockville, MD: National Institute of Drug Abuse.

Miller, P., (2005), Scapegoating, self-confidence and risk comparison: The functionality of risk neutralization and lay epidemiology by injecting drug users, *International Journal of Drug Policy*, 16: 246-253

Mills J., Bonner A., and Francis K., (2006), Adopting a constructivist grounded theory: Implications for research design, *International Journal of Nursing Practice,* 12 (1): 8-13

Mullen, L., Keenan, E., Barry, J., Long, Dr J., Mulholland, D., Grogan, L. and Delargy, I. (2010) *Factors predicting completion in a cohort of opiate users entering a detoxification programme.* Irish Journal of Medical Science.

National Advisory Committee on Drugs (2008), *Drug use in Ireland and Northern Ireland 2006/2007 Drug Prevalence Survey: Regional Drugs Task Force (Ireland) and Health and Social Services Board (Northern Ireland).* Dublin & Belfast: NACD & PHIRB.

National Collaborating Centre for Mental Health (2008), *Drug misuse: Opioid detoxification, The Nice Guideline,* Leicester: The British Psychological Society and The Royal College of

Psychiatrists.

Neale J., (1999), Drug users' views of substitute prescribing conditions, *International Journal of Drug Policy,* 10:247-258.

Neale J., Tompkins C., Sheard L., (2007), *Factors that help injecting drugs users to access and benefit from services: A qualitative Study,* Substance Abuse Treatment, Prevention and Policy, 2:31.

Neale J., Godfrey C., Parrott S., Tompkins C., Sheard L., (2007b), *Barriers to the Effective Treatment of Injecting Drug Users, Final Report*, Department of Health and the London of Hygiene and Tropical Medicine.

Nelson-Zlupko, L., Dore, M. M., Kauffman, E., & Kaltenbach, K. (1996). Women in recovery. Their perceptions of treatment effectiveness. *Journal of Substance Abuse Treatment*, 13, 51–59.

Noble A., Best D., Man L., Gossop M. & Strang J. (2002). Self-detoxification attempts among methadone maintenance patients What methods and what success? *Addictive Behaviors,* 27, 575–584.

Oppenheimer E., Tobutt C,m Taylor C., Andrew T., (1994), Death and survival in a cohort of heroin addicts from London clinics: a 22-year follow-up study, *British Journal of Addiction* 89: 10, 1299–1308.

Oppenheimer E., Sheehan M., Taylor C., (1988) Letting the Client Speak: drug misusers and the process of help seeking, *British Journal of Addiction,* 83:6, 635–647

Pani et al., (2000), Buprenorphine: a controlled clinical trial in the treatment of opioid dependence, *Drug and Alcohol Dependence*, 60:39-50.

Parker, H., Aldridge, J., & Measham, F. (1998). *Illicit leisure: The normalization of adolescent*

*recreational drug use*. London: Routledge.Patton M.Q., (1990), *Qualitative Evaluation and Research Methods*. Sage: London: 295.

Perneger, T. V., Giner, F., del Rio, M., *et al* (1998) Randomised trial of heroin maintenance programme for addicts who fail in conventional drug treatments. *British Medical Journal*, 317:13-18

Peterson, J , Schwartz, R, Mitchell, S, Schacht Reisinger, H, Kelly, S, O'Grady, K, Brown,B, & Agar, M (2010). Why don't out-of-treatment individuals enter methadone treatment

programmes? *International Journal of Drug Policy*, 21, 36–42.

Power R., Hartnoll R., Chalmers C., (1992), The Role of Significant Life Events in Discriminating among Illicit Drug Users, *Substance Use and Misuse*, 27 (9):1019-1034.

Prochaska J.O. and Diclemente C.C., (1986). Towards a comprehensive model of change. In Miller WR and Heather N (eds) *Treating Addictive Behaviours: Processes of Change*. New York, Plenum Press, 3-27.

Ritchie J., (2003), The Application of Qualitative Methods to Social Research, in Ritchit and Lewis J. (eds.) *Qualitative Research Practice,* London: SAGE Publications

Rhodes, T. (2002), The 'risk environment': a framework for understanding and reducing drug-related harm, *International Journal of Drug Policy*, 13: 85-94

Rhodes T., Barnard M., Fountain J., Hariga F.Romo Avilés N., Vicente J., Weber U., (2001), *Injecting drug use, risk behavior and qualitative research in the time of AIDS*, Belgium: European Monitoring Centre for Drugs and Drug Addiction

Rhodes, T., (2000), The multiple roles of qualitative research in understanding
and responding to illicit drug use, in Greenwood G. & Robertson K. eds. *Understanding and responding to drug use: the role of qualitative research*, Belgium: European Monitoring Centre for Drugs and Drug Addiction

Rogler, LH. and Cortes, DE. (1993), Help-seeking pathways: a unifying concept in mental
Healthcare, *American Journal of Psychiatry*, 150:554-561

Rae K, Matheson C, Bond CM (2001) *General Practitioners' referral for In-patient Rapid Opiate Detoxification (IROD): An exploration and rating of the factors involved in decision making*. Aberdeen, Department of General Practice and Primary Care, University of Aberdeen. Robertson R and Wells B (1998) Detoxification and achieving abstinence. In Robertson R (ed) *Management of Drug Users in the Community: a practical handbook*. Arnold.

Salter G., Davies S., Clark D. *Recovery from Addiction and the Role of Treatment Processes, A qualitative analysis of interviews with clients on an abstinence-based structured day-care programme,* unpublished document.

Sannibale C; Fucito L; O'Connor D; Curry K. Process evaluation of an out-patient detoxification
service. *Drug and Alcohol Review* 24(6): 475-481, 2005.

Schwartz, R. P., Kelly, S. M., O'Grady, K. E., Peterson, J. A., Reisinger, H. S., & Mitchell, S. G., (2008). In-treatment v. out-of-treatment opioid dependent adults: Drug use and criminal history. *American Journal on Drug and Alcohol Abuse*, *34*(1), 17–28.

Sees K.L, (2000), Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence. A randomised controlled trial., *Journal of American Medical Association*, 283 (10): 1303-1310

Shen, Q., McLellan, A. T.,&Merrill, J. C. (2002). Client's perceived need for treatment and its impact on outcome. *Substance Abuse*, 21, 179– 192.

Sheridan J, Wheeler A, Walters C. (2005) Health problems and help-seeking activities of methadone maintenance clients at Auckland Methadone Service (AMS): potential for community pharmacy service expansion?, *Harm Reduction Journal*, 2(1):25.

Simoens S, Matheson C, Inkster K, Ludbrook A and Bond C (2002) The effectiveness of treatment for drug users: An international systematic review of the evidence. Effective Interventions Unit, Scottish Executive, Edinburgh.

Siqueland, L., Crits-Christoph, P., Barber, J. P., Connolly Gibbons, M. B., Gallop, R., Griffin, M., et al. (2004). What aspects of treatment matter to the patient in the treatment of cocaine dependence? *Journal of Substance Abuse Treatment*, 27, 169– 178.

Smyth, BP., Barry, J., Lane, A., Cotter, A. . O'Neill, M., Quinn, C. and Keenan, E.(2005) *In-patient treatment of opiate dependence: medium-term follow-up outcomes*. British Journal of Psychiatry, 187: 360-365.

Smyth, BP., Barry J. and Keenan E. (2005) *Irish injecting drug users and hepatitis C: the importance of the social context of injecting*. International Journal of Epidemiology, 34:1, 166-172.

Smyth, BP., Barry J. Keenan E. and Ducray, K. (2010) *Lapse and relapse following inpatient treatment of opiate dependence*. Irish Medical Journal, 103:6, 176-179.

Sorensen, LL & Copeland, A.L., (2000). Drug abuse treatment as an HIV prevention strategy: a review. *Drug and Alcohol Dependence*. 59, 17 31.

Stewart D, Gossop M, Marsden J, Strang J (2000) Variation between and within drug treatment modalities: Data from the National Treatment Outcome Research Study (UK). *European Addiction Research*, 6: 106-114.

Strang J., Bacchus L., Howes S., Watson P., (1998), Turned away from treatment:maintenance-

seeking opiate addicts at two-year follow up, *Addiction Research and Theory*, 6 (1):71-81

Strang J, McCambridge J, Best D, Beswick T, Bearn J, Rees S, Gossop M (2003) Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. *British Medical Journal,* 326: 959-960.

Strauss, A. and Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* USA: Sage Publications.

Strauss, Anselm L. (1993). *Continual Permutations of Action.* NY: Aldine de Gruyter. Who 2000

Strauss A. and Corbin J., (eds.), (1997), *Grounded Theory in* Practice, USA: SAGE Publicaions

Strauss, A. and Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. USA: Sage Publications.

Sugarman J., (1994), Toward achieving meaningful informed consent in AIDS vaccine trials with injection-drug users, *AIDS Public Policy Journal,* 9:167-172

Sweeney LP; Samet JH; Larson MJ; Saitz R. Establishment of a multidisciplinary health evaluation and linkage to primary care (HELP) clinic in a detoxification unit. *Journal o Addictive Diseases* 23(2): 33-45, 2004. (26 refs.)

Trotter II R.T & Medina-Mora M.E, (2000) Qualitative Methods, in WHO, *Guide to Drug Abuse Epidemiology,* Department of Mental Health and Substance Dependence, World Health Organisation, 91-124

Van Hout, MC (2009). Drug use among rural Irish adolescents. *Drugs and Alcohol Today.* Vol 9 (1) 20-26

Van Hout, MC (2009). Youth Alcohol and Drug Use in rural Ireland- a Parents View. *The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy.* http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=1171

Van Hout, MC (2010). Travellers and Substance Use in Ireland-Recommendations for Drug and Alcohol Policy. *Drugs Education, Prevention and Policy.* In press.

Varney, S., Damaris J.R., Achintya N.D, Myers M.G, Zwick W.R, Monti P.M, (1995) Factors associated with help-seeking and perceived dependence among cocaine users, *Substance Use and Misuse*, 21 (1):81-91.

Ward J., Hall W., Mattick R. (1999), Role of maintenance treatment in opioid dependence, *Lancet*, 353:221-226

White J., (2007), Opioid Maintenance: a comparative review of pharmacological strategies, in

*Expert Opinion on Pharmacotherapy*, 8 (1):1-11.

World Health Organisation, United Nations Office on Drugs and Crime, UNAIDS, (2004), *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*: *Position Paper*, WHO.

World Health Organisation. Dept. of Mental Health and Substance Abuse (2009) *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. Geneva: WHO

Wright N., Oldham N., Francis K., Jones L., (2006), Homeless drug users' awareness and risk perception of peer 'Take Home Naloxone' use – a qualitative study, *Substance Abuse Treatment, Prevention and Policy,* 1:28

Zule,W.A., & Desmond, D.P. (2000). Factors predicting entry of injecting drug users into substance abuse treatment. *American Journal of Drug Alcohol Abuse*, *26*(2), 247–261.

**News Articles**

Evening Herald, 22nd July 2006:14, 'Some Dublin drug users still awaiting treatment'

Irish Medical Times, (1st September 2006), '*Too few rural GPs on methadone protocol',* 2.

Irish Times, (21st November 2005), '*Tailored drug treatment programmes more effective, research suggests'*, 6.

Meath Chronicle, (30th September 2006), '*North East Drugs Task Force commission research on the need for drug treatment services'*, 9.

Westmeath Independent, (10th June 2006), '*HSE confirms rapid increase in treatment waiting lists in midlands'*,

**Appendix A – Group X Initial Interview Guide (Heroin Users)**

What do you understand when I say 'detoxification'?

Can you tell me, in as much as you feel comfortable in sharing with me right now, what your experience has been, if any of detoxification?

If it's ok with you, I'd like to focus the discussion on the experiences you have mentioned?

If it's ok with you, I'd like to focus the discussion on why you have never sought detoxification?

Have you ever sought detoxification for heroin use?

(No) Can you explain to me why you have never sought detoxification?

Can you tell me about that/those experiences? How did you seek detoxification? Who helped you?

Did you *access* detoxification each time you sought detoxification?

Did your experiences of seeking detoxification meet your needs and expectations?

Have you ever given advice or information to anyone about detoxification? Have you supported anyone through withdrawal?

Where have you gotten information on detoxification from?

Were you aware of any dangers of detoxification?

What was helpful? Not helpful?

In hindsight, would you do anything differently?

What do you feel would have helped you as you sought detoxification?

What would you change within service provision in your area at the moment?

**Appendix B – Group Y Initial Interview Guide (Service Providers)**

What do you understand by the term ‘detoxification’?

Do you/your organisation provide detoxification for heroin users?

In your work, have you ever engaged with problem heroin users as they seek detoxification?

Have you ever provided information on detoxification to a heroin user or family member?

Have you ever referred heroin users to a detoxification service?

Can you tell me about these experiences?

What do you understand the needs of heroin users to be, in terms of detoxification?

What would you change in current detoxification service provision?

## Appendix C: Inclusion Criteria for Group X Participants (Heroin Users)

- Aged 18 years or over at time of interview
- Presented to a service provider as a dependent user of heroin within the last year
- Resident in Carlow/Kilkenny at time of contact with service provider
- Service user participants may be those who;

Are dependent users, who have not accessed detoxification services to date

Have accessed detoxification service to date, but have not completed and currently not in treatment

Have accessed detoxification service to date, completed and currently not in treatment

Have accessed detoxification service to date, completed and currently in treatment (community/residential)

Currently in treatment, detoxed 'at home'

Currently not in treatment, detoxed 'at home'

**<u>Exclusion Criteria:</u>**

In the last year has not presented to a service provider as a dependent user of heroin

Under 18 at time of interview

## Appendix D –Overview of Concepts within Narratives

SU denotes Group X participants (heroin users)
SP denotes Group Y participants (service providers)

| | **Concept** |
|---|---|
| 1 | SU found it difficult to find information on detoxification options are available to them |
| 2 | SU had difficulty in accessing a detoxification service due to waiting list |
| 3 | SU had difficulty in accessing treatment other than detoxification due to waiting list |
| 4 | SU had difficulty in accessing detoxification service due to being a woman |
| 5 | SU had difficulty in accessing residential detoxification due to being a woman |
| 6 | During active using as a heroin user, regularly contemplated giving up heroin use |
| 7 | In the early stages of heroin use did not know what was happening during first withdrawals |
| 8 | In the early stages of heroin use found out information from other drug users re. withdrawal |
| 11 | SU recalled attempting self-detoxification at least once throughout long-term heroin use |
| 12 | SU recalled attempting self-detoxification more than once throughout long-term heroin use |
| 13 | SU recalled completing self-detoxification at least once throughout long-term heroin use |
| 14 | SU recalled completing self-detoxification more than once throughout long-term heroin use |
| 15 | SU identified weariness of life on heroin as a motivation for self-detoxification |
| 16 | SU identified weariness of life on heroin as a motivation for opiate detoxification-seeking |
| 17 | SU identified maintaining a job as motivation for self-detoxification |
| 18 | SU identified maintaining a job as motivation for opiate detoxification-seeking |
| 19 | SU identified responsibilities to children and family as motivation for self-detoxification |
| 20 | SU identified responsibilities to children and family as motivation for opiate-detoxification seeking |
| 21 | SU identified judicial issues as motivation for self-detoxification |
| 22 | SU identified judicial issues as motivation for opiate-detoxification seeking |
| 23 | SU expressed that their were very vulnerable when looking for detoxification and needed guidance |
| 24 | SU reported getting information on detoxification and treatment services from other addicts or people in recovery |
| 25 | SU reported going to GP's as the first time they 'looked' for help for their addiction – with no expectations |
| 29 | SU asked a GP to for medication to assist with withdrawal |
| 30 | SU approached GP initially for information or referral to a detoxification service |
| 31 | SU has experienced the impact of the stigma attached to heroin use |
| 32 | SU sought opiate detoxification in collaboration with family members |
| 33 | SU worked out/is working out detoxification options with service providers |
| 34 | SU expressed the danger of using tablets to detoxification from heroin |
| 35 | SU has experience of not getting the information that they needed with regards to med-detoxification from a GP |
| 36 | SU expressed that opiate-Detoxification seeking was their first step in help-seeking to become abstinent |
| 37 | SU experienced detoxification as a medicated withdrawal from heroin in a residential setting |
| 38 | SU experienced detoxification as being a self-detoxification using tablets prescribed by GP |
| 39 | SU experienced detoxification as being supported a psycho social unassisted withdrawal |
| 40 | SU experienced Detoxification as being as being 'cold turkey' |
| 41 | SU experienced detoxification as being withdrawal from methadone |
| 42 | SU wants to detoxification from methadone in the short-term |
| 43 | SU accessed a methadone programme as there was no other option to meet their needs |
| 44 | SU experienced difficulty detoxing with methadone |

45 SU experienced difficulty detoxing from methadone
46 SU experienced difficulties attending a residential detoxification or treatment service
53 SU expressed the ease of relapse following detoxification and or self-detoxification
54 SU expressed the difficulty of withdrawal from heroin
55 SU identified aspects of a successful formal detoxification
56 SU identified aspects of a successful self - detoxification
58 SU expressed their awareness of danger of using after detoxification
59 SU expressed the value of a self-detoxification, or formal detoxification as a 'break'
60 SU expressed supportive aspects of services during opiate-detoxification seeking
61 SU expressed that the process of seeking detoxification brought the drug user in contact with other drug services
62 SU has experienced/experiences negative perceptions of services as a barrier to services
63 SU expressed the need for aftercare following detoxification (self or formal)
64 SU expressed the need for more detoxification services for Carlow and Kilkeny
65 SU expressed the need for a needle exchange for Carlow and Kilkeny
66 SU expressed the need for a service user forum for Carlow and Kilkeny
67 SU expressed the need for more family support for Carlow and Kilkeny
68 SU expressed the need for a low threshold, drop-in service for Carlow and Kilkeny
69 SU expected detoxification service to be in place
70 SU experienced a difference of opinion on what *detoxification* is per se
71 SU expressed awareness of dangers during self-detoxification
72 SU identified injecting as a prompt for self-detoxification
73 SU is abstinent following self- detoxification
74 SU is abstinent following self-detoxification residential treatment
75 SU is abstinent following residential IPD and residential treatment
76 SU is on methadone maintenance following failed self-detoxification
77 SU self-detoxed at home with others present
78 SU self-detoxed alone
79 SU experienced severe emotional and mental during withdrawal
80 SU experienced severe emotional and mental during withdrawal as a reason for failing self-detoxification
81 SU attempted self-detoxification as didn't know what else to do
82 SU found physical symptoms manageable during self-detoxification
83 SU was fearful contacting family GP to admit addiction
84 SU planned self-detoxification prior with family
85 SU pleased that they completed self-detoxification and is drug-free
86 SU approached GP looking for safe process of withdrawal, not phrased as 'detoxification'
87 SU had/has fear around life without heroin prior to self-detoxification
88 SU had/has a fear of withdrawal
89 SU has experienced self-detoxification as a process of longer than 24 hours
90 SU has experienced self-detoxification as a process of longer than one week
91 SU expressed that becoming abstinent is achievable when ready
92 SU used for a while before they realised they had to come off it
93 SU identified a long-term motivation as motivation to self-detoxification
94 SU identified a long-term motivation as motivation to seek formal detoxification in residential
95 SU identified a long-term motivation as motivation to seek help from a GP
96 SU identified a long-term motivation as motivation to access methadone

| | |
|---|---|
| 97 | Age was a barrier to accessing a detoxification residential service |
| 98 | When looking for detoxification, an immediate appt. with a drugs counsellour helped as therapeutic alliance |
| 99 | SU approached a detoxification centre but had to be detoxed first |
| 100 | SU had withdrawal in hospital |
| 101 | SU experienced withdrawal in a hospital with no information on withdrawal/aftercare/specialist support |
| 102 | SU used again following hospital withdrawal |
| 103 | SU experience the benefits of a continuum of care outside of C/K |
| 104 | SU has/is participating in a therapeutic alliance which they expressed they are satisfied with |
| 105 | SU expressed a call for a community detoxification |
| 106 | SU expressed a call for methadone within a clinic |
| 107 | SU has a negative view of methadone |
| 108 | SU recalled the benefits of a long-term stay for detoxification |
| 116 | SP found it difficult to provide information on detoxification options are available |
| 125 | SP experiences clients heroin user who require abstinence |
| 126 | SP identified weariness of life on heroin as a motivation for self-detoxification |
| 127 | SP identified weariness of life on heroin as a motivation for opiate detoxification-seeking |
| 128 | SP identified maintaining a job as motivation for self-detoxification |
| 129 | SP identified maintaining a job as motivation for opiate detoxification-seeking |
| 130 | SP identified responsibilities to children and family as motivation for self-detoxification |
| 131 | SP identified responsibilities to children and family as motivation for opiate-detoxification seeking |
| 132 | SP identified judicial issues as motivation for self-detoxification |
| 133 | SP identified judicial issues as motivation for detoxification seeking |
| 134 | SP identified injecting as a prompt for self-detoxification |
| 135 | SP clients who use for a while before they realised they had to come off it |
| 136 | SP identified a long-term motivation as motivation to self-detoxification |
| 137 | SP identified a long-term motivation as motivation to seek formal detoxification in residential |
| 138 | SP identified a long-term motivation as motivation to seek help from a GP |
| 139 | SP identified a long-term motivation as motivation to access methadone |
| 163 | SP experiences clients who experienced difficulty detoxing with methadone |
| 164 | SP experiences clients who experienced difficulty detoxing from methadone |
| 165 | SP experiences clients who expressed the difficulty of withdrawal from heroin |
| 166 | SP experiences clients who experienced severe emotional and mental during withdrawal |
| 167 | SP experiences clients who experienced severe emotional and mental during withdrawal as a reason for failing self-detoxification |
| 168 | SP experiences clients who found physical symptoms manageable during self-detoxification |
| 169 | SP experiences clients who approached GP looking for safe process of withdrawal, not phrased as 'detoxification' |
| 170 | SP experiences clients who had/has a fear of withdrawal |
| 171 | SP experiences clients who has experienced self-detoxification as a process of longer than 24 hours |
| 172 | SP experiences clients who experienced self-detoxification as a process of longer than one week |