CANAL COMMUNITIES LOCAL DRUGS TASK FORCE

NEEDS ANALYSIS AND REVIEW
OF
DRUG FREE SUPPORT INITIATIVE

A review conducted by

Community Action Network (CAN)

on behalf of

Canal Communities Local Drugs Task Force

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September 2012

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BACKGROUND

This report was commissioned by the Canal Communities Local Drugs Task Force (CCLDTF)[1], one of fourteen local bodies set up by the Irish government during the late 1990s to assist in developing an integrated approach to drug problems in those areas where these problems were greatest: thirteen in Dublin and one in Cork. These task forces bring together representatives from local communities, and statutory and voluntary agencies to agree and implement measures such as education and prevention, treatment and aftercare, and the generation and representation of relevant information on drug trends and developments[2]. The task forces operate under the overall framework of the National Drugs Strategy[3]. This current strategy, 2009-16, is an update on two previous national strategies commencing 1997; both these previous strategies were focused on illegal drugs exclusively, while the intention of the current strategy is to include alcohol as a new component[4].

As part of its strategy the CCLDTF in 1999 established a Drug Free Support Initiative (DFSI) to promote a drug free option whereby drug users in recovery[5] could be supported to socially integrate and participate in drug free social activities. The proposal in relation to this initiative is outlined as follows in the task force service development plan (2000)[6]:

> Action 16: Drug Free Worker - Although the Task Force is keen to further invest in supporting the development of rehabilitation responses, concern has been expressed in relation to the development of formalized structures at this end of the continuum of care. It is felt that while recovering drug users frequently require assistance and support as they disengage from treatment services, and although many may not be ready for work or structured training, it is nevertheless felt that developed service provision may lead to a

> culture of dependency and ultimately, disempowerment. Rather than continue to develop rehabilitation models, there is a preference for seeking to support recovering drug users to integrate into mainstream employment and training supports as appropriate. Brief: The role of the Drug Free Worker would be to support people to become and remain drug free. The worker will have a roving remit and the work will involve outreach and support work to recovering drug users, and will include setting up support groups and developing other services, as appropriate and based on a needs assessment. An important emphasis will be on linking recovering drug users back into their community, addressing integration and other needs

The specific aims of the DFSI were subsequently outlined as:

- Promote the drug free option to services, organisations and the broader community in the CCLDTF area;
- Provide a safe space for those who have chosen a drug free option;
- Continue to be a resource and link support worker to drug free people, individuals and groups, as and until, they integrate fully into the community and disengage from direct drug services;
- Assist, support and facilitate drug free people to maintain their drug free state;
- Participate in community development processes in order to further the work within the Task Force and the community[7].

In practical terms there are now three key components to the initiative: the first is the employment of a drug free worker (DFW) with direct responsibility to provide supports to people contemplating the drug-free option. The second component is a drug free social evening, which is held every Tuesday evening at a local community premises and which is open to persons in recovery who are drug-free or on a pathway that could lead to them becoming drug-free. The third component is that out of this social evening a self-organised Drug Free Integration Group (DFIG) was formed and essentially it, with the assistance of the drug free worker, provides a basic structure for organising the social evening.

Thirteen years after this initiative first commenced, the task force decided to examine the initiative and to review the relevancy of the original terms of references in light of the information gathered and wider policy and other developments in this field, and present key recommendations in this regard. To implement this review it issued an invitation to tender and Community Action Network (CAN) was awarded the review contract. CAN is a not for profit, independent, organisation that uses community development to work with people towards improved participation in society, to have their voice heard and their choices respected. Its core work includes leadership training, organizational development and participative research[8]. Monica Manning from CAN oversaw the contract; she also had responsibility for leading discussions with the various community and organizational respondents. Independent research consultant, Dr. Barry Cullen, worked in association with CAN and had overall responsibility to compile, draft and write reports.

The aims of this review as set out by CCLDTF are to:

- Assess the Strengths, Weaknesses, Opportunities and Threats of the current initiative
- Identify additional or alternative support needs that may respond to the social, economic, environmental and intellectual needs of those a) who are drug free and b) those wishing to become drug free

An action-research structure was used to develop and compile this review, which took place over a five-week period, June-July, 2012; the draft report was presented during July, 2012. In this approach an analysis of early stage data

informed the questions to be addressed in second and further stages; during the early stage the research team met with three key project stakeholders: the commissioner group, the drug-free worker, and the replacement worker[9], and these discussions helped to frame the overall questions to be addressed, in setting parameters for data collection and for dealing with logistical issues in getting the review set up and completed. During the second stage the team conducted focus groups with three sets of key informants: core members of DFIG, a group of external service providers, and representatives from the commissioners. At a later stage the team visited the social evening and had several individual and small group (5 x 3 persons) discussions, as well as an opportunity to make general observations; this visit was followed up with some focused interviews with individual DFIG members, including an interview with the drug-free worker. Finally, the team also had an opportunity to meet again with the commissioners to clarify issues that had arisen and to seek further information as appropriate. During the period, research team members also took the opportunity to acquaint themselves with relevant reports and literature, particularly dealing with issues concerning "rehabilitation" and "peer support". Throughout this review process the team was treated with warmth, courtesy and openness and experienced no resistance to the work or questions; in this regard the team acknowledges, with thanks, all those who gave of their time, ideas and energies to participate in this process.

INTRODUCTION

Public efforts to tackle substance misuse problems have many components straddling various departments and layers of government and several community and voluntary agencies. In this report, the concern primarily is with one component, that of recovery from drugs and alcohol problems and in exploring this component the concern more specifically is with the role, potential and limitations of peer support groups, within a community context. A working assumption underlying the initial task force decision to take this initiative is that it is possible to mobilise social supports for rehabilitation through a community development process, that participation in or membership of peer support groups can add value to an individual's rehabilitation plan and that the development of such groups can also, more widely, contribute indirectly to society's support for rehabilitation. In many respects it is hoped that, through this report, these assumptions may be explored and tested, although in doing so it is important to acknowledge that first, peer support groups are affected by changes and developments within the rehabilitation policy environments in which they operate, and secondly, while peer support is an important adjunct to the management of addiction, it is not in itself a formal therapy or treatment.

As with any report or discussion of these matters, definitions are central to providing structure and focus. In this regard, this report commences with definitions of the concepts of rehabilitation and peer-support and this is followed by more detailed separate overviews of the policy and practice environment for rehabilitation, as it currently operates. Thereafter the report reviews the

experience of the drug free support initiative and its related peer support group, their achievements, challenges and future prospects, and makes reference to the rather limited research literature on this topic. Finally, the report makes recommendations in relation to the continuation of this initiative within the context of developments in alcohol and drugs rehabilitation in the Canal Communities area.

DEFINITIONS – REHABILITATION AND PEER SUPPORT

Rehabilitation is broadly concerned with restoring to individuals some or all of their capabilities that were damaged, disrupted or lost arising from trauma, illness, disease or periods of social disengagement - either forced or voluntary. In the more specific health, social and judicial-related fields with which it is associated the rehabilitation concept is multi-faceted and subject to variable, social, moral and legal meaning. This is particularly the case with respect to substance misuse straddling, as it does, this range of domains. Generally, drug rehabilitation refers to the process whereby an individual misuser engages in re-establishing control over alcohol and drugs such that these no longer cause them problems. There are, of course, contrasting views as to the nature of control and specifically whether total abstinence from use of alcohol and ALL drugs is a necessary requirement for exercising control.

A related issue is the use of pharmacological therapies in rehabilitation and whether these, when used as a stand-alone treatment, constitute a rehabilitative intervention, or whether, with rehabilitation aims, they should be used only in combination with other psychosocial programmes. Later in this report reference is made to ambivalence in relation to the meaning of control particularly as it relates to the use of prescribed drugs.

Peer support groups are basically defined as self-help groups that facilitate the interaction of peer members in helping to strengthen and sustain efforts to tackle personal and social problems. Such self-help groups operate across a

range of different fields and there are thousands of such groups throughout Ireland, dealing with issues such as visual impairment, dyspraxia, multiple sclerosis and mental health, to mention just a few. In the field of addiction, the longest established peer support group is Alcoholics Anonymous (AA)[10], which in turn has spawned the development of Narcotics Anonymous (NA)[11] and Cocaine Anonymous (CA)[12]. Together, these support groups are sometimes referred to as the Fellowships (or the As).

In addition, other peer support groups have also emerged and some of these developed as a reaction to aspects of the Fellowships, for example Fellowships emphasise the need for total abstinence from all drugs and alcohol in order to achieve sobriety and to facilitate rehabilitation; they also underline a spiritual dimension to recovery. Such distinctions have led to the formation of groups such as Moderation Management[13] – which does not necessarily aim to achieve abstinence, and Self-Organization for Sobriety[14], which supports abstinence but emphasizes secular as distinct to spiritual values. In general it can be stated that peer support groups for substance misuse recovery function in order to facilitate the interaction of peers to provide and/or receive advice, information and social engagement that helps to strengthen and sustain ongoing recovery from addiction.

These groups have common characteristics: for example they usually consist of members who self-identify as dealing with drug-use recovery; supports are also provided in an exchange between peer-members; and the main type of support offered tends to be social, emotional combined with practical. These various

groups also have differences, particularly in terms of focus of recovery (abstinent or not); length and extent of membership (lifelong or short-term); focus on surrendering to external power or self-empowerment; remuneration for paid members with specific work roles; the involvement of non-peer members / external advisors; mechanisms for self-support (groups, outings, workshops, etc.); and role in external affairs (education, prevention, promotion, etc.). The general thrust of these various groups is to create and support the development of social networking opportunities that are free of alcohol and drugs and where members can form, develop and nurture new, alternative social relations to assist their recovery.

REHABILITATION OVERVIEW

The policy and practice environment that operates to reduce the problems and harms arising from and associated with substance misuse in Ireland operate across a range of domains under two broad headings: *supply reduction* - including legislative controls, taxation, policing and law enforcement – and *demand reduction* - including advertising programmes, school-and youth-based prevention, outreach counselling, medical and non-medical treatment, and rehabilitation (or recovery). Each type of measure has their own literature base, providing details of programmes, their aims & objectives, their modalities and evidence of success or not [3].

Under the general heading, *demand reduction*, the concept of rehabilitation is multi-faceted and subject to variable meaning. For some, treatment and rehabilitation basically mean the same; for others treatment means medical interventions, such as drugs detoxification and methadone maintenance, whereas rehabilitation refers to psychosocial programmes, such as motivational interviewing[15], behavior modification[16], therapeutic community[17], 12-steps facilitated therapy[18], and community reinforcement[19], that assist individuals to re-integrate back to normal social and family functioning where they no longer rely on alcohol or drugs. In some respects these different understandings can arise depending on the level of medical interventions required or provided within any particular context, which change across both places and time. In recent decades, a concern with public health issues arising from the transmission of blood-borne viruses through opiate needle injecting has brought a focus to the

need for harm reduction measures; previously medical involvement was exercised primarily through the mental health sector whereby addiction was designated a mental health illness or disease.

The integration of treatment and rehabilitation into a single policy category has been a given in successive Irish drug policy statements since the 1960s, initially through the involvement of mental health practitioners and more latterly through both mental health and public health, in tandem. The current overall policy, the National Drug Strategy, is a rare working example of an integrated policy across several government departments, spanning police, customs, courts, health authorities, training and education bodies; since 2009 the Strategy includes both alcohol and drugs within its remit. At its outset the Strategy had community organisations in a leading position, but their role has waned in more recent years, with suggestions that under the latest Strategy structures for community support have been "eroded" and "dismantled"[20], a situation that is described as follows by one contributor to this review:

> The driving force behind task forces is now changed. If things had stayed the way they were in terms of the overall national strategy, the integration at all the different levels that worked for a while would continue. But, it has become disintegrated for all sorts of different reasons (DFIG, FG).[21]

One feature of the overall initial integration is that the Strategy itself was first formulated during the mid 1990s in response to an illicit opiate problem that was perceived as posing a significant health and public order crisis, arising in part from the poor availability of methadone prescribing and consequently the putting into place of medical facilities for such prescribing has dominated much

of the Strategy's work programme, thereby providing medical authorities a central, dominant role in treatment and rehabilitation. Indeed at an early stage drug task forces seemed pre-occupied with trying to get these facilities into place

> The general thrust of the national strategy and the drugs task force was harm reduction and that was driving us; the drug teams were also coming from that angle. It wasn't to get people off drugs! (DFIG, FG).

The decision to put prescribing facilities into place followed a period of intensive research interest in the subject of methadone maintenance, particularly in the UK and Australia, building on previous work undertaken in the US during the 1950s[22], and the publication of important reviews that provided substantial evidence these measures had a significant role to play in reducing HIV infection[23] and in improving the health and social well-being of heroin users[24, 25, 26]; the value and validity of these interventions has been upheld since in treatment outcome studies, which on the whole demonstrate that increased treatment, particularly methadone, leads to reductions in drug-related behaviours and is also cost effective[27, 28, 29, 30, 31].

The requirement for medical intervention through methadone prescribing does not arise in relation to other illicit drug problems and by the time the mid-term review of the National Drugs Strategy (2001-8) was undertaken in 2005, there was wider public and community concerns in relation to the need for rehabilitation programmes, both for persons who were long-term on methadone and for persons with other non-opiate drug problems. Indeed, these emerging difficulties, particularly in relation to alcohol and cocaine were heralded by outcome studies[32], and were also becoming evident through local research in the

canal communities area[33]. These developments led to various calls for the setting up of quality, alternative, non-medical services[34, 35. 36]. At the time the roll-out of intensive methadone services had been in train for over a decade and various individuals and public bodies, including many community agencies, were beginning to wonder was there much more to state authorities' cache of rehabilitation interventions on drug problems than methadone, which was exclusive to opiate problems only?

Moreover, although emerging results from national longitudinal research on drug treatment outcomes – which commenced in Ireland in 2002 - were generally represented as positive, less than 30% of the group researched remained free of illicit drugs at 3-year follow-up, and 60% were on methadone[31]. Of course, retention on methadone prescribing is considered a positive outcome, and indeed "continuity of treatment" is what manages to keep methadone prescribing in the "firing line"[37], where quite easily it can be forgotten that it plays an important role in mitigating other drug-using and drug-related behaviors and that it can also ensure more effective individual health screening and monitoring. It is noteworthy nonetheless – especially given that the study included drug free treatment also - that a higher percentage of research participants, in the Irish study, at year 3 were on methadone maintenance than at the study's outset.

Individuals and groups who would wish to see more evidence of medical interventions leading to drug free outcomes were hardly sanguine by these research results. Some submissions to a 2010 review of the Methadone Protocol

advocated an expansion in community detoxification facilities and the need for more efforts “to support and encourage drug users to undergo detoxification[38]”. One submission to the Protocol review expressed a fear that some medical practitioners were reluctant to countenance detoxification programmes: it described “an unexplained unwillingness on behalf of some prescribing GPs to engage in reducing methadone dosage” including in cases where this was the “client’s stated wish” and where the reduction was “supported by treatment and rehab service providers”[39].

With these factors as background, a distinction emerged in the Mid-Term review report between “treatment” and “rehabilitation” and indeed the latter has since been included as a fifth component (pillar) in the National Drugs Strategy, alongside, supply, prevention, treatment, and research. The emerging distinction between treatment and rehabilitation potentially brings more focus to policies and practice that are specifically designed to assist individuals in their rehabilitation with respect to addiction and dependency matters, as distinct to practices and policies that seemed focused solely on maintaining them in a relatively stable state, such as on methadone; in this regard there is an emerging body of research supporting the role of psychosocial interventions applied in combination with methadone as making a positive contribution to detoxification and rehabilitation[40]; and indeed the report of the Protocol review stressed that “detoxification alone with no other psychosocial input is not a proper treatment and there is a need to ensure that detoxification is embedded in a strong psychosocial and rehabilitative context” [40].

Arising from the mid-term review policy adjustment, there was a rising expectation from community and other agencies that separate rehabilitation budgets and programmes would begin to flow, and that these, of course, would be additional to existing resources for methadone treatment. The downturn in the Irish economy has flattened these expectations. While service developers and providers would expect to be able to garner new ideas and proposals for rehabilitation there is a lack of optimism that improved funding will be made available to support such provision.

In addition to establishing a new, fifth pillar in the National Drug Strategy, another development arising from the Strategy's mid-term review was that of providing a more coherent definition of rehabilitation. The process embarked upon in seeking a definition reflected processes previously utilized in drug policy formulation, with an emphasis on consultation[41] and on generating information[42]. The process also took cognizance of similar developments in other jurisdictions and was undoubtedly aware that internationally a re-focusing on rehabilitation-as-abstinence was underway[43, 44]. In 2008 for example, the devolved Scottish government set out a new vision of drug policy that viewed that all treatment and rehabilitation services needed to be underlined by the "concept of recovery" which is described as "a process through which an individual is enabled to move on from their problem drug use towards a drug-free life and become an active and contributing member of society"[45]. This new policy made clear that "significant change" was required at service and practitioner levels and that a stronger emphasis in commissioning and supporting services would in future be put on "outcomes and on recovery". An

important background to the Scottish government's decision was a 2007 report by its advisory committee on drugs misuse[46] which citing Scottish drug treatment outcomes research[47], reported *inter alia* that some methadone had "leaked" into illicit markets, that there had been some "methadone-related" deaths, that methadone was sometimes perceived not as a route to rehabilitation but as a "de facto lifelong prescription", and that many persons on methadone encountered resistance from service providers in trying to move from maintenance to detoxification programmes.

The architects of Irish drugs policies would of course be aware of developments elsewhere and were likely anxious that policy discussions in Ireland would not become polarized around a debate between abstinence on the one hand and methadone maintenance and harm reduction on the other. They would likely have wished to have avoided the situation that existed in Ireland prior to the early 1990s when a strict policy focus on abstinence-only service aims, alongside a centralized, specialized treatment regime, contributed to considerable political inertia with respect the mounting injecting opiate problems that subsequently reached crisis levels in many socially marginalized neighbourhoods, such as in Canal Communities catchment area. Official contemporary discussions in Ireland point to a broader UK debate based on a similar process in the US in which attempts are made to agree a consensus statement on rehabilitation

Significantly, the US consensus panel avoided an absolute distinction between "abstinence" and other approaches, even though treatment policies in that jurisdiction continue to be dominated by an abstinence ethos[48]. The panel[49]

defined recovery as "a voluntarily maintained lifestyle (characterized) by sobriety, personal health and citizenship", and went on to differentiate stages of recovery, classed as "early sobriety" (the 1st year), "sustained sobriety" of between 1 and 5 years, and "stable sobriety" of more than 5 years. Sobriety was viewed as "primary and necessary for a recovery lifestyle" and the panel emphasized that the condition could be "most reliably achieved through the practice of abstinence from alcohol and all other drugs of abuse". However, it also acknowledged that although persons on drug-maintenance programmes within the US would not generally be recognized as in recovery, this position is quite different in many other jurisdictions whereby such participation is also often described as "medication-assisted recovery". Aware that its intention was more with the "condition" than with the "method" of recovery the panel decided that its definition of recovery included persons on maintenance programmes provided, of course, they were "abstinent from alcohol, all illicit drugs, and all nonprescribed or misprescribed medications."

The UK consensus report avoided a pre-occupation with abstinence and defined recovery as "voluntarily sustained control over substance use, which maximizes health and well being and participation in the rights, roles and responsibilities of society"[50]. This nuanced approach was referenced within the Irish process, although the UK consensus did not stave off government efforts there to review the provision of prescribed methadone and to make abstinence central to rehabilitation policies; under new policies persons on methadone maintenance are expected to "move towards full recovery as quickly and as appropriately as they are able to"[51].

In their approach to defining rehabilitation, contemporary Irish policy-makers have, so far, avoided making the achievement of abstinence a central policy aim and adapted instead a more nuanced approach in which rehabilitation is aimed at reducing harm and at addressing individual health social needs. This definition was elaborated on in 2009 in the National Drug Strategy in which rehabilitation is described as:

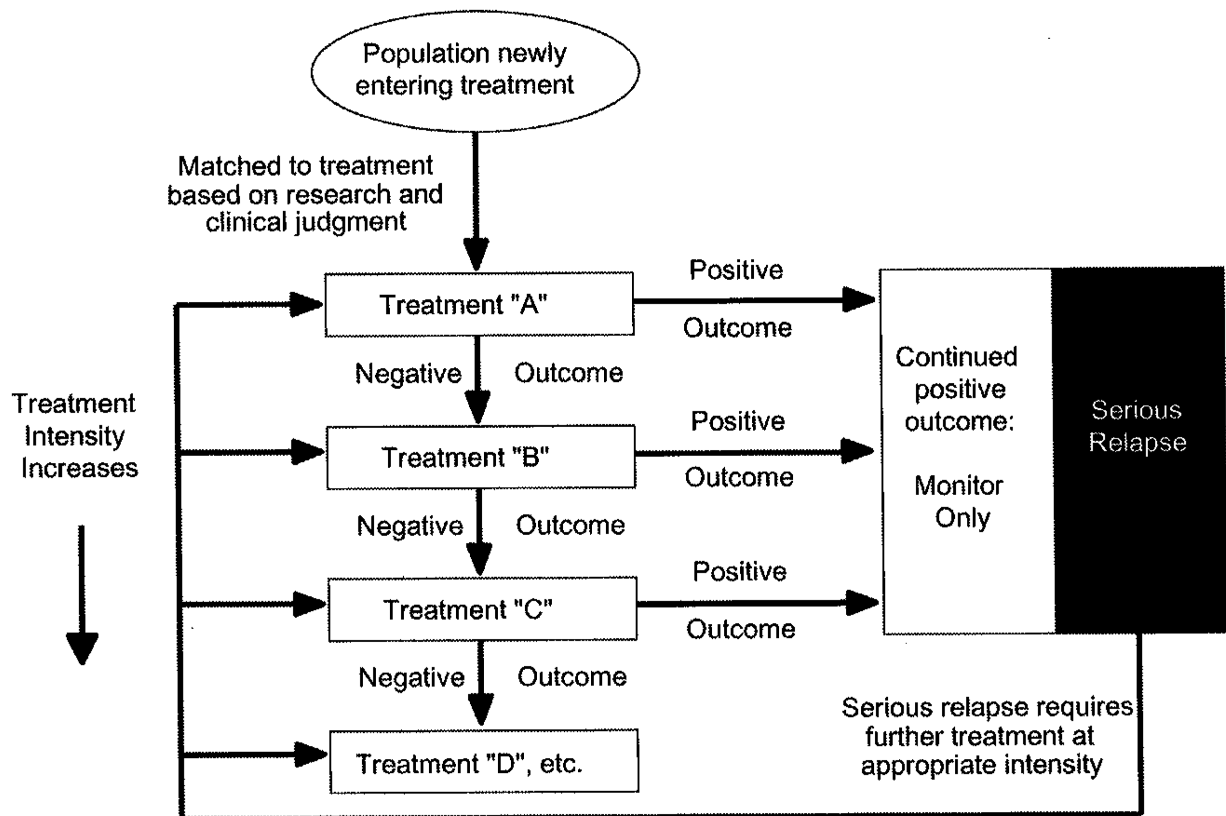
- Including a structured development process focusing on individuals;
- Involving a continuum of care that is aimed at maximising their quality of life and enabling their social and economic reintegration into communities;
- Aiming to empower recovering problem drug users so that they can re - engage with society in a manner consistent with their needs and expectations;
- Stressing the importance of self-activation and self-preparedness; and
- Viewing motivation as critical to achieving a successful outcome[52].

It is clear that neither this definition nor outline seek to impose abstinence from drugs as an underlying aim in rehabilitation, and that whatever new impetus Irish policy seeks to give to rehabilitation it does not, as of yet, extend to any dramatic reversal of its commitment to methadone prescribing. It should be expected however, particularly given the concerns that have been expressed to date, and in light of emerging international debates on the subject, that tighter controls over methadone prescribing alongside more intensive efforts to assist programme participants in reintegrating back into social and community life, will gather momentum. Indeed the task force commissioners of this DFSI review expressed that a re-focusing on rehabilitation will undoubtedly feature in future strategic plans and developments.

These wider developments with respect the incorporation of rehabilitation into drug policy and practice naturally provide, of course, a background and context to the development of rehabilitation plans at the level of local treatment agencies and services in Ireland. To date, the most significant development, from a rehabilitative perspective, has been the roll-out of an integrated care planning and case management system[53], which is focused on creating individual rehabilitation pathways that would ensure that "individuals affected by drug misuse are offered a range of integrated options tailored to meet their needs" and in accordance with the 4 –tiered system – spanning primary, secondary, specialist and intensive care systems - for managing such problems, an approach that is consistent with the *stepped-care model*[54]. Figure 1 (Stepped-care model) illustrates that persons with substance misuse problems enter (or re-enter) treatment at levels that match the seriousness of their problems, at any particular time. Within the model, interventions are multi-faceted and operate across a range of psychosocial modalities, depending on the individual's level of problems, their readiness to change and the overall complexity of their relationships and living situations.

The stepped-care model and case management systems are underlined by a commitment to participants' self-directed rehabilitation and avoids the "one size fits all" approach towards a more eclectic system of psychosocial programmes. International reviews of effective programmes draw attention to the importance of pragmatic, community-based therapies such as community reinforcement therapy and of cognitive behaviour programmes, preferably provided in

Figure 1 Stepped-care model



community as distinct to residential settings, although the latter would obviously be required in exceptional circumstances[55, 56]. The general approach highlights the importance of community as distinct to specialized systems in providing ongoing contact, support and encouragement to persons with substance misuse problems: mobilising potential community supports – including peer supports - to the misuser seeking rehabilitation forms an important component of this stepped-care, systems approach, while overall rehabilitation objectives, as previously stated, remain flexible, depending on the individual, their circumstances, their motivation and desire to change[57].

Peer support groups can obviously play an important role in supporting,

community-based rehabilitation strategies, although there is little or no mention of these in official policies. There are wide variations between peer support groups although they all share the central idea of peers helping peers to overcome their alcohol and drug problems and to achieve recovery, however defined. Self-selecting peer-support groups do not lend to classic research enquiry, although there is a body of literature, based mainly on AA and drinking outcomes, supporting their efficacy[58]. One longitudinal study, for example, of a non-clinical population sample of people's drinking found that significant numbers of the cohort gradually recover over time, and that this recovery is achieved through a combination of non-clinical events or developments – such as substitute dependency, health problems, social support, inspirational sources – and that AA, or similar, have played an important role bringing these together[59]. Various reviews and studies report that persons who attend AA during or after other professional treatment do better more generally than persons who do not attend[60, 61, 62, 63] and that outcomes for AA members – in terms of reduced addictive behavior - are more favourable for those with more intense involvement, more frequent meetings, more likely to have or be a sponsor, to lead meetings and to have worked through the full twelve steps after completing formal treatment[64]. Higher rates of abstinence through attendance at 12-steps meetings are also evident both within a year[65] and after five years in relation to both alcohol and drugs[66, 67].

Clearly, there is research evidence supporting peer-support as a valuable resource for complementing other programmes, basically adding value at little or no cost to community programme providers and funders. Two particularly

important dimensions to the development of peer-support within AA is that firstly, 12 steps attendance has benefits for persons who otherwise have no abstinence-based support networks[68], and secondly, such groups are available freely, long-term, with easy access and on a self-chosen frequency that participants can regulate themselves according to their own individualistic needs[69]. In this regard therefore, peer-support fits comfortably with self-directed rehabilitation and it would seem self-evident that any formal organization involved in alcohol or drugs rehabilitation from either policy or practice perspectives would invest some time, energies and resources into exploring and promoting the development of AA and/or other peer support groups, as a complement to other efforts.

Over the course of the last 15 years since the National Drug Strategy was established the rehabilitation policy environment has changed in a number of ways. First, the Strategy commenced within the context of the need for an urgent response to a seeming out-of-control opiate injecting problem; with new facilities and a substantial increase in methadone maintenance numbers, this particular urgency has abated. Secondly, a lot of concern has been expressed about the role of rehabilitation with respect to methadone prescribing and also in relation to non-opiate drugs and these concerns have led to the inclusion of rehabilitation as a separate pillar in the National Drug Strategy and have also contributed to the concept of rehabilitation becoming more spelt out in official documents. Thirdly, the downturn in the Irish economy has meant that these changes have not led – as was expected - to any new investment of resources into community-based rehabilitation. Fourthly, it is evident that in spelling out the

meaning of “rehabilitation”, official documents have avoided re-adopting the approach of placing abstinence on the top of a hierarchy of rehabilitation models, as is the case in the US and is on the way of becoming the case in the UK. For the present at least the rather nuanced official approach to rehabilitation provides for the possibility that persons on methadone maintenance who are stable and off other drugs are officially considered available to participate in psychosocial programmes, or peer-support initiatives, provided of course they wish to and that the programmes exist. In general, the case-management, stepped-care approach, which has evolved over fifteen years, remains relatively intact, although funding, particularly for community-based components, including rehabilitation, is insecure. Finally, it is noteworthy that peer-support as a rehabilitation concept is consistent with the eclectic, stepped-care, tiered-model, as espoused in official policies, yet there is little reference to it in these policies. There is a good body of research supporting the value of peer-support, particularly as a complement to other programmes and services. In this regard, it would make sense for locally based organisations, such as task forces to promote peer-support ventures.

THE DRUG FREE SUPPORT INITIATIVE

The Canal Communities Local Drug Task Force (CCLDTF) Drug Free Support Initiative commenced in 1999 with the specific aim of ensuring there was in place a support mechanism to assist persons in treatment for drug problems to develop a drug-free rehabilitation pathway, should they so choose. The main, initial component to the initiative was the employment of a Drug-Free Worker (DFW). It is noteworthy that, at the time, the task force juxtaposed drug-free rehabilitation programmes with problem-focused psychosocial services[70]; in the main the former had become associated with specialist services such as therapeutic communities[71], and with organisations that provided 12-steps facilitated therapy, for example the Rutland Centre[72] and Aiseiri,[73] whereas the latter advocated a more generalist model wherein services would reach out and engage drug misusers through harm reduction[74] ; the former saw drugs abstinence as the primary goal, while the latter settled for getting a measure of control over drug-related personal, health and social problems, with abstinence as an aspirational, albeit optional, goal.

In the initial preparations for the service plan the task force gave some consideration to the need for a more intensive, drug-free rehabilitation programmes, but given the tendency, at the time, to see rehabilitation in specialist and indeed in residential terms it became obvious that it would not be possible to put such facilities into place in any individual task force catchment area. In due course, alternative rehabilitation programmes were developed locally through Community Links and Turas [75]. In general, the task force's

service plan – in line with many other local plans at the time - gave priority to the need to develop problem-related services and programmes, thereby eschewing a direct focus on abstinence and drug-free rehabilitation as an overriding goal, while dealing with the provision of methadone places, health and social care, family support, psychological issues and educational deficits.

As an alternative to its initial ideas around a rehabilitation facility the task force decided to employ a drug free worker as a resource to the drug teams and other services and projects in the area, although initially it was unclear as to how this person's workload would pan out. Essentially a lot depended on how the DFW would interpret the role and from an early stage this became focused on providing outreach support to facilitate drug-users within the area to engage in recovery pathways that are either drug-free or leading to being drug-free.

The inclusion, within the service plan, of a commitment to employ a drug-free worker, might in retrospect, be considered a concession to individuals and bodies who were less-assured about a problem-focused, harm reduction approach to drug treatment, although it is clear that at the time some task force members were particularly keen to include at least one initiative of this type.

In commencing this role the DFW promoted drug-free rehabilitation pathways at individual project level in the task force area, and also provided individual social supports to persons engaged in or seeking this pathway. Two other important developments gradually emerged: first, was the setting up of a regular social evening whereby persons who were already drug-free or actively engaged in a

drug-free pathway could come to socialise and receive other supports; second, was the setting up of the Drug Free Integration Group, which effectively acted as a self-organised committee for the social evening and also engaged in promoting other social support activities. Other dimensions to the DFW's role also evolved; for example, over the years, the DFW engaged with local service providers in relation to the issue of drug-free rehabilitation and also organised a number of area-based seminars on the topic. However, the most important dimension to the role as it evolved, involved providing direct social and personal support to individual drug users contemplating or engaged in rehabilitation. It is emphasised that this is not a visible therapeutic role and that it does not follow a specific therapeutic model.

> (The) one-to-one contact with individual members is on a non-therapeutic basis. (There is) a contact sheet for people who engage… in this individual way. (T)he limitations of (the) role are (clear) and ideas around re-integrating (are agreed), ….such as building a CV, filling in time and so forth (DFIG, FI).

One difficulty in exercising this support role initially was that of choosing appropriate settings whereby the DFW could access and engage individual drug users. Existing drug services and other therapeutic settings were considered inappropriate, although as already mentioned the worker did engage with personnel from these services in order to brief them on the work. However, by making direct contact with drug users in drug services the DFW risked confusing this role with that of the respective services, although it is noteworthy that the social evening was eventually provided at

a drug-service premises, albeit one that is well integrated into other community facilities.

The idea of a social evening for persons who were drug free arose early during the DFW's employment and in due course the idea was sustained not least because it provided the DFW with an appropriate setting for engaging with and developing social support with drug users. It also suited the DFW's preferred community development approach to the work. In essence this approach involves working with a group in relation to their identified needs in a manner that facilitated the development of collective leadership and eventual ownership of the group process. The social evening and the establishment and development of DFIG were consistent with this preferred model. While the DFW played an important role in developing the social evening, it is also clear that the social evening is itself an important access point for the DFW in providing more direct support to drug users.

> If people wanted further support as a result of raising things at the social evening then this support was there for them through the drug free worker, who would follow up (LS, FG).

This direct support is referenced across the range of people associated with the initiative, and it draws attention indeed, to the importance of the DFW as an external worker in providing DFIG with back up to be effective as a social support group. The development has also meant that individual drug users who required additional individual, one-to-one support could engage the DFW directly in relation to this support at the social evening and during follow-up meetings afterwards.

Throughout review consultations, references to the drug free social evening were primarily positive. The evening, which is held every Tuesday evening at 7pm, is described as

> A social space that people who are in recovery can come to and can know in advance there will be no alcohol or drugs consumed, there will be no offers of drugs, there will be no talk about highs and the effects of different drugs, and there will be no individuals present who are currently stoned or confused as a result of drug intake (DFIG, FG).

As matters currently stand responsibility for organising each evening lies with the Drug-Free worker (or replacement) plus one other, rotated member of the Drug Free Integration Group (DFIG) – both of whom are "in charge" for the evening. Each social evening is planned ten days in advance and is held in the foyer area of the Rialto Community Drug Team premises. On a monthly basis DFIG meets to review recent social evenings and to discuss new ideas and plans. This forward planning ensures that at any single event participants present are made aware of plans for the next event.

The premises are located adjacent to the community centre and other community facilities in Rialto and there is regular footfall into the overall premises for all sorts of other activities; the entrance to the social evening is separate to other activities; inside there is a central octagon-shaped concourse area with chairs, armchairs, coffee table and off this area there is access to a number of smaller group rooms and a kitchen. In the kitchen there is tea, coffee and plates of sandwiches. The food dimension is highly popular and several

persons referred to its importance, particularly in relation to participants who were homeless or with irregular income, or meals.

On approaching the premises during a social evening there is no distinct indication that a drug-free social, or other activity of a drug-related nature, is in train, even though some members of the group – as is common with many such facilities – stand outside for smoking purposes. There is plenty of parking for attendees and their cars are mixed with cars from persons attending other events. The social evening is not restricted to local participants but is open to persons from all over the city who wish to explore the drug-free pathway. At a basic simple level it has obvious attractions to people who are trying to develop a lifestyle in which they do not use alcohol or drugs, in that it provides some badly needed social contact with other like-minded persons. This aspect is highlighted through a range of comments from separate social evening participants:

> If I'm at home and want to get out of the house for a while, I can't go to a pub. Some people think it should be easy for me to go to a pub, but they don't understand. Once a week I can come here and people understand here why I can't go to the pub (SEP).

> When you've worked hard all day you just want to get with like-minded people and socialise with them. I can do that here (SEP).

> When I come into the social I can really relax, I can be completely myself I don't have to be on my guard (SEP).

> I just know when I'm here I won't need to be looking around thinking someone is going to say: "are you coming for a joint? "(SEP)

> People from the As (AA, NA, CA) saw it as a place they could go with like-minded people. People come up from meetings, from after care – and after

> care can be very serious. But when you come to the social it is more laid back, more where people are at and no challenging unless people are unable to function (SEP).

> When you get clean you don't want to go out the front door. People lock themselves away they are too frightened to go out and the social is a good way of getting people out even if it is just for a night and it helps to slowly draw people out again – another option for people who have locked themselves away (SEP).

Apart from its general operation, there are some basic rules in relation to providing the social evening[76]. The most important rules relate to no-drugs and no-drink; obviously this means that no consumption of drinks or drugs is allowed on the premises but it also means that attendees are expected not to have consumed alcohol or drugs prior to attendance.

In any situation this would be a difficult rule to operate with complete effect, as apart from on-the-spot urine tests and results it would be impossible to accurately gauge drug and alcohol intake. The rule and its implementation therefore is built greatly on trust: attendees are trusted to abide by the rule but are also expected to comply with requests that they leave if it is suspected by those in charge that they have used drugs or alcohol and that their presence as a result is disruptive for others.

> Drugs can be in their system – we request obviously that they don't take drugs while they are there. If they are incoherent we might ask them to take a walk and come back when they are more lucid – we ask them not to be under the influence (DFIG, FG).

The situation in relation to methadone intake is different and a lot more complex. There has been a lot of discussion on this issue over the years and the group has veered between different approaches towards persons on methadone and whether they should be made welcome at the social evening, and although the current situation – as outlined below – allows for the participation of methadone users, it is not certain that this particular arrangement will not change, although it is accepted that more certainty with respect this matter is required.

Philosophically some people organising and attending the social evening hold a strong view in relation to the importance of drug free in recovery and offer the perspective that recovery cannot be achieved without an aligned commitment to achieving drug abstinence, including abstinence from prescribed mood-altering medications. They are moreover conscious that historically the social evening was set up with a specific drug-free focus – given that the task force at the time was pre-occupied with harm-reduction measures - and it is recalled there was some expectation that the social evening would provide a space where such people could come and meet up and be able to be together in the knowledge that they did not take drugs of any kind, and would not be subjected to further influence to do so.

> It was a place for people who were stable and drug free that they could come to and know they could come to without the use of drugs – any drugs – and just meet without the use of drugs (DFIG, FG).

For other members however there was ambivalence in relation to what constituted being drug free and that quite apart from the difficulties of

monitoring intake, they had to be aware that people could be on a drug-free recovery pathway and still taking methadone and that others had a dual diagnosis requiring they be prescribed alternative mood-altering drugs. In their view, such persons were in much need for a drug-free space for socialising as others and that it seemed unfair that they be excluded.

> They are people who are stable on methadone and we would see them as drug free, because they are taking their fixed amount every day and there are no street drugs involved. They are basically taking their medication (LS, FG).

> It would be for people who are on their methadone who are stable and who would want to get off their methadone and they get support from different people – there wouldn't be people there however who are affected by their methadone (DFIG, FG).

This particular issue has persisted over the years to dominate many of DFIG's discussions and it appears it has been resolved in alternative ways at different times, depending on the situations that arose. It is acknowledged that when this initiative was first taken there were always going to be difficulties in promoting a drug-free pathway to recovery, given (1) the wider emphasis on providing methadone programmes that were so badly needed at the time, and (2) that many drug free advocates had a bad press because they were perceived as being unreasonably trenchant in their opposition to methadone for too long. Aware of these difficulties, proponents of the drug-free pathway within the drugs task force felt they had to proceed cautiously following the task force's decision to employ a DFW. Rather than actively promoting the drug-free pathway, it was felt that ideas in relation to it had to be presented gradually and through painstaking

encouragement to people who provided some indication of a desire for this particular approach.

> It (a drug free support initiative) was always going to be hard to pull off in the first place. The drug free option was considered hardline and a lot of damage was done. It was about trying to get (the initiative) moved on and ….. that it (the work of the task force) wasn't all going to be about methadone (DFIG, FI).

> You can get people putting themselves on pedestals and it does happen and it drives others away. And the thing is you want people on methadone going in and they are looking at people who are drug free and then saying to themselves well that is where I would like to be. You get the sense well if he can do it then I can do it: he's no different to me (LS, FG).

Obviously, having slowly built up this drug free approach over the years, there is some reluctance to loosen the structures if this was to mean that the integrity of the drug free pathway was undermined. Thus, while there has been some broadening of the definition of drug free to allow wider participation, there remained reasons as to why this should continue to be approached slowly and with caution. The focus has shifted somewhat from drug free to a focus on what constitutes being on methadone and being stable. The ambivalence in relation to what does or not constitute drug-free however is evident, and it is suggested that this might reflect wider ambivalence in society, which in turn might suggest the need for clearer debate and discussion on the topic.

> There are different responses from different people – divergence about drug free mirrors the slight greyness that is out there generally (DFIG, FG).

In the consultations for this report, three different groups of persons on methadone were outlined to the research team: Firstly there is a group who are

on methadone and who are still using illegal drugs regularly and who are relatively indistinguishable in terms of their social behaviour from street-drug-users who are not on methadone; it is made clear that the social evening is not for members of this group as they would be considered volatile and have too negative an impact.

> We don't see any difference between the street drug-user and the person on methadone using street drugs. They are not different….Most people who are in recovery would hold the view there are people who are on methadone and are causing as much harm to themselves and to the wider community as other users who are not on methadone (DFIG, FG).

Secondly, there is a group who has stabilised on methadone and who would not be using other illegal drugs or alcohol. Essentially members of this group are perceived to be on a drug-free pathway and to be relying on methadone for stability and are therefore encouraged to attend the social evening.

> Methadone is not an issue because that is the objective - we're trying to give people a mirror for people to say "yes I can do that too"……They come in and see that there are people who are drug free and they see that yes it can be done (DFIG, FG).

Some members from this group were there on the nights the research team visited and were spoken to. They highlighted the importance of the group in giving them hope that they could overcome their addiction and they gave practical examples of other members making suggestions as to how to overcome particular problems they currently experienced with respect to their recovery. It was clear also that more established members were also open to their attendance, although differentiating between those who were stable and others clearly posed some difficulties.

The third group of methadone-users is relatively stable on methadone but dabble occasionally in other recreational drugs, such as "smoking a joint" or "having a pint" in circumstances where it is claimed such use "has no negative impact on (their) overall stability". There is considerable ambivalence in relation to this group as clearly they are not perceived as being on a drug-free pathway. There appears to be reluctance in some quarters to exclude them completely from the social evening if they are relatively stable and if they appear to be in control of their own additional alcohol and drug intake. On the other hand, some members of the core, drug-free group maintain that the forms of controlled drug-use referred to in relation to this group are not easily attained, in the manner that is often described and that occasional dabbling can quite easily lead back to other, more serious forms of drug intake.

> People who are drug free often take the view often that if they use a drug for the first time again then their addiction is going to be out of control again……..it's the one (use of drug) that brings you (back) there (DFIG, FG).
>
> Some people have tried a form of control and there are people who were not successful and there are people who have been successful in doing it. But for the people who attend the social and who tried that and it didn't work for them they fundamentally believe that addicts find it difficult to control and they need to become abstinent (DFIG, FG).

During these consultations the research team did not meet members of this controlled-use group, and it appears that members of this group are not currently encouraged to attend, although the prospects of reaching out to them in the future is likely to arise. In the meantime the focus of encouragement, as already mentioned, is more with the second group of stable methadone users,

even though there are some drug free persons who would still prefer that the social evening be restricted only to persons who are drug free.

> I accept the group decision that stable people should be welcome (to the social evening) but my strong personal preference is to have this group abstinence based. For me it is about safety and it is not safe for people early in recovery to mix with anyone other than completely drug free (SEP).

> I don't want people pulling coke out of their pockets ……I don't want them saying "have you got a works"? Its not just about being free of drugs but it is about being free from a social underworld where they don't have to be thinking about drugs day and night (DFIG, FI).

These concerns notwithstanding, in discussions with participants in the social evening the mutual impact of long-term (drug-free) and relatively new (stable on methadone) attendees on each other was striking. New members spoke openly about the importance of seeing older members and seeing how well they were doing as a result of being on a drug-free recovery pathway. Some of these people they would have known from their previous drug-using periods and they would have known how unhealthy their lifestyles were then: seeing them now doing so well was really important in giving them hope and inspiring them to believe that they too could succeed on the same pathway. It was incredible for them to be able to look around the room and see people, whom they knew to have used drugs, to be playing cards, listening to music, having friendly conversations and not to be coming across as "hassled".

> Some people come to check it out. They might say after a while: "y'know I have seen some people there who are able to function without their methadone and y'know maybe it is time I started to do that" (DFIG, FG).

> People can come in on methadone and they see there that there are people who are drug free and they see that it can be done (DFIG, FG).

New members spoke about the importance of meeting people who could relate to some everyday experiences they were going through in relation to their own recovery plans, and of being able to get practical advice and suggestions for dealing with these. For instance this might involve them having to go and see an official in a training agency, or similar, and they would relate through informal discussion with members of the group their fears about having to do this and often a member of the group would instance a similar experience and would offer to accompany them or provide advice or similar. They would get good encouragement from this and a very simple conversation could make the difference between going to meet the official or not going.

For their part, older members of the group explained the importance to them, in their recovery pathways, of being able to link up with new members. In an immediate sense it helped remind them how far they themselves had come within their own recovery, as they were meeting people who were on methadone and they could remember when they were on methadone and the difficult pathway they had gone through to come off methadone. They also highlighted the importance of being able to offer support and provide assistance to others as helping sustain their own recovery; they would feel good as a result and would feel positive they had reached a stage of being helpful. It is emphasised that older members are always keen to reach out to new members and are constantly seeking opportunities to listen in and offer the support.

> So, we are having a game of cards and something gets said, like someone says "there's a game of ball on Saturday, there's a five-a-side" and somebody (else) might say "I'd love to do that" and (the other) would say "really, well I'll pick you up. I'll meet you." So there is nothing in it other than the person knowing he was in a similar situation and somebody did it for him: somebody reached out. It was done for them, they want to do it for others. This part is crucial for me that people are able to do this – you hear it all the time and you see it all the time. ……So for instance, if someone having a problem with their partner is going through the family courts over a breakup or their children, there is always someone there who has been through that system, who understands it and who can help them, who can access a barrister, or simply say: I'll find out for you; I'll meet you there". Those little subtleties make the difference. I really know. I've seen it happen so many times during the drug-free social (DFIG, FG).

> You get to know new people. You get to meet people that have been through stuff that you are experiencing at that time and you can get their take on that. It opens up a lot. We go down and have a karaoke, sandwich and a bit of interaction, watch a football match, watch a DVD and while you are doing that you get the chance to talk to people, to talk to them informally. When you are sitting in groups of people like a meeting or a therapeutic group it is very intimidating for people and they can't talk and they won't share what's going on for them. But if you are sitting watching a football match, or having a game of cards and all this stuff is being talked about and it gives you a chance to open up and you can put your stuff out as well. You listen to people and you get their take on things and you get their experience. When you meet people who have been through what you have been through and can give you the benefits of their experience and they are able to tell you that this stuff that you are going through does pass well then it helps to normalise your experience. That is good for you (SEP).

In the discussion it was made clear that the nature of the support offered through the social evening is social and practical, and not directly therapeutic.

> Drug-free social is a networking place where people can come and meet; it is where people come and learn social and personal skills…..I would always encourage people to go in terms of developing their own social skills (LS, FG).

> We are very clear it is a social setting not therapeutic but there is a therapeutic value in the peer support offered here (SEP).

While people may have found some exchanges therapeutic in the sense that it helped them get deeper insights into their situations and ways of dealing with it, therapy was not the initial, intended focus of such exchanges.

Focus group participants from drug services emphasised the therapeutic importance of peer-to-peer support, for two reasons in particular: first that it re-assures participants they are not alone in dealing with their recovery and that there are others constantly going through the same experiences they have, and second, that it encourages participants to take greater responsibility, particularly for their own recovery, but to also develop an ability to be there for each other.

> It is really peer driven and that is great in terms of putting the responsibility onto the group and there is a lot of support for this aspect - role modelling - and for us – as (drug) workers - not to be taking on this responsibility (LS, FG).

> People go and have a cup of coffee – but they are engaging and we are helping them to achieve what they choose in their road to recovery, that they be empowered (DFIG, FG).

While the group is described as social/practical in orientation, it is also emphasised that the learning, personal development and building of social skills that takes places is much greater than what appears on the surface. For example, right across the various individuals who participated in discussions for this report there are several references to the use of Karaoke as an activity during the social evenings. These references are all positive and it is indeed remarkable the extent to which there was such positivity in relation to it; one explanation was as follows:

> They (peer members) have found their voice - sometimes simply through Karaoke. It is a way of people who have less confidence about becoming drug-free of finding a link out of the group thing that goes on with them in their addiction, to something new (DFIG, FI).

Other events organised by DFIG include day outings and weekend seminars on holistic therapies; at one stage a few members went on a foreign holiday together. It is clear that outings and weekends are viewed positively by DFIG members and helpful in sustaining recovery, but more broadly these other events are not referenced as carrying anything near the same importance or relevance as the social evening, partly because usually only small numbers can participate in out-of-centre events and obviously there are both direct and opportunity costs involved.

The consistency of having the social evening on every Tuesday evening has received most of the positive comment; in this sense it has become an established event that is well known among recovering drug-users and drug workers in local services.

> The social was the most important (event) and it is the one you go to at least once. If the social had not been there I would not have been able to meet up with people in DFIG (DFIG, FI).

> Knowing the social evening is on every Tuesday in itself contributes to people's sense of safety – even if they don't always attend there is a reassurance knowing it is there (LS, FG).

During two social evenings, research team members were conscious of latent, individual vulnerability. Yet, it was obvious that members wished to represent their experience of the social from a positive perspective and could outline comprehensively their understanding of how peer social support helped them to sustain their recovery. In this regard, both the practice and benefits of peer social support were outlined in simple terms and it appeared there was a challenge in representing these benefits in a tangible manner, and in ensuring the group's integrity would not be compromised through comparative references to therapeutic methods.

Group members repeatedly underlined that although it was not therapy, peer support was a necessary requirement for sustaining recovery and that the support they got from the social evening was an important dimension to this. Other natural support systems were also referenced in this regard, particularly in relation to family members. However, the unique importance of peer support was that it was support from others who had experienced similar moments and difficulties in their own pathways to recovery and were able, it was claimed, to demonstrate empathy in a manner that might not be possible from other support or therapeutic systems. Those who

showed empathy, were, as a result, able to progress their own recovery even further.

> I'd tell people about my own experience when I was feeling like that and what I did to overcome the same feelings that they were now going through. Afterwards, when I think about it, I remember just how far I've come myself and especially that I no longer have the desire to use and I tell people that that desire lessens. When you go into recovery first you still have that desire, but it does get less and less and when you tell this to people they are really blown away and impressed that the desire can actually go away. But, when you go into recovery first it is always on your mind – "I want to use; I want to use" (DFIG, FI).

The representation of this type of support was indeed quite simple and it appeared that as this was the core of what the group did, it should be careful to ensure that it does not become complicated through a direct association with therapeutic interventions. As already mentioned, some DFIG members had participated in weekend seminars on holistic therapies and it is understood that on one occasion a social evening had included some holistic therapy sessions. It appeared that the seminars in particular had been successful, but that views in relation to the social evening sessions were more mixed and it was suggested that such arrangements might potentially raise other concerns such as the social evening being used to recruit members onto therapeutic courses or programmes. Importantly, the weekend seminars were held away from the social evening, at an alternative location. Given the logistical requirements for such events it appears they attract only those who have a long-established involvement with DFIG. It is suggested that such alternative arrangements should continue in relation to

any therapeutic activity that is organised by DFIG, thus minimising the potential confusion between its core social support and other activities.

Clearly, in these discussions, the social evening was represented quite positively, although it is generally pointed out that it could be promoted more, and indeed other challenges arise in relation to its continued development.

Some negative perceptions of the social evening were also encountered during this research exercise, particularly amongst some service providers in the area. One person spoke of referring a client to the social evening and they had a negative experience; it was described as being like a clique where they felt a sense of disapproval from members because they were still using methadone. Most people in the service provider's focus group believed the DFI promotes total abstinence and confirmed this is a common perception within the wider community.

The arrangement whereby the social evening, while ostensibly operated by DFIG, but is yet supported through the DFW and the task force, draws attention to the issue of autonomy and leadership within this group. Some, reference is made to these issues as they apply to AA and it is clear that on this particular context the Fellowship has sustained its independence and autonomy and does not accept external funding, although it is noteworthy that in some respects it does employ people in administrative and other 2nd-tier support roles: finance, organisation, publishing, etc.

In addition to the DFW's role in supporting this initiative, the task force has, over the years, also financially supported DFIG – specifically through providing small grants (typically €4-5,000 p.a.) to cover costs associated with tea, coffee, sandwiches, social outings and a stipend paid to a DFIG member to assist the DFW in setting up and providing stewardship for each social evening: this responsibility is rotated through DFIG members and the stipend paid as appropriate.

In general, these have proven to be important supports and it is questionable whether DFIG and the social evening could have continued in operation without them; indeed most people have said that it couldn't survive without this support.

> I think it (the social evening) would survive to some degree on its own if the facility was there, if it was (more) organised and having somebody at the helm. The paid worker has been very crucial. The paid worker is always there and makes the commitment (DFIG, FG)

To receive grant aid DFIG was formally established, adopted a structure and opened a bank account. In a sense these dimensions provide evidence of DFIG's developing independence. It is noteworthy that DFIG was able to allow itself be supported by the DFW and through task force external funding. Although the essential funding required keeping the social evening functioning is minimal, these were really important supports.

The question was raised whether it might have been possible for these supports to have been provided directly through an existing service

provider and it is interesting to note that in general this idea seemed to be resisted; there was a sense indeed that individual services might wish to promote their own particular rehabilitation model, and that this would generate a perception that the peer group had a role in promoting that model.

> If you are linked to that organisation isn't that what you are promoting? When you have the independence it's different: it's members running the group for the members. The whole thing about peer support is that peer support is the model: peers supporting peers. That's the model (LS, FG).

For its part the task force is mindful that, although rehabilitation has in recent years become a focus of national policy that for many years local agencies, because they were pre-occupied with responding to injecting heroin problems, had little time or opportunity to invest time and energies into supporting that cohort of persons who were struggling to remain drug-free. While the task force had initiated the Drug Free Support Initiative and employed the DFW it nonetheless acknowledged more was required from it to promote this type of development both within the task force and more widely.

> The way I understand it is that when task forces were set up they responded to heroin and you had to get people in the door and try to look after them. Then suddenly we realised: "oh it's bigger than that" and then we started to look at the families, then we looked at the children and then we had to look at prisoners….Suddenly we've come up with a cohort of people who no longer use illegal drugs, who have come off methadone and most legal medications and we have not got there in terms of supporting them. In this area we have a drug-free worker virtually from the beginning there was lots to do in terms of supporting it but I don't think any of us were ready for it

> and it took a long time for us to realise this was a gem in a way that we did not exploit and it is really for all task forces (TF, FG).

There is some concern from within DFIG that to date it has been so pre-occupied with keeping the social evening going it has not taken the opportunity to step back to assess and promote the wider value of peer-support. For its part, the task force has expressed similar concerns and has indeed acknowledged that it, as a body, has not referenced peer-support for example in submissions to the National Drug Strategy. It is noteworthy that the Strategy itself in its documentation does not reference peer-support. The task force nonetheless has an interest in DFIG's continued operation and in continuing, where possible, its role in supporting it, in particular because it sees its value from a community development perspective.

> Peer support in terms of community development would be an obvious way of helping people to address their own needs within a collective model, with the support of others……(It is) important that the task force provides some type of facilitated support to the peer group; it has been successful throughout the years, and the people involved are getting a social benefit from it and a personal benefit. Without that it would leave a gap. It has value and I don't think we have the resources to exploit the value. We would seriously need to invest more in peer support (TF, FG).

Despite its expressions of support for the group the task force is aware that the grant scheme previously used to channel funds to DFIG has discontinued and that other dimensions to its own future funding and operation are also unclear. DFIG obviously needs to be able to look to alternative sources of funding support – a difficult challenge for any

relatively new voluntary or community group in contemporary, recessionary times. One option here, of course, is if at a National level a decision is made to create a fund with the specific intention of providing grant-aid to pilot the further development of peer-support groups. In the US in 2011 community agencies were invited to submit proposals to access such a fund with the purpose of delivering:

> …peer-to-peer recovery support services that help prevent relapse and promote sustained recovery from alcohol and drug use disorders. Successful applicants will provide peer-to-peer recovery support services that are responsive to community needs and strengths, and will carry out a performance assessment of these services[77].

Where DFIG as a group works best it is in relation to organising the social evening, and the practical details associated with this. It is not considered to be as organised in relation to other, more long-term dimensions to its operations, for instance in developing a long-term vision agreeing a structure for deciding rules and in being able to promote itself more widely to recovering drug users and drugs agencies and also in being able to make the case for funding from public and other bodies. Dealing specifically and as unambiguously as it possibly can with the issue of including methadone users, and the parameters of such inclusion would be a priority matter that requires early attention. While it was evident that the social evening is open to persons who are stable on methadone the research team was surprised to realise the number of persons, both service personnel and others involved previously with the group who seemed unaware of this.

In the course of the consultations for this report it was reported that at one stage it was envisaged that the social evening be available to any person from within the community who had been dealing with personal issues within their lives and wished to have a drug-free social event to assist in their own on-going recovery in relation to these other matters. One person directly represented this approach and in a discussion one other person indirectly supported it. This approach was not represented by any other person, including the persons whom met at the social evenings; indeed the evidence from consultations is that participants wished to have the evening restricted to persons who self-identified as having drug or alcohol problems and who wished to have a drug-free social evening as a support in their recovery: in the main they understood that was the event's purpose.

While the idea of an open, drug-free social event has many potential benefits for the wider community it can be argued it is premature for the group to be developing plans in this direction at this juncture. The social evening is still relatively new and while it has succeeded in establishing itself it would need a further period of consolidation before engaging in a more public manner with wider concerns, if indeed it should do so at all. The issue of providing broader, occasional drug-free events – such as no-name clubs - is perhaps something the task force could address within the context of discussions with service agencies and community bodies and plan and implement such events as important community occasions, not necessarily dependent on persons who continue to be engaged in dealing with their own recovery, although obviously such persons should be made welcome to participate if they so wish.

CONCLUSION AND RECOMMENDATIONS

At its outset, during the late 1990s, the drugs task force, like other community bodies, adopted a problem-focused approach to service developments, an approach that was influenced greatly by the absence of adequate methadone prescribing and other health and social care facilities. Although, the task force promoted the development of vocational-based rehabilitation for persons attending methadone programmes, it was quite restricted from a resource perspective in making a substantial investment into drug-free rehabilitation pathways, and decided instead to assign a drug-free worker (DFW) to assist individual drug users in moving towards rehabilitation. For all sorts of reasons not least was the urgency in developing appropriate methadone and other harm-reduction services within the Canal Communities area, the DFW initially lacked the support of a clear framework or structure giving direction to this work, and at an early stage an outreach, detached role was utilized, with the DFW offering supports to individual drug users on a drug-free pathway, but in a manner that was not directly aligned to any existing service.

The DFW adopted a community development approach to this outreach role, in three different respects:

Firstly, emphasis was brought to non-therapeutic, social supports, whereby drug-users were assisted to engage more actively in taking control of their own recovery, through developing their personal and social skills.

Secondly, drug-users who were being assisted in this manner were brought together in a collective manner – through the social evening – where they were encouraged to provide social support to each other on a peer-to-peer basis, thereby utilizing their shared experiences to further improve and develop their personal and social skills, and to take greater control over their own recovery.

Thirdly, persons attending the social evening were encouraged and supported collectively to form a group, DFIG, to give structure to the peer-to-peer model of support that was emerging through the social evening; DFIG has developed some autonomy and independence and provided it can continue to be supported the indications are that this model of support could develop and grow further.

An important strength to DFIG, its development and the development of the social evening and the social supports that are used, is that a community development approach was utilized; the fact that the approach was utilized in part because of the absence of a more structured framework is hardly here nor there, what is important is that the task force had the foresight to take this important initiative at a time when it was under considerable pressure to invest its time, energies and resources into developing other, more urgently-required services. In the midst of these latter developments, the Drug Free Support Initiative has survived and it is important that it continue and that its successes be built upon further.

It is recommended that the Drug Free Support Initiative continue to be supported both directly through existing task force resources where

feasible, and additionally through seeking to have peer-to-peer support groups designated for funding through an appropriate national funding programme.

As indicated previously, peer support can potentially play an important role in helping people to opt for recovery and, in due course, to sustain it. In both direct individual work and in relation to the supports that were developed through the social evening and DFIG, it is clear that social support has been the main component to the overall support that is provided. This type of social support is described as non-therapeutic, although it is claimed that it can and does have a therapeutic effect, for example it helps individuals get insight into their situation and into how they can overcome obstacles that hinder their efforts to sustain their recovery.

Significantly, the act of providing social support is in itself identified as helping the people who are providing this support to sustain their own recovery. Because of this mutuality it is particularly important that the support system within this group continue to be represented in this relatively modest, uncomplicated manner. There is always the risk that support of this nature be represented within a therapeutic milieu. However, formal therapies are provided by one group of professionally trained persons to individuals who need the therapeutic assistance being provided; if that structure was applied to DFIG and the supports it provides – for example older, established members acting as therapists to newer members – there is the risk that the reciprocity inherent in its existing support system would be dismantled, and disappear.

It is evident that a key dimension to the success of this initiative is its focus on social support; it is this aspect that is continuously referred to by persons who attend the social evening and it is this aspect that members of DFI and others are able to outline and describe most clearly. This social support dimension should be further developed, explained and promoted.

It is recommended that social support, as provided both individually and through peer-to-peer support, continue to be the main component to the Drug Free Support Initiative.

It is clear that given the distinctions that were made between on the one hand, harm reduction and methadone programmes *and* on the other hand drug-free rehabilitation, that the initial focus of the DFW's work has been with persons who were on a drug-free pathway that did not include prescribed medications, such as methadone. Indeed, the fact that this worker was given the title drug-free worker reinforces this distinction. The distinction was more pointed during the late 1990s than since; in recent years drugs rehabilitation has been conceptualized more clearly, and although a rehabilitation hierarchy – with drug-free at the top – has become evident elsewhere, in this jurisdiction persons who are on methadone and not using illicit drugs or alcohol and who are actively trying to stabilize and sort out other aspects of their lives, are considered, for all intents and purposes, to be drug-free. This broader definition of drug-free has impacted on DFW's work and DFIG and it is evident that the group, both individually and collectively, is struggling with making sense of this definition in

a manner that allows it to maintain the safety and integrity of the social evening.

The group would benefit from developing more clarity with respect the definition of drug-free as currently understood within policy; the group has moved to ensure that persons who are stable on methadone are welcome to attend the social evening, but they also need to be supported to put in place a mechanism that allows them to differentiate stable methadone-users from those who are not stable, who are currently using other drugs and who could potentially bring confusion and disorder to the social evening and its support system.

The potential complications arising from the official definitions of drug-free are not of course confined to DFIG; there are indications that these arise both for the task force itself and for different services within the area. While a wide range of issues in relation to rehabilitation have been discussed and debated within the context of national policy, there is need to have an open debate locally within the Canal Communities, so that its implications can be fully explored across a range of services and experiences; the task force could take an initiative on this and in doing so could potentially provide DFIG with a clearer framework for helping it to resolve and deal with these issues long term.

It is recommended that the task force provide a forum for a local debate on the issues of drug-free and rehabilitation leading to developing a framework document that would assist local agencies and bodies such as DFIG incorporate a clearer understanding of these issues into their

everyday work and development.

It is also recommended that DFIG participate in such debate and that it conduct its own intensive discussions on drug-free leading to a statement that gives clear direction to its current work and mission.

It is noteworthy that the peer-support / social-support framework that is evident in this review and report emerged directly from the task force's initial decision not to pursue a drug-free rehabilitation programme but to focus on employing a DFW instead. It appears indeed, although this cannot be stated with certainty, that the absence of a strategy towards establishing a formal, drug-free rehabilitation programme - possibly residential in nature – led to the task force embracing an alternative strategy, which in turn led to the formation of the peer-support group. In retrospect, this was perhaps fortuitous for, as previously stated, psychosocial programmes that emphasise the mobilization of indigenous family, community and peer supports potentially have better outcomes than those that remove people from their natural environments into residential settings, with the hope that they can return rehabilitated.

The Drug Free Support Initiative is an important, albeit understated, development. Given its progress to date, there is a case for it to be continually supported, indeed there is a case for it to be replicated, perhaps initially through establishing a second social evening in an adjacent task force area, and a gradual build-up from there. There is also a case to have the work and the model utilized more widely promoted. DFIG obviously has a role to play here, but so too

potentially has the task force, which after all carries responsibility for establishing the initiative in the first place. The task force could potentially focus on the experience of DFIG to date in promoting the potential of peer-to-peer supports in helping in the rehabilitation of drug users and to represent it to other communities and to other interested parties.

It is recommended that the task force engage directly with DFIG with a view to establishing a mechanism for promoting the DFIG peer support model both internally within the task force area and externally to other task forces and other interested parties.

APPENDIX – DFIG SOCIAL EVENING RULES

Terms of Reference for work at the Drug Free Social Evening in Rialto

- The drug free social evening is part of a non-therapeutic response to the identified needs of the target group.
- The workers will meet as a team once a week to plan the development of the process through a team response by sharing ideas and sorting out problems and issues as they arise collectively.
- If any fundamental differences or disagreements arise direction will have to taken from the drug free worker. She can then take them to her advisory group to be solved if needed.
- Feedback on each Social Session to happen at each meeting.
- Meetings to be minuted and recorded.
- Actions to be agreed assigned and followed through.
- Any difficulty with following through should be communicated as early as possible.

- Workers are responsible for the safety of the premises, of ensuring a drug free environment, a friendly, welcoming, and absolute respectful atmosphere for all people who attend.
- It is required that workers do not to impose their opinions on participants in relation to any particular "way" to recover. But to share information on all options and opportunities which are available and conducive to integration and maintaining drug free state.
- It is required that each person working on the socials agrees the terms of reference and commit to the upholding of it.
- Show up on time and share the opening / locking up of the building
- Communicate to the drug free worker any difficulties, i.e. with their roles, issues with group or individuals, how things are running, not being able attend or anything that may disrupt the smooth running of the night, at the earliest possible time

- Predatory behaviour plus drinking or taking substances with participants is unacceptable.
- Any sign or hint of drug taking, drug selling, should be brought to the attention of the rest of the team and dealt with appropriately
- If a person is under the influence of drink or drugs, they cannot stay.
- Any disrespectful attitude, including criticism or personal remarks towards a worker from other workers or participants is unacceptable. If any situation arises the individual will be asked to leave
- If an individual is struggling, encourage them to come to the Drug Free Worker with you, a course of action can be agreed and followed through. (if the situ can't be addressed with the workers and the individual, we will refer them on appropriately)
- It is most important that we don't engage in knee jerk reactions and panic, to any situation that may arise.
- Any violent situation if it cant be addressed very quickly we will call Garda
- Any children coming to the door are to be treated with respect and courtesy

The above suggestions are at this point open for further discussion and clarification; any suggestions to the above are more than welcome.

The aims of the group have to be kept in mind at all times.

June 2007

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[21] The following notation is used for quotes:
DFIG, FGC = DFIG focus group contributor.
DFIG, FI = DFIG member, focused interview.
LS, FG = Local service, focus group contributor
SEP = Social evening participant
TF, FG = Task Force, focus group member

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