Recovery without walls: a mixed method evaluation of community based recovery at Brandon House

Dr Rebekah Brennan and Barry Corkery
HSE Social Inclusion Southwest

FSS – an tlardheisceart
HSE South West

Recovery without Walls

Table of Contents

Recovery without Walls

Table of Contents

Executive Summary

This report presents the findings of a mixed methods evaluation of the Adult Recovery Group (ARG) at Brandon House Treatment Centre, a Tier 3 addiction service within HSE Southwest. The ARG delivers a structured, abstinence oriented group programme rooted in the Minnesota Model of addiction treatment in a non residential, community setting.

Aim

The overarching aim of the evaluation was to examine how participation in the ARG impacted drug and alcohol use, wellbeing and recovery capital in participants, and to understand how the programme operated as a community based alternative to residential treatment.

Methods

The study used a mixed methods longitudinal design. All procedures complied with GDPR and HSE research governance. Ethical approval was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals (CREC). Data collection ran from August 2024 to August 2025.

Quantitative

Sixty two clients consented to take part at baseline (T1). Thirteen took self discharge or treatment pathway changed after their first time point and two cases contained incomplete data, leaving forty seven client cases available for quantitative analysis across T1, six months (T2) and twelve months (T3), with some natural variation in participation at each time point.

Standardised measures included an amended HSE assessment form, the Alcohol Use Disorders Identification Test (AUDIT), the Drug Use Disorders Identification Test (DUDIT), and a Happiness Scale capturing subjective wellbeing. These were administered by Barry Corkery in person at Brandon House.

Quantitative

The qualitative strand comprised thirty semi-structured interviews with service users (nineteen men, eleven women) and eight interviews with staff members (six men, two women). Service user interviews were conducted at approximately six and twelve months, while staff interviews were completed at twelve months. Interviews explored experiences of the ARG, strengths and challenges of the programme and the value and limitations of community based treatment. Data was analysed thematically using thematic analysis (Braun & Clarke, 2006)

Key findings

Abstinence from drug and alcohol use

At the twelve month point, 79% (37/47) of service users were abstinent from alcohol and 79% (37/47) were abstinent from drugs, suggesting that the ARG model provides an effective community based route into abstinence for many service users.

Recovery capital

Beyond changes in substance use, the evaluation found strong evidence of growth in recovery capital across personal and social domains. Many described establishing daily routines, returning to or sustaining employment, reengaging in hobbies and physical activity, and developing a more hopeful orientation towards the future.

Participants described becoming more present and reliable in family life, rebuilding trust and communication, and developing new drug and alcohol free peer networks within and beyond the group. The ARG itself functioned as an important relational resource.

Several participants described forming connections with others who lived nearby, meeting informally for coffee or mutual support, and maintaining contact after the Intensive Phase ended. Although longer term and community level outcomes were beyond the scope of this evaluation, the data suggests that the ARG has potential to contribute to the emergence of a local recovery ecology over time.

The value of a community based model

Participants highlighted the distinct advantages of the community based setting. Remaining in the community allowed people to work on drug and alcohol use while simultaneously addressing housing, employment and family issues. Families and close others had the opportunity to witness and respond to change as it unfolded.

Help seeking was normalised through situating treatment in an ordinary, non-clinical environment. For many, this model was experienced as sustainable and closely aligned with the reality of where long term recovery must be lived: in places where we work, rest and play (Ivers, 2025).

Opportunities for development

Resourcing was a key constraint. Professional participants described operating at or near capacity, with limited flexibility to absorb staff absence while maintaining the frequency and quality of group delivery, individual work and crisis response.

Contextual feedback also highlighted specific areas for further development, including the absence of permanent female counsellors and women only group space, which may limit the model's potential for women with trauma histories. Staff also suggested scope for further community engagement by Brandon House, including increased visibility in local events and activities, to contribute to the formation of an emerging recovery ecology.

Conclusion

Overall, the evaluation indicates that the ARG at Brandon House operates as an effective community based, abstinence oriented intervention for many participants, supporting both reductions in substance use and the accumulation of recovery capital across personal and social domains.

The model's location within the community, rather than in a residential setting, appears to be a core strength, allowing recovery work to be integrated into everyday life and making change visible to families and local networks.

At the same time, the findings highlight challenges related to structural staffing constraints. While the limitations of sample size, setting and follow-up period require cautious interpretation, the evidence suggests that the ARG contributes meaningfully to abstinence and to the building of recovery capital in the local area.

With sustained investment and targeted refinement, the programme has the potential not only to improve individual outcomes, but also to strengthen the wider recovery ecology in which those outcomes are embedded.

Background & Context

Introduction

The conceptualisation of recovery has evolved in the past two decades with a stronger emphasis on community and social context. Recovery capital, the aggregate of personal, social, and community assets that support sustained addiction recovery and wellbeing, does not operate solely 'inside-out' through individual motivation, but also 'outside-in' (Best et al. 2025) via environments that enable belonging, purpose and contribution.

This conceptual lens is especially fitting for Ireland, where addiction treatment largely occurs in outpatient and community settings and where there is a strong grassroots recovery ethos. At the time of writing, Irelands new National Drug Strategy (NDS) 2026-2029, has been published in draft format and builds on the health led approach previously taken in the NDS before, with new emphasis on social integration and recovery capital.

Addiction treatment outcomes in Ireland

Ireland's addiction treatment system is relatively new, emerging in the 1980s (Ivers, Oct 2025). This system has since undergone more than one evolution, from an opiate centred model toward a broader, multi substance, community oriented framework. The Health Research Board (HRB) (2024) reports a total of 13,295 cases entered drug treatment in 2024 which is the highest annual number recorded by the National Drug Treatment Reporting System (NDTRS) to date.

This data illustrates both the continued issue of problem alcohol use and the growing complexity of drug treatment cases, with increasing polydrug use involving cocaine, benzodiazepines, and cannabis (HRB, 2024). Although Ireland's treatment network is diverse, comprising state, voluntary, and community organisations, the majority of cases are treated in outpatient settings.

HRB data (2024) show that approximately two-thirds of service users access treatment through community clinics or general practitioners, while residential services account for a smaller share. Best and Hennessy (2025) note that clinical stabilisation alone rarely produces enduring recovery unless embedded in social identity transformation and community participation.

Abstinence based approaches in Ireland

Ireland's addiction treatment landscape has historically been strongly influenced by abstinence oriented philosophies, particularly within the residential treatment sector. Although not considered treatment, Twelve Step mutual aid groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) remain the most widespread forms of community based recovery in Ireland.

Research has associated regular AA and NA participation with better abstinence outcomes and positions the fellowships as (Kelly et al., 2020, Dekkers et al. 2020, Kelly et al.,2014, Gossop et al. 2008). The Minnesota model was developed around the principles of AA, emerging in the 1950s in the U.S. Central to the model is the integration of professionally trained clinical staff with staff who are themselves in recovery.

The Minnesota model offers a highly structured intervention that includes an individualised treatment plan, active involvement of family members, engagement with AA during and after treatment, and a strong didactic component in the form of lectures and seminars on addiction framed within a disease model (Ivers & Barry, 2018). Minnesota model addiction treatment is historically practiced in residential settings, but has also been applied in community settings (Winters et al., 2000).

Recovery Capital

Recovery capital is generally understood as the sum of internal and external resources that individuals can draw on to initiate and sustain recovery from problem drug and alcohol use. It was first formally defined by Cloud and Granfield (2008) as personal, social and community resources that support positive change e.g. physical and mental health, skills, stable housing, supportive relationships, and access to meaningful roles in work, education and community life.

Recovery capital can also be an indicator of post traumatic growth in people in recovery (Pyke et al. 2026). Understandings of 'recovery' have evolved beyond control of drug and alcohol usen alone to include other aspects of health and wellbeing (De Meyer et al. 2026, Day et al. 2024).

Vanderplasschen et al. (2025) recently noted that addiction services that intentionally build recovery capital produce higher rates of longterm abstinence and wellbeing.

The programme under evaluation in this study represents a structured Minnesota model delivered within community based treatment, connecting residential abstinence traditions and the psychosocial ethos of community services.

Adult Recovery Group

at Brandon House Treatment Centre

Introduction

Brandon House Treatment Centre is an addiction counselling service within HSE Social Inclusion, located in a community setting in Tralee, Co. Kerry. It offers structured treatment for people who use alcohol and other drugs, and for family members or others affected by substance use. The service is a Tier 3 intervention within the Irish treatment system, providing more intensive support than primary care while remaining embedded in the local community.

Brandon House in context

Brandon House operates within the policy direction set by the National Drug Strategy (NDS), which frames substance use as a health and social issue. As an HSE service, it is expected to work to values of care, respect, trust and ongoing learning, and to maintain clear clinical governance. Classified as a Tier 3 service, Brandon House provides structured, planned treatment for people whose drug and alcohol use related difficulties require more than brief or low intensity input.

It works in close contact with General Practice (GP), Mental Health services, social services, probation, courts services, other drug and alcohol services, and a specialist Community Employment (CE) scheme. This networked way of working is designed to support shared care, smooth onward referral and attention to housing, employment and other social determinants alongside direct work on drug and alcohol use.

Staff are qualified and accredited counsellors and are expected to keep up to date with developments in addiction and recovery practice.

Therapeutic orientation and pathway through the service

The Brandon House Treatment Centre model of treatment draws on a range of psychological and recovery approaches rather than a single school of therapy. The main influences include Motivational Interviewing (MI), Cognitive Behavioural Therapy (CBT), the Transtheoretical Model of Change (TTM), the Minnesota Model, person centred counselling, Dialectical Behaviour Therapy (DBT) and harm reduction principles.

These are applied in different ways across one-to-one work, group interventions and psychoeducational sessions. Entry to the service starts with assessment. Initial contact leads to a screening and, where appropriate, to a more detailed assessment that includes substance use history, mental health, social circumstances and readiness to change. Urine analysis can be used as part of this process. A named counsellor holds responsibility for each person's care and develops a plan with them based on their needs and goals.

Adult Recovery Group

at Brandon House Treatment Centre

Many people arrive unsure about abstinence or ambivalent about change. MI and the TTM framework are used to explore this ambivalence and to build a sense of possibility before people move into more intensive programmes.

The overall pathway can be understood as stepped. People can start with less intensive, harm reduction focused support and, when ready, move into structured recovery groups such as the ARG.

Others may arrive already committed to abstinence and be assessed directly for the ARG, provided that the timing and clinical fit are appropriate. Movement between programmes is possible, and the pathway is adjusted as circumstances change.

Programme components within Brandon House Treatment Centre

Supporting Positive Change Group

The Supporting Positive Change Group (SPCG) is aimed at people who want to reduce harm and gain more control over their substance use. It is facilitated by counsellors and uses a mix of person-centred practice and MI. The group provides a forum to set realistic goals, reflect on triggers and patterns, and begin to experiment with change. For some participants this group acts as a preparation stage before entering the ARG, while for others it is the main intervention they need at that time.

Concerned Persons Programme

The Concerned Persons programme is designed for family members, partners and others affected by a loved one's drug or alcohol use. It recognises the impact of this on relationships and family systems, and aims to support relatives to prioritise their own wellbeing, set boundaries and understand addiction and recovery processes. Trauma awareness and person-centred practice are important elements. The programme also encourages links with mutual aid groups for families, such as Al Anon and similar fellowships.

Preparation Group

The Preparation Group is a short, time limited programme that introduces people to the structure, expectations and culture of more intensive group work. It follows initial and comprehensive assessment and is used as a bridge into the ARG or the Concerned Persons programme.

Sessions cover topics such as group norms, confidentiality, the use of written exercises and reflective worksheets, and basic ideas drawn from the Minnesota Model and CBT. This gives people a chance to experience the group format, to test their own readiness and to ask questions before committing to a longer programme.

Aftercare

Aftercare provides follow on support for people who have completed the intensive phases of the ARG and the Concerned Persons programme. It runs over several months and is delivered in person and online, which enables participation by people who live at a distance, have caring responsibilities or face transport barriers.

Groups draw on relapse prevention methods, continued peer feedback and ongoing application of Minnesota Model and CBT tools. The emphasis is on consolidation of gains, managing risk of relapse, navigating relationships in recovery and sustaining links with wider support networks.

Understanding and Managing Emotions – Addiction (U&Me-A)

The U&Me-A programme is an online group for people who are living with both substance use and mental health difficulties. It uses DBT as the main framework, with support from CBT and motivational strategies. Participants complete diary cards and practice emotional regulation, distress tolerance and interpersonal effectiveness skills in their daily lives, bringing examples back to the group. The U&Me-A programme was evaluated in 2014 (Flynn et al. 2014).

Outreach and wider links

Brandon House Treatment Centre provides outreach to other locations in the region. A counsellor meets people in their own towns, offers brief assessment and helps them access services, in Brandon House Treatment Centre or in other services.

Adult Recovery Group

at Brandon House Treatment Centre

Adult Recovery Group (ARG)

The ARG is the principal abstinence oriented programme in Brandon House Treatment Centre and is the subject of this evaluation. It is rooted in the Minnesota Model and uses the Twelve Steps as a guiding framework. Step work, reflection on consequences and peer feedback are built into the routine of the group, and the Twelve Steps are visible and referenced throughout. Participants complete 144 group hours as part of a full treatment episode. The ARG can be understood in three linked stages.

Preparation group

People do not enter the Intensive Phase immediately. The Preparation Group gives a chance to become familiar with group processes, explore the meaning of abstinence in their own lives and consider what commitment to the programme entails. Staff use this time to assess safety, group fit and timing. Where there are concerns, further individual work or an alternative pathway can be explored.

Intensive group phase

The core of the ARG is a structured group programme facilitated by two counsellors. Across the intensive phase, each participant completes a substantial number of group hours, working through a curriculum that includes step based reflective work, use of CBT tools and peer feedback.

Attendance at AA, NA or related fellowships is strongly encouraged during this phase. These external groups provide a peer community that extends beyond the clinic, offering examples of longer-term recovery and opportunities to build sober social networks.

Aftercare

On completion of the Intensive Phase, participants move into Aftercare. This stage supports people as they navigate day to day life in recovery, including work, family, housing and health. It provides ongoing accountability and a space to discuss setbacks, successes and dilemmas. The presence of both former ARG participants

Methods

Introduction

This study employed a mixed method, longitudinal approach to explore both quantitative outcomes and qualitative experiences associated with an abstinence oriented, community based addiction recovery programme over a one year period.

Research Aim

The overarching aim of this research is to evaluate the effectiveness and experiential impact of the ARG. The ARG is a Minnesota Model addiction treatment delivered at Brandon House Treatment Centre, a community based setting in Tralee, Co. Kerry.

Objectives

To assess changes in drug and alcohol use patterns over time through analysis of de identified assessments conducted using validated screening tools (AUDIT, DUDIT) for substance use.

To evaluate changes in subjective wellbeing over time using the Happiness Scale.

To explore service users' experiences of the ARG through semi structured interviewing.

To examine professional perspectives on programme delivery, strengths, challenges, and development needs through semi structured interviewing.

To develop a logic model that clearly articulates the inputs, activities, mechanisms of change, and short-, medium- and long-term outcomes of the ARG.

Research Design

A mixed method longitudinal evaluation design was chosen to provide both statistical and narrative insights into participant recovery trajectories. The quantitative component provides measurable evidence of change in substance use and wellbeing, while the qualitative component captures the lived experience of participants and professionals. Integrating these data allows for triangulation, enhancing validity (Creswell & Plano Clark, 2018) and enabling nuanced interpretation of how recovery capital develops in community based care.

Assessment data was collected at three time points which varied across service user trajectories: initial assessment (T1); six months into treatment (T2), and twelve months into treatment (T3). This temporal design allows for observation of short and medium term outcomes. Interviews were conducted at T2 and T3 where service users volunteered to take part. No service user volunteered to take part in two interviews, therefore data collected illustrates snapshots of subjective experiences of taking part in the ARG.

Participants

People who access the ARG

Participants were adults aged 18 or older. Inclusion criteria required participants to have capacity to provide informed consent and to be active service users. Exclusion criteria included individuals lacking capacity or not accessing the ARG at Brandon House. Sixty two clients completed an initial assessment. Of these, thirteen were discharged, and two cases contained incomplete data, leaving forty seven unique client cases available for quantitative analysis across their treatment timepoints T1, T2, and T3.

There was some variation in participation at each stage due to natural attrition. To complement the quantitative data, thirty structured interviews were conducted with service users (eleven women, nineteen men) to explore lived experiences of participation in the ARG, and subjective and broader wellbeing outcomes.

Professional Participants

A purposive sample of eight professionals at Brandon House Treatment Centre volunteered to participate in qualitative interviews. This included addiction counsellors facilitating the ARG. Their input provided contextual understanding of implementation processes and service level outcomes.

Recruitment and Consent Procedures

All service users were introduced to the study by the co-investigator, Mr. Barry Corkery, a Senior Addiction and DBT Therapist known to participants. An information sheet which detailed the purpose of the study, confidentiality assurances and withdrawal rights, was given to interested participants. Participants were given two weeks to consider involvement and were informed that participation was voluntary and would not affect their treatment in any way.

Written consent was obtained prior to inclusion. Professional participants self selected after receiving an information sheet and provided informed consent before interview. All participants retained the right to withdraw at any time, or up to two weeks post interview for qualitative components, consistent with GDPR (2018) requirements for data erasure rights (European Parliament and Council of the European Union. (2016).

Data Collection Procedures

Quantitative

Anonymised assessments were obtained for the purposes of this evaluation. This data included service user's age, gender, and any previous treatment for alcohol or drug use. The data also included three measures: Happiness Scale, the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al., 2001), and the Drug Use Disorders Identification Test (DUDIT) (Hildebrand, 2015). These three measures were assessed at three timepoints during the service user's treatment at Brandon House which were: on admission (T1); at 6 months (T2); and at 12 months (T3).

Happiness scale is a 10-item questionnaire used in drug treatment services to assess how service users consider certain aspects of their life as being important to their overall well-being and can be understood as subjective indicators of personal, physical, and social recovery capital. These items are drug and alcohol use; job/education; life skills; social life; physical health; mental health; relationship/family; legal issues; emotional life; communication skills; housing; and spirituality. Response scores are interpreted as follows: 1–3 = low happiness; 4-7 = medium happiness; and 8-10 = high happiness.

AUDIT measure is a 10-question screening tool for alcohol consumption and related problems, consisting of questions about drinking habits and alcohol-related issues. Total response scores are interpreted as follows: 0–7 = low risk; 8–15 = increasing risk; 16–19 = higher risk; and 20 or more = possible dependence.

DUDIT measure is an 11-question screening tool to assess drug use patterns, symptoms of dependence, and harm, with scores ranging from 0–44. Total response scores are interpreted as follows: 25 or more = high probability of dependence on one or more drugs; 6 or more (males) = probable drug-related problems; 2 or more (females) = probable drug-related problems.

Qualitative Data

Semi structured interviews were conducted by Dr. Rebekah Brennan. Interviews took place with service users who were in treatment at least six months and a

Methods

maximum of twelve months from August 2024 to August 2025. Interviews with professionals took place in September 2025. All interviews were conducted in person at Brandon House.

Each lasted 45–60 minutes and followed a topic guide exploring experiences of treatment and recovery, perceived benefits and challenges of the ARG, the role of community and professional support in sustaining abstinence and recommendations for service improvement. All interviews were audio recorded, transcribed verbatim, anonymised, and securely stored on a HSE server. Recordings were deleted once transcribed.

Data Analysis

Quantitative analysis

All monitoring data was entered into an excel spreadsheet where it was cleaned. The dataset was then downloaded into SPSS software where it was recoded and prepared for analysis. Descriptive statistics and frequencies are presented for the purposes of this report.

Qualitative Analysis

Qualitative data was analysed thematically following Braun and Clarke's (2006) six-phase framework. This involved (1) familiarisation with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the final analytical report. Themes were developed inductively, allowing the voices of participants to shape the findings.

Findings from the qualitative analysis were integrated with quantitative results during interpretation to allow for triangulation. This mixed methods integration provided a holistic understanding of programme impact, consistent with recommendations for mixed methods evaluation in health and addiction research (Fetters et al., 2013).

Data Management and Confidentiality

Data handling adhered strictly to General Data Protection Regulation (GDPR, 2018) requirements and HSE research governance policies. All digital data is stored securely on an encrypted, password-protected HSE laptop accessible only to Dr. Rebekah Brennan. Physical documents, including signed consent forms, were digitised, and the original paper copies were securely shredded once electronic versions were verified. Audio recordings were deleted immediately after transcription, and transcripts were anonymised through the removal of personal identifiers.

Each participant was assigned a pseudonym or coded reference to ensure confidentiality. All anonymised research data is stored in a password-protected folder and will be retained securely for ten years in line with HSE data retention and audit requirements. Thereafter, the data will be permanently destroyed. These procedures ensured full compliance with ethical standards for data protection and confidentiality in health research.

Ethical Considerations

Ethical approval was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals (CREC) in November 2023. Participants were informed of their rights, potential risks, and benefits, and confidentiality was assured.

If participants experienced distress during interviews, procedures were in place to pause or terminate interviews, with immediate access to in house support.

Rigor and Trustworthiness

For the quantitative component, rigor was achieved through the use of validated and

standardised assessment instruments (AUDIT, DUDIT, and the Happiness Scale), each with well established psychometric properties (Saunders et al., 1993; Hildebrand, 2015; Lyubomirsky & Lepper, 1999). Standardised administration procedures were followed across all three time points, and data was screened for completeness, consistency, and accuracy before analysis.

For the qualitative component, credibility was supported by prolonged engagement with participants and member checking, where participants were invited to review and confirm the interpretation of findings. Member checking took place between Rebekah Brennan and research participants on 25th March. Barry Corkery continued to meet with research participants and conduct member checking in the following days.

Limitations

Participant attrition occurred across the three data collection points. Of the sixty two clients initially included, thirteen were discharged following their first assessment, and two provided incomplete data, leaving forty seven unique cases for analysis. The experiences of those who disengaged or took alternative treatment routes may have differed from those who remained in treatment.

To mitigate this, two people that took discharge were interviewed for their experiences as part of data collection. The study relied on self-reported data from service users through the AUDIT, DUDIT, and Happiness Scale measures and interviews. Self-report data are inherently subject to recall bias and social desirability effects. Triangulating these quantitative outcomes with qualitative interviews helped to mitigate this limitation.

The study was conducted within a single community based treatment centre, which will limit the generalisability of findings to other settings. However, the aim of this evaluation was depth rather than breadth, to garner understanding of how recovery capital develops within a community delivered abstinence model.

While every effort was made to ensure analytic rigor, the dual role of the researcher as an evaluator within the HSE system may have introduced subtle bias in interpretation. This risk was mitigated through reflexivity, member checking and peer debriefing during analysis.

More broadly, there are inherent limitations in research that seeks to map treatment outcomes within addiction services. As highlighted by Ivers (Oct 2025), mapping of addiction treatment outcomes often falls short of long-term follow-up, particularly at three-, five-, and ten-year points post-treatment. Such extended longitudinal data is really essential to understanding the stability and sustainability of recovery outcomes.

The current study was limited to a twelve month period and thus cannot capture the full trajectory of post treatment recovery or the enduring impact of the ARG beyond programme completion. This limitation reflects a broader challenge within the addiction research field, where structural and resource constraints often inhibit longterm tracking of participants after discharge.

Despite these limitations, the study provides valuable insight into the implementation and outcomes of a community based, abstinence oriented recovery model, offering an important contribution to the evidence base on recovery capital and integrated treatment within the Irish health led framework.

Results

Quantitative results

Forty seven people who accessed the ARG are represented in the quantitative dataset, of which thirty one (66%) are male; and sixteen (34%) are female. The ages of these ARG service users ranged from twenty two to seventy five years.

The number of service users who responded to each item differed at each timepoint. As some questions were left blank, the findings are presented here to reflect any anomalies as a result.

Previous Treatment

Figure 1 below shows that almost two thirds of all participants had engaged in some form of addiction treatment or had attended fellowship groups, which was recorded as previous treatment, before attending Brandon House.

The largest group had previous residential treatment combined with AA or NA (34%), followed by those who had not engaged in any prior treatment (32%) and those who had only attended AA or NA (21%).

Smaller proportions reported previous standalone residential treatment (7%), outpatient treatment (2%), or outpatient plus AA/NA (2%), and one service user did not answer this question (2% missing data).

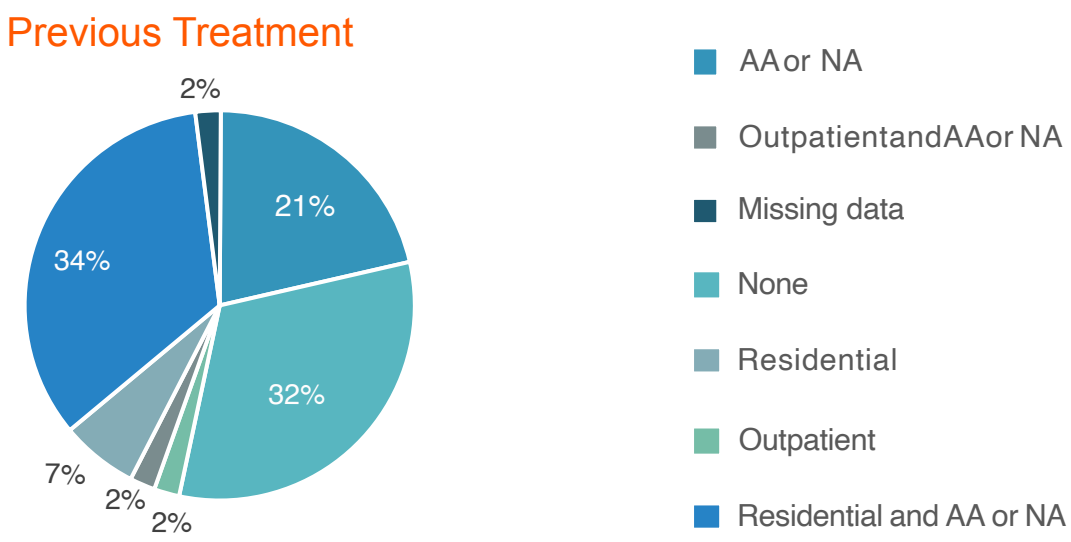


Figure 1. Previous Treatment

Treatment Outcomes[1]

Abstinence from alcohol and drug use

At T3, 79% (37/47) of service users were abstinent from alcohol and 79% (37/47) were abstinent from drugs. When categorised as younger and older, at T3, 87% (14/16) of those aged 30 or younger and 77% (24/31) of those age 31 or older were abstinent from alcohol. T3, 87% (14/16) of those aged 30 or younger and 77% (30/31) of those age 31 or older were abstinent from drugs. The younger and older groups both show very high abstinence at T3, with slightly higher drug abstinence in the older group.

[1] The number of service users who responded may have differed for each item. Findings are presented to reflect this

Dinking risk

On the AUDIT drinking-risk scale, people generally started in the higher-risk bands at T1 (almost half in the "possible dependence" range and only 6% in "low risk"), but by T3 all service users who provided data were in the "low risk" category.

That is consistent with a strong reduction in drinking risk over time for those who stayed in the study.

Drug use risk

On the DUDIT drug-risk scale, at T1 no participant was in the "no drug-related problems" category and a substantial proportion fell into "harmful use/dependence risk" or "dependence".

By T3, almost everyone (97%) was in the "no drug-related problems" category, with only a very small minority still scoring in the "harmful use/dependence risk" range and nobody classified as "dependent".

Frequency of alcohol use

Patterns of alcohol use shifted over time towards less frequent drinking and, for many participants, abstinence. At T1, regular alcohol use was common: 37.0% reported drinking four or more times per week and a further 26.0% were drinking between twice a month and three times per week, while no one was categorised as abstinent. By T2, no participants reported drinking four or more times per week and over half (57.4%) were drinking monthly or less, with 19.1% reporting that they did not use alcohol.

At T3, almost all participants who provided data were classified as abstinent (94.9%). Taken together, these findings are consistent with a move away from frequent alcohol use and towards abstinence among those retained in the study (see Table 1 below).

Table 1: AUDIT - How often do you have a drink containing alcohol?

	T1 n=46	T2 n=47	T3 n=39
Never	3 (6.5%)	6 (12.8%)	1 (2.6%)
Monthly or less	5 (10.9%)	27 (57.4%)	0 (0.0%)
2 - times per month	6 (13%)	4 (8.5%)	0 (0.0%)
2 - 3 times per week	6 (13%)	1 (2.1%)	0 (0.0%)
4+ times per week	17 (37%)	0 (0%)	0 (0.0%)
Does not use alcohol	0 (0.0%)	9 (19.1%)	1 (2.6%)
Abstinent	0 (0.0%)	0 (0.0%)	37 (94.9%)

RESULTS

Quantity of alcohol use

Participants moved from predominantly heavy drinking to abstinence or very low-level use by T3.

On entry to the programme (T1), most respondents who drank, reported heavy typical consumption: two thirds (67.4%) drank 10 or more standard drinks on a typical drinking day, with only small proportions drinking 1–2 (6.5%) or 7–9 (6.5%) drinks, and 19.6% reporting that they did not use alcohol.

By T2, this pattern had shifted toward lower typical consumption, with fewer people in the 10+ category (46.8%) and more reporting 1–2 drinks (17.0%) or no alcohol use (19.1%). By T3, only one participant still reported drinking alcohol, indicating 1–2 drinks on a typical drinking day, one indicated they do not use alcohol, and 37 were abstinent therefore indicated 'never' using alcohol a T3 (see Table 2 below).

Table 2: AUDIT: How many standard drinks containing alcohol do you have on a typical day when you are drinking?

	T1 n=46	T2 n=47	T3 n=39
1-2	3 (6.5%)	8 (17%)	1 (2.6%)
3-4	0 (0.0%)	1 (2.1%)	0 (0.0%)
5-6	0 (0.0%)	0 (0%)	0 (0.0%)
7-9	3 (6.5%)	7 (14.9%)	0 (0.0%)
10+	31 (67.4%)	22 (46.8%)	0 (0.0%)
Does not use alcohol	9 (19.6%)	9 (19.1%)	1 (2.6%)
Never	0 (0.0%)	0 (0.0%)	37 (94.9%)

Frequency of drug use

Patterns of drug use appear to shift towards abstinence over time among those who completed follow-up. At T1, responses were split between very frequent use and no current use: 28.3% reported using drugs four times a week or more, while 45.7% reported not using drugs. By T2, the proportion reporting very frequent use had dropped to 8.5%, with small increases in the "never" and "once a month or less" categories (both 14.9%).

By T3, 82.2% of respondents were categorised as abstinent, and no participants reported ongoing drug use. These findings suggest a move away from regular drug use and towards abstinence among the cohort who remained in the study, although changes in sample size across timepoints and the absence of T3 data for some participants mean this pattern should be interpreted cautiously (see Table 3 OVERLEAF).

Table 3: DUDIT - How often do you use drugs other than alcohol?

	T1 n=46	T2 n=47	T3 n=45
Never	1 (2.2%)	6 (12.8%)	1 (2.2%)
Once a month or less often	3 (6.5%)	16 (34%)	0 (0%)
2 - 4 times a month	2 (4.3%)	4 (8.5%)	1 (0%)
2 - 3 times a week	6 (13%)	0 (0%)	2 (0%)
4 times a week or more	13 (28.3%)	0 (0%)	3 (0%)
Does not use drugs	21 (45.7%)	21 (44.7%)	7 (15.6%)
Abstinent	0 (0%)	0 (0%)	37 (82.2%)

At T1, just over half of participants were using drugs, with 28.3% reporting using drugs seven or more times on a typical day when they used; a further 21.7% spread across lower-frequency categories; and 45.7% reported not using drugs at all. By T2, the proportion reporting very frequent use (seven or more times per day) had dropped to 8.5%, and more people were in the lowest use categories or reporting no drug use (44.7%).

By T3, 82.2% of participants reported being abstinent from drugs and no one reported using drugs three or more times on a typical using day, with only one individual (2.2%) indicating any ongoing use. Overall, these findings point to a marked reduction in self-reported daily drug use over time, with most of the sample reporting abstinence by T3 (see Table 4 below).

Table 4: DUDIT - How many times do you take drugs on a typical day when you use drugs?

	T1 n=46	T2 n=47	T3 n=45
0	2 (4.3%)	7 (14.9%)	0 (0%)
1 – 2	3 (6.5%)	7 (14.9%)	1 (2.2%)
3 – 4	4 (8.7%)	5 (10.6%)	0 (0%)
4 – 6	3 (6.5%)	3 (6.4%)	0 (0%)
7 or more	13 (28.3%)	4 (8.5%)	0 (0%)
Does not use drugs	21 (45.7%)	21 (44.7%)	0 (0%)
Abstinent	0 (0%)	0 (0%)	37 (82.2%)

RESULTS

Figure 2 opposite shows an upward trend in how satisfied participants are with their alcohol and drug use over time. At T1, both men and women report relatively low happiness with their use (M=3.72 for men; M=4.36 for women), consistent with concern about their substance use on entry to the programme.

By T2, mean scores markedly increased (M=6.67 for men; M=7.45 for women), and by T3 both genders report high levels of satisfaction (M=8.22 for men; M=8.18 for women), indicating that, over the course of treatment and follow-up, service users feel progressively more content with changes in their alcohol and drug use, with gender differences largely disappearing by the final timepoint.

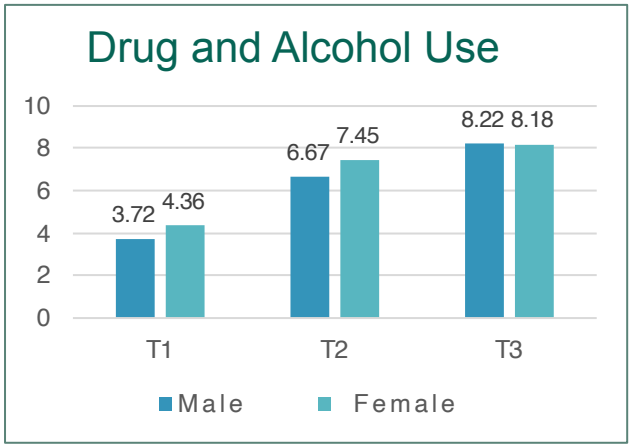


Figure 2. Happiness Scale - Drug and Alcohol Use

Other outcomes

The Physical Health Happiness Scale provides mean scores (1-10) across n=29 matched cases, Figure 3 shows improvements in self-rated physical health from T1 to T3 for both men and women. At entry (T1), mean scores are in the mid-range (M=5.61 for men; M=5.27 for women), suggesting participants felt moderately satisfied with their physical health.

Mean scores remain in the medium satisfaction range at T2 (M=6.94 for men; M=6.55 for women) and again at T3 increasing slightly (M=7.67 for men; M=7.36 for women), indicating increased happiness over time. Men rate their physical health slightly higher than women at each timepoint, but the gender gap is small and remains fairly consistent, with both groups reporting notably better physical health by

The Life Skills Happiness Scale scores (0–10) increase over time for both men and women. At T1, men reported higher satisfaction with their life skills (M=6.39) than women (M=5.64). By T2, scores had risen for both groups, with men at M=7.22 and women at M=7.00, and this upward pattern was maintained at T3 (men M=7.44; women M=7.27).

Overall, the graph suggests that, on average, participants felt more able to manage day-to-day life demands as they progressed through the programme, with gender differences narrowing over time (see Figure 4 opposite.

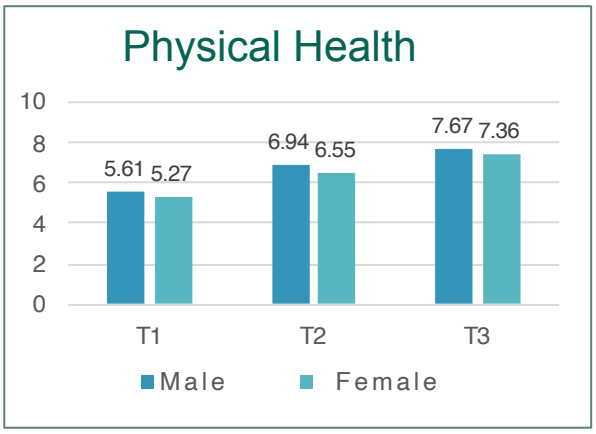


Figure 3. Happiness Scale - Physical Health

The Emotional Life Happiness Scale (0–10) scores increase over time for both men and women. At T1, men reported M=5.53 scores and women M=4.55, suggesting that, on average, both groups were only moderately satisfied with their emotional lives at entry, with women slightly lower. By T2, scores had risen to M=6.94 for men and M=6.82 for women, and this upward pattern continued to T3 (men M=7.71; women M=7.45).

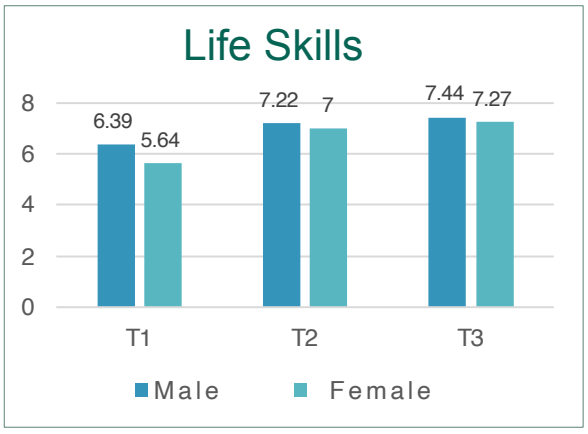


Figure 4 Happiness Scale - Life Skills

RESULTS

Overall, the findings suggest improving emotional wellbeing across the three timepoints, with the initial gender gap narrowing so that men and women report broadly comparable levels of satisfaction with their emotional lives by T3 (see Figure 5 opposite).

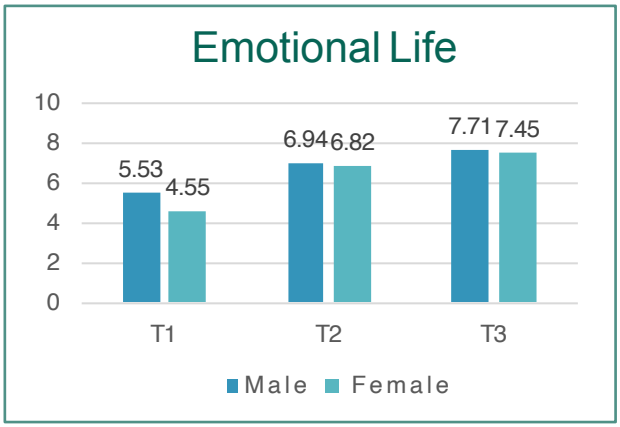


Figure 5 Happiness Scale - Emotional Life

On the Mental Health Happiness Scale (0–10) men reported M=5.61 scores at T1, increasing to M=7.22 at T2, and M=8.06 at T3. Women started lower at T1 (M=4.00) but showed a similar upward pattern, rising to M=6.73 at T2 and M=7.64 at T3. Overall, the chart shows a steady improvement in self-scored mental health for both men and women over time, with the initial gap between genders narrowing so that scores are relatively close by T3 and in the high happiness range (see Figure 6 opposite).

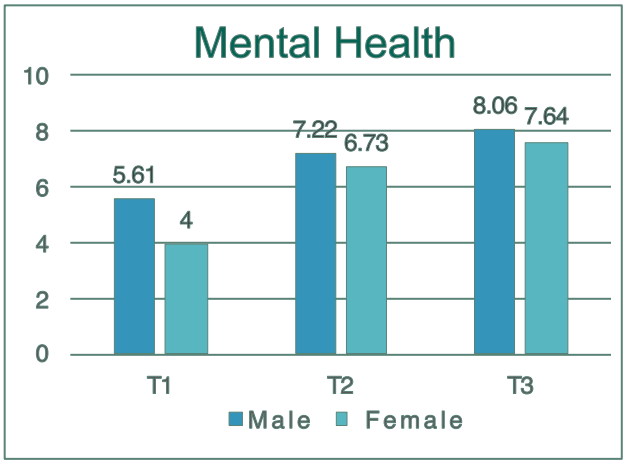


Figure 6 Happiness Scale - Mental Health

Mean scores for Happiness Scale Communication Issues item increased over time for both men and women. At T1, mean scores were in the medium-range and very similar for men (M=6.83) and women (M=6.90). By T2, scores had risen for both groups (men M=7.78; women M=8.40), and they were higher again at T3 (men M=8.28; women M=8.70). Taken together, these findings suggest that participants became more satisfied with how they manage communication and related difficulties over the course of the programme, with women reporting slightly higher scores at each follow-up (see Figure 7 opposite).

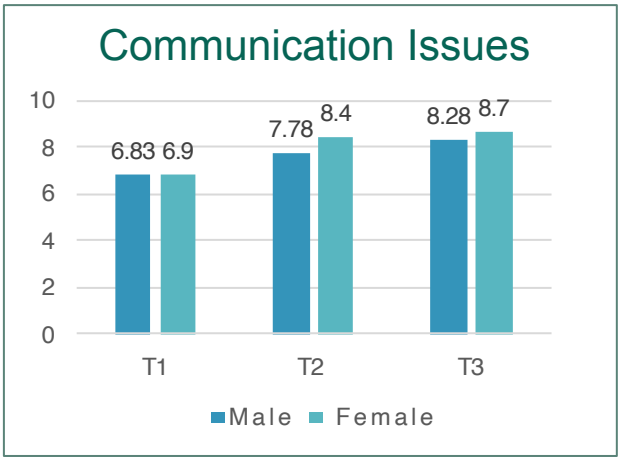


Figure 7 Happiness Scale - Communication Issues

Mean scores on the Happiness Scale for Spirituality increased over time for both men and women. At T1, men reported lower mean scores (M=5.06) than women (M=6.64). By T2, scores had risen for both groups (M=6.44 for men; M=7.45 for women), and they were higher again at T3 (men M=7.56; women M=8.18). Overall, the pattern suggests that participants' sense of spirituality or connection grew across the programme, with women consistently reporting slightly higher levels than men at each timepoint (see Figure 8 opposite).

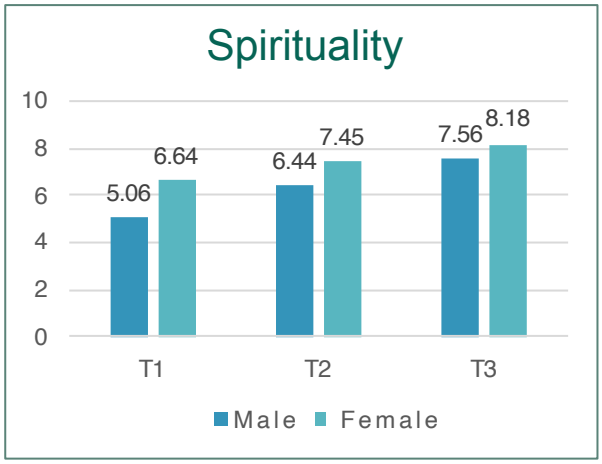


Figure 8 Happiness Scale - Spirituality

Mean scores for Housing on the Happiness Scale (1-10) were relatively high at all timepoints, with men consistently reporting higher satisfaction than women. For men, mean scores increased from M=8.17 at T1 to M=8.89 at T2, and M=9.17 at T3. Women's mean scores were lower and stable between T1 and T2 (M=6.91 at both points), followed by an increase to M=8.00 at T3, suggesting some improvement in perceived housing stability or satisfaction over time, particularly for women between T2 and T3 (see Figure 9 below).

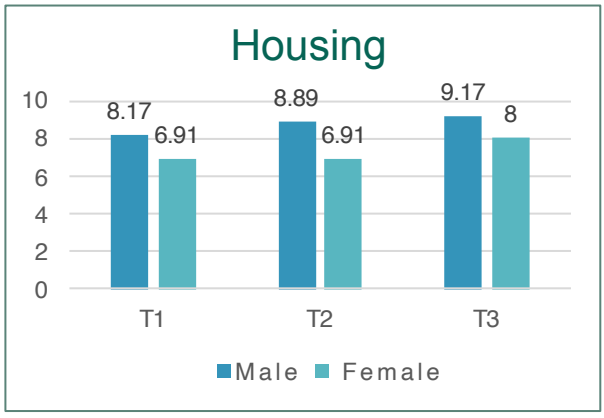


Figure 9 Happiness Scale – Housing

RESULTS

Mean scores for Legal Issues on the Happiness Scale increased over time for both men and women. At T1, men and women reported similar satisfaction with their legal situation (M=7.18 for both). Scores increased at T2 (M=8.00 for men; M=8.82 for women) and remained high at T3 (M=8.47 for men; M=8.73 for women). This pattern is consistent with a gradual perceived improvement in legal circumstances over the course of the programme, with women reporting slightly higher satisfaction from T2 onwards (see Figure 10 opposite.

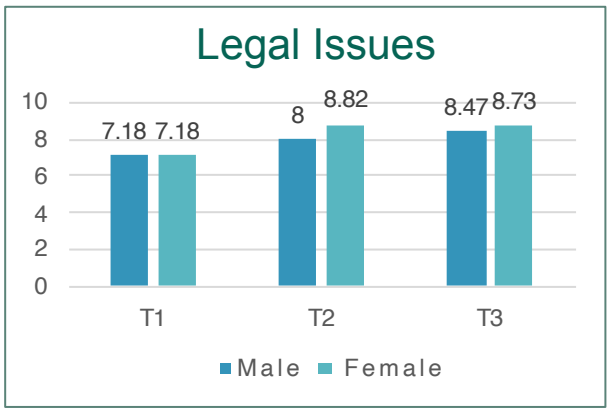


Figure 10 Happiness Scale - Legal Issues

Mean scores for Job or Education Progress increased across all three timepoints for both men and women. At T1, men reported higher satisfaction (M=6.28) than women (M=4.55). Scores rose at T2 (M=7.11 for men; M=5.91 for women) and by T3 both groups reported progress (M=7.67 for men; M=7.27 for women). This pattern suggests that, over time, participants felt increasingly positive about their work or education, with women's scores in particular catching up to men's by T3 (see Figure 11 opposite).

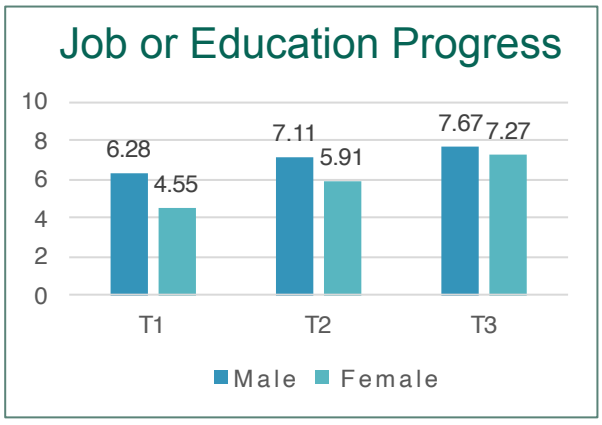


Figure 11 Happiness Scale - Job or Education Progress

Mean scores for Relationship and Family life on the Happiness Scale (0-10) improved over time for both men and women. At T1, men reported higher satisfaction (M=6.47) than women (M=4.64). By T2, scores had increased for both groups (M=7.41 for men; M=7.09 for women), and by T3 mean scores were high and closely aligned (M=8.29 for men; M=8.00 for women). This pattern suggests that, over the course of the programme, participants perceived gradual improvements in their family and relationship circumstances, with women's scores in particular moving closer to those of men (see Figure 12 opposite).

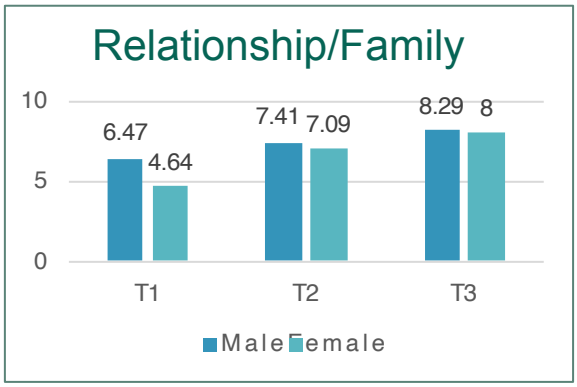


Figure 12 Happiness Scale - Relationship/Family

Mean scores for Social Life increased over time for both men and women. At T1, mean scores were relatively low (men M=4.44, women M=4.00), rising at T2 (M=6.00 for men; M=6.18 for women) and increasing more by T3 (M=6.94 for men; M=6.91 for women). This pattern suggests that participants experienced gradual improvements in how satisfied they felt with their social lives during and after the programme, with men and women following a very similar trajectory by T3 (see Figure 13 opposite).

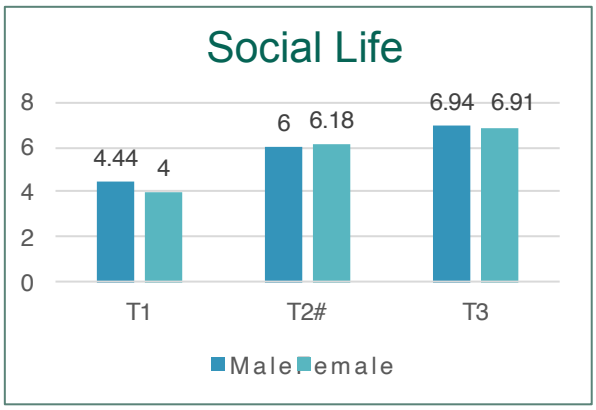


Figure 1 Happiness Scale - Social Life

Qualitative Results

Of the forty seven people represented in the quantitative data, thirty took part in qualitative interviews at either six months or twelve months post entry. These findings are organised thematically and presented here.

Accessing the Adult Recovery Group (ARG)

Participants described a wide range of entry points into treatment. Formal referrals from social work, child protection services and GPs were described. The criminal justice system was also described as a pathway into treatment.

Others arrived after acute health crises, or other personal crises. Approximately two thirds of research participants had experience of drug and alcohol services or the fellowships before entering the ARG (see Figure 1 pg.13).

Several participants came on the recommendation of others in recovery, particularly through AA and NA meetings. There are also self referrals, a mechanism which helps to reach people with hidden alcohol or drug use:

"I did not hear about it in the community here because I was keeping my drinking secret… I just went online… saw there was a Tralee phone number… I thought, right, I will just call… left a message for whoever could talk to me." (female, 7)

Pathways out of the ARG are similarly varied, with some people moving on to residential treatment and some returning back into Brandon House after gaps of years. In every case, staff describe using the AUDIT and DUDIT measures at assessment in order to identify need, and note that people often contact other services first or do not initially recognise their problem as addiction. There are alternative programmes to the ARG at Brandon House and programmes are offered according to the needs of the client.

Strengths of the ARG

The strengths that service users and staff describe are both relational and structural. Several participants connect their involvement in the ARG directly to major turning points, including regaining contact with children and experiencing sustained relief from distress.

Structured programme

The group is experienced as structured but not overwhelming. Participants place strong value on the practical tools given through Twelve Step work and daily reflections, and on the clear message that the first task is to stabilise substance use. Staff are clear that a strength of the model is its disciplined focus on addiction in the early stages, with trauma and other issues addressed later when people are more stable:

"The psychotherapy piece… comes in the door… but I think the focus has to be first and foremost the addiction, it has to be addressed first… when the time is right then you can go back into the other stuff." (professional, 2)

Sense of safety

Participants describe the group space as safe, non-judgmental and manageable in size, a key condition for doing deep work.

"I shared more of my childhood in my six consequences Tuesday, and I felt a lot lighter after it… that's freeing to be able to get it out there, in the right setting, in with the right people… and there's no judgement, there really isn't." (female, 3)

Another participant summarises the quality of the shared space and the sense of being held by staff:

"one of the first things they said is, look, we'll hold you… They were holding me. Reminding me I was in a place where I was going to be cared for." (female, 7)

The quality of relationships runs through the data. Counsellors are described as knowledgeable, persistent and willing to challenge as well as comfort.

"The therapists, they were outstanding… I really enjoyed just the way the course went, the way it took you through the different stages… I was quite interested in the whole structure of it all and how it worked… They're just great people. I love the way that they will never let anyone down. You've got to be the one to let them down. And even at that, they still won't let you down." (male, 19)

The value of a community based treatment setting

For this client group, the ARG offered an intensive, structured intervention located in the same communities where participants are parenting, working and socialising. In doing so, it provided not only direct support in abstaining from drug and alcohol use, but also a mechanism for building and mobilising recovery capital in the very settings where long term recovery must ultimately be lived. Across the data, community based treatment was described as allowing recovery work to be integrated into everyday life. One professional contrasted community provision with residential models where the person is "cocooned away" for thirty or ninety days and "the family are left sitting with it", emphasising that in a community programme "the family should see the change occur as well".

Engagement with the ARG was associated with occupying community spaces and relationships:

"With Brandon House I've started to expose myself more… … now I am playing football (with a local group) and I look forward to every Wednesday." (female, 1)

Participants also emphasised the importance of the centre as a non clinical, ordinary environment. One professional (professional, 3) described inviting a young man who was "shaking with fear and anxiety" into a space that was intentionally "not that clinical" and where "people can be themselves". Service users echoed this, describing Brandon House as relaxed, normal and safe, and stressing that staff were "just normal people" (female, 4) who could mix lightness and seriousness in a way that reduced defensiveness.

Several participants reported that family members commented on positive changes over time, suggesting that recovery was recognised and mirrored within the household. For some participants, the ARG was the only form of structured treatment they could afford or fit around their responsibilities.

Several participants describe residential as something they would have avoided altogether. Others link the impossibility of residential directly to childcare and family care. Being a single parent, or having young children or dependent parents, made leaving home for weeks or months unfeasible.

"I always would have liked to have done treatment, you know, but I suppose I couldn't afford it… it doesn't cost thousands to come in here… I did not realise there was such a place, like an outpatient kind of service… purely because it would not break up the family." (male, 15)

Not "a bubble": practicing recovery in real life

Participants with experience of residential programmes commonly refer to the same image: a "bubble." They describe residential units as highly contained environments that feel safe, followed by a jarring return to the outside world.

"What I am doing in my community here in Kerry… I have continuity. I have a routine… that weekly routine over… 52 weeks as opposed to four weeks in residential…being supported across 52 weeks, that is more valuable to me than a short period of intense time." (female, 7)

For these participants, the challenge of the ARG is also its strength. It is "more challenging" because they go home after group, face triggers, school runs, bills and arguments. Recovery is practiced in the context in which they actually live:

"For me, going for 30 days… you can go in there and you can pretend to be somebody else for 30 days… instead of like coming here two days a week, being totally myself, throwing it all out there, leaving here and getting on with life, still being able to do those things. It is a bit more challenging maybe, but it is a bit more real." (female, 8)

Several participants talk about the extra demands community based treatment places on their own responsibility, as this participant quote illustrates:

"Here… it is still a little bit daunting because you can walk out the door after your therapy, you know, and you have got to do the work. But at the same time… I know lads that had gone [to residential] … they might do it for two weeks and from being locked away, they will just walk out and leave… the pressures of the head of what is going on at home, what am I missing… In one sense it is very good to be able to come here and go." (male, 15)

Others describe outpatient treatment as what makes their recovery possible in the first place because it allows them to keep jobs and avoid putting extra financial pressure on partners:

"It was outpatient. I could still work and I still have my job and I could still go about my day to day life… I would be worried about rent and bills… I feel like I would be putting the burden of the rent on my partner… [if I went residential]." (male, 17)

There is also nuance about fit. One participant notes that there is still a place for inpatient care:

"It depends on the individual… I think some people do need to go to residential, you know, and turn off the phone… they probably need the support of counsellors and people around them… just to stop them… where here… you have got to do the work." (male, 15)

For others, the ARG facilitates transfer into residential when community based treatment is not a good fit:

"I did [drop out] … because I relapsed and I had a very good conversation with my counsellor, who I think saw that in my case, I need to go to residential." (male, 10)

Recovery Capital: Personal, Social and Community

Participants described a gradual accumulation of resources in their lives which were both intrinsic and relational.

Personal recovery capital

At an individual level, participants reported improvements in energy, emotional stability and a renewed sense of possibility. Many contrasted a previous state of exhaustion or chaos with a more grounded and confident way of living. Small but repeated shifts in sleep, diet, routine and self care can be understood as markers of personal recovery capital.

"Oh, so much, like it's just easier to get up in the morning. No matter what comes my way I'm like 'I'm able for it, I'm ready for this.'" (female, 3)

Participants spoke about experiences of sleeping through the night, managing depression, going to the gym, travelling alone or applying for a mortgage. Taken together, these changes point to improved life quality and growing agency.

Social recovery capital

Participants also described shifts in their social worlds. Relationships that had been damaged began to repair, and new connections formed within and beyond the group. Several participants spoke about moving from avoidance and social anxiety to active participation in family life, sport and social events. The data also pointed beyond individual and immediate social change to a broader sense of community belonging. For some participants, this was entirely new territory after years of isolation. One participant described how connections formed through the ARG extended into her local area:

"I have made friends. I have made connections… links with people who live in my geographical community as well. We know who we are. We go for coffees; we support each other in text messages. We send each other little happy memes. There's a lot of, you know, the word community is really, really important for me." (female, 7)

Here the ARG is experienced as a platform for building networks in the local area. These ties extend through coffee, messages and informal check ins. Social and community resources are key predictors of sustained change (Best et al. 2025).

Distinct groups

Young adults in an abstinence oriented programme

Younger participants are in the minority in the ARG groups although they are represented. According to research participants, this produces a mix of belonging and distance. Listening to older peers can be frightening and motivating at the same time. This group experience treatment through a distinct lens. Age shapes how they see addiction, how they relate to peers in the group, and how they hear messages about recovery and abstinence. For some younger participants, understandings of drug and alcohol use may differ from Minnesota Model frameworks:

"I didn't think an addiction was like a disease… I was convinced that, oh no, like, I just have a problem with coke. I still have that mindset of … I want to be able

to ... go on a mad one in the summer… I have a problem with long thinking… I'm thinking about here in the future like, I can't even get to the end of the day." (female, 5)

Professional participants recognise these challenges and are cautious about locking young people into a rigid narrative when they are still forming adult identities and peer groups:

"Who is to say… maybe you will outgrow this… if you would change your peer group, particularly when you are twenty seven instead of nineteen… you are not as wounded, you are not as vulnerable… So, is it lifelong and all that? I have as much reservations as them and I do not tend to copper fasten that around people." (professional, male, 2)

The emphasis for some staff is on "just for today" and daily recovery. Some younger participants had been in and out of the service for years before engaging fully. One participant first came at seventeen, drifted in and out of brief contacts, and only committed to the ARG in his late twenties:

*"I never got into the actual treatment thing… I was coming in, meeting someone and then f**ing off again. I started doing the ARG …last year." (male, 13)*

Another describes entering at nineteen or twenty, dipping in and out during his early twenties, and only "going through with it" in his current attendance. Staff confirm this pattern. They talk about young people arriving before eighteen, reappearing in their twenties, and sometimes still in contact many years later:

"There are kids that are here since I started… or they are adults that are here since I started here. So, they would start out under eighteen… some of them have transitioned… more of them are still here. But it is the same people that keep coming back… they were young… it may have been too much… life did not get better. Life got worse." (professional, female, 1; professional male, 1)

Early exposure to treatment creates a reference point that some young people can fully use when they run into problems later. For younger service users, who may not yet have seen peers seek help, anxiety about treatment is a barrier. The staff description of careful orientation and relationship building at intake is a deliberate response to that. Younger service users engage with the group and programme content, but some of the tools carry associations that present challenges.

One participant describes resenting written tasks because they remind him of school:

" What did you enjoy least? The homework. But that is just down to me. I never liked school. I never liked anything like that. So, it was just sit there, write down… Maybe that was my age when I first came in here too. I was nineteen, twenty then." (male, 17)

Some of the Twelve Step content, and especially the idea of a higher power, is also experienced as confusing and sometimes alien for younger people who do not identify with formal religion:

"To be honest, I genuinely have not a clue about it… this whole thing of a higher power and stuff, I do not know. I feel like a lot of people relate to it as religion… I thought that I was like 'do I have to start going to church and start praying' and he is like 'no it is whatever you want it to be'… I feel like the higher power thing, I have not a clue… it is not even explained… what it actually means is a different thing." (female, 5)

Staff acknowledge that they informally adapt the way they present the Twelve Steps, placing more weight on daily practice and less on long term abstinence for younger people:

"The daily reflection of recovery rather than the long term reflection of long term abstinence is something that has to be implemented… work on your recovery today… we do not have to talk about long term abstinence… I do not think it is done as a structure. I think it is done individually… it is trying to balance that." (professional, male, 3)

This is a practical attempt to hold the frame of the model while making it tolerable and meaningful for young people. The ARG is functioning as an early intervention space for young adults. The model holds through flexibility in how it is applied with young people.

Women in treatment

The data shows the ARG is carrying a cohort of women with gendered experiences of addiction, violence and caring responsibility, within a structure and culture that has developed around male staff and mixed groups. The mixed model is valued amongst participants; however, one participant spoke about her experience of being surrounded by men in NA meetings and in treatment:

"I went to an NA meeting and I'm the only girl in there and like here like my counsellor is male, sure inside there's a male, like it's all males… I feel like alright for a male to be an addict, but I feel like for a female, I feel like it's not." (female, 5)

Both women service users and staff describe the absence of permanent female counsellors as a significant gap. The current team is described as “very male dominated”. Female staff talk about the impact of this on women who have experienced abuse:

"I was shocked when I came in day one and realised that I was the only female counsellor… there's been a lot [of clients] that have been coming from maybe abusive relationships… just that intimidation of… sitting in front of another man… especially if they've come from domestic [violence]… even simpler again, like menopause… I think it's vitally important that… there’s a female counsellor on the team." (professional, female 2)

Another worker notes that the men are skilled but cannot substitute for lived gendered experience:

"And it's great knowledge the lads have… they’re not a woman. You need a woman… It is a completely male dominated environment… without a doubt. We need a new female counsellor." (professional, female 1)

Most professional participants agree and are clear that women should have the option of a female therapist:

"Some of them might prefer a female counsellor, or they would like to have the choice… they might need a safe space to process some of that stuff… and they might feel more comfortable… with female counsellors and maybe around females… I have no doubt that females come in here who would prefer to talk to a female but maybe not able to voice that." (professional, male 1)

There is support among staff for a women only group as an addition to the core model. Several suggest that mixed intensive groups should remain, because of what men and women can learn from each other about toxic and abusive relationships, but that women need their own space at some point in the pathway, most likely during aftercare or alongside it:

"I do think there's definitely… room for… a women's group maybe after… as part of an aftercare programme or something separate, because I do think it's good to have the mix in treatment as well… there is an awful lot of toxic relationships… I think they can learn from each other… [but] there's a place where they might need a safe space… rather than having males in the room because they could be triggered." (professional, male 1)

Professional participants are frank that current staffing and funding mean these needs are recognised but not fully met and link the lack of female counsellors and limited capacity to wider pressures on the service.

Challenges experienced

Groupwork

Engaging with the ARG programme is intensive work. The difficulties participants describe are challenges encountered when showing up honestly in a structured group, and in navigating some practical and organisational limits in the system. For many, the first barrier is not the content but crossing the threshold into group work at all. One woman describes spending months in Prep Group, repeatedly postponing entry because of anxiety about talking in front of others:

"It took me ages to even get into the group. I kept saying no, like I'll do it next week… I think I was in Prep group for like 5 months. I just get so anxious… about talking around people… And it's hard to share things in front of a group of people as well." (female, 10)

Others echo the fear of speaking in front of a group, often linked to previous negative experiences of NA or other meetings:

"Talking in front of a group of people… I had tried NA previously and I hated it and I thought coming in here it was basically like NA… but I think it was easier as weeks went on." (female, 6)

Group work is therefore experienced as both a challenge and a developmental task. The model pushes people into a mode of relating that can be challenging. The structured Twelve Step exercises that are central to the ARG were described by some participants as the hardest part of treatment.

"The hardest part… people seeing your ways. How selfish you are… opening up and your consequences and seeing your ways and going away and having to deal with that in your head." (male, 16)

For people who have used drugs and alcohol to manage social anxiety or who see themselves as "better listeners than talkers," the social rules of the group can be uncomfortable. One participant says the expectation to provide feedback for others was the only aspect she would change:

"They kind of put you on the spot as well… you have to feedback to other people… I just do not like feeding back on somebody else's experience… everybody's different… I just do not like feeding back to other people." (female, 9)

Written work brings its own resistance, which is likely to be compounded in adults with literacy issues:

"Doing the Step 10, you know writing down my feelings and personal inventory… because I do not write or I have not written all my life… if you give me a piece of paper and a biro… [that] is hard." (male, 8)

While the Intensive Phase is almost uniformly praised, a minority of participants were more critical of the aftercare configuration. The main issues are group size, noise and the mixing of “concerned persons” with people in treatment.

“I didn’t like the aftercare. I think the group was too big. There’s a lot of people talking over each other… I was about to get up and walk out… I get overwhelmed with things like that… when there’s people talking, there’s noise and there’s people coughing…”
(male, 13)

“I was not mad for the aftercare… I didn’t like the mixture between the concerned people and the… [clients]. I remember at the time, none of us liked it. It was kind of like us and them.”
(male, 14)

Resourcing of staff

Professional participants spoke about the limits of current staffing. They describe being at capacity and running into difficulties on the rare occasion when staff are absent in sustaining the delivery of groups. This inevitably constrains what can be offered: frequency of groups, availability of one to one work, and flexibility in crisis. Participants repeatedly describe staff as committed, responsive and "never letting you down", indicating that any issues with resourcing services are structural.

ARG structure and content

Participants gave very specific feedback on how the groups could be improved, which varied due to different perspectives. As already stated, aftercare groups are large, mixed spaces with both 'concerned persons' and chemically dependent clients. A majority find this helpful; others feel like outsiders or judged. There are some suggestions for separate aftercare groups for people in their own recovery. A balance of didactic material and facilitated discussion was favoured in group, e.g., some videos that were shown being experienced as too lengthy. Some service users said they would have ARG groups three times a week if they could. A short extra check-in or additional group could act as a safeguard in the early months of recovery for those who would prefer more contact.

Workforce development and replication

Professionals underscored the potential of Brandon House as a "training and teaching treatment centre". Student placements from social work, psychotherapy and related courses are seen as an investment in the future addiction workforce. There was a sense that the ARG model itself, structured, free, community based, with clear links to higher tiered treatment including residential should be replicated in other regions, with appropriate resourcing and specialist addiction training.

Logic model for the ARG

A logic model was developed to provide a clear description of how the ARG was expected to produce change for participants. This model set out the programme core activities, immediate outputs and short and medium term outcomes in relation to substance use, wellbeing and recovery capital. Drafts of the logic model were discussed and refined with Brandon House staff to ensure that it accurately reflected local practice and theory of change.

Inputs

- A small multidisciplinary team of addiction counsellors and support staff, with specific expertise in the Minnesota Model, psychoeducation, and case management.
- The physical building and fixed presence of Brandon House in the local community, which offers a familiar and accessible site.
- Governance, administrative support, information systems and outcome tools such as AUDIT, DUDIT and the Happiness Scale.
- Referral pathways from general practitioners, residential services, social work, and self referrals.
- A dedicated abstinence oriented programme, drawing from the Minnesota Model.

The evaluation confirmed that these inputs are present but also highlighted pressure points, particularly staffing.

Activities

- Engagement and assessment: telephone and in person screening, initial use of AUDIT and DUDIT, explanation of the programme, and early case management.
- Intensive group and individual work: delivery of structured group sessions that include Twelve Step, cognitive and emotional skills, along with one to one counselling, family sessions and ongoing case management.
- Aftercare and ongoing support: less intensive but continuing group work, telephone support, crisis response where possible, liaison with mutual aid, and further links to education, training or residential treatment where indicated.

The qualitative data show that service users experience these activities as valuable. They emphasised the value of regular group routines, skilled facilitation, family sessions and the ability to remain in their community while in recovery.

Outputs

Although this evaluation did not focus on detailed service utilisation statistics, staff and participants described regular group attendance, frequent one to one contact during the intensive phase, and active case management. These narratives indicate that the outputs are occurring at scale, within the capacity of a small team.

Outcomes

Short term outcomes (weeks to three months)

- Initial reductions in alcohol and drug use, including movement from daily or high risk use to early abstinence or markedly reduced consumption.
- Increased insight into addiction, consequences and patterns of thinking, as expressed in group work.
- Stronger engagement with the group and with individual counsellors, and emerging trust in the ARG.
- Early improvements in sleep, routine, and management of anxiety or low mood.

Intermediate outcomes (three to twelve months)

The quantitative and qualitative data both point to:

- Sustained abstinence from alcohol and drugs for many participants who remain engaged through twelve months, reflected in low risk AUDIT and DUDIT scores and self reported abstinence.
- Growth in personal recovery capital, including improved mental health, emotional regulation, physical health, confidence and self efficacy.
- Growth in social recovery capital, through rebuilding of family relationships, reconnection with children, renewed trust from partners, and development of sober peer networks.
- Potential for growth in community recovery capital, as people become more involved in local activities, sport, work, education and community spaces while staying in their own locality.
- Increased satisfaction across multiple domains on the Happiness Scale, especially family life, social life and overall life satisfaction.

Longer term outcomes (beyond the study period)

Over time, the accumulation of personal and social recovery capital among a cohort of service users has the potential to alter the communities in which they live, not only their individual trajectories. While this evaluation could not measure those effects directly, the patterns observed and the wider recovery capital literature allow some cautious inferences about likely community level outcomes.

As more people stabilise in recovery while remaining in their local area, they contribute to what Best and colleagues (2025) describe as "community recovery capital", the shared norms, relationships and resources that support recovery as a collective process.

A stable local recovery community around Brandon House is already visible in the way participants continue to attend aftercare, meet each other informally, and stay in contact with staff. Over the longer term, such networks can become a routine feature of local life, making recovery more visible and more achievable for others.

At community level, the logic model anticipates several longer term outcomes.

A more visible and accessible local recovery community

As cohorts move through the programme and remain in the area, informal recovery networks are likely to grow. This can normalise help seeking and provide multiple visible examples of sustained recovery in the locality.

Reduced stigma and a shift in local narratives about addiction

When recovery happens in the community family members, employers, neighbours and local services see change occur. Communities encounter people in stable recovery in workplaces, schools and voluntary groups. This can reduce stigma and support more nuanced local conversations about alcohol and drug use.

Increased participation in education, training, employment and civic life

Many participants in this evaluation described returning to work, entering education or training, or engaging with local clubs and activities. At scale, these individual changes contribute to higher levels of participation and productivity in the local area. People who previously cycled between crisis, unemployment and informal economies can become regular contributors to formal and informal community life.

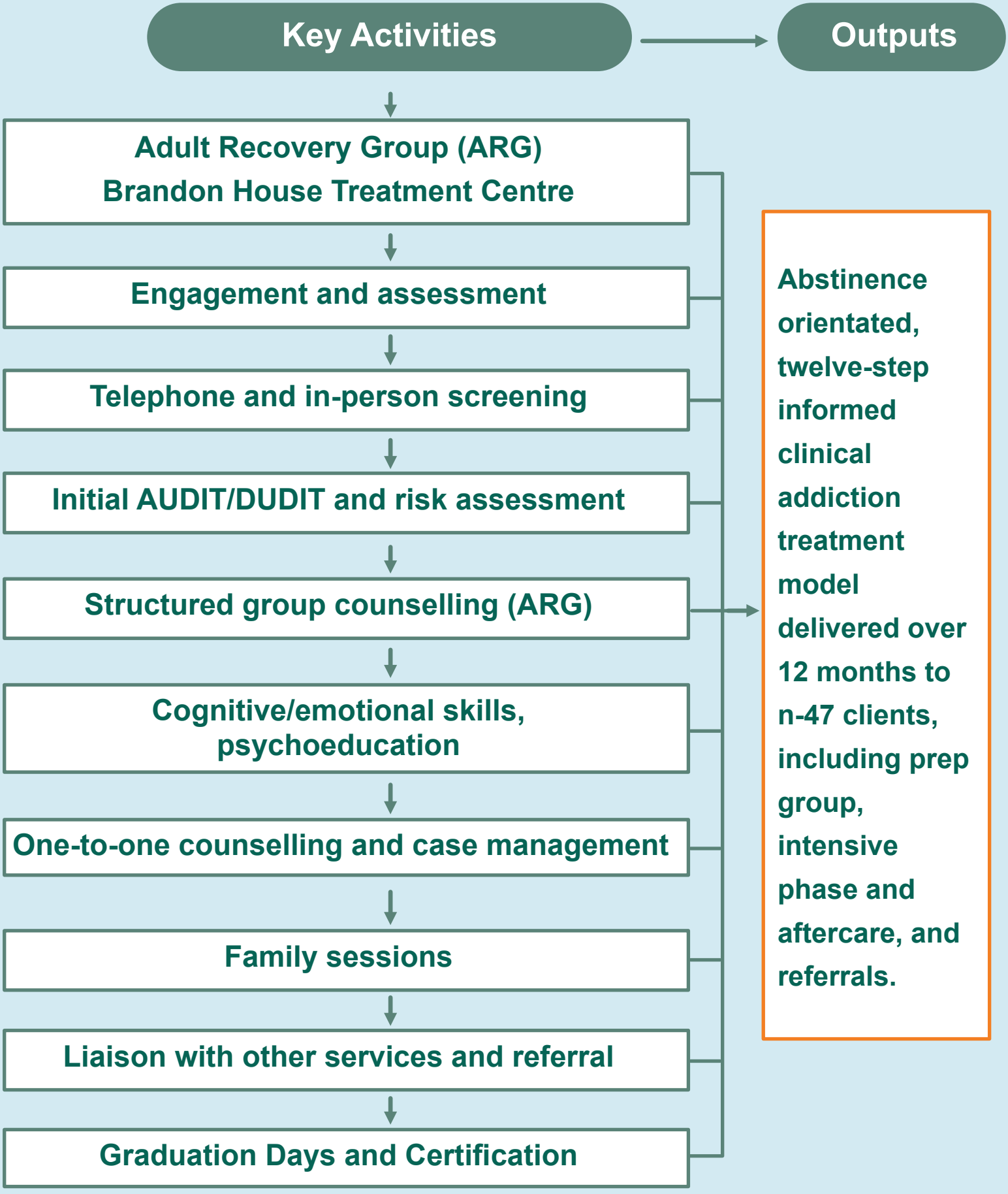
Intergenerational benefits for children and young people

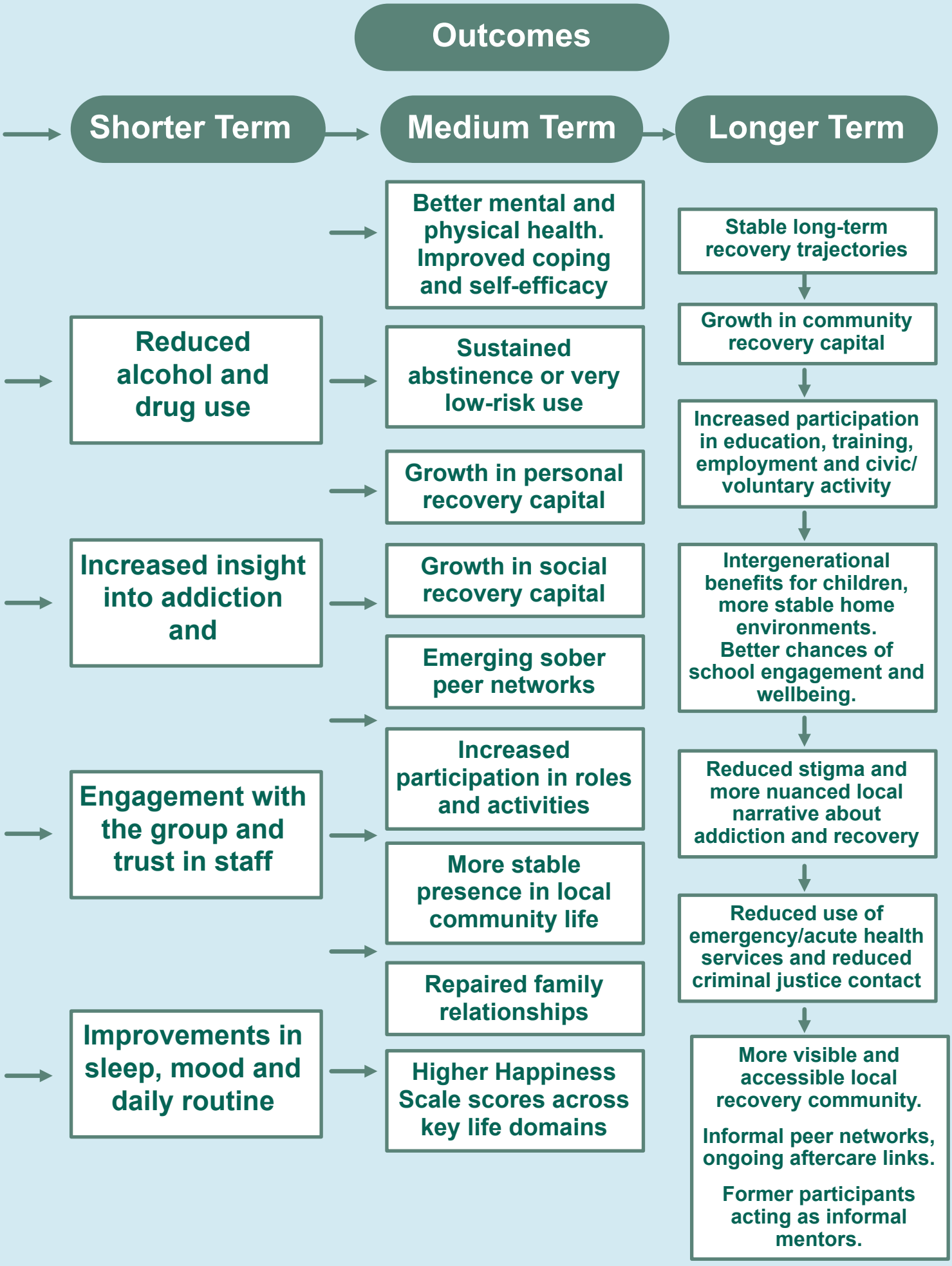
Parents in this study spoke about being present for children's routines, having the energy to attend school events, and repairing relationships after periods of absence or conflict. Over the longer term, such changes can alter the developmental environment of children growing up in the locality, with implications for school engagement, mental health and later substance use. These impacts will never be attributable to the programme alone, but the logic model recognises parenting and family stability as key pathways through which recovery capital influences community wellbeing.

These projected outcomes underline that the value of the ARG is not confined to the people who attend the programme. Where recovery is supported in place, gains in personal and social recovery capital can, over time, accumulate into a modest but real increase in community recovery capital. The scale and durability of these effects will depend on wider structural conditions such as housing, employment, income security and local service provision, but the ARG provides a focal point around which a local recovery ecology can form.

Context, feedback and refinement:

- The absence of permanent female counsellors and of women only group space constrains the potential of the model for women, particularly those with trauma histories.
- Further community level engagement by Brandon House, increasing visibility of the service and participation in community events and activities.


Key Activities
Outputs
Adult Recovery Group (ARG)
Brandon House Treatment Centre
Engagement and assessment
Telephone and in-person screening
Initial AUDIT/DUDIT and risk assessment
Structured group counselling (ARG)
Cognitive/emotional skills, psychoeducation
One-to-one counselling and case management
Family sessions
Liaison with other services and referral
Graduation Days and Certification
Abstinence orientated, twelve-step informed clinical addiction treatment model delivered over 12 months to n-47 clients, including prep group, intensive phase and aftercare, and referrals.


Outcomes
Shorter Term
Medium Term
Longer Term
Reduced alcohol and drug use
Increased insight into addiction and
Engagement with the group and trust in staff
Improvements in sleep, mood and daily routine
Better mental and physical health. Improved coping and self-efficacy
Sustained abstinence or very low-risk use
Growth in personal recovery capital
Growth in social recovery capital
Emerging sober peer networks
Increased participation in roles and activities
More stable presence in local community life
Repaired family relationships
Higher Happiness Scale scores across key life domains
Stable long-term recovery trajectories
Growth in community recovery capital
Increased participation in education, training, employment and civic/ voluntary activity
Intergenerational benefits for children, more stable home environments. Better chances of school engagement and wellbeing.
Reduced stigma and more nuanced local narrative about addiction and recovery
Reduced use of emergency/acute health services and reduced criminal justice contact
More visible and accessible local recovery community.
Informal peer networks, ongoing aftercare links.
Former participants acting as informal mentors.

Discussion

The present research set out to examine outcomes and lived experiences of the Adult Recovery Group (ARG) at Brandon House Treatment Centre. The ARG model offers an intensive group intervention, grounded in Twelve Step, but combined with professional counselling, case management and links to wider services.

This was a mixed methods study. The quantitative data show large reductions in alcohol and drug use over twelve months, alongside improvements in self reported wellbeing across key life domains, illustrated with insights from qualitative enquiry.

Drug and alcohol use outcomes

Across twelve months, most participants who remained in the study moved from high risk or dependent patterns of alcohol and drug use into abstinence. The abstinence focus of the ARG is consistent with strong evidence for the effectiveness of Twelve Step programmes in improving the likelihood of long term abstinence from drug and alcohol use (Kelly et al., 2020).

Of note is that these principles are embedded in a health service context, delivered by accredited counsellors, in a local community setting, in line with national policy directives (Department of Health, 2017). The present research indicates that a community based programme can support comparable abstinence among those who stay engaged, but without removing people from their families, work and local networks.

Intensive abstinence-oriented recovery interventions are commonly delivered in residential settings, such as therapeutic communities and residential rehabilitation (European Centre (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2014).

Recovery capital

While the Happiness Scale is not a measure specific to recovery capital (Bunaciu et al. 2024) it presents snapshots of perceived improvements in areas relative to recovery capital. Recovery capital refers to the resources that people can draw on to start and sustain recovery, including skills, self belief, relationships and community connections (Cloud & Granfield, 2008; Best & Hennessy, 2025; Bunaciu et al., 2024). Participants reported gradual improvements in satisfaction with family life, social life, mental health, and job or education progress across the three timepoints.

The qualitative data describes positive life changes such as reunification with children, rebuilding of trust with partners and parents, entry to education or training, and a stronger sense of belonging in local community spaces. These patterns align with evidence that growth in recovery capital is associated with improved quality of life (Cloud & Granfield, 2008; Nisic, 2025; Ross-Houle & Porcellato, 2021). Family relationships, peer networks and opportunities for meaningful activity are central to recovery, and programmes which explicitly seek to build these resources tend to show better outcomes (Munton, Wedlock & Gomersall, 2014).

Brandon House is well positioned to develop in this direction. Recovery capital research highlights that community based assets – local groups, peer networks, voluntary organisations and visible recovery events – are central to sustaining change beyond formal treatment (Best et al. 2025). Recovery community organisations (Ashford et al., 2021) are presented as formal, community based structures that function both as hubs for recovery support and as vehicles for advocacy and public education.

They typically provide a physical space for recovery activities, coordinate and deliver peer-led recovery support services, campaign for improved policies and funding, and seek to reduce stigma by educating the wider community about substance use and recovery (Ashford et al., 2020)

In the Irish context, Recovery Academy Ireland has emerged as a national hub for community recovery capital, hosting Recovery Walks, pop up cafés, comedy nights and other public events that make recovery visible and allow people to practise sober connection in ordinary spaces. The evaluation shows that many service users begin to rebuild not only personal and social recovery capital, but also a foothold in community life while they are still in treatment. To consolidate this, consideration should be given to making "building community capital" an explicit practice goal, strengthening the web of community relationships, roles and spaces that support recovery in place (Best & Hennessy, 2025).

The value of a community based, abstinence oriented model

Participants with experience of residential treatment repeatedly contrasted the ARG with the sense of being in a residential treatment "bubble". They valued the fact that recovery work took place while they remained embedded in family roles, employment and local social worlds. The challenge of leaving the group room and walking past familiar pubs, dealers or routes home was mentioned, but was also framed as an opportunity to practice new skills in real time.

For many participants, community location was the factor that made treatment possible at all. Parents caring for children, people in precarious employment, and those who had already tried residential care described the ARG as the only realistic or acceptable option. Similar arguments have been made in research on mothers in residential therapeutic communities, where lack of childcare and fear of family separation are major barriers, and community based services are seen as vital for access (Morkan, 2023).

Young adults in an adult recovery group

The study shows that people under thirty are accessing the ARG. For some younger adults in this research, the main barriers were stigma, ambivalence about naming "addiction" in their early twenties, discomfort in groups dominated by older adults, and fear that committing to abstinence meant stepping permanently outside the norms of their peer group. There was also a sense that the ARG's structured group exercises resembled school. However, the majority in this study achieved abstinence at T3. Young people may need tailored approaches that address identity formation, peer belonging and future orientation more explicitly (see İnce, 2025).

Women specific provision

While the mixed group is valued by participants, women have unique support needs (Faye et al. 2025; Pladys et al. 2025). Women service users and staff in the present research describe as a "completely male dominated" clinical team with no dedicated women only group space. Research on mothers in addiction recovery in Ireland, including recent work in Coolmine Therapeutic Community, has highlighted the centrality of stigma, guilt and fear of child removal in shaping women's engagement with services (Morkan, 2023).

National policy frameworks recognise these issues (Department of Health 2017) and its later evaluation both highlight the need for gender responsive interventions and better attention to women's specific needs,

including parenting, trauma and economic dependency (Department of Health, 2025).

System learning and model transferability

The ARG model is characterised by:

- A dedicated programme delivered by six accredited addiction counsellors with lived experience, in a community setting.
- High accessibility – free to service users, and self-referral is possible
- Strong case management from first contact through to aftercare.

There is a realistic case for using Brandon House Treatment Centre as a reference site to support replication or adaptation of the model in other regions nationally, particularly in areas without access to residential programmes.

Limitations

The study has several limitations that need to be acknowledged when interpreting the findings and making recommendations. The quantitative data are based on a modest cohort with attrition across timepoints. Those who were lost to follow up may have had poorer outcomes. As a result, the abstinence and wellbeing data should be read as describing those who remained engaged with the service. Quantitative analysis is descriptive.

There are no inferential statistics to test the strength of observed changes or to compare subgroups in a formal way. There is no comparison group. It is not possible to say how participants would have fared with no intervention, with harm reduction only, or with residential treatment during the same period. The discussion therefore focuses on plausibility and coherence with the wider literature rather than on strong causal claims. The study is rooted in a specific regional context with particular local services, population patterns and referral routes.

The findings may not be generalisable to other regions. Finally, the instruments used focus on substance use risk and self reported happiness in key life domains. They do not provide a full measure of recovery capital or of structural factors such as housing stability, income or criminal justice involvement. Future evaluations could use validated recovery capital questionnaires to build on this work (see Bunaciu et al., 2024).

Recommendations

The ARG model is a valuable programme that provides an effective community based route into abstinence for many service users. Beyond changes in drug and alcohol use, the evaluation found strong evidence of growth in recovery capital across personal and social domains. The following recommendations are arising from this research.

Practice recommendations

Given the current client profile and the literature on women and recovery, the service should consider recruitment of female counsellors and development of a women specific component to treatment.

That consideration be given to framing existing practices more clearly in recovery capital terms. This might include use of a validated recovery capital questionnaire. This would bring everyday practice into closer alignment with understandings of recovery capital (Best & Hennessy, 2025).

That consideration be given to positioning Brandon House as recovery community organisation (Taylor, 2009) through further engagement with the community in Tralee. Consideration should be given to actively linking service users to Recovery Academy Ireland activities and to hosting low threshold, recovery friendly community spaces, as well as further exploration of developing a what is a thriving community service as a recovery community organisation.

Policy implications

The findings also carry implications at system level.

Women are one in three of people who take drugs globally, often experience addiction pathways progress faster (Van Hout et al. 2025), and have unique support needs (Faye et al. 2025; Pladys et al. 2025). The strong demand from women in this service, combined with national and international evidence on gendered barriers, supports further investment in women centred, community based addiction services.

That consideration be given for the use of brief, standardised recovery capital assessment tools across drug and alcohol services.

Conclusion

This evaluation has shown that the ARG helps people stabilise their drug and alcohol use, rebuild personal and family lives, and begin to participate more fully in community life, while remaining embedded in their own homes and localities. Additional gender-responsive provision and protected staffing to sustain the depth of the work is recommended.

There is also opportunity to develop Brandon House as a recovery community organisation in Tralee, reducing stigma and supporting community capital. Resourcing models like the ARG offers a concrete way to strengthen recovery oriented responses in the Irish treatment system and to support both individual and community recovery in place.

Ashford, R. D., Brown, A. M., Ryding, R., & Curtis, B. (2020). Building recovery ready communities: The recovery ready ecosystem model and community framework. Addiction Research & Theory, 28(1), 1–11. https://doi.org/10.1080/16066359.2019.1571191

Ashford, R. D., Brown, A., Canode, B., Sledd, A., Potter, J. S., & Bergman, B. G. (2021). Peer-based recovery support services delivered at recovery community organizations: Predictors of improvements in individual recovery capital. Addictive Behaviors, 119, 106945. https://doi.org/10.1016/j.addbeh.2021.106945

Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for use in primary care (2nd ed.). World Health Organization.

Best, D., & Hennessy, E. A. (Eds.). (2025). The handbook of recovery capital: Understanding the science and practice. Bristol University Press.

Best, D., Duffy, S., Smith, D., Bryson, J., & White, B. (2025). An “outside in” model of recovery capital growth: Building personal and social recovery capital from community resources. Addiction Research & Theory. Advance online publication. https://doi.org/10.1080/16066359.2025.2523825

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101.

Bunaciu, A., Bliuc, A., Best, D., Hennessy, E. A., Belanger, M. J., & Benwell, C. S. Y. (2024). Measuring recovery capital for people recovering from alcohol and drug addiction: A systematic review. Addiction Research & Theory, 32(3), 225–236. https://doi.org/10.1080/16066359.2023.2245323

Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. Substance Use & Misuse, 43(12–13), 1971–1986. https://doi.org/10.1080/10826080802289762

Coolmine Therapeutic Community. (2023). Coolmine strategic plan 2023–2026: Responsive sustainable recovery. Coolmine Therapeutic Community.

Creswell, J. W., & Plano Clark, V. L. (2018). Designing and conducting mixed methods research (3rd ed.). Sage.

Dekkers, A., Vos, S., & Vanderplasschen, W. (2020). “Personal recovery depends on NA unity”: An exploratory study on recovery-supportive elements in Narcotics Anonymous Flanders. Substance Abuse Treatment, Prevention, and Policy, 15(1), Article 53. https://doi.org/10.1186/s13011-020-00296-0

Department of Health. (2026). Draft National Drugs Strategy 2026–2029. Government of Ireland.

Department of Health. (2017). Reducing harm, supporting recovery: A health led response to drug and alcohol use in Ireland 2017–2025. Government of Ireland.

Department of Health. (2025). Evaluation of Ireland’s national drug strategy “Reducing harm, supporting recovery” 2017–2025. Department of Health/Grant Thornton.

European Parliament and Council of the European Union. (2016). Regulation (EU) 2016/679 of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation). Official Journal of the European Union, L 119, 1–88.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2014). Therapeutic communities for treating addictions in Europe: Evidence, current practices and future challenges. EMCDDA: European Monitoring Centre for Drugs and Drug Addiction

Faye, R. A. Y., Desclaux, A., & Diagne, A. (2025). The gender factor in meeting the needs of women who use drugs in Senegal. Harm Reduction Journal, 22(1), 50–17. https://doi.org/10.1186/s12954-025-01186-z

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs—Principles and practices. Health Services Research, 48(6 Pt 2), 2134–2156.

Flynn, D., Joyce, M., Spillane, A., Wrigley, C., Corcoran, P., Hayes, A., Flynn, M., Wyse, D., Corkery, B., & Mooney, B. (2019). Does an adapted dialectical behaviour therapy skills training programme result in positive outcomes for participants with a dual diagnosis? A mixed methods study. Addiction Science & Clinical Practice, 14(1), 28. https://doi.org/10.1186/s13722-019-0156-2 .

Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. Addiction, 103(1), 119–125. https://doi.org/10.1111/j.1360-0443.2007.02050.x

Hildebrand, M. (2015). The psychometric properties of the Drug Use Disorders Identification Test (DUDIT): A review of recent research. Journal of Substance Abuse Treatment, 53, 52–59. https://doi.org/10.1016/j.jsat.2015.01.008

İnce, F. (2025). Youth addiction and well-being: Analysis of social, behavioral, and economic factors. Youth, 5(4), 115. https://doi.org/10.3390/youth5040115

Ivers, J. H., & Barry, J. (2018). Evaluation of Tabor Group addiction services. Tabor Group.

Ivers, J.-H. (2025, October 9). From harm to hope: The science of addiction [Keynote presentation]. EWODOR Conference 2025, Braga, Portugal. https://www.projectohomem-braga.pt/ewodor-conference-1

Kelly, J. F., Humphreys, K., & Ferri, M. (2020). Alcoholics Anonymous and other twelve-step programs for alcohol use disorder. Cochrane Database of Systematic Reviews, 2020(3), CD012880. https://doi.org/10.1002/14651858.CD012880.pub2

Kelly, J. F., Greene, M. C., & Bergman, B. G. (2014). Do drug-dependent patients attending Alcoholics Anonymous rather than Narcotics Anonymous do as well? A prospective, lagged, matching analysis. Alcohol and Alcoholism, 49(6), 645–653. https://doi.org/10.1093/alcalc/agu066

Lyubomirsky, S., & Lepper, H. S. (1999). A measure of subjective happiness: Preliminary reliability and construct validation. Social Indicators Research, 46(2), 137–155.

Morkan, A. (2023). An exploration of the experiences of mothers in addiction recovery at Coolmine Therapeutic Community. Community Academic Research Links, University College Cork.

Munton, T., Wedlock, E., & Gomersall, A. (2014). The role of social and human capital in recovery from drug and alcohol addiction. HRB Drug and Alcohol Evidence Review 1. Dublin: Health Research Board

Nisic, M., Patton, D., & Best, D. (2025). Recovery capital and quality of life: Recovery as an aide to improving wellbeing and quality of life. In D. Best & E. A. Hennessy (Eds.), The handbook of recovery capital: Understanding the science and practice. Bristol University Press.

Pladys, A., Fonte, D., Loyal, D., Bader, D., Stefanowski, M., Anwar, I., Estellon, V., & Roux, P. (2025). Profiles, needs and satisfaction with healthcare among women with psychoactive substance use disorder in France: The CALLIOPE mixed methods study protocol. BMJ Open, 15(10), e102731. https://doi.org/10.1136/bmjopen-2025-10273

Ross-Houle, K., & Porcellato, L. (2021). Recovery capital in the context of homelessness, high levels of alcohol consumption, and adverse significant life events. Drugs: Education, Prevention and Policy, 30(2), 173–184. https://doi.org/10.1080/09687637.2021.2014402

Van Hout, M., Elsayed, H., Elgamil, R., Rabie, M. A., Aly, R., & Sonnan, M. T. (2025). 'Secrecy, trust, safety': A multi-stakeholder situation assessment of gendered and contextual vulnerabilities and service level responsiveness to the needs of women who use drugs in Egypt. International Journal of Mental Health and Addiction, 23(1), 870–893. https://doi.org/10.1007/s11469-023-01143-6

Vanderplasschen, W., De Meyer, F., & De Ruysscher, C. (2025). Commentary on Day et al.: From concept to practice—Challenges in building a continuum of recovery support services in Belgium. Addiction, 120(8), 1521–1523. https://doi.org/10.1111/add.70020

FSS – an tlardheisceart
HSE South West