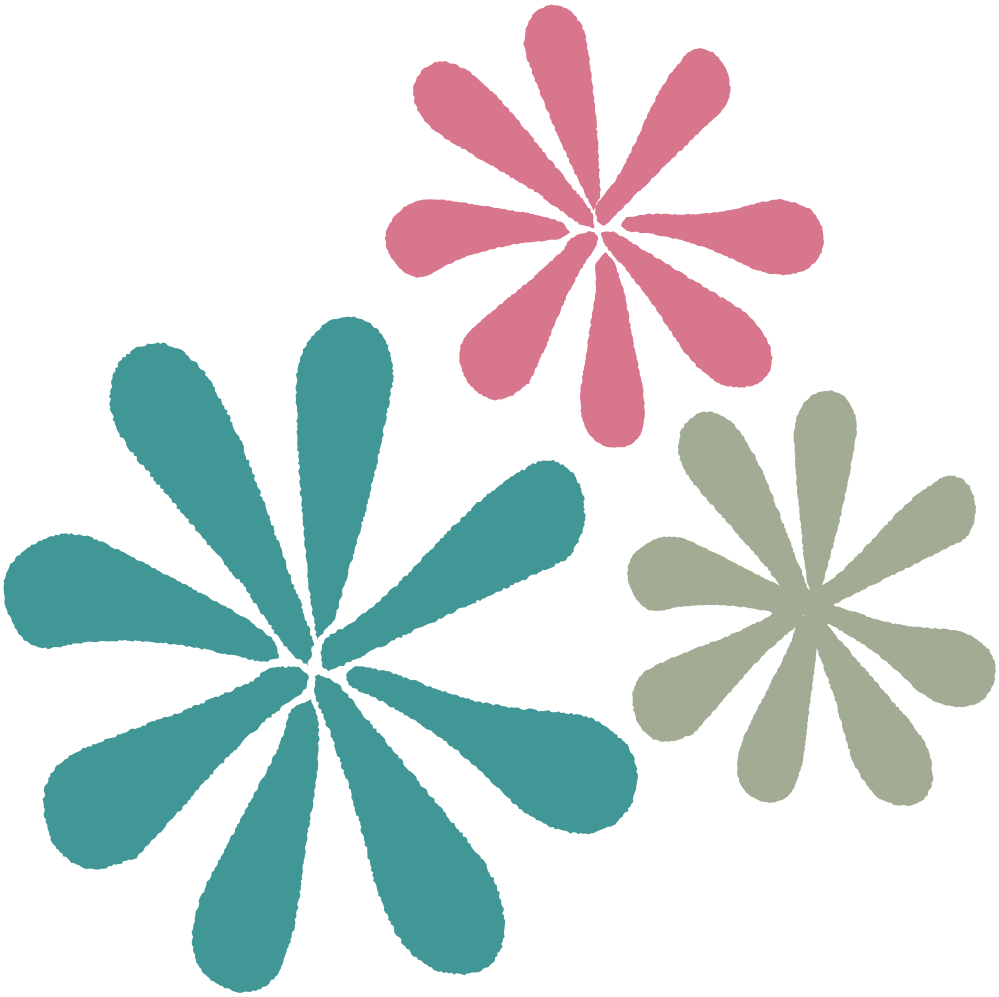
COOLMINE
OVERCOMING ADDICTION, SUPPORTING RECOVERY



PATHWAYS THROUGH TREATMENT

A MIXED-METHODS LONGITUDINAL OUTCOMES STUDY OF COOLMINE THERAPEUTIC COMMUNITY

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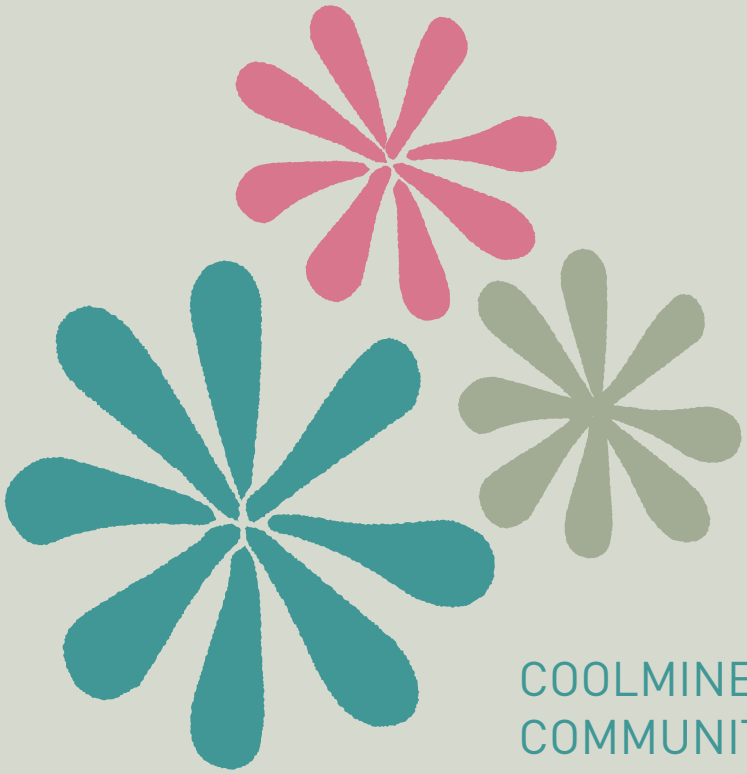
ANITA HARRIS

COOLMINE THERAPEUTIC COMMUNITY
OCTOBER 2015



COOLMINE THERAPEUTIC COMMUNITY WISHES TO ACKNOWLEDGE THE SUPPORT FROM OUR CORE FUNDERS, ALL OF WHOM HAVE CONTRIBUTED TO MAKING THIS STUDY POSSIBLE.

DEPARTMENT OF HEALTH

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SOUTH INNER CITY LOCAL DRUG AND ALCOHOL TASK FORCE

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MAIN REPORT

TERMINOLOGY

Abstinence
In this report, abstinence refers to the act or practice of refraining from using illicit drugs or alcohol.

Addiction
Addiction is defined as a primary, chronic disease of brain reward, motivation, memory and related circuitry. It is characterized by:
(a) engagement in the behaviour to achieve appetitive effects,
(b) preoccupation with the behaviour,
(c) temporary satiation,
(d) loss of control, and
(e) suffering negative consequences.
(Sussman & Sussman, 2011).

Agency
There is a wide body of literature on the construct of 'agency' and its various sociological, political, and philosophical manifestations. However, for the purpose of this report, 'agency' refers to the *capacity* of an individual to make her/his own free choices and act independently. (Di Nucci, 2014).

Community
In the context of therapeutic communities and within this report, 'community' is used to denote the collaborative environment inclusive of clients and staff, but also the physical environment of the TC. The community is understood to be primary method through which change is actualized (DeLeon 2000).

Dependence
Dependence is defined as a state wherein an individual functions normally only in the presence of a given substance and is manifested as physical disturbance when the substance is removed. (Sussman & Sussman, 2011)

Illicit Drugs
Illicit drugs are non-medical drugs that are prohibited by international law including cannabis, amphetamines, cocaine, heroin and other opiates, and MDMA (WHO, 2013).

Peer
In the TC model, a peer is an individual who is also engaged in the treatment programme within the community.

Pull-Up
A formalized element of communication within a therapeutic community where peers confront each other with seemingly problematic behaviour or lapses of awareness.

Recovery
While recovery is sometimes used interchangeably with the term 'abstinence', recovery involves more than 'not taking' drugs or alcohol. Recovery, rather, is about users gaining benefits in a number of areas including health, relationships, well-being, employment, and self-care. It is understood to be an on-going process.

Right Living
A broad concept within therapeutic communities which involves remaining drug free, following the rules of the community, maintaining a clean space, taking care of one's physical and emotional health, and displaying socially appropriate behaviour.

Substance Abuse
Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.

Therapeutic Community (TC)
The therapeutic community (TC) is an intensive and comprehensive treatment model developed for use with adults that has been modified successfully to treat adolescents with substance use disorders. The core goal of TCs has always been to promote a more holistic lifestyle and to identify areas for change such as negative personal behaviours--social, psychological, and emotional--that can lead to substance use. Residents make these changes by learning from fellow residents, staff members, and other figures of authority. (DeLeon, 2000).

ACKNOWLEDGEMENTS

We would like to extend a very sincere thank you to all of the Coolmine Therapeutic Community (CTC) clients who agreed to participate in this research. Taking part in a project of this sort can be demanding and we greatly appreciate the time and effort invested by everyone involved.

This project would not have been possible without the support of CTC's staff. Thank you to the in-house research team, specifically Anita Harris, Ger Twohig, Lora Daly, Lucy Whiston and Romy Paust, guided by the external expertise from Anne Marie Carew at the Health Research Board, Louise McCulloch and Paul Kelly. All were instrumental in co-ordinating the research, tracking participants, and conducting preliminary analysis of the quantitative data. We want to extend sincere thanks to all staff at Coolmine who facilitated this research on top of their existing workload.

The qualitative research team from Trinity College, including Dr. Paula Mayock, Sarah Sheridan, Eoghan Brunkard, Danika Sharek, and Lynne Cahill, worked diligently over a two-year period, conducting fieldwork, tracking participants, and generating high-quality qualitative data through their interviews. A generous thank you is extended to them for all of their work on this project. A special thank you is extended to Dr. Paula Mayock, who provided valuable feedback on early drafts of this report.

The Coolmine TC Clinical Advisory Group, supervised by Dr. Joanne Fenton, oversaw this project from inception to completion. A sincere thank you is extended to all members for their support and feedback.

CTCs Clinical Advisory Group Members:

- Dr. Joanne Fenton Consultant Psychiatrist
- Eoin Coughlan Researcher
- Anne-Marie Carew Health Research Board
- Jo-Hanna Ivers Trinity College Dublin
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CTC would like to acknowledge the former Chief Executive, Mr. Paul Conlon who originally envisioned the project and the initial funding support, back in 2011, from the Health Service Executive Social Inclusion Unit.

Finally, we wish to express our sincere appreciation to Dr. Eamon Keenan, Consultant Psychiatrist in Substance Misuse, HSE National Drug Treatment Centre for sponsoring this study. Ethical approval was granted for this study from the HSE National Drug Treatment Centre Ethics Committee.

Dr. Kate Babineau, Author of Report
Anita Harris, Researcher/Project worker (CTC)
Pauline McKeown, CEO of Coolmine Therapeutic Community

EXECUTIVE SUMMARY

BACKGROUND TO THE STUDY

In recent years, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)[1] published Guidelines for the Evaluation of Drug Prevention (1998), while the World Health Organization (WHO) and the United Nations Drug Control Programme (UNDCP) both emphasised the need for rigorous drug treatment programme evaluation.[2] Nationally, the Research Outcome Study in Ireland Evaluating Drug Treatment Effectiveness (ROSIE), commissioned by the National Advisory Committee on Drugs (NACD), was the first national longitudinal drug treatment outcome study in response to these international recommendations.[3] In 2011, CTC undertook a longitudinal outcome study in their primary treatment services to contribute to the national and international literature surrounding drug and alcohol treatment evaluation.

The complete findings from this study are presented in the full report entitled 'Pathways through Treatment: A mixed methods longitudinal outcomes study of Coolmine Therapeutic Community'. In this executive summary, an overview of the quantitative findings is presented to highlight the broad trends identified in the numeric data. The qualitative data herein is summarised briefly and analysed thoroughly in the main report.

METHOD

A mixed methods research design was particularly suited to the study's aims. First, it permitted a broad, on-going examination of treatment retention, progress, and outcomes among a larger sample to investigate salient patterns and trends. Second, it facilitated an in-depth exploration among a smaller sample of the different pathways individuals take through treatment. A two-tiered, concurrent data gathering approach enabled the collection of both qualitative and quantitative data over a 24-month period.

Baseline quantitative data were collected at intake to a CTC primary treatment service between February 2011 and February 2012 using the Treatment Outcome Profile (TOP).[4] Four follow-up data collection phases were staggered, depending on the date of the initial baseline interview, with the aim of following-up at six month intervals. A total of 144 clients participated in the baseline quantitative survey. Participants ranged in age from 18 to 50 years. The average age at entry to treatment was 30 years, with the average age for males (31 years) being slightly higher than for females (28 years). More than half of the respondents (53%, n=77) reported problem use of more than one substance, although 71% reported opiates as being the primary problem drug of use.

Qualitative data collection occurred in four stages: treatment intake, 6 months, 12 months and 18 months from the period March 2011 to June 2013. In total, 86 semi-structured interviews were conducted with 28 clients. A purposive sampling strategy was used and all participation was voluntary. Qualitative participants ranged in age from 20 to 47 years and the average age was 32 years. A total of 16 (58%) were male and 12 (42%) were female. There was a near equal representation from three CTC primary treatment programmes where 10 were living in the Lodge, 8 were living in Ashleigh House and 10 were engaged with the DFDP service. Poly-drug use was commonly reported by participants. However, the majority of qualitative participants (86%, n=24) reported opiates as their primary problem drug.

[1] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2011). 2011 Annual Report on the State of the Drugs Problem in Europe.

[2] Marsden, J., Farrell, M., Bradbury, C., Dale-Perera, A., Eastwood, B., Roxburgh, M., & Taylor, S. (2008). Development of the treatment outcomes profile. Addiction, 103(9), 1450-1460.

[3] Comiskey, C., Kelly, P., Leckey, Y., McCullough, L., O'Duill, B., Stapleton, R. & White, E. (2009). The ROSIE study: Drug treatment outcomes in Ireland. Stationery Office.

[4] Treatment Outcome Profile (TOP) measures change and progress in key areas of the lives of people being treated in drug and alcohol services. Developed by the National Treatment Agency for Substance Misuse (NTA) in the UK it produces outcome data that can be used to evaluate treatment effectiveness. TOP consists of 20 simple questions focusing on the following areas - substance use, injecting risk behaviour, crime, health and quality of life.

LIMITATIONS

One main limitation of the current study is that the data presented here represents only those clients who were tracked throughout the life of the project. The overall retention rate for the study was 72% for the 24 month period. While this is a solid figure for a longitudinal study, there is an unavoidable loss of data from those participants who could not be tracked for continued participation. A further limitation is that TOP questionnaires are time specific and participants are asked to recall data in relation to a defined period of 30 days prior to interview. In addition, data collected through TOP is self reported and thus, could be susceptible to social desirability bias.[5] Finally, the data is from a sample at a specific treatment centre and as such, the findings are not generalisable to treatment experiences either nationally or abroad. Despite these limitations, this study makes a valuable contribution to the growing body of literature on drug treatment and evaluation.

RESULTS

SUMMARY OF KEY FINDINGS

- 72% (n=80) of retained participants reported to be free from illicit drug use 24 months after intake to a CTC service.[6]
- 62% (n=68) of retained participants were still engaged with CTC 6 months after intake.
- 36% (n=40) of CTC retained clients completed the full CTC programme including primary treatment, integration, and aftercare programme through to graduation.
- 85% (n=34) of graduates reported to be illicit drug free at 24 month follow up.
- 62% (n=39) of participants who exited treatment early[7]reported to be illicit drug free at the 24 month follow up.
- The average length of programme participation before exiting treatment early was 4.4 months.
- At the 24 month mark, self-discharge was highest among females in residential treatment (53%, n=16).
- The average length of programme engagement prior to self-discharge was 4.7 months.
- At the 24 month mark, programme discharge was highest among males in residential treatment (29%, n=15).
- The average length of time engaged in the service prior to discharge due to violation of protocol was 4.1 months.
- 5% (n=5) of participants who exited treatment early re-engaged in CTC during the course of the study.
- At intake, female participants scored lower on self-reported psychological health and well-being scales as compared to their male counterparts.
- Overall, participants reported improvements in physical health, psychological health and well-being across all three CTC treatment programmes.
- Employment rose from 3% (n=4) at treatment intake to 25% (n=28) at 24-month follow up.
- Engagement in education rose from 2% (n=2) at treatment intake to 17% (n=18) at 24-month follow up.
- Engagement in criminal activity in the previous 30 days fell from 9% (n=12) at treatment intake to 2% (n=2) at 24-month follow up.
- 22% (n=30) of participants reported acute housing problems at treatment intake and this increased to 23 % (n=25) at 24-month follow up.

[5] Comiskey, C., Kelly, P., Leckey, Y., McCullough, L., O'Duill, B., Stapleton, R. & White, E. (2009). The ROSIE study: Drug treatment outcomes in Ireland. Stationery Office. That said, the ROSIE study noted that extensive literature on self -reporting information about drug use and criminality was both valid and reliable.

[6] Percentages have been rounded off to the nearest whole number.

[7] 'Exited treatment early' refers to participants who are asked to leave the community due to significant violations of protocol, such as continued breach of groundrules, termed early discharge. It also includes participants who self discharge (those who leave the community early through personal choice).

PROGRAMME RETENTION AND SUBSTANCE USE

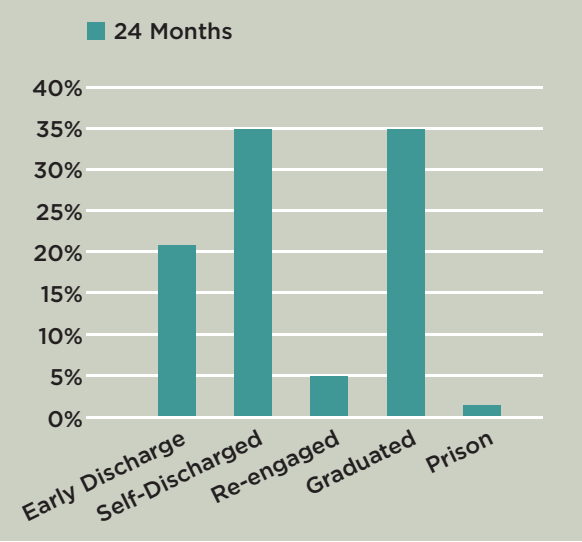
RETENTION IN TREATMENT

At treatment intake all 144 participants were actively engaged in one of CTC's three programmes. At the six month follow up 75.7% (n=109) baseline participants were retained in the study. Of this sample, 62.4% (n=68) were still engaged in treatment, 21.1% (n=23) had self-discharged and an additional 7.3% (n=8) were discharged due to violation of protocol. An additional 6.4% (n=7) had left the programme and then after re-engaged, one client (0.9%) had graduated, and 1.8% (n=2) had returned to prison. At the final 24-month data collection phase, 77.1% (n=111) participants were retained in the study. Of this final sample, 36% (n=40) clients completed the full CTC programme through to graduation. More than one third (35.1%, n=39) self-discharged and an additional 21.6% (n=24) were discharged by CTC. Of those who discharged early, 4.5% (n=5) re-engaged in the programme during the study and 2.7% (n=3) returned to prison. Figure 1 presents CTC's programme retention outcomes at 6 months, 12 months and 18 months.

Figure 1
CTC programme engagement over an 18 month period[8]

Figure 2 presents the overall programme retention at the end of the study.

Figure 2
Overall programme retention at 24-months

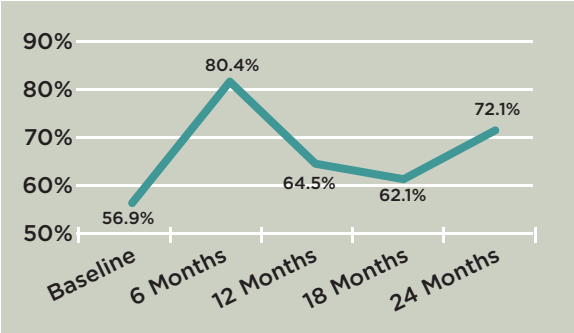


[8] Total numbers of participants varied according to retention rates. They are as follows: Baseline – 144 (100%); 6 Month – 109 (75.7%); 12 Month - 110 (76.4%); 18 Month – 103 (71.5%); 24 Month – 111 (77.1%).

SUBSTANCE USE

A majority (72.1%, n=80) of study participants reported no illicit drug use at the point when the final survey was administered. This was true for the majority of those who completed treatment (85%, n=34) but also for a large number of clients who discharged early (61.9%, n=39). Figure 3 shows the illicit drug-free status of clients during the two-year period.[9]

Figure 3: Self reported drug free status over 24 months



TREATMENT OUTCOMES BY PROGRAMME

Figure 4 presents the overall retention of participants in each of the three CTC treatment programmes. Upon examining engagement across the three programmes, one can see a similar trend to the overall data with regards to graduation and drug-free status at 24-months. Namely, the numbers of clients reporting illicit drug-free status was approximately double that of those who graduated. Some differences between programmes emerged as well. Ashleigh House had the lowest graduation rate at 26.7% (n=8). The Lodge had a graduation rate of 36.5% (n=19) and the DFDP had a graduation rate of 50% (n=9). Over half of the original cohort of women from Ashleigh House self-discharged (53.3%, n=16), as did 44.4% (n=8) of DFDP clients. Self-discharge was notably lower among male residential clients in the Lodge (21.2%, n=11) but discharge due to violation of protocol was the highest among this group (28.8%, n=15).

Figure 4: Client programme retention at 24 months

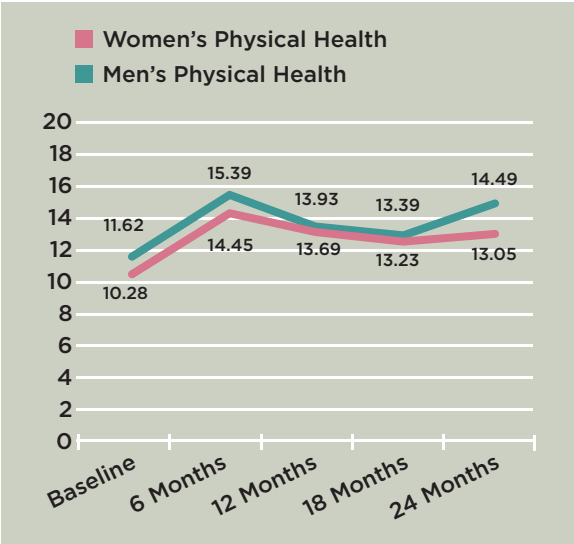
The discrepancy in retention and drug-free status between clients in DFDP and residential treatment should be interpreted with some caution, as the qualitative data uncovered a key difference between clients in these two programmes. Specifically, the majority of clients in the DFDP entered after completing a separate residential treatment programme and therefore, were entering treatment after a period of sobriety and with previously acquired knowledge of treatment programmes. Furthermore, qualitative data found that many were highly committed to actively practicing recovery, as they voluntarily opted for additional day treatment following a residential programme.

[9] At treatment intake, more than half of participants (82, 56.9%) are reported as drug-free. This reflects the timing of the survey and the nature of the question used to measure drug-free status, which assesses substance use in the past 30 days only. Many clients received the baseline survey after they had been in treatment for 30 days and thus, they are coded as 'drug free'.

PHYSICAL HEALTH AND PSYCHOLOGICAL HEALTH

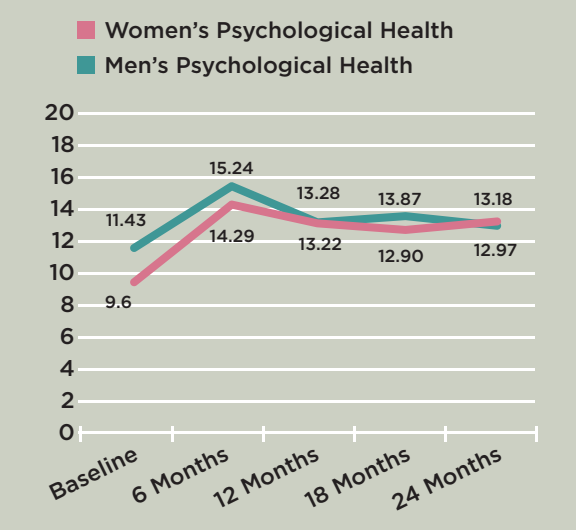
This study revealed self-reported improvements in physical health for both male and female participants over the life of the project. As shown in Figure 5, female participants' physical health remained lower than males' throughout the life of the project. However, both groups experienced visible increases in self-reported physical health during, and following, treatment.

Figure 5: Physical health over 24 months: Mean scores



As with physical health, there were notable improvements in self-reported psychological health over the life of the project. Analysis of baseline (intake) data revealed that female respondents' psychological health scores (M=9.60, SD=3.70)[10] were significantly lower than their male counter parts (M=11.43, SD=3.95) (t (128)=2.63, p=.10)[11]. Although there was a noted peak in psychological health at the 6 months mark, it was followed by a slow decline at 12 months, 18 months and 24 months. Both male and female participants reported improvement in their psychological health at the final 24-month data collection point when compared with intake.

Figure 6: Psychological health over 24 months: Mean scores



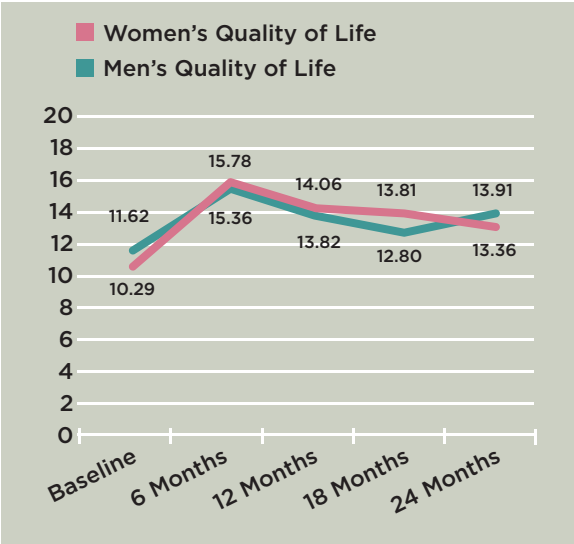
These improved health findings in the quantitative data were consistent with interview participants' accounts of their physical and mental health over the course of the study. While many reported on-going health problems, including in some cases serious and chronic co-morbidities such as HIV and Hepatitis C, most who remained drug-free stated during their final interview that their physical health was markedly better than prior to entering treatment. Positive mental health was often presented as something that had to be actively maintained through behavioural measures such as attending and participating in fellowship meetings, and adhering to a structured daily routine as rehearsed/defined within the TC approach. Female participants were more likely to explicitly report mental health issues, such as periods of depression, anxiety, self-harm, suicidal ideation and suicide attempts, than their male counterparts. While analysis revealed fluctuating mental health issues post-treatment for females, there was nonetheless a notable improvement in their psychological health at 24-months as compared with baseline.

[10] M= mean average. SD = standard deviation
[11] Refers to statistical significance.

QUALITY OF LIFE

Analysis of self-reported quality of life revealed a similar trend as the health outcome variables. Intake data found that female respondents' quality of life scores (M=10.29, SD=3.70) were lower than their male counter parts (M=11.62, SD=3.95). Females demonstrated lower scores than males at intake, then a noted peak in scores at the 6-month mark, followed by a slight decline at 12 months and 18 months. Further analysis found that the final scores were higher at the final 24-month for both male and females than at intake.

Figure 7: Self-perceived quality of life over 24 months: Mean scores



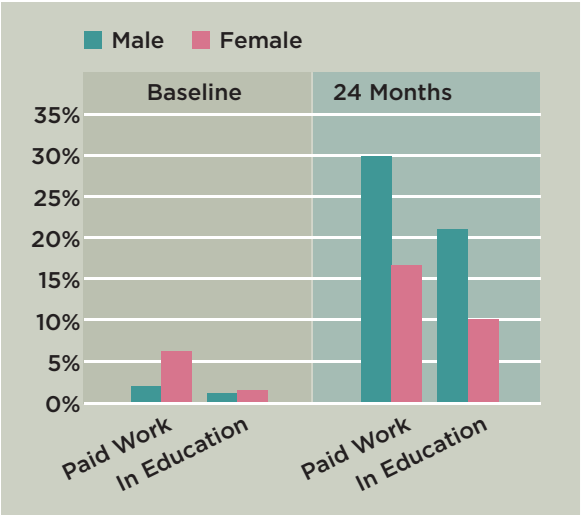
Improvement in overall quality of life was also reflected in the qualitative data. While engaged in CTC, men and women in residential treatment reported varying experiences of daily participation in the TC structure and routine. Most of the women who had their children residing with them in Ashleigh House during their residential treatment programme noted challenges. While acknowledging that they would not have entered treatment without the option of on-site childcare, some women felt detached from the group-treatment experience when compared to those who did not have children in residence with them, as they struggled to balance parenting and participation in the full TC residential programme.

Post-treatment improvements in quality of life were reported by all participants. Establishing a routine, maintaining a household, moving away from full-time recovery-focused activities, (re)connecting with family, (re)building relationships with their children were all cited as sources of fulfilment, joy and self-esteem. Overall, participants aspired towards what they described as ordinary or everyday things, such as family contact, a home, children, a pet or the means to travel. The sense of hope extended beyond the material world to a more abstract, overarching sense of optimism that emerged from the narratives of drug-free participants.

EMPLOYMENT AND EDUCATION

Findings from the study revealed that clients were distinctly more active in their attempts to engage with education and the labour market after engaging with CTC. At intake, 3.5% (n=4, 3 female and 1 male) of survey participants were engaged in paid employment and 1.4% (n=2, 1 male and 1 female) were enrolled in an educational programme. As shown in Figure 8, this increased to 25% (n=28) in paid employment and an additional 17% (n=18) who returned to education at the 24-month period. Males were more likely to be in paid employment (30%, n=21) and education (21.4%, n=14) at the two year follow-up than their female counterparts. At the 24-month period, 17.1% (n=7) of females were engaged in paid employment and 9.8% (n=4) were in some type of formal education.

Figure 8: Employment and education at treatment entry and 24 months

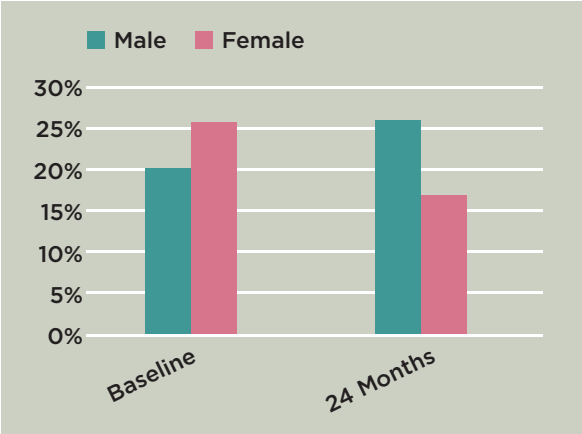


All participants expressed a desire to transition into employment. Maintaining abstinence was viewed as the most immediate and important goal and, for this reason, a considerable number expressed a preference for employment that was not overly demanding or stress-inducing. Of note, several qualitative participants gained employment in a drug and alcohol treatment service. Other participants reported being unable to secure employment due to their past criminal activity and this invariably became a source of frustration over time. Qualitative data revealed that the main difficulty experienced in securing paid employment was a lack of formal education qualifications. In turn, this led many participants to consider returning to education.

HOUSING

Following treatment, clients reported varying levels of success with securing housing as shown in Figure 9. At intake, 21.7% (n=30) of participants reported acute housing problems during the month prior to entering treatment. This included 20% (n=19) of males and 25.6% (n=11) of females. The 24-month analysis revealed the overall figure had increased slightly to 22.8% (n=25), including 25.7% (n=18) of male participants and 17.1% (n=9) of female participants. This increase in reported housing difficulties may be related to the fact that many clients at intake had been engaged in CTC or another formal treatment service and so were not experiencing acute housing problems during that time. For others the temporary housing provided by residential treatment may have removed their acute housing issue. Of note, 23% of participants were in acute housing need 24 months after treatment engagement. The average length of time in treatment ranged from 4.1 months to 14 months, indicating that housing difficulties persisted for many clients over a length of time following exit from treatment.

Figure 9: Housing difficulties at treatment entry and 24 months

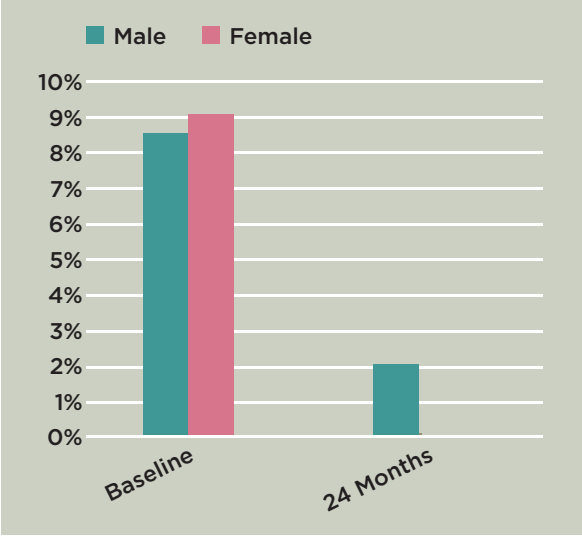


The majority of the study's qualitative participants relied on housing services for assistance with securing housing and many did find clean, safe, and comfortable places to reside. For others, the experience was challenging and far more precarious due to prior periods of homelessness and incarceration.

CRIMINAL ACTIVITY

Qualitative data revealed that most participants had a background involving some level of criminal activity. The vast majority reported having committed some form of crime to support a lifestyle largely focused on drug acquisition and use. This was particularly the case for male participants, most of whom had been incarcerated at some stage in their lives. The proportions of respondents reporting recent involvement in crime were substantially lower than lifetime involvement in crime. Intake analysis from the quantitative survey revealed 8.6% (n=12) of participants had committed a criminal act (i.e. drug-selling, shop-lifting, burgurlary, theft) in the previous 30 days. This included 8.3% (n=8) of male participants and 9.1% (n=4) of female participants. By the 24 month follow-up the number of participants who had engaged in criminal activity in the previous 30 days was reduced to 1.8% (n=2) as detailed in Figure 10 below.

Figure 10: Criminal activity at treatment entry and 24 months



CONCLUSION

The current study found an improvement in nearly all measured outcome areas over the two year longitudinal study. The total number of clients who were free from illicit drug use in the 30 days prior to survey administration rose from 56.9% at treatment intake to 72.1% (n=80) at 24 months. This implies that CTC's relapse rate (27.9%) is relatively low, as compared with TC rates recently reported in a systematic review (25-55%).[12] Self-reported health measures improved notably with regards to physical health, psychological health and quality of life. The total number of individuals engaged in paid employment increased from 3.5% at intake to 25% (n=28) at the 24 month follow-up period. The number of participants engaged in formal education increased from 1.4% (n=2) at intake to 17% (n=18) at the 24 month follow-up period. Improvements were also revealed in social functioning; individuals engaged in criminal activity decreased from 8.6% to 1.8% (n=2).

The majority of participants in the current study maintained an illicit drug-free lifestyle following their treatment at CTC. This was true for participants who graduated from the programme and included those who discharged early due to personal circumstances or a violation of protocol. Establishing a routine, relationship (re)building with family members and children, employment, and education were focal points for many. The data also uncovered some gender differences in treatment pathways, experiences and outcomes.

This executive summary has presented a brief overview of key findings of the longitudinal mixed-methods study of CTC. For a detailed report, please refer to the main publication.

[12] Vanderplasschen, W., Colpaert, K., Autrique, M., Rapp, R. C., Pearce, S., Broekaert, E., & Vandevelde, S. (2013). Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective. The Scientific World Journal, 2013

INTRODUCTION

INTRODUCTION TO THE STUDY

This report documents the key findings from a mixed-methods, longitudinal study of service users at Coolmine Therapeutic Community (CTC), a drug and alcohol treatment centre in Dublin.

The project was originally envisioned by the former Chief Executive of CTC, Mr. Paul Conlon, in late 2009. In the following months, Mr. Conlon arranged a series of preliminary meetings to assess potential funding sources and possible research design strategies. In 2010, CTC collaborated with its Clinical Advisory Group regarding the design of the project. CTC then submitted a proposal to the National Drug Treatment Centre Ethics Committee for ethical approval for a longitudinal, mixed-methods research project, which was granted on the 29th September 2010.

The design of the quantitative arm of the study was led by Pauline McKeown, Head of Services in CTC (current CEO), and guided by the expertise of Dr. Eamon Keenan (NDTC), Dr. Jean Long (HRB) and Ms. Anne Marie Carew (HRB). These consultants played a central role in selecting the main quantitative measures for the project. For the qualitative arm of the study, CTC enlisted Dr. Paula Mayock of Trinity College Dublin, an expert in the field of qualitative methods and drugs research. Dr. Mayock designed the qualitative research stream, including the qualitative methodology, the qualitative data collection tools, and the recruitment and management of qualitative research staff. Quantitative data collection commenced in February 2011 and qualitative data collection began the following month. There were four waves of data collection in each arm, with data collection completing in August 2013.

The following chapters introduce the background and methodological approaches to the study and present the findings detailing various 'pathways' into and through treatment. Much attention is given to exploring the qualitative data and the 'process' of treatment. Of note is that this report does not present all aspects of the study's findings, nor does it claim to be a complete account of clients' experiences with Coolmine Therapeutic Community, or drug and alcohol treatment, more broadly.

The report opened with the Executive Summary, comprising of an overview of the quantitative findings highlighting the broad trends identified in the numeric data whilst briefly summarising the qualitative data. This summary was created to be a 'stand alone' document for those seeking a brief overview of key quantitative findings.

The main report is structured as follows:

Chapter 1 provides an introduction to Coolmine Therapeutic Community and the therapeutic community (TC) treatment model. Here, an overview of TC outcomes is reviewed, along with the literature on treatment entry and treatment processes.
Chapter 2 outlines the research design, methodology, and administration procedures. Quantitative and qualitative approaches are discussed and the participant profiles of both streams are presented.
Chapters 3, 4, and 5 present the key quantitative and qualitative findings in three sections: pathways into treatment, the treatment process, and life after treatment.
Chapter 6 concludes the report by discussing the key findings, placing them in the broader context of national and international drug and alcohol treatment outcomes, and summarises key messages for therapeutic communities.

CHAPTER 1 THERAPEUTIC COMMUNITIES AND TREATMENT

BACKGROUND AND INTRODUCTION TO THE RESEARCH

INTRODUCTION TO COOLMINE THERAPEUTIC COMMUNITY

Coolmine Therapeutic Community (CTC) is a drug and alcohol treatment centre providing residential and non-residential services to men and women with problematic substance use. Established in Ireland in 1973, CTC was founded upon the philosophies of the Therapeutic Community approach to addiction treatment, which will be explained in detail later in this chapter. CTC operates three key treatment programmes, which served as the focal point of this research project: Male residential (the Lodge), Female residential (Ashleigh House), and the drug free day programme (DFDP). Within each of the three services there are a series of programme stages through which clients progress. While the timeline and structure vary slightly between the residential and day programme, clients typically proceed through the following stages:

- **Phase 1 - Primary treatment**
  (approx. 6 months)
  For residential clients, this phase consists of full-time, live-in treatment at either the Lodge or Ashleigh House. For DFDP clients, this period comprises of attendance at a highly structured, full-time day programme which runs weekly, Monday to Friday.
- **Phase 2 - Integration**[13]
  (approx. 2 - 6 months)
  For residential clients, the integration phase is typically marked by a transition from the residential treatment facility into community housing with other CTC peers. Some clients, however, transition directly to other accommodation such as short term transitional accommodation units or private rented accommodation; others return to a family home / previous tenancies.
- **Phase 3 – Aftercare**
  (approx. 6 months)
  For both residential clients and DFDP clients, aftercare services offer clients continued support through group counselling and one-on-one counseling as they transition to a new, drug and alcohol-free life.

Figure 1 features a diagram of the services offered by CTC throughout all stages of the treatment process.

Figure 1: Diagram of Services Offered by CTC

Contact and Assessment	Primary Treatment	integration	Aftercare	Life Long Aftercare
Flexible & ongoing	**Minimum 5 months**	**Minimum 2 months**	**Minimum 5 months**	**Flexible & ongoing**
Outreach: Prisons & Community	Men's Residential: 30 Participants & 2 Methadone Detox Places	Step Down	Clients supported back into the community	Lifelong aftercare which is peer lead
Drop In: Lord Edward Street	Women's Residential: 15 Participants & 2 Methadone Detox Places		Graduate Support	
Stabilisation: Day Programme	Mother & Child Accommodation			
Contingency Management	Drug Free Day Programme in Lord Edward Street	Community Employment	Community Employment	
	Drug Free Day Programme in Dublin 15			
Family Support: Flexible & ongoing Client Participation Forum				

[13] In 2011, CTC reformed Phase 2 to include a more intensive, step-down treatment programme for residential clients. This involves a Monday-Friday day programme, modeled off the DFDP, wherein clients receive regular group therapy sessions and weekly one-to-one counseling sessions.

The design of the programme varies between services depending on the needs of the individual clients. However, the overall structure typically comprises the following daily components:

- Morning Focus (mindfulness meditation / morning meeting)
- Domestic Duties
- Group Work (Relapse prevention, life stories, open groups)
- Educational classes / workshops (health promotion, parenting classes, communication skills, anger management)
- One-to-one key working and case management
- One-to-one counseling / psychotherapy

Clients have a structured daily living routine that includes therapeutic groups and educational workshops. Group work involves a wide range of activities and workshops including health promotion, relapse prevention, social skills, self and peer evaluation groups, weekend planning and review, art classes, computing courses, horticultural projects, acupuncture and yoga. In parallel with the programme, clients work with their individually assigned key-worker to develop a care tailored to the needs of the client.

CORE ELEMENTS OF THE THERAPEUTIC COMMUNITY MODEL

Coolmine Therapeutic Community was founded upon the philosophies of the 'Therapeutic Community' approach to addiction treatment. Over the years, therapeutic communities (TCs) have proven to be a powerful treatment method for individuals who suffer from drug and/or alcohol dependence. TC is defined as a social and psychological, *self-help* approach to the treatment of addiction. 'Therapeutic' refers to the social and psychological goals of treatment, while 'community' denotes the primary method through which the goal of change is actualized (DeLeon, 2000). In this model, the community itself is the therapist and teacher while the overall programme relies upon a highly structured and well-defined set of practices. The community serves to provide emotional healing for individuals and to raise awareness of behaviours, attitudes, and healthy living (Broekaert, Koyyman, & Ottenberg, 1998).

The therapeutic community as a treatment modality has evolved since its inception in the mid-20th century and a number of definitions of its main components have been advanced. The following definition incorporates the key characteristics of many TCs:

> *The TC forms a miniature society in which residents, and staff in the role of facilitators, fulfil distinctive roles and adhere to clear rules, all designed to promote the transitional process of the residents. Self-help and mutual help are pillars of the therapeutic process, in which the resident is the protagonist principally responsible for achieving personal growth, realizing a more meaningful and responsible life, and of upholding the welfare of the community. The program is voluntary in that the resident will not be held in the program by force or against his/her will' (Ottenberg, Broekaert, & Kooyman, 1993, pp. 51–62).*

In the TC approach to treatment, drug and alcohol dependence is viewed as a an embedded component in the person of the person, rather than a problem of the substance. Substance abuse is therefore not distinguishable from the abuser. Despite many individual differences, people who suffer from drug and alcohol dependence share notable similarities, including problems with cognitive, emotional skills and overall psychological development such as a life in chaos (out of control behaviour, risk-taking, threat of death or injury), the inability to maintain abstinence or sobriety, social and interpersonal dysfunction, and an anti-social lifestyle (DeLeon, 2000). Many also suffer from low self-esteem, lack of self-awareness, faulty judgement, negative identity, high levels of guilt, hostility, and deviant coping strategies. Hence, the goal of the TC is to treat the whole

person, inclusive of all of these 'dysfunctional' elements, rather than focusing specifically on the drug or alcohol dependence.

The community approach in the TC aims to provide clients with the tools necessary for self-change. The phrase 'community as method' is commonly employed in TCs, referring to the intended goal of teaching individuals to use the context of the community to learn about themselves. In the community *context*, peer and staff relationships, social roles, and structured daily activities require clients to learn interpersonal skills and model behaviour for their peers. Community *expectations* place the onus on the individual for participating, constructively, in community life. Community *assessment* refers to the group's involvement in the individual's journey towards recovery, including honest feedback on both positive and negative behaviours and attitudes. While much of the community involvement depends on peers, staff members also play an active role in the TC, acting as rational authorities, mentors, and role models rather than 'power-holders'. Clients, staff, and organisational ethos all contribute to the 'climate' of the TC. Factors such as communications between TC staff / decision makers, quality of group processes such as involvement, support, and staff role clarity in relation to clinical tasks in the TC have been identified as pertinent to the effective functioning of the TC (Cristofanelli, Fasso, Ferro, & Zannaro, 2010). Traditionally, job functions, chores, and other facility management responsibilities are seen as vehicles for self-development. Apart from individual key-working and counselling, activities are performed collectively. Days are highly structured, with allocated times for meals, chores, group activities, seminars, and formal and informal interactions with peers and staff.

The intended outcome of a drug and alcohol oriented TC is 'right living' or 'recovery'. While 'recovery' is a core principle of the drug and alcohol sector and an identified goal of many treatment programmes, it remains a contested concept without a clear definition (Neale, Tompkins, Wheeler, Finch, Mardsen, et al., 2014; Paylor, Measham, & Wilson, 2012). Typically, it is viewed as more than a reduction of substance use and rather, is defined by individuals attaining benefits in a wide range of life areas such as health, employment, housing, self-care, and personal relationships (ACMD, 2013; Neale, Nettleton, & Pickering, 2012). Within the TC, recovery is conceptualised as a comprehensive change in lifestyle and identity that occurs through the healing communal element of the TC. Through the community itself, individuals learn the art of what is deemed 'right living': how to relate to themselves, others, and society at large, and other key beliefs and values essential to recovery (Warren, Harvey, De Leon & Gregoire, 2007). The peer community model is used as an agent for change, through which clients learn how to reconceptualise themselves and the world around them. Clients are expected to adopt a self-help approach and also a 'mutual self-help' approach, wherein individuals assume responsibility for their peers in order to maintain their own recovery. The TC approach also underscores the importance of readiness, agency, and personal commitment in the recovery process (DeLeon, 1994). Often the 'mutual self-help' task of peers is focused on encouraging participants to continue with the process by reminding them of past losses and future possibilities.

The recognition of recovery as an on-going 'process' is another essential element of the TC approach. Recovery is framed as a developmental journey, a learning or re-learning of 'right living' for clients. Behavioural change, reflection, and self-understanding are all key steps towards changing dysfunctional or damaging behavioural patterns and attitudes. This recognition of recovery as a process impacts on the response to client lapse and relapse in a TC. While abstinence is widely considered a fundamental indicator of success in a TC, lapse/relapse is seen as an opportunity for learning (DeLeon, 1995). Clients are

encouraged to analyse the circumstances surrounding the relapse and to evaluate the extent to which they are absorbing the recovery treatments. From this perspective, lapse/relapse can be viewed as a powerful step along the journey of recovery.

The characteristics described above are applicable to many TCs focusing on drug and alcohol dependence. Since its inception, CTC has structured its three drug-free programmes upon these TC principles. Today, the following interactive elements contribute to the core ethos of the organization:

- **Self-Help**
  Clients are responsible for their own recovery, with peers acting as facilitators of change.
- **Community**
  The primary therapy and the main agent for change is the TC. Living together communally in a highly structured programme provides clients with the tools necessary to change old behaviours through on-going, constructive interaction with staff and peers.
- **Hierarchy**
  The overall community structure relies upon a hierarchical system within which older residents act as role models to newcomers. The community is operated entirely by clients, with staff acting as supervisors. This 'peer-run' scheme provides clients with the opportunity to both be mentored and to serve as a role model to others.
- **Confrontation**
  Within the TC protocol, all clients are encouraged in a group setting to challenge others who are displaying negative behaviours or attitudes that are believed to be counterproductive to the therapeutic community philosophy. This mechanism is typically referred to as the 'pull-up' system.

ROUTES INTO THERAPEUTIC COMMUNITIES

The empirical literature on the therapeutic community model is vast, documenting the many environments in which TCs are employed, including drug and alcohol treatment, psychiatric treatment, and criminal rehabilitation. Pathways into treatment in the literature tend to focus heavily on two distinct avenues referred to as 'self-motivated' entry and 'coerced' entry.

'Motivation' is a multidimensional construct, which consists of the level of internal desire experienced by a client, the cognitive appraisal of one's situation, perceptions about risks and benefits to oneself, and external or contextual pressures that may influence the decision making process (Wolfe, Kay-Lambkin, Bowman, & Childs, 2013). Specifically with drug and alcohol dependence, internal motivation comprises of cognitive and emotional factors such as distress, desire to change, and dissatisfaction with current circumstances related to substance use. External motivation can come from a variety of environmental elements such as the impact of substance use on the family, employment, housing, or health (Hiller, Knight, Leukefeld, & Simpson, 2002). While internal and external motivations are often linked, this is not necessarily true in all circumstances.[14]

Studies on personal motivation and 'readiness' to enter treatment consistently underscore the importance of motivation in treatment engagement (Prendergast, 2009; Melnick, Hawke, & DeLeon, 2014). In fact, personal motivation has been demonstrated to be relevant to all stages of the treatment process, including treatment seeking, engagement, retention, and outcomes (Melnick, DeLeon, Thomas, Kessler, & Wexler, 2001; Simpson & Broome, 1998; Klag, Creed, & O'Callaghan, 2010). Several studies indicate that clients with high motivation are more likely than those with low motivation to become actively involved in treatment, to complete the prescribed course of treatment, and to have better long-term outcomes following treatment. For instance, Melnick, DeLeon, Hawke Jainchill and Kressel (1997) found that clients who exhibited a low level of internal motivation for change were more likely to drop out of treatment early. Similarly,

[14] Various measures are used to assess motivation levels (or indicators of motivation) in the existing research. A full explanation of motivation measures is beyond the scope of the current report but additional information can be found in the following sources: Miller, 1999; Neff & Zule, 2002.

Simpson & Broome (1998) reported that, among clients in community treatment programmes, most of whom were involved in the criminal justice system, those with high motivation for change at treatment admission (measured as "desire for help") were nearly twice as likely to have positive outcomes for substance use and criminality as those with low motivation.

On the opposite end of the conceptual spectrum is 'coerced' or 'socially pressured' entry into treatment. Traditionally, 'coerced' treatment referred exclusively to clients who were admitted into substance treatment via the criminal justice system (Sullivan, Birkmayer, Boyarsky, Frances, Fromson et al., 2008). The relationship between substance abuse and criminal behaviour has been well documented (Nurco, 1987; Inciardi, 2008). Over the years, some methods have been developed to encourage a more effective working relationship between treatment programmes and the legal system, both in Ireland and internationally. One such measure consists of drug and/or alcohol treatment in lieu of time served, whereby clients are offered a reduced sentence in exchange for entering residential treatment. For these individuals, failure to complete the programme often results in legal sanctions or repercussions (Fletcher & Chandler 2006; Kinlock, Gordon, Schwartz, Fitzgerald & O'Grady, 2009). In the literature, these clients are typically categorized as having been 'coerced' into treatment. In recent years, the concept of coercion has been extended to include formal and informal non-legal sources such as pressure exerted by familial and social supports, including overt identification of problematic substance use, threats, and negative interpersonal consequences associated with continued drug and alcohol use. Formal non-legal coercion is typically generated by employers, healthcare professionals, and government bodies such as child protection or family courts (Klag et al., 2005; Wolfe, 2013).
Studies report mixed findings regarding the impact of coercion on treatment retention. While some suggest that those entering on the back of external pressure are more likely to discharge early, others find that personal perceptions of legal implication serve as an impetus to stay in treatment (Wild & Hyshka, 2012). However, it has been widely demonstrated that even among those who remain engaged, perceived coercion negatively impacts on therapeutic engagement and peer / staff relationships while in treatment (Sheehan & Burns, 2011). 'Coerced' clients are typically less internally motivated and more apathetic about participating in treatment activities than those who enter on their own accord (Anglin, Prendergast & Farabee, 1998; Kinlock & Gordon, 2006). Coerced clients have also been shown to have a lower desire for help, weaker problem self-identification, and less commitment to maintaining a substance free lifestyle (Marshall and Hser, 2002). Specifically, research has suggested that coerced clients are particularly resistant to treatment, with little motivation for change and low levels of confidence in the therapeutic process.

The empirical and theoretical literature on coercion typically focuses on the external factors influencing an individual's pathway into treatment. However, subjective and objective studies of coercion have found that perceptions of coercion can exist among those who self-admit into treatment and can be absent among those who were legally sanctioned to enter treatment (Wild, Newton-Taylor & Alletto, 1998; Prendergast, Greenwell, Farabee & Hser, 2009). Consequently, coercion can be more usefully understood as a subjective issue – that is, perceived coercion is a more valuable indicator of programme engagement than external circumstances and there is ample evidence suggesting a lack of direct correspondence between direct external pressures and perceived coercion (Wild, Cunningham & Ryan, 2006). Specifically, what matters most is if a client *perceives* themselves to be pressured into treatment. A perceived sense of personal autonomy, even in circumstances of legally

mandated treatment, predicts treatment retention (Wild, Wolfe & Hyshka, 2012). It is frequently argued that treatment can only be effective if the individual is truly motivated, which is not the case for many coerced clients. Thus, it can be contended that the extent to which individuals engage with the therapeutic process depends on the extent to which they feel as though they were autonomous in their decision to enter treatment. At the very least, coerced clients tend to be more resistant to engaging in the therapeutic process than those who voluntarily enter treatment.

ENGAGEMENT WITH THE TREATMENT 'PROCESS': RETENTION AND DROP-OUT

Programme completion is widely recognized as the most desirable treatment outcome in TCs. Completion, and length of time in treatment, is associated with long-term substance abstinence, fewer relapses, lower levels of criminal activity, and more positive well-being. However, early discharge, either through drop-out or violation of community protocol, is a common occurrence in most TCs. Reports of early discharge from TCs range from 23-50% in out-patient treatment and 17-57% in inpatient treatment. A recent systematic review found that, on average, clients stay in TCs for one third of the planned time (Malivert, Fateas, Denis, Langlois & Auriacombe, 2012). While reported estimates of early discharge vary greatly, they highlight the regularity with which programme non-completion occurs.

Researchers have also sought to identify predictors of retention in, and graduation from, TCs and the factors associated with better outcomes fall into two broad categories: client characteristics and treatment characteristics. In relation to the former, those individuals who have high levels of personal motivation at treatment entry are more likely to remain engaged. However, they are also more likely to connect actively with the therapeutic process, including the formation of therapeutic alliances, the development of peer relationships, and programme participation. Beyond individual levels of motivation, age has been identified as a significant predictor of programme retention, with young clients having higher drop-out rates than older clients (Melnick et al., 1997; López-Goñi, Fernandez-Montalvo, Illescas, Landa & Lorea, 2008). However, this could be attributed to lower levels of personal readiness in many younger TC clients (Malivert et al., 2012). Clients who suffer from certain comorbidities, including depression and other mental health illnesses, are also more likely to discharge prematurely from TCs. Low retention rates have also broadly been associated with heavier substance use, more extensive polydrug use, injecting drug use, and heavier criminal involvement (Ravandal & Vaglum, 1994; Malivert et al., 2012).

Specific treatment elements have also been explored in some detail to determine their distinct influences on retention and positive outcomes among clients. Patients' perceived satisfaction with treatment (Hser, Evans, Huang & Anglin, 2014) and counsellor rapport have both been found to be strong predictors of retention and completion (Joe, Broome, Rowan-Szal & Simpson, 2002). Programme participation and engagement is a well-noted predictor, increasingly seen as central to all substance abuse treatment (Joe, Simpson & Broome, 1999; De Leon, 2000) and a key factor in retention in treatment (Simpson, 2004; Simpson & Joe, 2004). Because TCs are based on mutual aid between residents, researchers have also tried to gauge interpersonal interactions as a measure of effective participation. Mandell et al. (2008) found that more positive response to TC social processes at week one predicted retention among adult TC members at one month, while improvement in residents' social responses in the first 30 days of treatment predicted retention at three, six and nine months, respectively. These findings suggest that personal engagement with the community and positive social interactions predict retention. A recent study on engagement with the structured

confrontation system in TCs (that is, the pull-up system) found that pull-ups sent and received from peers and staff predicted graduation rates (Warren, Hiance, Doogan, DeLeon & Phillips, 2013).[15] Another element of the TC treatment process that has been examined recently is affirmation, whereby residents support each other for actions in accord with TC norms while correcting each other for violations of those norms (De Leon, 2000; Hawkins & Wacker, 1986). Data has shown that residents who received affirmations were more likely to affirm others, promoting engagement and short-term pro-social behaviour within the TC (Warren, Doogan, DeLeon, Phillips, Moody & Hodge, 2013).

The findings of a considerable number of studies therefore suggest that interpersonal interactions between residents play an important role in determining treatment success. This is not a surprising finding; such interpersonal interactions form the core of the TC philosophy that the community of residents is itself the method of treatment (De Leon, 2000). TCs have gone so far as to formalize a number of specific ways in which residents are mandated to interact with peers. Residents are expected to affirm each other for acting in accordance with TC norms, correct each other when acting contrary to TC norms, participate in encounters with peers, work at the TC, attend groups, and act as role models for peers, among other behaviours (De Leon, 2000; Harvey, 2005).

Overall, the empirical inconsistencies surrounding personal-level predictors of treatment retention suggest that there is not a clear-cut 'type' of client who will succeed in a TC. Personal motivation is key, and previous experience with a TC is helpful. However, within the treatment process, those who are actively engaged in treatment, features such as one-on-one counselling, pull-ups, affirmations, and community engagement are more likely to complete the TC programme.

THERAPEUTIC COMMUNITIES: OUTCOMES IN THE INTERNATIONAL LITERATURE

The TC approach is currently employed by approximately one in three drug and alcohol treatment centres in Europe (EMCDDA, 2011; Vanderplasschen, Vandevelde & Broekaert, 2014) and has been established by many as 'good practice' in the field of addiction treatment in North America and in Europe for decades (DeLeon & Wexler, 2009). However, the long-term effect of TCs on drug treatment outcomes remains debated in the literature (Vanderplasshen, Colpaert, Autrique, Rapp, Pearce et al., 2013). Much of the international research has indicated that drop-out rates among clients in TC programmes are significantly higher than among those who seek other forms of treatment (Guydish, Sorensen, Chan, Werdegar, Bostrom et al., 1999). In longer residential programmes, the early drop-out rate is particularly high (McCusker, Bigelow, Vickers-Lahti, Spotts, Garfield et al., 1997; Gossop, Mardsen, Stewart & Rolfe, 1999).

Substance use outcomes among TC clients also vary substantially in the literature. A recent systematic review reported substance use levels following treatment varying from 25% to 55% at 12-18 months (Vanderplasshen et al., 2013). Some studies report very low early relapse (4-15%) rates (Hartman, Wolk, Johnston & Coyler, 1997; Nemes, Wish & Messina, 1999) while others find these rates to be substantially higher (53%) (Prendergast, Hall & Wexler, 2003). Longer stays in treatment and engagement in aftercare are associated with lower relapse rates (DeLeon, 2010; Malivert et al., 2012; McCusker et al., 1997; Nielsen, Scarpitti & Iniardi, 1996; Wexler, DeLeon, Thomas, Kressel & Peters, 1999). In terms of psychosocial outcomes, TC clients consistently rank higher when compared with clients of alternative treatment interventions. For example, TC clients report closer family relations and on-going, positive interpersonal relationships than clients in other treatment modalities (Guydish et al., 1999; Martin, Butzin, Saum & Inciardi, 1995). Employment rates among TC clients also remain higher than those involved in other treatment settings. Positive legal outcomes, lower self-

[15] Within the TC system, it is expected that peers will monitor others behaviour and hold them accountable for their actions. The corrective feedback supplied in this exchange is known as 'pull ups'. 'Pull-ups' are directed at specific behaviours which are seen as problematic lapses of proper conduct within the TC. Pull-ups can be received from peers and staff.

reported criminality, and low levels of anti-social behaviour are also more significantly associated with TCs compared to alternative interventions (Vanderplasshen et al., 2013).

Despite the varied outcomes of TCs in the literature, systematic reviews report that TCs appear to generate significantly better outcomes in comparison with other viable treatment interventions in two out of three cases (Vanderplasshen et al., 2013). However, it must be noted that many of the studies available in the literature and included in the systematic reviews were conducted with incarcerated populations in the USA. Therefore, many of the reported findings may not be generalisable to the Irish context nor to community-based TC programmes more broadly.

DRUG TREATMENT OUTCOMES IN IRELAND: THE ROSIE STUDY

There is an urgent and widely recognized need for further research and evaluation of drug treatment programmes at global and European levels. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has published Guidelines for the Evaluation of Drug Prevention (1998), while the World Health Organization and the United Nations Drug Control Programme both emphasise the need for rigorous drug treatment programme evaluation (Mardsen, Osbourne, Farrell & Rush, 2000). These calls to action have been acknowledged internationally and many countries have initiated scientific drug treatment evaluation programmes. In the United States, the Drug Abuse Treatment Outcome Study (DATOS) published a five year outcome study of treatment effectiveness in 2003 (Hubbard, Craddock & Anderson, 2003). The Australian Treatment Outcome Study followed suit as the first, national outcome study of heroin dependence in that context (Ross, Teeson, Darke & Linsey, 2006). In the UK, the Drug Treatment Outcomes Research Study (DTORS) published a national assessment of treatment outcomes in 2009.

In Ireland, the ROSIE study, commissioned by the National Advisory Committee on Drugs (NACD), was the first, national, longitudinal drug treatment outcome study to be undertaken in Ireland (Comiskey, Kelly, Leckey, McCullough, O'Duill et al., 2009). The study explored the four distinct treatment options that were available in Ireland at that time, including: a) Methadone maintenance, b) Structured detoxification, c) Abstinence-based treatment programmes, and d) Needle exchange. An initial sample of 404 opiate users were recruited between September 2003 and July 2004 and tracked for a period of three years. The study's final retention rate was 72% (N=289). They found that 38% of participants recruited in methadone treatment remained in their intake setting, with a total of 59% of participants receiving methadone treatment at the three-year follow up. The authors described this finding as encouraging for methadone treatment services and associated positive outcomes. Of the participants recruited in detoxification and abstinence services, a relatively high rate (70%) completed intake treatment.

There were reductions in all forms of drug use over the course of the study, with heroin reducing from 77% to 46%, cannabis reducing from 64% to 49%, cocaine use reducing from 44% to 20%, benzodiazepine reducing from 44% to 32%, and crack cocaine usage reducing from 15% to 7%. The percentage of drug-free from all illegal substances in the past 90 days increased significantly from 9% at intake to 28% at one year. There was a small increase from 28% at one year to 29% at 3 years. There were also significant reductions in criminal behaviour between intake and one year, although little change was recorded between one year and three years. The number of individuals selling drugs dropped from 30% to 13%, while the number of individuals handling stolen goods reduced from 25% to 10%.

In terms of physical and mental health outcomes, the positive effects were less apparent, with no significant positive physical

outcomes recorded between intake and the follow ups. Positive outcomes for mental health were observed at year one, with significant reductions in anxiety and depressive symptoms recorded compared with intake. However, by year three, many of the anxiety symptoms had increased significantly from year one. Social functioning, on the whole, improved among the cohort. For example, participation in training courses increased from 16% at intake to 33% at 3 years, while employment rose from 16% to 29%. Participants living in their own rented accommodation increased from 34% at intake to 49% at the 3 year follow up. Of the initial ROSIE sample, 68 participants were engaged in abstinence-based treatment programmes. A relatively high number, 69.1%, of the participants completed their intake abstinence treatment. Overall, findings from the first national, longitudinal drug outcome study were positive and encouraging from the perspective of the individual and the community at large. However, more research is clearly required to assess the efficacy of individual treatment approaches in the Irish context.

THE TREATMENT PROCESS: TCs THROUGH A QUALITATIVE LENS

The vast majority of empirical research on TC programmes is quantitative. However, there have been some studies that focus on the 'process' or nuanced experience of drug treatment through a qualitative lens. These studies compliment the quantitative body of research through their distinctive insight into the multiple lived realities of drug and alcohol treatment and recovery (Neale, Allen & Coombes, 2005). This generates an understanding of the complex processes of treatment for clients in distinct settings and circumstances.

For example, Neale & Tompkins (2007) explored facilitators for drug treatment programme access and completion among injecting drug users (IDUs) in the UK. For many clients in Neale et al.'s study, the decision to enter treatment came after a 'life-changing' incident. Some described the power of becoming a parent and the responsibilities therein as being a key motivating factor to seek help while others were driven to seek help after the death of a loved one, periods of poor mental health, or physical illness. The importance of supportive relationships, both familial and beyond, were emphasised by many who made the decision to enter treatment. Wanting to 'win back' the trust of family members following years of addiction provided further incentive for many. Conversely, those who had little support from family expressed feelings of pointlessness around abstinence. Apart from emotional support, families often provided practical support including financial help, housing, and initiating contact with treatment services. Many drug users also emphasised the supports they received from formal entities such as drug treatment services, social workers, and counsellors.

Among this sample, researchers found that clients were generally happy with the services and their ability to access them. However, many felt burdened by the level of bureaucracy in the treatment experience. There was a near universal desire for services to allow for more flexibility in the treatment process to cater to the wide-ranging and unique needs of individual clients. On the whole, the respondents reported positive experiences with the staff, citing a preference for staff members who were welcoming, non-judgemental, and had a personal history with drugs or alcohol. However, there was a consensus that services were over-worked and under-staffed and that this led to a deterioration of services offered. Clients also felt that further training and increased employment of former drug-users as staff would enhance the quality of the treatment.

Other qualitative studies suggest that a community of peers within the TC provides an opportunity for clients to identify and normalize their behaviours, resulting in an acceptance of past behaviours and 'difficult to face' events (Gueta and Addad, 2015).

Also, in a qualitative study of women's treatment experiences in Canada, one-to-one counselling was found to be the single most helpful element of the recovery process. While women in this study found group work to be beneficial, they preferred individual counselling sessions, particularly with staff that had a similar background of drug and alcohol treatment and recovery (Kruk and Sandberg, 2013). It was argued that staff members with similar backgrounds provided clients with a deep sense of hope, optimism, and perceived empathy.

Research conducted by Soyez and Broekaerdt (2003) looked specifically at the transition from aftercare into the world beyond, known as 're-entry' in the TC process. For participants in this study, the period was marked by a wide range of mixed emotions. Participants were eager to re-connect with the world but were also fearful of relapse as they re-engaged with a broader society wherein alcohol and illicit drugs were more easily accessible. Clients had relatively small and insular social worlds during this time, consisting largely of peers from treatment, and many found it difficult to expand their social networks. Feelings of loneliness and isolation were common. Furthermore, the re-entry phase was marked by financial difficulties by clients as most were unable to provide beyond the necessities (food, housing, transportation).

Neale, Nettleton & Pickering's (2012) report focused primarily on the everyday lives of former heroin users in the UK. This body of qualitative work highlighted key aspects of daily living including the (re)building of family relationships, management of household and routine chores, and gaining employment. The findings suggested that the intense and engrossing structure of treatment followed by the 'routine' of everyday life left many former users struggling with boredom. The mundane aspects of life were difficult to manage without heroin for some and some expressed a sometimes urgent need to 'stay busy'. Many hoped to do this through employment, though most respondents had few academic qualifications and little prior work history and thus, struggled to find stable employment. This was reciprocally related to high instances of housing instability and financial difficulties in recovery.

Gender-focused qualitative studies

In the body of qualitative literature on therapeutic communities, several studies focus on various gendered aspects of the treatment and recovery process. Therein, elements of sameness and difference among men and women with regards to treatment access and entry, the treatment experience, and recovery are reflected upon. A prominent theme in these studies is that of parenthood, or motherhood more specifically. For women in treatment and recovery, motherhood proves to be a particularly complex and difficult to navigate experience.

More often than men, women cited their children as motivators for entering treatment and maintaining a substance free lifestyle (Neale, Nettleton & Pickering, 2014; Gueta & Addad, 2015). Neale et al. (2014) found that men and women were equally eager to improve relationships with their children after treatment but women were more likely to say that their children motivated abstinence. More often than men, women were responsible for childcare prior to treatment, a circumstance which concurrently served as both a barrier and an incentive for accessing treatment.

Following treatment, women faced numerous practical difficulties relating to personal finances, housing instability, and domestic duties. Many described the day-to-day routine of domestic responsibilities and motherhood to be intermittently stressful and boring (Neale et al., 2012). In a study of Israeli women, several respondents continued to battle the urge to use drugs and alcohol, years after leaving treatment (Gueta & Addad, 2015).

The gender-focused body of qualitative

research stresses the demand for women-only and women-focused treatment programmes wherein gender-specified needs can be addressed (Strausner & Brown, 2001). Incidences of physical, emotional, and sexual abuse are high among women with alcohol and drug dependence, as are co-morbidities including psychological trauma and mental health problems (Tuchman, 2010). Women are often also situated differently with regards to family and personal life outside of the treatment centre. Many risk factors (e.g., a history of traumatic exposure) and consequences (interference with parenting) of drug or alcohol dependence are exclusive to women, giving rise to special treatment needs of this population (Carlson, 2006; Covington, 2002, 2008; O'Connor, 1994).[16]

CONCLUSION

This chapter has introduced the reader to Coolmine Therapeutic Community and to the Therapeutic Community (TC) model more broadly. The core elements of the TC approach including self-help, community, hierarchy, and confrontation were introduced and defined. Literature on circumstances surrounding treatment entry including motivation and coercion was reviewed, as was research to date on outcomes of TCs. The qualitative literature was explored in some detail, with an emphasis on gender differences in the treatment and recovery process. Also, a brief summary of existing treatment outcomes from the ROSIE study provided readers with a contextual understanding of recovery outcomes in the Irish context. The following chapter will introduce the current study's aims and document the key methodological features of the research.

[16] There is a sizable body of literature surrounding women's treatment for drug and alcohol dependence, as well as research on the impact of a mother's drug or alcohol dependence on the well-being of the child. See Carlson, 2006; Covington, 2002 for a more detailed account.

CHAPTER 2
RESEARCH METHODOLOGY

This report documents the findings of a longitudinal, mixed-methods study of clients' pathways through treatment at Coolmine Therapeutic Community (CTC). The study consisted of two separate data collection projects: a longitudinal *quantitative* stage and a longitudinal *qualitative* stage. The stages were planned and conducted independently but the design of, and the approach to, the project was cohesive. Ultimately, both quantitative and qualitative components were designed to achieve the same research aims, albeit with each adhering to its own methodology. This chapter provides an overview of the research design, methods of data collection, and analyses. Both phases of fieldwork are discussed in some detail with a focus on the sample characteristics and research methods. The ethical issues and challenges that arose during the conduct of the study are also discussed.

STUDY AIMS

Ireland's National Drugs Strategy (2009-2016) emphasised the on-going need for research on outcomes related to drug treatment interventions. In line with the NDS recommendation for research focusing on the outcomes of rehabilitation services and the need to adapt services to deal with the consequences of new drug trends, CTC undertook a longitudinal, mixed-methods study of its three abstinence based services.

Specifically, the research aimed to:

1) Gather baseline data on the drug use, health, and behavioural status of clients at the point of entry to three CTC services.

2) Track clients longitudinally over the period of their involvement in CTC and for a subsequent period of at least 18 months.

3) Compare outcomes for clients of the different CTC programmes, and to compare outcomes for CTC clients more broadly with the outcomes from the ROSIE study.

RESEARCH DESIGN: A MIXED METHODS APPROACH

While a quantitative longitudinal design could have generated sufficient data to achieve the research aims (and it is true that this is the 'go-to' design for most similar studies), this study also includes a qualitative longitudinal component. The inclusion of both qualitative and quantitative data collections methods permitted clients' treatment pathways to be explored broadly but also in focused, contextual, and subjective terms.

The incorporation of qualitative and quantitative elements into the same project is most often referred to as 'mixed methods' research. Mixed methods research may take many forms, although a defining feature is that "a researcher or a team of researchers combine elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration" (Johnson, Onwuegbuzie & Turner, 2007). This involves collecting both qualitative and quantitative data, analysing groups of data, and combining the datasets in a meaningful way to develop an overall interpretation (Tashakkori & Teddlie, 2010). Despite the many benefits of a mixed methods approach, it remains relatively rare in drug and alcohol treatment studies, particularly longitudinal studies, due in large part to the significant challenges associated with its implementation, including logistical challenges, high demand of resources, and the investment of time. However, mixed methods approaches have been employed more recently in a number treatment outcome studies and evaluations of therapeutic communities (see, for example, Brener, Von Hippel, Resnick & Trelacor, 2010; VanDeMark, 2007). Indeed, it is argued that health and addiction research needs to adopt ways of incorporating complementary methods into research designs (Morgan, 1998).

A mixed methods approach was particularly suited to this study's aims. First, it permitted a broad, on-going examination of treatment retention, progress, and outcomes among a larger sample to investigate salient patterns and trends. Second, it facilitated an in-depth exploration of the different pathways individuals take through treatment. Quantitative data is inherently limited in its inability to provide contextual details, situational elements, and unique facets of personal experience. For example, quantitative data can tell us about the patterns of programme engagement at any specified time period while qualitative data can help us to identify the situational factors influencing a client's decision to enter or, alternatively, exit treatment. Furthermore, qualitative methods are particularly capable of 'demystifying' drug- and alcohol-related behaviour and serve as an effective means of accessing 'hard to reach' populations (Neale et al., 2005). A two-tiered, concurrent data gathering approach enabled the collection of both qualitative and quantitative data over a 24-month period. The result is a comprehensive, robust account of clients' experiences in, and pathways through, a drug and alcohol TC treatment centre.

LONGITUDINAL DESIGN: QUANTITATIVELY AND QUALITATIVELY

Longitudinal research designs have many established benefits in the study of drug and alcohol treatment. Unlike cross-sectional research[17], longitudinal studies collect data from the same subjects *over time*. This permits the identification of developments or changes in the target population at both individual and group levels.

Both nationally and internationally, the majority of longitudinal drug treatment outcome studies employ strictly quantitative designs and these studies have several advantages over cross-sectional designs.[18] Perhaps the most significant advantage of longitudinal quantitative research is that it allows researchers to track both the cohort *and* the individuals over time. Multiple data collection points gather information on how clients are progressing through treatment, thus permitting the investigation of change (or continuity) in terms of key features of the treatment process (Hser et al., 1997).

Qualitative longitudinal research is also founded in the exploration of change over time among individuals, and also typically examines the processes, environments, and behaviours that may influence change (Saldana, 2003). The focus on temporality is an intentional focal point of longitudinal qualitative research design and analysis (Thomson & Holland, 2003), making the approach particularly suited to examining the interaction between contextual and personal factors influencing a person's pathway through treatment. The approach therefore permits the repeated and incremental investigation of events and experiences, whilst placing the perspectives of clients *throughout* the treatment process. The current study set out to track clients for a 24-month period from the point of entry to treatment at CTC. Entering treatment is unquestionably a time of transition for clients, irrespective of whether they complete the programme or exit early. A longitudinal qualitative design permitted a comprehensive exploration of clients' personal and treatment experiences, and recovery pathways. Furthermore, it permitted the re-evaluation of these and other experiential dimensions of the treatment process on a continual basis, marking the trajectories of clients along their treatment passages.

QUANTITATIVE METHODS

Administration

The quantitative component of the study was initiated in February 2011 and involved the participation of 144 clients who had entered into the Lodge, Ashleigh House, and the Drug Free Day Programme, respectively. Baseline data were collected between February 2011 and February 2012. Follow-up data collection phases were staggered depending on the date of the initial baseline interview, with the aim of following-up at six-month intervals.

[17] Cross-sectional research involves one round of data collection.
[18] See Hedeker & Gibbons, 2006 for a technical presentation of these benefits.

Table 1 documents the timeline and the number of participants retained during each subsequent stage of the quantitative study.

Table 1: Timeline for the Quantitative Data Collection

Phase	Dates	Number of Participants
Baseline	Feb 2011 – Feb 2012	144 (100%)
6 Month Follow Up	July 2011 – November 2012	109 (75%)
12 Month Follow Up	Feb 2012 – March 2013	110 (76.4%)
18 Month Follow Up	July 2012 – November 2013	103 (71.5%)
24 Month Follow Up	Feb 2013 – March 2014	111 (77.1%)

Surveys were administered to participants in pen and paper format with the help of a staff member or key worker at CTC. All staff received training in the administration of the Treatment Outcome Profile measure (described below). All participants were assigned a unique identifier code to ensure anonymity.

Treatment Outcome Profile Measure (TOP)
Quantitative data were collected using the Treatment Outcome Profile (TOP) monitoring measure. This instrument was developed by the National Treatment Agency (NTA) in the UK in collaboration with the National Addiction Centre at Kings College, London. Following a test-retest validation process, a final measure of 20 outcome items met inter-rater reliability criteria (Mardsen et al., 2008). The instrument effectively measures seven outcome areas: substance use, injecting behaviour, criminal activity, physical health, psychological well-being, quality of life, and social functioning and is widely used in studies of addiction and substance treatment.

The physical health, psychological health, and quality of life items are presented to participants as a scale from 0-20, asking them to rank their overall physical health, mental health, and quality of life over the past thirty days.

Quantitative Analyses
All quantitative data was input into SPSS v. 22 (IBM). Data was screened for outliers, missing data, and double imputation. Descriptive statistics were generated for each wave of data collection to provide an overview of the key variables in the study. Given the relatively small size of the sample and the descriptive aims of the quantitative element of the project, inferential tests were not conducted for this report.

QUALITATIVE METHODS

The primary aim of the qualitative component of the study was to gain clients' views, from the point of admission to the programme, on their progress throughout the treatment process. The aim of garnering client views and perspectives, alongside the quantitative data, offered a clearer, more focused understanding of why certain clients change and others do not, the contextual contingencies that may affect programme compliance, and reasons why particular clients may leave the programme prior to completing treatment.

Pathways Approach
Drug and alcohol dependence and addiction are dynamic experiences that are subject to change, fluctuation, and gradations; similarly, addiction treatment is not a linear process. Rather, individuals may take many different paths into and through treatment, often taking 'one step forward, one step back' with their progress (Larmier & Palmer, 1999). In fact, relapse is widely considered to be part of the recovery process. The qualitative component of this study drew upon a pathways approach, which considers the processes at work in participants' treatment trajectories and the experiences that shape a person's treatment involvement. It therefore considers the heterogeneous, often nonlinear

directions that treatment may take over time. It also permitted an exploration of the manner in which addiction treatment interacts with other processes and experiences such as family, work life, physical and psychological well-being, criminal activity, and so on over time, thus yielding a comprehensive and holistic exploration of participants' pathways through treatment at CTC.

Administration

Qualitative data collection occurred in four stages from March 2011 to June 2013. Baseline interviews (n=28) were conducted as participants entered CTC and three subsequent follow-up interviews were conducted at six month intervals over a period of 18 months. Table 2 presents the timeline for each wave of qualitative data collection. In total, 86 semi-structured interviews were conducted.

Table 2: Timelines for the Qualitative Data Collection

Phase	Dates	Number of Participants
Baseline	March – Aug 2011	28 (100%)
Wave 2	Nov 2011 – Feb 2012	21 (75%)
Wave 3	May 2012 – Oct 2012	17 (60%)
Wave 4	Feb – June 2013	20 (71%)

Four research assistants were recruited to undertake the qualitative component of the study. Each research assistant was an experienced qualitative researcher and all received training on the treatment system at CTC, the conduct of qualitative interviews, and the interview protocol. Each assistant recruited seven participants at baseline, with the help of staff members at CTC, and was responsible for 'tracking' those participants at six month intervals for the duration of the project.

Typically, interviews were conducted at a CTC building in Dublin's city centre. If participants were living in a residential centre, they were provided with transportation to and from the site by a staff member. Clients were provided with information sheets and told that participation in the study was voluntary and not a requirement of the treatment programme. Researchers distinguished themselves clearly from CTC staff prior to the conduct of interviews, emphasising to participants that the interviews were confidential and that no personal or identifying information would be shared with staff members or other clients. Written, on-going consent was obtained from all participants prior to each interview. Interviews typically lasted from between 30 and 90 minutes, depending on the topics covered and the client's level of engagement.

During the baseline interviews, participants were asked if they were willing to provide additional contact information, including the phone number of a family member(s), a partner or friends in order to aid the tracking process. However, because of the transience associated with treatment exit and the estrangement of some participants from their family members, it was not possible to track all participants via the contact details provided. It was only after multiple failed attempts to reach participants through their own contact details that researchers contacted a family member and/or members of CTC staff in an attempt to reach participants. Often, this was a lengthy process and one that required persistence on the part of the researcher. Through family contacts, several participants were tracked and expressed their willingness to engage in follow-up interviews. However, a number of participants decided to opt out of the study as it progressed and this decision was respected by the researchers.

Qualitative Data Collection

In-depth qualitative interviews were used to examine clients' motivation for entry to CTC, their perceived readiness for treatment, their

perceived progress over time, as well as several aspects of daily life and living, including health status (physical and mental health), behaviour (e.g. criminal activity), and quality of life (education, training, employment and relationships).

During each new phase of data collection, modified interview schedules were developed in line with emerging issues and themes identified during previous phases. This approach helped to ensure that the research instrument was responsive to the individual client's pathway through (or out) of treatment. Interview schedules varied slightly for participants in residential treatment and the Day Programme, as well as for participants who exited treatment early as compared with those who completed treatment. In other words, instrument design was sensitive to both the treatment context and to individual clients' pathways through treatment.

A brief questionnaire was administered to all participants during the conduct of the first interview. This instrument collected baseline demographic data and also logged relevant contact information. All participants received a 30 Euro gift voucher upon the completion of each interview as a token of appreciation for their time.

Qualitative Data Analysis
The analysis of longitudinal qualitative data presents unique challenges due to the extremely large volume of information generated. This process was further complicated in the present study by the number of qualitative interviewers collecting the data. Early in the conduct of the study, systems were put in place to ease the burden associated with the process of analyses. Following baseline interviews, a 'case profile' was created for each participant and was updated incrementally following the conduct of each subsequent interview. These profiles included thematically relevant subheadings such as: life before Coolmine; decision to enter Coolmine; drug use history; prior treatment history; Coolmine expectations and impressions; Coolmine treatment approach; life beyond Coolmine; health and well-being; reflections and future directions. These case profiles, along with additional coding, allowed for a rounded cross-sectional analysis of participants pathways into, through, and out of CTC.

ETHICAL CONSIDERATIONS

Formal ethical approval for this study was attained from the National Drug Treatment Centre in 2010.

Data Storage:
The Data Protection Act of 1998 guidelines was adhered to as protocol for data storage. All participants were assigned a unique identifying code, which was used on their personal records at Coolmine, as well as their TOP questionnaires. Qualitative participants were assigned a pseudonym for the purpose of reporting data. To ensure confidentiality, audio files, interview transcripts, written questionnaires, and all other documents pertaining to research were stored in locked filing cabinets at CTC or at Trinity College Dublin. To ensure anonymity, all information which could be used to identify participants (places, names of family or friends, dates) was removed prior to the written dissemination of findings.

Ethical Challenges:
The potential vulnerability of clients was recognised during all stages of the project. Research aims and the nature of involvement were presented and discussed prior to the conduct of each interview. Informed written consent was obtained at each stage and participants were reminded that they could terminate the interview at any time or decline to answer any question. Furthermore, the research team took particular care to ensure that all clients understood that the interviews were being conducted for research purposes and that the interview was in no way connected with their treatment at CTC. The qualitative research team always emphasised that they did not work for CTC and that

honest answers, even if critical or unfavourable, carried no negative repercussions.

During the qualitative interviews, in particular, clients were asked a variety of potentially sensitive questions about their drug use, their personal relationships, and their physical and mental health. Interviewers were mindful of the sensitivity of these topics and of their potential to cause emotional distress or discomfort. In instances where a participant showed signs of discomfort, s/he was informed that they could take a break or, alternatively, terminate the interview.

Several measures were taken to ensure the safety of all interviewers at all times during the conduct of the study. Firstly, a diary was maintained by all interviewers, documenting all interview locations, interview times, and any relevant field notes. Secondly, interviewers were required to check-in by telephone after each interview both to inform the office that the interview had been successfully completed and to ensure the safety of the interviewer. Interviewers were encouraged to discuss any difficulties, personal or professional, arising from the research with the researcher supervisor.

LIMITATIONS

The findings presented in this paper are subject to a number of limitations. First, the mixed methods data were collected by two separate project streams. While ultimately serving the same aim, there existed disconnections between the two data collection methods. Second, the large amount of qualitative interviews produced a volume of data that was too large to be effectively analysed and summarised within this report. As such, many aspects of the treatment and recovery experience are left unaddressed. The author will work towards disseminating these stories and findings in further publications. Third, the data herein was collected at one therapeutic community over a two year period. The findings, therefore, do not purport to be generalisable to treatment experiences either nationally in Ireland nor abroad. Finally, and perhaps most notably, the data reported here presents only the experiences of those clients who were retained throughout the life of the study. A certain amount of attrition is inevitable in any longitudinal study and indeed, was the case here. We have no way of knowing whether the experiences reported here accurately reflect those of the clients who did not participate in later stages of data collection.

BASELINE PARTICIPANT PROFILES

Quantitative Sample

A total of 144 clients participated in the baseline quantitative survey. Participants ranged in age from 18 to 50 years. The average age at entry to treatment was 30 years, with the average age for males (31 years) being slightly higher than for females (28 years). More than half of the baseline sample were attending the Lodge (52.1%, n=75), with the remainder either attending Ashleigh House (26.4%, n=38) or the Drug Free Day Programme (21.5%, n=31). The sample comprised more than twice as many male (68.8%, n=99) as female (31.3%, n=45) respondents.

At the time of baseline, 56.9% (n=82) of participants were drug and alcohol free, 36.8% (n=53) were using illicit drugs at the time the survey was administered, and 9 (6.3%) were using alcohol only. More than half of the respondents (52%, n=77) reported problem use of more than one substance, although opiates were the primary problem drug for a majority (71%). Table 3 on following page summarises the demographic profile of the survey participants at baseline.

On the whole, retention rates for the quantitative sample were high. At the six-month follow up phase, 109 (75.7%) participants were tracked and, at 12 months, the retention rate was slightly higher at 76.4% (n=110). At 18 months retention rate was slightly lower with 71.5% (n=103) participants before increasing to 77.1% (n=111) retained in the final, 24-month follow up. Given the

duration of the study and the fact that drug users are a recognised 'difficult-to-track' group (Griffiths et al., 1993), the retention rates are very robust.

Table 3: Demographics of the Baseline Quantitative Sample

Demographic Variable	Response Categories	Number and % (n = 144)
Gender	Male Female	99 (69%) 45 (31%)
Treatment Program	The Lodge Ashleigh House Day Programme	75 (52%) 38 (26%) 31 (22%)
Primary Problem Drug	Opiates Alcohol Cocaine Benzodiazepine Crack Other	102 (71%) 16 (11%) 10 (7%) 7 (5%) 6 (4%) 2 (2%)
Age Range	18 – 29 30 - 39 40 – 49	69 (48%) 60 (42%) 15 (10%)
24 Month Follow Up	Feb 2013 – March 2014	111 (77.1%)

Table 4: Participant Retention and

	Baseline	6 Month	12 Month	18 Month	24 Month
Participants (% of baseline)	144 (100%)	109 (75.7%)	110 (76.4%)	103 (71.5%)	111 (77.1%)
Engagement					
Engaged	144 (100.0%)	68 (62.4%)	25 (22.7%)	2 (1.9%)	0 (0.0%)
Early Discharge		8 (7.3%)	24 (21.8%)	20 (19.4%)	24 (21.6%)
Self-Discharged		23 (21.1%)	35 (31.8%)	35 (34.0%)	39 (35.1%)
Re-engaged		7 (6.4%)	7 (6.4%)	6 (5.8%)	5 (4.5%)
Graduated		1 (0.9%)	17 (15.5%)	38 (36.9%)	40 (36.0%)
Prison		2 (1.8%)	2 (1.8%)	2 (1.9%)	3 (2.7%)

Engagement in the Quantitative Study

Retention was, in part, influenced by the participants' level of engagement with CTC over the two-year period of the study. Table 4 presents the retention and programme engagement rates for participants during the life of the study. Later chapters will discuss the various types of programme engagement, re-engagement, and discharge in some detail. However, for now, one can observe that, with the passing of time, direct engagement in the programme decreases. Rates of self-discharge and mandated discharge increase notably between the 6 month and 12 month points of follow up.

In the month prior to the baseline survey, 57% (n=82) of quantitative participants reported that they were drug and alcohol free. As stated earlier, a total of 37% (n=53) had used some illicit drug use in the previous 30 days and an additional 6% (n=9) were using alcohol only. A total of 55.6% (n=80) had injected drugs at some point in their lives. Some criminal activity was reported among the baseline sample, with 3.1% (n=4) having sold drugs and 4.3% (n=6) having committed theft or burglary during the previous 30 days. Overall, employment and education rates in the previous month were low (3.5%, n=4 and 1.4%, n=2 respectively). A total of 21.7% (n=30) had experienced an acute housing problem during the previous 30 days. CTC

clients were typically poly-drug users with a long history of substance use dating back to childhood or adolescence. The majority (71%, n=102) identified opiates as their primary problem drug. An additional 11% (n=16) stated that alcohol was their primary problem drug, while the remaining 18% identified cocaine, benzodiazepine, crack, or 'other' substances as their primary problem drugs.

Qualitative Sample

A total of 28 CTC clients participated in the baseline qualitative interviews. Participants were selected as a cross-section of the clients accessing CTC's services, including men and women in both residential and DFDP programmes. Participants ranged in age from 20 to 47 years and the average age was 32 years. A total of 16 (58%) were male and 12 (42%) were female. Twenty five participants were born in Ireland, two were born in the UK, and one was from an Eastern European country. There was a near equal representation from the three CTC programmes: ten were living in the Lodge, eight were living in Ashleigh House, and ten were engaged with the Drug Free Day Programme. Poly-drug use was a commonly reported by participants. However, most (86%, n=24) reported opiates as their primary problem drug. Table 5 presents a demographic profile of the qualitative interview participants at baseline.

Retention rates for the qualitative participants (Table 6) fluctuated throughout the follow-up stages of data collection. At the point of first follow-up, 21 participants (75%) were tracked and retained and this number fell to 16 (57.1%) following a period of 12 months. Four previously untrackable participants were contacted and re-interviewed during the final wave of data collection, bringing the final retention rate to 20 (71%).

As previously discussed, tracking problems are widely recognised in the conduct of longitudinal qualitative research of this kind. Particularly when researching addiction and treatment longitudinally, relapse and substance use are likely and also impact on the research process (Kletchinsky, Bosworth, Nelson, Walsh, & Shaffer, 2009). Many of those who could not be tracked were reported to have relapsed by Coolmine staff members, family members, or other CTC

Table 5: Demographics of the Qualitative Baseline Sample

Demographic Variable	Response Categories	Number and % (N = 28)
Gender	Male Female	16 (57%) 12 (43%)
Treatment Program	The Lodge Ashleigh House Day Programme	10 (36%) 8 (28%) 10 (36%)
Primary Problem Drug	Opiates Alcohol Cocaine Other	24 (86%) 3 (10%) 1 (2%) 1 (2%)
Age Range	20 - 29 30 - 39 40 - 49	9 (32%) 14 (50%) 4 (18%)

Table 6: Qualitative Participants and Retention

	Baseline	6 Month	12 Month	18-24 Month
Participants (% of baseline)	28 (100%)	21 (75.0%)	16 (57.1%)	20 (71%)

clients. However, the precise details and circumstances of these participants were not available to the researchers. One participant was reported as deceased following the first interview and another was in prison during the final two waves of data collection. Finally, a small number of participants opted out of the study for personal reasons.

THE PRESENTATION OF FINDINGS

The following chapters examine clients' pathways into and through treatment and their lives after treatment. Quantitative and qualitative data are presented simultaneously, providing a broad overview of situational features along with a highly detailed account of individual circumstances, contextual influences, and personal treatment experiences. While this was a mixed methods research project, much of the presentation of findings focuses on the qualitative component. The decision to focus, in depth, on the qualitative data hinges on the data's unique ability to highlight the processes involved in treatment and recovery. The quantitative data provides us with a valuable summary of drug use among CTC clients over time, presenting statistics on the broader patterns of recovery. This information is crucial to understanding the efficacy of the services and the overall outcomes of clients. However, without delving into the qualitative data, we would be unable to gain a deeper understanding of these patterns, or of the lived experience of treatment routes within the CTC programmes. Furthermore, the recognition of recovery itself as an on-going process compels the use of qualitative data in order to capture the intrinsically and inherently evolving nature of the experience.

CONCLUSION

This chapter outlined the research design and presented the methodological details of the administration, data collection, and samples of the current longitudinal mixed methods study. Chapter 3 goes on to present the three broadly categorized pathways into treatment and documents the factors impacting on engagement and retention at CTC.

CHAPTER 3
PATHWAYS INTO TREATMENT

Just as there is no single path associated with the process of becoming drug or alcohol dependent (DiClemente, 2006), entry routes into treatment are varied and diverse. For most who were interviewed, the process was incremental and, typically, entry to CTC was preceded by multiple overlapping experiences and events including, in some cases, prior drug treatment experience. The qualitative baseline interviews yielded a large volume of information about participants' lives prior to entering CTC. While each individual's life history was unique, a number of notable themes emerged from the in-depth interviews. Before exploring clients' pathways into treatment in detail, it is important to examine their accounts of drug and alcohol use initiation.

LIFE BEFORE TREATMENT

For almost all qualitative participants, substance use began during early adolescence. Some clients came from families where they were exposed to high levels of substance use on the part of parents and/or siblings. Others were raised in areas or estates where substance use was highly visible.

> *Not one of us is not on drugs. Me ma and me da, even me aunts and uncles. All of us have been on drugs ….Heroin, crack, tablets…*
> **JP, 29, Lodge, Wave 1**

> *All of them on me ma's side, me ma and me sister and cousins, all of them … Yeah me da was a heroin addict he died from the virus in 91 and then me uncles, his brothers died and then one of me aunties on me ma's side she's a heroin addict but she is on methadone still, she's 15 years on methadone so …*
> **Ashley, 29, AH, Wave 1**

Some began consuming alcohol on their own; others with family members, but most were initiated into drinking through their peer groups. All reported that the aim of early drinking was to become intoxicated: 'always to get drunk' (Ashley, 29, AH, Wave 1). Illicit drug use quickly followed and, for a majority, cannabis was the drug of first use. Most participants reported first trying a drug during their teenage years, typically between the ages of 13 and 17. As with alcohol, illicit drug initiation often occurred in the company of a family member (typically a sibling) or a friend. Practically all participants described their illicit drug use as escalating or intensifying, sometimes quite dramatically, over time (Neale et al., 2012). Roger described his progression from alcohol to cannabis use and, subsequently, to the use of other drugs, including opiates:

> *Ehhhh I probably started at 15 and that would be alcohol. 17 it would be hash and then you have got speed then, drink, hash, acid, ecstasy, and then you go into the next step, which would go into the opiates and then from the opiates you go into the benzo territory and sleepers and methadone and then it turns into whatever you can get your hands on.*
> **Roger, 46, Lodge, Wave 1**

For most, early drug use was seen as a social activity and took place in a peer group context. However, many clients acknowledged a gradual disconnect between their personal drug-taking behaviour and that many of their peers:

> *But then like, it seemed that a lot of my friends were able to move on from that, you know what I mean, from those – what 16 to 21, 22 – that's what life was about, working all week, going out at the weekend, and getting totally out of it like. That was alright, and then I suppose-, then you're supposed to grow up a little bit, you know, and my friends did that, but then some of them would still be able to take drugs every now and then like. But for me, it just never stopped, you know what I mean?*
> **Sarah, 31, AH, Wave 1**

The 'escalation' of drug use was not necessarily depicted as a linear, ever-

intensifying trajectory and, instead, drug use typically ebbed and flowed over a period of several years. However, the negative impact of drug use on participants' lives was recognised and highlighted by a large number. Many had become involved in criminal activity and, for some, drug use and criminal activity were 'part and parcel' of a lifestyle largely focused on drug acquisition and use. This was particularly the case for male participants, most of whom had been incarcerated at some stage in their lives:

> *It was just that cycle of taking drugs. You know, if I didn't have money for drugs then I'd go out and get it and the attitude I had within meself was to just go ahead against anyone who tried to stop me, you know?*
> **Kevin, 37, Lodge, Wave 2**

> *Just went part and parcel with me: Drugs, prison, drugs.*
> **Peter, 44, Lodge, Wave 2**

> *My past was just jails and jails and getting caught and jails and jails and more jails... From taking drugs. All the crimes were drug related.*
> **James, 33, DFDP, Wave 1**

> *I was addicted to crime as well, like, you know?... I was. Just my personality. My addictive personality. That's what I think. But I'd get a buzz off of robbing cars. I just used to love the sirens behind me. The hairs on me neck would stand up.*
> **Stephen, 34, Lodge, Wave 1**

A large number continued to use drugs during periods of incarceration. Kevin described prison as "crawling with heroin", claiming that he "came out worse" that when he was first incarcerated (Wave 1). Others were able to detox while in prison. As will be discussed in the following chapters, the legal system often provides a pathway for many clients to enter treatment. However, for those who were released from prison directly into society, abstinence typically did not persist.

Gemma explained that she detoxed from heroin during a six-month period of incarceration at the age of 18 years but relapsed immediately upon release.

> *I was like, "When I get out, I'm not touching that stuff ever again". And I swear, I walked out of the prison, right? Walked across the road … I met a fella tapping, you know, begging, didn't know him or anything and I scored (purchased heroin) off him … They actually gave me money in prison when I was leaving, like, when they released me. They gave me 54 Euro and I just felt like they were telling me to get a bag, you know?*
> **Gemma, 21, DFDP, Wave 1**

Housing problems and homelessness was also commonly reported among CTC clients prior to their entry to treatment (Neale et al., 2012). During the 30 days prior to the administration of the baseline quantitative surveys, 20.0% of males (n=19) and 25.6% of females (n=11) had experienced an 'acute housing problem'. Some had experienced almost persistent homelessness over a period of years while others had moved in and out of homelessness. During periods of homelessness, some slept rough while others resided in hostels; a considerable number reported situations of 'hidden' homelessness and had resided with family members or friends for short or more protracted periods of time. As with criminal behaviour, the relationship between homelessness and drug use was frequently intimately linked:

> *Yeah, so floating around a lot really. A lot of hostels, some bedsits, crappy bedsits and stuff so I was in hostels and bedsits for three years … it becomes quite a lifestyle, and still in addiction as well so that was how that was working … It was just crap. Really crap. But, yeah, everything centred around getting heroin.*
> **Paul, 30, Lodge, Wave 1**

While each individual's trajectory prior to treatment was unique, participants reported a

number of similar experiences, including a long history of substance use from the early to mid-teenage years, spiralling poly-drug use, increased involvement in criminal activity, and experiences of homelessness and housing problems.

The quantitative baseline data collected from participants as they entered CTC provides insight into clients' substance use, risk-taking behaviour, housing circumstances, family relationships, and physical and mental health during the 30 days prior to completing the survey. The majority of men (51.1%, n=23) and women (57.6%, 57) had injected drugs at some stage in the past. However, only 6.7% of men (n=3) and 4.0% of women (n=4) had injected in the 30 days prior to baseline data collection.

The data presented in Table 7 provides an overview of clients' lives immediately before entering treatment and highlights some of the gender differences present in the sample. Women were slightly more likely than men to have engaged in paid work but they were also more likely to have experienced acute housing problems. Just over 9% (n=4) of women and 8% (n=8) of men had engaged in some criminal activity in the previous 30 days. As indicated by the self-report health and well-being scores reported in Table 8, women reported notably lower physical and psychological health and well-being than their male counterparts. Figure 2 presents these scores visually.

Figure 2: Health and Well-Being Scores at Entry, on a Scale of 0-20

Decision to enter treatment

While there were a complex series of circumstances in participants' pre-treatment lives, they converged with a decision to enter into treatment for drug or alcohol

Table 7: Criminal Activity, Housing, and Employment in the 30 days Prior to Entering CTC, Presented by Gender

	Female (N, % of 100)	Male (N, % of 100)
Engaged in criminal activity in previous 30 days	4 (9.1%)	8 (8.3%)
Experienced an acute housing problem in previous 30 days	11 (25.6%)	19 (20.0%)
Engaged in paid work in previous 30 days	3 (6.7%)	2 (2.0%)

Table 8: Health and Well-being Scores at Treatment Entry, Presented by Gender

	Female	Male
Self-reported Physical Health (Scale 0-20)	11.09	13.6
Self-reported Psychological Health (Scale 0-20)	9.60	11.4
Self-reported Quality of Life (Scale 0-20)	10.28	11.6

dependence. However, there was not uniformity in the decision making process. Rather, the decision to enter treatment was defined by personal circumstances and experiences. As documented in Chapter 1, the literature distinguishes between those individuals who are self-motivated to enter treatment and those who are 'coerced' (Wolfe et al., 2013). However, this study's qualitative data revealed three main pathways into treatment. Before identifying and discussing these routes in detail, it is important to note that there was variation both among and within each of the three pathways. That is, while similarities were observed among participants within each pathway, there were many different contextual circumstances influencing the decision- making process.

Among the participants who were interviewed in depth, pathways into CTC could be broadly classified into three categories: 'self-motivated' entry, 'incentivised' entry, and 'combination' entry. 'Self-motivated' entry describes participants who decided to enter treatment voluntarily, in the absence of any legal or family pressure. 'Incentivised entry' describes participants who entered treatment either through conditions imposed by the courts or pressures exerted by a family member(s). In the literature, this latter category is often referred to a 'coerced' entry (Farrabee et al., 1998) but it was felt that 'incentivized' more appropriately captures the circumstances typically described by participants in this study. The term 'combination' entry then is used to describe clients who expressed strong levels of internal motivation to enter treatment (i.e. a desire to change) and who also faced some level of external pressure (for example, related to child custody issues or court conditions). Table 9 presents the qualitative participants according to pathways into treatment.

Eighteen clients described themselves as self-motivated to enter treatment; an additional six described feeling motivated by personal and external circumstances, while four entered because they felt pressured or incentivized by external factors. Among residential clients at the Lodge and in Ashleigh House, self-motivated entries accounted for half of the qualitative sample entering treatment. Among the Day Programme participants, almost all were self-motivated, due in large part to the fact that many had accessed the Day Programme as a 'step down' transition having previously attended another residential treatment programme. This pattern is discussed in greater detail later in this chapter. Incentivised entries were equally split between the residential programmes attendees at both the Lodge and Ashleigh House, as were 'combination' entries.

The remainder of this chapter examines the three broad pathways into CTC in greater

Table 9: Qualitative Participants' Pathways into Treatment

Pathway Into Coolmine	Lodge Clients	AH Clients	DFDP Clients	All
Self-Motivated Entry: i.e. Clients who felt personally motivated to enter treatment	5	4	9	18
Incentivised Entry: i.e. Clients who were court conditioned or faced formal, legal consequences and felt externally 'pressured' to enter treatment	2	2	0	4
Combination Entry: Clients who were self-motivated but also faced tangible and immediate external pressures	3	2	1	6
Total	10	8	10	28

detail and attempts to unravel the contextual and personal situations influencing the decision to seek treatment. Descriptive data from the quantitative sample is included when relevant to provide information on a larger cohort of CTC clients.

SELF-MOTIVATED ENTRY INTO TREATMENT

Of the 28 qualitative participants, 18 made a self-motivated decision to enter one of the CTC programmes. Of these, 9 entered the Drug Free Day Programme and 9 entered a residential treatment programme, either in the Lodge or Ashleigh House. As will become apparent later, the circumstances surrounding self-motivation differed substantially along the lines of residential versus day programme treatment.

Critical Moment

Many of those who made a self-motivated decision to engage with CTC had recently experienced a 'critical moment' or a 'turning point' that propelled them to seek help in relation to what they self-identified as addiction. These clients were typically coming from a period, often lengthy, of active drug use immediately prior to engaging with CTC. Many had been in treatment for drug use in the past and, for some, this was followed by a period of abstinence while others returned to drug or alcohol use immediately after treatment. Peter, for example, had been using heroin for twenty-five years and had been in treatment seven times. Describing his previous treatment experiences as "a waste of time", when his girlfriend overdosed on heroin, he explained that he felt ready re-engage with treatment.

> *I thought she was dead [...] I would say in the space of that four or five minutes, I lost two stone. I was up on top of her giving her CPR and pushing her chest and banging her and screaming, roaring, you know?! Jesus, my whole life flashed in front of me like, thinking to myself, 'if she dies what am I going to do?' [...] It was definitely one of the most frightening experiences I ever had in my life. It really was! And that was it, like. I was done.*
> **Peter, 44, Lodge, Wave 1**

While external circumstances triggered Peter's decision to enter CTC, he underwent what might be described as a personal turning point during this traumatic experience in that something shifted in his perceptions about his lifestyle during that moment. Linda, age 47, who had used alcohol and drugs heavily over a twenty-five year period, explained that the public nature of her arrest and detention for a criminal offence led her re-think her situation and seek treatment:

> *... getting taken out of my house in handcuffs in front of me son ... I was mortified and I was sitting there in the cells thinking 'How did I end up here? How, in the name of God, did I end up here?' With the shame and the guilt ... it was all over the papers, making a show of me kids and me family.*
> **Linda, 47, AH, Wave 1**

For women with children like Linda, family was commonly described as a motivator for them to enter treatment. Ashley's journey to this 'moment' was more gradual than Linda's. Over the course of several years of dependent heroin use, she had lost her job, her partner, and finally realised that she was unable to take care of her young daughter.

> *It just came to the end were I had lost everything. I lost my family, I lost me partner. I lost everything I had, like material wise, I lost everything I had and stuff like that. It came to the point that ... me daughter, I was feeding her milk for three days when I should have spoon feeding her, so I was like I couldn't carry on and drag her through it.*
> **Ashley, 29, AH, Wave 1**

Sinead's 'turning point' came after fifteen years of juggling heroin use and parenting. As her dependence on the drug escalated, she began "breaking her own rules" and injecting the drug in the presence of her daughter.

However, she had been able to maintain employment and custody of her daughter during this time and believed that, on some level, she was coping. Yet, she explained that she subsequently experienced intense feelings of guilt and shame related to her continued drug use and that these feelings acted as a catalyst for change:

> *What changed was, eh, I actually couldn't look her in the eye. And I never had – no matter what I'd done on her, I'd always win. I manipulated and manipulated my family to bits. I used them and abused them, like. And I actually couldn't look her (daughter) in the eye over what I was doing. I couldn't. And it was guilt and shame more than anything else. But this time, I don't know what – I don't know why but I just couldn't look at her anymore. I just couldn't. I was looking at meself one day and I was like, 'Jesus Christ, how did I get like this?' How did I get so fucking bad?"*
> **Mairead, 35, AH, Wave 1**

Self-identified feelings of 'guilt' and 'shame' were commonly reported among female participants, particularly among those who had children (Gueta & Addad, 2015). Some worried that they had neglected their children or inflicted trauma and suffering as a result of their drug use. Aoife, who had been misusing alcohol, cocaine, and heroin for over a decade, began to fear that her behaviour was impacting negatively on her seven year old daughter.

> *I suppose looking at me daughter growing up and it was affecting her. I didn't realise it was affecting anyone, I thought it was just affecting myself, but it wasn't, it was affecting my child and my family, you know?*
> **Aoife, 37, AH, Wave 1**

Others expressed concern about the longer-term effects of their drug use on their families, and worried that their children would someday follow in their footsteps.

> *I worry that if I don't break these chains with me drug addiction then it's going to go on to her like, because it's like watching history repeating itself looking at me and me ma and me da, you know, it's like in my genes, do you know? I worry about that. That if I don't break the cycle that it's just going to go on and on and on.*
> **Ashley, 29, AH, Wave 1**

Seven of the nine mothers interviewed cited their children as a key motivating factor for their entry to treatment (Neale et al., 2014), although not all described reaching a 'critical moment' in relation to their families. For many, critical moments, 'rock bottom' experiences, or 'turning points' carried personal significance and appeared to trigger a shift in how they perceived the effects of their drug or alcohol consumption. For these participants, what stands out is the subjective need for change that they experienced. Ashley, who had been to treatment twice prior to entering CTC, pointed out that the difference this time was that she was personally committed to becoming and remaining abstinent.

> *No, this time I wanted to go and do it myself. No one held me by the end to do it, going to pre-entries, keeping appointments, giving urines. I put the effort in myself and I worked hard to get there. You know? Something I wanted to do.*
> **Ashley, 29, AH, Wave 1**

The examples above reveal the range of circumstances that can lead to an individual deciding to enter treatment. For some, a 'critical moment' was triggered by a dramatic event such as an arrest or a near-death experience. For others, the moment transpired more gradually, after years progressing down the path of addiction. What is the defining feature of these individuals' stories is that they can identify a moment wherein they made an active decision to enter treatment for substance use. The motivation

to enter the TC was entirely their own and they expressed a strong desire to change their relationship with drugs or alcohol.

CTC as 'Step Down': Treatment immediately prior to engagement

The data presented thus far has focused on those who entered treatment following a 'turning point' experience. All of the stories above were from clients who described a period of active, heavy drug/alcohol use prior to entering treatment and all but one entered one of CTC's residential programmes. However, among those self-motivated entries, half had entered CTC immediately after completing another residential treatment programme.

Using the Drug Free Day Programme (DFDP) as a 'step down' from a previous treatment centre was common among those who felt they needed further help and support with the process of re-integration. For example, Sandra entered the DFDP after spending eighteen months in another TC treatment programme. She chose to enter the day programme because she felt she was not ready to leave the treatment environment completely.

> *For me it would be about to continue working on meself, to continue learning about me feelings, me addiction, to keep changing because I went into treatment, I was 29 when I went into [treatment centre] so it took me 29 years to learn … so 18 months in there didn't break every last one of those habits I had, so, I needed to continue on doing something.*
> **Sandra, 30, DFDP, Wave 2**

In general, clients who entered CTC from another treatment programme were in a markedly different position to those who entered directly from active drug and/or alcohol use. They were typically familiar with the structure of the programme, with the language used in treatment, and with daily activities, including group therapy, key working, and household responsibilities.

Almost all of these clients were highly motivated and spoke enthusiastically about the "work" required to complete the programme.

> *When I came in here, I was five and a half or six months off drugs so then I was ready to do some serious work on meself.*
> **Matt, 32, DFDP, Wave 1**

Sinéad decided to enter the day programme after completing a four-month residential treatment programme and a six-month day programme. She felt that one day programme was not sufficient, expressing a desire to "top-up" her recovery during the first year post-treatment.

> *My plan was that my first year in recovery would be the most important – to sort of get me feet grounded and get as much out of it as I can. To help me go on. Cause it's up to me, what I do. Eh, so that's why I was thinking maybe the two day programmes.*
> **Sinéad, 35, DFDP, Wave 1**

From an analytic standpoint, it was not possible to directly compare clients entering CTC immediately from another treatment programme with those who had taken an alternative route to CTC. The contextual circumstances were entirely distinct, as were the resources with which they approached their recovery. Table 10 presents baseline data for quantitative participants arranged by CTC programme. As demonstrated, those who are engaged in the DFDP have higher outcomes in all categories. Almost all (96.8%, n=30) were substance free for 30 days prior to the first survey, compared with 59.6% (n=59) of those in the Lodge and 60.8% (n=23) of the women at Ashleigh House. DFDP clients were also more likely to be engaged in paid employment and less likely to have experienced an acute housing problem. DFDP clients also scored notably higher on measures of health and well-being compared to residential clients and they were also less likely to have recently experienced acute

Table 10: Substance Use, Housing, and Employment in the 30 days Prior to Entering CTC, Presented by Treatment Group

	Men's Residential (n=75)	Women's Residential (n=38)	Day Programme (n=31)
Substance Free	59 (59.6%)	23 (60.8%)	30 (96.8%)
Engaged in Paid Work in Previous 30 Days	6 (6.1%)	6 (8.1%)	8 (12.7%)
Experienced Acute Housing Problem in Previous 30 Days	17 (22.7%)	11 (28.9%)	2 (6.5%)

Table 11: Health and Well-Being Scores at Treatment Entry, Presented by Treatment Group

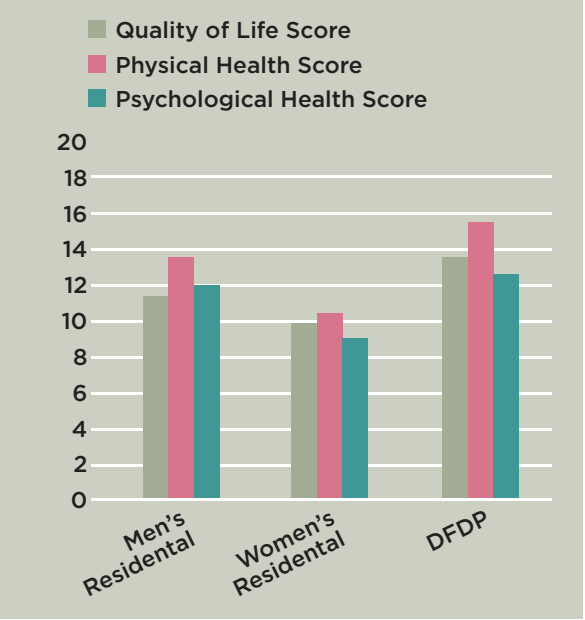
	Men's Residential	Women's Residential	Day Programme
Quality of Life Score (Scale 0-20)	11.28	9.39	13.23
Physical Health Score (Scale 0-20)	13.18	10.29	15.17
Psychological Health Score (Scale 0-20)	11.50	8.73	11.94

housing problems. Table 11 demonstrates the disparities in health and well-being scores, with residential clients scoring notably lower than DFDP clients on self-reported measures.

Figure 3 presents these numbers visually, where one can see the difference in scores between residential and day programme clients. Women entering residential treatment scored notably lower on self-reported measures of quality of life, physical health, and psychological health than men in residential treatment and clients in the day programme.

Many DFDP clients were at an advantage because of their familiarity with treatment approaches and clear on-going commitment to recovery and also because their physical and mental well-being was more stable than those participants who had been actively using substances more recently. Prior treatment experience does not necessarily guarantee programme completion or long-term abstinence. However, it does impact on the nature of the treatment experience and subsequently, on the findings, as will become apparent from the data presented in this report.

Figure 3: Health and Well-Being Scores at Entry, on a scale of 0-20



So far, the analysis has focused on clients who described feeling self-motivated to enter treatment by personal circumstances such as a 'critical moment' or a desire to continue treatment after completing another programme. These participants depicted themselves as very much in control of the

decision to enter CTC and made the decision with a strong sense of agency. Other clients, however, did not enter CTC out of a sense of personal motivation and a smaller number entered CTC because of pressure or 'coercion' from external sources. The following section presents data on clients who felt incentivised to engage with CTC.

INCENTIVISED ENTRY INTO TREATMENT

Of the 28 participants interviewed, four felt 'incentivised' to engage with CTC; two of these individuals had entered the Lodge and two had entered Ashleigh House. Unlike the narratives presented earlier, these participants did not describe their entry to treatment in terms of an active decision-making process; rather, they engaged due to a series of external circumstances that left them feeling that their choices were limited. For these individuals, entering treatment was perceived as a last resort and, in fact, all had received a suspended sentence in exchange for entering a residential drug treatment programme. However, these circumstances alone did not determine their categorization as an 'incentivised' entry. The attitude with which incentivised clients approached their recovery demonstrated a lack of personal agency as well as uncertainty and sometimes suspicion about the nature and benefits of treatment.

For example, Eva had moved to Ireland from Eastern Europe when she was 16 years old to join her brother and, upon arrival, discovered that he was heroin-dependent. Within a year, she was also engaged in a pattern of dependent heroin use; she was also pregnant and involved in a relationship with a physically abusive man. Her son was taken into State care when he was one week old and, since that time, Eva had been homeless and engaged in shoplifting and drug selling to support her drug consumption and everyday needs. She had no personal contacts in Dublin apart from her brother and had not had contact with family members in her country of origin for over a year. She had served three sentences for drug offences, during which time she continued to use heroin in prison.

Immediately prior to entering treatment, Eva had served three months of a fifteen month sentence and was encouraged by her probation officer to enter CTC.

> *Erm, yeah I think yeah, probation want that I come here. They ask many times to like … erm, would they let me go and she said, 'No it doesn't want to let you go', and she said, 'It'd be better for you if you come here'*
> **Eva, 21, AH, Wave 1**

Eva's lack of social support and family involvement, as well as her struggles with the English language, all contributed to her vulnerability. She had been instructed to engage with CTC by the courts but it became evident during the interview that she did not feel ownership or control over this decision.

> *I feel like locked in. […] its treatment, but like jail. Before that I was many times in jail and it isn't a very good feeling. Maybe I don't know, maybe it's like … erm, like a four-month sentence, I can't leave Ashleigh House. If I leave I'll be sent to jail.*
> **Eva, 21, AH, Wave 1**

For Eva, the material and symbolic conditions within Coolmine and prison were similar; she did not perceive treatment as an opportunity for change but, rather, as something that had to be endured. Roger, like Eva, had been incarcerated immediately prior to entering treatment. He viewed CTC as an avenue out of prison, although unlike Eva, did not feel coerced into treatment. Rather, he aimed to capitalise on the availability of treatment in order to achieve the goal of getting out of prison.

> *I felt pressured myself to do something and to comply with probation. When I was in prison I had all these great ideas about getting out of prison, to be released, but I knew I would have to comply with probation so I had this idea of doing whatever day programme was*

available but then … I suppose I started realising that to be safer in what I was doing, in keeping probation happy … it would be better to do residential you know? I felt like I had to be there.
Roger, 46, Lodge, Wave 1

For Roger, CTC was a means to an end and he, at no stage, mentioned abstinence or recovery as motivating his entry to treatment. Another participant, Mags, similarly depicted CTC as a source of capital: namely, getting out of prison and eventually obtaining stable accommodation. She admitted to having experienced enormous pressure to enter treatment after she spent money given to her by a housing charity to purchase drugs.

If I didn't, I probably would have ended up homeless like, I would have ended up on the roads and I probably would have been taken back to court.
Mags, 23, AH, Wave 1

Mags did view the acquisition of skills to remain abstinent as a potential positive outcome of engaging with treatment but this was depicted as a secondary aim.

If I do the six months - I won't be left on the streets like, I'll get a place and it will give me the tools to stay clean like.
Mags, 23, AH, Wave 1

Those who were incentivised to enter treatment did generally express a desire to become and remain abstinent, even if their primary goal was to find a route out of prison. Though on the whole, the narratives about entering treatment among incentivised participants were notably less empowered than those of self-motivated clients. Furthermore, a lack of agency and active decision-making resulted in some feeling 'trapped' within the treatment programme.

COMBINATION ENTRY INTO TREATMENT

Not all clients who were pressured to enter CTC by the courts can be classified as incentivised entries. Among the 28 individuals interviewed, five who had formal external incentives to enter treatment (i.e. the promise of a suspended prison sentence or possibility or regaining custody of their child(ren)) also demonstrated high levels of self-motivation and personal autonomy in the decision to enter treatment. These clients, as such, should not be classified purely as self-motivated, nor as 'incentivised' due to the sense of personal commitment that they possessed at entry. Thus, a third category labelled 'combination' was created to describe clients with elements of both 'self-motivated' entry and 'incentivised' entry.

For example, Brendan had experienced a great deal of guilt about his heroin use and, until he was admitted into the Lodge, had been living in the family home with his mother and his younger brother. His father had recently died and he described an acute awareness of the pain and suffering experienced by his family members as a direct consequence of his drug use. For Brendan, this knowledge and awareness appeared to be a strong catalyst and motivator for change. However, it was a suspended court sentence that served as a final "push" to enter treatment.

I just got sick of it, letting my family down. Like my mother, she could've thrown me out years ago, like. And she, like, she stuck by me the whole way … So I'm doing it for myself, like, but I'm doing it for her too… Her and my brother, like … and then I was in court and I got a three year suspended sentence then which is better for me because if I ever feel like leaving, that's the push to keep me there as well.
Brendan, 24, Lodge, Wave 1

Kevin was engaged in pre-entries at the Lodge for four months but had not succeeded in maintaining a regime of abstinence. He explained that, during this time, he questioned his own motives for entering treatment.

I suppose I was questioning my motivations – like am I doing this just for, ehm, helping me in court? Um, I was questioning meself like, 'Am I doing this to get people off me back?', you know? Cause it woulda been something that I had done most of me life. So I had to really question my motivations around pre-entries and going into the Lodge and, you know. I know today what me motivations are and that's to get in there, get well, and put the past where it should be and that's the past. And to live some sort of decent, normal-ish life. And also, to me, it's just to wake up in the morning and not have to stick a needle in your arm to feel ok.
Kevin, 36, Lodge, Wave 1

Kevin's account of self-questioning and self-interrogation demonstrates the complicated decision- making processes that can be associated with entry to treatment. Not all clients had experienced a 'critical moment' but many nonetheless recognised the potential benefits, both personal and external, of entering treatment. Kevin concluded, after much internal debate, that entering CTC was the right choice for him, irrespective of his motivation:

But at the end of the day, like, if it's a thing that I have to go to prison when I finish Coolmine, at least I'll go there [prison] with new eyes and know that I'm a different person...
Kevin, 36, Lodge, Wave 1

Eoin entered the Lodge on a court order. However, once engaged, he began to recognize the treatment process as an opportunity to improve his situation and his relationship with his children.

Well, at the start it was to cop out of my sentence, when I first put in for it I had 9 months left and I felt, "Sure why not?", But, eh, as I got clean again properly, I made the decision that I wanted to better myself and knew I needed help, as regards get clean, stay clean and focus on me kids.
Eoin, 31, Lodge, Wave 2

Eoin's account suggests that a commitment to treatment prior to entry may not be a mandatory prerequisite for motivation and/or engagement with treatment programmes. The decision-making process involved for many drug and alcohol dependent individuals is not straightforward. However, as the next chapter describes, differences emerged in treatment pathways between clients according to the circumstances surrounding their entry into treatment.

CONCLUSION

This chapter briefly summarised clients' lives before treatment and then explored, in some detail, three types of 'pathways' into drug and alcohol treatment at CTC. All clients reported early and escalating use of drugs and alcohol from their teenage years. Many male participants, in particular, had a 'part and parcel' relationship between drug use and crime. At the time of entry into Coolmine, opiates were the most commonly reported 'drug of choice' for clients, with over half of the clients having injected drugs in the past. Female clients self-reported lower levels of physical health, psychological health, and well-being. This finding is in line with international literature emphasizing the unique needs of women with alcohol and drug dependence, and mental health comorbidities (Covington, 2002; Kruk & Sandberg, 2013; Tuchman, 2010).

Qualitative interviews provided insight into three categories of entry into Coolmine: self-motivated entry, incentivised entry, and combination entry. Clients who were classified as self-motivated demonstrated a strong personal commitment to change and desire to enter treatment (Wolfe et al., 2013). Incentivised clients entered treatment as a result of external pressure and felt forced or 'trapped' by their current position. Clients who were classified as combination faced external pressures but also demonstrated

high levels of desire to change (Wild et al, 2012). Clients' personal motivation and attitudes towards treatment at entry are widely regarded as key predictors in programme engagement and treatment outcomes and thus, were worth exploring in some detail (Wolfe et al., 2013; Anglin et al., 1998; Miller, 1999; Thomas & Bull, 2013). The following chapter draws concurrently on qualitative and quantitative data to describe clients' experiences within Coolmine's treatment programmes, highlighting both individual and treatment elements' impact on engagement and retention.

CHAPTER 4
THE TREATMENT EXPERIENCE

As documented in the previous chapter, clients entered CTC via a number of pathways which were categorised as follows: self-motivated entry, incentivised entry, or 'combination' entry. Once involved in the TC, clients took diverse routes through the treatment process, engaging with different programme elements and availing of various services. Despite the multitude of influential factors, their treatment routes can be reasonably classified in one of three ways: programme completion, early discharge, or self-discharge ('drop-out').[19] While these categories are somewhat crude and inevitably limited in terms of their ability to classify the intricacies of the treatment process, they are frequently used in the literature in the depiction of retention rates and treatment outcomes (Darke et al., 2012).

Before exploring clients' pathways through treatment in some detail, it is important to examine the overall pattern of programme retention based on the findings from the quantitative data, which provides a broader picture of CTC client trajectories. Table 12 presents the overall engagement of CTC clients over a two-year period. Of the initial baseline quantitative sample (n=144), 36% of clients completed the programme and graduated from CTC. More than one third (35%) self-discharged and an additional 21% were discharged by CTC. Of those who discharged early, 5% re-engaged in the programme.

These quantitative data are useful in providing an overview of the rates of retention and discharge for the sample. However, they can tell us very little about the processes and experiences underpinning these outcomes. What factors influenced programme completion or early discharge? How and why did clients' make decisions to leave treatment early? In what ways did CTC services enable clients' to complete the treatment programme? The qualitative data provides nuanced insight into treatment experiences. Of those qualitative participants who were interviewed individually at baseline (n=28), 11 completed all stages of the CTC programme and 17 either self-discharged or were discharged by CTC (Table 13).

Table 12: Participant Retention, Engagement, and Drug Use in the Quantitative Study

	Baseline	6 Month	12 Month	18 Month	24 Month
Participants (% of baseline)	144 (100%)	109 (75.7%)	110 (76.4%)	103 (71.5%)	111 (77.1%)
Engagement					
Engaged	144 (100.0%)	68 (62.4%)	25 (22.7%)	2 (1.9%)	0 (0.0%)
Early Discharge		8 (7.3%)	24 (21.8%)	20 (19.4%)	24 (21.6%)
Self-Discharge		23 (21.1%)	35 (31.8%)	35 (34.0%)	39 (35.1%)
Re-engaged		7 (6.4%)	7 (6.4%)	6 (5.8%)	5 (4.5%)
Graduated		1 (0.9%)	17 (15.5%)	38 (36.9%)	40 (36.0%)
Prison		2 (1.8%)	2 (1.8%)	2 (1.9%)	3 (2.7%)
Illicit Drug Free	82 (56.9%)	86 (78.9%)	71 (64.5%)	64 (62.1%)	80 (72.1%)

Table 13: Pathways through Treatment for Qualitative Participants

Pathway Through CTC	Lodge Clients	AH Clients	DFDP Clients	All
Completed Programme	2	4	5	11
Early Discharge	4	1	2	7
Self-Discharge (Drop-Out)	4	3	3	10
Total	10	8	10	28

[19]Early discharge is used to classify clients who were discharged due to violation of protocol (i.e. mandated discharge). Self-discharge refers to clients who made a personal decision to exit treatment early.

Again, these broad categorisations of treatment pathways are helpful in that they provide a framework within which to examine the factors influencing clients' pathways through treatment. They are nonetheless quite rudimentary in that they present quite a one-dimensional picture of clients' treatment experiences. The study's qualitative data, in fact, revealed that the journeys taken through treatment differed for each client and that the responses of each individual were uniquely influenced by their personal histories and contextual circumstances. This chapter goes on to discuss key aspects of the treatment experience for residential and day programme clients, looking in depth at programme-level characteristics as well as the role that some key individual level characteristics (i.e. personal motivation) play in this process. At the end of the chapter, some attention is focused on 'discharge' stories in an attempt to gain a deeper understanding of the diverse circumstances affecting programme non-completion among the study's participants.

THE TREATMENT PROCESS

Attachment to the community

There was a near universal sense of anxiety among clients during the days leading up to their entry to CTC, particularly among residential clients. Upon arrival, many felt overwhelmed by feelings of unease and, during the initial days, most struggled to adjust to the routines, structures, and peer dynamics of the programme. Most clients in the Lodge found the 'big brother / little brother' scheme, which pairs new arrivals with more senior clients during their first week, to have aided their integration in early days.

> *They do the little brother thing to make sure that you're not coming in on your own and being on your own and they make sure that there is someone there with you at all times, introducing you to people. And that's where the comfort comes in.*
> **Brendan, 24, Lodge, Wave 1**

The 'hierarchical' treatment model allowed more experienced members of the community to mentor newcomers and participants often commented that, for newcomers this facilitated interaction with peers who were further along in the treatment process.

> *The lads have been great, we're all the same level, nobody thinks they're better than anyone else, you know? Because they're little further through their treatment than others, they actually give back what they learned through orientation.*
> **Tim, 29, Lodge, Wave 1**

Most men in the Lodge found the community welcoming and developed a strong sense of belonging quite quickly. Indeed, some described the community as a 'family'. The speed with which many Lodge clients settled into the structure, routine, and network was often commented upon with surprise and enthusiasm.

> *What's going on here like!? I am only there a week and a half and I feel I am getting to know people so well like and speaking to them – it seems like I'm here two months!!*
> **Peter, 44, Lodge, Wave 1**

> *I have only been there a few days and it feels like a few months, you know what I mean? You don't feel unwanted. You don't feel uncomfortable.*
> **James, 29, Lodge, Wave 1**

In a shared living environment, it would have been remarkable and unusual if all members integrated without conflict. Of course, this wasn't the case in the Lodge. However, it was common for men to have a positive attitude towards each other, even in cases where personality differences were apparent. Reflecting on his time in the Lodge at Wave 3, Paul described his approach towards remaining friendly with his fellow clients:

> *We got on, mostly. There's a lot of egos that come through services but I try to get on with everyone. And even if I don't*

get on with them, I still show them respect and you know, you don't like everyone you come in contact with and that's just life – recovery or outside.
Paul, 31, Lodge, Wave 3

As previously touched upon in the literature, engagement with the community and active participation in the therapeutic process are established predictors of retention and programme completion (Simpson, 1998; Hser et al., 2014; Wolfe et al., 2013). Among clients who remained engaged in the Lodge, there was a strong sense that the peer community was one of the programme's most beneficial attributes (Ezzell, 2012).

While communal engagement was consistently reported by male clients in the Lodge, this was not typically the case among the women in Ashleigh House. For most women, the transition into Ashleigh House was depicted as difficult and challenging and the 'big sister' aspect of the programme was generally not well received. Brigid had entered Ashleigh House reluctantly after her two-year-old son was taken into State care. Extremely shy, lacking in confidence, and with a history of diagnosed depression and anxiety disorder, she was assigned a big sister upon her arrival but found her to be equally unknowledgeable about the structure and rules of the residence.

She's relatively new herself and I think it took her a while to settle in and get used to it. There's not a really clear guide of what you have to do. When you come in, you're just thrown into the structure. You have to clean at a certain time and you have jobs, a certain amount of jobs and who'll be cookin', this that and the other. There's meetings but it's not really clear as to what the meetings are, what you're supposed to be doing. Sometimes she [big sister] seems just as confused as I was.
Brigid, 21, AH, Wave 1

Brigid's experience with her big sister was echoed by others at Ashleigh House. Aoife described her big sister as "useless", claiming that she learned "nothing" from her. Jane also found the component to be unhelpful, as often the women in a position of mentorship appeared to be unprepared and unable to help the newcomer.

It didn't work for me. And I heard some of the girls had difficulties with it, like. Like a big sister is supposed to lead by example but they didn't usually pick the girls right so some of the girls they would pick for big sisters, their little sisters would be telling them you know. It didn't really work.
Jane, 30, AH, Wave 2

On the whole, Ashleigh House clients reported far greater challenges in adapting to the residential community than their male counterparts in the Lodge. While most women reported that they 'connected' with some peers, a strongly gendered narrative emerged from many Ashleigh House clients when describing the difficulties of women co-habiting.

Eh, just whatever like – having attitudes with each other like, bitching, the most challenging part is just the bitching, people talking behind people's backs and people talking about people which isn't allowed or whatever but it still happens.
Jane, 30, AH, Wave 2

It's a house full of women, women are bitches and that's just the way it is and that's not going to change for nothing or no one.
Ashley, 30, AH, wave 2

You're with sixteen women and you know, when women are all together, all bickering over stupid things...
Aoife, 38, AH, Wave 3

As is evident from the excerpts above, interpersonal problems were often regarded as an inevitable and unavoidable feature of communal spaces occupied by women. Furthermore, most appeared largely

unaffected by interpersonal conflict of this nature. The extent to which Lodge residents embraced community engagement and the women in Ashleigh House rejected it emerged strongly from the narratives. While many of the female clients quoted above remained in treatment, they were notably less positive about the community engagement component of the therapeutic process. It is perhaps noteworthy that, while community engagement is widely acknowledged to be a key factor in programme retention, many clients in Ashleigh House remained active in treatment despite an apparent lack or absence of commitment to community engagement.

Among clients in the DFDP, the community aspect was emphasised to a lesser degree compared to both the Lodge and Ashleigh House residents. All clients spoke positively about their peers, although most were neither overly affirmative nor did they describe negative interactions or conflict. As with the residential treatment centre residents, the sense of a shared history and a unique ability to relate to each other was depicted as a binding characteristic of the community.

> *In the real world, if you want to call it that, if someone turned around to you and said, 'Well, I bait my sister for a bag of heroin', you'd go, 'Ohhh'. But in here people are more accepting of addiction and where it brings you and how you've changed.*
> **Gemma, 22, DFDP, Wave 3**

As documented in the previous chapter, many DFDP clients had recently exited a residential treatment programme so it could be argued that the DFDP environment was relatively less intensive. Furthermore, unlike residential settings, clients were only required to interact with each other during working hours on weekdays. The built-in time apart might have allowed them to view each other through a more tolerant and measured lens. Matt, age 32, explained that when he enrolled in the DFDP, it was not on a quest to make friends. However, he recognised the importance of group work within a recovery setting and made an effort to engage with the community:

> *I have been knocking around NA meetings and I have so many friends in recovery like, I didn't sort of, I didn't come here (DFDP) looking for friends or that because you are sort of – they want you to make an effort here and ring people you're in group with and meet up with them on the weekends and all and I sort of – I have only started doing it, the first few weeks I didn't bother, I wasn't into it like … so I have to push myself to do that like …*
> **Matt, 32, DFDP, Wave 3**

Of note is that Matt felt that he had to "push" himself to engage with the community. Rather than shy away from this challenge or refuse to engage with the other clients, he made a conscious and active effort to partake in the group activities because he recognised the importance and necessity of community in the treatment process. This level of 'treatment-oriented' knowledge was common among DFDP clients who had previously completed a TC programme.

Therapeutic elements: Group sessions, pull-ups, and key working

In line with the broader TC model, all three of Coolmine's programmes incorporated both group therapy sessions and individual, one-to-one key-working sessions. The extent to which clients felt willing and able to engage in these elements emerged as a signifier of their level of engagement with the programme more broadly.

Overall, DFDP clients were more accepting and less critical of group work than their residential peers, recognising that groups were "only as good as the members" and that clients "get what you give".

> *I think what you put into the group, you'll get out of it … the more you put into it, and I've found that wherever I've been …*

the more you put into it the more you get out of it. It benefits yourself in the long run.
Tom, 36, DFDP, Wave 2

As with other treatment elements, the previous experience that many DFDP had with group therapy meant that many were more comfortable with this aspect of the programme than newcomers. More experienced DFDP clients were familiar with the structure, expectations, benefits and challenges of group work and felt that they approached this therapeutic element in a more serious manner. Gerry, who had entered the DFDP after having spent four months in a residential treatment centre, explained that the changing membership of the group resulted in varying group dynamics that could at times influence his own therapeutic experience.

I mean certain times there would be people who bring a bit more to group and, yeah, then you would bring a bit more to group. But the kind of group that's here at the minute they're not as serious, so obviously groups can fluctuate as well. When other people are there and they're not as serious then I can be not as serious as well.
Gerry, 34, DFDP, Wave 2

Gemma, who had entered the DFDP after an intensive residential treatment programme, also identified differences between more versus less experienced group members, referring specifically to group therapy sessions. She felt that clients who had been enrolled in other intensive residential programmes were leading the groups and putting in more effort than others who had less treatment experience.

See it's very much on the clients with the new approach. It's about your responsibility and what you put in you get back. So sometimes I felt that it was – everyone would be at different stages. Some people were putting loads in. That's what I mean by people who were in [treatment centre] would be a lot more full on while other people would be like, 'Ehhh, I think you're great'.
Gemma, 22, DFDP, Wave 2

In both of the residential treatment centres, mixed feelings were expressed about group therapy sessions. While there was a general acceptance that the group therapy was beneficial, some clients were clearly less comfortable with the interactive elements than others. Furthermore, the size of some of the larger groups proved intimidating for several participants. Smaller group sessions, which occurred on a less frequent basis, provided an avenue for more introverted clients to share their experiences in the company of peers. Indeed, these smaller sessions seemed to benefit all clients, irrespective of their preferred communication style. Brendan, one of the younger, more soft-spoken clients in the Lodge, explained his preference for smaller group sessions:

Even though I know they're there to help I just don't even want to go into them [large groups]. I just didn't feel comfortable in front of them, in front of the 20, 20 odd people. But there's some groups then just once or twice a week – the junior, middle, and senior groups and there's only five or six then and they're always stronger groups then … That's the thing. The less people, the more you're going to be able to say.
Brendan, 24, Lodge, Wave 1

Brendan's feelings were echoed by other clients, as well. Tom, who was one of the more gregarious and outspoken clients in the Lodge at the time, also recognized the therapeutic value of the smaller, more intimate group sessions.

People are more comfortable in them (small groups) and a lot more good work gets done in them I think. The bigger groups are too…there's something about a lot of people in a room looking at you.
Tom, 35, Lodge, Wave 1

The confrontational 'pull-up' aspect of the therapeutic community was a feature of the programme that also generated mixed feelings among clients. While engagement with the 'pull-up' system can indicate a level of commitment to the treatment process (Warren et al., 2013), being on the 'receiving end' of frequent pull-ups left many feeling personally attacked and alienated by their peers. Even those who did not feel overly criticised during the 'pull-up' process recognised that this sentiment was common across the community.

> *Eh, some people can take it and then other people think that you're trying to attack them or you're trying to have a go at them. If you say something, they think, 'Look at you, you're only pulling me up cause you're in bad humour and you want me to feel as bad as you', you know?*
> **Ruari, 30, Lodge, Wave 1**

While Ruari acknowledged that some of his peers felt this way about 'pull-ups', he and many others felt that some were being overly sensitive. However, among the women in residential treatment, similar attitudes towards 'pull-ups' were expressed. Using group sessions to air personal grievances was thematically present in Ashleigh House, as well. Molly, for example, felt that the 'pull-up' system was misinterpreted and used improperly by some of the women in Ashleigh House:

> *I don't think there's enough education on pull ups... People were pulling up people for the wrong things and they were getting it out of context. I think that when you come in, you should be sort of sat down and have maybe an hour chat about what it's about and how you do it properly and stuff.*
> **Molly, 22, AH, Wave 2**

A perceived lack of understanding about the appropriate procedures for confrontation, coupled with the absence of community cohesion in Ashleigh House led many clients to feel that group therapy sessions were ineffective. Indeed, they were frequently described as settings where clients confronted each other about domestic issues rather than attempting to raise awareness about problematic behaviours.

> *It's usually generally just girls with problems with other girls in the household. Just trying to sort out arguments and disputes.*
> **Aoife, 37, AH, Wave 1**

This wasn't true for all Ashleigh House clients, nor was it true of all group work sessions. Nonetheless, it was mentioned by many Ashleigh House residents and with more frequency than clients from the Lodge or the DFDP.

Complementing the group work in all three programmes was individual, one-to-one key working sessions. Compared to other areas, there was a consensus with regards to this service: practically all clients expressed a desire for more one-on-one interaction and wanted it to be more consistent. Brendan describes his key-working sessions as the most beneficial aspect of his treatment, finding himself able to open up about personal issues in a way that he had never before:

> *Oh, it's crazy. I never thought I'd be talking to anyone like that. Do you know that kinda way? And I only know her [key worker] like two and a half months as well. Do you know, just getting it all out there. It's the best thing here.*
> **Brendan, 24, Lodge, Wave 1**

However, Brendan also highlighted inconsistencies in the availability and frequency of key working sessions.

> *But some now, like, another lad – he's been there like three months and he's only had two sessions. I was like I had two in the first two weeks.*
> **Brendan, 24, Lodge, Wave 1**

Among women in Ashleigh House, complaints

about the irregularity and unpredictability of key working sessions were widespread. Aoife spoke positively about the community aspect of Ashleigh House during her first interview, two weeks after arriving. However, at that point, she reported very little contact with staff members and had yet to have a key-working session.

> *Now I haven't really seen any of the staff I was supposed to have seen ... I don't know what he is called, I suppose a counsellor, but he hasn't come to me yet and I'm there two weeks. And I have put it out to them that nobody has seen me yet, a staff member hasn't seen me yet since I came in, which I found very poor.*
> **Aoife, 37, AH, Wave 1,**

The staffing element was also addressed by Brigid, who also had received no key working session during her three weeks at Ashleigh House.

> *I think that they're understaffed, anyway. I think that they have serious problems because like for something so important, I think key working sessions and all that stuff have to be followed up on ... I just think the staff are overstretched. That's one of the things that irritated me when I was in there. And in the three weeks that I was in there, I didn't get a key working session like.*
> **Brigid, 22, AH, Wave 3**

While staff in Ashleigh were generally well-liked by the clients, several women felt that the staff presence was not adequately strong. The women were often empathetic in their descriptions, acknowledging that the staff were overworked, but felt nonetheless that the staff were not as involved in the TC as they had expected.

> *I suppose like the whole therapeutic community is about the girls helping each other, but I still think that the staff should be a bit more involved in the daily helping of each other, basically.*
> **Jane, 29, AH, Wave 1**

> *You could see young girls there hanging on by a thread. If you were suffering from rejection or abandonment and you can see the boss going off in her car and you're standing in that hallway like a feckin ejit, going, 'How do I unload this? What do I do with this? What do I do with these hurt feelings?' I was taken aback by that...*
> **Linda, 47, AH, Wave 3**

Conversely, the 'hands-off' approach of the staff in the Lodge was widely well-received by clients. The independence afforded to the clients in relation to household chores, programme structure, and daily routine was interpreted by many as a marker of autonomy.

> *We run the house in there, you know, everything goes through us, the house council and everything... we actually run the whole thing in there ourselves which I think is great like. Like, the staff don't really get involved in it. We decide what we want to eat, you know, all the meetings are in the structure. The staff, I suppose, sort out the structure but we are running the whole thing ourselves, you know, which is brilliant.*
> **Peter, 44, Lodge, Wave 1**

On the whole, CTC staff were well liked and respected in all three of the programmes. Their range of knowledge regarding alcohol and drug dependence, their approachability, and their non-judgemental attitudes were highlighted by many clients. Clients were also reassured to learn that many staff members were former Coolmine clients themselves, a status which appeared to legitimise their feedback and advice, particularly for new clients. There were situations where clients were sceptical about certain staff members during the early stages of treatment, particularly those staff that did not have a personal history of drug or alcohol dependence. However, over time, these feelings typically transitioned into ones of respect and trust.

> *One staff member, I wouldn't have got on with her because she wasn't an addict. It*

wasn't that I wouldn't get on with her at all but I have nothing in common with her. Towards the end of me 3 months, I think she was probably the best staff member out of the lot. Again, she has a big heart and she was there to help people rather than be there for a pay check.
Paul, 30, Lodge, Wave 3

Um, when I first came and I heard [staff member] in group I went, 'I want her' cause she was so old school Coolmine.[20] I knew she'd be good. I need someone hard-core who's gonna tell me all about meself … but they put me with this really passive girl …. but she actually taught me a lot … I was so shocked and surprised cause I was like, 'Oh you won't be able for me'.
Gemma, 22, DFDP, Wave 2

Mothers and their Children

As previously touched upon, Ashleigh House is a women-centric treatment facility wherein mothers are encouraged to bring their young children (under school age) to reside with them during the treatment process. This removes barriers regarding childcare for many clients and also facilitates a strengthening of the mother-child relationship (Carlson et al., 2006; Covington 2002). Ashleigh House has an on-site crèche with childcare services which enables women to engage in their therapy sessions and other individual and group activities during the day. In the qualitative study, interviews were conducted with three Ashleigh House participants who had their children on-site. While this is a relatively small number, their accounts nonetheless provide considerable insight into the treatment experiences of women with children in their care.

For all three women, the availability of the on-site childcare services was the main feature that drew them to CTC residential programme. For example, Jane was estranged from her family and the father of her child and, without the live-in child care services, would not have been willing to enter treatment.

So my other option would be to put the child into care for two months, and I just wouldn't do it.
Jane, 29, AH, Wave 1

Jane and the other mothers were extremely grateful to have their children residing on-site and made the decision to enter CTC based primarily on the availability of this service. However, they also felt isolated from the larger community, as 'women with children' in a residential centre.

I suppose I expected that the evening times would be a bit different, you know, I just find like there's two girls in there – me being one of them – that have their children, and it's like they're kind of isolated a lot in the evenings because they're all in bed with their kids like, and you can't hardly leave your child in an apartment when you're across in the house, you know what I mean?
Jane 29, AH, Wave 1

Jane, quoted above, also found that she struggled with full-time parenting without the crutch of drugs or alcohol and, at times, felt hampered by the responsibilities and complexities of motherhood (Gueta & Addad, 2015). The contrast between her daily routine at Ashleigh House with her child and those who did not have their children on site compounded her feelings of burden.

… Having that responsibility when other people don't have that responsibility and, yeah, it would kill me to lose my kids, or for my kids to go into care but sometimes you're like, 'God, a break would be lovely' you know? That's the biggest challenge I think yeah.
Jane, 29, AH, Wave 1

Unlike Jane, Aoife's daughter stayed with her only on the weekends because she attended school during the week. Aoife struggled with being separated from her child on week days and felt emotionally conflicted about remaining in treatment due to the distance between them.

[20]Coolmine Therapeutic Community previously relied upon a more rigid, authoritative approach to treatment before adopting a Community Reinforcement Approach (CRA) in the past decade. Some clients referenced the 'old' model of CTC to describe someone who was 'tough' on the clients.

I find it great [that she stays on weekends] but I do miss her during the week because I had her with me all the time. I just miss her, you know? … Like when she was crying on the phone last night I just felt like getting up and leaving but I couldn't because I have to be here … I was trying to explain to her on the phone that I am doing this for her own good and she will understand when she is a little bit older why I did it.
Aoife, 36, AH, Wave 1

For women in residential treatment living away from their children, distance was an on-going struggle. Even with the availability of weekend residential services for her child, Aoife felt the impulse to exit treatment early in order to be reunited with her child, though in the end, she remained in Ashleigh House.

Molly was also drawn to Ashleigh House because of the live-in childcare facilities. However, after engaging, she was told that she would have to wait a few weeks before her son could join her. This was a set back and, as time passed, she struggled to settle in. Eventually, she decided to leave residential treatment and engage in the day programme because she felt it was better suited to her personal situation and allowed her to establish a routine with her son at home.

I was told a few weeks into the programme that he wasn't actually going to be able to come into the crèche, which really upset me. So I was told that they didn't know when he'd be able to have a place there, whereas the social workers were telling me that, 'Yeah, you can start seeing him. He can start staying over next week'. And the thought that I could just leave Ashleigh House, have him with me, staying, living in me house, setting up a routine at home rather than settling into Ashleigh. Rather than having to settle into a new routine there and then change it all when he's been back and forth and back and forth and all over the place. It was just too tempting to give it a shot. And I felt strong enough in meself that I was able to resist temptation. So. I made the move …I was determined to get [my son] back. And I wanted to be cleaning my own house, not somebody else's.
Molly, 22, AH, Wave 2

Transitions to Phase 2
Following a six-month period of residential treatment, clients moved from 'Phase 1' to 'Phase 2', at which point most resided in transitional community houses and received aftercare services including group sessions and one-to-one key working from the TC.

In line with Soyez and Broekaert's (2003) qualitative study on TC transitions, this period of time was charged with apprehension, enthusiasm, and conflicted emotions for all clients. For residential clients, Phase 1 was marked by a period of constant support from peers, CTC staff, and these supports were bolstered by the structure of a live-in treatment facility. For some, it was the first time that they had lived in a sober, stable environment. Leaving the protective 'bubble' of residential treatment came as a shock for many participants and most faced struggles and considerable difficulties during this time. The juxtaposition of all- and every-day supports during Phase 1 and the occasional and intermittent formal supports offered at Phase 2 was particularly challenging for many clients.

Just going out of that [Phase 1], we were wrapped up and confined inside there and the unknown and what way was it going to go, was I going to have the same motivation and was I going to move on, what was I going to feel, what would I do in my spare time and everything like, just a fear of going back out there and trying to live life on life's terms.
Philip, 44, Lodge, Wave 2

I was all messed up, I didn't know what I was feeling, I was terrified like. It was like I was only after been landed on this earth like, I didn't know what to do, I didn't know my arse from my elbow like. I was terrified to be honest…
Caolmihe, 30, AH, Wave 2

For some, the transition felt very sudden and abrupt. Stephen was disoriented, as though he had been rushed out the door when his time in the Lodge was complete.

It was just, a bit of a hurry like "off you got to Phase 2". I was kind of confused. Like what am I going to do with myself now?
Stephen, 32, Lodge, Wave 2

For others, the lack of formal support available during Phase 2 from CTC came as a surprise. Clients understood CTC's strategy for encouraging self-sufficiency but nonetheless felt that the contrast between the abundance of support during Phase 1 and lack thereof during in Phase 2 was simply too sharp.

I didn't really feel supported in Phase 2 by staff, I really didn't. And, em, I know I am not the only one there ... I think I only got three phone calls in three months asking how I was, what I was up to ... I can understand Coolmine's approach, because it's like personal responsibility for your own recovery that, if you have a problem, you go up and assert yourself and talk to staff about it and look for help. But maybe I was so used to being sort of pampered in Phase 1 by staff and they were at your beck and call and then when they weren't there in Phase 2, you're like, 'What the fuck is going on here?!'
Kevin, 34, Lodge, Wave 2

I don't feel that Coolmine helped me that much through any of that time, do you know what I mean. [Through that Phase 2 you mean?] Yeah ... I think that you get an awful lot more support in Phase 1 and then, when you are in Phase 2, it's kind of like .... Wow, I am on my own kind of.
Jane, 31, AH, Wave 3

In Phase 2, I find that you're kind of left to your own devices. I think they should kind of link in with you a little bit more ... there's not enough support there for people that's out in the big world like 'cos that's where people struggle. It's alright when you're in Phase 1, you're in a bubble but when you're out in the real world, some days it does be hard like.
Aoife, 37, AH, Wave 2

Relapse following the transition from Phase 1 to Phase 2 was common among clients and their peers. This contributed to the unease felt by many participants during an already difficult period of transition.

A load of people have relapsed, like even when they came back into the groups they've relapsed and I've found that difficult because you're trying to stay clean. I'm trying to stay focused and then you've people coming back into the groups and they've been using so I find it a bit difficult around that.
Aoife, 37, AH, Wave 2

Peer drug use emerged as a source of stress for several participants (Soyez & Broekaert, 2003). As clients witnessed peers from treatment relapse and/or return to using, some felt increasingly concerned about maintaining abstinence for themselves. Others found themselves in situations where they were aware of violations of protocols regarding substance use but were unsure of how to proceed. Jane described her conflicting feelings about her peers' drug use, particularly in relation to informing Coolmine about rule violations.

I was aware of some things, like there was a couple of people drinking and lying about it and all that kind of stuff. It's difficult like, especially when you are living in one of Coolmine's houses and you are living with someone from Coolmine who is not doing what she is supposed to be doing. You are supposed to go back to Coolmine and tell them this but it's very hard. That's what I find the most difficult about the programme: you are expected to be friends with people

but you are expected to pass feedback on them as well which can be difficult.
Jane, 30, AH, Wave 2

Most clients anticipated a stressful transition but were surprised by the sharp contrast in available supports between the two phases. They understood that the gradual tailoring-off of supports was a required step on the pathway to independent living. However, the seemingly widespread tendency for clients and/or their peers to relapse during this time left many feeling abandoned by CTC support mechanisms.

The On-Going Importance of Self-Motivation
A personal commitment to change, or lack thereof, as described in Chapter 4, emerged as a strong determinant of individuals' treatment pathways. These individual-level characteristics were especially pronounced among clients who remained engaged in the programme through to completion. Commitment of this kind was on-going, active, and involved and required a regular 'recommitment' to change on a daily basis. Matt explained that, for him, treatment involved giving "one hundred per cent" of his effort on a daily basis:

I just sort of, I just got stuck in here and em, I was here, I just got here every day early and then I just participated, I gave one hundred per cent in to everything in here.
Matt, 32, DFDP, Wave 3

Those who were self-motivated at the point of entry and remained self-motivated throughout the treatment programme had a distinct narrative that placed a personal commitment to change centre stage. These clients also demonstrated a clear sense of autonomy with regards to programme engagement, highlighting the importance of active commitment with the treatment process. An endurance mentality was common, with self-motivated clients feeding off of the struggle that accompanied progress in the treatment process.

You have to be open minded to what's being put to you. I know the truth hurts, and if it didn't, we wouldn't be here so like. So you have to hear what you don't want to hear. You have to be open minded to take everything on board.
Kevin, 43, Lodge, Wave 2

I'm not under any illusions, I'm not going to be cured, I know it's a process and I'm always going to be working on myself.
Linda, 47, AH, Wave 1

Kevin and Linda's accounts demonstrate an understanding and acceptance of the process of recovery and a strong awareness of the effort required on the part of the service user. As Linda did not expect 'to be cured' and recognised that, in order to complete the programme, she had to actively engage. This 'active' approach to recovery was strongly connected to self-motivation, which is widely regarded in the literature as the key predictor of programme retention and success in TCs (Darke et al, 2013; Hiller et al., 2002; Wild et al, 2006; Wild et al, 2012).

During wave one interviews, many participants spoke of a 'desire to change' as the main motivating factor encouraging them to remain abstinent and engage with the treatment process. Notably, those who remained in treatment continued to raise this issue during each successive interview, suggesting that their personal commitment to change remained in the forefront of their minds and a focal point of their treatment journey. Peter commented on his desire for change during his first interview and also spontaneously reflected on change during his third interview one year later.

I'm an addict and I don't want to be an addict anymore. I will always be an addict but I just want to recover. I want a normal life. I want what normal people do. I don't know what that's like anymore ... To get married, to settle down, to live a life without drink and drugs like.
Peter, 44, Lodge, Wave 1

I really wanted to change like, from the inside out like, I really wanted to change this thing – I just had enough like... And I didn't want that life anymore.
Peter, 45, Lodge, Wave 3

As time in treatment progressed, a narrative of transformation became apparent in many cases, as several described themselves as having a renewed sense of self and a more positive self-identity. The ways in which these participants constructed and re-constructed their identities was a distinctive feature of these narratives.

[Key worker] was saying to me, like, she was speaking about giving ourselves affirmations and that was something I would struggle with now, I was saying to meself, why should you give myself an affirmation after the life you lived, after the damage you caused to people and what's so good about you? That's the way I look at myself you know? ... But I started to going to [key worker] and I could see myself different, I could see the person that I was because people were telling me this and I had to look around and say there's nobody else standing there and it's obviously me they are speaking to!
Peter, 44, Lodge, Wave 2

To be honest with you, I just turned my life around at Coolmine. It brings up different stuff for you, behaviours and all like ... To be honest with you, I never went through an experience like that, I broke down crying like a child with the stuff that was coming up because you think about it, thirty years of abusing yourself all different drugs or whatever and I didn't know any different. I am 43 years of age but I am only growing up now, the inner child...
Kevin, 43, Lodge, Wave 2

Participants also began to see ways in which their own behaviours and perspectives had altered since they entered treatment. Tricia, aged 38, put it succinctly:

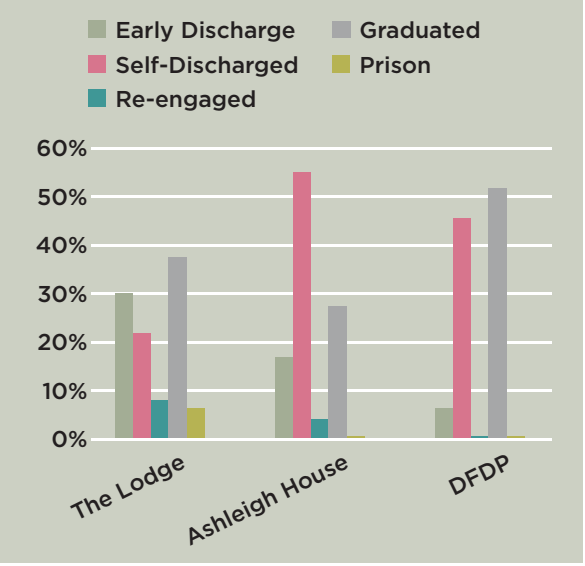
Nothing has stayed the same, everything has changed.
Tricia, 38, AH, Wave 2

The narratives of change documented above resonated strongly among those clients who remained engaged with the treatment programme over the course of the study. These clients also appeared to recognise the need to remain focused and committed; they engaged in all aspects of the programme, even when they struggled; they found support and solace in the community; and relied upon the structure of the programme to help them gain a sense of routine and normalcy.

EARLY DISCHARGE STORIES

As touched upon previously in this chapter, early discharge is relatively common in Coolmine Therapeutic Community, as is true for therapeutic communities more broadly (Malivert et al, 2012). Within this study, a high level of programme non-completion was observed in all three CTC programmes.

Figure 4: Programme Engagement at 24 Months



Tables 14 and 15 present the engagement and discharge rates of all three CTC programmes at six months and at 24 months. At the six

Table 14: Programme Engagement at 6 Months[21]

	The Lodge	Ashleigh House	DFDP
Participants (% of baseline)	53 (70.7%)	32 (84.2%)	24 (77.4%)
Engagement			
Engaged	35 (66.0%)	21 (65.6%)	12 (50.0%)
Early Discharge	6 (11.3%)	1 (3.1%)	1 (4.2%)
Self-Discharge	3 (5.7%)	10 (31.3%)	10 (41.7%)
Re-engaged	6 (11.3%)	0 (0%)	1 (4.2%)
Graduated	1 (1.9%)	0 (0%)	0 (0%)
Prison	2 (3.8%)	0 (0%)	0 (0%)

Table 15: Programme Engagement at 24 Months

	The Lodge	Ashleigh House	DFDP
Participants (% of baseline)	52 (69.3%)	30 (78.9%)	18 (58.1%)
Engagement			
Engaged	0 (0.0%)	0 (0.0%)	0 (0.0%)
Early Discharge	15 (28.8%)	5 (16.7%)	1 (5.6%)
Self-Discharge	11 (21.2%)	16 (53.3%)	8(44.4%)
Re-engaged	4 (7.7%)	1 (3.3%)	0 (0%)
Graduated	19 (36.5%)	8 (26.7%)	9 (50.0%)
Prison	3 (5.8%)	0 (0%)	0 (0%)

month mark, approximately two thirds of the residential clients were engaged, as were half of the day programme clients. Of those who were no longer engaged at six months, Ashleigh House and DFDP had higher levels of self-discharge (31.3% and 41.7% respectively) than the Lodge (5.7%). However, the Lodge had a notably higher percentage of early discharge due to violation of protocol (11.3%).

In Table 15, the total programme completion rate for the quantitative sample in all three programmes is presented. Ashleigh House had the lowest graduation rate at 26.7% (n=8). The Lodge had a graduation rate of 36.5% (n=19) and the DFDP had a graduation rate of 50.0% (n=9). Over half of the original cohort of women from Ashleigh House self-discharged (53.3%, n=16), as did 44.4% (n=8) of DFDP clients. Self-discharge was notably lower among male residential clients in the Lodge (21.2%, n=11) but discharge due to violation of protocol was the highest among this group (28.8%, n=15).

As with pathways into and through treatment, stories of early discharge were diverse and each client's exit from CTC occurred amidst a distinctive set of circumstances. Personal discharge narratives were at times contradictory and inevitably one-sided. However, it is important to understand how clients interpret and understand their exit from treatment and the ways in which their treatment experience and individual characteristics played into this decision.

Roger entered the Lodge on a suspended court sentence. He felt pressure to comply with the terms of his probation and his decision to enter CTC was therefore incentivised; in his own words, treatment "seemed a little better than where I was at". However, Roger found it difficult to settle in during the days and weeks post-admission. Relating to his peers was particularly problematic and he described the structure and routine as "exhausting".

I was really deeply, deeply depressed and

[21]The numbers in these tables present data on clients we were able to track. It is most likely that untrackable clients also discharged from CTC early, though we do not have information on the nature of those exits.

what I found was you go there straight to an environment that's very kinda – congested and compressed and, er, it's a very long day, you know what I mean? You are on the go, you are on your feet all day and I became exhausted.
Roger, 48, Lodge, Wave 4

As highlighted previously, engagement with the community and the therapeutic process predict programme completion and retention (Joe et al., 1999; Simpson & Joe, 2004). Roger's alienation and lack of engagement at the Lodge grew deeper as time progressed.

Well I tell you, you see people come in [to CTC] and they take to it like a duck takes to water – and I didn't. I don't see myself as stupid, I just think -it's not easy.
Roger, 46, Lodge, Wave 2

When it came time to complete his life story exercise – a mandatory requirement of the programme where clients relay their personal narrative to their peers – Roger felt that he "wouldn't have been able to get through it". At this point he was told that he the exercise was not optional and, if not completed, he would have to leave the programme. It was at this point that Roger opted to leave.

...it's them saying after five months, well if you're not doing your life story, you are going. And that's what I mean. I was glad to go.
Roger, 48, Lodge, Wave 4

Joseph had also entered the Lodge on a suspended sentence and admitted that he entered treatment solely to escape incarceration. However, following his entry to CTC, he began to view treatment as an opportunity to set and achieve other goals.

Well, at the start it was to cop out of my sentence, when I first put in for it I had 9 months left and I felt, "Sure why not?", but eh, as I got clean again properly, I made the decision that I wanted to better myself and knew I needed help, as regards get clean, stay clean and focus on me kids.
Joseph, 29, Lodge, Wave 1

For Joseph, family was a priority and, during his first interview, he expressed concern that his partner would not be allowed to visit him because she was on a methadone maintenance programme. This would in turn impact on his level of contact with his children.

But if they won't let her (partner) up then I have no one to bring the kids up and I don't think that would be fair on the kids. I couldn't see myself staying ... that would be the only thing that would make me leave Coolmine.
Joseph, 29, Lodge, Wave 1

In the months following Joseph's first interview, the grandmother of his partner died and he began taking additional nights away from the Lodge to provide support and child care. He was subsequently discharged for this violation of protocol and felt that he had been unfairly treated.

The unfortunate thing was I had to leave on unfortunate circumstances. Me partner's nanny passed away and I had to take extra overnights and I was being punished for that ... I was being clean and I was being punished ... that should be changed, you know what I mean?
Joseph, 30, Lodge, Wave 2

Joseph felt pressure to choose between his family and his treatment and regretted that he had not had the opportunity to complete the programme.

I was disappointed with myself that I didn't complete it, to be quite honest with you like. Of course my partner wasn't happy either, she was disappointed because I was disappointed and didn't get to finish what I did, do you know what I mean? But that was that.
Joseph, 30, Lodge, Wave 2

Mags also entered Ashleigh House on a suspended prison sentence and was further incentivised to engage with the treatment process by external pressure, including housing instability and outstanding financial debts. During Phase 1, she relapsed once and subsequently relapsed twice during Phase 2 of the programme. She described her first relapse episode, for which she received a written warning:

> *I suppose I was in the middle of the programme and I was there about three months and I just didn't feel great in myself, I didn't want to be there anymore and I was arguing with a lot of the girls in the house [...] I dunno, I just walked in on Monday and I knew I wanted to use and so I had that and it was my first slip.*
> **Mags, 24, AH, Wave 2**

After completing her residential treatment at Ashleigh House, Mags moved into a transition house with other peers from CTC. At the outset of Phase 2, she relapsed again, explaining that the relapse was triggered by "being on the outside again and living without drink and drugs". After this second relapse, Mags stopped attending the CTC group meetings and counselling sessions. Within a short period of time, she discharged from CTC.

> *I wasn't getting that structure and I was getting very lonely in myself and isolated and that and I just ended up picking it up... I had another relapse again but like, I dunno I just didn't snap out of it this time.*
> **Mags, 24, AH, Wave 3**

Unlike Roger, Peter and Mags, JP had entered the Lodge voluntarily and with a high level of self-motivation. He had engaged with CTC ten years earlier for 12 months and, afterwards, had remained abstinent for a period of one year before he started to drink and subsequently returned to heroin use. At the point of entering the Lodge, he was enthusiastic about becoming and remaining abstinent and settled into the structure of the community quite easily. However, he was discharged from the programme following a period of two months when it became apparent to staff members that he had become romantically involved with a female client at CTC.

> *I can understand – at the time I couldn't understand 'cause there were people who would drink while they were on the programme and use tablets while on the programme and they were kept and I remember sitting in the room with staff and the whole community and I said, 'Look, I need help with this. I really need to stay and to help me'. And I was called outside the room and I was told I was being kicked out and I felt that it was a bit unjust.*
> **JP, 31, Lodge, Wave 3**

As indicated in the above quote, JP felt that his discharge was unfair, particularly when compared with protocol-breaking behaviours of other clients in the Lodge. He relapsed immediately following discharge and explained during his Wave 3 interview (nearly one year after being discharged) that he had spent a number of months in what he described as a deep depression. He harboured feelings of anger and resentment towards Coolmine staff at that point and believed that his discharge was a result of personality differences rather than protocol violation.

> *That whole situation of being discharged, I find it hard to let go of that. You know, I think they need to change their policies about how they make the decision and who makes the decision. I think the way I see it is when I saw that I wasn't coming back, the decision was left with the manager of the Lodge at the time and me and the manager of the Lodge didn't get along. Now maybe I might be wrong, but it just seemed like he was having the last say. He didn't give me the option of going back where as if it had been a group decision with all of the staff members, maybe I woulda been brought back. But*

then who's to say that it wasn't a group decision? I just see it that way because I didn't get on with him and this that and the other.
JP, 31, Lodge, Wave 3

JP subsequently entered into another residential treatment programme and later returned to Coolmine to participate in the Day Programme, feeling that he needed support with "living life in the real world".

I needed to still work on meself on a daily basis. I needed a day programme and living life in the real world. And if something comes up for me in the real world at night time or whatever, I have a community. I like that... So yeah. I knew that Coolmine – I knew what it had to offer me. And I saw certain staff members and that's why I came back.
JP, 31, Lodge-DFDP, Wave 3

At the time of his final interview, he had re-framed his discharge from CTC, believing it to have been a positive turning point in his recovery.

I think the best thing that happened to me was they said, 'Listen, I think you should try somewhere else', 'cause I did. I went to [other residential treatment setting] and I worked out me failure was the best thing that ever happened to me.
JP, 31, Lodge-DFDP, Wave 4

Not all clients who left the programme early, whether voluntarily or required, recounted the kinds of events or behaviours described above. Likewise, not all who discharged early reported negative experiences within CTC. Many of the early dischargers in fact spoke positively about their time at CTC and their accounts suggest that they had actively engaged with the programme, sometimes for over a year, prior to self-discharging for personal reasons or being asked to leave following a violation of protocol. For example, Sam had attended the Day Programme but was discharged because he had attended events where alcohol was available. Despite his early discharge, he remained positive about his experience of treatment at CTC.

I found Coolmine good, the staff are in a good place. They've a lot of experience dealing with people and I know that when they were pointing stuff out to me they were coming from a very good place. I just found it hard to change certain things I was doing at the weekend. So I could see their point of view and I would have loved to finished the two months and graduate. It's something I would have liked to do because they did help me immensely when I was there.
Sam, 36, DFDP, Wave 4

Similarly Travis, who self-discharged from the Day Programme, was not critical of CTC but left because he felt that the Day Programme did not meet his needs. He found it difficult to reconcile the intensity and stress of group work and the freedom of the outside world.

I hold nothing against this place (CTC), it's brilliant. I know loads of people that are after been through it, they swear by it. I know other people that never gave it a chance and they're back using. It works for some it doesn't for others. I know personally that it wouldn't work for me because I found the groups as, I found myself a wee bit too opening up and then going home [doesn't finish sentence]... Groups would be okay, you know, in the main place, you know, where you stay there ... it opened up a hell of a lot but I couldn't, I dealt with it the way I used to deal with it, I turned and ran.
Travis, 35, DFDP, Wave 4

Early discharge, whilst an undesirable outcome, did not always indicated a relapse or a return to drug use for former clients. This is strongly reinforced in both the quantitative and qualitative data. Table 16 documents the drug and alcohol free status of the quantitative sample over course of the study.

As the table 16 shows, substance free status of clients who were engaged in treatment or

graduated from treatment was the highest throughout the study. However, these data indicate that discharge, whether mandated or by choice, did not necessarily lead to a return to drug and/or alcohol use. Particularly among self-dischargers, clients maintained relatively high levels of abstinence. At the two year follow-up, over half of the self-dischargers (54.3%, n=19) were drug and alcohol free and an additional 12.4% were using alcohol only. While these figures are lower than those recorded among those individuals who completed the programme (72.2%, n=26 of whom remained abstinent), they indicate that many clients maintained a regime of abstinence despite their disengagement with CTC.

CONCLUSION

The findings presented in this chapter demonstrate the various ways in which clients engage, or disengage with the treatment process. For all clients, the ability or willingness to remain in CTC was influenced by individual-level circumstances and characteristics, as well as treatment-level elements.

The three different CTC treatment programmes inevitably provide three separate environmental treatment contexts. Within all three programmes, there were elements of difference and sameness. Early days of treatment were marked by feelings of anxiety for all clients (Neale et al., 2012). In the residential centres, people 'settled into' the community at different rates, and with varying levels of ease. Gender was a prominent feature in the treatment experience. Among male clients in the Lodge, there appeared to be a high level of social cohesion and satisfaction with the community. The hierarchical authority structure was well-received by most, and male clients were typically positive, or at least tolerant, when discussing their peers (Ezzell, 2012). Female clients, specifically those in the residential programme, were more likely to have a difficult time engaging with the treatment community. Women were more likely to describe the structure as unorganized, their peers as disengaged or unsupportive, the group sessions as ineffectual or in extreme cases, detrimental. Women with children in this sample felt particularly disconnected from their peers in the residential centre and also struggled with deep feelings of guilt with regards to their parenting (Kruk & Sandberg, 2013; Tuchman, 2010; Neale et al, 2014). The extent to which these inconsistencies in treatment experience are related primarily to individual gender differences, or to discrepancies between the treatment programmes themselves (the Lodge and Ashleigh House) cannot be determined.

On the whole, staff members were well-liked and respected. Clients could particularly relate to staff with a personal history with drug or alcohol dependence, mainly those who had been through through CTC themselves (Gueta & Addad, 2015; Vanderplasschen, 2014). This status 'validated' the staff members and legitimised their input and feedback. The transition from residential treatment to 'Phase 2' was marked

Table 16: Drug and Alcohol Free Status over time by Engagement Group

	Baseline 144 (100%)	6 Month 109 (75.0%)	12 Month 110 (76.4%)	18 Month 103 (71.5%)	24 Month 111 (77.1%)
Engagement					
Engaged	144 (100.0%)	61 (89.7%)	19 (76%)	1 (50%)	N/A
Early Discharge		3 (37.5%)	10 (41.7%)	7 (35%)	7 (33.3%)
Self-Discharge		13 (56.5%)	22 (62.9%)	21 (60%)	19 (54.3%)
Re-engaged		5 (71.4%)	6 (85.7%)	3 (50%)	4 (80%)
Graduated		1 (100%)	14 (82.4%)	22 (57.9%)	26 (72.2%)
Prison		N/A	N/A	N/A	N/A

by mixed emotions for all clients (Gueta & Addad, 2015; Soyez & Broekaert, 2003; DeLeon, 2000). Most believed they were well-equipped to exit residential treatment but felt abandoned on some level by the lack of formal supports upon transitioning. Relapse at this time was quite frequent among clients and their peers.

At the individual level, clients who demonstrated high levels of personal motivation at treatment entry were more able to stay dedicated and optimistic throughout the treatment process. These clients drew upon elements of the treatment process to further their internal 'work' and framed their recovery as something proactive, on-going, and demanding of personal attention and commitment. They accepted personal responsibility for their levels of engagement with the process. For incentivised clients, conversely, feelings of pressure, or being 'trapped' in treatment persisted and resulted in early discharge from the programme for all four 'incentivised' entries (Ravndal & Vaglum, 1994; Sheehan & Burns, 2011; Urbanowski, 2010). Clients who discharged early from the programme faced a number of personal and treatment-level barriers including feelings of 'non-belonging' in the community, external family pressures to exit treatment, and violations of CTC's established protocol. Among those with mandated discharge due to protocol violation, clients typically maintained positive sentiments towards the treatment process and staff, combined with feelings of unfairness, disappointment, or resentment surrounding the discharge circumstances. On the whole, programme non-completion was not synonymous with relapse, nor was it a predictor of a return to using. Over half of the clients who self-discharged reported maintaining an abstinent lifestyle.

The following chapter explores life after CTC for participants who completed the programme, and also among some of those who discharged early. The qualitative data, in particular, demonstrates the ways in which former CTC clients rely upon the tools they learned and the community they established while in treatment to maintain abstinence post-treatment.

CHAPTER 5
LIFE AFTER TREATMENT

Due to the longitudinal nature of this study, we were able to gather information not only on participants' pathways into and through CTC programmes but also on their life after leaving treatment. Table 17 presents the final programme engagement and retention figures for the quantitative sample once again, to provide an overview of patterns before examining life post-treatment in-depth.

Participant retention, on the whole, was strong with a 77.1% (n=111) of the original sample participating in the final follow up survey at 24 months. Over one third graduated from the programme, another 35.1% (n=39) self-discharged, and 21.6% (n=24) were discharged due to violation of protocol. This creates a total discharge rate of 56.7%. A small number of participants re-engaged with the programme (4.5%, n=5) and another 2.7% (n=3) returned to prison. No data exists for those 'untraceable' clients who did not participate in follow-up data collection waves.

As discussed in Chapter 4, treatment experiences varied considerably according to gender. Table 18 presents clients' substance use status at the point of entry and at one and two years, respectively, for male and female participants. For both males and females, there was a peak in self-reported drug-free status at the one-year mark. 72.2% (n=26) of the females and 60.8% (n=45) of the males surveyed were drug-free at this juncture. By the two-year mark, however, there was an evident decline in drug-free status among females. The final percentages of drug-free clients were in fact similar to those recorded at baseline. A total of 51.2% (n=21) of females and 62.9% (n=44) of males reported that they were drug-free at the final 24-month follow up survey.

These findings must, however, be interpreted with caution. Firstly, there was a drop in retention over the course of the study and no information was available on the substance use/ abstinence status of those who opted out of the project. Secondly, while 'substance-

Table 17: Participant Retention and Engagement in the Quantitative Study

	Baseline	6 Month	12 Month	18 Month	24 Month
Participants (% of baseline)	144 (100%)	109 (75.7%)	110 (76.4%)	103 (71.5%)	111 (77.1%)
Engagement					
Engaged	144 (100.0%)	68 (62.4%)	25 (22.7%)	2 (1.9%)	0 (0.0%)
Early Discharge		8 (7.3%)	24 (21.8%)	20 (19.4%)	24 (21.6%)
Self-Discharge		23 (21.1%)	35 (31.8%)	35 (34.0%)	39 (35.1%)
Re-engaged		7 (6.4%)	7 (6.4%)	6 (5.8%)	5 (4.5%)
Graduated		1 (0.9%)	17 (15.5%)	38 (36.9%)	40 (36.0%)
Prison		2 (1.8%)	2 (1.8%)	2 (1.9%)	3 (2.7%)

Table 18: Substance Use over Two Year Period, by Gender

	MALES			FEMALES		
	Baseline (n=99)	12 Months (n=74)	24 Months (n=70)	Baseline (n=45)	12 Months (n=36)	24 Months (n=41)
Substance Free	59 (59.6%)	45 (60.8%)	44 (62.9%)	23 (51.1%)	26 (72.2%)	21 (51.2%)
Illicit Drug Use	34 (34.3%)	23 (31.1%)	16 (22.9%)	19 (42.2%)	8 (22.2%)	15 (36.6%)
Alcohol Use Only	6 (6.1%)	6 (8.1%)	10 (14.3%)	3 (6.7%)	2 (5.6%)	5 (12.2%)

Table 19: Substance Use among Qualitative Participants

	Lodge Clients	AH Clients	DFDP Clients	All
Illicit Drug-Free (including those who reportedly used alcohol socially)	4	5	8	17
Return to drug use	4	2	1	7

free' percentages for baseline and final surveys are very similar, the illicit drug use rates were notably lower for both genders while the use of alcohol-only increased. The limitations of the quantitative data (i.e. data available only according to these raw categorisations) means that more detailed information on the nature of alcohol use among clients was not available and neither is it possible to speculate on the drug use status of those clients who were not retained in the study. However, the qualitative data enables a more detailed exploration of life after treatment. Table 19 presents life after treatment for the qualitative participants. The status of four participants who participated in the qualitative component of the study is not reported in Table 19. One participant from the Lodge was incarcerated at the 24-month mark and another participant was deceased. It was not possible to track two additional clients, one from Ashleigh House and one from the Day Programme, and no information was available on their substance use status. While information was available on 24 participants at the two year mark, only 20 were re-interviewed; the remaining four opted out of the qualitative study for personal reasons prior to the conduct of the final interview.

The remainder of the chapter focuses primarily on clients maintaining an illict-drug-free lifestyle, with a short description of those who returned to drug use. The analysis pays particular attention to the tools that participants rely upon to sustain abstinence and circumstantial factors that may influence a return to using.

MAINTAINING A DRUG-FREE LIFESTYLE

A significant proportion of clients (72.1% of the study's quantitative participants) were reportedly maintaining a drug-free lifestyle (i.e. not using illicit drugs) at the point when the final survey was administered. This was true for the majority of those who completed treatment (85%, n=34)[22] but also for some clients who discharged early (61.9%, n=39).[23] Throughout their time in the therapeutic community, participants struggled to adjust to new routines and structures. This remained true after engagement with CTC, as clients worked to settle into what they frequently framed as a 'normal life' without depending on illicit drugs.

Routine and Housing

At the time of exiting treatment, many felt prepared. Those who completed the programme had spent at least one year engaging in recovery activities and the structure, routine, supports, and lifestyle had become normalised. While most were eager to move on, some felt that they had to readjust their thinking and behaviours in order to move out of 'treatment' mode. Kevin described this experience as a process of 'de-programming'.

> *I felt I needed to de-programme myself from Coolmine, even the language – there's a different language in Coolmine and I felt that I was only hanging around Coolmine people because they only understood what I was saying and it was not until a month or two ago that when I started to back away a little bit that I felt me language even, the way I speak, even coming back to the way it was, you know.*
> **Kevin, 37, Lodge, Wave 3**

Similarly, Gemma, who had completed the Day Programme having spent four months in

[22] 34 out of 40 who graduated.
[23] 39 out of 63 who self-discharged or discharged early.

another residential treatment centre, also struggled to detach herself from the recovery 'mind-set'.

> *It's like, when you get out of treatment, your whole life is more centred on recovery than it was with addiction. It's obsessive, it's repetitive, it's issues, it's behaviours, it's problems, its ahh you're gonna relapse! You're gonna relapse!*
> **Gemma, 22, DFDP, Wave 3**

Many voiced the need to step into a new space where treatment was no longer at the forefront of their daily activities. This was frequently expressed as desire for stable, routine, independent living. Having a permanent residence, taking care of one's chores, returning to education and/or work, and getting on with everyday life were all frequently referenced by participants as ultimate goals at the point of completing treatment.

> *I: So is there anything in particular that you are really looking forward to?*
> *R: I suppose going to college, buying a house, having a normal life, basically.*
> **Jane, 29, AH, Wave 1**

Post-treatment, many who remained drug free felt that these goals were within their reach, even if they initially struggled with the responsibilities that accompanied independent living. For example, a considerable number experienced stress and anxiety and difficulty with 'day to day' responsibilities such as cleaning the house, managing finances, taking care of children, commuting to and from work, and balancing a professional and personal life.

> *You can hide away from life for about ten years taking drugs and all, do you know what I mean? But then you have to then pay bills and pay rent and bring your kids, do you know?*
> **Jane, 32, AH, Wave 4**

Financial strain was by far the most frequently discussed day-to-day challenge for clients post-treatment.

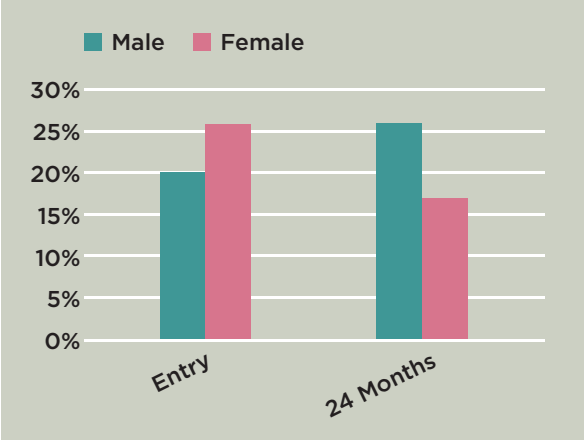
> *The one thing that's starting to bother me is money now. Because I have the freedom, I am still drug free and me life is going really well, so it's the only thing – like I am sort of getting to a stage where I am, er, breaking even every week.*
> **Mike, 34, DFDP, Wave 4**

> *I have money problems now... So it's getting to me. I am feeling the squeeze now.*
> **Philip, 44, Lodge, Wave 3**

Following treatment, clients reported varying levels of success with securing housing. Among the quantitative sample, 21.7% reported acute housing problems during the month prior to entering treatment and this figure had increased to 22.8% at the 24-month follow up. This increase in reported housing difficulties may be related to the fact that many clients in the baseline sample had been engaged in CTC or another formal treatment service prior to the initial survey, meaning that it is unlikely that they were experiencing housing difficulties during that time. However, in the years since the administration of the baseline survey, the rental market in Dublin has grown increasingly competitive and difficult to navigate (Kitchin, Hearne, O'Callaghan, 2015). Figure 5 presents a comparative graph of housing difficulties at intake and at 24 months according to gender. As shown, there was a gendered shift in those experiencing acute housing problems following engagement with CTC.

A large number of former clients relied on housing services for assistance and support with securing housing and many did find clean, safe, and comfortable places to reside. For others, however, the experience was challenging and far more precarious. Paul described a lengthy and unpredictable process of securing housing.

Figure 5: Housing at Entry and at 24-Months, Presented by Gender



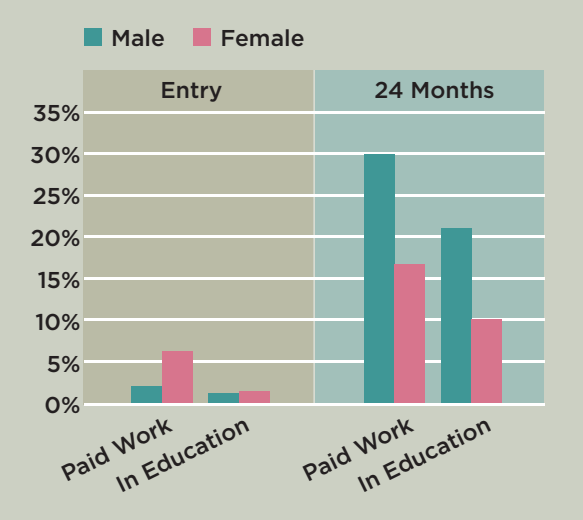
I had to go into the homeless services [specific service] so I went into them. So I went into the recovery house, then I went to [location] were I got a 6 month lease, then I got a 5 month lease, which is another 11 months like and usually then the person has their accommodation. But it didn't work out like that for me. They [accommodation services] gave me extensions and they worked with me like. You know, I kept putting in for Garda clearances like, and so I went over and got an avadavat for my son and all, like a court order saying I have access to him every weekend and they were trying to put me in private rented but it wouldn't have suited me, because I probably would have ended up in a bedsit. Eventually, things start to work out...
Paul, 36, DFDP, Wave 4

John, age 30, also struggled to find permanent housing and attributed his difficulties to his prior history of homelessness, incarceration and addiction.

I'm on the homeless list all me life now cause I went through State care and I've been homeless since I came out at the age of 18. But because I've been in and out of jail and treatment centres, I haven't been going into the place. You have to go in and get the thing stamped and show them that you're still around. So every time I've been away, I've been took off the list and every time I go back on, I start at the bottom again. So by right, I should have my own place years ago cause active addiction and all that comes with it. Up and down, up and down the list.
John, 30, Lodge, Wave 4

Employment & education

Figure 6: Employment and Education at Entry and 24-Months, Presented by Gender



Those who maintained a drug-free lifestyle were markedly more active in their attempts to re-engage with education and the labour market. At baseline, only 3.5% (n=4) of survey participants were engaged in paid work and just 1.4% (n=2) were enrolled in an educational programme. At the two year follow-up, however, 25% (n=28) were employed and an additional 17% (n=18) had returned to education. Figure 6 presents engagement in employment and education at intake and at 24 months arranged by gender. As demonstrated in the figure, male clients were more likely to be formally engaged in paid work and education than their female counter-parts.

The need to 'ease' into employment and the world of work was highlighted by several of the qualitative participants. Maintaining abstinence was viewed as the most

immediate and important goal and, for this reason, a considerable number expressed a preference for employment that was not overly demanding or stress-inducing. Several male participants had found work within an addiction treatment service: a number worked with CTC through a CE scheme, while others took employment positions in Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). These participants felt that the benefits of employment were two-fold; they were working and earning money whilst simultaneously remaining connected with the larger community and their own history of addiction. Mike described the benefits of working with recovery service.

It's all part of, what keeps you sort of clued in and all is the giving back end of it. And you see people who are still using and you tell them how to do it and that type of stuff and that keeps you linked in...
Mike, 32, DFDP, Wave 4,

However, many others were unable to secure employment and this invariably became a source of frustration over time. Travis emphasised his inability to find work during each consecutive follow up interview, growing increasingly discouraged as the months went by.

See that's the main thing as well, I worked me whole life, I was cutting grass and paper rounds when I was nine, ten years of age, and I worked up 'till I went to treatment ... And now I've NOTHING and it is so hard, it really is.
Travis, 31, Wave DFDP, Wave 2

Ah it's been up and down as well but that's me. Looking for work, so many interviews and it starts taking its toll after a few ... After a few [interviews] you kind of start going, 'Is there any fucking point?'
Travis, 31, DFDP, Wave 3

Ah yeah, that's [unemployment] the main thing that is getting me fucking down. It's not only the money side of it, it's getting out in the morning, having somewhere to go. I'd work for the same money I'm on now, you know, the dole money, if they gave me a job fucking sweeping the roads an all, I'd go out and do that for me dole money.
Travis, 32, DFDP, Wave 4

For Travis, the lack of structure and activity was as detrimental as the lack of financial stability. He was not alone in expressing frustration and disillusionment in relation to his failed attempts to secure work. Several others, particularly those who had no formal education or employment history and/or a criminal record, were unable to find stable work.

I answered ads in the paper and stuff like that but I had no qualifications like, do you know what I mean? So straight away, I couldn't even get a bleedin' interview.
Peter, 31, Lodge, Wave 4

I think it was more down to my criminal record. I told her (employer she interviewed with) that I had no experience. I told her I did three weeks in my transition year in a shop. I wasn't gonna lie to her, you know what I mean?
Gemma, 22, DFDP, Wave 4

Difficulties experienced in securing a job due to lack of formal educational qualifications led many to consider returning to education and a number expressed an interest in pursuing a degree in addiction, counselling, or community services. Molly explained that she was interested in this kind of work because of her own encounters with services throughout the course of her life.

I'm really happy that I'm going to community development as well cause I'm mindful of a lot of services and a lot of places and where to go if I need to find what would help with me. And I know I've helped a lot of people that I know – even not with addiction – even with mental health issues or childcare issues or – I've

sorted needed every, nearly everything at one stage.
Molly, 22, AH, Wave 3

Indeed, the presence of recovering drug users among CTC staff served as a source of inspiration for many clients. They believed that they had gained valuable knowledge through the experience of treatment and recovery and could help others in similar circumstances.

Formal supports, Informal supports, and Family

Many clients continued to engage with some type of recovery-oriented formal support systems, including Narcotics Anonymous (NA), Alcoholics Anonymous (AA), housing services, key working services, and recovery day programmes. However, as participants accrued more 'sober time', their reliance on formal supports typically diminished; although several continued to draw upon formal supports as they worked towards maintaining abstinence. Some of the most frequently accessed formal supports were NA and AA. Male participants, in particular, spoke of the value of NA meetings and some attended on a regular basis.

I don't think I would be able to manage my life without those meetings.
Peter, 44, Lodge, Wave 3

Regular attendance at meetings such as NA and AA provided a number of men with a continued sense of community and a safe environment where they could share their experiences and struggles with people who had understood and could empathise with them. Indeed for some, this functioned as a family.

But people used to say to me – like, who do you have for you? I wouldn't have any of me family. But I have a fellowship. And I have my key worker here and counselling session and friends. So I look to the fellowship as a bigger family. I use the fellowship more than I can use my family. They're my family.
JP, 31, Lodge, Wave 3

Female participants, on the other hand, were far less likely to engage in formal recovery-oriented support and none of the females interviewed were attending NA or AA meetings at the time of their final interview. Many, however, did remain engaged in aftercare programmes either through CTC or another treatment service.

Despite maintaining abstinence and a widely articulated appreciation for CTC and the community, many participants began to express fatigue with the treatment process during later interviews. This theme began to emerge from the third interviews and was more apparent during the final interviews. Some expressed desire to move on from treatment or recovery contexts, finding recovery-oriented activities repetitive after some time.

Yeah it just doesn't suit me, I just don't like it [group meetings]. Don't want to go there and talk about drugs all the time. I want to forget about it and move on.
Sarah, 33, AH, Wave 4

I don't really go to meetings anymore, I'm tired of beating that drum, you know?
Daniel, 35, DFDP, Wave 3

For others, life post-treatment was busy and they no longer felt a need for constant support to maintain recovery. These participants had typically returned to work or education and were otherwise engrossed in re-building family relationships and/or caring for their children.

I just do be so busy and everyone says it's an excuse or whatever but by the time 6 or 7 o'clock in the evening comes around I want to put my child to bed and sit down and watch television, do you know what I mean? I don't want to be going out to meetings or anything like that so … that's why I don't go, and it's OK at the

moment, do you know?
Jane, 31, AH, Wave 3

Support from family members and friends was important for all clients as they worked to stay abstinent and re-build lives. All participants who remained drug free reported improved family relationship. Among quantitative participants, those who were in contact with family increased from 97.8% at baseline to 100% at the two year follow up.

Many participants had entered treatment with very strained family relationships. Jane, for example, reported little to no contact with her mother during her Wave 1 interview. However, by Wave 4, this relationship had notably strengthened.

Oh, it's definitely a lot better now. She still drives me mad like, but she's a mother, I think she's supposed to do that like! But, yeah, I definitely get on an awful lot better with her. I get on better with my sister, too, and all that kind of stuff.
Jane, 32, AH, Wave 4

For female participants who were caring for their children, the processes of re-establishing a routine and developing a stronger mother-child relationship was a complex process. Establishing bonds with their children and acting as a responsible parent were sources of fulfilment, joy, and self-esteem. However, many expressed open trepidations about the day-to-day challenges of being a caregiver.

Hard. Very, extremely hard. I never dealt with that responsibility (caring for children) before. When I first went to Coolmine she (daughter) would have stayed with me ma, never mind social workers but my ma, that was our agreement because I couldn't even look after myself never mind her. But now I look after her, she is my responsibility now it's good in a way but sometimes it's hard and I do sometimes struggle with it. But it's a learning experience and if I didn't do something right today then I can always do it better tomorrow.
Ashley, 30, AH, Wave 3

The 'double-edged' nature of motherhood was widely discussed. Most women with children described a difficult period post-treatment when they were adjusting to the daily routines of motherhood. Yet, the rewards of parenting were strongly apparent in their accounts as several transitioned to caring for and spending time with their children for the first time.

I don't want him (son) to be in full-time crèche yet. I want him to be with me because I didn't give him much time before I went into Coolmine. It was kinda a strained relationship so it's kinda nicer to spend time with him now. Now that I'm a bit more able to cope with him. Sort of build up a bond before he goes off to school and I have me own free time.
Molly, 21, AH, Wave 2

Furthermore, women frequently identified their children and their emerging role as 'mother' as central aspects of their sober lives. Women, more often than men, cited this role as a fundamental driver in maintaining abstinence.

I'm enjoying the experience of motherhood again because, even though I have a 13- year-old, I didn't experience motherhood like other people would because I was a drug addict and my life revolved around that, you know? So I am enjoying being a mammy at the moment. It's keeping me going.
Jane, 32, AH, Wave 4

Men and women were both eager to rebuild relationships with their children following treatment. Many of the male participants, in particular, had not been actively involved in the lives of their children for years prior. Of those who attempted to reconnect, they experienced varying levels of success. JP had two children, one of whom he hadn't seen in seven years prior to entering treatment. In his

first interview, he describes his reluctance to initiate contact with his daughter.

> *She (daughter) hasn't met me in 7 years so I don't, I don't want to force too much on her. She accepts presents and cards and she knows I'm here but it's just, it's just a wait until she's ready to approach me. You know, she's still in school. I don't want to mess with her head.*
> **JP, 30, Lodge, Wave 1**

By the time of his final interview, JP was caring for both of his children on the weekends and building a healthy relationship with them was his main priority.

> *I met me daughter in the Lodge when I was in Coolmine and I hadn't seen her for 7 years. And I got back in touch with her through the Lodge ... Since then, me and her mother have been getting along well and, as I said, I get her every weekend and I bring her swimming every weekend with my son. And we're building up the bond. It's getting strong and stronger.*
> **JP, 32, Lodge-DFDP, Wave 4**

Physical and mental health

Those participants who remained drug free reported that their physical and mental health had improved while in treatment, even if many experienced on-going physical and mental health issues. Tables 20 and 21 present the average scores for physical and mental health for the study's quantitative participants over the two-year period according to gender. The scores peaked after the initial six months of treatment for both men and women and at 12 and 24 months the scores demonstrate a small but notable drop. Women entered treatment with lower overall scores for physical health, mental health, and quality of life. However, their scores remained higher than men at the final two year follow-up survey, suggesting a substantial improvement overall.

These quantitative findings were mirrored in interview participants' accounts of their physical and mental health over the course of the study. While many reported ongoing physical and mental health problems, including in some cases serious and chronic co-morbidities such as HIV and Hepatitis C, most who remained drug free stated during their final interview that their health was markedly better than prior to entering treatment. Mental health was often presented as something that had to be actively maintained through behavioural measures such as attending meetings, and adhering to a structured daily routine.

Female participants were more likely to discuss mental health problems explicitly

Table 20: Women's Health and Well-Being through the Life of the Project

	Baseline	6 Month	12 Month	24 Month
Quality of Life (Scale 0-20)	10.29	15.78	14.06	13.36
Psychological Health (Scale 0-20)	9.60	14.29	13.22	12.97
Physical Health (Scale 0-20)	10.28	14.45	13.69	13.05

Table 21: Men's Health and Well-Being through the Life of the Project

	Baseline	6 Month	12 Month	24 Month
Quality of Life (Scale 0-20)	11.62	15.36	13.82	13.91
Psychological Health (Scale 0-20)	11.43	15.24	13.28	13.18
Physical Health (Scale 0-20)	11.62	15.39	13.93	14.49

during interview. Many had been prescribed anti-depressants prior to entering treatment and three openly discussed a past suicide attempt(s). While most still struggled with mental health issues post-treatment, there was nonetheless a notable improvement in their overall psychological well-being. During her first interview three weeks after entering Ashleigh House, Aoife described her struggle with depression.

> *Well I'm on anti-depressants, I suffer from actual depression at the moment. Like before I was, I was always trying to kill myself and all like through my addiction because I just felt like that I couldn't cope … I couldn't cope with life and life's terms basically, you know what I mean? The first time I tried to commit suicide, I think [daughter] was 3 months old …*
> **Aoife, 37, Wave 1, AH**

By the time of her final interview, Aoife described her mental well-being as greatly improved.

> *Aw improved, definitely improved because I'm only on one anti-depressant so me medication has cut down … I've more good days than bad days, do you know what I mean, it's good. So that has improved greatly like.*
> **Aoife, 38, Wave 4, AH**

Like Aoife, Gemma had been medicated for depression and hospitalised following a suicide attempt. She entered the DFDP after completing a residential programme and felt more stable than she had in many years.

> *A year, year and a half ago, I was in a mental hospital. My mind was gone. I was depressed – well, not depressed but suicidal. My mind was gone. Up and down up and down. I feel now it's more balanced. Especially when I compare back, it's definitely more balanced. Eh, yeah. I'm very positive most of the time.*
> **Gemma, 22, Wave 2, DFDP**

All participants who had maintained a drug-free lifestyle ultimately acknowledged that their quality of life had improved dramatically since entering treatment. When they discussed the future, most aspired to having what they described as 'ordinary' or 'everyday' things such as family, a home, children, a pet, or the means to travel. Some were thinking about or planning to move abroad while others aimed to use their new sobriety to 'give back' to those who are struggling with addiction. The sense of hope extended beyond the material world to a more abstract, overarching sense of sanguinity that emerged from the narratives of drug-free participants.

> *Optimistic, I'm optimistic in that I'm kind of at the stage where I take each day as it comes and sit back and say, 'Right, things will happen as they are meant to happen, to be worrying about money, don't be worrying about this and don't be worrying about that, so just relax.*
> **Jane, 32, AH, Wave 4**

> *I look back now, and I just say 'Yeah, you were one of the lucky ones mate. Grab a hold of it and don't let go like'.*
> **Peter, 43, Lodge, Wave 3**

Gemma goes so far as to frame her heroin addiction as a positive experience, having helped her to become a more evolved version of herself.

> *I hate the stuff (heroin), you know. I do, I hate it. But at the same time, I have a bit of respect for it as well, you know that kinda way? Like eh, I'm glad … there's a lot of positives out of becoming a heroin addict. I was able to get help for everything that was going on in me life before heroin … And I wouldn't be where I am today, I wouldn't be the person I am today if it wasn't for all that. And because of all the therapy and all that, I like who I am today. So it's kinda – there's more positives to it.*
> **Gemma, 21, DFDP, Wave 3**

A RETURN TO DRUG USE

As discussed in some detail in Chapter 1, early discharge and relapse is a common occurrence among TC clients (Malivert et al., 2012). In the current study, over one-third of the participants in the quantitative sample returned to drug use. This figure is, in all likelihood, probably lower than the actual number of clients who returned to using, as it was not possible to track many other participants and their drug use status was therefore unknown. In the qualitative study, we were able to gather information on some who were not re-interviewed from family members, social workers, or other CTC clients who confirmed that they had returned to drug use. However, since we were unable to conduct interviews with these clients, the information that we have on those who relapsed is limited. Of the seven qualitative participants who resumed drug use, just four were re-interviewed during the final wave of data collection. Of the clients who were incentivised to enter into treatment, all exited treatment early and eventually returned to using. In their early interviews, these clients demonstrated lower levels of personal motivation and readiness to change than many of their peers. However, some clients who self-identified as highly motivated in the early interviews also returned to illicit drug use after exiting the programme early.

The under-representation of data on clients who returned to using prevents this report from providing an in-depth exploration of their situations, experiences, and lives post-treatment. Those who were interviewed were all active in heroin addiction, unemployed, and experiencing housing instability. Two of these clients expressed feelings of guilt, remorse, and shame over being drug dependent. Two of them felt that they had not been ready to become abstinent when they entered treatment and that their drug use now, after having gone through part of CTC's programme, was more 'manageable' than previously. All four participants expressed a desire to work towards abstinence in the future. However, they felt that they weren't personally ready to undertake that journey at that time.

CONCLUSION

Many participants in the current study went on to maintain a drug-free lifestyle following their treatment at Coolmine Therapeutic Community. This was true both of clients who graduated from the programme, and for those who discharged early due to personal circumstances or a violation of protocol. Maintaining a drug-free lifestyle was a source of immense satisfaction and confidence, but also presented many new challenges. 'Recovery' continued to be conceptualised by most as an on-going process, but clients were less likely to spend as much time actively engaged in recovery-specific activities (Neale et al., 2012). Instead, establishing a routine, relationship (re)building with family members and children, employment, and education were focal points for many. Day-to-day tasks such as maintaining a household, completing chores, and managing finances proved to be stressful for many, all the while clients continually re-emphasised their desire for a 'normal' life (Kruk & Sandberg, 2013). Obtaining safe and stable housing was difficult for many, as was securing employment without experience or formal qualifications. However, despite the large number of everyday hurdles, a strong sense of optimism for the future pervaded the final interviews among abstinent clients.

CHAPTER 6
SUMMARY AND KEY MESSAGES

As evidenced by the data presented in this report, no two pathways through Coolmine Therapeutic Community were the same. Each client came from their own setting, shaped by their unique relationship with drugs and/or alcohol and the contextual factors at play in their own lives. Decisions to enter treatment varied, as did the treatment options offered by CTC. Once linked in with CTC, some clients stayed engaged for the remainder of the programme while others discharged early, either by their own accord or as a result of a violation of protocol. Some clients remained drug free; others relapsed and then eventually re-engaged with CTC. Unfortunately, some returned to active addiction. The pathways through treatment were not always straight, nor steady.

This final chapter discusses the key findings to emerge from this mixed-methods longitudinal study of CTC clients which was conducted between 2011 and 2013. As outlined in Chapter 2, the study's primary aim was to 'track' clients' pathways into and through treatment. The quantitative component of the research aimed to produce descriptive data on clients' engagement with the programme, their substance use, social well-being, and physical and mental health outcomes over time. The qualitative component aimed to explore the processes and contextual factors that influenced clients' trajectories through CTC and their experiences of treatment. This mixed-method, longitudinal design enabled an examination of overall trends as well as an in-depth exploration of individual experiences among CTC clients.

This report has documented clients' pathways to treatment and their 'journeys' through and out of treatment. As such, this study is unable to provide a comprehensive picture of the clients' lives, their histories of drug use, nor their future trajectories. More importantly, it does not claim to paint a representative picture of drug use and drug treatment in Ireland. Rather, it focuses on gaining a better understanding of clients' subjective experiences with CTC and some of the facilitators or barriers they encountered along their recovery pathway.

This chapter begins by summarising the key descriptive quantitative data and then moves on to review the key findings from the qualitative data, emphasizing the importance of a sense of personal motivation and the differences that emerged along the lines of treatment programme and gender. It ends by producing 'key messages' for CTC and similar therapeutic communities with regards to programme elements and implementation. It is probable that these recommendations could be applied to other therapeutic communities and drug treatment programmes both in Ireland and abroad.

SUMMARY OF QUANTITATIVE OUTCOMES

The current body of research aimed to explore clients' pathways into and through CTC. However, it also set out to compare outcomes of CTC clients with those reported in the ROSIE study of drug treatment outcomes in Ireland. While the findings from the current study cannot be compared directly to those of ROSIE due to reliance on different quantitative outcome measures, an overview of the key quantitative findings are summarised in this section and a descriptive table of all quantitative outcome data is included in the appendices. This will place the current findings in context and allow for future researchers and practitioners to build upon the outcomes of this longitudinal study.

The current research found an improvement in outcomes in all areas over the two year longitudinal study. The total number of clients who were free from illicit drugs in the 30 days prior to survey administration rose from 56.9% at the baseline to 72.1% (n=80) at two years. This implies that CTC's relapse rate (27.9%) is relatively low, as compared with TC rates recently reported in a systematic review (25-55%) (Vanderplasshen et al., 2013). Clients who remained engaged with their CTC programme through to completion reported significantly lower relapse rates than those

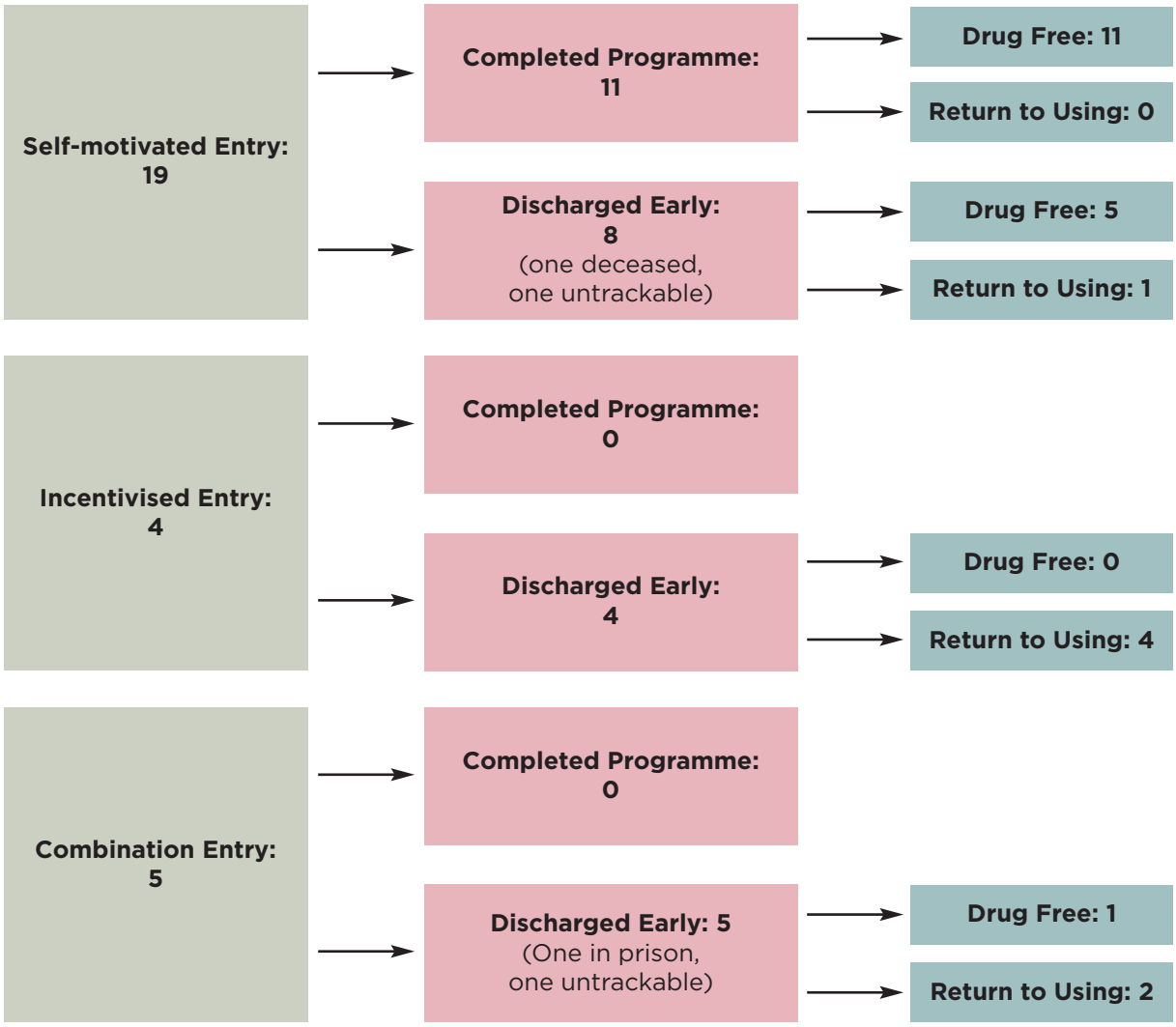
who discharged early (DeLeon et al., 2000b; Nielsen et al., 1996; McCusker et al., 1996; Malivert et al., 2012). The total percentage of clients who reported injecting behaviour in the previous 30 days fell from over the two year period. Self-reported health measures improved significantly with regards to physical health, psychological health, and quality of life (Guydish et al., 1999; Martin et al., 1995; Comiskey et al., 2009). The total number of individuals engaged in the labour force increased 21.5% from 3.5% at baseline to 25% at the two year mark, while the number of participants engaged in some type of formal education increased from 1.4% to 17%.

Improvements were also observed in other areas of social functioning. On the whole and in line with international literature, there were improvements in all outcome areas including substance use, injecting behaviour, social functioning, crime, and health, reinforcing national and international findings on the benefits of the therapeutic community model for drug treatment (Comiskey et al., 2009; Malivert et al., 2012).

TREATMENT PATHWAYS

The quantitative data was supplemented by qualitative data, which focused on the routes into and through treatment, as well as on the

Figure 7: Pathways through Treatment for Qualitative Participants



processes within the treatment experience. A key element highlighted in the qualitative data was the ways in which a client's 'pathway' into treatment impacted on the remainder of her or his treatment experience. These pathways were not predetermined; rather, they were selected to describe various personal behaviours and attitudes that clients possessed as they initially came into contact with CTC and its services. Figure 7 contains a diagram demonstrating the various pathways into and through treatment taken by qualitative participants. Once engaged in a programme, clients either completed the programme or discharged early, through their own decision or due to a violation of protocol. After leaving CTC, some clients maintained a lifestyle free from illicit drugs, while others returned to active drug dependence. All of stages of the treatment process proved to be inter-connected, influenced by a number of individual-level and treatment-level circumstances.

While the numbers presented in Figure 7 are low and therefore not representative of the whole of CTC clients, nor generalizable to the study's sample, the figure is able to present a streamlined summary of the qualitative participants and their trajectories during their time engaged with CTC.

As the figure demonstrates, the majority of qualitative participants (n=19) were self-motivated to enter CTC. That is, to say, that they made the decision to enter treatment individually and autonomously. Those who were highly motivated often engaged following a 'critical moment' or a 'turning point' in their lives. This took different forms for different clients, ranging from a near-death experience of themselves or a loved one, an encounter with the law, a confrontation with their child, or a moment of clarity from which they could not turn away. Irrespective of the specific circumstances, the critical moment triggered something within the client, resulting in a shift of mind-set. This drove the client to experience an overwhelming 'desire to change'. They sought treatment because they felt motivated to become and maintain abstinence, often because they felt that their lives were unmanageable. Typically, these clients demonstrated a strong sense of agency in the decision making process. Of the self-motivated participants, 11 remained engaged in the programme through completion, all of who reported maintaining a drug-free lifestyle at the final interview. Eight of those who entered treatment voluntarily discharged early, either because of personal reasons or due to a violation of protocol. However, five of those eight continued to maintain a drug-free lifestyle at their final interview.

Conversely, four participants were classified as having been 'incentivised' to enter treatment following a negotiated suspended prison sentence. The distinguishable feature of these clients was not exclusively the external pressure to enter treatment (i.e. the court sanction) but rather their own personal narratives surrounding their entry (Wilde et al., 2012). These clients felt coerced into treatment, often seeing the process as the 'lesser of two evils'. They did not feel in control of their recovery, nor did they enter the programme with a sense of readiness to change. They reported feeling trapped, with the symbolic elements of treatment mirroring that of prison. All four of these clients discharged early and all four had returned to using by the final interview.

Clients who were classified as 'combination entries' (n=5) were personally self-motivated to achieve abstinence but also faced tangible external pressures to comply with treatment (i.e. from the legal system, child protection, family members). They expressed elements of both of the aforementioned entry pathways in their narratives and their journeys through treatment reflected both self-motivation and perceived external benefits. Internal dialogues and negotiations surrounding the challenges and benefits of treatment, coupled with self-evaluations of personal motivating factors, were commonplace. However, 'combination entry' clients were typically less confident

regarding their ability to achieve long-term abstinence than their 'self-motivated' counterparts. Indeed, when examining the long-term outcomes for the qualitative participants, most had returned to drug use or were untraceable at the final data collection wave.[24]

Overall, while these 'pathways' into treatment are helpful in the understanding, processing, and classifying of clients' recovery routes, it is important to note their limitations. For one, the pathways should not be conceptualised as mutually exclusive, 'black and white' routes into treatment. In reality, most clients possess degrees of both self-motivation and perceived external pressure (Wolfe et al., 2013). However, the qualitative data from this study was able to produce sufficient evidence to allow for the broad categorisation of individuals based on their self-expressed reasons for entering into CTC. Indeed, the circumstances surrounding an individual's entry into treatment seemed to play a noteworthy role in their treatment process and in that sense, these classifications proved helpful in the analysis of the qualitative data.

THE IMPORTANCE OF MOTIVATION AT THE POINT OF ENTRY

Once engaged in Phase 1 of treatment, those who had expressed high levels of self-motivation from the onset were more engaged with the therapeutic programme (Burke & Gregoire, 2007; Day et al., 2010; Hiller et al., 2002; Joe et al., 1999; Klag et al., 2010; Melnick et al., 2001; Simpson & Broome, 1998). These clients often spoke of giving '100%' and recommitted themselves remaining abstinent on a regular basis. There was an expressed sense of active effort on their part. Meanwhile, those who entered treatment out of a sense of obligation or pressure (i.e. incentivised clients) often found it more difficult to engage (Prendergast et al., 2009; Farabee et al., 1998). Several found the community element to be alienating, the structure to be 'too rigid'. As time passed, differences in levels of engagement of those who were reported high levels of self-motivation and those who were incentivised became more apparent. For example, all of the qualitative participants who entered treatment after being incentivised discharged early. However, several participants who entered treatment voluntarily also discharged early. The difference was noticeable in their lives after treatment. In wave four interviews with participants who left early, all but two of those who entered willingly and left early were maintaining a drug free lifestyle. The sense of agency that featured regularly in their interviews while engaged with CTC was still prominent. They remained motivated; they remained committed to recovery. Alternatively, many of those who felt pressured into treatment had returned to using drugs. During the final interviews, many spoke candidly about their lack of engagement with the programme, explaining that they 'weren't ready' at the time of treatment entry.

These qualitative findings converge with the international literature, suggesting that a personal sense of agency, a high level of self-motivation, an active willingness to complete treatment, strongly influences one's treatment engagement and outcomes over an extended period of time (Simpson et al., 2004; Wild et al., 2006; Wolfe et al., 2013). This was true for many motivated clients who left treatment early, as well. However, those who entered because they felt 'forced' to, those who found the programme difficult to engage with early on, continued to struggle as time went on (Ravndal et al., 1994; Wilde et al., 2012).

IMPACT OF TREATMENT ELEMENTS ON RETENTION

Of the quantitative participants, approximately one third of CTC clients remained in treatment throughout the life of the programme. These findings are consistent with retention rates reported in a systematic review of therapeutic communities and are indicative of the difficulties TCs face with regards to retaining clients (Malivert et al., 2012; McCusker et al., 1997; Gossop et al., 1999). Both individual level and treatment

[24]The symbiotic features of self-motivation and external pressure are complex and there is a range of literature discussing the interactive role of motivation and 'coercion'. See Hampton et al., 2009; Prendergast et al., 2009; Wolfe et al., 2013 for a more in-depth presentation.

level factors influenced clients' decisions to remain engaged or leave the programme early (Mandell et al., 2008). Among qualitative participants, personal circumstances including childcare and family commitments were the most commonly cited reasons for self-discharge. Others felt that certain elements of the treatment process were incompatible or too demanding. The life-story experience, for example, was cited by more than one participant as a trigger for programme disengagement. The most common time for participants to disengage from the programme was following the transition from Phase 1 to Phase 2. During this time, relapse was common for participants and also their peers (Soyez & Broekaert, 2003) and tensions among clients cohabitating in transitional housing was commonplace. The drop-off of formal supports from CTC left many feeling unbalanced and abandoned, while clients had mixed feelings surrounding their personal freedom and negotiating the 'outside world' without drugs or alcohol.

Clients who remained engaged in the programme had developed strong personal ties with both peers and staff members (Hser 2014; Joe et al., 2002). Levels of engagement with treatment processes were high, as were levels of commitment to the recovery process. It has been suggested in the quantitative literature that clients who struggle to adapt to TC social processes early in the treatment experience are more likely to exit treatment within the first few months (Simpson, 2004; Joe et al., 1999; Mandell et al., 2008). With some qualitative participants, this did, indeed, seem to be the case.

UNIQUE PROGRAMMES, DIFFERENT TREATMENT EXPERIENCES

Residential vs. Day Programme

While CTC is one holistic community, this research focused on three separate and distinct programmes: the men's residential treatment at the Lodge, the women's residential treatment at Ashleigh House, and a mixed-gender Drug Free Day Programme. These programmes are all guided by the core, fundamental principles of the therapeutic community approach to drug and alcohol treatment. Furthermore, they share similar structure and treatment practices including group therapy, one-on-one key working sessions, and a peer-led authority structure. However, the findings suggested that there were many variances between the three treatment arms and clients' provided different accounts of their experiences in each.

First, the day programme stood apart from the residential treatment in an evident and influential way. Clients attended the programme for eight hours a day, Monday through Friday, and then returned to their private residence. There was no communal living or weekend obligations. Many clients lived with family members and maintained contacts outside of CTC. Most of the DFDP clients interviewed had entered the programme directly from a separate residential treatment facility. As such, they had been clean for several months and were already familiar with, and entrenched in, the 'treatment' and 'recovery' mind-set. The day programme was relied upon by these clients as a 'step down', a transition phase between residential treatment and 'the real world'. Many chose to enter the programme because they were aware of unresolved personal issues that had risen during residential treatment and wanted to address these in some depth. There was a strong sense of personal agency and commitment among these clients. Compared to the residential clients, most entered treatment in a more stable mind-set. In the month leading up to treatment, 96.8% of the quantitative participants were substance free, compared with 60% of residential clients. This is noteworthy when examining treatment outcomes. Despite being part of the same community, the DFDP and its clients differ notably from live-in treatment and clients. This is something to keep in mind when speaking about CTC holistically as one programme both in this report and in the future.

Gender differences in residential treatment
Some prominent differences emerged between the male clients in the Lodge and the female clients in Ashleigh House. The quantitative data demonstrated strong gendered differences between male and female health measures at the time of entry to treatment. Women's physical health, mental health, and self-reported well-being were several points lower than men's in all three categories on a scale of 0-20, consistent with much of the literature on women's biological, physical, and psychological needs entering treatment (Covington et al., 2002; Tuchman, 2010). The qualitative findings suggested strong feelings of guilt, anxiety, and shame among the female participants during wave one interviews (O'Connor et al., 1994). This was particularly true of women with children, who spoke often of family obligations, embarrassment, and guilt over the impact that their drug use had on their family (Covington, 2008; Vandermark, 2007).

Once engaged in treatment, men and women appeared to respond differently to some key elements of the TC programme. Broadly speaking, many of the men in Lodge responded positively to group living. The communal residential spaces, the shared chores, and the group therapy aspect of treatment were all typically well-received. Most men in the Lodge described the community as welcoming and while some personality clashes occurred, most described this as an 'inevitability' in group living rather than a problem. In contrast, several women in Ashleigh House struggled with the group element of residential treatment. There were many accounts of interpersonal conflict, of arguments regarding chores, and of women feeling marginalized or 'picked on' during group sessions. Again, some wrote this off to 'cattiness' and dismissed it, while a few found the group dynamics so problematic that it interfered with their treatment, instilling feelings of anxiety and insecurity.

Also, some women in Ashleigh House were in the unique position of caring for their children while in treatment, which can serve both as an incentive and a hindrance (Covington, 2002; Gueta & Addad, 2015). As the only mother-child rehabilitation programme in Ireland, these women were grateful to have retained custody of their children. Without this service, all felt that they would not have been able to seek treatment. However, they also felt that having a child at Ashleigh House at times alienated them from the larger group and affected the overall group dynamics. Particularly during unstructured time, the women with children were removed from those who did not and this caused a perceived riff in the group.

With regards to retention and completion, Ashleigh House faced the highest levels of client self-discharge of the three programmes. What remains uncertain is the extent to which women discharged early due to the apparent lack of community cohesion and general incompatibility with key treatment elements in Ashleigh House, or due to their own personal circumstances such as family obligations or psychological needs. In all likelihood, these factors were interdependent rather than mutually exclusive. Some women entered residential treatment with a distinctive set of needs, including higher levels of diagnosed depression, histories of physical and sexual violence, lower perceived well-being, and reported feelings of guilt and obligation regarding their families (Covington, 2008; DeLeon, 1997). Once in treatment, many struggled to engage in the therapeutic process and connect with their peers, resulting in a more stressful treatment environment than their male counterparts. The lack of cohesion and heightened stress of treatment coupled with the myriad of personal needs experienced by many women likely resulted in notably higher levels of self-discharge than men in the Lodge.

It is important to note that this phenomenon is not unique to Coolmine Therapeutic Community and there exists an abundance of literature on identifying and addressing the needs of women in alcohol and drug

treatment (Covington 2002, 2008; Grella, 2008; Nelson-Zlupko et al, 1995). However, it is vital to highlight the occurrence of divergent residential treatment experiences between Ashleigh House and the Lodge as CTC, and other therapeutic communities, work to improve and expand their services for all clients.

KEY MESSAGES FOR THERAPEUTIC COMMUNITIES

Despite the many instances of relapse or return to using, the positive of impact of CTC on clients is undeniable. Outcomes improved consistently for clients in all three programmes. Overall substance use lowered, physical and mental health improved, and clients demonstrated improvements with regards to housing, employment, education, and family relationships. Among those who discharged early, many remained abstinent and demonstrated improvements in the aforementioned areas. In qualitative interviews, many clients cited the tools they learned in treatment as key mechanisms for continued change. However, some had suggestions for ways in which CTC could continue to improve the delivery and implementation of their services. All of these suggestions were referenced directly by clients in the qualitative interviews and substantiated through the findings in the data. These key messages can be applicable for Coolmine Therapeutic Community but also, hopefully, for drug and alcohol TCs more broadly.

Flexibility in delivery of programmes

One feature that encourages programme completion and continued success of CTC clients, as well as other TCs, is a certain level of flexibility in the delivery of treatment programmes (Neale et al., 2004). As emphasised recurrently in this report, each client arrived at CTC with a unique history and personal circumstances. For some, extenuating circumstances made completing aspects of the programme in the prearranged time frame challenging or in more extreme situations, unachievable. For example, a few clients who were attending the DFDP were the primary caregivers of their young children. Coupled with long commutes and the cost of outside childcare, they found the required attendance at DFDP too difficult and costly and thus, withdrew. Both mentioned that the presence of on-site childcare or more flexible arrival hours could have facilitated their completion of the programme. Flexibility may also extend to scheduling, structure, and treatment timeline. It could also extend to treatment elements, including the facilitation of additional one-on-one support or the inclusion of multiple programming options (Kruk & Sandberg, 2013).

Additional one-on-one support

A common criticism among clients from the Lodge, Ashleigh House, and the Day Programme was that they didn't receive 'enough' one-on-one support from key-workers or counsellors during their time at CTC, particularly in Phase 1. At the time of the first interview (typically one month after entry), several clients had not yet met with their key worker. In follow up interviews after transitioning from Phase 1, many clients expressed concern over the limited number of personal sessions they received while in residential treatment. Most believed that this was due to staffing constraints, many expressing sympathy for the staff and the amount of work that they have on a daily basis. However, there was a consensus that additional one-on-one counselling would have been beneficial to clients in all three programmes. Similar studies of TCs have found that clients' reported one-to-one key working and/or counselling sessions to be the single most important facilitator for programme success and completion (Neale & Tompkins, 2007).

Smaller group sessions

Group therapy is a fundamental aspect of the therapeutic community drug and alcohol treatment experience (DeLeon, 2000). However, the size of many of the group sessions was intimidating, and at times counterproductive, for some of the more

introverted clients. There was consensus among clients that smaller group sessions, when they occurred, were beneficial for all clients as they provide a more intimate environment for personal sharing and facilitate more meaningful inter-personal communication.

More support during the transition to Phase 2
One of the clearest messages arising from the qualitative data was the need for more formal support from therapeutic communities during the transition from residential treatment (Phase 1) to transitional housing (Phase 2). It is the intention of this transition to allow the clients to accept responsibility and autonomy during their reintegration into the 'outside world'. However, the juxtaposition between the 'bubble' of supports in Phase 1 and the dearth thereof in Phase 2 left clients feeling abandoned, unsupported, and in some cases, angry. The availability of additional formal supports from CTC during the Phase 2, particularly during the early weeks, would likely be welcomed and beneficial to clients as they navigate this extremely difficult and complicated transition.

Day programme as step-down
The data showed that many DFDP clients entered the day programme after completing a different residential treatment programme. Most of these clients felt that they had reformed their behaviour in residential treatment but were not yet secure enough in the recovery process to reintegrate into the 'outside world'. Many used the CTC's day programme as a 'step down' from residential treatment and most arrived at the programme demonstrating a high level of personal motivation and a desire to continue 'working' on themselves. Coupled with the articulated desire for more formal supports during the transition from Phase 1 to Phase 2, these findings suggest that CTC may benefit from offering a formal day programme for clients exiting residential treatment.

Motivation Enhancement
In line with international literature, personal motivation appears to be a critical component with regards to treatment success and long-term recovery for drug and alcohol dependence. However, sources of motivation appear to vary greatly and are largely subjective. How, then, can practitioners work towards bolstering motivation and in turn, chances of treatment success and beneficial outcomes? Researchers and psychologists have established a number motivation enhancing practices including motivational interviewing (MI) and motivational enhancement therapy (MET), both of which involve cognitive therapy focused on improving clients' internal motivations and willingness to change. The body of literature surrounding the effectiveness of these treatment modalities is growing, though a full description is beyond the scope of the current paper. TCs should, at the very least, be aware of the powerful role that personal motivation can play on clients' treatment trajectories and have structures in place that can address the needs of clients who enter treatment with low levels of personal motivation.[26]

[26]For a comprehensive introduction to motivational interviewing (MI) and motivational enhancement therapy (MET), see Miller 1999.

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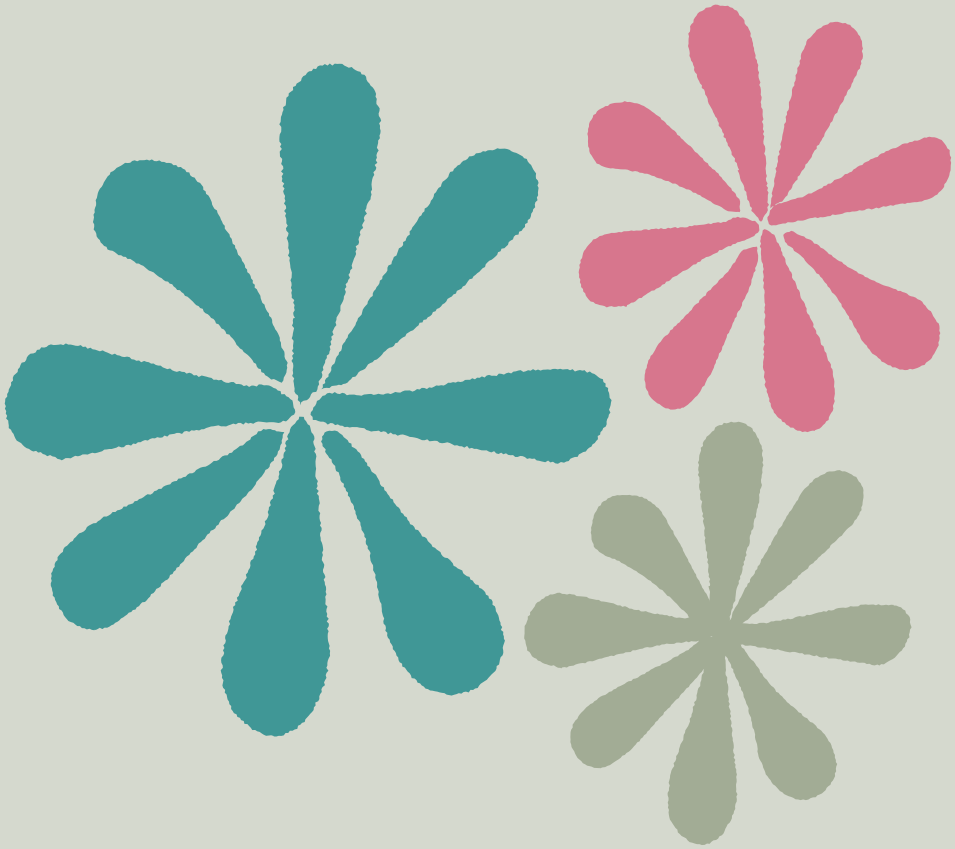


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