A Process Evaluation of the Introduction of Mindfulness-Based Relapse Prevention (MBRP) into a Therapeutic Community for Substance Abusers

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Under the supervision of Dr Shane Butler

DECLARATION

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Wherever you go, there you are
(Jon Kabat-Zinn)

ABSTRACT

Coolmine Therapeutic Community (TC) has been in existence for almost forty years and for most of this period utilized confrontational forms of therapy both within its explicit therapy sessions and as an integral feature of the community lifestyle. However, significant changes had been made to the Coolmine programme in recent years which have seen a gradual move away from confrontational therapy as its main form of treatment. These changes have included the introduction of a number of evidence-based practices (EVP) to its programme. One such EVP introduced recently has been the mindfulness-based relapse prevention programme (MBRP). Research has shown mindfulness based therapies to be an effective therapeutic intervention for a wide range of chronic and psychological disorders. However, little is known about *how* it may be helpful to individuals with addictive disorders. Preliminary studies, though not conclusive, have suggested it may be an effective relapse prevention strategy for people with addictive disorders. This qualitative study set out to evaluate the impact of the newly introduced MBRP programme on the TC to which it was introduced and to explore clients and staffs perceptions of the programme. It also aimed to examine *how* it may be helpful for individuals with substance abuse problems. Twenty-three participants were interviewed, which included both staff and clients, in two phases. Phase one consisted of semi-structured interviews with six participants. Phase two conducted three focus groups in each of the three Coolmine services to which it was introduced. Ethical approval was sought before any data was gathered. Findings suggested that MBRP was largely positively received by both staff and clients and was considered a programme with real perceived gains. Overall, the programme appeared to be both valuable and beneficial to individuals with addictive disorders.

Keywords: mindfulness, meditation, therapeutic communities, substance abuse, addiction.

TABLE OF CONTENTS

CHAPTER 1

Introduction

Coolmine Therapeutic Community (TC) has been in existence for almost forty years. It was established in 1973 in response to the growing drug problem being witnessed in Dublin. Like other therapeutic communities, this was founded as a specific treatment modality where drug users and alcoholics live together for a period of time and help each other stay sober. For most of its period in existence, it utilised confrontational forms of therapy, both within its explicit therapy sessions and as an integral feature of the community lifestyle. However, Coolmine, like other European Therapeutic Communities has made significant changes and modifications to its programme and structure over the past number of years. Perhaps the most significant change has been the gradual move away from confrontational style therapy to more motivational approaches to change, through the adoption and integration of a number of evidence-based practices. Research has consistently shown therapeutic communities to have relatively high relapse rates and drop-out rates which pose significant problems in terms of treatment. In response, Coolmine has committed to adopting a range of evidence based practices in a bid to reduce relapse and increase retention, across all of its services (Strategic Plan, 2012-2015). Most recently, one such practice introduced to Coolmine, across three programmes, has been the mindfulness based relapse prevention programme (MBRP). Relapse (where an individual returns to drug use following a period of abstinence), poses major problems in the drug treatment field. It is estimated that relapse rates exceed 60%, even after treatment. To date, the most widely used strategies for dealing with relapse are those based on the Cognitive Behaviour Model of Relapse, developed by Alan Marlatt and colleagues (1986) over thirty years ago.

Whilst this model has been widely accepted in the drug treatment community, relapse rates continue to exceed 60%, highlighting the need for alternative or adjunctive treatments to be developed and explored. One such approach, advanced by Marlatt and colleagues (2011), is the mindfulness based relapse prevention programme (MBRP). Research has shown mindfulness based therapies to be effective for a variety of psychological disorders (Kabat-Zinn, 1992; Segal, 2002). Combining over twenty years of research on relapse prevention with mindfulness Meditation Techniques, the theoretical framework for MBRP suggests it may be a promising

approach to treating addictive disorders. Designed as an eight week after-care programme, MBRP aims to cultivate mindfulness awareness in individuals, whilst providing them with the skilful means to cope with triggers and cravings. (Witkiewitz et al, 2005).

Traditionally rooted in ancient Eastern tradition, mindfulness based therapies have been adopted by the west in recent years as an effective intervention for a number of chronic and psychological disorders. The most frequently cited programme is mindfulness based stress reduction (MBSR), developed by Jon Kabat-Zinn (1990) for individuals suffering from chronic pain and stress-related disorders. Research has shown this intensive Eight Week MBSR Programme to be an effective intervention for a range of disorders. Promising results from the MBSR have led to a number of modified mindfulness-based interventions being developed for specific populations including MBRP, especially modified for individuals with addictive disorders (Bowen, Chawla and Marlatt, 2011).

Mindfulness has been defined as "the intentional, accepting and non judgemental focus of ones attention on the emotions, thoughts and sensations occurring in the present moment" (Zgierska et al, 2011: 267). This intentional, accepting and non-judgemental focus is commonly achieved through meditation techniques. This teaches individuals to be fully present in the moment and attentive to their current experience without being preoccupied by it or as Marlatt (2011) would state "wiped out by it". Through cultivating mindfulness awareness it is suggested that individuals can create a space whereby they can respond skilfully instead of reacting automatically. In addition to cultivating mindfulness awareness, MBRP provides individuals with the 'skilful means' to cope with urges and cravings through a number of techniques that assist them to identify and observe cravings without having to react to them.

Furthermore, it is suggested that a mindfulness approach to recovery can assist individuals develop an accepting and compassionate attitude to unwanted or uncomfortable thoughts and emotions. It is suggested that this may be highly valuable to individuals with substance abuse problems as their disorder is often associated with a culmination of unwanted thoughts, feelings and emotions. The literature states its their unwillingness to accept unpleasant emotions and feelings and the tendency react automatically and habitually to these emotions that cause a great

deal of addicts to relapse. Therefore, it is suggested "in the context of addictions, mindfulness might mean becoming aware of triggers for cravings...and choosing to do something else which might ameliorate or prevent craving, so weakening the habitual response". (Groves and Farmer, 1994: 189)

Rationale for the Study:

Following a number of quantitative studies that suggest MBRP is an effective relapse prevention strategy (Bowen et al, 2006, 2009, Zgierska, 2008), Coolmine Therapeutic Centre decided to introduce MBRP into their programme in an effort to improve treatment outcomes for their clients. Prior to implementation, a period of piloting the programme was conducted with both clients and staff and I, myself, attended the pilot as a participant observer. Following the Eight Week Pilot Programme, MBRP was implemented in May 2012 across three of Coolmine Services, the drug-free day programme and the men's and women's residential services.

To date, several studies have examined the effects (Bowen, 2006, 2009) of mindfulness meditation on populations with addictive disorders, yet little qualitative studies exist which explores how MBRP can reduce the risk of relapse. It is noted that MBRP research is in its infancy but if MBRP is to be considered an effective relapse prevention strategy, research must clarify the process underlying participant's use of mindfulness in a drug free setting. Whilst preliminary evidence supports the efficacy of mindfulness meditation with addictive disorders, the evidence is not conclusive. Research would benefit from a comprehensive account of the programme by staff and clients who have direct experience of participation. Ellen Tuchman (2011) states that successful implementation of any evidence-based practice into any drug treatment settings requires a thorough understanding of both staff and clients attitudes toward the new practice. Therefore, a qualitative exploration of both staff and clients perceptions, experience and attitudes can contribute to the already gathered of knowledge on MBRP as a new approach to drug treatment.

Purpose of the Study:

In the absence of empirical qualitative accounts regarding the process of mindfulness, the focus of the present study was a qualitative exploration on how mindfulness was received and viewed by participants in a therapeutic community setting. Specifically, the present study aims to evaluate the impact of the MBRP Programme on the therapeutic community to which it was introduced. In addition:

1. Gain a thorough understanding of the MBRP Programme as perceived by both clients and staff.
2. Investigate the mechanisms by which it may be helpful to individuals with substance abuse problems.
3. Examine the implementation process within the context of a therapeutic community setting.
4. Explore participant's personal experience of the programme and gain insight into the self perceived effects/benefits of the MBRP Programme.

CHAPTER 2

Literature Review

Introduction:

The primary aim of this research project is to explore the impact of mindfulness-based relapse prevention (MBRP) on the therapeutic community to which it is being introduced. The study aims to: 1) Give a detailed account of what the MBRP programme is. 2) Investigate how it may be helpful to individuals with substance abuse problems. 3) Place it within the context of a therapeutic community and 4) explore the impact this programme is having on both staff and residents of the therapeutic community to which it is being introduced. There are vast amounts of literature on substance abuse. Therefore, this literature review will confine itself to existing literature and research on both American and European therapeutic communities. The explicit aim of this chapter is to provide a theoretical framework for the introduction of a new model of treatment into a TC already embarked on a change process. Implementing new programmes into already existing practices is not an easy task in the addiction field. This resistance to new practices is a strong theme throughout the literature.

Therefore, an understanding of the past history of the TC is acknowledged and this chapter will begin by reviewing existing literature on how TCs evolved, with particular reference to the American concept-based therapeutic communities. It will explore the concept, philosophy, beliefs and practices that underpin the traditional TC in order to gain an understanding of the resistance of many TC's to change or implement new practices. It will proceed to highlight how the American TC movement influenced European TC's and review the research conducted on the effectiveness of these models in their approach to drug treatment. Hereafter, it will pay explicit reference to the changes experienced at Coolmine since it came into existence forty years ago with particular emphasis placed on the number of evidence-based practices that have been adopted and implemented. Mindfulness is yet another new evidence-based practice been implemented and a thorough review on existing literature on mindfulness will be conducted.

American Concept-Based Therapeutic Communities:

Synanon, established in 1958 by Charles Dederich in Santa Monica, California is credited as providing the basis for a number of therapeutic communities that developed throughout America and Europe in the 1960's and 1970's. Some would say that the origins and development of 'therapeutic communities' could be traced back ten years earlier to the pioneering work of psychiatrist, Maxwell Jones (1953), but it is Synanon that is attributed with providing the basis for therapeutic communities for addictions. Whilst Synanon could have been influenced by the development of the psychiatric TC's in the U.K which placed heavy emphasis on the "therapeutic use of groups" (Harrison & Clark, 1992; 698), there is no evidence to suggest it directly influenced TC's for the addictions. *TC concepts, beliefs and practices are traced to indirect influences found in religion, philosophy, psychiatry, and the social and behavioral sciences.* (De Leon, 2000; 13).

Although heavily influenced by the self-help approach of the AA movement, this concept based community (Synanon) grew out of Dederich's disillusionment with AA's passive nature and non-confrontational manner. In effect, Dederich along with a number of other regular members of AA established Synanon, an alternative community where drug addicts and alcoholics, committed to abstinence, could live together for an indefinite length of time. Rejecting existing approaches to drug treatment which primarily relied on the disease model of addiction, Synanon primarily evolved outside of mainstream healthcare and psychiatry. It became a peer-based, self-supporting community whose aim was to not only modify the individual's behaviour, but to also change their social environment. This was a closed community where residents were expected to remove themselves from 'normal society' and dedicate themselves to the community which was based on a rigid hierarchical structure, strict rules with no trained professionals. (Rawlings and Yates, 2001). Within this community, positive behaviour change was rewarded with increased responsibility in the community, whilst negative behaviour was intensely confronted. Underlying the concept of this community was that the individual was the problem, not the drug and, therefore, through modifying ones behaviour, one could maintain a drug-free lifestyle. Based strongly on behaviour modification, this approach stresses the importance of peers and

role models as facilitators of change, where old drug using behaviour can be modified through the constant interaction within the community. Traditional TCs were viewed as:

> To provide total rehabilitation for an individual in an existential context by challenging and reinforcing that which is positive and normal in him so that he can eventually overcome that which is distorted and sick in his own personality. Addiction as a way of life is merely a symptom. (Warren-Holland, 1978).

This definition is very reflective of its time and it was this concept that laid the foundation for the use of the confrontational style therapy known as 'the Game', or later on as encounter groups. Much of the therapeutic work in traditional TC's centred on these groups, where residents were encouraged to forcefully and often aggressively (verbally) confront each other on issues that caused them anger or frustration. The theory behind this was that through confrontation, residents could change their behaviour and attitudes that had caused them problems and maintain a drug-free lifestyle (Broekeart, 1998). Synanons alternative approach to treating drug addicts was embraced by senior authorities in the U.S, as its harsh 'boot-camp' regime contained elements of retribution to drug users which reflected politicians stance on 'the war on drugs'. Reports of humiliating rituals, haircuts and aggressive verbal assaults were often ignored by policy makers who welcomed this approach to drug treatment as a viable treatment method for drug users. (Rawlings and Yates, 2001). Drug addiction was perceived as wrong and illegal and individuals who were addicted were regarded as "emotional and immature who had to be reborn" (Broekaert, 2002: 372) and this approach was deemed most effective by TC's to achieve this.

There is no empirical data or evidence base to support this method of treatment as any research that was conducted, was conducted internally and not subjected to any independent critique or analysis. Broekaert (2002) notes that in the beginning TC's were reluctant to participate in any independent research or evaluation as they solely believed in the 'power of the concept' and were suspicious of any outsiders or professionals that did not understand the TC methodology. However, due to its harsh regime, dropout rates and relapse rates were high with the literature suggesting that at least fifty percent of residents left Synanon before graduating. In reviewing

four decades of treatment outcome research, Miller (2007) found there was no scientific evidence to support the use of confrontational methods to treat substance users. Rather he found that confrontational methods were often counterproductive. One therapist who worked in a TC since 1977 noted:

> The encounter and its hard confrontations strove to 'break' the image of the addict. However it often happened that this radical method did not destroy the 'image' but that the person himself felt broken, devalued, humiliated and without support. Many stopped their treatment prematurely because they did not get time to experience the support and comprehension that made the therapy tolerable. (Bracke cited in Rawlings and Yates, 2001: 39)

Whilst it started well, due to its questionable legal and financial activities, erratic behaviour of its leader and ever strengthening rejection of mainstream society, Synanon eventually fell into disrepute from the late 70's and was eventually disbanded in 1991 after being branded a cult (Jansen, 2001). It did, however, provide the impetus and framework for the TC's that subsequently developed across America in the late 60's and 70's, in particular Daytop Village and Phoenix House. Founded by ex-Synanon members, these new TCs sought to differentiate themselves from Synanon who was receiving much publicised criticism, by allowing daily activities to be documented and reported and placing openness as one of its central principles. However, like Synanon, aggressive confrontation was still used as their primary therapy regardless of its lack of evidence base. Early studies were mainly conducted internally and can be regarded as attempts by the founders to convince authorities that the TC was an effective model, and in effect secure funding as well as protecting them from ideological attack. Much emphasis was placed on describing the process, structure and rationale of the TC which was primarily conducted by researchers who were part of the organisation. (Ravndal, 2003).

Perhaps the most noted departure from the Synanon prototype was, these new American TCs no longer saw themselves as a community where addicts removed themselves from society because they could not function in it, to a community that prepared individuals for returning to society.

Reintegration became a primary goal of these new TC's and it was these models that provided the framework for the expanding numbers of TCs that developed subsequently, both in America and eventually Europe. (Rawlings and Yates, 2001). Many studies show reasonable success rates of the American concept-based TCs, however dropout rates and relapse pose significant problems. A number of outcome studies including two large scale studies (TOPS and DATOS) initiated by NIDA support the effectiveness of the TC model in general, but state they are no more effective than other models. However, a number of methodological issues have been forwarded in the literature. The literature suggests that a number of these outcome studies are follow-up studies which focus on "successful graduates" and issues of time lines have also been consistently raised. (Malivert, 2012).

Europe and Ireland:

The American TC movement has had a significant impact on the addiction treatment field in Europe. After visiting a number of TC's in America, a number of psychiatrists in the 60's, working in the field of addiction returned to Europe and declared the TC a viable method for treating drug addicts. As a result, an expanding number of TC's were established right across Europe, including Ireland where Coolmine was established in 1973 with the help of graduates from Phoenix, London. Whereas European TCs did retain many aspects of the American system, "various intervening influences led to some profound differences in organisation, philosophy and practices". (De Leon, 2000: 24). Unlike the American system which was initiated and developed by addicts themselves, the European TC's were primarily developed by psychiatrists and employed both recovering addicts and professional staff. Whilst not all TC's are the same and some display profound differences, De Leon (2000) states that to a large extent they have adopted the concepts, philosophy and essential components of the hierarchical American concept-based programme. These essential components that are defining characteristics of the therapeutic community are summarised by De Leon as follows:

1. Self help: Residents are responsible for their own recovery, with peers only acting as facilitators of change. It is primarily a self help approach.

2. Community: The primary therapy and the main agent for change is the community. Residents must conform to TC behaviour whilst living in the community. Through living together as a group in a highly structured daily programme, old drug using behaviours can be changed through constant interaction with staff and peers.
3. Hierarchy: The community is based on hierarchy where older residents act as role models. The community is operated by residents with staff acting as supervisors. "*Role models within the drug-free TC are viewed as individuals who have self-motivation, a commitment to work and who consistently maintain the attitudes and values of the community*". (De Leon, 2000: 152).
4. Encounter groups: All residents are encouraged in a group setting, to confront others who are displaying negative behaviour and attitudes which is interfering with the community's concepts. Within the traditional TC, use of these groups to confront others can develop resident's awareness of negative behaviour and facilitate individuals to change.

These components alongside a commitment to total abstinence and 'community as method' are defining features of a therapeutic community both in America and Europe.

Resistance to change:

The 1980s proved to be a challenging time for many TC's across Europe, including Ireland, where the AIDS and opiate epidemic caused increasing fears for the public and policymakers. Policies and funding began to be directed at harm reduction approaches, methadone maintenance and health promotion. During this era of harm reduction, European TCs retained abstinence as their ultimate goal. Under significant pressure to adopt harm reduction policies, European TC's resisted this pressure to change and continued to promote abstinence. The TC

> is built upon the belief that everyone has the potential to develop, that the responsibility to change lies within the person themselves, that others

> can only assist by being role models, that honesty pays, that guilt sharing blocks destructive practices and that a drug-free lifestyle prevails. (Broekaert, 2006: 1677).

Although research has never played a significant role in the development of TCs, a review of the literature suggests that by the 1980s, it was recognised by TCs internationally, that independent research was important in order for them to survive. Prior to the 1980s, Broekaert (2002) states that in Europe, where dropout rates and relapse was relatively high, there was no evaluative research on the organisational modalities of TCs in Europe. A literature search conducted on ebscohost, psychinfo and pubmed supports this statement. However, in the 1980s, a number of studies emerged which comprised mostly of follow up studies and evaluations aimed at highlighting TCs outcomes and improving their programme. It is generally accepted now by the TC movement that the outcome of TC treatment follows the one third rule; "one third succeed, one third mild relapse, one third severe relapse". (Broekaert, 2002).

Many studies for the most part show reasonable success rates of the TC model; however dropout rates remain relatively high especially, in most cases fifty per cent within the first thirty days. In a systematic review of the studies conducted within TCs Marion Malivert (2012) found that whilst the studies did indicate that that there was an initial reduction in consumption of drugs, that relapse rates were significantly high. One of the most significant findings that have been echoed in numerous studies is that retention predicts outcome. That is, the biggest predictor of successful outcome was time spent in the programme. (De Leon, 1986; Gossop et al, 1999; Simpson, 1984; Kooyman, 1992). According to Broekaert (2006), the European TC movement has recently adopted a somewhat 'post-modern approach' to drug treatment and is responding to research through adopting a number of evidence-based practices.

Evidence-based practices:

The literature suggests that although there was a breakthrough in the 1980s where TCs appeared to accept the importance of research, there remains a significant 'research to practice gap'. (Lamb, Greenlick and McCarthy, 1998). There remains a resistance in substance abuse

treatment to implement new treatment practices that studies have proven to be effective. The literature states that this is not because treatment providers do not want what is best for their clients, but is the result of a number of factors. One of these factors include how addiction treatment was initially developed, outside of mainstream healthcare and primarily provided by individuals themselves in recovery. As a result of this unique development of addiction treatment, many competing approaches to treatment have evolved, where treatment providers have developed strong identification and allegiances to particular models, regardless of its evidence base. Miller (2006) suggests that this allegiance and identification with particular models is reinforced during professional training where evidence-based practices that appear to conflict with a treatment providers values or model, are often ignored and not implemented.

Established patterns of thought and practice may require unlearning before innovations can be learned and applied. Like other human beings, therapists are reluctant to re-evaluate cherished assumptions and familiar practices. (Meyers and Miller, 2001:166).

Research shows that in addition to strong allegiances to particular models, how knowledge is disseminated is another important factor as to why there continues to be a significant research to practice gap. Researchers tend to rely on academic journals to disseminate new knowledge, where numerous studies have consistently demonstrated that clinicians tend not to use academic journals to inform themselves of new practices. They tend to learn about new practices primarily through informal channels, usually from colleagues and reading. In a bid to attempt to 'bridge this gap', a number of strategies have been developed to improve communication between researchers and clinicians, and in effect improve the implementation of evidence-based research into practice.

One such strategy initiated by the National Institute of Drug Abuse (NIDA) has been the publishing of a number of manuals for a number of evidence-based treatments, to help guide the implementation of EBTs into practice. Research has shown, however, that there is mixed attitudes by practitioners towards the use of manuals to inform them of their practice. (Roman and Johnson, 2002). Much research has been directed at developing change models for transferring research to practice and identifying barriers and incentives for adoption of EBT's. (Simpson, 2002; Rogers, 2003; Lamb, Greenlick and McCarthy, 1998). These studies

acknowledge there are both personal and systemic barriers. Programmes resources, staff attributes, organisational climate and perception of new practice are deemed to all influence the extent to which change or an adoption of a new practice will occur. In his diffusion theory Rogers (2003) suggests that there five factors, all to do with perception, that will determine whether an organisation will adopt a new practice. These include:

1. Relative advantage-is the new practice/treatment better than what they are currently doing
2. Compatibility-is the new practice compatible with the organisations values and goals
3. Simplicity-is it easy to understand
4. Triability-can the organisation try out the new practice before implementing it
5. Observability-can the benefits be readily observed
   (Rogers 2003 cited in Miller, 2006: 27).

> In order to change practices through the adoption of a new clinical initiative, a program must be ready to accept that change and be prepared to adopt and maintain the new intervention. Keys to successful change include the relevance, utility and effectiveness of the proposed initiative as well as support, sufficient resources and expertise to enact the change in practice.
> (Flynn and Brown, 2011: 567)

Research has shown that there is a process for a diffusion of new practices into existing organisations, that if overlooked or rushed through will result in the new practice been implemented ineffectively or not at all. Similar to Prochaskas and DiClementes (1984) trans-theoretical model (TTM) which focuses on how individuals change and the processes they must pass through to sustain the change, organisations must do the same. The stages of change an individual or organisation must pass through have been described by Prochaska as:
1) precontemplation 2) contemplation 3) preparation for action 4) taking action 5) maintenance.
With regards to treatment providers, research demonstrates that in order for the new treatment techniques to be effectively implemented, attention to each of these stages is critical. This usually requires preparatory knowledge and education about the new practice, usually with a

specifiable theory of how and why it works which has been more recently specified with the development of intervention manuals for specific interventions. Following this, research shows monitored practice with feedback and ongoing support is crucial as studies have shown it is easy for practitioners to revert back to old practices if supervision is not enacted. (Miller, 2006).

Coolmine:

Research has shown that drug treatment based on confrontation is largely ineffective.
(Miller, 2008). Due to a number of studies that have consistently demonstrated relatively high relapse rates and drop -out rates, Coolmine, like other TCs has modified its programme and approach to treatment. These include adapting its programme in 2008 to include women accompanied by children and persons with dual diagnosed disorders. In addition, they have also shortened its length of stay, introduced a number of community based services and increased the number of professional staff working in the community (Coolmine Annual Report, 2006). Perhaps more radical, the group technique within Coolmine, as in other European TCs has evolved from one of intense confrontation to more dialogue and discussion. Research has found that, *the use of shaming techniques to produce change has been discarded in favour of more motivational approaches to change*. (Rawlings and Yates, 2011; 187).

This gradual move away from confrontational therapy has been replaced with a number of evidence-based treatments for which there are numerous studies to support their efficacy. Empirical evidence strongly supports contingency management for treating substance use disorders with multiple research studies finding community reinforcement approach (CRA) to be one of the most effective treatment methods available. Due to positive findings of Azrin and Hunts studies (1973) with alcohol dependent individuals, CRA has been refined and modified for substance abuse treatment. Briefly, CRA can be best described as a multi-component behavioural treatment that recognises the importance of environmental contingencies for encouraging or discouraging drug use. Based on this premise, CRA provides a set of procedures to therapists, that can help individuals rearrange their lifestyle so that a drug-free lifestyle can be more rewarding than their drug-using lifestyle. Therefore, this approach works on increasing and enhancing non-drug reinforcers that individuals may get from the community. There is

strong empirical evidence that supports CRA in addiction treatment and numerous studies have shown CRA to be one of the most effective treatment methods for substance use. (Miller et al, 1995; 1998, 2003, 2005; Finney and Monaghan, 1996). Findings from a number of controlled trials have found that, "*Effective psychosocial interventions like CRA are fundamentally important to the treatment of cocaine and opoid dependence*". (Meyers and Miller, 2001: 123). With regards to alcohol treatment, it is considered to be one of the most efficacious and cost effective treatments out there. (Miller, 1998). As a result, many treatment providers have adopted CRA as their primary clinical treatment. It is now a central feature of Coolmine where they have, to date, the highest number of trained and accredited staff in CRA in Europe. (Coolmine Strategy 2012-2015). An integral part of CRA is relapse prevention which is the ultimate goal of any treatment provider. In its commitment to attempt to further reduce the rates of relapse, Coolmine have introduced a new programme which combines elements of relapse prevention with mindfulness techniques in what has been named mindfulness-based relapse prevention.

Mindfulness:

Traditionally rooted in Eastern spiritual tradition, in particular Buddhism, mindfulness has been adopted by the West as an effective therapeutic intervention for a number of psychological disorders. Mindfulness can be described as *paying attention in a particular way; on purpose, in the present moment, and nonjudgmentally* (Kabat-Zinn, 1994: 4). That is, individuals are encouraged to attend to internal (physical sensations, emotions and thoughts) and external (environmental) stimuli as they arise, and approach them with an attitude of non-judgment and acceptance (Baer, 2003). This paying attention in a particular way is taught through the regular practice of guided meditation where individuals are taught to accept emotions, thoughts and sensations in a nonjudgmental way. Emphasis is placed on the breath and teaching individuals to return to the present moment when thoughts, emotions or feelings do arise.

These practices are thought to assist individuals in accepting and tolerating unpleasant thoughts and emotions which can lead to a decreased reactivity to passing thoughts and emotions and in effect improve the health and well-being of a large number of people that suffer from a range of

psychological disorders (Baer, 2003). With regards to addiction the *Theoretical foundations for integration of mindfulness with traditional cognitive-behavioural relapse prevention suggests that mindfulness may help develop a detached and de-centered escalation of thought patterns that may lead to relapse*". (Bowen et al, 2009; 296). Research on mindfulness, in the treatment of addictive behaviours, is beginning to receive increased attention in the literature following several studies which have demonstrated the effectiveness of mindfulness-based therapies with a number of populations with specific psychological and medical disorders.

Perhaps the most cited and researched mindfulness-based therapy with different populations is mindfulness-based stress reduction (MBSR), developed by Jon Kabat-Zinn (1982, 1990) for patients suffering from chronic pain and stress-related disorders. First developed in an in-patient setting where patients were either dissatisfied or unresponsive to the medical care they were receiving, Kabat-Zinn developed an alternative or complementary treatment to help assist these patients. MBSR is conducted in a group setting where participants meet once a week for a session lasting two to three hours for a course of eight weeks. In these sessions participants are taught through guided meditation to observe uncomfortable thoughts, feelings and sensations in a non-judgmental way. Focus is always on the breath and being in the present moment. Practices include sitting and walking meditation, body scan, yoga and a number of mindfulness techniques that can help cultivate awareness in daily life such as mindfulness practices when showering or washing up.

All in all, practices are designed to foster awareness in individuals and teaching them to use the breath to anchor attention and return to the present moment when faced with unwanted or unpleasant emotions, feeling or sensations (Baer, 2003). Following the initial programme in an in-patient setting where patients reported benefits such as reduction in pain, anxiety and mood disturbance, MBSR has been welcomed by many practitioners in behavioural medicine in both in-patient and out-patient settings. Several studies have shown MBSR to be effective in reducing stress, chronic pain and increasing psychological wellbeing. (Baer, 2003).

Following the positive findings of MBSR, a number of researcher's integrated mindfulness practices for a number of psychological disorders in different populations. Segal et al (2000)

developed a mindfulness based intervention for people with recurrent or relapsing depression. Mindfulness-based cognitive therapy (MBCT) integrates elements of cognitive therapy with components of MBSR and has been shown to be effective for relapse prevention in chronic depression. In a randomised controlled trial which compared outcomes of patients randomly allocated to an MBCT group with patients allocated to treatment as usual, Teasdale et al (2002) found that MBCT significantly reduced the risk of depression relapse. This was especially evident a year following treatment with individuals who had experienced three or more episodes of relapse. (Segal, 2002). MBSR and MBCT are only two mindfulness-based interventions that have been shown to be effective and beneficial for a wide range of physical and mental disorders. Mindfulness meditation is also a central component in other widely used interventions such as Acceptance and Commitment Therapy (ACT) and Dialectical Behaviour Therapy (DBT).

Mindfulness-Based Relapse Prevention:

To date, the most widely used strategies for dealing with relapse are those based on the cognitive behaviour model of relapse, developed by Alan Marlatt and colleagues (1986) over thirty years ago. This cognitive based model has been very influential within the drug treatment field and has become a central feature of most psychosocial treatments for drug use. *The RP-model proposed by Marlatt and Gordon suggests that both immediate determinants (e.g., high risk situations, coping skills, outcome expectancies and the abstinence violation effect) and covert antecedents (e.g., lifestyle factors and urges and cravings) can contribute to relapse.*
(Larimer and Palmer, 1999: 151).

This model of relapse has been widely accepted in the drug treatment community and overall, findings from several studies support the overall model of the relapse process and its effectiveness for substance use populations. (Carroll et al, 1991; Kadden et al, 1989). In a comprehensive review of the relapse prevention literature, Kathleen Carroll (1996) found that whilst relapse prevention strategies were not consistently better than alternative treatments, there was evidence that supported its effectiveness. In particular she found

Outcomes in which relapse prevention may hold particular promise include

> reducing the severity of relapses when they occur, enhanced durability of effects, and patient-treatment matching, particularly for patients at higher levels of impairment along dimensions such as psychopathology or dependence severity. (Carroll, 1996; 46).

Based on similar structure and format of MBSR, Alan Marlatt and colleagues (2011) combined over twenty years of research on relapse prevention techniques with existing research on mindfulness to develop a new relapse prevention programme called mindfulness-based relapse prevention. To help facilitate the implementation of the programme, Marlatt and colleagues developed a manual to assist and guide the implementation process. Whilst MBRP is informed by the principles of CBT, it is the mindfulness practices which differentiate it from other forms of relapse prevention strategies. Therefore, personal practice is considered highly important if an individual is to cultivate mindfulness awareness. Marlatt also states that in order for the programme to be effective, it is important for facilitators of the programme to have mindfulness training, sufficient experience with group facilitation in a substance abuse setting and perhaps more important consistent personal practice of mindfulness meditation. Designed as an outpatient aftercare programme, it is suggested that this may be a new and effective approach to treating addicted individuals and reducing relapse rates which pose significant problems in the drug treatment field.

It is widely accepted in the substance abuse literature that addiction is characterised by 'experiential avoidance', whereby addicted individuals are constantly trying to change or avoid unpleasant feelings and thoughts through continued drug use. Larimer (1999) argues that addiction *is the repeated desire to avoid the present moment, which contributes to the urge to use*. Two studies demonstrate how mindfulness meditation can reduce experiential avoidance by encouraging participants to acknowledge and accept negative thoughts and emotions as they arise and to accept them rather than trying to change them or suppress them. (Simpson et al, 2007; Shapiro et al, 2006).

Like other mindfulness programmes, MBRP is a group-based therapeutic intervention that encourages the acceptance of the present moment through formal and informal mindfulness

practices. *The purposes of these practices are to increase awareness of triggers and habitual reactions, to develop a new relationship with these experiences, and to learn concrete skills to use in high-risk situations.* (Bowen, Chawla & Marlatt, 2011; 4).

Preliminary empirical data, though not conclusive, supports the use of mindfulness meditation with addictive disorders. Results from a number of clinical trials support the feasibility and efficacy of MBRP. In a study with an incarcerated population, Bowen et al (2006) found significant decreases in alcohol and drug related problems for prisoners who participated in the MBRP group compared to the treatment as usual group. A number of subsequent quantitative studies support the use of MBRP as an aftercare approach. (Zgierska and Marcus, 2009, 2010). A pilot randomised clinical trial found that participants allocated to the MBRP group had significantly less days of alcohol use compared to treatment as usual group. (Bowen et al. 2009). Whilst these studies have provided initial support, there are noted methodological limitations that require further research in order to establish it as an effective treatment model.

Summary:

This chapter has presented an overview of the literature surrounding the evolution of the TC movement, from a treatment modality that utilised aggressive confrontational treatment as an integral part of its treatment process to a treatment modality that now promotes dialogue and discussion as its main forms of treatment. Significant changes have occurred within the TC movement, including Coolmine, which has seen the introduction of a number of evidence-based practices being implemented to their programme in recent years. This overview was necessary in order to provide a theoretical framework for the introduction of a new model of treatment already embarked on a change process. Therefore, the introduction of the MBRP programme is not the first break with Coolmine tradition. It may be surmised that since both staff and clients have now become accustomed to change, the introduction of MBRP ought not to generate much distress or resistance. However, MBRP is a brand new treatment modality and research on mindfulness meditation with addicted individuals is still in its infancy. The literature review has presented a number of studies which provide preliminary evidence of the efficacy of the programme, however these studies are not conclusive and further research is required. Whilst

there have been a number of quantitative studies conducted, there remains little or no qualitative studies which explore the mechanisms or the underlying process of the use mindfulness meditation with individuals with addiction problems. Therefore, this research aims to fill that gap and contribute to the already gathered knowledge on how mindfulness meditation may be helpful to individuals in recovery in the context of a therapeutic community.

Over the past 18 months, however, significant changes have been made to the Coolmine programme through the introduction of the Community Reinforcement Approach (CRA). This treatment modality is strongly supported by research evidence and is entirely non-confrontational. Therefore, the introduction of the mindfulness approach (MBRP) as a form of relapse prevention is not the first break with Coolmine tradition. It may be surmised that since both staff and clients have now become accustomed to change, the introduction of MBRP ought not to generate distress or resistance. However, little qualitative studies exist that explore the mechanisms by which this programme may help reduce the risk of relapse. This study aims to address this by contributing to the knowledge already gathered and in effect answering the research questions.

CHAPTER 3

Methodology

This chapter will present a discussion on the methodology employed by the researcher, to guide the research project. It will outline the choice of methods and include a discussion on data collection and analytical procedures. In addition, ethical considerations, position of the researcher and limitations of the study will also be presented.

Choosing a Research Design:

As outlined in the introduction, the purpose of this study was to explore the impact of the newly introduced MBRP programme on the clients and staff of the Therapeutic Centre, to which it was introduced. It aimed to clarify the processes underlying participant's use of mindfulness in the Therapeutic Centre setting and investigate the mechanisms by which it may be helpful to individuals with addictive disorders. Specifically, it aimed to explore this process in the context of a Therapeutic Centre setting, where it has been outlined in the literature, have undergone significant amounts of change in recent years. Given that the focus of the research would be on understanding and exploring participant's perception of the programme, a qualitative approach was decided upon from the outset. The research sought to answer the following:

1. How was the programme received and viewed by both clients and staff at Coolmine?
2. Is mindfulness based relapse prevention consistent with the therapeutic centres approach to treatment?
3. Is it a practical and useful coping strategy for individuals with addictive problems?
4. Can it help client retention in Coolmine?

These central research questions influenced a mixed methods research design or a multi-method approach, whereby qualitative methods were chosen to answer the questions.

Why Mixed Methods?

Mixed methods mean adopting a research strategy employing more than one type of research method. It also means working with different types of data to "create a bigger picture" (Bryman, 2001). Participant observation was also employed as the researcher had engaged and participated in the Eight Week Pilot Programme and had gained an insight of the programme prior to beginning the research. It was deemed important by the researcher to *step into the shoes* of those being studied to gain an understanding of the programme under study.

Semi-Structured Interviews:

In view of the research aims and objectives, qualitative semi-structured interviews and focus groups were employed as the research felt these would provide the data required to answer the research questions. Interviews preceded focus groups. Individual semi-structured interviews consisted of interviewing both participants and facilitators of the MBRP Programme. In total, eight individual interviews were conducted, six with clients of Coolmine and two with staff members. It was particularly useful as a data collection tool as it gave a number of participants the opportunity to discuss, at length, their perceptions of the mindfulness programme and the mechanisms by which it may be helpful to them, in their recovery. The interview schedule for both clients (Appendix A) and staff (Appendix B) sought to generate data about processes, perceived effect and benefits, utility and practicality. The qualitative interview is one of the most highly used qualitative research methods as it provides *an undiluted focus on the individual* (Ritchie, 2003).

Each interview began by asking participants to speak about their experience of the mindfulness, prior to participating in the Eight Week Programme. This gave participants the opportunity to relax into the interview setting, allowing more in depth questions to follow. Whilst the researcher adhered to the interview schedule, there was a lot of discretion about the order in which questions were asked. This allowed the researcher to access the required information without *pigeon holing* (Bryman, 2008) the responses of the interviewees.

Focus Groups:

As noted, individual interviews preceded focus groups and the questions asked in the focus groups were very similar to the questions posed in the interviews. What was learned from the individual interviews was integrated into the focus group schedule (Appendix C), calling on participants to discuss as a group their attitudes to and perceptions of the mindfulness programme. This was deemed important by the researcher to establish how participants negotiated their accounts of the programme in the context of their peers. The researcher also acknowledged potential positive bias that exists with participants who volunteer to participate in individual semi-structured interviews. Bearing this in mind, it was decided that focus groups would allow for the production of data that might be less accessible without the interaction of the group. No staff members were in attendance. As such, each method produced a different aspect of inquiry and was regarded by the researcher as complementary mixed methods. Overall, the methods employed by the researcher included six semi-structured interviews with clients; two semi-structured interviews with staff and three focus groups (one in each programme to which MBRP was introduced).

Participants:

Within qualitative research, participants are often chosen due to their particular insight or position (Denscombe, 2007). Due to the nature of the study, participants were purposively chosen, across all three programmes, with regards to the level of engagement or participation in the MBRP programme. After gaining approval from the Trinity Ethical Committee access to participants was granted by the CEO of Coolmine. In order to participate in the study, participants had to meet the following criteria:

1. Participants must be drug free.
2. Participants had to be engaged with a MBRP group in any of the three Coolmine programmes.

All participants were given an information sheet and consent form one week prior to the study commencing, inviting them to participate in the research. The information sheet fulfilled a number of key ethical and practical duties (Appendix D). It outlined the purpose of the study and gave participants sufficient time to consider whether they wished to participate. Twenty-three participants, in total, agreed to take part in the research and written consent was obtained by all. Of the twenty-three participants, two were staff and the remaining twenty-one were clients of Coolmine in one of its three services. Clients were between the ages of twenty and forty-one and length of time drug-free ranged from four weeks at the time of interview to fourteen months. Seven participants from each treatment services took part in the focus group discussion, twenty-one in total. Of the twenty-one participants, six agreed also to participate in semi-structured interviews.

Procedure:

Phase one of the process involved conducting semi-structured interviews with the six participants who agreed to take part. All interviews took place in a quiet room on site of the treatment programme to which the respondents were clients, three in the men's residential, two in the women's residential and one in the day programme. Interviews lasted between, on average, thirty minutes and fifty-five minutes and depended on how much the respondent wished to elaborate. Interviewees were informed of their right to withdraw at any stage of the interview and thankfully no-one took up this offer. A Dictaphone was placed on a table between the researcher and interviewee and remained visible at all times.

Phase two of the research process involved organising and conducting three focus group discussions. These took place in the drug treatment service to which the participant attends and took place immediately following completion of the eight week programme. In total, twenty-one participants took part, seven in each focus group. This number of participants was not intentional; it happened that there were seven in each group that had consented to participate. It has been well documented that there is a risk that the interviewer may impose a possible bias on the data generated (Denscombe, 2007). In the interest of avoiding researcher led bias, the wording of questions was as impartial and open-ended as possible. Similar to the individual

interviews, interviews were audio-recorded to ensure accuracy of the data collected. In addition, field notes were also compiled during and after each focus group which included my own observations to participant's body language and non-verbal communication.

The limitations of focus groups became evident in one of the focus groups in the day programme where many of the participants remained quiet. The researcher made efforts to encourage contributions from all group members but many remained quiet. Many participants, from this particular group, remained quiet and made little contribution to the research. Other limitations included difficulty hearing a number of respondents who spoke quietly which required replaying the material in order to get accurate information.

Analysis:

From the outset it was decided that qualitative thematic analysis would be used to analyse the data. This model involves breaking down the data and analysing it to identify key themes that emerge. A preliminary idea of some themes was presupposed by the researcher in order to cover the topics of interest, in relation to the research title. Other themes were likely to transgress following data collection, which was the reason for choosing this model of analysis.

A verbatim transcript of each interview was prepared by the interviewer to fully absorb the data generated. Following this process, each transcription was compared with the relevant field notes', resulting in what Robert Krueger (1998) defines as an *abridged transcript*. These transcripts were then coded manually by the researcher producing a series of codebooks. The four main emerging themes to emerge from the data were: receptivity to the programme, utility and practicality, awareness and confrontation. From these main themes, a number of sub-themes emerged (Appendix E).

Ethical Considerations:

In all areas of social research, certain ethical considerations must be considered at all stages of the research process. Bryman (2008) suggests four main areas that must be taken into account at all times:

1. Is there any risk of harm to the participant?
2. Is there a lack of informed consent?
3. Is there an invasion of privacy?
4. Is there deception involved?

In order to ensure the research was carried out ethically, a number of safeguards were implemented. Prior to conducting any of the research, ethical approval was granted by the Trinity College Ethical Committee. A combined consent form and information sheet (Appendix D) was developed and distributed to participants before any interviews were carried out. The interviewee was given time to read over the form and keep one copy for their own records. The informed consent form contained the following:

- Participants were informed of the nature of the study and the purpose of the study;
- It gave written confirmation of potential use of the data, notifying them that it was part of the requirements for the researcher's master's degree but also notifying them that the findings may be shared, published and/or used in research publications;
- The form provided contact details for the researcher and the researcher's supervisor in the event of any questions or concerns;
- Participants were reminded that participation was entirely voluntary and they could detract from the study at any time;
- Respondents were also made aware that interviews would be recorded but deleted upon transcription and every effort would be made to ensure anonymity and confidentiality.

Confidentiality and Anonymity:

With regard to confidentiality and anonymity, it is impossible to guarantee absolute anonymity in qualitative research (Berg, 2009). Anonymity concerns the identity of participants in the research not being known outside the research team. Steps were taken to maintain anonymity and confidentiality; these included assigning pseudonyms wherever names were mentioned along with the removal of identifiers. It was decided by the researcher not to include ages of respondents in the analysis process due to the marked differences in ages between some respondents; age may have been an identifier. With regards to staff members, it was very difficult to maintain anonymity as there were only two staff members. In effect, the researcher contacted the staff members, during the analysis process, and received consent to include quotations that would, perhaps, identify them.

For the duration of the transcription process, recordings were stored on password protected computers. All recordings were deleted one the interviews had been transcribed and these transcriptions were also kept on a password protected computer. Any documents that may identify participants, such as consent forms, were stored in a safe place, separate to transcription.

Position of the Researcher

Reflexivity:

An eight week work placement was a partial requirement of the masters programme which was in Coolmine Therapeutic Centre, where the researcher completed her placement. It was important to be aware of the personal values and beliefs brought to the study due to this researchers personal experience of the mindfulness programme. This researchers understanding of mindfulness derives from participation in the eight week pilot programme that took place immediately preceding implementation. Prior to this, this researcher had no experience of mindfulness meditation but was aware that she was a participant observer in the enquiry process and not a neutral observer. Attempts not to interject the researchers own personal ideas of the programme into the data were made by drawing up an impartial and open-ended interview schedule, but acknowledging some research bias may possibly exist. On the other hand, the work experience and participation in the eight week programme enabled this researcher to build

a rapport with both clients and staff which helped create an atmosphere of understanding and connection.

In addition, the researcher was also aware that she may have inadvertently influenced some of the data, not only through her presence but also being present at the time of implementation. It is recognised that some participants may have associated the researcher with the MBRP Programme and could have supplied answers they thought were expected. Although it was reiterated a number of times that the researcher had no involvement with the MBRP Programme, it remains important to be aware that there could have been some researcher-led bias. With regards to researcher bias and researcher-led bias, David Silverman states: "To suppose that any researcher enters a field without past experience or some pre-existing ideas is unrealistic. To suppose their presence will not exert an influence on the data is equally unrealistic" (Silverman, 2010: 29).

Limitations:

This study was designed to explore the impact of MBRP on participants who had completed the eight week mindfulness programme. However, due to the nature of the drug treatment this was not possible in all three programmes. Of the three services to which the programme was introduced only one group, men's residential, had a closed format where all the participants at the end of the eight weeks had started together, at the beginning. The other two services had an open group format, where participants all joined the group at different weeks. This limitation may have detracted from the power of the study.

As noted in the methodology section, limitations with the use of focus groups also arose. Some participants, in each of the focus groups, remained quiet throughout the discussions. Efforts, made by the researcher, to encourage contributions by all participants were difficult and a small number remained quiet and contributed little to the discussions. In effect, the findings can only discuss what individuals did say in relation to their experience of the mindfulness programme and cannot generalise to participants who chose not to respond to the questions. As such, when

analysis refers to ‘the majority of respondents’, this can be taken to mean over seventy-five percent of participants shared similar opinions, perspectives or responses.

Finally, only two staff members participated in the study which limits the research to making any generalisations in relation to how staff of Coolmine received and viewed the programme. These were facilitators who volunteered to facilitate the mindfulness programme and due to the small number this cannot be taken to reflect staffs knowledge, perceptions or attitudes to the programme.

CHAPTER 4

Findings

From the initial reading of the data generated, through both focus groups and individual interviews, it became clear that there were mixed views on how the MBRP Programme was viewed and received by both staff and clients of Coolmine, across the three progammes to which it was introduced. Whilst there were some notable differences, there was also a number of emerging themes that the majority of respondents seemed to feel similarly about. The data collected was grouped into four main themes which are as follows:

- Receptivity to the Programme.
- Utility/Practicality.
- Mindfulness and Awareness.
- Mindfulness and Confrontation.

Receptivity to the Programme

Expectations/Preconceptions:

Interviews began by exploring participants' understanding and experience of Mindfulness meditation, prior to participating in the formal eight week MBRP Programme introduced to Coolmine. This was deemed essential in order to establish if the participants had any definite expectations of what the programme might involve and to examine the extent to which the programme matched up to their expectations.

Two staff members who acted as facilitators of the newly introduced MBRP Programme stated that they had both participated in an Eight Week Pilot Programme in the weeks immediately preceding implementation. One of the faciliatators stated whilst this was his only experience of Mindfulness, that he had twelve years of experience with formal meditation stating, *I've been a practitioner of Reiki since 2000, so I was pretty comfortable with the role.* (Staff member). In contrast, the second faciliatator stated that she had little experience nor understanding of

Mindfulness prior to commencing the programme. *Like, I'd some awareness of what it was and the benefits of it but it wasn't something I'd ever practiced before.* (Staff member).

The remaining twenty-one participants were clients of one of the three Coolmine Programmes. Of the twenty-one participants, two stated they had "a little" experience of Mindfulness meditation. The remaining nineteen respondents stated they had no previous experience with any form of formal meditation, prior to commencing the MBRP Programme. The majority of respondents stated that they "never heard of it before " and "it was brand new to me".

Given that the majority of respondent had little or no experience of Mindfulness meditation prior to participation in MBRP, all respondents were asked to comment on their expectations of the course. In all three programmes, nearly all respondents stated that that their expectations and preconceptions of MBRP were, that it was a programme of "relaxation". Many of the respondents equated meditation with relaxation and went on to discuss that these expectations were immediately adjusted after their first or second session of the Mindfulness Programme. A statement that typically represents respondents' initial expecations of the MBRP Programme was described by the following respondent: *You know, I thought it was for relaxing, centering yourself; you know the usual expectations I suppose people would have of meditation.* (Gareth). Following the second session of Mindfulness, he goes on to discuss how his experience did not meet up to his expectations.

> You know, an example when we first went in, I think it was our second class we were told to get into a comfortable position in the chair and close our eyes and I thought, 'lovely, nice chill out session'; but then they go through like being aware of the chair you're sitting in, how your feet touches the ground, noticing any aches or tingling in any part of your body and like actually feeling your weight in the chair. Like, that's just an example of when I first went in and my expectations were blown out of the water. This wasn't about relaxing; it was actually making my brain more aware than it had ever been. (Gareth).

Similarly, another respondent discussed how her experience of the Mindfulness Programme did not match up to her expectations. After her first session she describes:

> I could just feel pain, it brought up loads; and, I think, because I wasn't expecting that, I thought mindfulness was, we were just going to relax and do a bit of meditation; then it really knocked me for six when all these emotions and feelings start coming up, you know. (Marie).

Initial Experience of the Programme:

In order to assess whether the MBRP is a useful or beneficial programme to Coolmine, all respondents, in both focus group interviews and individual interviews, were asked to comment on their experience of the MBRP programme.

Across all three programmes, respondents expressed initial negative experiences with the MBRP programme with many stating they found it "too long" and "confusing". Many of the respondents noted that in the first two- three sessions, sitting for two hours was very difficult and the majority of respondents reported this period as both challenging and difficult. Many reported *difficulties understanding the programme and how it could help in their recovery* (Carla) as their biggest challenge. This initial difficulty, to understand the MBRP programme, contributed to the majority of respondents disliking the programme at the beginning and was echoed throughout the majority of respondents' interviews. One respondent notes*:*

> Well, at the start I didn't like it. I thought it was too long, what's the point of it, thinking "this isn't going to help me", this is gobbledegook. I really hated going into it, I just did not like it…. (Paula).

> Ye, I didn't like it either. I found it very hard. I kept falling asleep and sitting and getting agitated and that. I didn't want to sit with anything but, like, as the time went on it got easier. (Sharon).

Bearing this in mind, there were mixed views on whether mindfulness should be optional or compulsory. When respondents were first asked if participation in the course should be optional or compulsory, the majority of respondents stated, it should be optional. However, on reflection of their initial negative experiences of the programme, many of the participants changed their mind. Several participants stated, they would not have returned after the first session if they were given the option. This decision would have been based on their first impressions, with many stating that they would not have received the benefits of the programme if they had been giving the option of leaving.

> I think it should be compulsory because if it was optional, I would have turned around after the first two or three weeks, when I was going through experiences I didn't like, and not going back. I'd have taken that option, I know I would have. I'd have said, 'ah no, I'm not going back' but, by me having to do it, I did get into it and ended up really liking it. (Paula)

Understanding Mindfulness:

For the majority of respondents, their experience of the mindfulness changed in weeks three or four of the programme. In discussing their experience of the programme, most respondents in the men's and women's residentials stated that these were key weeks when their attitudes to the programme changed, from one of "confusion" to one of "gratitude" with many stating that they finally got an understanding of how mindfulness could help them in their recovery. *I was a bit iffy about it at the start, didn't know how it could be at the start but now I'm seeing how beneficial it can be cause I'm seeing now how it can slow your head down*. (Jenny)

Many reported feelings of relief and joy when they experienced for themselves how mindfulness meditation could help them in their recovery process. One respondent described a critical turning point when she experienced for herself how mindfulness could help her with her recovery process:

> ... because if you'd have seen me the first two weeks I was dreading even the word mindfulness… but something happened to me in that room in the third week. It was like I could feel it, all the tension and worry wash away

> from me just for that twenty minutes or whatever it was. I had relief from my head. I felt it, I felt relief for the first time since I'd been in here and since then I love it; I can say, hand on my heart, I love mindfulness, it gives me that relief; and I don't think anyone would understand how much it means to have relief from your own head unless they had been tormented themselves with their head. (Marie).

For many of the respondents, understanding mindfulness was very important to them in accepting and embracing the programme. When asked to describe mindfulness, nearly all respondents described it as " a practice of self-care" with the majority stating "it's about being in the moment". When asked further how this could help them in their recovery one respondent summed it up as follows:

> It's about living in the moment and it teaches you how to do that. Like, we've all heard the saying a million times: live in the moment, but this actually shows you how to do it. It's like, builds up your awareness of your emotions, your feelings and where you're at in the moment. It's good, you know. (Gareth).

Whilst the majority of respondents in residential care stated they got an understanding of the programme by week three or four of the course, this was not true for everyone. Three respondents stated that they still struggled to understand mindfulness and how it could benefit them at the end of the eight weeks. One respondent, in particular, stated that he struggled with the language being used and hence could not understand the programme or how it could benefit him.

> I haven't a clue what you are talking about, I never know what's going on. Like what did (Stephen) say there, it's about self-care or whatever he said; I don't even know what that means. I just don't get it, I'm lost in any of these like discussion things because I just don't know what any of you do be talking about. (Peter).

In contrast to the residential programme, most respondents in the day programme stated that by the end of the eight week course, they still struggled to understand mindfulness or how it could help them in their recovery. Five of the seven day programme respondents stated that they were only getting an understanding of the programme in the seventh or eight session, when the course was over. Reasons for not fully understanding the programme were cited by many as "too much messing" and "too many people coming and going from the day programme".

Implementation Issues:

Throughout the interviews many respondents from the day programme commented that they had no input or say as to whether they wanted to participate in the mindfulness programme. Many participants commented that participation should have been optional. Other complaints noted, included the time and day of the weekly group session, with all respondents stating that a two hour session on a Monday morning was a bad day. *I just find it difficult on Monday morning to come in and sit for two hours and, to tell you the truth I'm tired and nothing's really going in anyway.* (Paddy).

Furthermore, many respondents in the day programme appeared to have a number of issues with how it was introduced. *Ye, like we didn't get any notice or anything. It was just explained to us one week, like a bit what it was about and it started the following Monday.* (Mark).

> And, like, one of our groups was taken away from us to put this in, which I think was more important than this. Well, it was for me anyway [...] and also cause we don't have to be in until eleven on Mondays and we had to come in then for nine o'clock so it took nearly two hours that we didn't have to be in so I didn't like that either….. (Lisa).

These implementation issues, in addition to a lack of understanding on how mindfulness could help them in their recovery, appeared to affect how the partcipants received the programme. However, four of the seven respondents did note that whilst they were not initially "open" to the

programme, that they were becoming more open to it as the weeks went on. One respondent noted:

> Like, I think now that it's over, I'm kind of only getting a little bit of what it's about, like, even that sober breathing I didn't know what that was about but it's kind of coming to me now and now the course is over. I think there was probably too much messing for the first few weeks and, like, too many people coming and going; that it's only become a bit settled now in here that I'm kind of listening now – say in the last two weeks… (Louise).

Four respondents stated they believed it was implemented "too fast". This opinion was also shared by the facilitator of the mindfulness in the day programme who, when asked to comment on the implementation process of the mindfulness programme stated that whilst she could personally see the benefits of mindfulness, she also believed it was implemented too fast.

> I think it was rushed, it happened too fast. That's the best way of me describing how I think about the implementation of it. Even not so much on myself, like on me as well but also with the group we're working with – because the day that was set for mindfulness was important to the group for other groups. It wasn't really thought through long enough, in my opinion. Like it was just a matter of one day you're being shown to do some mindfulness and then bang, it's structured into the programme. Like there was no getting your head around it. (Staff member).

With regards to training, the facilitator noted that she was the only staff member in the day programme trained in mindfulness facilitation and would like to see more staff trained in order for it to have more of an impact on the day programme. This was also noted by the facilitator of the residential programme who stated:

> Ye, I think, if we're going to use it as one of the cornerstones of our

programme in the organization, then, I think, it's essential that all staff have some basic training so that they can, at least, facilitate a mindfulness practice. (Staff member).

The facilitator of the day programme also reported that whilst she was becoming more confident in her role as a mindfulness facilitator as the weeks progressed, she felt slightly overwhelmed and anxious in the beginning stages and could have benefitted from more training and support in adapting to her new role.

"[...] How can I teach something that I haven't got my head around? Having done the eight weeks pilot course, I got loads of learning....But like to go in after only eight weeks of personal participation in the pilot course and then to go in as a facilitator - I don't think it was enough time or I had enough training". (Staff Member).

Utility/Practicality

Across all three programmes, participants were asked if they felt mindfulness was a beneficial or valuable programme to Coolmine. There were mixed and varied responses to this question across the programmes. In both residentials, the majority of respondents stated that they believed it was a useful and a highly beneficial programme, with many stating thay had received great personal benefits as a result of participating. Benefits cited by most of the interviewees included:

To learn to sit with yourself is a positive and good thing and, I have to say, that's what it has taught me to do. (Anthony).
Just to stop what I'm doing for a few moments, check in with myself, and just realize how I'm feeling and be okay with it. (Lee).

I have got so much awareness. (Carla).

It also appears the mindfulness programme was intellectually stimulating for a number of participants, with several respondents stating it has 'opened their minds' and given them a 'new way of looking at things'. In relation to the discussions following the meditation practices the following respondent stated: *I look forward to them, he's (facilitator) very stimulating, I suppose. Like he can help you think about things in a very different way to what you originally went in thinking.* (Gareth).

With regards to overall experience of the programme, the majority of respondents stated that the mindfulness programme was "more than they expected". The following respondent summed up his experience of the programme as follows:

> It's more than what I expected. Just being aware of how I was feeling and that I'm going to be okay. Like it wasn't only sitting with yourself or reflecting or that, like, actually becoming aware and being okay with sitting with my feelings. And the fact that we would have the discussions after the practices was great because with the help of (facilitator), I could actually find the words, like, to describe the way I was feeling or where I was feeling. So, like, it wasn't just meditation where you sit and relax, it was then going through any experience you had and, like, talking about relapse and emotions and stuff. (Lee).

When facilitators were asked how mindfulness can be beneficial to Coolmine, one facilitator noted:

> To get clients to be okay with how they're feeling, and not wanting to alter or change them, that will be hugely beneficial to both Coolmine and its clients. That's a huge milestone in helping clients to advance into recovery and change their lives and, I believe, mindfulness can do that. (Staff member).

Retention:

A recurring theme to emerge from the data from residential care was how mindfulness has helped participants to live and stay in the residential community. Many respondents discussed how living in residential care was often difficult and intense. Many reported how mindfulness has given them a tool to deal with conflict that often arises in residential treatment, as well as the techniques to help them remain in treatment when they are often confronted with urges to leave and discharge themselves from treatment. In discussing how mindfulness can help retention, one respondent describes how participation in the mindfulness programme helped her in her decision to remain in the community:

> Like, I knew I wanted to get clean and stay clean but I didn't know whether I wanted to be here; and I just needed to know how to say no to drugs. And like, the staff member let me have my rant and he said to me, "just stop and listen"; and when he said that, I think, it was the first time in seven years that I heard anything; that I heard birds or cars or anything at all and he said, "that's all you have to do, just stop for a moment, stop talking, stop thinking, just stop and listen". And you know that explained it for me what mindfulness is. Literally just stopping and taking in sounds, like sights and what's around you now. And that's what I like about it; when your head starts telling you, "you don't need to be here, you are clean now, you can go home". Just to stop, do the sober breathing and focus on what you're doing now, (Marie).

The majority of respondents in residential care stated they felt the mindfulness programme would be a highly beneficial programme to Coolmine. With regards to conflict another respondent noted:

> Ye, it can help loads in here. You know it can get very intense in here sometimes so it's good to have something that you can do on your

> own, to give you a clearer head instead of adding sometimes to an already intense situation, sometimes. (Gareth, 37).

Several respondents spoke of utilizing mindfulness techniques they have learned on several occasions when they were faced with high risk situations. When asked to give examples of how they have used mindfulness skills in high risk situations, one respondent noted:

> I had seen my partner, my ex-partner, walking down O'Connell Street and he was after being taken a load of zimmos [street slang for a benzodiazepine-type prescription drug] and I happened to be walking home [...} and he was like, "here's a few zimmos for you, take a few" and I'd have loving to. I really wanted to but I know where they're going to lead me to, I'd end up going back using. But I started doing that sober exercise - I was stopping, observing, breathing, like, all in my head but giving me that few minutes, sitting down having a cup of coffee with him, I was doing that in my head. It brought back everything to me what I'm after learning, even when I was sitting there doing the observing, I even said to myself, "what are you doing sitting here?" and, like, I said no. (Paula).

The sober breathing technique appears to be the most practical and helpful practice amongst the participants with the majority of respondents reporting that they have used it on numerous occasions. In relation to utilizing the sober breathing in high risk situations, one respondent discusses how he has used it on numerous occasions.

> I've did it on three or four occasions with regards to drink. You know we can fool ourselves that it's only a few cans but I've enough awareness now I think to know that for me it's never only a few cans. I don't do a few cans. So for me, applying the sober breathing in times like this has been very helpful and to just realize alcohol is a trigger and to stay away from putting myself in situations where alcohol is there. And where I

> can't help it or stay away, be aware of that it's a trigger – keep myself in the moment and don't run away with, I suppose, a fantasy story of how great it would be. You know before I did mindfulness, I don't think I had the ability to walk away, I'd have ran with my head and said why not. (Gareth).

Whilst the majority of respondents viewed the mindfulness programme as a useful, valuable and beneficial programme, not all shared this opinion. Five of the seven respondents from the day programme reported that whilst they could see personal benefits as a result of participating in the programme, they would not regard it as a practical programme for the day programme.

> Now I'm not saying I have noticed any effects. I have got better with sitting with myself in silence, like, I'd have never did that so even for that it has had been helpful. And I use the CD at night to go asleep, you know. Even though I wouldn't do it again, like, I did get a lot from it. (Derek).

Others commented that they found it too long and boring: *I'm just not into the mindfulness. I don't be able to wait to get out the door from the minute I get in.* (Lisa). In terms of mindfulness being a useful or beneficial programme to the day programme, one of the facilitators agreed that whilst she believed it could be a useful and beneficial course to the day programmme, a number of changes needed to be made in order for it to be successful. She elaborated on this further by stating it *was too rigid for the day programme* and noted that it may be more useful for people further into their recovery. In contrast to the residential programme, the facilitator reported that clients in the day programme have not "done much group work on feelings and emotions" and may benefit more from group therapy initially, before being introduced to mindfulness meditation.

> Like when people land in here it's like they've landed on a different planet. You know, all of a sudden the minute they walk in we are talking about feelings. You know, a lot of people aren't okay with

> their feelings and it's probably going to take a while to even get them to acknowledge they have feelings. So I think trying to get them to sit with their feelings – I do think it would work better with people further on in their recovery. (Staff member).

With regards to further implementation, the facilitator states it would probably be more successful in the day programme if she was *able to put her own twist on it*. However, the literature states that fidelity to the manual is essential in order to stop adherence drift. This is where the programme becomes so diluted that the essential components are lost and in effect the programme becomes ineffective. Both facilitators stated they found the manual to be helpful and had no problem working from the manual but did report that they would like to insert their own style of facilitating into the programme. Both stated they found it challenging adapting to the role of mindfulness facilitator and not offer solutions to participants. In discussing this one staff member stated the following:

> The mindfulness, it's different, there's a different dynamic. It's not so much about making interventions, where a lot of the other approaches would be. Like, they would be deliberate interventions, where the mindfulness is simply bringing out what's already there, with regards to thoughts, feelings and sensations; and just allowing clients to be with that and sit with it. And, that has its challenges for me, because it's in my nature to want to jump in there and make some interventions.

Mindfulness and Awareness

In all three Programmes, the majority of participants expressed how they have experienced heightened awareness as a result of participating in the mindfulness programme. This was particularly emphasised by participants who had completed the eight week programme. Heightened awareness of feelings, thoughts, and emotions featured strongly for many of the respondents. In addition, participants also spoke of heightened awareness of themselves, of others, of triggers and cravings, with the majority of respondents stating they have gained greater

awareness as a direct result of mindfulness meditation. In discussing awareness and how it may be beneficial to clients in recovery, three respondents in particular, who had previous experience of relapse, noted they relapsed previously because *they didn't know any better*. Many participants spoke of running on automatic pilot where they "usually ran with their first thought". Participants also commented that this new awarenesss has given them a *new way of looking at things* and a new way of dealing with often conflicting and challenging emotions and feelings.

Thoughts are just Thoughts:

It became clear throughout the interviews that participants across all three programmes are faced with ongoing negative thoughts. These negative thoughts form a conflicting internal dialogue for many participants, ranging from a harsh critical voice to self doubt. Many participants reported how their desires to stay drug free were often conflicted with thoughts of using drugs, with five respondents noting how these conflicting thoughts had resulted in relapsing on previous occasions. The intensity of these thoughts was described by the following respondent:

> And you know sometimes it's hard to stop the thoughts but like before I did the mindfulness, when I was going to relapse, all I'd hear pounding in my head would be 'go and use, go and use, go and use'. Nothing else would filter in, no consequences, no nothing. That would be all blocked out. I would only hear go and use, sure you're going to do it anyway, you're only fooling yourself, you may as well do it now and I'd go and I'd use. And I'd keep using till it broke me again. (Lee).

This respondent further discusses how participation in the mindfulness programme has helped him become aware of his thought patterns and has provided him with a technique to observe and explore his thoughts so that he can respond positively instead of reacting negatively.

> So I'm hoping that when I get this voice saying go and use, that before it gets too loud that I can stop, observe what's going on, if I'm bored,

ring someone, see if they fancy doing something and breathe – Don't be running with it. (Lee).

Prior to participation in the mindfulness programme, many respondents stated they did not know how to stop the constant flow of negative thoughts which were often intense, distressing and destructive.

Ye, like that one 'it's just a thought' that is like a lifesaver cause that's all they are, thoughts and it is up to us whether we want to run with them and feed them or stop them. And we now have the technique to stop them, to bring ourselves back to the present moment before it goes too far and we've set ourselves up for a full-out relapse. (Mark).

As noted above, on a number of occasions throughout the interviews, many respondents stated that mindfulness has given them a 'new way of looking at their thoughts' with many stating that they no longer have to *run with their first thought.* Many reported they could now observe their thoughts, accept them as 'just thoughts' with many saying that mindfulness had given them the technique to stop the constant flow of negative thoughts which appears to be a dominant feature of many of their lives. Many respondents also commented that this concept of 'thoughts are just thoughts' was a powerful message to them and it has encouraged them to discuss their thoughts, not only with their group but in follow up therapy sessions with staff members.

Well, I think for a lot of girls, they think it's abnormal, a lot of the way They think .Well I know I did and, I think, it's the same for some of the other girls. So even just to let them know that they are only thoughts. I think that it is really good for that and a lot of people will benefit from knowing that and, I suppose, keep hearing that; like, cause it took a while for this stuff to sink in with me, like, when people would say, 'thoughts are just thoughts', I didn't really know what that meant. But as time went on I kind of got to understand what that means, like, when he would do the exercise that showed us how to watch how our

> thoughts come and go, like. You know, a lot of the girls are afraid to open up and that, afraid they be judged. (Jenny).

For the most part, many respondents reported that mindfulness has shown them how to stop the flow of negative thoughts by showing them how to return to the present moment. For many participants, being shown how to return to the moment was of great importance. Several participants mentioned that they had heard this phrase on numerous occasions beforehand but never knew what it meant or how to do it. This was a point noted by many respondents, mindfulness actually showed them how to return to the present moment. For most it involved applying the sober breathing exercise. It involved stopping, observing, breathing, expanding the breath and responding. In addition to the sober breathing technique, many of the respondents ,in the study, stated that practicing the *body scan meditation* has been especially useful at night-time when they are often faced with conflicting internal dialogue, with many commenting it helps them sleep and *slows their head down*. One girl in particular describes how mindfulness meditation helps her return to the present moment when she is faced with negative automatic thoughts:

> Like, I still need to do it now before I go to sleep but it really helped me when I was detoxing. You know, my head would be racing and I'd be thinking constantly of the kids and that, and the mindfulness really helped me with that. It helped me to stop, just stop thinking, do the body scan or whatever and bring myself back to the here and now. (Marie).

It is also became clear from analysis that clients undergoing drug treatment have a very harsh judgemental internal dialogue going on a lot of the time. In discussing how participants relate to themselves one respondent stated, *I would not talk to a dog the way I speak to myself* . (Lee).
This is a typical reflection of the self defeating thinking that arises in many of the participants views of themselves. Through engaging with mindfulness practices many respondents stated that they are now more aware of the critical voice inside their mind and try to apply a more gentler

and positive approach to to the automatic negative thoughts which arise on a regular occurence. One respondent notes:

> Like, everything I did was wrong. I'd always put myself down [...] before the mindfulness I was never aware of how critical I was of myself. I believed it to be true. Where now I say, "ye, you're feeling down but that's just because you're in a bit of bad space today but it will pass, just don't dwell on it"; and I say now "I'm not that bad, I'm alright. (Paula).

Whilst the majority of respondents stated that the mindfulness has encouraged them to be less critical of themselves, this was not shared by all interviewees. Three respondents, all clients of Ashleigh House, stated that they struggled with a session on 'loving kindness'. This session encourages respondents through guided meditation to observe their thoughts and show themselves some compassion and kindness. In discussing this, one particpant stated the following: *That's the one I struggle with. I just can't do it. I really don't like that one. It brings up too much for me; I don't feel I should be wishing myself anything.* (Niamh).

Similarly, another respondent stated:

> It's like you feel you don't deserve it. I feel any way that I don't deserve it; all the shit I've done to people, like my family and that, all the hurt and pain I've caused them. Ye, I don't deserve it. (Jenny).

<u>Awareness and Acceptance of Feelings and Emotions:</u>

It also became clear from analysis that participants undergoing drug treatment in each of the three programmes experience a wide range of negative emotions. These include feelings of guilt, shame, frustration, anxiety, remorse and anger. These emotions are often overwhelming and difficult and would be regarded as high risk situations for many.

For many participants, mindfulness has not only helped them become aware of the different range of emotions and feelings they experience , but has also helped them identify them, situate them, manage them and perhaps more importantly 'sit with them' and allow them to pass.

> The most positive parts, just building up your awareness of how you are, how you're feeling, how your body and mind are connected and one. And like beforehand, I would have separated them, I would have only been thinking about my head; like my head is wrecked but you know getting awareness of how your body and mind are connected. (Gareth).

Whilst the majority of respondents stated that a heightened awareness of feelings and emotions was both helpful and beneficial to them, not all respondents shared this view. Three respondents from the day programme stated that they did not like that mindfulness brought up strong feelings and emotions for them and furthermore, they did not feel 'ready' to deal with them. With further questioning, several participants in the day programme stated they have not much work on feelings or emotions. With regards to mindfulness bringing up strong emotions, one interviewee from the day programme stated: *Like, I think it's up to the person whether they're ready to deal with emotions and feelings, and I'm not...*(Lisa).

This statement would tend to support an earlier statement noted earlier by the facilitator of the day programme when she suggested that clients in the day programme had not done enough work on feelings and emotions prior to beginning the MBRP programme for it to have the desired impact.

In contrast, the majority of participants from the residential programme spoke of how this heightened awareness has been helpful and beneficial, with many stating it has enabled them to explore their feelings and talk about them in a group setting or through individual therapy. However similar to participants from the day programme, many respondents from the womens residential also reported that they have not done much work on feelings and emotions prior to particiating in mindfulness. One participant commented: *Ye, like I really look forward to the*

mindfulness because there isn't really any other groups that does focus on feelings and emotions. (Paula).

Several respondents reported that prior to participation in the MBRP programme, they were unable to to verbalise or put into words,how they were feeling. For many, mindfulness has given them the ability to explore and put into words how they are actually feeling and in effect, talk about them. One respondent in particular reported:

> Like, this is all new to me, it really is. I never knew about feelings or different feelings or anything. The only thing I ever knew was that I was feeling crap and needed something to help me and it always ended up being drugs, you know. (Paula).

In discussing how participation in mindfulness has helped her deal with these emotions and verbalise them she reports:

> Like, the whole meditation practice brings up a lot, in silence, nothing to distract you, on; [...] Like the way he (facilitator) really asks you to explain where, how, what feelings, like he helped me to put into words what I was feeling and that's big for me because I never knew how to. So, I wouldn't have even been able to talk about this kind of stuff in other groups because I didn't know how; and, like, then going in to talk to my therapist after it, I can, even now, put into words for her what's going on. (Paula).

For many participants, the very act of being able to identify and talk about feelings and emotions has enabled them to gain acceptance around strong emotions. 'Its okay' appeared to a powerful message for many of the respondents with many stating that the repetition of this phrase in the mindfulness meditation has helped them to change the way they relate to negative emotions. Several respondents noted how they tell themselves on a regular basis. One respondent noted:

> It's okay, it's okay to feel this way. Really, really powerful; nearly choked me up at one stage when I heard it in one session. I really felt like crying. But it's something I tell myself a lot of the time now. That meant a lot to me. (Stephen).

For many respondents, acceptance of their feelings is a major challenge. Many participants noted that they used drugs to change how they were feeling . Others noted that whilst they cannot use drugs in treatment to change how they are feelings that they use other forms of distraction in an attempt to alter or avoid uncomfortable feelings or emotions. Therefore, many respondents commented that learning how to sit through negative feelings and emotions and being accepting of these is very important to them . This was also noted by a staff member as one of main advantages that clients can derive from the mindfulness programme. In discussing this, the staff member stated:

> Realising that it's okay to feel uncomfortable. That you don't have to, necessarily, have to do anything about that; and to some extent getting comfortable with being uncomfortable because a good part of anyone's life is painful [...]. Whereas with the mindfulness is, well it not actually changing how you feel but getting an acceptance on how you do feel, even if it is uncomfortable and painful. The sooner we get over our resistance to pain the better and even more so for people in addiction. They have always taken painkillers to try resist the pain, where, I think, the main thing and the huge thing that clients can get from the mindfulness is to acknowledge and accept their pain or discomfort and be okay with it. (Staff member).

Anger Management:

Several participants reported that one of most beneficial outcomes of the mindfulness Programme has been how it has helped them control and manage their anger. This was especially evident in the data emerging from the men's residential but could also be observed in the day programme and womens residential. Several respondents from the mens residential,

noted that through engaging in regular morning practice, they felt a lot less stressed throughout their day. They also discussed how the sober breathing technique has helped them create a space between emotion and reaction which for many has resulted in them getting into a lot less conflict. Through applying the sober breathing, many participants stated that it gave them the ability, on many occasions, to step back from often intense situations which prior to engaging with mindfulness meditation would have probably resulted in verbal or physical aggression. One respondent in particular elaborated on this further by stating:

> I couldn't say if I hadn't have done the mindfulness and got that sober technique. I don't think I'd be probably in here to tell you the truth. I think I would have lost my temper and lashed out and probably got into a physical fight because I've been up a lot of times where I really wanted to punch the head off someone and usually I would have. But I have just did the breathing thing that (facilitator) showed us and it has helped me, I suppose, walk away from situations and be okay with walking away, on a good few occasions. (Lee).

Similarly, another respondent reported how he applies the sober breathing technique in helping him deal with anger and conflict: *I just say stop, relax, chill; just pause before you approach someone, helps a lot in here.* (Gareth).

<u>Awareness of Triggers and Cravings:</u>

In addition to reports of heightened awareness, a greater awareness and recognition of triggers and high risk situations were also reported by many of the respondents. In discussing this, a large number of participants stated that prior to participation in the MBRP programme, they were aware that *people, places and things* were triggers for relapse. However, many stated they were unaware of bodily sensations, emotions and thoughts that often precede cravings.

> Ye, like, I'd have thought I knew what my triggers were, like, say places where I used or scored or that, but I'd have never have been aware that

> emotions and that were triggers, like never. And I can definitely see now how they are big triggers, for me anyway. Like, if I relapsed before I'd have put it down to that I met someone and they had drugs and I used. But now I can see how probably for days before actually using I was depressed or sad and I left myself dwelling in it, putting on sad music, not talking to people and isolating myself. But I was never aware of any of that, that I was like setting myself up to relapse and that when I'm feeling that down that I relapse. (Paula).

Many respondents spoke of their tendency to act on 'automatic pilot', without full awareness of what they were doing. In discussing this, many interviewees stated that they can now see how on many occasions they had set themselves up for relapse. For many, this awareness was new to them and stated that through engaging with mindfulness meditation they are now more aware of when they are setting themselves up.

> I was walking through town and started walking down a street that I know people would be there that I used with and when I was there I actually stopped, asked myself what the hell was I walking down there for; took a couple of deep breaths, turned around and walked away. (Louise).

In addition to greater awareness of triggers and cravings, several respondents stated that the programme has enabled them to openly discuss cravings in a way they probably would not have previously. The following respondent stated how she felt comfortable in the mindfulness group to discuss cravings:

> Well, for me, I wouldn't have been open and honest in the groups before this, about craving or anything; and I'd have really struggled with that. I was constantly craving but I wouldn't have said it because I'd have been afraid I'd get judged or that. Like, the staff or the group would think that I didn't really want to get clean. (Lynn).

Closely associated with participants' discussions of triggers and cravings was choice. *Like, that's another thing I've learned now, it is my choice whether I use, if I stop, do my breathing and still choose to use, I've made a choice.* (Marie).

Mindfulness and Confrontation

Another overarching theme to emerge from analysis was how confrontational, mindfulness meditation can be for many participants. As noted earlier, most participants equated Mindfulness with relaxation prior to attending the sesssions. Whilst a number of respondents stated it did help them with relaxing, for many this was only a small part of their experience of the mindfulness programme.

> I think they should take the word meditation out of it. I think that's false advertising (laughs). That makes you think you're coming in here to be nice and relaxed when that's not the case at all. You're going to be confronted with a whole range of emotions and feelings and thoughts that you probably didn't even know was there; or you did but have pushed them away and now you're being asked to let them come up like and then talk about them. It should be called 'hard-work relapse prevention' not meditation. (Gareth).

The majority of participants described it as *hard work* with many reporting *sitting with yourself, as work* in itself . Many respondents discussed how they would usually use distraction as a method of dealing with unwanted emotions and feelings but could not do so in the two hour mindfulness session.

> I think when we're not in here, in this room like, we can distract ourselves, like, when we're getting triggers or cravings, you know, go out, have a cigarette, turn on the music, talk to the girls. Whereas, in here when something comes up you can't distract yourself; you just have to sit with it. (Carla).

For most respondents, this was good thing as it has helped them to come face-to-face with unwanted feelings and assisted them in how to deal with a range of emotions which would have been otherwise suppressed. Many respondents commented that they have been confronted with the strongest emotions, feelings and cravings, whilst sitting in a mindfulness session with one participant reporting:

> You know the only times I've ever felt strongly that I wanted to walk out of the room or out of a group was during mindfulness. Like the strongest feelings I've ever got in here was during mindfulness. You know, sitting with yourself, getting confronted, I suppose, with some strong emotions, like what Lee was saying, being confronted with strong cravings and triggers and having to sit with them and then discuss what went on for you during the exercise. That's very hard. Like, sometimes I wanted to just get up and walk out but it I didn't. (Stephen).

Another respondent described how he was confronted with the most intense cravings to use drugs after session two of the mindfulness programme. This session encourages participants to experience triggers, cravings and thoughts of using drugs, without reacting. Several respondents reported this session as being highly confrontational but one in particular described the intensity of the cravings to use drugs following this session. He described it as the most confrontational work he ever experienced.

> You know the week we doing the triggers and cravings, you know, I got really, really angry about it because we were doing it with (facilitator) and, like, he made us bring up situations where we get cravings ; I was only in the door a week you know and this was the second session, I think. And I got these mad cravings as soon as he did it and I wanted to just go and use there and then. The sweat was pouring out of me and he did an exercise with us then to take us back away from the craving and I just

> couldn't do it; I couldn't come back from it. I went bleeding mad, I did. I told him I thought it was stupid and irresponsible to be making us do that, you know it wasn't right. (Lee).

Several respondents, who had stated throughout the interviews that they did not particularly like the mindfulness programme, cited the confrontational nature of it as one of the reasons they did not like it. This was particularly evident with a number of women, in the study, who reported that they were often confronted with painful memories and strong emotions during meditation practices. For many, they felt they were not ready to deal with these emotions. The following quotation typically reflects the responses given by a number of respondents who stated that they did not like the programme due to its confrontational nature: *Ye, that's why I don't really like it, it brings up too much stuff for me that I don't want to be thinking about. I don't know, I don't think I'm ready to be sitting with my thoughts*. (Niamh).

On the other hand, many stated that they have benefitted greatly from the confrontational aspect of the programme, with many describing their experience of mindfulness in Coolmine as *the hardest work I've done on myself since I got here*. (Paula). Throughout the eight week course, several respondents acknowledged that whilst on occasions they were confronted with strong emotions and feelings, that it had given them something to work on, in the context of the group or with their individual therapist.

> I'm delighted it was hard work because the mind is a powerful thing. It can make us believe things that aren't true and any tool that can help me with my mind and sort the rubbish from the truth, I'm only happy to do. (Chris).

Mindfulness in the context of other groups at Coolmine:

All respondents were asked to comment on how mindfulness groups differed to other groups held at Coolmine. As noted earlier, many respondents stated they felt that mindfulness deals with emotions and feelings unlike any other groups at Coolmine.

> Like, the other groups would be open groups, they wouldn't compare to the mindfulness. Like, they wouldn't get into how you're feeling or about your thoughts or anything. Like, the mindfulness brings up a lot of stuff for me to work on where the other groups it's, like, whatever the topic is, that's it. And for me, it's more like a discussion on the topic rather than any kind of therapy; where for me, the mindfulness really gets in on you and it's, like, therapy for me. I feel, like, I'm actually getting something from it that is helping me recover. (Paula).

With regards to confrontation, many respondents stated that mindfulness was *confronting yourself rather than others.* It appered that some participants were more comfortable with being confronted by others than sitting with themselves in the MBRP group: *Whereas if someone comes in and does a pull up or gives you a concern you just say alright. So for me it's a lot harder to sit with yourself. I can take a pull up on the chin.* (Paul).

However, this was not true for everyone. Many stated that they were more comfortable with confronting themselves, with many saying they felt nervous and uncomfortable in concern groups or groups that challenged them on their behaviours or attitude. In discussing concern groups, one respondent noted *I get very nervous or something. I much prefer the mindfulness; I'd be more comfortable in there. (Andy).*

Some participants commented that they found it was completely different to any other group they have attended in Coolmine:

> And you know it was kind of like a shock because in here (mens residential) you're asked not to think about using, not to talk about using.
> So it was kind of opposite to what we're usually told. It was a bit different, a different approach, I suppose, to what Coolmine would usually take. Like, we're told not to be thinking about using, and then we came in here and we were told to think about it so I think it threw a lot of people. (Paul).

The extent to which mindfulness conflicted with Coolmines usual approach to relapse prevention was discussed by a number of respondents. In discussing this issue, a member of staff noted:

> Again, I've brought this up a lot. In early recovery I would have advised people to avoid situations and maybe even avoid things that you associate with drugs or things that may trigger you, avoid them. So, I do be a bit conflicted here around it, around the 'urge surfing' like the person who would have taught me that would have said: Don't use that technique until someone is at least three years in recovery. So ye, I think people who are in early recovery and we're asking them to say 'urge' surf, I think it's a bit much, too early. (Staff member).

Finally, whilst a number of respondents did note that it was a new approach taken by Coolmine, the majority of respondents did state it *fits well* with Coolmine, as it is a self-help approach and can be practiced alone or as part of a group. One respondent noted:

> It's a new approach and, like, their trying new things in here at the moment. And, like, I've been a client in here, when it was old Coolmine and then more recent, new Coolmine. And while I wouldn't agree with everything, I like the mindfulness and I feel it will be very beneficial to the Coolmine programme – and, like, it fits well with Coolmine as well because it's self-help, you know, and that's what Coolmine is all about. (Chris).

Similarly, another respondent noted: *Like, it fits in well around here anyway. It fits in with the anger management workshops and it's dealing with emotions and feelings; and you know you're helping yourself; it's another tool to help yourself.* (Lee).

Chapter 5
Discussion and Conclusion

This project set out to conduct a qualitative study on the introduction of MBRP into a drug-free therapeutic community. Against the background of a therapeutic community already engaged in a change process it specifically aimed to:

1) Gain a thorough understanding of the MBRP programme as percieved by both clients and staff.
2) Investigate the mechanisms by which the programme may be helpful to those with substance abuse problems.
3) Examine the implementation process in the context of a therapeutic community.
4) Explore participants personal experience of the programme and gain insight into the self percieved effects/benefits of the programme.

Through a detailed analysis of the data generated it is possible to explore these aims.

Receptivity:

The findings presented in detail in chapter 4, in combination with the literature review show clearly that significant changes have occured within Coolmine TC, both at staff level and client level-in that both groups are largely positive, albeit a few, about the introduction of MBRP to the Coolmine programme. Whilst the findings suggest some implementation issues, in the day programme particularly, in general the programme was well recieved by both clients and staff. These findings would support the view that Coolmine as an organisation has changed signficantly, from an organisation that was once so resistant to change to an organisation now more open to change. As noted in the literature, the TC as an addiction modality, evolved from the highly controversial American TCs where aggressive confrontation was an explicit feature of its therapy and community lifestyle. However in recent years significant changes has being observed in Coolmine as in other European TCs where there has been a gradual move away from confrontation style therapy to therapy more based on dialogue and discussion. This significant shift was further developed by the introduction of CRA in 2010, as Coolmines

primary form of treatment. In contrast to aggressive confrontation that was once the cornerstone of TC treatment, CRA is entirely non-confrontational and client centred in its approach. The findings of this research would suggest that the acceptance and largely positive reception of the MBRP programme by both clients and staff serve to further support the view that Coolmine TC is open to new treatment modalities which as the findings suggest appear to offer real benefits for its clients.

In relation to how the programme was recieved in Coolmine an interesting point to emerge is that MBRP was better received in the two residential services, while clients and staff in the day were programme were less enthusiastic about it. There appeared to be mixed views in the day programme with some stating, that whilst they could see the benefits of mindfulness meditation, they were unsure as to the purpose, value or utility of the practices. There appears to to be no one reason for this lack of enthusiasm by the clients in the day programme but the findings would point to a number of implementation issues that may have contributed to the differences. Prochaskas and DiClementes (1984) stages of change theory suggest that any individual or organisation must pass through five stages of change before any new practice can be implemented. These stages are 1) precontemplation 2) contemplation 3) preparing for action 4)taking action 5) maintenance. This theory also suggests that if any of the stages are overlooked or rushed through that the practice will be implemented ineffectively or not at all. This study would suggest that perhaps the first two stages were overlooked in terms of the day programme, and as such, clients and staff perception of the programme was slightly different to how clients percieved it in the residentials.

The mindfulness literature also states that mindfulness facilitators should have sufficient time and training in order for them to deliver the programme effectively. The findings would suggest that more training and time would have been desired by the facilitator of the MBRP programme. It must also be noted that all three programmes are not the same, they have a different dynamic, different structure and and have differing client needs which clearly reaffirms that shows that whilst all the services are Coolmine programmes, one size does not fit all.

Linking in with the literature, this was a interesting finding, as the MBRP programme is designed as an outpatient and aftercare approach to treatment. The literature also states it is best suited to individuals whom have completed an inpatient or outpatient programme (Marlatt, 2011). These findings would perhaps contradict that statement, as the clients who reported the real benefits were clients from the residential programmes, and in particular clients who were detoxing. Many participants described how a number of practices, in particular the body scan and the sober breathing exercise, helped them through their detoxification period by helping the return to the present moment when they often felt overwhelmed and frustrated. The findings support the addiction literature which state that individuals in early recovery are often overwhelmed by painful and stressful thoughts and emotions and mindfulness meditation can help with this.

The literature states that in recent years, TCs have adopted and implemented a number of evidence- based pratices in an effort to increase retention and reduce relapse ,as studies have shown TCs to have relatively high realpse and drop-out rates. The findings of the study would suggest that MBRP could increase retention in Coolmine as many participants spoke at length of the difficulties and challenges they experienced in the residential programmes and how the mindfulness practices has helped them in their decision to stay in the community. Research has consistently shown there is a positive relationship between retention and outcome where the biggest predictor of successful outcome was time spent in the programme. (De Leon, 1986) (Simpson, 1984) (Kooyman, 1992). Therefore, findings from this study would suggest that if mindfulness meditation can help clients stay in the community and complete their treatment better outcomes for clients can be predicted.

Mindfulness is defined as *paying attention in a particular way on purpose, in the present moment, and nonjudgmentally* (Kabat-Zinn, 1994). That is, individuals are encouraged to attend to internal (physical sensations, emotions and thoughts) and external (environmental) stimuli as they arise, and approach them with an attitude of non-judgment and acceptance (Baer, 2003). This proved to be very helpful to clients in Coolmine as it became clear from the findings that individuals with addictive disorders are often faced with a constant flow of negative and unpleasant thoughts and emotions. Prior to participation in the mindfulness programme, many

particiants stated that they did not know how to stop the flow of negative thoughts and emotions which were often distressing and destructive for a large number of clients. For many participants, mindfulness helped reduced the flow of negative thoughts by showing them how to bring awareness to the present moment. Being shown how to return to the present moment was an important concept for many participants as many stated, they had heard this phrase a number of times but didn't know how to do it. This idea emerged a number of times in the data, where participants discussed the most beneficial aspect of the programme was being shown how to engage with the practices. The findings also suggest that it has enabled many of the clients to identify and communicate their feelings through engaging with the formal practices. For many participants, this was highly beneficial, as linking with the literature, many clients had poor awarenes of thoughts and feelings on entry to drug treatment and could not verbalise or communicate how they thought or felt.

Another important finding was participants desires to understand the MBRP programme. A large number of participants report a critical turning point in the programme, as when they got an understanding of mindfulness and how it could be beneficial to them in their recovery. Understanding mindfulness came at different stages of the programme for most participants. Those who began at the beginning of the eight weeks reported weeks three and four as their critical turning point where others who joined the groups in the middle of the programme reported different weeks. Although the findings suggest that no matter when individuals began the MBRP programme, it took about three to four weeks to gain an understanding of mindfulness and how it could be helpful to them in their recovery. Linking in with literature, Marlatt designed this programme as a closed format group where it is designed with the expectation, that those at the end of the eight week programme where there at the beginning of the eight week programme as each session builds on the session beforehand. Research carried by Marlatt and colleagues found that individuals who missed or had been unable to attend any of the earlier sessions tended to be less engaged with the programme and unable to 'catch up'. This research would support that finding as it was noted that a number of participants who entered the groups mid-way through the programme found it difficult to comprehend mindfulness or engage with the programme. This was especially evident in the day programme, where due to the nature of

drug treatment, clients were coming and going from the programme at various stages of the day programme.

One of the most interesting findings in the broader context of the traditional TC, is that nearly all clients report MBRP as quite confrontational. Many reported surprise at how confrontational they found mindfulness to be. Prior to participation, most participants equated mindfulness meditation with relaxation and as the literature notes, this is explicitly not the aim. However in MBRP, clients are confronting themselves, whereas as the literature notes, in the old TC style of treatment, clients were confronted loudly and aggressively by staff and peers. To confront literally means 'come face to face' and the findings of this study would suggest that mindfulness meditation has clearly helped clients come face to face with their present situation and in effect has helped them confront negative thoughts and emotions that would otherwise contribute to their urge to use.

Conclusion:

The addition of MBRP as an adjunctive treatment to Coolmine appears to confirm that this organisation has now shifted significantly away from its history of aggressive confrontation tactics to a new style of client management which has proven to be more effacious. This study set out to explore how MBRP has impacted on the TC to which it was introduced and examine how both staff and clients percieved the programme. To a large extent it was received quite positively and findings from this study would suggest it to be a highly beneficial and valuable treatment modality to Coolmine. The educative and therapeutic elements of the MBRP programme appear to fit in well with the TC approach to drug treatment. Within the TC tradition, recovery is seen as developmental learning process where the individual is the main contributor to their own change. Their perspective also holds the drug use is a disorder of the whole self and addiction is merely a symptom. In effect the TC approach to approach to treatment has been to address the whole person. The findings of this study would suggest that MBRP is consistent with the TC approach to treatment as it also addresses the whole self through raising awareness of negative thoughts and behaviours and placing clients at the centre of their

own recovery. It is also a self help approach which uses ‘group as method’ which is a central component of TC treatment.

Recommendations:

- It is recommend that more thought be put into exploring the differences between day programme and residential programmes, so that while not discounting the value of MBRP, its future use will be based on a recognition of difference, with such difference being reflected into the provision of staff training for use of MBRP with clients who are not in the relative safety of residential care.
- It is also recommended that more thought be put into deciding whether it should be open or closed group format, as finding from this research would support findings from earlier studies that suggest it may be more beneficial if the groups are ‘closed’
- Further training is a must for mindfulness faciliators with the pssibility of traing all staff in performing basic mindfulness practices.
- It is recommended that more effort be put into expaining the programme to clients as understanding mindfulness was a critical turning point for many clients

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APPENDIX A: Interview Guide for Clients

As you know, I am interested in hearing peoples opinions of the mindfulness meditation programme which has recently been introduced here at Coolmine.

- Before your participation in the Coolmine MBRP, what did you know about meditation or what experience did you have?
- What expectations did you have of the MBRP prior to starting it? How clear or vague were your expectations?
- What, in general, has been your experience of the programme?
- What, in your opinion, are the most positive aspects of the mindfulness programme?
- What did you like least about it?
- Was there any key point that you remember when your feelings about the programme may have changed?
- Have you learned anything about yourself as result of attending these groups?
- Can Ii ask you what is your experience of relapse?
- Do you feel this programme will be helpful for you in dealing with triggers and cravings?
- What was the most challenging part of the course for you?
- Did you find it to be valuable?
- If you could change anything about the course, what would it be?
- Do you think you will continue to practice once the course is over?
- Finally, would you recommend it to others?- {what would you say to them}

APPENDIX B: Interview Guide for Staff

- Can you tell me did you have any experience of meditation before this programme?
- I'm wondering, prior to your recent experience of meditation here at Coolmine if you had any definite expectations and if so to what extent did your experience match up to your expectations?
- In overall terms, what views have you formed about the way in which the meditation programme has been implemented in Coolmine?
- Tell me about your training. Did you find the manual helpful?
- Do you feel you have had enough support?
- How does it compare with facilitating other groups at Coolmine?
- My impression is that there are mixed opinion about how staff facilitate meditation based groups, some think it is much easier than facilitating other groups, others believe the opposite. Where do you stand on this?
- What are the main things you have learned about yourself as a result of participating in the programme?
- What, in your opinion, are the main advantages which clients will derive from the meditation programme?
- What changes in individual clients have you see thus far which may be attributed to the meditation programme?
- In your opinion, is the meditation programme suitable for all clients or could you identify some types of clients who you would consider to be unsuitable?
- If you could change anything about the programme what would it be?

  What in overall terms do you think is the value of the mindfulness programme for Coolmine on its clients?

APPENDIX C : Focus Group Schedule

Welcome

- Good afternoon and welcome. Thank you for taking the time to come here today to discuss knowledge of and attitudes to mindfulness as a relapse prevention technique. My name in Anita Harris. I am a Masters student in Applied Social Research in Trinity College Dublin.

Overview of the Topic

- My study is seeking to gain an insight into your opinions and views of the recently introduced mindfulness-based relapse prevention programme.
- The aim of the study is to explore your views and perspectives of the programme as you can make a valuable contribution to our understanding of this newly introduced programme.
- The session should last about 60 minutes. The aim is to explore a number of broad questions.
- I am here to learn from you. I'd like to hear about your understandings, thoughts and opinions on mindfulness. I am interested in hearing as many different things about this as possible and from as many of you as time allows.

Ground Rules

- There are some things that will help the discussion go smoothly. First, it would help if we could have just one person speaking at a time and if you could just state your name before you speak, that would be really helpful.
- I am here to ask questions, to listen to you, and to make sure that everybody has a chance to share their view. I am interested in hearing from each one of you.
- There are no right or wrong answers. I expect that you will have differing points of view. If your view is a little different from what others are saying then that is exactly what we want to hear from you. Please feel free to share your point of view even if it differs from what others have said.

- I am recording the session because I don't want to miss any of your comments. Your comments will be treated as strictly confidential and no names will be included in any reports or publications.
- And can we establish that what is says in the room stays in the room
  Before we begin, I would like to thank you for your time and participation. I understand its a Friday morning/afternoon and you may be feeling tired so again thank you, it is much appreciated.

Im going to start with what I know is a really difficult set of questions about mindfulness and how people understand this idea:

<u>Knowledge</u>

- How many of you had heard of this idea before it recently became part of the Coolmine programme?
- How easy or difficult would you say it is to really understand mindfulness?
- If you were asked by someone to explain what mindfulness means by somebody who had never heard of it, how would you respond to this?
-

<u>Attitudes</u>

- How can mindfulness be helpful to you in your recovery?
- What do you most like about the mindfulness programme?
- What do you find most difficult about the mindfulness programme?
- Was there a key moment for any of you when your thoughts or feeling about the course may have changed?
- Im aware that there was quite a big group at the start of the 8 weeks and a lot dropped out, can you say why you think a lot of them dropped out of this group?And why did you decide to stay?
- How did you find (Facilitators name) style of conducting this group?
- Ive heard some people suggest that clients going through addiction treatment become relatively comfortable with more confrontational style groups, but oddly enough, find meditation quite uncomfortable, have you any views on that?

Behaviours

- What effects, if any, has anyone noticed since joining the MBRP group?
- Do you think you will continue with the practices once the course is over? Is there any specific ones in particular?
- How beneficial, in overall terms, would you say that mindfulness will have to the Coolmine rehabiliation system?

APPENDIX D: Informed Consent Form

<u>Project title</u>: A process evaluation of the introduction of mindfulness-based relapse prevention (MBRP) into a therapeutic community for substance abusers.

Who am I?

My name is Anita Harris and I am a student at Trinity College, Dublin where I am currently doing a masters in Applied Social Research. For the past couple of months, I have been doing my work placement at Coolmine where I have been following the implementation process of the newly introduced Mindfulness- Based Relapse Prevention Programme.

Purpose of the study-

As part of my dissertation, I am conducting a study on the MBRP programme and with people who have participated in the eight week programme. The study aims to explore personal experiences of the programme as your direct experience, views and opinions will be of great value to further groups and the full integration of this programme in Coolmine. Participation is completely voluntary.

What does taking part involve?

If you agree to take part in this study you may be asked to take part in an interview. The interview will involve just you and the researcher and interviews will remain confidential. The interview should take approximately 40-60 minutes in a time suits you in a room at Coolmine that you would feel comfortable in.

The interview will be confidential and your name or any personal details that may make you identifiable will be removed from the study. For the purpose of accuracy, interviews will be recorded with the use of a

dictaphone and transcribed. After we have our interview, I will listen to them and type up what we said. These will be kept in a safe and secure place and as soon as interviews are typed up, recordings will be deleted immediately.

A focus group will also be conducted at the end of the eight week programme and you may asked to participate in this also. This is to ensure that everyone who wants to participate gets a chance to give their opinions and views of the programme. This group will also be audiotaped for the purpose of accuracy and to ensure I pick up what everyone has to say. Once again no names will be used and any identifying details will be removed from transcriptions. It is upto you how much or how little you want to say in the focus group and again, participation is voluntary.

Do I have to take part?

Although your experience of the programme is of great value and interest, you should not feel you have to participate in this study. In other words, taking part is voluntary and it is your choice. If you decide to take part, you can change your mind at any time, even during the intervew. If you feel uncomfortable with any of the questions, you do not have to answer them. You can terminate the interview at any time and any recording will be deleted.

Confidentiality

The interview and focus group interviews will be confidential and your name will not be mentioned in the final research project or any further research publications or presentations.

What you say in the interview is **completely confidential**. The researcher cannot tell another person what was said in the interview **except** where there is immediate risk of harm to you or another person. If this arose,this would be discussed with you. Fell free to ask me questions about this.

All information I collect will be kept in a password protected computer and tapes in a locked filing cabinet until they are to be destroyed. In order to protect your identity I will be giving you a “fake name” and in any

documents, it will be this fake name that is used. Any other information that may make you identifiable will also be removed.

What happens to the information you provide?

The information you provide will be used for my final dissertation. It may also be used in any for further presentations or publications. Your name or any information that may identify you will not be used in any of these reports.

Contacts

If you want to discuss any aspect of this study or have any questions please contact me at :

Researcher: Anita Harris. Phone number: 085 733 8872

Supervisor : Shane Butler Phone number (01) 896 2009

Consent Form For Participation Research

Informed Consent Form

Declaration:

I have read this consent form and understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this study.

I have been given information about this study and have read and understand the purpose of the study which was outlined in pages 1 of this document.

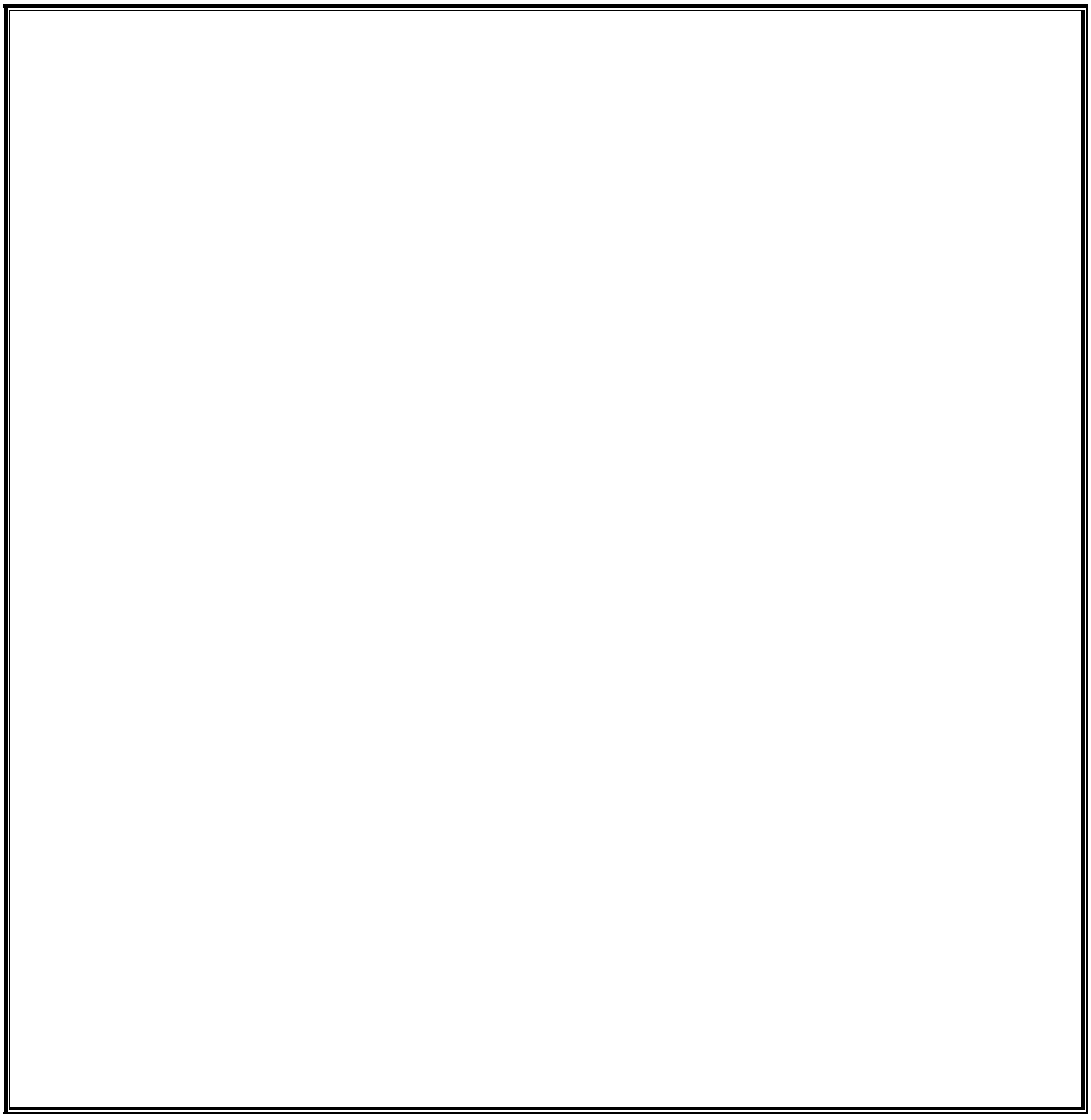
I understand that any information I give will be treated with complete confidentaility and in anonymity. I understand that if the information is published or used for further research, my name will not be used in any of these records.

I understand that as part of this study, audiotapes of interviews will be made. I understand that my name will not be used in any of these records and that only the researcher will have access to these tapes.

Name of participant (in block letters) _____

Signature of Participant _____

Date / /



APPENDIX E: Coding Categories

Receptivity to the Programme

- Expectations/Preconceptions
- Initial experience of the Programme
- Understanding mindfulness
- Implementation issues

Utility/Practicality

- Retention

Mindfulness and Awareness

- Thoughts are just thoughts
- Awareness and acceptance of feelings and emotions
- Anger management
- Awareness of triggers and cravings

Mindfulness and Confrontation

- Mindfulness in the context of other groups at Coolmine.