

Understanding former heroin users' experience of change.

An Interpretative Phenomenological Analysis

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ABSTRACT

This study aimed to explore the experiences of those who have been involved in change from problematic heroin use and how they have made sense out of their experiences.

Seven participants, who had been abstinent from heroin for a minimum of two years were interviewed about their experience of change. Practicing drug workers were chosen who had previously used heroin and were now employed to support individuals who were still using drugs. In this way they represented former drug users who had made significant long-term change.

Interviews were analysed using Interpretative Phenomenological Analysis (IPA). Three superordinate themes were identified, which were, 'Making sense of change', 'Identity, Relationships and Lifestyle' and 'Internal Distress'. A number of subthemes were also identified for each superordinate theme.

Implications for substance misuse and Counselling Psychology included increasing awareness of the complexity and factors involved in change and appreciating change from former heroin users' perspectives. This challenged current and more popularly-held perspectives consistent with political and organisational agendas which focus upon costs associated with heroin use.

Factors such as a change of mind-set, identification of avoidance behaviours to manage emotional pain and distress and finding alternative ways of managing pain may also apply to other forms of change, such as other forms of addictions and weight loss.

Implications for Counselling Psychology included a consideration of self-transformation and the factors which may initiate behavioural change and the importance of appreciating ongoing aspects of change including identity, relationships and lifestyle.

INTRODUCTION

Why understanding change is important

It is important to understand what a person involved in substance misuse would consider 'change' to mean. This idea is in line with a Counselling Psychology approach to understanding the individual and how he/she makes sense of the world from a unique perspective (British Psychological Society, 2005, p1-2).

In the field of substance misuse, the terms 'recovery', 'abstinence' and 'change' are often used interchangeably. These are often politically and socially motivated terms in which 'recovery' is often focused on treatment outcomes, based on short term change and reducing the financial impact of problematic substance use. The costs of problematic heroin use are severe, whether in terms of economic impact, social issues, relationship and family impact, health or mental health (National Treatment Agency, 2013a).

The disease model of addiction describes an addiction as a disease with biological, neurological, genetic, and environmental sources of origin (McLellan, Lewis, O'Brien, and Kleber, 2000, p1689-1695), and can be likened to a chronic disease similar to other chronic diseases such as type II diabetes, cancer, and cardiovascular disease. However, critics of the disease model, particularly those who subscribe to the life-process model of addiction (Booth Davies, 1997; Peele, 1992), argue that labelling people as addicts keeps them from developing self-control and stigmatizes them. As noted by the harm reduction specialist Tatarsky, "The essence of this model is the pragmatic recognition that treatment must meet active substance users "where they are" in terms of their needs and personal goals. Thus, harm reduction approaches embrace the full range of harm-reducing goals including, but not limited to, abstinence" (Tatarsky, 2003, p249).

The life-process model of addiction is the view that addiction is not a disease but rather a habitual response and a source of gratification and security that can be understood only in the context of social relationships and experiences.

Laudet and White (2008, p.28) maintain that 'findings from most studies speak to recovery initiation only, not to the challenges and processes involved in achieving and sustaining long-term recovery'. In addition, they contend that most of the research is mainly focused on treatment outcomes, while recovery from addiction is more than not using drugs or alcohol in an otherwise unchanged life. For the participants in their study, 'resolving an addiction involves profound identity work for years after the factual cessation of the problem behaviour' (p. 200).

I aim to outline the complexity and contribute further to the work of researchers such as Tatarsky and Laudet by considering themes which are likely to be important when considering change from heroin use from ex-heroin users' perspectives, including factors involved in achieving and maintaining change and why this may be difficult to achieve.

LITERATURE REVIEW

Theories of understanding change

Understanding how people change has long been of interest for both counselling and psychology. Various theories and models have been put forward to assist people in achieving and managing different forms of change. There are several forms of behaviour change theories such as the Health Action Process Approach (Schwarzer, 1992), Theories of Reasoned and Planned Behaviour (Ajzen, 1991) and Social Cognitive Theory (Holt and Brown, 1931). Each of these theories cite environmental, personal and behavioural characteristics as the factors that determine human behaviour and can be applied to changing from substance using behaviour. Self-efficacy (Ormrod, 2006) is an individual's belief of their own ability to perform a challenging task based upon factors like previous success, psychological state and outside sources of persuasion. An individual's attempts at changing substance use will be influenced by these factors and point toward the importance of how they have made sense out of previous change attempts to change, mind-set and environmental factors. This could be applied to substance misuse in the sense that services may wish to embrace and appreciate these factors when supporting an individual's change attempts, such as learning from previous success, assessing psychological state with regard to preparedness for change and the importance of outside sources of influence and persuasion, which may include family dynamics, social networks and, indeed, the influence of service staff aiming to initiate change. At present, none of these factors are fully acknowledged by treatment services when considering a service user's motivation for change.

Self-efficacy is thought to be predicative of the amount of effort an individual will spend upon initiating and maintaining change, so although not a behavioural change theory per se, it is an important element of many of the theories, including the Health Belief Model developed in the 1950's by social psychologists Rosenstock, Hochbaum, Kegeles and Leventhal (Rosenstock, 1974), Theory of Planned Behaviour and the Health Action Process Approach.

According to Social Learning Theory, also known as Social Cognitive Theory, behavioural change in the individual is influenced by their interactions with others and with regard to change from substance use points toward the perception of other's change attempts as a learning process. This may indicate the importance and influence of perceiving change attempts by others as not only possible but also worthwhile. This form of social learning is currently evident in the way that services are designed, which encourages the involvement of Peer Mentors and Recovery Champions, to influence recovery in others.

The most popular and commonly used model in the field of substance misuse is the transtheoretical model of change proposed by Prochaska and DiClemente, (1983), also known as the Stages of Change or Cycle of Change model. This model explains that behavioural change is a five step process between which individuals oscillate before achieving complete change. These stages are pre-contemplation, contemplation, preparation for action, action, maintenance and termination. A problem faced with the Stages of Change model is that it is very easy for a person to enter the maintenance stage and then to fall back into earlier stages. Factors which contribute to this decline include external factors and personal issues that a person may be dealing with, which emphasises the importance of learning maintenance strategies and the need for adequate preparation as part of the cycle. Learning maintenance strategies is presently evident in the form of

Routes to Recovery utilised within Mutual Aid support groups. However, it could be argued that the underlying factors of what contributed to dependence upon substances as a coping strategy are not being acknowledged by the techniques of these interventions.

A further argument is what constitutes 'change' when applied to heroin use and whether and when people actually reach the 'termination' stage. The most common parameters and markers of change tend to focus upon abstinence. However, change behaviours may also be experienced both before and after this, debatable, milestone.

Why understanding change from heroin use is important

With regard to substance misuse, change is often defined in terms of 'Recovery' and 'Abstinence', and therefore change is in terms of not using heroin anymore.

There are obvious benefits of abstinence, in terms of reducing the consequences of heroin use. However, heroin and morphine-related deaths have increased by almost two-thirds over the past two years, contributing to the mortality rate from drug poisoning rising to the highest level since comparable records began in 1993 (Office for National Statistics, 2015).

There were 3,744 drug poisoning deaths involving both legal and illegal drugs in England and Wales registered in 2016; this is 70 higher than 2015; an increase of 2%. Over half (54%) of all deaths related to drug poisoning in 2016 involved an opiate; mainly heroin and/or morphine (Office for National Statistics, 2017). It is noticeable that these figures have occurred during a period of a change of drug strategy from harm reduction to recovery and abstinence.

According to research conducted by Scott, Dennis, Funk, Laudet, and Simeone (2011), those suffering from drug dependency and addiction die an average of 22.5 years earlier than those not diagnosed with drug affliction. In addition, due to lowered tolerance levels to

heroin use after achieving abstinence, the risk of overdose is increased should they return to drug use. According to the National Treatment Agency for Substance Misuse (NTA), the overall financial cost of drug addiction is huge, every year it costs society £15,400,000,000. The annual cost of crime associated with substance misuse is £13.9 billion; any addicted person not in treatment commits crime costing on average £26,074 per year. In 2011, the cost of deaths related to drug misuse was £2.4 billion and every year drug misuse costs the NHS £488 million (NTA, 2013a, p12). The figures do not include other consequences such as the impact upon public health in the form of the spread of diseases, such as HIV, Hepatitis C and Hepatitis B, homelessness, Family and Children's Service involvement, relationships difficulties and the impact upon the drug user and those affected by drug use, mental health and well-being. The drug user is also likely to have reduced employment rates which may increase the annual overall cost to in excess of £18 billion.

A recent commission established by the UK's leading medical journal, the Lancet and Johns Hopkins medical school (Murkin, 2016), has condemned the disastrous failings of current global drug policy and calls on governments to begin experimenting with the legalisation and regulation of drug markets. They argue that current drug policies based on prohibition and criminalisation are fuelling homicides and overdose deaths. The spread of infectious diseases, such as HIV/AIDS and Hepatitis C, and are preventing people from accessing essential treatment and harm reduction services. Such calls as these have been made before, most notably from the World Health Organisation, UNAIDS and the UN Office on Drugs and crime, however are based on a response to drug use as a societal issue, rather than attempting to understand the reasons why people may have the desire to use drugs and therefore be able to inform, guide and support those involved in the process.

A problem with a short term focus upon change is with regard to relapse. Relapse is the return to abusing a substance regularly and sometimes uncontrollably. Relapse rates for heroin users who receive no further treatment following reaching abstinence may be as high as 90 percent (Health Research Funding, 2014). Many treatment facilities offer detoxification but little or no treatment beyond detox. A study published in the Journal of Addiction indicates that patients who received further treatment within 30 days were 10 times less likely to relapse (Johns Hopkins Medicine, 2012). This highlights the importance of continued care following abstinence.

The first year of the pilot 'Payment by Results for Drugs Recovery' scheme in England, linking payments to outcomes, reduced the probability of service users completing drug misuse treatment and increased the proportion service users declining to continue with treatment compared with those treated in comparison areas (Mason, Sutton, Whittaker, McSweeney, Millar, Donmall, Jones and Pierce, 2015). This indicates that for those in Payment by results areas, service and service user goals of treatment may not be mutually compatible. Therefore, it could be argued that, in order to sustain change beyond abstinence more understanding is needed to appreciate the complex factors involved.

Theories of change from substance use

Various models have been put forward to help understand the nature and complexity of substance dependence. The Biopsychosocial model theorized by Engel (1977), is a widely used model in the field of addictions and posits that biological, psychological and social factors all play a significant role in human functioning in the context of disease or illness. This model is considered important as it highlights that multiple factors are involved, each of which may need to be addressed if long-term change is to be achieved.

When applied to considering change from substance use these factors may, respectively, relate to physical addiction (which may be managed through substitute medication), psychological dependency, such as drug use to manage psychological health, and environmental factors such as the availability of drugs and the influence of drug using relationships. If only one of these factors is addressed such as overcoming physical dependency through withdrawal at a detoxification facility, then maintaining this change is far less likely. The other aspects also need to be addressed such as social issues, which may involve distancing or managing interpersonal relationships and psychological factors which may apply to increasing motivation to initiate change or developing coping mechanisms to manage emotional difficulties that may increase the desire to use drugs.

With regard to increasing motivation for addressing drug use, a commonly used therapeutic approach to substance misuse in Britain is Motivational Interviewing (Miller and Rollnick, 1991). According to this approach motivation for change occurs when people perceive a discrepancy between where they are and where they want to get to. Counsellors seek to generate this perception by helping clients examine discrepancies between their current behaviour and future goals. When clients can appreciate that their behaviour is not consonant with some important future goal, they become more motivated to make significant life changes, such as stopping heroin use which may impact upon the likelihood of achieving other goals.

Following Festinger's (1957) theory of cognitive dissonance, motivational interviewing argues that change is motivated by a perceived discrepancy between current behaviour and important personal goals and values. The discrepancies between expressed intentions and actual behaviour are manifested in Orford's (2001) account of the deep ambivalence and conflict which go hand in hand with the development of addiction.

However, it could be argued that these motivations are centred on the immediate circumstance and motivational factors in initiating change, which is consistent with a short term focus on achieving drug abstinence and not the factors around sustaining this change in the long term.

Despite the widespread use of Motivational Interviewing, a review analysis found that though motivational interviewing was better than no treatment at all, it proved no more effective than other approaches, including CBT and traditional treatment at improving outcomes (Smedslund, Berg and Hammerstrøm, 2011). Each of these approaches have a focus upon the present aspects of change, rather than considering factors which may have led to psychological dependency, which is consistent with the current strategy of recovery, and service targets for 'successful discharges'. Utilising other therapeutic approaches, or psychological formulation, which may offer a more comprehensive understanding of the role the drug use, may be perceived by services and commissioners as slowing down the process of treatment outcomes. With an aim of improving effectiveness and treatment outcomes a new Drug Strategy was implemented in 2010, based upon the phenomena of Natural Recovery.

Natural Recovery

In 1999, Granfield and Cloud conducted research with participants who had spontaneously recovered from problematic alcohol use without the need for treatment, which they called 'Natural Recovery'. They coined the term 'recovery capital' to refer to the "... the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drug] problems" (Granfield and Cloud, 1999, p154).

Cloud and Granfield (2009) revisited their initial concept and argued that there are four

components to recovery capital; Social capital, which is defined as the sum of resources that each person has as a result of their relationships, and includes both support from and obligations to groups to which they belong. Physical capital, which is defined in terms of tangible assets such as property and money that may increase recovery options. For example, being able to move away from existing friends/networks or to afford an expensive detox service. Human capital, which includes skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital, and will help with some of the problem solving that is required on a recovery journey. And Cultural capital, which includes the values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours. In the same paper, they summarise early evidence among naturally recovering individuals (people who did not seek professional treatment or participate in mutual aid support groups) suggesting that both the quality and the quantity of recovery capital play a major role in predicting recovery success both in and out of treatment, and crucially that the growth of recovery capital can signal a 'turning point' in addiction careers.

In this sense, recovery is a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal being an ongoing quest for a better life. With recovery conceptualised as a process in this way, recovery capital refers to the sum of resources that may facilitate the process.

White and Cloud (2008) assert that the type of interventions that will be appropriate will depend in part on the balance of recovery capital and problem severity/complexity. Thus, people with high recovery capital and low problem severity may be appropriate for brief interventions of various types. People with high recovery capital but also high problem severity may be appropriate for out-patient detoxification with intense community support. White and Cloud argue that people with low problem severity and low recovery capital may be appropriate for residential rehabilitation with appropriate follow-up and people with low recovery capital and high problem severity may need a combination of intensive interventions.

Best, Irving, Collison, Anderson and Edwards (2017) support the Recovery Approach, arguing that there is consistent evidence base showing that recovery pathways are initiated and enhanced by positive social networks and the underlying changes in social identity that is associated with the transition from stigmatised and excluded groups to positive prosocial groups. There is also a growing literature that focuses on community engagement as a vital ingredient of recovery journeys, with engagement in recreational activities, training and employment, volunteering and mutual aid and other peer activities seen as important components of a Recovery Orientated System of Care.

A Recent history of Drug Treatment

Despite the growth of the substance misuse field over the last 30 years, addiction remains a pervasive social problem in the UK (Singleton, Murray and Tinsley, 2006). Under the New Labour administration (1997–2010), the drug treatment sector was subject to significant reconfiguration, investment and expansion (Buchanan, 2010). A more central role for the criminal justice sector accompanied by centralized ring-fenced funding overseen by the

National Treatment Agency (NTA), led to an increase in the numbers accessing and retained in treatment services. However, concerns had been expressed about an expanding treatment population 'parked' in substitute prescribing drug services (Dawson, 2012), which led to debates surrounding recovery (Best and Laudet, 2011; Laudet, 2008; Wardle, 2012). The UK drugs strategy published in 2010, aimed to increase the number of people achieving 'full recovery', by presenting recovery as synonymous with abstinence (Monaghan and Wincup, 2013).

The Recovery Agenda in 2010 (H.M.Government, 2010), took the lead from Natural Recovery in America but questions remain about whether it is applicable for generalisation to heroin users in the UK, especially when considering the factor of physical dependency which is likely to require supported reduction and that opportunities for accessing recovery capital among problematic heroin users may either not be present or had diminished as their relationships were impacted, lifestyles deteriorated as their substance use progressed. The theory of Natural Recovery was based upon a sample of 46 middle class Americans, who had 'spontaneously recovered' from alcohol use. In their original study, Grandfield and Cloud (1999) identified that the participants in their study had less severe issues and therefore may be candidates for less intrusive treatment. It could be argued the middle class Americans, may have greater opportunities to access Recovery Capital, than heroin users in the UK. A similar argument was also put forward by Biernacki (1986, cited in Grandfield and Cloud, 2001, p1548), when he points out "a white, middle class, high school educated, male addict will have more personal and social resources to draw from when he decides to give up drugs than will a Chicano addict living in a barrio".

It was also identified that these participants who had spontaneously recovered, had less significant issues with alcohol, which did not require formal treatment. It could therefore,

be argued that the principles of Natural Recovery are not generalizable to populations with more problematic use, particularly when considering the possible role of substances to self-medicate trauma and distress, which the current strategy has, so far, failed to acknowledge.

On first appearance, a recovery oriented drug and alcohol treatment system may seem eminently sensible. In the field of mental health, where recovery has a longer history, Davidson, Rakfeldt and Strauss (2010, p10) argue that many people outside the sector automatically assume that services are recovery focused, asking '... if services are not focused on promoting recovery, what else might they be for?'

Recovery is, however, a contested concept that lacks clear meaning (Neale, Finch, Marsden, Mitcheson, Rose, Strang and Wykes, 2014; Neale, Nettleton & Pickering, 2014; Paylor, Measham & Asher, 2012). Indeed, definitions may range from the vague and nebulous to the highly prescriptive, abstinence from all forms substance misuse, including alcohol.

This mixed and conflicted understanding of the term 'recovery' has constructed a discourse fraught with tensions from which many potential problems arise (Roy, 2012). There are important questions about how recovery is constructed and interpreted by different groups. Some express concern about an over-emphasis upon abstinence (Ashton, 2008), others are uneasy with the recent top-down approach to recovery (Roy and Prest, 2014), and some are concerned that the expansion in volunteer peer-led recovery services is a political move towards significantly reducing the paid workforce (Roy, Willocks and Buffin, 2013).

The recovery agenda has now become a central policy objective promoted and led by the government. This political shift raises issues about ownership, interpretation and direction, ultimately raising difficult questions about any shared understanding of the term. In a prolonged period of austerity, the government's notion of recovery can easily appear focused upon cost cutting, abstinence and responsabilisation, rather than rehabilitation,

social reintegration and developing the pathway to full citizenship (Monaghan and Wincup 2013; Roy 2013; Watson 2013). This social and political context raises important issues at a time when budgets and responsibility for the new substance misuse treatment system are now locally determined, no longer ring-fenced, and payment by results encourages service providers to concentrate on measurable outcomes rather than deliverables.

The addictions field is now overflowing with references to 'recovery' with service providers and workers increasingly designated as 'recovery-focused', although in many areas there is confusion as to what this means in practice and what needs to change. There is an awareness that some people do recover, but we have limited knowledge about what facilitates recovery or at what point in the journey recovery is sparked and made sustainable.

The concept of recovery capital reflects a shift in focus from the pathology of addiction to a focus on the internal and external assets required to initiate and sustain long-term recovery from alcohol and other drug problems. Recovery capital is conceptually linked to natural recovery, solution-focused therapy, strengths-based case management.

Many of the barriers and facilitators to change are psychological, but psychosocial interventions are now offered by all those involved in Recovery including staff and service users. This approach has an ethical issue linked to mental health and the potential vulnerability of those receiving psychosocial interventions delivered by unqualified and relatively untrained persons. This is even more relevant when considering that there is a correlation between heroin use and managing mental health and psychological distress.

The Recovery Agenda has involved everyone in building recovery capital, which has helped to address the issues of confidence, joining in meaningful occupations, maintaining accommodation and staying in recovery. But there are challenges, with many of the

psychosocial interventions being undertaken by people who are not qualified psychologists; outcomes are greatly affected by the quality of the working alliance. Organisations are prone to high caseloads, high turnover of clients and a lack of resources for training.

There appears to be a confused and mixed models, between a disease model and life-process model, with regard to current treatment and associated terminology such as 'addiction', and incorporating elements of harm-reduction, such as substitute prescribing and needle exchanges, whilst aiming toward targets for discharges.

The predominant therapeutic approaches involved in Recovery, of Solution Focused Therapy and Motivational Interviewing, tend to be primarily focused upon achieving short term goals of abstinence, rather than understanding and overcoming the reasons why they have developed a psychological dependence upon heroin. In this respect, it leaves the question of how those that achieve abstinence, will manage distress in the absence of heroin, and whether this increases potential vulnerability. The 'successful' person may be reluctant to re-engage with services, due to concerns that they may be perceived as 'unsuccessful', or may believe that the service does not sufficiently address the issues involved. In which case, should they then use heroin then they are more susceptible to overdose due to lowered tolerance levels. These approaches and substitute prescribing may also reinforce the philosophy, informed by a medical model, that distress and pain is not tolerable and drugs (whether illicit or prescribed) are the ways to move oneself from such experiences.

There are some obvious benefits of heroin abstinence, but there are also concerns that the current strategy is not meeting service users' needs.

Criticisms of the Recovery Approach

Since the end of the last decade the substance misuse field has been increasingly focused on recovery, leading to the impression that there has been a substantial and consistent increase in the recovery rate nationally. Unfortunately that has not been the case, and indeed there is a marked absence in terms of any debate regarding how as a sectors drug and alcohol treatment is performing. Two figures are prominent.

According to the NDTMS (NTA, 2015) website the current recovery rate for opiate users was 6.6 per cent- a drop from 8.59 per cent in 2011-12.

During the same period, drug related deaths have risen and continue to rise. They have risen higher than at any point since data was first collected in 1993.

There has been a significant increase in opioid related deaths since 2012 and the government has failed to acknowledge contributing factors such as the consequences of short term commissioning and worsening socio-economic circumstances for vulnerable groups. Changes to treatment and a focus on recovery has side-lined harm-reduction as there is a pressure on services to achieve drug-free exits.

In July 2017, a new drug strategy was announced, (H.M. Government, 2017) continuing with an emphasis on Recovery, which was the defining feature of the previous strategy, but acknowledges the recent rise in drug-related deaths, particularly among long term opiate users with associated health problems and complex needs. The focus of the new strategy is on “individually tailored treatment” which is an acknowledgement that not everyone wants or is ready for recovery and that harm reduction remains an important approach for many. It promises more robust evaluation, including better segmentation of recovery rates in order to assess whether new initiatives are successful. However, a definition of ‘success’, may be open to debate. The document does not, unsurprisingly, address the likely impact of

the reduction of funding for both drug treatment and health promotion in the last seven years since the previous drug strategy.

The 2017 Drug Strategy claims that the people who slip through the cracks of dual diagnosis from mental health and problem substance use are to be better catered for, rather than passed between services reluctant to take on complex and demanding cases. However, does not make reference to an integrated service between mental health and substance misuse, delivered by qualified and competent practitioners with joint commissioning.

A point of concern is that all the ambitions for treatment and associated services, are taking place against a backdrop of decreasing financial support for local substance misuse services.

According to recent analysis by The King's Fund (2017) tackling drug misuse in adults will face a 5.5% cut, with larger cuts to alcohol services, and larger still for specialist services for children and young people. This is on top of reductions in many areas over the last few years. With an emphasis on abstinence, there needs to be an awareness of the further factors involved in change beyond abstinence.

Sustaining change beyond abstinence

Research on the process of recovery (e.g. Biernacki, 1986; Margolis, Kilpatrick and Mooney, 2000) indicates that the recovery experience is a complex and dynamic process that changes over time. For example, Koski-Jannes (2002) notes that although research on recovery from addictive behaviours 'has mainly been geared toward improving the immediate techniques of change...the initial change in self-concept is followed by other, more far reaching identity projects that help make the resolved state more meaningful and rewarding for the individual' (p 184). These include developing new skills and values and the formation of a new identity and 'life-projects'. This perspective considers that overcoming addiction may

take years of work after stopping the addictive behaviour and acknowledges that change continues beyond abstinence.

Watson and Parke (2009) used IPA to explore the experiences of heroin users, in not only motivations that precipitate drug use and abuse, but also the changes which take place in the social environment that enable individuals suffering from an addictive disorder to 'break the cycle' and reach a position of recovery. New relationships, new responsibilities and new opportunities appear to be significant motives in relation to attempting to reduce drug consumption. This indicates the importance of further changes beyond reaching abstinence.

Although there is a large body of research studies on recovery, few have examined long-term recovery from a qualitative perspective. Laudet (2008) points out an important yet neglected question is "what does recovery mean to persons engaged in the process?" (p2003). In her study (Laudet, 2007) of definitions and experiences of recovery among person's who self-identify as in 'recovery', over half provided answers describing range of features that did not focus upon substance use, such as a new life, well-being, a process of working on oneself, self-improvement and learning to live drug-free.

Laudet, Savage and Mahmood, (2002) point out that the majority of research studies have follow-up periods ranging in length from 1 to 24 months. This indicates an absence of research and focus upon what is involved in change from heroin use beyond this period.

Identity as an important part of change

Change may involve not wishing to identify themselves to others as 'recovered'. For example, in Granfield and Cloud's (1996) study of 'natural' recovery, most participants refused to identify themselves as addicted or as recovering or recovered. Most hid their addictive past for fear that disclosure would jeopardize their new identity. Howard (2006)

maintains that the 'recovery' label provided by a treatment programme/group can be both potentially helpful when accepted at a suitable time, and potentially damaging in so far that it can limit the scope of recovery. This suggests that there may be a process and different stages involved in changing heroin using behaviour.

Granfield and Cloud (1999) suggest the importance of some forms of recovery capital in dis-identification narratives, reflecting how they had made sense out of change.

According to Howard (2008), people de-label when they move away from assigned and possibly accepted definitions of self to form a new self-identity. Heroin users represent a population who are likely to experience the effects of a deviant label and experience issues regarding de-labelling during recovery. Exploring these differences and how they deviate from political and social definitions may offer insight into how heroin users experience change and how they manage changes in self-identity. Howard suggests that the resources of 'recovery capital' one possesses are not only important in facilitating recovery but can be equally significant in enabling a process of dis-identification with an addict label.

Changing heroin using behaviour is a complex process which involves social support, self-efficacy, motivation and environmental factors. Hughes (2007) argues that the construction of a self-identity that does not involve the characteristic of 'substance abuser' is a fundamental task in this process, which suggests that moving away from such associations is a necessary part of change.

The phenomenon of self represents the recognition of the "true self" (Winnicott, 1965), that which remains central to the person regardless of context. This may relate to the internal conflict that is experienced as a motivation for change and resonates with the findings of McLellan & McKay, (1998) who explain that change is motivated by reaching a point of degradation wherein a fundamental crisis of existence, rather than a developmental crisis.

This may also be considered as a turning point, to not sink any lower and often referred to as hitting 'rock bottom' as being the point of change. Often, this point is triggered by a particular experience in a person's life, such as deterioration in health, facing possible jail or custody disputes, strained financial resources, and family dysfunction. In many instances, such events have led to those engaging in substance abuse recognizing their problematic lifestyles (Hanninen & Koski-Jannes, 1999). With this realisation comes the need to reconstruct an identity and lifestyle without addiction, often accompanied by changes in one's living environment. Although these perspectives do have some merit, they fail to explain why others who experience such crises are not compelled to change their substance using behaviour. This suggests that change from heroin use is a subjective and complex process.

Doukas and Cullen (2009), questioned whether a person who has experienced long-term substance abuse could ever establish an identity that does not incorporate the dimensions of a recovering addict, suggesting that recovery is an on-going process. This stance has significant implications for the individual, because it implies that the addictive identity needs to be integrated into the new identity. Recovery is seen as a life-event that, once achieved, involves the creation of a new identity wherein the old self is sloughed off.

Hughes (2007) wrote of the capacity for the transformation of self-identity from user to non-user, a journey that is achieved by adopting positive identity formation practices. One important arena wherein positive identity practices can be fostered is within the person's social network. The development and maintenance of stable, personal relationships has long been recognized as influential on positive psychological well-being and health in the general adult population (Ryff & Singer, 2000). As such, there is a role for social support and a need to develop and maintain healthy social networks in recovery from problem

substance abuse. Healthy social networks have been associated with recovery and the maintenance of long-term sobriety (McIntosh & McKeganey, 2001).

According to the social identity model of identity change (Haslam, Holme, Haslam, Iyer, Jetten & Williams, 2008) maintaining social identities and support over time is good for health and well-being, particularly during stressful transitions. However, a study conducted by Dingle, Stark, Cruwys and Best (2015) argues that under certain circumstances maintaining a social identities such as 'substance user' may be harmful to health, and that a successful transition constitutes identity change. Their findings indicated that moving from a substance using identity towards a recovery identity constitutes an important step, in this process.

According to (Goehl, Nunes and Quitkin, 1993) just because social networks exist does not automatically ensure that the members have a positive influence on the recovering addict. Havassy, Hall, & Wasserman (1991) add that some social connections, particularly those established during the addiction phase of a person's life, might facilitate relapse rather than recovery. Yet these social networks have been significant and, at times, the sole social support, which may make distancing themselves from such relationships important but problematic. Adding to the complexity is the absence of social networks from the drug using context. Although previous relationships might re-emerge and have the potential to underpin "healthy" networks (Wills, 1990), some members might be insensitive to or unaware of the problems inherent in drug cessation. These non-drug using relationships might also elicit feelings of inadequacy in those recovering from addiction or may have been a factor in why they had initially turned to drugs. They may also experience a negative response from such relationships and difficulties in overcoming issues relating to their

previous drug using behaviour, such as guilt, shame and problems in developing trust, possibly resulting in further distancing and isolation.

Such negative perceptions may relate to stigma. Much research tends to focus upon stigmatising reactions to deviant labels but little work has been carried out on how people move away from stigmatising identities, such as 'drug-addict' or 'user'. Social stigma is the extreme disapproval of, or discontent with, a person on the grounds of characteristics that distinguish them from other members of a society. Goffman (1968, p3) defined stigma as 'the process by which the reaction of others spoils normal identity', which hampers the person from gaining full social acceptance. Deviance stigma occurs when an individual is identified as deviant, linked with negative stereotypes that engender prejudiced attitudes, which are acted upon in discriminatory behaviour. There are different ways in which stigmatized people manage their 'spoiled identity'.

Research conducted by Biernacki (1986), with former heroin addicts, described three main courses through which drug users transform their identity. Some returned to a previous identity if it had not been damaged too badly by the period of problematic heroin use. This would mean that they had not ruined all their previous relationships and therefore did not spoil the social identities within them. When they resolved to quit drug use, they attempted to re-establish old relationships and return to the identity rooted in it.

Other people developed an identity that remained during the period of problematic heroin use and had somehow remained intact. This course was typically taken when identities were not spoiled as knowledge of their addiction became widespread or if the person had compartmentalised different parts of their lives and maintained roles in social worlds unconnected to their drug use. A third course of recovery involved creating an emergent identity that was not present during or before the period of problematic heroin use.

Regardless of the route to which the person establishes a non-drug using identity, the person requires the opportunity to facilitate and construct a non-addict identity and positive sense of self, which had been compromised due to the stigma associated with heroin use. Regaining trust, being accepted and responded to in ways which confirm their new identity can be a difficult process and failure to do so may contribute to returning to their previous drug-using relationships, where a sense of self had been recognised and accepted within drug-using relationships. This may lead to an increased likelihood of a return to drug use. According to Biernacki, acceptance as a non-user may be developed by behaving in conventionally expected ways, such as gaining employment, meeting social obligations, and possessing some material objects to establish trust', which also relate to lifestyle changes. At the same time the non-drug user's feelings of uncertainty and doubt will reduce as they gradually accept their new identity and associated life and relationships. Biernacki's arguments resonates with the premises of the social recovery capital, with regard to developing a recovered lifestyle and an important factor for integrating into the community. However, debates remain about opportunities to access and develop such resources, away from treatment support. McIntosh and McKeganey (2001) offer a similar argument as the need to repair a spoiled identity and a desire for a new identity and a different life-style, as central to their participants' accounts. They suggest that 'the key to the recovery process lies in the individual coming to an understanding that his or her damaged sense of self has to be restored together with a reawakening of the individual's old identity and the establishment of a new one' (p. 1503). So the formation of a recovery identity may involve integrating their previous identity with the creation of a drug-free identity.

Koski-Jannes (2002) contend that recovery from addiction 'involves profound changes in a person's self-concept, values and orientations in life' (p. 184). In Biernacki's (1986) account, deciding to stop using drugs takes place when the addict identity conflicts with other identities important for the person in ways which are unacceptable to him/her.

This resonates with the findings of the studies by Weisz (1996) and Downey, Helmus and Schuster (2000) which suggest that perception of dissonance, discrepancies and conflicts between substance use, valued identities and self-standards can constitute an effective motivator for changing addictive behaviours. Miller and Rollnick (2002) contend that most people who seek help already perceive significant discrepancy between motivations. Yet they are ambivalent, caught in an approach-avoidance conflict, in which heroin use serves a function of alleviating the distress which it also creates.

Heroin dependence and coping

In addition to addressing the issues associated with sustaining change beyond abstinence, it is important to acknowledge the role that heroin may have played in managing psychological distress and emotional discomfort, as a factor of psychological dependence. It could be argued that without developing an adequate, alternative method of coping, we may be removing an effective, although socially disapproved, coping mechanism.

Heroin is an effective pain reliever, and when administered intravenously by injection, it is up to four times more potent than morphine and faster in its onset of action (Sawynok, 1986). Heroin falls under a class of drugs known as opiates due to the impact upon the opiate receptors in the body, especially those in the brain. Opiate receptors help control pain, as well as producing feelings of pleasure along with a sense of euphoria that users translate to feeling 'high'. This reduction on pain is felt both on physical pain and emotional

pain in users with co-existing disorders like anxiety and depression. Due to the effects of heroin, the drug can become the medicine of choice for those self-treating themselves for emotional disorders, which may be referred to as 'self-medication' (Khantzian, Mack & Schatzberg, 1974) by causing a sense of calm, relaxation, contentment and pleasure that can temporarily combat uncomfortable feelings.

However, as well as relieving anxiety studies have shown that heroin users are also more prone to experiencing anxiety symptoms. There may be several reasons, for this, CBT theory may purport an avoidance strategy, or it may be related to experienced stigma.

Dual diagnosis refers to those individuals who suffer from co-occurring disorders of mental illness and addiction to drugs or alcohol. Dual diagnosis patients make up a large percentage of the addiction community, yet little is known about their condition outside of the profession.

Over 50% of those individuals who abuse drugs or are addicted to drugs are believed to all have at least one significant mental illness as well. More than 35% of alcoholics or individuals with an alcohol-related substance abuse problem have at least one mental illness. Almost a third of all individuals with a mental illness also suffer from alcohol or drug addiction (Facts and Statistics about Dual Diagnosis, 2010).

The term "comorbidity" describes two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between the illnesses that can worsen the course of both (Drugfacts, 2011).

Lopez, Turner and Savedra (2005, p275) claim that "comorbid and pure anxiety disorders were found to be predictive of the number of alcohol and drug use problems".

Heroin dependence may develop as a way of avoiding life stresses, anxiety and pain, and in this sense represent an effective though maladaptive coping response.

Coping behaviour occupies a central role within most cognitive-behavioural formulations of addictive disorders (Marlatt & Gordon 1985; Annis 1986). Goldfried (1980, p993) defines coping skills as 'any class of cognitive or overt behaviour patterns that would deal effectively with problematic situations'. Early research into relapse identified the important role which could be played by coping behaviours (Litman, Eiser, Rawson, and Oppenheim, 1979; Litman, Stapleton, Oppenheim, Peleg and Jackson 1984; Allsop & Saunders 1989). Indeed, it is a primary goal of relapse prevention to teach drug users how to identify, anticipate, and cope with the pressures and problems that may put the individual at increased risk of relapse (Marlatt, 1985). Various manuals such as Routes to Recovery (NTA, 2013b) and SMART recovery (Smart Recovery, 2014) are used within substance misuse services to teach coping behaviours to service users. However, these coping techniques tend to be focused upon managing life issues rather than management of anxiety, for which heroin may have been used.

Heroin and the management of anxiety

Heroin dependence is a chronically relapsing disorder that has been characterized by a compulsion to seek and use heroin despite negative consequences (Koob and Volkow, 2010; Ferri, Davoli and Perucci, 2010). In heroin-dependent patients, there is a frequent comorbidity with psychiatric disorders. Psychiatric comorbidities have been found in up to 97% of these patients (Frei and Rehm, 2002). In particular, affective disorders have been frequently described in heroin addicts. (Nunes, Sullivan and Levin, 2004; Carpentier, Krabbe and van Gogh, 2009); Maremmani, Pacini, and Popovic, 2009). Studies have indicated that individuals who regularly use heroin are at high risk for elevated levels of anxiety and anxiety linked disorders (Darke and Ross, 1997; Grenyer; Williams and Swift, 1992). These

studies suggest an association between anxiety and heroin use. There are multiple reasons to expect an association between anxiety and chronic heroin use. It has generally been found that individuals with high levels of anxiety tend to use psychoactive substances. (Novak, Burgess and Clark, 2003; Stewart, Karp, Pihl RO, 1997; Stewart, Zvolensky and Eifert, 2002; Zvolensky and Leen-Feldner, 2005). High levels of anxiety and stress have been found to be associated with drug craving and drug use. In heroin-dependent patients, heroin craving was most robustly associated with increases in sadness and anger (Epstein, Willner-Reid, and Vahabzadeh, 2009). Therefore, there seems to be a direct correlation between heroin craving and negative emotions in heroin dependence which can be suppressed by heroin use.

Clinical observations have identified many emotion-related signs in the development and maintenance of drug addiction. It has been argued that the escape and avoidance of negative affects—manifested as specific emotion such as anxiety, irritability, or sadness—are a key motive for further addictive drug use. (Baker, Piper and McCarthy, 2004; Wang, Zhang, Wu, 2010).

Such affective disorders may be the result of previous traumatic experiences, for which heroin is used to manage.

Heroin to manage trauma

Much has been written concerning the longer term effects of the experience of sexual abuse in childhood. Emotional effects include depression, low self-esteem, guilt, shame, anxiety, anger and obsessive-compulsive disorders (Sanderson, 1990), together with problems of interpersonal relationships and self-destructive behaviours, including substance misuse.

Substance misuse can help the survivor to block memories and internal discomfort that may be reaching conscious awareness. Spak, Spak and Allebeck (1997, p273) reported that 'child sexual abuse was the strongest predictor for the later development of alcohol abuse together with a history of psychiatric problems'. They also added that 'sexual abuse prior to age 13 exasperated presenting symptoms'. This was supported by Swett, Cohen, Surrey, Compaine and Chavez (1991, p.57), whose research indicated that physical or sexual abuse prior to the age 18 may be associated with a higher consumption of alcohol compared to those who had not experienced sexual abuse in childhood.

A number of studies have reported an association between various forms of victimisation and later problematic substance use among adolescents and adults, although sexual abuse appears to be the focal point of attention for many studies (e.g. Bergen, Martin, Richardson, Allison and Roeger, 2004; Dube, Anda, Whitfield, Brown, Felitti, Dong and Giles, 2005; Harrison, Fulkerson and Beebe, 1997; Holmes, 1997). This body of research illustrates the role of childhood abuse as a possible contributing factor to the development of substance abuse that not only increases the likelihood of substance use per se but also complicates the clinical picture of substance abuse by adding a component of psychological and behavioural distress (Bergen, Martin, Richardson, Allison, and Roeger, 2004). Many mechanisms have been postulated to explain the association between childhood victimisation and illicit drug use. In these conceptualisations, substance use represents a strategy to cope with the stress produced by these events (e.g. Garnefski and Arends, 1998; Kilpatrick, Acierno, Saunders, Resnick, Best and Schnurr, 2000; Miller and Mancusco, 2004; Weiss, Longhurst, and Mazure, 1999). Distress caused by negative experiences such as victimisation may drive individuals to engage in behaviours that reduce negative emotions, such as situational avoidance or drug use (Kilpatrick, Acierno, Resnick, Saunders and Best,

1997). That is to say, substance use or abuse following negative events may be an effective, albeit maladaptive, strategy to mask the negative affect associated with such experiences. 'Self-medication' (Nordqvist, 2011) of emotional distress and mental health symptoms with illicit drugs and alcohol, offers a plausible mechanism for the co-occurrence of mental health disorders and substance use disorders. There is a high prevalence of mental illness comorbidity within the general population (Robinson, Sareen, Cox, and Bolton 2011), with significant costs and consequences. It is therefore important to clarify the underlying mechanisms through which co-morbidity develops. This would have considerable implications for prevention and treatment. A reduction of self-medication through non-prescribed, illicit drugs or alcohol would likely lead to a significant decrease in 'co-morbidity in the general population.

Weil (2004) writes about altered states of consciousness, a perspective which draws upon the Integral Theory of Ken Wilber (1977). In his 2004 paper, Weil argues that "drug experience can be understood only if it is viewed as an altered state of consciousness rather than as a pharmacological event", Weil argues that people have a natural desire to alter their states of consciousness, with drug taking a popular form of this kind of behaviour. He claims that this approach will make it possible for society to reduce significantly the problems associated with the use of psychoactive drugs. Most persons use sedative-hypnotics to reduce anxiety by substituting a "high" state of consciousness that permits sleep, relaxation, or the mild dis-inhibition valued in certain social encounters (Weil, 2004). Weil advocates the use of meditation to aid recovery, and it has been interesting to note the recent use of mindfulness within the NHS, for help with addictions. (Zgierska, Rabago, Chawla, Kushner, Koehler, and Marlatt, 2010).

Diamond points out that 'reality can be both painful and anxiety provoking, which comports with Freud's pleasure principle (Freud, 1895), that we all tend to avoid pain and seek pleasure. Addicts prefer the pleasure of intoxication and the bliss of oblivion to the suffering and difficulties associated with day to day reality' (Diamond, 2010).

Co-existing substance misuse and mental health disorders (dual diagnosis) are the norm, rather than the exception. A report commissioned by the Department of Health and NTA in 2002 found that 75 per cent of users of drug services and 85% of users of alcohol services were experiencing mental health problems and 44 per cent of mental health service users either reported drug use or had used alcohol at hazardous or harmful levels in the past year (Weaver, Madden, Charles, Stimson, Renton, Tyrer, Barnes, Bench, Middleton, Wright, Paterson, Shanahan, Seivewright, and Ford, 2002).

Despite the high prevalence of people with dual diagnosis and the associated negative consequences on the physical, psychological and social domains, there is a clear gap in service delivery for these clients.

NICE guidelines for Psychosis With Co-existing Substance Misuse (2011) also highlights the importance of not excluding people with co-existing conditions, seeking specialist advice and initiate joint working for very complex cases, the need to challenge stigma, be culturally aware, engage with families and carers, be aware of the possible concealment of difficulties, be aware of possible safeguarding issues and use NICE guidelines for specific mental health and alcohol and drug problems.

In a recent study Webber, Clark and Kelly (2016) state that 'Addressing the psychological distress of individuals experiencing substance use disorders has too often been relegated to the 'too hard basket' (p27), leaving those affected with little choice but to receive treatments aimed solely at addressing their drug and alcohol issues. Also, individuals

receiving support for mental health support are often underdiagnosed with regards to any comorbid substance misuse problems'. They argue that, 'no definitive treatment model exists that gives equal focus to the treatment of both psychological well-being and substance-related addictions. This is not to suggest, however, that existing treatment programmes for substance misuse are not impacting positively on clients' mental health, rather that further research is needed in order to determine what it is that is supporting such improvements'. An integrated model which appreciates the role the substance use has upon mental health and vice versa may lead to a preferable service which encapsulates the issues experienced by these people.

Conclusion

Research investigating the effectiveness of approaches to substance misuse is mainly based upon outcome research, focusing on what works so people can stop drug use and so cost society less. While outcome studies are important they do not shed light upon how the individual who experiences change from heroin using behaviour understands this process. This is a crucial area to explore if we aim to understand the complexity of the factors involved in initiating and sustaining long-term change. Few studies have focused upon how ex-heroin users' experience change. Furthermore no studies have included former heroin users who now work as drug workers. This can provide an important contribution of individuals who have experience of occupying both roles, and may offer insight into how self-identity changes and an understanding of how theory and practice can be developed. Due to their background former heroin users are in an informed position to comment upon the usefulness of psychological interventions which aim to facilitate change and it is presumed that they will have reflected upon the process and aspects of their life involved.

Ethically, many clients have an awareness of the underlying issues (reasons) for their drug use, such as a coping mechanism childhood abuse, depression or anxiety. Their contribution may increase therapeutic knowledge of whether it is appropriate to encourage abstinence, without first resolving these issues.

Neale, Allen and Coombes (2005), claim that qualitative methods are valuable in demystifying drug and alcohol use and replacing stereotypes and myths about addiction with more accurate information that reflects the daily reality of substance misusers' lives. It is hoped that the present study is able to utilise the accounts of the participants' to increase and improve understanding of the experience of change.

Rhodes and Moore (2001) present qualitative methods ideally suited to describing the 'lived experience' of drug users from participants' perspectives and Smith (1998) encourages researchers' to use a research approach which preserves the uniqueness of the experience from the sufferer's point of view'.

Since 2010, the approach for addressing substance misuse has been through the Recovery Agenda and accompanied by commissioning targets for 'successful outcomes'. These outcomes are often related to initiating abstinence, at which point service users are 'successfully discharged' from treatment. However, based upon initial work on Natural Recovery, in which a small number of middle class Americans had 'spontaneously recovered' from alcohol use and therefore did not require formal treatment highlighting the importance of developing recovery capital. This approach fails to acknowledge the complexity of sustaining change from heroin use beyond abstinence and may not be generisable to a different population. Therefore this research aims to investigate whether the principles of natural recovery apply to former heroin users' experience of change.

Much research has highlighted the complexity of the factors involved in changing heroin using behaviour such as Engle's Bio psychosocial model and Biernacki and the significance of relationships and identity and lifestyle in supporting change, and notes the high probability of relapse should those who achieve abstinence not receive further treatment. This research aims to consider important areas of ongoing change.

Psychosocial interventions such as Solution Focused Brief Therapy (SFBT) and Motivational Interviewing, generally delivered by staff and service users, focus upon initiating change behaviour, without acknowledging that the person may have developed dependence upon heroin as a response to managing psychological distress and emotional difficulties. This issue is further compounded by a reluctance of mental health services, with their own targets to meet and resources to manage, to offer treatment to those with substance misuse issues. It is therefore important and relevant to investigate the role that psychological distress play in heroin use and how such distress is managed in the absence of heroin.

The recent 2017, Drug Strategy appears to offer a continuation of this approach and further funding cuts are predicted, however the rates of people achieving of recovery is falling and the number of drug related deaths are at the highest level since records began.

Research argues that there are different understandings of the term 'recovery', particularly between services and service users.

Understanding the impact of heroin use is significant in many forms including public service costs, including treatment, health care, the impact upon communities in the form of crime and public health, families and social relationships and not least to the heroin user themselves.

AIMS OF THE RESEARCH

This research utilises the insights of those who have experience of changing their heroin using behaviour and are employed within substance misuse services so are in an informed position to appreciate recovery and change , including appreciating the complexity of factors, barriers and difficulties involved in initiating and sustaining change.

This can help to inform practice, policy and Counselling Psychology and can have significant implications for society and those impacted by heroin use. Appreciating the factors associated with initiating and supporting long-term change from former heroin users' perspectives and reducing the likelihood of a return to heroin use, will have massive advantages, whether these are financial through cost savings or improving the quality of life of those affected by heroin use.

In addition, it is aimed that the findings of this research can be extended to other forms of substance use and behaviour change.

Research questions

What is 'change' from heroin use?

The research focuses upon the understanding change from heroin use from the perspectives of those who have been involved in the process. Change is most popularly understood in terms of abstinence from heroin use. However, change behaviour may extend both before and beyond this point. It is important to gain understanding of what these points of change are so that we are more able to support change at each stage.

Is change from heroin the same as recovery?

The literature identifies that there is a different understanding of recovery among stakeholders, particularly among those who direct and deliver treatment services and those who are reliant upon these services. It is therefore relevant to understand from the perspectives of those who have attained long-term change whether the principles of recovery apply to their experience.

What triggers a change in heroin using behaviour?

When attempting to understand change, it is important to understand the parameters of this change. For example, is change upon stopping using heroin, or does it begin before this and what factors are important in initiating this change. This has implications for all those interested in change behaviour and whether this is supported by current treatment models.

What is involved in making change sustainable?

The research highlighted that relapse rates are high for heroin use and due to decreased tolerance levels this increases the probability of overdose and drug-related deaths. It is therefore important to understand the factors involved in maintaining change from those who have managed to sustain this change. It is necessary to appreciate the aspects of change following abstinence in order to reduce the likelihood of a return to substance misusing behaviour.

Is heroin used to manage psychological distress?

There is a strong argument in the literature associating heroin use with psychological distress. However, the current Recovery drug policy does not seem to acknowledge or support this. It is therefore relevant to consider whether, and in what ways, the participants in this study had used heroin to manage psychological distress.

How do participants manage distress in the absence of heroin?

If the participants had used heroin to manage psychological distress, then how do they manage this in the absence of heroin? This is important to consider with regard to increasing awareness of alternative coping strategies, for which heroin may have previously been used.

METHODOLOGY

Rationale for methodology

Humanistic Psychology relates to an approach which studies the whole person, and the uniqueness of each individual and looks at human behaviour not only from the perspective of the observer, but also of the person doing the behaving.

Sometimes the humanistic approach is called phenomenological. This means that the person can be considered from the point of view of the individual's subjective experience. In this sense the focus of psychology is upon how individuals perceive and interpret events.

Positivist, scientific research is concerned with gaining knowledge in a world which is objective by using scientific methods of enquiry. Positivist research is derived from a philosophical position that regards knowledge as unitary which is available through a standardised set of procedures (McLeod, 2003). However it can be argued that quantitative outcome studies do not reflect individual experience or the sense that individuals have made of their experience.

According to Strawbridge and Woolfe (2003) 'Counselling Psychology extends the notion of what is scientific beyond positive perspectives to include qualitative, inter-subjective accounts which are perhaps more relevant to its practice than the production of nomothetic data' (p710).

Qualitative research methods enable health sciences researchers to delve into questions of meaning, examine institutional and social practices and processes, identify barriers and facilitators to change, and discover the reasons for the success or failure of interventions (Starks and Brown Trinidad, 2007).

Most qualitative researchers adopt a philosophical stance that human knowledge is contextualised and local, and best defined as a set of procedures, rather than as a phenomenon that can be strictly circumscribed. The design of this research used qualitative methodology to explore the participants' subjective experiences of change from heroin use. Interpretative Phenomenological Analysis (IPA) researchers are especially interested in what happens when the everyday flow of lived experience takes on a particular significance for people. This occurs when something important has happened in our lives, as in the case of change from heroin use.

Due to its concern for the detailed examination of human experience, IPA was chosen as the most suitable methodological approach. The aim was to increase understanding of the experience of change from heroin use, rather than to seek explanation, by exploring the meanings that the participants had given to these experiences and the impact that they had had upon their lives.

Interpretative Phenomenological Analysis is concerned with exploring in detail how participants are making sense of their personal and social world. The approach involves a detailed examination of the participant's lived experience. This is what makes IPA phenomenological and connects it to the core ideas unifying the phenomenological philosophers. IPA concurs with Heidegger (1962) that phenomenological inquiry is from the outset an interpretative process. IPA was used to understand former drug users' experiences and what sense and meaning they make of these experiences.

Guidelines put forward by Jonathon Smith, who developed IPA (Smith, Flowers and Larkin, 2009; Smith, 2008) were used to obtain the themes of interviews conducted with participants. IPA is a qualitative research approach committed to the examination of how people make sense of their major life experiences. It is an interpretative activity which aims

to understand a person's individual perception of the phenomenon, by exploring their hermeneutic, here the client's experience of obtaining and maintaining abstinence from heroin use. At the same time it was important to understand the researcher's own experiences and perceptions and how these may have influenced to the interpretation of the data. This is known as double hermeneutic (Giddens, 1987).

Braun and Clarke (2006, p80) suggest that "What is important is that the theoretical framework and methods match what the researcher wants to know, and that they acknowledge these decisions, and recognize them as decisions."

Following discussion with the research supervisor, it was identified that qualitative methods were the most appropriate match as they would provide the best opportunity to explore the complexity of the experiences involved in change from heroin use. However, deciding exactly which qualitative method to use was a carefully considered process.

Two main alternatives to IPA were considered.

Thematic analysis is the most common form of analysis in qualitative research. It emphasizes pinpointing, examining, and recording patterns (or "themes") within data.

Themes are patterns across data sets that are important to the description of a phenomenon and are associated to a specific research question. Thematic analysis can be applied across a range of epistemological and theoretical approaches and so the method allows a flexible and creative way of working. However, it can be criticised for the absence of clear and concise guidelines on how to carry out such an analysis and therefore if not applied carefully thematic analysis creates little beyond mere description and has insufficient interpretative value (Braun and Clarke, 2006).

Grounded Theory is a set of methods which consist of systematic guidelines for gathering, synthesising, analysing and conceptualising qualitative data to construct a theory (Charmaz, 2001). IPA and a qualitative approach to Grounded Theory share many common factors (Smith, Harré, & Van Langenhove, 1995). For instance, both involve analysing data to identify themes and categories to capture the essence of the phenomena under investigation and aim to represent participants' views of the world. In terms of analysis, both start with one individual case and then integrate further cases to produce a rich and detailed picture and use similar terminology (Willig, 2001). However as the aim of the research was to improve understanding rather than to seek an explanation IPA was considered the most appropriate methodology. IPA is specifically a psychological research method designed to primarily gain insight into people's everyday experience of reality in order to facilitate understanding of the phenomenon under investigation (McLeod, 2001). Grounded Theory has been traditionally used to address sociological research questions. Willig (2001, p69) explains "Grounded Theory aims to identify and explicate contextualized social processes which account for phenomena. By contrast, IPA is concerned with gaining a better understanding of the quality and texture of individual experiences; that is, it is interested in the nature or essence of phenomena."

Semi-structured Interviews

Interviewing is a widely used in qualitative research as it offers a flexible way of gathering data that is detailed and personal. IPA uses semi-structured interviews which allows the researcher to enter into a dialogue with the participant where questions can be modified in light of their responses and draws attention to particular areas of interest that may arise which can be probed in more detail than more structured methods may allow. The flexibility

offered by semi-structured interviews allows detailed investigation into how the participant has made sense of their experience.

IPA requires a rich, detailed, first person account of the experiences. In-depth interviews are the most suitable way of accessing such accounts, as they facilitate the elicitation of stories, thoughts and feelings about the phenomenon under investigation. The interviews were designed to provide the participants with the opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas and express their concerns at sufficient depth. The quality of information obtained also depends on the level of rapport and trust between interviewer and interviewee. Therefore, efforts were made to develop rapport between researcher and participants prior to the interviews.

Guidance of constructing a schedule for a semi-structured interview was taken from Smith, Flowers and Larkin (2009), to enable the participants to provide a detailed account of the experience under investigation. Questions were designed to be open and expansive, to encourage the participant to talk at length and in detail about their experiences. The interviews started with a question which allows the participant to recount a fairly descriptive episode or experience; 'Tell me about your experience of change'. The participants were encouraged to be more reflective of their experience as the interviews progressed. Questions were phrased in order to elicit expansion of their sense making not to make assumptions about the participant's experience or concerns, or lead them toward particular answers (Smith, Flowers and Larkin, 2009) and a combination of open and closed questions and prompts were utilised as recommended by Booth and Booth (1996) in order to facilitate the communication.

Participants

Following research approval, and organisational consent to conduct the research, Service Managers at substance misuse services in the East of England were contacted, outlining the aims of the study and inviting potential participants who met the selection criteria to contact the researcher for further information.

Responses were received by email from seven people employed in substance misuse, who continue to work directly with clients who access the services.

Potential participants indicated their interest in the study by completing a 'consent to participate' form (see Appendix D). Only those people who returned the slips were contacted for the purpose of providing additional information about the project, initiating the consent process, clarifying the interview procedure and establishing rapport. In some cases potential participants were already known by the researcher, and status of their previous heroin use had already been shared. Although in these cases, rapport may have been developed to varying extents which could potentially influence the depth of disclosure, in all cases, principles of confidentiality was maintained, including reassuring participants that none of their information would be discussed or shared with others within the organisation.

Further information of the study was then provided to the potential participants and a time and location, convenient to the participants, was arranged to conduct the interviews.

As the majority of the participants were located more than an hour from where the researcher was based, the researcher agreed to travel to the participants' location of employment to conduct the interviews.

The study recruited seven participants which is roughly consistent with the guidelines of between three and six participants judged as a reasonable size by Smith, Flowers and Larkin

(2009). A discussion was held between researcher and researcher supervisor about whether seven participants would be too many. It was decided that all seven participants would participate in the study and that material would be used. It also allowed for the research to continue should a participant choose not to participate or withdraw consent following the interviews. Seven interviews provided adequate data for the researcher to explore similarities and differences without being overwhelmed by the amount of data generated. A minimum of two years heroin abstinence was requested, at recruitment stage. This is consistent with organisational policy for employment and was therefore taken as a measure to ensure suitability. The rationale behind this decision is that relapse is common during early stages of abstinence. Two years drug abstinence was also considered time to participants to have reflected upon the change process and to have established a level of change where relapse would be less likely from participation in this study.

The following inclusion criteria applied:

1. Must have obtained abstinence from problematic heroin use (including substitute medication).
2. Must have maintained abstinence for a period of a minimum of 2 years.
3. Men and women will be selected.
4. Participants will be practicing drug workers.

Five males and 2 females participated in the study, all aged between 38 and 50. Although the selection criteria had only requested a minimum of two years heroin abstinence, all of the participants had not used heroin for more than 6 years.

Interviews

Interviews were conducted using the interview schedule included in the appendices (Appendix B), at five different substance misuse agencies, which were all part of the same organisation, in the East of England. The same agencies were used on two occasions to conduct two separate interviews, as the participants were based at the same agency. The agencies used were community drug services, which assist people in overcoming dependence to drugs and alcohol.

Counselling rooms were used to conduct the interviews to ensure privacy and sufficient time was allocated to prevent distraction. Participants were interviewed individually for around to one hour. These interviews were audio recorded then transcribed verbatim.

Ethical considerations

Ethical approval for this project was first sought from the researcher's University. Before applying for organisational approval, the project was subjected to a thorough peer review process which entailed several amendments being made to the project protocol and supporting documentation. Once full approval had been granted, the study was then scrutinised by the local research and development unit of the substance misuse agency where the interviews were to be conducted and then given the final approval by the research and social governance.

Risk Management

The risks of this study were assessed as being relatively low. However, it was recognised that it could be perceived as intrusive in terms of the participants' experiences of drug use, reasons for starting and exploring potentially emotive topics around change, including

difficult childhood experiences. Fox (1976, p63) points to risks inherent in qualitative research and states that such participation 'even on a purely verbal level, may arouse feelings, stir memories, or force perception which otherwise may not have occurred'. To protect against possible distress caused by the potentially emotive nature of the area of investigation, the following measures were taken:

Supervision from the researcher's university ensured that any difficulties were avoided or resolved to guarantee the care of participants.

The researcher made attempts to reduce any anxiety in participants by developing rapport prior to collecting data. In addition, it was explained that participants could terminate the interview at any point, should they chose.

Counselling skills, including an empathic and non-judgemental approach to conducting the interviews were used to attempt to establish a sense of safety for the participants to share their experiences.

Participants were reminded at the beginning and during the interview that they could refuse to answer any questions that they found too personal or intrusive.

Participants were monitored for signs of distress and interviews could be paused or terminated should they find participation and discussion of their experiences too difficult.

None of the participants opted to terminate the interview, although if this had occurred, the researcher would have offered the participant a debriefing session to alleviate distress before they left the interview. Details of the research supervisor were provided to each participant should they have any complaints about the research process.

Informed consent

The issue of informed consent is particularly challenging in research with potentially vulnerable individuals with addiction histories. For instance, consideration was given to whether the individuals taking part in this study may be harmed by their participation, which could potentially result in relapse. This may have been in the form of discussing potentially distressing topics, which had contributed to their use of drugs.

The importance of the researchers' attitude to consent and the importance of ensuring that participation in research is an on-going process and not something that is only established at the beginning of the process, but should be ensured and checked throughout, including prior to publication.

Informed consent was gained from participants, by explaining what to expect from the interview and how the information that they provided would be used and protected. This included letting the participants know the types of topics to be covered. The likely outcomes of data analysis, were also explained, particularly the inclusion of verbatim extracts in published reports, in which any data would be edited to protect anonymity.

It was explained to participants that the researcher would share content with the research supervisors though all identifying information would be anonymised before further publication.

It was clearly explained that participants had the right to withdraw their consent at any time during or after the research up until write up and submission. Participants were also assured that their refusal to participate in the research would not have any adversely impact their employment.

It is conventional to offer the participants the 'right to withdraw at any time', though it was highlighted that this may not be possible once publication has occurred. For this reason the

participants were offered the right to withdraw up until the point of that publication takes place.

The participants were provided with the contact details of the research supervisor, and the Employment Assistance Programme, should they find the research distressing or had any complaints. However, it was expected that participants would find the research useful as they were given the opportunity to voice and share their experiences. Generally, the research seeks what contributes to change and allows the participant to share their success, which is thought will be empowering for the individual participant.

Confidentiality and Data Protection

Informed consent was gained to use verbatim extracts from the interviews in any write-up with the reassurance that all identifiable information would be removed to ensure anonymity.

The anonymised, written transcripts and audio-tapes were stored in line with organisational policy and procedure. Any identifying data was stored separately under lock and key and only accessible to the researcher. All data gathered by the project: written, electronic and audio-taped, was kept securely with reference to guidance from the Data Protection Act (1998). Data shared with the research supervisors was anonymised.

Data Analysis

The interviews were transcribed verbatim as soon as possible after the interview and initial analysis started during transcription. This was to ensure the interaction between interviewer and interviewee was recalled in detail and to utilise the interviewers' initial interpretations made during the interview. This analysis was then included in the analysis and subsequent identification of themes in the data.

'The assumption in IPA is that the analyst is interested in learning something about the participant's psychological worlds. This may be in the form of beliefs and constructs that are made manifest or suggested by the respondent's talk, or it may be that the analyst holds that the respondent's story can itself be said to represent a piece of the respondent's identity' (Smith, 2003, p66). The aim is to try to understand the 'meaning' that the participant has given to the experience.

IPA can be characterized by a set of common processes, such as a commitment to an understanding of the participant's perspective, with a psychological focus on personal meaning making in particular contexts which are applied flexibly, according to the analytic task (Reid, Flowers & Larkin, 2005).

Data analysis began by looking for themes in the first case. This began informally during the interviewing in which the interviewer's thoughts and initial interpretations were later recalled and continued through transcription and reading and re-reading the transcripts in order to become as familiar as possible with it. Comments were made in the left-hand column regarding interesting and significant issues such as associations, use of language, preliminary interpretations to identify preliminary themes.

Once completed for the whole transcript, the researcher used the right-hand margin to document emerging theme titles with the aim of capturing the essence of what was found

in the text. No attempt was made to omit or select particular passages for special attention as this may have demonstrated the researcher's hermeneutic and biased the analysis.

The emergent themes were initially listed chronologically and the researcher looked for connections between them. This then led to a more analytical or theoretical ordering as the researcher noticed clustering of themes. As these clusters emerged, they were checked in the transcript to make sure that they matched the actual words of the participant. (Smith and Osborn, 2003).

The researcher used an interpretative focus during the analysis to make sense of the participants' narratives and constantly checked their own sense making against this information. These thoughts and interpretations were bracketed off in a separate diary.

A table was then produced to capture the main themes from the participants account.

Clusters of themes were labelled and represented the super-ordinate themes. During this process certain themes were not included if they did not fit appropriately into the emerging structure or were not very rich in evidence within the transcript.

The analysis then developed to incorporate interviews with the other participants by repeating the process with each of the remaining transcripts in which thoughts from prior analyses were 'bracketed' off so as to be consistent with IPA's idiographic commitment.

After all transcripts had been analysed a final table of super-ordinate themes was constructed.

The transcripts together with the superordinate themes were considered to discern repeating patterns and acknowledge any new issues that had emerged, in an attempt to recognise convergences and divergences in the data and respecting the ways in which the accounts were similar and different.

The research supervisor was consulted to offer critical examination of the themes and levels of agreement to ensure themes were firmly grounded in the original transcripts.

The final write-up involved translating the themes into a narrative account in which the themes were illustrated using verbatim extracts from the transcripts and the analysis was supported by the researcher's interpretation of the extract.

Trustworthiness of the research

Various strategies were used to promote trustworthiness (Lincoln & Guba, 1985) in this study. Reflexivity (Finlay and Gough, 2008), was used to promote credibility through the use of a reflective diary to ensure that any biases or predispositions toward change from substance use I may have had would not affect the research. This was aided by bracketing my pre-understandings of the topic. When using a hermeneutic phenomenological approach it is not possible to not be influenced by prior sense making of the topic (Koch, 1995).

Regular meetings with my supervisor also ensured that the study remained credible by ensuring that my own preconceptions were not imposed on the actual lived realities of the participants (Malterud, 2001).

All of the researchers listened to the audio recordings, as failure to do so may increase the potential to superimpose my own presuppositions or interpretative bias onto the data. We reached consensus after engaging in a shared analysis of the data. An example of this was when one of the participants described as 'bullshit' the idea that heroin can be used to manage difficult emotions associated with sexual abuse. This challenged my own assumptions, but after discussing with my research supervisor I was able to comprehend that there is more than one way to make sense out of the experience and added value to

the study by suggesting that relations to sexual abuse may provide an excuse to continue using heroin and therefore diminish the likelihood of change.

I kept an audit-trail to document various decisions made in my study especially around the construction of themes and this strategy ensured that my decision-making remained consistent and did not negate prior decisions that were made.

Member checking was used to ensure that the experiences of the participants were translated into data accurately (Lincoln & Guba, 1985). This involved giving the participants the opportunity to check the accuracy of a summary of the findings of their interview which increased the credibility of my findings (Johnson & Christensen, 2012) by making the experiences of the participants recognisable to them in the study's findings.

The participants were emailed a document outlining the key themes that I formulated from their interview, each of the sub-themes was substantiated with direct quotes from their own interview transcript. The participants were encouraged to confirm or challenge what had been formulated to ensure what they had said was accurately represented. The participants confirmed that the formulation was an accurate representation of what they had said. No recommendations for more appropriate interpretation were suggested.

Whilst it is impossible for the findings of this study to be universally transferable, a level of transferability was achieved through providing the relevant background information of the study, the methods that were used and the study's findings (Malterud, 2001). Future researchers have a clear guide about what degree of transferability the present study would have for them in shedding light on their own research questions (Malterud, 2001) and findings.

Finally, the use of low-inference descriptors, which are in the form of verbatim quotes from the students, are used extensively throughout my findings chapter. By citing these quotes the reader is able to understand the students' experiences from interpretations of their own words rather than any other more indirect source (Johnson & Christensen, 2012).

REFLEXIVITY

Of course, we have all experienced some form of change in our lives. The closest that could relate to the participants in this study was through my own personal experiences. Although I have never used heroin, I had tried a variety of illicit substances in my youth and had smoked cannabis for several years. I believe that the reason that I did not try heroin, and possibly develop dependence upon it, is because it was never introduced to me or available. I reflect that at the time I had wanted to gain acceptance and approval from my elder peers, and was also curious about the ways in which substances could change the way I felt. My own experience of change was related to an exasperation of the negative effects that cannabis was having upon my psychological and emotional health and it involved disassociation with my peers and was assisted by a change of location.

I conducted the research as an experienced counsellor within the field of substance misuse having practiced counselling and psychotherapy since qualifying in 1999 and within substance misuse services since 2000.

I have practiced as an Adult Counsellor in substance misuse services since 2002. As part of my work and studies I am very interested in what creates and maintains change.

Whilst working in Liverpool Prison as a group facilitator with former heroin users on a detoxification wing, a group member suggested that “change happens when the penny drops” and that “if I wanted to be a good drugs counsellor I will find a way to make the penny drop sooner”. Although this raises the question of responsibility for change, I suppose that I am motivated to be that ‘good drugs counsellor’ and see this research as a step toward achieving this.

An interesting question therefore, is if the 'penny drop' represents obtaining and maintaining a drug free lifestyle, and a drug free lifestyle represents change; how can I facilitate this change?

I believe that my counselling skills and an ability to communicate an understanding of the issues involved in substance misuse allowed me to develop rapport with the participants. This was often demonstrated by an increasing depth of disclosure and reflection as interviews progressed.

I began this research with a particular hermeneutic of change, which had been influenced by my counselling background in which I primarily identify from a person centred tradition and have a hope for a self-actualising tendency. This hermeneutic has also been influenced by my years working with clients and for an agency attempting to meet commissioning demands within an austere economic climate. A 'recovery agenda' with targets linked to 'successful discharges' had raised some concerns that substance misusing clients were not having their ongoing needs met beyond reaching organisational and political objectives. These concerns were supported by the accounts of the participants who were able to explain, in detail through their experience, how they had made sense out of their experience of change.

However, there were also a number of points in the research that challenged my hermeneutic. I had a belief that heroin, due to its physical pain relieving properties, was a means of managing emotional pain. This way of thinking is supported by correlations between heroin use and childhood sexual abuse, and poor mental health and substance misuse. Although this was also supported by a number of the participants, others strongly rejected this theory advocating ownership and responsibility for change, insisting that it is

important to get to the point of identifying that they used “because they wanted to” (Simon 538 & Derek, 774) which related to an ownership of their heroin use issue.

Initially I found this way of understanding change difficult to appreciate. At first I assumed a lack of empathic awareness on behalf of the participants, of why people who had experienced traumatic experiences may develop a dependency upon heroin to manage their pain. However, support from my supervisor enabled me to understand that ‘there may be more than one route to addiction’. This offered a valuable contribution to my research findings. This argument also led me to question whether my, (possibly more compassionate) perspective had unintentionally offered a means of externalising responsibility and therefore be non-facilitative in initiating change behaviour. I found such an experience difficult to manage and led to me questioning both the effectiveness of my skills and the value of my approach to counselling.

This research has led to an increased personal understanding of the paradigms of the Recovery Agenda and its interpretation and application as a governmental strategy.

Solution-Focused and Person Centred approaches are considered to slow down the process and the opportunity for services to achieve targets set by commissioners with decreasing budgets in a time of austerity.

The participants’ accounts were retrospective, from a position of ‘success’, with regard to accomplishing and maintaining change from heroin, this may have influenced their hermeneutic of ‘change’. However, Roger asked a question with regard to his experience of change, when asking how his change would be compared with others, who had not used heroin? Implying that there had been a focus upon his change due to a societal perception of heroin use as being a deviant behaviour.

These questions influenced my hermeneutic leading me to question whether my own understanding of change was valid.

We therefore may have shared an assumption that a construction of change is both valid and worthwhile. However, their challenges to the notion of recovery may also reflect a separation and a process of dis-identifying with a commitment to recovery, as this may no longer be a necessary part of more established change.

They were able to share extensive changes beyond my personal comprehension of change, as somebody who has never used heroin, or experienced their associated issues.

I am indebted to these participants for increasing my knowledge and awareness and the trust that they invested in me whilst sharing their experiences.

ANALYSIS

The following section will give an overview of each super-ordinate theme accompanied with subsequent critical discussions and interpretations of meanings. It does not include an exhaustive analysis of the data corpus. Instead, the most salient features of participants' accounts have been extracted and presented which highlight both commonalities and divergences in narratives. Three super-ordinate themes with multiple sub-themes were identified from the data following Interpretative Phenomenological Analysis as summarized in the table below.

Super-ordinate Theme 1: Internal Distress – “Always a sense of unease”.	Sub-theme 3a: Heroin to manage emotional discomfort, distress and pain
	Sub-theme 3b: Heroin as a creator of distress
Super-ordinate Theme 2: Making sense of change	Sub-theme 2a: What is change?
	Sub-theme 2b: Facilitating change
	Sub-theme 2c: Change as an ongoing process
Super-ordinate Theme 3: Longer term process of change; Identity, Relationships and Lifestyle	Sub-theme 3a: Change identity. So who am I? What do I do? Who do I want to be?
	Sub-theme 3b: Changing Relationships; Relating to people without drugs
	Sub-theme 3c: Changing Lifestyle; “It’s about living. And how you manage, or how I manage my life”.

Superordinate theme 1: Internal Distress - 'Always a sense of unease'.

The first superordinate theme considers internal distress associated with heroin use.

Subthemes focus upon how and whether heroin may be used to manage distress, a second subtheme, appreciates heroin as a creator of distress.

Throughout the analysis the participants had referred to experiencing emotional pain, distress and discomfort, though this seemed to be in a variety of ways and forms.

Analysis identified that heroin may have been used to manage uncomfortable feelings, though may also have contributed toward exacerbating emotional distress.

Change incorporated the capacity to manage this discomfort, pain and distress, in other ways, after stopping using heroin, in which the analysis identified that a variety of strategies had been developed.

Sub theme: Heroin to manage emotional discomfort, distress and pain

Each of the participants referred to an experience of distress, pain or discomfort in relation to their heroin use, though this tended to be in different forms. The first of these forms was present from an early age and substance misuse was related to underlying psychological distress. The second seemed more related to pain resulting from significant events which had happened as a reason for starting drug use, or as an escalation of their dependence. A further form was related to distress created by involvement in a drug using lifestyle, which involves some of the factors previously discussed such as morality and identity conflict, a diminished sense of self-worth, relationship difficulties, and marginalisation from a normalised population.

Roger, Barbara and James referred to internal distress prior to heroin use. Roger referring to an inferiority complex which I interpret as not feeling good enough in comparison to others,

outlining a tendency to go inside himself when he is alone and describing himself as his own worst critic.

“I think I always knew I had an inferiority complex. I always knew that, do you know what I mean. There’s no doubt about it.” (Roger 1069-1070).

He relates this inferiority complex as the underlying issue which led to his drug use and also an important factor in his ongoing change.

“I’ve always gone inside myself as a temporary measure. But I’ll always go inside myself when I’m alone; I’m my own worst critic.” (Roger, 31-32)

This seemed a significant process in which he experienced internal discomfort which became more acute during a process of self-reflection and suggests relief from his pain, distress or discomfort is related to his desire to use heroin.

These tendencies revealed an internal distress, which Roger had previously referred to as ‘the root of stuff’ (Roger 269) and indicated the need for support to help him to manage these issues in relation to his substance misuse. He believes that had his issues been recognised and supported at an early age then his dependence may not have happened and the absence of adequate and ‘specialist support’ (371-373), ‘just made things a worse’ (Roger 272).

James recalls from his earliest memory he had ‘always a sense of unease’, never feeling right, never felt a part of it’.

“I’ve never felt I was part of it. Never from my earliest, earliest memory. I’ve never, never felt right. Always out of unease. There was always a sense of unease. That’s how I’ve always felt from my earliest memory. Always a sense of unease” (James, 658-669).

James also relates his substance use to underlying psychological distress, explaining his use of substances to manage his discomfort. The relief when he had a drink at the age of 12-13

and his sense of unease disappearing so that he could feel normal, felt important and is consistent with the notion of heroin as a pain reliever. This seemed significant and highlighted a struggle to cope with the self and feelings which was alleviated by the relief provided by heroin use.

“It’s to do with how we feel and we use them things to change the way that we feel. That’s what I think. You know, that’s the tip of the iceberg. There’s the drinking, you end up doing that, or drugging. Because of something else that’s going on. It’s just a sense of unease that I’ve always had. And I remember early on 12, 13, taking a drink and that sense of unease, just disappearing. Just, ‘Oh, I feel normal’ whatever that was.” (James, 664-668).

Barbara (157-160) also offers support to the idea of heroin use to manage emotional pain, explaining that the reason why she first started taking it [heroin] and the reason why she kept taking it, is that it took away all of her thoughts and feelings of confusion and depression. This indicates a relation between unhelpful thoughts and uncomfortable emotions for which substances were used to manage.

The point that Roger tended to go inside himself when he is alone also seemed important, and was matched by both Carol (562-563) and Derek (827-831), with Cathy saying that she can ‘never sit and do nothing’, and reporting that she has issues with this.

Derek raises the importance of keeping himself occupied; disclosing that “sometimes when I sit with me it can be hard work”, suggesting that he is not comfortable when he is alone with his thoughts and has more opportunity to reflect upon himself. This points toward the persistence of psychological discomfort after achieving abstinence and offers a question of how such difficulties are managed in the absence of the relief provided by drug use.

Stuart and Carol refer to a situational form of distress rather than internal where they relate their drug use to specific events or experiences. Stuart (190-193) describes paternal

abandonment and the death of his Grandmother as factors which escalated his drug using behaviours. He also refers to childhood abuse (360-362) as having an impact upon his life. Carol (141-144) relates her heroin use to the death of her son through cot-death and an affair by her husband. She explains that (281-282) she lost trust in the world and that she just wanted the pain to stop. In this sense heroin may also provide a means of coping with emotional difficulties that arise through life events.

From each of the accounts it seemed that heroin had been used to alleviate internal pain, distress or discomfort. However, both Derek and Roger were critical of the idea that difficult life events give way to drug use and they believe that this kind of reasoning could hinder change by externalising the cause of the problem and not accepting ownership and responsibility. (Roger 1155-1156) and Derek (704-705) suggest that an experience of sexual abuse may provide a reason and therefore excuse to use heroin.

“it’s not offloading in onto something else. You know I think what they’re doing, and another good point, they’re not accepting responsibility. And I’m using because this happened to me or that happened to me and it, and it stops me thinking about the stuff that’s happened to me. Bullshit, that’s what I say to that, you know what I mean. ‘Cos er, what you’re doing is your just giving yourself free-reign to use again. Do you know what I mean, your justifying your use and until you, sort of, surrender and say, ‘it’s beat me’ do you know what I mean.” (Derek, 761-766).

Sid and Derek both reported that their initial heroin use was not related to psychological distress or emotional pain, but out of curiosity, fun and enjoyment.

“I didn’t start using to hide or to cover anything or to run away or anything like that. I used just to get out of my head. I used just to enjoy myself, or get carried away or erm, ‘cos obviously, at... at the time it wasn’t just this I was using. I’d go out every weekend and

during the week and be using something along the way. Just to...just to enjoy myself.” (Sid, 193-196).

They highlight the positive aspects of drug use, such as an aid for fun and the appeal of the physical pleasure of heroin use.

“Yeh. I didn’t have any pain to relieve. It was possibly the most enjoying drug I’ve ever had, in just the way that it makes you feel so, in a cocoon and so smooth and so intoxicated and so warm and inviting. And it...and that's what I liked.” (Sid, 1014-1016).

However, the consequences associated with prolonged heroin use seemed to override this initially pleasurable activity.

“And when it became an addiction, when it became needed, it lost all of it’s fun. I lost enjoyment of it and it was just doing it for the sake of doing it and getting dragged down.” (Sid, 197-198).

And Derek explaining an initial appeal and that he was unaware of the consequences of using heroin saying;

“when I first started using it was like, sort of, shiny and new and it was desirable too because you just felt like that you was, er, in like a sort of, secret club sort of thing, do you know what I mean? I started using with a friend of mine and always under, always under the impression that I’d never be addicted. ‘Cos my idea of er, drug using and junkies and stuff like that that what I’d seen on Starsky and Hutch.” (Derek, 9-13).

According to Carol, all heroin users are hiding from some kind of pain and after stopping heroin use this pain still needs to be managed. The different rationales put forward by the participants suggest that there may be different pathways to heroin dependence.

“Whatever a drug user or heroin user is hiding from, and we’re all hiding from some kind of pain, it doesn’t help. You still have to deal with it at the other side. And that’s why

keyworkers are so important, 'cos it does have to be dealt with. Because at the end of all my, taking drugs and cold-turkey and getting straight, I was still grieving for my son. I just put myself through hell in between, it was still there. It still had to be dealt with. Whatever we're hiding from and you talk to any service user and they're hiding from something, even if it's from themselves. It doesn't help." (Carol, 480-483).

The participants suggested that they had developed an increased tolerance of distress to manage emotional difficulties in the absence of heroin use. This included strategies to allow pain 'to pass', using support, not isolating themselves and 'doing something about it'. These changes seemed to represent a difference from using heroin to manage emotional discomfort or pain.

Roger explained his developed strategy for managing distress in the absence of heroin.

"I understand that it will pass, it will not kill me. I'm not scared of that kind of stuff anymore, do you know what I mean. I still am scared of being alone, I'm scared of my parents dying, these things, I'm scared of grief like everybody else is. I know that I'm able to manage it. I can do that. (Roger, 1209-1212).

Derek also communicated an improved ability to tolerate distress and also highlighted the importance of support as an alternative to using heroin.

"As anybody else would. Without using drugs, you know. Work through it. Like grief and recognising the feelings that come with grief, knowing that you're going through the anger, guilt all that stuff. And that it does pass, you know. And, also again, leaning on the support, what I've already got. I think if I tend to isolate, don't use that, things can manifest itself, you know what I mean. But then I recognise, this is where I am. And I need to do something about it. But, again, you know the option isn't to go to [City of residence], find the nearest drug dealer" (Derek 817-822).

Sub theme: Heroin as a creator of distress

A third form of distress developed from engagement in a drug using lifestyle, in which internal distress is both developed and exacerbated as lifestyle deteriorates with drug use.

Sid explains that heroin created his problems rather than relieving them and that some of these issues continue long after heroin use has ceased.

“But then it’s all the other stuff around it, you created all my problems rather than relieving them. Me getting more and more er, dependant on it, or engrossed in it, created the problems that I’ve still... still dealing with” (Sid 1016-1019).

Barbara describes a deterioration in her self-care and appearance, which she used as a comparison to illustrate the extent of her change to how she presently appears.

“because I was such a vile, mess. I remember once, I went to my Mum’s, she wouldn’t let me, there was a few times, she wouldn’t let me through the door, without stripping off at the door, putting everything in the washing machine and go into the bath. Then I could come down and talk to her. And there was one time where I sat in her kitchen and she de-loused my head. And I don’t know how many, hundreds and hundreds of nits, she’d got out of my hair. And I’d got these, it wasn’t even dreadlocks, it was this matted hair. She sat in the middle of her kitchen all night and then the next day combing these matts out of my hair.” (365-371).

Roger explains the extent to which he was unconcerned about matters related to his heroin use and again offers a comparable shift in attitude, responsibility, health and lifestyle with regard to change from heroin use.

“I had been using for that long, twenty odd years. Ten of that had been full-on heroin use and that, seven of that were heroin and crack use. I was a mess, I mean physically I were in a right state. I had DVTs, my body were falling to bits, I had loads of issues, in and out of

hospital all of the time. In and out of court all of the time, in and out of rehabs all of the time. It were my life, you know. Nothing seemed to touch it. I had 2 kids while I were using. And I have some horrendous tales, like neglecting my own children and stuff like that, but it didn't put a dent in it. I just kept going". (Roger, 61-67).

Carol shared her own experience which illustrates the lack of regard that she had for herself and her life. Her change therefore, represented an improved valuing of herself and her life.

"Another time I was passed out and I came 'round with a works, the tornicay still tight, the works just dangling, thinking, 'oh my god, I've just passed out doing that' I felt so, you know, just stick it up. That again was my low point, so I know where my low points were, I know that was my own hell and as deep as I could go and as crap as I could get. But that was where I was going. That didn't matter." (Carol 337-341).

Both Sid (202) and James (13) acknowledge a sense of shame associated with their heroin use.

"And I've never felt so low and so ashamed of myself ever" (Sid, 202)

And I was walking 'round like a tramp. But knowing it at least I didn't care. So stuff like that really. Really kind of challenges to your self-esteem and your self-worth and your self-image. Loads of stuff like that." (Roger, 296-298).

Roger (1129-1132) explains that heroin takes away bad thoughts and feelings as after persistent use, he 'did not have much else' and Derek highlights a function of his ongoing heroin use was to manage the distress associated with his heroin use.

"It is one of the key issues, you know, 'cos actually heroin does take that away from you. And I think 'cos it's a dirty drug, do you know what I mean, it's, it'll take away, you know

what I mean, your respect and your morals, it'll take everything and you'll start to use to mask that feeling of I'm worth...I'm a piece of shit. No-one likes me." (Derek, 735-739).

James outlines a relief of his sense of shame and anxiety accompanied by change.

"I was very ashamed, disgusted, anxious about my previous life, I suppose. Erm, all those have disappeared. I'm not anxious anymore." (James, 13-14).

Superordinate theme 2: Making sense of Change

The second superordinate theme incorporates three sub themes 'What is Change?' in which analysis identified confusion among participants and different ways that participants had made sense of their experience. 'Facilitating change' in which various instigating factors were identified to create initial change, and thirdly 'Change as an ongoing process' in which analysis strongly aligned change as a longer term process than simply achieving abstinence from heroin use.

This theme is related to distress as the participants related their motivation to initiate change was often as a result of an expiration with internal conflict associated with their heroin use and they also needed to find new ways of coping with distress, in the absence of heroin and as part of ongoing change.

These subthemes shared a commonality between understanding the process of 'change' from the participants' experiences and identifying important factors that may be involved. Analysis identified that there was a difference between a short term conceptualisation of change, which was based upon achieving abstinence and change as a longer term process. However, there was agreement that abstinence is an important 'first step' and a 'foundation on which further change could be built. It was, therefore, relevant to combine these subthemes, in order to understand how the participants had made sense of their experience of change.

Sub theme 1: What is change? Because I'm really not too sure about whether I understand what change is anyway.

"And what is change? Because I'm really not too sure about whether I understand what change is anyway." (James 879-880).

James initially communicates confusion in explaining his change from heroin use indicating a lack of understanding and clarity about how change applies to his experience. In this sense James conveys that although he has vast lived experience of change from heroin use, he finds articulating this experience difficult. This possibly reflects a lack of focus and previous opportunity to reflect upon and consider what was involved in this process. James' confusion was matched by the accounts of the other participants, in their attempts and struggles to articulate their experience of change. James expressed that change is a 'broad concept' suggesting that many factors may be involved (James 4) and (Stuart 121) questioned how to define 'success' indicating that this is subjective and Roger highlighted a lack of markers to identify change other than abstinence (Roger 1290-1291).

"Cos there's not many markers, we just talked about 14 years- worth of my life. So I think, it is hard to kind of, quantify it, and say here are some definite points of change" (Roger, 1290-1291).

Barbara indicated an internal ambiguity in her initial change attempts in that 'parts of her wanted to change' (8-9), but that she 'did not know what she wanted to change or change into'. This suggests that there are various aspects to change and that change may involve a change of identity. It also suggests that there is a 'not knowing' aspect in this process; that a person can change but not know what this will look like or what it would translate in to. This 'not knowing' aspect of change may be evident in 'change guidance questions' following initial abstinence, where the goal of stopping problematic heroin use has been reached but then the person may experience an absence of knowing what to do next or what then needs to change.

Carol used a simple definition of change from heroin use, which represents a commonly accepted notion;

"I used to use and I don't anymore" (Carol 4-5).

Carol's way of describing her change implies that change is simply to stop using heroin and occurred early in the interview before deeper elaboration as the interview progressed.

Developing rapport enabled Carol to consider and explore her experience of change in more depth. However, further exploration and analysis into both Carol's and the other participants' experiences highlighted a much more complex process than simply not using drugs anymore. This more complex process of change was evident in the participants' confusion around the notion of 'recovery'. Highlighting that stopping using drugs is only one part (a physical part), and that there is much more involved.

They also questioned the parameters associated with recovery and abstinence from heroin use.

Carol argued that change may include less harmful or frequent use rather than abstinence (181-183), while others, pointed toward a replacement of heroin with other substance use.

"if it's total abstinence, what about people who choose to drink sociably compared to people who might choose to have a joint on a Friday night?" (Stuart, 151-152)

Sid expressed confusion around a notion of abstinence, indicating that there is a focus upon heroin abstinence, but was unsure whether this included abstinence from other forms of substance use.

"alright, my heroin use has stopped, erm, which is the one that I had the biggest problem with stopping. But I still drink. I still, well I don't, I have since stopping heroin, used other things." (Sid, 433-435)

Sid questioned his own validity of recovery, disclosing that he has used other substances, since abstaining from heroin.

“And also you know, er, with feelings and emotions, they’re all ended by substances. Maybe you know the other times, when I’ve got clean before, I didn’t get clean because I was drinking and taking a bit of this and taking a bit of that. So I wasn’t dealing with me. So maybe the abstinence, you know, for whatever period of time, is what you need, you know.” (Derek 589-592).

Derek, suggests that a policy of total abstinence from all forms of substance use, may be necessary, relating his unsuccessful attempts to achieving heroin abstinence but using other substances as a replacement.

Barbara questioned her own experience in terms of ‘recovery’, indicating that she has achieved the simple definition with regard to overcoming physical dependence, however in other regards she was less sure as to what the term relates. She suggests that there are other factors involved in change from heroin use, but that these factors are less clear and not as easy to identify.

“But have I recovered? Yeh I’ve stopped taking heroin. But have I really recovered? From what? What have I recovered from? From that physical side of the drug taking-yeh. But there’s a whole, everything else”. (Barbara, 171-173).

Roger offered a similar view, indicating that there may be different understandings of recovery and that a conception of recovery based upon physical dependence is inaccurate. He explains that his experience was ‘not to do with drugs’, it was more about self-change, including his beliefs and how he feels about himself and is an ongoing process and suggests that change may involve managing underlying personal and psychological difficulties.

“If you’re gonna say, the problem was my daily drug use, or my drug dependency; that’s done, do you know what I mean. So, if you’re gonna say that’s recovery, then

I'm recovered. But I don't think that. I don't think that at all. 'Cos it's not to do with drugs do you know what I mean, it's not to do with drugs. That were about me and what I believed and all my insecurity, all of that stuff. I still am with that, that's not changed". (Roger, 553-557).

They also suggested that the term 'recovery' has a political and organisational focus, rather than applying and relating to the experiences of those that are involved in the process.

"And what are you recovering from? I think it kind of gets lost. It's a lost word, I don't know. I don't really know what it means to me. I don't know. I don't know what it means to anybody else. I know what it means to organisations and what it's forced to mean now but I don't really know what that means to me." (Sid, 412-415).

The reference to a 'lost word' suggests a widely used term that lacks critical consideration, beyond how it has been constructed to meet political and organisational agendas. It also suggests that this term does not capture, match or appreciate the experiences of those involved in the process.

Roger indicates that the parameters of change from heroin use are also based upon a notion of stopping using drugs. He also sees that in this sense he is perceived as a success.

"As far as treatment services go, I'm a success story. That's this thing. You're successful. You've stopped doing what you were doing and you can get on with your life" (Roger, 565-566).

Roger is dismissive in this sense, as he believes that this is a limited conceptualisation which fails to appreciate or support the ongoing factors which may be involved.

In this sense the participants are able to acknowledge service goals and external markers but are also able to make sense of change at a deeper level. However, the participants did

not believe that a short term view of change either captured or supported further changes that were necessary.

“It is all about ‘Brilliant, just get clean, just get clean.’ Rather than, it’s not very planned, is it. ‘Just get clean’. Then what? And all this talk about jobs and all that kind of foundation stuff. But the actual, the way your beliefs change and things is incredible.” (Roger, 1336-1339)

Barbara was quite dismissive of the conceptualisation of recovery, highlighting that recovery is a much ‘wider issue’ than drug use and includes aspects such as lifestyle, feelings, thoughts, a social situation and handling life. She also believes that current support is insufficient to facilitate these further changes.

“Recovery? I don’t know, I don’t know. I don’t even know what the word means. Because what are you recovering from? What are you recovering from? Are you recovering from drug use? Are you recovering from lifestyle? Are you recovering from your feelings and your thoughts? Are you recovering from a social situation? Are you recovering from, like, how you handle life? I think the term that drug services use as ‘recovery’ is to stop taking drugs. Or to reduce in alcohol or to stop drinking or to recover from substance use. But recovery for me is a massive, wider issue. That by having one to one sessions every week, doesn’t even touch on.” (Barbara 135-141).

There was a sense of frustration in the participants’ narratives, which seemed that they had had to go through important parts of this journey alone and without adequate guidance, opportunity and necessary support, which may have made their experiences more understandable. These may also have assisted them to manage the issues which they would face beyond reaching abstinence.

Derek felt that the term 'change' is a more suitable term to describe his experience and highlights the importance of 'maintenance' and 'consistency' in this process. He suggests that support and understanding is necessary in these regards, beyond achieving abstinence.

"Er, I suppose, it would be better to say what does 'change' mean. And also, maintenance of change and consistency. 'Cos you can change so quickly and change in such a short space of time, how do you sustain that change? How do you maintain it?" (Derek, 323-325)

He explains that change may be initially quick, such as initiating change by stopping drug use, but encapsulates a longer term and more comprehensive process than commonly understood, i.e. staying stopped. The terms maintenance and consistency may indicate the changes which need to be incorporated into his lifestyle in order for the initial change to continue, indicating a longer term notion than associated with the more simple understanding of stopping using drugs.

"Now what is that change? I was...my change from use to using daily and living that lifestyle of thinking about nothing else, but want to change the way that I feel, which is what the drug did for me. And not being able to manage my life on a daily basis.... And no anxieties". James (6-12)

James attempts to identify aspects of his experience of change, highlighting a change of lifestyle which did not revolve around drug use, 'thinking about nothing else' which suggests a change of cognitive focus and extending his attention to other things and that when drug use stops he may be more aware of other things in his life. Changing his attention from wanting to 'change how he feels' which indicates that change may involve a reduced desire to alter the ways that he was feeling and possibly a lessened need to use drugs to manage difficult feelings or emotions. This would indicate an improved ability to 'manage life', which

matches other accounts highlighting the importance of managing life in the absence of drug use. James also reports an absence of anxieties, which suggests a relation between heroin use and psychological discomfort as aspects of change. James later refers to a 'penny drop moment' (James, 158-160) in which he became aware of life issues. By changing the ways in which he 'managed life', it appeared that his sense of anxiety reduced so that he had less need to use heroin to change this uncomfortable feeling. In this regard different aspects of change may be inter-related and influence each other.

In this sense there appeared to be different ways of understanding 'change'; one with a service perspective of stopping using drugs and another from the participants which involves identity, relationships, lifestyle and psychological factors.

Sub theme 2: What helped me change? 'What the fuck are you doing with your life?'

(Stuart, 221)

Analysis of the accounts suggested a number of factors that instigate change which may commonly be referred to as when the 'penny dropped' (James, 140). Sid (239-241), Stuart (87-90) and Barbara (283-287) put forward significant events related to this initial change. Sid and Barbara relate this initial point of change to impending parenthood;

"When my partner said she was pregnant. We were having a little boy, that was..that was the biggest wake-up call and that's the one that I put, if I think about why did I stop, that's the reason I put it down to," (Sid, 239-241).

Impending parenthood was referred to as a 'wake-up call' (Sid, 240) and in this sense seemed to represent a moment in which they became aware that their drug using behaviour as not compatible with their vision of their role as a parent.

And Stuart to being informed that his best mate had died from drug use.

“Then I got a letter under my door, from, well one my best mate’s partner, said he’d died, he’d overdosed, so I just made the decision at that point that I wanted to stop using.” (Stuart, 29-31)

Stuart’s experience seemed to bring into focus the potential consequences of continuing with this heroin using behaviour.

Other participants associated their initial change to exasperation with their drug using lifestyle. James recounts his exasperation with arguing with himself regarding his drug use, displaying internal conflict.

“Cos, every time that I was going to use or drink or do whatever, I had this, the devil and the angel. I argued with myself for years, for years. I was sick of that arguing, you know, in the end.” (James, 168-169).

Derek (64-67, 119-121, 180-182) recalls feeling desperate to change and an awareness of his deep dissatisfaction with his heroin using lifestyle, in his narrative and refers to this as being a ‘catalyst’ (163) for his change.

“a moment I was walking along this railway track and I just thought ‘Shit’, you know, ‘If there’s a god, then I’m asking you now, mate’, you know what I mean, ‘change this ‘cos this life I’ve got is shit” (Derek, 64-67).

“I thought ‘I don’t want this anymore, I just...everything that I’m doing is such a bind, such a..., you know, I just wanted something different so...” (Derek, 119-121).

Regardless of the reason for change, these facilitative factors were associated with realisation questions, such as ‘What am I doing with my life?’ (Stuart 88-90) in which the participants experienced an awareness of the extent of the impact of their drug use. The participants referred to these significant experiences as ‘a moment of clarity’ (Derek 107-

109), or 'sticking my head above the parapet' (James 48-50) or 'a light' (Sid 201-202). These moments of realisation seemed related to an experience of internal conflict in which their identities had been compromised by their heroin use. They questioned their identities, beliefs and purpose, looking for meaning in life in which they asked questions relating to themselves, such as 'who am I?', 'what am I?', 'why am I doing this?', 'And what do I do with my life?', 'What do I do now?' (Sid 356-359).

"when times came when I couldn't get hold of anything and it only takes a day or 2, and you straighten up. I questioned myself every time then. Who I am? What am I doing? What am I? Why am I doing this?" (James, 469-471).

This suggested that a short period of abstinence led to clarity ('straightened up').

Analysis also suggested a need for guidance following abstinence, through the expression of questions asking for direction in establishing change. These questions were related to identity, motives and lifestyle change. Sid suggested that these factors are critical in support change at this stage.

"that was kind of the most difficult time I think. It was 'what do I do now?" (Sid, 61-62).

"Well who am I? What do I do? what do I do with myself? what do I wanna be? What can I be?.... That was a massive one for me, not knowing what to do" (Sid, 356-359).

These questions suggest that the change process is a long and complicated one, not just about abstinence. Once the person has decided to abstain and then does, this is only the beginning as various other areas of their lives are laid bare. It is likely that they are able to see the devastation and loss that their drug use has caused such as the impact on their relationships, health and self-esteem.

“I suppose like one of the things, was losing the relationship really, you know what I mean. And then the crime would be that you’d end up going to prison. Being in prison with no-one, coming out to no one. .. Your self-worth, your confidence, I couldn’t face people in the street. I used to walk along some, sort of, railway embankment, you know a disused railway track, sort of thing, taken off public pathways, it would keep me off the main road, it would keep me off looking at people.” (Derek, 15-38).

Derek conveys the deep shame, sadness and loneliness in the desperation of his situation in which he describes himself as ‘emotionally dead’ (164 & 554).

Despite change being considered as more than stopping heroin use, abstinence from all illicit drugs, including possible substitution with illicit drugs was considered necessary to create change (Roger 422-425, Derek 377-380, Stuart 327-329). Derek explained that this space allowed him to build his change on ‘a solid foundation’.

Roger (422-425) agrees saying that “You’re not going to do it if you fuck about with the drugs. You’re not going to do it. There needs to be a separation.”

“I think abstinence is a policy at first, to, to ,to, sort of, you know, back to terminology, it’s about building on solid foundations. And if you affect that foundation by, ‘okay I’ll stop taking heroin but I’ll have everything else’, it’s not gonna work. So maybe having a period, which I did, you know what I mean, of not having it, was to make a solid foundation.” (Derek, 377-380)

Creating this initial change by abstinence seemed to be accompanied by a change of mind-set, possibly as result of an increased awareness of the devastation that their drug use had caused, which are important in sustaining this change to prevent excuses for opportunities to use and therefore to maintain change beyond initial abstinence. The change of mind-set included ownership of their drug use and taking responsibility for addressing this.

“it was an accumulation of all of this 10 years, everything that I’d been through and then turning ‘round and saying ‘yes it is mine’. The penny dropped there and then. It was weird, it was a real weird moment. I’ll never forget it, ever. I don’t want to forget it either. Erm, I had to do it for me, I knew then, I had to do it for me.” (James, 160-163).

James (160-163) related his ownership in his initial stage of change “yes it’s mine” as the moment the penny dropped and a realisation that he had to do it for himself. He also highlights that he doesn’t want to forget this experience, suggesting that it is important in maintaining his focus and motivation for continuing change. Sid (1180-1182) highlighted the importance of ownership relating this to not using excuses to use again and therefore assisting him to maintain abstinence and develop change. This change of mind-set also included taking responsibility, determination and commitment.

“And it’s not offloading in onto something else. You know I think what they’re doing, and another good point, they’re not accepting responsibility. And I’m using because this happened to me or that happened to me and it, and it stops me thinking about the stuff that’s happened to me. Bullshit, that’s what I say to that, you know what I mean. ‘Cos er, what you’re doing is your just giving yourself free-reign to use again.” (Derek, 761-765).

The aspect of not accepting or allowing excuses relates to a change of responsibility, whether this is directly related to substance use, or with regard to managing life issues.

“So then it was about changing my mentality, I suppose and all the things I’d let slip. Underneath my bed was a massive pile of bills and paperwork and just stuff that I hadn’t thought about or wanted to deal with for all that length of time. It was about starting to do that.” (Sid, 65-68).

The participants' accounts also highlighted a determination and commitment, which was particularly important during the initial stages of change.

Sid (1230-1231) emphasised this determination in that "nothing else is going to get in my way". However he reflected that this sense of determination reduced as his change became more established. However James (229-234) emphasised his sense of ongoing commitment in 'not letting his guard down' to prevent the possibility of complacency leading to potential relapse. In this sense he believes that his change is "always ongoing" (James, 366).

Sub theme 3: Change as an Ongoing Process. "It's not about the drug..., it's about everything else" (Jeff, 892-894).

The first subtheme pointed toward a short-term focus of change from heroin use, with a common perception within society in general that change is accomplished by reaching a point of abstinence. However, Roger described "being abstinent from drugs is easy" (Roger, 1331-1332), and that the bit after is more difficult.

Roger (40-43) describes stopping using drugs as 'insignificant', therefore communicating the part that this had played in his overall experience of change, compared to the stuff that he has faced since, as part of ongoing change. He highlights that "living life without drugs and being prepared to look at yourself is much more difficult". This suggests the development of self-awareness and self-acceptance as being an important part of ongoing change.

James, Barbara and Roger emphasise change as an ongoing or lifelong process, however they reflect on a lack of support after achieving abstinence, which is reflected in treatment provision. Roger (1336-1339) describes a service attitude of 'Brilliant- just get clean' and Stuart (42) likens the allocation of resources to provide services as a "funnel with all of the money going to the front end with none left for the important part". Sid (354-355) shares

this perception that services weren't designed to support ongoing change with an attitude of "we've done our bit- now it's up to you to do it all" and Stuart (114-116) describes people as "being dropped like hot potatoes" following treatment completion.

These shared perspectives emphasise a frustration at the emphasis placed upon reaching abstinence and a lack of appreciation and resource to support further changes.

"And then you kind of erm, 'oh', felt, it isn't the big rose garden of greatness that it's painted out to be and it is the massive dull empty space that you've got to fill somehow. I don't know, you're led to believe that being clean is it. That's the most amazing bit, but it's not." (Sid 362-364)

Sid used an analogy to explain his disillusionment at the inaccuracy of a short term conceptualisation of change, describing the disappointment that he experienced after reaching abstinence, with a rose garden illustrating his expectations of life without heroin. His quote illustrates the importance of an increased awareness of further necessary lifestyle changes beyond achieving abstinence.

Analysis of the accounts indicated strongly that the participants felt unsupported with regard to ongoing change and that there was a lack of understanding and appreciation of the complexities of the issues involved in change beyond cessation of heroin use.

"I sometimes wonder if there's enough of this conversation that are stepping into this. I do wonder that, I just think, it's easy to do the kind of being abstinent from drugs and stopping them behaviours but after that, you've got to be careful about." (Roger 1330-1333)

Roger's statement points toward the necessity of an increased awareness of the complexities associated with maintaining change beyond abstinence. Roger does not indicate with whom this conversation should be, but may relate to an improved awareness

of the difficulties and complexities at all levels associated with ongoing change. This may inform all levels involved in this change process, from political agendas, commissioning decisions, service aims and treatment support, worker approaches, an improvement in a social understanding and perhaps most importantly the expectations of the service user themselves.

Superordinate theme 3: Longer term process of change.

“I could actually rebuild what I wanted. ‘Cos everything else were fucking obliterated”

(Roger, 1321-1322)

The third superordinate theme considers significant changes to identity, relationships and lifestyle associated with change from heroin use and is related to the previous themes in that these factors may be important in instigating change or as part of a longer term process beyond reaching abstinence and instead of using heroin social relationships and new opportunities, such as employment became an important means of establishing change and managing distress.

These three aspects were identified as most relevant in the process of change. Although these subthemes may converge and be contribute to each other, there were important processes involved in each of these dimensions in the participants’ experiences of change from heroin use.

Sub theme 1: Change identity. So who am I? What do I do? Who do I want to be? (Sid 713-715)

Initial change seemed to be associated with a conflict in the self, triggered by a significant event, such as impending parenthood or an exasperation with a drug using lifestyle. Conflict was also demonstrated through the participants’ changes in morality and sense of selves.

“Like I said about following that woman, it feels really clear now. Doing it and talking to myself as I’m doing it, thinking ‘yeah, there’s a tenner in there, whatever, go on just grab it, nick her handbag’ all this sort of stuff and... It was just like a light. ‘What

are you doing?’ And I’ve never felt so low and so ashamed of myself ever. And to feel that way without actually doing it kind of says a lot to me. That that’s it for you, you don’t go lower than that and I couldn’t.” (Sid, 199-204).

Sid described this conflict in an event which led him to ask himself ‘what are you doing?’ describing this moment as ‘a light’ which influenced his change. The shame which he experienced seemed to be an important experience in which he could see the conflict in his values and perception of who he was.

“Before, my moral code, I used to step over my moral code, all the time. Making promises, saying I’ll be there, making appointments, not turning up, lying, hiding, ducking, diving, sneaky, conniving, all those. I did all those things. I’ve changed all that. And I continue to change all that. I try to be a better person on a daily basis.” (James, 257-261).

James described changes in his own morality on a ‘daily basis’ describing his heroin using behaviour as “sneaky and conniving” and he sounded uncommitted and avoidant of life-demands and irresponsible toward social expectations. Whereas his account indicated a drastic change of attitude in this regard in which he declares that he “tries to be a better person on a daily basis”. The commitment that he conveys and attitude toward life he believes helps him to sustain his change efforts. Stuart (330-333) also outlines changes in his morality, when describing his identity change explaining that during drug use he ‘would burgle every day and that now he would be scared to even shoplift’. This demonstrates a significant shift in both behaviour and sense of morality as part of his change.

A conflict of self was highlighted in statements by James (437-438) saying that it was ‘going against who I was’, suggesting that his drug using behaviour was conflicting with his self-identity, leading him to question his behaviour and how this behaviour was defining him.

Self-questioning seemed significant in regard to identity conflict when initiating change, beyond reaching abstinence, illustrated by Sid's words (713-715), "well 'oh, what do I do? How do I enjoy myself now? How do I...what, what do I want? Who am I? What have I got going on?' And I suppose it's taken time to find that again. So who am I? What do I do? Who do I want to be?" This signals an opportunity to create a new identity. His metaphor communicated the devastation caused by his drug use and the amount of work, courage and spirit that was needed to build from this point.

"Because if you destroy everything, this is like Germany, isn't it. This is like Germany in the 2nd world war. It all got obliterated. So they could choose what they wanted to build. They weren't stuck with this. That's my thoughts. I suppose that's one of the benefits of what I've been through, is that I could actually rebuild what I wanted. 'Cos everything else were fucking obliterated." (Roger,1318-1322).

From a reflective position, Roger likened his experience of change to Post-war Germany, in which everything had been 'obliterated', which gave him the opportunity to rebuild himself and therefore create a new, non-heroin-using identity.

Maintaining an addict label seemed significant for James (38-39 & 652) 'cos I know what I am, and I still believe I still am, under, just under my skin is 'I'm an addict, I'm just not practicing at it today' and for Carol (126-127) 'there are personality things and I think I have an addictive personality'. They believe that their desire for drug use is an intrinsic and inherent issue, with James, explaining "I think I was born an addict", which will always remain a part of them, despite other changes. Change in this case, is therefore about being able to develop a lifestyle while simultaneously not succumbing to the continuing and ongoing urge to use drugs again.

However, Roger argues “I can’t believe that for one minute. All that business about you being predisposed or you carry an addictive gene. And maybe that helps at first. I think, sometimes, it might help just to go ‘I aren’t sure, I aren’t taking any chances” (657-659) and that it is “important to separate himself from an addict label and to recognise himself as a person rather than an addict” (135-136).

From this position he believed that maintaining an addict label limited the opportunity for further change. Though he did appreciate that this label may help when initiating change by creating a separation from a drug using lifestyle in which other aspects of change could develop.

“I had a big ex-user label on me for ages and I kept hold of it ‘cos it helped me, I think. ... it helped me to have an identity, ‘cos I didn’t have one.” Roger (47-49)

Roger explained his process of using a label as an ‘ex-user’ as helping him to have an identity in the absence of drug use and separate from heroin user. He described how this aided a transition to fitting in with a normalised, drug-free population (52-54). Stuart adds that “people are genuinely interested” (460-461) when he disclosed that he was an ex-user.

This ex-user label seemed to provide an opportunity to relate with others when attempting to fit in with a non-drug using population; a population with whom their newly found drug-free identity could be accepted. But as change became more established then he needed to separate from this ex-user label to become a ‘non-user’ and illustrates change as a journey of self-awareness and acceptance. He aligns the process of becoming a non-user to discovering who he was. Sid (700-704) offered concurrence of the value of an ex-user label during a transition period of developing a non-user identity explaining that when attempting to create new relationships he believes “the ex-user label adds some intrigue, mystery and excitement to your character...or at least something to talk about”. In this sense the ex-user

label was functional in aiding identity development and relationships with a non-using population.

“I knew that recovery had not really started. I’d been hiding in this ex-user label, recovery had nowhere near started. The bits that I wanted for me, about having some contentment and having some happiness and having some peace, I needed that, do you know what I mean. I realised that I were nowhere near.” (Roger, 415-418).

Roger further explained that he used the ex-user label to hide and therefore not expose himself possibly due to fear of non-acceptance and that as his journey progressed he recognised his desire for contentment, peace and happiness. This indicates that there may be different stages involved in change as a long-term process.

The desire for contentment, peace and happiness also suggest a desire for an absence of internal anxiety, conflict or distress and that as his journey progressed and he became more secure in his identity as a non-user then he was more able to focus upon these aspects.

Sub theme 2: Changing Relationships. Relating to people without drugs

Identifying with a non-using population or respected other was significant for both Roger (110-114) and Derek (256-258) at an early stage of their change. Roger recalled that he recognised attributes in this population that he desired.

“I was never like a devout 12 stepper or anything. But I went along and I met these guys and they were sound, do you know what I mean. I just wanted to be like them, do you know what I mean. You’ve still got that edge that I like about people, do you know what I mean. I can still identity with you and associate with you. And I prefer being around you, than this crew in the detox ward.” (Roger, 110-114).

This seemed to represent an important step in which he moved from one group (drug users) to another (ex-users).

However, disassociating with drug users was an issue for Barbara and Carol (196), but both considered that this was a difficult but necessary part of their change.

“There were so many people that I was associating with and was friends with. What am I..you know, I can’t see these people again, and that was a really, really big, erm, thing to change. A massive thing to change. My social life, even though it wasn’t healthy, it was still my social life.” Barbara (426-433).

Barbara indicated the significance of disassociation as ‘a massive thing to change’ and related a confusion of her identity in the absence of associating with these people and points toward the importance of developing new relationships.

An important process involved in change related to ‘fitting in’ with a non-using population. Barbara (428-432) described her fear of a lack of support and confusion about who she was by distancing herself from other drug users. This fear is possibly related to the prospect of being isolated, alone, or not accepted. Stuart agrees describing a fear of not belonging on either side, drug-users or non-drug users.

“One of the things that I think people are scared about is not belonging on either side, being on that fence.” (Stuart, 453-456)

This stage of change seemed critical in whether change is sustained and requires opportunity, resilience on the part of the person attempting to integrate and empathy on behalf of others to communicate acceptance of the person.

“People talk about, you know, the void, after using. That’s not a separate thing from you that void. It is you. You are the fucking void. So you might hear that, ‘Oh, you’re at that point, I know what you’re going through’. So you might sit ‘round with a

group of people at a table, and you are the odd one out then. Simple as.” (Roger 895-898).

Roger described this process as a void, but rather than commonly understood within substance misuse to refer to an absence of activities to fill time, he explained that ‘he was the void’ due to his lack of commonality with a non-drug using population, as an accumulation of his experiences and identity as a heroin user. He describes ‘feeling like the odd one out’. In this sense he was different to others and vulnerable to others acceptance of him as a person. He indicates that difficulties also arise due to his expectations of others acceptance of him perhaps hoping for recognition of his change efforts but may experience rejection.

Sid offers a similar point, explaining that he felt like an ‘outsider’ (623) and that ‘at first he didn’t have anything to offer’ (559-560).

“You might put yourself out there and trust or you might even think I deserve to be rewarded in some way for this. But some people don’t, some people think you’re a fucking scum-bag.” (Roger, 900-902).

The non-acceptance from others seemed to be associated to a fear of potential isolation and rejection of the self as a person without drugs as not having enough to offer, to fit in with a normalised population. This rejection from others may also be evident due to stigma and prejudice related to their previous heroin using identity.

Disclosure of previous heroin use was a process which was managed in different ways by the participants. Stuart (123-125) explained that he had never hidden his ex-user identity, believing that this may prove inspirational for others. In this way he had integrated an identity as a former heroin user and a role model for others, possibly as result of a motivation to make good of his experience.

"I tend not to share. I don't see it as a secret, sometimes I tell people, like I'm telling you now about my life, talk about it with my colleague, I feel dirty. You know what I mean, I still feel like I'm airing out my dirty washing. Er, 'cos you know, I am an ex-user, I am an ex-convict, you know what I mean. So, you know, er, it does impact upon me. 'Cos I feel like I'm exposing myself really" (Derek, 618-622).

However Derek (617-621) expressed a different approach toward his disclosure, indicating a feeling of shame and embarrassment regarding his previous drug use. This indicates a concern of how his drug use may be understood by others and therefore how he, in turn, feels accepted as a non-drug user assimilating change.

"It's gradually changing, 'cos I've never been one to sort of say 'I'm a heroin addict and I've used heroin before and therefore my ways the right way, I know how to get off it'. That's never been, it's something I don't...and this is what I kind of mean by, another change to the . At first I didn't tell anybody, that's, that's the way that I've kind of come through it. Or why I came into this work." (Sid, 115-119).

Sid (115-119) describes a gradual process of disclosure, suggesting that as his non-drug using identity becomes more established then it is less likely to be jeopardised by the vulnerability of sharing his past with others and possibly experiencing non-acceptance. He explains his position of a 'passionate' ownership of his change. This passionate ownership and a reluctance to share his experience, seemed important for Sid. It seems that he was focused on his way of developing change and did not want this to be influenced by others. This also relates to his previous statements in which he explained that "it had to be mine, 'cos if for any possibility there could have been a way out, I would have taken it." (Sid, 1216-1218).

Acceptance was important in continuing to develop relationships, with both Derek and Sid (565-566) explaining this as a two-way process, which suggests a further development stage in improving the quality of relationships.

“It’s about accepting and it’s about being accepted, as well,..your acceptance and er, the perception from others has changed.” (Derek, 538-539).

In this sense, as well as gaining acceptance from others, it was also important to be able to accept others. This may represent a process in which they became less defensive, as their sense of vulnerability in relation to others decreases as their new, drug-free identity becomes more established.

Derek also highlights the importance of relationships providing support through ‘understanding and empathy’.

“I’ve got people, in my life, who’ve done all that, who can understand me when I talk about how I’m feeling. ‘Cos they understand, they’ve got that empathy” (Derek, 422-423).

This understanding and empathy may be important in developing more congruent identity in the absence of heroin use, which may then be continued to be expressed in improving the quality of relationships.

“I formed a relationship with somebody, because it’s me it’s not somebody under the influence of drugs or alcohol” (Derek, 308-309).

The change becomes established to the point where this more congruent and accepted identity and associated relationships are considered ‘normal’, which reflects the distance travelled in this change. The person identifies with a normalised population.

“I suppose they just mean well now; they’re not false. Erm, I got married, I’m not using, not drinking so my wife’s never seen me drink or drug. Erm, how’s it changed, I

mean, it was always just false before, you know, or I was trudging my way through it.

It's just open and free now. It's normal." (James, 301-303).

Stuart and James also noted the ability to form relationships and to be accepted as a person without drugs. Their descriptions suggested that a 'real self' had been allowed to appear and it was significant for him to have this accepted by another.

Both Stuart, Carol (508-511) and James (340-342) highlighted the importance of significant relationships in sharing temptations to use and uncomfortable thoughts and emotions which lead to drug use.

"I gave it about probably 3 or 4 seconds of time of day in my head, and I just turned around to her straight and said 'do you know what I'm gonna do when I get off the plane?' I said 'this is what my head's been telling me'. And she went mental at first, 'What are you doing, you've been clean for god knows how long!' It wasn't for her, it was for me. But she was pleased in the end. It knocked it dead in the water. My plan, my addiction had had all its plans scattered. I couldn't do anything with it". (James 348-353).

Subtheme 3: Changing Lifestyle;

"It's about living. And how you manage, or how I manage my life and that's going to be until the day I die.... it's not the drug; it's everything else." (James 897-898).

Changing location was put forward by several participants (Carol, Sid, Barbara & Stuart) as an important factor of their change. Stuart (92-94) acknowledged that 'moving away' allowed him to build a family and develop support', indicating that he did not believe he would have been able to do this had he remained in his drug using environment. Both Sid (937-939) & Carol (187-190) acknowledged the importance of space from their drug using

environment in order to develop themselves as a non-user, suggesting that this space was significant in order to distance themselves from a drug using lifestyle. Barbara (396-397) and Carol (400-403) acknowledge that their change of identity was assisted by not being in their drug using environment and therefore influenced by factors related to their drug use. However, Derek (93-96) and Roger (72) were more critical about the relevance of changing location. With Roger explaining “if there was a drug scene, I would have found it”, suggesting that despite changing location his desired and opportunity to use heroin remained. Derek quoted in reference to his residential rehabilitation experience that he “might as well have gone down the Tower for 12 months” (93-96), using a metaphor of a dungeon in which he was denied contact with a non-using population and therefore did not learn how to cope with adjusting to a different lifestyle. He suggests that changing location does not develop a capacity to cope with life without drugs and identified that ‘I was still me- I’d just stopped using’ which again highlights the significance of internal-change rather than a simple notion of abstinence. Derek indicates that regardless of his location he still had a desire to use drugs, highlighting the relevance of addressing psychological factors associated with drug use.

“You know, so, wherever I went I took my head with me, my desire to use and all that come with me. So it wasn’t about an...it wasn’t about going somewhere, ‘cos that doesn’t, that didn’t work.” (Derek, 167-169).

Sid shared an amusing anecdote of when he travelled to Cornwall to self-detox, spent all of his money in an afternoon on drugs then drove back home (210-223). He reported that he ‘didn’t know what to do’ (221-222), which again indicates a more comprehensive process than addressing the physical aspect of dependency and may include occupying his time. It

also indicates the importance of awareness and planning for lifestyle changes beyond abstinence.

The importance of being able to cope with life without drugs or manage life was recognised by all of the participants. Barbara (57) suggests that she was unable to 'do life' prior to her change from heroin use, indicating a lack of capacity to meet life demands. Roger explained that he is now able to manage difficulties or challenging situations (without drugs), which suggests the development of life skills as part of his change. Carol (521-522) asserts that you have to have a different way of dealing with what's thrown at you, indicating the development of an alternative strategy than drug use to manage difficulties. Stuart (381-382) explained that he no longer needs to turn to drugs to deal with life difficulties, again suggesting that he has developed the capacity or skills to manage life difficulties in the absence of heroin use.

"Change for me has been about being able to handle life. Erm, meeting people, seeing my kids not out of my face, erm, have a proper relationship, being honest, open and honest." (James, 15-16).

James directly relates his change to improvements in the quality of his relationships and an ability to 'handle life' and that he had used heroin as a crutch to help him with life difficulties. He relates his change of responsibility (30-32) to being able to learn to deal with day to day living and therefore to keep himself clean. James emphasises the importance of being 'open and honest' as a factor which assists his change, indicating his courage and ability to present himself to others.

"Because I used the heroin and many, many other things as well as a crutch to get me through these things." (James, 24-25).

The ability to manage life issues was associated to an emotional response, for which heroin had been used to manage.

"I don't have to go running and bury my head in the sand. I've learned emotionally to deal with...it's about day to day living for me, that's what it's all about. And if you learn to deal with day to day living, how to keep myself clean." (James, 30-32).

Carol agrees explaining that 'the biggest thing is teaching them how to deal with things differently emotionally' and 'not going into a panic mode where she needs to hide in heroin use' (Carol, 637-639). The panic mode to which Carol refers, suggests an anxious response to emotional difficulties and that a more thoughtful and calmer response may be more beneficial in managing life difficulties.

All of the participants were able to reflect on advantages of their change. These were in two forms, either as an absence of negative consequences or as new found life gains as a result of their change. Roger (1157-1159) questions that he may have been an "arrogant and nasty piece of work" and not liked himself as much, suggesting an improved sense of self as being important. Barbara (275-277) explains that she does not "want to go back to living on death's door", indicating that improved health and a valuing of her life as significant aspects of change. Derek puts forward a number of benefits of his change, including material possessions, feeling well, being less anxious and more productive, indicating advantages in a variety of regards, including both physiological and psychological health and esteem. Sid (1137) explains that the reason why he does not go back (to a heroin using lifestyle) is because his change "feels so much better and a lot more positive" and therefore he is less inclined to return to his previous behaviour.

"cos In a morning when I'd wake up then.. it's was like...there was more of like.. you know when you look at the world and there's like an ozone layer over the world, and

the sunlight and everything doesn't come.. doesn't get in. That's what it's like when taking heroin. The world's just covered by a horrible grey fog, but not taking...not taking it, the world's, even though on a horrible dull day, that, that cloud's gone, so all the light, sort of, comes through." (Barbara, 580-585).

Barbara poetically described her experience of change, using an analogy of a horrible grey fog, representing her mood, self-esteem and perception of the world, covering her existence; without heroin this cloud has disappeared which allows sunlight (positive life events) to be experienced, illustrating how her outlook has changed in the absence of heroin use.

DISCUSSION

The interview data provided a rich source of material detailing the participants' understanding of change and their experience of the factors which initiated their change and understandings of long term change from heroin use.

Although the participants' experiences varied, there were common themes. The participants saw their change as beyond a common understanding of recovery and more than abstinence from heroin use, identifying factors such as developing identity, changing relationships, managing life issues and coping with distress which supports the arguments of Laudet and White, (2008). All of the participants saw their change as an ongoing process, which is supports previous research on the process of recovery (Biernacki, 1986; Koski-Jannes, 2002; Margolis et al., 2000). Analysis also suggested an experiential discrepancy between change definitions and common understandings of recovery, with recovery being perceived as drug-focused and change involving a process of self-awareness and a journey toward self-acceptance. This supports the literature put forward by (Laudet, 2008).

Although the participants in this study had abstained from heroin use prior to the introduction of the Recovery Agenda in 2010, and its further development in 2017, they had experience, knowledge and familiarity of Recovery through employment in the field of substance misuse. They were quite dismissive of the Recovery concept as not applying to their experience of change, echoing the sentiments put forward by Neale et al, (2014); Paylor et al, (2012) and Roy, (2012) .

There may be reasons why the participants were dismissive of the concept of recovery, such as being proud of their achievement, and may represent ownership, rather than attributing

it out to others, or it may have represented a stage of transition where they no longer wish to be considered in terms of Recovery.

Analysis identified heroin as both a cause and reliever of psychological distress, highlighting the impact that it had had upon their lifestyles, self-identities and relationships. There was a recognition that heroin can also alleviate such distress, which correlates with the escape and avoidance put forward by Miller and Rollnick (2002), and Baker (2010), whether this distress is related to significant events such as bereavement or childhood abuse or as the result of a heroin using lifestyle.

Consideration was given to ways in which they had managed this distress after achieving abstinence and in the absence of heroin as a coping strategy, particularly when this may relate to anxiety, shame, repairing problematic relationships and difficulties experienced in a transition from heroin user to non-user.

“People will do anything, no matter how absurd, to avoid facing their own souls”.-Carl Jung (1955-1956)

“You talk to any service user and they’re hiding from something, even if it’s from themselves.” (Carol 482-483).

Analysis identified heroin use as both a creator and reliever of psychological and emotional distress, in relation to psychological pain, distress and discomfort for starting and maintaining heroin use. Heroin had been used to provide relief from deep rooted psychological issues, including insecurity and anxiety; in relation to emotional pain resulting from significant events such as bereavement and abuse. A first form of distress referred to the existence of internal anxiety prior to the substance use. James, Roger and Barbara referred to this form of internal distress, Roger disclosing ‘an inferiority complex’ (33), James disclosing ‘always having a sense of unease, from his earliest memory’ (659-660), for which substances were used to alleviate and Barbara referring to self-esteem issues and depression (55 & 486-487). This is a, slightly different yet, significant finding than identified in the literature, which associated substance misuse with anxiety (Darke and Ross, 1997; Novak et al, 2003; Stewart et al, 1997, 2002; Zvolensky and Leen-Feldner, 2005 and Epstein, 2009) . The analysis pointed toward a more deep rooted experience of psychological discomfort, than an experience of anxiety. The most usual approaches to presentations of anxiety tend to be either prescribed medication or the psychotherapeutic approach of Cognitive Behavioural Therapy (CBT). However it could be argued that prescribed medication follows the same philosophy, as heroin use, of removing the person from the source of distress, albeit by legal means, rather than resolving the underlying cause of the experience.

It may also be argued that CBT, with a focus upon the present, is not the most appropriate psychotherapeutic approach for working with such issues as experienced by the participants and that Person Centred Therapy or Psychodynamic Therapy, among others, may assist the person in addressing more deep rooted issues.

Some participants associated their substance use to significant events such as sexual abuse, bereavement or relationship problems. This second form of distress may also lead to pain or anxiety. This claim is supported by much research showing correlations between Child Sexual Abuse and substance misuse and comorbidity of substance use and mental health issues (Spak, Spak and Allebeck (1998), Bergen, Martin, Richardson, Allison and Roeger, 2004; Kilpatrick, Acierno, Saunders, Resnick, Best and Schnurr, 2000; Miller and Mancuso, 2004; Weiss, Longhurst and Mazure, 1999).

Regardless of the reason of psychological distress, the relation to heroin use, points to the need to either resolve these issues or find an alternative means of coping in the absence of the use of heroin.

However, as a result of limited funding, high waiting lists, and separate service targets, mental health services are reluctant to offer treatment to those with substance misuse issues. Alongside the possibility of adversely affecting treatment targets, by being a difficult population to treat, there is also an argument that these people are not able to engage therapeutically whilst using substances and that they should stop using substances prior to accessing treatment. Consequently, substance misusers with mental health difficulties are directed to work with substance misuse services, who are not commissioned to work with mental health issues. However, these service responses go against NICE (2011) recommendations that people with substance misuse issues should not be excluded from services.

This service restriction leaves the heroin user with mental health issues, with an absence of adequate treatment to address the underlying issues and therefore reduce the likelihood of developing the capacity to cope without heroin. This may have significant implications, should the person be discharged from substance misuse services, in which case the person may become overwhelmed by their distress, leading to a potential increase in mental health and relational difficulties and/or an increase in the likelihood of a return to problematic drug-use.

However, two of the participants rejected these types of associations, consistent with the previously discussed sense of ownership and responsibility, preferring the notion that they “used because they wanted to” (Derek, 705). They believed that such relations to psychological distress and events provide an excuse to continue heroin use and therefore a diminished motivation to stop using and reduced likelihood of either initiating or maintaining change. These arguments demonstrate a conviction of the importance of responsibility and ownership and that maintaining this stance enables these individuals to sustain their change. Avoidance and externalising responsibility may be associated with substance misuse. A process of change may be supported by acknowledging and accepting responsibility for change and ownership of their heroin using behaviour. There appears to be a lack of literature on this area, however it could be an importance area to consider further. The principles of which may be evident in the 12 Step approaches of Alcoholics Anonymous and Narcotics Anonymous programmes, whereby group members are encouraged to identify themselves as ‘an alcoholic’ or ‘an addict’. Though there may be issues with labelling in the 12 Step approach, accepting ownership and responsibility may be facilitative of initiating and sustaining change behaviour. These differences in positions with

regard to ownership of change, reflect the debate between a disease model (McLellan et al, 2000) and life-process model of addiction (Booth Davies, 1997).

A third form of distress appeared to be from the involvement in a drug using lifestyle, where the substance user may experience dissonance (Weisz, 1996; Downey et al, 2000), internal conflict, deterioration of health, and quality of relationships, including stigma (Goffman, 1968), trust issues and increased practical difficulties of not adequately managing life issues. Heroin used to manage emotional distress may be seen as a self-medication (Nordquist, 2011) and an attempt to emotional regulate. In this sense, by reaching a point of abstinence the issues associated with heroin use should subside. This is more supportive of the Recovery approach, which aims to encourage abstinence and the use of approaches such as Solution Focused Brief Therapy and motivational Interviewing to instigate change, as it does not associate substance misuse to other forms of distress. The development of coping strategies from Mutual Aid and support from others who have followed the recovery pathway may be facilitative in sustaining this form of recovery.

A psychological dependence on heroin may be in response to managing emotional pain and psychological distress and discomfort, regardless of the origin. A current remedy from a medical model and a harm reduction approach, is in the form of the provision of alternative medication, whether this be substitute opiate medication, including methadone and buprenorphine, or other prescribed medication such as SSRI's and anti-depressants.

Though there may be value from a harm reduction perspective of such initiatives, there seems a contradiction about a philosophy of change in which a person is expected to address their dependence on (illicit) drugs by using (prescribed) drugs. The message remains the same; that emotional distress cannot be tolerated and must be removed- even if only temporarily through the relief provided through drugs.

This perspective may represent a common social attitude to distress and may relate to the formation of mental health issues within the population, such that emotional distress and discomfort cannot be tolerated and the person must not experience such feelings.

This perspective may also associate with a need for instant gratification, as both an individual and societal response, to distress. This is contrary to a humanistic philosophy held by Counselling Psychology (Woolfe, 1996), which perceives pain and distress as a natural human phenomenon.

A counselling and psychological perspective may be to understand the cause and response to developing psychological dependence, in order to change the psychological relationship to heroin. This therapeutic perspective was evident in the ways in which the participants' in this study had learned how to manage pain and therefore maintain heroin abstinence and long-term change.

However the Recovery response with targets based upon short term outcomes (Monaghan and Wincup, 2013; Ashton, 2008) fails to adequately acknowledge a consideration of the function of heroin use to manage psychological distress. Longer-term psychological interventions may be perceived by commissioners and service providers as being ineffective toward achievement of service goals and targets and likely to slow down the process to 'successful discharge'.

The participants referred to an improved ability to tolerate emotional discomfort and distress. This relates to the idea of 'self-soothing' (Rinsley, 1988), in which they develop the capacity to manage feelings of frustration and helplessness, rather than using drugs to self-medicate as a coping behaviour.

The identification of such coping strategies supports the use of Dialectical Behaviour Therapy (Linehan, Schmidt, Dimeff, Craft, Kanter, Comtois, 1999) for substance misuse incorporates these strategies.

Recovery highlights the importance of social capital (Granfield and Cloud, 1999), which was supported by the participants in this study in the form of improved relationships which became a resource for managing distress. Analysis of the participants' accounts identified improved relational and psychological functioning (Ryff and Singer, 2000, McIntosh and McKeganey, 2001). This included sharing uncomfortable thoughts and emotions with others, including temptations to use drugs and an increased capacity to tolerate distress as factors which enabled them to maintain their heroin abstinence and further develop their drug-free identities and lifestyles. Mutual Aid forums can provide an opportunity to share difficulties with others who have the experience to empathise with such issues, but further support should be offered to provide ongoing support networking opportunities, for those who either do not wish to engage with treatment services or have issues which may not be appreciated by traditional support with a short-term focus upon change.

The value of sharing uncomfortable thoughts and emotions with others, whether this was in social or therapeutic relationships, may demonstrate both an improved awareness of issues and the security both in self and others that their issues are acceptable.

The development of self-awareness and self-acceptance could therefore be considered integral to long-term change from heroin use and is consistent with the outcomes and benefits reports by the participants, such as 'liking myself more' and improved self-worth.

The 2017 Drug Strategy, has pointed to an intention to provide more tailored support of client's individual needs. This is paramount with regard to those experiencing coexisting substance misuse and mental health issues or psychological difficulties.

This may be most appropriately delivered within the framework of an integrated treatment model, the aim would be to provide support from two separate but related issues. An all-encompassing treatment approach that involves interventions would be more likely to meet the complex needs of these clients and to strengthen their community recovery capital (White and Cloud, 2008).

And what is Change Anyway? (James, 879-880)

The participants' accounts highlighted a confusion regarding the term 'change' from heroin use. The participants were critical of the term recovery, as not adequately capturing their experience. This echoes the arguments put forward in the literature review (Ashton, 2008) who question how recovery is constructed and interpreted and Neal, Finch et al., 2014; Neal, Nettleton and Pickering, 2014; Paylor, Measham and Asher, 2012) who argue that recovery is a contested concept that lacks clear meaning and Laudet, 2008) who emphasised the importance of the neglected question of 'What does recovery mean to the person involved in the process?'. The analysis explored the participants' perception of Recovery when applied to their experience.

The participants in this study believed that recovery has a short-term focus on achieving abstinence and were critical of the parameters of 'Abstinence' and 'Recovery'. For example, whether abstinence includes the use of other illicit or licit drugs and alcohol. The use of other drugs, following heroin abstinence, may be in the form of 'substitution'. Substitution in the context of substance misuse is the practice of replacing one drug with another that is expected to have the same clinical or psychological effect. This may relate to when service goals are seen to have been met (i.e. stopping heroin use), but the person has simply changed the substance that they use with another. Changing type of substance may have little effect upon other dimensions that may be involved in change, such as lifestyle, relationships or self-worth and therefore continue to experience similar problems.

These points support the argument in the literature review (Dawson, 2012) regarding a discrepancy between measures of Recovery currently being used within the addictions field and the goals and aspirations of people who experience drug problems.

Indeed, when initially proposed Natural recovery was argued by Grandfield and Cloud (1999) to be a reduction in substance misuse. However, outcomes measured in the Payment by Results scheme incentivises and rewards service providers for supporting individuals to become free from drug dependence. In practical terms, services receive payment for 'successful discharges', i.e. when service users exit treatment drug-free. Abstinence from drug and alcohol use is the goal, and little consideration is given to service users following discharge. This raises an ethical issue of non-maleficence, whereby potential harm of not receiving ongoing care to support change is hidden by an assumption that the service user will automatically benefit by being encouraged toward abstinence.

The participants suggested a common understanding of change tends to hold a short-term focus of 'just get clean' (Roger 1336-1337) which contributes to a lack of recognition and acknowledgement of accurate markers of change beyond achieving abstinence. The pathway may also be informed by identification and recognition of identifiable markers of change beyond abstinence, including various aspects of change which did not include drug use. These further aspects were in the form of life changes, cognitive changes, managing life and coping without heroin to change the ways that they feel. 'Abstinence' generally appears to be the only marker that is currently recognised, both socially and in terms of service markers. Although change from heroin use extends both before and beyond this point. Even the marker of abstinence is debatable; with regard to substitution and whether abstinence includes the use of other drugs, which may be less socially unacceptable. For instance is it still ok to use cannabis? alcohol? or prescribed medications? which may offer a similar function. Other markers which may be relevant to identify change prior to abstinence, include a change of mind-set, meeting social obligations such as attending appointments on time or taking substitute medication as prescribed, a change from injecting to smoking

heroin. We may better support clients by identifying recognising and facilitating these changes which then may lead to heroin abstinence or benefits that the person may recover. Using this short term definition, participants were considered a 'success story' upon reaching abstinence where they were presented with an attitude of 'You've stopped doing what you were doing and you can get on with your life' (Roger 565-566). This was seen to be when financial resources for support ended and successful clients were 'dropped like hot potatoes' (Stuart, 115-116).

This discrepancy between an experience of change, a social construction of recovery, and a 'not known' aspect seemed to highlight confusion during the initial process of change, which led to reliance upon others to validate their change efforts. This external validation may be in the form of being considered a 'success-story' by the organisation, or social or familial recognition of their accomplishment of achieving abstinence, where by significant others may expect the problem to have been resolved and envisage an end to associated difficulties and issues. This external validation may also be related to locus of responsibility, where change efforts may be in response to pressures to achieve abstinence, in the form of compliance and coercion, which do not appreciate the reasons why the person may have developed their dependence or factors which may be involved in sustaining this initial change.

In this sense the participant is left vulnerable to manage ongoing change, without their coping response of heroin and unaware of the complexities and issues involved in further change, such as identity transition (Doukas and Cullen, 2009; Hughes, 2007, Haslam, 2008) changing relationships (Wills, 1990; Biernacki, 1986), managing life and coping with psychological and emotional difficulties.

The participants believed that the term 'change', rather than 'recovery' more adequately encapsulates their experience as it considers both initiation and maintenance and appreciates aspects of the process involved beyond achieving abstinence. Whereas the term 'recovery', in line with political agendas and social understanding, was seen as drug-focused and based upon a short-term outcome of "Brilliant-just get clean" (Roger 1336-1337), in other words to stop taking heroin.

With regard to Natural Recovery (Granfield and Cloud, 1999) on which the Recovery Agenda is influenced, it could be argued that the participants in the original study- 46 middle class Americans- were identified as having less severe substance misuse issues and are likely to have had more access to recovery capital, including financial resources (middle class) and different opportunities to access recovery communities, so may have been in a better position to sustain recovery without the need for further support, than typical heroin using clients in the UK. It is therefore questionable whether the principles of recovery, adequately meet the needs of heroin using clients. However, the principles of Recovery may meet the aims of those directing policy, as an opportunity to cut costs to a population who face societal stigma, in the form of being undeserving of treatment and may be a more convenient target than other causes. If this is the case, then I believe that it is a naive and short-sighted approach and potentially harmful, even if Recovery was achieving outcomes of increasing the number of people reaching abstinence. However, the literature pointed out that recovery rates are falling and drug related deaths are at the highest level since records began and have been increasing each year, since the introduction of the Recovery Agenda in 2010 (NTA, 2013a). Although, the new Recovery Agenda, does acknowledge these statistics, there is little clarification upon how this will be addressed, other than supply of Naloxone medication, in relation to overdose.

There has been recognition in the 2017 drug Strategy of the need for more tailored support to meet individuals' needs. However the Strategy is not explicit and suggests more joined-up working between agencies to manage issues such as mental health, housing and employment. Although this would be welcome, it does not specifically elaborate upon the development of Recovery Capital for the issues that may be experienced by heroin users whose lifestyles may have been devastated by their drug use.

In order to sustain recovery beyond abstinence, interventions and support are required to provide a pathway to develop a drug free identity, relationships and lifestyle.

Such a pathway would be better informed by appreciating some of the practical difficulties as experienced by those attempting to make this transition, such as managing spoiled identity, disassociation (Dingle et al, 2015, Goehl et al, 1993) from drug-using relationships (McIntosh and McKeganey, 2001), forming drug-free relationships, including managing disclosure of their previous drug use, developing trust, meeting social obligations and managing difficult emotions in the absence of heroin, whether these be the result of poor mental health or facing everyday life demands.

Changes following abstinence were highlighted as significant in ongoing change and will be discussed further in the following sections. Though accurate markers would at least provide some preparation and acknowledgment and guidance of change.

The Penny Drop -“A belated realisation of something after a period of confusion or ignorance” (Phrase finder)

The analysis in this study identified the importance of significant events, such as impending parenthood, or the death of a close friend as contributing to the initial motivation to change their heroin using behaviour.

Others in the study suggested that exasperation with a drug using lifestyle was a key factor in their initial change. Consistent in the analysis was that the reported instigating factor, whether this be referred to as ‘a moment of clarity’ or ‘wake-up call’, or ‘the moment the penny dropped’, was when the participants were able to see the devastation heroin use had caused and the potential consequences of continuing with this behaviour, in which identity and relationships and lifestyle had deteriorated and emotional distress had increased.

This is supportive of the claim put forward by McLellan and McKay, (1998) and Hanninen and Koski-Jannes (1999) who argue that this point is triggered by a particular experience or existential crisis in a person’s life.

Biernacki (1986) argued that deciding to stop using drugs takes place when the addict identity conflicts with other identities important for the person in ways which are unacceptable to him /her and resonates with findings by Weiss (1996) and Downey et al. (2000). Dissonance, discrepancies and conflict between substance use, valued identities and self-standards can constitute an effective motivator for changing addictive behaviours.

These moments of realisation were captured in self-questioning –“What the fuck are you doing with your life?” (Stuart 221) and represented a highly significant event to which the participants attributed their initial change. The significance of these questions provided the

energy, motivation and drive to both initiate change by working toward and achieving heroin abstinence and to sustain their change efforts beyond abstinence.

In light of this finding, in order to support change, it may be important to provide a facilitative environment/ therapeutic relationship, to enable the client to experience this wake up call. This may be in individual sessions (Cathy- 'keyworker not talking shit') with the use of appropriate psychological and therapeutic interventions or through group support and bring about a change of mind-set of responsibility, determination and ownership with a recognition of the consequences of their behaviour.

It is unlikely to be facilitated by a Top-Down approach of Recovery (Roy and Prest, 2014), whereby the person is expected to conform and comply with treatment expectations and may be resistant to change.

At this stage the participants' accounts highlighted a change of attitude including determination, commitment and ownership to change. These attributes were vital in maintaining change beyond abstinence, to reduce the likelihood of relapse and develop further aspects of change. This included a change of locus of responsibility where by the participants were less likely to externalise factors which may have previously been attributed to their drug use.

Facilitating ownership and responsibility of service users has been a recent, if unintended, result of the Recovery approach to substance misuse, as service targets, high caseloads and funding cuts encourage service users to comply with treatment expectations, such as attending appointments on time and following recovery plans; failure to do so failure to do so can result in result or withdrawal of substitute medications upon which they may be reliant. There may be an ethical argument about this approach in practice, however such

expectations can facilitate service users to move from a chaotic and unstructured lifestyle to one of meeting social obligations.

Though, the participants challenged the short term focus of recovery, heroin abstinence was considered 'an important first step' to facilitate further change and represented an identifiable marker. However they also emphasised that this abstinence should include all forms of illicit drug use and alcohol, with Roger highlighting "You're not gonna do it if you fuck about with other stuff" (424). Derek described this as a 'foundation' on which successful change can be built.

Further clarity is needed about the definition of 'Abstinence', so the importance of initiating a sense of normality can be communicated to others. For example is total abstinence necessary, and what are the parameters of this? Investigating what is understood by the term abstinence and considering associated parameters may be an area for further research.

With regard to treatment outcomes abstinence may include possible substitution to other forms of illicit drugs, alcohol or even reliance upon prescribed medication, which may then be used to manage issues.

Further to abstinence being considered an important first step toward change, analysis suggested the significance of a space of time without using drugs in order to facilitate a transition to a non-drug using lifestyle. This space, also described as 'straightening up' brought their issues into acute focus and initiated a sense of normality. The transition enabled a non-drug using identity to develop and to learn strategies to manage life issues without reverting to drug use.

After achieving abstinence a second type of questions were identified, in the form of 'change guidance questions' in which the participants asked questions such as 'What do I do

now?'. These questions may arise from a lack of clarity of the processes involved in change beyond abstinence and demonstrate a lack of understanding and appreciation of the significance of long-term change factors. This is consequential of a recovery focus being placed on reaching abstinence (Monaghan and Wincup, 2013), however in order to sustain change after abstinence then more understanding and support is needed of the factors involved in longer-term change.

Regardless of their reported reason for change, the participants related their initial change to a change of mind-set, including taking ownership, accepting responsibility and commitment and dedication in both initiating and maintaining change beyond abstinence. These findings suggest a differentiation between recovery initiation factors and recovery maintenance factors (Best, Ghufuran, Day, Ray, and Loaring, 2008) within a developmental model suggesting that for most people recovery is a process and not an event or state, reached by achieving abstinence.

There appeared to be a variety of reasons behind what had caused the change, but each seemed significant. For the participants in this study, the decision for change behaviour was not attributed by a treatment service, but by life events which brought about a change of mind-set, which included focus, commitment and determination and ownership. However, as services aiming to facilitate change they could highlight the importance of these attributes to assist the people in initiating the change.

This may be utilised by involvement in recovery meetings, where such events can be discussed and considered.

“Quitting is easy- I’ve done it hundreds of times”- Mark Twain (1938)

“I’ve stopped hundreds of times- hundreds!” (James 53-54)

Analysis identified that the process of change from heroin use is an ongoing life-long event, which extends far beyond achieving abstinence from heroin use (Laudet, 2007; Koski-Jannes, 2002, Watson and Parke, 2009). Roger describes reaching abstinence as ‘insignificant’ (41) compared to the changes that he has experienced since stopping using heroin. Sid (59-60) explains that continuing change beyond abstinence ‘is when the hard word work happened’.

Indeed, Best and Laudet (2011, p2) describe Recovery as a “process rather than an end state” and though Recovery Capital may have some relevance the opportunities to access or develop a Recovered lifestyle, ongoing factors of change beyond abstinence remain relatively unconsidered in the Recovery Agenda.

Relating to the participants in this study, though they acknowledged the lack of treatment support following abstinence, they did indirectly refer to forms of Recovery Capital which had been important in their change, such as improved family relationships and developing hobbies and interests away from drug use. Also the opportunity to practice as drug workers meant that they continued to be involved in a Recovery environment.

However, there is also an argument that change extends beyond this Recovery Environment and that part of the process is moving from ‘ex-user’ to ‘non-user’ (Hughes, 2007) and relinquishing the associated identity. This supports the research put forward by (Howard 2006, 2008) regarding moving away from assigned and possibly accepted definitions of self (and possible forms of consequential stigma) to the formation of a new identity. This is a

similar perspective to critiques of the Recovery model within the Mental Health field, where it may be important for patients to discard a recovery label.

However, it was also highlighted that, in relation to a short term focus of change, that reaching abstinence was the point at which treatment support ended. With Stuart describing resources for support as 'like a funnel, with all the money going to the front end, with none left for the important bit' (42). Roger emphasised that 'being abstinent from drugs is the easy part (1331-1333) - it's the next bit that's more difficult. This resonates with the arguments of Laudet 2007, in her definitions and experiences of recovery among persons who identify as in recovery over half provided answers describing a range of features that did not focus on substance use such as a new life, well-being a process of working on oneself, self-improvement and learning to live drug free.

The current understanding and focus upon short term change (initiating abstinence) was seen to influence commissioning and direct treatment provision in what Roger describes as an attitude of 'Brilliant- just get clean' (1336). And that after treatment completion service users were 'dropped like hot potatoes' (115-116). The consequences of this short term focus of change, was highlighted as having a possible detrimental effect on those attempting to create long-term change by leading to disillusionment, by creating unrealistic expectations of life beyond heroin abstinence.

With Sid explaining- "It's not the great rose garden of wonderfulness it's painted out to be, it's a massive dull grey space that you somehow have to fill" (Sid, 362-364). Without effort, commitment and necessary support to facilitate ongoing areas of change then the likelihood of relapse is surely increased.

The consequences of a lack of understanding and consequential commissioning decisions of the changes that an individual may experience could lead to the individual attempting to

make a transition with a relative lack of support and awareness of the difficulties that that they may face in making the transition to a lasting drug-free lifestyle.

Some studies estimate relapse from heroin is as high as 90% (Health Research Funding, 2014), and other studies suggest that a person may experience up to 10 relapse episodes before successful resolution (Johns Hopkins Medicine, 2012). However, it could be argued that this second estimate, is very conservative, and depends up on the parameters associated with relapse. For example James, explained that he has stopped using heroin 'hundreds of times' (53-54) and had therefore also relapsed hundreds of times.

It would be consistent to consider as relevant Roger's argument that stopping heroin use is comparatively the easy part and that much more attention, resource and support should be invested in the factors which are likely to underpin long-term and sustained change.

There are likely to be significant cost savings by reducing the prevalence and number of relapses and therefore reducing the costs associated with heroin use, whether this be in the form of reduced crime, reduced demand to seek help for physiological and psychological related health issues, social service involvement, substitute medication, public health.

There are also likely to be huge financial gains by this population being an active member of a normalised population, and therefore more likely to positively contribute to an economy.

It would therefore make sense to invest resources to support long-term change, at areas which are likely to support this.

There are also other advantages, which may be more difficult to financially quantify, such as improved family functioning, decreasing the likelihood of intergenerational substance misuse, improved self-esteem and well-being and reducing the effects of heroin use up on those impacted within family and social relationships.

The analysis identified that upon reaching abstinence the participants had experienced a need for guidance, through questions such as “What do I do now?” (Sid)

These questions emphasised a lack of awareness and preparation beyond a focus of initiating heroin abstinence. The importance of support to assist the person in identifying their directions, including identifying possible recovery capital and guidance from others who may be experienced and informed about the processes involved and opportunities in which to continue their change process are all vital aspects.

In addition the participants put forward a number of important aspects of ongoing change including how to conduct self, respond to people, a response to fear or anxiety and managing life, these areas related to the themes identified as part of ongoing change.

"The quality of your life depends directly on the quality of your relationships and none more important than the relationship with self, so look inward, you'll find the revolution there." - J. Carl Newell (2007)

Change may have been initiated through a conflict in self (Orford, 2001; Weisz, 1996; Downey et al, 2000; Winnicott, 1965), which may have been evident in response to the reasons that the participants gave which instigated their decision to stop using heroin. Some of the participants recalled impending parenthood as being the factor. This may demonstrate a realisation of role conflict in which their heroin using behaviours, lifestyles and identity are not compatible with their ideas of parenthood. These arguments may concur with the use of Motivational Interviewing and applies to Festinger's theory of cognitive dissonance.

Others in the study reported exasperation, in which they communicated internal conflict. This conflict also relates to the notion of true-self (Winnicott, 1965) and to Rogers' (1961) theory of self in which a state of incongruence is experienced by the individual.

A conflict in self may have initiated change in the form of 'it was going against who I was' (James 437), and when Sid described a moment in which he considered mugging a lady in the street as 'like a light' (202) possibly linking to the notion of a true self, beyond a substance using identity in which their values and behaviours were discrepant.

Ongoing change involved developing and assimilating a more congruent self-identity.

Noticeable changes to morality were identified in comparison to different identities, including behavioural changes in which James described his drug using behaviour as sneaky and conniving (259) and his changed behaviour as trying 'to be a better person on a daily

basis' (260) and Stuart disclosing that he 'used to burgle everyday' (331) and now he'd 'be scared even shoplifting' (333).

Further questions were identified, demonstrating a lack of direction as part of this process, "Well who am I? What do I do? what do I do with myself? what do I wanna be? What can I be?" (Sid 356-357). These questions also represented a need an opportunity to develop a self-identity away from the drug using identity that had become established. This should be central to the support that is offered to assist a person in establishing change and supports the arguments put forward by Goehl, et al. (1993)

Development of a changed identity may be facilitated by an environment and alternative opportunities to support change. Transisting this identity involves dis-identification with other drug users and being accepted by a non-drug using population.

The role of Recovery Champions, Recovery Communities and mutual Aid may provide some support in this process, as the person initiating change moves from identifying with a drug using population to an ex-drug using (recovery) population. However the value of this may be limited as the person only has the opportunity to identify with other former drug users, rather than a non-using, normalised population.

In order to facilitate a change of identity beyond reaching abstinence, analysis noted a disassociation from drug using relationships, was a difficult but necessary process (Hughes, 2007). The participants had developed strong bonds and identification with this population, however continuing associations were seen to adversely the likelihood of ongoing change (Dingle et al, 2015). This supports the argument of Havassy (1991) who highlighted the importance of disassociation from drug using relationships.

During a transition stage the value of an ex-user identity appeared to provide some function with participants explaining that this enabled them to have an identity during a process of

separation from a heroin-user identity and in relation to the void caused by disassociation from a drug using lifestyle (Howard, 2008).

This was considered an important part of the process for a number of participants, though it was interesting to note that participants who had adopted the philosophy of 12-step programmes, maintained an 'addict' identity as a means of safeguarding against a return to drug use. For them, they believed that accepting that they have addictive personalities or where born an addict was necessary to manage their behaviours and therefore reduce the possibility of relapse. This notion was challenged by other participants as limiting the process of change, in which further aspects of the self could be developed. These further aspects at this stage included developing self-awareness, self-acceptance, peace and contentment (Roger 416-417) and to understand the underlying reasons for their drug use (269-270).

A problematic part of this transition process was with regard to 'fitting in' with a normalised population. The participants accounts emphasised a lack of commonality and identification with a non-using population, which Roger (895-896) referred to as 'the void', and concerns of non-acceptance by the non-using others with whom they are attempting to identify.

A limitation of current Recovery support is that it tends to be substance focussed and populated by either other service users or staff, limiting the opportunity for engagement with a normalised/ drug free population. In order to make the further transition then there needs to be focus upon opportunities to integrate in environments not associated with substance misuse and beyond treatment services. Integrating and associating with non-using others may be the key principle associated with the original findings of Natural Recovery, and supported by the development and utilisation of Recovery Capital, however is not being fully supported by UKs implementation of the Recovery Agenda.

Analysis raised a consideration of the importance of self-labelling in order to maintain change. A number of the participants continued to identify themselves as 'addicts' despite years of substance abstinence. For them the label seemed to offer a protection against complacency which may jeopardise their attempts to maintain a drug free lifestyle. It was noticeable that these participants had previously engaged in 12 Step, rehabilitation programmes and their approach toward maintaining an addict label, is consistent with the 12-step philosophy and is consistent with a disease model of addiction.

However, others believe that adopting an addict identity limits the possibility for further necessary change, with participants explaining that they found it necessary to discard this label in order to find out who they were (Howard, 2006). This supports the observation by Grandfield and Cloud (2006) that most people in their study refused to identify themselves as recovered. And Howard (2008) and Hughes (2007) regarding dis-identification with Recovery and the construction of a non-using self-identity.

These differences of beliefs represent different approaches to addiction, the disease model and the choice model or life-process model. This suggests that following a transitional period of change there comes a need for 'individual growth and search for meaning' (Freyer-Rose, 1991). This stage may represent the need to develop self-awareness and a more congruent form of self.

The same principles applying to the 'addict' label may also apply to the 'Recovery' label and is an issue which is recognised within the Recovery Model used within the NHS mental health services. Similar to the 'addict' label, the 'Recovery' label may have some initial function, but may not be supportive of longer-term change and construction of an identity unrelated to substance misuse, which supports the arguments put forward by Howard (2006) and that further change may occur when the person discards this label.

The findings of this study suggest that a considerable area of change involves the development of a self-identity which can develop to maintain change. This supports the findings of Koski-Jannes, (2002) and Watson and Parke, (2009).

Developing non-using relationships were an important aspect of change, which correlates with the views of Wills (1993). This was with regard to integrating a changed identity and developing the support to maintain and develop further change, particularly with regard to accessing help in managing life difficulties. A means of developing a new identity was in the form of forming different relationships, which Granfield and Cloud may consider an aspect of social capital.

This is a primary focus of recovery within current substance misuse treatment services, in the form of Peer Mentors, Recovery Champions and Mutual Aid. This point supports a Social Cognitive approach (Holt and Brown, 1931), that at first it was important to identify and be inspired by others who had accomplished change and it was considered necessary to disassociate with other drug users and form new relationships.

However, the participants pointed toward difficulties in 'fitting in' with a drug free/normalised population, outside of treatment services, in which several participants experienced problems in ending previous relationships, due to attachment and feelings of guilt and others experienced problems in developing new relationships.

This represents a limitation to Recovery and an important part of the change process, in moving beyond Recovery relationships to relationships not associated with substance misuse. Roger considered himself a void, due to his lack of commonality with others and experienced a sense of stigma and shame. Utilising an 'ex-user' identity and label was facilitative at this stage, in which sharing their previous drug using experience aided the

development of new relationships by adding 'an element of mystery or intrigue' or at least giving something to talk about.

However, it was also noticed that over time this need to utilise an 'ex-user' label diminished to a point where the participants had established sufficient security where the likelihood of a return to drug use had diminished they could more confidentially adopt a 'non-user' identity (Howard, 2006, 2008). This finding resonates with the point by Goffman (1968) that overcoming stigma, involves acceptance from others and adds support to the literature by Hughes (2007) in highlighting the importance of different stages of change.

Developing self-acceptance as part of assimilating change, indicates the value of a person centred approach which is likely to contribute to the capacity to manage emotional and psychological discomfort in the absence of heroin.

As the persons' self-acceptance increased, so too did the quality of their relationships. In which it may be that a more congruent form of self was being presented and accepted by others, which in turn reduced internal conflict and anxiety.

This is a further and significant contribution to the literature and knowledge base regarding substance misuse. Relating to self-acceptance and concerns of acceptance by others, disclosure can be a powerful means of establishing trust and rapport and developing significant relationships.

Of course, it is safe to disclose in some environments, such as Recovery Communities, where the person is less likely to be judged and offered empathic understanding.

However it may be more difficult in environments populated by a normalised population, who may have negative perception of drug use and drug users.

They may continue to experience stigma, lack of trust and negative judgement from others as a result of their previous drug using behaviour, which may prove a barrier toward further

change beyond a recovery community, such as employment or developing social relationships with non-drug users.

An interesting aspect in the process of developing drug-free identity is with regard to the processes involved in the disclosure of their former drug-use to others. The participants each provided various rationales with regard to the processes involved in sharing their drug using history to others, varying from immediate disclosure as they assimilated change identity as a role model to others who remained reluctant to disclose due to a continuing sense of shame. Disclosure of their previous heroin use is a crucial aspect of change and not easy to put into practice. However, discussion and awareness of how to manage this transition, such as highlighting different responses they may receive as they attempt to develop relationships, may better prepare the person in making this transition.

Alternatively, some chose not to disclose their previous drug use, due to fears of non-acceptance which could potentially make them vulnerable to a return to drug-using behaviour (Granfield and Cloud, 1996).

Others in the study had less difficulty in disclosure, communicating pride in their achievement and had less concern about how their previous drug use would be perceived by others. This is also an interesting area to explore further. In this case, disclosure provided a platform for their change experience to be acknowledged in a positive sense and may reinforce the person's changed identity.

The issue of managing disclosure is noted in the literature by (McIntosh and McKeganey, 2001) who argued that a new identity must integrate the previous drug using identity.

It is perhaps understandable that those who have overcome a difficult issue may have pride in this achievement, and that this is particularly recognised within substance misuse services. The fact that the participants in this study were employed by substance misuse

services, is relevant that they were able to share their experiences and achievement with service users, which may reinforce their position of success and become rewarding, especially associated with a role of inspiring others toward recovery.

However, it could be argued that by focusing upon their own experience of Recovery, that they are not able to appreciate the service user's individual barriers toward recovery.

The analysis identified significant changes in respect of lifestyle, and may be inclusive of and contribute to the development of the other themes. Lifestyle, including relationships, may also be seen to be representative of the environmental or social factors, to which Engle (1977) highlights as a part of his bio-psycho-social model of addiction and supports the development of recovery capital (Granfield and Cloud, 2006).

In relation to change from heroin use, the participants raised location as an important variable when attempting to create a change of lifestyle to facilitate change from heroin use. This has not been identified in previous literature, though managing environment is a significant factor regarding substance misuse and should be appreciated as a factor of change. Exposure to the possibility of heroin, is an influential factor regarding drug use.

Analysis of the accounts showed that a number of the participants benefitted from the opportunity to develop a drug-free identity and relationships away from their physical area of drug use. They found that a change of environment as beneficial as it enabled them to make steps to develop substance free lifestyles away from the influence of problematic relationships which may have disempowered and undermined their change efforts.

However, the importance of changing location was challenged by other participants who explained that other processes are also necessary, such as the previously mentioned commitment and determination and addressing their desire to use drugs, which may relate to the biological and psychological dimensions of Engle's model. The participants explained

their unsuccessful attempts at creating change by changing location, in that wherever they went they also took their desire to use heroin, and that a change of location in itself was not sufficient, as 'nothing had changed'.

Changing location in itself was not considered sufficient without being accompanied by a reduced desire to use heroin and a change of mind-set including commitment, determination and responsibility.

A change of ownership and responsibility also related to an improved ability to manage life issues, in which those who have initiated change may need to develop techniques for coping with life-demands. It may also suggest the development of life-skills (Koski-Jannes, 2002), which may be absent in members of a drug-using population, which again suggests the need for support to develop these skills. In addition to being responsible for the issues related to their substance use this change of responsibility also extended to managing life issues such as debts, finances, which may otherwise have heightened distress for which heroin may have been used to alleviate.

Identity is also closely related to this ongoing lifestyle change, beyond abstinence, through the capacity to develop self-awareness and self-acceptance, as Roger explains "Living life without drugs, or living life being prepared to look at yourself is much more difficult" (Roger 42-43).

The opportunity to develop this drug free identity and relationships was consistent with and part of developing a drug free lifestyle, in which they identified the importance of applying their responsible attitude to manage and cope with life difficulties, whilst resisting their desire to use. This seemed associated with a change of cognitive focus upon thinking about nothing else (but heroin use) and dealing with things differently.

Analysis also highlighted a counterbalance as valuable in sustaining change in which their lifestyles had improved to the extent of which a return to a substance using lifestyle had less appeal. For the participants, a perception of positive changes facilitated ongoing change efforts.

This counterbalance seemed to be in two forms; either a reduction of the negative effects associated with continuing a drug using lifestyle including relationships problems and health concerns or through new found gains by developing a change of lifestyle. These may be in the form of material positions, improved relationships, relief from anxiety and improved self-esteem.

Conversely it may be assumed that no identified improvements following change or a deterioration, such as increased boredom or increased emotional pain in the absence of relief provided by heroin, may increase the likelihood of eventual relapse and a return to a drug using lifestyle.

CONCLUSION

This study offers a valuable insight into understanding the experience of change from heroin use. Change from heroin use is often defined in terms of Recovery and Abstinence, however analysis of the participant's accounts highlighted that change is different than a socio-political perspective of Recovery which is predominantly based upon abstinence. Although a significant milestone, change extended both beyond and after the, often ambiguous, event of stopping using heroin.

The U.K. Government Drug Strategy of 2010, outlined the need for a Recovery Focused model of treatment and services have been trying to adapt since. Treatment providers are delivering services that are primarily designed to achieve targeted outcomes, rather than supporting the individual needs of service users. This study highlights that there is an absence of support after achieving service goals. Abstinence was considered a 'starting point of change', and that change is far more comprehensive than not using drugs anymore' and involves significant areas such as changing identity, changing relationships and changing lifestyle. It is by appreciating the significance of these areas that the likelihood of change will be facilitated and sustained.

The importance of the current Drug Strategy as not meeting service users' needs should not be underestimated, in light of a record number of drug related deaths and lowered rates of recovery since implementation. Commissioners have limited resources to employ services and service providers can only present treatment models based upon the resources that they have available. In an economic climate of austerity, social care is woefully underfunded and substance misuse, with a social perception of being less deserving and self-inflicted, is an easier target to enforce funding cuts.

This is particularly relevant to both mental health and substance misuse. With a focus upon demonstrable outcomes and 'successful discharges', psychological interventions are based upon achieving targets rather than acknowledging the issues or reasons why a person may have developed dependence. Psychological interventions are delivered by relatively untrained staff and service users in the form of psychosocial interventions, and there is an absence of any ethical consideration of the potential harm that may be caused by this approach. Psychological interventions would be more appropriately delivered by adequately resourced services and qualified practitioners, who are able to formulate the role of substance misuse in impacting upon mental health in both developing and maintaining dependence.

Further, there is a lack of consideration of the potential negative consequences of encouraging service users toward abstinence without necessary and sufficient support in developing alternative coping strategies to manage difficulties.

There is an assumption that life will, automatically, be better without heroin use, with an attitude of 'Brilliant-just get clean', whereas the possibility of relapse into a drug using lifestyle and potential overdose, due to lowered tolerance levels, may be increased should the person not receive sufficient support or opportunities to making further changes.

The research identifies a number of factors important in initiating and sustaining change from heroin use, such as managing distress, relationships and lifestyle and the issues that a person may experience as they attempt to change from being a 'heroin user' to 'non heroin-user'. By increasing awareness of the findings of this research it is hoped that such persons will be more able, and receive necessary support and opportunities, to make such a transition.

Limitations

All selected participants will have been 'successful' in their attempts to achieve 'recovery' or 'change'. They will also have chosen a 'recovery career' (Hoffmann, 2003) where this impacts upon their reformulated identity. Possible motivations may include; sharing their experience and 'success' or utilising an area they have knowledge and experience of change. It is important to consider why they have chosen to do this rather than moving away from the 'ex-user' identity (Granfield and Cloud, 1996), by choosing another career or identity project not associated with substance misuse. It may be relevant to consider how such a Recovery career, environments and relationships, with both colleagues and heroin using clients, may contribute to change. The interviews did not sufficiently explore this aspect of change and the accounts did not indicate this factor as a prominent theme. However, such factors may be influential upon whether change is maintained and are likely to be implicated with identity reformulation as part of change. It would therefore be useful to investigate this area further and to also attempt to understand the experiences of those who have experienced change but have not chosen to work in the field of substance misuse.

A further limitation is with regard to selection criteria. The participants who applied, and were selected for this study, were all white British and aged between 38 and 50. Although this homogenous sample offered the opportunity to consider similarities in their narratives, it would be interesting to appreciate more diverse population's experience of change from heroin use, such as the influence of cultural understanding, sexuality and age, for example whether a 'maturing out' (Winnick, 1962) of addiction process is relevant.

The findings of this study suggest that change is a process that develops through different stages. The selection criteria requested a minimum of two years heroin abstinence however by being more specific about the length of heroin abstinence may have indicated whether

this may be related to different stages of change. It is also recognised that change may be variable and processed at different rates and different speeds and the aim of this study was increase understanding of their experience of change.

Abstinence from other substances was also not specified, which allows the possibility that other substances may have been used as a substitution for heroin. Clarity of whether this may have impacted upon change may have influenced the findings. Further studies, may wish to investigate an experience of change of heroin use, whilst not abstaining from other substances, including alcohol.

IMPLICATIONS

There are a number of implications resulting from this research. The study supports some previous research on various aspects of change and highlights important areas which are not fully appreciated by current research and service provision.

Policy implications

'Recovery' does not capture the experience of change from heroin use.

Change from heroin use is generally considered in terms of 'Recovery' and 'Abstinence', however, the participants all challenged those notions as not adequately capturing their experience of change, highlighting that change from heroin use is more comprehensive than reaching abstinence and involves aspects of self, relationships, lifestyle and managing distress. They argued that 'recovery' is drug focused and that resource and formal treatment support ends upon reaching this goal.

Raising awareness through sharing the findings of this study and further related research would be a way of considering aspects of long-term change from heroin use. Encouraging various stakeholders to contribute and debate what may be involved in 'change from heroin use' would raise understanding. These stakeholders may include service users, others affected by heroin use, support staff, service managers and commissioners.

The aim would be that services embrace a long-term perspective of recovery, better preparing the service user for long-term change and securing resource to support this aim.

With regard to costs associated with heroin use, the research hopes that there would be considerable benefits in reducing relapse rates, by adequately supporting those to develop and maintain change from heroin use. This of course would contribute toward huge

financial savings, whether this be in the form of reduced crime, improved health and therefore less demands upon the NHS, or improved employability.

There is a need for treatment which meets the needs of those who suffer psychological distress and substance misuse.

As an effective pain reliever, analysis identified various ways in which heroin had been used to manage pain and distress. This was in the form of managing pain and distress present from an early age such as deep rooted anxiety, a sense of not being good enough, or insecurity. A second form was in response to pain resulting from a significant event such as bereavement or childhood sexual abuse. An implication of this study is that there appeared to be an absence of 'specialist support' to be able to help the person manage these difficulties and therefore their coping response had led to heroin use to alleviate this distress. Analysis identified that all of the participants had experienced a deteriorated lifestyle and sense of self due to their involvement in heroin use. The participants experienced anxiety and distress as a result.

An implication of this study is to strongly recommend adequate provision and support, in which a consistent and coherent formulation of the person's issues can be constructed. This would preferably be in an integrated service in which comorbid issues can be effectively managed. Improved access to therapeutic support would assist the person to manage emotional distress and would preferably be in the form of an approach which is able to appreciate and understand the role that substance misuse has in both alleviating and exacerbating distress.

However, such services should not be limited to those with significant or diagnosed mental health issues, but also available to help suffers of other forms of distress, whether this be related to bereavement, anxiety or sexual abuse.

Practice implications

There a number of factors which contribute toward initiating change.

Reaching abstinence, although considered relatively 'insignificant' (Roger 41), in terms of overall change, was considered 'an important starting point', and 'a foundation upon further change can be built' (Derek 377-380). Analysis identified a number of factors which may contribute toward initiating change. Change may be initiated by a significant event in which identity conflict is experienced, including impending parenthood or exasperation with a drug using lifestyle.

An implication of this study would be to be aware of the importance of these factors, particularly with regard to externalising locus of responsibility, and may be encouraged by services and supportive others in encouraging these attributes, such as attending appointments on time.

The research identified the desire for clear parameters associated with change from heroin use, this was particularly with regard to 'success' associated with abstinence. Services may not focus upon this issue, as substitution may indirectly contribute toward successful outcomes of achieving heroin abstinence. However, the likelihood of sustained change, is likely to be diminished.

There is a need to facilitate opportunities to access establish change.

Upon reaching abstinence participants recalled asking guidance questions in which the participants conveyed difficulties in transiting to a drug free lifestyle beyond reaching abstinence. Who am I? What do I do now? What am I? What can I be?

This stage appeared vitally important with regard to developing a drug-free identity and lifestyle and is a stage where far more attention, support and awareness is necessary in order to facilitate this transition.

This seems critical and likely to be related to high relapse rates at this stage as effort had been focused upon reaching abstinence, and an inadequate appreciation of the issues of transition beyond this point. This could lead to disillusionment in which their expectations were not matched by the reality of their experience post-abstinence. Analysis identified the importance of developing an identity in which they experienced acceptance from normalised, drug-free others. This seemed to be a process in which some used an 'ex-user' label, however others withheld disclosure of their previous use and attempted to develop new relationships or by changing location where their previous drug using identity was unknown and they were less exposed to factors which may have contributed to their drug use.

All participants believed that it was necessary, although often difficult, to distance themselves (disassociate) from other drug users, in order to both reduce the temptation to use and to aid a process of 'fitting in' with non-drug-users, in which they could start to see themselves as a non-drug user. However, a lack of commonality, with this population, was a problem, with a risk of non-acceptance or a lack of opportunity to develop these relationships. Such difficulties may increase the likelihood of a return to previous drug using

relationships in which they experienced acceptance and commonality and therefore returning to a drug using lifestyle.

An emphasis should be placed upon identifying and facilitating social support opportunities in which a drug free identity can be fostered and developed. A difficulty appears that at present, such opportunities where there is support to facilitate such a transition is provided through substance misuse services and populated primarily by drug users, with whom the person is attempting to disassociate.

Out of service support may be suitable, in which social networking activities are facilitated. This may include continuing support, where an awareness of the issues of those attempting change, is available to assist the person to manage issues such as developing trust, managing stigma, whilst offered with empathy and a non-judgemental attitude. Such support could also assist the person in managing life difficulties that may have accrued through their drug use, and further encourage the importance of maintaining commitment, ownership and responsibility. This support could possibly be offered by an on-line forum, though participants would need access to such technology to provide this.

Implications relevant to Counselling Psychology

There is an important role for counselling psychologists to support change from heroin use.

The profession of Counselling Psychology can play a crucial role in ensuring that the needs of people who have developed dependence on heroin, are better understood. Counselling Psychologists have a unique skill set which enables them to exert an influence at multiple levels of the system.

The formulation skills of Counselling Psychologists can be drawn upon to encourage a more coherent process in services which also identifies other contributory factors, rather than the focus being entirely on heroin use as the primary problem. This is particularly important for clients with co-occurring difficulties such as mental health problems, in the form of comorbidity and dual diagnosis, where addressing one problem is often contingent on the other.

People with co-occurring substance misuse and mental health problems have a significantly worse prognosis post-treatment than those with substance misuse problems alone. This suggests that specialist services which utilise continuing care strategies may be required for individuals with more complex issues, and psychologists are highly trained to work with such clients.

The development of coping strategies to manage distress is a necessary part of change.

For the participants, distress was relieved over time as the person developed their drug-free lifestyles, improved relationships and developed a more congruent form of self which was accepted by others. They developed various strategies to cope with emotional issues,

including a capacity to tolerate distress, sharing uncomfortable thoughts and emotions with others and a variety of distraction techniques.

An implication of this finding is that although there may be various routes to heroin dependence, it is important to be able to manage distress which may have led to or been exacerbated by heroin use. This points toward the need for specialist support to assist the person in reducing anxiety, or psycho-education in developing coping responses and improving emotional regulation.

An interesting area of the study was with regard to how people cope with psychological and emotional issues in the absence of heroin as a pain relieving medication. Several of the participants pointed toward behaviours which they may have adapted in response to the absence of heroin to provide a similar function, such as keeping cognitively occupied, whether this be in the form of an obsession with knife making (James), laying paving slabs (Roger), or having busy lifestyle's (Carol and Steve). Consideration of what is being avoided (emotional pain) may provide a pathway for further self-development and acceptance, or as Roger puts it 'peace, contentment and happiness' as a final destination of the process of change.

Extensions and further research

An important area for further research is with regard to potential cost savings of supporting sustained change from heroin use. Although there is a proliferation of outcome studies, most focus upon initiating short-term change. However, heroin use is associated with high rates of relapse, in the form of returning to their previous use.

By increasing awareness of the likely financial advantages of sustained change, may lead to the provision of resources to areas to support this. This may be in the form of increasing the opportunities to integrate with non-drug using populations and developing change identities, or an integrated mental health/ substance misuse provision.

The findings of this research may also apply and extend to other forms of behaviour change, such as change from other problematic behaviours, including other forms of substance dependence, gambling and weight loss.

Two current social concerns are with regard to obesity and gambling. The World Health Organisation has recently defined obesity and the risk of developing Type II Diabetes as an 'epidemic' (WHO, 2016). Recognising changes in the ways that we move and live and the relating to huge financial demands on health services and risks of serious health concerns. Gambling is also an increasing problem with the increase in mobile technology and proliferation of online betting opportunities.

Though, the mechanisms may be different, for example legality and social acceptance and tolerance of these behaviours, whether this be by comfort eating or other forms of substance misuse including alcohol, it is possible to see these behaviours as a form of avoidance strategy from acknowledging emotional pain. These behaviours may also create a bio-chemical response to alleviate emotional pain in a similar way to opiate use, whether

this is in the form of illicit drugs, alcohol, or sugar and caffeine found in food and drinks, or a rush of adrenaline and anxiety associated with gambling.

This research identified heroin use as a type of avoidance behaviour and of course there are many other ways in which people may avoid discomfort and pain. However, from a humanistic approach it is worth acknowledging that pain and suffering are part of being human. In this sense in order to develop self-awareness and self-acceptance it may be important to consider the nature of what is being avoided, in order to acknowledge and resolve emotional issues and resultant pain.

An important area of the study was with regard to internal conflict / or dissonance experienced by clients during heroin use and the initial stages of change. Analysis indicated the importance of a 'real-self' being developed post abstinence, where the person can experience being accepted as a person without drug use, at this point they are able to distance themselves from substance use.

The Person centred Approach is a dominant approach within Counselling Psychology which highlights the importance of developing a congruent identity. By utilising this therapeutic approach, the person may be better supported in developing self-acceptance and be in a better position to establish the resources needed to maintain change.

By fostering facilitative conditions, then the participants may further develop the capacity for distress tolerance and the ability to self-soothe when faced with psychological distress or uncomfortable thoughts and emotions, for which they may previously have used substances to manage.

Drawing on therapeutic approaches may lead to an awareness of unresolved issues such as a lack of self-acceptance or unresolved trauma, and the associated pain which the individual is attempting to avoid by 'working through' the underlying issues, the person may develop

awareness of how this avoidance may impact upon their relationships and psychological health.

The training of Counselling Psychologists highlights the importance of continually evaluating their work. It may therefore be considered appropriate to conduct further research, following these findings to investigate reported reasons for relapse from heroin abstinence to see if the reasons match the themes identified in this study. Counselling Psychologists, are in a position to conduct such research. By doing so important markers may be further identified and allocation of resources may be better directed to support sustained change from heroin use.

Such research may consider utilising different populations. A replication of this study, but using different samples would be useful to further understand former heroin users' experience of change. Such a study would be particularly informative of further understanding the how people develop change when they have not adopted pursued careers in substance misuse or continue to associate with substance misuse services.

This may highlight strategies for developing social support, away from a more empathic, understanding environment that is informed and knowledgeable about issues encountered by heroin users and how they manage the issue of sharing issues such as a temptation to use.

It also leads to consideration of separation from substance misuse. It would be interesting to find how identity has developed in this regard. For example, are they more likely to use a disclosure strategy of not sharing their heroin using past with others, for fear of a lack of acceptance.

Further related research may also be conducted to investigate whether the themes identified in this study are central to reasons for relapse. Such research may further assist in identifying important markers of change and indicate where resource to provide necessary support should be allocated to support sustained change and reduce relapse rates.

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APPENDICES

TABLE OF PARTICIPANT DEMOGRAPHICS

Participant	Age	Gender	Number of years using heroin	Number of years of heroin abstinence
Barbara	39	Female	8	11
Carol	48	Female	3	26
Derek	49	Male	15	8
James	50	Male	10	13
Roger	41	Male	10	14
Sid	38	Male	8	8
Stuart	43	Male	12	13

Interview Schedule

Interview Questions

- Can you tell me about your experience of change from drug use?
- What led you to be involved in this change?
- What factors facilitated / helped change?
- Did you experience any difficulties in creating this change for yourself?
- Were there any barriers toward creating this change?
- What do you understand by the term 'recovery'?
- What does 'abstinence' mean to you?
- Do you feel that your self-identity has changed since being involved in drug use?
- In what ways?
- Have your relationships changed?
- In what ways?
- Have your interests changed?
- In what ways?
- How do you make use of your time.
- Have your feelings toward yourself become different?
- In what ways?
- Some people believe that heroin helps to deal with problematic / uncomfortable experiences thoughts or emotions. Does this relate to your experience?
- (Childhood)
Some people relate their drug use to difficult childhood experiences. Does this relate to you?
- How do you manage things in the absence of drug use?
- Has the way that you deal with emotions changed?
- (Distraction)
Have you found different ways to take your mind off things?
- Heroin is a pain reliever or emotional suppressant.
Since you have stopped using heroin have you found different ways to manage emotional pain?
- (Altered states of consciousness)
Have you found different ways to alter you states of consciousness?
- As a keyworker do any particular theories relate to your individual experience of drug use?
- Is there anything else that you would like to add?

Research Information sheet

Professional Doctorate in Counselling Psychology Research Project: Participant Information Sheet

You are being invited to take part in a research study as part of a student project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Who will conduct the research?

Andrew Tye
University of the West of England
School of Psychology
Faculty of Applied Sciences
Frenchay Campus
Coldharbour Lane
Bristol
BS16 1QY

Title of the Research

Understanding former heroin users' experience of change: An Interpretative Phenomenological Analysis.

What is the aim of the research?

This study aims to investigate the experiences of several former heroin users, by using interpretive phenomenological analysis. By considering their unique experiences, it is hoped that it will inform and increase our knowledge around what is considered to be 'change' or recovery from an ex-heroin user's perspective and the important factors involved in achieving and maintaining this change.

Why have I been chosen?

You have been chosen as one of six participants who has previous experience of heroin use and present experience as a practicing drugs worker.

What would I be asked to do if I took part?

You will be asked to share your thoughts in response to a series of questions. These questions will involve you considering both your past and present experiences. The interview is expected to last for approximately 45 minutes.

What happens to the data collected?

The interviews will be audio recorded, then transcribed. Interpretative Phenomenological Analysis will be used to gain an understanding of your experiences and what sense and meaning you make of these experiences.

How is confidentiality maintained?

The audio recordings will be transcribed and stored in a secured location in a locked cabinet. Only Dr. Antonietta DiCaccavo, and Guy Saunders, as supervisors of the project, and Andrew Tye will have access to the material. All information you give to us is strictly confidential. Your privacy will be carefully protected in any reports of the findings of this project. No injury or bad effects are expected to occur as a result of taking part in this research at any time.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself.

If you choose to withdraw later or to not participate now, there will be no consequences for you.

Will I be paid for participating in the research?

No

What is the duration of the research?

The interviews will take place in August and September 2012. Then they will be transcribed and analysed. The research will be completed by June 2016

Where will the research be conducted?

The interviews will take place at the substance misuse agency where you work, at a mutually convenient time.

Will the outcomes of the research be published?

The research forms part of a mini-project as part of the Professional Doctorate in Counselling Psychology. Your permission will be requested any before publication and/ or dissemination.

Contact for further information

If you have any questions or concerns, either now or later, please feel free to ask or voice them. You may also contact project supervisors Dr Antonietta DiCaccavo or Guy Saunders on 0117 3282181 about the project or any complaints or problems with regards to this project or about your rights as a study participant.

Research Consent Form

STATEMENT OF INFORMED CONSENT FOR RESEARCH PARTICIPATION

Andrew Tye, with the support of Antonietta DiCaccavo and Guy Saunders at the University of the West of England, School of Psychology, is interested in: 'Understanding former heroin users' experience of change: An Interpretative Phenomenological Analysis'.

To do this you are invited to take part in a n interview in which you will be given the opportunity to share your experiences in response to several questions.

These interviews will be audio recorded.

We expect this research to take approximately 45 minutes of your time.

The audio recordings will be transcribed and stored in a secured location in a locked cabinet. Only Dr. Antonietta DiCaccavo, Guy Saunders and Andrew Tye will have access to the material. All information you give to us is strictly confidential. Your privacy will be carefully protected in any reports of the findings of this project. No injury or bad effects are expected to occur as a result of taking part in this research at any time. If you choose to withdraw later or to not participate now, there will be no consequences for you.

This form is an indication of your voluntary agreement to take part in this study. If you have any questions or concerns, either now or later, please feel free to ask or voice them. You may have a copy of this consent form if you wish. You may also contact Dr.DiCaccavo or Guy Saunders on 0171 3282181 about the project or any complaints or problems with regards to this project or about your rights as a study participant.

The researcher of this study has explained to me what I shall do in the study, and I consent to take part in it. Neither my name nor any other identifying information will be disclosed to anyone outside this lab. I understand that all information I provide will be kept strictly confidential.

Further, I understand that participation in the study is voluntary, and that I am free to withdraw consent and discontinue participation at any time.

Signature Print name Date

Age: _____ Sex: _____

~For Researcher Use~ _____

I have discussed with _____ the above procedures, explicitly pointing out potential risks and discomforts. I have asked whether any questions remain and have answered these questions to the best of my ability.

Researcher signature: _____ Date: - _____

Research Debrief Sheet

'Understanding former heroin users' experience of change: An Interpretative Phenomenological Analysis'.

Thank you for participating in our project.

The main objective of the study in which you just participated is to consider the unique experiences of several former heroin users. It is hoped that it will inform and increase our knowledge around what is considered to be 'change' or recovery from an ex-heroin user's perspective and the important factors involved in achieving and maintaining this change.

If you experience any distress following the interview please feel free to contact me,
a.tye@addaction.org.uk
Tel; 07979706435

Thank you again for participating in this project. Without you, our research would be impossible. Your involvement helps us to better understand the nature of change.

Journal Article

Abstract

Background

Research on the process of recovery indicates that the recovery experience is a complex and dynamic process that changes over time (e.g. Biernacki, 1986; Koski-Jannes, 2002; Margolis, Kilpatrick and Mooney, 2000). Although there is a large body of research on recovery, few have examined long-term recovery using Interpretative Phenomenological Analysis.

Aims

The aim of this study was to explore the experiences of those who have been involved in change from problematic heroin use and how they have made sense out of their experiences.

Methodology

Seven participants, who had been abstinent from heroin for a minimum of two years completed semi-structured interviews about their experience of change. Practicing drug workers were selected as this provided confidence of long-term change. It was anticipated that this particular group would be able to consider important aspects associated with change from their individual experiences. The interviews were analysed using Interpretative Phenomenological Analysis (IPA).

Findings

The superordinate theme discussed in this paper regards 'Making sense of change', in which participants conceptualised change as continuing far beyond reaching abstinence. Of particular note is the idea that stopping using drugs is the start of change rather than an end point in itself, as abstinence impacts heavily on a number of aspects of life.

Discussion/ Conclusion

Implications for substance misuse services and counselling psychologists who work with this population, including increasing awareness of the complexity and factors involved in change. This includes changes of identity, relationships and lifestyle and managing emotional distress in the absence of heroin.

Introduction

In the field of substance misuse the terms 'recovery', 'abstinence' and 'change' are often used interchangeably. These are often politically and socially motivated terms in which change from heroin use is often focused on treatment outcomes, based upon short term change and abstinence.

This research aims to outline the complexity and consider some important factors which may be important when considering change from a heroin user or ex-heroin users' perspective, including factors involved in achieving and maintaining change and why this may be difficult to achieve.

Koski-Jannes (2002) notes that although research on recovery from addictive behaviours 'has mainly been geared toward improving the immediate techniques of change...the initial change in self-concept is followed by other, more far reaching identity projects that help make the resolved state more meaningful and rewarding for the individual' (p 184). These include developing new skills and values and the formation of a new identity and 'life-projects'. This perspective considers that overcoming addiction may take years of work after stopping the addictive behaviour.

The concept of change is often seen as being on par with if not the same as recovery. However, Laudet (2008) points out, 'an important yet neglected question is 'what does recovery mean to persons engaged in the process?' (p2003). In her study (Laudet, 2007) of definitions and experiences of recovery among person's who self-identify as in 'recovery', over half provided answers describing range of features that did not focus upon substance use, such as a new life, well-being, a process of working on oneself, self-improvement and learning to live drug-free.

Although there is a large body of research and empirical data on the short-term effectiveness of various treatment approaches, the majority of these studies have follow-up periods ranging in length from 1 to 24 months (Laudet, Savage and Mahmood, 2002). Laudet and White (2008, p.28) maintain that 'findings from most studies speak to recovery initiation only, not to the challenges and processes involved in achieving and sustaining long-term recovery'. In addition, they contend that most of the research is mainly focused on treatment outcomes, while recovery from addiction is more than not using drugs or alcohol in an otherwise unchanged life.

Method

Quantitative outcome studies do not reflect individual experience or the sense that individuals make of their experience. A qualitative methodology was used to explore the actual experience of participants, the meaning that they give to their experiences and the impact that they have had on their lives. The analysis was structured around a narrative pattern that was reflected in the majority of the participants' stories.

In terms of devising data collection method, IPA is best suited to one which invited the participants to offer a rich, detailed, first person account of the experiences. In-depth interviews are the best way of accessing such accounts.

Rapport and the researcher's background and understanding of substance misuse were important to communicate empathy and facilitate open and reflective dialogue of their experiences.

Participants

Seven participants, were selected from drug services, who were currently employed as substance misuse workers, directly working with clients, have a history of heroin use and had achieved abstinence from problematic heroin use including substitute medication for a minimum of 2 years.

Five males and two females were selected, all of the participants were white, British and ages ranged between 38 and 50 and though criteria requested a minimum of 2 years heroin abstinence, the lengths of abstinence of these participants was between 8 and 13 years.

Data collection

Data was collected using semi-structured, face to face interviews utilising open questions.

The researcher used the guidance of constructing a schedule for a semi-structured interview, from Smith, Flowers and Larkin (2009), with the aim of developing a comfortable interaction which enabled the participants to provide a detailed account of their experience.

The researcher pre-prepared questions to be open and expansive, to encourage the participant to talk at length and used guidance around suitable questions for research interviews, utilising descriptive, narrative, structural, contrast, evaluative circular, comparative, prompts and probes to guide questioning.

Ethical Considerations

The proposal was approved by the University of the West of England, according to their ethical committee. The proposal was also approved by the substance misuse service with whom the participants were employed and the study was carried out according to ethical guidelines.

Informed consent was gained from participants, not only for participation in data collection but also to explain what to expect from the interview.

Analysis

Each interview was transcribed as soon as possible to enable the interviewer's thoughts and interpretation to be utilised and to recall the interaction in detail.

As with many other approaches in qualitative psychology, the essence of IPA lies in its analytic focus which directs attention toward participant's attempts to make sense out of their experience.

When people are engaged with an 'experience' of something in their lives they begin to engage in a considerable amount of reflecting, thinking and feeling as they work through what it means. IPA research aims to engage with these reflections. Therefore the analysis focused in detail at how the participants made sense of this major transition in life.

As an interpretive endeavour IPA is informed by hermeneutics, the theory of interpretation. IPA shares the view that human beings are sense making creatures, and therefore the accounts which participants provide reflect their attempts to make sense of their experience. IPA also recognises that access to experience is always dependent upon what participants tell us about that experience, and that the researcher then needs to interpret that account from the participant in order to understand the experience.

IPA is committed to the detailed examination of the particular case. It enables the researcher to understand the sense a participant makes of an experience, what sense this particular person is making of what happened to them. IPA have a small number of participants and the aim is to reveal something of the experience of each of those individuals.

Findings

Analysis of the semi-structured interviews found a number of superordinate and subthemes. For the purposes of this research article, the superordinate theme, of 'Making sense of change' will be the focus, including subthemes, of 'What is Change?' and 'Change as an Ongoing Process'.

Quotes from participants have been included to illustrate the data and all names have been changed to protect anonymity.

Making sense of change

The participants were able to reflect on their experience of change and showed that it was multifaceted concept. This led to identifying two key strands of interest represented by the two subthemes. These subthemes shared a commonality between understanding the process of 'change' from the participants' experiences and identifying important factors that may be involved.

Analysis identified that there was a difference between a short term conceptualisation of change, which was based upon achieving abstinence and change as a longer term process. However, there was agreement that abstinence is an important 'first step' and a 'foundation on which further change could be built. It was, therefore, relevant to combine these subthemes, in order to understand how the participants had made sense of their experience of change.

Sub theme 1: "And what is change? Because I'm really not too sure about whether I understand what change is anyway." (James).

James initially communicated confusion in explaining his change from heroin use indicating a lack of understanding and clarity about how change applies to his experience. In this sense James conveys that although he has vast lived experience of change from heroin use, he finds articulating this experience difficult. This possibly reflects a lack of focus and previous opportunity to reflect upon and consider what was involved in this process. James' confusion was matched by the accounts of the other participants, in their attempts and struggles to articulate their experience of change. James expressed that change is a 'broad concept' suggesting that many factors may be involved (James) and (Stuart) questioned how to define 'success' indicating that this is subjective and Roger highlighted a lack of markers to identify change other than abstinence.

"Cos there's not many markers, we just talked about 14 years- worth of my life. So I think, it is hard to kind of, quantify it, and say here are some definite points of change" (Roger).

Barbara indicated an internal ambiguity in her initial change attempts in that 'parts of her wanted to change', but that she 'did not know what she wanted to change or change into'. This suggests that there are various aspects to change and that change may involve a change of identity. It also suggests that there is a 'not knowing' aspect in this process; that a person can change but not know what this will look like or what it would translate in to. This 'not knowing' aspect of change may be evident in 'change guidance questions' following initial abstinence, where the goal of stopping problematic heroin use has been reached but then the person may experience an absence of knowing what to do next or what then needs to change.

Carol used a simple definition of change from heroin use, which represents a commonly accepted notion;

"I used to use and I don't anymore" (Carol).

Carol's way of describing her change implies that change is simply to stop using heroin and occurred early in the interview before deeper elaboration as the interview progressed. Further exploration and analysis into both Carol's and the other participants' experiences highlighted a much more complex process than simply not using drugs anymore. This more complex process of change was evident in the participants' confusion around the notion of 'recovery'. Highlighting that stopping using drugs is only one part (a physical part), and that there is much more involved.

The participants also questioned the parameters associated with recovery and abstinence from heroin use.

Carol argued that change may include less harmful or frequent use rather than abstinence, while others, pointed toward a replacement of heroin with other substance use. Sid expressed confusion around a notion of abstinence, indicating that there is a focus upon heroin abstinence, but was unsure whether this included abstinence from other forms of substance use.

"alright, my heroin use has stopped, erm, which is the one that I had the biggest problem with stopping. But I still drink. I still, well I don't, I have since stopping heroin, used other things." (Sid)

Derek suggests that a policy of total abstinence from all forms of substance use may be necessary, relating his unsuccessful attempts to achieving heroin abstinence but using other substances as a replacement.

"And also you know, er, with feelings and emotions, they're all ended by substances. Maybe you know the other times, when I've got clean before, I didn't get clean because I was drinking and taking a bit of this and taking a bit of that. So I wasn't dealing with me. So maybe the abstinence, you know, for whatever period of time, is what you need, you know." (Derek).

Barbara questioned her own experience in terms of 'recovery', indicating that she has achieved the simple definition with regard to overcoming physical dependence, however in other regards she was less sure as to what the term relates. She suggests that there are other factors involved in change from heroin use, but that these factors are less clear and not as easy to identify.

"But have I recovered? Yeh I've stopped taking heroin. But have I really recovered? From what? What have I recovered from? From that physical side of the drug taking- yeh. But there's a whole, everything else". (Barbara).

They also suggested that the term 'recovery' has a political and organisational focus, rather than applying and relating to the experiences of those that are involved in the process.

"And what are you recovering from? I think it kind of gets lost. It's a lost word, I don't know. I don't really know what it means to me. I don't know. I don't know what it means to anybody

else. I know what it means to organisations and what it's forced to mean now but I don't really know what that means to me." (Sid).

The reference to a 'lost word' suggests a widely used term that lacks critical consideration, beyond how it has been constructed to meet political and organisational agendas. It also suggests that this term does not capture, match or appreciate the experiences of those involved in the process.

Roger indicates that the parameters of change from heroin use are also based upon a notion of stopping using drugs. He also sees that in this sense he is perceived as a success.

"As far as treatment services go, I'm a success story. That's this thing. You're successful. You've stopped doing what you were doing and you can get on with your life" (Roger).

Roger believes that this is a limited conceptualisation which fails to appreciate or support the ongoing factors which may be involved.

In this sense the participants are able to acknowledge service goals and external markers but are also able to make sense of change at a deeper level. However, the participants did not believe that a short term view of change either captured or supported further changes that were necessary.

"It is all about 'Brilliant, just get clean, just get clean.' Rather than, it's not very planned, is it. 'Just get clean'. Then what? And all this talk about jobs and all that kind of foundation stuff. But the actual, the way your beliefs change and things is incredible." (Roger)

Barbara was dismissive of the conceptualisation of recovery, highlighting that recovery is a much 'wider issue' than drug use and includes aspects such as lifestyle, feelings, thoughts, a social situation and handling life. She also believes that current support is insufficient to facilitate these further changes.

"Recovery? I don't know, I don't know. I don't even know what the word means. Because what are you recovering from? What are you recovering from? Are you recovering from drug use? Are you recovering from lifestyle? Are you recovering from your feelings and your thoughts? Are you recovering from a social situation? Are you recovering from, like, how you handle life? I think the term that drug services use as 'recovery' is to stop taking drugs. Or to reduce in alcohol or to stop drinking or to recover from substance use. But recovery for me is a massive, wider issue." (Barbara).

There was a sense of frustration in the participants' narratives, which seemed that they had had to go through important parts of this journey alone and without adequate guidance, opportunity and necessary support. This may have made their experiences more understandable and assisted them to manage the issues which they would face beyond reaching abstinence.

Derek felt that the term 'change' is a more suitable term to describe his experience and highlights the importance of 'maintenance' and 'consistency' in this process. He suggests that support and understanding is necessary in these regards, beyond achieving abstinence.

"Er, I suppose, it would be better to say what does 'change' mean. And also, maintenance of change and consistency. 'Cos you can change so quickly and change in such a short space of time, how do you sustain that change? How do you maintain it?" (Derek)

He explains that change may be initially quick, such as initiating change by stopping drug use, but encapsulates a longer term and more comprehensive process than commonly understood, i.e. staying stopped. The terms maintenance and consistency may indicate the changes which need to be incorporated into his lifestyle in order for the initial change to continue, indicating a longer term notion than associated with the more simple understanding of stopping using drugs.

“Now what is that change? I was...my change from use to using daily and living that lifestyle of thinking about nothing else, but want to change the way that I feel, which is what the drug did for me. And not being able to manage my life on a daily basis.... And no anxieties”.
(James)

James attempts to identify aspects of his experience of change, highlighting a change of lifestyle which did not revolve around drug use, ‘thinking about nothing else’ which suggests a change of cognitive focus and extending his attention to other things and that when drug use stops he may be more aware of other things in his life. Changing his attention from wanting to ‘change how he feels’ which indicates that change may involve a reduced desire to alter the ways that he was feeling and possibly a lessened need to use drugs to manage difficult feelings or emotions. This would indicate an improved ability to ‘manage life’, which matches other accounts highlighting the importance of managing life in the absence of drug use. James also reports an absence of anxieties, which suggests a relation between heroin use and psychological discomfort as aspects of change. By changing the ways in which he ‘managed life’, it appeared that his sense of anxiety reduced so that he had less need to use heroin to change this uncomfortable feeling. In this regard different aspects of change may be inter-related and influence each other.

There appeared to be different ways of understanding change; a service perspective of stopping using drugs and another from which involves identity, relationships, lifestyle and psychological factors.

Sub theme: Change as an Ongoing Process. “It’s not about the drug,..., it’s about everything else” (Jeff).

The first subtheme pointed toward a short-term focus of change from heroin use, with a common perception within society in general that change is accomplished by reaching a point of abstinence. However, Roger explained “being abstinent from drugs is easy”, and that the bit after is more difficult.

Roger describes stopping using drugs as ‘insignificant’, therefore communicating the part that this had played in his overall experience of change. He highlights that “living life without drugs and being prepared to look at yourself is much more difficult”. This suggests the development of self-awareness and self-acceptance as being an important part of ongoing change.

James, Barbara and Roger emphasise change as an ongoing or lifelong process, however they reflect on a lack of support after achieving abstinence, which is reflected in treatment provision. Roger describes a service attitude of ‘Brilliant- just get clean’ and Stuart likens the allocation of resources to provide services as “a funnel with all of the money going to the front end with none left for the important part”. Sid shares this perception that services weren’t designed to support ongoing

change with an attitude of “we’ve done our bit- now it’s up to you to do it all” and Stuart describes people as “being dropped like hot potatoes” following treatment completion.

These shared perspectives emphasise a frustration at the emphasis placed upon reaching abstinence and a lack of appreciation and resource to support further changes.

“And then you kind of erm, ‘oh’, felt, it isn’t the big rose garden of greatness that it’s painted out to be and it is the massive dull empty space that you’ve got to fill somehow. I don’t know, you’re led to believe that being clean is it. That’s the most amazing bit, but it’s not.” (Sid)

Sid used an analogy to explain his disillusionment at the inaccuracy of a short term conceptualisation of change, describing the disappointment that he experienced after reaching abstinence, illustrating his expectations of life without heroin. His quote highlights the importance of an increased awareness of further necessary lifestyle changes beyond achieving abstinence.

Analysis of the accounts indicated strongly that the participants felt unsupported with regard to ongoing change and that there was a lack of understanding and appreciation of the complexities of the issues involved in change beyond cessation of heroin use.

“I sometimes wonder if there’s enough of this conversation that are stepping into this. I do wonder that, I just think, it’s easy to do the kind of being abstinent from drugs and stopping them behaviours but after that, you’ve got to be careful about.” (Roger)

Roger’s statement points toward the necessity of an improved awareness of the difficulties and complexities at all levels associated with ongoing change. This may inform all levels involved in this change process, from political agendas, commissioning decisions, service aims and treatment support, worker approaches, an improvement in a social understanding and perhaps most importantly the expectations of the service user themselves.

Discussion

The interview data provided a rich source of material indicating the participants understanding of change and their experience of both the factors which initiated their change and understandings of long term change from heroin use.

Although the participants' experiences varied there were common themes. They saw their change as different from recovery and more than abstinence from heroin use, identifying aspects such as changing identity, improving relationships, managing life issues and coping with distress. All of the participants saw their change as an ongoing process, which is consistent with previous research on the process of recovery, that the recovery experience is a complex and dynamic process that changes over time. Analysis also suggested an experiential discrepancy between change definitions and common understandings of recovery, with 'recovery' being perceived as drug-focused and 'change' involving a process of self-awareness and a journey toward self-acceptance.

And what is Change Anyway?

The participants were critical of the term recovery, as not adequately capturing their experience. They believed that recovery has a short-term focus on achieving abstinence and were critical of the parameters of abstinence.

The participants suggested a common understanding of change tends to hold a focus of 'just get clean' which contributes to a lack of recognition and acknowledgement of accurate markers of change both before and beyond achieving abstinence.

The participants suggested various aspects of change which did not include drug use. These aspects highlighted life changes, cognitive changes, managing life and coping without heroin to change the ways that they feel.

Change as an ongoing Process

Although participants challenged the validity of abstinence as an accurate marker for change, they did acknowledge that abstinence was an important first step to facilitate further change. Analysis suggested the significance of a space of time without using drugs in order to facilitate a transition to a non-drug using lifestyle. This transition also enables a non-drug using identity to develop and to learn strategies to manage life issues without reverting to drug use.

These findings suggest a differentiation between recovery initiation factors and recovery maintenance factors (Best, Ghufan, Day, Ray and Loaring, 2008) within a developmental model suggesting that for most people recovery is a process and not an event or state, reached by achieving abstinence. As James quotes; "Stopping is the easy part; I've done it hundreds of times-hundreds!" (James).

Analysis of the participants' accounts highlighted that change from heroin use is more than abstaining from drugs. Roger describes this as 'insignificant' compared to the changes that he has experienced after and Sid explaining that this is when the hard word work started.

The current drug strategy (2010) with a focus upon short term change (initiating abstinence) was seen to influence commissioning and direct treatment provision in what Roger describes as an attitude of 'Brilliant- just get clean'. The implications of this short term focus of change, was highlighted as having a possible detrimental effect on those attempting to create sustained change.

The consequences of a lack of understanding and consequential commissioning decisions of the changes that an individual may experience could lead to the individual attempting to make a transition with a relative lack of support and awareness of the difficulties that they may face in making the transition to a lasting drug-free lifestyle.

The disillusionment, and possible perceived failure to achieve goals and not have their needs adequately met by treatment services, may lead to a demotivation to engage or re-engage with services with treatment services in the event of relapse and may be correlated to a record high in drug related deaths (Office of National Statistics, 2015).

Implications

The study attempts to understand change from the actual lived experiences of those who have been involved in the process of change from heroin using behaviour (Genest, 2002). An increased understanding can raise awareness of how ex-users' have made sense out of the process of change and highlights some important considerations which are not fully appreciated by current research and service provision.

It is hoped that this research may also contribute toward communication and debate among policy makers, practitioners and researchers concerned with social and health policy responses to legal and illicit drug use and drug-related harm.

Such an approach is consistent with Counselling Psychology philosophy which aims to understand the individual (Woolfe, Strawbridge, Douglas and Dyden, 2010) and thereby how they have made sense out of their experience.

There are also implications for Counselling Psychologists, particularly for those working with heroin users and other forms of change and how there may be a multitude of factors associated with establishing long-term change. This may be in the form of appreciating different agendas and definitions of 'success', how identity, relationships and lifestyles may change or a focus upon the function of 'the problematic behaviour' to manage pain, distress or emotional discomfort.

The points in this study have the potential to be applied in practice such as the relevance of the factors which may support long term change. This may be in the form of increased service provision and commissioning to support clients beyond abstinence to enable them to manage a transition to a drug free lifestyle. The factors associated with maintaining change includes a need for support and awareness, including identity, relationship and lifestyle factors and how to best support what can be a complex and difficult transition to established change.

Many approaches of counselling and theory highlight the importance of developing a congruent identity. Regardless of the therapeutic approach, by supporting this then the person may be better supported in developing self-acceptance and be in a better position to establish the resources needed to maintain change.

Conclusion

The findings of this research study suggest that change from heroin use can be a difficult, complex but ultimately worthwhile journey. Different agendas and a general lack of awareness of the factors involved in long-term change beyond abstinence can leave those involved feeling lost and unprepared for further necessary changes.

The research highlights a huge transformation that the participants have achieved which is testament to the capacity for change. This is consistent with Counselling psychology philosophy which is largely humanistic, with a view that humans are naturally self-actualising. (Rogers, 1951, p. 487).

The Government's awareness of the link between substance addiction and mental health issues is positive, although their strategy fall short. All too often those struggling with highly complex, individualised needs find it impossible to get the help that they need to begin the process of recovery when these services are separate specialisms. Integrated, dual-diagnosis services are vital in providing these particularly vulnerable individuals with a pathway to recovery.

Developing this theme further, it is imperative that the upcoming national guidance to support local areas in the collaboration across drug, alcohol and mental health services provides clear approaches and opportunities for integration. Given the repeated mentions in the strategy of the statistic that 70% of those in community substance misuse treatment experience mental illness, the lack of clear guidance and strategy on this issue is disappointing, and it undermines the shared aims of these services.

Also vital is the role that employment and secure housing plays in the recovery of those struggling to overcome addictions. The strategy rightly acknowledges this, but does not go far enough. The removal of the stigma surrounding substance misuse and (re)-integrating individuals into their communities is critical in recovery, and the government should take further, clear steps to support this.

The dominant concern, missing from the whole strategy, is investment: the sector requires more funding to effectively treat the vulnerable individuals that make up our client base. WDP remains extremely concerned that, once the ring-fence is removed after April 2019, it is inevitable that funding for drug and alcohol services will substantially decrease.

Continuing strong rhetoric around these issues by government is evidently not enough: funding for services has decreased across the board in the past few years. Local authorities require providers to supply the same services for less funds. This is disguised often by payment-by-results schemes,

which are aimed more at saving money than improving service provision. Alternatively, where there is no attempt to disguise, direct cuts are made which damage the whole sector.

Further reduction of funding would have catastrophic effects on all individuals going through recovery, and will put many lives at risk. If the government is seeking to improve the provision of treatment, it is vital that the declining resources available for service providers be reversed to allow effective, safe services to continue to be provided. Failure to invest is a form of investment itself, but the return on such a negative venture does not bear thinking about. The Government has an opportunity to make a substantial contribution to the national wellbeing with this strategy, let's hope it can seize the moment, and follow through with the right investment of materials, to match the investment of some promising ideas.

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