



Research paper

Pathways to ‘recovery’ and social reintegration: The experiences of long-term clients of methadone maintenance treatment in an Irish drug treatment setting

Paula Mayock*, Shane Butler

School of Social Work and Social Policy, Trinity College Dublin, the University of Dublin, Dublin 2, Ireland



ARTICLE INFO

Keywords:

Methadone maintenance treatment
 Long-term treatment
 Recovery
 Social reintegration
 Drug policy
 Qualitative research

ABSTRACT

Introduction: This paper examines the experiences of long-term clients of methadone maintenance treatment (MMT) in one area of Dublin in the context of a recent emphasis on rehabilitation and recovery in Irish drug policy.

Methods: In-depth qualitative interviews were conducted with 25 long-term clients of methadone maintenance treatment (MMT). All participants had first enrolled in methadone treatment at least ten years prior to participating in the research and a majority ($n = 16$) had first accessed MMT more than 20 years previously.

Results: While acknowledging several beneficial aspects of methadone treatment, research participants saw themselves as passive recipients of a clinical regime that offered no opportunity to exercise agency in relation to their ongoing treatment. Rather than perceiving themselves as progressing along a pathway to recovery, the treatment experience was depicted in terms of stasis or confinement. Neither did participants report any progress in attaining the kind of social reintegration that is commonly presented as a key aspect of addiction recovery and which, in the Irish context, is a central plank of drug policy discourse.

Discussion: The findings highlight a disconnect between policies that ostensibly aim to promote social reintegration and recovery and the experiences of individuals who are long-term clients of MMT. Irish policy aspirations of facilitating opiate-dependent clients to progress along a pathway to recovery are difficult, if not impossible, to realise given the marginal status of addiction services within the health system and the difficulties involved in securing ongoing cooperation from other public service sectors.

Introduction

Despite its efficacy and widespread use, methadone maintenance treatment as well as other harm reduction interventions have come under critical scrutiny over the past decade alongside the emergence of a renewed focus on ‘recovery’. The new recovery paradigm has been influential, particularly in the UK, where it has been embraced as an organising principle within drug policy (Duke, 2012; McKeganey, 2014). In Australia, new recovery has been treated with far greater scepticism, generating intense and often polarised discussion within research and policy communities (Lancaster, Duke, & Ritter, 2015; Lancaster, Seear, & Treloar, 2015). While the recovery concept has been the subject of considerable academic and policy debate, particularly in the UK and Australia, this debate has not come to prominence in Ireland where the notions of ‘reintegration’ and treatment ‘pathways’ have dominated policy discourse, with a parallel emphasis on service user involvement in

all aspects of their treatment. However, with almost two-thirds of Irish methadone treatment clients remaining in specialist addiction clinics (Health Research Board, 2017) and clear evidence of barriers to patient advancement along a methadone treatment ‘pathway’ (Moran, Keenan, & Elmasharaf, 2018), questions might be asked about the extent to which Irish drug treatment systems enable opiate-dependent clients to progress along a path to social reintegration and recovery.

This paper examines the experiences of long-term methadone maintenance treatment (MMT) clients in the Irish context, focusing not on their perspectives on recovery *per se*, but on the lived reality of, and meanings they attach to, methadone treatment. The findings presented – which draw sharp attention to tensions and complexities in how long-term MMT clients perceive the role of methadone in their lives – highlight a disconnect between policies that ostensibly aim to promote reintegration and recovery and the experiences of individuals who are engaged with MMT over a prolonged period.

* Corresponding author.

E-mail address: pmayock@tcd.ie (P. Mayock).

The emergence of ‘new recovery’ in drug policy: a brief history

Throughout the twentieth and into the twenty-first century, healthcare systems in many countries experienced ongoing complications in their efforts to respond to the needs of opiate-dependent clients: complications arising not merely from the lack of effective therapeutic technologies but also from the moral opprobrium and legal sanctions attaching to the use of these drugs. Where opiate use could be construed either as a crime or a form of illness, it was unclear what the appropriate role for the health sector was, or to what extent therapeutic interventions should complement criminal justice activity by being aimed solely at getting and keeping clients drug free. For much of the twentieth century, international drug control systems – particularly those of the United Nations which was established in 1945 – reflected the prohibitionist perspective of the United States of America. This was a perspective that saw illicit drug use primarily as a moral evil or form of social deviance to be managed by criminal justice systems, with healthcare systems playing a subordinate role by assisting drug-using clients to become and remain abstinent (Bewley-Taylor, 1999).

Despite the dominance of American views on this subject, international practice in relation to such drug use was by no means homogeneous, and through much of the mid-twentieth century significant differences existed between the policy and practice of the USA and that of the United Kingdom. The so-called ‘British System’ of this period generally displayed greater flexibility and pragmatism, and specifically – in a way that would later be referred to as ‘harm reduction’ – permitted maintenance prescribing of opioids for patients for whom detoxification and abstinence proved unsuccessful (Strang & Gossop, 2005). While neuroscientists have argued in recent decades that ‘addiction is a brain disease’ (Leshner, 1997; Volkow & Li, 2004), critics of this perspective have challenged both its basic logic and its capacity to improve the status and quality of life of individuals with a substance use disorder (Davies, 2018; Hall, Carter, & Forlini, 2015); and to date few if any treatment innovations of a neurological kind have emerged from this ‘brain disease model of addiction’.

From the mid-1980s, now explicitly under the rubric of harm reduction, healthcare practice aimed at reducing health and social harms without necessarily keeping clients drug free became dominant internationally, as health services responded to the newly-identified human immunodeficiency virus (HIV) and the risk of its transmission between drug users who shared injecting equipment (Rhodes & Hedrich, 2010). During the first decade of the new millennium, however, formal drug policy making in many countries, particularly the United Kingdom, reverted to what was commonly, if ambiguously, referred to as a *recovery* perspective (HM Government, 2010; McKeganey, 2014; Scottish Government, 2008). Proponents of recovery were generally critical of harm reduction but particularly opposed to the use of methadone as a long-term substitution treatment for opioid dependency, arguing that the social reintegration of drug users was best served by a return to traditional abstinence-based approaches to addiction treatment (Best et al., 2010). Defenders of harm reduction, and of conventional methadone maintenance treatment in particular, have argued in response that this type of opioid substitution was supported by a compelling evidence base, that post-detoxification relapse was common and carried with it an unacceptably high risk of fatal overdose, and that a majority of opiate-dependent clients were characterised by such a wide range of personal and socioeconomic deficits that it was naïve to think that abstinence alone could guarantee social reintegration (Advisory Council on the Misuse of Drugs, 2015; Newman, 2005). The development, diffusion and political acceptance of the new recovery ideal (Duke, Her-ring, Thickett, & Thom, 2013; Neale, 2013; Thomas, Bull, Dioso-Villa, & Smith, 2019) have generally been viewed by policy analysts as a process marked by ideological contention and inter-stakeholder conflict rather than the consensual application of scientifically derived research evidence.

Drug policy in the Republic of Ireland

Prior to what epidemiologists referred to as the ‘opiate epidemic’ (Dean, O’Hare, O’Connor, Kelly, & Kelly, 1985) – clusters of injecting heroin use that emerged in 1979 in socioeconomically deprived areas of Dublin – Ireland had little or no experience of heroin use or of injecting drug use of any kind. As the 1980s progressed and as this wave of heroin use showed no sign of abating, Irish drug treatment services introduced a range of harm reduction strategies (including needle and syringe exchange, low-threshold support services and indefinite methadone maintenance), effectively bringing this country into line with similar developments internationally. Where Ireland differed from other countries was in the unusually covert way in which these changes in policy and practice were introduced. Eschewing all of the usual trappings of policy transparency – including public debate and consultation, widespread dissemination of policy proposals, and public announcement of final policy decisions – political leaders and public servants in Ireland pushed ahead with the introduction of harm reduction measures which, if publicised, were likely to be challenged, if not completely thwarted by a conservative electorate (Butler, 2002; Butler & Mayock, 2005).

As the new millennium progressed, a more transparent approach to drug policy making was introduced in Ireland, largely revolving around the publication of national drugs strategies and typically covering a seven-year period (Butler, 2007). A mid-term review of one such strategy in 2005 revealed a degree of public disquiet with methadone maintenance (Department of Community, Rural & Gaeltacht Affairs, 2005) comparable to the criticisms being voiced by recovery advocates in other jurisdictions, and this set in train a series of policy activities over the next decade aimed ostensibly at making ‘rehabilitation’ a central focus of Irish drug policy. These activities included the publication of: the *Report of the Working Group on Drug Rehabilitation* (Working Group on Drug Rehabilitation, 2007); the *National Drugs Rehabilitation Framework Document* (Doyle & Ivanovic, 2010); and the *Evaluation of the National Drugs Rehabilitation Framework Pilot* (Barry & Ivers, 2014). The fact that those involved in all of this policy activity chose to use the word ‘rehabilitation’, rather than ‘recovery’, may perhaps be seen as evidence of an ongoing determination on the part of political leaders and civil servants to avoid having Irish drug policy enmeshed in the kind of contention between recovery advocates and their critics that was a feature of policy debate elsewhere. It was not until 2017 that the word ‘recovery’ eventually appeared in a national strategy document, *Reducing Harm, Supporting Recovery – a health led response to drug and alcohol use in Ireland 2017–2025* (Department of Health, 2017).

These Irish drug rehabilitation documents, which are broadly similar in content to policy frameworks emanating from recovery advocates in other jurisdictions, may be summarised in terms of two main, overlapping themes. The first and arguably the dominant theme is that which makes continuous use of the spatial metaphor of ‘pathways’ or ‘integrated care pathways’, to suggest how users of Irish addiction services may be helped to move along a continuum and to make a journey towards recovery – which may or may not involve becoming abstinent. The second theme is that which deals with the importance of forms of service provision that are respectful of service users, treating them as equal partners with service providers in the planning and delivery of services.

The appeal of the pathways metaphor may be readily understood in the context of a parallel metaphor criticising methadone maintenance for keeping its clients ‘parked’ in ongoing addiction, with an overall poor quality of life and a stigmatised identity. However, the task of moving opiate-dependent clients along a pathway to social reintegration necessarily involves the cooperation of other services and agencies – in the fields of housing, education, training, employment and criminal justice – outside of the health sector, as well as the cooperation of the wider health system outside of specialist addiction services. It was envisaged that case managers from the addiction services would

coordinate the cross-sectoral responses necessary for the social reintegration of their clients. However, considerable doubt was cast on this difficult and ambitious scheme by the unannounced and unexplained dismantling – just as drug rehabilitation/ recovery was being made part of official Irish policy – of formal cross-cutting drug policy structures (Butler, 2007) that had been in place for more than a decade. Neither did it augur well that a national mental health policy document, *A Vision for Change: Report of the Expert Group on the Mental Health Policy* (Department of Health & Children, 2006), made it clear that mainstream mental health services were unwilling to accept any responsibility for addictions.

The suggestion that service users should be meaningfully involved in all aspects of their treatment is one that has been made not just in national drug strategies but in various other Irish policy documents. For instance, the clinical guidelines for opioid substitution treatment published by the Health Service Executive (HSE) in conjunction with the Irish College of General Practitioners, the Irish College of Psychiatry and the Pharmaceutical Society of Ireland (HSE, 2016: 11) describes service user involvement as follows:

Involving service users as active partners in their drug treatment is essential and is associated with better outcomes. Service users should be fully involved in the development of their care plans, setting appropriate treatment goals and reviewing their progress in treatment. It is also good practice to involve service users in the design, planning, development and evaluation of services, and in advocacy and support groups linked to local services.

By and large, however, empirical research to date has found little evidence that Irish drug treatment services have taken on board these recommendations. King (2011: 283), who conducted a qualitative study of methadone provision in an urban setting, concluded: “The principal finding of this study was that the policy rhetoric of service user involvement was not matched by the reality of service provision in the drug treatment systems investigated here”. Van Hout & McElrath (2012) explored a similar theme in relation to the potential of service user forums to involve clients in addiction treatment program developments in a rural area, but found that the mantra of service user participation was not matched by actual events and experiences. Studies of service users’ experience of methadone treatment in primary care setting in Ireland (Latham, 2012; O’Reilly, O’Connell, O’Carroll, Whitford, & Long, 2011) have reported satisfaction with individual prescribing practices but a more general feeling that the potential for greater service user participation – as reflected in policy statements – was not being realised.

These research findings are broadly similar to those documented in research internationally. Indeed, the findings of several qualitative studies make it clear that, whatever the research evidence of the value of methadone maintenance at a population health level, the subjective experience of its clients is at best *ambivalent* but more commonly negative (Conner & Rosen, 2008; Fraser, 2006; Fraser & valentine, 2008; Harris & McElrath, 2012; Neale, 1998; Van Hout & Bingham, 2011). While methadone clients frequently acknowledge the benefits they derive from treatment, they do not as a rule see themselves as ‘normal’ health service users who are availing of legitimate, evidence-based medicine.

It is against this policy background that the research reported in this paper was undertaken in one geographical location in the Greater Dublin Area. The overall aim of the study was to examine the experiences of individuals who are long-term participants in methadone maintenance treatment and this paper specifically aims to explore the degree to which the experiences of the study’s participants match up with Irish drug policy aspirations and goals. In other words, the findings presented examine the extent to which these clients view their interactions with addiction services as dynamic and progressive and as assisting them to move along a pathway to greater social reintegration and a generally enhanced quality of life.

Methods

The research was designed to examine the experiences and perspectives of individuals who are long-term participants in MMT¹ and was conducted in the Dun Laoghaire Rathdown area of South Dublin, in parts of which a high prevalence of drug problems has been recorded since the 1980s opiate epidemic (Dean, Smith, & Power, 1984). To be eligible for participation, individuals had to be: 1) over 18 years; 2) have accessed drug treatment for the first time at least 10 years prior to participating in the study and; 3) report at least one episode of opioid substitution treatment since they first accessed treatment. Interviewees were recruited through contact with specialist addiction clinics, community and voluntary addiction services, primary care settings and a supported temporary accommodation service. The research – and consequently, the recruitment process – was particularly focused on recruiting clients of specialist addiction services, which comprise a mix of larger addiction centres and satellite clinics (Farrell & Barry, 2010). Drug users who attend larger addiction centres typically have less stability in their lives than clients of MMT who attend primary care settings (Department of Health & Children, 2005).

Between August 2017 and February 2018, 25 clients of MMT were recruited to the study and, of these, 16 were male and nine were female. Thus, broadly mirroring the total clinic population (Health Research Board, 2018), approximately twice as many males as females participated. Twenty-two were clients of specialist addiction services and the remaining three attended a primary care setting. All interviews were scheduled in consultation with participants who nominated a time and location of their choice to meet, with most interviews conducted in a local community-based service setting ($n = 16$) and fewer taking place in the homes of participants ($n = 6$), a café ($n = 2$) or in the office of the researcher ($n = 1$). The interviews, which were audio recorded with participants’ consent, lasted for between one and two hours and a majority ranged in duration from between 60 and 80 min. Prior to commencing the interview the research aims were clearly explained and participants were encouraged to ask questions and to seek clarification on any issue. The confidentiality and anonymity protocols were outlined using plain language. Participants received a €25 gift voucher as a token of appreciation for their time. Ethical approval for the conduct of the research was obtained from the Research Ethics Committee, School of Social Work and Social Policy, Trinity College Dublin.

Data collection

The in-depth interview was used to explore a range of issues deemed relevant to understanding participants’ experience of MMT and commenced with the open-ended question, ‘Can you tell me a bit about your life at the moment?’. This initial question was designed to encourage participant comfort and to give respondents control over the issues that they deemed important in that moment. Following this opening question, several topics were targeted for discussion, including: current living situation and housing; education and employment history; drug use and drug treatment history; experiences of drug treatment; any difficulties or set-backs experienced; everyday life (daily routines, family and social relationships); physical and mental health; perceived social and

¹ The classification of ‘older’ people within drug treatment research is frequently defined by long histories of problematic drug use, typically commencing in the teenage years, meaning that an older user could be an individual in their 30s (European Monitoring System for Drug Use and Drug Addiction (EMCDDA), 2010). There is currently no agreed or standard definition of a long-term or ‘older’ drug user in treatment (Carew & Comiskey, 2018). Older drug users have been defined by some as persons ‘35 years old or older’ (Boeri, Sterk, & Elifson, 2008; Atkinson, 2016) while other research has classified ‘older’ as aged 50 and over (Beyon, Roe, Duffy, & Pickering, 2009; Doukas, 2017) or 45 years or more (Carlsen, Gaulen, Alpers, & Fjaereide, 2019). The stated cut-off point for older drug users is defined as 40 years by the EMCDDA (2010).

health care needs and; perspectives on the future. While strong attempts were made to address all of these topics with each respondent, this aim was balanced with flexibility in responding to and capturing personal perspectives and stories (Fraser & valentine, 2008; Neale, 1998). Thus, while the interview was topic-centred, it was fluid in structure (Mason, 2018), with respondents encouraged to speak openly and to discuss their views. Service users' experiences and perspectives were therefore at the core of the research interview, which sought to elicit detailed accounts of the lived experience of long-term MMT. At the end of the in-depth interview, a brief questionnaire was administered to record demographic details as well as data related to participants' housing, education, employment/sources of income, family (number and age of children and where they resided) and physical and mental health. This questionnaire was administered to aid the construction of a detailed sample profile.

Data management and analysis

All interviews were transcribed verbatim and checked for accuracy. Analysis was guided by a grounded theory approach (Charmaz, 2006), which is inductive in orientation, meaning that categories and sub-categories emerged from the data rather than determined *a priori*. Following a thorough review of a selection of the transcripts, 17 coding categories were used to organise the data into more manageable 'chunks' (Miles, Huberman, & Saldaña, 2014) using the qualitative data management software NVivo. To locate the analysis in participants' broader life experiences, a 'case summary' was prepared for each participant documenting key issues related to their drug use and drug treatment histories, experiences of MMT, their views and perspectives on MMT and the meanings participants attached to recovery. The analysis presented in this paper draws on three code books, including those labelled 'Positive aspects of MMT', 'Drug treatment experiences' and 'Perspectives on treatment and recovery'. Thematic analysis was used to interrogate, identify and organise significant patterns within these data (Braun & Clarke, 2006) and, throughout this process, individual case summaries were constantly revisited to allow relevant contexts to come into focus in the production of a situated analysis (Mason, 2018). Each participant was assigned a pseudonym and all possible identifiers, including the names of family members, friends, service professionals and places (neighbourhood locations, the names of services accessed and so on), were removed from the raw data. As a further measure to protect the anonymity of participants, an age range rather than precise age is used alongside the pseudonyms attached to the narrative excerpts presented in this paper.

Description of the sample

The average age for the sample was 43 years; eight were between 35 and 39 years (a majority of them 37 years or more), 14 were aged 40 to 49 years and the remaining three participants were aged 50+. All were Irish and of white ethnicity. Of the 25 individuals interviewed, 16 had first accessed MMT more than 20 years previously, with the average age of first entry to treatment being 23.9 years for the sample. At the time of interview, the vast majority ($n = 22$) were taking a daily dose of prescribed methadone and the average daily dose for the sample was 65.1 mgs. The highest daily dose reported was 135 mgs while the lowest was 2 mgs. Two participants were abstinent from all drugs, including methadone, for six and seven years, respectively.² However, many reported the current use of at least one substance apart from methadone. Some were using a single drug, including heroin ($n = 2$), benzodiazepines ($n = 5$) or cannabis ($n = 3$) while others reported the use of a combination of drugs, including heroin and benzodiazepines

² One of these participants had been in methadone treatment for a total of 17 years and the second for a period of 16 years.

($n = 3$) or cannabis and benzodiazepines ($n = 2$). Six participants stated that they were not currently using any substance apart from methadone while one did not disclose information about current use of substances other than methadone.

The educational attainment of participants was generally low. Six had no formal educational qualifications, having left the education system either during or shortly after their primary level schooling. More than half ($n = 13$) had progressed to Junior Certificate level (equivalent to O-level in the UK and Intermediate Certificate level in Australia) before leaving secondary education at age 15 approximately for a range of reasons, including to take up employment, due to expulsion, upon learning of a pregnancy or because of problems related to addiction or homelessness. Just one participant had completed secondary-level education while a small number of others ($n = 3$) had obtained a third-level qualification. One participant had returned to education as a mature student and obtained a postgraduate degree. At the time of interview, only three participants – all female – were employed full-time and the vast majority ($n = 21$) were reliant on social welfare payments.

Finally, just under half ($n = 12$) were securely housed and living in local authority (council) housing ($n = 7$), housing provided by a not-for-profit organisation ($n = 2$) or in private rented housing ($n = 2$) while one lived in a privately owned home. The remaining participants lived in the home of a family member ($n = 5$), in transitional homeless accommodation ($n = 7$) and one was couch surfing. Over half of the study's participants ($n = 14$), the majority of them male ($n = 10$), had experienced homelessness at some point in their lives.

Findings

The vast majority of study participants reported that methadone treatment had impacted their lives positively in at least one respect. These accounts focused on three perceived positive ramifications, the most commonly stated benefit being that methadone brought stability and normality to their lives. Participants regularly referred to ways in which daily life had become more manageable, often drawing attention to feeling a renewed sense of personal purpose.

And look where it [methadone] led me ... it led me to good places ... and getting some real stability in my life and being able to be useful again in society and in the community because I did do a lot of damage as an addict in the community (Ronnie, age 45–49).

For a considerable number, the stability brought about by methadone treatment meant that they could engage more positively with their families and children³ and take responsibility for everyday tasks that had previously presented significant challenges. These participants emphasised their greater ability to fulfil their roles as family members and/or parents.

Yeah, it's [methadone] kind of settled me. I found that I was better at the house and better looking after the kids and more settled ... rather than being disorganised, you know. I was making dinner, everything was just normal, you know. What I classed as just normal to me ... not wanting to use all the time and just trying to have a normal family life with the kids (Yvonne, age 40–44).

A second benefit – referred to by male participants in particular – was associated with stability but related specifically to a reduction in criminal activity and criminal justice contact. For Stephen, "normal" functioning meant less "strife" because he no longer had to steal to finance his drug use.

³ A majority ($n = 18$), including nine women and nine men, had children. Over half had one or two children ($n = 10$) and the remaining participants were parents to three ($n = 6$) or four ($n = 2$) children. Participants' children ranged in age from three to 26 years.

Yeah, it's [methadone] very beneficial – you've less strife in your life, it brings a bit more normality back into your life. You can function normally without fucking robbing a shop just to get a fix (Stephen, age 40–44).

The third significant benefit identified by respondents related to health gains attributed by them to MMT. Participants in this study had typically accessed treatment at a point when the quality of their lives had deteriorated dramatically; heroin use, and the demands of securing a supply of the drug to avoid withdrawal symptoms, had also taken a serious toll on their physical and psychological health. Several noted improvements in their health, sometimes contemplating what may have transpired had they not engaged in treatment.

Maybe the maintenance did save my life? I don't know? Maybe if I had kept using drugs I probably would have HIV now – 'cos I have hepatitis C – I could have full blown AIDS. I could be dead, I probably would be dead (Craig, age 35–39).

Thus, accounts of the perceived benefits of methadone focused, in the main, on some element or elements of transformation in their lives, often associated with a release from the demands of illicit drug use and the introduction of stability and normality. However, while acknowledging one or a number of benefits, a complex constellation of negative perspectives were recounted. The remainder of this section seeks to unpack participants' accounts of the lived experience of methadone treatment, which focused heavily on stagnation and the absence of a path to 'recovery' and meaningful participation. Temporality was at the centre of these accounts; over time, clients of MMT increasingly questioned the role and place of methadone treatment in their worlds and, in particular, the extent to which it enabled the achievement of broader personal goals related to participation, reintegration and a sense of belonging in their communities.

Lives on hold

While gaining stability was a primary perceived benefit of methadone treatment, this positive consequence was almost always juxtaposed with a characterisation of methadone as constraining or controlling core functions, with attention frequently drawn by participants to the suppression of emotions and a general inability to move forward with their lives: "It's like it [methadone] weighs you down, like mentally and physically" (Bernie, age 40–44). Dillon described methadone as "stalling" but not "fixing" the problem, arguing that methadone maintenance was a 'place' where progress did not materialise for most.

... but like the phy⁴ [methadone], it's only stalling the problem, it's not fixing it. It's only just keeping it at a certain stage, it's not getting any better, you know what I mean. I just feel like the phy is holding everyone (Dillon, age 35–39).

Dillon's depiction of methadone as "holding everyone" was expressed – albeit in different ways – by many others. At the core of these narratives was a perceived absence of a path, with a large number articulating a sense of being 'stuck' or trapped in a cycle that did not lead to progress or change. For Yvonne, a mother who attributed her vastly improved family situation and relationships to MMT, methadone represented a "ball and chain", its meaning tightly bound to stagnation.

It [methadone] represents to me a ball and chain, a ball and chain. Liquid handcuffs we like to call it. To me it represents stagnant, no change (Yvonne, age 40–44).

⁴ A large number of the study's participants used the term 'phy' – an abbreviation for physeptone – when they referred to methadone. While physeptone was the first opiate or opiate substitute drug used by a number, this was not in fact the case for a majority of participants. It appears, therefore, that the use of this street term or colloquialism has endured, certainly among the 'older' opiate treatment population.

When discussing daily life as a methadone user, Conor also used the term "liquid handcuffs". Takeaway arrangements had eased the "daily grind" of clinic attendance but he nonetheless felt constrained by the weekly regime of methadone maintenance.

And then it starts again – Friday, Saturday, Sunday, Monday, Tuesday – then attend [the clinic] on Wednesday. So, twice a week go to the chemist. But it's taken me years to get to that stage, years to get off the daily grind of every day, right? But the reality is that it's like liquid handcuffs. You're chained to that ... (Conor, age 35–39).

Conor went on explain that he understood the context and rationale for the introduction of MMT but asserted that it left "addicts" with no choice. His reference to the term "lifer" highlights a perceived inevitability of MMT as unending.

It shouldn't happen, to be honest with you. I understand the AIDS thing and all and that they needed to come up with something. But it just put it on ice, it did, and now it's, it's fucking being abused. In the worst way. It's left addicts with like, with no choice ... you go on methadone and you're a lifer then, you know (Conor, age 35–39).

Embedded in very many accounts were references to the constraints that methadone imposed, which had symbolic as well as material significance. One of 16 participants who first accessed treatment more than 20 years previously, Bernie felt "hostage" to MMT and described a routine of being "oiled up" in order to start her day.

But like, it's like you're held hostage by this green substance ... and you don't even know what's in it. How can I say it feels? Like the Tin Man out of the Wizard of Oz that has to be oiled up every day. Like, to me, methadone is like you take it before the start of your day. Like the Tin Man has to take his oil before he starts his day (Bernie, age 40–44).

The 'Tin Man' metaphor is a powerful one, used by Bernie to convey the enduring bind of the daily dose. The perceived constraints imposed by MMT were spontaneously mentioned by many others and likened by Richie to a life of confinement: "... it's not a life ... it's like I'm still in prison. I have to go and collect my phy [methadone] every morning ... I can't plan anything because of it" (Richie, age 40–44). As respondents related their experiences, they tended to focus on the present but most also talked about the future, often articulating a sense of the unknown. Very many wanted to escape the routine of methadone treatment but almost always expressed doubt about whether that aspiration could be realised. References to growing older featured centrally in these accounts, as did feelings of anxiety and fear and, at times, expressions of anger.

I've been on it [methadone] for that long. Ok, I've worked but a lot of it has been drugs, drug, drugs. And I know there's more to life out there than drugs ... I don't want to be 50, 60 years old on methadone (Danny, age 40–44).

Well I always thought that it [methadone] was going to be a temporary thing ... I never envisaged it as being as long as it is and I'd say I'm going to be on it for the foreseeable future. I just can't see a [pause] ... anything changing. A lot of just cynical anger sometimes (Lorraine, age 40–44).

Lack of autonomy and control within the treatment setting

While participants' accounts drew strong attention to the impact of methadone, as substance and 'substitution', on their everyday lives, a majority also identified a host of negative experiences associated with the clinical experience of MMT. For the sample as a whole, accounts of 'the clinic' and associated methadone dispensing systems were negative, highlighting practices perceived by them as undermining their autonomy and ability to have a say in their treatment. A large number depicted the treatment experience as instrumental rather than caring, often describing their interactions with prescribing physicians – commonly referred to as "methadone doctors" – as focused solely or primarily on the substitute drug or 'script'. Encounters with health profession-

als were brief and did not, in the main, incorporate discussion of their broader personal and social circumstances or any issues or challenges they may be facing.

Now don't get me wrong, there are nice people that work in the clinic ... But they're just kind of getting the job done, that's it. Like, not much interaction or anything. It's just literally like, 'Here for your methadone, there's your script, go over there, do that, do your urine, bye'. That's really the way the clinics are (Rachel, age 40–44).

Participants appeared to have limited input into the course of their treatment and of particular note was their constrained ability to influence their treatment plan. Most had entered into MMT with the expectation that they would attempt to 'come off' the substance at some point but learned that this aspiration or goal was strongly discouraged.

Not once have I heard a doctor encourage me to come off methadone. Even when I was wanting to come off I was actually told that I couldn't (Dillon, age 35–39).

You're sort of going through the motions, but getting someone off, you'd imagine the treatment services, well in my mind, should be there to get somebody eventually leading a drug free life (Lorraine, age 40–44).

Participants also described many barriers to negotiating specific aspects of their treatment. For example, several told that they had, on numerous occasions, requested a reduction in their daily dose but that this request was viewed negatively or refused without a full or detailed discussion of the pros and cons of embarking on such a path. Others reported feeling side-lined or dismissed when they requested a dose reduction. Indeed, a large number of participants were critical of what they described as regular offers on the part of their prescribing physicians to have their daily dose increased but with no mention or discussion of a dose reduction.

Like I see [prescribing physician] once a week or whatever. But all they seem to do is just, 'You alright? Do you want to go up [increase the dose]?', you know what I mean, 'Do you want to go up?'. And you're telling them, 'No, I don't even want to be on the fucking thing and you're asking me do I want to go up' (Conor, age 35–39).

I'm on methadone because I want to be clean ... so why can't they just trust that I'm doing it? Say that I'm doing it and let me do it and push for me to do it, instead of keep saying every week, 'Oh, do you want me to put you up'. Not, 'Why didn't you sleep?' or 'You didn't sleep because you have a lot on your mind or you're stressed'. Everything is just, 'Oh, we'll just put you up' (Yvonne, age 40–44).

Yvonne was not alone in referring to the matter of trust. Several others explained that the trust of prescribing physicians had to be earned and was associated primarily with providing 'clean' urines. Many struggled to establish and maintain a trusting relationship with their prescribing doctor and, over time, also learned that trust could be abruptly withdrawn, which had implications for the granting or continuation of certain privileges, particularly those related to takeaway doses.

Yeah, giving urines about three times a week, two times a week, one time a week ... My doctor would say, 'If you're not clean in two weeks, that's it, you're back on dailies' (Chris, age 35–39).

I think I gave one dirty urine and the doctor was saying, 'Oh, I don't think this is going to work out, I think we just have a personality clash and I think you'd be better off on a [larger addiction] clinic' (Leanne, age 40–44).

Thus, rather than seeing themselves as included in the planning of their treatment, this study's participants felt alienated, often fearing the potential negative ramifications of providing a 'dirty' urine sample. More broadly, several asserted that their knowledge about their personal situations and their bodies was not considered or acknowledged.

These respondents felt that assumptions were made about their lives and decision-making capacities.

Like the doctor will put me up as high as I want, but when I start questioning, 'Doctor, can I go down a bit?', it's like, 'Why would you want to go down? What makes you think that?' It's crazy and the doctors trying to tell you, an addict who knows his own body, and they're telling you how you feel (Cormac, age 35–39).

They're giving out maintenance too quick. Maintenance and that's it. It's not asking, 'What do you think?' (Craig, age 35–39).

These accounts highlight the extent to which participants felt that they had no say in their current or future treatment and also reveal the role played by their relationships with their prescribing physician in shaping their perspectives on methadone. By and large, participants depicted treatment as a dispassionate instrument that dispensed methadone without any consideration of the broader social, emotional or health care needs of its patients. Perceptions of any sense of progress along a pathway to recovery were largely absent and, instead, participants felt unable to exert control over their treatment.

A life beyond 'the script'?

The sense of stasis articulated by service users when they discussed the experience of methadone treatment was mirrored, to a large extent, in their accounts of everyday life. As stated earlier, most were unemployed at the time of interview. Furthermore, very few were seeking employment because they felt that, with low educational qualifications, they had little or no prospect of getting a job. Other barriers to labour market participation included the challenge of potentially having to balance the demands of MMT with those of maintaining employment: "If you're on methadone you need to take time off to get your script, to go to the chemist, you know, and these cause terrible issues" (Catherine, age 40–44). Participants also expressed concerns about the perspectives and assumptions of prospective employers, particularly in the event of them becoming aware of their drug use history and participation in MMT.

And then you're thinking like, 'What if they ask for a medical?'. Even though they don't know me, there is a stigma straight away, like who wants to employ someone who is on methadone? (Bernie, age 40–44).

Labour market engagement was generally perceived as out of reach and observed by a number to be the exception rather than the rule for clients of methadone maintenance treatment.

One or two will cross over and get jobs or whatever but the majority of people are being kept in the same place for years (Dillon, age 35–39).

A large number of participants depicted everyday life as difficult and, very often, as lacking or devoid of meaningful interaction with others. Many appeared to have few, if any, dependable or trusted people in their lives.

I mean, trust-wise I'm not one for trusting people much myself, I've got a few issues around that ... Friends-wise I would have one person I would consider a real friend. The rest are sort of people you met through drugs and stuff so I wouldn't consider them close friends (Alvin, age 40–44).

Family relationships and ties were often tenuous and a considerable number expressed feelings of shame over family ruptures associated with their past drug use. Family members were not generally viewed as available or in a position to provide social or emotional support and, even when relationships had improved, they were frequently described as distant or superficial.

I've three sisters, but I wouldn't have any relationship. I mean I do talk to them, I say, 'Hello, how are you? How's things?'. I wouldn't visit them, they wouldn't visit me. But when I see them I'm polite to them and they are to me and they say, 'How are you?', 'How's the kids? Great', that's it (Christine, age 50–54).

Having and maintaining friendships also posed challenges since practically all felt a need to dissociate from individuals who belonged to their former circle of drug using peers. Particularly in more recent years, a large number had experienced bereavement associated with the death of friends, leading to sadness and also generating feelings of anxiety and stress. Thus, friendship was a complicated ‘space’ for many; its meaning closely connected to prior drug use contexts and interactions as well as to loss and bereavement. Forming new relationships and friendships was often perceived as daunting, leading many to withdraw from social relationships.

No, I don't have friends. The only social thing I do is go to the gym twice a week. I don't go out at the weekends, I don't go out drinking, I don't meet people for dinner ... I couldn't say to you, 'Oh Mary's my friend', because I don't have a Mary, you know (Christine, age 50–54).

The extent to which the study's participants described daily lives characterised by seclusion and loneliness was striking. A strong sense of social anxiety emerged from their accounts, sometimes linked to shame but, more frequently, because they did not feel a sense of belonging in their communities. Alvin told that he spent a lot of time “hiding away”, explaining that he found it “pretty hard to reintegrate into normal society”. He had few social connections and, like many others, tended to self-isolate.

I would go fishing during the summer, I do a bit of fishing ... Other than that I sort of isolate myself a bit, I'm not one for hanging around on the streets. The way I look at it I've done enough of that over the years, you know. So other than that and visiting the brother at the weekends I wouldn't really be out and about much (Alvin, age 40–44).

Growing older as a long-term client of MMT amplified feelings of marginality, making social interaction more difficult. Participants' accounts of their daily lives, experiences and relationships strongly suggest that they were isolated rather than socially integrated. A majority had multiple unmet needs related to education and employment and also reported social and emotional challenges that presented strong barriers to social participation.

Discussion

Participants in this study, while acknowledging some of its advantages, were predominantly negative about the experience of long-term methadone maintenance. By and large, they saw themselves as passive recipients of a clinical regime that offered no opportunity to express their viewpoints or to exercise agency in relation to their ongoing treatment. Those who aspired to reducing their daily methadone dose or becoming drug free reported not merely that they were not assisted in striving towards these goals, but that clinicians did not permit them to discuss such an aspiration. Consistent with the findings of previous research that has examined patient experiences and perspectives on MMT (Conner & Rosen, 2008; Fraser & valentine, 2008; Harris & McElrath, 2012; Van Hout & Bingham, 2011), a majority described methadone treatment in terms of stasis or confinement; a perspective often expressed as comparable to being “a lifer” or occupying a “holding space”. Particularly over time and with advancing age, MMT represented a “ball and chain”; its meaning tightly bound to stagnation and to a perceived absence of alternatives to a life defined by the use of a substitute drug. Neither did this study's participants report any progress in attaining the kind of social reintegration that is commonly presented as a key aspect of recovery and, instead, continued to experience the same level of social and economic exclusion that characterised their lives prior to entering treatment. These findings – and the fact that this study's service users had no meaningful involvement in their treatment – point to a strong disconnect between Irish drug policy aspirations and goals and the lived reality of long-term methadone treatment.

Lancaster's (2017: 758) suggestion that “[t]reatment services do not simply treat a group of marginalized and stigmatized clients; rather,

treatment practices can confirm and reproduce these identities” seems to be especially apt in relation to the participants in the present study. The fact that these MMT clients were being treated in specialist addiction clinics as opposed to general medical practice settings – which, as noted earlier, was the case for almost two-thirds of MMT clients in Ireland when data collection for this project took place (Health Research Board, 2017) – is itself indicative of a failure to progress these patients along a path that supports them to transition to more normalised treatment settings. In the Australian context, Fraser (2006: 200) has described MMT clients as caught in the ‘chronotope of the queue’, suggesting that the demands of the clinic “reproduce rather than depart from the model of waiting and dependence widely seen as characteristic of lifestyles associated with regular heroin use”. This study's participants similarly depicted themselves as suspended in time and space, within a set of allegedly therapeutic practices and systems that ultimately served to confirm and reinforce their status as deviant and unproductive. And, whether consciously or unconsciously, most appeared to refute the utopian rhetoric of ‘pathways’ and ‘progression’ that has dominated recent Irish drug policy documents; perhaps understandably, since they did not perceive themselves as progressing along a path to recovery. Finally, Fomiatti's (2020: 1) critique of “normative fantasies of healthy society and citizenship” in the context of community reintegration of clients of drug treatment systems seems highly relevant to this study's methadone clients, who reported rejection and stigmatisation both within healthcare service systems and the wider community settings where these services are located. There are obvious parallels to be drawn with the international experience of mental health service developments, where hoped for therapeutic advances based on neuroscience have largely failed to materialise and where simple faith in ‘community care’ has proven illusory (Scul, 2019); unpalatable as it may be, healthcare systems are frequently confronted with the fact that the community simply does not care.

International perceptions of the appropriate role for healthcare systems in the societal management of drug problems – and in particular opiate-related drug problems – have shifted periodically across the last century, reflecting varying political cultures, professional interests, and concerns with wider health and social problems as much as scientific and technical advances in addiction treatment (Berridge, 2012). As relative newcomers to this scene, Irish policy makers have, over the past forty years, tended towards a cautious avoidance of anything that might provoke public controversy or contention. The covert implementation of harm reduction strategies described earlier – that began during the 1980s and 1990s in the context of an opiate epidemic – was a pragmatic policy response that recognised the effectiveness of such interventions as methadone maintenance (Ward, Mattick, & Hall, 1998), while simultaneously seeking to avoid any political difficulties that might arise from a conservative electorate likely to regard such strategies as unacceptably tolerant of rule-breaking citizens (Butler & Mayock, 2005). Conversely, more recent and much-publicised national drug policy documents extolling the desirability of ‘rehabilitation’ (generally referred in other jurisdictions as ‘recovery’) have been largely aspirational (Barry & Ivers, 2014) and have had no discernible success in their attempts to deliver a broader package of community supports – in such areas as housing, education and training, employment, and physical and mental health – that international commentators argue are essential prerequisites for recovery from addiction (McKay, 2017; Neale et al., 2014).

It perhaps comes as no surprise that Irish versions of the ‘recovery’ concept have not delivered improved outcomes for opiate-dependent clients who, like their international counterparts, come from backgrounds characterised by multiple deprivations and difficulties. As described earlier in this paper, Irish recovery aspirations were first articulated at a time when ‘cross-cutting’ drug policy structures were being abandoned, service budgets were experiencing major cuts and the adult mental health system was emphatic in its rejection of having any responsibility for the management of addiction. If Irish methadone treatment clients are to be helped to move along pathways to an improved quality

of life, whether or not this involves abstinence, it would seem that a new and more realistic policy – to replace the recovery/rehabilitation framework – is urgently needed.

Declarations of Interests

The authors have no conflicts of interest to declare.

References

- Advisory Council on the Misuse of Drugs (2015). How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? (Letter to Rt. Hon. Mike Penning, MP, Minister for Policing, Crime and Criminal Justice). London: Home Office. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/470399/ACMD_RC_OPTIMISING_OST_REPORT_231015.pdf
- Atkinson, C. (2016). *Service responses for older high-risk drug users: A literature review*. Glasgow: The Scottish Centre for Crime & Justice Research.
- Barry, J., & Ivers, J. (2014). *Evaluation report of the national drugs rehabilitation framework pilot*. Dublin: Department of Public Health and Primary Care, Trinity College Dublin Retrieved from <http://www.drugs.ie/NDRICdocs/Evaluation%20Report%20of%20the%20National%20Drugs%20Rehabilitation%20Framework%20Pilot.pdf>.
- Berridge, V. (2012). The rise and fall of recovery in drug policy. *The Lancet*, 379, 22–23.
- Best, D., Bamber, S., Battersby, A., Gilman, M., Groshkova, T., Honor, S., et al. (2010). Recovery and straw men: An analysis of the objections raised to the transition to a recovery model in UK addiction services. *Journal of Groups in Addiction and Recovery*, 5, 264–288.
- Bewley-Taylor, D. (1999). *The United States and international drug control* (pp. 1909–1997). London: Pinter.
- Beyon, C. M., Roe, B., Duffy, P., & Pickering, L. (2009). Self reported health status, and health service contact, of illicit drug users aged 50 and over: A qualitative interview study in Merseyside, United Kingdom. *BMC Geriatrics*, 9(45), 10.1186/1471-2318-9-45.
- Boeri, M. W., Sterk, C. E., & Elifson, K. W. (2008). Reconceptualizing early- and late-onset: A life course analysis of older heroin users. *The Gerontologist*, 48(5), 637–645.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.
- Butler, S. (2002). The making of the methadone protocol: The Irish system? *Drugs: Education, Prevention and Policy*, 9, 311–324.
- Butler, S. (2007). Rabbit revisited: The first report of the ministerial task force on measures to reduce the demand for drugs – ten years on. *Administration*, 55, 125–144.
- Butler, S., & Mayock, P. (2005). 'An Irish solution to an Irish problem': Harm reduction and ambiguity in the drug policy of the Republic of Ireland. *International Journal of Drug Policy*, 16, 415–422.
- Carew, A. M., & Comiskey, C. (2018). Treatment for opioid use and outcomes in older adults: A systematic literature review. *Drug and Alcohol Dependence*, 182(Suppl C), 48–57.
- Carlsen, S-E. L., Gaulen, Z., Alpers, S. E., & Fjaereide, M. (2019). Beyond medication: Life situation of older patients in opioid maintenance treatment. *Addiction Research & Theory*, 27(4), 305–313.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.
- Conner, K. O., & Rosen, D. (2008). You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population. *Journal of Social Work Practice in the Addictions*, 8, 244–264.
- Davies, J. (2018). Addiction is not a brain disease. *Addiction Research & Theory*, 26(1), 1–2.
- Dean, G., O'Hare, A., O'Connor, A., Kelly, M., & Kelly, G. (1985). The opiate epidemic in Dublin, 1979–1985. *Irish Medical Journal*, 78, 107–116.
- Dean, G., Smith, R., & Power, B. (1984). *Heroin use in a Dun Laoghaire borough area 1983–84*. Dublin: The Medico-Social Research Board. Retrieved from <https://www.drugsandalcohol.ie/5331/1/1442-014HeroinUse.pdf>.
- Department of Community, Rural and Gaeltacht Affairs. (2005). *Mid-term review of the national drugs strategy 2001–2008*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
- Department of Health and Children. (2005). *Review of the methadone treatment protocol*. Dublin: Department of Health and Children Retrieved from http://www.drugs.ie/resourcesfiles/ResearchDocs/Ireland/2005/methadone_review.pdf?direct=1.
- Department of Health and Children. (2006). *A vision for change: Report of the expert group on mental health policy*. Dublin: Stationery Office Retrieved from <https://www.hse.ie/eng/services/publications/mentalhealth/mental-health—a-vision-for-change.pdf>.
- Department of Health. *Reducing harm, supporting recovery: A health-led response to drug and alcohol use in Ireland* (pp. 2017–2025). (2017). Dublin: Department of Health. Retrieved from <https://health.gov.ie/wp-content/uploads/2018/07/Reducing-Harm-Supporting-Recovery-2017-2025.pdf>.
- Doukas, N. (2017). Older adults prescribed methadone for opiate replacement therapy: A literature review. *Journal of Addiction and Preventive Medicine*, 2(1), 109. 10.19104/japm.2017.109.
- Doyle, J., & Ivanovic, J. (2010). *National drugs rehabilitation framework document. National drugs rehabilitation implementation committee*. Dublin: Health Service Executive. Retrieved from <http://www.drugs.ie/NDRICdocs/ndframework.pdf>.
- Duke, K. (2012). From crime to recovery: The reframing of British drugs policy. *Journal of Drug Issues*, 43(1), 39–55.
- Duke, K., Herring, R., Thickett, A., & Thom, B. (2013). Substitution treatment in the era of "recovery": An analysis of stakeholder roles and policy windows in Britain. *Substance Use and Misuse*, 48, 966–976.
- European Monitoring Centre for Drugs and Drug Addiction. (2010). *Treatment and care for older drug users*. Luxembourg: Publications Office of the European Union.
- Farrell, M., & Barry, J. (2010). *The introduction of the opioid treatment protocol*. Dublin: Health Service Executive. Retrieved from http://www.drugs.ie/resourcesfiles/research/2010/Opioid_Treatment_Protocol.pdf.
- Fomiatti, R. (2020). 'It's good being part of the community and doing the right thing': (Re)problematizing 'community' in new recovery-oriented policy and consumer accounts. *International Journal of Drug Policy*, 80. 10.1016/j.drugpo.2019.04.007.
- Fraser, S. (2006). The chronotope of the queue: Methadone maintenance treatment and the production of time, space and subjects. *International Journal of Drug Policy*, 17, 192–202.
- Fraser, S., & valentine, k. (2008). *Substance & substitution: Methadone subjects in liberal societies*. New York: Palgrave Macmillan.
- Hall, W., Carter, A., & Forlini, C. (2015). The brain disease model of addiction: Is it supported by the evidence and has it delivered on its promise? *Lancet, Psychiatry*, 105–110.
- Harris, J., & McElrath, K. (2012). Methadone as social control: Institutionalized stigma and the prospect of recovery. *Qualitative Health Research*, 22, 810–824.
- Health Research Board National Drugs Library (2018). Treatment data tables. Retrieved from <http://www.drugsandalcohol.ie/treatment-data/>
- Health Research Board (2017). Drug treatment in Ireland NDTRS 2010 to 2016. Retrieved from <https://www.drugsandalcohol.ie/28986/>
- Health Service Executive. (2016). *Clinical guidelines for opioid substitution treatment*. Dublin: Health Service Executive Retrieved from <https://www.hse.ie/eng/services/publications/primary/clinical-guidelines-for-opioid-substitution-treatment.pdf>.
- HM Government. (2010). *UK drug strategy 2010. Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life*. London: Home Office.
- King, A. (2011). Service user involvement in methadone maintenance programmes: The 'philosophy, the ideal and the reality'. *Drugs: Education, Prevention and Policy*, 18, 276–284.
- Lancaster, K. (2017). Commentary on McKay (2017). *Addiction*, 112, 758–759.
- Lancaster, K., Duke, K., & Ritter, A. (2015). Producing the 'problem of drugs': A cross national-comparison of 'recovery' discourse in two Australian and British reports. *International Journal of Drug Policy*, 26(7), 617–625.
- Lancaster, K., Seear, K., & Treloar, C. (2015). Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects. *International Journal of Drug Policy*, 26(12), 1198–1206.
- Latham, L. (2012). Methadone treatment in Irish general practice: Voices of service users. *Irish Journal of Psychological Medicine*, 29, 147–156.
- Leshner, A. (1997). Addiction is a brain disease and it matters. *Science*, 278, 45–47.
- Mason, J. (2018). *Qualitative researching* (3rd Ed.). London: Sage.
- McKay, J. (2017). Making the hard work of recovery more attractive for those with substance use disorders. *Addiction*, 112, 751–757.
- McKeganey, N. (2014). Clear rhetoric and blurred reality: The development of a recovery focus in UK drug treatment policy and practice. *International Journal of Drug Policy*, 25, 957–963.
- Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd Ed.). Thousand Oaks, CA: Sage.
- Moran, L., Keenan, E., & Elmasharaf, K. (2018). Barriers to progressing through a methadone maintenance treatment programme: Perspectives of the clients in the Mid-West of Ireland's drug and alcohol services. *BMC Health Services Research*, 18(911), 1–15.
- Neale, J. (1998). Drug users' views on prescribed methadone. *Drugs: Education, Prevention and Policy*, 5, 33–45.
- Neale, J. (2013). Commentary on substitution treatment in the era of "recovery": An analysis of stakeholder roles and policy windows in Britain. *Substance Use and Misuse*, 48, 1059–1060.
- Neale, J., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Strang, J., et al. (2014). How should we measure addiction recovery? Analysis of service provider perspectives using online Delphi groups. *Drugs: Education, Prevention and Policy*, 21(4), 310–323.
- Newman, R. (2005). Comment on 'What are drug users looking for when they contact drug services: Abstinence or harm reduction?' *Drugs: Education, prevention and policy*, 12, 265–266.
- O'Reilly, F., O'Connell, D., O'Carroll, A., Whitford, D., & Long, J. (2011). Sharing Control: User involvement in general practice based methadone maintenance. *Irish Journal of Psychological Medicine*, 28, 129–133.
- Rhodes, T., & Hedrich, D. (Eds.). (2010). *Harm reduction: Evidence, impacts and challenges*. Lisbon: European Monitoring Centre on Drugs and Drug Addiction. Retrieved from file:///C:/Users/pmayock/Downloads/EMCDDA-monograph10-harm%20reduction_final.pdf.
- Scottish Government. (2008). *The road to recovery: A new approach to Scotland's drug problem*. Edinburgh: The Scottish Government.
- Scull, A. (2019). *Psychiatry and its discontents*. Oakland, California: University of California Press.
- Strang, J., & Gossop, M. (2005). *Heroin addiction and the British system: Volume 11, treatment and policy responses*. London: Routledge.
- Thomas, N., Bull, M., Dioso-Villa, R., & Smith, K. (2019). The movement and translation of drug policy ideas: The case of 'new recovery'. *International Journal of Drug Policy*, 73, 72–80.

- Van Hout, M. C., & Bingham, T. (2011). *Holding pattern: An exploratory study of the lived experiences of those on methadone maintenance in Dublin North East*. Dublin: Dublin North East Drugs Task Force Retrieved from https://www.drugsandalcohol.ie/16231/1/Van_Hout_Bingham_Dublin_North_East_report_Holding_Pattern_%282%29.pdf.
- Van Hout, M. C., & McElrath, K. (2012). Service user involvement in drug treatment programmes: Barriers to implementation and potential benefits for client recovery. *Drugs: Education, Prevention and Policy*, 19, 474–483.
- Volkow, N., & Li, T. (2004). Drug Addiction: The neurobiology of behaviour gone awry. *Nature Reviews Neuroscience*, 5, 963–970.
- Ward, J., Mattick, R., & Hall, W. (1998). *Methodone maintenance treatment and other opioid replacement therapies*. Amsterdam: Harwood.
- Working Group on Drugs Rehabilitation. (2007). *National drugs strategy 2001–2008: Rehabilitation. Report of the working group on drugs rehabilitation, May 2007*. Dublin: Department of Community, Rural and Gaeltacht Affairs. Retrieved from <http://www.drugs.ie/NDRICdocs/Report%20of%20the%20Working%20Group%20on%20Drugs%20Rehabilitation%202007.pdf>