What enhances the formation of social bonds & facilitates better engagement & retention in an addiction service?

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Executive Summary

Purpose of the Study

The purpose of the research was to explore if there are key skills that staff members at the STAR Project Ballymun use or particular ways that they relate to service users which help with the formation of social bonds, which in turn leads to increased levels of service user engagement and retention. This summary presents the main findings and recommendations. Data for the study was collected through a literature review, ethnographic observation, interviews and focus groups; this included 60 hours of observation, 17 individual interviews and 2 focus groups with staff and service users.

Philosophical Position

The findings showed that STAR is very successful at engaging and retaining service users and it is their ability to form strong social bonds which is the key to its success. This is achieved through the philosophy of the project which is made up of three central tenets: a non-punitive approach, person-centred care and trauma informed care. The person-centred care approach facilitates the formation of a partnership between staff and service users in which they work together to achieve personalised recovery goals unique to each individual service user. The non-punitive approach stipulates that service users are not punished or judged for having a relapse, which results in the reduction of shame and the promotion of honesty. This non-punitive stance is experienced by service users as facilitative to their recovery, with some participants reporting that this approach was less evident in other models of addiction treatment. Trauma Informed Care allows service users to seek appropriate treatment for any possible underlying issues they may have, allowing them to fully engage in the service. The three interrelated strands of STAR's philosophy produce an approach to the treatment of substance misuse that is considered to be unique and different to many mainstream addiction models and provides a platform for the formation of social bonds.

Therapeutic Alliance

The philosophy also shapes therapeutic alliance, cohesion between service users, a safe environment and the staffs' approach to service provision, each of which in turn aid the formation of social bonds. There was evidence of strong therapeutic alliances in the project and as a lone factor it has been shown to be a significant predictor of treatment adherence and

retention in substance abuse health care. The staff place a considerable focus on the formation of an early therapeutic alliance which has been shown to predict both service user engagement and post-treatment substance-use outcomes. They do this through adopting a personal, respectful and collaborative approach to formal interactions such as assessments, which has the added benefit of reducing anxiety. Staff also place an emphasis on building trust and a strong connection with service users which they achieve through maintaining a non-judgemental approach, promoting mutuality and actively listening to service user narratives and feedback.

A Cohesive Group

Group cohesion is the attachment of the service users to the group as a whole and has been identified as one of the most important therapeutic factors in group therapy; the data showed service users at STAR to be a united and cohesive group. Service users used phrases such as '*no cliques'* and '*family atmosphere'* to describe their group; they also include staff in this group as they perceive them as '*equals*'. Additionally, their interactions with each other were characterised by a non-judgemental approach indicative of learning from experience and constant peer-support. A supportive atmosphere is an integral cog in the workings of an addiction service; research has shown that services which provide an engaging and supportive environment, in which service users form constructive relationships, produce better long-term outcomes.

A Safe Haven

The 'safe haven' or safe environment and atmosphere at the project is an important feature which aids the formation of these socials bonds. Essentially the service users see STAR as a safe place free from outside influence, triggers and judgement. Staff and service users share responsibility for maintaining this safety through the upholding of rules around being under the influence of substances and the use of provocative language, as well as through careful management of boundaries. This feeling of safety allows service users to engage to the best of their ability in the services provided.

Person-Centred Care

The staff use a person-centred approach to service provision. The Community Reinforcement Approach, which is based on the belief that environmental contingencies can play a considerable role in encouraging or discouraging alcohol or drug use, is observable in the

majority of the work in the project; at STAR it appears to build people's self-esteem, allow them to achieve goals, and improve their lifestyle and social environment while also recovering from addiction. Additionally, Motivational Interviewing is utilised to enrich the service user's experience through use of empathy and enhancing intrinsic motivation, it also allows service user's to build self-efficacy. The person-centred approach is also apparent in the facilitation of group work; the group process reflected a non-judgemental, collaborative, safe and trustworthy structure where strong social bonds are formed and maintained. It is clear that the philosophy of the project, in particular the non-punitive and person-centred tenets, contribute to the formation of strong social bonds.

Trade-offs and Challenges

There are some trade-offs as a result of adopting such a philosophy. It was discovered that staff place a large emphasis on trauma informed care; it is commendable that STAR have committed to an approach which endeavours to identify people who have been exposed to potentially life-threatening trauma and are impacted by symptoms of Post-Traumatic Stress Disorder, as well as their recognition of the value of referral to appropriate treatment services. The approach to trauma informed care at STAR has been influenced by the Adverse Childhood Experiences Study (ACE Study) in which researchers found that the more adverse events someone experienced in childhood, including non-life threatening as well as life-threatening events, the more likely it would be that they would suffer from more health and social problems, such as addiction, homelessness and mental health issues, as an adult. Given that there are a number of other confounding factors which may also be decisive, it is recommended that staff consider a balanced approach which remains open to other factors besides trauma and that is balanced with the community reinforcement approach, motivational interviewing and the person centred approach.

Secondly, the desire to unconditionally support service users is evident as staff constantly strive to do their utmost for service users across all aspects of their lives. While supportive and empowering to service users, this approach has the possible drawback of fostering dependency and impeding autonomy. Service users commented on how much they miss the service during the two-week summer break and how they struggle to perform certain tasks without help from staff. This dependency also appears to have manifested itself when it comes to finishing at the service, as service users appear to find this transition difficult. However, this is a problem that many addiction services face as people in addiction generally

suffer from a lack of external supports; therefore, when service users feel supported, have engaged in a program and built relationships, it can be challenging for them to move on from this service. It is recommended that the balance between high levels of support and promoting independence continues to be a central element of STAR's approach to active discharge planning.

Finally, the research has identified a need to upskill in areas such as mental health and couple counselling to further support service users who may have dual diagnosis or who are experiencing relationship problems due to substance misuse. However, the need for ongoing professional development and supplementary training appears to be an issue across addiction services.

Forming and Maintaining Social Bonds

It is clear that the STAR project is adept at forming social bonds which in turn appears to enable service user engagement and retention in the service. The data clearly demonstrated that the philosophy of the project is crucial to the formation of these social bonds and also influences therapeutic alliance, group cohesion, the safe environment of the project and service provision, each of which in turn also contributes to strengthening these social bonds as people strive to recover from substance use.

Introduction

Staff from the School of Nursing and Human Sciences, Dublin City University (DCU) and the STAR Project Ballymun (STAR) applied to the Irish Research Council (IRC) New Foundations scheme for funding to conduct this study to identify the key skills in the engagement and retention of service users in a community addiction service. The research team was concerned with observing, exploring and examining the relationships between staff and the people who use the service. The researchers hoped to identify if there are key skills that staff members use or particular ways that they relate to service users which help with the formation of successful helping relationships which in turn enable service users to engage with the services on offer in STAR over a period of time. The study had three key objectives;

- To identify the factors that service users and staff experience as central to facilitating engagement and retention.
- To explore whether there are key interpersonal skills and environmental elements that assist with the formation of social bonds between service providers and service users.
- To identify the key skills and aspects of the therapeutic alliance that assist the formation of successful relations that lead to better engagement and retention of service users.

Previous studies identify that early intervention is a factor in reducing the harms associated with substance use, and that many people engaged in substance use have chaotic lifestyles and are difficult to engage in treatment. However, the STAR project self-reported high levels of successful retention and engagement, and expressed an interest in identifying the factors attributable to this success in order to ensure it could be maintained as a central aspect of the programme, as well as being informative for similar projects in this field.

STAR

STAR Project Ballymun is a registered charity which provides a Drug Rehabilitation Programme and a Family Support Service to people who need support for Drug / Alcohol issues or who are dealing with the effects of addiction within the family.

Mission Statement:

STAR offers an intensive, holistic, personal development programme which supports a person and/or family member to make positive changes at his/her own pace in the process of recovery from drug/alcohol addiction and their effects.

History

STAR was founded in 1998 as a response to the lack of services for female drug users caught in a cycle of prolific drug use with little or no access to direct supports. STAR developed out of the Community & Family Training Agency (CAFTA). Initially it was supported by CAFTA before becoming a separate independent service. Since 1998, STAR has undergone many transformations in order to respond to the needs of female drug users and served as a low threshold service. The model of service provision has changed to reflect best practice and to cater to local needs. In 2012 STAR opened its door to men and currently operates as a pre-stabilisation, stabilisation and drug/alcohol free day programme service, as well as providing a Family Support service. However, despite the number of changes, what has remained consistent over the twenty years is a model of service provision which is person centred, supportive and non-judgemental.

Structure

The structure, criteria, programme and approach to care outlined below is STAR's description of their activities (STAR Project Ballymun, 2018). STAR has two main drug and alcohol rehabilitation programmes. These are delivered as Phase 1 and Phase 2. Each individual is assigned a key worker to support them while on the programme.

Criteria for Phase 1:

- No un-prescribed medication.
- If an individual is still using hash/weed, STAR will work with the individual if they are willing to reduce/cease use as a part of their care plan.
- If alcohol is the primary issue it is treated in the same way as any other drug.
- Strong levels of stability with prescribed medication only.
- Willingness to take part in a 5 day a week programme where a person is supported to look at all areas of their life.

Criteria for Phase 2

- No un-prescribed medication.
- Drug and alcohol free.
- Willingness to take part in a 5 day a week programme where a person is supported to look at all areas of their life.
- If an individual is coming to the end of a community detox programme they can be assessed as to suitability for this phase.

Rehabilitation Programmes

STAR self-reports integrating the following approaches into their rehabilitation programmes: Community Reinforcement Approach (CRA), Cognitive Behaviour Therapy (CBT), Motivational Interviewing (MI) and Mindfulness. Examples of training and group work within these programmes include: Fitness/Gym Programme, Relapse Prevention, Health & Nutrition, Stress Management, Computers & Literacy, Sexual Health, Creative Arts, STEPS programme, Emotional Regulation training, Mindfulness Based Relapse Prevention, Theme-based group work, Reduce the Use and Recover me. The programmes are reviewed on a regular basis with service users and updated to reflect best practice.

Other aspects of the programmes include:

Detox Support Plans: Service users work with staff in developing their own care plan and/or community detox plan to look at all areas of their lives needing support.

Group Work: This is a weekly facilitated part of the programme where individuals share and process where they are at in their lives. Individuals develop the skill of being able to reflect as a key learning outcome.

Quality and Qualifications Ireland (QQI) accredited training is also a component of the programme. This may include: Communication, Inter Culturalism, Food and Nutrition, Personal Effectiveness, Computer Literacy/Internet.

Holistic Therapies: The therapies include: Massage, Reiki, Drumming, Meditation

Overnight Trips: Residential trips for 1/2 nights away provide a valuable space for each person to come out of their everyday circumstances so that they can challenge themselves, examine cultural barriers, their sense of boundaries and explore perceived limitations.

Phone: Support service is available 7 days a week for service users**.**

Trauma Informed care

Trauma-informed care (TIC) is at the heart of all of the work done at STAR. Trauma informed care was adopted to better meet the needs of individuals seeking services for substance use disorders with histories of trauma, including experiences of childhood and adult sexual and physical abuse, exposure to violence or experiences of violent victimization, serious accident and intergenerational trauma (BC Centre for Excellence for Women's Health, 2013; Elliott et al., 2005; Fallot and Harris, 2005; Najavits and Hien, 2013; The Jean Tweed Centre, 2013).

STAR's Special CE Scheme- DSP

STAR is linked with the Department of Social Protection (DSP) as part of the Community Employment (CE) programme. As STAR is a Drug Rehabilitation Project (DRP), it is afforded special CE status which allows people that come from an addiction background to be exempt from having to meet certain CE criteria. CE rehabilitation schemes are delivered with a specific focus on opportunities for training and development for participants working towards recovery and re-integration into active community and working life. The path to recovery on CE reflects the personal journey of each participant and often requires additional interventions provided by local addiction recovery and support services.

Family Support

The Ballymun Family Support Service (BFSS) is a separate service, to the drug rehabilitation programme, operating under the banner of STAR. It is available to people over 18 years of age who are affected by the drug and/or alcohol use of a family member or significant other. Family support service includes:

A Weekly Support Group: This is a support group which meets weekly and affords family members a safe, non-judgmental place to talk about their current situation. The group aims to reduce feelings of isolation; improve coping with the impact of drug or alcohol use within

families; improve confidence and enable decision making regarding substance use in the family; reduce stress and anxiety and provide opportunities for improved physical and psychological health.

5-Step programme: The 5-Step programme is an evidence based intervention usually delivered in a group setting for those impacted by a significant other's substance use. The 5-steps are:

1: How the problem affects you and your family;

2: Increasing your knowledge and understanding;

3: Ways of responding;

4: Getting help from others;

5: Further help including pre and post Family member questionnaire (FMQ) to measure outcomes.

Strengthening Families Programme: The Strengthening Families Programme (SFP) (National Council of Ireland, 2018) is an evidence-based 15-week family skills training programme for parents and teens/children. Families enjoy a meal on arrival, then parents and teens /children engage in separate skills based sessions for 1 hour. This is followed by a family skills session in the second hour, where skills are practiced with parents and teens/children. This programme is delivered biannually and is an interagency initiative facilitated by the Ballymun Local Drug & Alcohol Task Force (BLDATF), support is also provided by staff from the BFFS.

Holistic Programme: The holistic programme was introduced to respond to the review undertaken with participants during 2016. Participants identified the need for skills to cope with the stress felt as a result of substance use. Techniques such as meditation were introduced to improve coping with stress and anxiety. STAR received funding from BLDATF to offer 2 x 5 week programmes during 2017.

Social / Respite activities: One of the difficulties facing Family Members living with substance use is isolation and stigmatisation. In order to help people feel more supported and connected to their community, the Family support service includes some social activities.

Literature Review

Addiction

Addiction is continued involvement with a substance or activity despite ongoing negative consequences (Donatella, 2006). Addiction occurs on a continuum where the behaviours initially provide pleasure or stability that is beyond the person's ability to achieve otherwise. Over time it becomes necessary to engage with the substance or activity to feel normal.

Ireland has a high level of alcohol dependence, compared to other western European countries; the World Health Organisation's (WHO) assessment of the prevalence of alcohol dependence in Europe showed that 3.8% of the adult population in Ireland is dependent (WHO, 2014). This is one of the highest rates in Western Europe and positions Ireland at the upper end of the scale alongside other high consumers of alcohol such as Finland, Norway, and Sweden. However, recent research from the Health Research Board (HRB), suggests the rate of dependence among Irish adults might be considerably higher. In a 2013 national survey, the HRB measured the prevalence of alcohol dependence amongst adults in Ireland at 7%, which is over 80% higher than the WHO's estimate (Long & Mongan, 2014).

Physical and Psychological Effects of Alcohol Dependence: Alcohol dependence is associated with a range of physical and psychological conditions. The amount of alcohol consumed on a daily basis has a direct correlation with the risk of liver cirrhosis, approximately 20% of people dependent on alcohol develop the disease. Chronic alcohol consumption is a significant risk factor for a number of cancers such as liver, breast, oesophagus, oropharynx, larynx and colorectum, as well as being a causal factor for both haemorrhagic and ischemic stroke. Alcohol dependence is associated with neuropsychiatric disorders such as depression, peripheral neuropathy, and cognitive impairment (Mongan, Reynolds, Fanagan & Long, 2007).

Alcohol was responsible for the deaths of approximately 800 alcohol dependent people in Ireland in 2008, that is the equivalent of around sixty-seven deaths a month (Lyons, Lynn, Walsh, Sutton & Long, 2011) The vast majority of deaths occurred before the age of sixty-nine, with the highest percentage of deaths in the fifty to sixty-four age bracket (Lyons et al., 2011).

Drug Use and Dependency in Ireland: Rates of drug use have risen in Ireland significantly in recent years. According to the National Advisory Committee on Drugs and Alcohol

(NACDA), the consumption of almost all types of illicit drugs has increased in the past decade. In 2003, the lifetime use of any illegal drug was 18.5% of the population, whereas in 2011, this increased to over 27% (Irish Medical Organisation, 2015).

Physical and Psychological Effects of Drug Dependency: Illicit drugs produce a plethora of different reactions in the body and in particular in the brain. Irrespective of the many chemical effects induced by different drug classes during intoxication, continued use of almost any drug is sufficient to bring about a usage disorder (IMO, 2015).

Hospitalisation and Mortality amongst Drug Users in Ireland: Statistics released by the HRB show that, from 2004 to 2011, a total of 4,606 deaths by drug poisoning and deaths amongst drug users were recorded, with the annual number of poisoning deaths rising from 267 in 2004 to 365 in 2011 (HRB and Public Health Information and Research Branch (PHIRB), 2014). In the majority of these deaths, a number of substances were used simultaneously, including alcohol. Alcohol alone was only responsible 17% of deaths due to poisoning in 2011 and 25% were caused by a single non-alcohol drug (HRB and PHIRB, 2014). Opioid use was shown to be the biggest killer as opioids were involved in 57% of poisoning fatalities (HRB and PHIRB, 2014). Ireland's rate of adult drug-induced deaths is 70.5 cases per million presenting annually, which is the third highest rate in the EEA, behind only Estonia (190.8 cases per million), and Norway (75.9 cases per million) (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2014). In Ireland, adult drug-induced deaths occur more than three times more frequently than the EU average of 17.1 cases per million, and more than twice the west European average of 29.1 cases per million (EMCDDA, 2014). 78% of those who die from poisoning as a result of opioid use are not part of a methadone treatment programme, which demonstrates the importance of treatment access (Ó Súilliobháin, 2014).

In 2011, 580 overdose cases were admitted to Irish hospitals that involved narcotics or hallucinogens including opioids, cocaine, and cannabis, with an additional 960 admissions from benzodiazepine ingestion (HRB, 2013). Moreover, people who suffer from drug disorders amounted to 18% of all admission psychiatric units and hospitals in 2013, which is around 3,300 admissions (HRB, 2014a).

Treatment: Detoxification and rehabilitation services for alcohol and drug dependency are provided by a combination of public, voluntary not-for-profit, and private services, which include psychiatric hospitals and general hospitals. The majority of substance use treatment is

carried out in outpatient facilities, with more complex treatment taking place in residential settings. There is no centralised strategy for the treatment of substance abuse in Ireland, and significant gaps in current services exist.

As previously mentioned, the prevalence of alcohol dependence amongst adults in Ireland is very high; however, the rate of those that are treated is relatively low. Problem alcohol use was treated in 8,336 cases in 2012 in Ireland (HRB, 2014b). When this is compared with the WHO's assessment of the prevalence of alcohol dependence in Ireland at 3.8% of the adult population, with other estimates suggesting closer to 7% (NACDA and PHIRB, 2012; WHO, 2014); it clearly highlights that health services in Ireland have been unable to treat the large portion of the Irish population who are alcohol dependent (IMO, 2015).

As Ireland has some of the highest drug-related death rates and opioid dependence rates in the EU, it is of great concern that there were reductions in the number of opioid-related problem drug cases entering treatment seen between 2011 and 2012. There was a 9% reduction in cases entering treatment year-on-year (4,351 in 2011 to 3,971 in 2012) which shows that despite the increasing prevalence of opioid use, fewer problem users are actually accessing treatment. In 2014, Ireland had 8,923 people undergoing substitution treatment for opioid use from a total opioid user population of approximately 21,000 people (EMCDDA, 2014; Long & Lyons, 2010). This does not compare favourably with many other western European states including the UK, the Netherlands, Luxembourg, Malta, Austria, and Italy, all of which report that the vast majority of their problem opioid users are receiving substitution treatment (EMCDDA, 2014).

Social Bond

Social bonds are the emotional (affective) and social relations that bind people together as family members, as well as in intimate relationships and broader social groups. The quality of a social bond relates to the amount and type of the emotional (affect) attachment involved. Social bonds are dependent on both conscious and unconscious elements and their social prescription is identifiable in Lacan's discourse theory which outlines four styles of social bonds, subject-Other relationships, transferences that determine the social functioning of an individual. The four discourse are Lacan's description of the nature of social order, what binds society together, his way of structuring social interaction, they represent the fundamental elements of social reality (Novie, 2008). A social bond is the degree to which an

individual is integrated into the society, or 'the social'. It is the binding ties or social bonding learnt in the family and later used as a model on which to form and build other relationships (Menzies-Lyth, 1989; Moore, 2012; Sampson & Laub, 1990). The social bond is a concept which attempts to explain the relationships which service users form with each other and with staff in the treatment setting. Therefore, it can be argued that in health-care, professionals rely not just on knowledge, skills and techniques but on the formation of social bonds with service users. This implies the use of the self or therapeutic use of self to enable the service user to progress. Therapeutic use of self describes the ability of a caregiver to use his or her personality "consciously and in full awareness in an attempt to establish relatedness and to structure interventions," Professional therapeutic use of self may evolve in a caregiver over time and involves building rapport, trust, respect, sincerity and empathy with the service user.

As there are unconscious aspects at play, these also need to be considered. We expect others to respond to us as we have been treated before, by our parents, siblings and other significant people, and we behave according to those expectations (Grant & Crawley, 2003). This process of behaving according to expectations is a demonstration of transference and requires a connection between consciously expressed expectations and unconscious desire (Moore, 2012). Health care delivery takes place within a transference relationship which differs from a social relationship. It should consciously aim to be a therapeutic professional relationship which places responsibility on staff to acknowledge and address their subjectivity yet it has unconscious elements or transferences. Lacan supports the ubiquitous nature of transference on the basis that; ‘there must be, outside of the analytic situation, pre-existing possibilities which the analytic situation combines in what is perhaps a unique way’ (Lacan, 1994, p. 124). Thus, it is important to be aware of the hidden elements of communication demonstrated in the social bonds between those in the treatment environment. Additionally, as previously mentioned, substance users have chaotic lifestyles (Hughes, 2007), experience social isolation (Sanders, Field, Miguel & Kaplan, 2000), replace the social bond with a relationship to a substance (Loose, 2002) and that in order to reverse this the substance user is required to re-establish an interpersonal relationship with another (Lubman, Hides, Yücel, & Toumbourou, 2007). Therefore, how this rupture in the social bond is addressed is vitally important to treatment. Additionally, when the unconscious element of transference is taken into consideration, it is possible to speculate that if the substance users have not previously experienced a positive transference/social bond with primary care givers they are not just re-establishing positive relationships with others rather than substances but they may also be

establishing positive transferences with significant others for the first time. Furthermore, it is possible that the success of treatment is not solely attributable to the therapeutic alliance demonstrated in social bonds but also to additional elements such as the therapeutic regime (Center for Substance Abuse Treatment, 2004) and esprit de corps (Bion, 1990) or the common spirit existing in the members that inspires enthusiasm. It has also been demonstrated through studies of groups in their natural surroundings, that a multitude of factors in the setting influenced how people engage with each other (Scheper-Hughes 2001, Moore 2012).

Group Treatment

As treatment for substance use is usually delivered in a group format and the service users participate in many different groups during their treatment, the salient relationships they form often include a variety of staff members and other service users. Although, most of the concepts related to therapeutic alliance can be applied to group settings, it may also be necessary to extend the application of the alliance construct used in individual treatment (Horvath & Greenberg, 1994), and combine it with a social climate construct, (Gifford, Ritsher. McKellar & Moos, 2006). In these group treatment environments, the alliance includes the service user's affinity with a network of relationships. This extended form of alliance has been shown to predict positive outcomes such as increased service user satisfaction and a greater tendency to set personal goals in treatment (Kasprow, Frisman, & Rosenheck, 1999; Middelboe, Schjødt, Byrsting, & Gjerris, 2001). It also been shown to contribute to the formation of larger social support networks and services users gaining more support from family members and friends (Richardson, 2002), which is a considerable issue for service users with substance-use disorders. A number of studies have also demonstrated that it is a predictor of greater improvement of substance use and mental health problems (Ouimette, Ahrens, Moos & Finney, 1998; Timko & Moos, 1998; Long, Williams, Midgley, Hollin, 2000). Additionally, research has shown that treatment centres which provide an engaging and supportive environment, in which service users form constructive relationships, and learn to accept and respond appropriately to internal states linked to using substances, yield better long-term outcomes, i.e. 2 to 5 years (Orford et al., 2006; Gifford et al., 2006).

Group Cohesion

Research has shown that group cohesion is one of the key aspects that improves a service users' chances to change (Burlingame, McClendon, & Alonso, 2011; Greenfield, Kuper, Cummings, Robbins, & Gallop, 2013; Pooler, Qualls, Rogers & Johnston, 2014). Burlingame

et al., (2011) describe group cohesion as having a structural aspect which relates to the cohesion between group members as well as the cohesion between service users, and a qualitative aspect which is concerned with the kind and degree of relationship. The cohesion between service users is regularly described as the strongest. However, it is not yet known whether the cohesion within the group as a whole or the cohesion between its members is more important and also whether certain service user groups and stages of recovery have different effects on cohesion (Burlingame et al., 2011). Nevertheless, it is seen as crucial that a focus is put on potential for change within the group as a whole as opposed to solely individual changes (Burlingame, Fuhriman, & Johnson, 2002). The role of the therapist is also crucial (Roy & Pullen-Sansfacon, 2016) as is working actively on relationships within the group (Wood, Englander-Golden, Golden, & Pillai, 2010) in order to strengthen group cohesion and bring about the process of change.

There are different schools of thought when it comes to the concepts of cohesion and alliance and whether they are separate. Lorentzen, Sexton, and Høglend (2004) stated that the quality of the service user–therapist alliance is important for positive outcomes and that the alliance is independent of group cohesion. They claimed that in order to maintain a positive alliance, staff should focus on individual group members and that negative transferences should not be addressed to the group as a whole. However, Crowe and Grenyer (2008) found that the service users only mentioned the importance of cohesion, when it came to treatment outcomes for depression, in a study which specifically measured the importance of alliance (between group members and therapist) and cohesion for treatment outcomes. The findings are mixed but this can be explained to some extent by varying methodologies. Von Greiff and Skogens (2017) posited that a stronger group cohesion could even be seen as an expression of alliance.

In a study by Von Greiff and Skogens (2017), they highlighted how group dynamics can be used by staff as a working tool. Recognition and empathy between the group members can provide motivation for service users as they don't have to learn solely from their own experiences, as they can also see themselves in others; therefore, they no longer feel alone, ashamed or guilty. Additionally, issues that actually concern specific service users that are hard to reach can be brought up and discussed in general terms in the group. Furthermore, group members that are further along in the recovery process bring experience to the group and can serve as inspiration for other group members. These group members are described as 'bearers of tradition' and act as a support for the staff (Von Greiff and Skogens, 2017).

Therapeutic Relationship

The collaborative aspects of the therapeutic relationship are generally described as therapeutic alliance (Hougaard, 1994). Therapeutic alliance is not equivalent to the therapeutic relationship but may still be influenced by the relationship. The therapeutic alliance develops in the complex interaction between the therapist and the service user (Baldwin, Wampold, & Imel, 2007); it is a process of interpersonal bonding between the two which includes trust and emotional labour (Horvath, Del Re, Flückiger, & Symonds, 2011; Larson and Yao, 2005).

Working alliance and helping alliance are two terms which are intrinsically linked to the therapeutic alliance. Working alliance as a concept emphasises the service user's capability to work with purpose in the treatment situation (Greenson, 1965); Whereas, helping alliance is primarily concerned with the helpfulness of the service user's experience of the treatment or their relationship with the therapist (Luborsky, 1976). The therapeutic alliance is comprised of three dimensions: goals, tasks and a service user-therapist bond (Bordin, 1979). The goals are mutually agreed upon, relate to the presenting problem and are the primary focus of the therapy. The tasks refer to the techniques and interventions that the service user and therapist feel will make those goals achievable (Horvath & Luborsky, 1993). The bond refers to the mutual trust between the service user and the therapist as well as the degree to which the service user is made to feel understood and respected. Recently, the relationship between the service user and the therapist has evolved into more of a collaboration or partnership (Charles, Gafni, & Whelan, 1999). Currently therapists generally adopt more of a "we" rather than a "me" approach to the treatment (Fuertes et al., 2007).

Outcomes

Most of the research related to therapeutic alliance has been in the generic psychotherapy field; numerous reviews and meta-analyses have shown that a good therapeutic relationship has been found to be a significant predictor of therapy outcomes across different treatment modalities (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Horvath & Bedi, 2002; Horvath et al., 2011) irrespective of how or when it is measured, how the outcome is evaluated i.e. a focus on specific symptoms or more global ratings (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath et al., 2011) or who rates the alliance, i.e. the therapist, service user or an independent observer (Horvath et al., 2011; Martin et al., 2000).

There are a number of limitations to generalising findings from general psychotherapy research to substance-use treatment. One such limitation is the differences in service user

characteristics, general psychotherapy populations are more likely to be higher functioning, have fewer psychiatric or other symptoms and are possibly more internally motivated to change (Richardson, Adamson & Deering, 2018). Differences in therapist characteristics, fundamental philosophies, treatment approaches and settings between the two may also affect the relevance of any conclusions that could be drawn (Orford, 2008). In comparison to general psychotherapy, there has been comparatively little research conducted into the effect of therapeutic alliance on outcomes in substance abuse treatment. However, the findings of the studies that have been conducted will be presented below. In a meta-analysis by Meier, Barrowclough & Donmall (2005), they found that the therapeutic relationship was a significant predictor of positive outcomes and adherence to treatment. Gibbons et al. (2010) found that, during a brief behavioural treatment, as therapeutic alliance increased cannabis use decreased. Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz and Gallop (2011) also found that a lower quality therapeutic alliance was associated with concurrent alcohol and drug use. Crits-Christoph, Johnson, Connolly, Gibbons and Gallop (2013) reported that positive therapeutic alliances were associated with a reduction in cocaine use, and Urbanoski, Kelly, Hoeppner and Slaymaker (2012) found that better therapeutic alliances were linked with better process outcomes in residential substance abuse treatments including reductions in emotional distress. Additionally, studies have found that positive therapeutic relationships lead to service users engaging in less drinking and drug use; the service users also remain abstinent for a greater period of time and are more involved in their treatment than those with weaker alliances (McKay et al., 2009; Connors Carroll, DiClemente, Longabaugh & Donovan, 1997; Simpson et al., 1997). Joe, Simpson, Dansereau and Rowan-Szal (2001), and Simpson, Joe, Rowan-Szal, & Greener (1997b) discovered that rapport, as reported by the therapist, predicted a number of post-treatment substance use outcomes. In a high powered study by Hser et al., (1999), alliance predicted long-term positive drug use outcomes. A number of other studies have also demonstrated that alliance is a good predictor of improved outcomes (Najavits & Weiss, 1994; Tunis, Delucchi, Schwartz, Banys, & Sees, 1995; Ilgen & Moos, 2005; Ilgen, McKellar, Moos, & Finney, 2006).

Some research has also found inconsistent findings, Fenton, Cecero, Nich, Frankforter, & Carroll, (2001) found that early alliance predicted in-treatment abstinence during out-patient treatment if assessed by an observer, but not when it was rated by the therapist or service user. Hser et al., (1999) demonstrated that early service user-rated alliance was a strong predictor of post-treatment abstinence in residential treatment settings but not, as in the

aforementioned Fenton et al., (2001) study, in out-patient settings. The majority of the studies which found contrasting and inconsistent finding were old and suffered from poor methodologies. Nevertheless, there are also a number of studies which have only found partial support for the association between therapeutic alliance and treatment outcomes (Connors et al., 1997; Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Fenton et al., 2001; McCabe & Priebe, 2003; Bethea, Acosta & Haller, 2008; Dundon et al., 2008; Crits-Christoph et al., 2009; Richardson et al., 2018: Cook, Heather & McCambridge, 2015). Finally, a number of studies have even reported there to be no relationship between alliance and favourable treatment outcomes (Belding, Iguchi, Morral & McLellan, 1997; Öjehagen, Burglund & Hansson,1997; Raytek, McCrady, Epstein, & Hirsh, 1999; Long, Williams, Midgley, & Hollin, 2000; Barber et al., 2001). Therefore, the findings related to the relationship between alliance and substance use outcomes are mixed.

In addition to the previously described diverse findings, two separate meta-analyses demonstrated that the association between therapeutic alliance and positive outcomes is not as strong in service users with substance use disorders compared to those undergoing general psychotherapy (Fluckiger et al., 2013; Horvath & Bedi, 2002). Fluckiger et al., (2013) also found that in general the relationship between alliance and outcome was weaker in studies which did not exclude service users with substance use disorders (SUDs). This is in contrast to other AXIS 1 disorders, as defined by the DSM, in which therapeutic alliance has been shown to have a positive influence, such as in depression (Crits-Christoph et al, 2011; Strunk, Cooper, Ryan, DeRubeis, & Hollon, 2012) and anxiety disorders (Hoffart, Borge, Sexton, Clark, & Wampold, 2012; Keeley, Geffken, Ricketts, McNamara, & Storch, 2011; Kendall et al., 2009; Strauss et al., 2006; Westra, Constantino, & Aviram, 2011). Fluckiger et al., (2013) posited that this may be due to long-term toxic effects of SUDs which are associated with a number of different neurological, psychological, social, interpersonal, and physical problems (Bates, Bowden, & Barry, 2002). Uekermann and Daum (2008) claimed that the enduring neurotoxic effects of alcohol may lead to impairments in social skills such as perceiving facial emotions, detecting theory of mind, and understanding humour. These impairments have the ability to influence the quality of the interactions between the therapist and service users, as well as the therapeutic alliance (Crits-Christoph, et al., 2011; Meier, Barrowclough, & Donmall, 2005). Furthermore, in terms of other psychological factors, higher levels of cluster B traits, i.e. people suffering from Borderline Personality Disorder, Narcissistic Personality Disorder, Histrionic Personality Disorder and Antisocial Personality Disorder,

have been show to hinder the establishment of a good working alliance in the treatment of addictions. These specific traits have been found to be common among service users with substance use disorders (Sher & Trull, 2002).

Retention

In general, longer stays and better attendance are associated with more positive outcomes in substance abuse treatment (Hubbard, Craddock, Flynn, Anderson, & Etheridge, 1997; Simpson & Lloyd, 1981; Zhang, Friedmann, & Gerstein, 2003). However, treatment retention and early termination of treatment continue to be a problem (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013; Sharf, Primavera, & Diener, 2010; Stark, 1992; Swift & Greenberg, 2012)**.** A number of reviews have noted the dearth of research when it comes to the identification of treatment variables associated with retention and have recommended that this void should be filled (Brorson et al., 2013; Swift & Greenberg, 2012).

Therapeutic alliance is one such treatment variable which has been found to be associated with better retention and this has been demonstrated in a number of studies (Barber et al., 1999; Barber et al., 2001; Brorson et al., 2013, Carroll, Nich & Rounsaville, 1997; De Weert-Van Oene et al., 1999; De Weert-Van Oene, Schippers, De Jong, & Schrijvers, 2001; Fenton et al., 2001; Knuuttila, Kuusisto, Saarnio, & Nummi, 2012; Luborsky, Barber, Siqueland, McLellan & Woody, 1997; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006**;** Petry & Bickel, 1999; Ruglass et al., 2012; Simpson et al., 1997b). However, a lot of these studies have one particular methodological weakness in that they only measure the therapeutic alliance at the beginning of treatment and at one other time point which means that the therapeutic relationship as a whole is not properly reflected. In a review by Meier et al., (2005), they found moderate effect sizes for the relationship between early therapeutic alliance in particular and retention.

In samples of opiate-dependent service users, Tunis et al. (1995) and Belding et al. (1997) failed to find any relationship between alliance ratings and retention. However, both studies had methodological weaknesses, such as small sample sizes. Furthermore, the two studies exclusively assessed the alliance at a late stage in the treatment and only included service users who had not dropped out. Therefore, as a good early alliance plays a key role in retention (Luborsky et al., 1995; Carroll, Nich & Rounsaville, 1997; Simpson et al., 1997b; Barber et al. 1999; De Weert-Van Oene et al., 1999; Petry & Bickel 1999; Barber et al., 2001;

De Weert-Van Oene et al., 2001; Fenton et al., 2001), Meier et al., (2005) posited that that service users with weaker or suboptimal alliances may have left by the time the alliance and retention were assessed for the first time, and stated that the alliance is less important for retention in later stages of treatment. The methodological weaknesses of these studies, which did not find a relationship between alliance and retention, make it difficult to ascertain under exactly which circumstances alliance predicts retention. However, the relationship between early alliance and retention in drug treatment appears to be a fairly consistent finding. Additionally, a good therapeutic relationship has also been found to predict attendance (Fiorentine, Nakashima, & Anglin, 1999; Simpson et al., 1997a) which naturally aids retention.

Engagement

A consistent finding in the treatment of substance abuse literature is that the successful engagement of service users in the treatment process is the biggest predictor of positive treatment outcomes (Simpson et al., 1995; Simpson et al., 1997a; Fiorentine, 1998; Joe, Simpson & Broome, 1999; Joe, Simpson, Greener & Rowan-Szal, 1999). Fiorentine et al., (1999) found that for women, the strongest predictor of engagement was therapist caring; however, for men, caring was not associated with engagement but helpfulness was. This suggests that women may respond better to an empathic therapeutic style, whereas men may have a stronger response to a more utilitarian style (Meier et al., 2005). Another predictor of engagement is early therapeutic alliance, it has been shown to be particularly effective and is desirable or even essential when it comes to treatment engagement, and retention as previously mentioned (Barber et al., 1995; Brorson et al., 2013; Greenson, 1965; Knuuttila et al., 2012; Meier et al., 2006; Strupp, Fox & Lessler, 1969). An early working alliance consistently predicts both service user engagement and post-treatment substance use when it comes to the treatment of addiction (Connors et al., 1997; Crits-Christoph et al., 2011; Fiorentine, et al., 1999; Horvath & Bedi, 2002; Martin et al., 2000; Simpson, et al., 1997b). Early therapeutic alliance also contributes to lower levels of drug abuse during treatment (Simpson et al., 1997a), even though this has not always been associated with treatment outcome (Barber et al., 2001; Connors et al., 1997). On the other hand, some studies once again found contrasting results, Simpson et al., (1997a) and Tunis et al., (1995) did not find a link between early therapeutic alliance and engagement; however, these studies had significant methodological limitations, including small sample sizes.

Although early therapeutic alliance has also been shown to predict treatment outcomes, dropout, and service user-rated alliance (D'iuso, Blake, Fitzpatrick, & Drapeau, 2009; Frühauf, Figlioli, Bock, & Caspar, 2015; Grace, Kivlighan, & Kunce, 1995; Hilsenroth, Peters, & Ackerman, 2004; Krieg &Tracey, 2016), not much is known about the relational factors which form the alliance (Cooper, 2012; Dollarhide, Shavers, Baker, Dagg, & Taylor, 2012).

Therapist Differences

Kramer, De Roten, Michel and Despland (2009) claimed that the relationship between the therapist and the service user is as important as the technical facets of therapy. In fact, in the treatment of addiction, the therapist with whom the service user is working with appears to be one of the strongest predictors of positive outcomes (Kraus, Castonguay, Boswell, Nordberg & Hayes, 2011; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; McLellan, Woody, Luborsky, & Goehl, 1988; Miller, Taylor, & West, 1980; Valle, 1981). In general psychotherapy, it has been demonstrated on a consistent basis that differences between therapists are responsible for between 5% and 12% of the variance related to service user outcomes (Elliot, Bohart, Watson & Greenberg, 2011). Studies have shown that a therapist's ability to develop positive alliances with their service users is associated with positive outcomes (Baldwin et al., 2007; Dinger et al., 2008; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010). Duncan, Miller, Wampold & Hubble (2010) posited that some therapists are more effective at forming alliances with their service users than other therapists. They demonstrated that the more effective therapists had a 50% less service user dropout rate and 50% more improvement among their service users than less effective therapists. These findings highlight how crucial the therapist's role is when it comes to the quality of the alliance as it is their actions and attributes which are integral to achieving beneficial outcomes (Del Re, Flückiger, Horvath, Symonds & Wampold, 2012). This suggests that it is important to understand which therapist characteristics, techniques and other therapeutic factors contribute to a positive alliance.

Connection

One factor which predicts the emergence of a good therapeutic alliance is the connection between service user and therapist. It is defined as the level of mutuality and intimacy between a therapist and a service user during therapy sessions (Sexton, Littauer, Sexton, and Tommeras, 2005). Additionally, it has been shown that the deeper the connection is between therapist and service user, the more the service user engages and is involved in the therapy; a deeper connection also leads to the service user being more in touch with their emotions**.** From the therapist's point of view, a deeper connection is associated with active listening, warmth, and emotional content. It has been demonstrated that the connection between the therapist and service user decreases during sessions when the therapist is not as engaged and when the content of the session is more cognitive content rather than emotional (Sexton et al., 2005).

Empathy

Empathy is one of the primary therapist characteristics which has been found to be linked to outcome. In a review by Bien, Miller, & Tonigan (1993), they found that an empathic therapeutic style was a common component of effective treatment. Miller, Taylor and West (1980) found that empathy accounted for 66% of the variance in service user drinking outcomes at 6 months. Even two years after treatment, 25% of the variance in outcome was still accounted for by therapist empathy (Miller & Baca, 1983). Pantalon, Chawarski, Falcioni, Pakes and Schottenfeld (2004) demonstrated, in a group of cocaine addicted women, that service user's ratings of their therapist's empathy were significantly correlated with abstinence rates and treatment engagement. Ritter et al., (2002) found that the therapist's empathy was associated with improved outcomes in service users undergoing treatment in an addiction treatment centre for alcohol abuse. Another study conducted with service users in an alcohol treatment program measured Rogerian attributes, which includes empathy, and found that the risk for relapse was up to four times higher and drinking days were at least four times higher for service users treated by a therapist low in these attributes. Although, empathy was not measured separately from the other Rogerian attributes i.e. respect and genuineness, they tend to be highly intercorrelated (Elliott et al., 2011; Moyers, Miller, & Hendrickson, 2005). Saarnio (2002) also found that treatment drop-out was associated with lower levels of Rogerian skills. In general, a warm, friendly and empathic interpersonal style among substance-use therapists has been linked to lower resistance in therapy (Miller, Benefield, & Tonigan, 1993; Patterson & Forgatch, 1985) and to better outcomes (Miller &

Baca, 1983; Miller et al., 1980; Valle, 1981). These studies demonstrate that empathy may be a reliable predictor of treatment success and it appears to play a greater role in addiction treatment than has been shown to be true in the general psychotherapy field, as it seems to account for a large portion of variance in service user outcomes.

Trust

A number of general personal attributes and therapeutic techniques from numerous different treatment modalities have been found to aid the development and preservation of a strong therapeutic alliance and they are presented in Table 1. Trustworthiness for example is one of the main therapist attributes that is integral to a strong therapeutic alliance (Horvath & Greenberg, 1989). Moreover, trust between the therapist and the addicted service user is seen to be another one of the key factors in the formation of the alliance (Miller, 2007; Thom et al., 2011; Jauffret-Roustide et al., 2012; Reyre et al., 2014). Trust on behalf of the service user provides the basis from which they can decide to take the risk of sharing personal information (Thom et al., 2011). However, the care professional also needs to be able to trust the service user to provide truthful information or to commit to a course of treatment (Miller, 2007). This trust from the care provider appears to enhance the service user's reciprocal trust in them (Cook et al., 2004, Thorne & Robinson, 1988); whereas a lack of trust on behalf of the care provider has been shown to be perceived negatively by service users and in turn affects themselves and the relationship negatively (Cook et al., 2004; Rogers, 2002). Therefore, it appears that mutual trust is beneficial for the relationship; it has also been shown to reduce the need for monitoring and increases cooperation (Cook et al., 2004). Furthermore, research has shown that mutual trust forms the base for successful and sustainable cooperation (Walker & Ostrom, 2009).

Table 1. *Therapist Attributes and Techniques key to the building of a strong alliance.*

Therapist Attributes	**Therapist Techniques**
Trustworthy	Reflection
Flexibility	Exploration
Honesty	Noting Past Therapy Success
Respect	Accurate Interpretation
Confidence	Facilitating the Expression of Affect
Experience	Attending to the Service User's Experience

Warm	Depth
Friendly	Involvement
Openness	Activity
Interest	Affirming
Alertness	Helping
Empathy	Understanding

Personal Therapist Attributes and Techniques

Other therapist attributes which have been shown to contribute to the therapeutic alliance include being flexible, honest, respectful (Ackerman & Hilsenroth, 2003), confident (Saunders, 1999), warm and friendly (Bachelor, 1991; Saunders et al., 1989), experienced (Mallinckrodt & Nelson, 1991), interested (Saunders, 1999) and open (Ackerman & Hilsenroth, 2003). Additionally, there are a range of therapeutic techniques which are thought to lead to a stronger alliance including reflection, noting past therapy success, accurate interpretation (Crits-Christoph, Barber & Kurcias, 1993; Ogrodniczuk & Piper, 1999), exploration (Allen et al., 1996; Bachelor, 1991; Gaston & Ring, 1992; Joyce & Piper, 1998; Mohl, Martinez, Ticknor, Huang & Cordell, 1991), facilitating the expression of affect, attending to the service user's experience (Ackerman & Hiksenroth, 2003), involvement (Sexton, Hembr & Kvarme, 1996), and activity (Dolinsky et al., 1998; Mohl et al., 1991). Other key techniques which are specifically related to empathy on the therapist's behalf are affirming (Najavits & Strupp, 1994), helping (Coady & Marziali, 1994) and understanding (Bachelor, 1995; Crits-Christoph et al., 1998; Diamond, Liddle, Hogue & Dakof, 1999; Najavits & Strupp, 1994; Price & Jones, 1998; Saunders et al., 1989). Additionally, the therapist's tone of voice has also been shown to be a strong predictor of success with regards to retaining alcoholics in treatment (Milmoe, Rosenthal, Blane, Chafetz & Wolf, 1967).

It is worth noting that there are also numerous therapist variables which have been identified to have no impact whatsoever on the therapeutic alliance. These include age, gender, experience, type of qualification and degree, their level of training, a therapist's theoretical orientation, the quantity of supervision they receive, type of treatment modality that a given therapist uses and whether or not the therapist actually attends therapy themselves (Duncan et al., 2010). However, Meier et al., (2005) found that the effects of certain therapist characteristics were not so straight forward; they found that service users rated the alliance as

better with therapists who were either male, experienced or ex-users themselves. Additionally, more experienced therapists tended to rate their alliances as worse than less experienced therapists.

Ruptures in the Alliance

Ackerman and Hilsenroth (2003) noted that the contributions made by therapists which assist the development and maintenance of the therapeutic alliance are similar to the features that are helpful when trying to identify and repair ruptures in a therapeutic relationship. Safran and Muran (2000) stated that ruptures are a normal occurrence in the treatment process and can often be used as an opportunity to deepen the alliance. Safran, Crocker, McMain and Murray (1990) even stated that positive outcomes from therapy are more closely associated with the successful resolution of ruptures in the alliance rather than a linear growth over the course of the therapy. Studies have shown that discussing strategies to repair alliance ruptures (Gaztambide, 2012) and detecting subtle misalliances (Constantine, 2007; Owen et al., 2011; Owen, Tao, Leach, & Rodolfa, 2011; Sue et al., 2007) can serve as starting points to begin productively repairing the relationship. It is in the repairing of the relationship where these similar features become apparent. The therapist must first acknowledge their contribution to the rupture of the alliance; they must take an affirming, understanding, and warm approach while validating the service user through exploration of their experience in order to gain a greater sense of understanding. As previously mentioned, trust is incredibly important to the therapeutic relationship, Reyre et al., (2017) demonstrated that restoring trust once it has been broken can greatly enhance the therapeutic alliance.

Therapist actions which help and hinder the relationship

In a qualitative study by Swift, Tomkins and Parkin (2017), they found that certain events or therapist actions which help the relationship are also sometimes the very same ones which act as a hindrance. An example of this is with listening or silence, service users find it beneficial when they are expressing strong emotions but don't find it helpful when they are discussing something less meaningful or are rambling on without interruption. Structuring of the sessions is something that may counteract this but Swift et al., (2017) found that if the structure didn't match the service user's preferences then once again it was seen as a hindrance to the relationship. Empathy when not expressed in the right way can also hinder the alliance. Instead of feeling understood, empathy delivered at the wrong time can make the service user feel judged or that the therapist is off track (Jarrett, 2017). Examples highlighted by service users that act as barriers to the therapeutic relationship include times when the

therapists offer advice that isn't in keeping with what they had discussed or when they attempt to steer the conversation to less important topics, as well as feeling like they are being judged or blamed by their therapists' statements, or when the therapist attempts to discuss a difficult past life event when they were not ready to do so (Swift et al., 2017).

Service user Factors

In terms of service user factors that may influence the alliance, numerous meta-analyses have demonstrated that the service user's demographic characteristics have no effect on the relationship between outcome and alliance (Connors et al., 1997; De Weert-Van Oene, et al, 2001). Findings from a Project MATCH study demonstrated that that there was a positive association between therapist rated alliance and female service users in outpatient and aftercare groups; it was also found that service user ratings of alliance were positively associated with age and negatively with educational level (Connors et al., 2000). In a group of methadone maintenance service users, Belding et al., (1997) reported that therapists rated the level of alliance higher when the service user was more educated. Urbanoski et al., (2012) also found that older age was associated with a stronger alliance. In general, these results are comparable to meta-analyses carried out on depressed populations (Klein et al., 2003; Zuroff & Blatt, 2006). However, when it comes to symptom severity, addicted populations and depressed populations differ slightly; research has shown that there is no relationship between symptom severity prior to treatment and the establishment of an alliance in depressed populations (Krupnick et al., 1996), whereas in addicted populations the findings are mixed (Connors, et al., 1997; Ilgen & Moos, 2005; Ilgen et al., 2006) as some studies found a relationship (Bethea, et al., 2008; Connors et al., 2000; Klein et al., 2003; McCabe & Priebe, 2003) whereas others did not (Belding et al., 1997; Meier, Donmall, Barrowclough, McElduff, & Heller, 2005; Öjehagen, Berglund, & Hansson, 1997).

There appears to be more consistent trends emerging regarding service user characteristics that may affect the alliance. Characteristics such as socialisation, social support, motivation and treatment readiness appear to be predictive of alliance (Calsyn, Klinkenberg, Morse, & Lemming, 2006; Connors et al., 2000; Cook et al., 2015; Meier et al., 2005). A secure attachment style, self-efficacy, effective coping skills and commitment to treatment have also been reported to be associated with alliance (Meier, et al., 2005; Urbanoski et al., 2012). Out of these characteristics, motivation has been shown to be one of the most important. However, the findings related to the role of service user's motivation on the alliance-outcome relationship are interesting as they tend to vary (Cook et al., 2015; De Weert-Van Oene et al.,

2001; Ilgen et al., 2006) even though in addicted populations motivation has been independently linked to both outcome and alliance. An example of this is in the Project MATCH study by Ilgen et al., (2006), when the service users rated the alliance it predicted improvements in drinking behaviour at 6 months but not at 12 months and motivation had no influence on this, whereas when the therapist rated the alliance it predicted improvements in drinking behaviour at both 6 and 12 months and was influenced by motivation, in so much that service users with low motivation benefited more from a good alliance. Wolfe et al. (2013) also found that service users' motivation at baseline was associated with service user-rated therapeutic alliance. Additionally, studies have even shown that post-treatment motivation is important for long-term drinking outcomes (Carbonari & DiClemente, 2000; Cook et al., 2015; Heather, McCambridge, & UKATT Research Team, 2013; Hunter-Reel, McCrady, Hildebrandt, & Epstein, 2010; Korcha, Polcin, Bond, Lapp, & Galloway, 2011) and Cook et al., (2015) found that a good alliance predicts this post-treatment motivation.

Another service user factor which have been shown to aid the development of a strong alliance is stage of change i.e. how committed the service user is to change (Prochaska & Norcross, 2001). Numerous studies have shown that stage of change at pre-treatment predicts a strong service user rated alliance (Connors et al., 2000; Cook et al., 2015; Emmerling & Whelton, 2009; Rochlen, Rude, & Baron, 2005), although again the findings are mixed as the association is not found when the alliance is rated by the therapist (Rochlen et al., 2005).

There are certain service user characteristics which have been shown to harm the alliance. Negative correlations have been found between the alliance and when the service user has a need for dominance (Paivio & Bahr, 1998) and intimacy (Saunders, 2001). Furthermore, when the service user has a self-centred or vindictive style of interpersonal behaviours, it is more likely to inhibit their ability to form a good therapeutic alliance (Kiesler & Watkins, 1989). Krieg and Tracey (2016) found that service users who had this need for dominance reported better alliance scores for male therapists whereas service user who had problems with non-assertiveness reported higher working alliance scores with female therapists. Additionally, it was found that when service users have self-centred or vindictive interpersonal problems, the initial alliance scores are lower, irrespective of the therapist's gender.

Factors which may harm the relationship

There are also other factors which can harm the relationship. Some drug treatment approaches which require the therapist to take an active and confrontational role may present challenges to the formation of a good therapeutic alliance (Millman, 1986). It was shown that in treatment environments where the therapist was required to act as the disciplinarian, or to withhold or administer the service user's dose of methadone led to problems with maintaining a therapeutic alliance (Schwartz et al., 2017). There are numerous other factors which can hinder the therapeutic relationship which will be outlined below.

Trauma

There is a growing body of research which shows that that a large proportion of service users who are seeking treatment for substance abuse and mental health problems have suffered some form of trauma (Cusack, Morrissey & Ellis, 2008; Drabble, Jones & Brown, 2013; Farro, Clark & Hopkins Eyles, 2011). In a population based analysis of over 17,000 people, the researchers concluded that addiction was a result of a largely unconscious attempt on behalf of the addict to gain relief from hidden prior traumas by using psychoactive materials (Felitti et al., 1998). In a report by the Substance Abuse and Mental Health Services Administration (SAMHSA), it was shown that 66% of people attending treatment for substance abuse reported some form of childhood abuse or neglect and that 75% of women reported having been sexually abused (Jennings, 2004) with some studies reporting rates of abuse as high as 80% among this population of women (Brady, Killeen, Saladin, Dansky & Becker 1994; Dansky, Saladin, Brady, Kilpatrick & Resnick 1995; Fullilove et al., 1993; Hien & Scheier, 1996; Miller, Downs & Testa, 1993). The SAMHSA report also stated that if this trauma was not addressed and no alternative coping methods for dealing with the pain were provided that the probability of relapse was high (Jennings, 2004). However, contrasting results were found in a study by Kim, Ford, Howard and Bradford (2010), who found that a history of trauma was associated with mental health problems but not with substance abuse in a sample of homeless men. Nevertheless, Herman (1997) stated that the therapeutic relationship was the most important factor in relation to positive outcomes in trauma treatment. The research also suggests that the possible long-term consequences of exposure to trauma such as difficulties with emotion regulation and developing and maintaining interpersonal relationships may make it challenging to establish a therapeutic alliance (Briere, 1992; Herman, 1997; Price, Hilsenroth, Petretic-Jackson, & Bonge, 2001). The rates for a comorbid diagnosis with posttraumatic stress disorder (PTSD) range between

30% and 60% and service users with this diagnosis usually have more severe clinical profiles than those with only one of the disorders (Brady, Back, & Coffey, 2004; Mills, Teesson, Ross, & Peters, 2006; Najavits, Weiss, & Shaw, 1999; Ouimette & Brown, 2003), which in turn may makes it more difficult to form and maintain an effective therapeutic alliance. Early therapeutic alliance has been shown to be particularly important when it comes to treating this population of service users, Paivio and Patterson (1999) found that early alliance was weaker for those with a history of more severe abuse and Cloitre, Stovall-McClough, Miranda, and Chemtob (2004) demonstrated, in a sample of women who had suffered abuse, that the quality of the alliance at the beginning of treatment was a significant predictor of a reduction in symptoms of PTSD later in treatment. Ruglass et al., (2012) found that therapeutic alliance was associated with significant decreases in PTSD symptoms and higher attendance but was not related to substance use outcomes.

Burnout

Although, professionals providing addiction treatment express high levels of job satisfaction, it has also been reported to be very challenging work (Livingston, Milne, Fang & Amari., 2012; Oser, Biebel, Pullen & Harp, 2013) and they often report high levels of psychological distress related to their jobs (Oyefeso, Clancy & Farmer, 2008), making staff stress and burnout another factor which may harm the therapeutic alliance (Garman, Corrigan & Morris, 2002; Lacoursiere, 2001). It has been suggested that risk factors for burnout have an impact on professionals' experiences of care which in turn may hinder the establishment of an effective care relationship (Lacoursiere, 2001). It has been posited that a poor therapeutic alliance derived from therapist burnout may be associated with poor service user outcomes, as well as low satisfaction and participation (Garman et al., 2002; Landrum Knight & Flynn, 2012) and low retention rates (Knudsen, Ducharme & Roman, 2006; McKay, 2009). Oser et al., (2013) demonstrated that service users are affected when their therapist is experiencing burnout, as a lack of continuity when it comes to therapist care and high rates of therapist absenteeism have been linked to early withdrawal from treatment (McKay, 2009; Schaefer et al., 2005; Bowen & Twemlow, 1978; McCaul & Svikis, 1991). Furthermore, service user satisfaction has been shown to be reduced when burnout is widespread within a health care setting (Landrum et al., 2012; Garman et al., 2002; Vahey, Aiken, Sloane, Clarke & Vargas, 2004). There are certain factors that can influence burnout such as being a young professional (Knudsen et al., 2006; Oyefeso et al., 2008), although being older (Vilardaga et al., 2011) and better educated can protect against burnout (Knudsen et al., 2006; Shoptaw, Stein & Rawson,

2000; Vilardaga et al., 2011). Certain populations have been shown to possess a greater risk of staff burnout such as those with highly complex cases (Shoptaw et al., 2000), high relapse rates (Vilardaga et al., 2011), a psychiatric comorbidity (McGovern, Xie, Segal, Siembab & Drake, 2006). Furthermore, professionals who work in environments which provide low job support (Shoptaw et al., 2000), have heavy workloads (Broome et al., 2009) and lower salaries (Ogborne, Braun & Schmidt, 1998) are also at a high risk of burnout. Whereas environments with good management and good social support have lower levels of burnout (Knudsen et al., 2006; Vilardaga et al., 2011).

Difficulties in the relationship

Reyre et al., (2017) identified four primary sources from which difficulties in the relationship can arise, i.e. the service users, the addictive substance, the staff, and the environment. The first of these relates to how certain characteristics and actions of the service users can affect the therapeutic relationship. Naturally, the professionals find it more difficult to form a relationship with service users who do not fully commit themselves to the relationship or even work against it. Professionals have also reported feeling anxious when service users present with serious health conditions, psychological suffering and have distressing personal histories to tell (Reyre et al., 2017), which is often the case when it comes to substance abuse. The professionals themselves are also responsible for a number of factors which can inhibit the relationship. One such factor is a lack of confidence in their own skills; if a professional feels like their training is insufficient or inadequate for coping with the strong emotions that the service user evokes in them, it can have a negative effect on the relationship. Furthermore, becoming too emotionally involved can also cause difficulties, especially if the professional has a history of substance abuse themselves, this can lead to the professional experiencing a "blurred boundary" between their experience and that of the service user Also, if a professional has a preconceived negative attitude towards the service user, this can also have a significant effect, especially if they fail to correct this attitude (Reyre et al., 2017).

This negative attitude towards substance use disorders is also present in society. There are often hostile attitudes towards people with addictions and the professionals working in this area often do not receive adequate support for the help they provide because of this. The political stances and the resulting health legislations can often be stringent and thus hinder the work that the addiction service wants to carry out (Reyre et al., 2017). Numerous studies have demonstrated that substance use disorders are more highly stigmatised than other health conditions (Corrigan et al., 2005; Rao, Mahadevappa, Pillay, Sessay, Abraham & Luty, 2009;

Ronzani, Higgins- Biddle, Furtado, 2009; Room, 2005; Schomerus et al., 2011). A survey by Beck, Legleye and Peretti-Watel (2003) demonstrated that 52% of people thought that "people who take heroin lack willpower" and 73% thought that "they are dangerous for people close to them". The survey was repeated by Costes, Le Nézet, Spilka and Laffiteau (2010), and it showed that there was a lack of "understanding" with regards to addiction i.e. not recognising the possibility of multiple causations. The stigmatisation affects both addiction to illegal substances (Ahern, Stuber, & Galea, 2007; Palamar, King & Halkitis, 2012) and alcohol (Keyes et al. 2010). Most importantly though, Goffman (2009) demonstrated that this stigma leads to mistrust on the part of the general public, and also among professionals. As mentioned previously, trust is one of the key elements to the formation of the therapeutic alliance between the service user and the therapist (Jauffret-Roustide et al. 2012; Thom et al. 2011). Therefore, the stigmatisation hinders the ability of the service user to establish sincere relationships, including those in the care setting (Reyre et al., 2017).

Other difficulties can also arise within the care environment. If an institution has a lot of administrative rigidity and consequently the professionals' hours are reduced with the service users, evidently this will have a negative effect on the relationship (Reyre., et al., 2017). There are a number of other factors related to the care environment that can affect the alliance such as is if the team of professionals do not have enough time and space to socialise, support each other and to develop their skills, which can also be due to administrative tasks. Social support from families can often be inadequate for both service users and professionals. Service users' families often judge and have negative attitudes towards their addicted relatives, and the support for their relative's commitment to treatment is often unpredictable (Reyre et al., 2017).

Conclusion

There is a limited body of research into the effects of therapeutic alliance on substance use treatment but the literature suggests that alliance contributes consistently but modestly to treatment retention, while the relationship of alliance to substance use outcomes is mixed. These findings are not in keeping with those related to the contribution of the therapeutic alliance to outcome in the general psychotherapy literature, which has consistently shown that the better the alliance the better the outcomes. Therefore, it is possible that relationship factors may operate differently in the treatment of addictions compared with the treatment of other psychiatric disorders.

Methodology

Literature Review

Search strategy

The literature review for the study was based on a structured search of relevant databases, libraries, and other sources, as well as the compilation of primary conceptual, methodological and empirical research.

PubMed, Web of Science, PsycLit, Medline, Science Direct, Cochrane Library and Embase (from their commencement to September 2018) were used to search for eligible papers using the following terms: therapeutic alliance, addiction, substance abuse, substance use, social bond, retention, engagement. The reference lists of identified articles were scrutinised, as were the references that were made to seminal papers on the topic.

Selection criteria

Studies had to be published in peer-reviewed journals (including advance online publication) and written in English or Spanish in order to be included. Studies and reports published up until September 2018 were included in the literature review.

Procedure

A number of the search terms were broad; therefore, each abstract was reviewed in the strict defined terms of the report i.e. treatment for addiction. A general review of broad terms was conducted to ensure comprehensiveness of the research. When an abstract was noted to be relevant, the full article was sought for review. In the case of annual reports, books and Government publication, the complete report was sought and reviewed for consideration of inclusion in the report. This resulted in the inclusion of 310 published works in the final report.

A critical summary was created from the reviewed literature, this helped to contextualise the research questions by identifying gaps and weaknesses, as well as critiquing, supporting and justifying the investigation. This approach provided a level of confidence in relation to what was already known in the field; therefore, the additional findings from this study will potentially extend the previous knowledge and theory (Beins, 2004). The literature also served the purpose of being a source of research ideas, orientating the researchers and providing conceptual and contextual information (Hollway & Jefferson, 2000, Howitt & Cramer, 2010, Diamond, 1993, Beins, 2004, McLeod, 2011). Research supervision, consultation, on-going curiosity and willingness to read in relation to the subject throughout the research period was maintained in order to avoid the inherent risks that under or over refinement results in the non-inclusion of significant texts.

Field Work

Ethnographic observation, focus group interviews and individual interviews were conducted. A field note template (Appendix A) from the observation phase and the interview question scripts are included in the appendices (Appendices B - F).

Observation

The observation phase of data collection was carried out in an ethnographic manner. Ethnography is concerned with experience as it is lived, felt or undergone (Taylor, 2006). The ethnographer participates in people's daily lives for a period of time, watching what happens, listening to what is being said, asking questions and studying documents. Essentially, they are trying to collect all possible available data in order to shed some light on the issue(s) with which the research is concerned (Banister, 2011). Ethnography is the study of social interactions, behaviours, and perceptions that occur within groups, teams, organisations, and communities. Through the collection of detailed observations and interviews, the researcher attempts to provide rich, holistic insights into people's views and actions, as well as the nature (i.e. sights, sounds) of the environment they inhabit. The ethnographer then documents the culture, the perspectives and practices, of the people in the settings (Hammersley, 1983).

The research assistant visited the STAR project and conducted non-participant observation of the staff and service users. Site visits were conducted during hours of service (09.00–16:30), as this reflected operational times for the service when all grades of staff contribute to service delivery and when service users were in attendance. In order to capture the total situation, the

participants were observed in their 'natural habitat' or the real life context of the service. The researcher conducted observations in the kitchen, garden, reception area, hallways, offices and in groups. Unrestricted access was granted but to begin with the researcher did not enter a group without seeking the permission of people taking part in them, access was never denied.

The observational part of the study involved gathering data from the total population of service users and service staff. The facility normally accommodates up to 20 service users on any given day, this does not include people attending for assessments. Additionally, there are 120 people registered for Family Support, 45 of which are active in attending prearranged sessional work. There is a staff complement of six full-time and four part-time staff (two of which are in the Family Support service), as well as three community employment staff.

For consistency purposes, all data was transferred onto a standard field note template which included indices of time, place and social circumstances. While consistency is important and used as an expression of validity there are inherent risks that valuable information can be misrepresented or lost in the process of translation from one medium to another. Therefore, original notes and recording were retained and referred to as transcripts and reviewed to ensure accuracy. Approximately 60 hours of observation was conducted over the course of a three-month period, between June and August 2018.

Interviews

This was followed by individual and focus group interviews with staff and service users which were conducted by members of the research team, in order to determine what key skills and aspects of therapeutic use of self are required to form social bonds that enable service user engagement and retention in a community addiction service. For the focus group with the service users, an interview guide was generated with information from the literature review and the field notes from the observations. This same method was employed to produce the questions for the focus group with the staff except data from the focus group with the service users was also incorporated. The question scripts for the individual interviews (Appendices D – F) once again drew on the literature review and observations, as well as all of the information gathered from the focus groups (Appendices B & C). A total of 19 interviews, both individual and focus group, were conducted by the research team in order to collect sufficient interview data to saturate the categories. A breakdown of the interviews conducted are listed below:

- 1 Focus Group with staff (6 Participants)
- 1 focus group with service users (9 Participants)
- 6 individual interviews with staff
- 11 individual interviews with service users

All focus groups and interviews were audio taped. This material was then transcribed and analysed by the research team. The results of this analysis are presented in the findings section of the report.

Findings

From the outset of the research, it was apparent that service users are very positive about the work conducted at STAR. Throughout the data collection phase most participants presented a similarly positive and uncritical perspective of STAR as is illustrated in the following comments from service users:

"I was offered a job two weeks' ago, an awful lot more money. Sure money is nothing compared to this place, what it can do for you. Amazing people in this building, absolutely amazing"

"I strongly feel that I am going to get my recovery out of Star where no other place has even done it for me and that is even jail, jail normally gives you the fright to wake up and cop on but it didn't do it for me and I feel that Star is going to be the making of me for my recovery"

"I came out of treatment about three months ago and I came out of there very broken and myself esteem and confidence was just completely shattered, and I am here three weeks and I feel my confidence has just sky rocketed"

"I haven't been as content or at ease with myself since as far back as I can remember to be honest with you, since I started attending here"

This research set out to identify the key skills or particular ways that staff relate to service users to form social bonds that enable client engagement and retention in the service. The data demonstrated that the philosophy of the project was crucial to the formation of these

social bonds; the philosophy was also found to influence therapeutic alliance, group cohesion, the environment of the project and service provision, each of which in turn also contributes to strengthening these social bonds. This is demonstrated in Figure. 1 below.

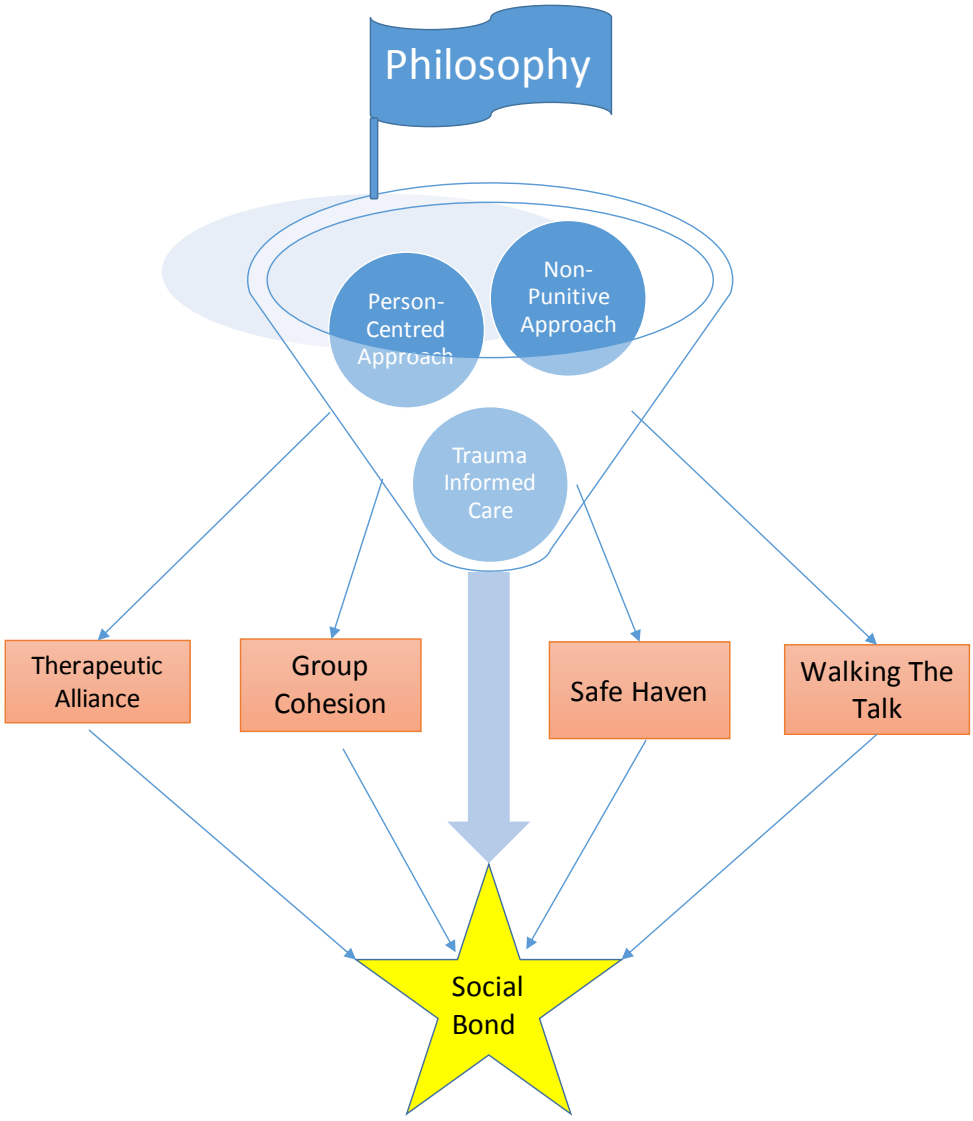

Figure 1.

Philosophy

Based on the analysed data, it is apparent that a strong influential philosophy underpins the service provision at the STAR Project Ballymun. The philosophy is also one that is enacted rather than just espoused, a member of staff highlighted this: *"I have seen it in other projects where the ethos is written but it doesn't happen. But in here I see it happening, it influences how I might approach a situation"*. This philosophy is made up of three interacting strands

which are described as a person-centred position, trauma-informed care and a non-punitive approach.

Person-Centred Care

The primary underpinning perspective of the philosophy at STAR is the person-centred care approach. From this perspective, the service user is recognised to be more than their addiction and careful consideration is given to the service users' unique experience of their situation, as well as their individual conditions, internal and external resources and constraints: *"Yeah they kind of look at people as an individual and they work with each person around their own experience".* In general, person-centred care consists of three key concepts: partnership, service user narrative and documentation. The data suggests that the most important of these is partnership which involves mutual respect for each other's knowledge and expertise. On the one hand, the service users' lived experience of addiction and on the other, the staff's expertise of addiction interventions. Throughout the research process, the staff and service users at STAR regularly stated how much respect they had for each other and how this enhanced collaborative partnerships: "*We do everything with respect and I find that the clients respond better that way"*. The data analysis clearly indicates that the staff at STAR are committed to listening to the service users' narrative. There are a number of formal and informal forums which provide opportunities for service users to share their narratives with staff and peers including check-ins at the beginning and end of each day; one-one-one sessions with key workers; monthly group meetings, structured and process group work; informal conversations in the kitchen and soft seating area: *"we have a monthly meeting so if there is anything that you are not happy with you can say it to them. In most places you are doing what is on the programme and that is it, and even if you don't like it you have to do it".*

The third component of person-centred care is the documentation of the service user narrative as well as a care plan. Each new service user works with their key worker to formulate a care plan which is tailored specifically to them and consists of long and short-term goals; "*You are asked what way you want to do your recovery, you are not told this is the way we do recovery here".* Many service users asserted that this approach is very different to their experience in other services where they were expected to follow a '*one size fits all plan'* and that if the treatment didn't work, the service user was deemed to be at fault. Instead in STAR: "*it was always look for solutions, not to sort of get things to all line up in a row and each individual is different so what might work for me mightn't work for somebody else".*

Trauma-Informed Care

The second strand of STAR's philosophy is a trauma-informed care (TIC) approach which influences service delivery and shapes how staff interact with the service users. This approach was adopted in order to try and better meet the needs of individuals seeking services for substance use disorders with histories of trauma. It involves an approach to service provision which recognises that the trauma experienced by a service user is fundamentally linked to substance use and mental health problems; there is also a focus on enhancing safety, choice and control in service settings. The staff at STAR promote and express believe in this approach and suggest it is the root of almost all addictions: *"I would go so far as to say certainly from our working with clients every client that has come through our doors, bar one or two, there has always been a history of some kind of physical, sexual, emotional abuse through childhood"* and *"we have noticed where clients really make a breakthrough is where trust is built up and then you start to deal with the original cause and what is going on for them"*.

This emphasis on TIC was very evident throughout the observation phase: *"the staff members highlighted at the end of one of the groups that it is the opening up about trauma that really leads to healing and recovery, and that they had seen it before"; the service users talk openly about their traumas during group work"* and *"A service user mentioned the beneficial effects of talking about trauma"*. It is part of a shifting framework which has moved from an older model of addiction work, where the addiction was at the centre of the work, to a newer more holistic model where the addiction is only seen as a part of the person's identity: *"I think what is different is we don't just say, look addiction is there on its own. We know it comes from trauma. So we are not so interested in the addiction, let's look at where the trauma comes from and what are people's coping mechanisms? What can they learn? What are the behaviours and positive choices?"*. This approach is designed to reduce stigma and give space for the trauma to be acknowledged. During the observation phase a number of service users mentioned that STAR is not as confrontational as other places in forcing them to open up about traumas and gives them time to do so.

All current staff team members at STAR have undergone Trauma Training with the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) and focus on creating a safe space to implement this approach. STAR's staff espoused attitudes towards TIC can be summed up by this quote: *"TIC is a developing body or way of working and TIC should be*

seen as a movement. We are moving forward and learning more all the time about this type of approach. This is an area we will keep developing skills in as opposed to ever being experts in as there is always something new to learn especially as neuroscience is still an emerging area of study. This type of approach takes time and is built upon as experience and research grows in this area and these are embedded into the work that we do".

Non-Punitive Approach

The third strand of STAR's philosophy embraces a non-punitive stance. Throughout the interview phase, service users repeatedly mentioned that they were not punished or judged in STAR if they had a relapse: *"after a relapse it was very non-judgemental, it is very sit down and we will have a chat about it, and nobody's attitude changes, nobody treats you any differently, you aren't sort of put back to the end of the line, he is one of the bad people, and have to work your way back up again and that sort of a thing".* At STAR, the service users are encouraged by staff to come forward in their own time and inform their key worker when they have a relapse. They are also encouraged to share with their group if they have had a relapse, in order to remove personal shame and allow others to learn from it*: "Even if a client has a relapse we would say there is a learning in it, what actually happened. So it is not about judging someone, it is let's look at what the learning is, what can we take out of it? Do we need to change the approach? What worked?*

What didn't? And the staff member is learning about that service user that they are working with, it is enhancing their relationship. Because there is never one size fits all and it is not a straight line". In turn service users suggest that they feel more comfortable disclosing when they have had a relapse. Service users indicate that because they are not judged or punished for being honest about relapses, it also means that they are inclined to be more honest about other things, which in turn is beneficial for building collaborative partnerships in order to treat addiction: *"If I have a problem or if I relapsed I can go to them, I am not worried about the repercussions or not getting support".*

According to the services users, the majority of whom have attended other addiction services, this non-punitive stance is something that is unique to STAR. Based on the testimonies of the service users, punitive measures and severe sanctions are implemented in some other services: *"if you have had a relapse or anything you come in and you tell them and they support you, they don't judge you whereas other places would".* In those services, this meant that the service users felt great shame after relapsing, for something that is a recognised

aspect of the recovery phase of addiction: "*I have seen other places where if you have a relapse you are put on the naughty step, you are separated from the other clients".* This also meant that in those situations, service users were more likely to be dishonest and let relapses fester, as they felt unable to ask for help. This viewpoint was reiterated by a number of service users: *"in other places I had been there was a punishment regime. If you had done something wrong or done something that didn't go along with the rules there was some form of punishment"*.

The three interacting strands of STAR's philosophy which embrace a person-centred position, trauma-informed care and a non-punitive stance produce an approach to the treatment of substance misuse that is considered by staff and services users to be very different to many mainstream addiction models and contributes to the formation of strong social bonds between service users and staff members.

Therapeutic Alliance

Research has demonstrated that therapeutic alliance is a predictor of retention and adherence to treatment in substance abuse health care (Brorson et al., 2013, Meier et al., 2005). It is a complex interaction between a therapist or care worker and a service user, which includes a process of interpersonal bonding between the two (Horvath et al., 2011).

Early Therapeutic Alliance

At STAR, considerable effort is put into the initial meeting between staff and service users: "*There is a very conscious welcome. It is not like the Red Coat in Butlin's but it is a very warm conscious welcome".* Addiction research has shown that a positive early therapeutic alliance is key to the retention of service users (Fenton et al., 2001; Meier et al., 2005) and has been shown to be particularly effective and even essential when it comes to engaging service users in treatment (Brorson et al., 2013; Knuuttila et al., 2012). The service users initially undergo an assessment with a member of staff. The philosophy of the project is very evident in this initial meeting: "*It is the dignity I think, the respect for the person and having an understanding of where they are coming from and trying to make sure that they have got enough information without feeling bombarded so they feel welcome. You can see people starting to relax after a short space of time"*. The staff also identified strategies employed during early engagement which include; the use of humour; management of power relations to promote equity and the avoidance of an overtly clinical or professional setting. One service

user commented on their first assessment: "*I could just tell from him that he actually genuinely cared. It just didn't feel like he was above me. And I didn't feel like he was judging me or just seeing me as an addict. He was really listening to me, it just felt more real kind of thing"* and another stated "*when I first came up here it was just that bit different, I couldn't quite put my finger on it but it seemed very non-judgemental and respectful"*. This non-judgemental and respectful welcome promotes the early formation of a staff/service user alliance.

Staff highlighted how technical language can be alienating and is avoided in initial meetings: "*I would be very conscious of jargon, how we talk, what we say. This is supplemented with placing an emphasis on the client autonomy regarding information seeking and decision making in the process. I'm very conscious of making sure that they ask questions. I would also say to them you are now engaged in the programme, even if I never see you again you are part of the Star family, you are part of what we do. You decide whether you come back. I will always say to somebody, the interview is for you to interview us, and that always throws them. I would say it is your programme, so I need to find out can we meet your needs but you need to find out can we meet your needs. So straight away you are trying to create a partnership and I think that is important"*. This early focus on building a partnership is crucial to the formation of an early alliance and the conscious effort made by staff does not go unnoticed: **"***I came over and had a chat but I knew straight away this was the place for me", "just straight away when I came in I had a really good feeling about the place, it was so warm and it just felt different to other places I was in, like I got a hug when I came in for my assessment"* and *"God I knew myself from the first week of being in here I was like I need this place. It is genuine"*.

Another added benefit of building a strong early therapeutic alliance that was commented on by several service users is that it reduces anxiety. Initial and ongoing anxiety are factors effecting engagement and retention of service users. A number of service users alluded to their initial anxiety and its management; *"they just made me feel really secure because I get really anxious if I have to come in and talk to people. Often after going into services or assessments I would come away feeling really vulnerable but I didn't feel that at all leaving here"*, "*I was really anxious, I was terrified. I think I said it today about 20 times before I started... I suffer from bad anxiety and it was explained that it was different to other places and to take that into consideration. You are not put under pressure"* and *"I have been to a lot of different places before and I didn't last long because my anxiety was that bad"*. The

approach adopted by STAR combined with the service users' reaction to it allows for the formation of a positive early working alliance, which has been shown to consistently predict both service user engagement and post-treatment substance use in the treatment of addiction (Connors et al., 1997; Crits-Christoph et al., 2011; Fiorentine, 1999; Horvath & Bedi, 2002; Martin et al., 2000).

Trust

Trust between the therapist and service users suffering from addiction is seen as a key factor in the formation of the alliance (Miller, 2007; Thom et al., 2011; Jauffret-Roustide et al., 2012; Reyre et al., 2014). STAR staff appear skilled and conscious of the need to build trust. Almost all of the interviewed service users stated that they have complete trust in the staff cohort. One service user commented: "*In this place that care bounces off you and you build up that trust. I am only in here, I am only in here a month or two and I have that trust in them*". The staff see trust as one of the crucial aspects of their work citing trust issues that may have arisen during addiction or as a result of trauma experienced as common in the addiction experience. For example, at interview a staff member stated: "*Trust is vital when you are working with a client group such as this, trust is really difficult for them for a whole range of different reasons, particularly in terms of past trauma"*. Service provision is structured in a way that places a particular focus on building trust; *"we try to create an environment that fosters trust so you are honest with people. You don't tell people things just because it is easier, you actually try to create an honesty".* Trust is fostered to enable personal disclosures. A number of service users stated that they have complete trust in the staff, particularly in their key workers: *"I can talk about anything, especially with my key worker because we have actually built up a relationship, he has met my family, he has met my doctor, we have had a good few one to ones so I have a trust there with him now"*.

Some service users indicated that they had disclosed material at STAR that they would not have shared previously with family members or other professionals: *"the one to ones they do with you, it actually works. I have told them stuff in here that I don't tell my own family and I know it's not going to go anywhere*" and "*I had been to see psychologists and all for years and I never told them any of that stuff when I was in hospital and all, I think it was like a trust thing or something*". Furthermore, the service users stated that they know that whatever they

shared with their key worker was held in confidence. Similarly, group work, was trusted as containing disclosed material within the STAR project.

Previous researchers have noted that care professionals need to be able to trust what the service user is saying and whether they can commit to a course of treatment (Miller, 2007), This trust from the care provider enhances the service user's trust in them (Cook et al., 2004, Thorne & Robinson, 1988); whereas a lack of trust on behalf of the care provider will more often than not be perceived negatively by service users which in turn affects them and the relationship negatively (Cook et al., 2004; Rogers, 2002). STAR staff make a conscious effort to trust service users at all times and this is highlighted by quotes made by two service users when comparing STAR with other services: *"They trust what you are saying here which is different to most of the places I was in, it was like once an addict always an addict. They always assumed you were being dishonest with them"* and *"In other places, they always assumed that you were up to something behind their back, they had this never trust an addict, he will say what he has to say just to get out of the uncomfortable situation. So you go in and tell the truth and then there would be a big interrogation trying to catch you out, this type of thing. Whereas in here they just take you at your word"*. Furthermore, mutual trust leads to more successful and sustainable cooperation (Walker & Ostrom, 2009). A reciprocal trust between staff and service users is very evident at STAR, as is the atmosphere of mutual respect and belief.

Connection

Connection between the service user and the therapist also predicts the emergence of a good therapeutic alliance. It is defined connection as the level of intimacy and mutuality between the therapist and the service user during therapy sessions. The deeper the connection between the therapist and the service user, the more likely the service user is to engage and be involved in the work (Sexton el al., 2005). Staff regularly talked about the importance of building this connection or relationship, as well as how they enable it during the interview phase: *"the relationship is key to working with our clients, it really is one of the foundations. You have to develop and build good relationships or certainly strong relationships built on no judgement, mutual respect, etc."*, "*I think in terms of the level of non-judgement and trying to accept where people are at builds up a really strong trust and relationship"* and "*we let the client in while still trying to keep a certain boundary but I think we push that maybe a*

little further than a lot of places so it feels less rigid. It feels like the relationship has more of a flow to it and it feels like more of a normal relationship".

At interview a staff member was asked what they think their relationship is like with service users, they responded: *"When I think about the relationship I just feel that warmth, that connection and I learn so much from the clients as well"*. This demonstrates that building a connection is key to the way work is conducted. The quotes above emphasise that being non-judgemental and facilitating service user engagement are important aspects of how staff create connections; however, during interviews it became clear that active listening is also a significant focus: *"I think the clients see that, I think the clients feel that no matter what it is they are coming in to talk to us and somebody is going to listen"*. Active listening has been found to be associated with a deeper connection (Sexton et al., 2005), when asked about skills or strategies used to form or build relationships, one staff member replied: *"one of the biggest skills any of us can have is listening and that can be a hard part sometimes but I think the clients feel that they are listened to and I think that is one of the reasons that the relationships are good"*. Staff try and focus on listening to the service user from the start: *"In the early stages it is very much active listening. It is making sure that you are hearing. You are really listening and you are looking for as much of what they are not saying as what they are saying".* This was acknowledged by the service users, two people said regarding their first interview: "*I didn't feel like he was judging me or just seeing me as an addict. He was really listening to me, it just felt more real kind of thing"* and *"during my assessment it was just the way he listened to me and responded to me, it just started making me feel hopeful again and I started looking forward to coming here"*. Active listening was reported by service users as part of their ongoing experience: *"they give nothing but 110% to people no matter what, no matter what hour of the day, no matter what day it is there is always somebody there to support and listen to you*" and *"Since coming in here I was listened to and was given options and stuff, so really amazing*".

Additionally, staff foster alliance and connection with service users through listening to feedback. Staff listen to both negative and positive feedback from service users regarding the service. There is a monthly meeting in which the service users air any grievances they may have or put forth suggestions. Staff see this as a key part of good relationships management: "*in the monthly meetings they are able to give their input into what they want for the service and I just think that is really important to them to be heard"*, *"they feel heard, they feel listened to. We are always asking them what is working, what is not working and I think it*

makes them feel I have been heard, I have been listened to, we are just not being told what to do" and "*if people have feedback that is challenging to us at times that we really listen to that and then we come back to people with ideas around how that could be resolved and if the clients have ideas around stuff like that that we would listen to them*". Besides listening staff try to use feedback to improve service delivery. If desired service improvement is not possible, regardless of the reason, service users are informed. This work practice is appreciated by the service users: "*The staff do listen to us because we have a monthly meeting where we sit down with the staff and we thrash out if there are any issues or any problems or anything, any new ideas, they will listen to us and take on board and discuss it and then come back to us. I feel that I am heard in here as well, that I am listened to, that we are all listened to so they take everyone's opinion on board as well"* and *"at the monthly meeting, you are allowed voice your opinion on things and you are listened to and if it works out they tell you 'we're not going back to it'"*. It is clear that the staff are adept at forming a strong connection with the service users and active listening is a central technique employed.

Cohesion

Cohesion is the attachment of the service users to the group as a whole and is also the uniting force in groups (Lorentzen, Sexton, & Høglend, 2004; Ogrodniczuk, Piper, & Joyce, 2006). Cohesion is identified as one of the most important therapeutic factors in group therapy (Yalom & Leszcz, 2005). It has been argued that cohesion in group therapy is analogous, if not synonymous, with the concept of the alliance in individual therapy. However, evidently cohesion represents a more complex construct. It not only includes the service user's relationship or bond with the therapist or member of staff, but also their relationships with the other service users, as well as their relationship to the group as a whole (Burlingame et al., 2002; Piper, Marrache, Lacroix, Richardsen, & Jones, 1983).

Group Cohesion

There is good group cohesion within the project at STAR, it was mentioned by almost all of the service users that there is a sense of togetherness and that there are no cliques. This togetherness was evident during the observation phase and is highlighted in these excerpts from the field notes: *"At the break, everyone shares tobacco and cigarettes and there is no animosity when someone asks for one. Shows that there is a good harmony in the group"* and *"One of the service users said it was the first service they had been in where they didn't feel*

judged, that there were no cliques here". It was also mentioned by a number of service users during the interview phase*: "everyone is in a different seat every day and beside a different person, it is never the girls together or the boys together, none of that, or certain people together"* and *"I love the way there is no cliques in here, there is no bullying, none of that goes on and it goes on in a lot of day programmes, I went to staff before in previous day programmes and they'd say, 'we can't avoid it, it happens.' Whereas here there is no way that would happen here, they would nip it in the bud straight away".* The last quote demonstrates how staff work hard to maintain this group cohesion and sense of togetherness. Furthermore, one service user outlined the possible benefits that maintaining such an atmosphere might have i.e. improved retention: *"There are no cliques in here, in other places where I have been where there are cliques and you feel all depressed and that can force people to leave the treatment centre and stuff like that"*. This cohesiveness also has other benefits as cohesion is a condition that is necessary to allow meaningful work and change to occur in a group therapy setting (Yalom and Leszcz, 2005).

As there are no cliques in the project, it also means that everyone is welcomed into the group and new people find it easy to assimilate with the others. One service user commented on this: *"When you see a new person starting I think that is where it shows. I have seen it a lot of times where a new person comes in and within a week and you see them outside with the others and it is as if they have been here for two years*". A number of service users also commented on their own personal feelings about how easy the found it to settle in: *My first day I was pretty anxious because I would suffer with social anxiety but within a day or two I felt really comfortable around everybody, everyone was really welcoming and it was a nice atmosphere here. I felt good after a few days", "I couldn't believe how quick I settled in, I just felt the connection with everybody, all the staff and my group and all. I couldn't believe how I got on with everybody individually and could relate to everyone, the support from everybody was amazing"* and *"The first day in here was great, the support I got was just unbelievable from the clients and the staff. There is no comparison with other places. In other places you go in and sometimes you are forgotten about, the new bloke, you are left sitting there on your own and it takes a long time to blend in. Whereas here you are just part of the family"*.

This concept of a family, mentioned in the latter quote, is incredibly strong among the service users. An abundance of quotes emerged during the interview phase about feeling together and like a family: *"It is like we are all one big family. Even when I went into recovery I missed*

here, I genuinely missed here because it is like leaving your brothers and sisters, your mother. It is like a family, everybody supports you, no one judges"; "*It is kind of like a big family or something, that is the feel of the place. The same even with the staff"*; *"I guess most people have been here for a while so the way they talk to each other is like they are brothers and sisters"*; *"it is like a big kind of family really. Everyone gets on with one another, there are no little cliques or anything like that"* and "*I've been here nearly two years and you get so comfortable in the place and it seemed like a family kind of and just the sense of connection that I had here that I had never really had before anywhere"*. It is clear from the above quotes that there is a real felt sense of togetherness and cohesiveness amongst the service users, which helps to form the strong social bonds present in the project.

The group cohesiveness also extends to include staff. The service users see staff as like them and don't feel like there is a hierarchy within the service. Once again, this was evident during the observation phase as the following excerpt from the field notes demonstrates: *"The service users don't perceive there to be any sort of boundary or disparity between staff and service users"*. One service user stated that this was the case from the beginning: "*staff were more approachable and they were fairly sort of honest, they include their own life experiences as they were talking to you as opposed to being the teacher at the top of the class, that sort of a way. and then you could approach them at any time"*. However, based on the service user testimonies it is not something that is only present when somebody enters the service, it is deeply entrenched in the way the service is managed and this is reflected in the following statements: "*the staff don't talk to you like they are above you, they talk to you like they are at the same level as you"*; "*Well there is boundaries but I don't see them as that, we're all the same"*; *" I find in here no one is above you but you don't feel like they are a higher authority to you, like everyone has a laugh and it doesn't matter who is the manager or who is the boss. We all get on"* and "*Everybody will talk to you in the same way, no one is higher than you or makes you feel bad about your struggle".* This high level of cohesion in the service is very important as Yalom and Leszcz (2005) suggested that high cohesion helps create the necessary therapeutic environment for groups to operate in a beneficial way. Often the therapeutic relationship can be more important than the actual intervention in individual work and this might also be the case in group work as group cohesion may be more important than the actual intervention used with substance users. Additionally, studies have shown that group experiences are therapeutic because people begin to realise they have something to offer others (Gitterman & Shulman, 2005).

Non-Judgemental Approach

One aspect of the service that aids cohesion and maintains togetherness is the non-judgemental approach that appeared to be taken by everyone. The service users are never overtly judged for what they say; when they are in groups, they can talk about their situation at home, how their recovery is going and even things that may have happened in their past. One service user stated that *"In here I find it is safe to share, especially in the groups and stuff like that, and with the staff as well when you are going for one to one sessions, I feel that everything is confidential, there is no judgement here".* This is also the case outside of activities and groups, the researcher repeatedly witnessed service users sharing problems and stories with each other, without fear of judgement, while in the garden or having tea in the kitchen. The researcher noted that: *"The service users are not judged and feel like they can say anything and people won't view them differently"*. The service users commented on this frequently and one person stated: *"there is no shame in here, no matter what you bring up or what you are going through, there is never any shame and no one is being judged"*. As well as not being judged by their peers, the service users do not appear to be judged by the staff. This was evident during the group work, as much like the service users, staff members were not seen to judge or reproach someone for something they had said. One service user commented during the observation phase that "*This is the first service I've been where I didn't feel judged"*. Furthermore, with regards to one-on-one work, which was not observed by the researcher, service users regularly commented that they have a great relationship with their keyworker and felt like they could say anything to them without fear of judgement. Research has shown that when service users feel they are being judged by their therapists, this acts as a barrier to a good therapeutic alliance (Swift et al., 2017). This stance taken by the staff also extends to when a service user does not adhere to the rules of the service: *"if somebody does come in under the influence, if I want to practice non-judgement I am saying to them, look that is okay, that is the way things are, let's talk about what is going on for you. But they are not getting the whole, I can't believe you did that"*. Even though, the service user would be asked to leave and wouldn't be able to attend the service that day, the exclusion would be conducted in a respectful manner.

Along with not being punished for relapsing, there was no evidence of a judgemental approach to relapses. There is a structured format applied which the keyworker follows when a relapse occurs, it is based on a community reinforcement approach; the staff help the service user to see where they went wrong and how they can change their behaviour in the

future. Throughout this process, the staff take a non-judgemental approach and one staff member stated as much *"I think genuinely people are trying to be non-judgemental here even when someone has a relapse and you have worked with someone and been so engaged with someone, you don't take that personally. Because people are doing the work on themselves"*. After, a service user has gone through this process, they tell their group about their relapse; once again, based on researcher observations, nobody was judged for this and they were always commended for their honesty. Additionally, as well as not being judged for what they say or do, the non-judgemental approach extended to a holistic concept of the person, i.e. who they are. Staff make a conscious effort to convey this in the way they work with the service users: "*We are dealing with people who have been judged their whole lives and I think it is vital that whatever is happening you can say to somebody I am not judging you for what you have done, or your behaviours, and we can separate the individual from the addiction"*. This represents a stark contrast to the environment outside STAR, numerous studies have demonstrated that substance use disorders are more highly stigmatised than other health conditions (Ronzani, Higgins- Biddle, & Furtado, 2009; Room, 2005; Schomerus et al., 2011). This stigma can lead to mistrust on the part of the general public, and also among caregivers (Goffman, 2009). As trust is one of the key elements which contributes to the formation of the therapeutic alliance between the service user and the caregiver (Jauffret-Roustide et al. 2012; Thom et al. 2011), a non-judgemental service is key to successful treatment outcomes. The perceived lack of judging at STAR is perhaps somewhat related to some staffs' lived personal addiction treatment experience. Whatever the reason is, it is something that has not gone unnoticed amongst the service users and this is exemplified by a quote made by one person "*I don't know how to explain it but there is decent people who aren't going to judge you. I just feel accepted here for the first time in my life. It gives me more faith" and "they don't judge anyone coming in here no matter what your background is"*. This non-judgemental approach from everyone at the service enhances the cohesiveness of the group and also allows service users to be less guarded and more engaged, which facilitates a positive experience.

Support

In addition to not judging each other, the service users constantly support each other which adds to the togetherness of the group. A supportive atmosphere is an integral cog in the workings of an addiction service; research has shown that treatment centres which provide an engaging and supportive environment, in which service users form constructive relationships,

produce better long-term outcomes (Orford et al., 2006; Gifford et al., 2006). At STAR, peer support is particularly evident during group work and the morning check-in. Every day starts with a brief check-in with each service user talking briefly about their current life experience and their emotional state. If an individual is experiencing challenges or emotional difficulties all of the service users respond with emotional support in the form of comforting, encouraging and supportive words. This was also observed in group work sessions, this supportive atmosphere is ever-present and the service users remarked on it during interviews: *"We all actually care for each other and support each other regardless of if you are after having a bad day or a relapse or whatever. We are taken in with open arms and said, let's go again, we are here for you"*. Data supporting this phenomena of high positive regard for others was collected during the observation phase and the researcher noted that: "*All of the service users are very supportive of each other and the atmosphere always seems to be very positive"*. However, this peer support is not only present during group sessions and check-ins, the researcher observed the service users offering each other support, over a range of issues, when they were just having a chat in the garden or sitting down in the kitchen. This supportive atmosphere extends outside the walls of STAR, as upon returning from a day trip with the project, one service user remarked to the researcher*: "At the beach, the men sat around together and just asked each other if they were ok, it was a great thing and something that I wouldn't have been used to growing up". Once again, this may be a complete contrast to the outside world, and the support they are getting there.* One particular service user said *"It is a safe place plus it is time for me to work on myself. I can't do that at home"*. This type of support may be an alien concept to some service users as support from families of substance users can often be inadequate, families are frequently reported as being judgemental and harbouring negative attitudes towards the substance user, and the support that service users receive with regards commitment to treatment is often unpredictable (Reyre et al., 2017).

"The service users are constantly supporting each other and giving each other advice based on their past experiences" was one such observation made by the researcher, i.e. the service users also support each other in terms of advice giving. As there are a range of novice to expert service users attending STAR, expert or longer term service users frequently give guidance and advice to new or novice members on what previously worked best for them, as well as sharing examples of where they may have been unsuccessful previously. This peer to peer advice giving was observed during formal groups and break times. This was commented

on by a service user during the interview phase "*I think everyone just wants to help each other out, give you little nudges when you need them and stuff. The people who have been here a long time pass it down, that is the way it has been passed down to me. Now I am helping out people when they come in. It is kind of like a generational thing, it is passed down from client to client"*. When people are not confident in their own abilities, which is often the case with people in recovery, they become more sensitive to the actions of others. Pooler et al., (2014) posited that it is possible that involvement in a cohesive group supports a new awareness of the "other" and the "other's" capacity to change. In a cohesive addiction treatment group, the "other" may be easy to identify with given the similarity of their life experiences and consequences of addiction.

Staff also offer support in the form of advice, and emotional support during group and check in. If a service user expressed feeling overwhelmed or disclosed a problematic issue, the staff facilitating the group usually offered immediate support or advice. Service users were on occasion advised to talk to their key worker about their dilemma so as they could avail of appropriate support. The service users expressed appreciation for the support they receive from the staff: "*People are here to help you and support you and that is amazing to have, to have that every day regardless of what comes up"*. Service users also commented that they receive support from staff outside of the group work: *"I feel I can go to any staff member here with any problem and they will do their utmost best to help you however they can. Where I feel I didn't get that in any other treatment centre"*. The staff also offer practical support to the service users. They liaise with doctors, dentists and other professionals about the service users' treatment, help arrange and give reminders about appointments. Staff would even go with service users to meetings such as those for management of their methadone dosage and help the service user to best communicate what they want; they would also go with them to an appointment if a service user thought they would become very anxious or overwhelmed as a result of it. During the observation phase, the researcher also witnessed the staff helping the service users with regards to clothes and housing.

Previous research on group treatment has demonstrated that group cohesion is integral to the group dynamic and ultimately for the participants' possibilities to change (Burlingame et al., 2011; Greenfield et al., 2013; Pooler et al., 2014). It is clear that the people at STAR are a very cohesive and united group, which appears to be due to the philosophy of the project along with the non-judgemental approach and supportive environment.

Safe Haven

The philosophy underpinning the ethos of STAR manifests in the environment in which services are delivered. Service users and staff describe the physical space in which they work collaboratively on recovery from substance abuse as a '*safe haven'*.

The safe physical space

Through researcher observation and analysis of the data, it became apparent that the actual physical environment of the project lends itself to being a safe place or refuge. The project is housed in a private building with secure access. Once inside the door, Service user's and staff are greeted by an open plan reception area furnished with a number of couches, one service user commented*: "the physical environment is nice and bright and all but there is just good energy in the place when you come in"*. A number of staff members also provided an insight into their first impressions about the place: "*The minute I walked in you could just feel there was a lovely atmosphere, the way the place is laid out, the sofas, and everybody was so friendly and welcoming"*; *"The first time I walked in this door, I got a sense of feeling about the place. I know you can walk into other places and you can feel a bit intimidated or whatever so I think it is almost organic"* and "*It is the set-up of the place or the feel or the vibe, I don't know, it just feels like a warm welcome safe space I suppose"*.

The overall space is small for the population size and forces constant contact between occupants. Three offices, two group rooms, a small therapy room, a kitchen, a reception area and an enclosed private garden on the lower level are available to the occupants. There are shared safe spaces and private safe spaces where individual service users can get support and guidance. Even outside of the security of the designated group work rooms, the rest of the building is seen as a safe place to share and help others. This small space is challenging for staff when planning and organising groups and individual work but it keeps the group tight-knit and together. The researcher noted: *"unless they are involved in one-on-ones, the service users are always together, whether it be in the kitchen or the garden, nobody is ever by themselves"*. In the morning all of the service users spent time in the kitchen and at break time they all tend to move downstairs to the garden; despite this togetherness, service users are free to use the space as they wish. All of this combines to create a safe intimate compact physical environment for people to relax and engage with each other. The staff describe the couch area in reception as being created to provide a relaxed engaging environment: "*it was*

designed in that way purposefully that people feel like they are coming in and it is not a sitting room but a couch area. There is a message in the furniture, this is a relaxing space. It is not upright steel chairs" and "*Even the setup of the couches out there lends itself to that, people just stroll by and sit down and have a chat*". The couches are organised so as to create an informal feeling, this is done so that service users don't feel pressured to open up or like they are in a typical health care setting, in which some of the service users may have had bad experiences: *"sometimes so much more can come from just sitting down at the couches than having a key worker session for half an hour".* During the observation phase, the researcher also witnessed people opening up and relaxing in the kitchen in the mornings: *"In the kitchen in the morning all of the service users were chatting away, all of them seem friendly and open with each other"*, it appears to be an informal setting where the service users are disinhibited and comfortable. However, it was noted that most informal peer support and sharing takes place in the garden: *"During the break, everyone gets a cup of tea and goes outside to the garden. Nobody stays in the kitchen or stays upstairs"*. Frequently the researcher observed service users talking openly in groups about concerns they had: *"In the garden, the service users sit or stand around in different groups but all of the service users are very comfortable with each other and chat away freely about problems or concerns they may have*". Often, people waited until they were in the '*sanctuary'* of the garden to take a peer aside, seek their advice or use this opportunity to express a concern: *"It was clear one of the service users was not in a good mood, in the garden at the break he asked one of the more experienced service users if he could have a one-on-one chat with him"*. The staff availed of the garden as a place to have individual conversations with service users: *"staff use the break as a time to have one-on-one chats, this is often done in the garden away from the other service users".* Based on researcher observations and key messages from both service users and staff, it is evident that the early formation of social bonds is supported by STAR's compact, welcoming, safe physical environment.

<u>Maintaining the safe space</u>

STAR is located in an area of Dublin which experiences high levels of social deprivation. The service users see STAR as a '*refuge*' from the storm that is their lives outside of the project. One of the staff members described this: *"They sometimes refer to their world outside as being like a jungle. There are guns, there is prostitution, there is quite dark and serious stuff that is quite gritty"*. This is juxtaposed by their attendance at STAR, as it offers a refuge for service users. A few of the service users commented on this during the interview

phase: "*When I come in here I can sit down and forget about what is going on outside in the world and just interact with my peers and staff until I leave here"* and "*It's a kind of a safe haven with people that have the same issues and problems as me with regards my addiction. They can identify with me about everything so it is just a safe place to be for a few hours*".

They also see it as a place in which to escape the potential pressures and temptations experienced in their life outside the project. STAR is an alcohol and drug free service so the service users know once they cross the threshold there will be no physical exposure to triggers that cause them to feel unsafe. This is maintained by asking service users who arrive under the influence of any non-prescribed mood altering substance to go home. Service Users are encouraged to police the environment and inform staff if a peer's active substance use has gone unnoticed in order to maintain the safe environment. This creates a shared responsibility for maintaining a safe drug and alcohol free environment which is supported by the peer group, reducing a 'them and us' division between staff and service users which in turn strengthens the social bond: *"people are coming in here to feel safe and to open up and talk about their problems so you don't want to be dealing with other stuff",* this was very clear during the observation phase and the researcher noted "*It is clear that the service users appreciate when their environment at STAR is safe, especially with regards to there being no talk about drugs/alcohol or other service users coming in under the influence. A number of service users admitted that they would tell the staff if they felt that another service user was disturbing this safe environment"*. This engagement in policing the service rules is furthered by asking service users to bring it to the staff's attention if they feel another service user is threatening the safety of the group in other ways. This self and peer monitoring and reporting implicates services users as accountable for the maintenance of project rules and the safe environment.

One of the most important facets which appears to keeps the project safe is a rule around the use of language. The service does not allow any sort of dialogue about drug use, outside of scheduled group activities or in individual sessions with key workers. As it is a core belief of the project's philosophy that service users' substance use may be triggered by talking about drugs or alcohol, no language which may relate to drug or alcohol use is permitted, even if it is not a direct allusion to substance use; for example, it is considered preferable to say "*it was great fun*" instead of "*it was great craic (crack*)". The researcher noted during the observation period that service users learnt to police themselves in this regard and did not hesitate to tell each other when they may have said something that was possibly provocative,

in order to maintain the rule and safe environment. Maintaining a safe environment was also a staff concern and it was expressed as a core values at interview "*Trying to create a safe space and a safe place from the moment someone comes through the door until they finally leave*".

Boundaries that protect the Safe Haven

As previously mentioned, the service users do not perceive a hierarchy within the project and feel they are on the same level as staff: *"I find in here no one is above you but you don't feel like they are a higher authority to you, like everyone has a laugh and it doesn't matter who is the manager or who is the boss. We all get on"* and *"the staff don't talk to you like they are above you, they talk to you like they are at the same level as you, the same page as you"*. This perception of equality helps with the formation of strong social bonds; however, staff have boundaries in place to keep the service safe, one staff member put it: *"The way we have been talking, it kind of sounds like clients come in and we all just give them a big hug but the boundaries are in place as well to keep the place safe, we would tell the clients this and they understand that"*. These boundaries are key to how the project functions.

No lending of money and no relationships inside the service are basic rules which keep the place safe and preserve a good working environment. Previous experience has demonstrated these areas as problematic: *"people lending money that can cause tension between people in the group so it is very hard then to give someone feedback when you have a tense relationship with them"*. Another rule enforce at STAR is that the service users have their tea or coffee in the kitchen in the morning. This eradicates the possibility that service users will, on arrival, commence talk with other service users about "*war stories*" or how they may have felt like taking drugs the previous day, prior to having the opportunity to discuss this with their key worker: *"Another great thing about it is there is no war stories, we used to come in in the morning and we would go downstairs for a cup of tea and someone would be talking about how they felt or what they did and other people would pick up on it".* This caused problems in the past and it was affecting the work in the groups: "*you would bring it up into the room and the atmosphere would change, the whole atmosphere would change. I have seen a big positive difference in that sense"*. It was evident through the observations and interviews that rules exist about how and where people talk and that these rules were constructed to maintain recovery, the sense of safety, service philosophy and group cohesion.

Aside from general rules, the manner in which STAR manages the boundaries with service users may be influenced by their level of emotional attachment to the work: *"it feels like a level of care and love but with boundaries", "you are working from your heart and you are being open"* and "*It can be difficult to let go of people because you grow to love people"* and *"I have a huge belief in kindness and trying to be open but have my boundaries"*. This openly expressed genuine care for the service users enabled the relationships formed with them to differ from service user-staff relationships experienced elsewhere: "*compared to anywhere else I have ever worked the level of letting the client in, understanding who you are as a person while at the same time making sure that it doesn't drop below a certain boundary"* and *"I think we push the boundaries maybe a little further than a lot of places so it feels less rigid. It feels like the relationship has more of a flow to it and it feels more normal"*. This promotion of informality and amiability enables a more natural relationship. However, staff assert that it is important to find a balance between this caring and friendly approach and maintaining appropriate boundaries: *"something we work really strongly at is finding that balance between holding the boundaries but also being able to work. So it is like a dance with a client"* and "*It is a real balancing act, my job is very much, yes you can have a friendship but to be able to know the boundaries, and to hold them"*. Staff maintain that as well as fostering a flow to the relationship based on mutual respect, this position allows them to build trust and improves conditions to succeed for the service user: *"I think if you are clear with your boundaries then trust builds up and you can have a 'friendship' but you can also be more true to yourself and the client, if you really want to get the best out of a client they have to see staff, not as robots, not as somebody that is really clinical, but the human side"*.

Managing the boundaries in this fashion helps to form good relationships but there are times when the safety of the project takes precedence over this individual relationship, such as when somebody attends under the influence and is asked to leave. This may cause a rupture in the individual alliance but is done in order to preserve the integrity of the project: *"I have to hold boundaries with them. It is a part of the job that is uncomfortable sometimes, when you have to take someone out of the group or you need to ask someone to leave the programme because they are under the influence"* and *"Sometimes when that happens they can hold that against you and blame it on you and it is trying to find that balance where you are trying to be fair with people but trying to hold the boundaries as well"*. The sobriety rule has evolved over time as a consequence of staff learning from experience: "*I know when we first started it could be quite chaotic in here. the threshold is a bit higher now so things run a*

bit more smoothly. when the threshold is a bit lower, you are not getting much work done with people when they are under the influence". The sobriety rule has improved working conditions for staff and reduced relapse triggers for service users. If someone relapses, they are excluded from group activities, boundaries are maintained and the service user attendance and participation is limited to individual work with the staff. A number of service users remarked during the observation phase that the project functions much better and is a lot safer than previously, one service user, who had been attending the service intermittently for a number of years, stated: "*I am here a few years now, the atmosphere I would say now in the last year is the best atmosphere I have ever experienced"*

The boundaries are also in place in order to keep the staff safe. One staff member commented: *"if you don't have boundaries you will be walked all over and you will suffer from burn out. You have to learn, it is so important that you don't bring these stories home with you because it would take over your life, you would have no home life"*. Staff maintain this safety by separating their working life from their personal life and while they may have friendly relationships with the service users at STAR, they are not friends outside. Staff safety is also maintained through supervision, the importance of supervision and its role in upholding boundaries was commented on by a number of staff: *"in supervision, they would say this has the potential to become an issue, you have got to watch this, hold the boundary on that"* and "*If I feel that at any stage that boundary line is being crossed I need to make sure I am talking about it to my supervisor or I am going to the manager"*.

The staff also collaborate with the service users in order to keep the project safe. At monthly meetings, service users are asked to give feedback on ways in which they feel the project's safety could be maintained and improved. This joint responsibility for maintaining a safe space, as held by staff and service users, has resulted in a facilitative therapeutic environment in which healthy social bonds are formed, challenged and maintained, enabling service users to more readily engage in the range of services offered.

Walking the Talk

STAR deliver a range of day-to-day activities which include QQI training, holistic therapies, computers, fitness classes. While the activities appear to be geared around perceived life and work skills which meet the community employment scheme aspect of the service they are not

necessarily tied to the core philosophy of the service. It is in the approaches to the service provision as well as the core group work activities where the person-centred tenet of the philosophy is particularly evident.

Community Reinforcement Approach

At Star the use of a Community Reinforcement Approach (CRA) appears to be designed to initiate changes in lifestyle and the social environment that will support individual's long-term sobriety. It is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging alcohol or drug use (Meyers, Smith, Serna, & Belon). CRA is rooted in operant principles. Positive reinforcement is used at all times, no matter how small the event or action may be. Consequently, staff must be willing to continually look for opportunities to positively reinforce service users; which is evident in the approach taken at STAR: "*If somebody comes in late I would say I'm glad you made it today. I'm sorry we don't have the whole day to work together, but I'm just glad you're here. Thanks for coming"*; *"If you had a problem with it we will discuss and find out why you have a problem with time keeping. It wasn't like you are a bold boy for coming in late three times a week or something*" and *"When somebody comes in after a relapse, I will always say that the most important thing you have done is just getting yourself back in that door. There is a reason why you have had the courage to come back in, and it doesn't matter if it is the sixth time in six months or whether it is the first time in four years"*. In this way staff are constantly validating service users' attempts at change.

When an individual has a relapse, staff engage the person in a CRA functional analysis structured interview which outlines both the antecedents and triggers for the behaviour and the consequences. A staff member explained the approach: *"So it is not about judging someone, it's about what can be learnt, what can we take out of it? Do we need to change the approach? What worked? What didn't? And the staff member is learning about that service user that they are working with, it is enhancing their relationship, because there is never one size fits all and it is not a straight line"*. This analysis can be carried out in an informal or flexible way, staff can go through the questions with the individual and complete the relevant paperwork later, e.g. one member of staff asserted that it allows for a more natural conversation and discussion on the issues at hand: *"it allows for a flow of conversation and at the end of it they were going, okay so that is what was going on for me. You talk about the triggers, talk about where they were, who they were with, weighing up the pros and cons of*

should they use, should they not. If they do what are the consequences, if they don't, the positives; it is very helpful.

In addition to reinforcing service user's attempts at change, staff are also committed to helping them identify potential positive reinforcements in the community. Thus helping the service user find "payoffs" for learning new skills and trying new behaviours, which in turn creates motivation for change, e.g. service users are taught to modify their communication styles in order to minimise interpersonal conflict with family members or significant others in their lives: *I've been taught how to communicate properly with my wife. Did I actually listen to her? We are all very good at putting our own points across and we say we hear what someone is saying but do we actually listen and hear what they are saying and have empathy for what they are saying?"*. One staff member commented that "A *lot of the clients now say that the house is so peaceful now, and that is down to the communication skills they have learnt"*. Service users also learn assertiveness and others skills which bolsters their self-esteem, a number of service users commented on this: *"For such a short time here so much has sort of changed in my own self-confidence, my own self-esteem, my own vision of the future, possibilities and opportunities and things*" and *"my own self-esteem and my own confidence and all that has risen. I don't know how you would quantify it but I don't feel so much as an outcast, I feel more part of society, I am not just labelled as an addict"*. This was also evident during the observation phase: *"It is clear to see that the more time that the people spend at STAR, the more confidence they gain and the more they come out of their shell"*.

Additionally, service users are asked to set goals as part of the CRA. These goals may be related to alcohol or drug use, money management, social life, personal habits, family relationships, legal issues, emotional life, communication, and general happiness. At Star, this is supported by the individuals care plan: "*So when you do a piece of work with somebody there is short and long term goals. When things are achieved, they are noted, they are kept on a database, they can be printed out, they can be given to the clients. At the end of the time you can see how many goals were achieved"*. CRA has been empirically supported with inpatients (Azrin, 1976; Hunt & Azrin, 1973), outpatients (Azrin, Sisson, Meyers, & Godley, 1982; Mallams, Godley, Hall, & Meyers, 1982; Meyers & Miller, 2001), and homeless populations (Smith, Meyers, & Delaney, 1998). Additionally, three meta-analytic reviews cited it as one of the most cost-effective alcohol treatment programs currently

available (Finney & Monahan, 1996; Holder, Longbaugh, Miller, & Rubonis, 1991; Miller et al., 1995). The CRA is observable in almost all of the work in STAR and it has the benefit of building people's self-esteem, allowing them to achieve goals, as well as improving their lifestyle and social environment while also recovering from addiction.

Motivational Interviewing

Motivational Interviewing (MI) is an effective strategy for engaging and treating substance abuse disorders. It is defined as a client-centred directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Miller & Rollnick 2002). In a review by Keane (2011), it was found that delivering MI to reduce substance abuse is more effective than no treatment and is comparable to interventions such as giving feedback on assessments or other types of psychotherapy. However, as outlined below, there are other reasons why STAR uses an MI approach. As MI is client-centred, it fits with the philosophy of the service. Importantly, this study found that staff place a focus on figuring out what service users want, not what the staff think is best for them.

There are four key strategies which underpin STAR's approach to MI.

- Staff express empathy with the service users and attempt to see the world through their eyes. This was commented on by one member of staff*: "I have so much respect and regard for the service users because I know how hard it is to give something up. And I really admire them for coming in and it doesn't bother me if they have a slip or whatever, just put it behind you"*. This way of working creates a strong bond between the staff and the service user, while also empowering the service user.
- Staff support self-efficacy, i.e. they give responsibility to the service user for choosing and undertaking what they want to change. One service user commented on this: *"When you first start here you fill out a plan, a plan of action and it is basically setting out your goals for your recovery, what you want to work at, what training you need"*. This is particularly important because self-efficacy has been established as predictor of substance use and a mediator of treatment outcomes (Kadden & Litt, 2011; Krentzman, 2007; LaChance, Ewing, Bryan, & Hutchison, 2009).
- Staff embrace resistance i.e. they do not fight the service user's resistance or ambivalence to change, they continue to assist service users to further explore

reasons why the service users may not want to change. This allows the service users to grow while not being judged.

- Staff help the service users to perceive a discrepancy between their current behaviour and their future goals and aspirations. This was evident during the observation phase as is clear from these excerpts from the field notes: "*Over the course of the group, the staff member pointed out to a number of the service there was conflicting thoughts and tried to get them to see what might happen if they continue this kind of behaviour"* and *"One of the staff members asked the service user to challenge the way she is feeling and showed her that she is missing out on living her life if she keeps feeling this way. The service user agreed to challenge the way she is behaving and thinking in the future"*.

The use of an MI approach instils hope and helps people realise they are human and fallible; staff and service users alike. Treating people with respect and dignity helps them to learn that their 'worth' is based on their humanity as opposed to their 'worth' being based on what they do. This impact is particularly evident in some of the quotes that emerged during the interview phase: *"I feel like I am making the most progress here that I have ever made in my addiction. I feel like I have learned more here than anywhere else combined. So it is a nice feeling to have that hope and I actually feel like I can do it this time where before there was always the doubts. I get stronger by the month"*; *"I am more optimistic, you can leave that behind you, you can have a completely different life, that is only a small part of who you are and what you are and what you are capable of doing"* and *"I haven't been as content or at ease with myself since as far back as I can remember to be honest with you, since I started attending here*.

Emotional Supports

Potential new service users at STAR are invited to attend the Wednesday group, a voluntary group run by the staff, for a few weeks prior to attending the full programme. It is a theme based group that focuses on a different topic each week. Topics vary between practical, social and emotional themes such as: "*boundary setting, emotions encountered due to stopping drug use, relapse prevention, and managing housing"*. Staff use a variety of facilitation skills, community development skills, counselling skills and conflict resolution skills during these groups. This group allows the staff to assess prospective service user's readiness to engage in rehabilitation while also allowing them to develop a social bond with the service user: *"if*

people are doing well we will say to them, do you want to take this further? And we do the one to one assessments. And at that stage the relationship is built up and that is how we do it". It also allows the service users to form relationships with their peers and eases them into the service as opposed to just being thrown in at the deep-end, two service users commented on the importance of this: *"you actually meet other Star members that are here a long time. I met a few of the guys there and they kind of went through the motions with me, what you do, etc., so when you come in you are not meeting all new people for the first time, you know people. That was a major thing"* and *"That helped me for when I was about to start here because I got to know and see the heads that were here. It made it easier for me to come in here then because I would recognise a couple of people".* This concept of building a social bond or a relationship before commencing the full programme appeared to be important for the service users.

This approach allowed service users an opportunity to see if STAR is a good fit for them and to be part of the decision making process from the onset. One staff member described this: "*it gives them a chance to see, is this for them? What is this space like? Who is here? What is going on? So they are not just coming in straight away for five days"*. Additionally, the service user may begin to see the benefits of attending such a service without the need to fully commit to it as one staff member pointed out: *"there is some structure, some safety. They are starting to see I am not on my own in this, there is someone else here who is also talking about something that I can relate to".* The group instils hope in new service users and allows them to see a range of new possibilities, one of the service users who is currently in the service and went through the process remarked on this: *"you begin to think. oh they have come from where I am at and look what they are doing, look how they are speaking, look at the things they are doing in their lives, and look at their hopes and dreams that they are actually talking about and sharing. Maybe my life could be a bit different".* Overall, the service users are very positive about the group: *"the Wednesday group is amazing and it is about addiction, addiction, addiction"* and *"the Wednesday afternoon group is voluntary, that group is amazing, it really is. I have heard people say that group was the group that I got the most out of and I could see that coming to it, it really is a brilliant group"*. It is clear that the service users appreciate the opportunity to form social bonds with the staff and service users before committing to fully attending the service and they all see it as a safe, non-judgemental and confidential place where they can be open and honest, in keeping with the philosophy at STAR. From a critical perspective it is possible to argue that the invitation

to attend the Wednesday group allows staff and services users to only select potentially successful service users for the full programme. Additionally, the element of self-selection speaks to much of the literature regarding engagement in treatment programmes that emphasises the essential element of service user motivation for successful outcomes.

Men's and Women's Groups

The service users have a weekly therapeutic group which is split twice a month into separate men's and women's groups. This was a service user led initiative: "*we were saying we wanted more women's groups, because there is not as many women as there is men and sometimes men don't want to speak around women, and girls have girl things that we wouldn't really want to say to a man"*. In the men's group there is an emphasis on the role of men in family, relationships and society but not limited to these areas as service users can talk about whatever they want in an open non-judgemental setting. The themed and open non-judgemental approach is significant as many service users have no previous experience of a forum where they could freely share their feelings. One of the staff members described what these groups as: *"the men are starting to trust, they will break down with the support of other men and the facilitators. It is done in a way that men can just be honest and real with each they can cry and other men will quietly come in and form that sort of tribal piece that I think we are missing in society"*. Another staff member emphasised this non-judgemental approach: *It allows the men to express their anger and frustrations in a safe way while feeling supported. They can talk about challenging discussions and topics that maybe they have never had a chance to talk about but now they have men who will listen to them compassionately and with no judgement and say that is okay*". The men can talk about their aggression and emotions in these groups. The service users responded positively to the men's group stating: *"In the men's group we sit down and we talk and we can talk about anything we want. Anything that is bothering you, you can just put it out there"* and *"The last men's group we had was really, really good, opening their hearts and it is safe, you don't have to worry about someone going off and blabbing on the streets. That is very important. In other places I didn't feel like that"*. Not as many quotes emerged during the interview phase about the women's group, this may have been due the fact that there are less women in the service, but the women's remarks regarding the group were positive during the observation phase. This safe and confidential space where people can share and support each other without fear

of judgement is like a microcosm of the ethos at STAR, which allows for bonding and growth.

Out-of-hours support

The person-centred philosophy is also enacted through the out of hours' phone service. This is a designated number that service users can call, outside of office hours, if they need to talk about a problem. This staff lead initiative is shared across team members. It is a support but it is also another protective element for the service user, from their social environment or challenges with remaining abstinent. Several service users commented on how much they appreciate this service: "*if we are outside in society and we run into a problem or we are struggling or thinking about relapsing we can pick up the phone and ring a staff member and they will talk to us. You don't get that anywhere else*". One service user commented on how they can always count on the out of hours' phone as a form of support: "*You know they are going to get back to you, no matter what they are going to get back to you and talk it through. I had a couple of incidents where I actually thought of using but because I was able to ring that number I didn't reuse".* This allows service users to have an attachment to the service even when not physically present and staff concerned about service users' welfare outside of working hours are addressed. The person centred tenet of the philosophy is extremely apparent in the manner of service provision at the project. It is evident from participant testimonials and researcher observation that the staff walk the talk when it comes to their person-centred manner of service delivery. It is apparent in their approach to group work, as well as being enhanced by their use of CRA and motivational interviewing.

Social Bonds

It has been argued that social bonds, i.e. people's relationships to other people and to society, are key to the phenomenon of addiction (Proudfoot, 2017). Research has evidenced that substance users have chaotic lifestyles (Hughes, 2007), experience social isolation (Sanders et al., 2000) and replace the social bond with a relationship to a substance (Loose, 2002). Drug use is essentially a solitary pleasure that involves neglecting the social bond and the pleasure of being with others in favour of the pleasure of the drug (Proudfoot, 2017). Additionally, some drug users may have formed social bonds with a community of substance users; Bourgois, Bourgois & Schonberg (2009) demonstrated that even in a group of

homeless heroin addicts who had sacrificed family, friends, jobs, and homes, whose lives revolved entirely around the pursuit of drugs, were part of a richly social world which consisted of norms, hierarchies, and systems for distributing goods among participants. Whether the substance user has replaced the social bond with a substance or was part of a social network with fellow substance users, Lubman et al., (2007) stated that in order for recovery, the substance user must re-establish an interpersonal relationship with another outside of a substance related world. These social bonds are also thought to be key to increasing engagement and retention.

The philosophy of the project contributes to the formation of social bonds, in particular the person centred and non-punitive approaches. In terms of the person-centred approach, staff factors such as personalising service user care and listening to the service user narrative provide the necessary conditions for nurturing a strong relationship. Other elements resulting from the person-centred approach such as mutual respect and collaborative partnerships also help to strengthen these social bonds. The non-punitive strand of the philosophy is also very important; as service users perceive that they are not punished for a relapse, the relationship is once again more of a partnership in which they work collaboratively rather than staff exercising control over the service user. Furthermore, as service users are encouraged to be honest and share with their group when they have had a relapse, this provides opportunities for peer support and bonding to occur amongst service users.

A positive therapeutic alliance is crucial to the formation of strong social bonds. Staff consciously use certain techniques to foster an early therapeutic alliance such as the management of power relations to promote equity, use of simple language, and avoidance of an overtly clinical setting. A positive early working alliance has been shown to be key to the engagement and retention of service users (Meier et al., 2005). Trust is another factor which enhances the strength of a therapeutic alliance and is at the core of all work done at STAR. The staff appear to unconditionally trust the services users and this is reciprocated by the service users. This creates an atmosphere of trust in the service including mutual trust between the service users. Furthermore, staff also focus on building a connection with the service users, they do this through being non-judgemental and facilitating service user engagement, as well as actively listening to the service users. Furthermore, staff provide a platform for the service users to give feedback on the service which also allows for a collaborative partnership.

However, the formation of social bonds can also be attributed to additional elements such as the therapeutic regime (Center for Substance Abuse Treatment, 2004), esprit de corps (Bion, 1990) or group cohesion (Yalom & Leszcz, 2005). The cohort at STAR is an extremely cohesive unit, themes such as no-cliques, a family feel and togetherness were prevalent in the data and were repeatedly mentioned by the staff and service users. The staff foster this cohesion through adopting a non-judgemental approach and encouragement of a non-hierarchical system. Additionally, the atmosphere is very supportive; peer support is ubiquitous amongst service users and staff are always there to provide emotional support and advice.

The safe haven also contributes to the formation of these social bonds. Studies of groups in their natural environment demonstrate that multiple factors in the setting contribute to how people engage with each other (Scheper-Hughes, 2001; Moore, 2012). In addition to the actual physical safe space at STAR, which provides a secure environment for service users to bond, the boundaries held by the staff and the rules enforced by both service users and staff alike help to provide a good foundation to form these strong social bonds. In particular, the policing of peers' inappropriate behaviour and careful use of language on behalf of the service users, and the promotion of a non-hierarchical system while maintaining a close but professional relationship on behalf of the staff. Both groups also provide each other with constant feedback on how to maintain this safe haven; therefore, once again the service users and staff are working together.

The person centred tenet of STAR's philosophy is particularly evident in their approaches to service provision and group work. The community reinforcement approach and motivational interviewing method naturally empower the service users while staff work with them in a dignified and respectful way. Once again, these approaches are collaborative and provide the foundations for the formation of a powerful bond. The Wednesday group allows the service users to build these strong social bonds with staff and service users before even entering the day programme, this was highlighted as being vitally important by a number of the service users. Once inside the service, the men's and women's groups in particular were highlighted as mediums for these bonds to be strengthened.

Self-reported engagement and retention levels at STAR suggest it is possible to overcome the challenges of engagement present in addiction, which may be attributable to the presence of strong social bonds in the project. It is possible that the success in forming these bonds is not

just due to the therapeutic alliance but that additional elements such as group cohesion, togetherness and a safe environment also contribute. Additionally, the non-punitive and person-centred attitudes adopted at STAR, as well as their approaches to service provision also appear to be decisive.

Philosophy Trade-offs/Enhancing the Philosophy

Although, STAR's philosophy is generally effective at forming social bonds and thus increasing engagement and retention in the project, there are also some costs, challenges and trade-offs that come with embracing and operationalising this philosophy.

Trauma Informed Approach

Psychosocial and psychotherapeutic approaches to care are influenced by trends in research; as an approach, Trauma Informed Care (TIC) is being used increasingly as the model of choice in treatment services. It was clear from the data that the staff place a huge emphasis on the TIC approach. This was recorded by the researcher in the field notes: *"Staff members highlighted at the end of one of the groups that it is the opening up about trauma that really leads to healing and recovery, and that they had seen it before"* and *"The benefits of attending to trauma and its roots in addiction were once again brought up by staff"*. The staff also commented on this during interviews: *"I would go so far as to say certainly from our working with clients every client that has come through our doors, bar one or two, there has always been a history of some kind of physical, sexual, emotional abuse through childhood"* and *"most of the people who come through the doors have an awful lot of trauma from their childhood"*. However, there was less researcher observation of or commentary from service users about TIC and as evidenced in the report, it was the other two tenets of the philosophy, person-centred and non-punitive approaches, alongside strong social bonds and well-developed therapeutic alliances, as well as factors such as not being judged, support, honesty and genuine care, which service users saw as being most beneficial. However, it is commendable that STAR have committed to an approach which attempts to identify people who have been exposed to potentially life-threatening trauma and are impacted by symptoms of Post-Traumatic Stress Disorder (PTSD) and that they recognise the value of referral to appropriate treatment services.

By definition PTSD occurs after exposure to traumatic events like combat, violence or sexual assaults (Kessler et al., 1995) and people suffer from intrusion symptoms, avoidance, hyper-

arousal and negative alterations in cognitions and mood (American Psychiatric Association, 2013). It is in the definition of trauma where most TIC centres differ, as well as life-threatening events such as sexual abuse, physical abuse and witnessing domestic violence; non-life-threatening events such as emotional neglect, parental substance abuse, parental separation or divorce, siblings brawling and incarcerated household members are also included. There is much debate as to which of these definitions should be used, i.e. the strict definition of PTSD or the broader definition of 'trauma'.

The approach to TIC at STAR has been influenced by the Adverse Childhood Experiences Study (ACE Study) and staff use the ACE questionnaire to explore trauma with participants (Felitti et al., 1998). In the ACE study, researchers asked over 17,000 adults about the number of adverse events in their childhoods, these events include non-life threatening events as well as life-threatening events, similar to the broader definition of trauma mentioned above. Researchers found that people who had more ACE events in childhood also had more health problems, such as addiction, homelessness and mental health problems, as adults. They interpreted this association as a cause and effect dose-response relationship by asserting that these ACE events caused the health problems in adults later in life. However, there are a number of criticisms of the ACE questionnaire. Firstly, it relies on participants to recall childhood experiences which can be an inaccurate way of establishing causation, not least because such recollections are subjective and unverifiable. Secondly, the nine ACE variables are imprecise and they do not indicate the severity, timing or duration of reported physical, verbal and sexual abuse, or physical and emotional neglect. Thirdly, the problematic outcomes which ACE questionnaires are said to predict include addiction, mental health problems, educational under-achievement, unemployment and criminal behaviour; making it difficult to exclude confounding factors when there is such a broad remit. Furthermore, in attempting to convert complex social experiences into biological, chemical effects, it eliminates the power of the human mind to interpret what may look like similar experiences in a variety of ways. Individuals who have been through the most harrowing experiences, such as concentration camps or military engagement, have been able to live fulfilling lives once a more normal life was restored; not everyone is traumatised by events categorised as traumatic, people possess difference levels of resilience (Ungar, 2013). This raises an issue about whether the ACE questionnaire classifies the individual as an object subjected to experiences, rather than a person who has the ability to interpret them. Finally, ACE questionnaires rely on a belief that what happens in early childhood determines the adult an

individual will become; this is by no means an established fact and there is much disagreement amongst experts in child development (Edwards et al., 2017).

As mentioned previously there are a number of confounding factors which may influence addiction, trauma is only one component of why many individuals struggle. Boredom, biological reasons, socioeconomic reasons, education and enjoyment can all play a part. One of the service users commented on this: *"I went to some other groups and they were really eye opening, they showed us that we decided to take the drugs, we are not just victims"*. As well as possibly victimising the service users, placing a large focus on trauma can have added dangers, which may include somebody becoming overwhelmed by exploring past or current trauma that staff are not fully trained to deal with or service users feeling a pressure to revise their history and produce a past traumatic event whether real or imagined in order to fit in.

Given that confounding factors may play a part in addiction, the existence of discrepancies surrounding definition and the added risks associated with exploring trauma, an approach that remains open to other factors besides trauma may be more beneficial to the service especially in light of the evidence reported by participants on what they found most helpful. Essentially, finding a balance between TIC, MI, CRA and the person-centred/ non-judgemental approach would only serve to enhance the work that is being done in the service. Additionally, a stronger evidenced based rationale to support the emphasis on TIC would be beneficial to the project and subsequent service provision. A clear definition for service users of the nature of trauma would also be of benefit, one that separates out those who have experienced PTSD due to life-threatening events and those who may have been negatively impacted by adverse life events. This separation may then assist staff in deciding who requires referral to specialist trauma services; who may benefit from psychoeducation on the impact of past experiences as contributory factors in addiction and whose recovery can be supported through non-punitive, person-centred care.

Fostering Dependence

As is evident from the data, STAR use approaches such as CRA and MI to build people's confidence and level of responsibility, which appear to be very effective. However, they are less successful in the promotion of autonomy, this may be in part due to staff desire to do their utmost for service users. Staff act in a mentor/parental role with service users, one staff member commented: "*I feel it is my responsibility to try and instil in them some sort of skills so that when they leave here they can cope better outside"*. Staff appear to help the service

users with a whole range of other everyday tasks ranging from making appointments and filling out application forms to helping them with housing and clothing; they also remind them of these appointments and may attend and advocate for them. During the observation phase, there was one incident where the service was going on a day trip, the service users were reminded to bring sun cream and food, yet nobody did, so staff provided it for them. While this demonstrates the dilemma that the staff may have with the service users, in that if they do not help them then the service users may not help themselves; adopting an approach like this has the capacity to foster a dependency. Supports such as the out-of-hours phone, which is only supposed to be an emergency service, mean that service users have access to the staff even when they are physically not in the project. Additionally, one service user alluded to how they felt when they weren't attending the service during the two-week summer break: *"I struggle big time. I really, really struggle. I start thinking why do they have to close over the summer, two weeks on my own, of sitting in doing nothing. I felt the same last year"*.

This dependency may also have manifested itself when it comes to finishing at the service, as service users appear to find the transition difficult. A number of the current service users have expressed concerns about the prospect of leaving and would like their contract to be longer; one service user who is no longer attending the service stated: *"I found it very difficult actually leaving…I had been here nearly two years and you get so comfortable in the place and it kind of seemed like a family and just the sense of connection that I had here that I had never really had before anywhere"*. As mentioned by that service user, part of the reason may be due to the strong social bonds they have built up and the family atmosphere. Staff have also noticed this: "*it can be painful for people to go. Sometimes people don't want to go and they are frightened about going"*. STAR have taken some measures to counteract this by using the care plan to work towards goals with an end date in mind. The length of the community employment contract has also been reduced to one year; however, under special circumstances service users can be offered an extension of another year and they can also stay in the project on a voluntary basis. The positive aspects of the service coupled with this potential fostering of dependency and the special CE contract appears to have created some confusion with the service users. Fundamentally, the service users are attending STAR to recover from addiction but once engaged many don't want to leave. There are service users who are in phase 2, i.e. have detoxed off drugs and alcohol completely, and who have been in the service for an extended period yet are still resistant to leaving. This may in part be due to

the fact that service users enjoy attending the service, which was evident during the observation phase: *"The service users seem to really enjoy coming to the project, especially the ones who have been there longer"*. It is recommended that the balance between high levels of support and promoting independence continues to be a central element of STAR's approach to active discharge planning.

Upskilling

It is clear from their work around trauma that the staff are adept at referring service users for help with appropriate professionals, one staff member stated *"we refer onto professionals. Our egos aren't so high that we go we can deal with everything"* and another staff member from the family support service indicated the same: "*I am a really good networker and team player as such. So now I understand I don't need to counsel a person, I can refer them to a counsellor, I can refer them to the job centre, I can refer them to a social worker, to a Guard, to whatever"*. It is positive that staff recognise their scope of competence and take appropriate measures; however, there is also room for staff to consider offering more interventions internally and this could be achieved through upskilling in a number of areas. It would benefit service users as they already have very positive working relationships with the staff and would allow for a more seamless service.

Couple's and relationship counselling is one such area in which staff consider they could benefit from additional training; at the moment they have to refer to services such as the Healthy Living Centre in Dublin City University for this work. This is a particularly important element due to the impact addiction and recovery can have on intimate relationships; it was also evident that some service users may not be receiving adequate support at home or there may be a lack of understanding when it comes to addiction by a significant other, which may serve to undermine the service user's progress. The staff highlighted the importance of this *"I feel when someone has changed in their addiction and the other person isn't in addiction or whatever sometimes the co-dependency or they sabotage or have a fear of what is going to happen",* "*invariably we have situations where there will be a lot of issues between partners"* and *"client is like oh my God things are impossible at home"*. Additionally, staff could also collaborate more often with the family support service on issues like this.

Additionally, staff could benefit from extra training is in mental health. Research in the UK has shown that dual-diagnosis is an area of huge concern, it was found that 75% of users of drug services and 85% of users of alcohol services have a co-occurring psychiatric illness,

and that 44% of mental health service users reported drug use (Weaver et al, 2003), similar rates were found in Ireland (Condren et al, 2001; Kamali et al 2000). STAR currently use tools such as PsyCheck (Lee & Jenner, 2010), ACE Questionnaire (Felitti, 1998), NDRIC Assessment Form (Doyle & Ivanovic, 2010) and the Pearlin Mastery Scale (Pearlin, Lieberman, Menaghan, & Mullan, 1981) to screen for mental health problems; however as with the majority of addiction treatment centres and mental health services, they are currently not equipped to treat people presenting with dual diagnosis holistically. HSE mental health and the College of Psychiatrists are currently developing a national Model of Care for Care for co-morbid mental illness and substance misuse in order to develop Community Dual Diagnosis Teams with access to inpatient drug treatment and rehabilitation units (Keenan, 2017). Nevertheless, until the realisation of such services, it is advisable that STAR and other addiction services engage in as much mental health training as possible. A number of staff members have highlighted the need to remain informed and also stated that they sometimes have difficulties with understanding, managing and working with dual diagnosis: "*Something I would struggle with sometimes is that a lot of our clients would have mental health issues and sometimes I think I could probably up-skill my knowledge around mental health and that area"* and one of the community employment workers stated: "*I still have a little bit of self-doubt with the mental health side. People have come in who have been suicidal and there mightn't be anybody else around, it is also difficult when somebody is very vulnerable or in a very high state of anxiety"*. All staff are trained in ASIST (Applied Suicide Intervention Skills Training) and CE workers would be aided in a situation with a suicidal service user, although it may be advisable for CE workers also to receive such training; nevertheless, diffusing situations in which suicide is potential and referring to mental health services is as much as addiction services can do currently. Therefore, it is advisable that staff at STAR keep abreast of contemporary approaches to working with dual-diagnosis and seek ongoing education and training in evidence based mental health interventions.

A feature of the approach at STAR is that they like to incorporate alternative ways of working into the programme of activities offered: *"we have done things that are looking at the mind, body and spirit, looking at the whole being, the whole person"* and *"it is the marrying of the alternative with the clinical or the more conservative ways of working because I think both have a role to play***".** While they use a number of mainstream interventions such as motivational interviewing and the community reinforcement approach, they also embrace interventions such as such as Reiki, Massage, Meditative Drumming,

Chanting, Meditation and Auricular acupuncture. Alternative approaches can function as an effective complement to their mainstream counterparts and as is clear from the data, the use of an informal and alternative approach has proved successful for staff as a technique to build relationships. However, services such as STAR that espouse alternative approaches and attempt to push the boundaries in the quest for more positive outcomes need to ensure that these interventions do not detract from those approaches and interventions that have a stronger evidence-base, with respect to positive outcomes for service users.

Finally, upskilling not only improves service user outcomes but it also increases staff's job satisfaction; therefore, building on skills in areas such as Couples and Relationship Counselling, CBT, MI, Brief Intervention and other evidence-based approaches will benefit the service as a whole. It appears as if STAR are cognisant of the need to upskill as they have undertaken to complete Seeking Safety Therapy Training (facilitated by the HSE Keltoi Rehabilitation Unit) in the coming months; nevertheless, as with other services, they must constantly strive to identify areas for improvement such as those previously highlighted and invest in strengthening them.

Conclusion

It is clear that STAR is adept at engaging and retaining service users by nurturing strong social bonds. A strong influential philosophy underpins service provision and it was found to be a powerful influence in the formation of these social bonds. This philosophy is made of three central tenets: a non-punitive approach, person-centred care and trauma informed care. The person-centred care approach promotes the development of a partnership between staff and service users in which they work together to achieve goals unique to each service user. The non-punitive and non-judgemental approach to relapses results in reduced shame and increased honesty. Trauma Informed Care allows service users to seek appropriate treatment for possible underlying issues they may have which in turn allows them to engage in the services to best of their ability. The three interrelated strands of STAR's philosophy produce an approach to the treatment of substance misuse that staff and service users consider to be unique and very different to many mainstream models of addiction and provides a platform for the nurturing of social bonds. The philosophy also influences therapeutic alliance, group cohesion, the safe environment of the project and service provision, each of which in turn contributes to strengthening social bonds and aiding men and women's recovery from substance use.

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*(1), 1–33.

Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and alcohol dependence*, *88*(2-3), 188-196.

Allen, J. G., Coyne, L., Colson, D. B., Horwitz, L., Gabbard, G. O., Frieswyk, S. H., & Newson, G. (1996). Pattern of therapist interventions associated with patient collaboration. *Psychotherapy: Theory, Research, Practice, Training*, *33*(2), 254.

American Psychiatric Association. DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5™*. Arlington, VA: American Psychiatric Publishing.

Azrin, N. H. (1976). Improvements in the community-reinforcement approach to alcoholism. *Behaviour Research and Therapy*, *14*(5), 339-348.

Azrin, N. H., Sisson, R. W., Meyers, R. J., & Godley, M. D. (1982). Alcoholism treatment by disulfiram and community reinforcement therapy. *Journal of Behavioral Therapy and Experimental Psychiatry*, *13*, 105-112.

Bachelor, A. (1991). Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist. *Psychotherapy: Theory, Research, Practice, Training*, *28*(4), 534–549.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology*, *42*(3), 323.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*(6), 842–852.

Banister, P. (2011). *Qualitative methods in psychology: A research guide*. Maidenhead, UK: McGraw-Hill Education.

Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, L., & Siqueland, L. (2000). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology*, *68*(6), 1027–1032.

Barber, J. P., Luborsky, L., Crits-Christoph, P., & Diguer, L. (1995). A comparison of core conflictual relationship themes before psychotherapy and during early sessions. *Journal of Consulting and Clinical Psychology*, *63*(1), 145.

Barber, J. P., Luborsky, L., Gallop, R., Crits-Christoph, P., Frank, A., Weiss, R. D., … Siqueland, L. (2001). Therapeutic alliance as a predictor of outcome and retention in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Journal of Consulting and Clinical Psychology*, *69*(1), 119–124.

Barber, J., Luborsky, L., Crits-Christoph, P., Thase, M., Weiss, R., Frank, A., … Gallop, R. (1999). Therapeutic Alliance as a Predictor of Outcome in Treatment of Cocaine Dependence. *Psychotherapy Research*, *9*(1), 54–73.

Bates, M. E., Bowden, S. C., & Barry, D. (2002). Neurocognitive impairment associated with alcohol use disorders: implications for treatment. *Experimental and clinical psychopharmacology*, *10*(3), 193.

BC Centre for Excellence for Women's Health. (2013). *Trauma-informed practice guide*. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Beck, F., Legleye, S., & Peretti-Watel, P. (2003). Penser les drogues: Perceptions des produits et des politiques publiques, EROPP 2002. *Rapport OFDT*, *227*.

Beins, B., C. (2004). *Research Methods: A tool for life*, Boston, MA: Pearson Education Ltd.

Belding, M. A., Iguchi, M. Y., Morral, A. R., & McLellan, A. T. (1997). Assessing the helping alliance and its impact in the treatment of opiate dependence. *Drug and Alcohol Dependence*, *48*(1), 51–59.

Bertrand, K., Brunelle, N., Richer, I., Beaudoin, I., Lemieux, A., & Ménard, J.-M. (2013). Assessing Covariates of Drug Use Trajectories Among Adolescents Admitted to a Drug Addiction Center: Mental Health Problems, Therapeutic Alliance, and Treatment Persistence. *Substance Use & Misuse*, *48*(1–2), 117–128.

Bethea, A. R., Acosta, M. C., & Haller, D. L. (2008). Patient versus therapist alliance: Whose perception matters? *Journal of Substance Abuse Treatment*, *35*(2), 174–183.

Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief interventions for alcohol problems: a review. *Addiction*, *88*(3), 315–336.

Bion, W., R. (1990). *Experiences in Groups and Other Papers*, London: Rathbourne Books.

Boardman, T., Catley, D., Grobe, J. E., Little, T. D., & Ahluwalia, J. S. (2006). Using motivational interviewing with smokers: Do therapist behaviors relate to engagement and therapeutic alliance? *Journal of Substance Abuse Treatment*, *31*(4), 329–339. 006

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252–260.

Bourgois, P., Bourgois, P. I., & Schonberg, J. (2009). *Righteous dopefiend* . Oakland, CA: University of California Press.

Bowen, W. T., & Twemlow, S. W. (1978). Implications of Staff Absence for Effective Treatment implications of Staff Absence for Effective Treatment. *Social Casework*, *59*(5), 305–308.

Brady, K. T., Back, S. E., & Coffey, S. F. (2004). Substance abuse and posttraumatic stress disorder. *Current Directions in Psychological Science*, *13*(5), 206-209.

Brady, K. T., Killeen, T., Saladin, M. E., Dansky, B., & Becker, S. (1994). Comorbid substance abuse and posttraumatic stress disorder: Characteristics of women in treatment. *The American Journal on Addictions*, *3*(2), 160-164.

Briere, J. N. (1992). *Interpersonal violence: The practice series, No. 2. Child abuse trauma: Theory and treatment of the lasting effects.* Thousand Oaks, CA: Sage Publications, Inc.

Broome, K. M., Knight, D. K., Edwards, J. R., & Flynn, P. M. (2009). Leadership, burnout, and job satisfaction in outpatient drug-free treatment programs. *Journal of Substance Abuse Treatment*, *37*(2), 160–170.

Brorson, H. H., Ajo Arnevik, E., Rand-Hendriksen, K., & Duckert, F. (2013). Drop-out from addiction treatment: A systematic review of risk factors. *Clinical Psychology Review*, *33*(8), 1010–1024.

Burlingame, G., Fuhriman, A., & Johnson, J. (2002). Cohesion in group psychotherapy. In J. Norcross (Ed.), *Psychotherapy relations that work*. Oxford: Oxford University Press.

Burlingame, G. M., McClendon, D. T., & Alonso, J. (2011). Cohesion in group therapy. *Psychotherapy*, *48*(1), 34.

Calsyn, R. J., Klinkenberg, W. D., Morse, G. A., & Lemming, M. R. (2006). Predictors of the Working Alliance in Assertive Community Treatment. *Community Mental Health Journal, 42*(2), 161–175.

Campbell, B. K., Guydish, J., Le, T., Wells, E. A., & McCarty, D. (2015). The relationship of therapeutic alliance and treatment delivery fidelity with treatment retention in a multisite trial of twelve-step facilitation. *Psychology of Addictive Behaviors, 29*(1), 106–113.

Carbonari, J. P., & DiClemente, C. C. (2000). Using transtheoretical model profiles to differentiate levels of alcohol abstinence success. *Journal of Consulting and Clinical psychology, 68*(5), 810.

Carroll, K. M., Nich, C., & Rounsaville, B. J. (1997). Contribution of the therapeutic alliance to outcome in active versus control psychotherapies. *Journal of Consulting and Clinical Psychology*, *65*(3), 510.

Center for Substance Abuse Treatment. (2004). *Substance Abuse Treatment and Family Therapy Treatment Improvement Protocol (TIP), 39*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Charles, C., Gafni, A., & Whelan, T. (1999). Decision-making in the physician–patient encounter: revisiting the shared treatment decision-making model. *Social Science & Medicine*, *49*(5), 651–661.

Cloitre, M., Chase Stovall-McClough, K., Miranda, R., & Chemtob, C. M. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. *Journal of consulting and clinical psychology*, *72*(3), 411.

Coady, N. F., & Marziali, E. (1994). The association between global and specific measures of the therapeutic relationship. *Psychotherapy: Theory, Research, Practice, Training*, *31*(1), 17–27.

Condren, R.M., O'Conner, J., Browne, R. (2001). Prevalence and patterns of substance misuse in schizophrenia: A catchment area case-control study. *Psychiatric Bulletin*, *25*, 17-20.

Connors, G. J., Carroll, K. M., DiClemente, C. C., Longabaugh, R., & Donovan, D. M. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of Consulting and Clinical Psychology*, *65*(4), 588–598.

Connors, G. J., DiClemente, C. C., Dermen, K. H., Kadden, R., Carroll, K. M., & Frone, M. R. (2000). Predicting the therapeutic alliance in alcoholism treatment. *Journal of Studies on Alcohol, 61*, 139–149.

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology*, *54*(1), 1.

Cook, S., Heather, N., & McCambridge, J. (2015). The role of the working alliance in treatment for alcohol problems. *Psychology of Addictive Behaviors*, *29*(2), 371.

Cook, K. S., & Kramer, R. M. (2004). *Trust and distrust in organizations: Dilemmas and approaches*. New York, NY: Russell Sage Foundation.

Cooper, M. (2012). Clients' and therapists' perceptions of intrasessional connection: An analogue study of change over time, predictor variables, and level of consensus. *Psychotherapy Research*, *22*(3), 274–288.

Corrigan, P. W., Lurie, B. D., Goldman, H. H., Slopen, N., Medasani, K., & Phelan, S. (2005). How Adolescents Perceive the Stigma of Mental Illness and Alcohol Abuse. *Psychiatric Services*, *56*(5), 544–550.

Costes, J. M., Le Nézet, O., Spilka, S., & Laffiteau, C. (2010). Ten years of change in French people's perceptions and opinions regarding drugs (1999-2008). *Tendances*, *4*.

Cournoyer, L.-G., Brochu, S., Landry, M., & Bergeron, J. (2007). Therapeutic alliance, patient behaviour and dropout in a drug rehabilitation programme: the moderating effect of clinical subpopulations. *Addiction*, *102*(12), 1960–1970.

Crits-Christoph, P., Barber, J., & Kurcias, J. (1993). The Accuracy of Therapists' Interpretations and the Development of the Therapeutic Alliance. *Psychotherapy Research*, *3*(1), 25–35.

Crits-Christoph, P., Gallop, R., Temes, C. M., Woody, G., Ball, S. A., Martino, S., & Carroll, K. M. (2009). The alliance in motivational enhancement therapy and counseling as usual for substance use problems. *Journal of Consulting and Clinical Psychology, 77*, 1125–1135.

Crits-Christoph, P., Gibbons, M. B. C., Hamilton, J., Ring-Kurtz, S., & Gallop, R. (2011). The dependability of alliance assessments: The alliance–outcome correlation is larger than you might think. *Journal of consulting and clinical psychology*, *79*(3), 267.

Crits-Christoph, P., Johnson, J. E., Connolly Gibbons, M. B., & Gallop, R. (2013). Process predictors of the outcome of group drug counseling. *Journal of Consulting and Clinical Psychology*, *81*(1), 23.

Crits-Christoph, P., Siqueland, L., Chittams, J., Barber, J. P., Beck, A. T., Frank, A., ... & Onken, L. S. (1998). Training in cognitive, supportive-expressive, and drug counseling therapies for cocaine dependence. *Journal of consulting and clinical psychology*, *66*(3), 484.

Crowe, T. P., & Grenyer, B. F. (2008). Is therapist alliance or whole group cohesion more influential in group psychotherapy outcomes?. *Clinical Psychology & Psychotherapy*, *15*(4), 239-246.

Cusack, K. J., Morrissey, J. P., & Ellis, A. R. (2008). Targeting trauma-related interventions and improving outcomes for women with co-occurring disorders. *Administration and Policy in Mental Health and Mental Health Services Research*, *35*(3), 147-158.

Dansky, B. S., Saladin, M. E., Brady, K. T., Kilpatrick, D. G., & Resnick, H. S. (1995). Prevalence of victimization and posttraumatic stress disorder among women with substance use disorders: Comparison of telephone and in-person assessment samples. *International Journal of the Addictions*, *30*(9), 1079-1099.

D'iuso, D., Blake, E., Fitzpatrick, M., & Drapeau, M. (2009). Cognitive errors, coping patterns, and the therapeutic alliance: A pilot study of in-session process. *Counselling and Psychotherapy Research*, *9*(2), 108–114.

De Weert-Van Oene, G. H., Jong, C. A. J. D., Jörg, F., & Schrijvers, G. J. P. (1999). Measurements, Instruments, Scales, and Tests: The Helping Alliance Questionnaire: Psychometric Properties in Patients with Substance Dependence. *Substance Use & Misuse*, *34*(11), 1549–1569.

De Weert-Van Oene, G. H., Schippers, G. M., De Jong, C. A. ., & Schrijvers, G. J. . (2001). Retention in substance dependence treatment: the relevance of in-treatment factors. *Journal of Substance Abuse Treatment*, *20*(4), 253–261.

Del Re, A. C., Flückiger, C., Horvath, A. O., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance–outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review*, *32*(7), 642–649.

Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (1999). Alliance-building interventions with adolescents in family therapy: A process study. *Psychotherapy: Theory, Research, Practice, Training*, *36*(4), 355.

Diamond, M. A. (1993). *The unconscious life of organizations: Interpreting organizational identity*. Westport, CT: Quorum Books/Greenwood Publishing Group.

Dinger, U., Strack, M., Leichsenring, F., Wilmers, F., & Schauenburg, H. (2008). Therapist effects on outcome and alliance in inpatient psychotherapy. *Journal of Clinical Psychology*, *64*(3), 344–354.

Dolinsky, A., Vaughan, S. C., Luber, B., Mellman, L., & Roose, S. (1998). A Match Made in Heaven?: A Pilot Study of Patient–Therapist Match. *The Journal of Psychotherapy Practice and Research, 7*(2), 119–125.

Dollarhide, C. T., Shavers, M. C., Baker, C. A., Dagg, D. R., & Taylor, D. T. (2012). Conditions that create therapeutic connection: A phenomenological study. *Counseling and Values*, *57*(2), 147-161.

Doyle, J. & Ivanovic, J. (2010). *National Drugs Rehabilitation Framework Document*. National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive

Drabble, L. A., Jones, S., & Brown, V. (2013). Advancing trauma-informed systems change in a family drug treatment court context. *Journal of Social Work Practice in the Addictions*, *13*(1), 91-113.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy*. Washington, DC: American Psychological Association.

Dundon, W. D., Pettinati, H. M., Lynch, K. G., Xie, H., Varillo, K. M., Makadon, C., & Oslin, D. W. (2008). The therapeutic alliance in medical-based interventions impacts outcome in treating alcohol dependence. *Drug and Alcohol Dependence*, *95*(3), 230–236.

Edwards, R., Gillies, V.,Lee, E., MacVarish, J., White, S., & Wastell, D. (2017). *The Problem with ACEs*. Submission to the House of Commons Science and Technology Select Committee Inquiry into the evidence-base for early years intervention (EY10039).

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or traumadenied: principles and implementation of trauma-informed services for women. Journal of *Community Psychology, 33*(4), 461–477.

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy*, *48*(1), 43.

Emmerling, M. E., & Whelton, W. J. (2009). Stages of change and the working alliance in psychotherapy. *Psychotherapy Research*, *19*(6), 687–698.

European Monitoring Centre for Drugs and Drug Addiction. (2014). *European Drug Report 2014: Trends and Developments.* Luxembourg: Publications Office of the European Union.

Fallot, R. D., & Harris, M. (2005). Integrated trauma services teams for women survivors with alcohol and other drug problems and co-occurring mental disorders. *Alcoholism Treatment Quarterly*, *22*(3-4), 181-199.

Farro, S. A., Clark, C., & Hopkins Eyles, C. (2011). Assessing trauma-informed care readiness in behavioral health: an organizational case study. *Journal of Dual Diagnosis*, *7*(4), 228-241.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258.

Fenton, L. R., Cecero, J. J., Nich, C., Frankforter, T. L., & Carroll, K. M. (2001). Perspective Is Everything. *The Journal of Psychotherapy Practice and Research*, *10*(4), 262–268.

Finney, J. W., & Monahan, S. C. (1996). The cost-effectiveness of treatment for alcoholism: a second approximation. *Journal of Studies on Alcohol*, *57*(3), 229-243.

Fiorentine, R. (1998). Effective Drug Treatment: Testing the Distal Needs Hypothesis. *Journal of Substance Abuse Treatment*, *15*(4), 281–289.

Fiorentine, R. (1999). Client Engagement in Drug Treatment. *Journal of Substance Abuse Treatment*, *17*(3), 199–206.

Flicker, S. M., Turner, C. W., Waldron, H. B., Brody, J. L., & Ozechowski, T. J. (2008). Ethnic background, therapeutic alliance, and treatment retention in functional family therapy with adolescents who abuse substances. *Journal of Family Psychology*, *22*(1), 167–170.

Flückiger, C., Del Re, A. C., Horvath, A. O., Symonds, D., Ackert, M., & Wampold, B. E. (2013). Substance use disorders and racial/ethnic minorities matter: A meta-analytic examination of the relation between alliance and outcome. *Journal of Counseling Psychology*, *60*(4), 610–616.

Flückiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology*, *59*(1), 10–17.

Frühauf, S., Figlioli, P., Böck, J., & Caspar, F. (2015). Patients' Self-presentational Tactics as Predictors of the Early Therapeutic Alliance. *American Journal of Psychotherapy*, *69*(4), 379–397.

Fuertes, J. N., Mislowack, A., Bennett, J., Paul, L., Gilbert, T. C., Fontan, G., & Boylan, L. S. (2007). The physician–patient working alliance. *Patient Education and Counseling*, *66*(1), 29–36.

Fullilove, M. T., Fullilove, R. E., Smith, M., Winkler, K., Michael, C., Panzer, P. G., & Wallace, R. (1993). Violence, trauma, and post-traumatic stress disorder among women drug users. *Journal of Traumatic Stress*, *6*(4), 533-543.

Garman, A. N., Corrigan, P. W., & Morris, S. (2002). Staff burnout and patient satisfaction: Evidence of relationships at the care unit level. *Journal of Occupational Health Psychology*, *7*(3), 235–241.

Garner, B. R., Godley, S. H., & Funk, R. R. (2008). Predictors of Early Therapeutic Alliance Among Adolescents in Substance Abuse Treatment. *Journal of Psychoactive Drugs*, *40*(1), 55–65.

Gaston, L., & Ring, J. M. (1992). Preliminary Results on the Inventory of Therapeutic Strategies. *The Journal of Psychotherapy Practice and Research*, *1*(2), 135–146.

Gaztambide, D. J. (2012). Addressing cultural impasses with rupture resolution strategies: A proposal and recommendations. *Professional Psychology: Research and Practice*, *43*(3), 183–189.

Gibbons, C. J., Nich, C., Steinberg, K., Roffman, R. A., Corvino, J., Babor, T. F., & Carroll, K. M. (2010). Treatment process, alliance and outcome in brief versus extended treatments for marijuana dependence: Marijuana treatment process. *Addiction*, *105*(10), 1799–1808.

Gifford, E. V., Ritsher, J. B., McKellar, J. D., & Moos, R. H. (2006). Acceptance and relationship context: a model of substance use disorder treatment outcome. *Addiction*, *101*(8), 1167–1177.

Gitterman, A., & Shulman, L. (2005). The life model, oppression, vulnerability, resilience, mutual aid, and the mediating function. *Mutual aid groups, vulnerable & resilient populations, and the life cycle*, 3-37.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon and Schuster.

Grace, M., Kivlighan, D. M., & Kunce, J. (1995). The effect of nonverbal skills training on counselor trainee nonverbal sensitivity and responsiveness and on session impact and working alliance ratings. *Journal of Counseling and Development : JCD; Alexandria*, *73*(5), 547.

Grant, J., & Crawley, J., 2003. *Transferance and Projection*, Maidenhead: Open University Press.

Greenfield, S. F., Kuper, L. E., Cummings, A. M., Robbins, M. S., & Gallop, R. J. (2013). Group Process in the single-gender Women's Recovery Group compared with mixed-gender Group Drug Counseling. *Journal of groups in addiction & recovery*, *8*(4), 270-293.

Greenson, R. R. (1965). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly*, *34*(2), 155-181.

Hammersley, M. (1983). *The ethnography of schooling: Methodological issues*. North Humberside, UK: Nafferton.

Health Research Board (2014a). *HRB Statistics Series 25: Activities of Irish Psychiatric Units and Hospitals 2013 Main Findings*, 4.

Health Research Board. (2013). *National Report (2012 Data) to the EMCDDA by the Reitox National Focal Point: Ireland – New Developments,Trends, and In-Depth Information on Selected Issues*, 88-89.

Health Research Board. (2014b). *Treated alcohol use in Ireland: figures for 2012 from the National Drug Treatment Reporting System*, 1. Dublin: National Health Information Systems.

Health Research Board and Public Health Information and Research Branch (2014). *Drug-Related Deaths and Deaths among Drug Users in Ireland: 2011 figures from the National Drug-Related Deaths Index*.

Heather, N., McCambridge, J., & UKATT Research Team. (2013). Post-treatment stage of change predicts 12-month outcome of treatment for alcohol problems. *Alcohol and Alcoholism*, *48*(3), 329-336.

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence: From domestic abuse to political terror* (rev. ed.). New York, NY: Basic Books.

Hilsenroth, M. J., Peters, E. J., & Ackerman, S. J. (2004). The Development of Therapeutic Alliance During Psychological Assessment: Patient and Therapist Perspectives Across Treatment. *Journal of Personality Assessment, 83*(3), 332–344.

Hoffart, A., Borge, F.-M., Sexton, H., Clark, D. M., & Wampold, B. E. (2012). Psychotherapy for social phobia: How do alliance and cognitive process interact to produce outcome? *Psychotherapy Research, 22*(1), 82–94.

Holder, H., Longabaugh, R., Miller, W. R., & Rubonis, A. V. (1991). The cost effectiveness of treatment for alcoholism: a first approximation. *Journal of studies on alcohol, 52*(6), 517-540.

Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. London: Sage.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work.* New York, NY: Oxford University Press

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of counseling psychology, 36*(2), 223.

Horvath, A. O., & Greenberg, L. S. (1994). The working alliance. Theory*, research, and practice.* New York, NY: Wiley.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of consulting and clinical psychology, 61*(4), 561.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of counseling psychology, 38*(2), 139.

Hougaard, E. (1994). The therapeutic alliance–A conceptual analysis. *Scandinavian Journal of Psychology, 35*(1), 67-85.

Howitt, D., & Cramer, D. (2010). *Introduction to qualitative methods in psychology*. Harlow: Prentice hall.

Hser, Y. I., Grella, C. E., Hsieh, S. C., Anglin, M. D., & Brown, B. S. (1999). Prior treatment experience related to process and outcomes in DATOS. *Drug and alcohol Dependence*, *57*(2), 137-150.

Hubbard, R. L., Craddock, S. G., Flynn, P. M., Anderson, J., & Etheridge, R. M. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, *11*(4), 261.

Hughes, K. (2007) Migrating identities: the relational constitution of drug use and addiction. *Sociology of Health & Illness, 29*: 673-691.

Hunt, G. M., & Azrin, N. H. (1973). A community-reinforcement approach to alcoholism. *Behaviour research and therapy*, *11*(1), 91-104.

Hunter-Reel, D., McCrady, B. S., Hildebrandt, T., & Epstein, E. E. (2010). Indirect Effect of Social Support for Drinking on Drinking Outcomes: The Role of Motivation. *Journal of Studies on Alcohol and Drugs*, *71*(6), 930–937.

Ilgen, M. A, & Moos, R. (2005). Deterioration following alcohol-use disorder treatment in project MATCH. *Journal of Studies on Alcohol*, *66*(4), 517–525.

Ilgen, M. A., McKellar, J., Moos, R., & Finney, J. W. (2006). Therapeutic alliance and the relationship between motivation and treatment outcomes in patients with alcohol use disorder. *Journal of Substance Abuse Treatment*, *31*(2), 157–162.

Jarrett, C. (2017). These are the therapist behaviours that are helpful or harmful, according to clients. Retrieved from https://digest.bps.org.uk/2017/11/23/these-are-the-therapist-behaviours-that-are-helpful-or-harmful-according-to-their-clients/

Jauffret-Roustide, M., Cohen, J., Poisot-Martin, I., Spire, B., Gossop, M., Carrieri, M. P., & the MANIF 2000 Study Group. (2012). Distributive sharing among HIV–HCV co-infected injecting drug users: the preventive role of trust in one's physician. *AIDS Care*, *24*(2), 232–238.

Jennings, A. (2004). Models for developing trauma-informed behavioral health systems and trauma-specific services. *Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning*.

Joe, G. W., Simpson, D. D., & Broome, K. M. (1999). Retention and patient engagement models for different treatment modalities in DATOS. *Drug and Alcohol Dependence*, *57*(2), 113–125.

Joe, G. W., Simpson, D. D., Dansereau, D. F., & Rowan-Szal, G. A. (2001). Relationships Between Counseling Rapport and Drug Abuse Treatment Outcomes. *Psychiatric Services*, *52*(9), 1223–1229.

Joe, G. W., Simpson, D. D., Greener, J. M., & Rowan-Szal, G. A. (1999). Integrative modeling of client engagement and outcomes during the first 6 months of methadone treatment. *Addictive Behaviors*, *24*(5), 649–659.

Joosten, E. (2008). Effect of shared decision-making on therapeutic alliance in addiction health care. *Patient Preference and Adherence*, 277.

Joyce, A. S., & Piper, W. E. (1998). Expectancy, the Therapeutic Alliance, and Treatment Outcome in Short-Term Individual Psychotherapy. *The Journal of Psychotherapy Practice and Research*, *7*(3), 236–248.

Kadden, R. M., & Litt, M. D. (2011). The role of self-efficacy in the treatment of substance use disorders. *Addictive behaviors*, *36*(12), 1120-1126.

Kamali, M., Kelly, L., Gervin, M., Browne, S., Larkin, C., & O'Callaghan, E. (2000). The prevalence of comorbid substance misuse and its influence on suicidal ideation among in- patients with schizophrenia. *Acta psychiatrica scandinavica*, *101*(6), 452-456.

Kasprow, W. J., Frisman, L., & Rosenheck, R. A. (1999). Homeless Veterans' Satisfaction With Residential Treatment. *Psychiatric Services*, *50*(4), 540–545.

Keane M (2011) *The role of education in developing recovery capital in recovery from substance addiction*. Dublin: Soilse Drug Rehabilitation Project

Keeley, M. L., Geffken, G. R., Ricketts, E., McNamara, J. P. H., & Storch, E. A. (2011). The therapeutic alliance in the cognitive behavioral treatment of pediatric obsessive–compulsive disorder. *Journal of Anxiety Disorders*, *25*(7), 855–863.

Keenan, E. (2017). Dual Diagnosis – Contemporary Issues in Ireland [PowerPoint slides]. Retrieved from https://www.hse.ie/eng/about/who/primarycare/socialinclusion/homelessness-and-addiction/dual-diagnosis/

Kendall, P. C., Comer, J. S., Marker, C. D., Creed, T. A., Puliafico, A. C., Hughes, A. A., … Hudson, J. (2009). In-session exposure tasks and therapeutic alliance across the treatment of childhood anxiety disorders. *Journal of Consulting and Clinical Psychology*, *77*(3), 517–525.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of general psychiatry*, *52*(12), 1048-1060.

Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B. F., & Hasin, D. (2010). Stigma and treatment for alcohol disorders in the United States. *American Journal of Epidemiology*, *172*(12), 1364-1372.

Kiesler, D. J., & Watkins, L. M. (1989). Interpersonal complementarity and the therapeutic alliance: A study of relationship in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *26*(2), 183–194.

Kim, M. M., Ford, J. D., Howard, D. L., & Bradford, D. W. (2010). Assessing trauma, substance abuse, and mental health in a sample of homeless men. *Health & Social Work*, *35*(1), 39-48.

Kinsella, M. (2017). Fostering client autonomy in addiction rehabilitative practice: The role of therapeutic "presence". *Journal of Theoretical and Philosophical Psychology*, *37*(2), 91–108.

Kirst, M., Aery, A., Matheson, F. I., & Stergiopoulos, V. (2017). Provider and Consumer Perceptions of Trauma Informed Practices and Services for Substance Use and Mental Health Problems. *International Journal of Mental Health and Addiction*, *15*(3), 514–528.

Klein, D. N., Schwartz, J. E., Santiago, N. J., Vivian, D., Vocisano, C., Castonguay, L. G., ... & Riso, L. P. (2003). Therapeutic alliance in depression treatment: controlling for prior change and patient characteristics. *Journal of Consulting and Clinical Psychology*, *71*(6), 997.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2006). Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment*, *31*(2), 173–180.

Knuuttila, V., Kuusisto, K., Saarnio, P., & Nummi, T. (2012). Effect of early working alliance on retention in outpatient substance abuse treatment. *Counselling Psychology Quarterly*, *25*(4), 361–375.

Korcha, R. A., Polcin, D. L., Bond, J. C., Lapp, W. M., & Galloway, G. (2011). Substance use and motivation: a longitudinal perspective. *The American Journal of Drug and Alcohol Abuse*, *37*(1), 48–53.

Kramer, U., Roten, Y. de, Beretta, V., Michel, L., & Despland, J.-N. (2009). Alliance patterns over the course of short-term dynamic psychotherapy: The shape of productive relationships. *Psychotherapy Research, 19*(6), 699–706.

Kraus, D. R., Castonguay, L., Boswell, J. F., Nordberg, S. S., & Hayes, J. A. (2011). Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research, 21*(3), 267–276.

Krentzman, A. R. (2007). The evidence base for the effectiveness of Alcoholics Anonymous: Implications for social work practice. *Journal of Social Work Practice in the Addictions, 7*(4), 27–47

Krieg, C. H., & Tracey, T. J. (2016). Client interpersonal problems and the initial working alliance. *The European Journal of Counselling Psychology*, *4*(2), 191–204.

Krupnick, J., M. Sotsky, S., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. (1996). The Role of the Therapeutic Alliance in Psychotherapy and Pharmacotherapy Outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, *64*, 532–539.

Lacan, J. 1994. *The Four Fundamental Concepts of Psycho-Analysis*. London: Penguin Books.

LaChance, H., Feldstein Ewing, S. W., Bryan, A. D., & Hutchison, K. E. (2009). What makes group MET work? A randomized controlled trial of college student drinkers in mandated alcohol diversion. *Psychology of Addictive Behaviors*, *23*(4), 598.

Lacoursiere, R. B. (2001). "Burnout" and Substance User Treatment: The Phenomenon and the Administrator-Clinician's Experience. *Substance Use & Misuse*, *36*(13), 1839–1874.

Landrum, B., Knight, D. K., & Flynn, P. M. (2012). The impact of organizational stress and burnout on client engagement. *Journal of Substance Abuse Treatment*, *42*(2), 222–230.

Larson, E. B., & Yao, X. (2005). Clinical Empathy as Emotional Labor in the Patient-Physician Relationship. *JAMA*, *293*(9), 1100.

Lee, N. K., & Jenner, L. (2010). Development of the PsyCheck screening tool: an instrument for detecting common mental health conditions among substance use treatment clients. *Mental Health and Substance Use: Dual Diagnosis*, *3*(1), 56-65.

Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*, *107*(1), 39–50.

Long, C. G., Williams, M., Midgley, M., & Hollin, C. R. (2000). Within-program factors as predictors of drinking outcome following cognitive-behavioral treatment. *Addictive Behaviors*, *25*(4), 573–578.

Long, J. & Mongan, D. (2014). *Alcohol consumption in Ireland 2013*. Dublin: Health Research Board.

Long, J., & Lyons, S. (2010). Problem opiate use in Ireland. *Drugnet Ireland, 32*, 11-14.

Loose, R. (2002). *The subject of addiction: Psychoanalysis and the administration of enjoyment*. London: Karnac Books.

Lorentzen, S., Sexton, H. C., & Høglend, P. (2004). Therapeutic alliance, cohesion and outcome in a long-term analytic group. A preliminary study. *Nordic Journal of Psychiatry*, *58*(1), 33-40.

Lubman, D. I., Hides, L., Yücel, M., & Toumbourou, J. W. (2007). Intervening early to reduce developmentally harmful substance use among youth populations. *Medical Journal of Australia,187*(7), 22.

Luborsky, L. (1976). Helping alliances in psychotherapy: The groundwork for a study of their relationship to its outcome. In J. L. Claghorn (Ed.), *Successful psychotherapy* (pp. 92 - 116). New York, NY: Brunner/Mazel.

Luborsky, L., Barber, J. P., Siqueland, L., McLellan, A. T. & Woody, G. (1995) Establishing a therapeutic alliance with substance abusers. In L. S. Onken, J. Blaine, & J.J. Boren (Eds.), *Beyond the Therapeutic Alliance: Keeping the Drug-Dependent Individual in Treatment* (p. 165). Rockville, MD: National Institute on Drug Abuse.

Luborsky, L., Barber, J. P., Siqueland, L., McLellan, A. T., & Woody, G. (1997). Establishing a therapeutic alliance with substance abusers. Beyond the therapeutic alliance: Keeping the drug dependent individual in treatment. *NIDA Research Monograph*, *165*, 233-244.

Luborsky, L., McLellan, A. T., Diguer, L., Woody, G., & Seligman, D. A. (1997). The psychotherapist matters: Comparison of outcomes across twenty- two therapists and seven patient samples. *Clinical Psychology: Science and Practice*, *4*(1), 53-65.

Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist Success and Its Determinants. *Archives of General Psychiatry*, *42*(6), 602–611.

Lyons, S., Lynn, E., Walsh, S., Sutton, M., & Long, J. (2011). *Alcohol-related deaths and deaths among people who were alcohol dependent in Ireland, 2004 to 2008*. Dublin: Health Research Board

Maisto, S. A., Roos, C. R., O'Sickey, A. J., Kirouac, M., Connors, G. J., Tonigan, J. S., & Witkiewitz, K. (2015). The Indirect Effect of the Therapeutic Alliance and Alcohol Abstinence Self-Efficacy on Alcohol Use and Alcohol-Related Problems in Project MATCH. *Alcoholism: Clinical and Experimental Research*, *39*(3), 504–513.

Mallams, J. H., Godley, M. D., Hall, G. M., Meyers, R. J. (1982). A social systems approach to resocializing alcoholics in the community. *Journal of Studies on Alcohol, 43*, 1115-1123.

Mallinckrodt, B., & Lee Nelson, M. (1991). Counselor Training Level and the Formation of the Psychotherapeutic Working Alliance. *Journal of Counseling Psychology*, *38*, 133–138.

Marcus, D. K., Kashy, D. A., Wintersteen, M. B., & Diamond, G. S. (2011). The therapeutic alliance in adolescent substance abuse treatment: A one-with-many analysis. *Journal of Counseling Psychology*, *58*(3), 449–455.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of consulting and clinical psychology*, *68*(3), 438.

McCabe, R., & Priebe, S. (2003). Are therapeutic relationships in psychiatry explained by patients' symptoms? Factors influencing patient ratings. *European Psychiatry*, *18*(5), 220–225.

McCaul, M. E., & Svikis, D. S. (1991). Improving client compliance in outpatient treatment: Counselor-targeted interventions. *NIDA research monograph*, *106*, 204-215.

McGovern, M. P., Xie, H., Segal, S. R., Siembab, L., & Drake, R. E. (2006). Addiction treatment services and co-occurring disorders: Prevalence estimates, treatment practices, and barriers. *Journal of Substance Abuse Treatment*, *31*(3), 267–275.

McKay, J.R. (2009). Continuing care research: What we have learned and where we are going. *Journal of Substance Abuse Treatment*, *36*(2), 131–145.

McKay, J. R., Carise, D., Dennis, M. L., Dupont, R., Humphreys, K., Kemp, J., ... & Haberle, B. (2009). Extending the benefits of addiction treatment: practical strategies for continuing care and recovery. *Journal of substance abuse treatment*, *36*(2), 127-130.

McLellan, A. T., Woody, G. E., Luborsky, L., & Goehl, L. (1988). Is the counselor an 'active ingredient' in substance abuse rehabilitation? An examination of treatment success among four counselors. *Journal of Nervous and Mental Disease*, *176*(7), 423–430.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. London: Sage Publications.

Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction*, *100*(3), 304–316.

Meier, P. S., Donmall, M. C., Barrowclough, C., McElduff, P., & Heller, R. F. (2005). Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction*, *100*(4), 500-511.

Meier, P. S., Donmall, M. C., McElduff, P., Barrowclough, C., & Heller, R. F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence*, *83*(1), 57–64.

Meyers, R. J., & Miller, W. R. (Eds.). (2001). *A community reinforcement approach to addiction treatment*. New York, NY: Cambridge University Press.

Mezies Lyth, I. (1989). Psychoanalytical perspective on social institutions. *The social engagement of social science*, *1*, 463-475.

Middelboe, T., Schjødt, T., Byrsting, K., & Gjerris, A. (2001). Ward atmosphere in acute psychiatric in-patient care: patients' perceptions,ideals and satisfaction. *Acta Psychiatrica Scandinavica*, *103*(3), 212–219.

Miller, W. R. (2007). Bring addiction treatment out of the closet. *Addiction*, *102*(6), 863-863.

Miller, W. R., & Baca, L. M. (1983). Two-year follow-up of bibliotherapy and therapist-directed controlled drinking training for problem drinkers. *Behavior Therapy*, *14*(3), 441–448.

Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. *Journal of consulting and clinical psychology*, *61*(3), 455.

Miller, W. R., Brown, J. M., Simpson, T. L., Handmaker, N. S., Bein, T. H., Luckie, L. F., Montgomery, H. A., Hester, R. K., & Tonigan, J. S. (1995). What works? A methodological analysis of the alcohol treatment outcome literature. In R.K. Hester & W.R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives (2nd ed.)*. Needham, MA: Allyn & Bacon.

Miller, B. A., Downs, W. R., & Testa, M. (1993). Interrelationships between victimization experiences and women's alcohol use. *Journal of Studies on Alcohol*, (11), 109-117.

Miller, W. R., & Moyers, T. B. (2015). The forest and the trees: relational and specific factors in addiction treatment: Forest and trees. *Addiction*, *110*(3), 401–413.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change (2nd ed.)*. New York, NY: Guilford Press.

Miller, W. R., Taylor, C. A., & West, J. C. (1980). Focused versus broad-spectrum behavior therapy for problem drinkers. *Journal of consulting and clinical psychology*, *48*(5), 590.

Millman, R. B. (1986). Considerations on the psychotherapy of the substance abuser. *Journal of substance abuse treatment*, *3*(2), 103-109.

Mills, K. L., Teesson, M., Ross, J., & Peters, L. (2006). Trauma, PTSD, and substance use disorders: findings from the Australian National Survey of Mental Health and Well-Being. *American Journal of Psychiatry*, *163*(4), 652-658.

Milmoe, S., Rosenthal, R., Blane, H. T., Chafetz, M. E., & Wolf, I. (1967). The doctor's voice: Postdictor of successful referral of alcoholic patients. *Journal of Abnormal Psychology*, *72*(1), 78–84.

Mohl, P. C., Martinez, D., Ticknor, C., Huang, M., & Cordell, L. (1991). Early dropouts from psychotherapy. *Journal of Nervous and Mental Disease*, *179*(8), 478–481.

Mongan, D., Reynolds, S., Fanagan, S., & Long, J. (2007). *Health-related consequences of problem alcohol use.* Overview 6. Dublin: Health Research Board.

Moore, G. (2012). *A psychoanalytic investigation of transference management in the Irish adult public mental health services* (Doctoral dissertation, Dublin City University).

Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors*, *27*(3), 878–884.

Moyers, T. B., Miller, W. R., & Hendrickson, S. M. L. (2005). How does motivational interviewing work? Therapist interpersonal skill predicts client involvement within motivational interviewing sessions. *Journal of Consulting and Clinical Psychology, 73*(4), 590–598.

Najavits, L. M., & Hien, D. (2013). Helping vulnerable populations: A comprehensive review of the treatment outcome literature on substance use disorder and PTSD. *Journal of clinical psychology, 69*(5), 433-479.

Najavits, L. M., & Strupp, H. H. (1994). Difference in effectiveness of psychodynamic therapies. *Psychotherapy: Theory, Research, Practice, and Training*, 114123.

Najavits, L. M., & Weiss, R. D. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorders: An empirical review. *Addiction, 89*(6), 679-688.

Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1999). A clinical profile of women with posttraumatic stress disorder and substance dependence. *Psychology of Addictive Behaviors, 13*(2), 98.

National Advisory Committee on Drugs and Public Health Information and Research Branch (2011), *Drug use in Ireland and Northern Ireland: First results from the 2010/11 Drug Prevalence Survey*, 13.

National Advisory Committee on Drugs and Public Health Information and Research Branch (2012), *Drug use in Ireland and Northern Ireland: First results from the 2010/11 Drug Prevalence Survey*, 10.

National Council of Ireland Strengthening Families Programme (2018, July 10). Retrieved from http://sfpcouncilireland.ie/strengthening-families/

Novie, G. (2008). [Review of the book *Jacques Lacan and the Other Side of Psychoanalysis: Reflection on Seminar XVII* by Clemes, J & Grigg, R] *Division, 39*

Ó Súilliobháin, C. (2014). Proceedings from the British Medical Association and Irish Medical Organisation All-Ireland Conference on Mental Health and Addiction 2014: *Access to Community Based Drug Treatment*.

Ogborne, A. C., Braun, K., & Schmidt, G. (1998). Working in addictions treatment services: Some views of a sample of service providers in Ontario. *Substance use & misuse*, *33*(12), 2425-2440.

Ogrodniczuk, J. S., & Piper, W. E. (1999). Measuring Therapist Technique in Psychodynamic Psychotherapies: Development and Use of a New Scale. *The Journal of Psychotherapy Practice and Research*, *8*(2), 142–154.

Öjehagen, A., Berglund, M., & Hansson, L. (1997). The relationship between helping alliance and outcome in outpatient treatment of alcoholics: a comparative study of psychiatric treatment and multimodal behavioural therapy. *Alcohol and Alcoholism*, *32*(3), 241–249.

Orford, J. (2008). Asking the right questions in the right way: The need for a shift in research on psychological treatments for addiction. *Addiction*, *103*(6), 875-885.

Orford, J., Hodgson, R., Copello, A., John, B., Smith, M., Black, R., … Slegg, G. (2006). The clients' perspective on change during treatment for an alcohol problem: qualitative analysis of follow-up interviews in the UK Alcohol Treatment Trial. *Addiction*, *101*(1), 60–68.

Oser, C. B., Biebel, E. P., Pullen, E., & Harp, K. L. H. (2013). Causes, Consequences, and Prevention of Burnout Among Substance Abuse Treatment Counselors: A Rural Versus Urban Comparison. *Journal of Psychoactive Drugs*, *45*(1), 17–27.

Ouimette, P. C., Ahrens, C., Moos, R. H., & Finney, J. W. (1998). During Treatment Changes in Substance Abuse Patients with Posttraumatic Stress Disorder: The Influence of Specific Interventions and Program Environments. *Journal of Substance Abuse Treatment*, *15*(6), 555–564.

Ouimette, P., & Brown, P. J. (Eds.). (2003). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. Washington, DC,: American Psychological Association.

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, *48*(3), 274–282.

Owen, J., Imel, Z., Tao, K. W., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling and Psychotherapy Research*, *11*(3), 204–212.

Oyefeso, A., Clancy, C., & Farmer, R. (2008). Prevalence and associated factors in burnout and psychological morbidity among substance misuse professionals. *BMC Health Services Research*, *8*(1), 39.

Paivio, S., & Bahr, L. (1998). Interpersonal Problems, Working Alliance, and Outcome in Short-Term Experiential Therapy. *Psychotherapy Research*, *8*(4), 392–407.

Paivio, S. C., & Patterson, L. A. (1999). Alliance development in therapy for resolving child abuse issues. *Psychotherapy: Theory, Research, Practice, Training*, *36*(4), 343.

Palamar, J. J., Kiang, M. V., & Halkitis, P. N. (2012). Predictors of stigmatization towards use of various illicit drugs among emerging adults. *Journal of Psychoactive Drugs*, *44*(3), 243-251.

Pantalon, M. V., Chawarski, M. C., Falcioni, J., Pakes, J., & Schottenfeld, R. S. (2004). Linking Process and Outcome in the Community Reinforcement Approach for Treating Cocaine Dependence: A Preliminary Report. *The American Journal of Drug and Alcohol Abuse*, *30*(2), 353–367.

Patterson, G., & Forgatch, M. (1985). Therapist Behavior as a Determinant for Client Noncompliance. A Paradox for the Behavior Modifier. *Journal of Consulting and Clinical Psychology*, *53*, 846–851.

Pearlin, L., Lieberman, M., Menaghan, E., & Mullan, J. (1981). Mastery scale. *Measures of Personality and Social Psychological Attitudes. San Diego: Academic Press, Inc*.

Petry, N. M., & Bickel, W. K. (1999). Therapeutic Alliance and Psychiatric Severity as Predictors of Completion of Treatment for Opioid Dependence. *Psychiatric Services*, *50*(2), 219–227.

Pooler, D. K., Qualls, N., Rogers, R., & Johnston, D. (2014). An exploration of cohesion and recovery outcomes in addiction treatment groups. *Social Work with Groups*, *37*(4), 314-330.

Price, J. L., Hilsenroth, M. J., Petretic-Jackson, P. A., & Bonge, D. (2001). A review of individual psychotherapy outcomes for adult survivors of childhood sexual abuse. *Clinical Psychology Review*, *21*(7), 1095-1121.

Price, P. B., & Jones, E. E. (1998). Examining the alliance using the Psychotherapy Process Q-Set. *Psychotherapy: Theory, Research, Practice, Training*, *35*(3), 392.

Prochaska, J. O., & Norcross, J. C. (2001). Stages of change. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 443-448.

Project MATCH Research Group. (1998). Therapist Effects in Three Treatments for Alcohol Problems. *Psychotherapy Research*, *8*(4), 455–474.

Proudfoot, J. (2017). Drugs, addiction, and the social bond. *Geography Compass*, *11*(7).

Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A., & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing*, *16*(3), 279–284.

Raytek, H. S., McCrady, B. S., Epstein, E. E., & Hirsch, L. S. (1999). Therapeutic alliance and the retention of couples in conjoint alcoholism treatment. *Addictive Behaviors*, *24*(3), 317–330.

Reyre, A., Jeannin, R., Larguèche, M., Hirsch, E., Baubet, T., Moro, M. R., & Taïeb, O. (2014). Care and prejudice: moving beyond mistrust in the care relationship with addicted patients. *Medicine, Health Care and Philosophy*, *17*(2), 183–190.

Reyre, A., Jeannin, R., Largueche, M., Moro, M. R., Baubet, T., & Taieb, O. (2017). Overcoming professionals' challenging experiences to promote a trustful therapeutic alliance in addiction treatment: A qualitative study. *Drug and Alcohol Dependence*, *174*, 30–38.

Richardson, D., Adamson, S., & Deering, D. (2018). Therapeutic alliance predicts mood but not alcohol outcome in a comorbid treatment setting. *Journal of Substance Abuse Treatment*, *91*, 28–36.

Richardson, G. E. (2002). The metatheory of resilience and resiliency. *Journal of clinical psychology*, *58*(3), 307-321.

Ritter, A., Bowden, S., Murray, T., Ross, P., Greeley, J., & Pead, J. (2002). The influence of the therapeutic relationship in treatment for alcohol dependency. *Drug and Alcohol Review*, *21*(3), 261–268.

Rochlen, A. B., Rude, S. S., & Barón, A. (2005). The Relationship of Client Stages of Change to Working Alliance and Outcome in Short-Term Counseling. *Journal of College Counseling; Alexandria*, *8*(1), 52–64.

Rogers, W. A. (2002). Is there a moral duty for doctors to trust patients?. *Journal of Medical Ethics*, *28*(2), 77-80.

Ronzani, T. M., Higgins-Biddle, J., & Furtado, E. F. (2009). Stigmatization of alcohol and other drug users by primary care providers in Southeast Brazil. *Social Science & Medicine*, *69*(7), 1080–1084.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and alcohol review*, *24*(2), 143-155.

Roy, V., & Pullen-Sansfaçon, A. (2016). Promoting individual and social changes: A hybrid model of social work with groups. *Social Work with Groups*, *39*(1), 4-20.

Ruglass, L. M., Miele, G. M., Hien, D. A., Campbell, A. N. C., Hu, M.-C., Caldeira, N., … Nunes, E. V. (2012). Helping Alliance, Retention, and Treatment Outcomes: A Secondary Analysis From the NIDA Clinical Trials Network Women and Trauma Study. *Substance Use & Misuse*, *47*(6), 695–707.

Saarnio, P. (2002). Factors Associated with Dropping Out from Outpatient Treatment of Alcohol-Other Drug Abuse. *Alcoholism Treatment Quarterly*, *20*(2), 17–33.

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology*, *56*(2), 233-243.

Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy: Theory, Research, Practice, Training*, *27*(2), 154–165.

Sampson, R. J., & Laub, J. H. (1990). Crime and deviance over the life course: The salience of adult social bonds. *American sociological review*, 609-627.

Sanders, C. E., Field, T. M., Miguel, D., & Kaplan, M. (2000). The relationship of Internet use to depression and social isolation among adolescents. *Adolescence*, *35*(138), 237.

Saunders, S. M. (1999). Clients' assessment of the affective environment of the psychotherapy session: Relationship to session quality and treatment effectiveness. *Journal of Clinical Psychology*, *55*(5), 597–605.

Saunders, S. M. (2001). Pretreatment correlates of the therapeutic bond. *Journal of clinical psychology*, *57*(12), 1339-1352.

Saunders, S., I. Howard, K., & Orlinsky, D. (1989). The Therapeutic Bond Scales: Psychometric Characteristics and Relationship to Treatment Effectiveness. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *1*, 323–330.

Schaefer, J. A., Ingudomnukul, E., Harris, A. H. S., & Cronkite, R. C. (2005). Continuity of Care Practices and Substance Use Disorder Patients' Engagement in Continuing Care. *Medical Care*, *43*(12), 1234–1241.

Scheper-Hughes, N. (2001). *Saints, Scholars, and Schizophrenics Mental illness in Rural Ireland*, Berkeley, CA: University of California Press.

Schomerus, G., Corrigan, P. W., Klauer, T., Kuwert, P., Freyberger, H. J., & Lucht, M. (2011). Self-stigma in alcohol dependence: Consequences for drinking-refusal self-efficacy. *Drug and Alcohol Dependence*, *114*(1), 12–17.

Schwartz, R. P., Kelly, S. M., Mitchell, S. G., Gryczynski, J., O'grady, K. E., Gandhi, D., ... & Jaffe, J. H. (2017). Patient- centered methadone treatment: a randomized clinical trial. *Addiction*, *112*(3), 454-464.

Sexton, H. C., Hembre, K., & Kvarme, G. (1996). The interaction of the alliance and therapy microprocess: A sequential analysis. *Journal of Consulting and Clinical Psychology*, *64*(3), 471.

Sexton, H., Littauer, H., Sexton, A., & Tømmerås, E. (2005). Building an alliance: Early therapy process and the client–therapist connection. *Psychotherapy Research*, *15*(1–2), 103–116.

Sharf, J., Primavera, L. H., & Diener, M. J. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *47*(4), 637–645.

Sher, K. J., & Trull, T. J. (2002). Substance use disorder and personality disorder. *Current Psychiatry Reports*, *4*(1), 25–29.

Shoptaw, S., Stein, J. A., & Rawson, R. A. (2000). Burnout in substance abuse counselors: Impact of environment, attitudes, and clients with HIV. *Journal of Substance Abuse Treatment*, *19*(2), 117–126.

Simpson, D. D., Joe, G. W., Rowan-Szal, G., & Greener, J. (1995). Client engagement and change during drug abuse treatment. *Journal of Substance Abuse*, *7*, 117–134.

Simpson, D. D., Joe, G. W., Broome, K. M., Hiller, M. L., Knight, K., & Rowan-Szal, G. A. (1997). Program diversity and treatment retention rates in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, *11*(4), 279.

Simpson, D. D., Joe, G. W., Rowan-Szal, G. A., & Greener, J. M. (1997b). Drug abuse treatment process components that improve retention. *Journal of substance abuse treatment*, *14*(6), 565-572.

Simpson, D.D, & Lloyd, M. R. (1981). Alcohol use following treatment for drug addiction. A four-year follow-up. *Journal of Studies on Alcohol, 42*(3), 323–335.

Smith, J. E., Meyers, R. J., & Delaney, H. D. (1998). The community reinforcement approach with homeless alcohol-dependent individuals. *Journal of Consulting and Clinical Psychology, 66*(3), 541.

Star Project Ballymun. (2018, July 10). Retrieved from https://starballymun.ie/drug-rehabilitation-programmes/drug-free-service/

Stark, M. J. (1992). Dropping out of substance abuse treatment: A clinically oriented review. *Clinical Psychology Review, 12*(1), 93–116.

Strauss, J. L., Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J. P., … Beck, A. T. (2006). Early Alliance, Alliance Ruptures, and Symptom Change in a Nonrandomized Trial of Cognitive Therapy for Avoidant and Obsessive–Compulsive Personality Disorders. *Journal of Consulting and Clinical Psychology*, *74*(2), 337–345.

Strunk, D. R., Cooper, A. A., Ryan, E. T., DeRubeis, R. J., & Hollon, S. D. (2012). The process of change in cognitive therapy for depression when combined with antidepressant medication: Predictors of early intersession symptom gains. *Journal of Consulting and Clinical Psychology*, *80*(5), 730–738.

Strupp, H. H., Fox, R. E., & Lessler, K. (1969). *Patients view their psychotherapy*. Oxford, England: Johns Hopkins Press.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*(4), 271–286.

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *80*(4), 547–559.

Swift, J. K., Tompkins, K. A., & Parkin, S. R. (2017). Understanding the client's perspective of helpful and hindering events in psychotherapy sessions: A micro- process approach. *Journal of clinical psychology*, *73*(11), 1543-1555.

Taylor, S. (2006). *Ethnographic Research A Reader,* London, Sage

The Jean Tweed, C. (2013). Trauma matters: guidelines for trauma-informed practices in women's substance use services. Retrieved from http://jeantweed.com/wp-content/themes/JTC/pdfs/Trauma%20Matters%20online%20version%20August%202013.pdf

Thom, D. H., Wong, S. T., Guzman, D., Wu, A., Penko, J., Miaskowski, C., & Kushel, M. (2011). Physician Trust in the Patient: Development and Validation of a New Measure. *The Annals of Family Medicine*, *9*(2), 148–154.

Thorne, S. E., & Robinson, C. A. (1988). Reciprocal trust in health care relationships. *Journal of Advanced Nursing*, *13*(6), 782–789.

Timko, C., & Moos, R. H. (1998). Outcomes of the treatment climate in psychiatric and substance abuse programs. *Journal of Clinical Psychology*, *54*(8), 1137–1150.

Tunis, S. L., Delucchi, K. L., Schwartz, K., Banys, P., & Sees, K. L. (1995). The relationship of counselor and peer alliance to drug use and HIV risk behaviors in a six-month methadone detoxification program. *Addictive Behaviors*, *20*(3), 395–405.

Uekermann, J., & Daum, I. (2008). Social cognition in alcoholism: a link to prefrontal cortex dysfunction? *Addiction*, *103*(5), 726–735.

Ungar, M. (2013). Resilience, trauma, context, and culture. *Trauma, violence, & abuse*, *14*(3), 255-266.

Urbanoski, K. A., Kelly, J. F., Hoeppner, B. B., & Slaymaker, V. (2012). The role of therapeutic alliance in substance use disorder treatment for young adults. *Journal of Substance Abuse Treatment*, *43*(3), 344–351.

Vahey, D. C., Aiken, L. H., Sloane, D. M., Clarke, S. P., & Vargas, D. (2004). Nurse Burnout and Patient Satisfaction. *Medical Care*, *42*(2 Suppl), II57–II66.

Valle, S. K. (1981). Interpersonal functioning of alcoholism counselors and treatment outcome. *Journal of Studies on Alcohol*, *42*(9), 783–790.

Vilardaga, R., Luoma, J. B., Hayes, S. C., Pistorello, J., Levin, M. E., Hildebrandt, M. J., … Bond, F. (2011). Burnout among the addiction counseling workforce: The differential roles of mindfulness and values-based processes and work-site factors. *Journal of Substance Abuse Treatment*, *40*(4), 323–335.

von Greiff, N., & Skogens, L. (2017). Understanding the concept of the therapeutic alliance in group treatment for alcohol and drug problems. *European Journal of Social Work*, 1-13.

Walker, J., & Ostrom, E. (2009). Trust and reciprocity as foundations for cooperation. In: Cook, K. S, Levi, M., Hardin R, (Eds.) *Who Can We Trust? How Groups, Networks, and Institutions Make Trust Possible* (pp. 91-124). Thousand Oaks, CA: Russell Sage Foundation.

Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., ... & Paterson, S. (2003). Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *The British Journal of Psychiatry*, *183*(4), 304-313.

Westra, H. A., Constantino, M. J., & Aviram, A. (2011). The impact of alliance ruptures on client outcome expectations in cognitive behavioral therapy. *Psychotherapy Research*, *21*(4), 472–481.

Wolfe, S., Kay-Lambkin, F., Bowman, J., & Childs, S. (2013). To enforce or engage: The relationship between coercion, treatment motivation and therapeutic alliance within community-based drug and alcohol clients. *Addictive Behaviors*, *38*(5), 2187–2195.

Wood, T. E., Englander- Golden, P., Golden, D. E., & Pillai, V. K. (2010). Improving addictions treatment outcomes by empowering self and others. *International Journal of Mental Health Nursing*, *19*(5), 363-368.

World Health Organisation (2014). *Global Status Report on Alcohol and Health 2014*. Geneva, Switzerland: World Health Organisation.

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy*. New York, NY: Basic Books.

Zhang, Z., Friedmann, P. D., & Gerstein, D. R. (2003). Does retention matter? Treatment duration and improvement in drug use. *Addiction*, *98*(5), 673–684.

Zuroff, D. C., & Blatt, S. J. (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and enhanced adaptive capacities. *Journal of consulting and clinical psychology*, *74*(1), 130.

Zuroff, D. C., Kelly, A. C., Leybman, M. J., Blatt, S. J., & Wampold, B. E. (2010). Between-therapist and within-therapist differences in the quality of the therapeutic relationship: effects on maladjustment and self-critical perfectionism. *Journal of Clinical Psychology*, *66*(7), 681–697.

Appendix A

Field Notes Template

Date and Time 11/06/2018 10:15-12:15	Location STAR Project	Event
		Reflection and Analysis

Appendix B

Service User Focus Group Questions

1. In one sentence, can you just say who you are and how many services you have attended before STAR, if any?
2. What is different about STAR compared to other places you have been?
3. What would you say the core values at STAR are?
4. Is there anything different about the way you interact as a group (of service users)?
    - Is there anything different about you feel as a member of the group compared with other services?
    - Does this atmosphere of support come about naturally or is it worked on?
    - Are the staff seen as part of the group?
5. Is there anything in particular about the staff that helps you in your recovery?
    - Is there anything about specific staff members (without naming them) that you find helpful or unhelpful?
    - Do staff treat the service users differently to in other services?
6. Has your motivation to recover increased since you joined STAR?/ Is there anything about STAR that has made you more motivated to achieve your goal of being clean from drugs (or were you always as motivated as you are now)?
7. Is there anything about STAR that makes you want to attend every day?
8. Is there anything in particular that STAR do which has helped you?/ Is there anything unique about STAR that you have found particularly beneficial?/
9. Is there anything that STAR doesn't do that you found helpful at other services?/ Is there anything you feel that STAR aren't doing that would help with your recovery?

Appendix C

Staff Focus Group Interview Questions

1 What is the philosophy (mission/purpose) of STAR?

2 What do you think makes STAR successful?

3 The Service Users we have met have been very positive about the staff, what do you attribute that to?

4 What steps are built into client assessment and initial engagement that develop the relationship between staff and service users?

5 How are relationships managed and maintained over the period a service user is attending? (How do you respond to non-compliance with the programme such as drug/alcohol use or poor attendance?)

6 How are relationships between staff members managed and maintained? (Is this different to how they are managed with service users?)

7 What happens if a staff member/key worker and a service user disagree?

8 How is success measured at Star?

9 We have picked up an emphasis on past trauma in the approach, which activities, if any, address this with service users?

10 Any other contributions

Appendix D

Individual Interview Questions: Service Users

How did you feel when you first starting coming to STAR? (give example)

Were you given at set of rules to follow when you first started?

How did you know what you should and shouldn't do?

What do you think the general atmosphere is like at STAR?

Why do you think it is like that?

What do you feel when you think of STAR?/ What does it represent for you?

Did coming to STAR change how you felt about drug use? (how? Give example)

What are the most helpful things the staff do or say? (give example)

What are the least helpful things staff do or say? (give example)

How do staff react if you do not attend (give example including how you felt)

Do you feel that being honest is important at STAR? (Why?)

Do you feel the need to hide things from other service users and staff? (Why or why not?)

Would you be more inclined to hide things from staff than other service users? (If so, why?)

Have you ever had a slip or relapse? (give example including the staff reaction)

Do you ever feel judged at STAR for something you said or did? (give example)

Has attending STAR changed how you think about things? (give example)

Is there anything about STAR that you would like to change?

Who do you feel is responsible for your recovery? (they will all say themselves, could say something afterwards like: is there anything that Star has done to help you take this responsibility)

What level of responsibility do you think the staff feel for you? (give example) (possibly "do you feel like you have become too reliant on Star" as a follow-up question)

Appendix E

Individual Interviews Questions: Staff

Can you describe what kind of relationship you have with the service users?

What skills/strategies do you use to form relationships with the service users? (give example)

What interrupts/ruptures/damages the relationship between staff and service users? (give example)

What are the core values of STAR?

How did you learn these values?

How do you transmit them to others? (give example)

Is the approach in STAR different to other places you have worked? (give example)

Are there any gaps in your knowledge and skills that would help you to manage the issues that service users present with?

When you feel frustrated by the work what do you do? (give example)

Have you ever suffered from burnout? (give example)

Are there times when you have to manage/control/sanction a service user? (give example)

What level of responsibility do you feel for the service users' welfare? (give example) (As a follow up to that question: Do you ever feel like the clients can become too reliant on project?)

Are service users encouraged to take roles and responsibilities in STAR? (give example)

What happens when there is a big falling out with a client? (give example)

It was mentioned that in the past some service users stayed in the service longer than they should have, why would this have been the case? (give example)

Is there a reason why there isn't more of a focus on addiction and relapse prevention in the programme?

Appendix F

Family Support Service Questions

Describe how the work you do relates to the STAR project for individual service users?

What overlap is there between the two services?

Are there shared beliefs and principles between the two services? (If so, describe them)

Are there differences in how the two services operate (If so, describe them)

What are the core values of the family support service?

How did you learn these values?

How do you transmit them to others? (give example)

Is the approach in the Family Service different to other places you have worked? (give example)

Are there things you would change about the service?

Are there any gaps in your knowledge and skills to manage the issues that service users present with?

When you feel frustrated by the work what do you do? (give example)

Have you ever suffered from burnout? (give example)

Are there times when you have to manage/control/sanction someone attending the service? (give example)

What level of responsibility do you feel for attendees' welfare? (give example)

Do you think both services should be more interlinked? (if so how)

Appendix G

Participant Informed Consent Form: Service Users (Focus Group interviews)

Research Study Title: Identifying the skills that enable client engagement and retention in an addiction service

Purpose of Study:

The aim of this research is to identify the skills and aspects of therapeutic alliance necessary to form social bonds that enable successful engagement and retention of clients.

Participation Requirements:

Potential participants will be invited to participate in a research focus group. You will be asked to complete and sign this consent form and will be invited to partake in a focus group with one of the research team. The focus group will last around 60 minutes and will be recorded. You can decide on the nature and depth of information you share and you are free to leave at any time without explanation. If you choose to withdraw at any time in the study process, you will be supported in this decision and will be given equal access to information and support services.

Participant Confirmation:

(Please answer each question)

I have read or had read to me the Information Sheet: Yes/No

I understand the information provided: Yes/No

I had an opportunity to ask questions and discuss the study: Yes/No

I received satisfactory answers to my questions: Yes/No

I agree to being recorded: Yes/No

I am aware that my participation in this study is completely voluntary and that I am free to withdraw for any reason from this study without judgement. My data will be kept secure at all times and my name will not be divulged to anyone. My name will also be anonymised to protect my identity. I am aware that anonymity cannot be fully guaranteed. Furthermore, this study will be subjected to legal limitations, which have been explained to me.

Participant Signature:

I have read and understood the information in this form and the attached information sheet. My questions have been adequately answered by the researcher and I have a copy of the consent form. Therefore, I consent to participate in this research project.

Participants Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

Appendix H

Participant Information Sheet: Service Users

Research Study Title: Identifying the skills that enable client engagement and retention in an addiction service.

Conducted by: The School of Nursing and Human Sciences, Dublin City University.

Principal Investigator: Dr Gerard Moore Tel: 7005340

Co-Investigators: Dr Rita Glover Tel: 7007936

Dr Catherine McGonagle Tel: 7008537

Research assistant: Daniel Phelan

Study Summary:

This project sets out to look at how a community based addiction service operates in relation to retention of clients. The study is concerned with observing, exploring and examining the relationships between staff and service users in order to identify the key skills and aspects of the therapeutic alliance that assist the formation of successful relationships that lead to better engagement and retention of service users.

You can change your mind about partaking at any stage without any interruption to your treatment in the centre. Anyone who does not want to take part will have their wishes respected. The focus group will be recorded on audio tapes which will be destroyed after relevant sections from the tapes are transcribed and analysed. All biographical markers will be removed to protect people's privacy. The information will be used to write a report.

Benefits and Risks:

Potential benefits to Participants Include:

• The therapeutic effect of voicing your experiences to an interested party.

• Being provided with information about local services, which you may choose to access.

• Influencing developments that will guide professional practice and service provision.

Potential Risks to Participants Include:

• Becoming distressed in the interview by the recall of painful events and memories.

In the event that you become distressed during your involvement in an interview for this study you may choose to or be advised to discontinue and will be supported to avail of suitable support systems. A supportive colleague and/or professionals involved with your care will be informed about your increased level of distress and you will be offered additional counselling support if necessary.

Anonymity and Confidentiality:

Anonymity of participants and confidentiality of interview material will be safeguarded through a number of measures, including:

Recorded material will be transferred to a password protected computer package for storage and retrieval. The audio recordings will be fully deleted once they are transferred to the desktop computer. This will be completed after the focus group.

Only those working on the research team, and named above, will have access to this material.

Signed consent forms will be stored in a locked filing cabinet and will not carry any identifying codes that connect individuals to specific recorded data.

Appendix I

Participant Informed Consent Form: Staff (Focus Group Interviews)

Research Study Title: Identifying the skills that enable client engagement and retention in an addiction service

Purpose of Study:
The aim of this research is to identify the skills and aspects of therapeutic alliance necessary to form social bonds that enable successful engagement and retention of clients.

Participation Requirements:
Potential participants will be invited to participate in a research focus group. You will be asked to complete and sign this consent form and will be invited to partake in a focus group with one of the research team. The focus group will last around 90 minutes and will be recorded. You can decide on the nature and depth of information you share and you are free to leave at any time without explanation. If you choose to withdraw at any time in the study process, you will be supported in this decision and will be given equal access to information and support services.

Participant Confirmation:
(Please answer each question)

I have read or had read to me the Information Sheet: Yes/No

I understand the information provided: Yes/No

I had an opportunity to ask questions and discuss the study: Yes/No

I received satisfactory answers to my questions: Yes/No

I agree to being recorded: Yes/No

I am aware that my participation in this study is completely voluntary and that I am free to withdraw for any reason from this study without judgement. My data will be kept secure at all times and my name will not be divulged to anyone. My name will also be anonymised to protect my identity. I am aware that anonymity cannot be fully guaranteed. Furthermore, this study will be subjected to legal limitations, which have been explained to me.

Participant Signature:
I have read and understood the information in this form and the attached information sheet. My questions have been adequately answered by the researcher and I have a copy of the consent form. Therefore, I consent to participate in this research project.

Participants Signature: _____
Name in Block Capitals: _____
Date: _____

Appendix J

Participant Information Sheet: Staff (for use with Focus Group Interviews)

Research Study Title: Identifying the skills that enable client engagement and retention in an addiction service
Conducted by: The School of Nursing and Human Sciences, Dublin City University.
Principal Investigator: Dr Gerard Moore Tel: 7005340
Co-Investigators: Dr Rita Glover Tel: 7007936
Dr Catherine McGonagle Tel: 7008537
Research assistant: Daniel Phelan

Study Summary:
This project sets out to look at how a community based addiction service operates in relation to retention of clients. The study is concerned with observing, exploring and examining the relationships between staff and service users in order to identify the key skills and aspects of the therapeutic alliance that assist the formation of successful relationships that lead to better engagement and retention of service users.

You can change your mind about partaking at any stage without any interruption to your treatment in the centre. Anyone who does not want to take part will have their wishes respected. The focus group will be recorded on audio tapes which will be destroyed after relevant sections from the tapes are transcribed and analysed. All biographical markers will be removed to protect people's privacy. The information will be used to write a report.

Benefits and Risks:

Potential benefits to Participants Include:
• The therapeutic effect of voicing your experiences to an interested party.
• Influencing developments that will guide professional practice and service provision.

Potential Risks to Participants Include:
• Becoming distressed in the interview by the recall of painful events and memories. In the event that you become distressed during your involvement in an interview for this study you may choose to or be advised to discontinue and will be supported to avail of suitable support systems.

Anonymity and Confidentiality:
Anonymity of participants and confidentiality of interview material will be safeguarded through a number of measures, including:

Recorded material will be transferred to a password protected computer package for storage and retrieval. The audio recordings will be fully deleted once they are transferred to the desktop computer. This will be completed after the focus group.

Only those working on the research team, and named above, will have access to this material.

Signed consent forms will be stored in a locked filing cabinet and will not carry any identifying codes that connect individuals to specific recorded data.

No information identifying an individual person or organization will be used in documentation pertaining to the study.

The transcripts of the interviews will be deleted completely with the secure file deletion option on the CCleaner software within five-years of the studies completion. All confidential paper work will be destroyed through the DCU secure confidential paper shredding services.

Study material will be subject to legal limitations, which means that it could be subject to subpoena, a freedom of information claim or mandated reporting by a professional. This would be necessary if you were assessed as being at risk of harm to yourself, or if you disclosed information that indicated that you presented a potential risk of harm, or had inflicted actual harm to another person.

You can contact any member of the research team at the numbers given above if you need additional information or what to discuss any aspect of the study. Additionally, it is important to note that if you have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee. C/o Office of the Vice-President for Research, Dublin City University, D. 9. Tel: 01-7008000

Appendix K

Participant Informed Consent Form (Individual Interview)

Research Study Title: Identifying the skills that enable client engagement and retention in an addiction service

Purpose of Study:
The aim of this research is to identify the skills and aspects of therapeutic alliance necessary to form social bonds that enable successful engagement and retention of clients.

Participation Requirements:
Potential participants will be invited to participate in an individual interview. You will be asked to complete and sign this consent form and will be invited to partake in an interview with a member of the research team. The interview will last around 30 to 60 minutes and will be recorded. You can decide on the nature and depth of information you share and you are free to leave at any time without explanation. If you choose to withdraw at any time in the study process, you will be supported in this decision and will be given equal access to information and support services.

Participant Confirmation:
(Please answer each question)

I have read or had read to me the Information Sheet: Yes/No

I understand the information provided: Yes/No

I had an opportunity to ask questions and discuss the study: Yes/No

I received satisfactory answers to my questions: Yes/No

I agree to being recorded: Yes/No

I am aware that my participation in this study is completely voluntary and that I am free to withdraw for any reason from this study without judgement. My data will be kept secure at all times and my name will not be divulged to anyone. My name will also be anonymised to protect my identity. I am aware that anonymity cannot be fully guaranteed. Furthermore, this study will be subjected to legal limitations, which have been explained to me.

Participant Signature:
I have read and understood the information in this form and the attached information sheet. My questions have been adequately answered by the researcher and I have a copy of the consent form. Therefore, I consent to participate in this research project.

Participants Signature: _____
Name in Block Capitals: _____
Date: _____

Appendix L

Participant Information Sheet Individual Interview

Research Study Title: Identifying the skills that enable client engagement and retention in an addiction service
Conducted by: The School of Nursing and Human Sciences, Dublin City University.
Principal Investigator: Dr Gerard Moore Tel: 7005340
Co-Investigators: Dr Rita Glover Tel: 7007936
Dr Catherine McGonagle Tel: 7008537
Research assistant: Danny Phelan

Study Summary:
This project sets out to look at how a community based addiction service operates in relation to retention of clients. The study is concerned with observing, exploring and examining the relationships between staff and service users in order to identify the key skills and aspects of the therapeutic alliance that assist the formation of successful relationships that lead to better engagement and retention of service users.

You can change your mind about partaking at any stage without any interruption to your treatment in the centre. Anyone who does not want to take part will have their wishes respected. The interview will be recorded on audio tapes which will be destroyed after relevant sections from the tapes are transcribed and analysed. All biographical markers will be removed to protect people's privacy. The information will be used to write a report.

Benefits and Risks:

Potential benefits to Participants Include:
• The therapeutic effect of voicing your experiences to an interested party.
• Being provided with information about local services, which you may choose to access.
• Influencing developments that will guide professional practice and service provision.

Potential Risks to Participants Include:
• Becoming distressed in the interview by the recall of painful events and memories. In the event that you become distressed during your involvement in an interview for this study you may choose to or be advised to discontinue.

Anonymity and Confidentiality:
Anonymity of participants and confidentiality of interview material will be safeguarded through a number of measures, including:

Recorded material will be transferred to a password protected computer package for storage and retrieval. The audio recordings will be fully deleted once they are transferred to the desktop computer. This will be completed after the interview.

Only those working on the research team, and named above, will have access to this material.

Signed consent forms will be stored in a locked filing cabinet and will not carry any identifying codes that connect individuals to specific recorded data.

No information identifying an individual person or organization will be used in documentation pertaining to the study.

The transcripts of the interviews will be deleted completely with the secure file deletion option on the CCleaner software within five-years of the studies completion. All confidential paper work will be destroyed through the DCU secure confidential paper shredding services.

Study material will be subject to legal limitations, which means that it could be subject to subpoena, a freedom of information claim or mandated reporting by a professional. This would be necessary if you were assessed as being at risk of harm to yourself, or if you disclosed information that indicated that you presented a potential risk of harm, or had inflicted actual harm to another person.

You can contact any member of the research team at the numbers given above if you need additional information or what to discuss any aspect of the study. Additionally, it is important to note that if you have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee. C/o Office of the Vice-President for Research, Dublin City University, D. 9. Tel: 01-7008000