Unlearning Addiction: Synthesising Knowles, Mezirow, and Freire into Community-Based Rehabilitation

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Keywords

Addiction recovery, recovery capital, adult education, Freire, Knowles, Mezirow, gender, Ireland.

ABSTRACT

Community based rehabilitation programmes developed as a grassroots response to the heroin epidemic in Dublin in the later 1970s and 1980s. Such integrated community programmes prioritise a holistic based approach representing a shift towards more empowerment focused care. This article explores how adult education, namely the approaches of Paulo Freire, Malcolm Knowles and Jack Mezirow, can enhance addiction recovery through three interconnected mechanisms: cognitive restructuring, collective conscientisation and self-directed learning. Taken together, these resources combine to activate 'recovery capital'.

Using semi structured interviews, this research focuses on the subjective experiences and outcomes of individuals who completed integrated adult education and community-based rehabilitation programmes. It explores how participants negotiated issues around recovery, social inclusion, education, employment and community participation. The article also seeks to demonstrate how adult education framework can be used to enhance rehabilitation practice for individuals working in the addiction field.

1. Introduction

During the heroin epidemic of the late 1970s and 1980s, an inadequate state response forced Dublin's working-class communities to pioneer community-led anti-addiction interventions through grassroots collective action. While subsequent state policy prioritised harm reduction, such as methadone maintenance, to minimise immediate risks, this medicalised paradigm often limited the long-term life chances of service users (O'Brien, 2013, pp. 59-70). Conversely, funding for holistic, community-led frameworks that promote abstinence-based recovery remained sparse. However, as the sector evolved, state funding has increasingly been allocated

to incorporate adult education within these community-based rehabilitation programmes, signalling a shift toward more integrated, empowerment-focused care. This study argues that integrating a synthesis of Paulo Freire's 'Critical Pedagogy', Malcolm Shepherd Knowles' 'Adult Learning Theory', and Jack Mezirow's 'Transformative Learning Theory' into addiction treatment successfully complements the rehabilitative process to optimise sustained recovery outcomes and enhance service users' life chances. This nexus is examined across three core dimensions: individual cognitive restructuring as a catalyst for cultural capital; collective conscientisation within peer-led networks to generate social capital; and the operationalisation of self-directed learning to build autonomous human capital. Consequently, converting these assets into physical capital activates all four dimensions of 'recovery capital', the requisite for sustaining recovery. Crucially, by leveraging bell hooks' (1994) model of 'engaged pedagogy', this framework counteracts early Freirean gender-blindness, ensuring the model explicitly addresses how gendered systemic barriers and distinct trauma profiles impede long-term recovery trajectories.

This study explores participants' subjective realities to determine how adult education can best optimise service user outcomes. Mainstream research evaluations often rely on superficial quantitative metrics like completion rates to justify state funding, failing to capture sustained, long-term outcomes. To address this empirical gap, this research investigates the long-term recovery trajectories and structural life chances of individuals who completed integrated adult education and community-based rehabilitation programmes (hereafter, integrated programmes) at least one year prior to data collection. The article begins by drawing on commonalties between person-centred and community-based addiction treatment and recovery models and core ideas that inform transformative adult learning, which in turn, correspond to 'recovery capital' as a conceptual framework. Next, detail is offered on the research process, along with an overview of key findings that emerged from the fieldwork. The findings demonstrate the importance of adopting a distinct and authentic andragogical approach by educators, acknowledges the importance of both informal and formal educational contexts in sustained recovery. Part of this process involves confronting prior educational traumas as well as recognising the impact of both gender and clinical stratifications on learning.

1.1 Conceptually defining addiction recovery

Mapping the structural and conceptual congruence between adult education and addiction rehabilitation requires a concrete conceptualisation of 'recovery'. Sheedy and Whitter (2009) define recovery not merely as clinical abstinence, but as a self-directed, holistic process of

healing and identity redefinition. Their twelve principles of addiction recovery explicitly intersect with progressive adult education frameworks (see Table 1).

Table 1: Sheedy & Whitters' (2009) Conceptualised model of addiction recovery (from Keane, et al. 2014, p. 21).

A Conceptual Model of Recovery
1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions
6. Recovery exists on a continuum of improved health and wellness
7. Recovery emerges from hope and gratitude
8. Recovery involves a process of healing and self-redefinition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

These principles advocate a holistic, person-centred, community-based approach to treating addiction and promoting recovery. They share extensive commonalities with Freire, Knowles, and Mezirow's models. Embedding this synthesised andragogical framework within integrated programmes systematically optimises rehabilitation outcomes by fostering transformative identity shifts while dismantling intrapersonal and structural barriers to recovery. This process accumulates 'recovery capital' by fostering empowerment, inclusion, and supportive peer networks. Derived by Cloud and Granfield (1999) from Pierre Bourdieu's social capital framework (Keane et al., 2014). This model defines recovery capital as the aggregate of internal and external resources vital to sustaining recovery and long-term life prospects (Cloud & Granfield, 2008, pp. 12-13). This asset base encompasses four dimensions: social, physical, human, and cultural (see Table 2).

Table 2: The four dimensions of recovery capital (from: Cloud & Granfield, 2008 cited in Keane, et al. 2014, p. 17).

Dimension of Capital	Conceptual Definition	Mechanisms of Impact
Social Capital	The aggregate of resources generated through an individual's interpersonal relationships, social support, and mutual group obligations.	Supportive peer networks, family reconciliation, and non-drug-using circles of belonging that are conducive to recovery.
Physical Capital	Tangible assets such as property and money that may increase recovery options.	Financial reserves, stable housing, secure transportation, and personal property create the stability required to meet basic needs and eliminate survival-driven anxiety, these assets provide the structural stability and access to resources conducive to recovery, thereby granting individuals the vital time and security required to sustain long-term, transformative recovery.
Human Capital	The combination of personal capabilities, cognitive resources, positive health and internal traits that drive self-actualisation.	Formal education and vocational skills build economic agency and self-sufficiency; physical and mental health provide the cognitive stamina necessary to manage stress that can trigger relapse; and personal aspirations and hope that drive the intrinsic motivation required for sustained recovery.
Cultural Capital	The internal values, beliefs and attitudes that link individuals to social attachment and the ability to fit into mainstream social behaviour and adhere to societal norms.	Foster recovery by enabling the behavioural and cognitive shifts necessary to avoid relapse and integrate into mainstream social and professional environments, thereby replacing self-defeating patterns with stable, goal-oriented habits.

1.2 Andragogical drivers of recovery capital

To understand how embedding andragogical principles within addiction treatment enhances post-treatment outcomes, empirical data must be evaluated through the lens of recovery capital (see Table 3).

Table 3: The andragogical drivers of recovery capital

Theoretical Framework	Primary Target Capital	Mechanism of Impact
Critical Pedagogy (Freire)	Social Capital	Catalyses the construction of new, non-drug-using peer networks and horizontal circles of belonging conducive to recovery, while enabling the navigation of systemic structures that act as barriers to enhanced life chances.
Transformative Learning Theory (Mezirow)	Cultural Capital	Restructures deeply embedded cognitive schemas and frames of reference, facilitating a shift from substance dependency to critical agency in sustained recovery.
Adult Learning Theory (Knowles)	Human Capital	Self-directed learning fosters the autonomous goal setting, critical agency, and intrinsic motivation essential for sustained recovery.
Synthesised Andragogical Approach	Physical Capital	Integrates these drivers to navigate recovery barriers and pursue formal academic credentials and career orientated goals: Knowles provides the autonomous agency and intrinsic motivation for academic achievement, Mezirow the transformative identity shift for goal attainment, and Freire the critical skills to transgress systemic barriers to social mobility.

2. Theoretical Alignment: Andragogical Mechanisms Conducive to Addiction Rehabilitation

2.1 Jack Mezirow's' transformative learning theory

Transformative learning experiences enable individuals to overcome the marginalisation, low self-worth, and apathy reproduced by social stigma. By shifting problematic frames of reference and worldviews (Mezirow, 1991, pp. 13-14), learners transition from hopelessness and dependency to self-determination. This shift fosters the agency required to dismantle deeply embedded internal barriers to recovery and unlock previously unattainable life chances.

Achieving a deep cognitive restructuring, historically described in early recovery literature as a 'psychic change' (Silkworth, 1939, p. XXVII), is essential for sustaining recovery and reducing relapse probability. This internal shift is particularly critical for countering what addiction literature terms 'euphoric recall', a cognitive distortion wherein individuals

selectively romanticise past substance use while minimising its destructive consequences, serving as a frequent precursor to relapse. Overcoming this distortion directly aligns with Sheedy and Whitter's (2009) second principle: Recovery is inherently self-directed and empowering. Cultivating this self-directedness is a critical intervention strategy; by preventing services from fostering a culture of dependency, it dismantles the systemic trap where participants frequently relapse upon disengagement from institutional support. Although early recovery may require significant external guidance, individuals must ultimately become the primary agents of change. This intentional shift toward autonomy allows participants to "become 'agents' of their own recovery, who utilise their agency to advance personal objectives" (Keane et al., 2014), directly strengthening human capital as a foundation for broader social and cultural integration.

Mezirow's framework offers a robust mechanism for personal liberation in recovery. Active addiction deeply compromises self-worth and breeds apathy, a psychological state sustained by rigid, maladaptive schemas. Recovery begins by confronting a 'disorienting dilemma', an existential crisis often cited as a 'rock bottom' in addiction literature. This crisis instigates Mezirow's ten-phase transformative progression which, when mapped alongside the dimensions of recovery capital (Cloud & Granfield, 2008), represents a systematic accumulation of internal and external assets.

Within a safe learning space, learners can navigate the complex grieving process of substance cessation, confronting psychological barriers like euphoric recall alongside deep-seated feelings of guilt and shame. By critically assessing these distortive assumptions (phases 2 and 3), participants cultivate the internal self-awareness central to human capital. They then recognise their shared discontent (phase 4), fostering social capital through peer solidarity, before acquiring new cognitive competencies that further augment human capital (phase 7).

These steps culminate in sustainable community (re)integration based on a transformed perspective (phase 10), aligning with the development of cultural capital by reconciling the individual's new values with the pro-social norms and conventions of mainstream society. This sequential progression provides the structural foundation for recovery capital, operationalising Sheedy and Whitter's (2009) mandate to transcend stigma through educational dialogue.

2.2 Paulo Freire's critical pedagogy

Whereas Mezirow focuses on individual transformation, a Freirean approach elevates it to collective empowerment, rejecting a didactic "banking model" of passive transmission of knowledge in favour of horizontal, problem-posing dialogue. Through these dialogical

relations, educators and learners co-construct knowledge. This process fosters two essential elements: 'conscientisation' the ongoing process of perceiving social, political, and economic contradictions and 'critical consciousness', the resulting cognitive state of structural awareness. These concepts remain distinct, yet they continually inform each other. Operating within horizontal learning environments, learners explore prior experiences through problem-solving dialogue to transform their lived realities (Freire, 1993, pp. 71-81).

Validating and utilising the participants' prior experiences generates human capital through the acquisition of new knowledge and skills. In early recovery, this critical re-evaluation empowers individuals to decode their personal histories, transforming passive blind spots into recognised relapse triggers that can be navigated and neutralised.

This horizontal architecture mirrors the peer-led partnerships championed by modern recovery-oriented systems of care. By dismantling the shame and isolation of active addiction, this non-judgmental dialogue establishes a psychologically safe space to discuss recovery barriers, such as cravings, with peers who share lived experience. Like structured aftercare groups, Twelve-step fellowships, or other mutual-aid groups, a dedicated learning space fosters transparent communication, significantly reducing relapse risk. These authentic peer interactions foster the deep, interpersonal connections that naturally expand into the supportive networks, family reconciliations, and non-drug-using circles of belonging vital for sustaining recovery.

This dialogical process serves as a mechanism for generating and converting recovery capital. This epistemological transformation enhances human capital, making it highly conducive to navigating both structural and intra-personal barriers to long-term recovery. Critical self-reflection within a supportive, horizontal learning space allows practitioners and participants to collectively enact praxis, unpacking the structural roots of addiction and dismantling the internalised, stigma-induced guilt and shame that that reinforces and reproduces it. In this architecture, these internalised stigma-driven deficits function as negative recovery capital, representing impediments and cognitive processes that actively restrict an individual's capacity to initiate change (Cloud & Granfield, 2008, p. 1972).

Through this framing, this transformative process systematically neutralises these deficits to foster profound intrinsic motivation, enabling individuals to reclaim agency from oppressive structures. As this internal shift converts personal insight into a transformative form of cultural capital, the framework moves far beyond preparing individuals for the labour market or basic societal reintegration; it empowers participants to actively challenge the status quo of addiction, overcome social stigma, and contribute to their communities through sustained praxis (Freire, 1993, pp. 125-128). In this manner, the internal generation of human capital

catalyses the conversion of personal growth into collective social capital. This ongoing, reflective action directly strengthens human capital, aligning with Sheedy and Whitter's (2009) third principle: Recovery involves a personal recognition of the need for change and transformation, and their sixth principle: Recovery exists on a continuum of improved health and wellness.

This dynamic serves as a microcosm of recovery; both operate as continuous, evaluative loops. The non-linear progression of recovery reflects Freire's cyclical framework, illustrating why a Freirean approach complements a lifelong commitment to recovery. Just as conscientisation is not a linear checklist but an iterative process of self-redefinition, sustained recovery demands that an individual perpetually re-evaluate their relationship with internalised triggers and oppressive external structures.

Consistent with Twelve-Step fellowships, this learning process shifts participants from active addiction's egocentricity toward internalised altruism, empathy, and active citizenship, all key drivers of social capital. This trajectory often leads recovering individuals to enter the social care sector, subverting negative cultural capital to transform their personal and professional environments. This transition toward civic and social responsibility is echoed in contemporary recovery literature: '...the sooner individuals face their problems within everyday living, just that much faster do we become acceptable, responsible, and productive members of that society' (Narcotics Anonymous, 1988, p. 35).

Unlike Knowles, who anchors transformation within foundational environmental conditions, or Mezirow, who outlines a linear psychological journey of sequential steps, Freire rejects any fixed or finite progression. Instead, his model operates as a cyclical structural loop of reflection and action, establishing a non-linear process that uniquely reflects the long-term realities of recovery.

2.3 Malcolm Shepherd Knowles' adult learning theory

While Mezirow and Freire provide the transformative framework, Malcolm Knowles' andragogical model offers the practical tools to facilitate these learning processes within an addiction recovery context.

Much like andragogy, recovery requires active participation; individuals must recognise the need for transformation (Sheedy & Whitter, 2009). Andragogical spaces facilitate critical reflection, empowering service users to navigate the grief of substance detachment, identify behavioural triggers, and process underlying trauma. A compelling congruence exists between Freirean dialogue, Knowles' assumptions on experience and learning orientation, and mutual-

aid programmes, all of which facilitate collaborative, problem-centred learning, although the latter operationalises this through structured 'shared monologues'.

Within these spaces, the process is dialogic and relational; individuals collaboratively apply abstract recovery principles to their lived realities. Drawing on prior experiences as a primary learning resource, participants generate the human and social capital central to Cloud and Granfield's (2008) framework, converting these assets into cultural capital as they align internal values with a recovery-oriented worldview. Incorporating these participatory, peer-led practices enriches long-term outcomes and fosters empathetic transformation (Boisvert, 2008, pp. 211–215), while expanding social capital through reciprocal peer obligations and supportive networks (Cloud & Granfield, 2008, p.1974)

Enacting Freirean praxis and achieving critical consciousness requires active engagement; Knowles' tenets of adult learning assume that success depends on intrinsic motivation and a readiness to learn, which catalyse self-directed agency. For recovering individuals, this agency is essential to take ownership of their path, developing human capital through the acquisition of problem-solving skills, emotional regulation, and enhanced self-efficacy (Cloud & Granfield, 2008, p. 1975). This aligns with the broader recovery trajectory, where individual volition remains foundational. The second principle of Sheedy & Whitter's (2009) model asserts that recovery is self-directed and empowering (cited in Keane et al., 2014, p. 23). This accumulation of human and social capital provides the foundation for individuals to secure and leverage physical capital such as housing, financial security and employment, which are all vital for sustaining long-term, community-based reintegration (Cloud & Granfield, 2008, pp. 1974-1975).

2.4 Mitigating Conceptual Limitations via a Hybrid Model

To construct an andragogical framework resilient enough for marginalised populations, one must address the limitations of individual learning theories. Brookfield (1986, pp. 91-97) critiqued Knowles's idealism for ignoring hegemonic power dynamics and the systemic lack of equal opportunity for marginalised groups. Similarly, Brookfield (2000, pp. 126-130) argued that Mezirow's transformative learning theory overemphasises rational-cognitive shifts while neglecting socio-cultural inequalities and the emotional dimensions inherent in learning environments.

Beyond these individualist critiques, Hooks' (1994, pp. 49-54) identifies Freire's model as gender-blind, an omission particularly problematic in the context of recovery, where trajectories often diverge by gender. In rehabilitative spaces, gender-blindness fails because women face distinct trauma profiles, social stigma, and socio-biological barriers that act as

institutional gatekeepers. By leveraging this intersectional critique to refine Freirean theory, this hybrid model ensures that praxis remains gender-responsive, optimising recovery capital accumulation for women.

This study explicitly accounts for these critiques, demonstrating how the structural weaknesses of one framework are neutralised by the strengths of the others (see Table 4).

Table 4: Synthesising Andragogical Frameworks to Neutralise Theoretical Limitations

Theorist	Core Contribution to Recovery	Critique (Brookfield/ hooks)	Hybrid Resolution
Knowles	Autonomy, leveraging life experience, problem-centred coping.	Idealistic; ignores systemic oppression and unequal opportunities.	Balanced by Freire: Hyper-individualism is grounded by Freirean structural critique. Individual self-direction is transformed into a tool to navigate institutional barriers, ensuring agency does not lapse into internalised blame for systemic failures.
Mezirow	Dismantling frames of reference; overcoming stigmatised shame, apathy and low self-worth. confronting the disorienting dilemma that addiction is no longer a means of survival, but the very obstacle preventing the life they are capable of living.	Overly rational/individualistic; ignores cultural and emotional dimensions.	Balanced by Freire's collective emancipation and Hooks' gendered lens. internal psychological transformation is connected to Freirean collective praxis.
Freire	Dialogue, collective praxis, dismantling stigmatising, and marginalising systemic power structures.	Historically gender-blind; assumes a homogenous marginalised experience.	Balanced by Knowles, Mezirow, & Hooks: Freire's macro-structural focus is balanced by Knowles' individual focus and Mezirow's internal psychological steps. Hooks' intersectional lens reconstructs the Freirean dialogue to be gender-responsive, recognising that building recovery capital requires addressing specific, non-homogenous trauma.

3. Methodology

Grounded in a social constructivist ontology (Schwandt, 2000, pp. 197-198), this qualitative study positions addiction and recovery as phenomena continuously constructed and renegotiated through social interactions. This lens prioritises how individuals interpret their trajectories from active addiction to sustained recovery (Robson, 2011: pp. 24-26), aligning Mezirow's' transformative learning framework, where learners transform existing frames of reference to reconstruct personal identity (Mezirow, 2003, pp. 58-63). Consequently, knowledge was co-constructed through the relational dynamic between researcher and participants.

3.1 Participants and sampling

Participants were recruited using a purposeful sampling strategy from integrated programmes in Dublin, Ireland, where adult education is embedded within rehabilitation. Given the tight-knit nature of this sector, a small sample was selected to provide deep, localised insights, rather than broad generalisability. The sample comprised two distinct stakeholder cohorts (see Table 5).

Table 5: Participant sample and selection criteria

Participant Group	Number	Selection Criteria & Profile
Practitioners	3	Experienced professionals (2 male, 1 female) with experience managing or delivering integrated adult education frameworks in community-based rehabilitation.
Ex-Service Users	4	To evaluate long-term recovery outcomes and evolving life trajectories, the inquiry engaged individuals (2 male, 2 female) who had completed an integrated programme at least 12 months prior to data collection. Additionally, a gender-balanced sample was intentionally recruited to prevent gender-blindness and ensure the inquiry captured the distinct systemic and structural barriers, as well as the intrapsychic challenges, faced by men and women in recovery.

In acknowledgment of the researcher's professional history within the Dublin addiction and education sectors, pre-existing professional relationships existed with three practitioners and three former service users. To maintain integrity, individuals with close personal ties were excluded, ensuring the sample possessed the objective expertise and lived experience essential to inform the inquiry.

3.2 Data collection, coding and analysis

Primary data was generated through qualitative, semi-structured interviews (Robson, 2011). Two tailored interview schedules were deployed to reflect the different vantage points of the cohorts: the practitioner schedule focused on institutional policies and andragogical practices, while the former service-user schedule emphasised the subjective impact of learning on individual recovery. Interviews were audio-recorded, transcribed verbatim, and anonymised (Denscombe, 2003, pp. 267-269). Data was analysed using systematic thematic coding (Braun & Clarke, 2022). Transcripts underwent multiple close readings to manually map the intersections between adult learning, rehabilitation, and systemic barriers, ultimately yielding seven primary themes.

3.3 Ethics and reflexivity

Ethical clearance was granted by the Maynooth University departmental ethics committee. Access was secured via institutional gatekeepers, and written informed consent, including the right to unconditional withdrawal, was obtained from all participants. Given the inherent vulnerability of individuals post-rehabilitation, the researcher maintained a non-judgmental stance and omitted trauma-triggering lines of questioning. When a participant became emotional during an interview, the session was temporarily paused to verify ongoing consent and offer a referral to a local support service. To mitigate insider power imbalances, strict confidentiality was maintained through pseudonymisation.

4. Findings

A number of core themes emerged through analysis of the data that highlighted both challenges and potential benefits from applying an andragogical approach in the addiction treatment and recovery context. The nature of these challenges are varied, including both structural issues as well as identifiable shortcomings within adult education ideas and theories that have informed this study. The key themes discussed here include recovery capital; recognizing the importance of maintaining a consistent and unified andragogical approach; the importance of both informal and formal educational contexts; acknowledging prior educational traumas; and recognising the impact of both gender and clinical stratifications on learning.

4.1 Recovery capital

Mirroring the unequal distribution of baseline recovery capital, Respondent 5 noted that younger cohorts presenting solely with cocaine addiction often exhibit higher success rates than long-term, marginalised opiate users:

> *"Unfortunately, a lot of people who come into recovery don't have recovery capital, and then they struggle with the basic stuff in life... They wouldn't be coming in with the same damage as a heroin user who's been living on the streets for years, who's been in and out of prison. Who has all the trauma that goes with that..." (Respondent 5).*

This disparity aligns with findings that successful recovery is often predicated on pre-existing human and cultural capital, such as educational qualifications, employment history, and lack of immersion in 'street' subcultures (Cloud & Granfield, 1999; Keane et al., 2014). Similarly, Respondent 4 highlighted how early engagement with recovery-oriented peers provides the foundation for sustained success:

> *"I was lucky. I found recovery... before I found education. So, the people in my life at that stage were in recovery... they were facilitators in day programs, managers... social care workers. So, I had a network of people I could text or ring"* (Respondent 4).

Respondent 1, whose work is influenced by the Freirean model, illustrated how andragogical principles cultivate recovery capital:

> *"Active addiction reduces the person's life to the point where... it's just them and the substance. Successful recovery involves creating wider circles of belonging, and that again is what the horizontal philosophy of adult education does... there's a much bigger picture at work"* (Respondent 1*).*

This testimony synthesises the three core adult learning theories discussed. First, Freire's horizontal, dialogical approach acts as a catalyst for liberation from the oppressive structures compounding addiction; by replacing triggers with supportive networks, participants actively generate social capital. Specifically, peer dialogue fosters a reflective praxis that mirrors the empathetic principles of Twelve-Step models, aiding the reintegration necessary to overcome societal marginalisation (Keane et al., 2014). Second, transformative learning prompts critical reflection on embedded beliefs, helping participants navigate 'disorienting dilemmas' to cultivate cultural capital and align their values with pro-social norms. Simultaneously, Knowles' framework of self-directed learning enhances human capital; by autonomously defining recovery goals, participants increase intrinsic motivation and acquire the skills requisite for sustained recovery.

4.2 A unified philosophy and the andragogical imperative

Embedding andragogical principles within integrated programmes enhances recovery by fostering empowerment and building recovery capital. As Cloud and Granfield (1999) demonstrate, addiction recovery and adult learning share deep commonalities; outcomes are optimised when transformative learning is prioritised over the simple delivery of content. However, a fundamental distinction exists between merely instructing adults and practicing authentic andragogy. Respondent 1 highlighted this boundary, cautioning against a didactic approach:

> *"The andragogical principles have to be central to everything… seeing people as adults with lived experience. Some people say we're doing adult education just because there are adults in the room. But that in itself isn't adult education; it's [about] actually enacting the principles and values that underpin good adult education work"* (Respondent 1).

This distinction is vital. Respondent 1 asserted that integrating adult education into addiction rehabilitation necessitates andragogical methods, as this person-centred approach prioritises individual development, ultimately equating critical pedagogy with the process of initiating recovery: *"With a Freirean philosophy of adult education and successful recovery the processes are the same: empowerment, inclusion and participation"* (Respondent 1).

To successfully operationalise these findings, several structural refinements are recommended to ensure adult education and rehabilitation function as a cohesive mechanism. From the outset, programmes must avoid parallel designs where the two fields operate with divergent objectives; as Respondent 1 cautioned, running these disciplines concurrently without a shared foundational ethos creates internal operational friction: *"...it's important that there's a collective team and they're not working against each other and that no one's working to undermine someone else."* (Respondent 1)

To offset the limitations of traditional, top-down psychotherapeutic models, this collaborative framework must be built from the ground up. Grounding practitioners in a unified, bottom-up philosophy ensures organisational cohesion, placing workers on what Respondent 1 describes as *"terra firma"* [solid ground]." By mitigating internal discord, organisations safeguard participant trajectories, thereby optimising recovery outcomes and enhancing the long-term life chances of service users. To eliminate institutional friction, management should implement mandatory shared training to cultivate a cohesive, multidisciplinary team. This systematic alignment ensures that all practices are explicitly driven by: *"what's in the person's best interest. Not the organisation, not the funders best interest"* (Respondent 1).

This structural grounding ensures that participant trajectories are never compromised by internal discord, optimising rehabilitation outcomes. Service providers should implement a

horizontal, non-formal framework to complement existing psychotherapeutic approaches, offsetting the limitations of rigid, didactic methods. By moving beyond traditional, teacher-led instruction, practitioners trigger the transformative learning necessary for sustained change.

When programmes prioritise didactic modes, they risk alienating participants and replicating the power imbalances that exacerbate addiction trauma. Genuine andragogical education respects learner autonomy, positioning lived experience as the foundation for knowledge construction and enabling learners to strategically navigate barriers to recovery. This learner-centred, peer-led approach is also critical for dismantling intrapersonal barriers to recovery, such as denial, minimisation, and fear of change.

Within these low-stakes, non-formal spaces, learners can safely process internalised shame, dismantle the apathy born of systemic marginalisation, and cultivate agency. By replacing top-down instruction with horizontal, problem-posing dialogue, andragogical practice transforms painful experiences from sources of isolation into subjects for critical reflection. By externalising struggles and challenging societal labels, learners transition from dependency to agency, taking ownership of their educational journey. This vital shift replaces cycles of negative affect with a self-directed sense of purpose conducive to sustaining recovery. While formal accreditation provides an essential human capital dimension, the application of andragogy generates cultural capital by internalising new values while fostering the social capital to build new recovery-orientated peer networks.

4.3 The critical role of non-formal education

Unlike formal academic structures, non-formal learning adapts to immediate needs and fosters the emotional regulation necessary for sustained recovery. By prioritising collaborative, peer-led environments, it strengthens the social and human dimensions of recovery capital, cultivating resilience through practical skills, mutual tolerance, and enhanced self-efficacy. This approach extends beyond immediate recovery outcomes. By fostering critical thinking and problem-posing dialogue, it empowers individuals to redefine their identities and societal roles and transition from dependency to autonomy. Navigating both the psychological cycles of early recovery and broader systemic barriers fundamentally alters long-term life trajectories. Building confidence in these non-formal settings further prepares learners to attain formal academic credentials, building a cognitive repertoire for wider achievement.

Respondent 1 highlighted this structural interplay, noting that while initial educational interventions prioritised an adaptive, non-formal approach, institutional demands inevitably

shifted the landscape: *"Initially the non-formal was a much bigger part of it. Later on, funding dictated that it became more about the employment market… they needed certification"* (Respondent 1).

This narrative underscores how non-formal engagement serves as the essential gateway to formal qualifications, translating early personal stabilisation into the structured human capital required by the wider socio-economic environment. As Sheedy and Whitter (2009) note, recovery is a holistic process of healing, self-redefinition, and active discrimination-transcendence that requires rebuilding a meaningful life within the community. Transformative learning processes deconstruct previous inert meaning schemes, reconstructing identity from a state of apathy to one of agency (Mezirow, 2000, pp. 22-28). Thus, this integration secures both sustained recovery and improved life chances. The data validates that synthesising Knowles' andragogical parameters with Freirean dialogue allows education to become a practice of freedom, directly engaging the concrete 'limit-situations' that historically impede individual autonomy (Freire, 1970, pp. 71-74). As learners acquire new skills within an accredited framework, their heightened self-efficacy serves as a powerful structural precursor to sustained recovery.

4.4 Formal accredited education and contextualisation

Formal, accredited education generates human capital by providing institutional qualifications that structurally enhance employability. These credentials grant the agency necessary to secure meaningful work or pursue further education, fostering the systemic stability, autonomy, and identity shifts vital to sustaining recovery and societal (re)integration. Respondent 2 noted how achieving these certifications fundamentally transformed his perspective and life trajectory: *"I've worked most days… and I've two jobs …. and it's not like working. It's going in and now I'm doing something that I enjoy doing"* (Respondent 2).

This testimony demonstrates that formal education solidifies recovery progression by translating intrinsic changes into tangible human capital. While the necessity of addressing these immediate learning needs was outlined in Section 4.3, Respondent 2 provides empirical evidence for why formal curriculum design must be contextualised. Because self-directedness and empowerment are essential for quality recovery metrics (Sheedy and Whitter, 2009), curricula must actively target and dismantle the systemic and psychological barriers that historically gatekeep improved life chances (Keane et al., 2014).

For these educational interventions to be effective, formal module design must prioritise contextualisation, utilising anticipated barriers to recovery as the foundation for learning. Because adult learners possess a problem-centred orientation, they engage most deeply when

they recognise an immediate, functional application for acquired knowledge (Knowles, 1980, pp. 43-45). Facilitators can leverage this intrinsic motivation by shifting the focus from passive consumption to active, self-directed inquiry. Framing assessment criteria around immediate survival concerns, such as relapse prevention, harm reduction, literacy, or navigating social welfare systems ensures that curriculum delivery directly mirrors participant reality.

4.5 Confronting social stigma and structural blockages

Sheedy and Whitter (2009) assert that recovery requires addressing discrimination and transcending shame and stigma, yet individuals face severe systemic blockages post-treatment. Illustrating these structural barriers, Respondent 3 noted how welfare constraints and social stigma actively penalise progression:

> *"The intrinsic motivation might be there, but... they may realise they don't have childcare, or there's something there that's blocking them, or maybe the block is that once they walk up to that program, it becomes known that they've had a substance use issue"* (Respondent 3).

Critical consciousness enables learners to navigate these obstacles by positioning their socio-political reality as an alterable landscape rather than a static destiny. Non-formal andragogical spaces provide the psychological safety to process the intense guilt or shame of 'disorienting dilemmas' (Mezirow, 1991, p. 168), empowering learners to challenge the institutional power dynamics shaping their lives.

4.6 Navigating historical educational trauma and academic self-doubt

Participants frequently experience profound apathy rooted in academic self-doubt and historical educational trauma. Non-formal education dismantles these barriers; its focus on collaborative peer learning and practical skills fosters self-understanding and redefines identity. Respondent 3 observed:

> *"I do think a big piece of it is the self-belief. It's the sense that they felt they were never that bright, or they were always put down the back of the class, and these are all the things that did happen in schools"* (Respondent 3*).*

As Mezirow (1991, pp. 4-5) posits, oppressive early experiences distort meaning perspectives. Confronting these disorienting dilemmas within supportive, non-formal environments allows participants to transform the embedded beliefs perpetuating self-doubt.

Respondents 4, 6, and 7 illustrate this transformation of meaning schemes, fundamentally altering their life trajectories. Respondent 4 noted:

> *"I never used a laptop. I left school when I was 14. So, everything... fell by the wayside. My spelling was bad. I didn't know how to manage sentences... Through doing* [Non-formal Educational] *group work it showed you your ability of what things you might*

> *be able for, like your interest that you wouldn't have known you had… you broaden your thinking"* (Respondent 4).

Respondent 7 also contrasted her aversion to traditional structures with her engagement in non-formal spaces, while Respondent 6 paralleled rigid schooling with carceral environments:

> *"It was a completely different approach. I was treated like an adult, not a child. I was talked to, not talked at… in the adult education I was treated a lot more respectfully than I was when I was a child"* (Respondent 6).

Exposure to a rigid banking model of education left Respondent 6 with oppressive internalisations; however, through non-formal and subsequent formal learning, he achieved long-term employment in addiction treatment. His trajectory embodies Freirean praxis, disrupting the dehumanising aggression he once experienced (Freire, 1993, pp. 67-72). This supports Sheedy and Whitter's (2009) assertion that recovery requires (re)building a life within the community, a transition facilitated by Knowles' (1980, pp. 24-47) andragogical design, where a respectful, collaborative learning climate dismantles the structural dependency induced by traditional schooling. Shifting the educator's role from an authoritarian instructor to a facilitator leverages the adult's accumulated life experience as a primary learning resource, fostering self-efficacy by validating their capacity for autonomous self-direction.

Significantly, both Respondents 4 and 7 engaged exclusively in non-formal learning during rehabilitation, later transitioning into higher education; Respondent 4 subsequently secured employment in the homeless sector, while Respondent 7 entered psychotherapy training and now works within an integrated programme. Their trajectories substantiate this theoretical synthesis, demonstrating how transformative learning permits individuals to transition from structural helplessness to autonomous self-direction. As Respondent 7 articulated: *"…the non-formal stuff over there was… more about how you are as a person, how you're gonna act as a productive member of society* [and] *to look at how to change our behaviours"* (Respondent 7).

This testimony affirms that leveraging prior experiences serves as an initial mechanism for generating human capital through new knowledge and skills. The data validates Knowles' (1980) assumptions regarding adult learners' intrinsic motivation, highlighting Freirean problem-posing dialogue as a catalyst for conscientisation. This dual process maps directly onto Phase 5 of Mezirow's (1991) transformative learning framework: exploring options for new roles, relationships, and actions. To stimulate this dialogue and operationalise the specialised clinical content outlined in Section 5.3, Respondent 6 shared a technique for encouraging participation in an aftercare group he facilitates:

> *"We know what comes up in recovery, and we know the stuff we don't want to talk about. That's what I'm saying, topic them! And go straight from there… I would say, I'll just pick the word and say this is the topic and let's just see what happens"* (Respondent 6).

This methodology creates positive meaning perspectives. When reflectively open, individuals regain autonomy, aligning feelings and values to enhance personal agency. Modifying compulsive or self-defeating patterns interrupts interpersonal conflict and chronic negative affect, preventing distressing states like guilt or shame that typically trigger a return to substance use (Marlatt & Donovan, 2005, pp. 4-5, 34-36). This behavioural modification aligns with operant conditioning theory (Skinner, 1953), which informs contemporary CBT (Beck, 2011, pp. 183-187). Respondent 7 noted this shift: *"…the non-formal stuff over there was to look at how to change our behaviours" (*Respondent 7).

4.7 Bridging gender-responsive praxis and clinical stratification

While structural marginalisation is pervasive in addiction recovery, female service users face systemic oppression that differentiates their needs from men's. Although core andragogical processes complement rehabilitation across genders, specific structural barriers must be addressed to ensure successful intake and retention. Respondent 4 highlighted the clinical necessity for gender-specific curricula, noting that female participants require safe spaces to address distinct, gendered dimensions of addiction:

> *"It would have been nice to have a class around stuff that women have to go through in addiction…. it's all well and good talking about your kids… maybe it's a sexual abuse, sexual trauma. You know, there's a there's a lot of stuff that effect women addicts…"* (Respondent 4).

Women encounter institutionalised condemnation and stigma far exceeding that their male counterparts. Respondent 7 identified this systemic fear as a primary deterrent to entering rehabilitation:

> *"The hardest part about getting me to come here was the stigma for a woman, the underlying fear of social workers and other organisations getting involved and breaking up their families. Afraid to come into a service in case they took your child off you"* (Respondent 7).

To address these acute intake anxieties, critical adult education frameworks can justify single-gender spaces within pre-treatment assessment groups. While gender-specific dialogical spaces offer a secure environment for processing these traumas, the immediate priority remains facilitating safe passage across the therapeutic threshold. State-funded research is urgently required to inform policy and allocate targeted resources to address the root causes of these intake fears. Once engaged, homogeneous gender groups fundamentally alter the linguistic and relational space, optimising the safety of problem-posing dialogue. This

relational alignment fosters the autonomy needed to critically reflect on the wider structural factors contributing to marginalisation. In doing so, self-examination alleviates the internalised fear and shame that act as barriers to recovery, concurrently empowering participants through a focus on their distinct needs. This aligns with hooks' (1994, p. 13) concept of engaged pedagogy, which posits that educators must foster environments where participants are not passive recipients of instruction but active agents capable of transgressing the structural marginalisation, shame, and institutionalised apathy restricting them.

Reflecting this stance, all the female respondents highlighted that severe, traumatic histories, including domestic abuse, childhood exploitation, and child-protection trauma, are silenced in co-educational environments due to safety concerns, shame, and guilt, which present immense barriers, causing distress that can destabilise rehabilitation when women are placed prematurely into mixed-gender groups (Covington, 2008, pp. 381-382). To prevent triggering relational trauma, Respondent 4 asserted that groups should remain gender-segregated early in the process, reinforcing the clinical and structural necessity for gender-homogeneous spaces:

> *"…We're not gonna talk about stuff in front of each other that we probably would outside, but it works on a deeper level if you are talking in a group of women. You do not get to do a lot of that because the groups are mixed… if I had a day program, the first half of it would be women on their own, men on their own. And then coming towards the end, say, for the other half of it, we could integrate the two together"* (Respondent 4).

Gender-specific groups fundamentally alter the linguistic and relational space. Women in all-female cohorts speak more openly, challenge one another constructively without triggering defensive responses, and explore a wider range of personal topics (Straussner & Brown, 2002, pp. 52-54). This aligns with a Freirean approach, where matching group composition with shared lived experience promotes active participation by optimising the safety of problem-posing dialogue. Grounding the intervention in hooks' (1994) intersectional critique counteracts Freirean gender-blindness, demonstrating that genuine transformation requires a gender-responsive praxis. hooks (1994, p. 84) asserts that the educational or therapeutic space must acknowledge the "whole self," ensuring gendered experiences of trauma are not silenced by institutional norms.

Yet, carefully managed mixed-gender psychotherapeutic and andragogical groups can yield transformative results by challenging historical frames of reference. Respondent 4 recalled that safely interacting with male peers allowed her to revise generalised assumptions of male exploitation, learning to view men as fellow human beings rather than a constant threat: *"….*

the groups were mixed and my facilitators was male…It was a big trigger for me, and that's okay because what it showed me then, that men are actually alright" (Respondent 4).

In tandem, male cohorts present distinct profiles that similarly benefit from targeted design, as Respondent 5 noted: "*I suppose for men, then there's the whole…lifestyle that they've lived, it's usually full of trauma, they come in fairly damaged. They tend to have a lot of what's called ACEs, Adverse Childhood Experiences*" (Respondent 5).

Covington (2019, pp. 45-52) outlines how all-male environments provide the safety necessary for men to challenge toxic scripts of traditional masculinity. She notes that in single-gender groups, men drop defensive "macho" postures far faster, allowing them to address underlying trauma and emotional regulation effectively. These spaces also facilitate targeted discussions on fatherhood, emotional isolation, and the societal pressures of being a provider, topics often suppressed or performatively handled in mixed-gender spaces (CSAT, 2013, pp. 55-62).

Heterogeneous co-educational spaces introduce operational challenges that can jeopardise long-term recovery metrics. Specifically, respondent 4 highlighted the detrimental impact of intimate or "*exclusive relationships*" forming within therapeutic spaces. She observed that intimate relationships developing between participants disrupt both the individual and the wider group dynamic, noting an instance where a male and female participant formed an intimate bond, dropped out of the programme prematurely, and subsequently relapsed: *"…they were being dishonest; they were having an exclusive relationship. I would not put up with that in a group… So, it caused a dynamic"* (Respondent 4).

While co-educational spaces offer long-term relational benefits, they must be carefully managed to prevent interpersonal distractions from undermining core therapeutic and transformative learning interventions.

4.8 Clinical Stratification: Medical and Substance Profiles

Beyond gender, clinical stratification must be organised around distinct medical and substance profiles. Separating abstinent participants from those undergoing active detoxification is vital; mixing these cohorts introduces severe relapse triggers and paralyses clinical utility by combining opposing medical priorities (CSAT, 2005, pp. 14-15; 2006, pp. 5-7). Similarly, substance-specific cohorts, particularly distinguishing between cocaine, opiate, and benzodiazepine dependencies ensure targeted intervention. As detailed in Section 5.1, Respondent 5 highlighted that long-term street heroin users arrive with more *"significant trauma than younger cocaine users"* and severely depleted recovery capital. This stratification does not alter the core curriculum but adapts its operational delivery so participants can navigate the distinct barriers of their specific substance histories.

5. Discussion and Conclusion

This study's conceptual framework operates as more than a mere juxtaposition of adult education and rehabilitation; rather, it functions as an operational mechanism where empirical data continuously validates a hybridised theoretical synthesis designed to neutralise the limitations of the individual learning frameworks utilised. While Knowles provides a baseline for learner autonomy, his framework frequently overlooks the systemic inequalities that restrict opportunity. Similarly, while Mezirow's transformative learning offers a pathway for cognitive restructuring, it can be over-rationalistic, neglecting the profound emotional and trauma-informed dimensions of recovery. By balancing these frameworks with Freirean dialogue and Bell Hooks' critical corrections, this synthesised approach systematically generates comprehensive recovery capital by leveraging autonomy to build human capital, cognitive restructuring to enhance cultural capital, and dialogical praxis to cultivate social capital. Converting these assets ultimately activates physical capital. This process ensures interventions are cognitively transformative, structurally inclusive, and socioeconomically empowering.

The empirical findings confirm this mechanism functions effectively in practice, particularly when the baseline distribution of recovery capital is inherently disparate (Cloud & Granfield, 1999). The data demonstrates that horizontal andragogical principles catalyse the replacement of isolating triggers with supportive social networks, thus generating social capital.

Uncritical application of critical pedagogy and transformative learning risks overlooking the non-homogenous trauma profiles of female service users. To rectify this, empirical evidence highlights single-gender, dialogical spaces as a clinical necessity to safely alleviate internalised shame and navigate institutional intake fears of family separation. Conversely, unmanaged co-educational environments introduce operational vulnerabilities where premature, "exclusive" bonds can subvert Mezirow's transformative progression and trigger relapse.

Additionally, the data supports the need for utilising dialogical group spaces for substance-specific cohorts; this stratification maintains the core curriculum while adapting its delivery, allowing participants to better navigate the unique barriers of their distinct substance use histories.

This synthesised model provides the mechanism to enhance treatment outcomes. Respondents' lived experiences demonstrate that problem-centred, gender-responsive, and structurally contextualised educational interventions systematically generate the human and social capital necessary for enduring (re)integration. Ultimately, shifting evaluative focus from

superficial programme completion rates to long-term recovery capital accumulation confirms that andragogical alignment is a vital catalyst for sustained rehabilitation.

Embedded within treatment, adult education informed by andragogical principles does more than manage clinical symptoms; it empowers individuals to reclaim agency, disrupt negative affect, and dismantle the intergenerational transmission of addiction. While Sheedy and Whitter define the systemic framework for recovery-oriented care, these participant trajectories prove the utility of this custom synthesis. By generating the human, social, and cultural capital required to secure long-term physical capital, this mechanism directly enhances life chances, sustainable recovery, and societal (re)integration. Given that this intersection remains significantly underdeveloped area of research, this study establishes a vital framework for future empirical inquiry and policy development to safeguard vulnerable individuals and alleviate community harms.

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