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# Consumer perspectives: Alcohol and other drug recovery

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Our gratitude towards the participants for being so willing to share their insights with us cannot be overstated. Our goal was to inform and enrich alcohol and other drug (AOD) recovery theory through the lived experience of consumers in recovery. The participants in the focus group made this goal possible and we are entirely thankful.

## Executive Summary

This report represents the views of eight consumers of alcohol and other drug (AOD) services in Perth who self-identified as being in recovery from AODs. They were interviewed in a focus group on 29 July 2016 about their recovery experiences to help inform and enrich the recovery theory that was to underpin a proposed AODtraining@MHC training calendar event: *'AOD Recovery – what does it mean for clients, workers and services?'*

The 11 interview questions explored recovery across the domains of clinical recovery, existential recovery, physical recovery, functional recovery and social recovery as identified by Whitley and Drake (2010). Further questions explored participant perspectives on their service and treatment experiences during recovery. The report attends to each question in turn, highlighting the main themes identified in each. Whilst it is acknowledged that the conclusions drawn in the report cannot be representative of the entire consumer population in recovery, valuable insights into the recovery experience were elicited which will help inform and enrich the content of the training event.

Below are the questions asked of participants, with themes identified in dot-points:

### **What does recovery mean to you?**

- There are rewards and challenges associated with recovery.
- The consumers generally viewed AOD recovery as part of a period of overall growth in their lives.
- Recovery is an active process.

### **What role has 'hope' played/plays in your recovery?**

- Some of the consumers found hope to be extremely important for their recovery, whilst others did not like the conceptualisation – stating that 'belief' was a stronger word for them.
- Having the support of others was identified as important for maintaining hope.

### **What does recovery mean to you in terms of your AOD use?**

- The focus of recovery was on cessation of AOD use in the early days; however, the consumers stated that they needed to develop other areas of their lives that weren't functioning well in order to maintain recovery.
- All of the participants were abstinent in recovery and had reached a point where they were able to be around users and not experience the urge to use.

### **What does recovery mean to you in terms of your identity? (E.g. how you see yourself now compared with when you were using/in treatment?)**

- Most of the consumers reported that a positive identity had been lacking while they were using. This was either a driver of use or a consequence of the behaviours that can accompany use.
- Reconciling negative ideas about the self was seen as important to recovery.
- Forming positive identities was seen as both necessary to recovery and a welcome outcome of recovery.

### **What does recovery mean to you in terms of employment, study?**

- This area posed a number of challenges for the consumers.
- Most reported that there was a lot of fear around re-entering work and/or study. Self-doubt appeared to be the main cause of this.
- An absence of referees and difficulty explaining gaps in resumes to prospective employers was cited as another barrier to re-entering the workforce. However, it was reported that the physical and psychological benefits gained from not using allowed for the possibility to make improvements in this area.
- All of the consumers stated that being able to work in a peer support role made the transition to work/study much easier, highlighting the broad value of peer support programs.

### **What does recovery mean to you in terms of your physical, mental, emotional, spiritual health?**

- There was a sense among the consumers that these areas of their health were poor and that attending to these aspects without drug use to mask what was lacking had been difficult.
- Support to gain strength in these areas of health was considered crucial to being able to manage recovery. This included professional, family and peer support.
- Questions were raised about whether this type of growth is unique to recovering drug users. It was speculated that growth in these areas of health describes normal, ongoing maturation processes – ‘life’.

### **What does recovery mean to you in terms of your social self (relationships, social etc.)?**

- Most of the consumers reported that this was the most difficult aspect of recovery to manage.
- Renegotiating existing relationships and learning how to manage new ones (work, dating etc.) were reported as extremely difficult when drug use was no longer a part of their lives.

- Peer involvement and support was a strong protective factor. The social interaction afforded by peer networks helped the consumers get used to sober relationships.

### **What has stood out as something really significant/helpful in your recovery journey?**

- Peer support was raised as important to recovery because being able to relate to others helped, as well as being inspired by those who were further along in their recovery process.
- The consumers generally agreed that the combination of peer and professional support was very useful. The type of support differed but was complementary.
- A couple of the consumers stated that they felt more supported by professionals when services relaxed their rules and allowed them to attend sessions intoxicated but not impaired.

### **Knowing what you know now, what is one thing that you would choose to do differently in terms of your recovery?**

- The consensus among the consumers was that they wished they had started sooner. Reasons they didn't ranged from cynicism at the process, impatience (wanting to be recovered now) and arrogance, which led to overconfidence, which led to relapse.
- When asked what needed to be different to enable starting sooner, most spoke of a need for more compassion and understanding from others, and less stigma from frontline and support workers. They also spoke of more education about what recovery entails, and more support for those who are not seeking abstinence.

### **What do you think would help for Workforce Development Team to do in order to inform the AOD sector about recovery?**

- The overwhelming response to this question was for peer support to become more widely available. Generally, the consumers identified that peer support afforded them an opportunity to learn about common recovery experiences, and gain validation from people with similar lived experiences.
- The consumers felt that professional supports do not need to 'sugar coat' the less savoury aspects of recovery (e.g. low mood and energy). They preferred workers to be truthful about what was happening in their brains to explain why mood improvement could take a few months.
- The issue of counselling whilst intoxicated was raised again. Some of the consumers maintained that counselling can still be beneficial. Furthermore, a couple of the consumers disclosed that feeling unable to manage attending counselling without using kept them away from treatment for a long time.

**Is there anything else you would like to share about the issue of recovery?**

- The consumers felt that access to quality free-of-charge or low-cost treatment does not appear to be well known among people who would benefit from it. Most agreed that “getting the message out there” was something that could be done better.
- There was discussion around media representations of drug users. The consumers agreed that this was unhelpful and contributed to the stigmatising of drug users.
- Finally, the consumers discussed the humanity of drug users. There was an understanding that drug users are people who are often grappling with significant issues.

## Introduction

The Workforce Development Team (WFD) of the Mental Health Commission (MHC) develops and delivers a semi-annual training calendar comprising approximately 20 skills and knowledge-based alcohol and other drug (AOD)-related training events. The calendar's target audience includes AOD-sector workers and workers from non-AOD fields who encounter AOD-using clients as part of their job role. The Semester 2, 2016 calendar included the training event: *Alcohol and other drug recovery – what does it mean for clients, workers and services?* Whilst the training package includes an exploration of some of the theory relevant to recovery, it was thought that the lived experience of the consumer would illustrate and enrich the theory, paying due respect to the consumer experience and enhancing the learning of the training participants.

Three services that provide to AOD-using clients are Palmerston (a non-government AOD service), Outcare (a non-government service that supports ex-prisoners and the Drug and Alcohol Withdrawal Network (DAWN) (a home-based withdrawal service). These three agencies collaborated on the Palmerston, Outcare and DAWN Capacity Building Project (PODCaB) that aimed to build the capacity of the three organisations to identify and treat clients who present with co-occurring AOD and mental health issues. As part of this project, Palmerston Association introduced SMART Recovery peer support groups. SMART (Self-Management and Recovery Training) groups are peer-led, 90 minute support groups that use cognitive and motivational techniques as well as peer support to help consumers manage their recovery process. Peer facilitators are consumers who are in their own recovery process. They are recruited and trained in SMART recovery principles and group facilitation. WFD identified this group as being ideal for the purposes of the consumer voice in recovery. Palmerston Association recruited eight peer support workers to take part in the focus group and held the focus group meeting at its Perth office

The focus group session was recorded. After signing a consent-to-participate form, the peer support workers were asked 11 questions covering aspects of recovery from AOD dependence as well as questions seeking insight into what they thought workers would benefit from knowing and understanding.

Participants were given five minutes to answer each question)Whilst the discussion generated by some questions went over the five allocated minutes, most were contained within the allotted timeframe.

All participants were remunerated for their time.

## Demographics

All participants were over the age of 18. There were four males and four females. No other demographic data were collected.

## Focus Group

### **Theoretical background and rationale for questions**

In recent years, the notion of 'recovery' in AOD treatment has evolved from traditional understandings in the AOD field that were based on the Alcoholics Anonymous/Narcotics Anonymous 12-step models and focused on the cessation of AOD use (Hunt, 2012). Current attempts to understand recovery have begun to embrace a 'new recovery' paradigm which encompasses a broader focus on a user's life. It has been noted that traditional notions (i.e. those that considered abstinence the main goal and tended to decontextualise AOD use) did not necessarily capture the lived experience of recovery for all users (Helfgott & Allsop, 2009).

Recent United States-led 'recovery-oriented systems of care' philosophies have been implemented at a policy level in the United Kingdom's AOD sector and have garnered considerable interest in Australia (Anex, 2012). Definitions of recovery have varied between jurisdictions, with some maintaining an abstinence orientation, and others maintaining that 'you are in recovery if you say you are', allowing much freedom for users to define recovery on their own terms (Anex, 2012).

Recovery-oriented approaches have been embraced by the mental health sector, and are reflected in national policies in the mental health sphere (Australian Government Department of Health, 2013). The lived experiences of the consumer and their families are central to recovery-oriented practice. It is client-centred, allowing consumers scope to define their own recovery (Australian Government Department of Health, 2013). It also includes a broader focus; on improvement across all domains of an individual's life. This is conceptualised by Whitley and Drake's (2010) multi-dimensional approach to recovery. The main feature is clinical recovery; however, this is impacted by existential, physical, functional and social recovery. There is some intuitive argument for this conceptualisation fitting equally well with people in recovery from an AOD dependence. This is encapsulated by the UK Drug Policy Commission's definition of AOD recovery:

*Recovery from problematic substance use is a process that involves not only achieving control over drug use, but also involves improved health and wellbeing and building a new life, including family and social relationships, education, voluntary activities and employment.*  
(UK Drug Policy Commission, 2012, p.14.)

A primary goal of the focus group was to explore Whitley and Drake's (2010) dimensions of recovery in an AOD-recovery context with the focus group participants. Of the 11 questions, numbers 2–7 were designed to explore this framework. There was also interest in exploring what helped and what hindered these processes and what consumers think is important that workers and

agencies know about the lived experience of recovery. Questions 7-11 reflected this intention.

As previously mentioned, there are a number of ways to conceptualise AOD-recovery. For the purpose of this focus group, the participants were in recovery 'as they understood it in their own lives.'

Quotes taken from the exercise are highlighted in italics throughout this report. It was important that, in writing this report, the main focus continued to be the voice of the consumer.

## The Focus Group questions

Eleven questions were posed to the group, eliciting a range of responses. Each will be discussed in turn.

### 1. What does recovery mean to you?

***“...recovery is not just about giving up AOD – it’s about learning to live the right way.”***

Question 1 was intended to set the scene for the focus group, allowing the participants to reflect on their own perspectives on recovery across various facets of their lives.

Through their responses, the participants illustrated the multi-dimensional and ongoing realities of AOD recovery. All responses indicated there are many rewards, but also challenges that people in recovery from AOD dependence face. Recovery encompasses: recognition of the changes that need to be made; learning; growth; reflection; and reconciling past trauma.

There was recognition that recovery meant healing from traumatic events in the past:

*“Healing from the past, childhood abuse, trauma, chemical dependency, relationships that were broken or destroyed throughout my addiction.”* and *“Recovering from my past – stuff that had happened before drugs led to more drug use but when I stopped it was still there.”* These quotes represent an understanding that using, then recovering from AOD can, for some, be a part of an overall process.

There was also an understanding that, in order to recover, honest self-reflection and a willingness to grow and learn would be necessary:

“...recognition that I had to overhaul my entire attitude”; “...learning to make smart, rather than self-sabotaging decisions”; and “...recognition of the fundamental nature of the problem was critical”. These quotes suggest that, for this group, growth is not just a desirable outcome of recovery, but fundamental to the process itself.

One of the participants discussed the need to develop an understanding of the triggers for use and to prioritise managing triggers even if, on occasion, this meant being ‘selfish’. For example, a decision to not go to a cousin’s wedding because it would have been triggering was difficult for some family members to understand. However, the participant acknowledged that he wasn’t, at the time, ready to manage such an event. For this participant, maintaining recovery meant prioritising recovery over all else.

However, there was also acknowledgement of the rewards that came with recovery: The participants talked about recovery as ‘improvement’. For example, one participant stated that recovery meant “...improving my health, relationships.” Another described it as “Freedom. Free from the everyday drive to use...” Other phrases used by the participants included gratitude, meaning, goals, hobbies, social groups, able to enjoy the simple things, anchors.

The responses provided by the participants demonstrated the utility of a definition of recovery that doesn’t only focus on changing AOD use. The perspectives highlighted that this aspect of recovery may best be viewed as part of an overall period of growth in a person’s life. For the participants in this focus group, it is a process that happens over a long period of time, is very active and needs to be worked on daily.

## **2. What role has ‘hope’ played/plays in your recovery?**

*“Hope’s not really the right word for me.”*

Recovery, as often discussed in mental health literature, emphasises hope as an important component of the process (Slade, 2009). There has been an assumption in the AOD sector that it would be equally important for people recovering from AOD issues to feel ‘hopeful’. This notion was explored with Question Two.

The participants voiced a variety of perspectives on the importance of hope in their recovery. Some maintained that it had played a “...huge role”, helping them to know that things can get better. Others stated that it had played a role initially – that it helped them to understand that life can improve.

Interestingly, a couple of group members stated that hope was not a useful conceptualisation for them. One participant stated that he found the word ‘belief’ had far more power, i.e. believing that recovery can happen is a more

powerful mindset than hoping it will happen:

*“...to me, hope was a useless word to me...I disbanded that word and clinged on to the word ‘belief’ instead. Belief was a more powerful word for me. I really believed that now is the time to get well. If I’d hoped I was going to get well, it’s a little bit flimsy. There’s not so much power in it.”*

Another participant stated that hope had become ‘rusty’. He had tried to change on so many occasions that hope had lost its meaning for him. However, it was re-gained through the support of peers and workers. This was because, with a ‘team’ of supports, he was no longer alone in the process, and this gave hope back: *“... because now I had a whole team behind me. I was no longer on my own. That gave me hope.”* Other participants had similar views about the importance of peers in facilitating hope through the recovery process: *“...hope in my peers...”; “...peers embodied hope...”*

The different perspectives on hope highlighted the importance of language and the importance of clarity of meaning. Hope, in this context, was shown to be quite an amorphous word. What one may call hope, another may call belief. Still others may conceptualise each word differently, and only have use for one. Workers need to be mindful of the words used when discussing hope with clients and ensure meaning is understood.

The important role played by peers and other supports was also highlighted throughout the discussion on hope. Recovery, for some, may happen in isolation, but for this group at least, hope was able to be held when there was a sense of being supported.

### **3. What does ‘recovery’ mean to you in terms of your AOD use?**

#### ***“Daily maintenance...”***

The purpose of Question 3 was to develop an understanding of how the participants viewed their recovery in terms of their AOD use. Prior to the focus group, it was assumed that all participants had self-identified as having been dependent on one or more drugs of concern, and had incurred harms as a result. However, it was unknown if any of them had chosen to reduce and control use, or if they were all abstinent in their recovery. The question was, therefore, intended to explore how their recovery from the dependence had changed over time.

The participants spoke generally of daily maintenance, and recovering from use being an ongoing process that evolves over time. The change in recovery over time was conceptualised as moving from getting through each day without using, to being able to think about AOD without having any actual urge to use. One participant spoke of the strength to choose not to – that he had a choice now.

Another spoke of the evolution of the recovery process:

*“An ongoing process...organic and it evolves as I get further from that day...recovery means something different. Early days, it was about just don't pick up...now it's family, relationships, independence, financial independence and management of behaviours...”*

One participant spoke of coming to the realisation that there are lots of people who live their lives and don't use AOD: *“...realising that the entire world wasn't drenched in drugs and alcohol was a new thing to me...”*. This may have benefit for the AOD workforce to understand: It is easy to lose perspective on AOD use when it encompasses your entire world. Users in recovery may benefit from having these perceptions challenged. The participant further stated, however, that he is still aware that there are lots of people who do use, and he needs to still be wary of his triggers around these people. Any challenges to perceptions around the rate of AOD use in the wider community would need to not undermine users' genuine difficulties in managing triggers in their social world.

There was general consensus about the importance of the development of a realistic awareness of AOD use and its impact on quality of life. One of the participants stated, *“My relationship with AOD is more rational and sane, rather than being completely delusional...I know now exactly what it has to offer my quality of life.”*

A couple of the participants spoke of their ability to be around drug use and not feel the urge to use. This is possible due to an understanding that choice now plays a part in how they view drug use:

*“...I choose abstinence...I don't have that middle road...and I live with people who are still using.”* and *“With drugs, recovery has been from couldn't be anywhere near them to now it wouldn't faze me.”*

Another participant spoke of the value in *“...reading myself when I'm reacting...”* Learning how to manage strong emotions, and being able to correctly identify them helped recovery from use because it eliminated a trigger for use: *“Why am I reacting like that? I should look at that....Being in touch with myself.”*

Another participant spoke of developing an understanding that her AOD recovery had broader implications:

*“Influence and...example to my children. I'm a mother, I'm also a grandmother and I know that I'm a huge influence in the life of my children and my grandson and if I'm not setting the right example, then I could be setting them up to fail...well I have done in the past but thankfully I came out of it.”*

All of the participants were abstinent in recovery. It may provide hope/belief for other users that many of them have been able to reach a point in recovery where the urge to use is gone, even if they are around people who continue to

use. This is likely a result of cognitive, emotional, behavioural and lifestyle changes that have been made since being in recovery. The general consensus was that recovery from using was the main focus in the early days, but it then became important to work on other areas of life in order to maintain recovery. 'White-knuckled' abstinence with no improvement in life did not constitute recovery for this group.

#### **4. What does 'recovery' mean to you in terms of your identity? (E.g. how you see yourself now compared with when you were using/in treatment)**

*"I like where I'm going...it's so easy, being this recovery person, um, I think it's a badge of honour and strength and pride. It's hard won...It was so hard, being me, before."*

Question 4 was asked in order to explore the changes in self-concept that take place as part of the recovery process. There was recognition amongst the participants that identity was either lacking or extremely negative when they were using. A negative self-concept was either a driver of drug use and/or a consequence of the behaviours that can accompany drug use.

The participants articulated much insight into the development of a positive self-identity throughout their recovery process. For example, there was an element of awareness that there is some choice about who you may want to be: *"What kind of personality traits do I want to cultivate, where I can feel good about myself?"*

One participant stated that she didn't know who she was when she was using and, for her, recovery is *"...learning who I am."* The negative self-concept and the formation of a positive identity through recovery was articulated by another participant who stated that recovery was *"...being able to look myself in the mirror and not hate my reflection....I used to avoid mirrors, but now I can go there and go, you're alright. You're alright."*

Others noted the impact AOD use has on identity through the breaching of one's own values (*"...you are continually breaching your integrity and that makes you feel like s\*\*\*"*). There was also discussion on the power of drugs for people with low self-esteem. One of the participants disclosed that he had been very insecure in his identity when he was using, and could only be comfortable in his own skin when he was using. He stated he identified with the powerful pulls towards drug use that can occur for people who do not have a secure self-concept.

Part of one participant's recovery was to recognise that he needed to 'turn things around'. There was recognition that there were flaws in his self-concept that needed working on. Involvement in peer support was identified as a major factor in supporting this process:

*"...a lot of my self-esteem has been built up by now looking at peers further*

*along the line, thinking what is it about them? They've got a quiet dignity and a kind of self-respect, and they respect other people and they've got a kind of humility about them. They're words that were important to me..."*

Another participant spoke of the integration of the old self with the new identity:

*"I have set things that I can believe in...I don't breach my integrity and it's ok that I used to use. It's not that bit that defines me anymore. It's what I do from now on that defines me..."*

Participants reported that reconciling negative ideas about the self that initially led to AOD use, then were maintained through AOD use, was an important component of recovery. The formation of a positive self-concept appeared within the group to be both a necessary component, and a welcome outcome of recovery.

##### **5. What does 'recovery' mean to you in terms of employment, study?**

*"...I wear my recovery as a bit of a badge now, because I have to. I get asked, can you give me references, and I'm like, no – nothing good anyway. If you want references from my last bosses...I don't think any want to give me one. You know like there's four years where I fell totally out of the system. How do I explain that? Now that I'm recovered I say, I had a bad patch but I'm doing better now, and I am looking for an opportunity to move forward."*

Often, when people develop a dependence on alcohol and/or other drugs, it becomes difficult to maintain work or study. This can mean that, in recovery, people need to venture back into a way of living that they haven't felt part of for an extended period of time. Question Five was intended to explore these lived experiences of the participants and how they have managed to overcome barriers to re-entering work/study.

There was consensus among the group that the process of recovery allowed them the time and space to improve in this area:

*"The brain actually heals....now I'm better than I was prior..."; "...letting go of all the crap, the childhood trauma, all the yucky stuff...now I think I'm better than I was before..."; "Building on those beliefs. Believing you can learn new skills, believing you can do the job."; "It's about getting up in the morning and going to work."*

There was also a sense that recovery in terms of identity, and the associated psychological benefits, allowed the possibility of functional recovery:

*"...those benefits that you get from your identity – your integrity and your values and your beliefs and, you know, standing in that strength, it made choosing*

*employment and study...and I didn't have to do stuff that I didn't want to do, that went against my values...recovery meant freedom in pursuing a skill."*

However, there were some internal and external barriers to overcome and there was much discussion on the difficulty in re-entering this area of life:

*"...the concept of work and study – I could never do it...I couldn't concentrate for long enough to study...I always got a lot of negative feedback...in recovery I was like how am I going to do this? It was, like, really overwhelming and scary..."*

Not having any worthwhile referees and not knowing how to explain gaps in resumes to prospective employees were the two issues that seemed to be given the most weight. One of the participants stated that he had been concerned that this would send him back to using:

*"I used to always feel like I was spinning my wheels. I'm clean and sober now, but how do I get back into the workforce? I was always worried that spinning those wheels would send me back...you need some sort of direction."*

The participants agreed that the expanded role of peer support had made it much easier for them to transition into meaningful work:

*"I didn't know how to explain the two years that took for me to go from being a mess to looking for work again on my resume...a lot of fear around how I would carry this forward...I'm really glad there's an increasing role for peers."*

Furthermore, from another participant:

*"Because of drug use I lost my job...then I was unemployed, I wasn't on Centrelink. I turned to sex work for my drug addiction. I wasn't on any tax...I wasn't registered with anything...When I was in rehab I was like I don't know how to get a job anymore. I don't have a referee anymore. Who can I get as a referee? All that sort of stuff...How do you explain yourself? What have you been doing? Well - shooting up heroin and having a really good time...so, rehab sort of...I got hope again that there were things I could do, and I could contribute, and not be a drain on society. The whole peer thing is massive. I now work at (name supplied), which is peer-based, I work at (name supplied), which is peer-based."*

Again – the impact of the development of a positive self-concept on functional recovery was seen as a major contributing factor to being able to overcome some of the external barriers to re-entering the workforce. This is illustrated in the following quote:

*"...I had to find a way back in because I'd been on the outside of that for a long time. I had worked for years. I'd done a fair bit of study too, in my using life. I didn't have high ethical standards. I wasn't a good employee; I was a bit of a scammer. And then I became unemployed for a really long time. So, I didn't*

*have a good track, I had bad form. How do I get back in? You can sign up for study courses and hope they don't want to look at your resume too close, but actual paid employment can be real difficult and the way I found back in was to start doing voluntary work. I actually had to work for free to build up a new track record. And I had to get real humble about that and be patient and think, this is going to take time...instead of being resentful for people not trusting me, understand why they wouldn't trust me and think, yeah this is going to take time. But I'm going to challenge people too. You know, if I get a knockback, I'm going to appeal and I'm going to explain and I'm going to be completely honest about the situation. No point bulls\*\*\*\*ing you know. Got to be honest and say, well actually I'm doing things differently now, and this is the new track record. That's how I had to approach it."*

Functional recovery, i.e. the capacity to re-enter study and/or work is potentially a major barrier to the sustained efforts of users in recovery. The reasons identified by this group included the amount of time (potentially years) that they couldn't account for in their resumes. Some did not even have a Centrelink record.

The participants also highlighted the importance of functional recovery on their identities, and conversely the impact an improved self-concept has on functional recovery. The discussion highlighted how difficult this can be post-use, particularly for those who had not been in the workforce for an extended period of time. The value in peer supports was raised again but this time it was identified as a way for the participants to contribute meaningfully in their working lives.

#### **6. What does 'recovery' mean to you in terms of your physical, mental, emotional and spiritual health?**

***"When I went to rehab, first time I didn't have my drugs or my alcohol, how weak these areas were...coming to the realisation these were things I was going to have to build on was just too overwhelming for me...but eventually, with encouragement from counsellors and peers and others giving you positive reinforcement I felt all of these areas growing...evidence that this can actually work."***

Question Six explored physical, mental and emotional health in terms of recovery. It was intended to get a sense of how these aspects may relate to each other, and if they informed each other.

A couple of the participants discussed these aspects in terms of comparing the 'then' with the 'now': *"When I wasn't well, I just couldn't have that balance..."; "It's good not to be sabotaging those things, isn't it. Because you tend to sabotage it. You want it, but you tend to sabotage it."* For these participants at least, the capacity to achieve and maintain physical, mental and emotional health when using was diminished. However, through recovery they were able

to regain balance across these areas.

One of the participants described the difficulty of having to consider these aspects of their health without drug use to mask what was lacking:

*“Once I’d taken the drugs away, I was faced with all of these and it was a very difficult thing...like I said earlier, I have a whole team behind me now...I’m not alone. I can talk to somebody about it. I tried to give up before and there was no one there for that. That’s what gave me the strength. Now I can address each of these in a sober state. I used to just want to check out. I didn’t want to think about any of this. And now I’m just left with having to face it. But I’m not facing it on my own, which is important.”*

This quote again highlights the difficulties that consumers can face when in recovery as well as the strength that can be drawn from having an effective support network. Whilst a couple of participants talked of their families, the importance of peer support continued as the dominant discourse throughout the focus group.

Further discussion centred on the importance of balance with physical, mental, emotional and spiritual health:

*“I’m still juggling them. It’s an ongoing process. It still hasn’t stopped.”;*  
*“Achieving that balance between all of them. If one of them is out, I think all are out...”; “Understanding it is a holistic approach.”*

One of the participants spoke of leaving rehab and thinking that all he had to do was “...go to the gym every day and run marathons...” in order to not use. He stated that he burnt out after three months and realised that he hadn’t been socialising in that time, nor had he been looking after his mental health or spiritual needs. For this participant, an understanding of the importance of balance between these aspects became integral to his recovery.

Two of the participants discussed whether managing the balance between aspects of health was unique to recovery or was this just ‘life’: *“I think non-users do it...”* and *“That is life.”* This perspective taps into some of the difficulty in defining ‘recovery’ from AOD dependence. At what point does ‘recovery’ stop being ‘recovery’ and start becoming ‘life’? Furthermore, assumptions that these processes are unique to the ‘recovery journey’ may be unhelpful because they continue to ‘otherise’ drug users.

These questions are further clouded by the following quote: *“So, like, um, like, recovery...using drugs was my solution that was my, it wasn’t a problem, it was my solution. And recovery to me is just another solution...”* This particular insight highlights some of the complex variables that shape an individual’s life. In this instance, drug use was identified as part of a solution. This shows that a definition of recovery that decontextualises a person’s drug use can be unhelpful. This person, for example recovered to, and then recovered from,

drug use.

The responses to this question indicate that, for this group at least, physical, mental, emotional and spiritual health were improved through recovery, and that it is important to 'work on' all of these aspects. For workers, however, it may be helpful to be reminded that drug use will occur in a 'bigger picture' and that working on maintaining balance between these aspects of health is not necessarily something unique to people in recovery.

### **7. What does 'recovery' mean to you in terms of your social self (relationships, social etc.)?**

***"Recovery meant learning a new way to have relationships...that were in line with recovery...I could no longer have dysfunctional relationships without them affecting me emotionally, spiritually, mentally..."***

Much of the recovery literature describes reintegrating with families, communities and social networks as an important component of recovery. It is well understood in the AOD literature that an absence of support can be a risk for relapse. This can be particularly difficult for those who do not have non-using people in their lives. This question was intended to seek insight into some of the complexities of negotiating a social world whilst in recovery.

Most participants described this aspect of recovery in terms of families, friendships and romantic relationships. They were able to provide significant insight into the challenges of learning the social 'rules' without alcohol and/or other drugs:

*"My social life has been a lot slower...I'm learning the skills now of building up friendships. When you're using, it's so instant and immediate. Bang! You're on! But without that...how do you go from knowing people to being friends with people? And that's not a skill that I've developed yet...I figure it will happen...my family relationships are so rewarding that it can mask that."*

And:

*"I had no idea that for 18-19 years I was 100% reliant on substances to socialise...I had no idea how to look people in the eye, I had no idea how to start a conversation. Just being in any kind of social situation I was close to panic for months and months and months...Three or four years down the track I still struggle with the social side of it. It's getting better, the anxiety is lessening...for me, socialising has been extremely, the hardest part of my recovery."*

Some participants acknowledged that, in recovery they learned that their relationships were not functional before drug use, and their using life had masked this. When they stopped using, they found they still had this to deal

with:

*“For me, it was learning that before drugs my relationships were a mess...like my whole life growing up was a whole pile of discontinued relationships because I moved so often. Found drugs and it was like instant relationships, instant inclusion, awesome! And post that, it’s back to dealing with f\*\*\* that’s really hard...I guess it’s gotten a lot easier...just knowing that those relationships were dysfunctional then, they’re not going to be better just because I’ve stopped using drugs.”*

And:

*“Family...my relationship with my extended family was quite dysfunctional to begin with...so having boundaries and maintaining my integrity and still, you know, my family relationships will never be what they were and there was this expectation that they would just roll on after I got out of rehab...you’re all better now but recovery meant learning a new way to have relationships that were in line with recovery. I could no longer have dysfunctional relationships without it affecting me emotionally, spiritually, mentally.”*

Dating was an aspect of recovery that was difficult for some of the participants:

*“And dating...dating straight?”; “...and it’s so hard to have that conversation with someone when you meet them...really uncomfortable.”*

One of the participants cited dating as the most challenging aspect of recovery:

*“I’m 33 this year and I still have not had a relationship...without alcohol or other drugs and to me that’s terrifying. And I have no idea how to tackle it. I’ve tried in the past year and it’s been a monumental failure. An extremely difficult part of my recovery is to learn how to have a relationship.”*

Two of the participants spoke of the value they had found in nurturing relationships in recovery:

*“...I was, like, empowered and I brought recovery into the home and they (children) were quite dysfunctional when I came back from rehab as well you know...so bringing recovery into the house made a huge impact on my children.”*

And:

*“It’s difficult because all of my relationships have been based around drugs. I’d go to a friend’s house to have a drink or to have a cone. We don’t go to a friend’s to see how his week went...and they’re still using and the trouble with people who haven’t ever used is you’re like the odd one in the room because you’re in recovery. I have to wear that because that’s what I am. But I’m getting better at it. I now legitimately go and visit a friend just for the sake of seeing*

*how they are and I have to say that even though some of them are still using and I don't feel the need to because it's my choice and I don't, I abstain, our relationships...are growing. He doesn't come round here to get s\*\*\*faced with me. He comes round because he cares...every time I walk away and I've built that relationship a little bit more, I feel very successful."*

Social recovery appeared to be the most difficult of the domains discussed to navigate for most of the participants. Whether it is re-negotiating old, dysfunctional relationships or navigating the dating scene without AOD or managing anxiety or wondering how to disclose a drug use history to a potential romantic partner, there was a sense that this needed time and effort to develop and maintain. However, with commitment and effort, new relationships based on things other than AOD could be nurtured.

For the facilitators, witnessing the participants share so openly with each other their difficulties in managing a social world without AOD highlighted again the value of a supportive peer environment. It was noted that they were all managing very well socialising with each other.

#### **8. What is something that has stood out as really significant/helpful in your recovery journey?**

***"That was the turning point for me... I resisted treatment until I saw actual people that had gone through what I went through. That was like a light went on in my head and I thought holy s\*\*\* I can actually do this."***

The goal of this question was to explore anything within the recovery process that stood out as significantly helpful at an individual level. Peer support was again identified as a major contributor to the recovery process of the participants. One reason for this was the opportunity to feel inspired by those who were further along the recovery process and were doing well:

*"100% there is a specific person that I went to rehab with who left rehab and has done well ever since and I have watched him like a hawk...There is so much bloody failure in rehab...so when you finally see...one or two people doing well it's like almost godly."*

For others, being able to relate to others who were living through similar experiences was a powerful part of peer support:

*"...there was somebody that said I was driving in my car, a song came on and I got a craving, it triggered me. I was thinking that was me the other day, I'm not the only one and we gotta choose not to and we chose not to – to follow up on that craving. But there's someone else in the room that was driving in the car that day, you know that's the kind of thing because that's the biggest problem is that I was confused. I live in my own little bubble and my recovery is all in my own little bubble too, so I had other people sharing with me."*

From this, trust in self can start to build:

*"I think part of that is that you are learning how to trust yourself again when you share something or hear something and other people are onto it, it's like that's real that's part of my trust building in that it resonates because you don't know if you are off track with stuff you are learning how to be again, like exist. I didn't know I was off track when I was a mess, I am learning to be on the track, what the track is, what it looks like."*

There was also consensus that, whilst peer and professional support served two different functions, the combination of the two was very powerful:

*"We've been talking about you know about the power of peers there but you know I've had milestones in my recovery that I've had with professionals too you know. That people have a bit of a skill to tease something out for me and just one example was that one of the counsellors, paid professional you know when I was down on (name supplied) many years ago and I was having a big whinge, a big sook-fest with him about some guy, some other resident that was doing my head in and he just kept sort of peeling back the layers, unfolding, unfolding, unfolding. Maybe I might not have been able to get that from a peer in the same way. He wound it right back to this point like to me what's behind all this? I don't want to feel like a goose, you know my ego was threatened and that was a really, that was a realisation for me. I wasn't really getting what's behind all this agitation; you know professionals can be helpful."*

*"I think what we are all trying to say to make it clear that although the peers are very important the one on one counselling was very, very important to me too."*

One of the participants noted that having daily goals to achieve had been a very important practical component of recovery:

*"Setting goals has been absolutely paramount to my recovery as well. Knowing when I wake up in the morning I have this to do and this to do and this to do – if I was to wake up tomorrow twiddling my thumbs, I know that for a fact my brain would start to – well you can have a beer or hang out with this person or that person, I know that that voice will eventually dissipate over the years but it's still there and it's still very strong. If I have goals and meaning and things to do each day I'm less likely to lapse or relapse."*

Interestingly, a couple of participants spoke of a 'relaxing of the rules' for services and being able to be in a counselling session 'under the influence' helped a lot:

*"...having a counsellor that didn't tell me off when I showed up like 15 minutes late because I had to get on before, and also her adapting to the fact that I was actually on substances when I came for counselling. A lot of people may think ok what are you actually getting in your brain when you are not under the influence stuff stuck with me, some things that she really ballsed into my face*

*and made me go oh yeah, ok, that's right I do do that, you know has stuck with me, still sticks with me today."*

This was reiterated by another participant:

*"I was going to say that too, that counselling when you are under the influence can be just as important it really can, even though they say no you're under the influence, not going to see you. It was really good for me at the time."*

The responses to this question further illuminated the role peer support can play in recovery. The participants also spoke of the combination of professional and peer support, noting the roles are different, but complementary.

Of further interest were the comments from some participants about the importance of being able to attend counselling whilst intoxicated, suggesting 'impairment' rather than 'intoxication' could be considered when determining whether a client is able to take value from a counselling session.

#### **9. Knowing what you know now, what is one thing that you would choose to do differently in terms of your recovery?**

***"I would have given it more space, more time. I was just in a hurry to get from there to there, like I wanted my life back, I wanted a career, I wanted this, I wanted that and I wanted it all right now."***

It was envisaged that this type of reflection on what consumers would have done differently with the benefit of hindsight, could lead to some insight into how workers may be better able to support clients overcome some barriers to recovery.

Most participants stated that they would have started sooner:

*"Yes to start it earlier, I waited until everything had fallen apart and I couldn't even think about it, because I was functioning outside I maintained a good base and it wasn't until everything had crumpled that I got into it."*

One participant acknowledged some cynicism toward the process and in hindsight would have gone in with more of an open mind: *"...I would try and be a bit more open minded right from the start, not so cynical and dismissive of what was being offered to me."*

A couple of the participants spoke of impatience at the start: *"The patience thing is a big thing you do hear that a lot. I want it now, I want it now", and "I just wanted to be cured, I didn't want a recovery. Two weeks (name supplied), wake up recovered."*

Another participant acknowledged his own arrogance through recovery and identified this as being a barrier to sustained recovery when he left rehabilitation:

*“For me it would have been to be less arrogant about my recovery. I started to feel that I was above those that drink in pubs or choose to drink or drug users. The first time I went to rehab I came out you know with my nose in the air, I’m the king now and everyone should listen to me because I know everything. A week later I relapsed massively and went back in rehab so that arrogance, that ego was very unhelpful in the beginning.”*

The responses given provided an opportunity to explore what needed to be different in order for them to have started earlier, or trusted the process more, or been less arrogant. Much of what came out of these reflections centred on more education, a wider range of treatment options, more compassion, less judgement:

*“Compassion and you know like that acceptance that if you were using at counselling you would still get treatment. Unconditional treatment without judgement. I tried to go for help in my teens, twenties and there wasn’t a real knowledge it was more of a – you need to change your attitude and....in my teens it was yeah you’re just rebelling.”*

And:

*“Everyone would say to me just stop using don’t do that and it’s like that’s not what’s wrong with me there’s something else wrong.”*

And:

*“Not treating it as a medical thing, the people on the frontline like your ambulance drivers, the police, support workers who have no awareness of what it is and who to actually go to, to actually decide that’s what it is. That pushed me away for almost two decades.”*

Another participant spoke of the lack of information available to consumers around what treatment and recovery actually means:

*“Just quickly I think it’s really great that you guys try to educate workers in the community sector but actually getting people that are thinking about going through recovery come and hearing what we have to say. I just thought I go to (name supplied), I go to rehab and I’ll be recovered. I didn’t realise I had to work on myself and I had to change. That was all really a new concept...communicating that more to the consumer.”*

And:

*“The education of it all is non-existent, I had no idea.”*

Another participant stated that services for people who weren’t necessarily seeking abstinence would have been useful. This participant felt that, without

this option, she had to wait until she felt ‘bad enough’ to warrant seeking treatment:

*“I think more access to a different variety of service, ‘cause back in my day there was only AA as an option. I wasn’t into abstinence at that time so if there were groups around I might have reached out if I had awareness, but otherwise I didn’t think I was bad enough. I had to wait till I destroyed everything before I thought I was ready, even like a couple of days I was fretting I wasn’t ready for rehab and my life was a mess, my usage was outrageous but I still had that thing I wasn’t bad enough, maybe I had to get worse.”*

The responses to this question highlighted some of the barriers to accessing ‘recovery’. They indicate that the barriers can be internal or external. For example, an internal barrier might be a cynical attitude towards the capacity of services to help, and an external barrier might be a lack of services that are not abstinence-based. A wider variety of services that are well communicated to consumers might help some consumers break down some of their internal barriers to treatment.

#### **10. What do you think would help for the Workforce Development Team to do in order to inform the AOD sector about recovery?**

***“Get peers involved more, get peers going out to the rehabs to say look I went through this and where I am now, it is possible. I wish I had had that.”***

Question Ten was intended to provide further opportunity for the participants to discuss what they thought the AOD workforce would benefit from knowing. Again, peer involvement was highlighted as an important factor in the recovery process:

*“I actually found out in group when other people started saying they were having nightmares as I had horrific nightmares.”*

And:

*“You see once again the peers thing, I only found out in group about the nightmares because I was waking up every 1½ hours and I thought I was just going crazy. And then other people said yeah same here, I was like oh thank God I’m not going crazy because they were so vivid.”*

The above quotes are two of several examples that start to illustrate specifically how peer involvement can benefit consumers in recovery. Peer support can help normalise the more subtle aspects of the recovery process that may not be well understood by family members or even clinicians they are working with. Furthermore, peer support may enhance the effectiveness of professional and peer-led groups working in tandem. For example, in a weekly, hour long

counselling session some of the more nuanced symptoms of long-term recovery (e.g. nightmares) may not be discussed. However, in a shared-experience group setting, these types of experiences have a better chance of not only being raised, but being normalised and validated.

Another issue the group was keen to impart was they generally felt that, whilst in treatment, they were not given enough information about the changes in the brain that take place during AOD use and recovery:

*"I think there is a story to be told there, maybe professional people can relate to a lot of stuff coming out in neuroplasticity and brain science now. You can tell the story and keep flipping it – this is what's going on in the brain this is how people accidentally wander through addiction. Our brains set a trap for us; people don't do it for like a career move. You get lost in it, then you get trapped but there is a way out in neuropsychology as well and that was very helpful for me to understand that it wasn't all about my will power and having this emotional strength, there was stuff going on in my brain. "*

...and the more negative aspects that need to be 'gotten through':

*"I definitely agree with that I wish I had been told more about the scientific factors of what's going on with me biologically instead of how are you feeling today? Oh you're feeling angry well maybe you need to concentrate on this. No there is a chemical imbalance because I've been shoving meth up my arm for the past ten years. Can you tell me what's going on in my brain then?"*

And:

*"Why it is three months later and I'm off the meth and still can't enjoy anything?"*

A couple of participants felt that this was because workers did not think that they would have been able to manage the more negative aspects:

*"I asked the coordinator...one day why aren't you telling people about neuroplasticity and she said because it scares them. They're scared it might take them ten months to recover from all the meth."*

However, most agreed that users in recovery cannot only manage this type of information, but actually benefit from it:

*"No give me the truth, give me a time frame, we're pretty tough people."*

And:

*"The education behind that and what drugs you use for each emotional state - the anxiety, depression."*

And:

*“There was a counsellor gave me a book on neuroplasticity while I was in rehab and that book was gold to me because it gave me an insight into what was going on chemically in my brain and why I was having flashbacks and things like that. None of that was explained through counsellors or anyone else.”*

Another issue that came up was the conditions that agencies often place on clients:

*“They have to have a look at their rules and boundaries and really ask whether or not they are actually doing more harm than good.”*

And:

*“I would like to say something about; we touched on it before about being under the influence in sessions. Because I tried counselling a few years before, but I couldn't be there unless I was high and I was told not to come back unless I was sober and so I didn't, it took me years.”*

There was a consensus that counselling could still be worthwhile if the client was intoxicated, particularly if using was a coping mechanism. However, all of them understood that this would be detrimental in a residential rehabilitation setting:

*“Yeah a different place for it, cause you have to be mindful of everyone else. If someone comes in high then everyone else is high.”*

There were also concerns raised about the length of time promoted for residential rehabilitation:

*“Longer rehabilitation programs encourage people to stay longer. I don't think you can go to a 10 week or 12 week program and expect to come out recovered.”*

Whilst the group understood that residents are generally able to stay for as long as they are benefitting (indeed, a couple of participants had stayed in rehabilitation for 10 and 16 months), it was thought that the language used in promotional material did not reflect this:

*“The flyer says 14 week program.”*

One of the participants raised that he did not think he was ‘heard’ when he was waiting for a residential bed to become available, particularly as he was in a very unsafe place at the time:

*“Also there are long waiting lists to get into centres, rehabs and I understand why there is a waiting list but one of the waits I had to do was about four or five months. I almost died twice in-between that wait and I kept coming in and*

*saying you have got to get me in here or I am going to die. They kept saying you need to be patient, recovery is about learning patience and I was like, I'm not f\*\*\*ing ready for patience right now, I'm about to die. You need to calm down, I was thinking you're not listening to me, this is serious, this is major."*

This led to a discussion about mandatory treatment:

*"I'm really scared for if they end up changing the meth like mandatory treatment and all those people with the waiting lists like they are already all those people willing and needing, needing because they are going to die and they're not on meth what are they going to do."*

*"Because we know it's a lot to do with being ready and those people that aren't ready are going to be taking the places of ones that are."*

*"It's a catch 22, I agree that I like the idea but you don't want to exclude the ones waiting."*

The participants raised a number of issues that illustrated their experiences navigating the AOD sector throughout their treatment process. One issue raised was that they felt services could become better equipped at informing clients of the neurological aspects of recovery. Most agreed they had felt, through their treatment, that what was happening in their brains hadn't been made clear to them. It had been reported that workers were concerned this understanding would be detrimental to their recovery. The participants stated that they felt this information *would* have been beneficial as part of their treatment. Furthermore, the issue of being able to attend counselling appointments intoxicated was raised again. The participants reiterated that they felt this would have been worthwhile for them.

#### **11. Is there anything else you would like to share about the issue of recovery?**

***"The reasons you use drugs aren't addressed, for me it was to deal with trauma and lack of life all that lead up to."***

With this question, we provided the participants with the opportunity to raise any aspect of recovery, or any message that hadn't been considered in the previous questions.

Mostly, the participants felt that the fact that people have access to quality, free-of-charge or low cost treatment isn't well known among people who would benefit from treatment:

*"I have one question dancing around my head. (Name supplied) as an organisation I never knew they existed, till I spoke to my doctor. Most people out on the street don't know that it's free, that you've got nothing to lose give it*

*a shot, you're not nailed down; go home if it doesn't suit you. I ran into some guy yesterday.....He wants to give up but doesn't know where to go and this was just up around the corner from here. I directed him... go there. So many people just don't know and I think so many more people would do something if they advertised nothing to lose it's free."*

And:

*"Exactly, that's how I explained it, you've got nothing to lose but everything to gain and they will help you through stopping but nobody knows that....they think if they go get therapy it's going to cost a fortune and I don't have the money...."*

There was discussion on whether this lack of knowledge was a result of negative media representations (i.e. is the lack of 'help' a popular narrative?), or whether the AOD sector does not promote its services adequately.

The participants also felt that the media's portrayal of drug use wasn't accurate:

*"It's so disappointing what the media put out there."*

*"There's no education behind it."*

When asked for a final word, one of the participants stated:

*"I'd love one day for Australia to go down the same path as Portugal. We're not criminals; people who use drugs aren't criminals."*

Another:

*"The war on drugs must stop."*

For this question, the issue of 'getting the message out there' about treatment options was the most pertinent raised by the participants. They felt that there is not broad knowledge in the community about how and where people can access help. The question of whether predominantly negative media representations around the availability of help hindered people's confidence that quality free-of-charge support was available was discussed. For this group, at least, it appeared that informal peer networks were working to bridge the perceived gap.

Lastly, there was a reminder of the humanity of drug users. It is well understood that they are a heavily stigmatised and marginalised group. Ultimately, however, they are people who grapple with significant issues and should be treated as such.

## Discussion

Whilst this was a one-off focus group that could only reflect the recovery experiences of the group's participants, a number of perspectives that may be pertinent to other people's recovery were raised.

Many of the questions were designed to fit the broad framework of Whitley and Drake's (2010) dimensional approach to recovery. This approach conceptualises mental health recovery as featuring clinical recovery, which is impacted by physical, existential, social and functional recovery. The responses within the focus group indicate that AOD recovery can happen across these domains. The group reported that managing their AOD use was the initial priority, however, over time the other domains became relevant as well. Whitley and Drake describe recovery within and between the domains often occurring in a synergistic manner. For example, functional recovery may help facilitate social recovery due to the exposure to broader social networks. Within the focus group, there was evidence of the inter-relatedness of all the domains. For example, functional recovery was, in many cases, made possible because of growth already made in the development of a more positive self-concept (existential recovery). Furthermore, social recovery was necessitated by clinical recovery, i.e. negotiating a social or romantic life without drugs is obviously something that can only be learned once drug use is no longer a problem in a person's life.

The rest of the questions were designed to allow the participants to voice the issues that they thought workers would benefit from knowing. This included the sorts of things that they wished they had known before they started their own recovery, as well as the types of things that would have been helpful from agencies.

Most of the participants agreed that they had not understood what they would be required to do in order to 'recover'. Most had thought that going through detox and treatment would somehow 'fix' them. They reported little understanding of the amount of self-work required or the changing at an individual, fundamental level that needed to happen for recovery across the dimensions to take place. It is difficult to know if helping clients develop an understanding of this early in their treatment would have much merit, particularly as most participants identified clinical recovery as being their priority at first. It may be that it is moving through the recovery process that actually enables the growth process, (i.e. one must happen before the other can take place) and so, an understanding of what is required to 'recover' from the outset may not have much meaning. If this is the case, helping clients understand what they are experiencing 'as they go' may serve them better.

The issue of whether clients should be able to attend counselling whilst intoxicated arose more than once throughout the focus group. Typically, agencies have expectations that clients attend their sessions sober and clients

will not be able to see their counsellor if they are intoxicated. The feedback from this group, however, suggested that this can actually be a barrier to attending counselling. A couple of participants reported that needing to be sober for treatment put them off seeking treatment for a number of years. Furthermore, once in treatment, there were occasions when they were not able to manage leaving the house without using. They also felt that they would have been able to engage with the counselling process whilst intoxicated. The level of intoxication that may interfere with engagement wasn't discussed with the group. It is acknowledged that if agencies were to consider relaxing boundaries around intoxicated clients, there would need to be some idea of how intoxicated is too intoxicated for any worthwhile work, whilst maintaining worker and client safety.

The length of time people needed to wait for their place in a rehabilitation centre was raised. It is well understood that clients on waitlists are in a precarious position and the sector aims to minimise their distress as much as possible. However, some of the peers expressed that the waiting period was difficult for them. Long waiting times for residential rehabilitation has been identified as a barrier to consumer engagement in treatment (Lubman et al., 2014), suggesting that strategies that address this issue are worth consideration.

Another issue raised concerned AOD service promotion and the perception that people who could benefit from treatment are unaware of 'what is out there.' It needs to be noted that this was a small group and their perceptions may not fit with the wider community. The ongoing issue of waitlist management in most services would suggest that 'enough' people are aware of AOD treatment services, and that agencies are stretched in their capacity to meet demand already. However, given that treatment has been shown to be effective for people wishing to address their AOD use issues (Lubman, et al., 2014), it would be remiss not to consider that a proportion of the using population may be unaware of how and who to access for help. This perhaps warrants further investigation by the sector.

The value of peers through the recovery process was emphasised throughout the focus group, and their impact, for this group at least, cannot be overstated. Not only did interaction with peers offer support and hope that 'things can get better', the more formal peer support available through agencies (i.e. SMART recovery) enabled a process where the participants could then provide this support to others. This has also had the, perhaps unexpected, bonus of providing employment and enabling some functional recovery for the participants.

## **Conclusion and future directions**

This project demonstrated the value in seeking to embed the consumer voice into training programs. All of the peer support workers contributed their own

personal insights into recovery. However, given that the group was small in number, and that they may have been particularly insightful (as perhaps expected of people who would choose to become peer support workers), there should be caution about generalising their insights to all people who recover from AOD-use issues. For example, there was particular emphasis on positive growth through recovery within this group. It cannot be assumed that this is a 'prescription' for how recovery should look. Others may be happy with recovery that only involves the use of a pharmacotherapy to achieve stability. Furthermore, this group emphasised peer supports as intrinsic to their recovery process. It is reasonable to assume others might prefer the support of family or others throughout their recovery.

For the members of this focus group, recovery did occur across all domains as identified by Whitley and Drake (2010). Even considering the caveats about generalising responses highlighted in the previous paragraph, the utility of this framework for conceptualising recovery goals for AOD-using clients should be considered. This group identified that the non-clinical domains had become depleted as a result of their AOD use, and that recovery had to take place across these domains for sustained clinical recovery to be possible. Given the breadth of harms experienced by AOD using people, interventions that explore recovery across these domains will likely have benefit. However, maintaining a client-centred perspective would be important – clients would still need to be afforded the freedom to define their own problems and solutions.

At a broader, philosophical level, this does raise the question of whether 'recovery' can be possible without personal growth. If someone ceases or develops control over their AOD use but other areas of their life are below satisfactory, is this person still considered 'in recovery'? The UK Drug Policy Commission Report (2012) maintains that 'white-knuckled' abstinence that does not consider people's individual needs and aspirations is not recovery, suggesting that there is more to recovery than a change in AOD use. However, the concept, 'you are in recovery if you say you are' suggests that it is entirely up to the individual to define his or her own recovery. Any conclusions in this area are beyond the scope of this report. However, these perspectives highlight that 'recovery' can be deceptively difficult to conceptualise and different people will relate to different meanings.

The question of how long recovery takes was not explored in this session. Given the broad definition of recovery that asserts that 'you are in recovery if you say you are' implies much latitude with the definition, an exploration of this among a diverse range of consumers may shed light on what this means to them. For example, in one of the questions, a participant asked if people who had never used drugs had similar growth experiences. It may be illuminating to explore what experiences may be attributed to post-using recovery and what may be attributed to normal maturation processes.

Future recovery-oriented workforce development training could include videoed interviews with consumers at various stages of recovery. Different perspectives

on what recovery means could be explored. It would be interesting to hear the perspectives of consumers who do not choose abstinence, for example. How would they 'know' they are in recovery? What would the criteria be?

In conclusion, this project has provided a platform for allowing the experiences of AOD-service consumers to enrich the theoretical and practical frameworks of an AOD workforce development training package. It will also serve to inform later training events and workforce development more generally.

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