What works in recovery? Alcohol and other drug professionals lived experiences of addiction, treatment and recovery in New Zealand.

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Abstract

The New Zealand Government's health surveys consistently identify that alcohol and other drug (AOD) addiction is an issue for New Zealanders. However, there is a lack of qualitative research on the lived experiences of people who have previously or currently experience AOD addiction in New Zealand. This research provides insight into the factors that contribute to, and create barriers to, successful AOD addiction recovery. The qualitative method of constructivism was the approach used to conduct the research. Eight participants took part in semi-structured interviews, sharing their stories in a narrative style and recounting experiences from the time their addictions began, their entry into AOD addiction recovery and their entry into the AOD workforce. Interview transcripts were analysed using thematic analysis, themes were identified that highlighted what contributed to participant's successful AOD addiction recovery and what created barriers to AOD addiction recovery. Nine themes emerged through the data analysis process these were: stigma; defining your own recovery; reconstruction of the self; the role of social learning; opportunities for career progression; specific populations including youth, people with co-existing mental health and AOD addiction issues, women, and families; strengths and limitations of the health, social service and AOD workforce; addiction and the law; and barriers to accessing AOD support services. A consistent finding across these nine themes was that the barriers to AOD addiction recovery in New Zealand experienced by the research participants were systemic, and preventable. The recommendations of this thesis are that the barriers to recovery, and contributors to successful recovery identified in this research are addressed; in particular the themes of stigma and systemic barriers to wellbeing.

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Lastly and most importantly, thank you to my participants. Words cannot express what an honour it was to be trusted with your stories. These stories have inspired and motivated me as a person who is also in AOD addiction recovery and as an AOD professional. It is my hope that your shared experiences, strength and knowledge will contribute to positive changes in our AOD and social service sector, making it easier for others to enter AOD addiction recovery.

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Chapter One: Introduction

In New Zealand there is a lack of qualitative research exploring the topic of alcohol and other drug (AOD) addiction, this research contributes to filling that gap. People addicted to AODs have been marginalised and discriminated against throughout history, and have been the subject of paternalistic laws and treatment interventions such as; the overmedication and subsequent institutionalisation of women in the 18th century who developed AOD addictions (Davenport-Hines, 2001). While current Government policies that guide the healthcare sector in New Zealand call for greater consumer participation in all areas of the AOD sector, this is not reflected in current New Zealand research on AOD addiction.

International research recognises the value of consumer participation and states that people with AOD addictions need to take an active part in their own treatment, as well as in all other areas of the AOD sector; from policy formation through to service provision (Alberta, Ploski & Carlson, 2012; Bassuk, Hanson, Greene, Richard & Laudet, 2016; Boisvert, Martin, Grosek & Clarie, 2008; Csiernik & Rowe, 2003; Deering, Horn & Frampton, 2012; Pulford, Adams & Sheridan, 2011). The active involvement of people who currently have, or who have had an addiction to AODs is not only a human rights based approach to tackling the issue of addiction to AODs, it is also an approach that gives power and autonomy back to a population of people who have historically, and

in many countries still are, considered to be incapable of making decisions for themselves (Csete et al., 2016).

The reality is that many people who have lived through an AOD addiction (in New Zealand) go on to become qualified professionals in the AOD sector, this is also the case internationally. This population has not been utilised in academic research despite being a valuable source of knowledge, that is why this research recruited participants who are currently working in the AOD sector, who have lived experience of AOD addiction and have gone on to become a qualified health, social service or AOD professional. This research recognises the unique and valuable knowledge of this population and explores, through qualitative one on one interviews, the question: What works in AOD addiction recovery in New Zealand?

Research questions

An answer to the aforementioned question is found through gaining an understanding of the in-depth experiences of the participants who shared their stories of AOD addiction and in particular; what contributed to their successful AOD addiction recovery, and what created barriers to AOD addiction recovery. Participant experiences are explored from when they first became addicted to AODs, through to their current experiences of being an AOD professional working in the AOD sector. This broad lens of inquiry is important, as AOD addiction recovery is an ongoing process that continues even once a person stops using AODs.

Rationale

Understanding what works in AOD addiction recovery in New Zealand is vital knowledge for the AOD and wider health and social service sector. To be able to understand what can be done to increase the likelihood of people with AOD addictions being successful in AOD addiction recovery, will be an asset to a range of AOD, health and social service professionals. While there is a large cohort of New Zealand based research on AOD addiction, this tends to focus on quantitative investigation. Using a qualitative perspective to explore what works in AOD addiction recovery (by understanding the experiences of people who have lived through AOD addiction, recovery and treatment in New Zealand) will provide a unique perspective to existing research. It is hoped that the knowledge gained from this research regarding contributors and barriers to AOD addiction recovery mean that these contributors and barriers can be promoted and mitigated by Government, policy makers, AOD services and wider social services. The ideal outcome proposed by the researcher is, that this will increase the number of people in New Zealand accessing support, and being successful in their AOD addiction recovery journeys.

Thesis structure

The introduction to this thesis begins with an explanation of the researcher's connection to the research and subjective research perspective, followed by an outline of the background and context of AOD addiction

(providing a brief international and New Zealand based history of AOD use, and statistical data on the prevalence of AOD issues internationally, and in New Zealand). Additionally, the way that AOD addiction is defined is explored, and the unique impact of AOD addiction on specific populations in New Zealand is outlined. Chapter two is the literature review which is split into four main sections, these are grouped around the broader topics of: perspectives on addiction; addiction and the law; addiction and stigma; and the AOD addiction sector in New Zealand. The third chapter outlines the methodology and why a qualitative constructivist approach was identified as the most appropriate one for the research. The research design (including participant recruitment, and data collection and analysis) are outlined, as are the ethical considerations.

Chapters four and five present the study's results, these results chapters are followed by the discussion. This chapter explores: the impact of stigma in AOD addiction recovery; existing institutional systems and their impact on AOD addiction recovery; social support and learning as a contributor to successful AOD addiction recovery; and gendered barriers to recovery. Lastly, the concluding chapter reviews the research aims, includes recommendations for enhancing contributors to recovery and minimising barriers to recovery, and outlines the strengths and limitations of the research.

The researcher's connection to the research

Qualitative research asserts that objectivity is not possible and that the researcher will always influence the research project with their own subjective experiences (Alvesson & Skoldbert, 2009; Gergen, 2009; Rubbin & Babbie, 2013; Shaw & Gould, 2001; Watson, 2005). An understanding is needed; that knowledge generated by insider research may have a unique perspective that outsider research does not. Whilst researchers share core academic qualities, insider research is defined as research conducted by a researcher who shares distinct knowledge with a particular group (Kirpitchenko & Voloder, 2014). The process of disclosing the researcher's insider status is important because the researcher's assumptions, biases and beliefs play a pivotal role in the process of knowledge creation (Kirpitchenko & Voloder, 2014). These therefore must be disclosed at the outset in order to firstly, understand how the researcher's insider status influenced the research and secondly, mitigate any harm that could be caused by publishing research without making explicit, prior assumptions, biases and beliefs (Kirpitchenko & Voloder, 2014). Subsequently the disclosure of my insider status is as follows; I am a cis female with New Zealand European heritage and single Mother, with my own lived experience of AOD addiction. I am also a registered social worker currently employed as a senior mental health and addictions advocate in the Hutt Valley and Wairarapa region.

The topic for this research was identified through my frustrations as a post-graduate student studying social work. I had always been taught that the

role of social workers is to provide evidence based interventions that give prominence to a person's stories, experiences and goals. What I found in New Zealand based academic research however, was a slew of quantitative research positing the AOD addict as the object to be researched, and a lack of qualitative research utilising research participants experiences as a valuable source of knowledge. My frustrations were compounded by existing elements of my professional and personal life, as I have faced similar experiences to those of the participants in this research.

The personal experience that has had the greatest impact on this research has been my experiences of exclusion. This theme runs throughout all participant stories and you will see that I have emphasised the themes related to exclusion, not only of those with lived experience of AOD addiction but also their whānau and support people. To create an exclusionary society where people with lived experience of AOD addiction face exclusion across all systems, creates a significant barrier to AOD addiction recovery. By naming this experience and proceeding to offer the participants' personal solutions to this barrier, it is my hope that this research will begin to mitigate the exclusion that we who have lived experience face in communities, workplaces, peer groups and wider societal systems and institutions.

Glossary of terms

Alcohol and other drugs: Denotes substances defined in the DSM-5 including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics and anxiolytics; stimulants; and other unknown substances.

Burn-out: The process whereby employees are unable to continue in their job roles due to emotional, psychological, and/or physical distress caused by their workplace.

Cis-gender: A person whose gender identity aligns with their birth sex.

Co-existing problems: When one person is diagnosed with multiple health issues for example, co-occurring mental health and addiction issues.

Colonial times: The time period between 1840-1915 in which new settlers to New Zealand actively colonised Aotearoa.

Community based social services: All not for profit organisations that provide support to people in need of support.

Diagnostic and statistical manual: A text published by the American Psychological Association that provides a comprehensive classification of all mental disorders.

Drug and alcohol practitioner's association Aotearoa New Zealand: The organisation that offers professional registration options to the AOD workforce in New Zealand.

Gin craze: The period in early 18th century Britain in which the consumption of gin increased rapidly.

Hepatitis C: A virus that can affect the liver which can be transmitted through blood to blood contact such as, sharing of injecting equipment.

Human immunodeficiency virus (HIV): A virus that attacks the immune system that can be transmitted through blood to blood contact such as, sharing of injecting equipment.

Human rights based approach: An approach to AOD use that utilises healthcare and social support options opposed to criminalisation and incarceration.

Joint United Nations Programme on HIV/AIDS: An international organisation comprised of multiple localised initiatives that provide direction and advice to Governments around the world in regards to ending the spread of HIV/AIDS.

Law Commission: An independent Crown entity that provides advice to Government and free legal support to communities.

Lived experience practitioner: Tangata matua a-wheako: A person with lived experience of AOD addiction who is employed in a professional AOD, health or social service role.

Matua Raki: The New Zealand workforce development organisation for the AOD sector.

Moralisation of substance use: The perspective of AOD addiction that views a person as being a deviant and a criminal.

New Zealand Drug Foundation: A not for profit organisation that provides advice on reducing harm from AOD use in New Zealand.

Opioid substitution treatment: A form of treatment in which medication is legally prescribed to people addicted to opiates.

Pathologised: The process of classifying a behaviour as psychologically abnormal.

Peer worker: A person with lived experience of AOD addiction that is employed in a job role in which their lived experience is actively disclosed and forms the basis of the therapeutic relationships with the people they support.

Pharmacocentric: A view of treatment and recovery that advocates for the use of medication as the main cure.

Prime Ministers youth mental health project: A project set up in 2012 by then Prime Minister the Honorary John Key, focussing on reducing the adverse mental health outcomes experienced by youth in New Zealand.

Reductionist: The process of reducing complex human behaviours to a succinctly defined set of symptoms.

Synthetic drugs: Drugs that are developed using man made chemicals and mimic other illicit drugs chemicals often use in the manufacturing of synthetic drugs include, synthetic cannabinoids and synthetic cathinones.

Takeaway arrangements: The process in which a person enrolled in an opioid substitution treatment program is prescribed medication (usually ingested in front of the pharmacist upon collection), and is allowed to take multiple doses of the medication home with them to ingest unsupervised, as prescribed.

Tangata Whenua: A term used to acknowledge the unique and valued status of Māori as indigenous peoples of New Zealand.

Te Pou o te Whakaaro Nui: New Zealand's workforce development organisation for the mental health sector.

Tino rangatiratanga: The ability of Māori to have power over their own political affairs.

Treaty of Waitangi: The founding document of New Zealand signed in 1840 by the founding tribes of New Zealand and British settlers.

Unconditional positive regard: A therapeutic characteristic held by AOD professionals in which they treat a person needing support, at all times with empathy and respect.

United Nations: Is an international organisation consisting of representatives from countries around the world whose purpose is to promote international peace and wellbeing.

United Nations General Assembly Special Sessions: Is the forum within the United Nations in which new policy is formulated in order to promote peace and wellbeing.

War on drugs: Historically refers to former US President Richard Nixon's assertion in June 1971 that he would enact a war on drugs. Referring to the process of intense prohibition and incarceration of those involved in illicit drug manufacturing, sale and use. This approach was enacted with military aid and law enforcement between the USA and international partners.

Whānau ora: An indigenous approach specific to Māori that seeks to support whānau wellbeing within the community as opposed to supporting the individual within institutional settings.

Women's temperance movement: Is a community group that was founded in 1874 in the USA leading to the development of international factions of the group, the group was instrumental in advocating and lobbying for complete prohibition of alcohol.

Background and context

An international history of AOD use

The rise of addiction rhetoric proclaiming AOD use to be problematic dates back to the sixteenth century, with much commentary focussing on Britain and the United States of America (USA) (Davenport-Hines, 2001). This history details the way that societal attitudes shaped the concept of addiction. Today it is widely acknowledged that the construction of addiction historically, had less to do with fact and more to do with politics, fear mongering and moral panic with regard to the potential for disruption to civilised society that people using substances might create (Carnwath & Smith, 2002; Davenport-Hines, 2001; Fraser & Moore, 2011; Nelson 2012).

In Britain and the USA opiates were commonly used in a wide array of readily available remedies claiming to cure all manner of ailments (Davenport-Hines, 2001). It was not until the gin 'craze' in Britain however, that the Government and the upper class started to take an interest in substance use (Davenport-Hines, 2001). The gin 'craze' created a problem for the bourgeoisie because labourer productivity and subsequent profitability were affected, it was at this point that AODs began to be regulated and prohibited (Nelson, 2012). In the USA these processes of regulation and prohibition began in response to the introduction of opium smoking to Western societies by migrating Chinese workers (Davenport-Hines, 2001). In the USA stories began to circulate that

opium smoking would lure well-bred American women into Chinese opium smoking dens, and also ruin the livelihood and opportunities of young American men (Courtwright, 2001; Davenport-Hines, 2001). Subsequent public outcry led to the beginning of control via moralistically and economically based Government policy in which AOD use was viewed as deviant behaviour negatively impacting the productivity of society, and regulated as such (Courtwright, 2001).

By 1912 substance use had evolved from being locally controlled to being considered a worldwide epidemic, with the International Opium Convention being the first international drug control treaty (Courtwright, 2001; Davenport-Hines, 2001). This signalled the beginning of the attempted control of AOD manufacturing, supply and use via various AOD policies and policing efforts (Courtwright, 2001). This is still the dominant approach that many countries take to address substance use, an approach that has been widely criticised as ineffective. With some even going as far as saying that the 'war on drugs' has caused more harm to communities, families and individuals than the drugs themselves (Csete et al., 2016).

Each legislative response to AODs has triggered a subsequent response toward people who use AODs by wider society, and by the professions tasked with supporting people with AOD addictions (Fraser & Moore, 2011). This began with the moralisation of substance use (Carnwath & Smith, 2002), then the criminalisation of substance users, drug trafficking and profiteering (Courtwright, 2001). This evolved into the concept that addiction is a brain

disease determined by biology and needing to be treated by the medical sector (Doweiko, 2014; Walters & Rotgers, 2012; West & Brown, 2013). Finally culminating in a new age of addiction epistemology: one that transcends existing AOD policy (that largely still criminalises AOD users) and instead recognises addiction as a multi-faceted issue and a person's biology; social learning; risk and protective factors; internal cognitive processes; and socio-cultural standing, all need to be taken into account in AOD addiction treatment responses (Walters & Rotgers, 2012).

New Zealand's history with AOD use

New Zealand's response to AOD use has mirrored international responses (Carnwath & Smith, 2002; Courtwright, 2001; Doweiko, 2014; Walters & Rotgers, 2012; West & Brown, 2013). Eldred-Grigg (1984) provides an insight into what AOD use in New Zealand was like in colonial times, stating that even though colonial New Zealanders are viewed by many as being puritanical and hard-working, many early New Zealand citizens freely used AODs for pleasurable and therapeutic matters. While legislative interventions on the manufacturing, sale and consumption of AODs began as early as the 18th century (Eldred-Grigg, 1984), the first National Drug Policy addressing substance misuse from a health and wellbeing perspective as opposed to criminal justice responses, was not developed until 1998 (Ministry of Health, 1998).

New Zealand first started regulating AODs in colonial times with increasing restrictions placed on alcohol and opiates (Eldred-Grigg, 1984). These two substances were lucrative sources of income for the New Zealand Government (Eldred-Grigg, 1984). However, the topic of AODs in New Zealand was a contentious topic, illustrated by the women's temperance movement who fought a highly publicised battle for full prohibition of alcohol. Also illustrated through various pieces of legislation that placed strict restrictions around the sale of liquor, as well as enacting discriminatory practices. For example, through the Old Age Pension Act 1898 that could refuse a person access to their pension if they were known to habitually consume alcohol (Dalley & Tennant, 2004).

These historic attempts to regulate and control AODs in New Zealand led to the establishment of the 1975 Misuse of Drugs Act. This was an attempt to counteract the 'hippie' culture of the time, by criminalising people who were considered to be behaving in ways unacceptable to existing social norms (Law Commission, 2011). This legislation started an era of total drug prohibition whilst leaving alcohol and tobacco legal (but subject to strict regulations) (Eldred-Grigg, 1984), illustrating the contradiction within a political sphere that exists where alcohol and tobacco are legalised, yet evidence based AOD policies fail to be enacted (Lancaster, Seear & Treloar, 2015; Law Commission, 2010; Law Commission, 2011; New Zealand Drug Foundation, 2017; Office of the Prime Minister's Chief Science Advisor, 2018; Spivakovsky & Seear, 2017).

Even though there is New Zealand based research investigating different aspects of the AOD workforce and AOD services, the majority of literature that is concerned with the AOD sector are Government reports, sector policies and sector guidelines. The Ministry of Health Workforce Action Plan (2017) is a seminal document for the AOD sector. This report has an impetus on fiscal constraint, requiring that the mental health and addictions workforce provide better outcomes and more effective services to people with the same or less resources (Ministry of Health, 2017). The Workforce Action Plan is seemingly contradictory, in that the plan identifies that there are significant gaps in existing services, including the negative disparities that still exist for Māori accessing mental health and addiction services. But then clearly states that it requires the mental health and addictions sector to provide better more effective services, (including rectifying these service gaps) with no extra resources (Ministry of Health, 2017).

While it could be argued that more effective services would involve efficiencies that could free up resources (Ministry of Health, 2017), New Zealand based reports highlight that the gaps in service provision within the mental health and AOD sector, are a symptom of wider systemic issues and not simply caused by inefficient services (Disability Commission, 2018). The Workforce Action Plan also recognises the need to align with international best practice that would see continued changes in the mental health and AOD sector, moving towards recovery-oriented models of care and greater recognition of the sociological and holistic factors that contribute to mental health and addiction issues. The plan also advocates for the strengthening of a

life-course approach that focusses on early intervention to prevent adverse outcomes for children and adolescents, and approaches that involve collaborative care across the entire health, AOD and social service sector (Ministry of Health, 2017).

An international estimation of the harms and prevalence of AOD use

AOD use world-wide is monitored by the World Health Organisation (WHO) with latest estimates on alcohol use by the WHO being: that the harmful use of alcohol causes 3.3 million deaths each year (World Health Organisation, 2014); on average each person (over the age of 15) drinks 6.4 litres of pure alcohol each year (World Health Organisation, 2017); and that at least 15.3 million people have a drug use disorder (World Health Organisation, 2018). The United Nations Office on Drugs and Crime (UNODC), (a second international organisation that reports on drug use worldwide), states that an estimated quarter of a billion people used an illicit drug at least once in 2015 and 29.5 million of those people have substance use disorders. UNODC also estimates that 12 million people worldwide are using drugs intravenously, with one out of eight of those people living with HIV and over half of those people living with Hepatitis C (2017).

New Zealand's estimation of the harms and prevalence of AOD use

The Annual Data Explorer shows that AOD use in New Zealand (measured in the New Zealand Health Survey 2016/17) appears to be decreasing, with rates of consumption for cannabis, methamphetamine and alcohol all having decreased compared to the previous New Zealand Health Survey (Ministry of Health, 2017). The survey also shows that 11.6% of the population have used cannabis in the past twelve months, 1.0% of the population have used methamphetamine in the past twelve months and rates of hazardous drinking had declined, amongst past twelve-month drinkers, to 24.7% (Ministry of Health, 2018).

The New Zealand Government also publishes the New Zealand Drug Harm Index, a report that calculates the economic and social harm of AOD use in New Zealand (McFadden Consultancy, 2016). One of the weaknesses of the report is that the statistics used regarding the numbers of substance users in New Zealand are not current, as they are based on data gathered in the 2012/13 New Zealand Health Survey (McFadden Consultancy, 2016). Despite this the report estimates that the total harm from drug use in New Zealand equates to $1.8 billion (McFadden Consultancy, 2016).

The National Drug Policy 2015-2020 also provides seminal data on AOD use in New Zealand but it is worth noting that the data is sourced from literature that dates as far back as 2007, so while the data may be accurate, it is not

necessarily reflective of current AOD use in New Zealand. The National Drug Policy 2015-2020 states: that only 12% of people who try substances will develop a substance use disorder (Inter-Agency Committee on Drugs, 2015), and that 83% of people in New Zealand who have a Hepatitis C diagnosis also have issues with intravenous drug use. As at 2011: 150,000 people in New Zealand had problematic substance use; 800 deaths per year are attributed to alcohol; Hepatitis C has reduced by 25% due directly to needle exchange programs; and in 2014: 25% of families with children in the care of Oranga Tamariki had AOD issues (Ministry of Health, 2015). Statistics specific to alcohol use state that: in 2010 alcohol was a contributor to 34% of Domestic Violence incidents; 575,000 people in New Zealand are drinking hazardously; and 10% of women drink heavily during pregnancy (Ministry of Health, 2015).

Defining addiction

Addiction is currently a pathologised phenomenon (Csiernik & Rowe, 2003). It was adopted as a health-related biological disorder by the medical profession in the 18th century (Doweiko, 2014; Walters & Rotgers, 2012; West & Brown, 2013) and was subsequently classified as a psychological disorder, using similar classification systems that define other mental health disorders (American Psychiatric Association, 2013; World Health Organisation, 2005). The two main examples of this can be found in the Diagnostic Statistical Manual (DSM) developed by the American Psychiatric Association, and in the International Statistical Classification of Diseases (ICD) a manual developed by the WHO. Each manual provides a comprehensive section detailing the

different aspects of addiction. A succinct definition from the DSM-5 (the fifth

edition being the most recent) is that addiction is "a cluster of cognitive,

behavioural, and physiological symptoms indicating that the individual continues

using the substance despite significant substance related problems" (American

Psychiatric Association, 2013). The DSM-5 restricts its scope of substances of

addiction to, alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids;

sedatives, hypnotics and anxiolytics; stimulants; tobacco; and other unknown

substances (American Psychiatric Association, 2013, p. 483). The ICD10

(version 10 being the most current) defines addiction as "a cluster of

physiological, behavioural, and cognitive phenomena in which the use of a

substance or a class of substances takes on a much higher priority for a given

individual than other behaviours that once had greater value" (World Health

Organisation, 2005, p. 69).

The classification of addiction as a psychological disorder is not without

its critics with the DSM's (both past and current editions) limitations well

established in existing literature (Frances & Dayle-Jones, 2014; Patil &

Giordano, 2010; Webster & Bosmann-Wātene, 2003). These include; the lack of

multi-disciplinary input into the development of DSM classification systems

(even though the DSM is utilised by an array of professions including social

work) (Frances & Dayle-Jones, 2014), that it is improbable to expect that

complex mental disorders can be reduced to a discrete set of symptoms with a

clear diagnosis, and that there is a lack of consideration given to socio-cultural

factors that an individual being assessed is facing (Patil & Giordano, 2010);

especially that person's cultural worldview (Webster & Bosmann-Wātene, 2003).

There have also been specific critiques of the pathologising of addiction and the effect that this can have on an individual's success in AOD addiction recovery (Wiens & Walker, 2015). Wiens and Walker (2015) recently conducted a quantitative study in Canada investigating how being labelled as a person with a biological disease increases internalised stigma. It was found that participants who internalised the disease concept of addiction had less agency over their drinking compared to those who internalised statements from a sociological or psychological perspective (Wiens & Walker, 2015).

These findings are supported by an article written by Adams (2016) a New Zealand researcher who looks specifically at individualistic treatment interventions that pose addiction as a symptom of internal dysfunction, as opposed to sociological perspectives that acknowledge that the development of an addiction involves the influence of sociological factors external to the individual. Adams recognises the dominance of the biological view of addiction that was contributed to by the WHO and the American Psychiatric Association, and the corresponding shift that addiction practice made into individualistic interventions. Adams challenges this in his theoretical discussion by suggesting that social models of addiction practice are needed, to truly be effective when working with individuals experiencing addiction issues. This is an interesting piece of academic writing given the dominance of the psychiatric and medical professions in the AOD sector in New Zealand (Adams, 2016), and it highlights

the need to extend addiction practice to sociologically based professions like social work (Nelson, 2011).

The social work profession has constantly been involved in advocating for changes to the medical model of addiction, Corcoran and Walsh (2010) synthesise the arguments that contribute to this discussion. Their focus is on clinical social work and the limitations that the DSM has because of the reductionist approach that it takes in its view of a person, their illness and recovery. (Corcoran & Walsh, 2010). This text explains mental illness and addiction from a social work perspective; which is that individuals should not be classified as abnormal, they should instead be viewed as a person-in-environment (PIE). This is a transactional process that takes place between the person and the different systems they interact with, it is these interactions that can become problematic and provide a basis for problematic biological, psychological or sociological functioning (Corcoran & Walsh, 2010).

In New Zealand, the Drug and Alcohol Practitioners Association of Aotearoa New Zealand (DAPAANZ) is a national organisation that offers non-compulsory registration for professionals working in the addiction sector, who have developed The Addictions Intervention Competency Framework that provides a New Zealand specific definition of addiction. DAPAANZ defines addiction as any problem people are having with a range of addictive mediums, the term problem encompasses those who may develop an addiction in the future, to those currently facing significant harms from addiction. The mediums

that a person could become addicted to is equally as broad and includes alcohol, tobacco, other drugs and gambling (DAPAANZ, 2011).

The National Drug Policy's definition of addiction however, only focusses on AOD issues. It states that addiction is when a person becomes psychologically and physiologically dependent on a substance and, "they need to keep using them in order to function normally" (Ministry of Health, 2015). The policy also recognises that harm from addiction is holistic and subsequent interventions must focus on not only the individual, but also their family, environment, community and employment (Ministry of Health, 2015). These two documents offer arguably the most relevant definition of AOD addiction for New Zealand and unintentionally highlight the disparity that exists between the acknowledgement that successful addiction recovery occurs with holistic sociological intervention (Adams, 2016; Corcoran & Walsh, 2010), and the current state of New Zealand's AOD sector in which there is an overabundance of medical professionals (Te Pou o te Whakaaro Nui, 2014).

Specific populations

Addiction and recovery are diverse, subjective, human experiences that need flexible and individually tailored responses, provided by qualified, empathetic professionals (Walters & Rotgers, 2012). However, there have been groups identified by research that face greater harm from substance misuse compared to the general population, these groups are: Māori; youth; people with co-existing mental health and addiction issues; women; and the families of people

who have AOD addiction issues (Lyons & Willot, 2008; Marie, Fergusson & Boden, 2008; Ministry of Health, 2012; Simpson & McNulty, 2008). In order to understand what works in AOD addiction recovery for certain population groups, it is important to understand the unique challenges that these populations face.

Addiction and Māori

In New Zealand Māori are Tangata Whenua and have unique rights to tino rangatiratanga under the Treaty of Waitangi, a document that has been integrated as the foundation of multiple pieces of Government legislation including the New Zealand Public Health and Disabilities Act (2000). Despite efforts to increase equity in social and health outcomes such as increasing the numbers of Kaupapa Māori healthcare providers, and requiring services to adopt a whānau ora approach when supporting Māori (Ministry of Health, 2008), Māori continue to experience higher rates of negative outcomes (Marie et al., 2008). For example: Māori are more likely to be imprisoned; live in poverty; suffer from physical health issues; mental health issues; Māori are more likely to be addicted to substances; and face greater harm from those addictions (Lyons & Willot, 2008; Marie et al., 2008). The latest Ministry of Health Mental Health and Addiction Workforce Action Plan acknowledges these disparities and advocates for a life-course approach to wellbeing, focussing services on early intervention and prevention, and implementing person-led recovery (Ministry of Health, 2017).

What works in AOD addiction recovery for Māori, as suggested by this Ministry of Health Action Plan (2017), is for the person to lead and define their own AOD addiction recovery plan with the full support of their AOD treatment team. The Ministry of Health's plan to mitigate and prevent further harm to Māori communities caused by AOD addiction is to apply Treaty of Waitangi principles, by developing strategies for better health and disability services in partnership with iwi, hāpu and whānau. The Plan aims to see the involvement of Māori at all levels of healthcare including decision making, planning, development and delivery of services, and to safeguard Māori cultural practices and values (Ministry of Health, 2017).

Addiction and youth

The Ministry of Health state that all experiences in a person's life from infancy onwards can have an impact on their future wellbeing, advocating for a life-course approach to AOD addiction issues in New Zealand (Ministry of Health, 2017). While this report prioritises children from the ages of 0-5 years, the previous Workforce Action Plan, Rising to the Challenge, identified youth as a target population group. That action plan recognised that "a significant proportion of mental health and addiction issues start to develop before the age of 25 years; adolescence is a particularly sensitive period of development" (Ministry of Health, 2012, p. 9).

New Zealand research identified that multiple risk factors for youth in regards to substance misuse have increased in recent years with access to

alcohol being easier after the "deregulation of the commercial environment, liberalisation of marketing controls, and the lowering of the age of legal purchase" (McCreanor, Barnes, Kaiwai, Borell & Gregory, 2008, p. 939). This research found that harm to youth via the consumption of alcohol has increased, with more youth engaging in binge drinking behaviour more often, more youth being involved in alcohol related car accidents, increased admissions to emergency departments, and greater contact with law enforcement because of disorder offences related to alcohol consumption (McCreanor et al., 2008). These changes have also coincided with the development of synthetic drugs. There is an emerging trend in New Zealand of harm caused by synthetic drugs which is pertinent to youth populations because, as identified in Davis and Boddington's research (2015), epidemiological data shows that the majority of users of synthetic drugs are young adults aged between 12-24years old.

Despite youth being a targeted group for AOD support services, "young people seldom seek help for AOD problems and treatment services generally meet their needs poorly" (Christie, Merry & Robinson, 2010). New Zealand research has found that services to youth are either delivered ad hoc as part of existing adult services, or are simply a modified version of adult AOD programs (Christie et al., 2010). The literature in this review also identified that AOD education for youth in New Zealand was sub-standard and inconsistent (Office of the Prime Minister's Science Advisory Committee, 2011). A report conducted by the New Zealand Government initiated a Government led project to improve and extend AOD education for youth within secondary schools (Ministry of

Education, 2014). The aim of this program is to have AOD education programs that are integrated across the whole school curriculum, as well as provided in health and physical education classes. Additionally, schools are required to implement early intervention and collaborative strategies in order to support the young person with the substance misuse issue (Ministry of Education, 2014).

Addiction and mental health

In New Zealand people experiencing co-existing mental health and AOD addiction problems (CEP) face the worst health and social outcomes. These people generally experience substantial physical health issues and face a reduced life expectancy of up to 25 years compared to the general population (Ministry of Health, 2012). In New Zealand, approximately 12 percent of people will have an AOD addiction in their lifetime and 70 percent of these people will have co-existing mental health challenges (Ministry of Health, 2012). Te Whare o Tiki provides an outline of the skills required for mental health and AOD addictions professionals, to be able to reduce barriers to support for people who have CEPs (Te Pou o Te Whakaaro Nui, 2013). The core competencies outlined in the framework are: cultural considerations; well-being and recovery; engagement; motivation; assessment; management; and integrated care.

International research explores what can be done to improve outcomes for people with CEPs (Butler et al., 2011; Christie et al., 2010; Schlosser & Hoffer, 2012; Staiger et al., 2011). Two studies in particular gave research participants a voice and empowered them to define what they needed in order

to succeed in recovery. Schlosser and Hoffer (2012) found that for people needing psychiatric medication, but still using illicit substances, the lack of consideration given to their complex contextual factors created an inadequate and at times dangerous pharmacocentric psychiatric response. While Staiger et al.'s research (2011) showed that in the wider mental health and AOD sector, staff attitudes created barriers to service utilisation as staff were judgemental towards people with CEPs. The research also showed that stable housing, a meaningful job and positive social support were contributors to AOD addiction recovery for people with CEPs (Staiger et al., 2011).

Addiction and women

Women are another population that face disproportionate and unique harm from substance misuse (Simpson & McNulty, 2008). This harm is compounded by higher levels of stigma experienced by women who are considered by wider society, to have breached their traditional gender defined roles by misusing substances (Lyons & Willot, 2008; McCray et al., 2011; Reid, Greaves & Poole, 2008; Sallmann, 2010). Women misusing substances are also more likely to face stigma within treatment services and within peer groups (Gunn & Canada, 2015; McKim, 2014). Some of the harms identified in existing research are that: women are more likely to have a drug using partner as opposed to men who misuse substances; women injecting drugs are more likely to share injecting equipment; are at increased risk of HIV and Hepatitis C infection; are more likely to be involved in sex work; have higher vulnerability to psychiatric co-morbidity including suicide attempts, eating disorders and post-

traumatic stress disorder due to sexual and physical violence; and women who

have children are more likely to have their children removed by child protection

services (Simpson & McNulty, 2008). Simpson and McNulty's research (2008)

found that treatment services do not address the unique risks and trauma that

women bring with them when entering the AOD addiction recovery journey. This

assertion is also relevant for female youth in New Zealand who lack access to

gender appropriate residential treatment (Schroder, Sellman, Frampton &

Deering, 2008).

Addiction and families

The role of families in AOD addiction and recovery was one of the dominant

themes that emerged during the thematic analysis. A subsequent review of the

literature ascertained that family experiences are well documented. Tunnard

(2002) documented the widespread exposure of children to parents with

problematic drinking. It was found that children exposed to problematic drinking

by parents have more behavioural and emotional issues, and are more likely to

experience difficulties in school (Tunnard, 2002). Additionally, Templeton,

Zohhadi and Velleman (2007) documented the negative impact of addiction on

family who are attempting to support a person with AOD addiction issues also

highlighting the lack of services available to support these families. Finally,

Copello, Templeton and Powell (2010) found that despite challenges that exist

for families in supporting a family member with an addiction, families do in fact

provide the highest levels of recovery capital; recovery capital being defined as

emotional support, or support with practicalities such as housing and finances.

The background and context section of this thesis has provided a succinct history of substance use, addiction and prohibition responses worldwide and in New Zealand. With an overview of the most recent health outcome information for those people using AODs and with AOD addictions also being provided, along with the diverse definitions of AOD addiction, and the unique impact of AOD addiction on specific populations. This section began to define key barriers to AOD addiction recovery including; the prohibition and criminalisation of people using illicit substances the lack of diversity within AOD addiction treatment options, and the lack of interventions specifically tailored to meet the needs of unique populations.

Chapter Summary

Chapter one began with an outline of the structure of this thesis, and then proceeded to provide an understanding of the researcher's connection to the research. Positioning her as an 'insider'; a person with lived experience of AOD addiction, and with similar experiences to the research participants both in AOD addiction, recovery and employment as an AOD professional in New Zealand. The background of AOD use internationally and in New Zealand was provided, with international and New Zealand based literature illustrating that AOD use has consistently been embedded in cultural practices. Also showing that the responses to AOD use and addiction have consistently been racialised and moralistic, with AOD use being increasingly regulated, prohibited and

criminalised. Despite this, there has been an increasing awareness of the need to recognise AOD addiction as a holistic and diverse experience that requires flexible and individually tailored treatment responses.

Chapter one also provided an outline of the context of AOD use and addiction (internationally and in New Zealand). With statistical data showing that the harms and prevalence of AOD use and addiction are high and that people with AOD addictions face disproportionate risk of experiencing other health and social problems. The diverse and often conflicting definitions of AOD addiction were outlined and a definition of AOD addiction relevant to New Zealand was given. Finally, the unique experiences of specific populations in New Zealand experiencing AOD addiction were outlined. This understanding of the background and context of AOD use and addiction internationally and in New Zealand is extended upon in the next chapter; the literature review, which explores in-depth, the dominant themes from relevant literature over the past ten years.

Chapter Two: Literature review

The following chapter creates the foundation for this research which asks the question - What works in AOD addiction, treatment and recovery in New Zealand? The examination of the literature, both internationally and within New Zealand on AOD addiction in the last ten years, explores factors that might contribute to, or create barriers to, successful AOD addiction recovery. This review assisted in formulating evidence based interview questions as well as providing a context for the research.

The literature review is presented in four sections with the first section, Perspectives on Addiction, exploring the differing theories of addiction. The second section, Policy responses, looks at addiction and the law including the current state of addiction policy both internationally and in New Zealand, as well as the impact of the New Zealand Criminal Justice System on people experiencing AOD addiction. The third section, Stigma and AOD addiction, examines the concept of stigma and the negative impact this has on people with AOD addictions, exploring the international literature that illustrates what works in negating stigma. The fourth and final section, the AOD Workforce, outlines the demographics of the AOD sector, the theoretical underpinnings of this workforce and how the AOD workforce both contributes and creates barriers to AOD addiction recovery.

Methods for the literature review

The literature review for this thesis began with an analysis of all articles that had been published in the last ten years and had AOD addiction as its main topic, articles included both international and New Zealand based research. The researcher utilised journal databases Scopus and Google Scholar. Search terms included "addict*", "New Zealand", "qualitative", and "social work". Articles were deemed irrelevant if they had been published more than ten years ago or if they were duplicate. However, any seminal research that was deemed to be relevant to the literature review was included, even if it fell outside of the search parameters. The next step the researcher took was to search for books relevant to addiction using the Massey University Library search engine, Discover. The purpose of this search was to source the most recently published textbooks with the topic of AOD addiction theory. The final step in this review took place after the thematic analysis was completed in which themes that had not been explored in the initial review were identified.

Perspectives on addiction

Section one sets the context for the concept of AOD addiction, as this concept has been fluid and highly contested throughout history. This is an issue for people trying to succeed in AOD addiction recovery because the way AOD addiction is defined determines the type of AOD addiction support that is available (Adams, 2016; Corcoran & Walsh, 2010). There are three

subsections: the first considers how current practices in AOD theory and practice contribute to AOD addiction recovery; the second considers the concept of addiction as a disease and the dominance of the medical model; and finally, alternative sociological views of AOD addiction are discussed; with barriers to AOD addiction recovery being identified in both the medical model and the sociological view of AOD addiction sections.

Addiction theory and practice

Addiction theory and practice are as equally diverse as the definitions of AOD addiction and are similarly influenced, depending on which professional discipline is attempting to explore the issue of addiction. The subsequent application of the chosen theory also influences the type of intervention that a person with an AOD addiction receives (West & Brown, 2012). The diversity of interventions available to people is a strength of the AOD sector and is a contributor to successful AOD addiction recovery because treatment can be tailored to match each individual's needs (Adams, 2016). However, this is wholly dependent on the ability of the AOD workforce to be reflexive in their practice (Walters & Rotgers, 2012).

Walters and Rotgers (2012) highlight which aspects of addiction theory and practice contribute to successful AOD addiction recovery, via the therapeutic relationship formed between the AOD professional and the person seeking help. The most significant theme that emerged throughout the text was the need for effective therapist characteristics including, acceptance, use of

complex reflections, avoiding warning and confronting, egalitarianism, empathy and warmth. Alongside this is the need to recognise that mandated treatment is not as effective as voluntary treatment and that the person accessing treatment needs to have autonomy in their choices, and confidence that they can change their behaviour (Walters & Rotgers, 2012).

Alongside the foundational components of the therapeutic relationship between the person needing support with an AOD addiction and the helping professional, are a range of different perspectives on AOD addiction that contribute to AOD addiction recovery. These perspectives include; abstinence only approaches to recovery, controlled use, harm reduction, brief intervention, recovery oriented approaches, and a life course approach. Matua Raki's (2014) document on the AOD sector in New Zealand provides an effective road map for understanding the different perspectives on AOD addiction and AOD addiction treatment in New Zealand. The three options for AOD addiction recovery as defined by this report are abstinence based recovery, controlled recovery, and harm reduction options (Matua Raki, 2014). Each option is dependent on the outcome of an initial assessment and the needs and goals of the person accessing support (Matua Raki, 2014).

Abstinence approaches to AOD addiction recovery became widespread with the establishment of Alcoholics Anonymous (AA) in the USA in 1935 (Laudet, 2008), and are still recommended as an effective treatment option for people who have severe dependence to AODs (Matua Raki, 2014). Abstinence based recovery is an internationally recognised approach to AOD addiction

recovery, with successes of the approach documented in international literature (Humphreys et al., 2004; Laudet, 2008; Laudet et al., 2004). Controlled use is a type of AOD addiction recovery in which a person maintains a low to moderate level of AOD use (Matua Raki, 2014), while harm reduction is a broadly applicable approach to reducing harm from AOD misuse (Matua Raki, 2014). Harm reduction approaches include providing advice on how to administer AODs in order to minimise harm (Matua Raki, 2014), providing access to safe equipment for administering drugs (Bixler et al., 2018), or adopting philosophies like the housing first strategy in which people are not denied access to essential supports even if they are still using AODs (Pauly, Wallace & Barber, 2018).

Brief intervention is a practice method that involves trained AOD professionals providing brief therapy sessions to people who may not be ready to engage in intensive therapy options, such as weekly counselling or rehabilitation (Substance Abuse and Mental Health Services Administration, 1999). The purpose of the intervention is to increase the person's motivation to engage in longer term treatment and address any immediately risky substance use in order to reduce the harm to the person (Substance Abuse and Mental Health Services Administration, 1999). This method can be effective, both in increasing the immediate safety and wellbeing of the person receiving the intervention, and also increasing the likelihood that the person will engage in longer term treatment (Substance Abuse and Mental Health Services Administration, 1999).

Additionally, recent sector reports and academic literature discuss the emergence of recovery oriented approaches to AOD addiction recovery (Bassuk, 2016; Boisvert, 2008; Matua Raki, 2014; Reif et al., 2014), alongside a life-course approach which has been posited as an effective approach for addressing AOD addiction issues, by the New Zealand Government (Ministry of Health, 2017). Recovery oriented approaches to AOD addiction recovery have been championed by the peer workforce internationally, as this is an approach that advocates for the person seeking support to be an active part of goal setting and planning in their recovery journey (Brekke, Lien, Nysveen & Biong, 2018). Recovery oriented approaches also recognise and attempt to address the issues external to the person needing support for example, conflict within the systems they sit within (welfare, housing). Further to this, recovery oriented approaches view a person's AOD addiction beyond the presence or absence of symptoms, instead focussing on the person's ability to live well in the community (Brekke et al., 2018).

Finally, in the most recent Government report on the AOD sector in New Zealand the New Zealand Government have called for the adoption of a life-course approach to AOD addiction issues (Ministry of Health, 2017). This appears to be an attempt at integrating recovery oriented approaches to AOD addiction recovery; addressing poverty, unemployment, low standards of living, with an early intervention strategy that recognises and addresses the traumatic experiences that can lead to adverse life outcomes if experienced in infancy, early childhood or adolescence (Ministry of Health, 2017). This approach requires cross-sector collaboration across the entire health, social service, and

AOD workforce to ensure that individuals have access to the treatment and support they need, the ability to define their own recovery pathways, that negative socio-economic factors are addressed, and that intervention is provided as early as possible to people of all ages who are at risk of current or future harm (Ministry of Health, 2017).

While the perspectives highlighted in this section provide an understanding of what contributes to AOD addiction recovery the following two sections highlight the systemic barriers that exist for people experiencing AOD addiction, and the need for a more balanced perspective of AOD addiction within the public sector as well as within academic literature.

The medical model

The recommendation of existing literature is that addiction practice be a field based in multiplicity, and one where qualitative research is viewed as an equal contributor of information as quantitative research (Broom & Willis, 2007; Cohen & Crabtree, 2008; Prasad, 2005; Walters & Rotgers, 2012). However, it is still a sector that is dominated by the medical profession and corresponding quantitative medical research (Barber et al., 2013; Bird & Schenk, 2013; Bosch, Benton, McCartney-Coxson & Kivell, 2015; Bosch, Peng & Kivell, 2015; Bradbury et al., 2014; Brennan, Putt & Truman, 2013; Broom & Willis, 2007; Capecci, Kasabov & Wang, 2015; Cohen & Crabtree, 2008; Doborjeh, Wang, Kasabov, Kydd & Russell, 2016; Fergusson, Boden & Horwood, 2011; Ferragud, Velazquez-sanchez & Canales, 2014; Grey et al., 2011; Gurney,

Shaw, Stanley, Signal & Sarfati, 2015; Harper, Hunt & Schenk, 2006; Harrison, Rucklidge & Blampied, 2013; Lin, Jan, Kydd & Russell, 2015; Lin, Jan, Lee, Jensen, Kydd & Russell, 2011; Miles et al., 2013; Moaddab, Hyland & Brown, 2015; Morani, Ewald, Prevatt-Smith, Prisinzano & Kivell, 2013; Pei, Mortas, Hoener & Canales, 2015; Prasad, 2005; van Ours, Williams, Fergusson & Horwood, 2013; Wang, Kydd & Russell, 2015; Wang, Kydd, Wouldes, Jensen & Russell, 2015; Wang, Wouldes, Kydd, Jensen & Russell, 2014; Wilkins, Sweetsur & Griffiths, 2011).

Undoubtedly quantitative research adds value to AOD addiction practice in New Zealand, providing a sound foundation to a research database that practitioners can access in order to provide evidence based practice interventions (West & Brown, 2013). What it does not do is provide a holistic, sociological understanding of addiction, utilising the knowledge of those who have personally experienced AOD addictions. This would not be problematic if quantitative and qualitative addiction research was taking place at the same rates in New Zealand, however AOD addiction research in New Zealand is overwhelmingly quantitative. This limits the options that practitioners have to practice in a holistic evidence based manner, creating a plethora of information that is only accessible to those who can interpret medical studies and apply them to practice. Prasad -argues persuasively that what this has done is to place AOD addiction in the realm of medical experts, creating a viewpoint that fails to see the value in having other professions contribute to the academic discussion on addiction, and taking away opportunities for those who have their own lived experience of AOD addiction to participate in the narrative (2005).

Addiction as a sociological issue

The sociological research on addiction in New Zealand provides an alternative and unique perspective on AOD addiction. This research is both quantitative and qualitative and focusses on the wider aspects of addiction including: the impacts of addiction on broader life outcomes for youth (Swain, Gibb, Horwood & Fergusson, 2012); the relationship between addiction and the stresses stemming from the systems that a person is participating in (Gibb, Fergusson & Horwood, 2012); research on barriers to addiction treatment (Todd, Sellman & Robertson, 2002); and research on consumer perspectives of treatment services (Deering et al., 2011).

Deering et al.'s research on consumer and provider perspectives of Opioid Substitution Treatment (OST) in New Zealand (2011), gives a voice to a population that faces high levels of discrimination and drug related harm, recognising the sociological factors that reduce a person's ability to succeed in treatment services. This research found that systemic barriers have a significant impact on a person's ability to access and be successful in OST services. The top two barriers identified were restricted medication 'takeaways' and having to go on a waiting list. The use of peer interviewers was a unique method used in this research, as was the investigation into the sociological barriers to successful treatment. Research prior to this only investigated individualistic failings in treatment adherence. Pagey, Deering and Sellman's (2010) research is an example of this, they analysed the files of youth clients, only identifying

barriers to treatment that were individualistic, placing the responsibility for non-attendance with the person.

An individualistic approach to addiction is problematic as it does not consider the personal and institutional factors affecting a person's ability to succeed in recovery. A sociological approach to addiction, when led by the social work profession is an effective response to individualised responses to AOD addiction. Interestingly the perspective of the social work professions' approach to working alongside people with AOD addictions is not explored in New Zealand literature however international literature highlights the successes of the social work profession, when taking the lead in implementing harm reduction options which have been shown to decrease barriers for people needing support with AOD addictions; for example safe injecting sites which reduce the risk of mortality but also act as an entry point to AOD addiction recovery, and other health and social service support (Csiernik & Rowe, 2003).

This section has identified the conflict that exists between medical and sociological perspectives of AOD addiction, while the medical model has historically (and currently) dominated AOD addiction treatment internationally and within New Zealand, more recognition is being given to the importance of sociological interventions. The social work profession was identified as an appropriate agent when advocating for this change in New Zealand given that the professions practice is grounded in sociological, holistic methods.

Policy responses

Policy responses to AOD addiction have consistently been based in prohibitive ideologies and the criminalisation of substance users (Csete et al., 2016; Global Commission on Drug Policy, 2017; Law Commission, 2011). This approach has in recent times been identified as problematic by international bodies such as the Global Commission on Drug Policy, and local organisations such as the New Zealand Drug Foundation. Subsequently, policy responses to AOD addiction internationally and in New Zealand have been identified as a barrier to AOD addiction recovery by entities such as these. This section provides the background and context of policy responses to AODs internationally and within New Zealand. Also providing insight into the role of the Criminal Justice System in AOD addiction recovery.

AOD legislation is facing worldwide reform because of growing recognition that existing legislation that criminalises people using illicit substances, creates barriers to AOD addiction recovery and broader holistic wellbeing (Csete et al., 2016). A report published in The Lancet provided an international perspective on the 'war on drugs' and the harm it has caused, the purpose of the report was to provide an update to the United Nations (UN) on illicit drugs worldwide. The report stated that the approach taken by the UN in the previous United Nations General Assembly Special Sessions (UNGASS) on illicit drugs; to have a world free from illicit drugs and subsequent investment in a 'war on drugs', has caused more harm to people and communities than illicit drugs have. The report goes on to outline these harms quantitively, in terms of

human life and potential lost, as well as fiscal losses. The report calls for an end to current models of criminalisation by replacing them with human rights based responses led by the health, AOD and social service sector (Csete et al., 2016).

The Global Commission on Drug Policy hold views similar to those of Csete et al.'s (2016) in that they recognise the harms caused by current criminalised responses to illicit drugs. They state that current laws need to be informed by research and evidence rather than moralistic views of AOD use (Global Commission on Drug Policy, 2017). The most recent report published by the Global Commission on Drug Policy focusses on the need to change existing perceptions of people who use illicit drugs, perceptions that: increase stigma; create barriers to healthcare; AOD addiction recovery; and community participation. The report recognises that illicit drug use is largely recreational with only a small number of people developing problematic AOD use. This makes the harms caused by laws that criminalise drug use problematic, as they disproportionally punish people for an activity that causes little harm to others. Additionally, where people have become addicted to AODs these laws prevent effective health based responses to people needing empathy, support and autonomy to choose their own way forward in AOD addiction recovery (Global Commission on Drug Policy, 2017).

These documents are the beginnings of international systemic change, moving responses to illicit drug use and addiction toward humanistic, health based responses and away from moralised and criminalised responses. These changes will help remove the barriers that a criminalised environment creates

for those with AOD addictions, in accessing support and being successful in AOD addiction recovery. Successes that are most significantly evidenced by legislative changes in Portugal in which personal possession of drugs and paraphernalia were decriminalised (Banbury, Lusher & Guedelha, 2018; Lagueur, 2015; UNODC, 2014). This legislative approach coincided with increased resourcing and accessibility to health focussed AOD interventions and supports, meaning that barriers to accessing supports were reduced, as were the barriers to wellbeing and recovery caused by interactions with the Criminal Justice System (Banbury et al., 2015; UNODC, 2014). Similar barriers and solutions are also highlighted and advocated for, in New Zealand based reports (Law Commission, 2011; New Zealand Drug Foundation, 2017).

In New Zealand there has also been greater recognition by those in authoritative positions, of the harms of prohibition and criminalisation of those using AODs (McFadden Consultancy, 2016; Ministry of Health, 2015). The New Zealand Law Commission for example, has called for changes to existing drug laws in their reports; Compulsory treatment for substance dependence: A review of the Alcoholism and Drug Addiction Act 1966 (Law Commission, 2010) and Controlling and regulating drugs: A review of the Misuse of Drugs Act 1975 (Law Commission, 2011). This led to a Government review and enactment of new legislation, the Substance Addiction (Compulsory Assessment and Treatment) Act (Parliamentary Counsel Office, 2017).

Alongside this are growing public debates on the way New Zealand regulates AODs and interestingly despite calls for decriminalisation, recent

public concern regarding tobacco and synthetic drugs led to legislative

responses that have seen prohibitive mechanisms strengthened; with synthetic

substances listed as prohibited substances, and increased taxation on tobacco

to deter rates of consumption (Ministry of Health, 2011; Ministry of Health,

2015). Comparatively, there has also been debate regarding the

decriminalisation of marijuana for medicinal purposes, and a recent

parliamentary hui facilitated by the New Zealand Drug Foundation looked

closely at international models of decriminalisation and regulation as possible

options for future illicit drug regulation in New Zealand (New Zealand Drug

Foundation, 2017).

The Criminal Justice System

The Criminal Justice System is defined as all legal systems that a person

with an AOD addiction could potentially be involved with including; the New

Zealand Police, the court systems, Community Probation, and prisons.

Additionally, the term, the Corrections System, refers to specific services within

the Criminal Justice System including; Community Probation and prisons. One

piece of research in particular, a Masters' thesis investigating the experiences

of women prisoners in Christchurch women's prison (Richards, 2014), found

that the structure of the prison environment effectively humiliates and de-

humanises prisoners (Richards, 2014). This process reduces the likelihood that

the person will be able to re-integrate successfully into society once they leave

prison due to internalised shame and stigma, alongside the unwillingness of

society to accept the person back into society (Richards, 2014).

Despite this, there are alternative views of the Criminal Justice System that state that incarceration rates and high recidivism rates are not necessarily only related to criminal justice laws and responses, they are also strongly influenced by a range of other systemic factors (Newbold, 2016). In fact, Newbold argues that in the past thirty years the changes that have been made to policing, courts, sentencing, sentence management and parole have led to a decrease in convictions (excluding convictions for women) including AOD related convictions (excluding methamphetamine related convictions) (Newbold, 2016). Alongside this is the Department of Corrections research (2016) regarding the high rates of AOD addiction amongst people in the Corrections System, specifically concerning those people incarcerated in prison. These figures state that 62% of people in prison have a mental health and/or addiction disorder. This led to a recent investment in mental health and addiction support for people involved in the Corrections System (Department of Corrections, 2016), with the purpose of ensuring that people have access to comprehensive, ongoing AOD addiction support whilst in prison and upon release (Department of Corrections, 2016).

The most recent report on the Corrections System in New Zealand however, was the report released by the Office of the Prime Minister's Chief Science Advisor in March 2018. The report disputes Newbold's commentary and shows that despite significant investment in mental health and addictions support in prisons, the New Zealand Corrections System has serious ongoing systemic issues (Office of the Prime Minister's Chief Science Advisor, 2018). A

key issue that is identified in the report is the prevailing belief in New Zealand, that increasing retributive justice responses is the most effective way to deal with crime in New Zealand. This has meant that while crime rates in New Zealand have decreased, incarceration rates have increased (Office of the Prime Minister's Chief Science Advisor, 2018). The report states that sending more people to prison does not create positive change, in fact prisons have been shown to: be a recruitment ground for further criminal and gang involvement often linked to the illicit drug trade; damage a person's employment, housing and familial prospects; and that people in prison have high rates of undiagnosed and untreated mental health and addiction issues (Office of the Prime Minister's Chief Science Advisor, 2018); assertions supported in local and international literature (Clear & Schrantz, 2011; Drake, Aos & Miller, 2009; Miller & Alexander, 2016; Pratt & Clark, 2005).

Stigma and alcohol and other drug addiction

International and New Zealand based research identifies stigma as a barrier to AOD addiction recovery (Brener, Von Hippel, Von Hippel, Resnick & Treloar, 2010; Butler & Sheridan, 2010; Clarke et al., 2016; Csiernik & Rowe, 2003; Deering, Horn, & Frampton, 2012; Gunn & Canada, 2015; McCray, Wesely & Rasche, 2011; McKim, 2014; Roussy, Thomacos, Rudd & Crockett, 2015). This section explores this barrier by firstly defining stigma, then outlining the negative impact that stigma has on people with AOD addictions. The ways that stigma can be challenged are explored and lastly, the role of redemptive self in relation to AOD addiction recovery is considered.

Defining stigma

Research shows that stigma is a pervasive concept that negatively affects people with substance misuse issues (Brener, Von Hippel, Von Hippel, Resnick & Treloar, 2010; Butler & Sheridan, 2010; Clarke et al., 2016; Csiernik & Rowe, 2003; Deering, Horn, & Frampton, 2012; Gunn & Canada, 2015; McCray, Wesely & Rasche, 2011; McKim, 2014; Roussy, Thomacos, Rudd & Crockett, 2015). McCray et al. define stigma as a process whereby "because of socially undesirable qualities (such as being in a socially undesirable occupation), an identity becomes spoiled imbued with meanings of abnormality, inferiority, and marginalisation" (p. 744, 2011). Gunn and Canada also consider stigma to be linked to an identity marred by meanings of abnormality but extend that definition by adding that stigma is also; a "cruel form of social control that turns individuals into their own jailor and chorus of denunciation" (p. 281, 2015). Meaning that stigma is not only problematic because it shapes how a person is viewed by wider society, institutions, and by themselves, it also creates barriers to the well-being of that person (Gunn & Canada, 2015).

The negative consequences of stigma on people with AOD addictions

Research conducted in New Zealand is consistent with international research on stigma that outlines the harm that is caused to a person with an AOD addiction (Brener et al., 2010; McCray et al., 2011; McKim, 2014). Deering

et al.'s research into improving OST services in New Zealand found that stigma creates a barrier for people trying to access OST (2012). The research found that stigma was both societal and institutional, people misusing drugs perceived that a wider societal stigma existed regarding people receiving OST, and once people entered OST services they found that staff attitudes and behaviour contributed to them feeling stigmatised (Deering et al., 2012). Butler and Sheridan's research into the views of primary healthcare practitioners found similar issues with staff attitudes (2010). Research participants expressed beliefs that the drug misuse was the patients "…own fault, that they are dirty people" (Butler & Sheridan, 2010, p. 4). Participants believed that addressing the substance misuse within primary care was not their role and instead advocated for criminal justice responses to these patients (Butler & Sheridan, 2010).

Both studies found that societal and institutional stigma was internalised by people misusing substances (Deering et al., 2012). This impacted on the person's recovery outcomes by reinforcing the addict concept, which is shown to reduce functionality, personal resources and social support networks (Deering et al., 2012). Stigmatising attitudes and behaviour of staff also reduced the likelihood that people misusing substances received the intervention and treatment that they needed. This included: holistic responses to sociological problems including access to counselling; support for physical and mental health problems; as well as providing support for the addiction (Butler & Sheridan, 2010; Deering et al., 2012).

The importance of people misusing substances receiving effective healthcare without fear of stigma or discrimination is an internationally recognised issue (UNAIDS, 2017). The most recent Joint United Nations Programme on HIV/AIDS (UNAIDS) report outlines the harms that arise from the stigmatisation of specific populations of people misusing substances (UNAIDS, 2017). They have found that these harms are heightened if you are: injecting substances; a woman with custody of her children; indigenous peoples; and people with diagnoses of HIV and/or Hepatitis C (Clarke et al., 2016; Csiernik & Rowe, 2003; McKim, 2014). The barriers caused by the stigmatisation of these groups helps to contribute to: the spread of HIV and Hepatitis C (Csiernik & Rowe, 2003); incarceration; removal of children (McCray et al., 2011; McKim, 2014); significant physical health problems; homelessness; poverty; and a higher likelihood of engaging in risky behaviours such as, sharing drug paraphernalia and engaging in unsafe sexual practices (Csiernik & Rowe, 2003).

Another negative consequence of stigma explored in the literature is how people misusing substances internalise stigma at an individual and group level. Gunn and Canada (2015) explore this concept in their research on intra-group stigma among women in AOD addiction treatment, the study found that women created classes of addicts with both positive and negative connotations. Women viewed peers who had used certain types of drugs and engaged in certain types of behaviour in two different ways. Firstly, by looking down on others for their drug use and behaviour for example, if a woman had stopped caring for their personal hygiene, or had engaged in sex work to fund their AOD addiction. The

second, being that women viewed those who had used what were considered, really bad drugs and had faced significant negative consequences from their AOD addiction, as 'real addicts' deserving of treatment and support. The effect of the former view was that the women faced greater levels of external stigma and internal shame, and with the latter view women minimised lower level drug use and behaviour. This meant that certain women were not considered bad enough to be in addiction treatment (Gunn & Canada, 2015).

Comparatively, Brener et al. (2010) focussed on stigma at an individual level, in their study on client's perceptions of OST in Australia. What they found was that stigma (perceived or actual) had a significant impact on people in addiction treatment. The fear of stigmatisation prevented people from seeking help, people were less likely to disclose their other health issues, people were less likely to adhere to the recovery program and interactions with staff were strained and uncomfortable (Brener et al., 2010). The research recommended that staff working in AOD addiction treatment services needed to have greater levels of understanding of the significant negative impact that stigma can have on a person's recovery. What the research also found was that services that employed staff who openly disclosed lived experience of addiction, were more likely to be successful in mitigating stigma and improving treatment adherence (Brener et al., 2010).

Challenging stigma

Stigma is a significant barrier to a person's successful AOD addiction recovery, stigma regarding substance use and misuse exists at a societal level, at an institutional level, and within an individual as internalised stigma (Brener, Von Hippel, Von Hippel, Resnick & Treloar, 2010; Butler & Sheridan, 2010; Clarke et al., 2016; Csiernik & Rowe, 2003; Deering, Horn, & Frampton, 2012; Gunn & Canada, 2015; McCray, Wesely & Rasche, 2011; McKim, 2014; Roussy, Thomacos, Rudd & Crockett, 2015). Stigma can and should be challenged and there is some research that explores the harm stigma causes, and suggests solutions to mitigate this stigma (Roussy et al., 2015; Shepherd & Pinder, 2012). The AOD specific research exploring how to challenge stigma largely focusses on workforce development and academic study as a modality to challenge stigma. A piece of international research exploring the use of reflective practice by students in addictions studies programs was conducted by Shepherd and Pinder (2012). The researchers conducted case studies with students, exploring their values and beliefs about people with addictions before and after completing a self-reflection exercise. The research found that the students had significantly changed values and beliefs after the self-reflection exercise, as the students had developed a greater level of empathy for people misusing drugs. This was especially true for the students who completed a self-reflection exercise after attending a class that had people with lived experiences of addiction sharing their addiction and recovery stories (Shepherd & Pinder, 2012). Roussy et al.'s research (2015) on consumer led training for professionals working in organisations providing support to people with CEPs,

also found that exposure to trainers with lived experience of addictions changed the way this group of people were perceived by health-care workers.

Stigma creates barriers to AOD addiction recovery by reducing the ability of a person to access AOD addiction treatment, and stigma disproportionally affects ethnic and gender minorities placing them at higher risk of HIV and Hepatitis C infection, violence, and statutory interventions (Clarke et al., 2016; Csiernik & Rowe, 2003; McKim, 2014). Stigma exists as a broader societal concept which can lead to internalised and intra-group stigma (Gunn & Canada, 2015), stigma is also an issue within AOD treatment and social services (Brener et al., 2010; Butler & Sheridan, 2010). To negate stigma, international research suggests that people with lived experience of AOD addiction have a greater role in educating and training those in the health, AOD and social service professions (Roussy et al., 2015; Shepherd & Pinder, 2012).

The alcohol and other drug workforce

This section explores the role of the AOD workforce in contributing to, or creating barriers to, AOD addiction recovery because AOD services can have a significant impact on a person's recovery journey. The philosophical underpinnings of the AOD workforce and the AOD peer workforce are explored, the strengths and limitations of these workforces are outlined, information on the current composition of the New Zealand AOD workforce is given and suggested best practice methods for this workforce are discussed.

An international perspective of the AOD workforce

New Zealand's AOD workforce is diverse and consists of multi-disciplinary teams (MDT) consisting of professions such as: social work; occupational therapy; nursing; psychiatry; and the peer workforce (Te Pou o te Whakaaro Nui, 2014). As noted earlier, the AOD sector has been dominated by a disease based ideology that posits addiction as an uncontrollable pathological disorder. The meaning of this is that the responsibility of care needs to sit with the AOD addiction professional and the option of self-governance needs to be removed from the person (Szott, 2015). This approach has faced some significant changes in recent years with the development of recovery oriented approaches. These approaches are based on a person's right to choose their own recovery pathway, with the professional's role in that process being to provide a menu of options and support the person to set and achieve holistic recovery goals (Bassuk, Hanson, Greene, Richard & Laudet, 2016). This rhetoric has created space for the growth of a peer workforce as well as more opportunities for non-medical professionals to participate in the AOD sector (Te Pou o te Whakaaro Nui, 2014). It has also led to an increase of research into the strengths and limitations of the AOD workforce and how these factors impact on people recovering from addiction (Butler & Sheridan, 2010; Deering et al., 2011; Pulford, Adams & Sheridan, 2011; Sheridan, Goodyear-Smith, Butler, Wheeler & Gohns, 2008; Walters, Raymont, Galea & Wheeler, 2012).

While the AOD sector world-wide has been through significant growth and diversification, an Australian research project identified that staff still had "negative unconscious attitudes" (Brener et al., 2010, p. 492), and that clients of the services found that staff who disclosed lived experience of addiction were better able to interpret their issues, and better able to provide non-discriminatory treatment (Brener et al., 2010). Negative attitudes toward people with AOD addictions has also been an issue for social workers, Richardson's research on social works' inability to work with clients misusing alcohol (2008) and Galvani's research into social works' inability to work with clients misusing a broader range of AODs (2007), both identify gaps in social work education. This is a significant issue for social workers who are increasingly required to work with people who have AOD issues (Nelson, 2012).

An international perspective of the peer workforce

The international development of the peer workforce has led to the promotion of the rights and needs of people using AOD services, the peer workforce being distinctly different from people with lived experiences working as health, AOD or social service professionals. Peer workers are employed in roles where lived experience of AOD addiction is actively disclosed and the mutual experience between peer worker and person seeking support is utilised as a therapeutic tool (Alberta, Ploski & Carlson, 2012). The foundation of the peer workforce is recovery oriented systems of care that seek to empower a person to lead their own recovery journeys, enabling them to achieve satisfaction in their lives (Alberta, Ploski & Carlson, 2012). These systems have

theoretical foundations in psychological practice and highlight the "roles of social support, empathy, and therapeutic relationships" (Reif et al., 2014, p. 854). It is possible to implement peer led, recovery oriented philosophies across all levels of AOD services, from acute inpatient care to community based drop-in centres. It is a system of care that offers an alternative way of supporting people, compared to traditional behavioural health models that posit the healthcare professional as the expert and the patient as a passive recipient of treatment. This provides an opportunity to build a therapeutic relationship with minimal power imbalance and hierarchy (Alberta et al., 2012).

Pantridge et al. (2016) define peer workers as "individuals who have personally experienced treatment for a substance use disorder (SUD) and are in recovery; they provide services and support to others in recovery from addiction within a recovery-oriented system of care". Peer services support people with a range of practical daily tasks such as: managing a household; budgeting; nutrition; finding employment; and sustaining tenancies (Boisvert, Martin, Grosek & Clarie, 2008). The different types of support provided by peer services have been categorised as informational support, instrumental support and affiliation support, that can be provided during treatment, during transition periods and during recovery management (Pantridge et al., 2016; Reif et al., 2014).

The peer philosophy has a well-established history in AOD support systems, it is a philosophy that started within twelve step programs that have existed since the early 1930's (Krentzman et al., 2010). Twelve step programs

provide peer led, community based spaces for people to share their AOD

addiction and recovery experiences. This approach to AOD addiction recovery

has extended beyond community based support groups to AOD treatment

services (Pantridge et al., 2016), with international research showing the value

of the peer workforce and the positive impact that it has on people in their

recovery journeys. Dugdale, Elison, Davies, Ward and Dalton (2016) also found

that people with an AOD addiction were less likely to relapse, and more likely to

complete a self-help program if they had a peer support worker.

There is however a lack of evaluative studies done on the successes of

peer led programs, the researchers suggest that this could be a reflection of a

wider systemic belief that peer workers are likely to relapse at some point in

their employment (Dugdale et al., 2016). The belief of research participants that

peer workers in the AOD sector would relapse, persisted within clinical and peer

teams despite there being no research to justify this belief. In fact, what the

researchers found was that peer workers are more likely to be successful in

recovery because of the work they were engaged in, due to the

reconceptualisation of the self that happened once the person was in

meaningful employment (Dugdale et al., 2016). Pantridge et al.'s (2016)

research exploring the roles of peer workers in addiction services highlighted

the discriminatory beliefs that exist about people with lived experience of AOD

addiction, even once they have been employed in meaningful employment.

These beliefs are problematic as they have the potential to increase

experiences of stigma and discrimination, and create barriers to AOD addiction

recovery (Pantridge et al., 2016; Szott, 2015).

Participant experiences in this study closely aligned with Dugdale et al.'s (2016) research showing that being employed in a peer role strengthened that person's recovery. Discussion during academic supervision identified an additional piece of research that explored the concept of the redemptive self in relation to people who had been gang members in New Zealand, who then went on to participate in helping professions once they desisted from gang membership (Radak, 2016). This is supported by other research showing that the ability to successfully construct a redemptive self increased a person's ability to maintain sobriety (Dunlop & Tracy, 2013), and that the use of story-telling in twelve step groups is a process that helps a person re-define the self, which subsequently increases the likelihood that they will remain in AOD addiction recovery (Lederman & Menegatos, 2011).

The AOD workforce in New Zealand

As noted earlier the AOD workforce in New Zealand has followed international trends in that it has become diversified with many different professions working together in MDT teams. This also includes a peer component, however New Zealand's peer AOD workforce is relatively small, only making up 2% of the AOD workforce (Te Pou o te Whakaaro Nui, 2014). Te Pou o te Whakaaro Nui's overview of the adult mental health and addiction workforce conducted in 2014, identified that the largest cohort of professionals working within the AOD sector are support workers, followed by nurses, allied health professionals, administration and management, and medical staff, with

the two smallest portions of the workforce being peer workers and cultural advisors (Te Pou o te Whakaaro Nui, 2014). This survey did not include the population of lived experience practitioners who are employed in AOD, other health, or support work positions as its own distinct category for investigation. The survey also identified that the largest provider of AOD services were District Health Board's, where 79% of Full Time Equivalent (FTE) workers in the workforce are employed. They identified that the medical professions occupy over half of the AOD workforce with 56% FTE positions in the workforce (Te Pou o te Whakaaro Nui, 2014).

The research done in New Zealand on the AOD workforce strengths and limitations gives insight into: the failure of OST services to transfer care of people who are considered stable in treatment to their GP (Sheridan et al., 2008); the lack of training for pharmacists dispensing medication to people receiving OST (Walters et al., 2012); the discriminatory views that primary healthcare practitioners have of people who are considered to be actively seeking prescription drugs from their GP service (Butler & Sheridan, 2010); and an investigation into medical professionals who are using their professional roles to access opioids for personal use (Chisholm & Harrison, 2009).

Alongside this sits a second cohort of research that explores the effectiveness of AOD services from the perspectives of those using the service, and from the perspective of those working in the service. The first is an evaluative piece of research by Deering et al. (2012) who interviewed people using OST services and found that what was needed in OST services was

greater consumer input, the removal of excessive paternalism, changes in service philosophies and staff attitudes, and matching holistic interventions to the specific needs of the people attending the service. The second piece of research conducted by Deering et al. (2011) sought feedback from the professionals working within OST services and the people receiving support from the services. This research highlighted similar issues but additionally identified staff attitudes and a lack of quality training and education as a significant issue (Deering et al., 2011). Lastly, Pulford, Adams and Sheridan (2009) conducted evaluative research with a wider scope, looking into what support people using AOD services wanted. This research found that the quality of the therapeutic relationship was the most important factor for people seeking support from AOD services, followed by basic facts about AOD misuse and harm reduction advice (Pulford et al., 2009).

The peer workforce in New Zealand

Compared to the wider AOD workforce, the peer workforce in New Zealand is under-researched, with no tertiary educational pathway and no professional body providing a registration option. This workforce does have one main guiding document published by Te Pou o te Whakaaro Nui (n.d.) providing a set of competencies for the mental health and addictions peer workforce. This document was intended to be the foundational document for aspects of the peer workforce including, training purposes, service development, and curriculum development. The peer values underpinning the competencies outlined in the document are mutuality, experiential knowledge, self-determination,

participation, equity, recovery, and hope (Te Pou o te Whakaaro Nui, n.d.). The competencies for the peer workforce are designed to be easily understood and applied, with the opportunity to improve competencies beginning with essential competency levels, then moving upwards to; peer practitioner, peer manager and peer leader.

Even though there are strengths within this document in the way that it provides an adequate definition of peer work, the limitations are; that the document assumes that the mental health and addictions peer workforces are homogenous, having the same definitions applied across both workforces and the same developmental needs (Te Pou o te Whakaaro Nui, n.d.). As well as the lack of competencies specific to the AOD peer workforce there is also a lack of acknowledgement of the diverse roles within the peer workforce (Te Pou o te Whakaaro Nui, n.d.). The document only provides two sets of competencies, one for peer support workers and one for consumer advisors, all other roles are expected to follow a generic set of competencies (Te Pou o te Whakaaro Nui, n.d.). While the AOD peer workforce does receive some recognition via this national competency framework, the lived experience workforce defined as those practitioners who have lived experience of addiction and now work as a qualified health, AOD or social service professionals, do not receive any attention in the research or grey literature explored in the scope of the literature review.

The AOD workforce has the ability to be a significant contributor to AOD addiction recovery and international research has identified that this is especially true of the AOD peer workforce. The strengths of the workforce include: the way that AOD professionals build therapeutic relationships based on autonomy, respect and unconditional positive regard; for peer AOD professionals this also involves processes of self-disclosure and mutuality. However, research has also identified that there is not an effective balance between medical staff and other professionals (such as social workers) in AOD support services, and that some staff within AOD services hold views and attitudes about people with AOD addictions that create barriers to AOD addiction recovery. Due to the lack of research in New Zealand on the AOD peer workforce, it is not possible to establish if the New Zealand AOD peer workforce aligns with the successes of this workforce identified in international research.

Chapter summary

Understanding what works in AOD addiction recovery is more important now than ever for New Zealand. The population is growing and ageing, as is the health workforce, meaning that the demand on health services will continue to grow (Ministry of Health, 2012). The previous New Zealand Government has provided a plan intended to re-focus the health workforce on what works in addiction recovery; a life course approach and greater recognition of holistic and sociological health needs and issues. This action plan seeks to give power back to communities to decide what works for them in the recovery process

(Ministry of Health, 2012) and aligns with the purpose of this thesis; to give a voice to those who have been the most marginalised, stigmatised and discriminated against but who also have the greatest knowledge of AOD addiction, treatment and recovery in New Zealand.

The literature review provides an understanding of what existing literature shows contributes to, and creates barriers to, successful AOD addiction recovery both internationally and in New Zealand. Barriers to AOD addiction recovery include: a lack of holistic AOD addiction support; the criminalisation of people with AOD addictions; societal and institutional stigma; and inadequately trained health, AOD and social service professionals. Contributors to successful AOD addiction recovery were identified as: sociologically based AOD addiction treatment options; the decriminalisation of all illicit substances; workforces with a good balance of AOD, medical and social service staff; education and training offered by people with lived experience of AOD addiction; therapeutic relationships based on autonomy, respect and unconditional positive regard; and effective utilisation of the peer AOD workforce. The literature review also identified a gap in New Zealand research, whereby no research within the scope of the literature review had utilised the lived experiences and professional knowledge of those people working within the addiction sector, who have lived experience of AOD addiction, treatment and recovery in New Zealand. These contributors to and barriers to AOD addiction recovery will be explored in the subsequent chapters which present the results of the thematic analysis.

Chapter Three: Methodology and Methods

This chapter outlines and justifies the methodology and methods used in this research project. The chapter begins with a brief explanation of the ontology and epistemology of the research project and how that aligned with the researchers' current qualifications and experiences as a registered social worker; next, the use of constructivism in the research project is explained. Finally, the considerations given to the researchers 'insider' status are outlined, followed by an explanation of the use of purposive sampling to recruit participants, the use of semi-structured interviews, the data analysis process is described, and finally the ethics application process is outlined.

Theoretical framework

The ontological beginnings of this research (ontology being how the researcher believes that knowledge is generated), were based in the "researchers' assumptions, existing knowledge, and reasons for engaging in research" (Starks & Brown-Trinidad, 2007, p. 1372). An exploration of these assumptions was considered a necessary function of this research project because the researcher aligns herself with the belief that research is always a subjective process (Watson, 2005). This exploration elicited that the researchers' ontological foundations were based in the social work profession. A profession that values the subjective experiences of individuals but requires practitioners to have knowledge and understanding of the historical and socio-

political context of the individuals they work with (Nelson, 2012), as well as promoting "the social and economic participation of groups that lack access to full participation" (Engel & Schutt, 2005, p. 9). Social workers seek to understand the unique, rich and diverse life experiences of the people that they work with (Nelson, 2012) and the systems they operate in, be it familial, societal or systemic (Engel & Schutt, 2005, p. 11). Additionally, Engel and Schutt state that the goal of social work research "is not to come up with conclusions that people will like, to find answers that make our agencies look better or that suit our own personal preferences" (2005, p. 18).

For the researcher this understanding also came with a need to respect the individual as the expert in their own life, meaning that any research paradigm would need to allow for the participants to be an informant in the research process, rather than an object to be researched (Gergen, 2009). The epistemological approach and corresponding research paradigm needed to match these requirements and align also, with "the desired product of" (Starks & Brown-Trinidad, 2007, p. 1372) the study. The desired product of this study was to understand the unique, diverse, in-depth experiences of AOD practitioners in New Zealand who also have their own lived experience of AOD addiction.

The epistemological approach was developed with an understanding that epistemology is the framework the researcher uses to analyse and interpret research data, in order to make informed conclusions and recommendations regarding the research topic (Starks & Brown-Trinidad, 2007). The epistemological foundation and corresponding research paradigm for this

research project was constructivist, and the methods employed were qualitative (data was gathered via interviews, and understood by thematic analysis). Qualitative research was considered an effective research approach to understand "social life in its naturally occurring, uncontrolled form" (Cohen & Crabtree, 2008, p. 422). Alvesson and Skoldberg extend this definition and define qualitative research as a process that posits the researcher as an observer in the world, transforming everyday practices into a series of representations, allowing for an analysis of these practices from a naturalistic approach and attempting to understand the meanings that people bring to them (2009). It is also a valuable approach for health researchers to take when delving into questions of meaning, exploring systemic processes, understanding barriers and facilitators for success, and identifying the reasons for the success or failure of different interventions (Starks & Brown-Trinidad, 2007). The selected paradigm was the best fit for the "scope of the study, the nature of the topics, the quality of the data and the study design" (Starks & Brown-Trinidad, 2007, p. 1374).

Constructivism

Constructivism is defined as a qualitative methodology that seeks to "establish an understanding of people's lives, experiences and the subjective meanings that could explain the process of decision making and action" (Broom & Willis, 2007, p. 24). Constructivism also recognises that reality is constructed, changeable and non-objective (Broom & Willis, 2007; Gergen, 2009; Watson,

2005) and it is individuals that construct their own reality by "associating 'meaning' with certain events or actions" (Broom & Willis, 2007, p. 25). The purpose of this research was to understand participants' experiences of AOD addiction, treatment and recovery in New Zealand, exploring in-depth what their journey through recovery meant to them and how their actions had been influenced by societal institutions and ideologies (Gergen, 2009). Given this, the researcher considered that constructivism was the appropriate paradigm to base this research project in because:

> by approaching an issue from this position, a researcher can establish regular patterns and irregularities in the meanings associated with particular life events. For example, there may be social patterning in terms of whether or not particular signs and symptoms are interpreted as an illness, whether professional help is sought, and how the chance of a cure is perceived (Broom & Willis, 2007, p. 25).

A constructivist approach allowed for the exploration of the experiences of individuals, their relationships with others and wider institutions, through language. It was a way to elicit knowledge from those participating in the research, knowledge that existed in that present time and context but spanned a lifetime of experiences, and was recalled through memories (Alvesson & Skoldberg, 2009). The research was grounded in a postmodernist approach that rejected social coherence and linear causality and instead favoured multiplicity, plurality, fragmentation and indeterminacy (Prasad, 2005). There was no attempt in this research to find a universal truth with the researcher

advocating for AOD addiction recovery to be recognised as an individual experience needing individualised responses. Generalisable results would have been inappropriate given the research paradigm and also, "so often the cost of attempting to generalise is that we do not see and investigate those aspects of a process that do not fit our presuppositions about a particular phenomenon" (Broom & Willis, 2007, p. 26).

Not only was constructivism an appropriate paradigm to use when exploring participants' experiences of AOD addiction, the use of constructivism filled a gap in New Zealand research highlighted in the literature review which showed a plethora of New Zealand led positivist addiction research but very little qualitative research. This is likely because AOD addiction is still defined internationally and locally as a health issue, aligning with Broom and Willis' claim that positivism still forms the "paradigmatic basis for much health research today" (2007, p. 19). A claim corroborated by Cohen and Crabtree who also state that positivism is the central paradigm in health research (2008). Prasad states that "this hijacking of routine problem solving by technical experts has some serious and undemocratic ramifications for society" (2005, p. 142), because only those with a certain level of knowledge are able to contribute to knowledge generation. Meaning that inadvertently, those who are marginalised in society but who hold unique and valuable knowledge about social issues, will not have the ability to add their stories and experiences to academic literature (Prasad, 2005).

Despite this, the purpose of this research project was not to engage in the debate of which methodological paradigm was best, as such arguments are ideological and neither positivist nor constructivist methods should be viewed as superior. Instead, the researcher sought to complement existing positivist addiction research by providing a unique perspective on addiction that helps others to understand what "events meant to research subjects: how people adapt and how they view what has happened to them and around them" (Broom & Willis, 2007, p. 25). This approach is supported by Broom and Willis who argue that "no description could be complete without a qualitative understanding of the subjective meanings of social actors involved in social interactions" (2007, p. 19). It is this theoretical framework that will inform the investigation and answer the question: What works in recovery? Alcohol and other drug professionals lived experiences of addiction, treatment and recovery in New Zealand.

Insider research

In this research, processes needed to be put in place to combat any bias that existed because of the researchers' insider status. This involved acknowledging the researchers own values and interests as a social worker and lived experience practitioner. The main belief of the researcher was that academic research should seek to confront "the many injustices and oppressive practices that pervade contemporary societies" (Prasad, 2005, p. 141), and that a qualitative researcher cannot collect and observe facts objectively as no part

of the research project is neutral and unbiased (Broom & Willis, 2007; Cohen & Crabtree, 2008; Gergen, 2009; Watson, 2005).

To mitigate harmful bias a research journal was kept by the researcher throughout the research process, this allowed the researcher to be "honest and vigilant about her own perspective, pre-existing thoughts and beliefs, and developing hypothesis" (Starks & Brown-Trinidad, 2007, p. 1376). The researcher identified that there was a need to recognise and put aside (but not abandon), her own values and beliefs regarding AOD addiction, "with the analytic goal of attending to the participants accounts with an open mind" (Starks & Brown-Trinidad, 2007, p. 1376).

Each entry into the research journal was considered to be a memo, these served the function of establishing an audit trail which documented the researchers thoughts, reactions and emerging impressions allowing for greater ability to engage with and analyse the data in the thematic coding process. (Rubin & Babbie, 2013). This process also enabled the researcher to remain aware of her existing knowledge and belief framework. Through reflective processes the researcher could welcome any challenge to this framework that arose throughout the data collection stages. Any emergent bias was viewed as "something used actively and creatively through the research process" (Cohen & Crabtree, 2008, p. 333).

Participant recruitment

Once the literature review and ethics approval process had been completed the researcher began recruiting research participants (Appendix C). The researcher used the method of purposive sampling, a method whereby research participants are selected by identifying unique qualifiers for participation (Broom & Willis, 2007). In this case participants must have had lived experience of AOD addiction, treatment and recovery in New Zealand and they must also have been employed in the AOD sector in New Zealand within the last five years. The reason for this selection criteria was to reduce the risk that might have come from interviewing people who were still actively addicted to AODs, for example if a participant had disclosed criminal behaviour that the researcher would have been obligated to report due to ethical requirements. The researcher recruited participants by placing an advertisement in the Matua Raki addiction sector bulletin (Appendix D), potential participants were able to email the researcher directly and at that point they were sent the information sheet via email. Through contact with potential participants an unanticipated snowballing effect took place whereby interested participants notified other potential participants about the research. These potential participants then made contact with the researcher via email and the information sheet was sent to them via email by the researcher.

The researcher sought to recruit six to eight research participants for one on one, hour long, semi-structured interviews conducted face to face, via Skype, or phone. Qualitative researchers commonly only recruit small sample

sizes (Royse, 2003) and six to eight participants was considered an appropriate sample size because, "… an individual person can generate hundreds or thousands of concepts, large samples are not necessarily needed to generate rich data sets" (Starks & Brown-Trinidad, 2007, p. 1374). The outcome of participant recruitment was that eight research participants were recruited and each participant met the selection criteria.

Interview methods

The qualitative method of semi-structured interviewing was chosen as the primary data collection method because it was consistent with the research paradigm. It provided "a means for exploring the points of view of … research subjects, while granting these points of view the culturally honoured status of reality" (Shaw & Gould, 2001, p. 143). Alongside this, it allowed the researcher to observe patterns across the groups behaviour (Broom & Willis, 2007). The method of semi-structured interviewing created a naturalistic conversational setting. A process that imitated real life, encouraging interactions that gave the researcher the opportunity to understand the everyday meanings that participants attributed to their experiences (Arksey & Knight, 1999). The setting that the researcher tried to create was one where the researcher provided only minimal steerage in the interview, allowing the participant to discuss the aspects of the broader topic that were important to them (Arksey & Knight, 1999). The interviewer purposefully created a flexible interview schedule (Appendix G) that not only created flexibility within the interview, but also flexibility between interviews. This allowed for the addition or subtraction of questions or topics

that were, or were not, relevant to subsequent participants (Rubin & Babbie, 2013).

What this did throughout the interviews was create a space where a mutual understanding developed between researcher and participant through the in-depth exchanging of ideas (Gergen, 2009). The longest interview lasted an hour and a half and the shortest lasted forty minutes, with the average time for the interviews being one hour. The researcher readily accepted the need to form a supportive, personal connection to participants in the interview discussions. This was an important process for this research project because participants were being asked to share their experiences of AOD addiction and recovery. Despite the cautionary measures taken to ensure participant and researcher wellbeing no known issues regarding participant or researcher wellbeing arose during the duration of the interviews.

Data analysis

Interviews were recorded using an audio recording device and transcribed verbatim by the researcher. A method commonly used in qualitative interviewing, as it allows the researcher to stay focussed on the research participant during the interview but accurately record everything that was said in the data transcription stage (Rubin & Babbie, 2013). The opportunity given to participants to read and correct, if necessary, their transcribed interviews was an important aspect of the data collection as it increased the rigor and trustworthiness of the research, by ensuring that the participants subjective

realities had been depicted in a way that was accurate to them (Rubin &

Babbie, 2013). To add depth to interview data the researcher also reflected on

notes that were written as soon as possible after the interview ended, this was

done to capture extra details from the interview such as; mood and body

language, that the audio recording was not able to capture (Arksey & Knight,

1999).

Data from interviews were analysed using inductive thematic analysis,

described by Shaw and Gould as "a commitment to the imaginative production

of new concepts, through the cultivation of openness on the part of the

researcher" (2001, p. 7). Data analysis began during the transcription of

interviews, the researcher was able to familiarise herself with the data and

began to identify some broader themes. At all stages of the thematic analysis

the researcher kept notes in the research journal. This provided a reflective

space where the researcher could unpack her own assumptions about

emergent themes but also begin to identify the patterns and broader thematic

story in the data.

Once transcription was completed the researcher went through each of

the eight transcriptions line by line and colour coded all emergent themes.

These themes were named and recorded in an Excel spreadsheet which kept a

tally showing how many times each theme appeared, and which themes

appeared in which transcript, this allowed the researcher to identify the

dominant themes. Once the dominant themes were identified some of the

smaller themes were able to be grouped into the dominant themes, while other

themes were deemed irrelevant as they had appeared in interview transcriptions only a few times. This process allowed the researcher to create a thematic map that showed that the dominant themes identified were largely grouped as contributors to, and barriers to, recovery and that this could be categorised further, into themes that were experienced by participants in their own AOD addiction recovery journey, and themes that were more relevant to their experiences as AOD professionals (Braun & Clarke, 2006).

Ethics approval

A full ethics application was submitted to Massey University Human Ethics Committee (MUHEC), was considered by the Human Ethics Southern A Committee, and final confirmation of ethics approval was given on the 17th August 2017 (Appendix A). The ethics application process was completed under the guidance of academic supervisors Dr Michael Dale and Ms. Lareen Cooper. This process also required the researcher to ensure that this research adhered to the Massey University Code of Ethical Conduct for research, teaching and evaluations involving human participants (Massey University, 2015).

Ethical framework

An ethical foundation to this research was the most important aspect of the research design because social research faces the task of conducting research to create positive social change and because of this, the rights and welfare of participants was the researchers main concern (Arksey & Knight, 1999). A sentiment also required of social work researchers by the Aotearoa New Zealand Association of Social Workers (ANZASW). ANZASW state in their Code of Ethics, that social work researchers must promote the wellbeing and dignity of participants, ensure that informed consent is sought, have approval by the relevant ethics committee and uphold the principles of Te Tiriti O Waitangi (ANZASW, 2007). The researcher believed that the research should be carried out in a way that was "respectful, humane, and honest" (Cohen & Crabtree, 2008, p. 333) as well as being empathetic, collaborative and grounded in the notion of service (Cohen & Crabtree, 2008).

Ethical considerations

An analysis of key ethical concerns identified a small potential for risk of harm to participants who were being asked to recount potentially traumatic experiences. There was also a small risk to the researcher that was identified, as hearing participant experiences had the potential to be traumatic for the researcher. The use of external supervision and existing AOD addiction recovery support systems such as twelve step groups and counsellors, were identified as sources of support to mitigate any trauma that was triggered for

research participants or researcher. Additionally, confidentiality was considered an ethical concern and the researcher identified processes that would keep participant identities confidential. This included the use of locked cabinets for consent forms, password locked IT devices that contained audio recordings and interview transcripts, as well as the use of pseudonyms in place of participants names within the published thesis. Ethical practice regarding direct contact with, and the impact of the research on, Tangata Whenua was also considered. The researcher utilised cultural supervision within her workplace to ensure that the interests of Māori were a key consideration throughout the research process (Appendix B).

Consent

Consent was gained from participants through use of a participant consent form (Appendix F). The process for recruitment involved potential participants being sent an information sheet and consent form by email, with the offer that they could call or email the researcher with any questions regarding participation. Participants needed to provide the researcher with a signed consent form, acknowledging that they read and understood the information sheet, before the interview could commence. Before each interview the researcher ensured that participants had read and understood the information sheet, and asked participants if they had any further questions or concerns before commencing the interview.

Participant rights

Participants in this study had the right to withdraw from the study anytime up until the point of thesis submission, this included stopping the interview if they felt they needed to. Participants were also given the opportunity to provide feedback and amend their interview transcripts. Two participants responded to the invitation to review their transcripts and stated that they did not wish to make any amendments, one participant did make emendations which were included in the final thesis, and five participants did not respond to the invitation to provide feedback on their transcript. Participants had the right to expect confidentiality in all matters, including not being identifiable by quotes published in the final thesis. Participants had the right to ask any question about the research before agreeing to participate, and participants had the right to choose the space most comfortable for them for the interview to take place in. Participants also had the right to have access to a summary of the research findings, this summary was sent to participants after the thesis was submitted.

Researchers responsibilities

The researchers responsibility was to ensure that participants met participant sample criteria, that participants had read and understood the information sheet (Appendix E), that participants provided a signed consent form before the interview took place, that participants felt comfortable in the interview space they had selected, and understood that they could stop the interview at any time. The researcher was also responsible for participant

wellbeing in the instance that the participant knew the researcher professionally. In order to mitigate any ethical issues, the researcher openly disclosed in the information sheet her identity and job title in her current workplace. This empowered potential participants to choose whether to participate, knowing from the outset the researchers identity and role in the AOD sector. This process was deemed necessary by the researcher and both supervisors, in order to mitigate any conflict of interest that may arise from the researcher having a previous professional connection with potential participants (Costley, Elliott & Gibbs, 2014). Additionally, participant confidentiality, including secure storage of all data and written information that could identify participants, the destruction of audio recordings and interview transcripts following the examination of the thesis, ensuring that participants had the opportunity to review their interview transcripts and make any amendments that were requested, were the researchers responsibility. As was ensuring that participants stories and experiences were reflected fairly and accurately in the final research report, and that participants received a summary of the findings once the thesis had been submitted.

Chapter summary

The methodology and methods chapter provided an outline of the theoretical framework of this research, exploring the consideration that took place in choosing the most appropriate methodological approach for the research topic. The research design was outlined, with the selected methods and methodologies being; qualitative and constructivist, using semi-structured

interviews to gather data and thematic analysis to analyse data, and ethical

considerations were also discussed. These methodological foundations

provided a basis for the presentation of the data that was collected during the

research process, the results of which are presented in the next two chapters.

Chapter Four: Lived experiences of AOD addiction, treatment, and recovery

This chapter outlines the results from the research which are displayed in two chapters: the first outlines the themes that were experienced by each participant in their own AOD addiction recovery journey as follows: stigma; defining your own recovery; reconstruction of the self; the role of social learning; opportunities for career progression; and specific populations including youth, people with co-existing mental health and AOD addiction issues, women and families. The second chapter involves participants experiences as AOD professionals and presents the following themes: strengths and limitations of the social service and AOD workforce; addiction and the law; and barriers to accessing AOD support services.

Each finding is illustrated using participant quotes, highlighting the barriers, and contributors to, AOD addiction recovery. These participants had a range of personal and professional experiences and were able to articulate clearly their experiences, thoughts and opinions on the topic - What works in AOD addiction recovery in New Zealand? The participants ages ranged from twenty-two years old to fifty years old and participants had been in AOD addiction recovery from five years to forty years. Participants had experienced AOD addiction, treatment and recovery in New Zealand but also in other countries. Participants had experienced addiction to a range of drugs including: alcohol, amphetamines; opioids; cannabis; ecstasy; LSD; and pharmaceutical

drugs such as temazepam. Participants held a range of different professional qualifications these included: Bachelor degrees; Post-graduate diplomas; Master's degrees; and PhDs. Participants had also experienced employment in a range of employment settings including: non-government organisations (NGOs); the Corrections System; AOD inpatient rehabilitation services; DHB hospital and acute care settings; national leadership positions; in self-employed counselling roles; and as lecturers in New Zealand universities and polytechnics.

Stigma as a barrier to all stages of recovery: Active addiction, early recovery, and maintaining recovery

All of the participants experienced stigma that created barriers to AOD addiction recovery, barriers to participation in the workforce, barriers to participation in communities, and barriers to participation within their own peer recovery groups. Stigma had also been internalised by two participants who then proceeded to express ideas that were stigmatising to others. The overarching theme of stigma was broken down into four sub-themes: stigma in addiction and early recovery; intra-group stigma; stigma in the workplace; and internalised stigma.

Stigma in addiction and early recovery

Participants' spoke of being stigmatised while they were still addicted to AODs and how this prevented them from reaching out for help, and participate meaningfully in their communities. Participant two recalled being isolated from her non-addicted peers, *"if they found out that I was using substances it is just like, stay away from them you cannot be friends with them"*. Participant three also detailed experiences of stigma that created barriers to her participating in her local community, *"the community put a petition up against me buying a house, there was a whole lot of stigma around me"*. Participant three further explained that:

> *There is a real lack of understanding, lack of compassion for people with addiction issues, it still blows me away on social media when people can comment on a person with an addiction issue and that vast array of comments that happen, that whole, it is their fault stuff.*

Stigma also created barriers for participants when trying to access professional support, participant five explained:

> *I have had terrible experiences in New Zealand, my second bout of pancreatitis just as I was being admitted my Father happened to mention to the admitting doctor oh* [he has] *been addicted to morphine and heroin and methadone in the past, as a way of just letting him know and they just refused to give me any pain relief.*

Participant three discussed being stigmatised by staff in an AOD service, *"when they found out that a referral had gone through for me they really did not support that referral"* … *"they thought I was a bit of a waste of time".* This participant continued to be stigmatised by AOD staff in a detox centre, she remembered being given medication by the staff stating that *"they not only gave me an intravenous lot of it they gave me tablets as well and then accused me of using".* Participant one described the stigma that was perpetuated within a residential treatment centre, *"…had a hierarchical structure that was all about um, if you want it enough you will change your behaviour and then you will get to be a tier three and then bully the tier twos".*

The experiences of stigma expressed by all participants were multi-layered, complex and pervasive. Stigmatisation began while participants were still using AODs and the stigma that they faced significantly impacted their recovery journey, by creating barriers to being able to participate in their communities. Participant two illustrated this through her experiences as a young person with AOD issues, the community around her, rather than being concerned for her wellbeing, instead ostracised and excluded her. The result being that participant two became more entrenched in a community of people where substance use was the norm, as this was where she could find acceptance.

Intra-group stigma

Intra-group stigma created barriers to career progression once participants had entered AOD addiction recovery. Participants one and six were discouraged from entering the AOD sector as this career was seen by peers as unoriginal. With participants' holding the view that every single person who entered AOD addiction recovery wanted to then go on and save other people with AOD addictions. It was also considered by peers to be a potential trigger for relapse. Participant six remembered, *"in NA they would say if you sit in the barber's chair long enough you will get a haircut and I got a lot of flak from people in NA about working at the needle exchange".* Going on to explain, *"they were just making me into this homogenous person the same as any other addict, that is the thing that can go a little bit wrong in twelve steps".*

Once participants entered recovery they continued to face stigma, this stigma was experienced within AOD treatment services as well as within peer led twelve step groups. The impact this had on participants was that they were less likely to seek help when they needed it, their treatment adherence diminished, and their personal agency when defining recovery and career goals was lessened. For some participants this stigma reinforced and internalised the notion that there is only one successful recovery pathway for all people with AOD addiction.

Stigma in the workplace

Participants discussed how stigma in the workplace prevented them from practicing self-disclosure. Participants also had their privacy breached by colleagues, participants' professional opinions were not respected, and participants were exposed to discriminatory language by other professionals. The effect on participants was that they felt excluded from their workplaces and unmotivated to continue working in their chosen professions. Participant six experienced a breach of privacy explaining:

> *…I had this horrific experience this one day when I turned up to work and the detox nurse was like hahaha have a look in the cupboard, so I had a look and there was my file from the mental health team because somehow my AOD history was there and they thought it was hilarious.*

Participant seven found that her Manager refused to accept her professional opinion, "*…he said you are only saying that cos you are in twelve step-recovery, and that is not true, and so it was actively anti, and my experience as a worker was not taken into consideration".* Participant five was exposed to discriminatory language by other registered health professionals who were stigmatising their own methadone patients. The participant explained that they were "*treating them like scum of the earth basically and they will never recover, and they will never get off".* Participant four explained the impact that stigma in the workplace has, *"it has taken its toll there have been times that I*

have thought, I cannot do this". Participant four explained that it has been the support of her family and friends, alongside her own ability to enact institutional change to reduce the stigma she faces within her own organisation that has enabled her to continue in the role.

For all participants, experiences of stigma continued throughout their progression in the workforce. This stigma persisted even once they had become skilled, qualified practitioners, and participants discussed experiences of being stigmatised by colleagues, managers and wider organisational systems. Participants recognised the potential negative implications of people finding out that they had lived experience of AOD addiction and faced a process of constant negotiation to validate themselves within their workforce. As well as having to predict and mitigate potential and actual stigma that might create barriers for them if they disclosed lived experience of addiction.

This was particularly relevant for participant four who has faced negative personal outcomes due to the constant stigmatisation that occurs within her team. What is concerning is that participant four is in a dedicated peer support role, yet she was the participant who experienced the highest levels of stigma within her workplace. Participant four spoke about having to fight for her role, even though peer roles are recognised internationally, as essential roles that add value to the experiences of people using mental health and AOD addiction support services. Participant four has had to justify and explain what her role is, why she does it and point out to colleagues that her client outcomes are all exceeding the targets set for the service.

Internalised stigma

The internalisation of wider societal and institutional stigma was identified in the analysis of the interviews in which participants expressed sentiments that stigmatised other AOD professionals with lived experience, creating barriers to their participation in the workforce. Participant one consistently expressed negative views regarding lived experience professionals who utilised their lived experience as a therapeutic tool. The lack of recognition that he had received for his clinical knowledge and therapeutic use of self-disclosure had tainted his perception of this style of practice, leading to him imposing his negative experiences on others. At one-point stating, "*I decided early on that that was a real lazy way of being a counsellor*", showing his lack of recognition of the value of the therapeutic use of self-disclosure. Comparatively, participant eight displayed evidence of internalised intra-group stigma whereby she believed that the only valid recovery pathway was abstinence based recovery in twelve step programs'. Participant eight had internalised twelve step ideologies to the point where she believed that they should be integrated into the workforce. Believing that "*they* [employees] *have to have a minimum of two years in recovery before they can supervise and I think people should be actively attending twelve step programs as well*".

Stigma had seemingly played a role in shaping some participant's views of other AOD professionals with lived experience. These participants appeared to lack the ability to respect each person's diverse recovery journey and the way

they may choose to utilise that in their own practice. Participant one illustrated this point when discussing using self-disclosure as a therapeutic tool. Despite having earlier acknowledged that self-disclosure is in fact a valid therapeutic technique that he has utilised in his own practice, and that in his experience clients prefer receiving support from an AOD professional that has lived experience, he viewed the use of self-disclosure as a therapeutic technique as a lazy way of practicing. He believed that by doing this, AOD professionals were cheating at their jobs.

Participant eight also expressed stigmatising views regarding those in the AOD sector who have lived experience. Participant eight is a person whose recovery pathway is based in twelve step philosophies and has had experience employing people with lived experience in a residential treatment service. However, participant eight was unable to express any acceptance that people with lived experience have multiple recovery pathways. Stating that as far as she is concerned, all AOD professionals with lived experience should be engaged in, and have to prove that, they are involved in twelve step support groups.

All participants recalled being a recipient of some form of stigma throughout their AOD addiction, recovery and professional career, with some participants showing evidence of internalised stigma and subsequent stigmatisation of peers. When discussing stigma, participants were more likely to recall having been stigmatised in the workplace than at any other time in their recovery and

the participant who had experienced the greatest levels of stigma within the workplace, was a person in a dedicated consumer/peer role.

Defining your own recovery

For each participant in this study the ability to define their own AOD addiction recovery pathway was the key to successful AOD addiction recovery. Each participant had a unique AOD addiction recovery pathway, highlighting the need for AOD support services to be able to provide a menu of options for people accessing support for AOD addictions.

Participant one knew from the age of sixteen that twelve step groups were the right AOD addiction recovery pathway for him, "*I did the twelve steps, I did the ninety meetings in ninety days I talked to my sponsor every day, I did the living the program pamphlet, which is a daily inventory thing, I did the daily reading thing*". Comparatively, participant two's AOD addiction recovery pathway was not one that included professional or peer based AOD addiction support stating that, *"[I] more did it by myself"*. Participant two knew what worked for her in her AOD addiction recovery and believed AOD addiction recovery should be *"…something that needs to be each individual person's choice on whether they are going to stay abstinent their whole life or maybe dabble in it and then become abstinent again or keep doing it until they die"*. Participant three explained that for her, learning and practicing basic life skills were what helped her succeed in AOD addiction recovery:

…that cleaning up had to happen on that level, was trying to keep myself

well, doing those basics, trying to get into a routine keeping some of the

skills that I had learnt, trying to build on those, going to meetings and the

stuff I learnt from there as well and I steadily did that for a year or two

and not much else.

Participant four chose to look after her holistic health through natural medicines and self-care, *"I chose to work with that naturally, herbalists, naturopaths, acupuncture"*. She explained that it is each person's right to decide what works for them in AOD addiction recovery, *"I am not pro or anti I am just so open minded about whatever someone wants to do"*. Participant five's academic study had led him to believe that AOD addiction was directly related to attachment issues stemming from childhood. Explaining that people with AOD addictions are using AODs to compensate for their attachment issues. He stated that, *"what works in recovery is connecting with lots of people"*. While participant six viewed her AOD addiction as a learned behaviour:

I still remember it clear as anything sitting out in the hallway of the

alcohol and drug centre I would have been all of twenty-three or twenty-

four, this little street kid who had left school at twelve or thirteen you

know had this horrific childhood… and she [AOD counsellor] *got me to*

draw these pictures and in the middle, was a beer bottle and my family

around it. So she just got me to draw something that represented my

family and it was this realisation that I was not like I was because of who

I was, it was because of the family I was in.

Participant eight recalled learning about the disease of addiction saying, *"for me it was a turning point because I learnt about the disease of addiction and I love the line you are not responsible for your addiction, but you are responsible for your recovery".* Participant seven articulated the need to respect the diverse AOD addiction recovery pathways that people take, *"there is many recovery paths right, there is no right one"* and participant one supported this sentiment saying, *"it is not about cookie cutter programs, it is about everyone's different everyone's an individual, who they are, where they come from, all of that stuff matters".*

In this study, every research participant had a unique pathway into and through AOD addiction recovery. Most participants acknowledged that the way to be successful in AOD addiction recovery, is to find the pathway that fits you best and have people around you who support you through that recovery pathway. Whether it is finding AOD addiction recovery in twelve step groups, going it alone with the support of friends, accessing naturopathic remedies, believing that AOD addiction is caused by biological changes in the brain, or that AOD addiction is a disease that will never be cured. For every participant in this study their view of AOD addiction and AOD addiction recovery is correct to them and their ability to live their AOD addiction recovery according to their own beliefs, is what helped them succeed in their AOD addiction recovery journeys. Most participants carried this philosophy with them in their careers as AOD professionals, allowing them to be reflexive in their practice, working from a

strength based perspective, respecting their clients decisions and empowering them to choose a recovery pathway that is right for them.

Reconstruction of the self

There were two groups of participants in this study, those whose reconstructed selves had been respected and valued by others (the reconstructed self being the process a person goes through to re-formulate how they view their own identity and situate themselves in their own lives), and those who had faced some form of stigma and discrimination when attempting to define their recoveries and themselves. The participants who were successfully able to reconstruct themselves actively adopted the role of the redemptive self, consciously giving back to their communities, challenging social norms and embracing the value of their lived experience. Those participants who became fragmented were not able to integrate their lived experience into their everyday life leading to a creation of two selves, one for the professional sphere and the other for their personal life.

The redemptive self

Six out of the eight participants felt they needed to support others who were experiencing AOD addiction once they entered their own AOD addiction recovery. Participant two explained, *"I knew quite early on I always wanted to*

do something that would kind of help people and benefit others". She also articulated how her work supported her in her own AOD addiction recovery, *"it can be really fulfilling sometimes it definitely keeps me motivated to continue being clean and continue not taking any kind of drug".* Participant three expressed similar sentiments and believed that the shared experiences of those with AOD addiction are valuable therapeutic tools. This understanding began with her involvement in twelve step groups and continued into her early career, *"it was a nice way of doing my own* [personal] *work and segue into doing my own* [professional] *work and then learning how to assist others with that".*

Participant quotes highlight the circular nature of the development of the redemptive self in which positive personal change is adopted, a desire to impart knowledge and support to others with similar lived experiences is felt and enacted, and then the process of providing support reinforces the persons positive changes thereby strengthening their own recovery.

The fragmented self

While six out of the eight participants integrated their lived experiences into their professional lives, two participants expressed a fragmentation of self in their interviews. Participant one talked about self-disclosure, articulating how this benefits clients yet when discussing personal beliefs, he held no value in this therapeutic technique. He also articulated that lived experience would negatively impact his career if he chose to work in one of the Government Ministry's. Participant one explained that he had been pigeon-holed into being a

lived experience practitioner and believed that he was not taken seriously as an AOD professional, despite being acknowledged as someone who had achieved great successes:

> *I had had a lot of awards and affirmation from that so I guess I was trying to seek affirmation that was from a different source, you know, it was about being a professional it was about being good at my job other than it just being, wow isn't it amazing that you got clean.*

Participant one was conflicted when trying to express why having lived experience of AOD addiction was not a valid therapeutic tool to use when working with people with AOD addictions:

> *I wanna make the biggest impact I can make on people suffering from addiction and if in order to do that disclosing the fact that I have lived experience is helpful then I will do it. If it is irrelevant then I probably will not bother doing it cos I have this little thing of making it on my own merits rather than getting my foot in the door because of this.*

Participant six could articulate this fragmentation more clearly than participant one as she had made a conscious decision to re-define herself separately: the professional; and the personal. This fragmentation occurred because of an awareness of the stigma that is imposed on those with AOD addictions:

I am still most comfortable when I am in an NA meeting or with sex workers because it is still my stronger identity so there is always this work that I do about managing my identity. Because I never reveal in these settings my true identity because they are not forgiving.

Participant six acknowledged the difficulty in managing this fragmentation:

It is still that negotiation for me of my old life and this new life I have and I never quite feel… I have been doing some work I did this psychodrama group last week like one moment I can be sitting out in that carpark dealing with my brother beside himself because some gang member wants to kill him or he is like oh my drugs are gone or can you ring the centre? Like all this stuff and then next minute I am like oh yes right well we are flying to [destination] *next week you know it is really hard to manage all these different dual lives.*

The psychological impact of stigma and discrimination on the participants in this study was an unexpected finding. Six out of eight participants expressed that they entered the AOD profession because of their lived experience and desire to help others. Those participants had been supported and nurtured by people around them as they were re-defining who they were as people in AOD addiction recovery, and as people who were AOD professionals. This group of participants embraced the role of the redemptive self, accepting that the reason for doing their job was because they wanted to help others. They could see the

value in mutual lived experiences, as well as the value that redemptive work adds to their own AOD addiction recoveries.

For two participants' however this was not the case, they illustrated clearly the impact that negative stigma and discrimination could have on a person with lived experience of AOD addiction trying to define themselves as people in AOD addiction recovery, and within the AOD sector as professionals. While both participants acknowledged that they entered the AOD workforce because they had a desire to help others, they both ultimately consciously chose to separate who they were in AOD addiction recovery, from who they were as AOD professionals. Participant six could articulate this more clearly than participant one who had a duality within his interview where he acknowledged the value of lived experience and at the same time discredited it as an invalid way of working. While participant six consciously chose a fragmented life because she could clearly envision the stigma that she would face if she embraced her lived experience within her professional sphere. For participant six this was a challenging process because she valued her lived experience and at the time of the interview, still connected best with people who had shared mutual experiences of AOD addiction recovery.

This theme was consistent for every participant and, although quite an abstract concept, it appears that the re-construction of the self is a contributor to successful recovery. Each participant had a unique recovery journey and each participant had a unique way of reframing their addiction story and reframing

themselves within that story. Participants were so attached to their reconstructed story and self that any challenge to their story was met initially with confusion, then with adaptation and justification. This enabled the participant to brush off any alternative view of their story and self so that they could keep their existing beliefs.

Negative social learning

Participants consistently recounted experiences in which AOD use was normalised and taught by other people within their familial and social circles, a process that increased their risk of harm in active addiction, and increased barriers to AOD addiction recovery by creating environments and support systems in which AOD use was the norm. Participant one explained:

It felt like that was just what society was you know? And I used to ask Mum, you know, from the age of about seven or eight or something, how long would it be till I could smoke marijuana or when could I take LSD.

Participant two stated, "*My parents did it so there were always drugs in the house, my older sister was starting to dabble in it a bit, my parents friends all did it*". Participant six also described a family home where AOD use was the norm, "*I had modelled to me that alcohol and drug use was the way to be*". For participant six the escape from the constant partying led her onto the streets, where with her adolescent peers she learnt how to use other drugs. Participant seven described a sense of not fitting in as a young person, this feeling was

allayed when she drank alcohol with a group of her peers, *I drunk this drink and it is like something in my brain just lit up straight away and I felt connected to people for the first time.*

For participant seven her peer group was where her initiation into hard drug use took place, and again she had the sensation that this drug was going to be the key that helped her fit into life:

I had this moment with the opiates that night that I took that smack, a group of us, one of them or two of them had used it before, we would snort, and I saw a neon sign saying this is it I had been waiting for something my whole life.

Positive social learning

For participant one this process began when family members started addressing their own AOD addictions, *"Mum decided that her drug and alcohol use was actually a problem for her and she got sober through Alcoholics Anonymous" … "I had a Godfather in recovery which is one of the reasons she got clean"*. Participant one recalled that a key element in his ability to commit to his AOD addiction recovery, was that he socialised with people who were role modelling AOD addiction recovery, *"I hung around with people who were talking about recovery after meetings instead of the people who were talking about drug use and all the war stories and stuff"*. Participant three also started attending twelve step groups seeing that, *"people were able to stay clean,*

people who had been in the scene that I had been in". Participant four also used twelve step groups to maintain AOD addiction recovery and learn new skills, *"…so my journey of recovery, after that really came immersed in the NA fellowship twelve step program"*.

Participants five and six also utilised twelve step meetings throughout their recovery journeys and participant six spoke about being able to reach out and speak to other people in the twelve-step group, *"I had spent this Saturday and Sunday before this course completely obsessed about drugs I was ringing everybody saying I wanna use I have gotta use and I did not end up* [using AODs]*"*. Being able to connect with others who could support her without expressing judgement was important, *"absolutely totally believed, never judged, or even if they did they did not say it"*. For participant six these friendships made in early recovery have endured, stating:

> *I have got non-addict friends but my core friends are NAer's which was like my backbone really cos they understand you, like I can say to these people* [non-AOD addicted] *oh my god I do not know who I am and these people look at me funny, but they* [twelve step people] *know what you are talking about.*

For participant seven, hearing someone expressing the same internal turmoil that she had experienced was a turning point for her:

…anyway, one night in a meeting I was lying there I was crook I was still detoxing and I was listening and hearing bits of what people were talking about in the meeting and I heard people talking about the inside stuff, the anxiety, the fear, and the shame and my ears kind of pricked up.

She explains that, *"I kept going to NA meetings and felt flashes of connection without it being drug induced".* Participant seven explained how AOD addiction recovery role modelling by others impacted upon her own success in AOD addiction recovery, *"if I had not seen those two women in NA that day I never would have known recovery was possible because we are each other's mirrors you know".* This role modelling happened again when participant six was considering going into tertiary study, *"again, there were a couple of women in recovery who did it and I thought if they can do it I can do it".* Participant seven explained that, *"recovery lives in the community not the treatment centre, it starts there".*

Initiation into AOD use by participants in this study was clearly influenced by the negative social learning they received via family, friends and people in their wider community. However, positive social learning was also an important part of each participants' successful AOD addiction recovery. Participants were taught how to complete basic life tasks, and were exposed to new concepts and environments that supported their ability to be able to progress from living in poverty, to being employable, successful professionals. For participants in this study these networks were accessed through twelve step support groups,

highlighting a need for greater recognition of the value of twelve step groups, whose members provide a level of practical day to day support that cannot be provided by AOD support services. This model of recovery community is not an ideal model for all people entering AOD addiction recovery however, as twelve step support groups are solely for abstinence based recovery. This highlights a gap in communities where those that choose not to enter abstinence based recovery lack the peer connection, social learning and mentoring that takes place within twelve step recovery groups.

Opportunities for career progression

Participants discussed how opportunities for career progression supported their success in AOD addiction recovery. This section addresses three topics; career progression as an exit from addiction, how career progression enables continued personal growth, and opportunities for career progression being a mechanism for the AOD sector to ensure that valuable skills and knowledge are retained.

As an exit from addiction

Participant two stated that her job was the reason she engaged in abstinence based AOD addiction recovery, *"I had been wanting to stop* [using] *for a while, but I did not really get any motivation to until I started working here".* Participant five expressed the same motivation, *"I could not within myself start a job without being abstinent myself, so I knew that was coming".* Participant three expressed frustration at the barriers that existed for some people who have prior criminal convictions attempting to use career progression as an exit from AOD addiction, *"for people with criminal histories this is really hard so there has been four in the past week, system meetings, that have had such good employment options but when the police check comes back they get put off.*

To continue personal growth

Participants stated that employment opportunities solidified their AOD addiction recoveries and enhanced their practice as AOD professionals. Participant four was supported by the same employer as she started off as a cleaner and is now a qualified AOD professional within the same organisation. For participant six the transition out of sex work and into an administration role was difficult, *"it was this really hard transition for me I had never had a straight job, I think I worked in a factory for three months but apart from that I had never had a normal job".* The support from those around her helped her transition into

roles where she could utilise her lived experience and then progress on to more challenging job roles.

To utilise and contribute valuable knowledge and skills

Career progression was also a vital part of retaining valuable knowledge within the AOD sector, participant one explained:

I still like addiction, I still like the industry but I just, I just did not feel like I could counsel, you know, six hours a day anymore. I was just over it and I had been over it in my last two roles so, I managed, I was really lucky, I managed to get a management job.

Participant six realised that to be able to enact change for people experiencing AOD addiction and continue to care for her own wellbeing, she would need to step into a national role:

I realised that to continue to make a difference in the world in order to effect change I wanted to do it at a different level, I could not do it at the coalface anymore.

Participants in this study expressed that entering the workforce contributed to their success in AOD addiction recovery. Gaining meaningful employment provided an incentive to succeed in AOD addiction recovery and participants

also expressed that employment allowed them to grow and flourish personally as well as professionally. Most participants not only entered and remained in the AOD addiction workforce but also enacted systemic change within their own communities and at times, throughout New Zealand. Participants abilities to be so successful were directly linked to their opportunities for career progression within the AOD workforce, as there had been enough diversity and opportunity for each participant to gain experience in their field of practice, and continue training and studying to specialise in their fields.

The unique contributors, and barriers to, AOD addiction recovery for specific populations

Factors influencing youth and AOD addiction recovery

Participants in this study explained that secondary school was the environment where they began experimenting with AODs and multiple participants were expelled for doing so. Participant one attended two schools that were aware of his substance use and expelled him, he was then required to go to an alternative education school, *"I was on like a course for naughty kids who get kicked out of school, I had been expelled from two schools".* Participant two began AOD use at the age of twelve and discussed the lack of AOD education at school, while they were required to do education about physical and sexual health, there was never any education about AODs. Participant two recalled having no knowledge that AODs could be addictive, had no idea how to

keep herself safe or seek help if she needed it, *"I think a lot of it was that I did not know much about drugs, both when I first started doing it and actually when I was still right into it. It was never something that was discussed in school".* Participant three expressed frustration that schools are still not doing enough to support young people and their whānau, *"I still think that schools provide a lot in the community and there is the opportunity for running evenings and groups for parents of children with an addiction issue".*

Participant two reflected in-depth on her experiences as a young person who had an AOD addiction:

In the health classes, do not necessarily put any kind of emphasis on drugs they have got their sexual education, they have got their don't eat junk food education but there is nothing around drugs and if there is it is always just you know, do not do it, that is it.

Once participant two was older she started seeking information about AODs online to educate herself about drugs:

When I got older around seventeen or eighteen I definitely did start Googling more just to see what I was doing but most of it was from personal experience like if you take this then that is going to happen but if you take these two together…. so it was more just a practical how to take drugs not, what is going to happen if you take drugs.

It was so I could know how to get the best benefits from it, that I could know how to, what would get me high the most, what would last longer what would work quicker.

As a person who experienced AOD addiction in her youth, approximately five years ago, participant two stated that, *"I do not think there should be a limit on the level of drug education, obviously you need to make it age appropriate"*. Going on to explain, *"with youth there is kind of this expectation that if there is someone that is doing drugs then it is kind of just a phase or they are just a washout"* Highlighting the lack of practical support available for youth who are either treated as 'no-hopers' who receive no support or, are not taken seriously and again, receive no support. Participant two felt that AOD education for youth was inadequate:

Teenagers are going to do things and they are going to experiment and that is fine, it is just making sure that there is open lines of communication and enough education so that they know experimenting fine, getting stuck into the addiction not fine.

Participant six also commented on her experiences related to AOD addiction in youth when she was a teenage mother, *I could do a thesis on the horrors of birthing a child at that age and the way I was treated and I could not even get a benefit for a year.*

One participant had experienced AOD addiction as a youth in the last five years, this participant expressed the complete lack of relevant information available to her when trying to figure out how to enter AOD addiction recovery. For this participant there was no useful information available online, only information on how to use AODs more effectively to maximise her intoxication. She expressed her belief that specialised AOD support services are only for people who have a severe AOD addiction, and that if she were to seek help for her AOD addiction she would only be taking up resources unnecessarily. The same participant stated that there needs to be a better appreciation for the ability of the youth population to understand and process maturely, education and harm reduction information about AODs. She explained that youth are using AODs, they are doing it unsafely and without guidance because the ideology of complete abstinence from all drugs, and abstinence from alcohol until the age of eighteen, is still the prevailing message for youth. However, she believed that this message is ineffective and out of touch with reality.

The lack of AOD education for youth in New Zealand was a prevailing issue identified in this research, spanning the last fifty years. No participant had received any form of AOD education in secondary school which is especially concerning given that all participants started using drugs in their youth. Participants expressed the need for AOD education to begin at intermediate age, continue throughout secondary school and be tailored to match students' levels of maturity. Participants stated that this education needs to be realistic about the fact that large numbers of youth will at least try AODs at some point, and provide harm reduction advice on how to minimise harm from AOD use, not

just provide abstinence based AOD education. As adequate education will contribute to the ability of youth to engage in AOD addiction recovery if needed.

Co-existing mental health and addictions

In this research three out of seven participants discussed having mental health issues. Participant four had ongoing mental distress linked to AOD addiction and described her experiences as a person with co-existing conditions:

Nobody ever asked me if I had an issue with drugs, at all. It was just you are psychotically depressed, you are manic depressive, you are paranoid schizophrenic, whatever, there was like so many different labels that I was given as a young youth. I was put in a lock up ward with criminally dangerous sex offenders, all sort of peoples, it was pretty horrific actually…

That was a hard-core stage of my addiction really when I think about it, some horrible things happened in that place that yeah, you know, just part of who I am. Really built some massive resilience and a massive passion for young people to be seen who have mental health and addiction issues.

Participant four stated that barriers to AOD addiction recovery for people with co-existing issues do remain, even though "*there are some services looking at those barriers for young people and adults*". Participant four also

stated that this needs to be extended across the whole sector saying, *"I would love all services to acknowledge co-existing and remove barriers"*.

Women and addiction

The experiences of women in this research had consistent elements that appeared to be attributable to their female gender. Participants discussed: the unique experiences of trauma that women with AOD addictions have; the increase in AOD use directly related to traumatic experiences; the negative impact that significant others had on women's AOD addictions and recovery journeys; and the unique way that women with lived experience of AOD addiction support each other.

Women's experiences of trauma whilst using AODs were connected to men, violence and sexual assault, with four out of six women disclosing that they had been raped, assaulted or both. Participant four spoke of her experiences with men, *"in my using being in situations where people had taken advantage of me"*, and as a woman engaged in sex work, *"this guy wanted me to do something I did not do and got really aggressive and he bounced me round the walls of this venue where I worked"*. Participant four expressed that:

> *It is not just the drug use but the vulnerability of sex working when you are under the duress of addiction, I mean there was stuff that had happened that should never have happened to a sex worker.*

Two participants explained that the traumatic events that they had experienced led directly to an increase in AOD use. For participant one AOD use became a coping mechanism she found that, *"it was definitely something I used as a crutch to kind of, I dunno hide from everything else"*. Participant one is now in a job role where she supports others who have lived through traumatic experiences and explained:

…when they call us when they are really drunk it is because there is something we can actually help with, like if they have been a victim of a crime or if they were you know, if they were a victim years and years ago and it has taken a toll.

Participant six also recalled a traumatic experience that triggered heavier AOD use, "*I was basically brutally abused and beaten and stuff and I started using every day because I developed, what I now know is, post-traumatic stress disorder so I could not be in a house on my own"*. While participant four was the only participant to recall her traumatic event being a trigger for reaching out for help:

I was 21 years old, I had just had an awful experience and I just found out I was pregnant with my first, with my daughter and basically you know I realised then that hang on a minute what am I doing and I, I must have gone and said help to somebody.

Participants recalled having dependents including children, partners and other family members that they supported in their AOD addiction. These significant others' created barriers to successful AOD addiction recovery, perpetrated violence, were in and out of prison, and two participants worked in the sex industry as a way to support theirs and their partners AOD addiction. Participant six recalled, *"when he would get out I would side use"*, saying*, "he would do things like steal my methadone or whatever"* explaining, *"I still needed to keep working and all that stuff to support his habit and my habit"*. Participant six said that:

> *When I was in this house he went to prison for six years I decided that I wanted to come off the methadone again so I started counting down and he was in jail so I did not have that influence of him.*

Five out of six women who participated in this research recalled having intimate partners who had their own AOD addiction, were committing crime, in and out of jail, stealing their OST medication, perpetrating domestic violence and for some, had been the person who initiated them into AOD use or introduced them to 'harder' AOD use. Participants recalled having to negotiate the chaos of the relationship on one hand, and having to remain relatively functional in their own lives on the other hand. They had children who were relying on them to provide a stable home and they had to work to maintain their own drug habit as well as the intimate partners.

Four out of six participants were Mothers and participant four recalled her experience of childbirth and specifically, how she was treated directly after the birth of her daughter which had triggered a manic episode:

For the first four days of my daughter's life I did not get to see her, they would not let me, they tranquillised me they stuck me in seclusion, I just remember screaming for days, probably about 48 hours, please let me see my daughter.

Participant seven remembered that, "*when I gave birth they took her away straight away and had her in a different room, but I think that has had a big impact on our relationship*". Participant three recalled how pregnancy contributed to her AOD addiction recovery, "*once I found out I was pregnant I decided what I was doing to myself was ok but I could not do it to another life*". Participant four also stated, "*I basically got a wake-up call when I fell pregnant with my daughter*".

Four out of six participants had experienced Motherhood while still addicted to AODs, for most of the women how they were treated during and after childbirth was intensely stressful, negatively influencing their mental health and having negative consequences on their relationship with their children. Despite these negative experiences the women explained that the moment they found out they were pregnant were catalysts for change in their AOD addiction recovery, and while all the women struggled to stay in AOD addiction recovery after this point, their entry into Motherhood was the moment that their AOD

addictions began to change. Upon finding out they were pregnant the women in this study became more stable in their lives, started contact with AOD support services, counselling and residential treatment. The women could recall some positive contact with these services during pregnancy and after the birth of their child/ren, with the relationships they had built with these services contributing to their ability to be successful in AOD addiction recovery.

All the women in this study explained that the support of other women was a major contributor to their successful AOD addiction recovery. Participant three remembered working in an organisation built on feminist ideologies, *"…really enjoyed the feminist perspective, being in the women's movement and what I learnt through there around power and control".* Participant four experienced support from other women throughout her career, *"but there is quite a few of the women that supported me still around me and one of those women employed me in this role".* For participant six women had supported her while still using AOD, *"she eventually took me in, she said to me one day I have got an appointment for you at the alcohol and drug service and took me".* Participant six was supported by other women in AOD addiction recovery as well:

> *I had these amazing women around me who really took me in like I had a woman take me to a university graduation and another woman took me to nice restaurants to teach me all these different things.*

Women participants in this study had all experienced domestic, physical and sexual violence at the hands of trusted people in their lives, as well as strangers. The women reported increasing their AOD use as a coping mechanism after a traumatic event, and the women had partners who exposed them to criminal activities and were reliant on them to provide an income to fund AOD use. Participants also explained that their lack of education regarding relationships meant that they were trapped in unhealthy relationships, with no understanding that the relationship was unhealthy or how to leave the relationship. Women in this study also had experiences of receiving inadequate support from AOD support services. Some of the issues with support services were that they were not grounded in trauma informed care, and that there was a lack of childcare options on site for them. These experiences created unique, gender specific barriers to AOD addiction recovery for participants.

Despite these barriers to AOD addiction recovery, female participants in this study spoke of the unique and valued support they had received from other women in AOD addiction, treatment and recovery. This support was a significant contributor to AOD addiction recovery with women receiving support from peers to use AODs safely, access AOD support services, and women lived together creating a home that had a level of stability and safety for children even while they were still using AODs. Women supported each other through twelve step groups creating meaningful life-long relationships, as well as in the workplace and tertiary education environment. These relationships with other women supported their AOD addiction recoveries in unique ways, leading to

internal growth and healing whilst learning how to function in a life not centred around AOD addiction.

Childhood, families and personal relationships

Through the re-telling of their lived experiences participants helped to identify themes that showed that social learning and familial support have the potential to significantly contribute to successful AOD addiction recovery. However, participants also identified that the lack of support for family members of people with AOD addictions and that social learning can be a negative phenomenon, with most participants being initiated into AOD use via familial and social groups. Participants explained how the trauma experienced by participants in childhood alongside family helplessness were barriers to recovery, but the positive support given to participants by families and significant others contributed to more positive outcomes.

Familial trauma in childhood was a consistent theme throughout the interviews, with six participants experiencing lack of parental attachment, physical and emotional neglect, and abuse. Throughout her interview participant two explained, *"I had an older sister who was um, kind of looked after me quite a bit but that was only to a certain extent and there was just a whole lot that I had literally no one for"*. Participant three recalled a similar experience of neglect, *"there was a lot going on for my family, that made my parents sort of unavailable".* For participant three the unavailability of her parents was compounded by childhood trauma, *"I had a sexual assault as a child".*

Participant five also experienced neglect and abuse from his parents, *"she would lose her temper a lot and do what quite a lot of Mums' did at that era which was use the wooden spoon to discipline the children",* and his Father, *"I had a Father that was busy setting up his businesses so he was quite absent most of the time".*

For some participants substance use and domestic violence were related as part of their family life whereas others spoke of violence without the substance use. Participant five remembered attending boarding school as a teenager where *"there was a lot of bullying and sexual abuse from the teachers and things".* For participant two this violence occurred within the home, *"my Dad was quite abusive towards my Mum and quite often she would go and smoke a joint after, you know, some kind of fight".* Participant six also witnessed violence in the home explaining, *"I kind of grew up in a white version, a whiter Pakeha version of once were warriors with not as much violence".*

Three participants had also experienced alternative forms of loss, participant one recalled, *"my Dad left when I was a baby so I did not have a male role model apart from my Grandad. He died when I was seven".* While both participants four and six had been adopted, participant four explained, *"I come from a history of adoption and I also feel like before I found alcohol and drugs I actually started starving myself as a little person".* Participant six explained, *"because I had been adopted I had this huge discourse around that I was broken and that there was something horrible about me".*

Three of the participants described supportive families who had done their best to help them with their AOD addiction, but really had no idea how to begin to provide support and help. Participant three remembered her parents having no idea how to help her, from very early on in her AOD addiction. They also had little involvement in her AOD addiction recovery journey, *"they knew, Mum had taken me to get methadone and I would be throwing up out the car, so they knew enough but not enough to help me, they did not know what to do".* Participant five explained that his family were supportive, but they did not understand his addiction:

> *They certainly were supportive, and they came to the family day at* [residential rehabilitation] *and even having said that though, my Mother drove me away from the hospital after attending all the lectures and did not bat an eyelid when I had a beer at the airport*

As noted earlier while six out of eight participants recounted some type of trauma experienced in childhood, six out of eight participants also spoke of family and friends who supported them throughout their addiction and recovery. Participant one spoke about his Mother saying, *"she was very loving and very caring".* Once in AOD addiction recovery, participant one was still surrounded by people who cared for him:

> *…he said I just got clean two months ago and my family, quite a wealthy family, they have set up a trust to pay for people so you do not have to*

> *go on a big wait list and I could send you down there* [residential
>
> rehabilitation] *within a week if you wanted to.*

and that same friend, later in his recovery, paid for his education:

> *Again, the same guy who paid for me to do the one course that he had*
>
> *paid, that his family's trust had paid to do the course, and for me to get*
>
> *clean said, hey look now we will pay for you to do postgrad.*

Participant two was a person who did not have a good family support system, her supports were her friends and partner, *"the girl I was seeing was not into drugs at all so I think that kind of helped a lot"*. Stating, *"I had a few friends that I would talk to about it which at that time made it quite a lot easier"*. Participant four was supported by her family to care for her child, *"my parents were very supportive as well, they became the official guardians of my daughter"*. Once participant four entered AOD addiction recovery her husband supported her to complete her tertiary education, *"my husband has been a consistent worker so I have been very lucky"*. Those same familial support systems have continued to support her as she has progressed in her career, *"I have a very supportive family, have very supportive friends and to have a life outside of work that has been really crucial for me"*. For participant six finding her birth mother was a healing process that *"really shifted who I was, when I met her I had finally found some turangawaewae, a place of standing"*.

The theme of childhood, families and personal relationships was a resounding message delivered by participants as they recounted childhoods in which there was familial poverty, abuse, neglect, and trauma that occurred inside and outside of the family unit. Once participants were in the stage of their life where they were actively addicted to AODs they shared experiences of their families trying to be supportive but not knowing how, participants' families were often isolated from their own support systems and had nowhere to turn to for advice and support. Participants also expressed concern at the exclusion of families from the recovery process, with the lack of education for families leaving participants responsible for educating their families as best they could, about their AOD addiction and recovery pathway. Despite the challenges that existed within the family unit, friends and family were the most common source of support for participants.

Chapter four has outlined the barriers and contributors to successful AOD addiction recovery that had been experienced directly by research participants in their AOD addiction recovery journeys. It explored stigma which had been consistently experienced by all participants, stigma created barriers to AOD addiction recovery, and to participation in communities, workplaces and peer groups. The participants' ability to define their own recovery was presented next, participants also identified their ability to develop a redemptive self as a contributor to their successful AOD addiction recovery. Comparatively, participants who had not been supported to define their own recovery experienced a fragmentation of themselves. The role of social learning was also

identified with negative social learning being a conduit for the development of an AOD addiction, and positive social learning being a process in which negative social learning was negated, thereby contributing to successful AOD addiction recovery. The theme; career progression, was also identified as a contributor to successful AOD addiction recovery. Participants explained how employment had facilitated their exit from AOD addiction and reinforced their ongoing AOD addiction recoveries. Lastly, the unique experiences of specific populations in relation to AOD addiction were outlined this included the experiences of; youth, people with co-existing mental health and addiction issues, women, and families. While chapter four outlined the themes experienced at an individual level by participants, chapter five outlines participants' professional experiences of systemic issues. These perceptions come from being lived experience practitioners employed as AOD professionals in the New Zealand AOD, health and wider social service sector.

Chapter Five: AOD professionals experiences of AOD addiction, treatment, and recovery

Chapter five presents the second half of the results obtained through the thematic analysis of participant interviews. While chapter four presented participants lived experiences of their AOD addiction recovery journeys, chapter five presents their experiences as AOD professionals continuing that recovery journey within the AOD, health, AOD and social service workforce. Participants were able to discuss systemic contributors and barriers to AOD addiction recovery including; aspects of the health and social service sector, legal systems in New Zealand, and barriers to accessing AOD support services; including funding issues and philosophical conflicts within the AOD sector. While participants experiences presented throughout this chapter are focussed on their professional knowledge there are instances of personal reflection in which participants compare their knowledge of existing systemic issues, with experiences from their past.

Contributors and barriers to AOD addiction recovery within health, AOD and social services

This chapter begins with participants professional perceptions of the strengths and limitations of the wider health, AOD and social service sector in New Zealand. Participants were able to comment on the aspects of these sectors

that support, or create barriers to, AOD addiction recovery. Topics explored include: the welfare system in New Zealand; community based social service responses to people with AOD addictions; the strengths and limitations of the New Zealand AOD sector; the lived experience workforce; the medical sector; residential treatment; and Opioid Substitution Treatment.

Welfare systems

Participant three discussed the welfare systems (Housing New Zealand, Work and Income) that supported her recovery by enabling her to purchase her own home, *"I was lucky because it was that housing corp. time where if you met the criteria you could put in to buy a house"*. She recalled that her home was the constant place in her life that she could come back to, *"I was lucky in a way because it laid down something to have, it was not a great house but it was something to start building from".* However, participant three also recalled feeling unsupported by welfare services even when, after seven years, she gained full-time employment, *"I always remember going in and saying I had a full-time job and that they will be rapt this unemployable person has now got a full-time job and the woman being less than impressed".*

Participant three stated that *"those opportunities are not there now for people I think it is really difficult for people to get their foot in the housing that they need"*, and when trying to access support from Work and Income she sees people *"having to apply all the time and justifying why they needed stuff".* Participants highlighted the barriers that welfare services create to AOD

addiction recovery, current welfare systems are hard to navigate and are based in punitive approaches to client engagement, this makes it difficult for people who are already struggling to survive within their own lives to access to basic resources and supports such as housing, income and employment.

Community based social services

Participant four explained that she was well supported during Motherhood by these types of services, "*I had a social worker, I had a counsellor, those people believed in me and they supported me*". Participant four did however discuss the challenges that exist in the child protection sector:

> *It can be really challenging where there is intergenerational abuse and a young person has been attached to a service for ten solid years and they are still not engaged in education and they* [child protection services] *are like, here you go you sort that out and we are like huh? How are we supporting whānau and young people we are just going to become another service involved and then what?*

Participant six recalled her experiences as a young person who felt as though she was failed by the child protection sector. Rather than having a formal process for moving her to her Nana's home which would have been a safe place for her away from the alcoholism within her family, participant six was told, ad hoc, that she could move without any proper explanation as to why that was being offered as an option for her:

They tried to get me to go and live with my grandparents but no one

handled that well. I remember sitting outside the pub one day waiting for

my Dad and my Mum said oh you can go and live with your Nana if you

want and go to school down there and that is all I was told.

These perceived failures were perpetuated with her son, comparative to participant four, participant six had no support from child protection services or social services, even though she was a teenage mother with AOD issues. For participant six the fact that her child now has his own mental health struggles is still an emotional topic and she stated that *"sometimes I wish there had have been* [social service support] *because it might have been different for him"*.

Participants in this study discussed the strengths of community based social services. Participants recalled feeling as though they were part of a mutually trusting, respectful relationship and were supported unconditionally, despite struggling with remaining engaged in AOD addiction recovery. The strengths of community based social services were contrasted with the limitations that participants experienced with statutory Government services, including child protection services and Work and Income. The perceived inadequacy within these services when working with people with AOD addictions were ongoing, meaning that participants were still seeing negative outcomes for people with AOD addictions because real change was not being enacted within whānau who needed support. This means that unhealthy environments, with cycles of poverty, abuse and addiction are still being perpetuated throughout generations.

The AOD sector

Participants discussed their perspectives of the strengths and limitations of the AOD sector these included: a lack of information on how to navigate the AOD sector; an overfunding of certain types of AOD interventions; the contribution of AOD professionals to successful AOD addiction recovery; and the competency of services when incorporating Tikanga Māori practices.

Participant one explained the lack of relevant information available for her as a young person with an AOD addiction. This led to her feeling as though it would not be appropriate for her to utilise AOD support services, *"that was always kind of a barrier, there is always someone out there that could benefit from it more than I could so I am just taking up resources"*. A second factor that participants considered were not supporting successful AOD addiction recovery were brief interventions. Participant one stated that *"[a] trend that is really unhelpful is giving someone a brief course of therapy and then discharging them and never seeing them again"*. This was a sentiment that participant six agreed with, *"there has to be more than one counselling session a month or whatever, there has to be"*.

However, participants did identify some strengths within the AOD sector. One of these was, having a key person within the AOD sector that upheld unconditional positive regard throughout a participants recovery journey. For participant four *"…she* [AOD counsellor] *was the one that kind of got me thinking that there might be another way or that I might have a problem with*

alcohol and drugs". Participant six had a similar experience, *"I had started working with this amazing alcohol and drug counsellor"* and stated that, *"I owe my life to her, well the life I have today"*. Participant seven also had a case manager that supported her throughout her AOD addiction and the relationship continued after participant six left residential rehabilitation, *"I was still able to check in with the case manager at the methadone clinic she was really supportive"*.

The second strength that was discussed was the ability of AOD support services to integrate Tikanga Māori into practice. Participant four explained that her service has had extensive cultural training, and Tikanga Māori practices are integrated into all aspects of the service, for example, *"…so karakia at the start of sessions you know, they are bringing in that spiritual component as just an everyday thing but as a team our challenge has been to incorporate that into our daily practice"*.

Participants discussed the difficulty that people face when trying to navigate the AOD sector because services are provided by a range of different service providers, who practice from a range of different ideological bases, and support different cohorts of people with different types of AOD addiction issues. Participants also talked about the value of the therapeutic relationship, for participants this relationship was rare and a large number of the interactions they had with AOD staff were negative. However, multiple participants did recall the one AOD professional who had the practice skills required, to build an

effective therapeutic relationship that contributed to their successful AOD addiction recovery.

Lived experience practitioners: Tangata matua a-wheako

AOD professionals with lived experience of AOD addiction were described by participants as being more trusted and easier to communicate with than other professionals they encountered in their recovery. The lived experience workforce was a constant theme identified in the thematic analysis, with participants explaining that contact with AOD professionals with lived experience of AOD addiction supported their successes in AOD addiction recovery. This main theme is split in two, the strengths of the lived experience workforce, and the limitations of the lived experience workforce.

Participant three explained that an AOD counsellor with lived experience was the person in her support team that she trusted most while she was still in active addiction, *"I was more likely to go to someone like her than the ones at the drug clinic".* Other participants described their professional roles as people with lived experience of AOD addiction once employed in the workforce. Participant two explained that she takes on a mentoring role with her colleagues by helping them understand what it would be like to have an AOD addiction and be striving to find recovery:

… if I am doing a de-brief with a worker and they are not really sure how to handle a call they just took, or a referral they just took I will try and, if I can, relate it back to reality I guess.

Participant four stated that what works in being a successful lived experience practitioner is good boundaries, *"needing to have clear boundaries for myself to support sustainability but that goes out to everybody co-workers, and young people, and the whānau that I work with".* What also worked was having the respect and support of colleagues. Participant seven expressed that in her current job role, *"I feel very valued in the team and my recovery story and the fact that I have got lived experience is very valued".* While participant four discussed her hopes for the continued successes of the lived experience workforce in the future:

You know what, ultimately in the future I will be part of a peer led team that works alongside. I frikn love what I do though and I am really passionate about those young people having that opportunity, if they need it, to have someone walk alongside them like I do.

Some participants identified as having worked in dedicated peer roles and/or having worked in roles where they were able to disclose lived experience of AOD addiction. These participants discussed how lived experience practitioners build therapeutic relationships based on shared mutual experience, trust, respect and hope in a way that is unique to people who shared a lived experience of AOD addiction. These participants also expressed good

knowledge of professional boundaries, a skill that was vital for participants to utilise in their practice. They could establish clearly within themselves, within their teams and with their clients what their boundaries were, how to express those to their clients and how to effectively use self-disclosure. Participants also discussed how valued they were within certain workplaces that they had been employed in, this was because colleagues, tutors and managers understood the value of lived experience of AOD addiction in the workplace. As well as the unique therapeutic relationships that are built between client and practitioner that cannot be emulated by those without lived experience.

Participants also expressed concern about the lack of understanding about dedicated peer roles in the AOD sector, the lack of support for the peer workforce, the lack of training and educational opportunities for peer workers and how these factors combined to impact negatively on participants' AOD addiction recovery. For participant four there was little understanding of her role as a peer support worker (a dedicated peer role distinctive from other clinical case workers), with colleagues attempting to limit her ability to do therapeutic work with people. She also expressed frustration at the lack of support and educational opportunities for the AOD peer workforce:

There was nobody for me to mentor the role off there was no actual training in …… or anywhere that I was aware of for specifically peer support, I was training in IPS [Intentional Peer Support] *last year, four-day training in peer support specifically. Other than that, I have pretty much made it up myself, or apart from that I have looked up William*

White, I have looked up a whole bunch of different practice models of peer support.

Participant four explained how this lack of support impacted negatively on her, *"I cannot do this anymore I cannot continue to fight by myself for this role and the value of it and the importance of it"*. A sentiment expressed by participant six who explained that a lack of support led to burn-out and was the reason she stepped out of a front-line role, *"I could not do it on the coal face it gets really hard because you carry your own, it gets really tiring"*

Participants also expressed concern about the lack of structure within the AOD sector to support the AOD peer workforce. There is a lack of educational and career pathways for peer professionals, peers in existing roles are having to justify why their roles are valid and prove that they can achieve positive outcomes with clients before they are respected within their own teams. The peer workforce was discussed at length by one participant who was employed in a peer role at the time of the interview. This participant expressed her concern at the high levels of stigma she experiences within her role, the lack of understanding of the peer role, the lack of education and training options for peers and the lack of mentoring support for peers. These issues are pertinent for the New Zealand AOD sector right now as multiple groups within the AOD sector, including the New Zealand Government, have taken an interest in growing the peer workforce within the AOD sector. However, given the levels of stigma and lack of support recounted by the participants in this study, there is clearly a lack of understanding of what peers with lived experience of AOD

addiction need if they are to be successful in dedicated peer roles. This includes developing workforce planning documents showing the current state of the workforce and what is needed to ensure those working in peer roles are supported, respected and protected by the wider AOD sector. There is also a need to develop seminal workforce documents, training and processes such as a Code of Ethics and registration options.

The medical sector

Participants in this study identified medical professionals who had provided them with support as factors that helped them succeed in AOD addiction recovery. For participant six this medical professional was a doctor in an OST service:

> *I stayed on that really low methadone dose because of course you do not want to tell the centre you have gone back up and was just side using. So then they got this new doctor and he was amazing, he just said to me one day you are on a really low dose how come? What's going on? And I said I was going to count down and he actually bounced me back up, I think he put me back up to 80mg's like just on that day and pretty much I never side used again, because I was not on the right dose.*

Participant eight also had a positive experience with a doctor in OST services who employed her as a consumer advisor, *"he was way ahead. It is a*

rarity in the field". Participant four described working within an MDT team of medical professionals saying that:

It is such a diverse group of individuals not one of us is the same, [it] *works, because I am peer support I work completely different I am not clinical however all the clinicians come with their own different backgrounds of their training and where they have come from.*

Participant four did however explain that there are still areas where the medical model and the peer model do not fit together, *"the power and the ego stuff that I have noticed, oh but I have got this training, oh but I have got this training, oh but I am the top dog because I am the psychiatrist".*

Residential treatment

Seven out of eight participants in this study attributed their success in AOD addiction recovery to residential treatment. Participant one explained:

If you have a really severe problem and all your family and everyone in your neighbourhood uses drugs, sometimes it is good to get four weeks away from that environment or six weeks or six months even and actually get clean. So that when you are back in that environment you have got the strength, you have got the skills, you are sufficiently detoxed and oriented.

Participant eight also attended residential treatment and felt that she could not have succeeded in AOD addiction recovery without it. Participant four agreed with this sentiment, *I was thinking about your question through the brief that you had and for me the things that really worked, the factors that made my recovery successful, was residential treatment.*

Seven out of eight participants attribute residential treatment as a turning point in their recovery process. For participants in this study residential treatment was a safe space for them when they were too tired to continue, and needed to have the care of themselves put in the hands of others until they were well enough to function again. Participants articulated that the benefits of residential treatment were that they could be removed from their lives for a period of time, enabling them to learn the skills and tools they needed in order to return to their lives and succeed in recovery. Participants also expressed concerns regarding the under-funding of residential treatments in favour of interventions that are brief and less costly to provide. Explaining that the few residential treatment facilities that remain in New Zealand today, have long waiting lists and not all of them suit all types of AOD addiction experiences and recovery needs.

Opioid Substitution Treatment

Seven out of eight participants had been involved in OST, all of them having experienced it in New Zealand and some having received treatment overseas. Each participant was able to recall negative experiences of OST

treatment in New Zealand. Participant six and seven explained the culture of fear that existed within OST services:

> Participant six: *I used to, and I still remember the trauma cos my son still talks about it. Make him pee into bottles so when I got drug screened I would try and use his urine so they did not pick it up, so that is how paranoid you were about getting caught with drugs.*

> Participant seven: *I had to live a double life cos OST, you were not supposed to be using anything else, you had to be creative with your urine samples, it might be different now, but I reckon the fear would always be there that it was going to be taken away.*

Participant five recalled that he ended up 'locked into' OST and that his friend is currently facing the same issue:

> *…he is coming off methadone, the clinic just tried every technique and manipulation I would say by the psychiatrist with the help of the so-called counsellors, they are not really counsellors they are just case managers, to keep him on the dose that he is on. Like they do not like people coming off and they say oh it does not really work and you should just stay on it a bit longer, which is the opposite of well-done that is really amazing how can we support you to come off?*

Participant five's perspective of (current) OST services was that they are not recovery based AOD treatment services:

They have misinterpreted and misused the methadone program to benefit society rather than the individual, the purpose of the methadone clinic in New Zealand, whether they admit it or not, is to stop crime, keep people quiet because the other option for treating them costs more.

Participant seven remembered that it was the flexible and ongoing nature of the support provided that helped her and she expressed concern that this has now changed:

The awesome thing for me with that service, my case manager saw me weekly for the next year, so what happens now if you stop OST you have to go to a CADS [Community Alcohol and other Drug Service] *counsellor. So even if you have been on for years you have to see a new counsellor, so while you are letting go of something that has been your friend and enemy for years* [methadone], *it is a big loss, you have to lose the connection with your case manager as well.*

Participant six said that attending groups at the OST service was a major part of her AOD addiction recovery, "*another thing that was really important to my recovery was adult children of alcoholics, so I did three of those workshops where you cried and unpacked*". Participant six expressed the need to move OST services back towards holistic AOD addiction support

Now it is like put people on do not give them any therapy, you know back then there was this sort of focus on rehabilitation, you know being able to give people therapy and stuff like that, I think it is changed. Now it is very medicalised.

Participants expressed concerns about OST services in New Zealand. Participants' experiences were predominantly negative as people who had accessed those services in the past, as AOD professionals, and as people supporting friends who were still engaged with OST services. Participants expressed concerns about the over-medicalisation of OST services and the removal of funding for holistic supports provided within OST services. Holistic support options were an aspect of past OST services that had contributed to the success of participants AOD addiction recovery. Punitive approaches taken by OST services if a person was 'side-using' or not complying with the expectations of the service also created barriers to AOD addiction recovery for participants. Participants also expressed concern that OST services are no longer recovery based services and are now run as people management systems, where people are encouraged to stay on OST to keep them compliant with wider societal expectations.

Each participants story highlighted factors within the wider health, AOD and social service sector that contributed to a successful AOD addiction recovery, but also created barriers to success in AOD addiction recovery. The lack of competency that Work and Income have in supporting people in AOD addiction

recovery was noted. A positive factor that assisted one participant in their recovery journey was the social services that provided support when her children were born. However, that same participant along with one other participant were able to discuss the perceived failures of child protection services, in preventing and halting intergenerational poverty, abuse and addiction. The limitations of the AOD sector were the lack of health navigation information relevant to different populations seeking support, and an overfunding of brief interventions. Participants stated that two strengths of the AOD sector were; the ability of AOD professionals to hold unconditional positive regard for the people they support, and the ability of services to incorporate Tikanga Māori into practice. Participants in this research had good knowledge of the wider health, AOD and social service sector in New Zealand, these discussions also extended beyond these systems, to the overarching policies, legislation and Criminal Justice Systems relevant to AOD addiction in New Zealand.

Barriers to AOD addiction recovery created by legal systems

New Zealand's Criminal Justice System

The New Zealand Criminal Justice System was a theme identified in the thematic analysis. Consistent sub-themes that ran through the discussions were; that participants were intentionally targeted by police and that the

Corrections System failed to provide any real exit from AOD addiction.
Participants believed that this was due to the lack of holistic AOD addiction
support provided to people who come into contact with the Corrections System.

Participant three recalled contact she had with the New Zealand police
where she was targeted in her own home because she was a known substance
user:

> …arrested me when I got my house for having no dog registration when I
> was seven months pregnant and the cells were half an hour away from
> home. The police in the cells said they could not lock me up while I was
> pregnant so they let me out but I had no way to get home so I was left
> stranded in town.

While participant six remembered that experiences working as an AOD
counsellor in the prison drug and alcohol treatment unit, although difficult, were
effective for the women they were supporting:

> We were trying to do restorative justice in a retributive system, so we ran
> the drug treatment unit like any drug unit and we would walk in and we
> would hug the women and they were allowed to go out to twelve step
> meetings at that point and we were just real whānau, family oriented and
> the prison officers would call us the touchy feely unit and they started
> taking away, I do not know what it is like now, but they started taking
> away the women's rights to do programs outside and so it just became
> more and more punitive you know and harder to effect the same change.

She went on to state that ultimately the Corrections System is not conducive to holistic AOD recovery and she knew that, *"a lot of them do not have a chance when they leave because they are going back into the same system that they were in"*.

Participants in this study discussed the barriers to recovery created by New Zealand's Criminal Justice System including; police, courts and prison services. The participants expressed concerns as people with AOD addictions who had interacted with these systems, and as AOD professionals who have worked within these systems. Participants perceived that: the current New Zealand Criminal Justice System is not conducive to AOD addiction recovery because of its overly punitive approach; that people with AOD addictions are intentionally targeted by law enforcement; that the Corrections System does not operate from a holistic recovery model; does not do enough to mitigate the negative sociological environments that people are released into once they leave prison; and that the Criminal Justice System creates barriers to furthering AOD addiction recovery through career progression because of long lasting criminal conviction histories.

The decriminalisation of all illicit substances in New Zealand

The current stance on criminalising AOD addiction in New Zealand was discussed by four participants who viewed criminalising AOD addiction as a major barrier for people trying to recover from AOD addiction. Participant three explained that, *"we have so much rhetoric still on the war on drugs and drugs are bad and all that sort of stuff, we must realise that actually this is about people"*. Participant two highlighted the futility of criminalising all drugs stating that, *"you are probably never going to find that drugs do not exist, there is always going to be a drug around, so just making sure that it is used correctly and safely.* Participant five expressed his view that New Zealand should be adopting a model of decriminalisation just as Portugal has done, stating that decriminalisation is the ultimate form of harm reduction:

> *Whether or not a GP's writing a script or not they will always find something to use, so in a harm reduction type way of thinking it is probably better they are using pure pharmaceuticals from a GP then sniffing glue or using street drugs with god knows what in them.*

Participant five went on to explain that, *"if all drugs are legal, if people are going to experience all the problems of dependency then they are going to do it without all the criminality behind it and without having to commit crimes"*. Stating that adopting a model of decriminalisation would also potentially mean that, *"if all drugs are legal I think the people who will come dependent will come dependent quicker, with less problems and be identified earlier and treatment*

options provided for them". Participant one stated, *"if we save all the money from putting them in jail, cos it costs a lot of money to put people in jail and on probation, we could put all that money into healthcare".*

Four out of the eight participants discussed the need to decriminalise illicit substances in New Zealand. All four of these participants expressed that in their professional opinions this model needs to be adopted in New Zealand to increase positive outcomes for people experiencing AOD addiction. This was an issue that participants agreed on despite having different professional views of AOD addiction and differing personal recovery pathways. Decriminalising all drugs in New Zealand was considered by participants to be a step forward in addressing AOD addiction issues in New Zealand society, as it would increase the ability of people with AOD addictions to access support and reduce the barriers that come from involvement in the Criminal Justice System.

Barriers to accessing AOD support services

This section of chapter five outlines the barriers to accessing AOD support services identified by research participants; the first being that there is an overall lack of funding in the AOD sector, the second being that current funding models are not conducive to services being able to provide collaborative services, and the third being that the philosophical conflicts that exist within the AOD sector negatively impact the people accessing support.

Lack of adequate funding

Participant four explained the negative impact that inadequate funding is having on the community she works within:

I really think the issue for me is the lack of money given to the sector and that creates some of the issues that I think I have seen in our small town with, you know there is services closing down people are really stressed.

Participant four also expressed concern about disparities in the way Government funding is spent, *"I certainly am concerned that some organisations seem to have very fancy offices and very fancy tricks everywhere and I am like hang on a minute you are meant to be working for us, aren't you?".* While participant six spoke about her concerns regarding the groups and counselling within OST services being cut stating that, *"Government keeps taking money out of services so no one is running groups".*

Participant eight had personally dealt with the struggle of accessing Government funding to get an AOD service up and running. Even after they had secured Government contracts the funding was still inadequate:

We have to have contracts with the health board and they really do not pay adequately and we have contracts now with justice and the [organisation name] *and we have to diversify our funding to have enough money, the way we have been sustainable really is to own our own property.*

While participant one discussed the benefits of having adequately funded services:

If you get a Government that funds health and mental health at a higher level then you will get um, staff will get paid more so you will get a higher calibre of staff wanting to work in that field and you will get more services and resources which means lower waiting lists and people will have higher access to quality healthcare.

The lack of funding for the wider health sector was a concern expressed by participants who spoke of being employed in services with extensive waiting lists and that holistic recovery support options were being consistently cut across the sector due to funding shortages. Participants explained that when funding can be accessed, it is inadequate and is coupled with excessive reporting requirements. The impact that this has for people in New Zealand trying to access support with AOD addictions is negative, people face long wait times to access supports, they have limited options for the types of treatment they can receive, and the staff supporting them are constricted in their practice due to high case-loads and excessive reporting requirements.

Current funding models

During his interview participant one spoke in-depth about existing funding models and their weaknesses, having seen the negative impact of evidence based funding:

A lot of really, really, good programs, do not get enough funding to do an evaluation of them so you do not create an evidence base on them, so these really good programs all around the world that we do not have any evidence base for, apart from anecdotal.

Participant one explained that the Government Ministry's:

…want to be innovative and cutting edge but they are very, very risk averse and wary of doing anything that might not work and they do not have much money so they want to spend their money wisely and what that does is, is it makes them heavily reliant and everyone else is heavily reliant on being evidence based.

Participant four expressed concern about the environment that has been created by the Government Request for Proposals (RFP) process:

The silo thinking, the people not talking to people, so one of the things I have watched our service do really well is build relationships with other organisations who see youth as well. There were some issues to resolve

initially because I think people thought we were taking money out of the

sector.

The state of funding for AOD addiction services was an issue participants in this study discussed as AOD professionals working in communities where current funding models encourage competition between services trying to access funding. The way these funding models reduce incentives for collaborative practice was identified, as was the negative impact this has on people needing holistic support in their AOD addiction recovery pathway.

Philosophical approaches to recovery

Participants discussed the tension embedded in differing philosophical approaches embedded within the AOD sector in New Zealand and its impacts on recovery. Participant five explained:

There were two separate camps and they were known as the abstinence camp and the harm reduction camp, although neither of those are exactly true but that is just a generalisation, and the abstinence camp would run their own conferences and the harm reduction camp would run their conferences in competition and things like that.

The inability for those in the two opposing factions to be reflexive in addiction practice had also affected other participants. Participant seven

recalled the impact when harm reduction was first mooted as an approach for AOD sector:

> *When harm reduction came in there was a polarisation in the sector it was either harm reduction or abstinence, and there was no matching of the person in front of you to the right way. What happened was that a lot of people went underground.*

In one particular job role, her manager was actively anti-abstinence based recovery models, "*the medical officer there at the time was very anti-twelve steps*". She explained that "…*what happened was he had come through that, he had taken the harm reduction vs. abstinence. Harm reduction good, abstinence bad*". The most concerning part of the conflict that arose in the AOD sector was that people accessing services were adversely affected, *"I think the people seeking support were affected by that"*.

An unexpected finding regarding the AOD sector in New Zealand were participants' perceptions of the fractured state of the AOD sector. Participants described the impact that the conflict between those with harm reduction ideologies and those with abstinence based ideologies, had on those receiving support from AOD services and those working within the AOD sector over the past forty years.

Results chapters summary: What works in AOD addiction recovery?

This previous two chapters outlined the key results that emerged throughout the thematic analysis, presenting participants views about what works in AOD addiction recovery, and what does not work in AOD addiction recovery.

Barriers to recovery

The results in this research showed what contributed to participants' successful AOD addiction recovery and what created barriers to AOD addiction recovery. A succinct summary of the barriers include: stigma; lack of input into their own recovery journeys; being unsupported in the workforce; criminal convictions preventing career progression; lack of AOD education as youth; limitations within the welfare system; limitations within the AOD sector; limitations within the Criminal Justice System and criminalisation of substance use; limitations within OST services; lack of cohesion and funding within the AOD sector; traumatic experiences unique to women; and traumatic experiences caused by families.

Participants identified that the barriers to their AOD addiction recoveries were being subjected to stigma in their communities, in the workplace and within peer recovery groups. Participants also found that stigma prevented them from being able to define their own recoveries and lives, with this stigma forcing

some participants to lead fragmented, dual lives which added stress into their personal and professional lives. Participants also found that working in dedicated peer roles created barriers to wellbeing in AOD addiction recovery, with the stress caused by constant stigmatisation by colleagues causing participants to lose passion for their roles. Participants also spoke of the barriers that were created in career progression (a contributing factor to successful AOD addiction recovery) because of criminal records.

Participants then went on to discuss their perceptions of the systems that exist within New Zealand society from their professional perspectives, starting with the barriers that a lack of AOD education in secondary schools creates for youth trying to stay safe when experimenting with AODs. The failures of welfare support systems were also discussed, with participants identifying that Work and Income case managers along with child protection social workers, had little understanding of how to work effectively with people who had AOD addictions. In addition, welfare and housing systems are now complex to navigate, with people not being able to access support to meet their basic essential needs (income and housing). Basic human needs that are vital in creating a successful foundation in AOD addiction recovery.

Other results of this study showed that participants had faced barriers to AOD addiction recovery caused by the AOD sector. These barriers were that there was a lack of diversity in AOD interventions, with there being an overfunding of brief interventions because they are considered to be more cost effective. As well as the difficulty of navigating the AOD sector; participants did

not understand where to go for support, or where to find information that would help them navigate the AOD sector. The New Zealand Criminal Justice System was also identified as a key barrier to AOD addiction recovery and participants recalled being discriminated against and intentionally targeted by the New Zealand Police. Participants also recalled working within the Corrections System which failed to provide holistic support for people with AOD addictions. Participants stated that people with AOD addictions that encountered the Criminal Justice System were being locked into cycles of crime, violence and AOD addiction because there is no real systemic change being enacted in New Zealand.

Participants went on to discuss the current model of criminalisation and how that model creates barriers to AOD addiction recovery. Participants also discussed current funding models in New Zealand focussed on cost-management, that provided inadequate funding increases comparative to the increasing demand for services. These models discouraged service collaboration and reduce the likelihood that people with AOD addictions are receiving holistic AOD addiction support. Participants also identified that there is a chronic underfunding of all AOD, health and broader social services in New Zealand. This increases wait times for people needing support, limits staff capacity to spend time with people needing support, and limits resources available for people needing support. Participants in this study also consistently identified barriers to AOD addiction recovery created by OST services, these services were based in punitive models that left participants too scared to be honest about their substance use. Participants also expressed that the over

medicalisation of OST services had taken away holistic recovery support options. Stating that OST services now play an active role in encouraging people to stay on OST medication, even if a person decides that is no longer their recovery goal.

Participants also recalled that the fracturing of the AOD sector that occurred between professionals who held opposing ideologies (harm reduction vs. abstinence), created conflict within the sector, this conflict created barriers for people trying to access the type of AOD addiction support that was right for them. This fragmentation also created barriers for participants in their own recovery journeys, as people with lived experience who faced greater levels of stigma and discrimination during this time of conflict within the sector. Within the AOD sector it was also identified that youth, Māori, and people who have co-existing problems have faced historical and ongoing barriers to AOD addiction recovery. The third specific population that face unique barriers to AOD addiction recovery, as identified by participants, was women. Women had unique experiences of trauma in AOD addiction, relationships and Motherhood that made it more difficult for them to access and remain in AOD addiction treatment and recovery. Families were also identified as a barrier to AOD addiction recovery, the traumatic experiences of participants that took place in childhood and within their families were factors that contributed to the development of an AOD addiction. Preventing entry into AOD addiction recovery due to the psychological trauma that was the result of those experiences.

Contributors to successful recovery

What was also identified in the results of this study were the factors that contributed to successful AOD addiction recovery. A succinct summary of the contributors include: defining your own recovery; adoption of the redemptive self; AOD professionals with adequate therapeutic skill; career progression; supportive workplaces; good boundaries and ethics when employed as AOD professionals; community based social services; access to housing and income; family and friends; holistic recovery options; residential treatment; and gender specific supports.

This started with participants stating that it was the ability to define their own recovery that contributed to their successes in recovery. Participants who were supported to define their own recovery developed a redemptive self, this enabled them to gain employment that was meaningful to them, because they were giving back to people who needed support and this in turn reinforced their successes in their own recoveries. Participants also identified factors that contributed to their successes in AOD addiction recovery provided by the AOD workforce. For participants in this study this came in the form of a key AOD professional who could build an effective therapeutic relationship with them. For some participants this person was an AOD professional with their own lived experience, this added a dimension of trust and rapport that could not be emulated by AOD professionals who did not have lived experience of AOD addiction.

Participants also discussed the contribution that career progression had in their successful recovery journeys. For most participants this started with entry into tertiary study and continued once they had been employed in their chosen profession. Participants recalled instances where they were supported and respected by colleagues and managers, which enabled them to work successfully in their roles. Participants also accredited their own internal processes and external supports such as good boundaries, ethics and supportive friends and families, as a key aspect of their continued success in AOD addiction recovery, especially when working in professional roles became challenging.

Participants also discussed external supports that contributed to their successful AOD addiction recoveries. These included: the positive support provided by community based social services; having easy access to an income and housing; and having family and friends that supported them in their AOD addiction and recovery, even though these support people did not always understand their AOD addiction or how best to support them. Participants also highlighted holistic recovery options as being a contributor to successful AOD addiction recovery, this included support groups run within AOD support services and twelve step groups. Alongside this, participants attributed residential treatment as a major contributor to successful AOD addiction recovery. These spaces provided opportunities for positive social learning and participants learnt basic life skills that contributed to their successes in AOD addiction recovery. For women, this positive social learning was particularly

associated with gender specific supports where other women helped them to create safe spaces for healing, recovery and personal growth.

Chapter Six: Discussion

This chapter explores the relationship between the themes outlined in the results chapters and how they impact upon AOD addiction recovery. The amalgamation of the themes into four discussion points facilitates discussion of the linkages between themes showing what inhibits, and contributes to, successful AOD addiction recovery. The recommendations are supported by the literature and sector reports scoped in the literature search for this research, that give evidence for, and advice on, changes needed to improve the outcomes for people with AOD addictions.

There are four discussion points in this chapter the first discussion point explores the dominant themes in the results chapters; stigma, the influence of decriminalisation and self-defined recovery. The second discussion point explores existing institutional systems and their impact on AOD addiction recovery. The third discussion point covers social support and social learning as a contributor to successful AOD addiction recovery and discussion point four explores the unique trauma and challenges that women with AOD addictions face.

Stigma, influence of decriminalisation, and self-defined recovery

All eight participants in this study had experienced stigma, this stigma was pervasive, occurring throughout their AOD addiction, treatment and recovery process. Participants recalled being stigmatised by their community, the police, staff in AOD support services, other medical professionals, by peers in twelve step programmes, friends, colleagues, and managers. Participants also expressed views and beliefs that showed stigma had become internalised and was subsequently being imposed on others with lived experience of AOD addiction in the workplace. Stigma is a theme that occurs frequently in international and New Zealand based literature on AOD addictions showing that stigma is a significant barrier to a person's AOD addiction recovery (Boisvert et al., 2008; Brener et al., 2010; Butler and Sheridan, 2010; Csiernik & Rowe, 2003; Deering et al., 2012). It is therefore unsurprising that themes of stigma were identified frequently in the analysis of the interview data.

This section explores the concept of stigma experienced by participants while they were in early recovery, within the workplace, how stigma was internalised by some participants, and how these themes relate to existing literature. Further to this is a discussion regarding the role of decriminalisation in negating stigma, and how having the freedom to define your own recovery helps to prevent stigma from becoming internalised.

Analysis of participant interviews showed that stigma creates barriers to successful AOD addiction recovery at all stages of the recovery journey and within peer groups, this is conducive to the findings in international and New Zealand based literature. Participants in this study were stigmatised by their communities which created a barrier to community participation, increasing the isolation of the participants and preventing help-seeking behaviours. This finding is supported by Deering et al.'s study on OST services in New Zealand (2012) who found that people with opioid addictions were aware of the stigma imposed by wider society on people receiving treatment from OST services, and this prevented these people from seeking support from OST services. The consequence of societal stigma imposed on those with an AOD addiction was explored by Csiernik and Rowe (2003), who found that societal stigma increases negative outcomes for people with AOD addictions. As was the case for participants who found that societal stigma prevented their ability to seek help and reinforced their participation in AOD using communities, where their AOD use and subsequent harms increased.

Participants were also stigmatised once they started seeking support to enter AOD addiction recovery. This stigma was experienced by participants accessing support from general health, AOD and social services including: hospital emergency departments; community based AOD support services; inpatient detoxification units; and residential treatment. The stigmatisation of people misusing substances by health, AOD social service professionals is documented in international and New Zealand based literature. Butler and Sheridan (2010) conducted a study into the attitudes of primary healthcare staff

and found that the GP's that took part in the study, held stigmatising views of people misusing substances that negatively impacted their ability to provide effective healthcare to them. While Brener et al. (2010) investigated the attitudes of staff in AOD support services and found that where stigmatising attitudes were held by staff, barriers to people accessing support from that service were increased.

Intra-group stigma was also experienced by participants attending twelve step groups, where only one AOD addiction recovery pathway was considered valid. These experiences appeared to reduce the personal agency of participants who were attempting to define recovery and career goals for themselves. For some participants wider societal and intra-group stigma became internalised and they in turn, developed and expressed ideas that had the potential to stigmatise others with lived experience in the AOD workforce. The role of intra-group stigma in restricting the range of AOD addiction recovery options for people with AOD addictions is documented in international literature. Gunn and Canada (2015) explored the attitudes of women in residential treatment, these women held views of what 'real' AOD addiction was and used these existing views as a way to measure whether another woman deserved AOD addiction treatment. While Boisvert et al. (2008) illustrated the way that intra-group stigma works to define only one AOD addiction recovery pathway as valid, considering all other AOD addiction pathways, invalid. The diminished personal agency that was experienced by participants because of this intra-group stigma is supported by Deering et al.'s study (2012) that shows that when

stigma is internalised, a person's personal agency and belief that they can be successful in their chosen AOD addiction recovery pathway is depleted.

The one aspect of stigma that participants experienced that was not identified in existing sourced literature was stigma in the workplace. Participants were facing stigma in the workplace from colleagues and managers and that this stigma impeded their ability to practice effectively, increased the likelihood that they would leave that job role, and impacted negatively on their own personal recovery and wellbeing. This appeared to be especially true for the one participant who was in a dedicated peer role, this is especially concerning given that the recent mental health and addictions workforce development plan identifies the peer workforce as a targeted workforce for growth and development, yet identified none of the existing stigma that this workforce faces and offered no options to ensure the reduction of existing stigma (Ministry of Health, 2017).

The role of decriminalisation in negating stigma and supporting AOD addiction recovery

International literature on decriminalising illicit substances has increased in the past five years, as evidence of the harms caused by criminalising substances cumulates (Csete et al., 2016; Global Commission on Drug Policy, 2017; Law Commission, 2011). Csete et al. (2016) published a report highlighting these harms, in which it was argued that the harms that have been caused by a failed 'war on drugs' are greater than the harms caused by illicit

drugs. Further to this, the Global Commission on Drug Policy (2017) identified the problematic perceptions held about people using illicit substances. This report also discussed that the laws that criminalise these people perpetuate societal and institutional attitudes that increase stigma and discrimination, subsequently creating barriers to AOD addiction recovery.

The views of participants in this study are consistent with the views of international literature. However, drug policy continues to sit in a moralistic political sphere that seemingly ignores academic evidence and advice (Csete et al., 2016; Drake & Walters, 2015). Drake and Walters (2015) published a research paper that identified this issue in the United Kingdom whereby academic policy advice was only taken into consideration if it matched the existing moralistic beliefs about illicit drugs and criminalisation. This assertion was also made by Csete et al. (2016) in their investigation into the harms caused by criminalising AOD use worldwide. Participants in this study expressed views on decriminalisation that match a chorus of voices that have joined the debate here in New Zealand and coincide with New Zealand based literature calling for existing legislations to be amended, and for an overhaul to our current system of criminalisation (Law Commission, 2010; Law Commission, 2011; New Zealand Drug Foundation, 2017).

Defining your own AOD addiction recovery and reconstruction of the self contribute to success in AOD addiction recovery

The ability for people with AOD addictions to define their own AOD addiction recovery pathway is a concept supported in international literature, that explores and recommends recovery oriented models of care as best practice when supporting people with AOD addictions. Bassuk et al. (2016) state that key concepts in a recovery oriented model of care are that the person seeking support is given the opportunity to define their own recovery, by choosing from a menu of recovery options provided to them by the healthcare professional. Alberta et al. (2012) also discuss recovery oriented systems of care and state that it is common for lived experience practitioners to hold this practice model as a foundational model, with Reif et al. (2014) explaining that recovery oriented systems of care are based on social support, empathy and a positive therapeutic relationship.

The concept of the redemptive-self outlined in Gabor Radak's thesis (2016) on the evolution of ex-gang members into social service professionals, provided guidance when analysing and clarifying this emergent theme. Literature in this area explores the positive impact that peer work can have on a worker's own AOD addiction recovery (Dugdale et al., 2016; Pantridge et al., 2016); how a person's ability to re-define their concept of self increases their ability to remain abstinent (Dunlop & Tracy, 2013); and how re-defining the self through the use of story-telling increases the likelihood that they will remain in AOD addiction recovery (Lederman & Menegatos, 2011).

Instances of stigma impacted upon each participant during their entire AOD addiction recovery journey and was clearly a barrier to AOD addiction recovery. The experiences of participants who had faced significant levels of stigma were juxtaposed against the experiences of those who had been supported in their AOD addiction recovery. This juxtaposition illustrated the impact that stigma had on participants' abilities to access AOD support, healthcare, broader sociological support, participation within their communities, participation within the workforce, participation within peer groups and personal autonomy. However, stigma is a systemic issue that can be mitigated through targeted campaigns within different spheres of society, institutions and workforces (Roussy et al., 2015; Shepherd & Pinder, 2012).

Existing institutional systems and their impact on AOD addiction recovery

The following section provides discussion on the Criminal Justice System, the wider social service, health and AOD sector, the lived experience workforce, OST services, residential treatment, the overarching issue of funding that appears to affect all systems and the barriers that these systems consistently created for participants in their AOD addiction recovery journeys.

The barriers to AOD addiction recovery created by the Criminal Justice System

International and New Zealand literature identify issues caused by Criminal Justice System approaches to illicit substance use (Csete et al., 2016; Law Commission, 2011). However, the literature identified within the scope of the literature review does not explore Criminal Justice System responses to illicit substance use from the perspectives of those with lived experience of AOD addiction, who have also worked within Criminal Justice Systems. What the literature does explore is the wider societal impact of Criminal Justice System responses to illicit substance use. Csete et al. (2016) published a report identifying the harms caused internationally by criminal justice responses to illicit substance use which aligned with participants' perceptions of the New Zealand Criminal Justice System. The report found that criminalisation leads to an increase in drug related deaths, reduces access to safe injecting equipment which subsequently leads to the spread of infectious diseases amongst groups of people injecting illicit substances, and that drug laws are applied in discriminatory ways upon ethnic and racial minority groups. This international research is conducive with the Law Commission New Zealand's report (2011) calling for changes to the Misuse of Drugs Act 1975, which found that New Zealand's law is outdated and not reflective of the current drug using environments in New Zealand. Stating that what is needed is health based legislative responses to personal drug possession and use that is applied consistently, proportionately and justly.

As well as the broader legislative issues that exist in New Zealand regarding the criminalisation of people with AOD addictions, participants also expressed concerns with the interventions being provided by services within the Corrections System. There is some information that supports participants' assertions that the Corrections System fails to provide any lasting change for people who become involved in this system (Office of the Prime Ministers Chief Science Advisor, 2018; Richards, 2014). However, literature also shows that since at least 2014 the Corrections System has identified and begun to address the disparities that exist for people in prisons, as these people are seven times more likely to experience AOD addiction issues than the general public (Department of Corrections, 2016). These responses seek to address issues similar to the issues identified by participants in this research: the lack of AOD recovery options while people are incarcerated; the lack of holistic support; and the lack of ongoing support once a person leaves prison (Department of Corrections, 2016).

The strengths and limitations of the wider social service, health and AOD sector

The strengths and limitations of the AOD sector relate to the quality of support given to people seeking support from AOD addiction and is another significant contributor to a person's success in AOD addiction recovery. The results from this research concur with international literature and local literature. Pulford et al. (2009) confirm that the quality of the therapeutic relationship has the potential to significantly contribute to a person's successful AOD addiction

recovery. Further, Butler and Sheridan's research (2010) confirmed that discriminatory attitudes about people with AOD addictions are still held by professionals in the wider healthcare sector. Research also alludes to the conflict within the AOD sector that participants identified, with Szott (2015) stating that historically the AOD sector has been dominated by medical models of addiction, and Alberta et al. (2012) stating that there has in recent times, been a rise in recovery based models. However, there was a lack of research identified in the scope of the literature review, specifically on the conflict between harm reduction and abstinence based models in New Zealand.

International literature also supports the experiences of participants whereby community based social services provided support that was respectful and effective. However, Galvani (2007) states that there is still a lack of competency within the social work profession in regards to working with people with AOD addictions. Despite this, social work is in fact well equipped to work with this population as social workers have the foundational knowledge required to build effective therapeutic relationships based on holistic, client led care (Galvani, 2007; Nelson, 2012). In regard to participants' experiences with state led welfare and child protection services, there was a lack of research identified in the literature searches. However, given the negative experiences of participants and the fact that these services are interacting with vulnerable populations in need of support, it may be pertinent for a review into the adequacy of training that staff within these services are receiving.

Lived experience workforce as a contributor to AOD addiction recovery

International literature support the results in this research that show that peer support roles within the AOD sector provide a unique space for therapeutic support with people who have AOD addictions. Alberta et al. (2012) found that the role of peer workers is to provide empowering support, encouraging people to define their own recoveries, selves and lives. They state that this therapeutic relationship is unique as it seeks to negate hierarchical power imbalances that can exist in traditional behavioural health models. Instead relying on foundational values of mutuality, empathy and respect, assertions supported by other international literature (Pantridge et al., 2016; Reif et al., 2014). Dugdale et al. (2016) also found that a unique aspect of the peer role was that it reinforced the peer workers successes in their own AOD addiction recovery. While this literature reflects participants' experiences in this research that show the uniquely successful aspects of peer roles in the AOD sector in New Zealand, at this point in time there has been no New Zealand specific research, identified throughout the duration of this research, looking at the strengths and limitations of AOD peer roles. Additionally, no international research reflecting the concerns raised by participants regarding the AOD peer workforce was found in the literature reviewed for the purposes of this study.

Current models within Opioid Substitution Treatment do not adequately support AOD addiction recovery

Participants' experiences of OST services were particularly relevant to two pieces of New Zealand based literature. The first, exploring treatment provider and client perspectives of OST services in New Zealand (Deering et al., 2011) and the second, looking only at client perceptions of OST services (Deering et al., 2012). The participants in both studies expressed concern similar to that expressed by participants in this research including, that OST services needed better takeaway arrangements and more flexibility. Further, OST services had a lack of counselling resources, people using the service had little input into treatment planning, treatment plans seemed to be homogenous rather than developed as unique individualised treatment plans and that negative sanctions for illicit substance use created an environment of fear where people wanted to be open about their substance use but did not, for fear of repercussions (Deering et al., 2011; Deering et al., 2012).

Residential treatment contributes to successful AOD addiction recovery

The role of residential treatment in successful AOD addiction recovery was identified in a piece of international research exploring the successes of peer support in recovery communities (residential treatment). Boisvert et al.'s research (2008) is consistent with participant experiences of residential

treatment, in that residential treatment was a place where people could go to learn the skills and tools needed to return to the community and be successful in AOD addiction recovery. The role of residential treatment in successful AOD addiction recovery was not a topic identified in the New Zealand literature. Given participants' assertions that residential treatment was a key contributor to AOD addiction recovery, the lack of investigation into the closure of residential treatment centres, move toward community based recovery support and how this is affecting people engaged in AOD addiction recovery, is concerning. Participants also expressed concern regarding the increase in use of brief intervention methods as a cost-cutting exercise however, international literature does show that brief interventions are effective (Centre for Integrated Health Solutions, n.d.; Substance Abuse and Mental Health Services Administration, 1999). Further research into participants' experiences of residential treatment and concerns regarding brief intervention, would provide a better understanding of how residential treatment and brief intervention contribute to, or create barriers to, AOD addiction recovery in New Zealand.

Current funding models and shortages are preventing service delivery to those trying to achieve AOD addiction recovery

The issue of funding for the AOD and mental health sector (Health and Disability Commission, 2018), has been a topic widely covered by the media and social advocacy groups in the lead up to the 2017 New Zealand General Election. While the newly elected Labour Government have committed to a review of the mental health and addictions sector, there is some unease within

the addictions sector that addiction was added into the terms of reference as an afterthought. The view of participants in this study, in which the data collection took place before the announcement of the review, is that a decision ensuring adequate and non-competitive access to funding for the AOD sector, must be made at a Government level. This has the potential to raise the quality of the whole healthcare sector and increase the success rates for people recovering from AOD addiction by giving them access to better quality services, more quickly.

In summary, the implications of a continued lack of inclusion of AOD related matters in all systems that were discussed in this section is that people will continue to present to services without major underlying causes (including AOD addiction), for hardship being recognised, addressed, and dealt with. All services in New Zealand whether they are statutory, health based, community social services or schools must incorporate holistic methods and engage with people on all levels of their wellbeing. While services may have a primary purpose in the work they do with people, it is naïve to think that services can continue to operate in silos, only supporting people in specific areas of their lives and expecting other services to address the other parts of the person's hauora. Wider issues of poverty, child abuse, domestic violence and criminality will not be resolved in New Zealand until all services take a holistic, life-course approach to supporting people needing help.

Social support and social learning as a contributor to successful AOD addiction recovery

The role of social support and social learning in AOD addiction recovery was discussed by research participants and can be categorised as follows; the role of families in AOD addiction recovery, the role of social learning in AOD addiction recovery, and AOD education for youth. While each category is distinct from the other a key theme running across all three is the importance of social support and social learning in contributing to successful AOD addiction recovery. The role of families is to provide a valuable source of recovery capital, yet participants identified that families are not adequately supported. The role of social learning leads to the learning or re-learning of essential life skills that specialist AOD services cannot provide, yet peer led groups are generally not resourced or are under-resourced, and under-valued. Finally, the role of learning for youth is a vital component of building protective factors for young people who are experimenting with AOD use however, participants in this research did not receive any AOD education in secondary school which increased barriers to their AOD addiction recovery.

Families as a source of recovery capital

The impact of AOD addiction on families is well documented in international literature (Copello, Templeton & Powell, 2010; Templeton, Zohhadi & Velleman, 2007; Tunnard, 2002), yet this literature has found that families continue to be

excluded from policy and service planning (Copello, Templeton & Powell, 2010). There are a range of online resources for families in New Zealand needing support (Alcohol and Drug Helpline, 2018; Kina Families and Addiction Trust, 2018; Ministry of Health, 2017). This indicates that the need for families who are supporting a person with an AOD addiction to be supported has been identified. However, the apparent lack of research on the role of families in AOD addiction would justify further investigation into this topic.

The role of social learning in AOD addiction recovery

The role of peer based positive social learning is well documented in international literature, showing that peer based recovery services provide support for people in AOD addiction recovery to learn basic life skills, including; managing a household, budgeting, nutrition, finding employment and sustaining tenancies (Alberta et al., 2012; Boisvert et al., 2008; Pantridge et al., 2016; Reif et al., 2014). While these might not be considered necessary AOD addiction recovery related skills, participant experiences in this study show that they are skills that needed to be learned/re-learned because of a combination of childhood neglect, and deterioration of lifestyle due to AOD addiction. This means the learning or re-learning of these skills are an important aspect of AOD addiction recovery. The value of positive social learning is also discussed in research investigating the role of harm reduction services, where peers are suppliers of safe injecting equipment, and educators regarding how to use the equipment safely (Csiernik & Rowe, 2003; Lancaster et al., 2015).

The lack of AOD education and health navigation information for youth

Youth were identified in the literature review as a population facing disproportionate and significant harm from AOD addiction. The inability of services to provide effective youth specific support and the overall unwillingness of youth to reach out for support was also identified (Christie et al., 2010). The lack of AOD specific education for youth is an issue explored in international literature. The Drug Policy Alliances publication, Beyond Zero Tolerance: A reality-based approach to drug education and school discipline (2013), recognises that punishment responses to substance use by school students is ineffective and can potentially reinforce substance using behaviours. It states that substance use is widely accepted in youth culture and what is needed is education that is based on honest, fact based, participatory learning, with access to intervention and support for those who need it (Drug Policy Alliance, 2013).

This gap in AOD education for youth was also identified by the New Zealand Government in 2014 who since then, have enacted a set of guidelines to improve and extend AOD education in secondary schools (Ministry of Education, 2014). This initiative recognises that youth need education that is designed to enhance their protective factors and decrease their risk factors, as this will enable youth to stay safe if engaging in AOD use (Ministry of Health, 2014). This philosophical basis for the AOD education in secondary school guidelines aligns with best practice as defined by international literature (Drug

Policy Alliance, 2013). An approach that aligns with participant experiences in which a lack of AOD specific education in secondary school increased their likelihood of developing an AOD addiction, and created barriers to AOD addiction recovery as they did not know where, or how, to access support.

The perception within New Zealand based policy on AOD addiction is that areas of intervention need to come from specialist AOD services. However, in reality the majority of support for people with AOD addictions comes from family and peer groups. To ignore this fact and not provide better supports for family and peer groups supporting people with AOD addictions, means that people with AOD addictions are receiving support from people who lack knowledge about AOD addictions, and are facing their own stresses and stigma caused by the supportive relationship. The alternative is to acknowledge the work being done by unofficial support people and groups, and provide easily accessible resources and support for these people in order to grow their capacity to do the work they are already doing, but in an informed and supported way.

Gendered barriers to recovery

Six out of the eight research participants were women and it became apparent throughout the thematic analysis that these women faced unique experiences in their AOD addiction that directly related to their gender. This is consistent with international literature that identifies the experiences of women who have AOD issues as being unique, stating that the support that women

receive when addressing their AOD addiction must match their unique needs (Schroder et al., 2008; Simpson & McNulty, 2008). Simpson and McNulty's research on women's experiences of AOD addiction in the UK (2008) aligned with the experiences of the women participants in this study, finding that women with AOD addictions were more likely to be involved in sex work, have higher vulnerability to psychiatric co-morbidity, have post-traumatic stress disorder triggered by sexual and physical violence, and are more likely to have had their children removed by child protection services. The research also identified the lack of appropriate women specific AOD support services, identifying a significant barrier that is not addressed in current services being childcare facilities provided within AOD support services. Finally, female participants discussed the unique and valuable support they received from other women, this support was a contributor to their AOD addiction recoveries. However, there is an absence of literature investigating the uniquely supportive relationships between women in AOD addiction recovery.

The lack of holistic support for women with AOD addictions has significant negative implications for individuals, their immediate family, their children and their communities. Women with AOD addictions do not experience AOD addiction in isolation from other physical, relational and sociological issues. The expectation that women in New Zealand should attend AOD addiction support services that are not formulated to provide gender specific therapeutic support, means that women are facing unique systemic barriers to AOD addiction recovery. For women to be successful in AOD addiction recovery what is needed is a holistic support service that works to mitigate all

barriers for women accessing the service. These services should be available for women nationwide and operate as a one-stop-shop for women. For example: providing physical health support; counselling; social work; education; advocacy; and peer groups (Schroder et al., 2008; Simpson & McNulty, 2008).

Chapter summary

This chapter raised four discussion points related to the key results in this research, the discussion points provided an opportunity to amalgamate smaller themes into meta-themes exploring the barriers and contributors to successful AOD addiction recovery. The discussion points covered the topics of: stigma; the influence of decriminalisation and self-recovery; existing institutional systems and their impact on AOD addiction recovery; social support and social learning as contributors to successful AOD addiction recovery; and the unique trauma and challenges that women with AOD addictions face. These discussion points were considered by comparing the experiences of participants to existing literature and some consideration was given to the implications of each discussion point. The issues identified thus far will be considered in the concluding chapter alongside potential solutions.

Chapter Seven: Recommendations

Review of the research aims

This research sought to understand what works in AOD addiction recovery in New Zealand from the perspectives of those people who had lived through AOD addiction, treatment, recovery in New Zealand. This research has subsequently assisted in understanding what factors contribute to AOD addiction recovery, and what factors create barriers to AOD addiction recovery. The participants were from a population group that arguably has the greatest knowledge of AOD addiction, yet has not been utilised as a valuable information source in academic research in New Zealand.

This concluding chapter will provide recommendations to enhance the contributors to AOD addiction recovery, mitigate the barriers to AOD addiction recovery. The strengths and limitations of the research will be outlined and finally, this chapter will end with some concluding comments from the researcher reiterating the need for positive change, to increase the ability of people with AOD addictions in New Zealand to be successful in AOD addiction recovery.

Recommendations

Participants in this research had lived experience of AOD addiction and as AOD addiction professionals, these experiences are well supported by existing literature. The issues that were raised highlighted the systemic barriers to AOD addiction recovery in New Zealand. The solutions to these barriers are already outlined in existing literature, in existing international programs and New Zealand based initiatives. The recommendations highlight the issues raised in this study but also highlight the solutions to these issues which are an important aspect of this thesis, as any critique is not complete without an attempt to provide a solution (Tuffin, 2004).

The implementation of person-led recovery

The most recent workforce development plan for the AOD sector states that healthcare must be led by the people accessing services (Ministry of Health, 2017). However, research in New Zealand (Deering et al., 2011; Deering et al., 2012) and internationally (Bassuk et al., 2016; Boisvert et al., 2008; Brener et al., 2010) supports participants experiences whereby they were not always empowered to lead their treatment and recovery process. Each participant was able to recall times when they had not been at the centre of care planning and times when they had been. It was the times when they had been given the space to express what they needed their AOD addiction recovery to be, that led to successes.

Gaps in our social service and healthcare sector are preventing person-led recovery. Addressing these gaps will require a focus on de-stigmatising and re-shaping attitudes about people with AOD addictions (Global Commission on Drug Policy, 2017). The paternalism that lingers, as a result of a dominant medical paradigm (Adams, 2016) and prohibitive policies and legislation (Csete et al., 2016) needs to change. These changes may already be happening in some areas of New Zealand, where inclusive, participatory programs are giving power back to individuals to lead their own treatment and recovery. These exemplars need to be identified, researched and extended, ensuring that there is greater consistency in care across all parts of New Zealand.

A workforce that is adequately trained and resourced

An adequately trained and resourced workforce is what will drive successful systemic change across the AOD, and wider health and social service sector. There is evidence showing the need to ensure that all frontline staff, who might work with people with AOD addictions, have adequate training in how to respectfully and effectively engage with this population (Galvani, 2007). Additionally, people working in the AOD sector would ideally have high levels of reflexivity in their practice. Able to understand the different paradigms of AOD addiction, selecting from a range of theories and practice methods depending on the needs of the person requiring support (Walters & Rotgers, 2012).

This workforce needs to be adequately resourced, and constructed of a diverse mix of health and social service professionals. Participants in this study stated that what worked for them in AOD addiction recovery was having professionals who could spend the time needed engaging in the therapeutic relationship, having access to holistic supports, and having ongoing support. Reviewing and changing funding models would be a step forward in ensuring services have the ability to be flexible in the services they provide, according to the needs of their communities this includes: offering a range of holistic care options; being able to see people for as long as necessary; reducing case-loads; and ensuring that funding is adequate and ongoing.

Wider societal and institutional systems that support AOD addiction recovery

The need to improve systems and institutions that support people with AOD addictions was identified by participants. While there is work being done to improve institutions like the Corrections System (Department of Corrections, 2016), the fact still remains that people who are involved in the Criminal Justice System experience higher rates of AOD related issues than the general public (Department of Corrections, 2016). As well as this, involvement in the Criminal Justice System creates barriers to AOD addiction recovery (Csete et al., 2016). Additionally, people are still facing significant barriers when accessing welfare support and housing (Salvation Army, 2018), an issue that participants identified as a barrier to AOD addiction recovery. Lastly, child protection services are still dealing with high rates of child abuse. With reports showing that a large portion

of the parents involved in child protection interventions have AOD related issues (Ministry of Health, 2015)

Solutions to these problems include, implementing evidence based drug policy (New Zealand Drug Foundation, 2017), decriminalising personal possession of drugs and utensils (Law Commission, 2011), and extending harm reduction options such as: safe injection sites which have proven to be successful in other countries (Csiernik & Rowe, 2003). Implementing changes like these in New Zealand will enhance people's abilities to succeed in AOD addiction recovery.

De-stigmatising AOD addiction by changing the perceptions of broader society, as well as workforces throughout the health, Criminal Justice System, welfare and social service sector is also a necessary part of these changes (Shepherd & Pinder, 2012). Similar work has been done in the mental health sector which has re-humanised the experiences of those with mental health experiences (Like Minds Like Mine, 2016) and some work is being done in the AOD sector already (Matua Raki, n.d.; New Zealand Drug Foundation, 2018). However, this work needs to be amplified to reach a wider audience, so that discriminatory perceptions of people with AOD addictions are shifted and the stigma that creates barriers to AOD addiction recovery is removed.

Strengths and limitations of the research

The limitations of this research relate to the small sample size and subjective nature of the research results. While these results provide valuable insight into the lived experiences of the eight research participants, it would be beneficial for further research with a bigger sample size (ensuring representativeness of ethnicity, gender and age groups) to be conducted, in order to provide a broader understanding of; What works in AOD addiction recovery in New Zealand. To truly understand the culture of AOD use in New Zealand, longitudinal, ethnographic research would be ideal. Another limitation of the research is that seven out of eight participants had been in AOD addiction recovery for more than fifteen years. While this adds validity to participant experiences due to their extensive knowledge of the process of AOD addiction recovery, and how to maintain AOD addiction recovery over a long period of time, it also means that participants perspectives on various elements of AOD related matters in New Zealand do not match current literature and initiatives taking place in New Zealand. For example, participant experiences of AOD education in secondary school are not conducive with current initiatives that ensure that secondary school students receive comprehensive AOD education. This is due to participants' having moved out of front line roles and being unaware of current initiatives within different social sector organisations, such as the Corrections System and the New Zealand Education System.

Despite this, an important observation to note is the success of the interviews with research participants. Participant responses were forthcoming,

participants felt comfortable to offer sensitive information, offering an insider perspective and unique perceptions of what contributes to, and creates barriers to, AOD addiction recovery in New Zealand. The high level of trust and disclosure by research participants is an indicator of effective research design in which constructivism was purposefully chosen, in order to create a space where participants subjective, lived experiences could be honoured. Participant's experiences and perceptions, and subsequently the research findings, were also strengthened by their high levels of academic qualifications and the length of time that participants had been employed in the AOD and wider social service sector (two to thirty years). This wealth of knowledge and experience helped to increase the validity of participant experiences and perceptions.

Concluding comments

People with AOD addictions are the experts in their own lives. These people are extraordinarily resilient and resourceful and if given the right support have the ability to harness these strengths and engage in recovery and life, in a meaningful and purposeful way. The final thoughts that I would like to leave the reader with, are that it is the exclusion of people with AOD addictions that is creating the most significant barrier to AOD addiction recovery. The solution to this is to harness and grow the inclusionary processes that people with lived experience of AOD addictions are already fighting for here in New Zealand.

As I write these concluding comments I cannot help but reflect on the impact that exclusion (or attempted exclusion) has had on me as a person, and

as a professional: being accused of not being a genuine peer and having people demand that I disclose my lived experience to prove that I am a legitimate peer, being advised to never disclose my lived experience because it is irrelevant and unimportant, with one policy analyst even going as far as suggesting that I should never be considered fit for professional registration because I have a chronic, debilitating disease. These personal experiences were brought to the fore throughout the process of recounting participants' experiences, which were also filled with stigma, discrimination and exclusion.

Thankfully, what was also highlighted was the resilience, strength and power of those with AOD addictions. People who have been the most excluded go on to challenge, resist and change New Zealand society and systems in order to ensure those coming behind them face less barriers to AOD addiction recovery than they did.

Reference list

Adams, P. J. (2016). Switching to a social approach to addiction: Implications for theory and practice. *International Journal of Mental Health and Addiction, 14*(1), 86-94. https://doi.org/10.1007/s11469-015-9588-4

Alberta, A. J., Ploski, R. R., & Carlson, S. L. (2012). Addressing challenges to providing peer-based recovery support. *Journal of Behavioral Health Services & Research, 39*(4), 481-491. https://doi.org/10.1007/s11414-012-9286-y

Alcohol Drug Helpline. (2018). *Had enough? We can help.* Retrieved from https://alcoholdrughelp.org.nz/

Alvesson, M., & Skoldberg, K. (2009). *Reflexive methodology: New vistas for qualitative research.* London, UK: SAGE.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Aotearoa New Zealand Association of Social Workers. (2007). *Code of Ethics.* Retrieved from https://anzasw.nz/wp-content/uploads/Code-of-Ethics.pdf

Arksey, H., & Knight, P. (1999). *Interviewing for social scientists: An introductory resource with examples.* London, UK: Sage Publications.

Banbury, S., Lusher, J., & Guedelha, F. (2018). Portugals 2001 drugs liberalisation policy: A UK service providers perspective on the Psychoactive Substances Act (2016). *Journal of Alcohol and Drug Education, 62*(1), 27-45.

Barber, P. A., Pridmore, H. M., Krishnamurthy, V., Roberts, S., Spriggs, D. A., Carter, K. N., & Anderson, N. E. (2013). Cannabis ischemic stroke and

transient ischemic attack: A case-control study. *Stroke, 44*(8), 2327-

2329. https://doi.org/10.1161/strokeaha.113.001562

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016).

Peer-delivered recovery support services for addictions in the United

States: A systematic review. *Journal of Substance Abuse Treatment, 63*,

1-9. http://doi.org/10.1016/j.jsat.2016.01.003

Bird, J., & Schenk, S. (2013). Contribution of impulsivity and novelty-seeking to

the acquisition and maintenance of MDMA self-administration. *Addiction*

Biology, 18(4), 654-664. https://doi.org/10.1111/j.1369-

1600.2012.00477.x

Bixler, D., Corby-Lee, G., Proescholdbell, S., Ramirez, T., Kilkenny, M.,

LaRocco, M., . . . Asher, A. (2018). Access to syringe services programs:

Kentucky, North Carolina, and West Virginia, 2013-2017. *Morbidity and*

Mortality Weekly Report, 67(18), 529-532.

Boisvert, R. A., Martin, L. M., Grosek, M., & Clarie, A. J. (2008). Effectiveness of

a peer-support community in addiction recovery: Participation as

intervention. *Occupational Therapy International, 15*(4), 205-220.

Bosch, P. J., Benton, M. C., Macartney-Coxson, D., & Kivell, B. M. (2015).

mRNA and microRNA analysis reveals modulation of biochemical

pathways related to addiction in the ventral tegmental area of

methamphetamine self-administering rats. *BMC Neuroscience, 16*(1), 43.

https://doi.org/10.1186/s12868-015-0186-y

Bosch, P. J., Peng, L., & Kivell, B. M. (2015). Proteomics analysis of dorsal

striatum reveals changes in synaptosomal proteins following

methamphetamine self-administration in rats. *PLoS ONE, 10*(10), 1-17.

https://doi.org/10.1371/journal.pone.0139829

Bradbury, S., Bird, J., Colussi-Mas, J., Mueller, M., Ricaurte, G., & Schenk, S.

(2014). Acquisition of MDMA self-administration: Pharmacokinetic factors

and MDMA-induced serotonin release. *Addiction Biology, 19*(5), 874-884.

https://doi.org/10.1111/adb.12069

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology.

Qualitative Research in Psychology, 3(2), 77-101.

Brekke, E., Lien, L., Nysveen, K., & Biong, S. (2018). Dilemmas in recovery-

oriented practice to support people with co-occurring mental health and

substance use disorders: A qualitative study of staff experiences in

Norway. *International Journal of Mental Health Systems, 12*(30).

Brener, L., Von Hippel, W., Von Hippel, C., Resnick, I., & Treloar, C. (2010).

Perceptions of discriminatory treatment by staff as predictors of drug

treatment completion: Utility of a mixed methods approach. *Drug &*

Alcohol Review, 29(5), 491-497.

Brennan, K., Putt, F., & Truman, P. (2013). Nicotine tobacco particulate matter

and methamphetamine produced locomotor sensitisation in rats.

Psychopharmacology, 228(4), 659-672.

Broom, A., & Willis, E. (2007). Competing paradigms and health research. In M.

Saks & J. Allsop (Eds.), *Researching health: Qualitative, quantitative and*

mixed methods. (pp. 16-31). London, UK: Sage Publications.

Butler, R., & Sheridan, J. (2010). Innocent parties or devious drug users: The

views of primary healthcare practitioners with respect to those who

misuse prescription drugs. *Harm Reduction Journal, 7*(21).

https://doi.org/10.1186/1477-7517-7-21

Butler, T., Indig, D., Allnutt, S., & Mamoon, H. (2011). Co-occurring mental

illness and substance use disorder among Australian prisoners. *Drug &*

Alcohol Review, 30(2), 188-194.

Capecci, E., Kasabov, N., & Wang, G. Y. (2015). Analysis of connectivity in

NeuCube spiking neural network models trained on EEG data for the

understanding of functional changes in the brain: A case study on opiate

dependence treatment. *Neural Networks, 68*, 62-77.

http://doi.org/10.1016/j.neunet.2015.03.009

Carnwath, T., & Smith, I. (2002). *Heroin century.* New York, USA: Routledge.

Centre for Integrated Health Solutions. (n.d.). *Brief intervention.* Retrieved from

https://www.integration.samhsa.gov/clinical-practice/sbirt/brief-

interventions#Brief_Intervention_Models

Chisholm, A. B., & Harrison, M. J. (2009). Opioid abuse amongst anaesthetists:

A system to detect personal usage. *Anaesthesia & Intensive Care, 37*(2),

267-271.

Christie, G., Merry, S., & Robinson, E. (2010). Do young people attending

addiction services differ from those attending youth mental health

services?. *Drug & Alcohol Review, 29*(4), 406-412.

Clarke, K., Harris, D., Zweifler, J. A., Lasher, M., Mortimer, R. B., & Hughes, S.

(2016). The significance of harm reduction as a social and health care

intervention for injecting drug users: An exploratory study of a needle

exchange program in Fresno California. *Social Work in Public Health,*

31(5), 398-407. https://doi.org/10.1080/19371918.2015.1137522

Clear, T. R., & Schrantz, D. (2011). Strategies for reducing prison populations. *The Prison Journal, 91*(3), 138-159.

Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: Controversies and recommendations. *Annals of Family Medicine, 6*(4), 331-339. https://doi.org/10.1370/afm.818

Copello, A., Templeton, L., & Powell, J. (2010). The impact of addiction on the family: Estimates of prevalence and costs. *Drugs: education, prevention and policy, 17*(1), 63-71.

Corcoran, J., & Walsh, J. (Eds.). (2010). *Clinical assessment and diagnosis in social work practice* (2nd ed.). New York, USA: Oxford University Press.

Costley, C., Elliott, G., & Gibbs, P. (2010). *Doing work based research: Approaches to inquiry for insider-researchers.* London, UK: SAGE.

Courtwright, D. T. (2001). *Dark paradise: A history of opiate addiction in America.* Cambridge, USA: Harvard University Press.

Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Balicki, M., Buxton, J., . . . Beyrer, C. (2016). Public health and international drug policy. *The Lancet, 387*(10026), 1427-1480. http://doi.org/10.1016/S0140-6736(16)00619-X

Csiernik, R., & Rowe, W. S. (Eds.). (2003). *Responding to the oppression of addiction: Canadian social work perspectives.* Toronto, Canada: Canadian Scholars' Press.

Dalley, B., & Tennant, M. (Eds.). (2004). *Past judgement: Social policy in New Zealand history.* Dunedin, New Zealand: University of Otago.

Davis, C., & Boddington, D. (2015). Teenage cardiac arrest following abuse of synthetic cannabis. *Heart, Lung and Circulation, 24*(10), 162-163. http://doi.org/10.1016/j.hlc.2015.04.176

Davenport-Hines, R. (2002). *The pursuit of oblivion: A global history of narcotics.* New York, USA: Norton.

Deering, D., Horn, J., & Frampton, C. M. A. (2012). Clients perceptions of opioid substitution treatment: An input to improving the quality of treatment. *International Journal of Mental Health Nursing, 21*(4), 330-339. https://doi.org/10.1111/j.1447-0349.2011.00795.x

Deering, D. E. A., Sheridan, J., Sellman, J. D., Adamson, S. J., Pooley, S., Robertson, R., & Henderson, C. (2011). Consumer and treatment provider perspectives on reducing barriers to opioid substitution treatment and improving treatment attractiveness. *Addictive Behaviors, 36*(6), 636-642. https://doi.org/10.1016/j.addbeh.2011.01.004

Department of Corrections. (2016). *Evidence-based principles for prison-based alcohol and drug treatment.* Retrieved from http://www.departmentofcorrections.govt.nz/resources/newsletters_and_brochures/journal/volume_4_issue_2_december_2016/evidence-based_principles_for_prison-based_alcohol_and_drug_treatment.html

Department of Corrections. (2016). *State of mind: Mental health services in New Zealand prisons.* Retrieved from http://www.departmentofcorrections.govt.nz/resources/newsletters_and_brochures/journal/volume_4_issue_2_december_2016/state_of_mind_mental_health_services_in_new_zealand_prisons.html

Doborjeh, M. G., Wang, G. Y., Kasabov, N. K., Kydd, R., & Russell, B. (2016). A
spiking neural network methodology and system for learning and
comparative analysis of EEG data from healthy versus addiction treated
versus addiction not treated subjects. *IEEE Transactions on Biomedical
Engineering, 63*(9), 1830-1841.
https://doi.org/10.1109/TBME.2015.2503400

Doweiko, H. E. (2015). *Concepts of chemical dependency* (9th ed.). Stamford,
CT: Cengage Learning.

Drake, D., & Walters, R. (2015). Crossing the line: Criminological expertise
policy advice and the quarrelling society. *Critical Social Policy, 35*(3),
414-433.

Drake, E. K., Aos, S., & Miller, M. G. (2009). Evidence-based public policy
options to reduce crime and criminal justice costs: Implications in
Washington State. *Victims and offenders, 4*(2), 170-196.

Drug and Alcohol Practitioners Association Aotearoa New Zealand. (2011).
Addiction intervention competency framework. Retrieved from
http://www.dapaanz.org.nz/vdb/document/22

Dugdale, S., Elison, S., Davies, G., Ward, J., & Dalton, M. (2016). Using the
transtheoretical model to explore the impact of peer mentoring on peer
mentors own recovery from substance misuse. *Journal of Groups in
Addiction & Recovery, 11*(3), 166-181.
https://doi.org/10.1080/1556035X.2016.1177769

Dunlop, W., & Tracy, J. (2013). Sobering stories: Narratives of self-redemption
predict behavioral change and improved health among recovering

alcoholics. *Journal of Personality and Social Psychology, 104*(3), 576-590.

Eldred-Grigg, S. (1984). *Pleasures of the flesh: Sex and drugs in colonial New Zealand: 1840-1915.* Wellington, New Zealand: Reed.

Engel, R., & Schutt, R. (2005). *The practice of research in social work.* Thousand Oaks, USA: Sage Publishing.

Fergusson, D., Boden, J., & Horwood, L. (2011). Structural models of the comorbidity of internalizing disorders and substance use disorders in a longitudinal birth cohort. *Social Psychiatry & Psychiatric Epidemiology, 46*(10), 933-942. https://doi.org/10.1007/s00127-010-0268-1

Ferragud, A., Velázquez-Sánchez, C., & Canales, J. J. (2014). Modulation of methamphetamines locomotor stimulation and self-administration by JHW 007: An atypical dopamine reuptake blocker. *European Journal of Pharmacology, 731*, 73-79. :https://doi.org//10.1016/j.ejphar.2014.03.015

Frances, A. & Dale-Jones, K. (2014). Should social workers use Diagnostic and Statistical Manual of Mental Disorders-5?. *Research on Social Work Practice, 24*(1), 11-12.

Fraser, S., & Moore, D. (2011). *The drug effect: Health crime and society.* Port Melbourne, VIC: Cambridge University Press.

Galvani, S. (2007). Refusing to listen: Are we failing the needs of people with alcohol and drug problems?. *Social Work Education, 26*(7), 697-707. https://doi.org/10.1080/02615470601129891

Gergen, K. (2009). *An invitation to social construction.* London, UK: SAGE.

Gibb, S. J., Fergusson, D. M., & Horwood, L. J. (2012). Working hours and alcohol problems in early adulthood. *Addiction, 107*(1), 81-88.

Global Commission on Drug Policy. (2017). *The world drug perception problem: Countering prejudices about people who use drugs.* Retrieved from http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf

Grey, A., Rix-Trott, K., Horne, A., Gamble, G., Bolland, M., & Reid, I. R. (2011). Decreased bone density in men on methadone maintenance therapy. *Addiction, 106*(2), 349-354.

Gunn, A. J., & Canada, K. E. (2015). Intra-group stigma: Examining peer relationships among women in recovery for addictions. *Drugs: Education, Prevention & Policy, 22*(3), 281-292.

Gurney, J., Shaw, C., Stanley, J., Signal, V., & Sarfati, D. (2015). Cannabis exposure and risk of testicular cancer: A systematic review and meta-analysis. *BMC Cancer, 15*(1), 897. https://doi.org/10.1186/s12885-015-1905-6

Harper, D. N., Hunt, M., & Schenk, S. (2006). Attenuation of the disruptive effects of (+/-)3 4-methylene dioxymethamphetamine (MDMA) on delayed matching-to-sample performance in the rat. *Behavioral Neuroscience, 120*(1), 201-205. https://doi.org/10.1037/0735-7044.120.1.201

Harrison, R., Rucklidge, J. J., & Blampied, N. (2013). Use of micronutrients attenuates cannabis and nicotine abuse as evidenced from a reversal design: A case study. *Journal of Psychoactive Drugs, 45*(2), 168-178. https://doi.org/10.1080/02791072.2013.785840

Health and Disability Commission. (2018). *New Zealands mental health and addiction services: The monitoring and advocacy report of the Mental*

Health Commissioner. Retrieved from

http://www.hdc.org.nz/media/4688/mental-health-commissioners-

monitoring-and-advocacy-report-2018.pdf

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Gallant, L., Haberle, B., . . .

Weiss, R. (2004). Self-help organisations for alcohol and drug problems:

Toward evidence-based practice and policy. *Journal of Substance Abuse*

Treatment, 26, 151-158.

Inter-Agency Committee on Drugs. (2015). *National drug policy 2015 to 2020.*

Wellington, New Zealand: Ministry of Health.

Kina Families and Addictions Trust. (2018). *Helping you understand the impact*

of addiction on your life and the life of your whānau. Retrieved from

http://www.kina.org.nz/

Kirpitchenko, L., & Voloder, L. (2014). Insider research method: The

significance of identities in the field. *SAGE Research Methods Cases.*

https://doi.org/10.4135/978144627305014533940

Krentzman, A., Robinson, E., Moore, B., Kelly, J., Laudet, A., White, W., . . .

Strobbe, S. (2010). How alcoholics anonymous (AA) and narcotics

anonymous (NA) work: Cross-disciplinary perspectives. *Alcohol Treat Q,*

29(1), 75-84.

Lancaster, K., Seear. K., & Treloar, C. (2015). Laws prohibiting peer distribution

of injecting equipment in Australia: A critical analysis of their effects.

International Journal of Drug Policy, 26, 1198-1206.

Laudet, A. (2008). The impact of alcoholics anonymous on other substance use

related twelve step programs. *Recent Developments in Alcohol, 18*, 71-

89.

Laudet, A., Magura, S., Cleland, C., Vogel, H., Knight, E., Rosenblum, A. (2004). The effect of 12-step based fellowship participation on abstinence among dually diagnosed persons: A two-year longitudinal study. *Journal of Psychoactive Drugs, 36*(2), 207-216.

Law Commission. (2010). *Compulsory treatment for substance dependence: A review of the alcoholism and drug addiction act 1966.* Retrieved from http://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R118.pdf

Law Commission. (2011). *Controlling and regulating drugs: A review of the misuse of drugs act 1975.* Retrieved from http://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R122.pdf

Lederman, L., & Menegatos, L. (2011). Sustainable recovery: The self-transformative power of storytelling in Alcoholics Anonymous. *Journal of Groups of Addiction and Recovery, 6*(3), 206-227.

Like Minds Like Mine. (2016). *Take the load off: Help end discrimination against mental illness.* Retrieved from https://www.likeminds.org.nz/

Lin, J., Jan, R., Lee, H., Jensen, M.A., Kydd, R., & Russell, B. (2011). Determining the subjective and physiological effects of BZP combined with TFMPP in human males. *Psychopharmacology, 214*(3), 761-768.

Lin, J. C., Jan, R. K., Kydd, R. R., & Russell, B. R. (2015). Investigating the microstructural and neurochemical environment within the basal ganglia of current methamphetamine abusers. *Drug and Alcohol Dependence, 149*, 122-127. http://doi.org/10.1016/j.drugalcdep.2015.01.026

Lyons, A. C., & Willott, S. A. (2008). Alcohol consumption gender identities and womens changing social positions. *Sex Roles, 59*(9), 694-712. https://doi.org/10.1007/s11199-008-9475-6

Marie, D., Fergusson, D. M., & Boden, J. M. (2008). Links between ethnic identification, cannabis use and dependence, and life outcomes in a New Zealand birth cohort. *Australian & New Zealand Journal of Psychiatry, 42*(9), 780-788.

Massey University. (2015). *Code of ethical conduct for research teaching and evaluations involving human participants.* Retrieved from http://www.massey.ac.nz/massey/fms/Human%20Ethics/Documents/MU HEC%20Code%202015.pdf?CA6CFFFAA5150271FD193A0B0C56C5C F

Matua Raki. (n.d.). *Real people share their recovery stories.* Retrieved from https://www.matuaraki.org.nz/uploads/files/resource-assets/Our-stories-booklet-WEB.pdf

Matua Raki. (2014). *A guide to the addiction treatement sector in Aotearoa New Zealand.* Retrieved from https://www.matuaraki.org.nz/uploads/files/resource-assets/a-guide-to-the-addiction-treatment-sector-in-Aotearoa-New-Zealand-June-2014.pdf

McCray, K., Wesely, J. K., & Rasche, C. E. (2011). Rehab retrospect: Former prostitutes and the (re)construction of deviance. *Deviant Behavior, 32*(8), 743-768. https://doi.org/10.1080/01639625.2010.514224

McCreanor, T., Barnes, H. M., Kaiwai, H., Borell, S., & Gregory, A. (2008). Creating intoxigenic environments: Marketing alcohol to young people in

Aotearoa New Zealand. *Social Science & Medicine, 67*(6), 938-946. http://doi.org/10.1016/j.socscimed.2008.05.027

McFadden Consultancy. (2016). *Research Report: The New Zealand drug harm index 2016* (2nd ed.). Wellington, New Zealand: Ministry of Health.

McKim, A. (2014). Roxannes dress: Governing gender and marginality through addiction treatment. *Signs: Journal of Women in Culture and Society, 39*(2), 433-458. https://doi.org/10.1086/673089

Miles, S. W., Sheridan, J., Russell, B., Kydd, R., Wheeler, A., Walters, C., . . . Tiihonen, J. (2013). Extended-release methylphenidate for treatment of amphetamine/methamphetamine dependence: A randomized double-blind placebo-controlled trial. *Addiction, 108*(7), 1279-1286.

Miller, R. J., & Alexander, A. (2015). The price of carceral citizenship: Punishment, surveillance, and social welfare policy in an age of carceral expansion. *Michigan Journal of Race & Law, 21*(291).

Ministry of Education. (2014). *Alcohol and other drug education programmes: Guide for schools.* Retrieved from http://health.tki.org.nz/Teaching-in-HPE/Policy-guidelines/Alcohol-and-other-drug-education-programmes

Ministry of Health. (1998). *A national drug policy for New Zealand 1998-2003.* Retrieved from https://norml.org.nz/downloads/national_drug_policy_1998.pdf

Ministry of Health. (2008). *Te puawaiwhero: The second Māori mental health and addiction national strategic framework 2008-2015.* Retrieved from https://www.mentalhealth.org.nz/assets/ResourceFinder/tepuawaiwhero-second-maori-mental-health-and-addiction-strategy.pdf

Ministry of Health. (2011). *Targeting smokers: Better help for smokers to quit.*

Retrieved from

https://www.health.govt.nz/system/files/documents/publications/targeting-

smokers-to-quit.pdf

Ministry of Health. (2012). *Rising to the challenge: The mental health and*

addiction service development plan 2012-2017. Retrieved from

https://www.health.govt.nz/publication/rising-challenge-mental-health-

and-addiction-service-development-plan-2012-2017

Ministry of Health. (2015). *National drug policy 2015-2020.* Retrieved from

https://www.health.govt.nz/system/files/documents/publications/national-

drug-policy-2015-2020-aug15.pdf

Ministry of Health. (2017). *Annual update of key results 2016/17: New Zealand*

health survey. Retrieved from

https://www.health.govt.nz/publication/annual-update-key-results-2016-

17-new-zealand-health-survey

Ministry of Health. (2017). *Help for families whānau friends.* Retrieved from

https://www.health.govt.nz/your-health/services-and-support/health-care-

services/help-alcohol-and-drug-problems/help-families-whanau-friends

Ministry of Health. (2017). *Mental health and addiction workforce action plan*

2017-2021. Retrieved from

https://www.health.govt.nz/system/files/documents/publications/mental-

health-addiction-workforce_-action-plan-2017-2021-feb17.pdf

Ministry of Health. (2018). *New Zealand health survey.* Retrieved from

https://www.health.govt.nz/nz-health-statistics/national-collections-and-

surveys/surveys/current-recent-surveys/new-zealand-health-survey#2016-17

Moaddab, M., Hyland, B. I., & Brown, C. H. (2015). Oxytocin excites nucleus accumbens shell neurons in vivo. *Molecular and Cellular Neuroscience, 68*, 323-330. http://doi.org/10.1016/j.mcn.2015.08.013

Morani, A. S., Ewald, A., Prevatt-Smith, K. M., Prisinzano, T. E., & Kivell, B. M. (2013). The 2-methoxy methyl analogue of salvinorin A attenuates cocaine-induced drug seeking and sucrose reinforcements in rats. *European Journal of Pharmacology, 720*(1–3), 69-76. doi:http://doi.org/10.1016/j.ejphar.2013.10.050

Nelson, A. (2012). *Social work with substance users.* London, UK: SAGE.

Newbold, G. (2016). *Crime law and justice in New Zealand.* New York, USA: Routledge.

New Zealand Drug Foundation. (2017). *Whakawātea te huarahi: A model drug law to 2020 and beyond.* Retrieved from https://www.drugfoundation.org.nz/assets/uploads/Whakawatea-te-Huarahi-July2017.pdf

New Zealand Drug Foundation. (2018). *Step into the light.* Retrieved from https://www.drugfoundation.org.nz/matters-of-substance/march-2018/step-into-the-light/

New Zealand Public Health and Disability Act 2000, 91, Parliamentary Counsel Office (1996).

Office of the Prime Minister's Chief Science Advisor. (2018). *Using evidence to build a better justice system: The challenge of rising prison costs.*

Retrieved from http://www.pmcsa.org.nz/wp-content/uploads/Using-evidence-to-build-a-better-justice-system.pdf

Office of the Prime Minister's Science Advisory Committee. (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence.* Retrieved from http://www.pmcsa.org.nz/wp-content/uploads/Improving-the-Transition-report.pdf

Pagey, B., Deering, D., & Sellman, D. (2010). Retention of adolescents with substance dependence and coexisting mental health disorders in outpatient alcohol and drug group therapy. *International Journal of Mental Health Nursing. 19*(6), 437-444.

Pantridge, C. E., Charles, V. A., DeHart, D. D., Iachini, A. L., Seay, K. D., Clone, S., & Browne, T. (2016). A qualitative study of the role of peer support specialists in substance use disorder treatment: Examining the types of support provided. *Alcoholism Treatment Quarterly, 34*(3), 337-353. https://doi.org/10.1080/07347324.2016.1182815

Patil, T., & Giordano, J. (2010). On the ontological assumptions of the medical model of psychiatry: Philosophical considerations and pragmatic tasks. *Philosophy, Ethics and Humanities in Medicine, 5*(3), 1-7.

Pauly, B., Wallace, B. & Barber, K. (2018) Turning a blind eye: Implementation of harm reduction in a transitional programme setting. *Drugs: Education, Prevention and Policy, 25*(1), 21-30. https://doi.org/10.1080/09687637.2017.1337081

Pei, Y., Mortas, P., Hoener, M. C., & Canales, J. J. (2015). Selective activation of the trace amine-associated receptor 1 decreases cocaine's reinforcing efficacy and prevents cocaine-induced changes in brain reward

thresholds. *Progress in Neuro-Psychopharmacology and Biological Psychiatry, 63*, 70-75. http://doi.org/10.1016/j.pnpbp.2015.05.014

Prasad, P. (2005). *Crafting qualitative research: Working in the postpositivist traditions.* New York, USA: Routledge.

Pratt, J., & Clark, M. (2005). Penal populism in New Zealand. *Punishment & Society, 7*(3), 303-22.

Pulford, J., Adams, P., & Sheridan, J. (2009). An investigation into whether clients and/or their respective clinicians are aware of pending service exit in the first two months of treatment admission. *Drug & Alcohol Review, 28*(6), 631-635.

Pulford, J., Adams, P., & Sheridan, J. (2011). What do clients want from AOD treatment services? A mixed methods examination. *Addiction Research & Theory, 19*(3), 224-234. https://doi.org/10.3109/16066359.2010.507893

Radak, G. (2016). *Ex-gang members who have become help-professionals: What influences their desistance from gang involvement and their career choice?* (master's thesis). Massey University, Auckland, New Zealand.

Reid, C., Greaves, L., & Poole, N. (2008). Good bad thwarted or addicted? Discourses of substance-using mothers. *Critical Social Policy, 28*(2), 211-234. https://doi.org/10.1177/0261018307087990

Reif, S., Braude, L., Lyman, R. D., Dougherty, R. H., Daniels, A. S., Ghose, S. S., . . . Delphin-Rittmon, M. E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services, 65*(7), 853-861. https://doi.org/10.1176/appi.ps.201400047

Richards, M. (2014). *Property of corrections: The experience of incarceration for female inmates in a New Zealand prison.* (master's thesis). Victoria University, Wellington, New Zealand.

Richardson, M. A. (2008). Social work education: The availability of alcohol-related course curriculum and social workers ability to work with problem drinkers. *Journal of Social Work Practice, 22*(1), 119-128.

Roussy, V., Thomacos, N., Rudd, A., & Crockett, B. (2015). Enhancing health-care workers understanding and thinking about people living with co-occurring mental health and substance use issues through consumer-led training. *Health Expectations, 18*(5), 1567-1581. https://doi.org/10.1111/hex.12146

Royse, D. (2003). *Research methods in social work.* Pacific Grove, CA: Brooks/Cole-Thomson Learning.

Rubbin, A., & Babbie, E. (2013). *Essential research methods for social work.* Belmont, CA: Brooks/Cole-Cengage Learning.

Sallmann, J. (2010). Living With Stigma: Women's Experiences of Prostitution and Substance Use. *Affilia, 25*(2), 146-159. https://doi.org/10.1177/0886109910364362

Salvation Army. (2018). *Kei a tātou it is us: State of the Nation report.* Retrieved from http://www.salvationarmy.org.nz/sites/default/files/uploads/20180214tsastateofthenation2018.pdf

Schlosser, A. V., & Hoffer, L. D. (2012). The psychotropic self/imaginary: Subjectivity and psychopharmaceutical use among heroin users with co-

occurring mental illness. *Culture, Medicine & Psychiatry, 36*(1), 26-50. https://doi.org/10.1007/s11013-011-9244-9

Schroder, R., Sellman, D., Frampton, C., & Deering, D. (2008). Profile of young people attending AOD treatment services in Aotearoa, New Zealand: Clinical file search. *Australian & New Zealand Journal of Psychiatry, 42*(11), 963-968.

Shaw, F., & Gould, N. (2001). *Qualitative research in social work.* London, UK: SAGE.

Shepherd, R. M., & Pinder, J. (2012). Reflective practice in addiction studies: Promoting deeper learning and de-stigmatising myths about addictions. *Reflective Practice, 13*(4), 541-550.

Sheridan, J., Goodyear-Smith, F., Butler, R., Wheeler, A., & Gohns, A. (2008). Barriers to and incentives for the transfer of opioid-dependent people on methadone maintenance treatment from secondary care to primary health care. *Drug & Alcohol Review, 27*(2), 178-184.

Simpson, M., & McNulty, J. (2008). Different needs: Women's drug use and treatment in the UK. *International Journal of Drug Policy, 19*(2), 169-175. https://doi.org/10.1016/j.drugpo.2007.11.021

Skager, R. (2013). *Beyond zero tolerance: A reality-based approach to drug education and school discipline.* USA: Drug Policy Alliance.

Spivakovsky, C., & Seear, K. (2017). Making the abject: Problem-solving courts addiction mental illness and impairment. *Journal of Media and Cultural Studies, 31*(3), 458-469.

Staiger, P. K., Thomas, A. C., Ricciardelli, L. A., McCabe, M. P., Cross, W., & Young, G. (2011). Improving services for individuals with a dual

diagnosis: A qualitative study reporting on the views of service users. *Addiction Research & Theory, 19*(1), 47-55. https://doi.org/10.3109/16066351003637278

Starks, H., & Brown-Trinidad, S. (2007). Choose your method: A comparison of phenomenology discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380. https://doi.org/10.1177/1049732307307031

Substance Abuse and Mental Health Services Administration. (1999). *Brief intervention and brief therapies for substance use.* Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK64942/

Substance Addiction (Compulsory Assessment and Treatment) Act 2017, 4, Parliamentary Counsel Office (2017).

Swain, N. R., Gibb, S. J., Horwood, L. J., & Fergusson, D. M. (2012). Alcohol and cannabis abuse/dependence symptoms and life satisfaction in young adulthood. *Drug & Alcohol Review, 31*(3), 327-333.

Szott, K. (2015). Contingencies of the will: Uses of harm reduction and the disease model of addiction among health care practitioners. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 19*(5), 507-522. https://doi.org/10.1177/1363459314556904

Te Pou o te Whakaaro Nui. (2013). *Te whare o tiki: Co-existing problems knowledge and skills framework.* Retrieved from https://www.matuaraki.org.nz/resources/te-whare-o-tiki-co-existing-problems-knowledge-and-skills-framework/437

Te Pou o te Whakaaro Nui. (2014). *Adult mental health and addiction workforce: 2014 survey of vote health funded services.* Retrieved from

https://www.tepou.co.nz/uploads/files/resource-assets/full-report-of-the-

adult-mental-health-and-addiction-workforce-2014-survey-of-Vote-

Health-funded-services-v2.pdf

Te Pou o te Whakaaro Nui. (n.d.). *Competencies for the mental health and

addiction service user consumer and peer workforce.* Retrieved from

https://www.tepou.co.nz/uploads/files/resource-assets/peer-support-

competencies-2014.pdf

Templeton, L., Zohhadi, S., & Velleman, R. (2007). Working with family

members in specialist drug and alcohol services: Findings from a

feasibility study. *Drugs: Education, Prevention and Policy, 14*, 137–150.

Todd, F., Sellman, D., & Robertson, J. (2002). Barriers to optimal care for

patients with co-existing substance use and mental health disorders.

Australian and New Zealand Journal of Psychiatry. 36(6), 792-799.

Tuffin, K. (2004). *Understanding critical social psychology.* Palmerston North,

New Zealand: SAGE Publications.

Tunnard, J. (2002). *Parental problem drinking and its impact on children.*

Dartmouth, UK: Research in Practice. Retrieved from

http://www.rip.org.uk

UNAIDS. (2017). *Agenda for zero discrimination in healthcare settings.*

Retrieved from

http://www.unaids.org/sites/default/files/media_asset/2017ZeroDiscrimin

ationHealthCare.pdf

United Nations Office on Drugs and Crime. (2017). *World drug report 2017.*

Retrieved from

https://www.unodc.org/wdr2017/field/Booklet_1_EXSUM.pdf

van Ours, J. C., Williams, J., Fergusson, D., & Horwood, L. J. (2013). Cannabis use and suicidal ideation. *Journal of Health Economics, 32*(3), 524-537. http://doi.org/10.1016/j.jhealeco.2013.02.002

Walters, C., Raymont, A., Galea, S., & Wheeler, A. (2012). Evaluation of online training for the provision of opioid substitution treatment by community pharmacists in New Zealand. *Drug & Alcohol Review, 31*(7), 903-910.

Walters, S. T., & Rotgers, F. (Ed). (2012). *Treating substance use: Theory and technique.* New York, USA: Guilford Press.

Wang, G. Y., Kydd, R., & Russell, B. R. (2015). Auditory event-related potentials in methadone substituted opiate users. *Journal of Psychopharmacology, 29*(9), 983-995. https://doi.org/10.1177/0269881115587929

Wang, G. Y., Kydd, R., Wouldes, T. A., Jensen, M., & Russell, B. R. (2015). Changes in resting EEG following methadone treatment in opiate addicts. *Clinical Neurophysiology, 126*(5), 943-950. http://doi.org/10.1016/j.clinph.2014.08.021

Wang, G. Y., Wouldes, T. A., Kydd, R., Jensen, M., & Russell, B. R. (2014). Neuropsychological performance of methadone-maintained opiate users. *Journal of Psychopharmacology, 28*(8), 789-799. https://doi.org/10.1177/0269881114538541

Watson, C. (2005). *Living the life of the social inquirer: Beginning educational research.* Paper presented at the Forum Qualitative Sozialforschung/Forum: Qualitative Social Research.

Webster, J. & Bosmann-Wātene, G. (2003). Walking in two worlds: A critique of

    the diagnostic and statistical manual of mental disorders from a

    perspective of Te Ao Māori. *Social Work Review, 15*(3), 8-11.

West, R., & Brown, J. (2013). *Theory of addiction.* (2nd ed.). New Jersey, USA:

    John Wiley & Sons.

Wiens, T. K., & Walker, L. J. (2015). The chronic disease concept of addiction:

    Helpful or harmful? *Addiction Research & Theory, 23*(4), 309-321.

    https://doi.org/10.3109/16066359.2014.987760

Wilkins, C., Sweetsur, P., & Griffiths, R. (2011). Recent trends in

    pharmaceutical drug use among frequent injecting drug users, frequent

    methamphetamine users and frequent ecstasy users in New Zealand,

    2006-2009. *Drug & Alcohol Review, 30*(3), 255-263.

World Health Organisation. (2005). *International statistical classification of*

    diseases and related health problems (10th ed.). Retrieved from

    http://apps.who.int/classifications/icd10/browse/2016/en

World Health Organisation. (2014). *Global status report on alcohol and health*

    2014. Retrieved from

    http://apps.who.int/iris/bitstream/10665/112736/1/9789240692763_eng.p

    df?ua=1

World Health Organisation. (2017). *World health statistics 2017: Monitoring*

    health for the SDG's. Retrieved from

    http://apps.who.int/iris/bitstream/10665/255336/1/9789241565486-

    eng.pdf?ua=1

World Health Organisation. (2018). *Facts and figures.* Retrieved from

    http://www.who.int/substance_abuse/facts/en/

Appendices

Appendix A

Date: 17 August 2017

Dear Rachel Jowett

Re: Ethics Notification - **SOA 17/29 - What works in recovery? AOD professionals lived experiences of addiction, treatment and recovery in New Zealand.**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: <u>Human Ethics Southern A Committee</u> at their meeting held on <u>Thursday, 17 August,</u>

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Brian Finch
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Cultural Supervision Contract

between

Rachel Jowett

and

Matey Galloway

for

Master of Social Work
College of Health
Massey University

2017

Supervision with Matey Galloway

Contact details

Email: manager@oasisnetwork.org.nz

Phone: 021 958 038

Office: (04) 566 1602

Postal address: Level 2, 14 Laings Road, Lower Hutt, 5010

Courier address:

Supervision Meetings

There will be three supervision meetings.

First supervision: To occur before research commences face to face interviews.

Second supervision: To occur halfway through the interview process.

Third supervision: After transcription and before analysis of transcribed data.

Statements of Expectations

Supervisor to:

1. Provide cultural supervision to the researcher regarding all matters pertaining to interviews with Tangata Whenua who are participating as interviewees.
2. To provide supervision on tikanga before interviews commence.
3. To provide a reflective space halfway through the interview process to ensure the researcher is upholding Tangata Whenua autonomy and rights and respecting tikanga in the interview process.
4. To discuss interview outcomes and encourage consideration of unique perspectives of Tangata Whenua to ensure fair and accurate analysis of interview data.

Your Supervisor can expect you to:

1. Notify him of the interview timeline once the final ethics application has been approved by the Massey University Ethics Committee and schedule the three supervision sessions accordingly.
2. Come prepared to supervision with concerns, issues, questions.
3. Make early contact if you can't keep to agreed schedules or meeting times with your supervisor.

Signed _____R. Jewett_____ Student

Signed _____ Supervisor

Date _____3/8/17_____

MASSEY UNIVERSITY
COLLEGE OF HEALTH
TE KURA HAUORA TANGATA

WHAT WORKS IN RECOVERY? AOD PROFESSIONALS LIVED EXPERIENCES OF ADDICTION, TREATMENT AND RECOVERY IN NEW ZEALAND

RACHEL JOWETT
MASSEY UNIVERSITY MASTER'S STUDENT

Dear ,

I am writing to you to request assistance with advertising the Master's research I am doing with the support of Massey University. I am a social worker who works in the mental health and addiction sector and am currently completing a Master's of Social Work. I am looking to recruit research participants for my qualitative research that seeks to understand the lived experiences of people currently working in the AOD sector in New Zealand, who have also personally experienced addiction.

If you could support me by advertising the opportunity for people to participate in this research on your mental health and addictions sector noticeboards and in your newsletter, that would be greatly appreciated.

Please feel free to contact me directly if needed, I have also attached the information sheet and consent form for your information.

Kindest regards,

Rachel Jowett

Mon 11/09/2017 5:08 p.m.

Rachel Jowett

Chatting at cutting edge

To 'Klare Braye'

Information sheet 2017.docx (128 KB)

Hi Klare

It was great meeting you last week, I'm glad that   introduced me to you.
We discussed the research I'm doing as a Master's student with Massey University and you gave me your card so that I could email through a blurb to put in the sector noticeboard re: recruiting participants.

Please find the blurb below, I've also attached the Information Sheet for the research so that you know I'm a legit research student with supervisors and ethical approval ☺

What works in recovery? AOD professionals lived experiences of addiction, treatment and recovery in New Zealand.

Kia ora tatou, I am completing a Master's thesis with the purpose of understanding addiction, treatment and recovery in New Zealand from the perspective of those currently (or who have been recently) working in the alcohol and other drug (AOD) sector in New Zealand and who also have lived experience of addiction. My names Rachel Jowett I am enrolled in the Master of Social Work programme at Massey University and am also employed as a Peer Advocate with Oasis Network Inc. in Lower Hutt, Wellington. If you'd be interesting in attending a confidential, one hour, face to face interview with me for this project please email me for further information at ███████████████████

Thank you for your support.

Nga mihi,

Rachel Jowett
BSW, PG Dip. Social Work, RSW
SWRB Reg# 8126

(Massey University letterhead)

<div align="right">**Appendix E**</div>

<div align="center">**Participant Information Sheet**</div>

Title of Project

What works in recovery? AOD professionals lived experiences of addiction, treatment and recovery in New Zealand.

An Invitation

Kia ora my names Rachel Jowett I am enrolled in the Master of Social Work programme at Massey University and am employed as a Peer Advocate with Oasis Network Inc. in Lower Hutt, Wellington. I am completing a research project that seeks to understand addiction, treatment and recovery in New Zealand from the perspective of those currently (or who have been recently) working in the alcohol and other drug (AOD) sector in New Zealand.

What is the purpose of this research?

The purpose of this research is to understand what works in addiction recovery from the perspective of those who have lived through AOD addiction. The qualitative methodology will allow for a rich, in-depth exploration of this topic, a methodological approach seldom used in AOD addiction research in New Zealand.

How were you chosen for this invitation?

This invitation has been extended to you because you have indicated that you identify as a person with personal experience of AOD addiction, that your experiences of addiction and recovery have taken place in New Zealand and that you are (or have been within the last five years) a qualified professional working in the AOD sector in New Zealand.

If you would like to participate, how do you volunteer?

If you would like to participate please email ███████████████████ .

Data collection is due to commence by the end of August so confirmation of your participation needs to be emailed through within two weeks of you receiving this information sheet.

The researcher will reply to you within one week of your initial email and will send you a Consent Form which you will need to sign and send back to the researcher before the interview can commence. Interviews are taking place in August and September 2017 and the time, date and location for the interview to take place will be organized so it best suits you.

If you participate, what will you need to do?

The researcher is asking that you attend one interview session lasting approximately one to one and a half hours.

- It is estimated that you will need approximately half an hour to go over the research questions for the semi-structured interview before you attend. The interview schedule will be sent to you at least one week before the interview.

- You will need to attend the interview in a location where you and the researcher feel comfortable and discuss your experiences of addiction in New Zealand, an example of the research questions are as follows; *General Can you please tell me about your journey through addiction recovery? What have your experiences been when accessing AOD services in New Zealand? Specific What were the factors that made your recovery from addiction successful? What were the successes and limitations of the AOD services that you accessed for support during your recovery? Now that you are a professional working in the field of AOD service provision, what do you consider to be the strengths and limitations of current AOD service delivery in New Zealand?*

- After the interview is completed the researcher will fully transcribe your interview and send the transcript to you for you to review and amend if necessary. The researcher will send the transcribed interview to you one week after the interview and asks that you send back any feedback and/or amendments within seven days.

If you participate, what are the benefits?

The greatest benefit of participation is likely to be the insight that other academics and professionals will gain, regarding what works in addiction recovery in New Zealand. We will also offer you a token of our appreciation (koha) upon completion of the face to face interview.

If you participate, what are the risks of being involved?

You may feel concerned about being identified via your interview data. I would like to reassure you that your interview recording and transcript will remain confidential and only be viewed by the researcher and the researcher's supervisors. The researcher will also ensure that any quotes or unique identifiers are modified before including them in the final thesis.

Participants should be aware that they need to safeguard themselves when discussing matters that could be considered 'criminal', participants are asked not to include identifiers in their interviews if they are going to be discussing topics of this nature.

If you participate, what are your rights?

You are under no obligation to accept this invitation. If you decide to participate:

- You have the right to withdraw from the study at any point

- Ask any questions about the study at any time during participation

- Decline to answer any question

You also have a right to a copy of the final research report, you will be sent a link to the full thesis which will be available online via the Massey University Library.

If you participate, how will your data be managed and stored?

All information that is kept for this study is kept on a computer that is password locked and can only be accessed by the researcher. Interviews will be audio recorded and transcribed. All written and audio recorded information is transferred to a computer file

and the hard copies are destroyed. All data will be destroyed after the 28th February 2018 which is when the research project will be completed.

Who else is involved in this research?

From Massey University, the researchers' academic supervisors are Dr Michael Dale (Senior Lecturer in Social Work and Social Policy) and Ms. Lareen Cooper (Associate Head of School – Social Work and Social Policy).

If you participate, what do you do if you have concerns about the research?

If you have any concern's, please contact one of the researchers Supervisors:

Dr Michael Dale

Email: M.P.Dale@massey.ac.nz

Phone Number: (06) 356 9099 ext. 83522

Lareen Cooper

Email: L.Cooper@massey.ac.nz

Phone Number: (06) 356 9099 ext. 83519

Who should you contact for further information about the research?

If you have any further questions, please contact the researcher directly at

███████████████ .

Thank you for your time.

Nga mihi nui,

Rachel Jowett

RSW

SWRB reg# 8126

Student Researcher | Massey University | College of Health

Oasis Network | 14 Laings Road | Lower Hutt | 5010

T: ██████████ | E: ████████████████████

This project has been reviewed and approved by the Massey University Human Ethics Committee:

Southern A, Application 17/29. If you have any concerns about the conduct of this research,

please contact Dr Lesley Batten, Chair, Massey University Human Ethics Committee: Southern

A, telephone 06 356 9099 x 85094, email humanethicsoutha@massey.ac.nz.

(Massey University letterhead)

What works in recovery? AOD professionals lived experiences of addiction, treatment and recovery in New Zealand.

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: **Date:**

....

Full Name - printed

....

AOD professionals lived experiences of addiction, treatment and recovery in New Zealand.

Interview Schedule

General

Can you please tell me about your journey through addiction recovery?

What have your experiences been when accessing AOD services in New Zealand?

What have been your experiences when discussing your lived experience of addiction in a workplace?

Specific

What was your experience with AOD addiction?

- How long ago was your active addiction?

- Could you tell me about the context of your addiction?

Could you describe any barriers that you faced when you decided to try and access support for your addiction?

- How did that make you feel?

- Did those barriers hinder your recovery journey? If yes, how?

What were the successes and limitations of the AOD services that you accessed for support during your recovery?

- What type of AOD addiction support did you receive?

Now that you are a professional working in the field of AOD service provision, what do you consider to be the strengths and limitations of current AOD service delivery in New Zealand?

- What kind of trends do you see in current AOD misuse in New Zealand?