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“Connection in isolation… nothing can keep us apart” —COVID-19 and Narcotic Anonymous

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Abstract

Addiction is a complex phenomenon, which can cause significant harm for individuals, family, whānau, and communities. Treating an addiction requires a fit for purpose, personalised and long-term treatment approach. One option is Narcotics Anonymous (NA), a twelve-step peer support group that is comprised of people with an addiction who help one another to have an abstinent-based recovery from using drugs. In March 2020 Aotearoa New Zealand went into a nationwide lockdown to stop the spread of COVID-19, which drastically changed the way NA had to operate. Currently, there is limited research on NA that is situated in Aotearoa, and none that explore NA during the nationwide COVID-19 lockdowns.

This study aimed to investigate how NA members managed their recovery during the COVID-19 lockdowns in Aotearoa between March 2020 to August 2021. Eleven NA members took part in a semi-structured interview to share their stories of addiction, recovery, NA, and COVID-19. A thematic narrative analysis was used to explore how the COVID-19 pandemic impacted on the recovery of NA members, and what role NA played in the lives of its members during this time.

The findings suggest that the recovery of NA members was able to continue throughout COVID-19 lockdowns because of the principles and fellowship of NA both prior and during lockdown. By rapidly moving meetings online and with technical support, participants were able to maintain their connections with others in recovery, express gratitude for what they had, experience new opportunities for self-care and sharing, and remain consistent in their recovery practices. Furthermore, the NA fellowship supported members to navigate the challenges of a novel online environment. The findings indicate how technology can be used in a disaster setting to continually provide support for vulnerable populations, highlight how NA is a successful treatment modality, and demonstrate the value of mutual, or peer-based recovery support. This has important implications for the way that we approach and understand addiction and recovery, especially in unusual times such as a global pandemic.

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Table of Contents

Abstract ii

Acknowledgements iii

Table of Contents iv

List of Figures vi

Prologue 1

Chapter One: Introduction 2

Addiction 3

Conceptualisation of Drug Addiction 3

The Stigma Associated with Addiction 5

Prevalence of Addiction 6

The Consequences of Addiction 8

Addiction and Recovery 9

Treatment Options 9

Narcotics Anonymous 10

History of Narcotics Anonymous in Aotearoa 14

The Recovery Movement 15

COVID-19 16

Research Objectives 19

Chapter Two: Literature Review 20

Theories of Addiction 20

The Moral Model 20

The Disease Model 21

The Concept of Recovery 23

Recovery Capital 25

Social Identity 27

Narcotics Anonymous Literature 28

Specific Research on NA and Long-Term Recovery Outcomes 29

Activities Within NA That Act as Mechanisms for Change 31

Other Theories and Mechanisms of NA 32

Critiques of NA 33

Research into Online Support 35

Conclusion 37

Chapter Three: Methodology 39

Theoretical frameworks 40

Critical Participatory Action Research 40

Narrative Theory 40

Procedure 42

Participant Selection 42

Data Collection 43

Reflexivity 45

Ethical Considerations 47

Data Analysis 49

Chapter Four: Findings 52

Background 52

COVID-19 53

Maintaining Connections 54

Through Online Meetings 54

Through Other Options 60

Expressing Gratitude 63

For the Fellowship 63

For Recovery and Being a Member of NA 65

For Giving to Others 68

A Case Study 69

Creating Opportunities 70

New Possibilities 71

Self-care opportunities 76

Upkeeping Consistency 77

Service in an Online Environment 81

Summary 85

Chapter Five: Discussion 87

Online Support 87

NA and Long-Term Recovery 89

Theoretical Insights 90

Perceptions of Recovery 91

Reflections and Future Research 92

Chapter Six: Conclusion 96

References 97

Appendices 124

Appendix A: Theories of stigma and its relation to addiction 124

Appendix B: Additional information about Narcotics Anonymous 128

The history of Narcotics Anonymous internationally 129

The twelve-steps of Narcotics Anonymous (sourced from Narcotics Anonymous, 2008) 131

The twelve-traditions of Narcotics Anonymous (taken directly from Narcotics Anonymous, 2008, p. 60) 131

Zonal Map of NA 2020 132

Sample meeting format 133

Appendix C: New Zealand COVID-19 Alert Level Summary 135

Appendix D: Ethics documents 136

Information sheet 136

Consent form 139

Interview guide 140

Transcript release authority 142

Where to seek help document 143

List of Figures

Figure 1 12
Figure 2 17
Figure 3 43
Figure 4 128
Figure 5 132
Figure 6 135

Prologue

As I embarked on this thesis in late February 2021, it was marked by the one-year anniversary of Aotearoa New Zealand's first COVID-19 case, and the anniversary of our first level four lockdown was approaching. Words like lockdown, social distancing, and quarantine quickly became part of our everyday vocabulary. People were encouraged to stay home to reduce community transmission and flatten the curve. A common short-sighted narrative asserted in the media and by the Aotearoa government was that 'we are all in this together' (Ryan, 2020). However, while as a country we may have all been faced with the same restrictions we all had massively different experiences of the pandemic. Lockdowns posed unique challenges for everyone, yet for certain groups such as those with an addiction, these challenges were potentially intense and, at times, heightened. During lockdowns, access to much needed support services, such as Narcotics Anonymous, were limited and moved online.

Chapter One: Introduction

"No one is immune from addiction; it afflicts people of all ages, races, classes, and professions"

—Patrick J. Kennedy

The aim of this research was to explore how members of Narcotics Anonymous (NA) living in Aotearoa managed their recovery during the various COVID-19 lockdown periods from March 2020 to August 2021. This research presents their experiences of addiction, recovery from addiction, their time under COVID-19 restrictions and the role that NA played in these experiences. In order to situate this study, this chapter begins by outlining what a drug addiction is and the various ways it is conceptualised by different stakeholders. The complex intersection of addiction and stigma is explored, as well as the prevalence and consequences of addiction. These discussions are important as they refer to the policies and practices that impinge on groups like NA and the challenges people who have an addiction endure.

From there, I move to discuss recovery from an addiction. Treatment options will be covered, and the primary focus group of this thesis—NA, will be explored. This will involve outlining the NA programme, including its history both internationally and in Aotearoa and the unique service components and structure. The recovery movement will also be discussed. Because this research is contextualised within the COVID-19 pandemic, I also outline the pandemic so far, the experiences we have had within Aotearoa in 2020 and 2021, and the impact this has had on those recovering from a drug addiction. The chapter will finish with the research objectives for this study.

For those with a drug addiction, the time spent in the grasps of that addiction can be chaotic and often the only way out is with a complete lifestyle change. Compounding this is that society's understanding of addiction is limited at best. This means there is little allowance within social policies to help those with an addiction, creating limited treatment options (Kennedy-Hendricks et al., 2017). Many treatment modalities provide short-term care only, but with a chronic relapsing condition, like an addiction, long-term care is often necessary. One treatment option for people who experience addiction is mutual support groups. These groups offer long-term, cost-effective care by providing advice and social and spiritual support from peers who share a common problem (Kelly et al., 2014). One well-known support group is NA, a twelve-step mutual support group that is comprised of people with an addiction who help each other to have an abstinent-based recovery from using drugs. Within this thesis, the stories and experiences of members of NA within Aotearoa will be examined within the context of the COVID-19 pandemic that has gripped the world.

Addiction

Conceptualisation of Drug Addiction

The definitions and use of the word addiction can vary, and as with any construction of a phenomenon, it has an impact on how people with an addiction are treated and what resources are available. The most widely adopted definition is from the American Society of Addiction Medicine (ASAM) who define an addiction as a treatable, chronic medical disease that involves a complex interplay of brain circuits, genetics, the environment, and an individual's life experience. An addiction can form to a substance, and when one is addicted to something, their use or engagement with the substance becomes uncontrollable, compulsive, and continuous, despite the harmful consequences it produces for the individual and those around them (ASAM, 2019). NA also views addiction as a disease, in which there is no distinction between drugs; there is only addiction itself (the model of addiction as a disease will be discussed in the next chapter). As such, a person does not have multiple 'addictions' to different substances that can be addressed separately, all substances are problematic, and it does not matter which one is used (Travis, personal communication, March 6th, 2022).

In contrast, in 1964 the World Health Organisation (WHO) expert committee replaced the concept of addiction with dependence because they believed the term better referred to the physical dependence of a whole range of psychoactive drugs as well as specific references to a particular drug (World Health Organisation, n.d). WHO defines dependence syndrome as "being 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, n.d). NA, as with others, maintained the use of the term addiction however. For instance, within the addiction workforce sector in Aotearoa, the term addiction encompasses a broad spectrum of substance use behaviour that ranges from being risky/harmful to 'disorders' of increasing severity (Koning, 2019; Paterson et al., 2018).

The American Psychiatric Association uses the DSM-5 to define and diagnose an addiction. They use the umbrella term, substance use disorder, which incorporates both substance abuse and dependence. Substance use disorder is when a person has a problematic pattern of substance use that leads to clinically significant impairment or distress, including cravings, persistent desire, unsuccessful efforts to cut down or control substance use, and developing a physical tolerance or physical withdrawal without the substance (American Psychiatric Association, 2013).

The general public in Aotearoa appear to take up the term addiction and understand it as those at the 'extreme end' of the drug use spectrum. At this extreme end people with severe substance use problems are thought to no longer have control over taking or using a substance and

characteristically have cravings, neuroadaptation, tolerance, and withdrawal (Health Navigator New Zealand, 2022). Public ideas around addiction are also influenced by Aotearoa's neoliberal political landscape.

Neoliberalism is comprised of three principles—individualism, free market via privatisation and deregulation, and decentralisation (McGregor, 2001). It encourages the idea that state care is inefficient, and instead private markets are more cost-effective and consumer-friendly. This results in limiting public expenditure on social services, such as healthcare, and the deregulation and promotion of individual responsibility (Barnett & Bagshaw, 2020). This advances the idea that health is a personal responsibility, and for a health problem like addiction, people are quick to believe that it is the result of poor personal or lifestyle choices and is an individual moral failing. With these social dictates, fewer resources and support are given to social policies for addiction as it is not seen as a health issue—rather a criminal issue. As such, there are fewer services or treatment options for those that use drugs. A neoliberal society also pushes for legal consumption, such as the purchasing of alcohol, as this adds to the economic pool through production, distribution, and other related activities (Room, 2011). This consumption must be done in a way that does not impact on social roles and expectations however, for example not at work, when driving a car, or caring for someone else. Once again, the blame is placed on the individual to manage any arising conflicts that come from the consumption of these substances (Room, 2011). Ultimately, the addiction landscape in Aotearoa is political; our neoliberal society influences the public's beliefs of addiction and produces moral dictates around drug use, which then makes substance use a costly and contested issue.

Various policies have attempted to address problematic beliefs and conceptualisation of drug use and addiction within Aotearoa. For instance, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* was conducted in 2018 to hear the voices of the people who have lived experience of mental health and addiction problems, as well as the voices of the community and others affected by these problems (Paterson et al., 2018). The report aimed to capture the overall picture of mental health and addiction in Aotearoa and share what needs to be changed. In relation to addiction, *He Ara Oranga* argues that across Aotearoa, many people considered alcohol and other drug use a serious public health concern that can have detrimental consequences for communities. Additionally, people reported that there was a high social cost of not addressing addiction, with harm to family, whānau, children, and communities occurring. There was a clear call to adopt an approach to drug use that minimised harm and provided more pathways to recovery. The report recommended that there needs to be a shift in the national mindset away from stigmatising addiction towards viewing addiction as a health issue that requires care and support for effective management.

The Stigma Associated with Addiction

The WHO found that substance use disorder is the most stigmatised health condition, and alcohol use disorder is the fourth most stigmatised condition (Room et al., 2001). This stigma comes from both the public and trained healthcare professionals and works to extensively discredit a person (Best, 2016; McGinty et al., 2015; Rao et al., 2009). Driving this stigma is the widespread belief that addiction is the result of weak character, poor choice, and a lack of self-discipline rather than a disorder of altered brain circuits (Volkow, 2020). Many believe that the associated behaviours are immoral, illegal, dangerous, and deviant and for those with an addiction, these behaviours become inseparable from them as a person (Link & Phelan, 2001). The Jones et al. (2010) survey of the general public of the United Kingdom found that nearly half of the respondents agreed that people with an addiction are a burden on society. Furthermore, Phillips and Shaw (2013) found that generally there was limited faith in recovery for those with an addiction, and people would prefer to be distanced from substance users, even if they are in recovery. Within healthcare settings, internationally it has been found that health professionals had highly stigmatised attitudes towards those with an active addiction, however these attitudes were less stigmatising towards those who were recovering (van Boekel et al., 2013). This means that those with an addiction can face additional barriers when seeking help for both general health problems and their addiction. Stigma is an important complex factor to consider and understand for those with an addiction, but it is not the main focus of this research. An acknowledgement of stigma is necessary though, as it is prevalent throughout stories of addiction, it influences the recovery journeys for people with an addiction, and it helps to understand why anonymous support groups like NA are needed (for more information on stigma see Appendix A).

While the word addiction is still widely used, the derivative term 'addict' is argued to be derogatory and adds to the stigma that substance users face (Atayde et al., 2021). The language we use to speak about addiction matters as it can contribute to the stigma that many with an addiction already face and can change understandings of the concept (Broyles et al., 2014). If language is utilised problematically it can have a negative impact on the way society perceives substance use and those who are affected by it (Ashford et al., 2018). The stigma that specific language causes can have detrimental effects on the health of those with an addiction and can also act as a barrier for basic care and treatment.

Within this research, the terms addiction and addict will be engaged because this terminology aligns with the preferences of NA. In their approach, addiction itself is the problem, rather than a specific drug or person, hence the founders of NA understood and phrased the

problem of addiction as a disease (Peyrot, 1985). It is also important to recognise when NA was established, as the language and terminology used in the NA programme and relevant NA literature can reflect that time. As later editions of NA literature have been published, such as the Basic Text[1], the literature has been reviewed and edited. Other key pieces of NA literature, (i.e., twelve-steps and twelve-traditions) maintain their original focus on people seeking recovery (Narcotics Anonymous, 2008) and has not been updated.

Furthermore, I will mainly utilise the term 'substances' or 'drugs' instead of 'alcohol and other drugs' (AOD), as these terms encompass all drugs and do not categorise or place a sanction on alcohol because of its legal status. This aligns with the principles of NA as they do not make a distinction between the various types of drugs (Narcotics Anonymous, 1986) and have members that use a range of legal drugs, such as prescription drugs, alcohol, and opioid substitution therapy, as well as members that use a range of illegal drugs, such as marijuana, methamphetamines, opiates, hallucinogenics, etc.

Prevalence of Addiction

Substances can be used for a variety of reasons, including recreationally, for spiritual discovery, performance enhancement, or to medicate emotional or physical pain (New Zealand Drug Foundation, 2021). One international study by Boys et al. (2001) found that among young poly-drug users, 96.7% said they used substances to relax, 96.4% said substances were used to become intoxicated, 95.9% used to keep themselves awake at night while socialising, 88.5% used to enhance an activity and 86.8% used to alleviate a depressed mood. Substance use can be thought of on a spectrum from no use/low-risk use, through to hazardous use/harmful use/mild dependence and up to moderate/severe dependence (New Zealand Drug Foundation, 2015). It is within this moderate/severe dependence that addiction is typically diagnosed. While this provides a relatively simple way for some people to understand addiction, it can be limiting as they may not think their dependence and use is bad enough to warrant an addiction, even when it could be creating concern in various elements of their own, and others lives.

Reported substance use within Aotearoa varies depending on the type of substance, but it is estimated that 93% of the population will try alcohol at some point in their lives, and at least 44% will try an illicit drug (New Zealand Drug Foundation, 2020). Very little is known about current rates of use for illicit drugs as the last comprehensive survey published by the Ministry of Health on illicit drug use was over a decade ago in 2007/08. This survey found that rates of illicit drug use were

[1] This is a complete textbook for NA written by addicts, for addicts. It outlines the NA programme, how It works, the twelve-steps and twelve-traditions, and personal stories from people who work the programme.

significantly lower than people perceived, with the findings showing that in the twelve months prior to the survey collection point 5.6% of adults used BZP party pills (which were legal at the time of the survey), 2.6% used ecstasy and 1.3% used LSD and other synthetic hallucinogens (Ministry of Health, 2010). More recent statistics from the New Zealand Health Survey 2019/20 found that 82% of adults drank alcohol, 15% used cannabis in the last year, and 1% consumed amphetamines (Ministry of Health, 2020). Overall, these statistics demonstrate that it is relatively common for people to have used some sort of substance in Aotearoa.

While it is possible to gauge substance use levels in Aotearoa, it is much more difficult to understand the prevalence of addiction resulting from substance use. The government attempts to quantify addiction through problematic substance use, which is defined by moderate to high levels of use. The Ministry of Health 2016/2017 Health Survey found that 1.2 million New Zealand adults are at risk of problematic substance use, mostly from tobacco[2] and alcohol use (Ministry of Health, 2020). When all substances are considered, almost a third of people have a moderate to high risk of experiencing health and other problems from their current pattern of use.

Another method utilised to quantify addiction is by counting the number of people who access treatment for substance use, including community and live-in services. Each year roughly 50,000 people in Aotearoa receive support for substance use, but it is hypothesised that this is only a third of those experiencing problems (New Zealand Drug Foundation, 2020). As mentioned earlier, factors such as stigma may come into play, as it can act as a barrier for people to access treatment. There are various concerns with trying to capture addiction in these ways. Problematic substance use does not always mean someone has an addiction, and addiction is often difficult to measure and capture with statistics. This is because an addiction is unique and complex for everyone, and the terminology of addiction in itself is contentious, as was shown above. Often terms like substance use disorder, or dependency disorder are used, but these require a formal diagnosis which is only achieved when one seeks treatment. Thus, those who are not ready, do not want to, or cannot seek treatment would not be included in the statistics of addiction therefore statistics may not accurately represent the size of the problem. Ultimately there is a small proportion of the population that engage in problematic substance use, which can lead to an addiction (New Zealand Drug Foundation, 2021). This can cause harm and affect for not only the person, but also their family, whānau, friends and the wider community.

[2] Tobacco and caffeine are not considered drugs in Narcotics Anonymous.

The Consequences of Addiction

"Addiction is a disease, which, without recovery, ends in jails, institutions and death"
—NA literature.

Worldwide, it was estimated in 2019 that over 180 thousand deaths were directly linked to substance use disorders (World Health Organisation, 2020). The physical and psychological dependency addiction causes can have many other effects on individuals. Those addicted to a substance face many of the short-term side effects of drug use, such as tiredness, nausea, hallucinations, increased body temperature, chills, sweats, blurred vision, anxiety and so on (Chaparro-González et al., 2018). Subsequently, addiction can then have greater long term physical problems, including respiratory depression, lung disease (Benson & Bentley, 1995), liver cirrhosis, cardiac crisis, oral health issues, and infectious diseases such as hepatitis or AIDS (Chaparro-González et al., 2018). There is high psychiatric comorbidity for those with an addiction, and depression and other psychological disorders frequently occur (Schaefer et al., 2013). The effects of withdrawal also need to be considered for those who are addicted to a substance, because although withdrawal is unique for each substance, it can pose a myriad of physical and mental health concerns (O'Brien, 2011).

Personal harm also leads to problems for family or whānau such as financial strain, uncertainty, poor relational wellbeing, and stress on the family system. Family members living with people with an addiction can also experience increased depression, anxiety, and stress (Ólafsdóttir, 2020). This harm forms part of a larger community harm, which encompasses the social consequences from any crime associated with maintaining illicit drug use, including injury to others, the assorted harms to family and friends, and a reduced tax base (McFadden et al., 2022).

Addiction can then be considered a serious public health issue, unless managed in ways that meet the person where they are at (e.g., Opioid Substitution Treatment Programmes, Needle Exchange), and the stigma, criminalisation, and lack of support for drug use in society accentuates these problems. Alongside the detrimental and complex effects for the individual and their family and whānau, they can create significant negative consequences on the health, economy, productivity, and social aspects of communities (Degenhardt et al., 2018). If problematic drug use or addiction is not supported well it can have repercussions on the crime rates in society, and also places a higher burden on the healthcare systems (Robbins & Everitt, 1999). Furthermore, the *He Ara Oranga* inquiry suggested criminalisation of drugs has contributed to other social issues such as the involvement of gangs in the supply of drugs, prison overcrowding, unemployment, and family separations in Aotearoa (Paterson et al., 2018).

The Aotearoa government has quantified the impact of addiction on society through a drug harm index, however, it is important to note that this index only considers the harm from illicit drug use and not from legal drugs such as alcohol. It is estimated by the NZ Drug Harm Index 2016 that the total social cost of drug-related harms and interventions is $1.8 billion per year (McFadden Consultancy, 2016). This social cost has three components—personal harm, community harm and the cost for treatments or interventions. Each of these social components has an economic impact, and it is estimated that for each dependent user the social cost of drug use is estimated at $33,800 (McFadden Consultancy, 2016).

When considering the significance of the consequences it is vital that there is a range of treatment options and support services available to minimise the impact that addiction has on various lives, I now turn to explore these options.

Addiction and Recovery

"Addiction treatment starts a recovery journey"

—David Best.

Treatment Options

With such a significant impact for the individual, family, whānau, community and society, finding ways to help those with an addiction is of utmost importance. With appropriate treatment and support, overcoming addiction for those that want to, is possible. The treatment adopted depends on the nature of the addiction and is unique to each person, but often involves a combination of medication and individual or group therapy (American Psychiatric Association, 2020). As many aspects of a person's life are impacted by addiction, multiple forms of treatment that address the specificity of an individual's situation to address a range of medical, psychiatric, and social problems, is considered the most effective treatment for a sustained recovery.

Medications are utilised to relieve symptoms of withdrawal, control drug cravings and prevent relapses (National Institue of Drug Abuse, 2019). Psychotherapy can equip people with more effective coping mechanisms, a better understanding of their behaviours and attitudes, and increase life skills. Mutual support groups, also known as peer-based recovery support, are often accessed alongside treatment. This support is run by peer-led organisations, like NA, and they focus on socially supportive communication and the sharing of addiction and recovery experiences and skills and are free to attend. They are known to reduce the risk of relapse by mobilising changes in social, psychological, and neurobiological aspects of people's lives (Kelly & Yeterian, 2013). One of the biggest strengths of these support groups is the continuation of care they offer (Costello et al., 2019). When addiction is treated as a chronic and relapsing condition, long-term continued care can

be accessed. Often this is not feasible with other treatment modalities, such as the care provided in rehabilitation centres because they are time-limited. Mutual support groups can provide effective long-term support and are most often used for those who want to have an abstinent-based recovery lifestyle (Kelly et al., 2014). There are three main types of mutual support groups—secular (non-twelve-step), religious and twelve-step. While there is a range of treatment options available, this research focuses on one particular twelve-step group, namely NA. Therefore, the focus throughout will be on twelve-step mutual support groups as a treatment modality for recovery.

Narcotics Anonymous

NA originated in the United States during the 1950s, amidst rising addiction to opioids and other drug-related harms throughout the population (White et al., 2020). It faced a difficult beginning, with its birth rooted in a culturally hostile environment (White et al., 2013). To illustrate, the political and social climate of that time contributed to this difficult start. Various laws introduced throughout the 50s meant an increase in minimum prison sentences for possession, as well other surveillance policies such as a 'loitering addict' law where known addicts faced severe consequences for simply associating with other addicts in public.

During the 1950s, the Alcoholic Anonymous (AA) fellowship started to notice that some members had drug use problems and wanted to share these stories too during their meetings. There was a great deal of debate as to whether addiction issues could be addressed within the AA programme, as the focus within these meetings was specifically on alcoholics and alcohol use. As a result, a group of AA members who identified as addicts founded a NA meeting and the NA fellowship in California in 1953; that fellowship still exists today (Budnick et al., 2011; Narcotics Anonymous World Services, 1998; Peyrot, 1985). The founding members, Jimmy K, Gilda K, Paul R, Steve R, Frank C and Doris C[3] believed that they were not getting the type of support they needed because AA was designed to assist alcoholics, and not those who used drugs. They argued that it would be more suitable to phrase the problem as a personality trait, namely 'addiction' rather than referring to a specific substance (White et al., 2011). They initially named this fellowship Alcoholics Anonymous and Narcotics Anonymous (AANA), but this was shortly changed to Narcotics Anonymous, as they were advised by AA's general service office that they could adapt the steps and traditions but not use AA's name (Budnick et al., 2011).

The Californian group were aware of other NA fellowships existing across the United States, but believed these group did not adhere to the twelve-step traditions and principles (Budnick et al.,

[3] To ensure anonymity is preserved in NA, members are referred to by their first name and the first initial of their last name. These founding members are still recognised today.

2011). The inaugural NA meeting in California was held on August 17th, 1953, and by their third meeting they had decided that a regular meeting would be held at 8.30 every Monday evening. Due to the social disdain of drug use at that time, early NA meetings were forced to consistently rotate locations to avoid police surveillance and harassment, and with this pressure NA nearly collapsed in 1959 (Budnick et al., 2011). However, Jimmy K, Sylvia W, and Penny K vowed to restart NA and follow the traditions more closely which meant that NA not only survived, but it also flourished as a significant recovery and support resource in many communities worldwide (White et al., 2020; see Appendix B for more information about NA, including the history and key dates).

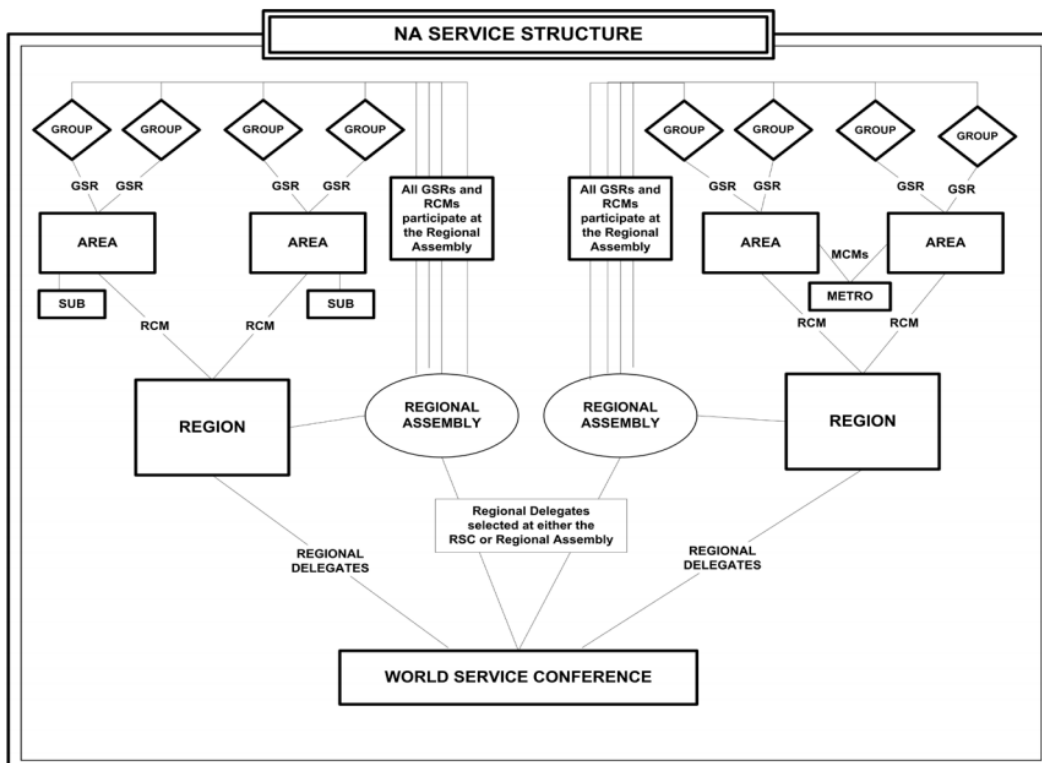
NA Today. This ethos of NA, which continues today, means that all meetings are free and provide people with support to recover from the effects of addiction in their lives (Narcotics Anonymous, 1986). Currently, there are nearly 76,000 NA meetings held weekly in 143 countries worldwide (Narcotics Anonymous World Services, 2022). The only requirement for membership in NA is the desire to stop using substances, and the key tenants are complete abstinence from all drugs, regular attendance, and following the twelve-steps as a guide to achieve wellbeing. Alongside these twelve-steps, there are twelve-traditions (see Appendix B) which are the foundational principles of NA — they outline the purpose of NA and the policies that guide NA activities (Peyrot, 1985). While there is no particular religious, organisational, or institutional association governing NA, it is based on a set of spiritual principles that facilitate finding and believing in a "power greater than ourselves" (Narcotics Anonymous, 1986, p. 4). These spiritual principles are standard across cultures, however the translations of NA literature work on the notion of 'conceptual fidelity' meaning that any concept is not bound to one meaning and can be interpreted to fit the specificity of a culture (Travis, personal communication, March 6th, 2022). Having said that, it is important to recognise that NA is still a product of its social and cultural context and born from a predominantly Western way of knowing. Anonymity is upheld at all meetings and supports an atmosphere of equality at the meetings which works to offset the impact of the illegality and stigma associated with drug use. Furthermore, NA members are encouraged to talk about their recovery rather than what they have used or done in the past (Narcotics Anonymous, 2008). Service to groups and the NA service structure plays a vital role in the NA community, and the various service positions are outlined below.

- One can be a sponsor, which is a NA member that has experience with NA's twelve-steps who supports and guides a newcomer to the programme through regular contact.
- One can be elected as either the group, area, or regional representative.

- One can work on a subcommittee such as:
    - Hospital and Institutions (H&I). This includes making sure that the message of NA is heard by correctional inmates and patients in treatment centres.
    - Public Relations. This includes carrying the NA message to government and private agencies, the news media, those in the helping professions and the community in general. This is done in the hope that addicts seeking recovery will have the opportunity to be referred to NA.
    - Literature supply.
    - Activities.
    - Outreach.
    - Web.
- One can do service in their home group by taking on a position as chairperson, secretary, or treasurer.

Figure 1

NA Service Structure (Narcotics Anonymous & Narcotics Anonymous World Services, 1998, p. 6). Reprinted by permission of NA World Services, Inc. All rights reserved.



Narcotics Anonymous and Narcotics Anonymous World Services (1998) explain the typical service structure of NA (see figure 1 above). This structure is non-hierarchical in the sense that there is no person in charge. In Aotearoa they follow the service structure shown on the left and there is no Metropolitan Service Committee (referred to as Metro in the diagram). The group level refers to any NA group that holds NA meetings to carry the message of recovery to addicts. GSR on the diagram refers to a Group Service Representative, who is elected by NA group members to represent or carry the conscience of the group at the Area Service Committee (ASC). The ASC is the primary way in which services for a region of the NA community are administered. Some of these services include a phone line for people to access help, supplying literature to groups, organising social activities, and so on. There are GSR, administrative officers, subcommittee chairpersons, and regional committee members (referred to on the diagram as RCM) who have roles in this committee. At the regional service level, representatives from the ASC attend an 'all of region' committee (RSC—Regional Service Committee) to draw together the experience and resources of the areas and groups it serves. Finally, at the world service level (also referred to as the NA World Services—NAWS) there is a Board, an office, and a worldwide conference. The Board contributes to the growth and continuation of NA, while the office deals with matters that relate to communication and information for the fellowship. These services deal with the needs of NA groups as a whole, and the conference provides an opportunity and event for members to come together every two years (Narcotics Anonymous & Narcotics Anonymous World Services, 1998).

Aside from service work, other key components of the NA programme are attending meetings and working the twelve-steps and twelve-traditions. The meetings are usually run in either a discussion or speaker format (Narcotics Anonymous & Narcotics Anonymous World Services, 1998). In speaker meetings, which are rare in Aotearoa, one or more members are asked to share their experience of recovery for an extended period of time; whereas discussion meetings allow members at that meeting to take turns sharing their experience of recovery, but feedback to someone else's sharing is not permitted (see Appendix B for a typical meeting format). Although NA meetings are not group therapy sessions, they do rely on the "therapeutic value of one addict helping another" (Narcotics Anonymous, 2008, p. 68). Members can share only once per meeting, focussing on their experiences rather than responding to others. They are asked to share about their "experience, strength and hope" (Narcotics Anonymous, 2008, p. 50) and avoid sharing any drug focused distorted thinking around addiction, that promotes denial or rationalisation of drug use (Twersky, 1997).

History of Narcotics Anonymous in Aotearoa

NA was introduced in Aotearoa properly in 1982, however seeds were sown earlier in the late 1960s for a twelve-step recovery community for addicts (Anonymous, 2005). During the 1960s there was a rapid increase in drug taking in Aotearoa's major cities. This explosion of illegal drug use drew a harsh response from authorities which resulted in tighter laws, greater policing, and a lack of understanding around addiction. Convicted drug users had limited treatment options and were either jailed or committed to mental institutions or hospitals. There were a handful of self-help meetings held in Auckland for people who identified as addicts. These meetings were experimental in the sense that they were run along the lines of AA, by AA members who were sure there was a better way for those who suffered with addiction. Specifically, it was an active AA member named James K Baxter, a well-known Aotearoa poet, that sparked this uprising (Anonymous, 2005). Like the movement in the United States, he believed that addicts, like alcoholics, needed groups with fellowship so people could help each other. As such, sometime during July 1969, the first ever unofficial NA meeting in Aotearoa was held at the Quaker Hall in Mount Eden. While this meeting operated under the NA name, no NA literature was used nor was any contact made with the emerging NA communities in the United States and Australia. Despite success in the first meetings, they were sporadic and short-lived. Some believe it was police surveillance that discouraged people from attending. Regardless though, these first experimental NA meetings showed that recovery from addiction could be achieved in the community.

By the late 1970s there was a growing realisation among local addicts that they needed regular meetings if they were to achieve any long-term abstinence from drug use, as is the aim of twelve-step fellowships (Anonymous, 2005). Rehabilitation centres also began to open in Aotearoa and psychiatric hospitals and jails were no longer the only options for treatment. In September 1982, the first official NA meeting opened its doors in a building at View Road, Mt Eden. This meeting quickly acquired the name 'New View' and is now synonymous with the birth of NA in Aotearoa. This initiative was led by Janet C, who had been introduced to NA through treatment in Sydney and decided to bring NA to Aotearoa. During this time, AA members helped to set up NA, and the influence of the AA fellowship remained strong for the first few months. After NA literature was acquired from the Australian NA fellowship, the spirit of an NA based recovery was cultivated and the appropriate terminology and service structure became everyday practice. Within nine months of the first meeting, another two regular meetings in different locations in Auckland became established (Anonymous, 2005). The New View meeting soon spread the NA message around Aotearoa, with Napier being the next city to establish its own meeting in 1984. By 1985 there were 14 regular meetings underway throughout the country in areas including Ashburton, Auckland,

Christchurch, Hamner Springs, Napier, Palmerston North, and Wellington. Regardless of initial worries around money (to pay for spaces, literature, and so on) for many of these meetings NA's twelve-traditions were a strong guiding force for members.

By 1985 members had begun to think about unifying groups and forming a national service structure in order to lay the groundwork for a lasting Aotearoa NA community (Anonymous, 2005), as outlined above. The impetus for a service structure also came about after NA members from Aotearoa joined the first Regional Service Committee (RSC) run by members from the Australian NA. This collaboration was named the Australasian RSC. This pushed the Aotearoa NA community to form its own Area Service Committee (ASC) and elect an Area Service Representative (ASR) at a NA convention, the *Greater Unity* convention in 1986. This convention featured sharing meetings and workshops on the twelve-traditions of NA, the responsibilities of chairing NA meetings, and NA's relationship with AA. Following the formation of the ASC, the NA community grew exponentially.

Meetings doubled, a Hospital and Institutions, a literature review, and a policy sub-committee were formed and there were attempts to translate the NA twelve-steps into Māori. In September 1988 at the 15th ASC meeting, Aotearoa decided to divide into three areas—two in the North and one in the South. Shortly after, in 1989 a landmark vote was made to split Aotearoa from Australia and become a standalone region. Since then, it has continued to grow and strengthen. Today Aotearoa has more than 100 meetings a week (New Zealand Narcotics Anonymous, n.d).

The Recovery Movement

While NA does not consider itself to be under a recovery movement umbrella, in recent years there has been a shift in AOD treatment towards a recovery movement. This is a perspective where people learn to manage, if not recover fully from an addiction over time outside of formal treatment settings (Davidson, 2016). There is much debate around whether one can reach 'recovery' as an accomplished state, or whether it is better thought of as an ongoing journey; however, it is believed that 58% of individuals with chronic substance dependence will achieve sustained recovery (whether they think of this as a final destination or a continuous journey), although these rates can vary from 30–72% in different studies (Best & Lubman, 2012). The recovery movement, and the theories and models that underlie it are explored next chapter as recovery is a central concept throughout this research. While the recovery movement is not a philosophy of NA, these ideas align with NA's view that "recovery is a continuous, uphill journey" (Narcotics Anonymous, 2008, p. 83).

COVID-19

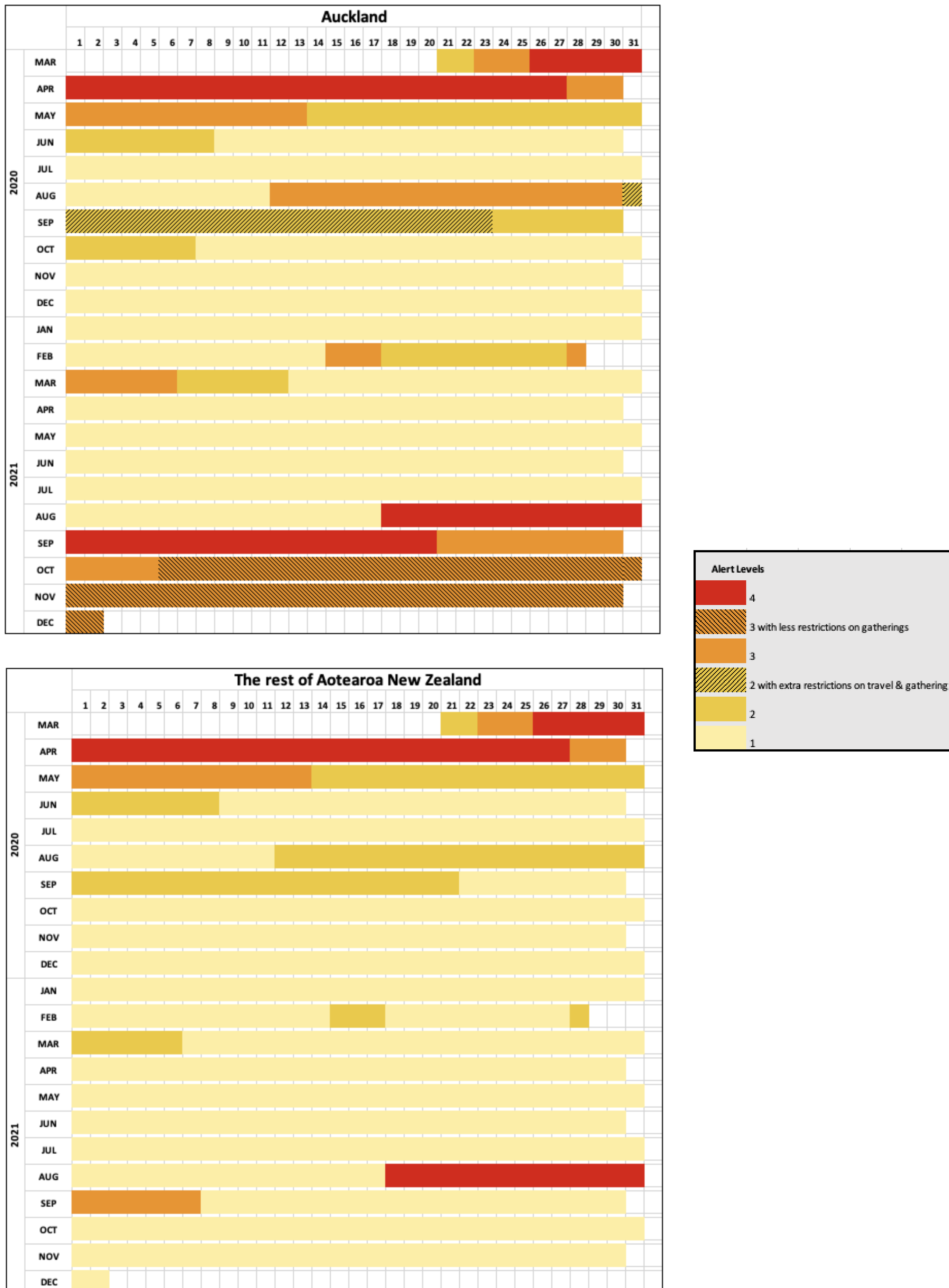
The focus of this research is understanding how members of NA living in Aotearoa managed during the various nationwide and regional lockdown during the period of March 2020 until August 2021. Recognised as a human-generated disaster (Tierney, 2014), the COVID-19 pandemic continues, therefore it is essential to trace a history during the period of my research. In December 2019, the first report of an outbreak of a novel human pneumonia was recorded in Wuhan City, China (Liu et al., 2020). In the following weeks, this virus spread to neighbouring countries and whole-genome sequencing results showed that the causative agent of the virus was a novel coronavirus. Subsequently, in February 2020 the World Health Organisation (WHO) officially named the virus 'Coronavirus Disease 2019' (COVID-19). In the early months of 2020, COVID-19 spread to other countries as a global and uncontrollable threat and subsequently in March WHO declared it a global pandemic.

Necessary health promotion measures were put in place to prevent the spread of COVID-19, including social distancing and the closure of non-essential services in times of high case numbers. Many countries, like Aotearoa, also went into lockdowns, where people were mandated to stay home to stop the spread of the virus. In Aotearoa, a four-tiered alert level system was enacted in late March 2020 to help combat COVID-19 (see Appendix C). The tiers and their meanings included:

- Alert Level 1—Prepare. The disease is contained, and the risk is low. Public health measures are in place, but no physical distancing is needed.
- Alert Level 2—Reduce. The disease is contained but risks of community transmission are growing. Businesses are open, but physical distancing requirements apply, and gatherings are limited.
- Alert Level 3—Restrict. There is a heightened risk that the disease is not contained, and the risk is high. The country needs to stay home, other than for essential personal movement and going to work/school. People should stay in their extended bubble which includes close family or caregivers.
- Alert Level 4—Eliminate. It is likely that the disease is not contained, and the risk is high. Everyone needs to stay at home, other than for essential personal movement and doing essential work. People need to stay in their immediate household bubble.

Figure 2

COVID-19 Alert System Timeline in Aotearoa



As shown in figure 2 above, Aotearoa fluctuated between alert levels. The country went into our first nationwide Alert Level 4 lockdown on March 23rd, 2020 (New Zealand Government, 2021). This lockdown lasted for just over a month, and then the whole country was gradually moved down the Alert Levels, returning to a new normal at Alert Level 1. Figure 2 illustrates the differences faced by the Auckland region having three Alert Level 3 lockdowns in August 2020, September 2020, and February 2021 while the rest of the country moved to Alert Level 2. In August 2021, Aotearoa discovered its first case of the delta variant of COVID-19, and the whole country moved back into Alert Level 4. Regions outside of Auckland gradually moved down the Alert Levels, while Auckland stayed under restrictions for longer. In December 2021, the whole country transitioned from the Alert Level system into the COVID-19 protection framework, otherwise known as the traffic light system (New Zealand Government, 2022). While this new framework had different implications on people lives, this occurred after the data was collected for this thesis, and therefore the framework is not discussed here.

Lockdowns create an environment of uncertainty, isolation, anxiety, and stress for members of the community, and posed a significant risk to those with mental health issues (Chiappini et al., 2020; Officer et al., 2022). The stressful and often lonely environment induced by the pandemic carries many risks for those with an addiction, such as changes in frequency of substance use, shifts to other substances, or relapse. Farhoudian et al. (2020) suggest that various conditions, such as a vulnerability to stress, poor health conditions, and a likelihood to engage in high-risk behaviours increased the risk for people with an addiction to use drugs during this period. Furthermore, having experiences of disadvantage from colonisation, poor health, insecure housing, and poverty, means that resilient coping can be arduous (Blake, 2020). Social support is another crucial element in a person's recovery, so forced social isolation becomes a risk factor for relapse (Volkow, 2020). Overall, the various stressors that were created by the COVID-19 pandemic increased the risk for use and relapse, yet there is limited access to services during this critical time (Bergman & Kelly, 2020).

Social distancing measures, such as lockdowns, have meant that mutual support groups like NA moved to an online delivery setting. While there was minimal research prior to COVID-19 examining participation in, or the effectiveness of, these online twelve-step meetings, some theorise that these online groups will mobilise the same therapeutic mechanisms as the in-person support groups (Bergman et al., 2021; Bergman & Kelly, 2020). These online groups are thought to create an environment of shared experience and universality, instil hope that change is possible, enhance coping, self-efficacy, and motivation skills and provide an opportunity to expand social networks by meeting others in recovery. A strength of these online groups is that the distance and location of meetings are no longer a barrier, however other barriers and weaknesses of this online delivery are

apparent. Concerns include whether a significant social and emotional connection can be created in digital spaces, and in-person activities and behaviours will be missed (Bergman & Kelly, 2020). Privacy breaches, broadband internet access, a lack of basic computer skills and other technological difficulties are among other concerns when delivering meetings online (Lewis et al., 2020). Although these online mutual support groups provide some promise, and a strong alternative in times of crisis, it is important to understand how online support group meetings are experienced by attendees, such as members of NA.

Research Objectives

The aim of this research is to explore how members of NA managed their recovery during the COVID-19 lockdown periods and beyond. It explores their experiences of addiction, recovery from addiction, and the role of NA both prior and during the COVID-19 restrictions. With the significant harm that can be caused by addiction, the vast number of people with problematic substance use in Aotearoa, and the lack of funding and strain on the current treatment options available, this is a vital area to research especially within the context of COVID-19. By focusing on this, I explore how those recovering from an addiction mobilised themselves during a time of crisis. This research communicates the stories of individuals that partook in the online delivery of NA during Covid-19 lockdowns and explored how this impacted their recovery journey. With this in mind, this research investigated two main questions:

1. How has COVID-19 impacted on the recovery of NA members?
2. What role has NA played during COVID-19 restrictions in the recovery of its members?

Other important questions that helped guide this research included:

- What are the participants stories of addiction?
- What are the participants stories of recovery?
- How has COVID-19 impacted on this journey?
- What experiences have they had with the twelve-step programme?
    - What were NA members experiences with the twelve-step programme during lockdown?
    - What were the advantages and disadvantages of this experience during lockdown?

Chapter Two: Literature Review

As this research focuses on how members of NA managed their recovery during the COVID-19 lockdown period in 2020, this chapter explores current research around addiction, recovery, NA, and online support. This literature review starts by exploring theories of addiction that underpin common understandings, and specific attention is given to the theory of addiction utilised throughout this research. Then, moving from addiction to recovery, I discuss the current discourses around recovery, including debates around the definition of recovery, the idea of recovery capital and social identity, and the role they play in abstinence-based recovery from AOD. NA, as a recovery-based mutual support group is then explored. This section outlines why active participation in NA plays a crucial role in long-term addiction recovery and enhanced quality of life in recovery. This includes examining evidence about how twelve-step groups work and the activities involved in NA that makes it so successful. Finally, as NA moved to an online delivery with the COVID-19 restrictions, I review current studies that explored online recovery support.

Theories of Addiction

In order to situate this research and understand the critical role NA and other twelve-step groups play in the lives of people with addiction concerns, in the everyday and during a pandemic, this section discusses two predominant theories of addiction — addiction as a (1) immoral conduct, and (2) as a disease (Thombs & Osborn, 2019). These theories have been chosen as it is common in lay understandings to think of addiction as immoral conduct, yet this is not what NA ascribes to. Instead, they understand addiction as a disease. People’s understanding of their addiction shapes their health behaviours, relationship with their care team, and willingness to accept treatment; it may also influence how they view themselves as addicts and impact their sense of self (Jack et al., 2019).

The Moral Model

Rise and Halkjelsvik (2019) found that addiction implies different moral judgements. When addiction is connected to agency, reduced willpower, and addictive behaviours or habits, greater moral responsibility is placed on addicts. Often termed the *moral model of addiction,* this perspective was dominant in the first half of the twentieth century and was central to the evolution of the alcohol and drug culture in the United States, in particular the ‘war on drugs’ (Lassiter & Spivey, 2018; Pickard, 2017). Traces of this model can be seen in some parts of society (Thombs &

Osborn, 2019) therefore it can be assumed that people who use drugs have been socialised by this model and, as such, it influences their behaviours and sense of self.

Two distinctive features of the moral model are that substance use is a choice, even for addicts, and that a critical moral stance is adopted against this choice (Pickard, 2017). Ultimately this moral model positions addiction as a personal choice, freely chosen, and a moral failing on the individual's behalf. Addicts are considered people of bad character with antisocial values who supposedly value pleasure, idleness, and escape above all else, regardless of the cost to themselves or others. Peele (1987) argued that the role of values is instrumental in creating and preventing addiction, which is a common theory in the moralisation of addiction (Frank & Nagel, 2017). With this view, the logical way to 'treat' addiction is to punish those who violate the standards of 'right' conduct and self-discipline (Sarabia & McTighe, 2021). The natural or societal consequences of an addict's actions must be faced, and the addict does not deserve care or help (Thombs & Osborn, 2019). Legal repercussions are normally upheld in these cases, with jail sentences, fines and other punitive actions seen as appropriate.

While this model has been praised for its straightforward, absolute, and clear explanation, there are many disadvantages. Addiction is anything but a simple phenomenon, it is highly complex with a multitude of possible origins from biological, social, psychological, and spiritual perspectives (Lassiter & Spivey, 2018). Furthermore, it is not clear that addiction is freely chosen or a matter of free will. The disease perspective described below will argue the very opposite of this. Finally, there is little evidence to support punishment decreasing rates of addiction but that it can actually have an unintended opposing effect by increasing organised crime, creating dangerous underground markets, and overcrowding prisons (Thombs & Osborn, 2019).

While the philosophies of NA encourage members to examine their own shortcomings, they in no way support a moral view of addiction. As stated earlier, within NA, the programme draws on the disease model for understanding addiction, although it may not be the only theory members draw on for understanding themselves and their addiction.

The Disease Model

Addiction can be thought of as a disease where excessive consumption is the result of an underlying disease process (Detar, 2011). This perspective maintains that a person struggling with addiction is a victim of an illness, substance use is not freely chosen and those suffering from the disease deserve compassionate care.

The disease model was born in an attempt to form a "unified framework for a problem-based field in conceptual disarray" (Campbell, 2007, p. 200). Broadly the disease perspective draws

on a biological understanding, and underneath it sits differing biological theories that each hypothesise different elements of how addiction is formed. Through the use of neuroscience and animal models of addiction, the most common disease understanding has a medical basis (Frank & Nagel, 2017; Hall et al., 2015). It suggests that addiction is a chronic relapsing neurobiological disease where repeated drug use changes the brain in a way where the desire for drugs becomes overwhelming and irresistible. Specific neural pathways and circuits are involved in addiction, particularly the mesolimbic reward system, which becomes flooded with a neurotransmitter known as dopamine when certain substances are taken (Hammer et al., 2012). Dopamine creates a euphoric effect and initially substance use makes the mesolimbic reward pathway more sensitive. However, over time the mesolimbic system becomes less sensitive as dopamine levels gradually decrease and a tolerance begins to build. The purpose of the mesolimbic system is to mediate reward and pleasure as well as create motivation to engage in essential life tasks (i.e., eating and reproduction). The process of addiction results in changes to the brain, and as a result an addicted person becomes reliant on a substance as a source of pleasure and any interest in non-drug related activities diminishes (Thombs & Osborn, 2019).

This biological understanding of addiction as a disease is very popular. For example, Hammer et al. (2012) explored how people who are addicted view their addiction against the framework of formal theories that currently exist to explain addiction. They interviewed 63 individuals in treatment for alcohol and nicotine misuse in Minnesota. They found that more than half of their participants articulated a biological understanding of addiction as a disease, and that treatment centres also shaped ideas around addiction. This study provided insight into not only the popularity of the biological understanding, but how essential it is to consider the sources or environment in which someone comes to understand their addiction. Treatment centres often have their own dominant narrative to explain addiction, and the language and ideology of treatment centres can shape how patients understand addiction.

With this in mind, it is important to note that while NA draws on a disease model it is somewhat different from the solely biological model described above. NA views addiction as an all-consuming disease that has three distinct elements—physical, mental, and spiritual (White, 2011). Physically addiction is understood through compulsion and a loss of control over decisions about using. The obsession with using comprises the mental element, and the self-centeredness of addiction is the spiritual element (Narcotics Anonymous, 2008). Each of these elements can be ‘arrested’ or controlled through the NA programme. Furthermore, the disease of addiction is also to be thought of as ‘allergies’ that are manifested in a person through a sense of restlessness, irritability, and discontent as well as implicit processes that perpetuate substance use in high-risk

situations (Narcotics Anonymous, 1988 as cited in Sussman, 2010). This narrative of addiction as a disease has been evident throughout NA's history, with the 1957 handbook stating:

> Here [in NA] we have come to realise that we are not moral lepers. We are simply sick people. We suffer from a disease, just like alcoholism, diabetes, heart ailments, tuberculosis, or cancer. There is no known cure for these diseases and neither is there for drug addiction. But, by following the principles of Narcotics Anonymous completely, we can arrest our disease of addiction to narcotics. (White et al., 2011, p. 19)

The first step of the twelve-steps of NA is that members need to accept that they are powerless over their disease, and that any substance use will release the disease again—hence abstinence is key to health and wellbeing. This abstinence-based approach to addiction as a disease is used in most twelve-step programmes, and two studies, while quite dated and focused predominantly on AA, show how members of twelve-step programmes conceptualise their addiction recovery and the importance of the disease model in this process (Hanninen & Koski-Jannes, 1999; Thune, 1977). Similar conclusions can be assumed for NA where people must surrender to the power of their disease of addiction and therefore not pick up a substance.

While this will be the predominant theory, it is also important to consider how addiction is a socially constructed disease too (Hammer et al., 2012). This means that understandings of addiction can differ across time and place. The socio-cultural aspects of addiction are essential as this changes the way that we understand it, and the meanings we attach to it. Some of the social factors that can influence understandings of addiction include a consideration of what social relationships, societal views or social policies promote or perhaps inhibit addiction. There are social circumstances, like colonisation, displacement, trauma, and poverty (Skewes & Gonzalez, 2013) that are ignored in the disease model, and some of these circumstances are harmful to people's lives and the understandings of addiction.

The Concept of Recovery

Recovery as a concept frames twelve-step mutual support groups like NA. As stated in the previous chapter, recovery in relation to substance use has faced great debate amongst different disciplines and schools of thought, as it is a subjective construct (Best et al., 2021). As a result, there is no one established definition that is used across all literature. There are also social, clinical, and financial implications of defining recovery in particular ways (Kelly & Hoeppner, 2015) which has similar effects to how addiction is defined. For example, in a clinical sense the definition of recovery

impacts the way in which treatment systems are structured, delivered, and evaluated (Hser & Anglin, 2011).

There are however leading definitions of recovery as embedded in the AOD field like the Substance Abuse and Mental Health Association (2012), the American Society for Addiction Medicine (2019) and the Betty Ford Institute (2007). These definitions vary slightly but have an overall focus on processes of self-directed or sustained action, in which individuals improve their health and wellbeing on biological, psychological, social, and spiritual dimensions to strive to reach their full potential. The latter two definitions emphasise the essential role of abstinence in addiction recovery. A strength of these definitions is their holistic approach to an abstinence-based recovery. They focus on the concept of wellbeing and quality of life, which De Maeyer et al. (2011) argue is central to the notion of recovery. Ashford et al. (2019) critiques the focus on abstinence in the latter definitions, as they, as well as others, argue that abstinence should not be required to consider an individual engaging with the recovery process (Kelly & Hoeppner, 2015).

Recovery is argued as being subjective to each person. For instance, Best et al. (2016) assert that recovery is a personal journey involving a socially negotiated identity transition that occurs through changes in social networks and related meaningful activities. Similarly, Kelly and Hoeppner (2015) argue that recovery signifies a profound and personal experience, and for that reason it is not appropriate for any one person to have the authority to define it. Instead, those with lived experience of addiction should define their own recovery. Work by Best et al. (2011) examined this with a sample of 205 people who reported a lifetime dependence on either heroin or alcohol. The people in the sample perceived themselves to be either recovered or in recovery from their addiction. Through both interviews and self-completed questionnaires, recovery was understood as an ongoing process rather than a milestone to be achieved at a set time and that recovery included, but also transcended, freedom from substance dependence. For the participants in the study who were involved with a twelve-step programme, recovery involved accepting an identity as an addict, which they believed was something that would always be a part of their make-up. This aligns with a belief in the literature (Flaherty et al., 2014; Laudet, 2008) that recovery in twelve-step fellowships is initiated only when attempts at abstinence have begun, with addiction considered a chronic disease that requires a lifelong commitment to the programme (Smith, 2007, as cited in Best et al., 2017). This is an important consideration for this research as the participants in this study are all NA members and so they may have similar perspectives on recovery. It should also be noted the focus of this research is not on individuals' concepts of recovery though, but rather how COVID-19 impacted on NA's ability to provide meetings and services for recovery. In essence, the research will explore COVID's impact on recovery.

Beyond definitions, various models and theories have been utilised to gain a greater understanding of recovery. One popular framework by Leamy et al. (2011) highlighted the essential elements of recovery. These elements can be thought of as the five key recovery processes and are best represented with the acronym CHIME—connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. These findings were derived from a systematic review on existing recovery research and the model provides a robust conceptual framework for understanding what is important in recovery. It has been utilised throughout later recovery-oriented research (Best, 2019; Carson & Ogilvie, 2021; Curran & Ogilvie, 2022; Shanks et al., 2013), and in particular, in relation to the recovery-supportive elements of NA (Dekkers et al., 2020). Additionally, various works by David Best have been instrumental in conceptualising recovery. Models that help to conceptualise recovery are important to consider, therefore, the model of recovery capital as well as social identity are unpacked in greater detail below.

Recovery Capital

When recovery is thought of as an ongoing process, recovery capital refers to the sum of internal and external resources that may initiate and facilitate the process (Best & Laudet, 2010; Davidson et al., 2010; Granfield & Cloud, 2001). Others, such as Hennessy (2017) suggest that recovery capital can be thought of as a lens that helps to identify distinct resources for improvement and barriers in an individual’s recovery process. The theoretical foundations for this concept originated from Pierre Bourdieu’s (1986) work on social capital, in which he described it as one of three basic forms of power, alongside economic and cultural capital. This concept was then later applied to the field of addiction by Granfield and Cloud (2001), who proposed that people who possess larger quantities of social capital are more likely to recover from an addiction, perhaps even independently of the intensity of use. A notion that commonly arose within early work on recovery capital was the idea that greater recovery capital meant that individuals could be ‘natural recoverees’ without the help of formal treatment. For this to occur, individual, interindividual and structural resources were critical to success in recovery (Granfield & Cloud, 2001). Recovery capital is an important concept to consider in this research as NA can be thought of as a programme that supports its members to build recovery capital that aids in maintaining an abstinence-based long-term recovery (Laudet et al., 2006). The components of NA, such as unity (i.e., the fellowship and principles of the programme), service (i.e., chairing and committee work) and recovery (i.e., working the programme and the twelve-steps), give members access to the resources needed for recovery such as social supports, a sense of belonging, life meaning, group membership, stress-buffering, and an enhanced quality of life. While recovery capital is not a conceptualisation or framing that NA

uses, this thesis will draw on this theoretical concept to make sense of how NA members experience recovery during COVID.

Over time, several models of recovery capital have been utilised in a range of qualitative and quantitative research, yet there is no consistent use of one particular model (Hennessy, 2017). One of the more utilised models was produced by Cloud and Granfield (2009) who argue that there are four components to recovery capital—(1) social capital, the sum of resources as a result of a person's relationships; (2) physical capital, tangible assets such as property and money that may increase recovery options; (3) human capital, skills, positive health, personal resources and aspirations and hopes that empower a person to prosper; and (4) cultural capital, the values, beliefs, and attitudes that allow both social conformity and the ability to fit into dominant social behaviours. Cloud and Granfield's (2009) qualitative research operationalised recovery capital along a continuum, and introduced the concept of negative recovery capital —the barriers to sustained recovery. Elements such as age, gender, mental health, health, and incarceration were theorised to contribute to negative recovery capital. Among other qualitative studies (Gueta & Addad, 2015; Neale & Brown, 2016; Neale & Stevenson, 2015), Timpson and colleagues (2016) used this model as a framework in their analysis. In this study they conducted a sociological discourse analysis from interview data with 32 individuals from six United Kingdom recovery communities. The discourses emphasised the importance and frequency of human, social, and cultural recovery capital in meanings of recovery. These research findings have led to a deeper understanding of experiences and meanings of recovery. They also highlight the resources that are essential for an individual on their recovery journey, many of which NA enable.

While these studies took a more general look at recovery capital, there have been a number of studies that focus on the relation between recovery capital, peer support, and twelve-step mutual support groups (Chen, 2018; Laudet et al., 2006; Majer et al., 2021; O'Sullivan et al., 2019). Research has suggested that being affiliated with and involved in a twelve-step group grants access to a range of different recovery capital resources, and so twelve-step groups could be considered a type of resource capital in, and of, themselves (Laudet et al., 2006; Majer et al., 2021). For example, Majer and colleagues (2021) conducted a secondary analysis of data from 627 participants recovering from substance use disorders that were living in a recovery home. Of their sample, 395 residents were involved in a twelve-step recovery and 232 were not. The residents that were involved in a twelve-step programme reported higher levels of recovery capital and also abstinence-based social support than those who were not involved in the twelve-step programme. Majer and colleagues (2021) quantified recovery capital through eight types of established measures (i.e., quality of life, self-

efficacy etc.), highlighting the importance that twelve-step communities have in building recovery capital.

Community psychology provides another way to conceptualise recovery capital resources in terms of a 'sense of community'. A sense of community relates to having a supportive environment when recovering from an addiction (Stevens et al., 2018). It ties into feelings of connectedness, belongingness, and group membership (Stevens et al., 2012). This is an important consideration as this research is entrenched in a community setting, which will be discussed further in the next chapter. Throughout this thesis, the concepts of recovery capital and a sense of community are used to describe the sums of resources available to people when they are recovering as part of a community like NA.

Social Identity

Social identity and the important role of groups in recovery has been another major area of interest within the field of addiction and recovery (Best et al., 2016; Buckingham et al., 2013). Social identities indicate who a person is in terms of the groups in which they belong to, and two key theories underlie much work in this space—social identity theory (SIT) and self-categorisation theory (SCT). SIT proposes that people's sense of self is derived from their membership in various groups and this membership is both emotionally and psychologically relevant for personal and group values, norms, perceptions, decision-making, relationships, and behaviour (Tajfel & Turner, 1979). SCT argues that people embody the perceptions, expectations, and similar qualities as their in-group members, thus when these qualities become outwardly displayed a person will gain increased status within the group (Turner et al., 1987), and perhaps a sense of community.

Social identity research suggests that when a person engages with group therapy or meetings a new identity associated with recovery is constructed (Oakes, 1987 as cited in Buckingham et al., 2013). These ideas have formed a foundation for a range of models that explain recovery from an addiction, such as the social identity model of recovery (SIMOR) (Best et al., 2016), the social identity model of cessation maintenance (Frings & Albery, 2016) and the social identity model of transition (Kay & Monaghan, 2019). While each of these models has its merits, in the research I will be applying the SIMOR as one way to explain addiction recovery as this model best fits the social community that is being researched.

Best et al. (2016) produced the SIMOR to frame the mechanisms of recovery as a process of social identity change. Within this change a person's dominant identity shifts from being defined by membership of a group whose norms and values revolve around substance abuse to a group whose norms and values encourage recovery from substance abuse. Once a person establishes a recovery-

based social identity for themselves, their behaviour is influenced by the normative expectations associated with that identity. It is through the internalisation of social group norms that attitudes and behaviours are shaped. Once prominent, social identities can act as resources that support psychological health and adjustment in the new identity (Jetten et al., 2014). Essentially, recovery is conceptualised as the emergence of a new sense of self and is understood as a socially mediated process that is facilitated and structured by changes in group membership from an identity of 'active use' towards 'stable' recovery (Best et al., 2016). A study by Bathish et al. (2017) explored the role of social networks and social identity factors in addiction recovery for 537 individuals. Through survey data, they found that the transition to recovery was marked by an increase in social connectedness as well as changes in the composition of social networks. The emergence of a recovery identity was pivotal in the transition. Another consideration is that SIMOR is particularly fitting for understanding how twelve-step fellowships work and reaches greater efficacy in their memberships (Best et al., 2016). Twelve-step fellowships, like NA, offer a positive recovery-based social identity for its members and many of the recommended practices are inherently social and all engender a sense of community, such as sponsorship and meetings.

Narcotics Anonymous Literature

NA is rich with its own literature that implicitly draws on its own ideas and some of the previous ideas outlined in this chapter. NA continually writes, and translates, new material (Travis, personal communication, March 6, 2022). There are various booklets, informational pamphlets, group readings, and printed and online books that share the message of NA, the fellowship, and ideas around addiction and recovery to its members. There are also workbooks for members to engage with while working the steps in the NA programme. The first piece of NA literature was published in 1954, but the more recent literature introduces new concepts (Narcotics Anonymous, 2008; Narcotics Anonymous World Services, 2020). So, although the twelve-steps and twelve-traditions have not changed, the understandings have, and this is reflected in the newer material.

While there is a plethora of resources to draw on, within scientific or empirical based studies there has been limited published research specifically focused on NA globally. According to White et al. (2020) the first qualitative and quantitative studies of NA only appeared a few decades after its origin in the 1980s. While the scientific literature on NA increased exponentially in the following decades, compared to other twelve-step groups such as AA, there is still only a small fraction of studies specifically with, or focused on, NA. Many confirm that the research on NA and its recovery-supportive elements is scarce and that perspectives of NA members remain understudied (Dekkers et al., 2020; White et al., 2020). It could be argued that the lack of research perhaps mirrors society's

marginalisation of people who use drugs and the stigma they commonly face. Fraser et al. (2017) argues that stigma is politically productive and by doing so establishes and maintains a certain social order. As a result, stigmatised communities may not have the same resources or opportunities, such as participating in research. This lack of attention is important to consider as it means this research is much needed, especially research that explores the perspectives and lived experiences of NA members.

When looking at the existing literature on NA, the majority of the published studies are from the United States, the Islamic Republic of Iran, the United Kingdom, or Australia, and to a lesser extent there are some studies from Greece, Israel, and Norway. While this is a good range of different countries, there is a significant focus in the literature on more Western groups, like Americans or Europeans, and their understanding and utilisation of NA. Dale et al. (2019) conducted a systematic review of research on addiction recovery mutual support groups and found that there were very few studies (only four published studies met the inclusion criteria) that evaluated the utility of support groups like NA for Indigenous people from Australia, Canada, the United States and Aotearoa. This means that there is a lack of empirical knowledge on the suitability of mutual support groups for Indigenous population, especially here in Aotearoa and stresses the importance of this thesis which is situated in a country with limited published research on NA.

Specific Research on NA and Long-Term Recovery Outcomes

One area of research that has been well studied is the relationship between twelve-step participation and long-term abstinence-based recovery from substance use. Some research findings look specifically at how attendance at NA will affect abstinence rates for certain substances such as opiates (Gossop et al., 2008), or how NA participation is linked to future psychological wellbeing (DeLucia et al., 2015). The study by DeLucia and colleagues (2015) was different as they wanted to examine quality-of-life outcomes beyond just abstinence. They conducted focus groups with 19 long-term NA members in the United States and examined various elements of recovery, such as the perceived key ingredients of recovery, the gifts of recovery, and recovery processes. They found that the gifts of recovery could be split into three categories, intrapersonal, interpersonal, and fellowship, that each related to enhancements in quality of life. These enhancements were mediated by their involvement in the fellowship. These findings are important as they highlight other beneficial factors of recovery with NA beyond abstinence.

In Aotearoa, Narcotics Anonymous New Zealand (2009) conducted research to explore the effectiveness, practicality, and success of the NA programme. A quantitative survey was used to collect data during a week of regular meetings, using outcome measures of employment, education

and income, health changes, and length of abstinence to determine how successful NA was as a programme of recovery. A total of 546 NA members completed the survey. The survey argued that long abstinence times (10% had been clean for 15 years or more) indicated success in retaining members and supporting them to stay drug free. Furthermore, there were also positive changes in members educational qualifications, income sources, occupation, and good physical and mental health. These findings supported a prior survey in 2005 (Narcotics Anonymous New Zealand, 2005), which demonstrated the consistent success of NA as a programme of recovery in Aotearoa for abstinence recovery outcomes, and other quality of life measures that are associated with recovery.

Generally, a broader approach has been seen with most research findings exploring the positive influence of twelve-step groups on abstinence as a long-term recovery outcome (Costello et al., 2019; Fiorentine, 1999; Krentzman et al., 2011). For example, Fiorentine (1999) conducted surveys and interviews with 262 participants to examine their involvement in twelve-step groups while receiving outpatient drug treatment. It was found that greater post-treatment attendance at twelve-step meetings was associated with higher rates of abstinence from both drugs and alcohol. These findings were also mirrored in a study by Krentzman et al. (2011) who found that when people are actively involved and affiliated with twelve-step members they were 4.1 to 8.6 times more likely to maintain abstinence; Costello et al. (2019) found that engagement in twelve-step activities was significantly associated with abstinence and the number of days abstinent. The differences between Fiorentine (1999) and these later studies was that twelve-step participation was not limited to just attendance at twelve-step meetings, but encompassed a more comprehensive approach to participation, including considering oneself a member of a twelve-step fellowship like NA, working the twelve-step programme, having a sponsor, doing service, and so on. The more recent wider view of participation will be used in this study to reflect the principles of NA. One limitation in these past studies is a focus on twelve-step meetings generally rather than focusing solely on NA. This means that general research on twelve-step groups masks the distinctive culture and contribution that NA offers. NA, as with any twelve-step group, has its own distinct programme of recovery founded on the general principle of the twelve-steps but altered to fit the specificity of the group. NA also has a particular recovery culture that is unique in its core ideas, history, language, recovery practices, service rituals, and of course its literature as unpacked in the following sections.

Overall, the research on NA tends to be more quantitative in design, with researchers attempting to conceptualise recovery through statistical analysis, such as the number of days abstinent from drug use (for example see Costello et al., 2019). More qualitative research is needed for in-depth explorations into NA, addiction, and recovery because of the complexities and unique nature of addiction and recovery, as well as the contextual elements of different recovery

programmes. These are relatively unexplored areas. As this research focuses on people who use NA, it is therefore important to understand the, albeit limited, current literature on NA.

Activities Within NA That Act as Mechanisms for Change

Krentzman (2021) asserts that NA sets a series of actions into motion, and that change, and the underlying mechanisms, subsequently support abstinence and addiction recovery. The programme of addiction recovery that is adopted in NA is rooted in the collective experience of its members, rather than in a particular theory or scientific investigation. White et al. (2020) suggests that it is this focus on experiential sharing of knowledge that allows members to achieve successful abstinence and other benefits from not using mind or mood-altering substances. They go on to argue that it is the way in which NA's basic text defines the solution to addiction in behavioural terms, provides clear measures of progress, assures continued group surveillance, support and self-monitoring, and rewards pro-recovery milestones that makes recovery achievable.

The impact of engaging in the activities that are part of this programme seems to be a popular area of research, and several recent studies suggest that it is the very activities within NA, such as doing service, sponsorship, and spirituality, that act as mechanisms for change and are critical for recovery (DeLucia et al., 2015; McGovern et al., 2021; Witbrodt et al., 2012). For example, Kelly et al. (2016) compared the sponsorship element of twelve-step programmes to the therapeutic alliance commonly seen between clinicians and patients. Their study of 302 young adults that attended twelve-step mutual support groups found through interview assessments that both having contact with a sponsor and having a stronger sponsor alliance was significantly associated with great twelve-step participation and abstinence. They suggested that a therapeutic alliance is created between a sponsor and those who they help ('sponsees'), which encourages a greater commitment to abstinence. Other studies have suggested that taking on the role of sponsor sparks the therapeutic effects of helping others and increases one's self-awareness, social skills, social competence, and psychological wellbeing (McGovern et al., 2021; White et al., 2013). One of the main principles of NA is the therapeutic value of one addict helping another, so sponsorship and sharing in meetings is an essential part of the programme. NA does acknowledge that the self-help given in the sponsor role is based on experiential knowledge and does try to convey that message to potential sponsors (Narcotics Anonymous, 2004), however some sponsors could lack personal experience with an issue.

Another element of NA that is commonly researched as a mechanism of change is the concept of a higher power or the spiritual awakening that occurs through working the twelve-steps of NA. Studies have shown that clinicians and non-religious members of society have an objection to

NA due to the perceived religious nature of the programme (Day et al., 2015; Galaif & Sussman, 1995; Kelly et al., 2011) whereas others have initial problems with the concept of a higher power (Vederhus & Høie, 2018). NA is not associated with any religion and is self-designated as spiritual, rather than religious. This spiritual element, or having a spiritual awakening, is theorised as a key element in long-term recovery and is instrumental in sustaining the integrity of the NA fellowship itself (Galanter et al., 2013a). Members are encouraged to define the nature of their higher power in their own way, which can include secular or pseudo-religious symbolism (Galanter et al., 2020; McClure & Wilkinson, 2020; Vederhus & Høie, 2018). By engaging in this spiritual process, Vederhus & Høie (2018) suggest that members find motivation and strength to cope with the everyday process of staying 'clean' (drug free) and to continue in an abstinence-based recovery lifestyle. These studies provide insight into how the activities of NA may act as mechanisms that positively encourage the achievement of long-term recovery outcomes such as abstinence.

Other Theories and Mechanisms of NA

Aside from the activities within NA that act as mechanisms for change, there is another body of research that has examined other theories and mechanisms to explain how NA and other twelve-step programmes work (Kelly, 2017; Moos, 2008; Yalom & Leszcz, 2005). It is theorised by Moos (2008) that twelve-step mutual support groups, like NA, work by initiating mechanisms of change for individuals. There is a particular focus on behavioural choice theories, stress and coping theories, social control theories, and social learning theories, with a combination of these theories have been expanded and contextualised in other theories (Moos, 2007, 2008).

Behavioural choice theories highlight how twelve-step groups provide involvement in protective activities, in particular substance-free activities, and offer alternative rewards, through reordering expectations for positive and negative consequences related to substance use and abstinence (Moos, 2007). Stress and coping theories emphasise that twelve-step groups alleviate the stress that drives people to use substances and builds members self-efficacy and self-confidence by teaching effective coping skills and the ability to identify high-risk situations and stressors. It also increases motivation to be abstinent and the self-belief in doing so (Moos, 2008; Yalom & Leszcz, 2005). Social control theories suggest that a strong bond with something external to the self or the substance motivates people to engage in a particular way that aligns with the external stimuli, in the case of twelve-step groups this would be abstinence. With social control theory in mind, research suggests that twelve-step programmes promote and motivate being completely abstinence, rewards milestones when achieving this goal, provide group surveillance through group membership as well as encourages broader dimensions of personal growth (Kelly, 2017; Moos, 2007). Finally, social

learning theories highlight how twelve-step groups facilitate new recovery-based social networks which eases a sense of isolation for individuals recovering from an addiction and provides role models within the group for abstinent-based lifestyles (Columb et al., 2020; Moos, 2008). Best et al. (2016) expand on the social models covered by Moos (2008) to suggest that the process of recovery involves a transformation of one's social identity and a shift in social affiliation (the SIMOR—social identity model of recovery previously described). In general, social learning theories offer insight into how twelve-step groups enable their members to recovery from addiction. These theories form a fundamental base for understanding how twelve-step groups work, and therefore how NA works. Although there are differences between the twelve-step fellowships, the basis can be viewed as consistent to some level.

While CHIME (connectedness, hope and optimism about the future, identity, meaning in life, and empowerment) frames notions of recovery more widely, as previously discussed, it is also used as a framework to explain successful recovery in NA. Dekkers et al. (2020) examined the recovery-supportive elements of NA, and found that members identified connectedness as the crucial component in their recovery. NA enabled this through their non-judgemental approach and a mutual understanding through sharing. Members were able to build up their social networks and have a safe space for sounding their problems and a safety net of people that cared for them. This ties in with ideas around recovery capital, in that NA generates social resources which positively facilitate the recovery process (Best & Laudet, 2010; Majer et al., 2021). Another element of the CHIME framework that is frequently examined in research is a NA identity. Leamy et al. (2011) suggest that a key part of recovery is regaining a positive sense of self and identity, which in turn helps overcome stigma. Several studies have found that when someone identifies as a member of NA, and embraces an abstinence-based recovery identity, a process of identity reconstruction occurs and the treatment retention becomes successful due to transformations in the individual's self-knowledge, attitudes, and worldviews (Jalali et al., 2019; Rafalovich, 1999).

When examining the myriad of mechanisms, frameworks, and theories that explain how NA works, it is easy to see how intertwined the concepts are. This is important as it demonstrates that no one explanation will encompass the complexity of recovering from active addiction and therefore the necessity of adopting a qualitative approach that prioritises the participants own stories and understandings.

Critiques of NA

While most literature on NA has been positive, there are critiques of NA and perceived barriers to membership. Vederhus et al. (2020) interviewed 10 previous NA members in Norway to

ascertain their reasons for disengagement with the NA programme, which actually served as a proxy for identifying problematic issues relating to twelve-step programmes. They identified three themes to explain disengagement. Firstly, 'the model did not fit' theme referred to either the strategies utilised in NA or its explanatory model of addiction as a disease. Secondly, the 'negative experiences spurred frustration' theme signified issues within the social environment (i.e., anonymity breaches, conformity pressure) and perceptions of being a second-rate member. Thirdly, 'the safe place can become a cage' theme represented participants view that life ought to be more than NA and that the fellowship should be a means to get you back into society rather than being 'stuck' there. Additionally, the study also highlighted the less ideal aspects of sponsorship as one participant brought up a traumatic event with their sponsor while working the steps, and their sponsor failed to consider the extent of the trauma that this individual had been through and instead said something harmful back. While this may not have been the intention of the sponsor, when a sponsor lacks personal experience or awareness of extra challenges faced by trauma survivors there is a risk that further harm could occur. However, NA was still regarded as a valuable recovery resource for these participants despite their "negative experiences and strong critique" (Vederhus et al., 2020, p. 8). The participants shared that they still respected NA as a recovery fellowship and acknowledged that it has saved the lives of many and has great benefit for other people. They emphasised how one size does not fit all, particularly in relation to the programme and principles of NA, and how it is important to have a 'menu' of recovery fellowships available. While the philosophy of NA did not suit the participants in the study by Vederhus et al. (2020), others have argued that NA allows its members the flexibility to make the programme their own (Kelly & Myers, 2007; Rafalovich, 1999). This also raises an important consideration when looking at any NA literature on a specific NA group because while the principles and traditions are the same across the fellowship each group has minor differences in the way it operates and interprets the principles for its meetings, so therefore experiences may differ between groups.

Other critiques of NA look at some of the obstacles to participation. For example, Christo and Franey (1995) and White (2011) identified that NA has strict views on abstinence which can spark issues for some users of the programme. It was found that some people interpreted NA as having expectations of complete abstinence and opposed the use of drug replacement therapies or maintenance medications to support recovery, which acted as a barrier to people attending. This is not necessarily accurate though, as while NA encourages members to be abstinent, the only requirement for membership is a *desire* to stop using. If one has used substances on the day that they attend a meeting, they are asked not to share during the meeting (as it may be triggering for others), but rather seek out a trusted member afterwards for support. As discussed earlier, religion

and the concept of a higher power are also frequently mentioned as obstacles to participation because people can be apprehensive about the use of the word God and assume that the programme has a religious base (Book et al., 2009; Day et al., 2015; Vederhus et al., 2010). A final obstacle to NA participation is issues of anxiety according to Day et al. (2015), as some clinicians believe that the meeting format is a poor fit for those with psychiatric issues like anxiety (Day et al., 2015; Vederhus et al., 2010). This may be because the group setting can be difficult for those with social anxiety and may seem frightening, intimidating, challenging, and intense. To explain, a study by Book et al. (2009) surveyed 110 individuals at community treatment programmes. They found that those who had clinically significant social anxiety were more likely to share that their shyness interfered with a willingness to speak up in group therapy, attend a NA meeting, or ask somebody to be their sponsor. This means that those with anxiety disorders may be less likely to attend NA because of these fears.

A final critique is focused on how members can have a difficult time questioning the principles of NA (Christensen, 2017; Reith, 2004). Christensen (2017) suggests that NA's ideological approach blinds people to the complexity of addiction and displaces blame from any failings within the programme onto the individual addict working to remain sober. This displacement is rooted in neoliberal ideologies of addiction and recovery (notions of individual responsibility and work), which discount situational factors for those struggling to maintain recovery.

Research into Online Support

For many people in today's society, online interactions are a common part of mainstream modes of communication (Bliuc et al., 2016), especially following the onset of COVID-19. In the context of recovery from addiction there is a vast variety of online communities of support, with options including online video recovery support meetings, discussion boards, chat groups, and recovery-specific social networking sites (Bergman & Kelly, 2020; Bunting et al., 2021). Data from a 2015 United Kingdom report on experiences of recovery found that a variety of online recovery support services are commonly accessed, including Facebook groups, self-management and recovery training's (SMART) online community, NA online meetings, Twitter accounts and blogs, and other online groups such as Intuitive Recovery and Breaking Free Online (Best et al., 2015). The same survey found that 65.4% of their sample (292 people) found online support helpful or extremely helpful for their recovery. Bergman and Kelly (2020) recently theorised how these online digital recovery support services (D-RSS) might be beneficial. They suggest that when people first engage with D-RSS they likely feel a sense of shared experience and universality based on identification with other participants which will then instil hope that change is possible. This prompts people to

increase their participation in D-RSS and as a result can potentially increase positive recovery expectancies, recovery coping skills, recovery self-efficacy and supportive network changes. This process will then lead to better substance use outcomes and improved health and wellbeing. While this model has not yet been applied in any studies, it was informed by various theories that support in-person recovery services, such as stress and coping, social learning, and social control theories.

In line with theorising by Bergman and Kelly (2020), other researchers have explored how D-RSS apply the same principles of recovery, such as group membership and shared experience (Bliuc et al., 2017; Naserianhanzaei & Koschate-Reis, 2021). Naserianhanzaei and Koschate-Reis (2021) studied two measures based on the SIMOR (social identity model of recovery previously discussed in relation to recovery) that are likely to affect the success of recovery—multiple group membership and active participation. Their dataset consisted of 457 participants who had self-announced their recovery on an online platform. They examined the postings of these participants and found that those who increased their group membership by one group decreased their chance of relapse by 4%, and more evenly engaging in different groups significantly reduced the risk of relapse. This study (Naserianhanzaei & Koschate-Reis, 2021) used naturally occurring online data to draw their conclusions, which is similar to a study by Bliuc et al. (2017) who examined how online participation in a recovery community can contribute to personal journeys of recovery. Data on recovery capital and online participation was gathered from the Facebook page of a recovery community (Bliuc et al., 2017). To operationalise recovery capital building, the researchers used indicators of increased levels and quality of online social interactions. The social network analysis of 609 participant online interactions, found that positive online interactions between members supported the recovery process because it assisted participants to develop recovery capital that binds them to groups supportive of positive change. These recent studies have begun to provide insight into the similarities with in-person attendance and the benefits of online recovery groups for people recovering from a substance addiction.

Other studies have explored feelings of support and satisfaction in D-RSS compared to face-to-face recovery options (Ashford et al., 2020; Barrett & Murphy, 2021; Graham et al., 2018). One study of particular relevance by Galanter and colleagues (2021), applied a survey to explore if a transition to virtual online meetings for NA members was effective for people in the United States. This research occurred during the beginning of the COVID-19 pandemic when many state and local officials first issued stay-at-home orders. Of the 2152 long-standing members of NA that responded, 64.9% reported that virtual meetings were at least as effective for maintaining abstinence as face-to-face meetings. Abstinence appeared to be the main outcome focus of this study, which is limiting because, as previously shown, there is more to recovery than simply abstaining from substances.

Another study by Barrett and Murphy (2021) took a broader approach by investigating the relationship between twelve-step meeting formats (both face-to-face and online) and members perceptions of meeting effectiveness, accessibility, the quality of social support and recovery networks. The survey was completed by 97 twelve-step community members from 'IntheRooms.com' (Barrett & Murphy, 2021). Participants reported online meetings provided more accessibility, but the meetings, the support quality, and recovery network quality were less effective. These findings suggest that it is possible to continue supporting one's recovery through online platforms, but they may not provide the same level of support and connection as face-to-face meetings.

While studies into D-RSS look promising, there are some potential concerns that need to be considered when judging the feasibility of this mode of support. One of the most important concerns relates to the technology of D-RSS. While the use of technology has grown exponentially in society, it is estimated that in Aotearoa between 6% to 9% of the population do not have access to the internet and the groups most likely to have limited access include Māori, Pacific, people living in country towns, and older members of society (New Zealand Government, 2018). As such, some people may not have access to the resources needed to utilise D-RSS, such as having broadband internet, a mobile device, or even a computer (Bergman & Kelly, 2020). Furthermore, those without access to technology may not be comfortable or confident using it. D-RSS can also create concerns about privacy risks, as people need to learn how to navigate and maintain online anonymity (Rubya & Yarosh, 2017). In a way, D-RSS can be more public than face-to-face meetings as it is not possible to know or control who may be viewing another participant's screen. Ultimately there is also the ever-present concern that D-RSS simply may not compare as well to in-person groups, in regard to connection and support quality. According to Graham et al. (2018), D-RSS could be a good complementary option though, as it may bridge the time spent alone and meeting attendance. This is a promising area for research and could involve examining how the connections and support compare from online to face-to-face.

Conclusion

This chapter has provided a comprehensive summary of existing literature relating to addiction, recovery, NA, and online support that was situated in a pre-pandemic time. While this literature is an essential base from which to understand phenomena, it is crucial that we have research that explores them within the COVID-19 pandemic context and the restrictions that came with it. Some online support research has begun to compare the role of online recovery support with face-to-face support, but there is limited qualitative research specifically with NA members.

Research is also lacking on how NA members made meaning of and experienced the COVID-19 pandemic and restrictions, and the impact that this has had on their recovery. This research aims to address these gaps, while also locating the research in Aotearoa.

Chapter Three: Methodology

My theoretical stance for this research needs to be clear, as my decisions on what can be known (ontology) and what is adequate and legitimate knowledge (epistemology) shaped the entire research process (McNeil, 2021). Throughout this research I adopted a relativist ontology, as well as a social constructionism epistemology. A relativist ontology implies that knowledge and reality will always be relative to the historical, cultural, and social context (Sullivan et al., 2012). Adopting this stance meant that knowledge is not grounded in terms of what is 'real' or 'true' as this varies on the context. A social constructionism epistemology meant that I was interested in how the phenomena was seen; meaning is therefore imposed by one's cultural and interactional context (Crotty, 1998). Like the relativist ontology, social constructionism challenges the notion that knowledge is produced through objective and unbiased observations (Burr, 2015a). Instead, a critical stance was adopted towards any assumptions about knowledge and this epistemology recognises that understandings of the world are produced through the engagement and constructions of it, which is reflected in socio-historical locations (Burr, 1995). Overall, both theoretical standpoints challenge the notion of an objective reality existing, and instead view knowledge and experience as subjective. These key ideas played a guiding role in what understandings I uncovered and aligned with previous studies on addiction (Irving, 2011; McCullough & Anderson, 2013; McGannon et al., 2020; Sibley et al., 2020).

Addiction and recovery can be thought of as social constructions; knowledge, understandings, and ideas around them have a social basis (Rhodes & Coomber, 2010). Neither addiction nor recovery are an absolute entity, rather the understandings of each are socially, historically, and culturally constructed and shaped by personal circumstances (McCullough & Anderson, 2013). Weinberg (2011) argues that all social scientific contributions to understandings of addiction come from a social constructionist position as they seek to identify social forces that influence the prevalence of behaviours deemed addictive. He goes on to argue that addiction is more than just these social factors, fundamentally it is a culture-bound phenomenon. This can be seen by the impact of differing social and cultural theories on addiction, as there is no universal law that dictates patterns of use, drug policies, or interventions. The socio-cultural environment in which one is situated dictates these ideas (Hammersley, 2017). Each person's addiction, and their recovery is therefore a complex, individual, and subjective experience; what one views as their addiction or recovery journey might be different to another's (Swords & Houston, 2021).

In the case of this research, NA members' recovery from a substance addiction was explored within the social context of COVID-19. Additionally, the inclusion and emphasis of multiple realities and personal stories made social constructionism appropriate as an epistemology as each

participant is in the best position to share their narratives around the impact of COVID-19 restrictions on their recovery.

Theoretical frameworks

Critical Participatory Action Research

Some of the principles that guided this research relate to an approach called critical participatory action research. It is argued that it is a methodology (MacDonald, 2012), a field of research (McIntyre, 2008), and even an epistemology (Fine & Torre, 2019). At its core, critical participatory action research endeavours to understand and improve the world by changing it (Baum et al., 2006). This involves some underlying tenants, such as a collective commitment to investigate an issue; engagement in self and collective reflection on the issue; a joint decision for collective action that leads to a beneficial solution for the issue; and the creation of an alliance between researchers and participants in all stages of the research process (McIntyre, 2008). Essentially, it is a way of conducting research that involves researchers engaging in a critical inquiry cycle where participants become co-researchers and they identify an issue, collect data on the issue and then implement some form of collective action (Lac & Fine, 2018).

The genesis for this research came about through discussions between my supervisor, Dr Denise Blake, and several members of NA. Through these discussions it was realised that it was important to capture the stories and experiences of NA members and their response to the COVID-19 lockdown. That idea was then proposed to me as a thesis topic. Accepting this mission, mean that I have talked extensively with Dr Blake who has strong connections to the NA community and in the AOD space, I also communicated consistently with members of the NA community, garnering advice, and consultation at various stages of the research process (i.e., ethics, recruitment, etc.). This consultative process was necessary as I hold an outsider position (discussed later) and therefore needed to be reflective of my role in the research, and my inexperience with the topic. These elements also aligned well with the social constructionism epistemology, in that critical participatory action research is driven by the communities under investigation and any community knowledge is privileged and therefore socially constructed (MacDonald, 2012).

Narrative Theory

This research was also guided by ideas from narrative theory. Through storytelling, narratives provide a way of understanding human experiences, which in turn facilitate a better understanding of the human phenomena and existence (Kim, 2016). Narratives also provide a way

for people to make sense of their experiences—in this way it is an essential part of meaning-making (Silver, 2013; Squire et al., 2013). The exact definition of a narrative is often debated among researchers resulting in diverse understandings of the term, however Riessman (2008) argues that this produces a major strength as it provides diversity in narrative studies. She also adds that people communicate and reinterpret their life experiences through stories, and these stories reveal sense-making while also highlighting common threads (Hatchell & Aveling, 2008). Stories are reflections of the current internal world of the narrator as well as aspects of the social world they reside in (Bamberg, 2012).

Addiction is often framed as a journey and access to how people understand addiction occurs through storytelling. The recovery process can also be conceived as a storied journey, where engagement in mutual support groups requires a continual re-storying. This is a process by which NA members are familiar, as the meeting format allows the opportunity to share a storied form of their experiences with addiction and recovery. The multiple ways of storing recovery represent recovery as unique, fluid, and ever-changing with an undefined ending. Narrative theory is positioned well to capture the fluidity of this journey, it allows researchers to understand how people make sense of their lives through the social understandings they have access to, and how they story their lives (Irving, 2011).

Narratives can be understood as the result of social relationships and those with an addiction, and in recovery, will structure their narratives in relation to the dominant cultural narratives that shape and become the context of their lived experience (Devar et al., 2020). In this way, narrative theory aligns with a social constructionism epistemology as the approach privileges positionality and subjectivity (Riessman, 2001). Narrative theory is also concerned with a critical analysis of the stories we hear, and the larger societal narratives that are embedded in our social interactions need to be acknowledged (Webster & Mertova, 2007). Drawing on the work of philosopher Paul Ricoeur, Burr (2015b) argues that the stories people produce are both enabled and limited by one's social world, which then impacts the possible ways of being and the identities people can construct.

The approach of narrative theory, with a social constructionism backing, allowed the stories from NA members to be a privileged source of knowledge. The methodology suggests that historical contexts are essential to interpretation (Riessman, 2001) and by doing so, it encourages the social context of COVID-19 to be considered when listening to the participants narratives of recovery. As a result, the research was focused around two main questions:

1. How has COVID-19 impacted on the recovery of NA members?
2. What role has NA played during COVID-19 restrictions in the recovery of its members?

Procedure

Participant Selection

The criteria for participation stipulated that the participants needed to be over the age of eighteen and a member of NA during a COVID-19 level 4 lockdown period in Aotearoa. The participants needed to reside in Aotearoa because our COVID-19 lockdowns varied in time and parameters from other countries. Preferably participants needed to have had attended one or more online zoom NA meetings. However this was not essential as the focus of the research was on stories of recovery during the COVID-19 pandemic and NA members could have engaged with the programme in other ways during the lockdowns (i.e. step work, sponsorship). Finally, participants needed to be willing to share their stories of recovery, being a member of NA, and COVID-19.

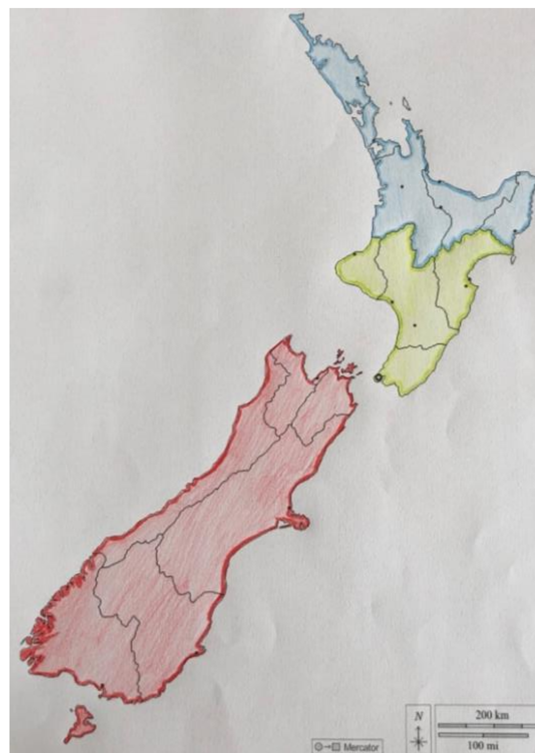
As advertising material is not allowed to be distributed at NA meetings, recruitment occurred through word of mouth with the help of two gatekeepers. These were two current members of NA who reached out to their networks within NA to see who would be interested in participating. The sensitive and private nature of the study required the knowledge of insiders to locate people for participation (Biernacki & Waldorf, 1981). The gatekeepers gave potential participants a brief overview of the research, and if they were interested they connected them to me via email. Using a gatekeeper is a common method with hard-to-reach communities as they provide a way to access groups and build rapport and trust (Emmel et al., 2007). Additionally, one participant was recruited through a snowball recruitment method. This is another commonly used technique for recruiting harder to reach communities. It involves participants referring others who may be suitable for participation (Biernacki & Waldorf, 1981). Many of the participants checked in with me to see whether I had enough participants and offered to help find more if need be. This is a credit to the strong network that NA has formed and the benefit of working with a community. Ultimately, these recruitment methods were well suited and very successful for this research.

In total, 11 participants were interviewed. This sample size was appropriate for this study design as the aim was to gain access to a deeper and more contextualised understanding of the participants lives (Neale et al., 2005). To protect the identities of the participants, as this is small community, only minimal details are provided in the findings chapter such as age of first use or preferred substances. The participants included eight females and three males. The age of participants ranged from 28 to 72 years old, and the ethnicities of participants included Māori and European/Pākehā. Participants resided in all three areas which make up the Aotearoa New Zealand region (see figure 3 below). This included two participants from the Northern area (the North Island north of Taupo), four participants from the Central area (the North Island south of Taupo), and four

participants from the Southern area (the South Island)[4]. In these different regions, nine participants lived in urban areas, one in a suburban area and another in a rural area. Finally, the clean-time (amount of time abstinent from drug use) of participants at the time of interviews ranged from 1.5 years to 41 years clean. As is well argued with qualitative research, the sample was not intended to be representative of the population, nor did the findings aim to be generalised to the wider population (Braun & Clarke, 2021). The aim was to get rich in-depth narratives about lived experiences which was achieved (Sullivan & Riley, 2012).

Figure 3

Map of the three areas that make up the Aotearoa New Zealand Region



Data Collection

Once participants were connected with me via email I replied introducing myself and outlined what was involved. I also explained and attached the information sheet for them to read over and discuss with others (see Appendix D for all ethics documents). Participants were informed that if they had any questions or concerns they could contact me either via email or mobile and these could be discussed at any point in the research process. If they met the criteria and still wanted to participate, they were told to respond to the email so that I knew they fit the criteria, had read the information sheet and were still interested in participating on their own accord. For those

[4] It is up to each groups discretion on which area they join.

that did want to partake, I replied with the consent form (see Appendix D) and arranged a time and location for the interview that was suitable for them. If any participant had any issues signing the consent form, the option was given to mail it to them or sign it in-person before any face-to-face interviews. As I am based in Auckland, I gave the participants in Wellington three possible dates for having face-to-face interviews in Wellington if they preferred. Other participants outside of Auckland were offered a zoom or phone interview at a time that worked for them. I checked with all participants if there were any culturally specific needs that would make the interview process more comfortable.

Due to the unpredictable nature of COVID-19, an alternative plan was in place to hold interviews over Zoom if Aotearoa unexpectedly moved to Alert Level 3 or 4. As most of the interviews were planned for zoom, this was not a serious concern. However, there was one interview that moved from face-to-face to zoom due to a change in Alert Levels.

All interviews began with a small introduction that explained my stance and reasons for interest in this research. This established and made explicit my outsider position. It also fostered an open environment and engendered a relationally ethical connection where participants felt they could share their stories with me (Hodgetts et al., 2021). I reiterated their rights as participants and provided another opportunity to ask any questions they may have had. I confirmed that they were happy for the interview to be audio recorded, and assured them that the recording was only for transcribing purposes. The same interview guide was used for all of the interviews (see Appendix D). The interviews were semi-structured so as to allow each person to tell their story and experiences in the manner they wanted. The interview guide was designed to encourage participants first to share their stories of addiction and recovery, then their experiences of NA before the pandemic and then during the pandemic. On completion of the interview, as per my ethics, each participant was given a thank you voucher as an acknowledgement of their participation.

All interviews were transcribed verbatim. Any identifying information was removed and transcripts were returned to participants for checking. Removal of identifying information was particularly important, as anonymity is important to NA members due to concerns such as social stigma. The participants had one month to make any changes, edits or comments. Once satisfied with their transcript, participants signed and returned the 'Transcript Release Authority' (see Appendix D). Some participants did make changes to their transcripts, which were included in the final version of the transcript used for analysis.

Reflexivity

Reflexivity is an important tool of qualitative research, not only to ensure rigour and quality in the work, but also to demonstrate trustworthiness, promote relational ethics, increase the creditability of findings, and deepen how people understand the work (Berger, 2015; Dodgson, 2019; Hodgetts et al., 2021). Reflexivity is an interactive process that entails the researcher drawing upon their knowledge of the topic and practising self-awareness throughout the research process. It is a process of a continual internal dialogue and critical self-evaluation of the researchers positionality as well as an active acknowledgement and explicit recognition that this position may affect the research process, outcomes and participants (Berger, 2015). In alignment with my epistemology of social constructionism, and the critical participatory action research approach, my role as a social constructionist researcher was not one of a witness or discoverer, but rather as a collaborator of knowledge (Willig, 2001). So I understand that the research was inevitably influenced by my life experiences, values, circumstances and the broader social context in which the research evolved, such as through supervisory conversations. In these ways, reflexivity can be thought of on a theoretical and a pragmatic level (Wigginton & Setchell, 2016).

My positioning in this research is as a young, Pākehā, educated, middle class, heterosexual, able-bodied and cis-gendered woman. As identified above, my role as the researcher is that of an outsider. When I began this research, I knew I did not have a great deal of knowledge of addiction, recovery, or NA. Within my undergraduate degree I completed a paper on AOD use and throughout my postgraduate reading list I found myself most drawn to the readings on addiction. Within my personal life I have had some exposure to substances through social circles, mainly due to the norms of my age group. I have seen people with problematic substance use, but I have had very minimal experiences with addiction. I cannot pretend to fully understand what it is like to have an addiction although I am empathetic, open and willing to learn. As previously discussed, elements of this research are based on the principles of critical participatory action research. Consequently, this research involved various discussions between Dr Blake, members of the NA community and myself. I held multiple meetings with Dr Blake to discuss the research topic and to work out a plan to increase my knowledge of this area which was limited. I had briefly heard NA mentioned within some TV shows, but I was more familiar with the fellowship of AA, again through media rather than personal experience. Initially when researching NA, I felt some hesitancy towards the use of the word God as asserted in the NA traditions and steps. As someone who does not have a specific religion I found this terminology confronting. I have always believed that there is something greater than us but have also been unsure of what this may be. However, after attending a NA meeting

(which I will discuss later) where the topic was on a higher power I realised that their use of the word God did not mean what I initially thought.

Hellawell (2006) suggests that our position as either an insider or outsider in research can be positioned on a continuum. He states that there are subtly varying shades of 'insiderism' and 'outsiderism' and that as researchers we can slide along more than one insider-outsider continuum and in both directions during the research process. This explanation really appealed to me, ultimately in this research I am strongly an outsider however there were moments when I interviewed younger participants, or female participants where I felt I moved closer on this continuum to insider. I could also relate to experiences of the COVID-19 lockdown in general, as there were some commonalities in terms of feeling trapped and having to follow new rules and restrictions. These small commonalities did not make me an 'insider' in terms of the NA community though, as I have never experienced addiction, recovery from an addiction, or been part of the NA fellowship. Regardless, it is important to reflect on the subtle and explicit ways in which my outsider position may have served to delegitimise or silence participants' experiences (Wigginton & Setchell, 2016).

It was very important to me to understand NA more before interviewing participants. Since I was asking participants to share their stories of the meetings both in-person and online, I believed that I needed to experience these meetings myself. Some NA meetings are open to visitors, and with my gatekeeper contacts I attended a few different meetings both in-person and virtually to get a feel for them. These meetings were eye-opening and thought-provoking. As I went through the research process, I realised at every step how important it was that I had attended these meetings. These meetings afforded me an insight that could not be gained through reading alone. Seeing the NA fellowship in action, hearing the raw unfiltered stories and feeling the genuine connection and network that members had with each other was incredible.

A final element that was of concern was issues of power and privilege, especially as this research focused on the experiences of recovery from a highly stigmatised condition (Wigginton & Setchell, 2016). Power differentials are always inherent within research relationships, and an understanding of these relations is integral to recognising how researchers are implicated in the operation of power and how researchers may respond in ways that will minimise differences in power in the research process (Berger, 2015). As I became aware of the potential power differential that could occur during the research process, I applied a few strategies to make this power more obvious to participants and offer some agency to them. For example, participants could choose where the interviews were held so they had agency over the setting and could feel comfortable sharing. Starting the interviews with a disclosure was also important. This involved sharing a little bit

about me, why I decided to do this research and making it clear I have no lived experience with addiction. Research disclosure has been promoted as a way of establishing trust and facilitating openness during the interview process and self-disclosure can also be a strategy for addressing power dynamics within interview interactions (Grant, 2014). Furthermore, by making it clear I had no experience and letting participants lead, it offered a way for the experience to be empowered and shifted the power dynamics (Berger, 2015). Participants later had agency over their stories by being able to review and change their transcripts.

The epistemological and theoretical frameworks of this research also worked to address power differentials. My choice of a social constructionism epistemology and narrative theory validated various ways of knowing by participants, in that there is no right or wrong way and who we are is always socially mediated (Burr, 2015a). The inclusion of principles from critical participatory action research encouraged consultation between the researcher and participants at certain stages in the research, which created a more balanced power distribution (Fine & Torre, 2019).

Another key area of development for me was completing a health psychology practicum with an organisation that focused on workforce development in the mental health, addiction and disability sector. As part of the practicum I produced a literature review that explored stigma and its association with substance use. This gave me increased insight into the world of addiction and the negative outcomes of stigma. The work also coincided with conducting my interviews so I found my assumptions and knowledge of addiction shifting as I neared the completion of my practicum. My biases and judgement could have impacted on the study but the strategies used to work with the community and to grow as a person and researcher helped me acknowledge them.

Ethical Considerations

While the discussion above signals the range of ways in which I enacted good ethic practice, it is also necessary to explicitly outline the steps I took to ensure ethical safety. A full ethics application was obtained Massey Northern committee (*NOR21/22*). This ethical process meant that I carefully considered research design, safety concerns and how these would be mitigated. This included issues of recruitment, informed consent, data collection, the potential harm to participants and cultural competency.

Prior to completing the university ethics process, I consulted with one of the research gatekeepers to ensure I covered all relevant ethical issues that might concern NA members. While this member was not representing NA in Aotearoa as a whole, they provided insight into good ethical practices. This included protecting personal recordings and offering a ‘Where to seek help’

document to participants (see Appendix D). Consulting with a NA member around the ethical concerns of the research was a valuable experience providing fresh insight.

One ethical issue that was of concern was privacy and confidentiality for the participants (Emanuel et al., 2000). The twelfth tradition of NA states that “anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities” (Narcotics Anonymous, 1986, p. 4). Anonymity in meetings fosters an environment in which NA members feel safe to share their stories about addiction and recovery, without the concern that these stories would be heard by people outside the room and thereby invoke forms of stigma. Protecting anonymity was imperative throughout the research process, especially so that participants did not experience any social harm from partaking in the research (Miller et al., 2010). In practice I assured participants that any identifying information would not be made available to anyone who was not directly involved in the research. Data was kept in an anonymised form, and each participant was assigned a number until a fictitious name was created in the write-up.

Other ethical risks were distress to participants, maintaining participants autonomy and the benefit to participants (Emanuel et al., 2000). While there was the potential that revisiting painful memories or events around addiction and recovery could cause emotional distress, this was minimised as participants were recruited from NA, so they were already very comfortable with sharing their stories within meetings and had strong support networks in place. As noted above a ‘Where to seek help’ document (see Appendix D) was created with the help of one of our gatekeepers. No participants requested the document.

As recruitment was done through a gatekeeper it was important that potential participants did not feel coerced to participate. This was ensured through the process of informed consent (Emanuel et al., 2000). As discussed, once the gatekeeper connected me with potential participants, I gave them further information about the study and encouraged them to consider and discuss their participation with others. In a second email, after confirming participants were still interested, they were given the consent form to sign. I encouraged the participant to ask any questions at any point if there was anything they were unsure of or hesitant about. Overall, all participants seemed very excited to participate and many expressed gratitude for the opportunity to share their stories of, and love for, NA. This process ensured the research participants were fully informed about the procedure and risks involved before they gave their free and uncoerced consent to participate (Miller et al., 2010).

Cultural safety was also important to any research (Tolich, 2001). While the majority of NA in Aotearoa is made up of Pākehā, it was estimated that 16% of NA members are Māori (Aotearoa New Zealand Narcotics Anonymous, 2008). With two participants identifying as Māori, I made sure I did

not assume what was appropriate or expected for these participants, as argued by Tassell et al. (2012). Rather I asked each participant what they needed to partake in the research, and whether I should introduce myself with my pepeha and a karakia or bring kai to the interview (if face-to-face). I also encouraged participants to bring whānau or a support person to the interview if they wanted. I worked alongside my supervisors and a cultural liaison at Massey University to create a flexible plan for any interviews with different cultural groups. The most important consideration was building trust with participants and listening attentively in the research process. Both Māori participants decided to open and end with a karakia themselves, which was a beautiful way to begin our research journey together.

I was also mindful of te Tiriti o Waitangi as the founding principles for equality, connections and relationality. I constantly tried to centre Māori so as not to repeat any human rights injustices that have traditionally occurred through colonial oppression (Graham & Masters-Awatere, 2020). I also ensured that I practised cultural safety through examining my own social and political position, perspectives, and attitudes during the interview and research process (Haarhoff, 2016).

Data Analysis

Narrative analysis is the act of finding narrative meaning in a set of data, and by interpreting the data researchers find meaning in peoples experiences (Kim, 2016). For my data analysis, I predominantly drew on the work of Riessman (2008) who proposed a typology of the four main types of narrative analysis: thematic, structural, dialogic and visual. In this research I utilised a thematic narrative approach, which is when the focus is placed on the content—'what' is said (Riessman, 2008). This required an emphasis on the told rather than the structure of the narrative, and common elements were identified in order to theorise across participants. The analysis is similar to that of Braun and Clarke's (2006) thematic analysis, where transcripts are read several times, data is organised, coding is done, and themes and subthemes are developed. What is unique with a thematic narrative analysis though is that the core narrative elements associated with each theme are identified and the themes are interpreted through a lens of narrative theory (Riessman, 2008).

Polkinghorne (1995) also highlights the difference between analysis of narratives and narrative analysis. In this research, I have done the latter, in that I have not analysed the language used to construct a narrative, rather I have used narrative tools and principles to focus on what content the narratives communicated. It is also important to note that while I conducted a thematic narrative analysis, and not a cultural or ethnic analysis, I was still mindful of bicultural relationships within Aotearoa and understood the importance of recognising and privileging Māori worldviews.

Informed by the processes described above, analysis began at the transcribing stage. While I transcribed each interview into a word document, I noted down any seemingly important narrative themes or ideas that stood out. In that document, any similarities or differences from across the different transcripts were grouped together and any standout quotes were added for later use. Once all interviews had been transcribed and checked over, I went through each transcript and coded the data based on the guiding research questions, specifically:

1. What are the participants stories of addiction?
2. What are the participants stories of recovery?
3. How has COVID-19 impacted on this journey?
4. What experiences have they had with the twelve-step programme?
    a. What were NA members experiences with the twelve-step programme during lockdown?
    b. What were the advantages and disadvantages of this experience during lockdown?

With the four guiding questions, the narratives were initially coded into four sections—addiction, recovery, COVID-19, and NA. I colour-coded each of these sections in order to understand their narrative journey. Throughout this analysis process I considered how the stories of NA and the fellowship fitted into each part of their journey. During this initial stage I realised that the guiding research questions needed to be synthesised into two main questions:

1. How has COVID-19 impacted on the recovery of NA members?
2. What role has NA played during COVID-19 restrictions in the recovery of its members?

These two research questions were then made visible during all parts of analysis for reference, and to continually check the relevance of ideas. I then individually summarised each of the participants' narrative themes under the four codes and compared these themes with the ideas initially noted during the transcription process. As a result, I created a collated thematic list, in which the narrative themes were categorised across each stage in a general story.

Upon reflecting on the two research questions I realised that the narrative themes underneath the addiction and recovery parts could be interwoven and utilised to contrast the participants experiences of the COVID-19 restrictions and the impact this had on their recovery. I took the key ideas under the COVID-19 theme and grouped them into their own distinctive sub-themes. This process involved extensive meetings with my supervisors to discuss the analysis. They

both provided a sounding board to explore multiple interpretations which enhanced the analytical process. The resulting themes included connections, gratitude, opportunities, consistency, and service in an online environment. The transcripts were then coded to highlight relevant quotes that related to each theme. These themes were developed and formed the findings of this research, which will be discussed in the next chapter.

Chapter Four: Findings

There were five main themes identified in the narratives of the participants which will be discussed in turn: maintaining connections, expressing gratitude, creating opportunities, upkeeping consistency, and service in an online environment. I first provide a background to contextualise the participants, which is done collectively. For all of the participants, their addiction stories and recovery journeys began well before COVID-19 so it is necessary to briefly set up the backstory before exploring how COVID-19 measures impacted on their recovery.

It is necessary to note that the participants' narratives in this section represent their personal thoughts, feelings and experiences only, they in no means represent NA, which as an organisation has no opinions on outside issues (Narcotics Anonymous, 1986).

Background

All the participants storied how they started their addiction to drugs in their teenage years, with their age of first use varying from young to late teens (11 years old to 16 years old). Their length of drug use ranged from 10 years to 38 years, with a few participants noting that they had periods of drug-free recovery within that time. Drug use included alcohol, cannabis, opiates, heroin, methamphetamine and other intravenous drugs. However, most participants indicated they dabbled in a bit of everything, and as Amy explains in the quote below, to most using addicts the type of drug does not necessarily matter. For Amy the 'it' is any substance.

> *I don't think it matters, it makes you go fast, it makes you go slow, it gives you coloured pictures. I would have everything and not question what it was…. I don't think it makes any difference. And the NA programme says it doesn't make any difference. It could be a bit of a hierarchy 'ah I used really hard'. But when you're really, you know, desperate, no matter what you're using, it's hard.* —**Amy**

As Amy says, the programme of NA makes a point not to differentiate between substances as the specific substances are not an important aspect of recovery in NA. The focus of the programme is instead on the ways addiction and recovery have had an effect on the lives of their members (Narcotics Anonymous, 1986).

In their addiction story, the participants all described the time when their addiction took over and they realised they were an addict. This was often a series of moments when their drug use became unsustainable in their everyday lives. Some recounted how they struggled to maintain control over themselves, life became chaotic and using drugs became their biggest priority. This led

many participants to what is known in the addiction field as 'rock bottom' or a series of 'rock bottoms'. Rock bottom exemplifies the turning point for addicts when they become tired of living in pain and want to do something about their drug use (Kemp, 2013; Shinebourne & Smith, 2010). In these moments, the participants story often pivoted from addiction into a journey of recovery.

For some of the participants, their recovery journey started in treatment centres where they were introduced to NA and other twelve-step programmes. For others in this research, the journey into recovery occurred in the community and was prompted by a friend suggesting they attend NA. Participants expressed how NA offered a message of hope and one promise — the freedom from active addiction. Narratives represented how recovery quickly became embedded in the participants lives, which involved making significant personal and social changes, committing to the process of recovery, putting in the effort at all costs, taking responsibility, and recognising the long-term work needed to maintain an abstinent-based recovery. For the participants in this study recovery was about more than just staying drug free, it was about behaviours and attitudes. These mindsets aligned with the NA programme, which looks beyond recovery as simply a matter of not using substances and instead supports a new way of living life (Narcotics Anonymous, 2008).

When the disaster struck, and COVID-19 restrictions were announced in 2020, all participants beside one had been maintaining a stable recovery. Even so, like most people's experiences during an extraordinary event like a global pandemic (Urban & Urban, 2020; Wang et al., 2020), some participants shared their initial feelings of being trapped, controlled and powerless, and that they had to learn to follow new rules. These feelings dissolved though, with eight participants reporting how overall they had a really positive experience in the Alert Level 4 lockdown even when they had to overcome hurdles, such as health issues, setting boundaries, and feelings of loneliness. In terms of recovery, most participants said that the lockdowns either positively impacted or had very little to no impact on their NA recovery. This may have been because the participants in this study had the support of the NA fellowship to guide them through. In the following sections, I further explore the ways in which COVID-19 has impacted on the recovery of the NA members in this study and the ways in which the NA fellowship mitigated this impact.

COVID-19

The participants stories of COVID-19 lockdowns refer to the time period between March 2020 to August 2021. A lockdown refers to when the country was at either Alert Level 3 or 4, such as the first COVID-19 nationwide lockdown from March to May 2020 and the Auckland regional lockdowns. Every mention of lockdown in these findings are referring to these lockdowns (not subsequent ones).

Maintaining Connections

A central principle behind the success of living a drug free lifestyle through twelve-step programmes, like NA, is creating connections and having a network of people in recovery. The importance of a recovery network stems from theories on social capital which refers to the sum of resources a person has as a result of their relationships (Best & Laudet, 2010). These resources include the support received from groups they belong too, and the obligations they have to those groups. Being part of a social group that has a connection to recovery helps to uphold recovery as it immerses people to both recovery values and processes (Best et al., 2016).

Participants described how prior to lockdown connection to others was core to them maintaining their recovery. By having various supports in place and developing a recovery support network through NA people were able to achieve a sense of belonging and purpose for themselves. They also experienced a sense of community through NA (Stevens et al., 2018). It follows then that connections to others in the fellowship were important during lockdown for all participants, whether it was staying connected, re-kindling old connections or creating new connections.

Through Online Meetings. There are various ways to be in connection or stay connected to people in the fellowship. As stated, connections occurs through attending in-person meetings with other addicts, partaking in service work which strengthens connection with others, getting a sponsor for personal connection and guidance, or sponsoring others and helping these sponsees create meaningful connections with other members of NA. Lockdown created barriers for these types of connection, and in doing so it challenged many of the participants to focus on maintaining connections and findings news ways to do so, as this was important to everyone.

> *I had to focus a lot more on [staying connected] in lockdown because I spent once a week, once a fortnight by myself. So that was really hard. I had to be able to find other ways to reach out.* —**Malia**

> *So, I did spend more time on video calls like on, well in the meetings especially, and talking on the phone, and videoing, you know, messenger videos and stuff like that.* —**Daisy**

Both Malia and Daisy understood that during lockdown they needed to put in more effort to remain connected as living through a pandemic lockdown required people to be confined at home, often physically isolated from their support networks. This separation and isolation can be mentally

demanding and challenging, even triggering for people with an addiction (Liese & Monley, 2020) and therefore both participants realised that it was important that they reached out to others. Daisy explains that there were many mediums to stay connected through, but one that was particularly important for NA members to remain accessible was online meetings. When the meetings were not able to be held face-to-face due to the COVID-19 restrictions, NA moved meetings to Zoom which meant members could connect about not only their recovery, but also how they were coping generally throughout the pandemic. This was important to many participants, as expressed in the following quotes.

> *It's a sanity restorer. You know, when you check in with other people, you've been to some meetings now you can sort of see how it goes.* —**Francesca**

> *With the uncertainty of the planet at the moment, knowing that we could easily access, I feel quite safe and secure in terms of having other recovery, other ways to keep doing my recovery and keep connected to the wider fellowships.* —**Daisy**

> *The fact that I was able to feel connected to my programme. The fact that I was able to connect with other people and that's it basically... You'd often hear people talking about COVID. And lockdown. Just the effect of that. Challenges of that. Because it affects everyone differently*. —**Eddie**

> *I learnt to enjoy [online meetings], they helped keep me connected.* —**Hannah**

Connections, as represented in check in's and engaging with the principles of the NA programme is what many, like Francesca and Eddie, valued the most about the programme. During active addiction it is theorised that people either lose their positive social identity, which leads to feelings of social isolation, or they become part of a substance using social network which offers a temporary sense of belonging but diminishes over time with experiences of rejection (Dingle et al., 2015). By moving online NA members were able to share thoughts and feelings during the lockdowns to lessen the burden on their mental wellbeing. Additionally, while many participants initially felt unsettled and unsure of the online meetings, like Hannah they realised that during a pandemic lockdown this was one of the best options for staying connected, with some even sharing that they learnt to enjoy online meetings. For Daisy, being able to access the meetings meant more

than just connecting with others, it made her feel *"safe and secure"* in her recovery because there were ways to get help for recovery in lockdown.

With the new and unfamiliar terrain of online meetings, there was also an element of concern for how people could celebrate achievements over Zoom, such as achieving a certain length of clean-time (referred to as clean-time anniversaries), and celebrating in the same way they did face-to-face. However, Hannah shared that this was possible, even though initially she was sceptical.

> *It was my 41-year clean-time anniversary in lockdown, and I thought I was gonna let it go and not celebrate it. And my home group organised the celebration and told people around the world, so we had about 100 people, and it was so much fun! I think that's where I sort of got over myself and barriers re Zoom.* —**Hannah**

For Hannah, this was her turning point when she realised that it is possible to maintain a connection with the rituals of the fellowship and twelve-step programme over Zoom. What is also relevant is that Hannah has spent a very long time in the fellowship at 41 years clean, so her connections and relationship to the NA lifestyle would have been stronger than someone who is newer to living an abstinence-based lifestyle.

Having solid connections provides a person with support early in recovery, especially when they are transitioning their social networks from one predominantly focused on using, to a network that is focused on recovery. During lockdown, Lloyd shared how he worked towards getting clean but this initially involved a relapse back into drug use. While he blames the relapse on himself, and not the lockdown, it is also clear that the people he associated with influenced how and why he thought and behaved in the way he did.

> *So I don't think it was lockdown in particular that influenced that [referring to the relapse]. It was just um me being willful really. Just running on my own will and thinking I can go hang out with people who were drinking. And like when I was only like a fuckin a week or so clean.* —**Lloyd**

Lloyd demonstrates how picking up a substance can eventuate when not drawing on recovery networks and running on self-will, and illustrates how social circles influence behaviours relating to addiction and recovery (Best et al., 2016). Many other participants talked about their time in active addiction as being surrounded by people using drugs and the influence of relationships on forming their addiction. For example, Hannah acknowledged some relationships were not

healthy, they guided her journey into drug use and enabled the dependency she formed on narcotics. To break this cycle, Hannah was encouraged by her family to move overseas, yet the first thing she did when she arrived at her new destination was look for ways to connect with other "*people like me*", meaning other people who use drugs so she could maintain access to them. This is a common experience for people who relocate in an attempt to change their patterns of drug use, with Dilkers-Frayne et al. (2017) finding that moving enacts either a new generation of drug use, a temporary disruption of drug use or the maintenance of current use. For Lloyd and Malia, reflecting on their time in active addiction highlighted how important it was to remain connected with their recovery network in lockdown, and the online meetings offered by NA was one way to do so. The recovery networks that participants stayed connected to reinforced the tools and strategies needed to maintain a abstinent-based recovery, which is necessary for flourishment and wellness.

For many participants the online meetings also created the opportunity to rekindle old connections. Most of the participants have been long-term members of NA (10+ years), which meant that many of them had created strong connections through years of attending meetings, doing NA service work at different levels, attending national conferences and so on. For some, friends within the fellowship had moved overseas or elsewhere within Aotearoa, so keeping up with them when life was busy was not always possible. When meetings moved online people became more accessible, no matter where they physically were—nationally or internationally. The following excerpts are examples of how online meetings enabled reconnection with friends in different countries and allowed people to share their recovery with these friends again.

> *Um recovery wise it was funny actually because you know, I know a lot of people from different parts of the world. So we were going to each other's meetings… it was good seeing people I hadn't seen for a while, you know, in other countries*. —**Francesca**

> *I think it reconnected me with friends around the world I hadn't seen or spoken to for a long time. I loved that part.* —**Hannah**

One aspect of COVID-19, as a global pandemic, is that throughout the world people were experiencing the same restrictions of movement and public gatherings (Koh, 2020), so in this way communities of practice could come together from around the world. Access to the wider NA community that online meetings provided was also beneficial for NA members that had smaller local fellowships, such as rural areas of Aotearoa. This was the case for Julia and Daisy, who are part of a much smaller fellowship due to the number of meetings available where they reside. By moving

meetings online, they could attend other meetings and equally people from other regions could attend their local meetings, creating more and wider connections. Julia and Daisy identify how this worked and what it meant for them.

> *It was also cool just checking in with… like I could go to a Wellington [Zoom] meeting and see people that I hadn't seen for ages from Auckland. It was great. What was cool was people from Christchurch came, people from the Auckland fellowship, and even the Wellington fellowship. So we were being supported by the more national population of NA.* —**Julia**

> *I think it's enhanced some of my relationships with people that live outside [my region] because, [my regional] fellowship is really small. And so through being in lockdown and having to do Zoom meetings and connect, I'd connected with addicts that I might see once a year at a regional campout. I felt that some of those relationships were strengthened, and new connections were made. Which supported me more... I enjoyed seeing all the people that I wouldn't normally see, you know, the people, the faces from other towns, and other countries. Meeting new people, hearing a different message.* —**Daisy**

With these other connections Daisy was able to hear new messages, perhaps learning new recovery tools and be inspired. Other participants also shared how they appreciated being able to make new connections. Lloyd said that knowing each other well has implications but being able to *"venture out"* into the world and hear how addiction is for people globally was *"nice".*

> *So our fellowships not as big as Auckland, but it's not as small as some of those rural places. Basically, it's small enough that everybody knows everybody. Which is all good, but it was fucking nice to be able to just venture out without actually having to leave my house… venture out into different cities, different countries, and see some new faces.* —**Lloyd**

Online meetings and the advantages they brought for Lloyd were invaluable for his recovery. It created a chance to see new faces, meet new people and hear different perspectives. For him, this was a new way to connect and expand from a smaller fellowship. Without innovation like online meetings, as prompted by COVID-19 lockdowns, connecting with other people in the NA fellowship may not have been possible for the participants. Constraints such as time and money factor in, as it can be expensive to travel to other regions for meetings and may not be feasible due to work, family or social commitments.

While it is clear that moving the meetings online had a raft of positive impacts on connections, there were some negative views of online meetings. Some participants shared how they did not enjoy the Zoom online format. One particular element that was commonly expressed amongst the participants was online meetings did not engender the same depth of connection. Most participants acknowledged that when there was no other options, Zoom meetings were fine but they considered face-to-face meetings as the best option. The following narrative by Julia illustrates the importance of in-person connection because of interpersonal dynamics and personal development.

Physical meetings are really good in terms of actually interacting with others, because everybody that goes to meetings, I don't always like… physical meetings actually challenged me to be nice for a whole hour to these other people that I just didn't like, so that was nice. And of course to be supportive. And so, I think being Māori as well, kanohi ki te kanohi, face-to-face, being in the perimeter of a physical sort of process is really quite important. And even being able to turn your head and actually see the person and observe the way that they're moving. Because I really relate to people who are sharing for the first time something really uncomfortable, and you kind of see their physiology change. —**Julia**

For Julia, the face-to-face meetings supported a cultural way of being that was not possible in online meetings. For Māori in-person communication is a key principle of being and doing, it allows one to see, hear, feel and smell who or what one is communicating with (Ngata, 2017). The values of this suggests that it is an essential way to connect for relationships so they flourish (O'Carroll, 2013). Julia's narrative was echoed by other participants such as Daisy and Travis. They shared that online meetings could often feel one dimensional due to the limited non-verbal feedback by others in the meeting. Everyone is asked to mute themselves, besides the person speaking on Zoom, therefore it is not possible to pick up on the nuances that are a key part of connecting with others in face-to-face meetings, such as laughter. Subtle noises and body language can enable connection and indicate how people are responding to the sharing. This can also strengthen the connection between people because of the shared experience of feeling a certain way (Jolly et al., 2019). In the words of Travis below.

You don't get that stuff over Zoom, it's all cut off because everybody's on mute. So it's very... it's missing a whole dimension of people being there and identifying with each other.
—**Travis**

While many of the participants in this study have been part of NA for a long time, and therefore have stronger existing connections to the fellowship the lack of connection might not have been as jarring. However, the one-dimensional aspect of online Zoom meetings, which only allow signals from a face rather than a whole body (Wiederhold, 2020) could have made it difficult for newcomers to the NA fellowship to make meaningful connections with members. This could have lessened the sense of connection to the fellowship and potentially negated feeling supported in their recovery. This is especially problematic if online meetings are the only option to connect with other addicts in recovery. Beyond the formal part of the meeting, a big part of in-person meetings is the fellowshipping that happens before and after meetings; socialising is considered the informal part of a twelve-step meeting. In the quote below, Lloyd describes how these elements are necessary to relationality and building strong and meaningful connections with others in the fellowship.

> *Sometimes going and doing stuff after meetings, it's cool. People go out for dinner… it's also a big part of fellowshipping. The meetings are sort of formal place and then you go, like one person shares at a time and then you go out for dinner, and you get to have conversations with people and you get to start to actually sorta build those up, those relationships more. I think it's really important. And you can't really do that on Zoom.* —**Lloyd**

"Fellowshipping" in the way Lloyd describes was definitely not a possibility during lockdowns where restrictions meant people could only interact with those within their household. This potentially made it difficult to service the deeper connections while preventing more in-depth interactions. To overcome these issues, Daisy shared how some meetings would leave the Zoom call running for people to stick around and chat with one another in a less formal way. While this was a good option under the conditions, it still presented problems with deeper connections as participants said that social cues were far more difficult to pick up on through a screen.

Through Other Options. Online meetings provided a consistent way to stay connected during the pandemic lockdown, however they were was not the only way participants stayed connected during lockdowns. Travis shared how a lot of other channels for connection were opened during lockdown, such as messenger chat groups. These still remain active today and, as with the online Zoom meetings, they may not have been discovered without lockdown measures being put into place.

Catching up with friends in the fellowship was a common way to connect during lockdown, especially for participants with established friendship groups within the fellowship prior to lockdown. Travis narrated how he did not enjoy the online meetings, however, online get togethers allowed him to maintain the social interactions with others in NA which supported his recovery.

> *Me and a bunch of friends, we kind of just got together on Zoom every week or every few days just to catch up. Because we'd normally catch up socially. So we transferred to that, and that was a bit more meaningful for me, mainly because it's close friendship*. —**Travis**

> *I've got a really tight crew of friends in NA. And we created, we would Zoom each other. So we'd sort of Zoom each other and chat and stuff like that. It wasn't a meeting. It was just like a catch up. Because we're quite social, you know, outside of lockdown we were social. So we tried to keep that up with lockdown*. —**Ashling**

Akin to Travis, Ashling also maintained a form of socialising with a tight knit group during lockdown. Keeping social during lockdown meant that they could try and resemble some sort of pre-lockdown normality in their life. Other participants also shared the importance of connecting with friends as this meant the difference between maintaining an abstinence-based recovery verses going back to active and problematic drug use during lockdown.

Katie discovered that another way to connect with people was through a communication app called Discord. She found that Zoom meetings in general caused her a lot of anxiety, so when she attended meetings held by her fellowship this made her feel like she could not participate or share in an authentic way. Discord enabled her with a way to still connect with the NA fellowship that did not trigger her anxiety.

> *So Discord is an app… you can go on and you can click on NA meeting voice. And then you can be part of this meeting. And if they ask you to share or if you choose to share, you just unmute your mic. And you can share. But with these people… they're all over the world and they don't know me. So there's something about sharing with them that it's a little easier. So I did that quite a bit. And I also went on to their chat. So instead of sharing with voice, I'd go on to the chat room. And I'd say something like 'really struggling today, anyone got any suggestions around this?' And people will just get back to you.* —**Katie**

The Discord app opened up a range of options for Katie as she was able to connect through audio rather than video in the meetings and also had the option to utilise a chat line if needing advice or another form of support. Although it is not enforced, and every meeting sets their format and is autonomous, a lot of the NA Zoom meetings ask members to keep their cameras on to help people feel connected. For Katie, this request felt like a pressure, however as is essential to a twelve-step based recovery lifestyle, Katie was able to connect with other addicts in a way that felt more comfortable.

Finally, maintaining sponsorship through Zoom and phone calls was another way to stay connected and engaged with the principles and practices of NA during lockdown. Sponsorship is a key part of the success of the NA programme; having a sponsor is highly recommended as sponsors can help with learning how to work the twelve-steps or living life substance free. Sponsorship allows an addict to check in with someone who has been through similar experiences and provides a listening ear for whatever struggles someone is experiencing in their recovery (Narcotics Anonymous, 2004). During lockdown, this need for support and connection from ones sponsor was no different, and in some instances more important due to the disruptive and novel ways of living that people were being forced to endure. For Amy the lockdowns opened up the possibility of connecting with her sponsor in a new way as they were able to attended online meetings together.

> *So I haven't really had a physical [sponsor] there for me, a sponsor to hug so I rely a lot on my peers, on the newcomers and local friends. So because I do so much FaceTime, and have a sponsor out of town always in my recovery. It wasn't such a hard shift to Zoom… I've only just started to [use Zoom meetings] but I like em and plus also my sponsor can meet me there.* —**Amy**

As Amy describes in her narrative, a physical connection with a sponsor has not always been possible as she has lived rurally for most of her life. Consequently, she had relied on technology to connect with her sponsor due to barriers of distance and lack of options when part of a smaller, rural fellowship with less twelve-step based people, or where the stigma of being an addict has social implications (Palombi et al., 2019). Krentzman and Glass (2021) found greater shame and stigma in rural communities kept individuals from seeking help or attending twelve-step meeting. With the widespread establishment of online meetings, Amy was finally able to attend meetings together with her sponsor which was something that she cherished. Many participants also shared how they continued to show up for the people who they sponsor, whether this was through a one-on-one Zoom meeting to work the steps or just a simple phone call to check in on how they were doing. This

was particularly important in a challenging and stressful time like lockdown as the process of sponsorship allowed a person to confide in another trusted addict about the problems they faced and provided the opportunity to work issues through together (Narcotics Anonymous, 2004).

Expressing Gratitude

A central principle within NA is gratitude, with the NA Basic Text stating that “as recovering addicts, we come to know gratitude” (Narcotics Anonymous, 2008, p. 97), because it is one of the greatest gifts of recovery. Gratitude frequently appears throughout other NA literature and in the guiding principles—particularly in tradition one, five and seven (see Appendix B). Gratitude can mean a range of things to different people in different contexts; it can be an emotion, an attitude, a virtue, a personality trait or even a behaviour (Allen, 2018). In general, expressing gratitude has positive implications for overall health, wellbeing, and relationships. For those in twelve-step communities, it is often known as a tool that facilitates wellbeing (LaBelle & Edelstein, 2018). Utilising the tools of gratitude allows members to keep the disease of addiction in check by stimulating positive emotions and building stronger connections which subsequently promotes recovery and protects against relapse (Chen, 2017). For these reasons it was not unexpected to see sentiments of gratitude for recovery and the NA fellowship in the participants narratives when they spoke about their time in lockdown.

For the Fellowship. One aspect of gratitude that was prevalent in the participants narratives were how thankful they were for the fellowship, particularly when Aotearoa went into lockdown. Upon joining NA people become part of a community that promotes helping one another to stay clean from problematic drug use and recover from the effects of addiction. When lockdown was announced members of the fellowship sprang into action and adapted the programme to make it work online. Francesca and Hannah started their stories about lockdown by sharing how quickly NA moved online, which allowed the meetings to remain accessible in a new form.

> *NA responded really quickly to the lockdown with Zoom… Our home group was on the next day… the woman's group went on first and we just checked in with them and said, how'd you do it and we were on and our home group just kicked off.* —**Francesca**

> *So the first lockdown um NA got online really fast. I was initially quite uncomfortable with going to the Zoom meetings cause I didn't like looking at myself in the camera (laughter)... I*

learnt to enjoy them, they helped keep me connected. And then I got sort of addicted to them. —**Hannah**

Both Francesca and Hannah signify how they recognised and appreciated the speed and scale in which the NA meetings became available over Zoom — to the point it was "*addictive"*. They were grateful for the forward-thinking and quick actions the fellowship provided. Like Hannah, Malia and Amy initially felt uncomfortable with online meetings, but with practical support provided by other members they became familiar with navigating online platforms and soon found elements to be grateful for. Again, gratitude towards these more practical aspects speaks volumes to how NA works as a community.

Further expressions of gratitude for the fellowship were noted when participants acknowledged the work that members in the fellowship did to make the meetings remain accessible. For instance, the web committee is a group of NA members that are responsible for co-ordinating the Zoom accounts with various meetings to ensure every meeting could be offered online. This was a momentous task, that involved managing over 100 meetings across four Zoom accounts. Katie and Ashling were both grateful that the members of this committee remained committed to helping the fellowship even when faced with the challenges of having new restrictions on their life (imposed by COVID-19). This is expressed in Katie and Ashling's quotes.

I really was grateful that they existed [referring to online meetings]. I was super grateful to the people in our fellowship that bothered to set them up. To, you know, to promote them on Facebook. I mean I thought that was amazing. Yeah, so I appreciated that. —**Katie**

What I really loved was when we went into lockdown, how the service, like the web committee and all of that just went into full action and just knew, you know, like, the community of NA was just like, we need meetings, how can we make this happen. And people in their real lives have IT knowledge and all the web committee just like flew into action. And we had all of our face-to-face meetings set up like that, like, it was just so awesome. It was really cool. —**Ashling**

While most participants expressed gratitude towards the fellowship and those doing service, some participants who did the service did not feel entirely appreciated at times. Gratitude can be complex (Elfers & Hlava, 2016), where one can be grateful for being part of a community while also feeling under appreciated. Travis shared how his experience of lockdown was filled with doing

service for the fellowship. Although he was happy to do this work and felt it was his responsibility, he did not always feel the gratitude of the fellowship.

> *Yeah I was doing a lot of service during that time as well. It was unbelievable. I don't think the fellowship properly appreciates how much work some people have done to keep everything going. You know, there's a lot of stuff.* —**Travis**

Other participants also shared that they thought the work and effort needed in service sometimes went unrecognised, especially during lockdown. Travis did not feel the scale of work was appreciated. This could be seen as a small critique of NA, as members are encouraged to do service and be thankful for others' service, but it can trigger resentment in those who have done vast amounts of the work. However, Eddie argues that at its core service is more for oneself than for others and essentially by engaging in service one is actually helping themselves in their recovery as there are therapeutic benefits when helping another addict.

> *My sponsor told me that, and I agree with this now, I get it. What we achieve in service, it's as much for our own recovery and our own good, at trying to make it work, than the actual results of the service.* —**Eddie**

For Recovery and Being a Member of NA. Another way gratitude was represented was when participants expressed how thankful they were for being in recovery. This included gratitude for how NA had set them up with the tools and capability to manage themselves and their recovery, even within the restrictions imposed by COVID-19. The qualities participants gained from being a part of NA influenced their ability to adapt and have acceptance, as shown in the following excerpts.

> *Recovery is all about learning how to adapt and how to accept and how to deal with what we have, be grateful for what we've got and all that, you know, so recovery was actually a really great tool and a great kind of resource kit when dealing with the challenges of COVID.* —**Eddie**

> *How lucky I was to have my recovery. Because I think that was one of the key things that made lockdown very manageable, was that I already had this toolkit for how to live life under very difficult circumstances, you know, I'd developed in my using a whole lot of skills that I probably still use today. Around survivability under extreme circumstances.* —**Malia**

Both participants explicitly shared feelings of gratitude, specifically for having the skills and a toolkit to deal with a challenging time. For Eddie this meant the lockdowns were manageable as he was prepared for any challenges that may have occurred. He was not alone in these feelings of being equipped with a toolkit to withstand lockdowns, as Malia also expressed gratitude for her recovery and time in active addiction, and the skills that recovery had taught her. While Malia described feeling lucky to have her recovery, luck is often synonymous with chance and her recovery did not happen as a result of chance. It was the result of difficult experiences, learning, and hard work which coalesced into the skills necessary to survive. In this way, Malia is thankful to have gotten to the position where she is today. Recovery can therefore be framed as having sufficient recovery capital to cope with the extra challenge of lockdown. While not explicitly linked to NA in the excerpts, the idea of having tools and skills to cope and be grateful is tied to NA's core principles, where reflecting on and learning how to reframe past hardships, or current challenges, with a deep awareness of gratitude for what one has got is essential.

Others such as Ashling were grateful for not facing the lockdown in active addiction and having to seek drugs.

> *One of the things that I thought of was like thank God I'm not using like the thought of a lockdown and not being able to go and get stuff or like... ah it was just like I'm so thankful that that's not me.* —**Ashling**

Ashling represents how participants were thankful that the chaos of active addiction was not the focus of their lockdown and that they were not concerned about where they could *"get stuff".* This concern was exemplified by Daisy in the excerpt below, who shared about a time in her addiction while on the methadone programme where she was anxious about barriers preventing her from getting the drugs she needed. The concerns Daisy had around methadone access meant she felt that addiction would have been near impossible to maintain during lockdown.

> *I tell you what I did think about though, because when I was on that methadone programme, one of my biggest fears was that there would be some kind of catastrophic event. And I wouldn't be able to get to the chemist and get my methadone. So that used to be on my mind. And I had, this plan that if that happened, I'd go to a gun shop, I'd get a gun, and then I go and rob the chemist, and then I'd shoot everybody who was trying to come into the chemist as well. So I had this extreme sort of apocalyptic plan, should that happen, because I*

needed that methadone every single day. So when this lockdown happened, one of my biggest reliefs, was, thank God, I haven't got a habit, thank God, I'm in recovery. Thank God I'm clean. —**Daisy**

While Opioid Substitution Treatments, like methadone is a valid and necessary treatment for addiction, it does require people to be able to access the medication especially in times of crisis (Blake & Lyons, 2016). Daisy's story illustrates the level of fear people have about being able to access their medications while receiving OST programme and the lengths people may go to ensure that supply. The contrast in her narratives between this potential plan and her actual ability to cope with COVID-19 lockdowns is stark. The gratitude that she did not have a "*habit"* and *"thank God, I'm in recovery*" is a complete narrative shift illustrating the complexities, and importance of supporting people to maintain their recoveries no matter what.

Alongside the gratitude of being in recovery and not in active addiction, participants narratives evidenced gratitude for being a member of NA. Participants expressed how NA helped them maintain their life of abstinence, enabling them to build up their clean-time and develop a greater sense of confidence in their new lifestyle. For the participants in this research, this meant that for most, the COVID-19 lockdowns did not spark any significant concerns about using drugs again. NA had equipped members with the tools to handle the novel time, which instilled a sense of confidence to manage any challenges that arose.

The longer length of clean-time for most of the participants seemed to give them a firmer grounding in which to maintain their recovery too. Being clean for more than "*half your life"* means habitual recovery behaviors strengthen the ability to stay substance free, even when faced with the challenges of a lockdown. Being able to achieve this longer clean-time was possible due to their strong social and community support and affiliation to NA (Galanter et al., 2013b; Laudet et al., 2002). Some expressed how having a longer time away from active substance use also strengthened their ability to manage emotions and avoid picking up drugs again, as the following two quotes demonstrate.

I do think that my clean-time played a big part in, because you know, I've got that solid foundation, that and other skills and other techniques to kind of manage my emotional state and not need to be triggered into needing to use to change how I feel. —**Daisy (clean-time of 11 years)**

When you've been in recovery for considerably more than half your life it's a bit hard to get out of the habit of being in recovery. It doesn't mean I'm not vulnerable to relapse… I can't remember the last time I worried about using. —**Travis (clean-time of 32 years)**

Their significant clean-time gave Daisy and Travis confidence that they did not need to pick up a substance to cope with the lockdown. In this sense, they were grateful for their clean-time as a buffer, or as Travis describes it a *"habit"*.

For Giving to Others. Another aspect of the gratitude narrative was giving to others, such as the newcomers, who are people that are new to an abstinent-based recovery. This concern for others was expressed by many of the participants. For example, Francesca and Amy shared stories of knowing newcomers who got into recovery during lockdown and applauded the tremendous effort this would have taken. This motivation to give up substances may be due to difficulties accessing drugs during lockdown, with one Norwegian study finding that there was both reduced drug availability and increased drug prices during their national lockdown (Welle-Strand et al., 2020). Nevertheless, being able to get into recovery during this time was considered an impressive feat and reinforced how it is possible to get clean on Zoom. Additionally, reciprocity and giving to others is a form of social capital and allows people to share in others success.

I do know someone this lovely young woman, she my friend's daughter, she lives down the line, she got completely into recovery. She celebrated a year just a few weeks ago, she got a clean in Zoom. —**Francesca**

I'm also in contact with a member who's in LA and he knows of newcomers that have never been to a meeting in-person. They've got like a year clean just from [attending online] Zoom [meetings]. So NA works however it works. And you know, newcomers can get clean on Zoom. —**Amy**

For these participants, the achievement of getting clean on Zoom seemingly endorses how NA can be effective online. Similarly, Galanter et al. (2021) found that 64.5% of their sample (n= 2152) found the online NA meetings to be at least as effective for maintaining abstinence as face-to-face meetings. Using abstinence-based measures in one way the effectiveness of online meetings could be gauged, and the following case study highlights how one of the participants in this study got clean, and stayed clean during lockdown, and the gratitude he had for the possibility to do so.

A Case Study. Lloyd became drug free and got *"clean on Zoom".* Lloyd had a history of fluctuating between using and recovery. He first started experimenting with drugs at the age of 12, but by the age of 15 he found himself drinking alcohol and using methamphetamine frequently. This substance use sent him down a *"really slippery slope"* where he struggled to simultaneously work and use substances. Eventually he gave up on working an *"average"* job and began *"wheeling and dealing"* which essentially involved him engaging in illicit activities to generate money to sustain his addiction. This led him to jail at the age of 18. To avoid serious jail time, Lloyd agreed to attend a rehab facility but once he was able to discharge himself, he slipped back into the same cycle. He described being stuck in a period where he was in and out of jail, while momentarily getting clean just to self-sabotage as soon as things looked alright. Lloyd said he experienced a series of rock-bottoms, he was tired of jail, stealing and ripping off people. Although sick of this lifestyle, he believed his location was the problem. He moved cities but soon learnt that it did not matter where he went—he was the problem and he needed to do work on himself to get better. At this point Lloyd turned to the twelve-step fellowship to help support his effort to get clean. He was serious. Ten months of abstinence followed, and in that time, he started a degree at university and found a part-time job. At the end of his first year at university, during the break, he relapsed again, first with a drink here and there which quickly spiralled back into old patterns of using. Lloyd believed he would stop using when university started back, but by the time university started he was using at an unsustainable amount again. Luckily for him, the start of university coincided with the March 2020 lockdown, so he attempted to get clean. He described the challenges of initially maintaining his addiction while the country moved into Alert Level 4. Lloyd had difficulties with the increased police presence and not being allowed to be out and about, due to the greater attention when seeking drugs. Lloyd describes these inevitable challenges of maintaining an active addiction in lockdown.

> *Then lockdown hit. And I was like, and prices went up. And prices of drugs went up. It became like harder to get out and about without getting stopped and everything like that because it was Level 4.* —**Lloyd**

Already exhausted by active addiction and struggling to meet the demands of university courses, barriers to *"scoring"* created an opportunity for Lloyd to stop using substances, without hitting the rock bottoms that he had in the past. With the challenges of accessing drugs and university classes suspended, in May 2020 Lloyd got clean. At the time of the interview, Lloyd had reached 14 months drug free, the longest time he had ever achieved. Lloyd was grateful that the

lockdown had created a chance to do recovery differently this time. Having meetings accessible 24 hours of the day filled the void he felt was left by his addiction.

> *I just used [lockdown] as an opportunity to isolate. Which is why the Zoom NA meetings that were held during lockdown were like super ideal because I didn't particularly want to leave the house in the state I was in you know. Like, coming off everything and just feeling like a real piece of, just feeling like a real shitbag really. And also, when that lockdown hit, uni got put on hold for a bit. So I've got the chance, I'd got the opportunity to like sober up. So I was like, this is like a gift from God. I mean, fuck I know, it wasn't good circumstances, but you know, really benefited me in so many ways.* —**Lloyd**

While Lloyd acknowledged that the lockdowns were not ideal for many, for him it felt like a gift and a chance to do something differently, to persist in recovery. The isolation of lockdown gave him a chance to stop and manage any withdrawals in his own way. Isolation was a good opportunity for him. However, according to Roe et al. (2021) isolation was not good for many people using drugs or in recovery from problematic drug use, due to the solitude that COVID-19 lockdowns created. Being alone is not necessarily conducive to recovery as social support has been found to be an important element of treatment (Johnson et al., 2018; Melemis, 2015). For Lloyd though, the connection to the NA fellowship allowed him to feel connected, supported and worked to bridge the social isolation during lockdowns. This was something he was grateful for, especially as the international NA meetings provided 24-hour access to other addicts that helped him abstain in the early days.

Ultimately, the sense of community that NA provides creates a social connectedness which gives members a feeling of belonging, purpose and meaning (Haslam et al., 2019). This helps members feel accepted and understood in their efforts to achieve or maintain a drug free lifestyle. And thereby generates an attitude and feeling of gratitude towards the fellowship. Opportunities like getting *"clean on Zoom"* for Lloyd may not have been possible without the support of NA offering online meetings.

Creating Opportunities

Many participants spoke about the opportunities that lockdown created for them, these opportunities could be divided into two broad categories. One is the opportunities created by the changes in the way the participants could engage in the NA programme or personalise their

recovery. The second category is the opportunity and time that lockdowns created for more self-care and what this meant for their recovery.

New Possibilities. The shift in the way the programme was delivered created new opportunities for NA members. This included the chance to do something new with regards to meetings, challenge themselves and their recovery in a different way and also break down barriers that can occur with in-person meetings. Every participants story represented at least one, if not more of these opportunities.

Participants identified novel ways of attending online meetings during lockdown. For instance, Julia shared how it was a real treat to be able to sit in her lounge and Zoom in. It was also seen as a chance to glance into other members lives, whether it was seeing their kids running around in the background or cats walking over laptops. It brought a different and more personal dimension to attending meetings compared with face-to-face meetings. The in-person meetings were largely held in public venues, such as community halls or church rooms and therefore personal lives, besides what one choses to share in meetings, were kept separate. And while this was key to personal anonymity, online meetings changed this dynamic in a positive way that still allowed members agency over their anonymity.

Additionally, some in this research discussed having the chance to attend a variety of meetings and hear divergent narratives about recovery. This was particularly interesting as the NA programme follows the same twelve-steps and twelve-traditions regardless of the country, but by opening up meeting attendance on an international scale there was an opportunity to hear different narratives about how other fellowships interpret and share the message of experience, strength and hope (Narcotics Anonymous, 2008). This highlighted the impact of culture on the way the NA programme is enacted. With underlying principles, such as conceptual fidelity, NA as a universal programme has diverse interpretations or lived experiences. As such, those who attended international Zooms, were exposed to different perspectives and personalities which enabled them to experience all kinds of recoveries.

> *Meeting people from all over the world. And hearing lots of different stories and lots of different experiences and experiencing really different kinds of meetings because no two meetings are the same, but particularly between countries. So, you know, lots of Americans go to some of the meetings, depending on the time zone difference and that. They're different the way they do it, the way they share and the way they run meetings, it's really interesting. And even the Australians, you know, are different.* —**Malia**

What I did do was I went overseas to certain other meetings and other countries. The American ones were interesting. Yeah… they were like 'sermon on the mount' sort of thing. I enjoyed going into Mississippi. Just sitting in totally black groups and listening to their struggle. I went over to Australia since I know some people in the fellowship in Melbourne and Sydney and in Brisbane. So Zoom actually opened up the wellness platform and in a kind of a cool way. Went over to Brighton and England. So it actually was very, very cool. —**Julia**

One of the successful elements of a twelve-step fellowship like NA is that it has global reach, and claims to know no class, race, religious, or ethnic bounds (Narcotics Anonymous, 2008). While this might not be completely attainable or possible in a sense, the twelve-step philosophy does use a set of twelve-traditions that provides a guide to remedy conflict and division between people and places. For example, the second traditions states "For our group purpose there is but one ultimate authority—a loving God as he may express himself in our group conscience. Our leaders are but trusted servants; they do not govern" (Narcotics Anonymous, 1986, p. 3). This tradition allows members to believe in whatever they deem to be a God and does not force one set of beliefs or religion on their members. As shared above by Julia, the opportunity to attend a range of meetings allowed participants to hear different stories, messages, and experiences from a variety of people. Some of these meetings meant they could hear messages from people with long clean-times. Like Julia said, Zoom opened up the *"wellness platform"* in a new way and showed members different ways and possibilities in their recovery.

Prior to lockdown many participants shared how they made the programme work for them, and this flexibility could also be seen during lockdown. COVID-19 did not change the overall programme but instead gave people the opportunity to think about recovery in different ways. The NA programme is designed to guide people on how to maintain an abstinent-based recovery, however it is up to their individual interpretation for how they do this, which was no different in lockdown.

The thing is within NA it just has that whole map… I really value that we don't fit in the box. It's not one size fits all. It's my interpretation of the step, you know, I just write my answers and share them, so I become the person that I've always had the potential of being. —**Francesca**

I just know it's kinda, it's not Marxist… but it's like the most free, choose your own path. No boss telling you what to do or how to do it. Kind of self-help, we heal ourselves with evidence of people, physical people that have done it. So basically, I love it because there's no process. No one's wagging the finger. —**Amy**

With this flexibility some participants also used lockdowns as a chance to challenge themselves in their recovery, to put their recovery first and learn new ways to recover. The new platforms for meetings created a different way of being vulnerable for participants as it was not an environment they were used to sharing in. The lockdown, and the challenges a pandemic presented in general, also served as a reminder that recovery needs to be continually worked at, regardless of how long one had been clean for. Being part of a type of personal-development group like NA supported members to be mindful of how they were coping in the pandemic lockdown and invest in the parts of their wellbeing and recovery that needed attention.

I guess, being aware that a lot of people I know weren't coping in various ways. And a lot of people were feeling incredibly lonely and incredibly anxious. And yeah, being aware of that kind of made me in one sense really grateful for my recovery, and really aware of how important it is to keep doing it on a daily basis. And I think it was not easy to get that balance. —**Eddie**

It took me outside of my comfort zone, I guess learning to work on Zoom and to participate in the fellowship on Zoom. Because we had activities also, NA activities... if I wasn't comfortable in myself, you know it challenged me to speak regardless. —**Hannah**

As Hannah describes, there were many activities held over Zoom. In her particular homegroup meeting they decided to dress up in different themes each week. This was a way to keep themselves entertained and have fun in their recovery during an otherwise difficult and stressful time. For those in addiction, it can be novel to have fun. When drug use takes control it comes with great costs, such as chaos, financial strain, and criminal behaviour, therefore having "*fun*" or carefree laughter is foreign (Kennett et al., 2013). In order to stay clean people need to learn to have fun as it can be a healthy alternative and distraction to using drugs (Melemis, 2015). The online meetings created an opportunity to maintain fun and escape some of the stresses and worries of lockdown.

So I know, Monday I think, the homegroup said 'all bring your pussys'. So, it was quite funny. And we're going you mean animals? All dressed up in animals (laughs). —**Hannah**

Members of the fellowship were quite productive within lockdown and went about organising a range of different events online. Prior to lockdown there were conferences, camp outs and other events that different NA regions held, so to make up for the loss of these community events members got creative around other ways to connect and spread the NA message. One particular event was a continuous marathon meeting that ran 24 hours per day, 7 days a week (24/7) over Zoom during lockdown hosted by people in Aotearoa. A marathon meeting enabled addicts to access a meeting whenever they needed. Eventually as restrictions started to ease after lockdown, this meeting dropped down to a 14/7 marathon meeting, meaning it runs every day of the week but for 14 hours from 9am till 11pm. Other events included celebrations around the history of NA, with milestones such as 40 years of NA in Australia and Aotearoa celebrated over Zoom, and guest speaker meetings that focused on certain topics.

When the programme delivery moved online, as shown the opportunity was created for people to overcome barriers that prevent them from attending meetings in-person. These included a range of individual, physical, and social barriers. As previously discussed for those who live rurally, attending an in-person meeting is not always possible or could require a significant amount of travel time. Similarly, people with a disability can find it challenging to access meetings (Davidsson & Södergård, 2016). For example, someone in a wheelchair might need to catch a number of buses which makes attending a NA meeting time consuming and difficult process. Another disability that may prevent attendance is those with a phobia, such as agoraphobia, which is a type of anxiety disorder in which a person fears or avoids places or situations that can cause panic and feeling trapped, helpless or embarrassed which makes it difficult to leave the house (American Psychiatric Association, 2013). Lastly if someone was feeling unwell or sick, online meetings meant that they could still attend a meeting without exposing others or even leaving their own bed. In this sense, the online meetings upheld the purpose of COVID-19 restrictions, as the online meetings prevented the risk of spreading the virus. In Eddie's narrative below, he summarises a lot of the barriers that have been broken through the option of online meetings.

There are definitely people around the country who go wow, you know, I heard a woman say she lives in [a remote place] and she can't attend but because of online meetings she can. Or another classic one is people with kids, solo parent with kids, can't get out, need a babysitter to go do anything. And they want to go and have some time out and be able to be really

> *open and personal in a meeting. They might feel more comfortable without their kids. Or just people who don't have transport or people who are injured or people who are unwell or older or whatever. So on that level... it's actually revolutionising NA and twelve-step programmes. And any kind of human communication programme I think is enhanced, and well revolutionise, it's probably more than enhanced, it's creating change for sure. So a lot of people now can access NA from anywhere.* —**Eddie**

Like others, Eddie identified how the changes with COVID-19 have strengthened the NA reach and increased accessibility for a range of people. He believed that the inclusivity created through online meetings allowed for greater human connection. Another barrier that NA tries to overcome is the stigma associated with identifying as an addict. At its core, the anonymity of NA helps tackle stigma, but the stigma perpetuated by social norms and judgements of addicts can be embodied (Link & Phelan, 2001). The self-stigma that addicts experience can create a barrier to attending meetings. Katie shares below how she believes the online meetings help to address internalised-stigma that certain addicts impose on themselves and others.

> *People like me, people who were not using illegal substances, pill poppers, people that go to pharmacies and buy panadine extra, nurofen plus and then get into their car and take 20 of them. Housewives that are doing that sort of thing. Women that are addicted to benzodiazepines because they're anxious. The new mothers. Plenty of alcoholics that are untreated. I think it's fairly underrepresented, why? Because they don't think they're bad enough. They're bad enough. Believe me. I think they're very underrepresented and I think they think if they were to go to a meeting, there's going to be some old guy with a paper bag, you know, covering his bottle. And that's it. But they don't understand that actually, there are everyday people in those rooms… I think they probably would've [attended online meetings]. If they knew that their anonymity was completely protected. Cause to that kind of addict, anonymity, well to any addict actually, but especially that one, anonymity is huge. Don't want the other mummies to find out or you know… Maybe ongoing online meetings, like say on the app, the discord app, would be fantastic for that group.* —**Katie**

Katie highlights how some addicts do not think that they are *"bad enough"* because they take up the social norm or stereotype about who addicts are and how they act and behave. By opening the possibility of online meetings for these people, they can see first-hand that the meetings are for anyone who struggles with their use of alcohol or drugs.

Self-care opportunities. Another way COVID-19 has influenced recovery for the participants in this study is affording them the opportunity to slow down and rest, as was also a common narrative in communities outside of twelve-step groups (Jenkins et al., 2021). Recovery for NA members is intertwined with other elements of life. It is part of their social identity and it is not possible for them to shed their recovery as if it is a separate identity. This means that recovery needs to have a holistic approach, by looking after themselves during lockdowns their recovery was also cared for. Francesca described how she *"cycled down"* during lockdown, meaning she used it as an opportunity to take things at a slower pace, listen to her body and mind, to re-evaluate what pace she wanted to continue on after lockdown.

> *I heard this term the other day, there was a guy sharing in the Debtors Anonymous meeting and he used the term cycling down. Because he's busy, busy, busy. And that's my thing to. Addiction manifests in many ways and busy-ness is one of them. And it's so upheld by our society… so that whole busy thing becomes a hook of course. It's handy to be on the run all the time, to be just that out of reach of the authentic feelings, on the run from the feelings. Mm, so anyway, what it did for me is brought me a lot more space [referring to lockdown]. And so I was able to slow right down and then not pick up to that extent again, and I haven't picked it up again in that way. Yeah. So when he was saying about cycling down, I thought, oh yeah, that's what I've been doing.* —**Francesca**

Francesca spoke about how it is easy to fall into the trap of always being busy, it becomes a convenient way to avoid reflecting on yourself and the processes one is going through. During lockdown people were forced to stop their busy lives, and for NA members the programme offered a way to learn how to slow down and live 'just for today'. Just for today is a key principle of a twelve-step programme. It encourages people who have catastrophising thinking, who cannot bear the thought of never using mind and mood altering chemicals again from becoming overwhelmed. Just for today enables people to tackle one day at a time (Narcotics Anonymous, 2008).

Of the participants who viewed lockdown as a chance to rest, some used the time as an opportunity for self-care and to prioritise their health. Melemis (2015) suggests that one of the key rules of recovery, and an often overlooked aspect, is self-care. Engaging in self-care is a way of meeting your basic psychological, physical and emotional needs. This aligns with philosophies within NA where people learn to have compassion, patience and love for themselves as getting clean and

staying clean is not easy. The participants below demonstrate some of the self-care actions taken during the lockdowns.

> *Oh I've stopped eating sugar which has come about from the steps. I've cut sugar because I mean, I've loved sugar all my life… but it was like, make direct amends to myself. I mean that's why. It's taken all these years going through the steps and still I thought 'fuck that I'm still eating chocolate'. But you know the time is right.* —**Amy**

> *Yoga with Adrianne. Yep, YouTube yoga was huge for me. Walking the hill—I live on a hill so I would walk to the bottom and back up the top. I started juicing. And I guess the other things I did was I ate really well. I cooked nice meals. And I tried to look after myself. And I tried to do self-care, watch good things on Netflix. Just all of those simple self-care things helped me.* —**Katie**

> *I think that being at home was a real opportunity to bring some more self-care. I started growing more plants. Well I always have had a veggie garden, but I had planted a really good winter veggie garden [in lockdown]. So that's something that's continued, like deliberately planting a winter vegetable garden and growing plants outside and inside. Plants in pots that give me a great deal of pleasure. And I got a bird feeder. That's right. So I could watch the tuis and the bellbirds, koromiko.* —**Malia**

All three participants expressed different forms of self-care in their narratives of lockdown. They were not alone in practising self-care either, with other participants sharing that they made a greater effort to go out for walks more or reach out to friends and family or they adopted simple changes in their everyday life during lockdown in order to better care for themselves. The self-care practises were also not only about physical health, but helped them to address their mental wellbeing at a time when people were dying of COVID (World Health Organisation, 2022). This narrative theme represented the vast array of opportunities that the COVID-19 lockdown provided for the participants in this study. This ranged from hearing a variety of diverse messages of recovery to finding new ways to care for oneself and their recovery.

Upkeeping Consistency

In NA there is a commonly used phrase, 'doing the work'. As discussed throughout this study, part of doing this work includes NA related activities such as participating in meetings,

completing step work, and engaging in service, like sponsorship or working on a NA sub-committee. When discussing their recovery prior to lockdown many participants narrated the importance of doing the work in NA to reap the security and rewards of an abstinence-based recovery lifestyle and to achieve a level of wellness. This idea of wellness in recovery was common in participants narratives, and was approached in a holistic way that included addressing the physical, mental, social and spiritual parts of their wellbeing (Substance Abuse and Mental Health Services Administration, 2012). Seven participants shared that they could feel when they were not consistently doing the work and that the impact could be detrimental to their recovery.

> *I can go to as many meetings as I want. But if I'm not doing the work, then it's gonna be the same shit, you know. I'm gonna get bored and pick up [a drug] again.* —**Lloyd**

> *I consider myself a reasonably healthy, reasonably balanced person today. I'm still a selfish, childish little shit when I don't work at my programme.* —**Eddie**

Both Lloyd and Eddie recognised the impact that fully engaging in the programme can have on their recovery. When working their programme, NA members learn new ways to behave, think, feel and engage (Narcotics Anonymous, 2008). For example, working step 10 (see Appendix B) provides people with the tools and thinking to create a personal inventory. This means that they continually reflect on their thoughts, behaviours and attitudes and when wrong they promptly act to rectify it (Narcotics Anonymous, 2008). Without fully working the programme, people in this study felt more prone to relapse. So when lockdown hit, participants knew that they needed to continue doing the work if they were to achieve the holistic recovery and wellbeing that NA promises. Such practices form the foundation of recovery. By being consistent with everyday programme activities that enhance recovery and wellbeing, the participants were able to challenge themselves to try new things while being secure in their recovery from drug use.

> *I meditated every day. And what else did I do? I kept doing service of course… I went for a walk every day. Um as you know, stayed in touch, and did a NA meeting every day. And supported other woman. I mean, there's things I do every day anyway. I write myself right in the morning. So I do three pages of writing. I do a daily reading every morning, the woman's book, and then I write myself. I continued to do that. Um a gratitude list with a friend that I do on messenger at night, but I also have been doing for years, my own five things I'm*

grateful for. That's just the thing I've done for many years. I just did or just carried on doing all of that stuff as you do. —**Francesca**

For me daily readings were really helpful., The 'Just for today' book? Yeah, daily readings. And for me at that time it was physical activity. Get out there and walk, do your yoga. You know, do 100 squats if you have too. For me, addictions always been quite a physical thing for me. And if I do some good exercise and release those endorphins that makes me, always makes me feel better. Yeah. And I was able to do that in lockdown. I didn't have kids. I didn't have anyone depending on me. So I was able to just... yeah. —**Katie**

I mean, my practice is pretty much the same. Just call someone, another woman in NA every day. And my sponsees text me or phone me. And I read literature, and I'll work the steps. So all of that I can do during lockdown. —**Amy**

A lot of the practises highlighted by participants illustrate how intersectional recovery, NA and everyday life are. Doing the work is needed whether or not one is enduring a pandemic.

While doing the work is necessary, the ideas of privilege was noted, as many participants specifically described themselves as *"privileged"* or *"lucky"* to be able to maintain a consistent recovery. Maintaining a consistent recovery is not always common, as relapse among abstinent drug users is frequent, with rates of relapse estimated to be as high as 90% (McIntosh & McKeganey, 2000; Lui, 2004 as cited in Yang et al., 2015). A range of psychosocial and biological factors have been assumed to cause relapse, such as adverse socioeconomic conditions, a lack of support, and even greater interpersonal pressures (Yang et al., 2015). As expressed above in Katie's narrative around recovery practises, she was able to concentrate on keeping up activities in lockdown because she did not have anyone depending on her at home. It was a privilege to be on her own as she could focus on what was most important to her for her recovery without being too concerned for others. Other participants shared how material privilege meant lockdown did not impact on their lives or their recovery as significantly as it could have.

It made me very aware that I am in a comfortable position and that I could go to the supermarket once a fortnight and get what we needed and have enough. But that some people were not living like that and don't live like that. So I think it's made me a lot more aware of people around me and in our society in general and how what you don't see you don't know… It was incredibly hard for some whānau aye. —**Malia**

I'm lucky, you know, I have Wi-Fi and I've got a good computer. —**Julia**

I didn't mind it at all because I've got a very comfortable home. —**Amy**

Some types of drug addiction involve people needing to commit crime in order to afford their drug of choice, or some people may be on Work and Income benefits. When financial capital is problematic this limits some of the recovery resources accessible to them and thus recovery may not be the most important concern to them at the time. These ideas of privilege that the participants acknowledge raises questions around how recovery during a lockdown could have been different for people with less privilege, or for people trying to overcome problematic substance use outside of a lockdown. These privileges could also be seen as forms of recovery capital, which supports the necessity of recovery capital to achieve and maintain the long-term abstinence-based recovery (Best & Laudet, 2010).

Regardless of privilege, for the participants in this research the key reason they were able to remain consistent in their recovery was due to NA. This involves the fellowship and how it has been created and the way that NA responded to the pandemic and the lockdowns. The strong community NA has enabled meant that people could thrive over lockdown with the right resources, such as having access to a digital space. Members could carry on with service work by being involved in the meetings, they could continue doing step work with their sponsors and sponsees over the phone or on Zoom calls, and they could feel connected with other members in whatever way felt comfortable for them. However, upkeeping consistency also required more work for certain committees, such as the web committee.

I'm involved with the web committee. And one of the jobs that we have is keeping a list of every single meeting that's operating in New Zealand and helping all the meetings that wanted to meet by Zoom to use the common Zoom accounts that we bought. So we bought a bunch of Zoom accounts, and we gave them out and the numbers and then we'd list their numbers and, you know, trying to provide them with help to facilitate a Zoom meeting, and security of Zoom. And so there's a lot of activity around that… I think there were periods where we're answering like nearly 200 emails a week. I think it's roughly 180 meetings a week in New Zealand. There's like five or six of us on the web committee. The emails were just pouring in. Like a deluge. Because one day after lockdown we had to de-list every meeting. So de-list 180 meetings, and start putting on virtual meetings as people came and

> *said 'oh this meeting is going to meet by Zoom' or 'can we have a Zoom slot? We're going to meet like this'. So yeah, there was a lot of work.* —**Travis**

In order for the fellowship to maintain consistency and support people to do the work in recovery by attending online meetings, the web committee had to facilitate a range of processes that took up a lot of time. During the first lockdown in March 2020, as previously mentioned, NA held up to four permanent Zoom accounts to ensure that there was a platform available for any meeting that wanted to move online. As described by Travis, this involved a plethora of background work by members of the web committee to coordinate the different meetings, as well as training people on how to facilitate the meetings on Zoom and producing informational guides for dealing with issues. By the time Aotearoa went into lockdown in August 2021, NA had eight of their own Zoom accounts running as well as other Zoom accounts that were purchased by groups and members, with approximately 113 Zoom meetings occurring. Without the web committee ensuring meetings remained available, the recovery of NA members could have looked very different during lockdown.

Service in an Online Environment

This theme discusses the specific challenges unique to navigating an online delivery. Amy shared how in a way she believed that the message of NA *"lives through technology"* as the message can be felt anywhere and simply needs the heart of a recovering addict to share it. While this may be possible, the online delivery posed a range of new challenges for participants in this research to navigate through. However, with the support of the NA fellowship many of the challenges felt mitigated.

Many participants shared that they felt anxious before the first online meeting, primarily around the use of the technology, rather than anxiety about sharing as this is something most people do during in-person meetings. For many participants this first meeting involved doing some element of service, because as a smaller community it was essential for those with more experience to step up and support the people that needed help. The service roles in the Zoom meetings were either as a chairperson or secretary for the meeting. In business as normal face-to-face meetings, the chairperson guides the meeting according to whatever meeting format is being used and the secretary plays a key role in ensuring the meetings happen by managing logistical concerns. When the meetings moved online, these roles adapted slightly and caused feelings of anxiety for participants around how they could still run the meeting using a new type of technology.

So we put all the [my region] meetings online. I had a crash course in Zoom over a weekend where we had to set all that up, it was intense. There was a bunch of us. We put all the [regional] meetings on so that we could have those meetings. Um I remember my first, I don't know if it was my first, but it would have been one of the early ones. Not everybody knew what they were doing. And there was all this stuff going on and cause lots of people didn't know how to use Zoom there was a whole lot of upskilling people in the fellowship on how to download Zoom onto their phones or their laptops and then running through some training so they could use it. There were some people around the country who were more knowledgeable than us lot. And so I got some training on Zoom. And then I trained people and then yeah, we need trusted servants and people to run the meetings. And then there's a whole lot of other stuff to figure out. But you know, those first meetings where people would go 'can you hear me? Can you hear me?' and the cameras pointing somewhere way over there or, you know, people falling in and out. And I'd get lots of phone calls before the meetings are about to start and there'd be people ringing going 'I can't do it, how do you do it'. A bit chaotic to start with, but we got all the meetings up and running in that first week, which was really awesome. —**Malia**

So I think the first online twelve-step meeting was the one that we set up ourselves. So fortunately, I had no idea how to do it, of course, I'd done no Zoom. But someone else in a [different region] fellowship, I had a video call with her, and she talked me through the whole set up for NA, and then that first, we ran it, we opened it… so this woman, she immediately linked in with me, and she taught me how to do it. And that week we set up with a Wednesday night meeting. We took our regular Wednesday night meeting online, onto the Zoom platform. And it was, it was awesome. People were like a whole lot of kids with a new toy. This is kind of cool. We were kind of making mistakes with reading preambles and unmuting and muting and, you know, chairperson who's talking now? But it was kind of fun. —**Daisy**

Participants, like Daisy, highlighted some of the technical problems that came with Zoom meetings, like people not realising they are muted, bad connections or muffled microphones. While this may have annoyed some of the participants, they realised that this is just what comes with having meetings online and it did not negatively impact on their recovery in any way. Participants reported that people quickly became comfortable using the online format, however Amy did share that the ease of being able to access a meeting did impact on whether or not they would attend. NA

made all the links to the national online meetings available online, but often participants were asked to join meetings friends recommended overseas. In these scenarios, unless their friends provided a link and simple instructions, Amy did not attend.

As some of the narratives show, feelings of uncertainty were pre-empted and supported by the fellowship, as others made themselves available to support members to become comfortable with using the new technology. Malia explained that it was not only those running the meetings that needed help using the Zoom platform. It was important that everyone who needed to get onto the meetings was able to, and this meant that people in the fellowship needed to help *"upskill"* one another in how to navigate the technology. Narratives like this demonstrates the pivotal role of recovery capital, and how the community that NA has created acts as a supportive environment where the purpose is for one addict to help another regardless of the situation (Best & Laudet, 2010; Stevens et al., 2018).

Another element that impacted on the ease of access was around the privacy and security of online meetings. Some privacy settings, such as using passwords to get into Zoom meetings, were used to prevent Zoom-bombings. Zoom-bombing is the term for when an individual gate-crashes a Zoom meeting. These uninvited guests share their screens to bombard attendees with disturbing or distracting content. The stories of Zoom-bombings that were shared in some of the participants narratives were generally not too harmful according to the participants. They were reported as more annoying than anything, some even found them humorous at times. However, Daisy shared a story of a very problematic Zoom-bombing that happened in one meeting she attended.

> *Sometimes because the Zoom platform wasn't secure as some people would crash in. And one meeting I was in, this person crashed in. And, and... he was shooting up [injecting drugs intravenously]. So you, at first you could see the spoon. He was heating the spoon and he had the torniquet on. And he was about to shoot up before whoever was chairing the meeting managed to kick him out or whatever. I didn't know how they did that. But there is a process to do that. Right. Yeah, that was… He must of been a sick cookie like, in a bad way or whatever to even think that, that was funny or whatever. I don't know what he thought. God it was like really, you know, had a real sort of force to it. It kind of, was a bit shaky for me for a while. It was just such an image. It flashes you so it kind of stays in your mind. If you're a newcomer and that's your first or second meeting, only clean a couple of days, and you're really struggling. I think that could have been really detrimental.* —**Daisy**

This was an example of a Zoom-bombing on the extreme end of the scale, however as Daisy explained it could have had serious implications for any newcomer that was just starting on their recovery journey as it could have triggered them into wanting to use drugs. To try and prevent Zoom-bombings, the web committee in Aotearoa needed to instigate extra security measures such as password protecting the Zoom meetings. Each individual meeting also developed their own ways of managing any inappropriate behaviour, and learnt how to quickly respond and eject the 'bombers' from the meetings.

Aside from the concerns around safety and privacy for the people attending the meetings, which is also key with stigmatised behaviours like drug use, another challenge was around feeling tired or disconnected in online meetings. This is often termed 'Zoom fatigue' and is when people become exhausted from maintaining connections over the screen (Bailenson, 2021). For participants that also used Zoom or videoconferencing in their employment, it could feel tiring to join another Zoom meeting in the evenings. As Travis describes below, the Zoom meetings felt like a continuation of his meetings from the day, there was no point of difference like he would get in the face-to-face meetings.

> *I'm very comfortable with IT and equipment. It's just like… I was using Zoom all day for my work, then I was using it for, in the evening to go to a meeting. And it was just like more work, you know, it didn't really feel different. There was no contrast to that. Whereas normally when you go out to a meeting, and then you have a laugh with people then you go out for food afterwards, it's completely different from work you know. It just felt like another obligation.* —**Travis**

Attending NA meetings should not feel like an obligation, rather an enjoyable or supportive process, so the online format was not ideal for Travis. Looking at a screen and focusing on the meeting did raise some other difficulties for participants, particularly around the struggle to stay present online.

> *My challenge is not looking at my phone while I'm on the meeting, because of course you can do that because no one can tell. They can't see what you're doing with your hands to see you looking. Or you know, one of my friends, might text and say 'what the hell is so and so doing' and I'm going 'I don't know it looks like he's naked' kind of thing… I've talked to a few people who say the same thing, it's easy to drift. One of the women I sponsor said to me the other day that she's often doing a Zoom meeting, she's listening, she's got her camera off, and*

> *she's playing solitaire constantly all the time, as we couldn't do that in a face-to-face meeting. So that's just a personal challenge for me, that I don't want to be that person who's on the phone when I want to be listening to someone story. That's part of a manifestation of addiction as well, you know just one more thing. So that's the most challenging part for me. Is my own behaviour around the phone when I'm online.* —**Francesca**

Francesca's narrative describes the struggle she faced staying present during online meetings because of the distraction her phone and other people created while being able to hide behind her screen. She went on to describe how "*devices can be divisive"*. Instead of listening to people talk about their recovery, which is core to the principle of the "therapeutic value of one addict helping another" (Narcotics Anonymous, 2008, p. 68), at times she caught herself doing something else on her phone. The Zoom meetings presented a new way to manage oneself, and the addictive tendencies around social media or gaming that can manifest when one has addictive behavioural tendencies (Grant et al., 2010). Additionally, those who struggled with the online format also felt like it was harder to remain authentic while sharing. This is important as authentic sharing allows members the chance to connect with others which keeps members from feeling isolated or alone on their recovery journey. It allows people to be vulnerable and find acceptance, support and love when most needed. These challenges of being present and authentic in no way reflect any problems with NA itself, rather it represents individual challenges that members with addiction faced.

Summary

Overall, the findings highlight how the COVID-19 lockdowns impacted on the recovery of NA members but surprisingly, most of these were positive. This occurred through reconnecting with other recovering addicts, nationally and internationally, expressing gratitude towards the fellowship, or having new opportunities that positively impacted on recovery. NA continued to play a significant role in the lives and recoveries of its members, even while in lockdown as they moved online very quickly. By moving meetings online the members of the NA fellowship in this study stayed connected, and had opportunities to maintain their recovery practices. While navigating this new online environment did produce novel challenges, the participants were supported by the fellowship itself and overall almost all of the participants were grateful and appreciative of having the option of online meetings.

The online meetings were a great option and evidently worked. People are still in recovery, and people have even gotten into recovery through the use of them but participants consistently

shared that they were not better than the lived experiences of in-person meetings, like laughter and sharing food. Most participants stated that there is something important about being in a face-to-face meeting that cannot be captured in online meetings. The online meetings gave them a greater appreciation for the in-person meetings, the genuine connection with their people, the social aspects of being part of the fellowship, and the challenge of being in the physical room. There were however advantages to Zoom meetings, such as listening to a variety of people sharing from around the world, an ease of use, and less barriers to attendance. It should be noted that Zoom alone may not be the only option with one participant preferring apps that allowed chat but no video.

Chapter Five: Discussion

This research explored how members of NA managed their recovery during the COVID-19 lockdowns imposed in Aotearoa between March 2020 to August 2021. For the members of NA, recovery practices had to be navigated in different ways due to pandemic restrictions, which included moving NA meetings online because engaging face-to-face was not possible. Like most others living through a global pandemic, everyday life was impacted in some way (Jenkins et al., 2021; Roe et al., 2021); for the people in this research these impacts were more positive than negative. The positive aspects included recovery consistency, maintaining connections to others, opportunities to attend diverse meetings, and gratitude for what people had. The time during lockdowns also opened possibilities for participants to engage in new forms of self-care to look after their wellbeing which in turn supported their ongoing recovery. Navigating meetings online did have some challenges and was not universally liked however, what was consistent from the findings is that these positive stories would not have been possible without the principles and fellowship of NA. The participants narratives illustrated that their membership in NA mitigated some of the burden felt by the lockdowns and continued to support their abstinence-based recovery despite COVID restrictions.

This chapter will firstly situate the key findings in the current research, and then explore the implications of these findings. This includes discussing the arguments around online support, the value of NA in abstinence-based recovery, theoretical insights, and conceptual considerations of recovery. I will conclude by reflecting on the thesis and discussing future research directions.

Online Support

The central focus of this research was how recovery-based mutual support groups, like NA, coped during a disaster. In these situations, it is not unusual for technology to be utilised in disaster settings, like a pandemic, to mitigate harmful impacts (Freeman et al., 2019; O'Connor et al., 2021), which is exactly what NA rapidly did in March 2020. This pivot to online meetings ensured that the NA community remained connected and supported despite restrictions. Consequently, NA members had to learn how to navigate new online environments, with a myriad of challenges.

Online meetings did not engender the same depth of relationships and were not universally popular. Almost all participants emphasised the importance of having face-to-face meetings for the success of the programme. Research by Barrett and Murphy (Barrett & Murphy, 2021) questioned the quality of the personal relations when compared to in-person support groups. Similarly, Yarosh (2013) found that participants worried that online meetings would become an excuse not to attend

and limit the meaningfulness that one could get from meetings. It was also argued that the depth of relationships could be due to people struggling with Zoom fatigue due to long hours on a screen.

The use of online support also raised issues of accessibility for NA members, which has been a key concern generally within the response to the COVID pandemic too. For example, many communities have had to change how they work, attend school, access healthcare, and maintain connections to others (Blake et al., 2021). It is important to note that communities cannot always rely on technology because, as shown in other disasters contexts, electricity and communication can be cut (Tierney, 2014).

Moving anything online, including mutual support groups, requires physical resources to work well, such as a computer or phone to connect to stable Wi-Fi or enough data to cope with the technology (Bergman & Kelly, 2020). In Aotearoa, there is still a large proportion without regular and stable access to Wi-Fi or a device (New Zealand Government, 2018) There were also privacy and security concerns with moving meetings online because anonymity for NA members is of primary importance (Rubya & Yarosh, 2017). In the instances where there were Zoom-bombings during the online meetings, the more sinister episodes were responded to quickly by NA implementing extra security measures.

With all of these critiques in mind, being a member of NA created a protective barrier. For example, some participants felt anxiety about using new technology, such as Zoom, but this was pre-empted by the fellowship Web committee offering technical support. Moving the meetings online also broke down barriers that previously prevented people from attending due to location or time commitments. While not in a disaster setting, West et al. (2009) noted that physical and mental barriers hindered access to addiction treatment for those with a disability in the United Kingdom. This supports findings in this study, where moving the meetings online meant some of these physical barriers were removed as people could attend meetings from their homes. The change in delivery also addressed some of the challenges in rural and smaller fellowships.

Research has shown people do find online support helpful for their recovery (Best et al., 2015) and in times when there are no other options online support and treatment is more effective than having no option (Te Pou, 2022). This creates the question of what should happen with online meetings moving forward? Many would benefit from the accessibility of online meetings, so they are important to have available. In periods post lockdown, some NA meetings in Aotearoa moved to become ‘hybrid’ meetings, meaning that one could attend either in-person or over Zoom. Ensuring that this option continues to be available could be a good way to balance the benefits of online meetings and the necessity of face-to-face connection that is important to NA members.

NA and Long-Term Recovery

The NA fellowship, and the way it sprang into action during lockdown meant that its members felt supported and able to maintain consistency in their recovery. Keeping consistent in recovery practices was a clear priority in many participants narratives, regardless of whether or not one is enduring a pandemic. This speaks to the importance of engaging in the activities within NA, such as sponsorship and service work, for long-term addiction recovery (Kelly et al., 2016; Witbrodt et al., 2012). Research has found that engagement in twelve-step activities was significantly associated with abstinence and longer clean-times from all drugs (Costello et al., 2019), and this was no different for the participants in this study. Continuing to do the work as they say in NA, was key not only for recovery but also for wellbeing and general quality of life (DeLucia et al., 2015; McGovern et al., 2021). The impact of not doing the work, for example by not attending meetings, engaging in step work, or connecting with a sponsor, could be detrimental for the participants recovery, but it also generally could have impacted on their sense of self and left members feeling vulnerable. Some participants shared that there was an element of privilege, or even luck, to be able to be consistent with recovery and its associated practices. Certain psychosocial and material resources can influence the level of ease that recovery is experienced (Yang et al., 2015), especially during a lockdown where access to certain resources, like social support, is limited. This consistency was only possible due to the extra service work of others in the fellowship, without it the recovery of NA members could have looked very different in lockdown.

While this project was not about evaluating the effectiveness of NA, it is clear that the participants found NA a very successful treatment modality where during an adverse extraordinary time people who have a life-or-death health condition, such as addiction, had support at hand which was not readily available at outpatient services. In 2020, the number of people accessing alcohol and other drugs treatment decreased in Aotearoa, likely because of the disruptions caused by the COVID-19 lockdowns and restrictions (New Zealand Drug Foundation, 2022). This speaks to the value of twelve-step groups like NA as a viable option to support abstinence-based recovery from problematic substance use within and outside of disaster settings. For the NA members in this study, they not only survived the lockdowns and maintained their abstinence, but elements of their recovery and wellbeing were able to flourish in new ways. It was apparent across all the participants narratives that there was no significant critique of the NA programme itself. The problems that people spoke about were due to personal challenges, which the fellowship of NA attempted to support in terms of encouraging one another to address individual challenges agentically. This aligns with other research that argues that twelve-step programmes in general have been found to support healthy coping practices (Groninger & Knapik, 2019). Participants knew that it was important to keep

consistent in their recovery, or risk using drugs problematically. They stayed connected to others for their recovery-based social identity, expressed gratitude for the recovery capital they had, and also looked after their wellbeing, which are all examples of coping strategies enacted during lockdown.

Theoretical Insights

A key theory underpinning this work was the notion of social identity (Bathish et al., 2017; Best et al., 2016). Once a person establishes a recovery-based social identity, their behaviour becomes influenced by the normative expectations associated with that identity. Engaging in NA as a community means the philosophies and traditions of the NA twelve-step programme need to become a salient part of a member's social identity. It can help members redefine and rebuild a positive sense of self without drug use (Leamy et al., 2011). For this recovery-based identity to be maintained networks with like-minded recovery people are necessary. The findings demonstrate how NA works by connecting people and aiding them to build a sense of collective belonging—having positive social interactions throughout the lockdowns with their community would have helped to maintain the participants recovery identity. These findings therefore corroborate the assertions of Best and colleagues (2016, 2018) that twelve-step fellowships, like NA, offer a positive abstinent based recovery identity for its members to model behaviours from, which is mediated by remaining connected, even while in challenging times like COVID-19 lockdowns. A stronger sense of identity also empowers a person to take control of their life and recovery, as framed by CHIME.

The CHIME framework (connectedness, hope and optimism, identity, meaning, and empowerment) speaks to the importance of the process of sharing (Leamy et al., 2011). It was obvious in this study, that NA members not only felt connected, but they also had a sense of hope and optimism about recovery and a motivation to change through the process of sharing. The changes in the way members were able to engage in the NA programme during lockdown also created opportunities to hear diverse sharing. Participant could attend a diversity of NA meetings worldwide, at different times, and for some with greater ease than face-to-face meetings. Different NA fellowships and members stories add value through increased diversity of sharing. As noted in earlier chapters, members share their experience, strength and hope in non-judgemental and mutual ways, which is a key to the therapeutic value of one addict helping another (Narcotics Anonymous, 2008).

Recovery capital was another mechanism that supported this research and the mechanics of recovery (Best et al., 2012). Recovery capital represents the resources underpinning the process of recovery (Best & Laudet, 2010; Granfield & Cloud, 2001). It is a concept that elucidates the particular resources that enable and constrain long-term change to sustain recovery from addiction. Previous

research has found that being affiliated with twelve-step groups grants access to a range of different recovery capital resources (Majer et al., 2021). Through the NA fellowship the participants had access to social, human, and cultural capital (Cloud & Granfield, 2009), such as social connectedness, self-awareness through gratitude, and a sense of belongingness. Being a member of NA was beneficial for participants because of the access it granted them to recovery resources. For example, gratitude provided the ability to cope in an extraordinarily stressful global pandemic, which attests to the strength of NA. Gratitude also correlates with future abstinence (Krentzman, 2017). It is promising that it was not just long-term members that coped with lockdown and recovery, but also those coming back or new to the fellowship could recover during lockdown. These findings could help us understand more about the role of recovery capital and NA membership, as traditionally research has focused more broadly on twelve-step groups in general.

Perceptions of Recovery

This study strengthens the idea that recovery needs to be understood as continuous and holistic. Many researchers tend to only focus on the abstinence aspect of twelve-step groups, as the measure to indicate success of the programme (Costello et al., 2019; Gossop et al., 2008; Krentzman et al., 2011). And indeed, it is an important aspect of the NA programme, however NA views addiction as a disease that has three distinct elements (physical, mental, and spiritual), recovering from this disease involves an approach that addresses each one.

This research supports the idea that recovery is multidimensional and involves caring for the body, mind, and soul. This is echoed in other studies (Best & Laudet, 2010; Kaskutas et al., 2014; Laudet, 2008); in particular by Costello and colleagues (2018) who found that people in Canada who had completed an addiction treatment programme saw recovery as a process and that abstinence alone was not a sufficient criterion for defining a successful recovery. Instead, a successful recovery involved achieving positive changes or improvements in various areas of life. The participants in this study also reported similar views. Recovery was about staying clean, but also about connecting with others, engaging in self-care to look after wellbeing, trusting in a higher power, eating healthy, staying active, and learning not to take life too seriously. All of these activities in turn kept people clean, which was an ongoing process.

This has important implications for how we understand the concept of recovery. By looking at recovery as multidimensional it can be argued that various dimensions need to be met for recovery to be maintained. Health practitioners should engage a multipronged approach to recovery wellness to best support people in recovery, including social, material, and psychological elements. It also has other implications for practice. If recovery is a continual process that needs a long-term

commitment, we need to encourage people towards mutual support groups, like NA, who can provide long-term low- to no-cost support. Ultimately recovery is a personal journey that is not about finding a 'cure' rather it is about learning to cope with life and the struggles that come with it (Kaskutas et al., 2014; Neale et al., 2015) and it is clear that NA strongly supports this lifelong journey.

As follows, community embedded mutual support groups (also known as peer-based support groups) need to become accepted as valid ways of treating addiction and supporting recovery. Problematically, the Aotearoa healthcare system is based on neoliberal, short-term models of care that prioritise certain forms of knowledge over others (McGregor, 2001). Further, while addiction is positioned as a mental health issue, rather than a health issue, it receives individualistic clinical-based treatment (Paterson et al., 2018). In this way, help in the form of professional care is valued over lived experience. Any social good as offered by mutual support groups can be overlooked.

The value of recovery-based mutual support or peer-based groups is its nonclinical approach, where there is mentoring and education by, and with, people who have lived experience of recovery (Bassuk et al., 2016). The theoretical basis for these forms of peer support highlights the importance of empathy, and therapeutic relationships (Boisvert et al., 2008), which are the cornerstone of twelve-step programmes. Research has also shown that peer support roles within the AOD sector offer a unique space for therapeutic support for those with a drug addiction (Jowett, 2018). Internationally, peer support models have been rolled out in a variety of settings such as in hospitals (Liebling et al., 2021), integrated primary care (Cos et al., 2020), detox and rehabilitation centres, prisons (Chapman et al., 2018), and in community outreach services (Sørly et al., 2022). In Aotearoa, there are some services that provide peer-based support (i.e., Pathways, Ember), but the workforce is small (Te Pou, 2020). Te Pou, a national workforce centre for mental health, addiction, and disability, have released a workforce development strategy for 2020–2025 around developing consumer, peer support and lived experience in the mental health and addiction workforce so there is hope this sector may grow (Te Pou, 2020). Overall, peer recovery support is a valuable and consistent long-term option that should be utilised for people that are recovering from an addiction.

Reflections and Future Research

The quality of data that is collected can be highly dependent on the skills and observations of the researcher (Mills & Birks, 2014). As someone with social and material privilege who has not had first-hand experience of addiction some participants may not have felt comfortable sharing parts of their story with me or thought that I might not understand therefore withheld their sharing.

Because of this outsider position, it was necessary to put measures in place to try to mitigate these problems. As stipulated in the methods, these measures included becoming familiar with knowledge of addiction, recovery, and twelve-step literature; attending NA meetings before data collection; and practising for interviews with my supervisors. Collectively by addressing these measures, a compelling argument can be made around the advantages of conducting outsider research (Wigginton & Setchell, 2016).

Another reflection was that some of the data was collected through Zoom, which could have impacted on the development of rapport, openness, and trust between the participants and me. This study's findings showed that in terms of the NA online meetings, most participants felt Zoom was a good option, but having a face-to-face connection was better. They may have felt the same way about building trust during the interview, but it was not always possible to conduct interviews in-person because of location and ongoing lockdowns. However, this could also be considered a strength of the research, because when changes were made to COVID-19 restrictions, it was possible to pivot to Zoom and still ensure consistency in data collection. Further this removed locational limitations on where data could be collected from. These strengths make a good argument for using Zoom, or other video-conferencing technology, in the collection of data, especially as everyone navigates a new normal of living and researching within a pandemic.

Although qualitative research does not try to generalise findings, there were some limitations in my sample regarding representation of experiences in NA. However, the limitations also present promising options for future research. Firstly, the participants in this study resided in regions across Aotearoa which is a strength in the study as I was able to hear different stories of the impact of lockdown, based on the restrictions in the participants region. However, as Auckland residents have endured the most restrictions compared to anywhere else in the country, it would have been interesting to talk to more participants from this region to ascertain the impact of continual lockdowns on recovery. Secondly, aside from Lloyd (a participant who got clean during lockdown), all the participants had clean-times that exceeded ten years. This meant they had attained a level of familiarity in their recovery where habitual recovery behaviours were embedded in their life and strengthened the ability to stay drug free, even when faced with the challenges of a lockdown. As a result, experiences may have differed for those with a shorter clean-time and it would be discerning to hear their narratives, or even the narratives of people that got clean during lockdown. Thirdly, there was a lack of ethnic diversity. There were only two participants that identified as Māori, and none that identified as Pacific or Asian. With priorities around Māori health and bicultural responsibilities, and with different ethnic groups residing in Aotearoa, it is imperative

to hear a broader range of perspectives about the impact of lockdowns on people's drug and alcohol use and recovery.

In terms of future research, while not necessarily part of the scope of work for this research, it is important to consider the cultural responsiveness of NA. NA claims to have no class, race, religious or ethnic bounds (Narcotics Anonymous, 1986), thus it would be useful to see how this is experienced by people from diverse cultures. As storied in the NA literature, the NA programme was largely developed by predominantly White males who resided in the United States (Budnick et al., 2011). Currently no published research has investigated the experiences of twelve-step programmes for Indigenous groups in Aotearoa or beyond (Dale et al., 2019). The findings of this study speak to the value of twelve-step programmes for recovery support, but it would be of interest to see future studies looking at the experiences of other cultures to provide equity in our treatment options.

Another area to examine in the future would be the ongoing impact of lockdowns and restrictions. The data collected in this thesis was situated in a period between March 2020 and early August 2021, however in late August 2021 Auckland went back into another lockdown which lasted for the remainder of the year (New Zealand Government, 2021). This resulted in Aucklanders living under some level of restrictions for fifteen weeks and those in the NA Auckland fellowship would have been restricted to online meetings throughout that time. Anecdotally, according to media reports, this lockdown was more stressful for many, and the fatigue of living through a pandemic for almost two years was increasingly apparent (Paine, 2021). Therefore, it would be interesting for further research to look at how the recovery of Auckland NA members was impacted during this time as the hope and positivity they felt in the first lockdowns might have waned by this point, or having the online meetings remain important.

Engaging a critical participatory action agenda would also produce important data into the future. The advantage of critical participatory action research is that the community dictates the research goals, they help in the analysis, and the purpose is to have some sort of meaningful outcome (Fine & Torre, 2021; McIntyre, 2008). This research was conducted with the community in mind, and people in the NA community were consulted throughout the project; however, it is important to remember that they should have the opportunity to lead projects and consistently collaborate. Critical participatory action research for NA could continue to be an empowering way to explore issues that are of great importance and could enact meaningful change (MacDonald, 2012).

Finally, the ongoing pandemic also raises concerns around the treatment of those with an addiction during this time (Lockett et al., 2021). Future research could unpack the impact of discriminatory practices that COVID-19 and disasters in general have for people with an addiction, especially around stigma and navigating a health system that does not sufficiently cater to their

needs (Blake et al., 2017, 2020). This includes understanding the impact of the constant changes in health directives around the management of COIVD-19. For example, the start of 2022 has seen Aotearoa face its first significant community outbreak of COVID-19. At least in the short term, some form of restriction remains in everybody's life whether it is isolating because you have COVID-19, because a household member has it, or maybe because health-wise you are vulnerable and do not want to risk catching COVID-19. This environment also creates several challenges for the provision of NA meetings—such as what happens with in-person meetings when there are surges in cases? What if the service members that organise the meetings get sick and cannot run the meetings? How does the fellowship approach checking vaccine passports for meetings larger than 25 people and what happens for those who chose not to be vaccinated? As a fellowship, these are areas of concern that I am sure they have considered but future research could examine how the fellowship decided to tackle these issues and the implications of these decisions.

Chapter Six: Conclusion

This research has shown how the COVID-19 pandemic has impacted on the recovery of NA members, and what role NA has played in the lives of its members during this time. The study was situated between late March 2020 to early August 2021, in which Aotearoa saw one nationwide lockdown and multiple regional lockdowns.

Addiction is a complex phenomenon, which can cause significant harm for individuals, their families, whānau, and communities; treating an addiction requires fit for purpose, personalised, and long-term treatment options (Gubi & Marsden-Hughes, 2013). Therefore, it was important to conduct research into these experiences as twelve-step fellowships, such as NA, are not well researched in Aotearoa and they provide a cost-efficient and clearly effective way to treat and support abstinence-based recovery from addiction. Additionally, the context of the COVID-19 pandemic is a novel time. Living through a global pandemic, and the resulting restrictions, is stressful and can impact on a person's wellbeing, especially people who experience layers of vulnerability such as those with an addiction. Research in these areas is essential so that people and communities can support themselves and be supported, particularly in disaster settings.

The study found that generally the COVID-19 lockdowns impacted on the recovery of NA members in mostly positive ways because of the principles and fellowship of NA. Participants were able to maintain their connections with others in recovery, express gratitude for what they had, experience new opportunities from the lockdown, and remain consistent in their recovery practices. At the same time, some had to learn how to navigate an online environment, which had its challenges but the NA fellowship supported them at every step of the way.

This study speaks to the incredible generosity, heart, courage, and commitment of all people who deal with the ongoing impact of addiction. In particular it gives a shout out to the people of NA. It has been said that addiction itself is a disaster, which has a range of powerful and often painful effects, when you combine this with a global pandemic it culminates in significant human rights concerns. It is necessary to remember that people with an addiction, no matter the reason, deserve social respect and care to have agentic choices in how they live their lives and the forms of recovery they seek. Societies should adequately resource a range of treatments for addiction so that people can receive appropriate care. NA is one step in that care.

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Appendices

Appendix A: Theories of stigma and its relation to addiction

Stigma is an important consideration for those with an addiction. It is usually prevalent throughout stories of addiction, and also influences the recovery journeys for people with an addiction. NA explicitly acknowledges stigma in its literature and recognises that addicts have lived a lifestyle that is perceived by outsiders as worthy of stigma (Sanders, 2012). Nevertheless, discussing the concept and associated theories of stigma was outside the scope of this research. The information below has been included for anyone that is wanting to know more about stigma.

Stigma is a complex phenomenon that has been conceptualised in various ways depending on researcher and the research context (Lancaster et al., 2017). One of the most instrumental definitions, as asserted by Goffman (1963), is that stigma is an attribute that is deeply discrediting for an individual in the eyes of society. Others define stigma as a mark of long-lasting social disgrace connected to a quality of a person, or more recently stigma is seen as essentially any attitude, belief or behaviour that discriminates against people (Canadian Centre on Substance Use and Addiction, 2019; Lloyd, 2013). Either way, this attribute or quality results in a person being devalued, discriminated against, and labelled as deviant. Goffman (1963) suggests that for stigma to arise, this attribute must be different from others in a way that is less desirable, weak, or even dangerous. The person is "thus reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 12). Drawing on Goffman's work, Link and Phelan (2001) expanded the conceptualisation of stigma to include five mechanisms that produce stigma. Firstly, people distinguish and label a difference based on undesirable social attributes which positions people with this attribute as different. Secondly, people are stereotyped based on those perceived differences and undesirable characteristics, which are normally determined by the dominant cultural beliefs. Thirdly, the people that have been labelled are placed in distinct categories of 'others' that creates a separate of 'us' from 'them'. Fourthly, the labelled persons experience status loss and discrimination through discriminatory thoughts and actions in which they are judged, marginalised, and devalued. Finally, due to stigmatisation being entirely contingent on access to social, economic, cultural, and political power, those who have been stigmatised can find it difficult to challenge the situation from an 'inferior position'. These mechanisms collectively contribute to processes and experiences of stigma, and do not need to occur in a linear fashion to be experienced (Link & Phelan, 2001).

In another line of work Corrigan and Kleinlein (2005) proposed that different types of stigma need to be distinguished, such as 'public stigma' and 'self-stigma'. They argue that analysing stigma on an

individual level provides only a partial picture of stigma, and beyond self-stigma there is also institutional (structural) and social stigma operating in society. Livingston et al. (2012) similarly suggests that there are three key forms of stigma – self stigma, social stigma, and structural stigma. Self-stigma is the internalisation of negative thoughts, feelings, attitudes, and stereotypes that emerge from identifying with a stigmatised group. It often results in shame, the expectation of negative social reactions, and can negatively impact on behaviour and an individual's subjectivity. Social stigma is caused by the attitudes and beliefs of the pubic, whānau, and friends based on negative stereotypes resulting in social exclusion and isolation from communities. This stigma is created through the process previously described and reinforced through social interactions and the media. Finally, structural stigma is produced by the policies and practices of organisations and institutes towards stigmatised groups that restrict their rights or opportunities. This form of stigma reduces the likelihood of the stigmatised receiving quality non-judgemental services or having access to the same treatment and opportunities that non-stigmatised groups receive. These types of stigma are experienced in either a 'felt' or 'enacted' way. When a stigma is 'felt' then a person has a real or perceived fear of discrimination from possessing the particular undesirable attribute (Brown et al., 2003). When a stigma is 'enacted', this refers to the real experience of discrimination that the stigmatised persons go through.

From the literature, it is evident that social and structural stigma towards people with an addiction is prevalent throughout public attitudes and within our healthcare systems (Lloyd, 2013; McGinty et al., 2015; Schomerus et al., 2011; van Boekel et al., 2015). The World Health Organisation found that substance use disorders are the most stigmatising health condition and alcohol use is the fourth most stigmatising condition (Room et al., 2001). Schomerus et al. (2011) reviewed population surveys from Aotearoa New Zealand, Europe, North America, Brazil, and Ethiopia and found that compared with people living with other mental health challenges, people experiencing problematic alcohol use were highly stigmatised. These groups were more likely to be held responsible for their own condition, more likely to provoke social rejection and negativity and were at special risk for structural discrimination. These findings were echoed by McGinty et al. (2015) who conducted a survey-embedded randomised experiment using a national sample of 3940 Americans from an online panel. They found that when presented with a vignette about a person with an untreated addiction, participants were more likely to have negative attitudes towards the fictional character. They were also less likely to want to work with them or have them marry into their family, thus suggesting a desire for great social distance from those with an addiction. Health services have also been identified as key sites of stigma when accessing both specialist and primary health services and

even in some sites administering harm reduction (Knaak et al., 2020; Lloyd, 2013; Paquette et al., 2018). van Boekel et al. (2013, 2015) found that healthcare professionals can hold stigmatising beliefs, including the belief that people with addiction tend to be aggressive, self-neglecting and untrustworthy and that addiction is a consequence of someone's weakness.

There is a wide body of research that looks at peoples lived experiences of stigma as a way of understanding the impact of stigma (Blake et al., 2020; Lloyd, 2013; Paquette et al., 2018; Radcliffe & Stevens, 2008; Vilsaint et al., 2020). Paquette at el., (2018) conducted 46 qualitative interviews with people who inject drugs in California with the aim to hear how their lived experiences of stigma influenced healthcare access and utilisation. They found that participants repeatedly cited the impact of stigma on syringe access, interactions with first responders and hospital staff and within drug treatment. Other studies have found that these experiences of stigma can even continue to occur even once in recovery. Vilsaint et al. (2020) examined the effect of stigma through experiences of micro and macro discrimination for United States adults who had reported resolving an AOD problem. They found that about one quarter of participants reported some type of micro discrimination, such as being held to a higher standard, and slightly less reported a violation of personal rights (i.e., couldn't get a job). These experiences were associated with higher psychological distress, a lower quality of life and lower recovery capital. Even in the disaster setting, stigma can still occur towards those with an addiction. Blake et al. (2020) looked at stigma in this disaster setting and found that experiences of stigma both enabled and constrained a sense of self in the social world. This means that stigmatising beliefs can manifest in disaster-response setting and this can have consequences for people who are already more vulnerable than others.

While most of the conceptualisations discussed here rely on some sort of attribute that prompts stigmatisation, Fraser et al. (2017) contends that stigma needs to be treated as politically productive, or rather as a contingent biopolitically performative process. They argue that stigma does not achieve anything as a stable marker of some kind of outward difference, so instead we need to treat stigma as politically productive to understand what it achieves and why it occurs. Ultimately, Fraser et al. (2017) see the stigma surrounding addiction as a process that occurs for very specific biopolitical reasons that remains crucial to contemporary liberal societies. To demonstrate why this is so, they analysed interview data on accounts of stigma from 60 people in Australia who consider themselves to have an addiction to substances. They found that stigma emerges in and through countless activities, relationships and circumstances and plays out in an almost infinite range of ways. They discuss how participants see the healthcare systems, the criminal justice systems, and

the media as key agents in the stigmatisation of substance use. This is similar to work by Parker and Aggleton (2003) who suggest that “stigma is deployed by concrete and identifiable social actors seeking to legitimise their own dominant status within existing structures of social inequality” (p. 18). These works convey the idea that stigma is central in establishing and maintaining social order and fall under a broader style of research that incorporates operations of power, marginalisation, and inequality into their analyses of stigma. It is driven by an explicit awareness of the operations of power and inequality that form the basis for stigma and discrimination and highlight how certain political terrains force individuals to act in particular ways (Fraser et al., 2017). If stigma is to be understood in this way, it prompts inquiries into the vast scale on which change would be required if we are to see lasting improvements in the social standings (or felt stigma) of those with an addiction.

Appendix B: Additional information about Narcotics Anonymous

This appendix includes a brief history of NA, the twelve-steps, the twelve-traditions, a zonal map of NA worldwide and a sample meeting format. This information has been sourced from various NA resources and other literature on NA. The relevant references can be found by each resource.

Below are some links to other common resources, literature, and websites from Narcotics Anonymous where you can find more information about the twelve-step programme.

- The Group Booklet
- The Basic Text
- Aotearoa New Zealand Narcotics Anonymous website
- Narcotics Anonymous World Services

Figure 4

A selection of NA pamphlets

The history of Narcotics Anonymous internationally

A BRIEF HISTORY OF

NARCOTICS ANONYMOUS

1953 – NA programme was founded in California, United States.

1954 – First NA publication was printed, called the *Little Yellow book* (also know as *Little Brown book*, and *Buff book*.

1959 – Jimmy K, Sylvia W, and Penny K take over the meetings again after NA nearly collapsed.

1960 – The first NA phone line started and new 6 new pieces of literature was created (including *Who is an Addict?, What is the NA programme, Why are we here, How it works, What can I do?, Recovery and relapse).* There were 2 NA meetings in the United States.

1961 – The NA *White book* and *We do recover* was written.

1963 – The first Hospital & Institutions (H&I) group was formed.

1964 – The NA Board of Trustees was established.

1966 – The *NA White book* (2nd edition) was republished to include the personal stories of many addicts.

1968 – The first issue of *The Voice of NA* (later knowns as *The Voice)* was published. Jimmy K also designed the NA logo, and NA reached Canada.

1969 – The first Public Information (PI) efforts took place.

1970 – There were 39 NA meetings worldwide.

1971 – The first NA World Conference was held in November in California, United States. NA also reached Australia.

1972 – Jimmy K wrote the Gratitude prayer.

1974 – The NA fellowship decides to incorporate the World Service Office.

1975 – The *NA Tree* is published and adopted by Trustees, which outlined the beginning of the NA service structure.

1976 – The first NA World Service Conference took place in California, United States.

1977 – NA reached Europe, with the first meeting in Germany.

1978 – The *White book* is translated into German. This was the first piece of translated NA literature.

- **1979** – The first NA World Literature Conference was held in Wichita, Kansas, US
- **1980** – There were 1,839 NA meetings worldwide and the literature was available in 2 languages.
- **1982** – NA reached the Asian-Pacific region, with the first meeting in Japan. The *NA Basic Text* was approved.
- **1983** – The *NA Basic text* was printed. NA also reached Central and South America.
- **1986** – NA reached the Middle East and Africa.
- **1989** – The *NA Basic Text* was translated into French, which was the first translation of the text. The Europe World Service office also opened.
- **1990** – There were 14,042 meetings worldwide, literature was available in 5 languages, and the *NA basic text* was available in 2 languages.
- **1991** – The *Just for today* meditation book was published.
- **1993** – The *It works: How and Why* was published. There was also NA meetings in 60 countries.
- **1996** – The NA World Services vision statement was adopted.
- **1998** – The World Service Office, Trustees and Convention boards were restructured as NA World Services. The *NA step working guides* was also published.
- **2000** – There were 28,443 meetings worldwide, literature was available in 16 languages, and the *NA Basic text* was available in 9 languages. The first bilingual world convention was held too.
- **2005** – Iran World Service Office opened.
- **2007** – There was NA meetings in 127 countries.
- **2008** – The 6th edition of the *NA Basic Text* was published.
- **2010** – There were 58,076 meetings worldwide in 131 countries, literature was available in 49 languages and the *NA Basic Text* was available in 20 languages.
- **2012** – The *Living Clean: The journey continues* was approved.
- **2013** – There was NA meetings in 139 countries.
- **2015** – The audio of the main speaker meetings were streamed live online from the 36th World Conference Narcotics Anonymous
- **2016** – The *Guiding Principles: The spirit of our traditions* was approved
- **2020** – There were 76,075 meetings worldwide, literature was available in 56 languages, and the *NA Basic text* was available in 35 languages.

The content for this timeline was taken from Budnick et al., (2011), NA World Service (2020), and White et al., (2011).

The twelve-steps of Narcotics Anonymous (sourced from Narcotics Anonymous, 2008)

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.

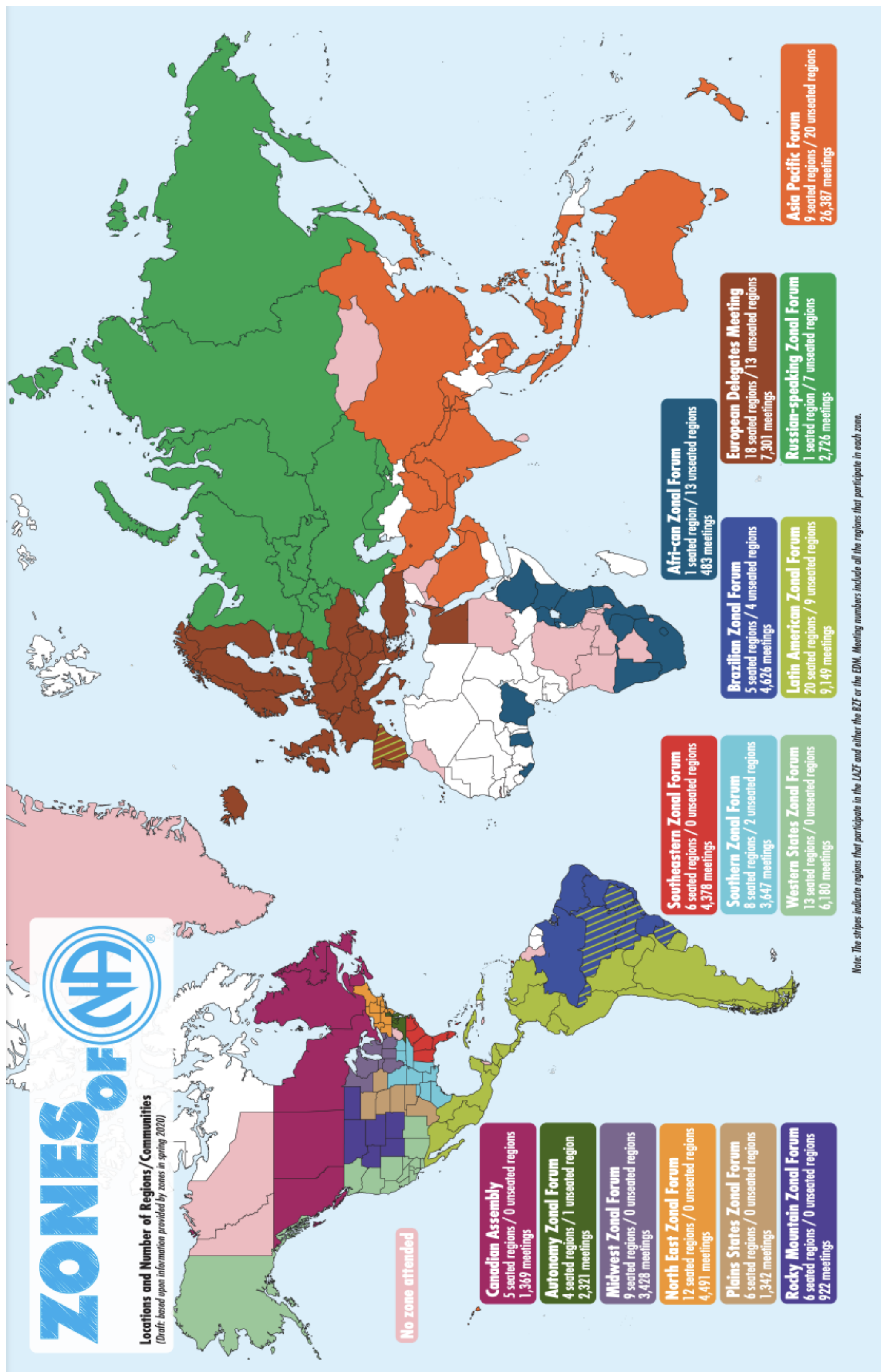
The twelve-traditions of Narcotics Anonymous (taken directly from Narcotics Anonymous, 2008, p. 60)

1. Our common welfare should come first; personal recovery depends on NA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for membership is a desire to stop using.
4. Each group should be autonomous except in matters affecting other groups or NA as a whole.
5. Each group has but one primary purpose—to carry the message to the addict who still suffers.
6. An NA group ought never endorse, finance, or lend the NA name to any related facility or outside enterprise, lest problems of money, property, or prestige divert us from our primary purpose.
7. Every NA group ought to be fully self-supporting, declining outside contributions.
8. Narcotics Anonymous should remain forever nonprofessional, but our service centres may employ special workers.
9. NA, as such, ought never be organized, but we may create service boards or committees directly responsible to those they serve.
10. Narcotics Anonymous has no opinion on outside issues; hence the NA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

Zonal Map of NA 2020

Figure 5

Map of the different regions taken from Narcotics Anonymous (2020). Reprinted by permission of NA World Services, Inc. All rights reserved.



Sample meeting format

Sample meeting format

This sample meeting format is just that - a sample. It's designed so that, if your group chooses, you can use it exactly as it is. However, you're encouraged to change it and rearrange it according to the needs of your group.

Leader:

Welcome members to the meeting and introduce yourself.

Hello, my name is______, and I am an addict. Welcome to this meeting of the______ Group of Narcotics Anonymous. I'd like to open this meeting with a moment of silence (15 to 20 seconds) for the addict who still suffers, followed by the Serenity Prayer.

We like to extend a special welcome to newcomers. If anyone here is attending their first NA meeting, would you care to introduce yourself? We ask this not to embarrass you, but to get to know you better.

- Is anyone here in their first thirty days of recovery? Introductions.
- Do we have any out-of-town visitors? Introductions.
- Is there anyone attending this meeting for the first time? Introductions.

If this is a closed meeting: This is a "closed" Narcotics Anonymous meeting. Closed NA meetings are only for addicts or those who think they might have a drug problem. If there are any non-addicts visiting, we'd like to thank you for your interest in Narcotics Anonymous. Our local NA meeting list on the literature table will direct you to an NA meeting in our community that is open to non-addicts.

If this is an open meeting: This is an "open" Narcotics Anonymous meeting. We'd like to welcome any non-addict visitors and thank you for your interest in Narcotics Anonymous. We ask that you respect the primary purpose of this meeting, which is to provide a place where addicts can share their recovery with one another.

Leader:

For the protection of our group as well as the meeting facility, we ask that you have no drugs or paraphernalia on your person at the meeting. If you have any now, please leave, dispose of them, and return as quickly as possible.

Leader:

Recognise those with various periods of clean time— thirty, sixty, ninety days, six months, nine months, one year, eighteen months, and multiple years. Key tags, chips, or medallions may be given out.

Leader:

Select people before the meeting to read one or more of the following short pieces. These readings can be found in our White Booklet, the Basic Text, IP No. 1, or the group reading cards.

a) Who Is an Addict?
b) What Is the NA Program?
c) Why Are We Here?
d) How it Works
e) The Twelve Traditions
f) Just for Today
g) We Do Recover

Leader:

Announce the type of meeting (participation, topic discussion, step study, speaker, etc.). Ask for topic or step and open the meeting for discussion, or introduce the speaker.

Leader:

About ten minutes before the meeting is scheduled to close, announce: That's all the time we have. I'd like to thank you for attending.

Leader:

Begin passing the basket around, announcing: The basket being passed around is one way of practicing our Seventh Tradition, which says, "Every NA group ought to be fully self-supporting, declining outside contributions." The money we collect pays for rent, literature, and refreshments. Through contributions from this group to various NA service committees, it also helps carry the NA message of recovery in our area and around the world.

If this is an "open" meeting: I'd like once again to thank our non-addict guests for the interest they've shown in Narcotics Anonymous. Because of NA's tradition of self-support, this group asks that you not contribute any money when the basket passes your way.

Leader:

Do we have any NA-related announcements? *(The GSR will make announcements of upcoming group activities and NA events in the area.)*

Leader:

After the basket has come back around: Again, thanks for coming tonight. Would all those who care to, join in a circle to close? *Various groups close in different ways: with prayers, brief recitations from NA literature, etc. When closing their meetings, some groups ask those attending to respect the anonymity of others they've seen and heard there*. Keep coming back. It works!

Above is a sample meeting format that has been taken from The Group Booklet produced by Narcotics Anonymous World Services (1997). This structure has been included here for people who may not have attended a NA meeting to become familiar with how a meeting might be run. However, it is important to note that not all meetings follow this structure, and each meeting can be run in its own way.

Appendix C: New Zealand COVID-19 Alert Level Summary

Figure 6

Table of alert level settings taken from New Zealand Government (2021)

New Zealand COVID-19 **Alert Levels Summary**

Unite against COVID-19

- The Alert Levels are determined by the Government and specify the public health and social measures to be taken in the fight against COVID-19. Further guidance is available on the **Covid19.govt.nz** website.
- The measures may be updated based on new scientific knowledge about COVID-19, information about the effectiveness of control measures in New Zealand and overseas, or the application of Alert Levels at different times (e.g. the application may be different depending on if New Zealand is moving down or up Alert Levels).
- Different parts of the country may be at different Alert Levels. We can move up and down Alert Levels.
- Essential services including supermarkets, health services, emergency services, utilities and goods transport will continue to operate at any level. Employers in those sectors must continue to meet health and safety obligations.
- Restrictions are cumulative (at Alert Level 4, all restrictions from Alert Level 2 and 3 apply).

Published 16 April 2020

ELIMINATION STRATEGY – New Zealand is working together to eliminate COVID-19

Alert Level	Risk Assessment	Range of Measures (can be applied locally or nationally)	
Level 4 – Lockdown Likely the disease is not contained	• Community transmission is occurring. • Widespread outbreaks and new clusters.	• People instructed to stay at home (in their bubble) other than for essential personal movement. • Safe recreational activity is allowed in local area. • Travel is severely limited. • All gatherings cancelled and all public venues closed.	• Businesses closed except for essential services (e.g. supermarkets, pharmacies, clinics, petrol stations) and lifeline utilities. • Educational facilities closed. • Rationing of supplies and requisitioning of facilities possible. • Reprioritisation of healthcare services.
Level 3 – Restrict High risk the disease is not contained	• Community transmission might be happening. • New clusters may emerge but can be controlled through testing and contact tracing.	• People instructed to stay home in their bubble other than for essential personal movement – including to go to work, school if they have to or for local recreation. • Physical distancing of two metres outside home (including on public transport), or one metre In controlled environments like schools and workplaces. • People must stay within their immediate household bubble, but can expand this to reconnect with close family / whānau, or bring in caregivers, or support isolated people. This extended bubble should remain exclusive. • Schools (years 1 to 10) and Early Childhood Education centres can safely open, but will have limited capacity. Children should learn at home if possible. • People must work from home unless that is not possible. • Businesses can open premises, but cannot physically interact with customers.	• Low risk local recreation activities are allowed. • Public venues are closed (e.g. libraries, museums, cinemas, food courts, gyms, pools, playgrounds, markets). • Gatherings of up to 10 people are allowed but only for wedding services, funerals and tangihanga. Physical distancing and public health measures must be maintained. • Healthcare services use virtual, non-contact consultations where possible. • Inter-regional travel is highly limited (e.g. for essential workers, with limited exemptions for others). • People at high risk of severe illness (older people and those with existing medical conditions) are encouraged to stay at home where possible, and take additional precautions when leaving home. They may choose to work.
Level 2 – Reduce The disease is contained, but the risk of community transmission remains	• Household transmission could be occurring. • Single or isolated cluster outbreaks.	• Physical distancing of one metre outside home (including on public transport). • Gatherings of up to 100 people indoors and 500 outdoors allowed while maintaining physical distancing and contact tracing requirements. • Sport and recreation activities are allowed if conditions on gatherings are met, physical distancing is followed and travel is local. • Public venues can open but must comply with conditions on gatherings, and undertake public health measures. • Health services operate as normally as possible.	• Most businesses open, and business premises can be open for staff and customers with appropriate measures in place. Alternative ways of working encouraged (e.g. remote working, shift-based working, physical distancing, staggering meal breaks, flexible leave). • Schools and Early Childhood Education centres open, with distance learning available for those unable to attend school (e.g. self-isolating). • People advised to avoid non-essential inter-regional travel. • People at high risk of severe illness (older people and those with existing medical conditions) are encouraged to stay at home where possible, and take additional precautions when leaving home. They may choose to work.
Level 1 – Prepare The disease is contained in New Zealand	• COVID-19 is uncontrolled overseas. • Isolated household transmission could be occurring In New Zealand.	• Border entry measures to minimise risk of importing COVID-19 cases. • Intensive testing for COVID-19. • Rapid contact tracing of any positive case. • Self-isolation and quarantine required. • Schools and workplaces open, and must operate safely. • Physical distancing encouraged.	• No restrictions on gatherings. • Stay home if you're sick, report flu-like symptoms. • Wash and dry hands, cough into elbow, don't touch your face. • No restrictions on domestic transport – avoid public transport or travel if sick.

Appendix D: Ethics documents

Information sheet

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745
Tel +64 9 414 0800 ext 43116
Fax +64 9 441 8157

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Narcotics Anonymous during Covid-19 lockdown: The lived experiences of recovering addicts

INFORMATION SHEET

My name is Meghan Mappledoram, and as part of my Master's of Science in Health Psychology I am interested in doing research about how members of Narcotics Anonymous (NA) managed their recoveries during COVID-19.

Project Description

While it is known that mutual support groups, such as Narcotics Anonymous have great value for those recovering from an addiction, COVID-19 has created an unprecedented environment where Narcotics Anonymous meetings could no longer be held in-person, and had to move to an online delivery. To date there is minimal research surrounding this online delivery meetings. This research is particularly interested in your experiences of this online delivery, what you found useful about it and what you did not. We are also interested in hearing how you kept yourself safe on your recovery journey during the COVID-19 lockdowns, what other resources you might have drawn on as well as your lived experiences of your recovery.

You are invited to take part in this study. Whether you decide to take part or not is your choice. If you do not want to take part, you do not have to give a reason. This Information Sheet will help you decide if you want to participate in this study. It outlines why I am doing the study, what involvement is needed from you if you wish to participate, any benefits or risks there may be, and what will happen at the completion of the study. Before you decide you may want to discuss the study with other people such as partners, family, whānau, friends, or health providers.

Who can participate in this project?

If you are interested in talking with me there is the following inclusion criteria to participate in this research:

- Must be over the age of 18 years of age.
- Reside in Aotearoa New Zealand.
- Be a member of NA
- Participants of any ethnicity are invited to participate; however, I will be conducting the interviews in English.

You will receive a $40 voucher to thank you for your time and sharing your story.

If you participate what will you be required to do?
If you wish to participate you will be invited to take part in a semi-structured interview, at a time and place that we mutually agree on. The interviews will be conducted either face-to-face (where possible) or via Zoom, Skype or telephone. If there is a change in alert levels, and face-to-face interviews are no longer possible then we will need to conduct the interview via Zoom, Skype or telephone in order to comply with social distancing rules. During the interview we will discuss topics around your experiences of recovery, the twelve-step programme and COVID-19. The interview should take about one hour, however there will be no time limit enforced.

Due to the personal nature of recovery from addiction, I appreciate you might only want to discuss certain aspects of your experience. You do not have to talk to me about anything that you do not want, you can stop the interview at any time, and you have the right to ask questions. I do not anticipate harm or discomfort as part of this research however, I do acknowledge that aspects of recovery can be difficult so if you would like to withdraw from the study, you can withdraw up to two weeks after the interview. If you do feel discomfort or distress following the interview, I can provide a list of services or places for you to seek further support.

The research team
The research team is made up of myself, and my two supervisors, Dr Kathryn McGuigan and Dr Denise Blake. Both have extensive experience in conducting research, and Dr Blakes research specialities are in drugs, marginalised groups and the social justice space. They have worked closely with me to prepare for these interviews, to ensure I approach all topics with respect, sensitivity and clear communication.

Data Management
The interviews will all be recorded on a voice recorder with your permission. Only myself and my supervisors will have access to this data; this data will be stored securely. The recordings will be transcribed by me, without the use of any audio transcription services. All identifying information will be removed from the transcripts to protect your privacy. Once this has been done you will be provided with a copy of your transcript, which you may edit and make adjustments if you feel necessary.

After you have read through your transcript, a Transcript Release Authority Form will be provided for you to sign if you are happy with the transcript. This will allow me to use the de-identified information in the transcription for the write-up of the research. If you do want to make changes to the transcript, you will have up to one month to do so and then send back to me.

On completion of transcription, the transcripts will be coded for themes and ideas presented throughout the interview. I will use the data for my thesis report but there is the possibility that your anonymised information may be used in other research publications.

All personal information and data will be stored in an encrypted file on a password protected computer until the research is complete in February 2022, it will then be deleted. Both the anonymous form of your transcript and coding, as well as the audio recording of your interview will be stored in an encrypted folder too and will also be deleted at this time.

If you want, a summary of the research findings can be emailed out to you on completion of the research. There is an option to request this on the consent form.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study (up to two weeks after the interview);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview.
- be provided with a document that includes further information on where you can access additional support services, should you want, other than those offered by Narcotics Anonymous.

Please contact the research or supervisor if you have any questions about the project. The contact details are below:

Researcher:	**Supervisors:**	
Meghan Mappledoram	Kathryn McGuigan	Denise Blake
meghanmappledoram@hotmail.com	K.Mcguigan@massey.ac.nz	Denise.blake@vuw.ac.nz

Compulsory Statements

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR21/22. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43347, email humanethicsnorth@massey.ac.nz.

Consent form

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745
Tel +64 9 414 0800 ext 43116
Fax +64 9 441 8157

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PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read, and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

Please indicate by ticking the following four boxes your preferences, and then sign and date the form.

- ☐ I agree to the interview being sound recorded.
- ☐ I wish to have my recordings returned to me.
- ☐ I agree to participate in this study under the conditions set out in the Information Sheet.
- ☐ I wish for a summary of the research to be sent to me upon completion of the research.

Declaration by Participant:

I ____ hereby consent to take part in this study.
[print full name]

Signature: _______________________________ Date: _________________

Interview guide

INTERVIEW GUIDE

General Questions:

- Name
- Age
- Ethnicity
- Location (Rural/Urban)

General Opening Questions:

- Can you tell me about your addiction story?
  - If it is not covered… Can you tell me about your recovery journey?
- What substances did you use? How long did you use these substances for?
- How long have you abstained from those substances? (Clean-time)

Key Questions/Prompts:

- What support services did you initially use? What support services do you use now? Do you use any other support services other than NA?
- Can you tell me about some of your experiences with the twelve-step programme before COVID-19? How were you introduced to the NA program? What was the biggest influence for you to come to your first NA meeting?
- Can you tell me about your engagement with the twelve-step activities?
  - Do you have a sponsor? Do you sponsor others? How often do you go to NA meetings? What is your progress with the twelve-steps? What NA services have you been involved with (i.e., group, area, regional, area, world)?
- What do you value/enjoy about the twelve-step meetings? What do you not value/enjoy?
- How did you find the lockdowns? What were your first worries, concerns, or thoughts when the lockdowns were announced?
- How do you feel the lockdowns or the ongoing COVID-19 pandemic has impacted on your recovery?
- Did you face any challenges in your recovery during the lockdowns?

- Were there any different things or practises you adopted to help you with your recovery throughout the lockdowns or since the COVID-19 pandemic?
- Tell me about your first online twelve-step meeting.
- Did it take you long to adjust to the online meetings?
- What did you value/enjoy about the online meetings? What didn't you value/enjoy?
- How many online meetings did you attend? Do you Aotearoa NZ based meetings or do you also attend international meetings online?
- Were there any barriers for you to access these online meetings?
- How did these online twelve-step meetings compare to the face-to-face meetings?
- Did you think or worry about using while in lockdown? What sort of things helped you to abstain throughout the lockdowns?
- Were you able to access other meetings or other support at these times? If so, can you tell me about that or if not, what might have prevented that.
- Who is missing from the meetings? Who do you feel the meetings represent? When you engaged in the zoom meetings did you see people who you felt more connected too?

Closing Questions:

- Do you continue to use the online twelve-step meetings? Even though we are not in lockdowns?
- Is there anything else you would like to add about your recovery journey, things that have helped you, or things you'd like other people to know?

Debrief:

- Thank the participant for taking their time to talk. Give voucher as a thank-you.
- Emphasise to contact me if they want to discuss anything further.
- If the participant appears distressed, ensure there is support they can talk to if they need to, refer to the contacts on the 'Where to seek help' sheet.
- Give time to process and reflect on the interview. How did they find it? Do they have any additional questions?
- Explain the next steps, transcribing and giving them a chance to edit if they want to.

Transcript release authority

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745
Tel +64 9 414 0800 ext 43116
Fax +64 9 441 8157

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AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: .... **Date:** ....

Full Name - printed ....

Where to seek help document

Talking about personal matters can prompt strong or unexpected feelings. Sharing at a meeting, talking to your recovery peers and with friends and family will help and we have provided some additional resources below. While I will keep everything we discuss completely confidential, you are welcome to share your experiences at the interview with anyone you trust.

Resources and support for all ages:

Depression.org.nz – Free text number 4202

Like Minds, Like Mine

Like Minds, Like Mine is a national anti-stigma campaign. The aim of this programme is to increase social inclusion and to reduce stigma and discrimination towards people with experience of mental illness.

Helplines

Need to talk? Free call or text 1737 any time.
Talk to a trained counsellor or call:

- the Depression helpline – 0800 111 757
- Healthline – 0800 611 116 – to get help from a registered nurse 24/7.
- Lifeline – 0800 543 354
- Samaritans – 0800 726 666

If you need urgent help

Call your local mental health crisis assessment team or go with them to the emergency department (ED) at your nearest hospital.
Auckland - Mental Health Crisis 0800 800 717 (operating 24/7)