Recovery

a practical guide for clinicians, frontline workers, family of people with problematic substance use, and consumers
Acknowledgements

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## Clinicians on Recovery

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<td><strong>Rose</strong></td>
<td>[Manager/nurse practitioner Uniting Care ReGen] “We’re a 16-bed community residential drug withdrawal facility in Ivanhoe and I’ve been working in the drug and alcohol sector since 1992 ... for people, the spark ignites, just through contact with the peer group and seeing peers who will be going on to residential rehab and they just say, you know, actually I think that this will work for me as well. So the peer just can help people shift and so that’s the role we have in Recovery-oriented services.”</td>
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<td><strong>Clare</strong></td>
<td>[Manager, Rehabilitation services, Windana Drug and Alcohol Recovery] “We probably pick up where you finish [Rose], in the therapeutic community which is the community being the main agent of change. It’s a self-help, mutual help model in a Recovery paradigm, in that the setting is very much about working with people’s strengths and working with each person in a holistic way so they can be the best version of themselves.”</td>
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<td><strong>Bella A</strong></td>
<td>[Manager, residential programs, Self Help Addiction Resources Centre] “… our model runs on the peer support model, which means that we believe that our residents get as much, if not more, support and inspiration from each other, than they actually do from us. Most of our staff are in recovery from drug and alcohol dependence themselves, which means they act as mentors and champions and role models, but we also encourage the residents to support each other in that model.”</td>
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Welcome to the Recovery unit

You will notice this unit looks a bit different to others in the NCETA Ice series. Whilst this Recovery unit was designed to be used alongside those units, it is intended that Recovery is a stand-alone practical document, available to front line workers, family of people who use substances and consumers, in fact anyone who wishes to find out more about Recovery and how it is applied in the Alcohol and Other Drug (AOD) sector.

Recovery often gets overlooked when considering and developing best-practice in AOD intervention. Those of us who work in the sector often see clients at the most difficult and chaotic periods of their lives, less frequently over the subsequent months and years of rebuilding and growth. As Recovery plays such an important role in the health and wellbeing of the consumer and also the broader community around consumers, we hope to address this imbalance here. In this context, Recovery is a process of change whereby people improve their health and wellbeing, aim to live autonomous lives, and strive to reach their full potential. The unit follows SAMHSA’s (Substance Abuse and Mental Health Services Administration) 10 guiding principles of Recovery which are widely valued as a pathway to recovery, and/or the successful management of symptoms (SAMHSA, 2012). There are four major areas that underpin these guiding principles and support a life in recovery. They are:

Health
Management of symptoms or disease, and making choices that support good physical and emotional wellbeing.

Home
Having a secure and safe place to live, and a place to call ‘home’.

Purpose
Participation in meaningful activities. This might be employment, family caretaking, volunteering – any relevant endeavour that provides people with the physical and emotional resources to enable them to participate in society.

Community
Social networks that provide friendship, support and love. These may be intimate relationships, family connections, friends, interest groups, spiritual communities and others.

In this unit you can expect to find practical advice on how to effectively communicate with clients, and put these principles into practice. At the end of this unit, you will also be able to:

- Have an appreciation of what Recovery is, and how best to implement Recovery principles
- Understand the concept of stigma and shame in people in recovery
- Have an appreciation of the importance of peer support in recovery
- Understand and appreciate the importance of Recovery Capital to people in recovery
- Better appreciate the experience of family members living with a person in recovery
People’s stories

| Garth’s story | [Garth works in the AOD sector with LGBTI clients and is also in recovery] “From the outset we’d be coming from a person-centred approach. …We strive to reduce stigma as much as possible and discrimination, so we want to make the person feel as comfortable and as welcome and as accepted as we can, so that they feel comfortable and can tell their story, and they feel really okay about accessing a service.

I think working in the LGBTI community, there’s another layer of stigma and discrimination around that. A lot of people have experienced poor, professional engagement, service engagement. So, we really strive to have just on the outset a lot of positive reinforcements in terms of collateral. We have it on the walls, literature available, just trying to be - not being shocked or judgmental - and trying to make them feel that anything they say is confidential, that we’re protecting their right as a human being to engage in the kind of practices that they want.” |

| Victoria’s story | [On the early phase of Recovery] “… the first few months it’s dark and it’s hard and I remember the first time that I laughed. For me that’s one of the best things … I would end up laughing as a physical response. I saw other people laughing. There was something that was funny, so I’d do those motions of laughing and making the noise of laughing, but not actually feeling anything. That also carried on into my recovery.

There was this fear that I had lost any spark for life until that day where I laughed, that whole belly-laugh where you bend over and you feel it and you get tears in your eyes. I thought I would never ever, ever get that back and the first day that I did that, I’m like – that was one of the main points when I was like okay, I feel like something’s changing; I’m getting a little bit of me back. There’s been lots of moments like that.” |
Recovery in practice

In the field of addiction, recovery has gathered momentum over the years and has been shown to have positive effects on the person concerned, their families and the wider community (Best & Lubman, 2012). The objective of recovery is not to ‘cure’, but to help alleviate symptoms and minimize relapse episodes, and to engage people in the world around them. In recovery, improvements may be small yet important and play a major role in the person’s journey to health, which in turn can lead to improved quality of life and greater wellbeing. To repeat the point made earlier, recovery is really about ‘personal recovery’. Although recovery may be a lifelong journey for some, it can and does happen. Approximately 58% of people who have a substance dependency will reach sustained recovery (Sheedy & Whitter, 2009).

The ‘personal’ nature of recovery raises the challenge of how best to embed Recovery principles into practice when needs, wants and desires vary widely, according to the person in recovery. In practice, if followed, the guiding principles will lead both helpers and helpees in the right direction. There is no such thing as a ‘one size fits all’ approach, and you will be guided by your clients’ requirements.

A little bit of background

Addiction recovery can be traced back to the late 18th century where alcoholism was first considered a disease (W. White, 2014). The current recovery movement however, has its roots in the 1960s and 1970s liberation and civil rights movements which raised questions about citizenship and equality. It was in this context that the advocacy groups which supported service users in the field of mental health came about to fight against stigma and discrimination. People subsequently identified themselves as ‘consumers’ of mental health services and not ‘patients’.

The Recovery approach gained impetus in the 1980s when research into mental health conditions challenged current thinking. Contrary to historic belief that major mental illnesses follow an inevitable declining path, researchers found a variety of health outcomes, and that many people do indeed recover. However, the journey for most people is changeable, with periods of recovery that are more sociable (Shepherd, 2017; Shepherd, Boardman, & Slade, 2008).

A core principle in the Recovery approach is an emphasis on what can be done, rather than what is not possible. The importance of self-management, quality of life and wellbeing are prominent factors and place the person in recovery at the centre of treatment, therefore providing them with the opportunity to gain a sense of control of personal circumstances and choice. As such, Recovery ideas are now becoming embedded in mental health policy in many countries, and this has been extended to the AOD sector.
**Stigma and discrimination**

Recovery is about enabling people to live their lives according to the way they want to live (Slade, 2009). However, many people experience stigma and discrimination on a daily basis.

Illicit drug dependence is one of the most stigmatized health conditions globally (Kelly & Westerhoff, 2010). Stigma and discrimination are important aspects of recovery, because recovery is made more difficult in the face of stigma – it is a major barrier for people living with addiction.

Stigma may come from the greater community resulting in exclusion from community life, through lack of employment opportunities, or from within the healthcare system whereby access to services is affected and restricts an individual’s access to healthcare. Stigma and shame may also be internalised – the outcome being it creates barriers to effective communication and support.

Experience of stigma and discrimination can wear people down, isolate them and contribute to low self-esteem. After a while this becomes the ‘norm’ and the expected way of being treated. The impact of constant marginalisation can diminish a person’s health and wellbeing. The knock-on effect may limit their ability to work and earn money to live, participate in social activities, access treatment or other support services, and a range of other factors.

Stigma and discrimination can result in:

- Disempowerment
- Development of self-loathing
- Diminished self-esteem and dignity
- Reduced quality of life
- Depression
- Exclusion from social and communal activities
- Limited access to housing
- Unemployment and difficulty obtaining employment
- Feelings of helplessness and isolation

Stigma can also have far-reaching effects on the family unit. Some families who live with people who experience problematic drug use have difficulty getting help for themselves or other family members. At the same time, there is a great fear in some people that if they reach out for help, Child Safety Services may become involved in their lives or they may be labelled as bad parents (Queensland Mental Health Commission, 2017).

In addition, feelings of shame and guilt can derail people’s recovery. These feelings can be devastating and fuel their addiction. It is therefore an important part of the healing process for the person to learn to understand and manage feelings of shame.

The elimination of stigma and discrimination are core elements in the Recovery philosophy. The negative fall-out from stigma can have great personal, emotional and physical costs, and so treating people with respect is the starting point for good practice in the eradication of stigma.

Knowledge and understanding of addiction and recovery are key components in the arsenal to protect against stigma and discrimination, and relate to the individual, the community and society.
Garth’s story

“There’s so much stigma and discrimination towards LGBTQ people whether it be from growing up in a homophobic setting … work environments, just out in general … it says that you (in the LGBTQ community) do not measure up like the rest of us. So there’s all these underlying issues where people are feeling stigmatised, they’re feeling isolated, they’re feeling rejected almost. So, alcohol and substance, or drug use, particularly meth, is a great way of just going ‘I don’t have to worry about that anymore’. Meth is really a de-inhibitor, so people can engage in wild sexual practices for a long time. I think there’s just this whole sense, particularly with LGBTQ community of feeling isolated, alone, not belonging. So when men engage in meth and sex, there’s this false sense of intimacy and of connection which can be incredibly intense for 12, 18, 24 hours, but then it’s gone. It’s this real false sense, and people are constantly trying to grab hold of that. It can be really – it’s devastating.”

“...I got to a point where I had nothing really left to live for. So, I made a decision, if I was going to continue down this way, I’d probably just kill myself, or I’d do something about it. Then my brother had a baby, and I thought I didn’t want my nieces growing up worried – I wanted to be around when they grew up, so I made a conscious decision to change. It was a long process. It didn’t just happen. I sought out help. I was living in Sydney at the time, so I saw ACON and they helped me with counselling, which was really great. It was really hard because it was this whole idea of I had to cut my life off from people I associated with drug use. So, I just had to cut it off. Then there was no-one – that was really, really hard. So, as well as going through this awful journey of recovery, stopping drugs in my life, I was really isolated and I felt I really had no-one to talk to. Having a counsellor was fantastic for that at helping me re-engage with things like just, they encouraged me to paint. I can’t really paint but it was such a great way of expressing myself, keeping a journal, things like that. I could write down stuff that I was feeling at the time which I actually found really quite cathartic. Re-engaging with my family was probably the primary thing for me, and being open and honest. That was hard, but I think it was vital, and I think it’s vital for the journey, the recovery journey, to make yourself accountable.

So, when people knew what was going on, they became able to recognise the signs. So, then if I did lapse or relapse, they were aware of it. I was lucky with my family. They were very supportive and really encouraging. So, I didn’t feel I had to hide it from them. Well, they called me on it anyway. So, it was good. That was really, really important for me. Part of my journey was I felt I had to change my life. I wanted to do something, so I went back to uni. Where my brother lives in Coffs Harbour, there’s a uni there and I wanted to get out of Sydney because that had a lot of triggers for me. So I applied for uni there and got into there. I lived with them for the first four years of their life [nieces] which was fantastic. I was lucky in that respect that I was able to replace that meth hole with a family experience. But I was able to bond really, really closely with my nieces. It was great.”
The box below offers some dos and don’ts to keep in mind when speaking with clients or people you know who use drugs. You can add to these suggestions, as and when new situations arise.

**Avoiding stigma**

**Do**
- Discuss stigma with the client
- Give the person room and use their name
- Be calm, non-judgmental and explain what you are going to do and why you are doing it
- Listen and promptly respond to requests for help
- Avoid smiling too much
- Monitor eye contact – too much appears threatening, too little implies indifference or untrustworthiness

**Don’t**
- Assume people will be or become aggressive, violent or dangerous
- Assume a person is intoxicated because they are showing signs of ice or other form of intoxication … if people appear drug affected, they may be showing signs of long-term changes in cognitive function
- Ask a lot of questions
- Argue, threaten people or use ‘no’ messages
- Make promises you can’t keep
# Practitioners’ tips for best practice Recovery

## Practical examples (provided by members of the Clinical Group)

For those who are at the beginning of the journey, seeing and speaking to someone who has been there can offer a sense of hope.

Use non-judgemental language ... “it’s not good/bad – it’s what it is”.

Get people to identify they’re going in the right direction ... “if you can get through the next minute/hour/day – you’re going in the right direction. Just go with it”.

Give clients data ... “in our service, X% achieve recovery”.

If someone is craving to use, try to get people to recognise they’re not doing it NOW ... “you’ve made it to the appointment – you’re here!”

If a person has no hope, tell the person you will ‘hold’ hope for them.

Encourage people to express hope ...“If you woke up this morning and felt optimistic about your recovery, what would it look like”?

### Notes:

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**Promote hope**

**Important note:** At the point of greatest distress, many people cannot make healthy/hopeful decisions – they’re probably in self-destruct mode. Because of drug use, when at the lowest point, people can be cognitively impaired, so the person should be guided by others at this point. In the beginning it is about what the person ‘needs’ not what they ‘want’. With improvement, people can be more autonomous and therefore you can ...

Acknowledge that people are the best experts on their lives.

Ask people if their wishes and needs are being met.

### Notes:

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**Recovery is person driven**
There are many pathways to recovery

Offer people options that brings recovery alive – this might be in the form of DVDs, books, introductions to peer workers, links to websites they can view in the office, hook them up with someone or thing.

Ideally, people should be able to choose from formal treatment services such as counselling, non-residential withdrawal, residential withdrawal, therapeutic day rehabilitation, residential rehabilitation, care and recovery, co-ordination, and drug therapy.

Engage people in discussions about their options.

Always consider waiting list management – as some services have waiting lists for weeks/months, you need to know this before recommending a service to someone. You don’t want the hopes of a client crushed by a series of knockbacks.

If a person has to wait for a space in a service, find out ways of supporting them while they wait for a vacancy. Groups such as peer support, AA, NA and SMART recovery groups could be offered.

Notes:

Recovery is holistic

Ask people if they have food, a GP, healthcare, housing, finances.

Support modern holistic practice – think about dealing concurrently with mental health issues and AOD challenges, not each in isolation.

Get people to think big – to imagine a life where all the important elements have come together. These would be phase-related, for example physical health, emotional health, financial, relational ... however, be mindful that each person is different.

A person is not just their addiction; there are many other parts to them “what other parts of your life are there that are working really well?” What are your strengths?

Notes:

Recovery is supported by peers

Get people to do a sociogram of their social links – this is like a mind map of all the people they know and the connections between those people.

It is strongly recommended people stay away from their old drug-using friends, so work out who in the sociogram is safe and
supportive, and who they might need to ‘let go’ – the clinician’s/friends/families job is to help people link with new communities of people who can support their changes. Self-help groups are great for this.

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<th>Recovery is supported through relationship and social networks</th>
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<th>Ask people to identify three people they want in their lives, and work towards enabling them to achieve their goal.</th>
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<td>Help people repair broken relationships by increasing their communication skills and encouraging them to apologise or understand the part they may have played in the breakdown.</td>
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<tr>
<td>Relationships and friendships are usually formed through mutual principles and common goals. Being a member of a group can confer meaning, status and a sense of belonging. Find out about the things your clients believe in, then you can find/recommend connections with these groups.</td>
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<th>Recovery is culturally based</th>
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<th>Don’t pretend to know about a person’s ‘culture’ unless you are truly in it. Even then, assume nothing.</th>
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<td>It is important to ask people what role alcohol or drugs play in their particular community</td>
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<td>If, for whatever reason, you make a mistake with a client – a genuine apology is much better than pretending it never happened.</td>
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### Recovery is supported by addressing trauma

It may help to use a parallel timeline linking trauma with drug use: On a large piece of paper draw a line across the middle, marking years of life along the line (1-5, 6-10, etc). Get person to mark drug use below the line (when it started, escalated, tried to stop, etc), then mark significant events above the line. This can help identify important connections between drug use and life events.

**Notes:**

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### Recovery involves individual, family and community strengths and responsibility

Ask people about their strengths, what they have found easy, and what works for them.

Celebrate people’s successes and achievements, for example ...

Remind people of how much they have already overcome personal obstacles.

**Notes:**

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### Recovery is based on respect

In the 80s, clients were encouraged to give themselves affirmations in the mirror and tell themselves they were doing well and were good people. One of the affirmations was “every day, in every way, I’m getting better and better”. Many clients found this ridiculous and felt like failures, so they were encouraged to say “I’m good enough” or “I’m all right”. These days we are more likely to elicit positive feedback from people in groups and we ensure the feedback is specific. So rather than saying “John is a good bloke”, we might say “I liked it when John gave me his chair in front of the TV”. This type of activity can lead to a growing sense of self as being ‘all right’.

**Notes:**

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Definitions of Recovery

Various definitions exist to describe recovery, with subtle differences between definitions. If you would like to know more about these definitions, some references have been supplied at the end of the document. Some of the most cited definitions include:

- ‘Recovery means gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self. Recovery is not synonymous with cure’ (WHO, 2013)

The World Health Organization established their Mental Health Action Plan for 2013-2020, which includes AOD, uses Recovery as a core objective. The emphasis is on quality of life, wellbeing and listening to and working with the individual. It uses peer support to help people achieve their goals, offers encouragement and creates a sense of belonging. In addition, multiple services support people at different life-stages, and in so doing, ensure people’s human rights are met, eliminating stigma and discrimination. Recovery does not impose drug-free living, nor profess to offer a cure.

- ‘Voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society’ (UK Drug Policy Commission, 2008)

The UKDPC recognises that recovery from AOD is made up of a range of factors in addition to substance use, such as health and wellbeing, and will vary from person to person dependent on resources and priorities. Therefore, measuring recovery simply in terms of substance use will not capture many important personal and societal effects. Since recovery is a deeply personal journey, what is important to one person may have little relevance to another, and will vary from family to family. Therefore recovery in this context is the recovery ‘process’. The UKDPC also recognises that ‘recovery’ implies getting over something and returning to a previous existing state, which may not be the case for some people. For example, a person may not have had a previously fulfilled life, so therefore may not want to return to it. In these instances, ‘recovery’ may be considered as a means to regain missed opportunities.

- ‘A voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship’ (Betty Ford Institute Consensus Panel, 2007)

The Betty Ford Institute uses abstinence as a core component in its recovery definition, and it is considered a necessary component. Sobriety is timeline graded: early sobriety = 1-11 months, sustained sobriety = 1-5 years, and stable sobriety = 5 or more years. However, it is recognised that abstinence is not the only factor in recovery, which is multidimensional by nature. In explaining citizenship, quality of life is discussed in the context of the WHO-QOL measurement tool, which looks at physical and mental health, and social and environmental factors such as friend/family networks, living arrangements, safety and access to facilities and services available to the wider population.
Ten guiding principles of Recovery

- Recovery emerges from hope
- Recovery is person-driven
- Recovery occurs via many pathways
- Recovery is holistic
- Recovery is supported by peers and allies
- Recovery is supported through relationship and social networks
- Recovery is culturally-based and influenced
- Recovery is supported by addressing trauma
- Recovery involves individual, family, and community strengths and responsibility
- Recovery is based on respect

An overall quality of optimism is embedded in the above guidelines. This is in contrast to the pessimistic view by some that addiction is a “chronic relapsing condition”, and that people who are addicted to substances are seen as responsible for their addiction; as though their condition is self-inflicted (O'Brien & Thomas McLellan, 1996).

A description of each of the guiding principles, what they mean, and how to incorporate them into practice, is outlined below:
Recovery emerges from hope

“The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them ... Hope is the catalyst of the recovery process.” (SAMHSA, 2012)

Creating a culture of hope is vital to enable people to ‘see’ themselves in recovery. People go into recovery for a variety of reasons. Some people need evidence that sustained change is possible, for some a family event acts as a trigger, while for others it might be a shift in personal circumstances, or a connection with the ‘right’ practitioner which makes recovery a possibility.

Recognising the need to change and understanding how to do it, does not happen all at once. It takes time for this process to happen. The practitioner can help by being supportive and persuasive, and listening rather than commanding a response. Adopting reflective listening skills can help, for example, paraphrase and restate the words and feelings of the people you are talking to. People must feel they are accepted and not judged.

For people in recovery, the belief that a renewed or re-invigorated self is a possibility helps them see there is a ‘light at the end of the tunnel’. Without hope, there is no driver to change. Hope is important because recovery may be full of frustrations and hurdles. The clinician can foster hope in people by providing information, books, DVDs, websites, and exposure to peers and peer workers, encouraging and facilitating people to attend peer groups.

When recommending DVDs or websites, it is a good idea to sit with people and watch together. You can discuss the content and answer any questions people may have.

Many people are surrounded by drug-users and may not have seen anyone recover. Therefore it’s extremely helpful for people to see someone who has ‘been there, and come out the other side’!

There are some important life questions to ask people:

- what was life like before drugs? (this is a sensitive question asked with care)
- where did you hope you’d be at this point in life?
- what were your dreams when you were young?
- what did you think of people who used drugs when you were younger?

Did you know

the simple act of taking a person out for coffee can give a feeling of hope for the future to someone in or contemplating recovery?

Tip

- Emphasize achievements and successes, and highlight progress using affirmative language

- Comment on behaviours and events that signal improvements and remind people of these
In doing this, you try to find the incongruence between who people would like to be and who they are now. Explore:

- their belief about change
- the areas in life where change is possible
  - general health
  - finances
  - relationships and parenthood
  - employment and study

Recovery is person-driven

“Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals.” (SAMHSA, 2012)

Although recovery requires the input and attention of others, it is still a self-governed process. The person in recovery has the power to make choices dependent on their awareness of their capacities and limitations, available treatment options and their recovery goals. This will lead them to reach the highest level of independence with which they are comfortable and capable of achieving. Even so, in the early phases of recovery, people are at their most vulnerable and may not have the power to make decisions, or appropriate decisions.

In linking people with support, clinicians should make sure the support is accessible – the person must be physically able to get to support (transport, finances etc), referrals should have available spaces, (beds etc) ... it is not enough to simply hand over a list of support groups and expect the person to make an appointment and attend. If people are set up to fail, this will have a strong impact on their hope for success in the future. To ensure people connect with support, the clinician could organise appointments, make sure space is available, and if a service has an ongoing waiting list, devise a plan of support to be followed in the meantime.

Recovery needs to be phased-based and the phases will vary according to the individual concerned. Much has been written about stages of change in relation to AOD and will not be covered here. However, if you wish to find out more about this, you could take a look at one or two of these articles: Stages of change (Norcross, Krebs, & Prochaska, 2011), Applying the stages of change (Prochaska, Norcross, & DiClemente, 2013).

Could people achieve their goals more easily if they modified their drug use?

• In the beginning, often people don’t know what to ask for. Firstly, establish that basic requirements are being met (somewhere to live, money to buy food). Each person is different, so their journey will be different. Ask them what they wish to achieve, and offer suggestions about how to get there.

• When people are ready, it is helpful for them to explore personal interests. It is important they don’t ‘put all their eggs in one basket’, so suggest they look at a range of potential interests.
Bella B’s story

“I had no capacity to make decisions or think for myself, yeah, none. I really stress that issue … or some people may think, oh they’re just a drug addict, why don’t they just stop taking drugs, they’re so selfish. I didn’t actually have the capabilities to stop. I didn’t understand when I stole from people or when I did the wrong thing, that it was wrong and that I was breaking the law and that I was hurting people. I had no idea that that was what I was doing, because when I take drugs I’m not me, like that’s taken away from me. My soul and my identity and who I am is out the door. I’m just a shell of drugs so I have no capacity to make decisions. In fact, I’d make very dangerous decisions.”

[Interviewer: When did you notice that your capacity to make decisions was coming back?] “Probably at about three months clean. It was about 90 days of sobriety I started to form judgments or views on other people, whether they were good or bad … I understood what I wanted and what I didn’t want, to a certain degree … at about three months clean I realized that I really needed some strong people in my life to help me stay sober.”

There are many pathways to recovery

“Individuals are unique with distinct needs, strengths, references, goals, culture, and backgrounds— including trauma experience — that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches” (SAMHSA, 2012)

There is no single road to recovery, and the journey is different from person to person. Some people thrive on drug substitution therapy, some on counselling, while others find the help they need in mutual support groups. The clinician’s job is to appreciate the person’s needs, strengths and interests, and to understand the range of opportunities for people including admission criteria and waiting list management. Offer the person options that will resonate with the person – perhaps DVDs, introductions to peers, links to websites in the office (many people will not have internet access or phone credit, so you need to find ways of filling this void), engage them in discussions regarding these options and provide them with effective referrals including providing or arranging assertive outreach where available.

There are eight formal treatment and support options currently offered across Victoria. These are:

- Counselling
- Therapeutic day rehabilitation
- Non-residential withdrawal
- Residential rehabilitation
- Residential withdrawal
- Care and co-ordination
- Drug therapy
- Youth supported accommodation
Some of these services may have waiting lists so it is important to consider how you will manage treatment options in this situation. As a clinician, best practice would suggest you contact the service before client referral. If there are waiting lists, you will need to find a way to support people while they wait for beds or spaces to become available. Peer support groups can be extremely helpful, as can AA, NA and SMART Recovery groups — although it should be stressed that these groups are excellent in their own rights and not merely a stopgap. Mental health care plans which are organised through GPs may also be a useful support in the interim.

It is important that people are offered choice and not just one treatment type ... and treatments should be appropriate for the person’s needs. If people are offered one form of treatment without consideration into its appropriateness, again, people are set up to fail which can see their hopes destroyed along with their confidence in a system set up to help.

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**Did you know**

‘pathways’ don’t start from the initial clinical meeting? They start before that. Find out from the client “what is the pathway that brought you here?”

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**Geoff’s story**

“... the nurses were really caring ... all the nurses that worked there were trained in group facilitation, so they would sit in and all of the counsellors there were drug addicts, either alcoholics or drug addicts themselves. At an intellectual level I really understood it all and I thought, wow, this is amazing. That was a 12-step program. I remember reading the steps and the traditions and thinking, wow ... if all these people are living these things, what an amazing place it’s going to be.”

**Bella B’s story**

“I had a lot of external help. My parents were very supportive of me once I told them what was going on. They didn’t really know and for a long time I lied to them because I was scared, yeah, I was scared, but I had a lot of help from [them] ... So, I started doing counselling before my first rehab stint ... it’s like a detox rehab. I had help from my GP as well. While I was in rehab I got aligned with a psychiatrist and support workers and stuff like that, which really helped me along my journey, and even though I kept relapsing and went out and used again, by the time I was 18 I knew what was there. I knew what services were available to me, I knew that they existed.”

**Evan’s story**

“I was pretty lucky because I knew some people who were financial counsellors, and I knew some people who were also working in AOD and they were really willing to point me in the right direction. Some of those directions were not just detox, but it was suggested that maybe I go to rehab, and that happened, and I went to rehab in a different state. Then from there, I was pointed in the direction of a supported accommodation, and I did that ... I was really guided by all these people who I had complete trust and faith in because they’d shown me that there was another way to move forward and, as long as I kept putting my hand up for help, the help was there.”
Recovery is holistic

“Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated” (SAMHSA, 2012)

Garth’s story

“We come from a very holistic approach. So recovery, it’s a very nuanced and multi-faceted journey and it’s very, very individual. Everybody’s idea of recovery is really different. I think it’s really important to tease that out with the client really early on. Some people don’t want abstinence. They might want to learn about harm minimisation, how to inject safely, reduced use, lessening the impact that substance misuse has upon their life. So, we go from there.”

“… from that, we look at a very holistic way. Does that look like individual counselling? Does it look like group therapy? Does it involve care and recovery co-ordination? It’s about re-engaging back into the community. It’s about education.

So we try to come from all angles and we try not to be just really set in one approach. That means engaging services, multiple services.”

Just as drug-use can affect almost every element of a person’s life, from being more vulnerable, to health crises, to losing sight of their ideals and dreams, recovery can give people a chance to ‘reset’ their lives. Recovery can help people achieve a more grounded life, integrating mind and body in regards to family, friends, work and the community.

Some people want to address their early life trauma (more about this in ‘addressing trauma’ section), whilst others are keen to get back to work. Some want to mend relationships with their children, whilst others want to avoid that distress and feel judged if this is discussed. We must ensure that clinicians’ biases about priority do not limit the client’s investment and plans.

Research shows that one of the basic elements of the recovery process is to take back one’s life, to revive previous identities and create new ones (Sheedy & Whitter, 2009). Frequently people in recovery have to re-establish connections with family and friends, whilst at the same time, removing themselves from relationships and environments that are linked to their addictive behaviours. Positive support, whether it is from family, friends or the community has shown to be key in maintaining recovery. Social support is vital in facilitating recovery. Indeed, experts say the lack of social support and interaction can have a negative impact on recovery and place people at risk of relapsing (Venner et al., 2006).

• Although Recovery is holistic, it doesn’t mean everything has to be done at once; people need different things at different times in their recovery
**Recovery Capital** is the term used to describe the supportive resources that can be drawn upon for a person to achieve and maintain recovery. These resources can be relationships, finances, knowing how to access information, emotional support, housing and a host of other factors (Best, 2012).

**Joe’s story**

“... I think connection is the biggest part of my recovery. I suppose not to feel alone, not to feel isolated, to feel part of a greater good. Really, I think that a lot of people look at connection as the opposite of addiction. For me it definitely was. That was my experience.”

“... Well it was a long time ago, but this counsellor had the ability to connect with people in early recovery. So he had the ability to speak the language of using the terminology that I would use, of swearing, because that’s the form of connection. He didn’t dress up, so he wasn’t intimidating. He didn’t use any big words, he just spoke like I was speaking to someone who I just met on the street who was using. He just spoke the same words. He came from the same world. So that’s what was the important part I suppose.”

“... Well, I mean I do everything with a lot of people these days. I connect and we go out and we do things like just normal things.”

**Recovery is supported by peers and allies**

“Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness” (SAMHSA, 2012)

The word ‘contagion’ is used frequently in Recovery. William White explains the contagion of addiction is spread like an ‘infection’ (that is, it is passed from one vulnerable person to another). On the other hand, the contagion of Recovery is spread through ‘affection’, and the people who spread the affection are called ‘Recovery carriers’ (W. White, 2010). These ‘Recovery carriers’ can be likened to peer workers. Details of William White’s work can be found at the end of the document.

**Did you know**

*recovery can be contagious?*

Recovery can be ‘spread’ through the support and kindness of people with lived-experience

Peer support groups, otherwise known as self-help groups, have played a major role in recovery. People who have lived-experience can offer first hand support from someone ‘who’s been there’ and can understand the vulnerabilities and challenges that might be present along the way.
Peer support workers offer much more than just assistance with treatment, they also provide hope, role modelling and shared experiences for problem solving. Experts have described four key themes to explain the way in which peer support works (Mead & MacNeil, 2006). Firstly, peer-learning – there are associated benefits when people learn from each other’s lived experiences. Secondly, a two-way support system evolves when people help others; in helping others, people also help themselves. Thirdly, empowerment is engendered by believing that recovery is a real possibility, and taking ownership of recovery for it to happen. And finally the fourth theme, advocacy – people learn to become advocates for themselves and others.

In the AOD sector, peer support is often observed in two ways – unplanned and planned. Unplanned tends to occur when people with similar experiences and goals connect with each other, for example, people attending treatment services. This type of support is valuable and offers a unique insight for the people concerned. Planned peer support is when organizations make a concerted effort to provide opportunities that take on a supportive role, for example, one-to-one mentorship where the mentor is further into the recovery journey than the person being mentored. Unplanned and planned peer support are equally important and work alongside each other. Indeed, as mentioned above, unplanned peer support is often a consequence of formal treatment settings. People generally value the opportunity to engage with each other, although this is not the case for everyone (Pickard & Clancy, 2017).

Peer support may be face-to-face in a confidential setting, or it may take the shape of a (confidential) phone line service or an online forum. Peer support can also be beneficial for the whole family. Increasingly, families come together to help and support each other. This type of support is frequently seen in the many self-help groups available where people with similar problems or situations meet to offer support, encouragement and practical advice. These family groups are flexible, and provide a unique service, not available from the professional service alone.

The three main peer support groups widely available in Victoria are Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and SMART Recovery, but there are many other support networks available. Alcoholics Anonymous is a fellowship of men and women who share their stories and offer strength and support, to help each other recover from alcoholism, and follow the 12-steps program.
Twelve-step groups are typically the service people think of in relation to peer support (Pickard & Clancy, 2017). These programs are based on a set of guiding principles the person follows in their recovery journey. The program covers factors such as: identifying the problem, becoming open to receiving help, reflecting on the past, identifying and changing patterns, making amends for hurting people, focusing on repairing relationships, practicing mindfulness and generosity. The essence of the 12-step program is that people are there to help and support each other to achieve abstinence and/or maintenance from drugs or alcohol, through these stages. Twelve-steps is a valuable tool for some people, but the practitioner should be mindful that it is one of many peer support services available to people, and may not suit everyone.

Narcotics Anonymous came out of the AA program and is available worldwide. Like AA, NA is a fellowship of men and women who help each other through the 12-steps program. Its aim is to offer a means whereby people can help each other stop using drugs and explore a new way to live.

SMART Recovery is a group-based support that offers meetings using self-empowerment to help people with addictions related to drugs, alcohol, and gambling, eating, shopping and other addictive behaviours. The program is based on a 4-point structure: 1. To build and maintain motivation, 2. To cope with urges, 3. To manage thoughts, feelings and behaviours, and 4. To lead a balanced life. SMART has its roots in science, leaning on cognitive-behavioural therapy and motivational interviewing techniques.

Victoria’s story

[of the 12-steps group] “The counsellor at the outpatients program also was a recovering drug addict and I got introduced to a 12-step fellowship as part of that program. Because I had spent my entire life thinking I was the only person who felt the way that I felt, and used drugs the way that I used drugs, and lied the way that I lied, and cheated the way that I cheated, and did all those things that went against my values and morals, to finally come across another human being who has been there and who understands and who is an example that you can actually get better, he gave me that extra push to try it. It’s been the idea of addicts helping one another that has allowed me to get to this point where I’m still clean today. Yeah, that’s exactly what it is … When someone finally puts a label to a feeling or tells me that the way that I’m feeling, that they’ve gone through it and that it does go away, or someone just can show me that I’m not alone, that loneliness factor is what perpetuated my using”

Did you know

people are more likely to attend a support session if someone from the group comes and picks them up or if their worker takes them there? It is also true that people are more likely to attend if they know what they are likely to expect.
It is important for the practitioner to acknowledge it is not enough to simply refer a person into one of these groups – the person needs to attend a group. A small study was carried out on a group of people who were in treatment. Half were given details on available meetings, and the other half were given the same referral plus access to a ‘buddy’ who would take them to their first meeting. All the people in the ‘buddy’ group attended a meeting, whereas nobody in the standard referral group went to a meeting (Sisson & Mallams, 1981). This highlights the importance of active participation (also known as active referral) when providing a support role.

Even so, not all people will have the skills available to them to confidently go out into the social world and freely engage with others. Explain to people that everyone feels uncomfortable and a bit uneasy when doing something new, and they are not alone in this. They may feel awkward the first time they attend a group session, but you will support them through a few sessions. Explain that when people go somewhere new, they’re buddied-up with someone. Some skill building might be necessary for some people, as well as helping some address and overcome social anxiety. It might be more appropriate for people to start off with support they feel comfortable with, such as DirectLine (telephone support). As mentioned earlier, if people are set up to fail, this will impact on their hope for success in the future.

**Recovery is supported through relationship and social networks**

“No important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation” (SAMHSA, 2012)

Frequently our social connections give us support and the physical or emotional resources required in day to day life. These social networks are an important part of life for many people, and come in a diverse range of settings. They might be family ties, friends, interest groups, fitness activities, spiritual connections, cultural communities, peer groups, and a whole host of other activity groups not mentioned here.

Similar to the explanation earlier about ‘Recovery contagion’, the supportive social environment in which recovery is spread may be referred to as the social contagion of recovery. This describes how patterns of behaviours may spread and exert an influence within a social group of like-minded people, or with groups of people with similar experience (Best & Lubman, 2012).

Evidence shows that the attitudes of people in our social groups can influence our own attitudes and behaviours, and relate to our identity (Best et al., 2016). These influences may result in poor health-related behaviours or positive ones. The term ‘social identity’ is used to explain how we see people in our ‘group’ as part of who and what we are (Dingle, Stark, Cruwys, & Best, 2015).
For some people, a ‘substance user’ identity may be a big part of who they are and a big part of their social group; in order to stop using drugs they may need to remove themselves from that social group. Certainly, some experts say that a big part of recovery from addiction is for people to transition to new social identities (Dingle et al., 2015). As clinicians, we should be mindful of how best we can help support people to make connections with others in social groups.

Drug use can play havoc on people’s relationships. Hearts are broken, trust destroyed and families left bereft. Clinicians can explore the importance of relationships with people and ask them to identify three people they want in their lives. Even if people say they want a partner and have children yet this seems unlikely, we never reject their ideas, but we might ask them what they want to get from these relationships to see if other people and networks that are more accessible might meet their needs.

Recovery has cultural dimensions

“Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual’s unique needs” (SAMHSA, 2012)

As with many things, culture is intrinsically linked with why we do what we do. Recovery is no different. A person’s recovery is shaped by their culture, beliefs and traditions.

‘Culture’ not only relates to a person’s ethnicity or racial group, it also connects with a whole range of lifestyle factors. For example, Australia has a strong drinking and drug culture—it appears quite normal for people to come to work complaining of hangovers and have others find it acceptable, even charming. When someone wants to step out of that culture, it’s important to discuss the importance of culture, what it means, how it impacts on relationships and events, and methods to swim against the tide.

The LGBTQI community experience higher rates of alcohol and substance use than the general population. The Center for Substance Abuse Treatment (CSAT) suggests the community is also more likely to drink heavily through adulthood, and be less likely to abstain from use (SAMHSA-CSAT, 2012). Even so, it should be made clear that problematic alcohol and drug use in the LGBTQI community is not the default position, and occurs only in a minority of people.

Many LGBTQI people live high stressed lives caused partly by prejudice, discrimination and being marginalized by society and this may impact on recovery.

Did you know

family and friends have a profound effect on the success of treatment – if they are in recovery or not actively using drugs, relapse is greatly reduced
Clinicians can help LGBTQI people by:

- not presuming a client is heterosexual
- becoming knowledgeable about the coming-out process
- dealing with one’s own prejudices
- taking steps to ensure the physical safety of the person if in danger
- becoming familiar with health issues including violence related issues, and promptly referring to relevant services where necessary

Within the LGBTQI community it is still hotly debated as to what comprises LGBTQI ‘culture’. LGBTQI people come from all walks of life and cover many backgrounds, racial groups, levels of educational attainment, and geographic locations, and so on. By definition, the LGBTQI community comprises people who are lesbian, gay, bisexual etc who may have their individual ‘cultures’ as such. It is therefore essential the clinician be culturally sensitive in every aspect ...

- How might lifestyle be viewed in a person’s culture?
- Is alcohol and drug consumption acceptable in a person’s culture?
- How may these factors impact on the person?

The notion of ‘mateship’ in Australia has a long proud tradition and is connected to national identity for a lot of people. The culture of alcohol consumption is synonymous with mateship. For some, to not drink alcohol or deny the offer of a drink is almost considered an insult. Similarly, sport and alcohol consumption are joined at the hip, and are often part of the Australian identity. It is important for clinicians and practitioners to understand how these factors may impact on people, and to talk through issues and/or provide strategies to deal with particular situations.

Work-culture can also be a sizeable source of stress. Although most jobs at one time or another can be stressful, some jobs have a high association with substance use. Pressure to meet quotas and deadlines, delivery of top-quality care or service in a fast-paced environment, combined with the stress of long working hours and for some jobs, access to drugs – these situations and more can increase the likelihood of people becoming addicted. This is not to say that all people in highly stressed jobs actively use drugs, but for some, it is a coping mechanism.

Some people carry a heavy burden of shame because their profession is considered ‘respectable’ in society. For those people it helps to meet others in a similar position, so they can see there are many people around, just like them. Group work is often very helpful in these situations.
Culturally appropriate aspects of an individual must be acknowledged and utilized for effective recovery (Flores, 2000). It is important to ask about people’s cultural background and how close they feel to the culture. This can be done with visuals where the person draws some cultural symbols and then places themselves on the page in relation to those symbols – close or far away. A graphic image such as this can help some people explain their situation. When engaged with an image people are somehow freer to talk about their inner world – you and they looking at an image, them telling their story. It is not enough to link people with what the clinician believes is their culture without exploring their relationship to that culture. If the person feels great shame, that must be talked through first. This is where peer workers can work so well.

**Did you know**
Indigenous people are less likely to drink alcohol than other Australians. And people whose main language at home is English are more likely to drink alcohol than those whose main language at home is not English? (Commonwealth of Australia, 2009)

| Mark’s story | “... Galiambile was able to help me reconnect to my culture as well, which is something which had probably fuelled the fire of my no-identity. I had no idea who I was, because my father was the Aboriginal in the family, and when he passed away, because he was through foster care, I couldn’t nail that family tree. Since being there [Galiambile], I’ve had help finding my identity, my culture. I paint; I do the Aboriginal dot paintings. I’m now playing the didgeridoo. I immerse myself in the culture today because I now feel comfortable there. Where I couldn’t, say, yesterday, because I didn’t have that identity. I didn’t feel part of it, and now that I do ... I’m very grateful for it.” |
| Garth’s story | “Working with the LGBTI community has been really interesting and challenging. Meth is a real problem for men who have sex with men, so that doesn’t just necessarily mean gay or bisexual men. We encounter a lot of men who have sex with men who don’t identify as either gay or bisexual, maybe queer, but we know the evidence shows us that members of the LGBTI community have high prevalence rates of mental health issues, high prevalence rates of alcohol and drug misuse.

I think it’s very cultural, as a community it’s quite a social community. Going back historically, a lot of meetings were done in backrooms of bars and pubs and things like that. They tend to be a party scene so a lot of alcohol was used. I think that was to reduce inhibitions. So, I think there’s this almost cultural and social expectation of members of the community to engage in that behaviour. Then I think as time goes on, we just become quite habitual around those things.” |
Recovery is supported by addressing trauma

“The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration” (SAMHSA, 2012)

In a clinical situation, it might be wise to assume the client has experienced some level of trauma in their lives. It may involve the family and relate to their own or others’ alcohol and/or drug use. If illicit drugs are used, the trauma may be due to the purchase of drugs and earning the money to buy the drugs. The trauma may come from any aspect of life. Whatever the trauma, the consequences of traumatic life events can be very serious and the person will need to be guided by a professional.

The likelihood of trauma means care must be taken with communication. Eye to eye conversations about trauma can shut down the talking – it’s far too confronting.

Some suggestions for dealing with traumatised clients include:

- avoid shaming language
- behave predictably
- see the person in a quiet room
- ascertain whether or not schooling has been interrupted – if so, this may have impacted on developmental milestones
  - quietly assess if people can read and write before offering them documents to sign

Avoid trying to address too many things at once in the early phases of recovery. It may be better to initially deal with the effects of substance use before delving into the underlying causes of trauma.

In general ... be mindful and sensitive.

Did you know

people experiencing mental health illness have higher rates of drug and alcohol use than the general population?

Recovery involves individual, family, and community strengths and responsibility

“Individuals, families, and communities have strengths and resources that serve as a foundation for recovery ...

Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery.” (SAMHSA, 2012)
In the early phases of recovery, it may be difficult for people to identify and articulate their strengths. They may be separated from their hopes and dreams, with their self-esteem at an all-time low. This makes it difficult for people to see what their strengths are, and if asked, their answers may reflect their state of mind, not their real strengths. Therefore in the early days, sometimes it’s helpful to just ask what people like to do – their answers often indicate their strengths, since most people do what they’re good at doing.

Talking about people’s histories can give a clear insight into their strengths. For example, if someone is a footballer, this means that they ...

- know how to train
- can learn new skills
- are a team player
- learn from their mistakes
- support others
- know that losing is not the end, because there’s another day and another game coming up

If people are struggling to identify their important relationships, get them to draw a sociogram. A sociogram is a type of graphic map where your client places him or herself in the middle. One by one, they add people close or not so close onto the map, depending on their situation. They then add in the community resources in the same manner so they can see how supported or isolated they have been. Sometime later they can draw another map to see the changes they have made. You could even get people to draw a map of their ideal social system, and get them to tell you about it. This can give people a few minutes of happiness as they live, just for a moment or two, in an ideal place.

As mentioned previously, when linking clients to community resources a soft-referral is better than people doing their own referral. Although some people are capable of actively arranging and attending an appointment, this does not work for everyone, and again, people can be set up for further failures. If we want to link a person into a community resource like the local fishing club or NA meeting, it’s much better to find someone to take them there, introduce them around, and be their buddy. It’s up to the service to maintain those connections. It is also very important that the people who help out are acknowledged – provide letters of thanks, invite them to open days or volunteer celebration days so they feel appreciated.

People with strong Recovery Capital do best and one of the most important elements is friends and family. The positive impact these people can have on treatment outcomes is sometimes not considered by some services.
At first, family members may want a break from the crisis and may step back in the early phase of treatment. After they’ve had a rest, they could be approached again and asked if they’re interested in being involved – you could then explain what services can do to help them regain their equilibrium. Family and friends typically know more about the client than anyone else, and generally care more, and are more prepared to invest their time and love than others are able to do.

**Recovery is based on respect**

“Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one’s self are particularly important” (SAMHSA, 2012)

Respect in the context of Recovery relates to the application of respectful engagement with the client, systems that not only eliminate discrimination but protect the person, and include social acceptance. At the same time, respect relates to self-respect and self-esteem.

The community may think it’s more open-minded about drug taking and mental health than it used to be, but that’s not necessarily how clients feel. To help counter this, services embracing the recovery philosophy use a peer support model of care. Clients are exposed to people like them as workers and peers, and as they learn to admire and appreciate these people, they learn that they have the same capacities – *if I’m like you and I like you, then maybe there’s something to like about me.*

People are encouraged to appreciate their own lived experience – experts by experience. This is probably easiest done in treatment where some clients are asked to take a leadership role to help others in the treatment community. They become respected by the community, which increases their self-esteem.

Did you know

*that language plays a pivotal role in building respect? The use of jargon can increase the gap between clinician and client*

- **tip**
  - Showing respect is an expression of empathy and understanding, and therefore requires intentional thinking
  - Use language that is appropriate for the individual

Most people build self-esteem by performing esteemable acts. If people live according to their consciences (which is much easier after giving up drugs), and are encouraged to support, teach others and do the right thing, they begin to see their value – this can kick start their self-esteem.
Recovery involves recognition of the need for change

Before recovery can begin, people must acknowledge there is a problem and have the desire to address that problem. The change in lifestyle might include intellectual, physical, emotional or spiritual factors. Successful recovery is closely linked to the individual’s motivation to change. Without this, people’s goals and aspirations will be less likely to be achieved (DiClemente, Bellino, & Neavins, 1999).

It is not the practitioner’s place to convince people to change. Personal recognition of the need for change is different for each person. For some, a family event acts as a trigger, for others, it might be a shift in personal circumstances, or a connection with the ‘right’ practitioner which makes recovery a possibility.

Recognising the need to change and understanding how to do it, does not happen all at once. It takes time for this process to happen. The practitioner can help by being supportive and persuasive, and listening rather than commanding a response. Adopting reflective listening skills can help, for example, paraphrase and restate the words and feelings of the people you are talking to. People must feel they are accepted and not judged.

**Evan’s story**

“I think that one of the more important points of me actually wanting to get clean and stay clean was that because I had the willingness to do something … there were some professionals around that were willing to help me. Because they saw that there was something that they could work with, and I was really willing … for the first time ever I saw that if I actually put my hand up and said that I had a problem, and that I didn’t know what to do and I’m open to get some help, is exactly when the help came.”

**Mark’s story**

“So I think it was when I decided that if I can’t die from this quicker than I want to, I’m going to die by my hand, I had it all – I knew what I was doing. I knew what I was going to do. I’d driven up to the top of a lookout back in my home town, and I was just breathing heavy, just huffing and puffing. I was nearly hyperventilating because I knew what I was about to do, I’d accepted it. I was like, I’m about to do this. I was just praying that something would just come in and just stop that, just stop that, that fire. I could say, you know, I just had that sense – it’s not going to solve me anything. It’s going to stop my pain but the pain is going to just ripple out through my family, because my father died from taking his own life on heroin … I was angry at him for years thinking that he’d left me, like, why didn’t he think about me? Why didn’t he, why didn’t I stop him from taking his life? But I understand that, today, that him doing that was his way of saving us. Stopping the pain, stopping the hurt which is where I was. I couldn’t stop hurting my family, my friends, anyone I came into contact with – I just could not stop sucking the life out of them. Then, when I realised that the world doesn’t have to change, but I do, that’s when I just made a decision that I don’t have to die. I just need to get well. I just need to do this for me. I need to get myself well.”
Recovery is inclusive

The road to recovery is not necessarily a direct one. It may waiver and include relapse. This is a natural part of the process, and is not considered the end of recovery. People can continue to improve their physical and emotional functioning and grow throughout recovery. For some, the struggle of recovery itself can have positive consequences, such as improved self-esteem and confidence. Good quality of life is the end product of continued improved self-care, and this can be achieved regardless of episodes of relapse.

We’ve discussed in the previous pages ‘what recovery is’ and how to embrace recovery principles. It is also important to be aware of what ‘recovery is not’.

Recovery is not

- based on a set of beliefs which depend on being able to ‘cure’ people’s symptoms.
- a stand-alone system.
- opposed to traditional treatments.
- an approach which holds that patients should decide everything.
- a new method of treatment, it is a way of thinking. Staff cannot make people recover; that is up to the person. However, staff can help the process.
- an approach that only has relevance in mental health. The expert patient, peer support, self-management, choice and control are relevant to the effective management of all long-term health conditions.

The view that recovery is a “chronic, relapsing condition” is rather dated and to some, it has negative, unintended consequences. Academic and writer William White discusses the use of language in illness, including substance use disorders (W. White & Davies Scimeca, 2016). White challenges the notion that people who have illnesses such as cancer, diabetes and other life-long conditions, are referred to as ‘cancer survivors’ and so on – the language is positive and full of hope. Whereas when the illness is a substance use disorder, the language is pessimistic and laden with stigma. This article and others can be found on his website (details at the end of the document).

Recovery helps establish a positive sense of identity and generate a feeling of meaningful existence. Throughout this journey many experience life-changing, positive results including a shift in life priorities, improved relationships with family and friends, and a sense of compassion towards others (McMillen, Howard, Nower, & Chung, 2001).
Recovery capital

Recovery Capital has been referred to a few times in the preceding pages. By now you will understand that Recovery Capital is the term used to explain the combined resources (internal and external) at a person’s disposal that supports them through their recovery journey.

There are three components to Recovery Capital – personal, social and collective Recovery Capital (Best, 2012).

- Personal Recovery Capital relates to the skills and capabilities a person has. This may include education, training and qualifications, but also enablers such as self-confidence, self-esteem, and coping abilities
- Social Recovery Capital relates to the connections people have with others. This might include family, friends, neighbours and the resulting shared commitment between those people
- Collective Recovery Capital can best be explained as the wider resources available, including treatment provision, but also opportunity and safety within the community

Research has consistently shown that people with greater Recovery Capital have better coping abilities, and better outcomes (Best & Lubman, 2012; Best, McKitterick, Beswick, & Savic, 2015; Laudet & White, 2008). Experts have found that people with low severity of drug problems but high Recovery Capital can often sort out their problems via friends and family, that is, without professional help. Whereas people who have high drug severity and complexity combined with low Recovery Capital often require greater levels of treatment resources and have poorer outcomes (W. L. White, 2009). However, do bear in mind that people are individuals with different requirements, so there will be variations in need within groups of people.

Victoria’s story

“The reality was for me that the last two or three years of using ice I really didn’t want to do it anymore. Everything was just too hard and I knew – there was always a part of me that knew that it was killing me and that I actually deserved better than that, but I still couldn’t stop. The fear of people thinking that I wasn’t what I presented really stopped me from actually putting my hand out and asking for help.

The main point of change for me was having a friend who didn’t use drugs, who saw my spiral and actually just showed up at my house and staged an intervention and searched through my room, and put me in a position where I couldn’t lie my way out of it, or fake my way out of it, or pretend like everything was ok.

That was the best and worst day of my life. I felt like – a lot of fear around, meaning that maybe I had to do something else and change my life and stop using drugs, but also this relief that I didn’t have to necessarily do it alone anymore.”
Assisting families through recovery

Families can be a significant source of support for people with problematic substance use. The support offered may be financial, practical (accommodation and provision of food), or psychological. However, family dynamics are often complex and relationships may also break down. This may be due to families using ‘tough love’ on their loved-ones or it could be that the person using alcohol and other drugs removes him/herself from the family. With these various family modalities in mind, the clinician may be called upon to help families navigate their way through their own recovery journeys.

We discussed earlier the notion of stigma and shame through the lens of the person with problematic drug use. However, families sometimes live these experiences too. Parents may have feelings of guilt believing they are responsible for their child’s problems, which may result in their withdrawal from their normal social activities (Bamberg, Findley, & Toumbourou, 2006).

Families’ physical and emotional health and wellbeing may become adversely affected. Evidence has shown some family members experience depression and raised blood pressure (Frye, Dawe, Harnett, Kowalenko, & Harlen, 2008), while anxiety and worry (not knowing where their child is) are experienced by many families (Usher, Jackson, & O’Brien, 2007). Stresses and tensions within the family may have an emotional cost, leading parents’ relationships to breakdown.

Siblings are often impacted by their brother/sister’s drug use. They may try to protect them, or they may experience feelings of resentment. Sometimes siblings are side-lined within the family dynamic. Evidence has shown that often siblings’ needs are overlooked or minimized because their parents are crisis-managing the person who uses drugs, which has ramifications for the sibling (Incerti, Henderson-Wilson, & Dunn, 2015).

Financial pressures may be felt by families. It is not uncommon for family members to ‘pay’ for the drugs their son-daughter-brother-sister needs so they do not have to resort to illegal activities or place themselves in unnecessary danger (Butler & Bault, 2005).

The experiences above are just some of the ways substance use can impact on the extended family. This is not an exhaustive list – there are many more situations, and they will vary from family to family.

Family members need support and practical advice on how best to understand their loved-ones’ substance use, and enable them to help if they can. And to do this, they need to be both healthy and emotionally strong. It is therefore vital that family members look after their own physical and emotional needs. As mentioned previously, the health of family members often can be adversely affected by substance use.
Clinicians can help family members of people with problematic substance use. You may find some of the suggestions below helpful.

### Tips for helping families

- Let families know they did not cause the addiction.
- Ensure families that feelings such as helplessness, fear, anger and embarrassment are ‘normal’ and felt by others in these situations.
- Explain the different treatment options available.
- Explain the various ways drugs are used, and that drug use does not always mean dependence.
- Help families develop a crisis plan with details that include emergency phone numbers, when and how to get help from mental health services, and how to communicate with the person in a crisis until help is gained.
- Encourage family members to tell you what they will and will not tolerate, and help them maintain their limits.
- Explain what strategies have been helpful, and gently encourage families to change their approach if they are not getting the outcome they seek.
- Explain how the person’s drug use can affect the family, and help them recognise subtle signs.
- Describe the ‘stages of change’ concept so families understand lapse and relapse.
- Describe the early signs and symptoms of psychosis and recommend a relevant approach. Emphasize that an outburst of anger does not necessarily mean the person is psychotic – it may just be a sign to back off.
- Remind family members to look after their physical and mental health and wellbeing, and not put their lives on hold:
  - Recommend stress management (if required), a healthy diet, adequate sleep and exercise.
  - Encourage family members to continue their usual day-to-day and social activities.
- Provide information about support services and encourage families to make contact with other families in similar situations.

Adapted from ‘Treatment approaches for users of methamphetamine’ (Commonwealth of Australia, 2008)
Summary

We hope you have enjoyed this document and now feel confident to navigate your way around the finer points of recovery. The following pages provide some useful links for further information and services, so you can add to your knowledge base, should you wish to do so.

Key points

- The objective of recovery is to alleviate symptoms, not to ‘cure’
- The elimination of stigma and discrimination are central to recovery
- Health, home, a sense of purpose and community, support a life in recovery
- Peer support can provide hope, role modelling and experiential knowledge for problem solving from someone ‘who’s been there’
- People with greater Recovery Capital have better coping abilities and better outcomes
1800 ICE ADVICE is a 24 hour 7 day a week confidential helpline that is a useful first port of call for consumers and family members concerned about ice:
Telephone: 1800 423 238

AA (Alcoholics Anonymous) Australia is a fellowship of men and women who share their stories and offer strength and support, to help each other recover from alcoholism. This site provides a tool to find meetings where you live, and online AA meetings:

ACON is a health promotion organization specializing in HIV prevention, HIV support and LGBTI health.

*Building the client’s relational base: A multidisciplinary handbook*. A book by Mark Furlong that describes the practical application of techniques a professional can take to help deepen the quality and range of their clients’ connections with people. The book was published by Policy Press in 2013.

Counselling Online is a 24 hour 7 day a week service offering free, text based support for people who are concerned about their own or another’s alcohol or drug use:
https://www.counsellingonline.org.au/

DirectLine is a confidential alcohol and drug counselling, and referrals service in Victoria. Here you can find a self-assessment, access to help for yourself, someone else and health professionals, and also information about how the AOD sector is changing:

Drug and Alcohol Clinical Advisory Service (DACAS) is a service offered to health professionals:
Telephone: 1800 812 804

Drug substitution therapy (which is called pharmacotherapy). This site provides an explanation and things to know:

NA (Narcotics Anonymous) is a society of men and women for people who experience problematic drug use. The site provides a tool to locate meetings, and also information for health professionals.

SHARC (Self Help Addiction Resource Centre) is an organization that provides opportunities to individuals, families and communities that are affected by addiction. Programs include Residential Peer Programs, Family Drug Help, Peer Projects:
SMART Recovery Australia is a free group program that assists people with problematic drug, alcohol and cigarette use, as well as gambling, food, shopping, internet and other problematic behaviours. A tool to find nearby meetings can be found on this site:

Touchbase provides information, support and services for LGBTI Australians. Topics covered include alcohol and other drugs, sexual health and mental health:
http://touchbase.org.au/

Turning Point (Eastern Health) provide AOD helpline programs, gambling helpline program, gambling help online counselling and support program, counselling help online and support program:

Victorian Government website (health.vic) provides an overview of Victoria’s alcohol and drug treatment system. This site gives a description of the six treatment and support streams found on: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-system-overview

William White is an academic and writer who specialises in addiction recovery and policy. He has an excellent website filled with dozens of papers, journal articles, interviews, book reviews and more:
http://www.williamwhitepapers.com/papers/

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**Emergency help**

National Alcohol and Drug Information Service: 1800 250 015
Fire, Ambulance or Police: 000
Lifeline: 13 1114
DirectLine (VIC): 1800 888 236
Mensline: 1300 789 978
Kids Helpline: 1800 551 800
# Glossary of terms used in Recovery

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Amends</td>
<td>Repaying of debts and harms, either literal or symbolic, which have been accrued whilst actively using drugs or alcohol</td>
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<tr>
<td>Amphetamine</td>
<td>A behavioural stimulant</td>
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<tr>
<td>AOD</td>
<td>Alcohol and other drugs</td>
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<tr>
<td>Biopsychosocial model</td>
<td>A framework for recovery that considers biological, psychological and social factors</td>
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<tr>
<td>CHIME</td>
<td>A framework for personal recovery that considers: Connectedness, Hope, Identity, Meaning (of life) and Empowerment</td>
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<tr>
<td>Doctor shopping</td>
<td>This occurs when a patient uses multiple doctors at the same time without their knowledge, to maximize the amount received of prescription medication</td>
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<tr>
<td>Drug substitution therapy</td>
<td>The use of medication to assist in the treatment of opioid dependence – referrals are required to approved providers and pharmacists</td>
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<tr>
<td>Drug tolerance</td>
<td>A progressive state of diminished responsiveness to a drug</td>
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<tr>
<td>Harm reduction/minimization</td>
<td>Lessening the negative impact associated with a particular behaviour, for example, alcohol or drug use</td>
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<tr>
<td>Maintenance</td>
<td>Stabilisation of alcohol or drug use, either at the lower end of consumption, or cessation</td>
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<tr>
<td>Mutual aid</td>
<td>Similar to peer support, but often used in the context of self help groups</td>
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<tr>
<td>Natural recovery</td>
<td>Recovery without treatment or support groups</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
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<tr>
<td>Peer support</td>
<td>Support from people who have lived-experience of the issue</td>
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<tr>
<td>Pharmacotherapy</td>
<td>A treatment using pharmaceutical drugs</td>
</tr>
<tr>
<td>Personal Recovery Capital</td>
<td>The skills, experiences and capabilities a person has, such as self-esteem, positive identity, qualifications and work experience</td>
</tr>
<tr>
<td>Recovery Capital</td>
<td>The breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol and other drugs</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>The belief in one’s ability to succeed in a specific situation</td>
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<tr>
<td>Self-medication</td>
<td>The use of prescription or non-prescription medication to self-administer treatment for a physical or psychological ailment</td>
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<tr>
<td>SMART Recovery</td>
<td>Self Management and Recovery Training is a non-profit organization that helps people with substance dependency. It uses principles of motivational interviewing, and techniques from cognitive behaviour therapy</td>
</tr>
<tr>
<td>Social Recovery Capital</td>
<td>The social connections and/or networks people have, including family and intimate relationships, that are supportive of recovery efforts</td>
</tr>
<tr>
<td>Social contagion</td>
<td>Ideas, attitudes and behaviour in a group of people are spread through imitation and conformity</td>
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<tr>
<td>Stages of change model</td>
<td>A framework of the different ‘stages’ people can go through in behaviour change</td>
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<tr>
<td>Therapeutic community</td>
<td>An approach that uses active participation in group living and activities, and focuses on the person to drive overall lifestyle change</td>
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<tr>
<td>Trigger/stressor</td>
<td>Something that sets off a past behaviour in relation to alcohol or drug consumption. For example, people, emotions or places associated with previous drug use</td>
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<tr>
<td>Twelve-steps</td>
<td>A set of guiding principles used as a method of recovery from addictive behaviours – originally used for alcohol dependency, now includes AOD</td>
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<tr>
<td>User movement</td>
<td>Service user groups that appeared in the 1960s/70s which raised questions about citizenship for people with mental health</td>
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References


White, W., & Davies Scimeca, P. (2016). Rethinking the characterization of addiction as a "relapsing condition". Selected papers William L. White. Retrieved from
Joe’s story

“… so I did quite a bit of travel that I was able to afford. I chased that dream that I had in me. After a while when I had done that, that dream started to change and I found a new direction. So I went and did a little bit of study and I got some qualifications, and then I went and started to chase that dream.”

“I did that dream and I started to work in the industry, and I’ve worked here and I’ve worked there and that was good experience at the start. I felt like I got to a point where the momentum of that dream changed. Not that I don’t want to do it anymore, but that momentum behind it, that inspiration that it was delivering kind of changed, and it changed into the direction of making hip hop which had always been with me. Then I started to make hip hop and I started to chase that dream. All the time chasing these dreams I’m fulfilled with the hope, direction and purpose, and I’m feeling amazing about it. And you know that gives me the sense of confidence and the sense of self-esteem, and the sense of self that really helps me be the person that gets me through life in a positive way.”