What Contributes to Alcohol and Substance Misuse Recovery While Parenting in Integrated Residential Rehabilitation?

Thesis submitted in partial completion of the requirements for the degree of Doctor of Clinical Psychology

Massey University, Auckland, New Zealand

Laura Stanley

2023

Abstract

Alcohol and substance use recovery while parenting is a complicated endeavour. People in alcohol and substance misuse recovery while parenting have unique and complex needs, which mainstream treatment approaches cannot always meet. Treatment often focuses solely on substance misuse and fails to pay attention to parenting, and most often, parents and their children are separated during residential treatment. Parents often face the tough decision to either take care of themselves or take care of their children. Integrated treatment services, which include both drug and alcohol treatment and parenting support, have been developed to break the often intergenerational cycle of substance use and troubled parenting. These programmes have rendered successful outcomes in participants achieving and maintaining abstinence, improving their mental health, and supporting responsive parenting. However, little is known about what particular factors in integrated services support these positive changes made in recovery while parenting. The current research explores the unique factors that have contributed to parents' recovery at the Family Centre, an integrated parent-child rehabilitation facility. The research additionally illustrates the needs of these individuals in recovery. Experiences of recovery and parenting were explored in semi-structured interviews and case studies with mothers undertaking a recovery programme. Through a reflexive thematic analysis, three themes were constructed: 'The Construction of Self' 'The Therapeutic Milieu', and 'Relational Recovery'. The complex histories and recovery journeys of research participants were given context through the use of case vignettes. The findings highlight the complex and multifaceted nature of recovery while parenting, particularly the role that parenting plays in driving recovery-orientated change. The relational nature of recovery was a prevalent factor in recovery, providing a developing perspective on how recovery is viewed in research and practice.

Acknowledgements

I would like to extend my gratitude to my supervision team, Dr Veronica Hopner, Dr Andrea La Marre, Dr Clifford Van Ommen, and past supervisor Associate Professor Paul Merrick. Thank for your ongoing encouragement and engagement with this project, your patience as I learned, and your knowledge and expertise. Our thoughtful conversations and feedback inspired me throughout the research journey.

To my classmates and friends, thank you for kindness and humour. A special thank you to Olivia, Natasha and Marike, this journey has been so much easier with you all by my side. Thank you for your support and empathy through the difficult times, and all the celebrations and laughs along the way.

To my family, in particular Mum and Dad. Thank you for your love, and unconditional support throughout my whole academic journey. Thank you for believing in me and encouraging me to believe in myself.

To Dane, I could not have done this without you. Thank you for your ongoing patience, support and encouragement. Thank you for being there for me through all the highs and lows. You've made every step of my journey more enjoyable.

To Odyssey, and your staff, thank you for your support and accommodation to complete this project.

Finally, thank you to the amazing mothers who took part. You demonstrated strength, vulnerability and honesty in sharing your stories with me. Thank you for trusting me with your stories, I hope that this project serves to contribute meaningfully to the community.

Table of Contents

List of Figures

List of Tables

Chapter One: Background and Literature Review

Issues of substance misuse have long been of concern and a focus of intervention across Western societies. There have been significant changes in alcohol and substance misuse treatment approaches, which calls for a closer investigation into the experiences of those in recovery. In particular, those who are parenting while in recovery experience substantial shame, guilt and barriers to support (Corrarino et al., 2000; Hankin et al., 2000; Kahler et al., 2003; Silva et al., 2013). Moreover, treatment can inadvertently fail to meet their complex and unique needs. As such, research is needed to provide further insight into the needs of those who are parenting while in recovery, and how we can better support these individuals to make recovery-orientated changes.

This chapter will outline relevant literature within the field. Firstly, a history of common understandings of substance misuse will be presented. Following this, the chapter will explore presenting issues of substance misuse and parenting, followed by an outline of literature on substance misuse recovery whilst parenting. Treatment methods and modalities will be explored, followed by a detailed exploration into the therapeutic community (TC) modality of treatment. Finally, a rationale for the current research will be detailed, as well as the aims of the research. Following this, an outline will be given of the Family Centre programme, the location of the current research, providing an overview to the programme structure and treatment modality. Chapter Two outlines the methodology of this study. A complete procedure of data collection methods will be described, as well as detailing ethical considerations, interview protocols and methods of data analysis. Chapters Three and Four present the findings of this research. Firstly, Chapter Three will provide individual case vignettes for each participant. Following this, in Chapter Five, research findings are discussed and analysed through a presentation of three core themes and their relevant subthemes.

Chapter Five presents key clinical implications from the research, as well the limitations of the study. The chapter also suggests directions for future research in this field.

Evolution in the Understandings of Substance Misuse

Throughout the past century understandings of substance misuse have changed vastly, and as a result the way professionals work with and treat substance misuse difficulties has adapted. Since the 1800s, numerous theories and models of substance misuse have been proposed; however, most were not comprehensive in their views of substance use, and thus perpetuated harmful attitudes toward substance misuse that shaped the views of the public and those who experienced substance misuse. The following section covers only some of the theories and models proposed.

Prevalent in the eighteenth and early nineteenth centuries, the 'moral model' was one of the first to describe substance misuse, claiming that people used substances because they had a moral deficit and lacked a sense of personal responsibility. The moral model conceptualised substance use as an expression of irresponsibility, sinful behaviour, and even evil possession (Lassiter & Spivey, 2018). Within the model, use was seen as freely chosen by the individual, the problem was treated by punishing the individual, and therefore substance use was criminalised. Legal sanctions, fines and jail sentences were introduced. Relapse was considered evidence of enduring evil in the individual and a sign that more punitive sanctions were necessary (Lassiter & Spivey, 2018). Although the claims of the moral models have been debunked, those theories still influence the way alcohol and substance use are regarded today, and the use of many intoxicating substances remains criminalised in society. These models associate substance use with shameful behaviour, leaving people with fear of being punished or blamed, and can make them less likely to seek treatment for their difficulties.

In 1857, the theory of ‘degeneration’ was proposed, which suggested that individuals with a psychological, physical or immoral deficit can transfer a more severe variant of this trait to the next generation (Morel, 1857). The concept was largely based on an evolutionary perspective which suggested that character traits were passed on to the next generation in a family (Hermle, 1986). Furthermore, the theory of degeneration focussed on the progressive nature of hereditary traits, proposing that traits passed on to the next generation would snowball until extinction of that family (Bynum, 1984). The consumption of alcohol and other substances was among the environmental influences that caused degeneration (Bynum, 1984; Levine, 1984). The theory of degeneration provided a medical explanation for alcohol use, but failed to take into account other perspectives influencing substance use, including social, psychological, cultural or systems influences. After medical knowledge increased on the transmission of heritable traits, the theory of degeneration declined (Hermle, 1986).

The temperance movement was also highly influential in bringing issues of alcohol misuse into public discourse (Mann et al., 2000). Proponents suggested that anyone who consumed excessive amounts of alcohol would suffer from alcohol-related problems. The movement argued that alcohol misuse was the cause of poverty, neglect and abuse, immorality and poor health. The movement was promoted by evangelical temperance reformers and church-goers, and among the middle classes, although it was non-religious in principle (Levine, 1984; Mann et al., 2000). The temperance movement additionally lead to the prohibition legislation in the United States (US), where the production, sale, transportation and importation of alcoholic beverages was banned for 13 years. Although alcohol consumption initially decreased by around 50% in the US during prohibition, the production of black market alcohol increased, leading to organised crime and violence (Mann et al., 2000). Although alcohol consumption was prevalent across all socio-economic levels at this time, how the prohibition law was enforced by ethnicity and social class differed

tremendously. Arsiniega (2021) described how race played a significant role in law enforcement, with funding for policing the prohibition being directed depending on race, class and ethnicity. Substance use was additionally viewed differently in society, with use of substances by working class labourers such as African Americans and Chinese individuals being viewed negatively and associated with substance misuse and crime. The movement failed to account for social and political factors that impact substance use experiences. Furthermore, during this time, the prejudices between substance use and minorities was connected, which still permeates in Western societies today (Lassiter & Spivey, 2018).

The first scholar to consider substance misuse to be a medical disease instead of an issue of bad character was Benjamin Rush, in the early nineteenth century, and over subsequent years many researchers, such as Thomas Trotter, T. D. Crothers and E. M. Jellinek, supported the concept and contributed to its development (Crothers, 1902; Jellinek, 1960). Jellinek in particular was influential in Western societies' current understandings of substance misuse as a disease, and saw it as critical that substance misuse be treated medically, instead of through punishment. The 'disease model' was first conceptualised alongside the moral model, where substance misuse was seen as a disease that affected those with 'weak' morals. The model later developed towards being one of a biological vulnerability (Svanberg, 2018).

In 1935 Alcoholics Anonymous (AA) was formed in the United States and the disease model was brought into public discourse (Bill, 1957). Over the next 20 years the AA 'recovery' approach shifted the way in which society viewed and treated substance misuse. Within AA, alcoholism was considered a disease of both the body and the spirit (Gross, 2010). The AA emphasis on religion was influenced by the Oxford Group, a fellowship opposing alcohol use which focused on the importance of spiritual values in daily living (Gross, 2010). In its beginnings, AA called for its members to completely surrender to God

through daily prayer and meditation. AA meetings had a religious basis and emphasised the healing powers of God. Within the AA movement, people achieve recovery through abstinence, and once abstinence is achieved the disease becomes dormant or in remission. This viewpoint is still dominant today within AA practice, and underlies the philosophies for groups such as Alcoholics Anonymous and Narcotics Anonymous (Leshner, 1997; Volkow et al., 2016). Since its beginnings, the theory behind AA has changed. The AA fellowship still promotes complete abstinence, whilst focusing on moral change and personal character. However, nowadays members of AA are encouraged to find their own higher power, and change occurs through this search, together with abstinence and mutual support (Gross, 2010).

Many treatment approaches today involve recognition of the disease concept of substance misuse. The disease model is characterised by an emphasis on altered brain structure and functioning, and assumes that individuals have no control over these. Thus, substance misuse was seen as irreversible (Leshner, 1997). Volkow, Koob and McLella (2016) summarise the primary symptomology that underlies the disease model, as: (1) desensitisation of the reward circuits in the brain; (2) declining function of the brain regions that facilitate decision-making and self-regulation; and (3) an increased conditioned response related to the substance an individual is dependent on. The disease model shifted thinking towards substance misuse being a health issue. As a result, people started to be treated in hospitals or rehabilitation facilities, instead of solely being criminalised and placed in prisons. Although the disease model shifted many people's understandings, some individuals are still criminalised for substance misuse difficulties. Many people still assume that substance misuse is not an issue related to health, and instead assume it as a weakness of character (Meurk et al., 2014). This misconception is damaging, minimising the immense

challenges people with substance misuse difficulties face, and contributes to the stigma experienced.

While the medical model has helped to clarify that substance misuse is not an issue of poor moral fibre, it too has limitations. Understanding substance misuse solely as a disease and treating it as a medical problem fails to take into account the complexity and differences in the ways in which individuals experience substance misuse. The biological understandings of substance misuse are necessary and helpful in many ways, highlighting the physical and chemical functions which are altered during substance use. These understandings have helped inform the use of a number of therapeutic drugs, such as opioid substitution therapy. However, they are not sufficient to give a comprehensive overview of the complexity of substance misuse and its roots in people's biological, emotional, psychological and social and cultural environments. Focusing on a disease model only has led to policy-makers focusing on treatment approaches based solely on medical solutions instead of on the multiplicity of a person's needs (Trujols, 2015).

Many psychological approaches have additionally been proposed to help understand substance use. Freud proposed psychodynamic theories of addiction at the end of the nineteenth century. Although such theories have developed substantially, the basic philosophy behind the psychodynamic approach postulated that past events, thoughts and circumstances shape an individual's present behaviours. Within psychoanalysis, chemical dependence was understood as an associated symptom of underlying psychopathology, rather than as the basis of the disorder. It was believed that past events, thoughts and circumstances result in unconscious processes that cause a person to act in a particular manner. As such, substance misuse was an unconscious defence against hopelessness or powerlessness, and a way to regulate unmet needs (Svanberg, 2018). Freud originally theorised that use of substances was a method to wean oneself from masturbation, which was seen as a self-

soothing mechanism, although this theory was not supported by empirical data (Svanberg, 2018). Other theories postulated that one comes into the world addicted, essentially comparing addiction with the need for nourishment through breast feeding. They proposed that that breast feeding was linked to satisfaction and happiness, and its absence to anger, hunger and frustration. If something was missing or interrupted in the 'oral' phase of development, then addictive symptoms would return later in life (Matusow & Rosenblum, 2013). A more contemporary psychodynamic theory was proposed by Edward Glover who advised that people use substance as an effort to cope with or escape emotional pain (Cordess, 1992; Glover, 1932). This belief still underlies today's understandings of addictive disorders.

The contemporary psychodynamic view aligns with the 'self-medication' hypothesis (Khantzian, 1987, 1997), which suggests that individuals use substances as a means to manage or reduce their psychiatric symptoms. The theory assumes that treating the underlying psychiatric condition may resolve any difficulties with substance use. Post-traumatic stress disorder (PTSD) and substance use commonly co-occur, and research suggests that this relationship may be explained by the use of substances to cope (Hawn et al., 2020). The self-medication hypothesis provides an understanding of what motivates substance use for some individuals, as well as a compassionate view on the use of the substances. However, it has been criticised for drawing attention away from substance use, and focusing on treatment methods that do not address substance use directly (Lembke, 2012).

Many further psychological approaches also sought to understand substance misuse, namely behavioural, cognitive and personality theories. Behavioural theories were the first to be influential in understanding substance use. Wikler (1948) advocated that substance use was strongly influenced by learning principles in particular classical and operant

conditioning. Classical conditioning suggests that learning occurs because of paired associations and ‘cues’. A cue that has previously been present when drugs have been taken will be more likely to elicit a conditioned response (Siegel, 1983). For example, the smell associated with the use of cannabis will continue to elicit the desire to use cannabis. This association is thought to underlie craving, and may explain why someone who was dependent on a substance but has been abstinent for some time still experiences strong cravings. Operant conditioning was another influential behavioural theory. It proposes that negative reinforcement (pain avoidance) and positive reinforcement (pleasure seeking) contribute to understandings of how substance use disorders are developed and maintained (Cavaiola & Smith, 2020; Newton et al., 2009; Stewart et al., 1984; Wikler, 1948). These approaches brought substance misuse, which at the time was largely seen as a medical issue, further under the lens and discipline of psychology.

More recently, social cognitive theories have provided considerable insight into the pathways to risk for substance use disorders. Such theories suggest that observation and modelling by role models can lead to substance misuse. These theories are significant, as they describe the development of adolescent substance use and contribute to people’s understandings of intergenerational substance use. People are more likely to observe and learn from role models who hold influence and power, making peers, older siblings and parents particularly influential in this model (Kilpatrick et al., 2000; Sussman et al., 2000). Adolescents are particularly susceptible to the influence of their peers’ drinking behaviours, and often drink to socialise and fit into the norm (Smith, 2020).

Other psychological theories also contribute to people’s understandings of substance use. Cognitive theories suggest that thoughts and beliefs act as a motivator to engage in substance use. Throughout people’s lives, their experiences contribute to the development of each individuals beliefs. These include beliefs about ourselves, others and the world in

general. Beck (1993) suggested that cognitions and beliefs have a strong influence on emotions and operate to influence behaviour. Cognitive theories hold that thoughts or beliefs may activate urges or cravings to use substances as a means of coping with negative emotions (Beck, 1993). Furthermore, a person may feel a need to consume substances to have fun, or believe that other non-substance-using activities will lead to boredom, and such beliefs will drive their behaviour (Beck, 1993; Cavaiola & Smith, 2020).

Personality theories have proposed that certain individuals were more prone to substance misuse, or have 'addictive personalities'. Eysenck (1997), for example, suggested that drug use develops to serve a purpose related to an individual's personality. In particular, the personality trait of impulsivity has been identified as involved in the initiation and maintenance of substance-seeking behaviour, as well as in relapse following periods of abstinence (Dawe & Loxton, 2004; Moallem & Ray, 2012). Personality theories alone simplify the complex difficulties of substance use, and no specific traits or cluster of personality traits have been identified to fully account for the onset or maintenance of substance use. However, personality traits may be a contributing or vulnerability factor (Moallem & Ray, 2012).

By the 1980s, thinking around substance misuse had been expanded to bring together biological, medical, psychological and social approaches (Engel, 1977). The biopsychosocial approach suggested by Engel was significant and central to current understandings of substance misuse, and to the ways in which to work effectively with those who experience difficulties in this domain. The biopsychosocial model brings the biological, genetic, psychological (thoughts, feelings, behaviours, personality styles), social, cultural, and environmental dimensions of a person's life together in understanding the complexities of substance misuse (MacKillop & Ray, 2018).

Engel's model placed attention on sociocultural factors, not just for individuals, but for society as a whole. From such a viewpoint, it is the worlds in which people live that has an impact on substance use. This model links inequity and drug use, suggesting that people who are disadvantaged socially and culturally are more likely to face difficulties with substance misuse (Roget, 2009; Smith, 2020). For example, identified risk factors for substance misuse include alcohol advertisements being more often found and illegal drugs being more readily available where socioeconomically disadvantaged people live and community poverty exists (Kendler et al., 2014; Sudhinaraset et al., 2016). These are identified as some of the factors of systemic or structural racism, and are linked to health inequalities for individuals, with systematic racism being directly related to an increase in substance use (Gilbert & Zemore, 2016; Smith, 2020). Furthermore, cultural norms regarding drinking patterns have a significant influence on the use of substances. Different cultures and countries have different views and beliefs regarding the consumption of alcohol and substances, and this is identified to have a large impact on how substances and alcohol are consumed.

Diagnosing Substance Misuse

Alongside the development of multiple theories of substance misuse, the ways in which substance misuse was diagnosed has progressed significantly throughout the years. In 1952, the DSM-I first classified alcoholism and drug addiction as arising from a sociopathic personality disorder (American Psychiatric Association, 1952). This definition was proposed by psychoanalyst William Menninger, and therefore largely influenced by psychoanalytic theories (Wilson, 1993). In 1968 when the DSM-II was published, alcoholism had been recognised as a medical disorder; however, little changed in terms of its psychiatric classifications (American Psychiatric Association, 1968). Published in 1980, the DSM-III was considered a major milestone and reflected research in the field at the time, specifically

the medical model. The DSM-III marked a shift from psychoanalytic dominance to the rise of descriptive psychiatry. In the DSM-III, substance use disorders gained their own classification, and no longer used the term ‘alcoholic’ in their descriptions. There was additionally the development of categories for substance abuse and dependence, where abuse was considered ‘milder’ to dependence (American Psychiatric Association, 1980). DSM-IV and DSM-IV-TR made small changes to diagnostic criteria, but did make a distinction between physiological and substance dependence, by adding specifiers with, or without physiological dependence to the criteria (American Psychiatric Association, 1994, 2000).

DSM–5 integrated the two DSM–IV disorders, substance abuse and substance dependence, into one single disorder called ‘substance use disorder’, with sub-classifications of mild, moderate and severe. Within the DSM-IV, legal problems were removed as a criterion for substance use disorders, and craving was added (American Psychiatric Association, 2013). Within the DSM-5, substance use disorders are defined and diagnosed by the use of one or more substances leading to a clinically significant impairment or distress in an individual’s life (APA, 2013). This definition includes taking the substance for longer than intended, wanting to cut down or stop using but being unable to, craving the substance, spending time in pursuit of the substance, using when doing so is causing social or interpersonal problems, increase in tolerance, and experiencing withdrawal symptoms (APA, 2013).

The DSM provides standardisation of diagnosis, and can be useful in guiding research and both psychological and pharmacological treatment (Khoury et al., 2014), however it has been critiqued as over simplifying human behaviour as well as an increasing tendency to medicalise behavioural patterns and mental health (Watts, 2012). A central aim of the DSM was to provide a common language and standardisation between what is considered ‘normal’ to what is ‘pathological’. Cultures differ dramatically in what is considered ‘normal’ versus

‘pathological’, and the definition of what is considered a ‘disorder’ if largely socially impacted (Khoury et al., 2014; Rosenhan, 1973; Zubin, 1967). Issues in labelling behaviour are complex. While some individuals may find diagnosis helpful and normalising, the DSM also can perpetuate stigma placed on individuals facing difficulties by labelling them and their behaviours (Corrigan et al., 2004; Corrigan & Watson, 2002). Regardless, the DSM manual is still used as a system for classifying individuals’ behaviours and difficulties in both research and practice.

Language Use

Within current and past literature, diverse names and classifications have been adopted to refer to the use of alcohol and other mind-altering substances. Within the present research, given its recovery-orientated nature, the terms ‘substance use disorders’, ‘addiction’ and ‘substance abuse’ have been replaced with alternative terms, including ‘alcohol and other drug (AOD) misuse’, ‘substance misuse’ and ‘at-risk substance use’. ‘Substances’ refers to the use of both drugs (e.g., methamphetamine, opioids, cannabis) and alcohol. Recovery-orientated language use is important given the stigma associated with language such as ‘abuse’ and ‘addiction’, and the role this terminology plays in preventing people from seeking support and instead perpetuating the shame they experience. The use of the term ‘substance misuse’ is not perfect, particularly due to the numerous different definitions of ‘misuse’ across literature, and the failure to take into account the broader impacts of use (Mahmoud et al., 2017). The term ‘misuse’ has also frequently been associated with the overuse of prescription medication (Bronstein et al., 2008). Other definitions include the patterns of alcohol consumption that put an individual at increased risk for harm (Coulton, 2011), or unhealthy, problematic or risky use of substances associated with negative consequences (McNeely et al., 2015). Substance use is experienced on a continuum, and some definitions of the level of misuse may not reflect the severity of harm experienced by a

person experiencing misuse. However, given the lack of alternative language, the term substance misuse is mostly aligned with this study's position.

Classifications, language, theory and understandings of alcohol and substance misuse have developed immensely over the past 100 years. Understandings of alcohol and substance misuse continue to broaden and advance, directing the development of treatment approaches which understand people in their familial, social, cultural, and political environment, and cater to the multitude of a person's needs as a person and in recovery.

The Current Context of Substance Use in New Zealand

Among the general population in Aotearoa New Zealand, there is a lifetime prevalence of 12.3% and a 12-month prevalence of 3.5% for substance use disorders (Oakley-Browne et al., 2006). More recent New Zealand estimates suggested 32% of New Zealanders were at moderate to high risk for experiencing substance use disorders (Ministry of Health, 2020b). Alcohol is the most commonly misused substance, with approximately 21% of New Zealanders reporting drinking at a hazardous level in recent years (New Zealand Drug Foundation, 2020). It is estimated that 1% of New Zealand adults used amphetamines in 2020, with these rates ranked amongst the highest in the world (New Zealand Drug Foundation, 2020; United Nations Office on Drugs and Crime (UNODC), 2016). The impacts of use are substantial and widespread, particularly for certain communities (Ministry of Health, 2016). In the 2019/20 Health and Lifestyle Survey, 15% of people over age 15 reported they had smoked cannabis, an increase from 10% in 2014/2015 (Ministry of Health, 2020a; New Zealand Drug Foundation, 2020).

Aotearoa New Zealand has also seen an increased trend in the use of psychoactive substances, such as synthetic cannabinoids and party pills (Wilkins et al., 2014). The use of synthetic cannabinoids is associated with range of psychological and physical symptoms, including difficulty sleeping, heart palpitations, anxiety, depression and agitation. Over 70

deaths have been connected to synthetic cannabinoids since mid-2017 (New Zealand Drug foundation, 2019). The use of these substances also has a negative impact on individuals' interpersonal relationships and finances (Wilkins et al., 2014). It is difficult to accurately identify the number of people using opioids in New Zealand, due to the limited data available. However, in a 2012 study, it was estimated that 0.3% of people aged 15-64 were dependent on opioids in New Zealand. Furthermore, the number of people receiving opioid substitution therapy is steadily increasing, from 5,158 in 2013 to 5,573 in 2018 (New Zealand Drug foundation, 2019).

People misusing substances are also more likely to be living with poor mental health. High comorbidity estimates are identified with substance use disorder, with 40% of those meeting substance use disorder criteria also meeting the criteria for anxiety, and 29% meeting the criteria for depression (Oakley-Browne et al., 2006). Comorbidity between substance use disorders is also common in New Zealand, with 45.3% of those with substance use disorder also meeting criteria for alcohol abuse and 30.7% meeting criteria for alcohol dependence (Oakley-Browne et al., 2006). In New Zealand, over 70% of people who attend services for substance misuse difficulties have co-existing mental health conditions, and over 50% of mental health service users are estimated to have co-existing substance misuse problems (Todd, 2010).

There is also greater vulnerability for some groups in relation to substance abuse due to factors such as colonisation and marginalisation. For example, Māori (the indigenous population of New Zealand) are twice as likely to have started using drugs at 14 or below and are more likely to have used drugs in their lifetime compared to non-Māori (Ministry of Health, 2010). A similar pattern is seen with alcohol, where Māori are significantly more likely than non-Māori to have consumed alcohol by age 14, consume larger amounts of alcohol, and drink more often. These statistics are mirrored with results suggesting a

disproportionate number of Māori experiencing substance use disorders (6%) compared with other ethnic groups (3%) (Oakley-Browne et al., 2006).

The harms associated with misuse of alcohol and substances are widespread and include social, economic, and both direct and indirect health impacts. These risks include higher risks of cancer and other diseases, mental health difficulties, sexually transmitted diseases and Foetal Alcohol Spectrum Disorder (Casswell et al., 2011; New Zealand Law Commission, 2010a, 2010b). Harmful alcohol use can negatively impact interpersonal relationships as well as overall personal wellbeing. It is also associated with decreased self-control and is indicated to play a role in at least half of youth suicides in New Zealand (Gluckman, 2017).

There is also an increased risk of harm associated with criminal activity, including driving while intoxicated, domestic violence, assault, murder, and engaging in the drug-related criminal black market and associated activities including substance supply (New Zealand Law Commission, 2010a, 2010b). In New Zealand, 492 people were charged with driving under the influence of drugs in 2018; in the same year, nearly 17,000 were charged with driving under the influence of alcohol (New Zealand Drug foundation, 2019). Similarly, low-level drug offences, such as possession of utensils, make up more than half of those imprisoned for drug offences, and in 2018, 801 New Zealanders were imprisoned for possession and/or use of utensils or illicit substances (Richardson, 2018). Although understandings of substance misuse have changed over centuries, with key research outlining the biological, psychological, social and cultural influences, individuals continue to be criminalised for the use of substances. Furthermore, imprisonment continues despite extensive evidence indicating that punishment of individuals does not decrease substance use (Chandler et al., 2009; Spohn & Holleran, 2002).

The Covid-19 pandemic had a significant impact on the mental health of people in New Zealand. Data from New Zealand's Level 4 restrictions (highest level of population, 'lockdown') in April 2020 indicates that for people who already used substances, there was an increase in alcohol and cannabis use during lockdown. Feelings of anxiety and boredom contributed to use (New Zealand Drug Foundation, 2020). The use of MDMA and cocaine did, however, reduce during Level 4 restrictions, likely due to disrupted international supply chains. Level 4 restrictions additionally meant that alcohol and other drug (AOD) services had to adapt, most changing to online and telephone channels. Although this change led to an increase in the flexibility of services and engagement for some services users, for others it presented significant barriers, especially due to lack of access to technology. Moreover, a New Zealand drug use survey from August 2020 indicated that many individuals who were actively implementing or maintaining abstinence from substances lapsed or relapsed due to Covid-19 stressors (New Zealand Drug Foundation, 2020).

Figures from the New Zealand Drug Harm Index for the years 2014/2015 estimated the social cost of drug-related harm and interventions to be NZ$1.8 billion (McFadden, 2016). This social cost includes harm to people's health, whānau (family), friends and the wider community. The government additionally spends approximately $350 million per year to address drug-related issues, with the majority of this expenditure spent on enforcement, rather than treatment. Individuals, families and communities continue to struggle with the impacts of alcohol and drug misuse, yet New Zealand's society lacks available supports. Treatment services have long waitlists, there is considerable stigma around the misuse of alcohol and substances, and limited treatment options are available (Global Commission on Drug Policy, 2017; New Zealand Drug Foundation, 2017; Paterson et al., 2018). This literature highlights the social and economic impact of substance misuse and further

reinforces the need for a greater understanding into the recovery journey of individuals facing difficulties with AOD misuse, and comprehensive intervention (McFadden, 2016).

Substance Misuse and Parenting

World Health Organization (2008) data pinpoints that approximately one-third of substance users are individuals of childbearing age, presenting a major public health concern to both individuals who misuse substances and their children. A recent study reported that 51% of mothers in New Zealand consumed alcohol during pregnancy, compared to 13% of mothers in US (Wouldes et al., 2014). A further study estimated that one in six New Zealand mothers drank alcohol throughout their pregnancy (Ministry of Health, 2015). The risk of consuming alcohol during pregnancy is significantly higher for younger women, in their first pregnancy, with no secondary school qualification, and/or with an unplanned pregnancy (Rossen et al., 2018). It is estimated that Māori women are five times as likely, and Pasifika women three times as likely, to drink during pregnancy, compared to Pākehā women (Mallard et al., 2013). Intergenerational trauma, colonisation, systematic racism and inequitable health policies unequivocally influence these statistics (Doyle, 2011; Houkamau et al., 2017; Talamaivao et al., 2020). Alcohol consumption during pregnancy can cause low birth weight as well as Foetal Alcohol Spectrum Disorder (FASD) (Larkby & Day, 1997; Popova et al., 2017; Wright et al., 1983). No New Zealand Data on the prevalence of FASD is available; however the Ministry of Health estimates that 3% of births may be impacted by alcohol, approximately 1,800 per year (Ministry of Health, 2018a).

Little is known about substance use during pregnancy in New Zealand. Internationally, methamphetamine is a commonly used illicit substance during pregnancy, with prevalence rates ranging from 0.7% to 4.8% (Arria et al., 2006; Derauf et al., 2007). Women who use methamphetamine during pregnancy are more likely to be poor, to be single, to also misuse alcohol, and to be diagnosed with a co-morbid mental illness (Wouldes

et al., 2014). Substance use during pregnancy can have profound and lasting impacts on the child's development and health. For example, low birth weight and stature have both been linked to prenatal exposure to methamphetamine (Smith et al., 2015). Exposure to methamphetamine in utero can also result in emotional reactivity, behavioural problems and impaired executive functioning (Smith et al., 2015). It is estimated that worldwide, 15–23% of children live with a parent with substance misuse or mental illness and these children have up to 50% chance of developing a mental illness themselves (Leijdesdorff et al., 2017).

Parenting and parenting beliefs are located in economic, social, cultural and political contexts. Sociodemographic, educational and past and present family environment factors can all have a large influence on an individual's parenting practices and beliefs (Taylor et al., 2000; Yoos et al., 1995). Socio-economic status is a significant variable in parenting and child health outcomes, with poverty and economic hardship negatively impacting parenting (Neppl et al., 2016; Taylor et al., 2000).

The family stress model suggests that poverty leads to stressors and dysfunction in the family system, which then can impede the parent-child relationship and interactions (Conger et al., 2000). According to the model, conditions of poverty and socio-economic disadvantage directly impact a parent's ability to engage in responsive, nurturing interactions with their children, which highlights the need for a broader systemic view of parenting (Conger et al., 2000; Justice et al., 2019; Perkins et al., 2013). Likewise, other societal factors such as parental education, societal norms, lack of supportive child care options and neighbourhood environment impacts the parent-child interaction and child development (Cash & Wilke, 2003; Hurt & Betancourt, 2017). Many studies do not pay attention to the societal impacts on parenting, and instead see parenting as an individual's responsibility. This limitation is a significant critique of much of the research conducted into parenting and substance use. While reviewing literature regarding parenting and substance use, it is important to keep in

mind the significant influence of economic, social, cultural, and political contexts on both substance use and parenting.

The family system and parenting play a significant role in child outcomes, and intergenerational continuity of parenting behaviour, patterns and beliefs is common (Rothenberg, 2019). Social learning theory (Bandura, 1971) suggests that through experience and observation, children learn behaviours from their home environment, internalise these behaviours, and continue to use them in social interactions into adulthood (Capaldi et al., 2003). Many parents misusing substances have themselves experienced histories of significant trauma and deprivation, inclusive of parental substance use, family violence and parental psychiatric disorders (Dyba et al., 2019; Kearney et al., 1994), leading to detrimental emotional, behavioural and developmental outcomes. Significant trauma histories and post-traumatic stress disorder (PTSD) are common among people experiencing substance misuse (Kingston & Raghavan, 2009; Mills et al., 2006; Reynolds et al., 2011; Ullman et al., 2013).

Due to parental substance use, children often lack adequate positive role models to map their own coping strategies as parents, and may also lack healthy parental attitudes and behaviours (Dyba et al., 2017). For example, it is common for children whose parents are misusing substances to assume responsibility for the household from a young age. This role reversal often has serious consequences for the development of age-appropriate skills and experiences, resulting in an impaired ability to form healthy and meaningful adult relationships or a healthy self-concept, both of which are important for future successful parenting (Prevaat, 2003). Histories of trauma and deprivation contribute to challenges in meeting the demands of being parents. They highlight an intergenerational cycle of problematic experiences in families and negative consequences for individuals' sense of self and parenting identity, and impacts on parenting beliefs attitudes and practices (Meulewaeter et al., 2019). Disrupted bonds with parents can result in a lack of trust in one's capability as a

parent, often resulting in unreceptive parenting and insecure attachment patterns, all impacting child development (Meulewaeter et al., 2019).

Substance misuse can additionally be lead to low bonding, and children developing insecure attachment with their parents (Hogan, 2007). Based on the work of Bowlby (Bowlby, 1969, 1982), attachment is identified as the emotional connection between caregiver and infant. One crucial tenet in the theory is that young children need to develop a relationship with at least one primary caregiver for normal emotional and social development. Attachment to a main caregiver begins at around six months of age, and if attachment is broken from six months to four years of age, it can cause major psychological damage to the child's development. The theory posits that the quality of care provided to a child, particularly responsiveness and sensitivity, leads to either secure or insecure attachment (Ainsworth & Bell, 1970; Bowlby, 1969). This attachment is internalised and is carried forward to influence expectations in other important relationships from infancy and into adulthood. Consistent, sensitive and nurturing parenting is therefore suggested to lead to a child developing a positive model of self and others (Dozier, 1995; Kobak & Sceery, 1988). Emerging research suggests it is not just early infant relationships, but instability in family systems over time, such as an parental substance use, and lower quality relationships in adolescence that can contribute to insecure attachment styles in young adulthood. Furthermore, attachment styles are more malleable in infancy, and as people age into adulthood, attachment styles become more rigid and harder to change (Fraley & Roisman, 2019).

Low-level bonding and disrupted attachment can result from preoccupation with substance-seeking, and parents can experience decreased pleasure in their parenting role (Neger & Prinz, 2015). Some parents who misuse substances report lower levels of satisfaction from their parenting relationship and spend less time interacting with their

children (Clausen et al., 2012; Lussier et al., 2010). Paying more attention to substance-seeking results in these parents being less attentive to their children's emotional, physical and psychological cues and needs. It has been argued that prenatal substance use impairs maternal parenting capacities by dysregulating three neural–hormonal systems vital to parenting - the dopamine reward system, the oxytocin affiliation system, and the glucocorticoid maternal stress system (Flykt et al., 2021; Rutherford et al., 2015; Strathearn et al., 2019). Long-term use of substances desensitises the dopamine receptors in the brain. While parents may be motivated to provide care and nurturing to their child, their sensitised state makes it increasingly difficult to override their preoccupation; diminished dopamine release does not provide sufficient mood elevation, therefore resulting in decreased pleasure in the activity (George et al., 2012). Abnormalities in maternal oxytocin, a hormone associated with maternal caregiving, are associated with postnatal parenting difficulties (Strathearn et al., 2019). In terms of the maternal stress system, stressful events, particularly parental-related stress, strongly trigger cravings and relapse (Rutherford et al., 2015), and prenatally distressed mothers are more likely to relapse as a result (Massey et al., 2012). Furthermore, when a person is in this stage of substance-seeking, often referred to as craving, their executive functioning is diminished, particularly when experiencing triggers to use substances (George et al., 2012).

During active substance misuse, the parent-child relationship is often characterised by unstable attachment, inconsistent care, and inadequate response to children's needs (Lussier et al., 2010; Solis et al., 2012). Mothers may feel ambivalence towards their pregnancy and motherhood, feel incompetent and ineffective, and experience low self-esteem and self-efficacy in the parenting role (Davis 1994; Kelley, 1992). Due to the ambivalence experienced, some mothers have described their roles as merely functional. For example, they may provide basic care to the child, but have little willingness to play or talk (Silva et al.,

2013), increasing the risk of general and emotional neglect (Hohman, 2012). During active substance use, when drug use is prioritised over parenting, children are often exposed to drug use, danger and, at the very least, an unstable routine and chaotic lifestyle signified by repeated experiences of loss and separation (Adinoff et al., 2014; Cattapan & Grimwade, 2008; Kroll, 2004).

Preoccupation with the consumption of substances can additionally result in parents experiencing difficulties in meeting their parenting responsibilities (McKeganey et al., 2002). These difficulties will depend on their histories of use and treatment. While parental substance use does not necessarily lead to poor parenting (Street et al., 2004), it can be associated with neglect and maltreatment (Blakey, 2012). Researchers have identified that it is not necessarily substance misuse itself which leads to troubled parenting, rather a variety of contributing contextual factors (Kettinger et al., 2000; Suchman & Luthar, 2000). Substance use within the context of environmental factors such as domestic violence, homelessness and stress increase the likelihood of parenting challenges (Kettinger et al., 2000; Suchman and Luthar, 2000). Likewise, comorbidity with mental health problems such as depression and anxiety is found to be related to troubled parenting (Lander, Howsare & Byrne, 2013; Luthar, Merikangas & Rounsaville, 1993). That research identifies that substance misuse and parenting is a complex difficulty with multiple influencing factors which often make seeking help, and recovery, incredibly difficult.

Parents facing challenges with substance misuse can additionally have diminished knowledge of parenting and child development, as well as maladaptive beliefs in regard to parenting (Valez et al., 2004). The relationship between knowledge and behaviour is complicated; knowledge in any area does not necessarily mean that people take action and change behaviours. Rather, behaviour change is likely to be a complicated and interrelated process that involves attitudes, norms, intentions and behavioural control (Ajzen, 1991).

Enhancing parenting knowledge has been identified as particularly important in reducing the risk of child maltreatment for parents facing these difficulties. Valez et al., (2004) found that pregnant women who were attending comprehensive treatment for substance misuse had limited parenting knowledge and expressed misconceptions about parenting practices such as child development and the impact of pre- and postnatal drug exposure. Lack of knowledge in particular parenting domains is likely to impact negatively on the parent-child relationship, especially during the post-partum period, and has implications for development of the child. Many parents dealing with substance use difficulties show limited knowledge surrounding their child's developmental stage and alternative strategies for dealing with child behaviour (Kerwin, 2005; Pajulo et al., 2006). Lack of parental knowledge could be explained by a lack of access to parenting education resources. Comprehensive education regarding the impact of drug use in-utero and postnatally is of crucial importance. Increased knowledge of core parenting practices may allow parents to better understand their children, which could impact the child's development positively and decreases the risk of child maltreatment (Velez et al., 2004). Although educating parents around specific child domains may increase their awareness, it is likely that education alone is not enough, and education and intervention services need to be more comprehensive to promote behaviour change.

Parenting behaviours and interactions can also be impacted by the misuse of substances. In the literature, parenting behaviours and interactions have been labelled as ‘dysfunctional’ where they lead to confusing and contradictory experiences for the child. Dyba et al. (2019) describe how parents who misuse substances may engage in both ‘lax’ and ‘overreactive’ parenting tendencies, as well as generosity and permissiveness in parenting situations. Parents who misuse substances may struggle with certain parenting practices, for example, engaging in limited responsiveness, inconsistent parenting, controlling and punitive

discipline, lack of involvement, extreme punishments and harsh criticism (Neger & Prinz, 2015; Suchman & Luthar, 2000). Given what is known about substance misuse and parenting, these behaviours do not develop from substance use alone, and typically are influenced by intergenerational, systemic and interpersonal challenges too.

The relationship between child maltreatment and substance misuse can have a significant impact on child health outcomes, and often leads to loss of custody and the placement of children in state care when parents are dealing with substance use disorders (Neger & Prinz, 2015). Parental substance misuse is a key feature of families identified through care and protection services worldwide, and there is usually a number of factors which contribute to children being taken out of a parent's care. For example, Australian researchers Leek and colleagues (2004) assessed every second application to care and protection in Western Australia over one year, totalling at 175 cases. Drug and/or alcohol use were identified as contributing factors for care and protection application in 57% of cases, although it was identified as the single reason in only 2% of cases (Leek et al., 2004). Multiple factors tended to contribute towards applications for care and protection orders, including comorbid mental health, homelessness, domestic violence, and emotional abuse and neglect. These findings identify the complex and multifaceted nature of substance misuse and parenting difficulties, and the need for intervention to meet the needs of these individuals and families.

As at June 30 2021, 5,250 children and young people were in the care and protection custody of the state executive in New Zealand. Māori children made up 57% of these 2021 figures and there are growing rates of Māori children being taken out of their parents' care and early in their lives (Oranga Tamariki, 2021a). In 2019, one in every 150 Māori new-borns were taken into state care, compared to one in every 750 non-Māori babies (Office of the Children's Commissioner, 2020; Oranga Tamariki, 2020). The disproportionate numbers

of Māori children seen in state care is not a new issue. Removal of Māori children from their whānau is prominent in New Zealand history. From the 1960s through to the 1980s large numbers of Māori children were taken into state care when Māori whānau moved into cities due to colonisation in New Zealand (Jackson, 1988; Moyle, 2013). The situation for Māori was likened to cultural genocide by Love (2002), who described how whānau, iwi and hapū grieved the loss of their children in distinct numbers.

In New Zealand, children placed in state care are often moved from placement to placement, having a detrimental impact on the development of secure attachment by these children, particularly those under four years of age (Atwool, 2010). These placements are often with non-family and as of March 31, 2020 around 58% of all children and young people in state care were in non-whānau care (Oranga Tamariki, 2020). Multiple placements are highly problematic for meeting both the emotional and physical needs of babies and children. When a child is placed in state care they may be separated from their parents for long periods of time, which can impact on the child's ability to form healthy attachments (Kalland & Sinkkonen, 2013). Providing a secure, responsive and loving environment where healthy attachment can be formed may mitigate these risks (Smith et al., 2015).

During the last six months of 2020, 214 children in care in New Zealand experienced 295 incidents of harm. Findings of harm included emotional, physical and sexual harm or varying degrees of neglect towards children in state care by Ministry-approved carers. Of these children, 60% were Māori, 13% Māori-Pasifika, and 3% Pasifika (Oranga Tamariki, 2021b). People who have been in state care for a portion of their childhood have an increased risk of experiencing mental and physical health challenges, including suicide, later in life (Cuffe et al., 2001; Evans et al., 2017; Farmer et al., 2001; Zlotnick et al., 2012). Moreover, a trend of intergenerational transmission results in children whose parents misused substances

being more likely to themselves face difficulties with alcohol or substance misuse (Melchior et al., 2011).

In 2016, the New Zealand government spent $529 million on direct services for vulnerable children in the care of Child Youth and Family (now Oranga Tamariki), with a further $254 million being spent on community investment and other services which supported Child Youth and Family (Ministry of Social Development, 2016). The impact of substance misuse is widespread and devastating, impacting children, whānau and communities as well as the people experiencing it. Parents experiencing difficulties with substance misuse face complex challenges, and further insight is needed into their experiences in order to best meet their needs in treatment and recovery.

Alcohol and Substance Misuse and Dependency Recovery

Since the publication of the 1998 report 'Blueprint for Mental Health Services in New Zealand', a recovery approach has been at the forefront of all mental health services in New Zealand, including substance misuse services (O'Hagan, 2004). The recovery model has been endorsed by key governing bodies and has guided many important policy documents (Mental Health and Addiction Inquiry, 2018; Mental Health Commission, 2012; Ministry of Health, 2006, 2018b). The recovery approach to mental health and substance misuse began after the wide-spread deinstitutionalisation of the mental health system in much of the Western world, during the second half of the 20th century. The approach to service provision has been attributed to the development of psychotropic medication and the view that treating people while living in the community was a more effective method than institutionalisation (Bassuk & Gerson, 1978).

Mental health care during this period was criticised for perpetuating the idea that people living with mental health difficulties had incurable symptoms and faced a lifetime of medicated management of symptoms (Mead & Copeland, 2000). As a result, advocates and

service users worked to promote an alternate definition of mental illness and how to best support people living with these experiences, ultimately developing the idea of recovery. Moreover, at this time, a body of scientific evidence promoted the idea of recovery as a process where people were able to live meaningful lives by recovering from mental illness or through learning how to live with it, despite residual effects of the difficulties (Davidson & Roe, 2007).

There is ambiguity around the concept of 'recovery' for individuals with substance misuse; some identify recovery as complete abstinence, while others take a more holistic approach of working towards a 'new life' of ongoing growth and self-change (Laudet & White, 2008). While ‘clinical recovery’ is generally concerned with overcoming symptoms through the use of clinical treatment services, ‘personal recovery’ is focused on a wider and holistic view of wellbeing and re-building a fulfilling life (Slade, 2009).

Within New Zealand, varying views of recovery are also depicted within policy. The Ministry of Health describes recovery as supporting individuals in a way which minimises distress and the impact on clients’ lives as much as possible (2018b); in contrast, the New Zealand policy document ‘BluePrint II’ describes recovery as living well within the community, regardless of an individual’s return to full health (Mental Health Commission, 2012). These definitions affirm the changes in understandings and positions as to what recovery comprises. What is clear, from the literature, is that the essence of recovery is a lived experience of improved individual and community life quality, and a sense of empowerment (Davidson & Roe, 2007; Laudet & White, 2008; Slade, 2009). The changes in language and definitions are positive steps toward more person-centred understandings of mental health and AOD misuse.

Abstinence remains central in discussions of substance misuse recovery. However extending beyond this, there has been an emphasis on improvements in psychological and

physical health, relationships, employment and stability. There may be lapses in recovery, but skills and coping mechanisms developed during treatment were seen as an important part of recovery, to identify and manage early warning signs and triggers, to prevent falling back into the cycle of substance misuse and relapse (Prangley, Pit, Rees & Nealon 2018). Multiple disconnects are seen within the views of recovery for mental health and substance misuse.

While mental health recovery is possible even with the experience of ongoing symptoms, substance misuse recovery generally starts with or leads to abstinence. Anthony (1993) defined mental health recovery as "a way of living a satisfying, hopeful and contributing life even with limitations caused by an illness" (p.15). In contrast, dominant definitions of substance misuse recovery suggest that "in addition to abstinence or stopping uncontrolled substance use, recovery implies improved health, function, and quality of life" (McQuaid et al., 2017, p. 14). The harm reduction approach has been particularly influential, aligning the recovery movement with substance misuse difficulties. Within harm reduction, the use of substances may continue, and the primary goal is to minimise or reduce the harms associated with on-going or active substance use. This approach grew in response to both the opioid crisis and the transmission of HIV/AIDS through use of needles (Marlatt, 1996). Harm reduction's defining feature, and the one that sets it apart from substance misuse recovery, is its non-judgmental stance regarding substance use (Marlatt, 1996) - something that is conceptually similar to mental health recovery's acceptance of ongoing symptoms (Bartram, 2020).

Many of the principles of recovery focus on hope, choice and freedom, that is experienced rather than diagnosed. Recovery is identified as a process rather than an end state (Best & Laudet, 2010), and there is an emphasis on individual variation in timeline, as well as in diverse pathways to recovery (Best & Lubman, 2012). According to Anthony (1993), recovery is the personal process of changes in one's feelings, values, skills and goals. It

involves developing new meaning in life and growing beyond the impacts of substance misuse or mental illness, and certainly extends beyond the relief of symptoms. Recovery extends beyond treatment and can be facilitated regardless of engagement in the treatment process. Recovery can occur, even if symptoms re-occur (Anthony, 1993), and this notion is key in understanding the recovery processes for alcohol and substance misuse in particular, given that lapse and relapse are common (Ivers et al., 2018). In this sense, recovery is not a linear process, and involves periods of rapid change, minimal change, progress, and setbacks (Anthony, 1993; Ivers et al., 2018).

A bulk of the literature focuses of recovery as being deeply personal and does not take into account how interconnected relationships affect the recovery process. Emerging literature acknowledges relationships as a cornerstone of recovery. While relationships can hinder recovery and maintain active AOD use, they can also be healing and supportive of recovery (Mudry et al., 2019). Although recovery is deeply personal, it occurs within a social and interpersonal context (Topor et al., 2011). The importance of positive relationships and social support is well identified in the literature as having a positive impact on individuals' health and wellbeing. More specifically, in recovery from substance misuse, social support and relationships are identified as a key protective factor, and social support is shown to have a clear relationship with recovery, abstinence and treatment retention (Dobkin et al., 2002; Stevens et al., 2015).

The relational character of recovery was highlighted by Mudry et al. (2019), who conceptualised natural recovery to be deeply relational, whereby interpersonal relationships and those with communities are transformative pathways in recovery. Topor and colleagues (2011) suggested that a number of relationships play significant roles in recovery, including friendships, families and the therapeutic relationships with professionals. Friendships, particularly those among service users themselves, hold significance to recovery. Giving and

receiving advice on one's difficulties and understanding that one is not alone in their experiences can be transformative (Davidson et al., 2006; Romme & Escher, 2000). Furthermore, therapeutic alliance is often described as more important than treatment modality. In particular reciprocity within the working alliance, where a person feels seen, respected and heard, are common themes within recovery research (Topor et al., 2006).

Family are identified as central to recovery (Anthony, 1993). Approximately 20% of Australians living with a severe mental illness have dependent children in their care, and over 50% of those have daily contact with one or more family members (Maybery et al., 2009). It is difficult to distinguish recovery from responsibilities as a parent and family relationships (Nicholson et al., 2014). Belonging to a family has a profound impact on the organisation of people's lives, which in turn impacts the ways in which individuals living with mental illness or substance use understand and manage their wellbeing and recovery (Price-Robertson, Manderson, et al., 2017).

Similarly, conceptualisations of family recovery have gained traction. These argue that the mental health of an individual often impacts the family system, especially for those living with dependent children, and the family provides the most significant social context for recovery (Maybery et al., 2015). The emerging research identifies the need to view recovery beyond an individualistic perspective, acknowledging the significant role relationships play in people's recoveries.

Despite literature acknowledging recovery as a deeply personal process, many recovery models have been proposed, in an attempt to identify commonalities among unique, recovery experiences. 'Recovery capital' (Granfield & Cloud, 1999) refers to the quality and quantity of resources one can use to initiate and sustain recovery from substance misuse. Within Granfield & Cloud's framework are four subtypes of recovery capital - social capital, physical capital, human capital, and cultural capital. Social capital is integral to recovery and

comprises the importance of, and benefits gained from, group membership in prosocial networks and supportive relationships. Social capital includes membership through family, intimate relationships and social support as well as other groups individuals belong to (Best et al., 2010; Granfield & Cloud, 2001). As suggested by the stress and coping social support theory, social support protects people from the negative health effects of stressful events, by influencing how people think about and cope with the events (Thoits, 1986).

Tangible assets such as money or property are defined as physical capital, which may increase recovery options, for example, the ability to pay for treatment. The attributes or human capital that aid individuals to function in society, including skills, employability and mental health, can also aid individuals' progress through treatment and recovery. Finally, cultural capital encompasses an individual's values, beliefs and attitudes, as well as their ability to have knowledge of and act in consideration of cultural norms in society. Higher levels of recovery capital prospectively predict sustained recovery, higher quality of life and lower stress (Granfield & Cloud, 1999; Laudet & White, 2008). Best and Laudet (2010) proposed that recovery capital could be categorised into three domains of assets: personal recovery capital, which refers to the skills and capabilities the person possesses; social recovery capital, the strength of associations to positive social networks; and community recovery capital, which is the availability and accessibility of resources such as jobs and houses in the local community.

An additional strengths-based recovery paradigm is depicted by the acronym CHIME - connectedness, hope and optimism about the future, identity, meaning in life, and empowerment (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). This model provides further conceptualisation of recovery in mental illness. The CHIME recovery paradigm was established within mental health populations and has been applied to the substance misuse recovery field (Best, 2012). Connectedness refers an individual's relationships as well as

societal connections. Hope refers to the belief in recovery and motivation to change. Identity refers to an individual rebuilding a positive sense of self. Meaning in life is about the need for an individual to find the meaning of life as well as meaning of their own recovery. Empowerment highlights the sense of personal responsibility and having a sense of control over one's life and treatment (Leamy et al., 2011). This recovery paradigm emphasises the importance of treatment approaches in helping individuals to deal with underlying difficulties, including poor coping mechanisms, low self-esteem and trauma, but notes that these interventions may not be enough to reach lasting recovery. The CHIME recovery paradigm also emphasises the importance of health professionals instilling hope and acting as connectors for groups, communities and families in individual's recovery journeys (Best & Lubman, 2012).

These models often to not fully consider cultural aspects of recovery, particularly in a New Zealand context. The frameworks are in their infancy of application within a New Zealand setting. Given the multi-cultural intricacies within Aotearoa, and research outlining the importance of cultural immersion to mental health (Brougham & Haar, 2013; Coupe, 2005; Kapeli et al., 2020; Williams et al., 2018), adaptations may need to be made to their applications within the New Zealand population. Recovery frameworks do, however, reinforce knowledge that recovery extends beyond symptom elimination or abstinence, encompasses multiple domains of individuals lives, and they provide a structure to assess recovery (Laudet & White, 2008). In this way, recovery frameworks lend themselves to adaptability to cultural sensitivity. The recovery movement has changed service provision throughout the world. As a result, recovery-based services assert to be largely designed to meet the multiplicity of specific needs of people struggling with substance misuse difficulties, instead of solely focusing on symptom elimination.

Parenting and Recovery

Parents in recovery seek support for a number of difficulties. There are a multitude of parenting challenges during active recovery as parents manage a range of emotions and behavioural concerns related to their recovery and to their children. Parents battling drug and alcohol misuse often face the tough decision to either take care of themselves or take care of their children.

During phases of active substance use, mothers often express strong feelings of guilt and shame, and experience considerable stigma (Corrarino et al., 2000; Hankin et al., 2000; Kahler et al., 2003; Silva et al., 2013). Stigma can be considered the negative views towards a person or groups of people when their attributes or behaviours are considered undesirable or inferior to societal norms (Dudley, 2000). The process is said to lead to a 'spoiled identity', where a person's identity is associated with meanings of abnormality and marginalisation (Goffman, 2009). Social stigma is a commonly perpetuated towards individuals with substance misuse difficulties, and these can be even more significant for parents (Clement et al., 2015; Crapanzano et al., 2018; Holder et al., 2019). Although often only considered to be socially perpetuated, stigma is also particularly problematic due to the way it shapes how a person views themselves. Stigma can often become internalised by an individual, leading to experiences of self- stigma which further contribute to experiences of guilt and shame (Corrigan et al., 2004; Corrigan & Watson, 2002). Stigma is also perpetuated professionally, whereby professionals may hold stigma towards certain cliental groups (Holder et al., 2019). This can be particularly common for parents who use substances, and these experiences can play a large role in recovery by parents.

For parents the stigma, shame and guilt associated with both substance use and parenting is self-imposed, as well as commonly perpetuated through media, societal expectations, and even by child protection agencies (Carlson et al., 2006; Liss et al., 2013).

This stigma often results in parents not seeking help due to fear of negative judgement. In order to avoid stigma, and instead of seeking help, mothers have been found to make attempts to balance their parenting and drug misuse, resulting in recovery being pushed to the side (Liss et al., 2013). Pregnant and parenting women report being concerned about the impact of their substance use on their developing baby, and in particular about the long-term impact of in utero drug exposure (Van Scoyoc et al., 2017). Given this concern, women are known to try and protect their children and reduce drug use. Van Scoyoc, Harrison and Fisher (2017) identified that some pregnant women, instead of seeking formal treatment, tried to protect their babies variously through staying active, taking supplements, eating only organic foods, and reducing substance use. These women had identified many of the developmental and physical harms in utero exposure to drugs can cause, and were motivated to seek treatment, but certain barriers, including stigma, stopped them from doing so (Van Scoyoc et al., 2017). Furthermore, Coyer (2003) noted that when threats of state custody were made, mothers in their study reconsidered drug use and pursued immediate changes. Many mothers wanted to maintain sobriety to fulfil a dependable and nurturing presence in their children's lives (Coyer, 2003).

Substance-using parents may be unlikely to start the recovery journey early due to fear of their children being taken out of their care, and those who have their children taken out of their care are more likely to lose the care permanently to the state (Neger & Prinz, 2015). For parents who do lose custody of their children, some may experience short-term motivation for recovery, but this loss also serves as a significant source of shame and guilt (Suchman et al., 2006). For those who have lost custody of their children, having increased access to their children and reunification can be important motivators in recovery for many parents. The process of reunion is seen as desirable by parents, and parents report experiencing happiness, excitement and relief when their children are placed back in their

care (Carlson et al., 2006). Early treatment commencement as part of the recovery journey has been associated with higher rates of reunion, and parents who do reunite with their children can be more likely to stay in treatment longer (Choi et al., 2012; Grant et al., 2011; Green et al., 2006; Huang & Ryan, 2011). The process, however, is complex, multi-faceted, and a significant source of stress (Carlson et al., 2006). Children who are placed in state care due to substance use in their household are shown to have lower rates of reunion compared to families where substance use is not the primary problem (Schaeffer et al., 2013).

System-related factors are linked to reunion rates, with multiple studies indicating particular system factors and case worker practices which contribute to lower reunion rates. For example, children with multiple placements (Davis et al., 1997), children who were placed in foster homes or the homes of relatives (Smith, 2003), and children with multiple case workers over time (Hayward & DePanfilis, 2007; Ryan et al., 2006) all have lower family reunion rates. Cheng (2010) also suggested that children who had more actively and positively engaged social workers had higher reunion rates.

Other practice-related factors which impact on family reunion include the limited availability of effective treatment services to support parents facing difficulties. The literature suggests that parents facing AOD difficulties often show particularly low participation rates as well as low compliance with care and protection orders (Barnard & McKeganey, 2004; Choi & Ryan, 2007). In a United States study, mothers involved in care and protection who used substances reported less strengths-based approaches and practices used by their caseworkers, compared to mothers who did not have a history of drug use. This lack of a strengths-based approach, and significant stigma attached to substance misuse, are likely to contribute to poor outcomes, possibly helping to explain the poor participation rates and further highlighting the practice-related factors contributing to low family reunion rates (Fusco, 2019).

Interpersonal stress associated with parenting has been linked to a greater risk of relapse and poorer substance use outcomes among women (Adinoff et al., 2014; Hodgkinson et al., 2014). Many parents who had ceased substance abuse still reported challenges and significant stress from parenting, as well as feelings of hostility and depression (Cattapan & Grimwade, 2008; Dyba et al., 2019). Parents in recovery expressed perceptions of not being competent as a parent, and of experiencing self-doubt, guilt and shame (Arendell, 2000; Cattapan & Grimwade, 2008).

Guilt and shame have significant impacts on the recovery process. Both guilt and shame have been positively associated with alcohol and substance use problems (Matendechere, 2018). Feelings of guilt and shame can drive individuals to seek relief through the use of substances (Cattapan & Grimwade, 2008). The interrelationship between parental stress and relapse is understudied. However, several mechanisms have been suggested, including low self-efficacy regarding parenting, negative emotions concerning how past drug use has affected one's children, and the belief that parental drug use will have negative consequences for their children (Baker et al., 2004).

These findings, as well as other literature surrounding the link between trauma and substance use, suggest the need for a strengths-based approach when working with parents who have misused substances (Dass-Brailsford & Myrick, 2010). Literature supports this approach, and parents are identified to be more engaged in services when strengths-based approaches are used (Platt, 2012). Several key principals underlie a strengths-based approach. Strengths-based approaches focus on what is working for an individual, and accentuates these aspects, rather than highlighting what is not working. Cultural competence and viewing a family’s culture as a source of strength is also seen as critical (Greene et al., 2005). Trauma-informed care, for example, is a strengths-based way of working with people that focuses on

enhancing coping and resilience. This care in treatment for substance use is crucial in order to negate the impacts of trauma and enhance recovery.

The principles of a trauma-informed approach recognise that an individual's behaviours and ways of coping should be viewed within the context of their trauma. People's behaviours and ways of coping can be viewed as a response to traumatic events, regardless of whether the event is currently being experienced (SAMHSA, 2014). Six key principles are outlined by SAMSHA (Substance Abuse and Mental Health Administration) (2014), which are representative of the principles for trauma-informed care outlined in the literature: (1) safety, focuses on looking after the physical and psychological safety of service users; (2) trustworthiness and transparency, the organisations decisions are transparent and focus on building trust between workers, service users and whānau; (3) peer support; mutual support is seen as a vehicle for developing hope, safety and trust; (4) collaboration and mutuality, everyone has a role to play within a trauma-informed approach, and organisations set out to minimise the power differences between services users and staff so that there is meaningful and shared decision-making; (5) empowerment, voice and choice; people's strengths, resilience and experiences are recognised and validated; organisations acknowledge that everyone's experience is unique and therefore approaches need to be individualised; (6) cultural, historical and gender issues, where organisations offer and promote services that are gender-responsive, culturally sensitive, value traditional cultural connections, and address historical trauma (SAMHSA, 2014).

New Zealand research has indicated that trauma-informed care also needs to include a focus on the impacts of colonisation and historical trauma events on Māori wellbeing, and their contribution to the health disparities experienced by Māori whānau (Pihama et al., 2014). It is important to note that a trauma-informed way of working goes beyond the individual, and should be implemented within the system, at the organisational level, to

create environments and relationships within services which foster relationships to build trust and a sense of empowerment (Leitch, 2017). These methods focus on strengths and resilience. An organisation's approach to treatment should seek to avoid re-traumatising individuals, and promote an environment that is safe (SAMSHA, 2014). They should move away from solely symptom- or problem-focused work, and focus on the development of skills and empowerment (Markoff et al., 2005).

Identity Development

Positive identity development during recovery is important for success, and for parents this also involves 'reworking' who they are as a parent. Identity theory (Burke & Stets, 2009) posits that all individuals claim particular identities given their roles in society, the groups they belong to, and the characteristics they use to describe themselves (Burke & Stets, 2009). Individuals may hold multiple identities because they occupy multiple roles, and these identities together form part of the 'self'. Sense of self refers to an individual's set of beliefs about themselves (Baumeister, 1999), and can be defined as an "individual's feeling of identity, uniqueness, and self-direction" (VandenBos, 2007, p. 542). Within identity theory and the process of identification, the self is categorised into roles, and meanings and expectations associated with the role are incorporated into the self (Burke & Tully, 1977). Through this lens, a person's identity is a set of meanings that are tied to and sustain the self as an individual, creating a label which attempts to integrate and differentiate a sense of self in different social and personal dimensions. These meanings, tied to identities, operate in various situations and guide behaviour (Burke & Stets, 2009). The meanings of these identities vary across social and cultural contexts and within families and communities (Burke & Stets, 2009).

Parenthood can play an important role in identity formation for parents in recovery, acting both as a motivator and a protective factor (Coyer, 2003; Pirskanen et al., 2017;

VanDeMark, 2007). Parenthood plays a critical role in meaning-making, and motherhood in particular is identified to be more influential than an individual's marital status or employment in identity formation (Arendell, 2000). Mothering is particularly important in facilitating recovery for mothers with a history of substance use (VanDeMark 2007). Lower participation in salient roles, including motherhood, has been shown to predict relapse to substance use and criminal behaviours, with both quantitative and qualitative results reinforcing these findings (VanDeMark, 2007). For a mother, their relationship with their children can serve as a primary motivator for recovery, and separation from their children can be harmful to their recovery. Children are often seen as a motivating factor in recovery, with mothers striving to be a role model for their children (VanDeMark, 2007). New positive relationships, opportunities and responsibilities are significant further motivators for attempting to reduce substance consumption (Watson & Parke, 2011). For some individuals, motherhood can serve as a primary role in recovery and can provide mothers with the strength and will to 'keep going', thereby promoting hope, a further key element of recovery. It can also provide meaningful interactions and opportunities for activities (Nicholson, 2010; Watson & Parke, 2011).

A further key aspect of facilitating personal recovery is the development of positive and multifaceted identities. In terms of development of positive identity in recovery and links to motherhood, it appears that building a positive sense of identity during recovery is varied. Some people identify wanting to return to their pre-misuse state of functioning (Bird et al., 2014). Others explain moving towards a 'new life' that is said to be gradual, and progress from negativity, illness dominated, to positivity, conceptualised by multidimensional domains and strengths (Bird et al., 2014; Hine et al., 2018). Mothers struggling with substance misuse can be under constant scrutiny by society and experience the challenges of having to show the capacity to be a 'good mother'. During identity development as a mother,

periods of competence and agency can be disrupted, not only by episodes of illness, but also by the display of stigma and prejudice towards their capacity to be a mother, most significantly, the removal of a child from their care (Hine et al., 2018). For mothers in recovery from substance misuse, the development of motherhood identity is often seen as crucial. Practitioners can empower mothers' strengths through acknowledgment and validation (Hine et al., 2018). The use of strengths-based language can further foster positive identity development, as well as recognising that challenges in parenting are universal, and not necessarily due to mental illness. For example, difficulties could be framed as a 'challenge' that a parent was facing, rather than a 'problem' that they have.

Mothers could benefit from being supported to build positive and realistic identities that allow them to respond to mental health needs without fearing the loss of their parenting role (Hine et al., 2018). Marbery and colleagues (2017) suggest that a programme focus on parenting identity development itself can be supportive in enhancing recovery. Many parents identify that, during recovery, they experience themselves learning how to be what they called a 'proper parent' (Pirskanen et al, 2017). They acknowledge having been a parent before recovery, but not fulfilling the psychological and social aspects of parenthood. Other parents highlight the difficult nature of parenting in recovery, identifying the struggle to manage children's demands, expressing feeling a constant state of worry (Pirskanen et al, 2017). For some parents, being in recovery is used as an advantage to understand their children more, especially in their adolescent years (Pirskanen et al., 2017). These parents learn from their past consequences and are able to monitor their children's challenges more closely. If a parent is to recover and abstain from the use of harmful substances, then their recovery can lead to changes in parenting as well as changes in family life (Pirskanen et al., 2017).

Due to the unique challenges that parents with AOD difficulties present with, concurrent treatment of substance abuse and parenting difficulties has the potential to enhance outcomes for both parents and children (Neger & Prinz, 2015). As such, understanding meaningful treatment approaches is critical, as well as the complex course of recovery for parents experiencing AOD misuse.

Treatment Approaches

Treatment is an important component in recovery for many people. This section briefly outlines some of the common treatment methods used with people experiencing challenges with AOD use. For many, abstinence remains a primary goal of treatment in the alcohol and drug treatment field; however, harm reduction models are becoming increasingly popular, particularly in community treatment settings. A harm reduction approach can be an appropriate method when abstinence is not possible or preferable to the client (Marlatt et al., 2001). Examples of harm reduction include cutting down the amount of substance used or the number of days the substance is used. Changing the method of use to reduce associated harm is also common, for example not using substances intravenously, using needle exchange programmes, and opioid substitution therapy (Connock et al., 2007; Marlatt et al., 2001; Wodak & Cooney, 2006).

Pharmacotherapy is commonly used in the treatment of both alcohol and substance dependence. Naltrexone has shown efficacy in the treatment of alcohol use disorders (Goh & Morgan, 2017; Murphy et al., 2022). Naltrexone is an opioid antagonist and works by reducing the cravings associated with drinking alcohol (Murphy et al., 2022; Roesner et al., 2010). Buprenorphine (with or without Naloxone) and methadone are commonly used and efficacious for the treatment of opioid dependence (Ministry of Health, 2014; Wesson & Smith, 2010). These medications are considered harm reduction approaches to help individuals manage withdrawal symptoms and reduce illicit opioid use. In this way

methadone and buprenorphine support individuals to reduce risky behaviour associated with opioid use, such as needle use and sharing, as well as the risk of overdose (Langendam et al., 2001; Saxon et al., 2013). Pharmacotherapy is considered to be most efficacious when used in conjunction with psychological therapies (Ray et al., 2020).

There has been a breadth of literature supporting the efficacy of different treatment approaches. Individual, family and group counselling methods are commonly used, including cognitive-behavioural therapy (CBT), contingency management and motivational interviewing (National institute on Drug abuse, 2009; Ray et al., 2020). The method of treatment used should be individualised to the person and their whānau's needs. These psychosocial interventions aim to address the many needs associated with the harmful use of substances and alcohol. They include developing skills variously to avoid the use of substances or manage situations in which substances are consumed, address psychological difficulties that promote the use of substances, provide social support, improve interpersonal relationships, and improve self-esteem and self-efficacy (Swift & Aston, 2015).

CBT is a psychological approach to treatment based on the premise that people's thoughts, feelings, physical sensations, and behaviours are all interconnected and influence each other (Beck, 2011). CBT assumes that psychological problems are based, in part, on both faulty thinking styles and learned patterns of unhelpful behaviour (Beck, 2011). A commonly adopted CBT approach is relapse prevention. Relapse prevention was developed to assist clients who have become abstinent to remain abstinent long-term. Within the intervention, individuals are assisted to identify high-risk situations and triggers that are both internal (e.g. grief) and external (e.g. walking into a bar), and that may put them at risk of lapse or relapse. It then supports them to develop new skills and adaptive coping strategies to use when faced with each person's particular triggers and high-risk situations (Marlatt & Donovan, 2005).

The community reinforcement approach is an additional CBT approach to after-care treatment which is based on behavioural reinforcement. Community reinforcement aims to concurrently reduce factors that maintain the consumption of substances and alcohol and increase activities that reinforce non-addiction behaviours (Meyers & Miller, 2001). The approach tends to focus on environmental, behavioural, social, familial and vocational reinforcers (Meyers & Smith, 1995). Contingency management is based on operant conditioning, where behaviours are, selectively, positively reinforced or negatively punished. Although commonly associated with treatment drop-out, contingency management has shown efficacy in the treatment of AOD misuse (Benishek et al., 2014; Lussier et al., 2006). In a meta-analysis comparing psychosocial interventions, contingency management showed the largest effect size (d = 0.58), as compared to relapse prevention (d = 0.32) (Dutra et al., 2008). These methods of treatment are often used in conjunction with other treatment methods. For example, in the same meta-analysis (Dutra et al., 2008), cognitive behavioural therapy in conjunction with contingency management showed the largest effect size (d = 1.02). Furthermore, motivational interviewing has been shown to be efficacious in the treatment of AOD misuse (Schumacher & Madson, 2014; Smedslund et al., 2011). Motivational interviewing is a client-centred intervention used to enhance intrinsic motivation (Miller & Rollnick, 1993; Miller & Rollnick, 1991).

Based on abstinence as a core principle, 12-step programmes such as those used by Alcoholics Anonymous and Narcotics Anonymous are popular treatment methods used within residential treatment facilities. These programmes are also very popular in community settings, particularly due to the long-term support available (Gamble & O'Lawrence, 2016; Ouimette et al., 1997). Due to the high rates of lapse and relapse experienced, continuing care through channels such as 12-step programmes or other available community supports is further emphasised as a crucial component of treatment (McKay, 2009). In order for

treatment to be effective, it must address the individual's substance use as well as their needs. This requirement includes addressing any associated medical, psychological, social, vocational and legal problems. It is also critical that intervention is appropriate for the person's gender, age, culture and ethnicity (National Institute on Drug Abuse, 2012; Substance Abuse and Mental Health Services Administration, 2013).

Therapeutic Communities: Concepts and Theory

TCs are residential drug-free treatment facilities in which the community itself is the principal means of change. TCs are based on a hierarchical model of peer influence and treatment stages that reflect increased levels of personal and social responsibilities. As residents advance through the stages of treatment, they earn increased privileges and responsibilities (De Leon, 2000). Community members promote self-change through becoming positive role models for each other, under the guidance of staff (De Leon, 2000).

TCs were developed in the late 1940s in both the United Kingdom (UK) and the US. In the UK, Maxwell Jones developed TC based on the 'democratic model', primarily for the residential treatment of psychiatric patients with longstanding personality disorders (Jones, 1984). The democratic approach was based on social learning principles. This model was a shift from individualised therapy to a social psychiatry approach, using group methods and multi-person involvement (Kennard, 1983). The basis of this model was that newer patients were trained by ones who had been in treatment longer, and that the relationship between residents and staff was less rigid, with a diffusion of authority. Residents actively participated in the decision-making and problem-solving that affects the treatment setting, giving them more autonomy over their recovery and treatment. This movement was a radical shift from the treatment of mental illness at the time, where professionals were more medically orientated and systems were hierarchical (De Leon, 2010). Although not directly aligned at

the time, TCs and the recovery movement shared many similarities, particularly in regard to flattened hierarchies and service user involvement (Clarke et al., 2018).

In the US, TCs were developed from the concept model, as drug-free residential living environments where individuals live together in a structured and organised manner to promote change towards a drug-free lifestyle (De Leon, 2010; De Leon et al., 2021). The concept model grew out of both self-help groups such as the Alcoholics Anonymous fellowships, and the 'synanon' - a confrontational therapy group founded by Charles Dederich in 1958. TCs were developed as a self-help movement for the treatment of substance misuse, primarily employing behavioural modification techniques, and emphasised the importance of building therapeutic relationships among individuals facing similar difficulties (De Leon, 2000).

Although both the UK and the US developed their communities from different models, the approaches shared key commonalities. They were both developed for the treatment of behavioural problems, and the community was largely directed and managed by the clients (Jones, 1984; Melnick & De Leon, 1999; Whiteley, 2004). Within the communities living together, showing concern for others and belonging were primary agents for therapeutic change and social learning. Confrontational groups were a treatment modality where negative behaviours, which may interfere with the community's values and rules, were confronted by other members of the community. The majority of contemporary TCs in operation today grew out of the concept model, developed with the help of trained professionals who had not themselves experienced substance misuse (De Leon, 2000).

A TC as a psychosocial intervention developed for substance-dependent clients (De Leon, 1995) was based on the premise that substance dependence is a complex disorder involving the whole person. Within the TC approach symptoms can be manifested in mood disturbances, distorted thinking, antisocial behaviours, and deficits in life skills. Individuals

can display patterns of self-destructive behaviour and thinking which impact individual functioning and lifestyle (De Leon et al., 2021). TC theory acknowledges the genetic, chemical, psychological and social influences that result in substance misuse, but views the individual as primarily responsible for their own substance misuse and recovery. Within a TC framework, 'addiction' is viewed as a symptom and not the essence of a disorder, and AOD misuse is a behaviour with multiple psychological, physical and social determinants. Individuals facing difficulties with substance misuse or dependence experience difficulties in cognitive, emotional, behavioural, social and interpersonal characteristics, and therefore treatment needs to be all-encompassing to meet these needs (De Leon, 2000; De Leon et al., 2021).

Within a TC view, recovery is broadly viewed as a process of changing identity and lifestyle (De Leon, 2000, 2010). Recovery is seen as a process involving multidimensional learning, including changes in emotion, cognition and behaviour, which make the foundation for recovery. For example, cognitive changes include developing new ways of thinking. Emotional change refers to acquiring new coping mechanism to manage and communicate feelings. Behavioural learning refers to eliminating antisocial behaviours and developing positive interpersonal and social skills (De Leon, 2000, 2010; De Leon et al., 2021; Tims et al., 1994).

Treatment in the TC is viewed as just one significant facilitator in the process of recovery. Within TCs, detoxification is primarily completed prior to programme entry, and the primary goal of treatment if to modify behaviour and lifestyle (De Leon, 1995; Melnick & De Leon, 1999). The holistic approach involves remaining drug-free, developing employment and life skills, eliminating antisocial behaviours, and developing prosocial values and attitudes. Behavioural and subjective change is developed through intervention that incorporates a range of strategies including group and one-on-one therapy, house

meetings, psychoeducational groups, and verbal feedback to service users. Although the basis of a TC is behaviour change, the model recognises that change is subjective, and therefore must be truly experienced and felt by the individual in order to be stable and long-lasting. A core component of the TC method is self identity change, involving changing elements of social and personal identities during treatment, and continuing to develop new identities after treatment (De Leon, 2000; De Leon et al., 2021).

The primary change process in TCs is based on behavioural and social learning principles. Individual differences and experiences, including a person's readiness to change, and their motivation and circumstances, are key mechanisms in the change process. Individuals also go through subjective means of change with the goal of viewing themselves, others and the world differently. Primary psychological goals include changing the maladaptive patterns of thinking, feeling and behaving that drive AOD use. In a social dimension, clients work towards developing a responsible, prosocial and drug-free lifestyle (De Leon, 2000).

Social learning theory can aid understanding of how change occurs within TCs. As previously discussed, social learning theory (Bandura, 1969, 1997) suggests that learning occurs through observation and modelling of others' behaviours, attitudes and emotional reactions. From a social learning perspective, TCs view recovery as dependent on not only what is being learned, but on how, where and with whom the learning occurs. As maladaptive behaviours, values and attitudes are not developed in isolation, they cannot be changed in isolation. Therefore, the community itself is the basis of change. Learning occurs through participation in the community, vicarious learning, and observation of role models, and is supported by prosocial relationships developed during the learning process (De Leon, 2000). Social learning theory integrates cognitive and behavioural components of learning, providing a comprehensive model of learning that occurs in the real world. The theory builds

on behavioural theories, and proposes that learning can occur simply through observation of reinforcement and punishment, termed ‘vicarious reinforcement’ (Bandura, 1997).

The quintessential element of TCs that distinguishes them from other treatment modalities is that the community is the primary medium for facilitating social and psychological change (De Leon, 2000; De Leon et al., 2021). The TC does this through the use of collective learning, inclusive of group therapy, meetings and psychoeducation. Each member of the community has the key task of being a role model to other members, and individuals are responsible for providing concerned feedback on peer’s behaviour to enhance improvement (De Leon, 2010). Peer encounter groups are an essential component of TC treatment. The primary objective of these groups is to increase awareness of each individual’s behaviour patterns and attitudes that are maladaptive and need to be modified. The encounter group processes may differ depending on the population with which it is being run, whether staff are directing the process, and the intensity of confrontation within the group (De Leon, 2010). TCs are highly structured and follow strict routines. Members of the community are given job functions, rules, structures, chores, and privileges. These aspects change as individuals progress through the programme, acquiring more responsibility and more privileges (De Leon, 2010). There is a promotion of socially responsible roles by participation in the community (De Leon, 2000).

TCs follow three main treatment stages - induction, primary treatment, and re-entry (to the community) (De Leon, 2000). During the induction phase the primary goal is to assimilate individuals into the TC, and this process usually lasts 30 days. Primary treatment is typically broken down into treatment levels, and is the main treatment phase which addresses social and psychological goals of treatment. The primary treatment phase length depends on the length of the programme that the person is engaged in. The last phase of treatment is re-entry, which aims to support individuals to transition from living in the TC to the wider

society. This phase generally involves supporting individuals to move into stable housing, find employment and engage in wider community supports. Following the completion of all programme phases, individuals are eligible to graduate from the programme (De Leon, 2000).

Traditional Versus Modified Therapeutic Communities

Over decades, TC programmes have made several adaptations to fit the treatment needs of particular populations. TCs now take a more comprehensive and holistic approach to recovery, by addressing individuals' other health and wellbeing issues in addition to their difficulties with substance misuse (Smith, 2012). Originally, following the TC model, treatment would last for at least 15 months, and up to 2-3 years on a residential basis. Today, programmes differ in length of time, ranging from outpatient day programmes to 12 months residential. There is also a less reliance on the community as the sole method of treatment, more individualised one-to-one treatment, and more family inclusion (De Leon et al., 2021; Melnick et al., 2000).

To serve the diversity of clients who receive treatment within TCs currently, a wide range of intervention strategies are employed, in addition to those specific to the TC programme. Key adaptations are more staff direction, greater emphasis on individual differences, moderated intensity of group process, and a more flexible programme structure. Moreover, modified TCs incorporate strategies and services which have proven useful in addressing particular problems and specific populations (De Leon et al., 2021). For example, the inclusion of CBT, motivational interviewing and dialectical behaviour therapy (DBT) is common in TC settings. TCs may additionally offer pharmacotherapies including psychotropics and methadone (Dye et al., 2009).

The staffing composition of contemporary TCs has also changed, with more reliance on trained staff. Staffing consists of alcohol and drug practitioners, mental health professionals, social workers, and medical staff, as well as peer support specialists or peer

support (Dye et al., 2009). Currently modified TCs are employed and have shown efficacy for working with a variety of presenting problems, inclusive of alcohol and substance misuse, mental health difficulties, personality disorders, and offending (Broekaert, 2006; De Leon, 2000; Melnick & De Leon, 1999). TCs are identified as particularly effective in the treatment of more severe substance use and psychological needs, when compared to other treatment modalities (De Leon, 2010).

Even where modified, where TCs may make changes to the programme structure and the therapeutic modalities of treatment, the essential elements of TCs must remain stable in order to identify as a TC. The Therapeutic Community Survey of Essential Elements Questionnaire (Melnick et al., 2000) was developed in order to define and assess the core elements of the therapeutic model. These elements are broadly categorised into six dimensions: (1) TC perspective; TCs perceive recovery, addiction and change in the same way (as covered above); (2) The agency; Treatment approach and structure applies the accepted TC model. Staff and members of the community adopt specific roles dependent on their time in treatment, and each member strives to be a role model. The programme is highly structured and routine in its rules, and the daily schedule, groups and programme components are designed to promote positive change for the individual and the community as a whole; (3) The community is a therapeutic agent of change; (4) Education and work activities, such as job functions within the community, are integrated into treatment, and are seen as a vehicle for self-development (De Leon, 2010); (5) Formal therapeutic elements remain are consistent. Open communication and shared experiences are used for therapeutic change, so that group therapy is a primary programme component; (6) The process and stages of treatment follow the three main programme stages - induction, primary treatment, and re-entry (De Leon et al., 2021; Melnick et al., 2000).

TCs have shown effectiveness in the treatment of substance misuse, offending and mental health difficulties (De Leon, 2010; Fernández-Montalvo et al., 2008; Sacks et al., 2008; Sacks et al., 2004) with particularly efficacious results for those who experience severe difficulties with substance dependence, offending or mental health (Welsh, 2007). People who had successfully completed treatment in a TC had more positive post-treatment outcomes, including legal resolution, significantly fewer negative psychological symptoms (Vanderplasschen et al., 2013), decreased substance use (Malivert et al., 2012), higher employment rates (Fernández-Montalvo et al., 2008; Vanderplasschen et al., 2013), and lower depression and PTSD scores (Sacks et al., 2008).

Overall, TCs have shown efficacy in the treatment of alcohol and substance misuse, as well as contributing to recovery. Key factors associated with improved treatment outcomes within TC's include being drug free on entry to treatment, longer treatment duration, the provision of allied services for special needs, particularly when associated with comorbidity, and cultural dimensions. Aftercare components, family involvement and, in particular, the inclusion of children living with their treatment-attending mothers have also been identified with improved outcomes (Bahr et al., 2012; Gowing, 2002).

Therapeutic Communities in New Zealand

Within New Zealand, TCs for AOD difficulties have been operating since the 1980s. The AOD TCs within New Zealand employ the essential components, specifically the community being the primary method of change. They also, however, employ additional methods to cater to the specific population receiving treatment.

A number of TCs operate today for AOD treatment, including Odyssey House in Auckland and Christchurch, Higher Ground in Auckland, and Moana House in Dunedin. Drug treatment units within the correctional system also employ the TC model for substance misuse treatment. Odyssey House, for example, uses the TC method of treatment, while also

employing other evidence-based methods including psychoeducation, cognitive behavioural therapy, and motivational interviewing. The programme is generally 9 to 12 months in duration. Higher Ground operates as a TC, and employs the 12-step principles as a primary method of intervention, alongside other evidence-based methods of treatment. The programme is 18 weeks in duration (King et al., 2016).

Consistent with international research, TCs have shown efficacy within New Zealand. In 3-month follow up measures following treatment from the Odyssey House adult facility, participants showed improvements in mood, reduced cravings to use substances, and improvements in physical health and interpersonal relationships (Gowing, 2002; Matua Raki, 2012). Reductions in rates of crime have also been shown following treatment in the drug treatment units in correctional facilities, as well as following treatment in residential treatment programmes (Department of Corrections, 2010; Gowing, 2002; Matua Raki, 2012).

A Moana House programme evaluation provided further support for the efficacy of TCs in Aotearoa (Adamson et al., 2010); its TC focus is on reducing recidivism, includes components of substance misuse treatment, and is based on strong tikanga Māori protocols. Positive results were seen, as measured by the Hua Oranga Māori assessment scale. For example, 96.6% of participants (n=29) indicated the programme has positive impacts on wairua (spiritual health) and hinengaro (mental health), 93.1% indicated positive impacts on tinana (physical health), and 92.9% reported a positive impact for whānau (family health) (Adamson et al., 2010).

Treatment Within New Zealand

Health inequities between indigenous and non-indigenous populations exist in numerous countries, including New Zealand (Bramley et al., 2005). Although a few studies have taken place in New Zealand, the majority of evidence used to inform service delivery in New Zealand is still adopted from international studies. Historically New Zealand has

adopted treatment approaches which emerged from the US, which has failed New Zealand's multi-cultural society and contributed to disproportionate rates of mental illness and substance misuse difficulties seen in Māori and Pasifika people within New Zealand (Oakley-Browne et al., 2006; Pihama et al., 2017). Many services offer a universal approach to treatment provision which can result in treatment which is not culturally appropriate or responsive to cultural needs (Barwick, 2000; Baxter, 2002). Instead of basing intervention on literature conducted overseas, treatment offered in New Zealand needs to be sensitive to Aotearoa and tikanga Māori (Māori customary practices), and be firmly grounded in Aotearoa's cultural context (Pihama et al., 2017). Family-focused interventions need to be culturally grounded in the ways in which family's function, the family structure, family roles, family norms, and family communication patterns (Centre for Substance Abuse Treatment, 2004). Parenting expectations, values and skills that parents seek to instil in their children are markedly influenced by and based on cultural background and upbringing (Neger & Prinz, 2015). Lack of recognition of culture when designing and assessing intervention and services that help parents improve their parenting is an oversight that needs attention (Neger & Prinz, 2015).

In Māori culture, whānau extends beyond blood relatives, and encompasses extended family, or descent from common whakapapa (Herbert, 2001). Within the Māori worldview, the collective health of the whānau is significant. The whānau unit encompasses several generations of members, who all have roles and responsibilities which are determined by their birth position. Unlike 20th century Western nuclear family model of parenting, Māori tikanga view parenting as the responsibility of the whole whānau. Although parents still held a caregiving role for their children, childrearing was primarily the responsibility of the grandparents (tupuna) (Marsden & Henare, 1992). The wider whānau adopted the role of providing additional care and support for the child. Kiro (2019) suggests that when parents

are surrounded by supportive whānau, it was more likely that emotional attachment would develop between the baby and their parents. Traditionally verbal and physical punishment was not used as a form of discipline (Jenkins et al., 2011). Whānau structures have changed dramatically in recent years due to processes of colonialization, so that traditional practices are not always in place. Grandparents now do not typically have a central role in raising tamariki (children) in the whānau, and extended whānau are less likely to live together, resulting in decreased sources of support (Kiro, 2019).

Māori philosophy towards health is based on a holistic health model. One model for understanding Māori health is the concept of 'te whare tapa whā' – the four cornerstones of Māori health developed by Sir Mason Durie (Durie, 1998; Rochford, 2004). The model describes health through the use of a wharenui (communal house), which is held together by four walls; taha tinana (physical health), taha hinengaro (mental health), taha wairua (spiritual health) and taha whānau (family health). All four walls are important for maintaining wellbeing, and if one dimension is damaged or unhealthy, then an individual may become 'unbalanced' and consequently unwell. Te taha tinana encompasses a person's physical health, inclusive of the body, exercise, development, and nutrition. Te taha hinengaro is an individual's mental and emotional health, how people think, feel and communicate. Te taha wairua encompasses spiritual health, such as religion, spirituality and culture, or a person's values, beliefs and meaning in life. Te taha whānau is described as a person's whānau health, and includes social interactions, support and family systems, as well as family culture, history and identity.

An extension to te whare tapa whā is the Meihana model, which encompassed the four cornerstones of Māori health, and adds two additional elements taiao, and iwi katoa. The model provides further guidance for clinical assessment an intervention when working with Māori (Pitama et al., 2017). Taiao is the external physical environment. This dimension

highlights the importance of exploring and providing a physical environment that meet the needs of Māori clients and their whānau. The physical environment includes elements such as assess, parking, feeling welcomed and having appropriate rooms for whānau to meet (Pitama et al., 2017). The dimension iwi katoa highlights how societal perceptions, beliefs, and services impact the wellbeing of the client and whānau. The model also highlights the importance of considering the impacts of colonisation, marginalisation, migration and racism on Māori (Pitama et al., 2017). These Māori mental health model highlight key considerations to working with Māori in order to be sensitive to culture and holistically meet the needs of Māori in treatment services.

Given the disproportionate rates of mental health and substance misuse difficulties among Māori, services within New Zealand need to be responsive to the cultural needs of those seeking treatment, and further research is needed within New Zealand to understand what works. Literature acknowledges the positive influence of Māori cultural identity for mental health and wellbeing (Russell, 2018; Williams et al., 2018). Higher levels of cultural knowledge, te reo Māori language and collectivism have been associated with increased cultural identity and improved mental wellbeing (Brougham & Haar, 2013; Russell, 2018). Furthermore, a sense of belonging, strong Māori identity and connection to cultural groups are identified as protective factors against suicide (Coupe, 2005). Recent research highlights the importance of cultural immersion and practices within mental health and AOD treatment, given the direct influence of positive mental health outcomes.

Durie (1999) endorsed a number of fundamental aspects for Māori mental health. Firstly, the promotion of a strong Māori cultural identity through the promotion of te reo Māori and Māori culture, autonomy and independence is important for Māori who are developing services, along with the improvement of Māori experiences within mental health systems. This includes the provision of kaupapa Māori initiatives which focus on Māori

aspirations, values and principles. Assessment and intervention should be carried out in a way that values and incorporates Māori cultural elements. A number of cultural interventions are also employed in New Zealand. For example, pūrakau (Māori creation stories) has been used as ideas and narratives which provide individuals and whānau with an alternative matrix to understand their difficulties without the use of medicalised language (Maree Kopua et al., 2020; Rangihuna et al., 2018).

There are few treatment programmes within New Zealand that adopt a primarily cultural model of treatment. Currently, a number of services operate within New Zealand which are developed for Māori, by Māori, including teams within Te Whatu Ora throughout New Zealand, such as the Whitiki Maurea Specialist Māori mental health and addictions team within the Waitematā, underpinned by Māori kaupapa and tikanga. Treatment facilities do however make modifications to their programmes to meet the cultural needs of people seeking treatment. Programme elements are additionally altered to meet the specific needs of parents within recovery. Family-centred facilities do this through the inclusion of children in treatment.

The Evolution of Family-Centred Services

The evolution of family-centred programmes began in the1970s, with the development of women-centred treatment. Women first received treatment in men's programmes, using male-dominated models; however these programmes failed to meet women's specific treatment needs (Werner et al., 2007). As a result, in the 1990s, family-based services were developed for pregnant and parenting women. Family-centred treatment services were developed for two primary reasons. Firstly, 70% of women entering treatment have children and, secondly, research focusing on women's substance use and treatment indicated that relationships, particularly with family and children, play a crucial role in substance use, treatment and relapse (Werner et al., 2007). These programmes were

developed to provide services for both women and their children, allowing parents to engage and participate in treatment while also bonding with children and meeting parenting responsibilities (Werner et al., 2007). At first parents in these programmes faced difficulties with parenting and attachment, due to the primary programme focus being on the parent and failing to take into account the needs of the child. More comprehensive programmes focusing on parental substance misuse, the parent-child relationship and the child's needs have since been developed (Werner et al., 2007).

Integrated treatment programmes are a contemporary and commonly used method of treatment for parents specifically. These programmes, which include drug and alcohol treatment, as well as services that target parenting, were developed in the US to break the intergenerational cycle of AOD misuse, poor parenting and poor outcomes for both parents and children. The predominance of research shows that many mothers who enter integrated treatment programmes with their children have successful outcomes in retaining or regaining custody, completing treatment, and achieving and maintaining abstinence (Carlson et al., 2006; Conners et al., 2006; d'Arlach et al., 2006; Grella et al., 2000; Hiersteiner, 2004; Neger & Prinz, 2015).

Milligan et al. (2015) suggest several theoretical rationales for the concurrent treatment of substance abuse and parenting concerns, namely: a) these programmes reduce barriers to engagement and remaining in treatment; b) parenting services may increase motivation to engagement; and c) integrated treatment has a synergistic effect. Qualitative research supports the findings that children provide a further motivating presence in their mother's substance use treatment that can sustain recovery (Sword et al., 2009).

Research suggests that women, in particular, show higher rates of engagement, retention, and recovery when children are included as part of the treatment process (Lundgren et al., 2003). Mothers have also demonstrated improvements in living skills, including

independent living, relationships and employment, when mother-child programmes were offered (Espinet et al., 2016; Lundgren et al., 2003). Improvements in psychological well-being, including decreased depression and increased self-esteem, have also been indicated (Barnard & McKeganey, 2004; Espinet et al., 2016; Stevens & Arbiter, 1995). The increase in self-esteem is indicated to positively influence overall maternal self-efficacy, which is also correlated with decreased levels of shame (Barnard & McKeganey, 2004; Sanders & Woolley, 2005).

Parenting interventions are shown to have an important role in recovery for parents, with studies suggesting that AOD misuse treatment in conjunction with parenting interventions lead to higher rates of abstinence when compared to control groups who are only receiving substance misuse interventions (Espinet et al., 2016; Moore & Finkelstein, 2001; Suchman et al., 2006). Other meta-analytic evidence suggests that integrated programmes have similar efficacy in improving substance use, as compared to standard care. However, when examining outcomes related to parenting, children's outcomes and mental health, integrated programmes are associated with significantly improved outcomes (Milligan et al., 2011; Milligan et al., 2010; Niccols et al., 2012). There is however a lack of consistency in theoretical and service models within integrated services, and challenges in interpreting meta-analytic studies (Meixner et al., 2016).

Further research suggests engaging women in the prenatal period is associated with increased service use uptake, and higher service use is associated with greater positive outcomes upon ending service use (Andrews et al., 2018; Conners et al., 2006). Mothers who engage in treatment during the prenatal period are more likely than those who do not engage in the pre-natal period to become abstinent, to have their children in their care (Andrews et al., 2018), have improved psychosocial status, parenting attitudes, and additionally stay in treatment longer (Andrews et al., 2018; Moore & Finkelstein, 2001; Suchman et al., 2006).

Hirsteiner (2004) interviewed mothers who were participating in or had previously participated in residential treatment programmes where their children were present. These mothers' narratives highlighted the centrality of parenting to their recovery. Most notably, all mothers highlighted the importance of the parenting components of their respective programmes, describing them as vital for the process of becoming and remaining abstinent. Similarly, in post-release follow-up, mothers who were engaged in mother-baby units in UK prisons had lower levels of substance use, mental health diagnosis and recidivism than did mothers who had not engaged in mother-baby units and had been separated from their infant (Dolan et al., 2013).

For parents who do lose custody of their child/ren, reunion rates are shown to be higher for those parents who attended treatment longer (Andrews et al., 2018). Moreover, mothers who were treated in programmes which provided a higher level of family-related services, such as integrated programmes, were approximately twice as likely to achieve reunification with their children, compared to those who did not have family-orientated services as a part of their treatment (Grella et al., 2009). Programmes that included continuing care components following residential treatment yielded further positive outcomes in terms of reunification (Einbinder, 2010).

Carlson and colleagues (2006) conducted qualitative research to better understand the reunification process following substance misuse treatment, conducting in-depth interviews with mothers and alcohol and other drug clinicians. The results highlighted several treatment needs for mother facing reunification with their children, including learning coping skills to manage intense emotions, access to and use of formal and informal supports and services, and development of parenting skills to aid in supporting the demands of parenting during recovery. The findings highlighted the need for ongoing support services as well as the development of self-care skills to manage parenting demands. Although desirable, mother-

child reunification following substance abuse treatment has often been described as overwhelming and fraught with parenting challenges (Carlson et al., 2006). Treatment focusing solely on substance use leaves parents with insufficient skills to manage child behaviour, resulting in them being more vulnerable to drug relapse as a coping mechanism (Carlson et al., 2006; Suchman et al., 2008).

Integrated treatment programmes, inclusive of parenting support, have been shown to not only support personal recovery, but also improve parenting behaviours and skills. Following engagement in integrated treatment, parents have shown significantly fewer psychologically aggressive parenting tactics, such as swearing, name-calling and threatening to discipline their children (Schaeffer et al., 2013), along with improvement in parenting attitudes (McComish et al., 2003) and parenting skills (Barnard & McKeganey, 2004; Hiersteiner, 2004; Neger & Prinz, 2015). These improvements in parenting skills are related to improvements in child outcomes, including cognitive functioning, school performance and physical growth (Barnard & McKeganey, 2004). Furthermore, improvements in child developmental and behavioural outcomes have been noted (Conners et al., 2001). In comparing integrated treatment versus no treatment, evidence supports integrated programmes for children, as they are associated with improvements in child development, growth and behavioural and emotional functioning (Field et al., 1998; Whiteside-Mansell et al., 1999). Furthermore, comparing integrated to non-integrated treatments, most improvements in behavioural and emotional functioning of children favoured integrated programmes (Luthar et al., 2007; Niccols & Sword, 2005; Noether et al., 2007). Simultaneous participation in AOD treatment and parenting interventions maximises efficiency of both treatments, which is important given that usually time pressures are placed on parents by care and protection services.

Integrated services were largely developed to break the intergenerational cycle of substance misuse and its consequences. Since the development of these programmes, many family-centred facilities have emerged throughout the world, including Canada, the UK, Australia and New Zealand. For example in Australia, Odyssey House Victoria, Odyssey House New South Wales, and the Bridgehaven Salvation Army service all offer residential care for parents seeking treatment for alcohol and substance misuse, with concurrent parenting support, and allow children to accompany parents to treatment. The Bridgehaven Salvation Army service provides treatment for mothers only, whereas Odyssey House Victoria allows both mothers and father to engage in treatment (Odyssey House Victoria, 2016; Salvation Army, 2020).

In New Zealand, the Merivale facility in Auckland offers residential integrated services, but focuses primarily on parenting. Parents can attend this programme with their children following the completion of a specialised substance use treatment programme. In 2008, the New Zealand Department of Corrections formed mother and baby units within three prisons - Auckland Region Women's Corrections Facility, Arohata Prison in Wellington, and Christchurch Women's Prison. These units were developed with the primary focus of fostering bonding and attachment that would otherwise be disrupted (Campbell & Carlson, 2012). Until recently, The Odyssey House Family Centre was the only facility which offered residential integrated services for parents with AOD difficulties in New Zealand. In 2022, Higher Ground opened Te Whare Taonga a Mothers and Babies Unit, which also offers residential integrated treatment.

Context for the Present Research

The predominance of the literature reviewed indicates the efficacy of integrated treatment services, not only in reducing substance use, but also in improving mental health, parenting, relationships, and living skills. There is, however, a lack of understanding as to

how parents understand and conceptualise their own service use within integrated treatment services as those relate to their own recovery, and what programme components contribute to changes in recovery. Much of the literature highlights the effectiveness of integrated services for parenting and substance misuse quantitatively, and there is a lack of qualitative literature which understands the subjective experiences of parents within these integrated services. A large proportion of the contemporary research focuses on a biomedicalised understanding of both alcohol and substance use disorders and recovery. Studies do not always take into account the complexity of recovery, and instead use objective measures of abstinence that do not always provide adequate understanding of recovery.

There is a dearth of research exploring parents' experiences in integrated programmes, which factors they find useful, what they engage in, how they engage in these services, and how these factors impact their recovery. Further understanding is crucial of the subjective experiences of parents in integrated treatment programmes, particularly in relation to parenting practices. Research is needed to enhance knowledge into how integrated programmes are effective in aiding recovering parents, from the voices of service users themselves. By researching the subjective experiences of parents, service providers can better understand the needs of parents within these services, so that clinical service delivery can best meet the needs of those parents.

To date, there has, to my knowledge, been no comprehensive research conducted in New Zealand to understand recovery or meaningful treatment approaches for parents with substance misuse or dependency difficulties. Moreover, international research in the area is outdated. With the rising rates of substance use disorders within New Zealand, as well as high rates of children in state care, further research is crucial. Understanding factors associated with change can enhance treatment effectiveness through directing clinicians to potent intervention targets. In recent years, research has focused on parents and children as

separate entities and has not attended to the important interactional dimensions of the parent-child relationship and the cultures they are embedded in (Staton-Tindall et al., 2013). Research that sheds light on the importance of the parent-child relationship in recovery will further aid in understanding the needs of parents in clinical practice. Investigating and understanding the systems in which parent-child dyads are developed and embedded may aid in understanding the efficacy of particular interventions for these parents.

Aims

The present study explored participants' experiences of their service use and the factors that have contributed to their recovery while in a parent-child residential treatment facility, the Odyssey House Family Centre. The Odyssey House Family Centre offers a unique programme which enables children to live with their parent, in a residential facility, while the parent engages in drug and alcohol treatment. The programme addresses substance misuse and parenting concurrently, and children can live with their parent during treatment to (re)build strong attachment and connections. The research sought to gain insight into the unique journeys of parenting while in residential drug and alcohol treatment. By further understanding the experiences of parents in integrated treatment programmes, the study aimed to enhance knowledge about how to best support the needs of parents in recovery.

Key objectives of the research included understanding:

i) The needs of parents in integrated treatment for substance misuse and dependency

ii) The unique factors that have facilitated parent's recovery within a residential integrated treatment facility.

The Family Centre

The Odyssey House Family Centre is a modified TC offering residential AOD treatment for parents, located in Auckland, New Zealand. In order to explore parents'

experiences within the programme, an understanding of the programmes' theoretical basis and components are necessary. The programme enables children to live with their parent during their recovery journey. The programme also engages pregnant women in treatment and supports the safe delivery of their child/ren while engaged in the programme. The Family Centre holds capacity for 10 parents and their child/ren. (Odyssey House, 2020).

Before admission to the programme comprehensive assessment takes place, and admission criteria apply for all individuals entering the Family Centre. Assessments are completed by a separate team, the Assessments and Admissions team who hold the clients on their caseload until the client is admitted into the Family Centre. Clients must be over 18 years of age, present with alcohol or substance use difficulties, and be eligible for admission under particular contracts. Parents are able to bring up to three children into the Family Centre, all must be under the age of 12. Individuals of all genders are able to engage in the treatment programme with their children, however, only one parent can be admitted.

Aligning with the TC model, the programme is broken into three clinical phases; induction, primary treatment and re-entry (De Leon, 2000). Clients begin treatment at start phase (induction), move through levels one to four (primary treatment) and graduate the programme in level four re-entry phase of treatment. Each phase, or level, of treatment focuses on building strategies and changing behaviours in different aspects of the individual's life. As clients move through the programme, they are given more responsibilities within the programme, and additionally more privileges (De Leon, 2010). Table 1 below displays the programme levels with a brief explanation of each level. Within the Family Centre, a client's level is evaluated weekly by the clinical staff team. Each level has a minimum time period, however, clients must show they are meeting certain goals, including behavioural improvements, in order to move to the next programme level.

Table 1

Family Centre Programme Levels

Level	*Meaning*
Starters	Starters refers to the first four weeks of treatment where residents learn about the programme and decide whether the TC approach to treatment is what they want to engage with. Progress to Level One is determined by time in programme, and completion of a comprehensive assessment where treatment goals are developed.
Level One	Residents in Level One have typically been in treatment for one month, they are settling into the programme and treatment focuses on foundational skills such as reaching out for support, using TC tools, and developing coping mechanisms. Level One is typically 5 weeks long. Movement to Level Two, as with movement at other Levels, is dependent on progress within the programme, which is evaluated by clinical staff members weekly.
Level Two	Residents in Level Two start to gain awareness into their alcohol and/or substance use and develop an individualised Relapse Prevention Plan (RPP). Level Two is typically five weeks long, however progression to level three is determined on successful completion of their RPP as well as other goals.

Level Three	At Level Three, residents gain increased responsibility which includes making sure other residents are abiding by the rules of the programme. Residents at Level three can leave the house with other Level Three or Four residents for short outings, they are also responsible for taking care of lower house residents when they leave the house for approved reasons. Level Three usually lasts eight weeks.
Level Four	The final stage of treatment is prior to living in the community. Residents in Level Four are considered role models in the house, they can leave the residence by themselves, go on day and overnight outings with friends and whānau. Residents at Level Four are preparing to move into the community and develop a more comprehensive relapse prevention plan. Level Four is usually 8 weeks long.
Level Four Re-entry	The final stage of treatment prior to graduation. Clients can live in the community, gain employment, study, and leave the residence without restriction. Clients at this stage are still engaged in the programme, however, they typically do not reside at the facility. Length of stay at Level Four Re-entry is varied and dependent on residents' wellbeing, progress, ability to find stable accommodation, employment etc.

A number of programme components and tools are innate to TCs, which are implemented in the Family Centre. These include encounters and closed groups. Encounters (often referred to as the encounter system) are a therapeutic tool used to deliver feedback to

other residents in a conducive and respectful manner. Encounters are run within a group forum with either staff or upper level residents (residents in Level Three or Four) present. Within this forum, an individual's behaviour that does not support the values of the community is challenged for the purpose of assisting them to stop an undesirable behaviour (De Leon, 2000; De Leon et al., 2021). A closed group is a therapeutic group where participants are made aware of behaviours, they may have displayed, that are against the rules of the programme. Closed groups are however used for more serious rule violations such as violence, threats of violence, theft, substance use or sexual behaviours. Within a closed group, encounters are used to deliver feedback in a constructive manner. Both staff and other residents in the programme additionally discuss the impacts the behaviour is having on the person and the community, help the resident to gain insight into their behaviour and decide on a consequence for the behaviour. Consequences could involve changes in programme levels, for example, being moved backward from Level Three, to Level Two. Along with a change in programme level, clients are given an individualised project, typically with the goal of reflecting on the behaviour and developing adaptive coping mechanisms to manage it.

Residents follow a regimented daily schedule, which is consistent week to week. On weekdays children attend day care or school. During this time parents engage in individualised AOD treatment including individual and group therapy, psychoeducational groups, parenting groups, house meetings, job functions, and day-to-day responsibilities. On a weekend, day-activity outings take place which are centred around building strong and healthy relationships between the parent and child (Odyssey House, 2020). On Sundays Whānau are invited to the Family Centre for weekly visits.

When in the Family Centre programme each parent has their own unit comprised of one or two rooms, and bathroom for themselves and their children. Laundry, kitchen, dining, and living facilities are shared with other residents of the programme. Likewise, daily living

responsibilities are shared such as cooking dinner, dishes and cleaning communal areas. There is additionally a playground on the property. The Family Centre facility is on the same property as the Odyssey Adult Programme, however in separate houses. When children are at day-care or school, clients attend the Adult Programme to participate in therapeutic groups, curriculum and daily responsibilities of the TC.

A number of process and psychoeducational groups are integrated into the programme and residents must complete particular curriculum before proceeding to the next stage of treatment. Core psychoeducational groups include phase one (focused on relapse prevention planning and emotional regulation), and phase two (focused on wellbeing, communication and relationships). Clients also engage in process groups, including men's or women's groups, parents' group, and level groups (The level they are currently in in treatment), which occur weekly. Additional curriculum and groups client may engage in include the Gamblers group, Smoking cessation, SMART recovery (Horvath & Yeterian, 2012), Incredible Years Parenting Programme (Webster-Stratton, 2001), Triple P parenting programme (Sanders, 1999), Parent Goal group and Circle of Security (Powell et al., 2013). As clients progress through the programme and are given more responsibilities and privileges, they are able to go to groups in the community and are encouraged to attend community recovery groups such as Alcoholics Anonymous and Narcotics Anonymous.

Upon admission into the programme, clients are allocated a staff member who is their case manager for the duration of treatment. Alongside group therapy, clients also engage in one-to-one personal therapy with their case manager to work on identified treatment goals. At the start of treatment personal therapy occurs on a client needs basis, however towards the end of treatment 'personal therapy' occurs weekly or fortnightly as client begin to reintegrate into the community and face further triggers. Case managers in the programme are typically

drug and alcohol practitioners or social workers, and therefore the primary clinical work is based on the skills and competencies within the professional registration of these professions.

The Family Centre employs a resident nurse who manages the medical needs, medication and doctors' appointments for all residents and children in the programme. A psychiatrist additionally attends the programme weekly to assess new clients, and review existing clients psychiatric, medication and mental health needs. Pregnant women entering the programme are supported by a local midwife who works closely with their case manager to develop an individualised birthing plan for the safe delivery of their child. Children in the programme also receive individualised support to meet their needs. Following birth, and for young children entering the programme, children have local Plunket nurses, and a childhood community nurse visits children in the programme to ensure they are meeting developmental milestones. Children are also referred to specific community mental health teams if needed. The Family Centre also has relationships with a number of community organisations which the clients and their children regularly engage with, including parenting programmes, relationship supports, rainbow supports, housing support, and community mental health supports.

The Family Centre is a modified TC. The programme is typically 9-12 months long, and programme components have been added and modified in order to best meet the needs of New Zealand people, and their tamariki entering the facility. The Odyssey House Family Centre incorporates te ao Māori and tikanga Māori into its schedule, groups and understandings of AOD difficulties. Odyssey House has specialised cultural supervisors who engage with the clients to help the service users with specific cultural needs. The programme also has specific therapeutic groups based on te ao Māori. Māori and Pasifika models of mental health are incorporated into psychoeducational groups, process groups, individual

therapy and the client's individual treatment plans. These cultural modifications are integral to the culturally relevant assessment and treatment of individuals in New Zealand.

At this stage, the Family Centre is one of two drug and alcohol treatment facility in New Zealand offering treatment which addresses substance misuse and parenting concurrently, allowing children to live on site with their parent. Given the lack of research within TCs and AOD treatment in general in New Zealand, and additional lack of understanding of parents in treatment for substance misuse and dependency, the Family Centre provides a location to gain a much needed understanding into the experiences of parents in recovery. This research will enhance knowledge into how to best meet the needs of parents in recovery within TCs, and treatment facilities throughout New Zealand. In this study, I explored parents' experiences within the Family Centre to understand programme components which contribute to their recovery.

Chapter Two: Methodology

Research Design

This research aimed to explore what unique factors which contribute to recovery for mothers involved in a family-centred treatment programme for alcohol and substance misuse and dependency, as articulated by participants using the service. Drawing on semi-structured interviews with 10 mothers, the study was designed to gain insight into participants' experiences of recovery within residential integrated treatment.

Interview questions were constructed to answer the following research questions: (1) What are the needs of parents in residential treatment of substance misuse and dependency? and (2) What are the unique factors that have facilitated parents' recovery within the residential treatment facility?

To explore unique stories, themes and meanings parents make from their experiences in recovery, exploratory qualitative research methods are optimal. A qualitative approach can give service users a platform to share experiences which may be ignored or unmeasurable in quantitative research (Creswell & Poth, 2016). It enables the collection of rich, diverse and multiple realities, as well as providing context to research participants' experiences (Nakhid & Shorter, 2014). The ability to provide context and rich description from the voices of services users is particularly important, considering the stigma associated with substance misuse in society. Such knowledge can aid in understandings of how interventions foster motivation and change, and how service delivery can adapt to service users' needs (Orford, 2008).

Qualitative research is an umbrella term that encompasses many different theoretical positions, methodologies and epistemological assumptions. The present research was grounded in a post-positivist paradigm, which seeks to understand how and why people function in the ways they do (McGregor & Murnane, 2010; Ryan, 2006). A post-positivist

paradigm argues that people make meaning of their lives through their experiences and their ideas and beliefs about the world, which are shaped by the culture and society they live in (McGregor & Murnane, 2010). Post-positivist research strives for trustworthiness, endeavouring to achieve dependability, credibility, transferability, and confirmability (McGregor & Murnane, 2010). To achieve trustworthiness, findings and meanings made from the research must be firmly grounded in the data and convincing to the reader (McGregor & Murnane, 2010).

The goal of qualitative research within a post-positivist approach is to provide a contextualised rich understanding of an aspect of human experience, in this research, recovery within the Family Centre. People are seen as central to the process within this paradigm and research happens within the daily lives of people and communities (McGregor & Murnane, 2010; Ryan, 2006). Research undertaken in a post-positivist stance reflects the subjective values of the participants and the researcher, so both the researcher and each participant holds a voice and role in the research. Research is conducted among people, learning with them, as opposed to conducting research *on* them (Ryan, 2006). In post positivist research, understanding emerges from one's past and present experiences and interactions as interpreted in socio-political contexts. The stance highlights the importance of theory, whilst also paying attention to the importance of social processes in understanding experiences (Ryan, 2006). This approach is important for research with service users, giving them a voice to share their knowledge and expertise, whilst also acknowledging their histories and the context in which they are living.

A post positivist approach was utilised as it aligns with the aims, objectives and positionings of the research. The approach supports the bringing together of theory and practice, and this was particularly important for the current research, given a purpose was to both understand experiences, and take these understandings to inform clinical implications

for parenting and AOD recovery. It was important that the research took place with people, highlighting their voice and expertise, whilst also being grounded in theory. A post-positivist paradigm supports this approach.

The voices of service users are often overpowered by clinical and medical knowledge that can dominate mental health research and discourse. The importance of service user perspectives has been highlighted, as they provide a subjective and 'lived experience' alternative voice (Flanagan, 2020; McLaughlin, 2010; Paterson et al., 2018). For service users, clinical and medical research is not always viewed as relevant or trustworthy, as it does not always factor in their expertise (Davies & Grey, 2017). Service users place high importance on the expertise of individuals with lived experience, and therefore a pragmatic approach can be beneficial, maintaining rigour through analysing evidence from a service user perspective (Davies & Grey, 2017). The initial idea and development of most research, including the present project, is however typically undertaken by researchers and academics themselves.

Data Collection and Analysis Methods

Ethical Approval

This research was approved by the Health And Disability Ethics Committee (HDEC) on 22 October 2020 (Reference 20/NTB/133). All relevant documents, including the interview guide, participant information sheets and consent forms can be found in this document (Appendices A, B and C respectively).

Confidentiality and Informed Consent

Due to the participants engaging in research regarding their treatment programme, ensuring confidentiality and informed consent was paramount. Participants were assured that their participation or non-participation in the research would not impact the programme treatment they received or their relationship with Odyssey House in any way. They were also

informed they could stop the research process at any point, including during the interview, and withdraw their data for up to two weeks following their interview. Participants also gave consent to the use of audio-recording, were advised how the interviews would be transcribed, and were given the opportunity to edit their transcriptions to ensure all information represented the way in which they wanted to voice their experiences. Participants were informed about how the information would be reported on, the potential for published reports, and that some anonymised information may be used, with extreme care. The researcher made it clear that participant confidentiality was paramount.

Due to the sensitive nature of the data collected, secure data storage was also important. Following transcription of interviews and checking transcripts, the audio-recordings were destroyed. Codes were used to refer to participants and were used on all audiotapes and transcripts to ensure anonymity. Identifiable data (list of codes, consent forms) were only accessed by me and were kept on a password-protected computer.

De-identified data (transcribed interviews) were stored for future studies by the Primary Supervisor Veronica Hopner on a password-protected computer at Massey University where participants had consented to that further use. Those data will only be able to be used with approval from me or the supervision team in anonymised form, and with further ethical approval. Those data does not include any identifiable information. For participants who did not consent for their data to be used in future studies, their transcripts, consent forms and codes will be kept securely at Massey University on a password-protected computer file for a 10-year period, after which they will be destroyed, adhering to Health and Disability Ethics Committee requirements.

Avoidance of Harm

Discussing individual recovery journeys and parenting may have been distressing for participants and may have caused whakamā (shame). Therefore I developed a comprehensive

protocol and safety plan to be followed if identifiable discomfort were to arise during the interview process or if participants became emotionally distressed. Relevant help organisations were offered to all participants at the end of the interview, and I debriefed with each participant following each interview. Supervision was sought from the supervision team throughout the interview process.

Participants were all open about their experiences of recovery and parenting in the Family Centre. They spoke of their struggles as well as successes. Several participants became tearful and emotional when speaking about the importance of their children in their lives and recovery. Guilt and shame regarding their parenting during substance use were also common themes which elicited strong emotional responses. When emotional responses occurred, I gave participants support and respite before proceeding with the interview. All participants were happy to continue with the interview.

Conflicts of Interest

At the time of the data collection, I was employed as a casual practitioner for Odyssey House, where I worked across multiple residential facilities, on an as needed basis, supporting the team to deliver therapeutic interventions in both individual and group formats. Before undertaking this research, I had worked in the Odyssey House Family Centre and Adult facilities as a full-time staff member. In consideration of the research project and to take steps to decrease any power imbalance in relation to programme clients taking part in the research, I ensured that for a period of one year before the start of data collection, I had not worked in the Family Centre facility. Individuals who had been engaging in the Family Centre programme while I worked as a staff member in the facility were excluded from participating in the current research.

Ensuring that the participants felt they could express their experiences of recovery in the Family Centre freely and truthfully was of utmost importance. Before they participated in

the research, I ensured participants that no information gathered within the research project would be shared with Odyssey House in any form, except in a final thesis or report form that would not disclose participants' identities. I assured them that participation and non-participation in the research project would not affect their treatment received or relationship with Odyssey House in any manner. My employment in the organisation may however have impacted the way in which the participants engaged in the interviews and made them less forthcoming with their stories.

Cultural Responsiveness

Although the study did not focus solely on Māori populations, and aimed to recruit persons of any ethnicity, including Māori and Pasifika participants, 70% of the participants were of Māori ethnicity. Accordingly, cultural guidance, advice and supervision for me as the sole researcher was integral to the project. Cultural consultation and supervision was sought throughout the project from a clinical psychologist in the Massey University Department of Psychology and the Odyssey House Cultural Advisor to ensure cultural appropriateness, responsivity, and support in terms of Odyssey cultural practices, and to ensure I was familiar and confident with te ao Māori and tikanga protocols. I sought cultural consultation and guidance during the design phase of the research as well as throughout data collection, analysis and interpretation, and reporting of results.

The guiding principles of the Treaty of Waitangi were acknowledged throughout the interview and analysis process to ensure the rights and dignity of Māori were given precedence. Participants were asked whether they would like to open and close their interview with a karakia or whakatauki. During interviewing and data analysis I made sure to consider a holistic approach and te ao Māori values. Cultural consultation during the analysis process was integral to the project. I discussed themes with cultural supervisors to ensure I

was understanding the findings in a culturally sensitive, responsive and appropriate manner, and to ensure participants' voices were being heard and understood within their worldview.

Recruitment and Sampling

Using purposeful sampling (Merriam, 1998), participants were recruited who were, at the time of the interview, engaged in recovery at the Odyssey House Family Centre. I endeavoured to recruit participants who were in different stages of the programme, to gain insight into what contributes to recovery at multiple programme stages, and to understand if participants' needs change across stages or at a particular stage of recovery.

Due to the relatively small sample size, the study did not intend to be representative of all parents who are in treatment for AOD difficulties, particularly not fathers, nor was it representative of all of the experiences of recovery. Instead, it focused on understanding how the participants view recovery within the Family Centre, and aimed to identify some factors that these mothers believe contributed towards their recovery and parenting.

I attended the facility and gave a short presentation to clients on the proposed research, providing information about the purpose and aim of the project, as well as information related to requirements, confidentiality and consent. In the presentation, I assured clients that participation or non-participation in the proposed research would not impact their treatment in any way. Clients who attended had the opportunity to ask questions and participant information sheets were left at the facility so individuals could contact me to express interest in participation or ask further questions as needed. Participants expressed interest at the time of the presentation, or through email. Once participants expressed their interest, I made sure they met the inclusion criteria and were not currently experiencing acute mental health difficulties, or identifying that that were actively unwell through a brief phone call.

Participants

Participants were 10 residents who were currently engaged in the Family Centre programme with at least one of their children. Participants were recruited from Level One to Level Four Re-entry phases of the programme (see Table 2). Guided by Malterud et al. (2016), 10 participants was considered a sufficient sample size due to the richness of the information that emerged during interviews, dense sample specificity and quality of dialogue between researcher and participants (Malterud et al., 2016).

Once each participants had agreed to participate in the research, I organised a time suitable for us both to conduct the interview. Interviews took place at Nga Wai Otihi, the Odyssey House main building. This location was chosen by all participants as it is private, safe, and a comfortable space.

Table 2

Participant Demographics

Pseudonym	Gender	Ethnicity	Age Range	Number of children	Number of children in FC	Number of months stay in FC at the time of the interview
Estelle	Female	Māori, *Te Arawa*	31- 35	5	1	Two and a half months
Maia	Female	Māori, Pākehā	31 - 35	6	1	12 months
Rebecca	Female	Pākehā	25 - 30	4	2	12 months
Natia	Female	Samoan, Pākehā, Māori *Ngāti Kahungunu*	25 - 30	2	1	Five months
Ātaahua	Female	Māori *Tainui*	25 - 30	5	1	Adult Programme two months; Family Centre two and a half months

Aria	Female	Māori *Ngāti Porou, Tūhoe*, Cook Island, German	25 - 30	4	1	First admission two months; Second admission three months
Isla	Female	Cambodian	30 - 35	4	1	Three months
Niamh	Gender-Fluid	Irish, Māori *Ngāpuhi*, *Ngāti Kahungunu*	25 - 30	2	1	Two and a half months
Sarah	Female	Pākehā	36 - 40	4	1	Three months
Hana	Female	Māori *Ngāpuhi,* Samoan, Pākehā	25 - 30	4	2	Two months

Interview Schedule

Semi-structured interviews, each lasting approximately one hour, were used in order to understand participants' stories of recovery within the Family Centre. The interviews were conversational in nature, and participant-led. In order to make the interviews conversational, a broad interview protocol was developed of topics to be discussed. However where possible I did not lead or direct the conversation. Merriam (1998) suggests that an interview should be guided by a list of questions or topics to be explored, but that the order of questions and exact wording of questions should not be determined ahead of time. Unlike structured interviews, semi-structured interviews allow participants to identify what is meaningful and important to them and their experiences, and express these in their preferred way. Semi-structured interviews also allow new ideas and meanings to be identified and explored, as topics of conversation are not pre-determined (Kvale, 1996; Kvale & Brinkmann, 2009). The interview schedule can be found in Appendix A.

At the start of the interview, time was spent building rapport with participants so they felt comfortable sharing their experiences of recovery within the Family Centre. I made sure

that my own verbal and non-verbal responses placed no judgement on the participants. The interview schedule was used as a source of questioning when more information about certain topics was needed. I encouraged each participant take the lead in their interview, to discuss what they found meaningful first, and then came back to further topics later in the interview if required. It was important that the participant's flow on a particular topic was not interrupted, as doing so could have impacted the richness of the data and the participant's feeling of being heard.

Creating the Cases

I audio-recorded and transcribed interviews verbatim. Following each interview I wrote my reflections on each participant's interview, including general feelings regarding the interview process, client's body language and non-verbal reactions such as hesitancy, laughter or crying. Participants were given the opportunity to review their transcripts, and five participants did so. None of the participants wished to change any aspect of their interview transcript. Giving participants the option to review their transcripts aims to enhance the validity of research, to ensure that what was reported was truly what the research participants intended to say, to portray their stories accurately (Creswell & Creswell, 2017; Merriam, 1998).

To preserve the confidentiality of participants, identifiable information was removed, including client names and age, and children's names. Pseudonyms were assigned or chosen by the participant to preserve anonymity. Following transcription and finalising of interviews, case vignettes were developed for each participant. Taking a case study approach allowed for exploration of each person's experience and is a valuable tool for detailing novel behaviours and for gaining a better understanding of human knowledge in complex real-world settings such as the Family Centre (Merriam, 1998; Yin, 2003). The case study approach is particularly useful in providing context to participants' stories, considering the complex

histories and factors associated with substance misuse, recovery and parenting. Using a multiple case study design enabled the identification of complementary aspects of recovery and different aspects of participants' experiences, specifically parenting and recovery and how these interact. Factors associated with recovery and parenting were central to gain an in-depth understanding of these particular aspects (Merriam & Tisdell, 2015).

Case vignettes were created using a combination of direct quotes and paraphrased information from the interviews. Contextual factors were included in order to provide an understanding of participants' journeys. Factors and themes central to participants' recovery journeys were discussed, including parenting.

The general structure of each case study was the same, first introducing the participant, why they were seeking recovery, and their definition of recovery. I then focused on answering each of the research questions by discussing any changes participants had made in their recovery, and what factors had supported these changes. I discussed both met and unmet needs.

An exploratory approach was taken to the case study design. This design is used to explore a distinct phenomenon and is particularly useful when there is minimal research in a particular area. The approach allowed for 'thick' description and understanding the subjective experiences of the participants (Yin, 2003). In doing so, the research could look at what factors within the Family Centre programme contribute to recovery, while also understanding complex contextual factors related to each participant, therefore giving an in-depth understanding based on the research questions.

Data Analysis

In order to generate unique themes and meanings, both transcripts and case studies were analysed. I aimed to analyse data and themes both within and between the transcripts and case studies to understand central themes of recovery and how these themes may change

throughout the journey of recovery within the Family Centre. Braun and Clarke's (2006) six phase process of reflexive thematic analysis was followed to analyse the data. Thematic analysis is a method for identifying, analysing and reporting patterns or meaning across participants' stories. It allows for examination across a complete data set, producing patterns of meaning known as themes (Braun & Clarke, 2006, 2013). Within thematic analysis, a number of different orientations and approaches can be taken - reflexive thematic analysis, code book thematic analysis, and the coding reliability approach - depending on the theoretical orientation, data and research focus (Braun et al., 2019).

Reflexive thematic analysis, used in the present research, emphasises the importance of the researchers' subjectivity as an analytic source, and the importance of reflective engagement with theory, data and interpretation. This approach was adopted as it acknowledges that the researcher influences the analysis of the data and plays an active role in the knowledge production process. Within reflexive thematic analysis, themes are conceptualised as meaning-based patterns that reflect shared understanding and unite data, rather than domain summaries which tend to report surface-level meaning or understanding (Braun et al., 2019). Notably, the data analysis process is not fixed, and codebooks are not used; instead, coding evolves and can be split, renamed and changed as the researchers conceptualise the data. Reflexive thematic analysis is theoretically flexible, and a number of orientations can underpin the analysis (Braun et al., 2019).

An inductive approach to data analysis was used, to be transparent and reflexive regarding potential assumptions and biases, and to ensure the findings were grounded in participants' responses. Data analysis began during the interview process, with notes being made following each interview. During transcription of interviews, further notes were made of items of interest. Case vignettes were then created for each participant. The transcripts and case vignettes were read and re-read multiple times to become familiar with participants'

accounts and to ensure cohesion and clarity of understanding across participants' interviews and case vignettes. Initial codes were then generated through analysing both transcripts and case vignettes, coding line-by-line to identify important features of the data which helped to answer the research question. Multiple reads of codes were done to make sure that all relevant features were captured. Initial themes were then constructed, through grouping codes together. Reflexivity was paramount during this stage, and I made sure to share early iterations with supervisors, to discuss decision-making around codes and themes, and for feedback regarding cohesion and clarity. I engaged in reflexivity about my role in shaping the data analysis. Thematic maps were used to support this process (Braun & Clarke, 2013). Themes were refined, separated, and reorganized several times to ensure they accurately captured and reflected the data.

Reflexivity

Unlike quantitative methodologies, which can be highly ridged and controlled, qualitative methodologies assume that research is a subjective process that is influenced by the researcher (Braun & Clarke, 2013). The researcher's age, gender, socioeconomic status, life experiences, and beliefs inevitably influence the way in which they conduct research including both research design and data analysis. In order to harness a researcher's subjectivity, and understand how it relates to the project, ongoing consideration, critique and reflection of the researcher's subjectivity is needed, through the process referred to as reflexivity (Braun & Clarke, 2013). Throughout this research I engaged in reflective practices through the use of a journal and discussion of decision-making with my supervisors, to better understand the decision-making process, my assumptions and preconceptions toward the research, my role in the research, and how these factors impact data-gathering and the analytic process.

Reflexivity was important for this project, given my personal experiences working in the Family Centre. Ongoing reflection was necessary to ensure that my own beliefs, attitudes and experiences of the Family Centre did not skew how I interpreted or reported on participants' experiences, to ensure the voices of the participants informed the presentation of results, alongside my interpretation of their voices.

The current project was inspired by my academic and professional experience and interests. During my experience working at Odyssey House, as well as my academic study, I became aware of the high rates of individuals suffering from substance misuse and dependency in New Zealand (Oakley Browne at al., 2006), and the devastating impact substance misuse has on people, whānau and children. There was a dearth of research understanding the needs of individuals with children who are also facing substance misuse challenges, which struck me as an important gap in the understanding of these phenomena, especially considering the increasing attention brought to this topic in public discourse. He Ara Oranga, the Mental Health and Addictions Inquiry (Paterson et al., 2018), was significant in highlighting the widespread impact of mental health and substance misuse in New Zealand and harm to individuals, whānau and communities. The inquiry bought to light the significant need for more rehabilitation and treatment services in New Zealand.

From working at the Odyssey House Family Centre I came to understand the importance of the parental role to the residents in their recovery. I observed the gratefulness from clients for being able to work on their recovery while building strong connections with their children. At the same time I observed parents from other services facing the strain of being separated from their children, while trying to focus on their recovery. It struck me as important to understand the particular aspects of the Family Centre programme that were contributing to parents' recovery, and helping them and their children to live meaningful lives.

I hoped that the research would highlight the intense difficulties parents have when choosing recovery, and further understand the ways in which the Family Centre cater to these needs. It is well known that society needs to pay more attention to the mental health and addictions sector, particularly treatment facilities that cater to the needs of people in New Zealand. I hoped that this research would illuminate these unique needs, and aid in understanding the relationship between the parenting and recovery for parents within New Zealand.

Power dynamics between me as a researcher and the participants as programme clients were skewed, which likely influenced the ways in which we engaged in the interview process and the ways in which the case vignettes where created. Both studying clinical psychology and having previous working experience in the substance misuse sector undoubtedly had an influence on the ways in which I interacted with the clients and data and then interpreted the findings during analysis. I attempted to minimise these power imbalances through making sure that I excluded all participants who had received treatment from me when I had worked at the Family Centre. I stopped working at the Family Centre one year prior to the start of data collection, to minimise influencing the ways in which the participants reflected on the programme or engaged in the interview process, as well as the ways in which I interpreted the participants' accounts.

I spent considerable time at the start of each interview building rapport with each participant so they felt comfortable discussing their experiences, and spent time ensuring all participants knew that no information, excluding risk, would be shared with Odyssey House. All participants appeared happy to share their experiences with me, and some shared how my having an intimate understanding of the programme was helpful for them in describing their experiences. The TC model which the Family Centre follows contains many rules, procedures and terminology. Through having a good understanding of the Family Centre

programme and the TC model in particular, I was able to gain in-depth information, as I understood the programme components and could prompt participants when they were discussing certain topics. I found the shared understanding helpful for both understanding the subtleties of the programme and understanding humour when participants spoke of their experiences in the programme. I believe this shared understanding helped with building rapport and allowed participants to share their experiences more freely and comfortably. However, at times, my prior knowledge of the Family Centre programme may have hindered my ability to explore events deeply. My preconceived beliefs and knowledge of certain aspects of the programme and how it runs on a day-to-day basis may have interfered with my exploration of events within interviews.

The researcher's insider/outsider status was an additional consideration in the research. Being an outsider, as someone without children, and with no personal experience with substance misuse, impacted the ways in which I interacted with the data. My knowledge prior to conducting the interviews was derived from research, clinical experience, talking to clients in the past, and my clinical training. In this sense, I lacked the lived experience of parenting and substance misuse of the participants, which likely meant I could not understand the experiences in the same depth as someone who had experience themselves. Although I did not have a direct understanding of what it was like to parent a child, or be in residential rehabilitation, I did have a genuine curiosity and motivation to understand such experiences, which as a result, may have meant I explored these events more deeply.

I found reflexivity particularly important during the interview process, especially in making sure I stayed in the role of a researcher and moved away from my previous clinical role and lens. On a number of occasions, particularly in initial interviews, when participants shared their experiences or thoughts, I found myself wanting to explore their thoughts or their beliefs, as I would have in the role of a clinician. I had to challenge myself throughout the

interview process to stay in the role of a researcher. When these difficulties came up during the interview, I often came back to the interview protocol and questioning as a reset, which was helpful to keep on track and in the researcher role. At times in the early interviews I also felt that I had failed to explore participant's experiences at a deeper level, instead taking what the participant said at face value and placing it into my preconceived notions of their experience. After my second participant interview I read through transcripts and listened to audio-recordings to reflect on what I could have done differently, and then implemented changes into the following interviews. My process and ability to explore events during interviews developed throughout the data collection process.

During the analytic process and write-up of results reflexivity was also crucial. In analysing the results I needed to be aware of my own preconceived understandings of how change occurs, understanding how both my training in clinical psychology and previous work experience may influence my understandings of participants' discussions. During this phase, I made sure to read transcripts, code, and re-read transcripts multiple times to ensure I was understanding participants' experiences as accurately as possible. Feedback from supervisors was also critical during this phase and helped in minimising my influence on the data.

A specific sub-theme of concern in my findings, which required reflexivity, was the use of evidence-based psychological therapy for trauma and mental health difficulties. During the analysis and write-up of this subtheme, it was important to reflect on some underlying concerns I had. I questioned whether my role as a clinical psychology trainee may have influenced participants' accounts of their experiences of therapy with psychologists at all. It is possible that participants were aware of my training when discussing factors related to trauma, therapy and recovery, or that I may have unconsciously focused on these topics more in the interviews out of my own personal interest. Although I worked hard throughout

the process of this research to be aware of my bias and reduce its impacts, it would be unrealistic to say that I did not have an influence.

Summary

This chapter has outlined the post-positivist paradigm and multiple case study approach which underpinned this research, as well as the specific methods of data collection and thematic analysis that were utilised. After eliciting the recovery stories of 10 participants who were engaged in the Family Centre programme, and who had agreed to participate in the research, reflexive thematic analysis was conducted to explore the research aims and objectives. The following two chapters present the findings of these analyses.

Chapter Three: Case Vignettes

The aim of this chapter is to provide an overview of each participant's recovery within the Family Centre. The 10 case vignettes provide context to participants' recovery stories, briefly describing their histories of use, some key circumstances that led them to their recovery and seeking help from the Family Centre, and some detail on previous treatment and recovery attempts. Specific details are provided, including the length of time they have been in the programme, and their programme level. An explanation of the Family Centre Programme Levels can be found in Table 1, in Chapter One (page 64). The case vignettes highlight the unique nature of each person's recovery and provide a background and perspective to better understand the collective findings from the thematic analysis (Chapter Four). The body of each vignette will focus on an analysis of the key elements of the Family Centre programme that participants identified as supporting their recovery, as well as any future needs.

Descriptions of recovery and parenting are woven into each participant's vignette. Across participant interviews, it was apparent that recovery encompassed parenting, though participants spoke about the two concepts separately.

Case Vignette One: Estelle

At the time of her interview, Estelle (Māori *Te Arawa*, age range 31-35) had been in treatment for two months. She came to the Family Centre on parole from prison, with her pre-school aged child. Estelle had never sought treatment previously, although she had resided in a Mothers with Babies Unit in prison, following the birth of her child. She had minimal whānau support, with most of her family living overseas. Estelle described a 20-year long history of methamphetamine use, related criminal offending, problem gambling and abusive intimate relationships. She was motivated to seek recovery and to live substance-free, and commented that it was *"the first time I've wanted to change"*. Estelle had four other

children, out of her care, that she also wanted to rebuild connections with once she transitioned into the community, following graduation from the Family Centre.

For Estelle, recovery was all-encompassing, involving *"*[changing] *offending, behaviours, all of those things…. having my children … stability, working and building a relationship with my children"*. Estelle described herself as early in recovery and commented that she was still figuring out what she wanted her future life for herself and her tamariki to look like. For her, the Family Centre was the only place she was motivated to receive treatment as *"there are no other options for me to have my children and rehab*".

Estelle's primary goal of treatment was to graduate from the programme with her child. At her current stage of treatment, she wanted to develop boundaries in relationships with family and other clients in the programme, develop her self-worth and confidence, and learn strategies to manage her emotions. She was proud of her progress in treatment, recovery, sobriety, and motivation to be a good parent to her children. She noted the positive impact others in recovery were having on her own recovery journey, not only motivating her to change but helping her notice factors that she needed to work on and change. Estelle expressed how she had difficulty trusting others, but was trying to develop trust by speaking to staff and receiving their support, as well as sharing her story with peers and hearing about their similar experiences. She also emphasised the relationships with staff and fellow clients she had already built within the Family Centre and noted that she knows their support will be continuous even when she does leave, *"to know I can come back here, it's a big thing for me. I know it's always here".* Her discussions emphasised the importance to her of support networks as well as aftercare staffing in recovery. Estelle spoke about the importance of routine in her recovery and finding things to be passionate about. For her, being able to experience positive emotions for the first time, while sober and in a safe environment, had re-sparked her love for cooking, helping others, and nature.

It was clear that Estelle's primary motivation for undergoing treatment was her child: *"I look at him and think I'm doing this for you, and it makes me feel good".* Her motivation for change appeared to centre around becoming the best mother for her children. She expressed not wanting her children to miss out on having parents who were loving and involved. Estelle noted that, before coming into the Family Centre, she wasn't an emotionally present parent and would only complete what needed to be done. Since entering the Family Centre, she was creating a strong relationship with her child, by them spending one to one time together. Estelle was growing to understand her child and his needs; she had learned to settle her child when he was upset, she felt confident in her parenting and proud of how far she had come, noting that *"It shocked me at first* [how much her parenting had changed]*, I was anxious, but it's good now, I am confident. It's always been about him. I want to better myself for him".*

Estelle's narrative presents a key contrast between who she was versus where she is now. She discusses moving from feelings of anxiety to confidence, and the feelings of surprise about her growing confidence in her parenting. Her discussion points to the major changes she feels she had made since being in the Family Centre, and how these changes in her parenting had impacted on her self-identity. As Estelle was moving through the programme, becoming more involved in her child's life, and re/building her connection with her child, she began to re/build her sense of self and her identity as a parent. Her narrative further reinforces that Estelle derives much of her motivation from her son. Moreover, it appeared that her growing confidence in parenting was reinforcing her motivation to change. Estelle's experience aligns with literature outlining the strong motivating role that children can serve in recovery (Carlson et al., 2006; Schultz et al., 2018).

Further reinforcing the role that her child was playing in her recovery, Estelle commented on the importance of learning parenting skills now, before re-entering the

community with the possibility of caring for her other tamariki (children). She spoke of the importance of having knowledge of parenting skills and wanted to have more core parenting programmes or resources as a part of the skills curriculum in the Family Centre, so that she could gain knowledge on her children's development, and ensure they were meeting all developmental milestones.

Case Vignette Two: Maia

At the time of her interview, Maia (Māori/Pākehā, age range 31-35) had been in treatment for 12 months. She was in Level Four Re-entry phase of treatment and was in the process of looking for stable accommodation for her and her children to move into the community. Maia had been waiting nearly two months for community accommodation and spoke of feeling stagnant in her recovery. She often felt challenged to remain motivated and grateful and indicated the need for more support regarding community housing. Her narrative raised concerns surrounding ongoing structural issues, in particular housing, and the negative impacts this has on individuals' recovery.

Maia entered treatment with one of her preschool aged children, and at the time of the interview had two of her older children transitioning into her full-time care within the Family Centre. Maia had another three children who were out of her care, living in the community, and she had no whānau support. Maia sought treatment from the Family Centre following methamphetamine and alcohol misuse since the age of 13 and experiences of significant physical and sexual trauma. It was the first time she had tried any treatment or recovery. She was originally referred to the Family Centre to re-gain custody of her children, but her motivation for recovery had changed throughout her time in treatment.

For Maia recovery was *"pulling yourself apart and rebuilding a better version… Finding out who you are as a person without drugs and alcohol involved. Building your strengths to do better for you, and your kids".* Here, Maia emphasises the development and

construction of her 'self' in recovery, as well as the relational nature of her recovery. She described her experience at the Family Centre as *"one of the hardest things I've ever had to do. It's been a tornado, but it's made me the person I am today".* Her use of the word 'tornado' reflects an experience which pulled apart her previous beliefs and attitudes. Her description of the programme being 'one of the hardest things' she'd ever done reflects the intensity of the programme in challenging the way she had lived her life.

Maia spoke of her journey at the start of treatment being a "*tick box*" for her. She wanted her children back in her care, and that was the only reason why she was doing treatment. Through staff and other residents constantly challenging her on her counterproductive behaviours, attitudes and beliefs, she faced a key turning point in treatment, becoming aware of why she needed to change.

Being here and being challenged on all of those thoughts and bad behaviours, being challenged on everything, I mean everything!... The lightbulb just went, oh I get it, change now or I will be like this forever.

Maia described an extrinsic motivation for treatment at the beginning of recovery, that she was only seeking treatment to get her children back in her care. Her primary motivation for treatment was her children, and not for herself. As she moved through treatment Maia developed the intrinsic motivation to want to better herself, for both herself and her children. Her story challenges common conceptions that an individual must enter treatment with the motivation to change for themselves to engage, and highlights that motivation can be and is developed while in treatment. Motivation is emergent, dynamic and contextual, and does not remain static. Maia needed the support of others to be able to become aware of why she needed to change, emphasising the relational nature of recovery in the Family Centre. For Maia, treatment was a platform for her to be able to develop this awareness.

Maia commented that the constant feedback from both staff and peers was key in her becoming aware of and acknowledging ingrained behaviours, particularly aggression and confrontation, that were detrimental to her recovery. She reported that the structure of the programme and TC components had also been helpful for her to gain insight into her past AOD use, and to make the necessary changes. Maia commented that the encounter system was challenging but had been a particularly important component in her becoming aware of and changing detrimental behaviours such as aggression and confrontation. Furthermore, ongoing support from staff had been crucial for her to be able to build intimate trusting relationships and learn to reach out for support when needed, in particular that *"it's continuous, the staff here have put in extra work for everyone, and I feel like a lot of us wouldn't be here if it wasn't for that extra effort they put in".* The support offered from staff had been helpful for when she had been in the community and faced triggers. She was engaging in Accident Compensation Corporation (ACC) sensitive claims counselling, for sexual abuse, with a clinical psychologist. She commented that she still needed to work through her underlying trauma, but having access to psychological support was valuable, and she was slowly opening up about her past trauma.

Maia's motivation was also driven by regaining trust from her older children, trust that she had broken over the years. A significant milestone for Maia had been rebuilding her relationship with her children which she said "*gives me hope"* for recovery. Hope, for Maia, was more than an intrapersonal process; it referred to her future with her children, hope for a better life as a whānau.

For Maia, the Family Centre was a place for her to discover herself as a parent and re-build strong relationships with her children. She commented that having her child with her in treatment had given her daily motivation to stay in treatment and helped her to realise the strengths she had as a parent. She also noted the importance of learning skills such as how to

be a parent and the challenges parents face within a safe environment, so that she had the skills to be able to nurture her children when the family moves into the community. She spoke of how the Family Centre was the only place where she could seek support, noting that *"I wouldn't have done treatment; I know that if I had been over at the main house* [Adult Programme] *I wouldn't have lasted".* Her words further emphasises the relational nature of her recovery, with her children being a key to her perceived success in recovery. Maia expressed the need for more parenting knowledge as a part of the recovery process. She believed more information or classes on how to manage difficult child behaviour would be helpful, since a lot of the children in the Family Centre have also experienced trauma in their upbringing. Her comments about the need for more parenting knowledge again emphasises the interconnectedness of parenting and recovery.

Case Vignette Three: Rebecca

Rebecca (Pākehā, age range 25-30) had been in treatment for 12 months at the time of her interview. She was in the Level Four Re-entry phase of treatment and was in the process of looking for a house so that she and her children could move into the community. The lack of available safe community housing was a challenge, and she had been waiting two months to find a house. Rebecca came into treatment with her two pre-school age children. She had two older children who were living with family in the community and with whom she was also rebuilding relationships.

Rebecca spoke of long-term methamphetamine misuse and a history of abusive intimate relationships which made it difficult for her to seek help. Rebecca had tried self-directed recovery in the community without external support prior to residential treatment and had achieved abstinence for one month. She spoke about how at that time she had been in a controlling and emotionally abusive relationship, which stopped her from being able to make changes needed for long-term recovery. After realising the impact her relationship was

having on her substance use, and the impact her substance use was having on her children, Rebecca separated from her partner and sought support from a Community Alcohol and Drug Services (CADS) pregnancy and perinatal service. She then self-referred to the Family Centre, as recommended by CADS.

Rebecca described recovery as *"a new state of mind",* emphasising that recovery is a lifelong journey, and *"once you achieve those goals don't just think that's that, you give yourself new goals… just because I achieve this programme doesn't mean I should just stop".* Her primary goal in treatment centred around developing a stable and loving environment for her children. Rebecca was realistic that recovery would be hard at times, especially when she entered the community. She discussed how recovery was ongoing.

> *INTERVIEWER (INT) = So, when you came here you said you had this 'will I stay clean' voice?*

> *Rebecca = It's always been here, it's just smaller than it used to be, I'm always aware of it, I think that's just addiction in general, you'll always have those euphoric recalls and the good times, but whenever that comes up, I always think of the bad times, because that's what's good for me. You know it's never going to be different, it's only going to be worse, especially now after I've done all of this* [recovery programme].

As Rebecca progressed in her recovery, doing so had become easier, more manageable. Whilst in Level 4 of the programme, Rebecca had been into the community and faced triggers. Learning to ask for help and the ongoing support from Family Centre was key in managing these situations, where *"I know we can always call them* [staff*]".* Rebecca's discussion around the importance of support when in the community emphasises both

relationality in recovery and the importance of aftercare support staff for those following programme graduation.

Rebecca described the Family Centre as a safe place to learn strategies and skills and make changes, noting that *"being somewhere safe where you can make those changes, it holds me accountable. I don't have to worry about all those things that could happen out there".* She observed how learning skills such as routines, cleaning and cooking had been important for her recovery and would continue to be important when she moved into the community. A safe and stable environment was an important platform for Rebecca to engage in recovery.

Learning to manage emotions and developing boundaries was another important aspect of Rebecca's recovery. While in the Family Centre, Rebecca learned strategies such as journaling and speaking to trusted people, which she implements when she is feeling emotionally overwhelmed or anxious. She developed strong boundaries through increased confidence in herself and as such could speak up for herself and her children's needs. She noted the importance of the TC rules and structures in supporting her boundaries and confidence, particularly the encounter system. Rebecca also spoke of how participating in cultural activities such as kapa haka had developed her self-esteem.

Rebecca emphasised that her peers had helped her develop strategies, and through observing and speaking with them, she developed self-awareness of her emotions and behaviours. Seeing changes in herself through her recovery had further built her confidence in herself and motivated her to stay in recovery. Receiving positive reinforcement and having support available 24/7 from staff, whānau and her peers had assisted her growing confidence. Rebecca's narrative highlights the relational role of recovery in her journey. She developed awareness and skills through others and received feedback that informed her ongoing recovery-orientated actions.

Through spending intentional time with her children playing games, going to the park, and reading together, Rebecca spoke of how her connection with her children had grown while in the Family Centre, she expressed feeling present when she is with them and was nurturing them and their needs, so that *"I feel like my bond here with my kids is really good, its changed, its better".* Rebecca discussed the positive impacts this bond had on her own recovery, that *"it makes me want to strive for more, and better*". For her, recovery and parenting came hand in hand, in that *"my recovery and parenting are very connected. I'm not sure what it would've been like if I had been in another place without them… because not having my kids, it just forced me to be worse".* Her motivation for change was derived not only from her children but from being a good mother. Being a present parent gave Rebecca the confidence to be herself and *"thrive".* For Rebecca, recovery and parenting were intertwined, each impacting the other. Progress in her parenting appeared to directly support and progress her recovery, and recovery directly supported her parenting.

Case Vignette Four: Natia

At the time of her interview, Natia (Samoan/Pākehā/Māori *Ngati Kahungunu*, age range 25-30) was in Level Three and had been in treatment for four months. Natia reunited with one of her two preschool aged children in the Family Centre, after being separated for over a year. She was having weekly visiting with her other child, in the hopes of gaining custody. Natia entered the Family Centre from prison, on release conditions requiring her to engage in the programme. She sought recovery and parenting support following several prison sentences, abusive relationships, and long-term methamphetamine misuse. She had experienced considerable sexual and physical trauma throughout her life and used substances to cope. It was the first time Natia had sought formal treatment in the community. She had remained abstinent in the community for a year previously while on release from prison, but

relapsed due to being in an abusive relationship. In a previous prison sentence, she had resided in the Mothers With Babies unit with her youngest child.

For Natia recovery was centred around her family being together, living in the community, being healthy, and being supported by prosocial people. Although Natia had applied for other rehabilitation programmes, entering the Family Centre was her first choice to work on her recovery and parenting and be with her child. It was apparent that Natia's primary motivation or treatment was her child, that *"He is my biggest motivation. I couldn't bear being away from him"*. She also spoke about her growing relationship with her child as supportive to her recovery, that *"It's good for me because he makes me want to do good by him".* The daily tasks of a parent such as bathing, feeding and changing as well as spending intentional time with her child doing activities like singing, reading and drawing had built Natia's sense of purpose and belonging, so that "*I'm a role model now, and I have to role model. It creates a sense of belonging and purpose which makes me feel better".*

Natia's narrative emphasised the development of an identity as a parent. Parenting her child had developed belonging and purpose as key protective factors in recovery. Her role as a mother further served as a motivating factor, in being a positive role model in her children's lives. At the time of the interview, Natia expressed struggling with finding a balance in her recovery, saying *"I think I find it really hard balancing my responsibilities and my parenting".* Considering the intertwining of parenting and recovery in participants' stories, Natia's comment emphasised the complex nature of parenting in recovery. Parenting can simultaneously foster recovery whilst also making it hard at times. Her comment points to the need to support participants' parenting as a key factor in their recovery, as difficulties in parenting likely influences substance use recovery.

A significant goal of Natia's was to learn to better manage her emotions and behaviours. In the Family Centre, with staff and peer support, Natia had developed skills in

consequential thinking, mindfulness and asking for help, which were supporting that goal. An additional key factor in Natia's recovery had been engaging with a clinical psychologist for trauma. She explained that much of her substance use stemmed from her traumatic experiences.

Natia expressed the importance of learning from those who are good role models in the programme. Being around others who are *"abstinent and want recovery"* had helped her on her journey in treatment, noting that "*They're motivating, it's so good to be around good people, it's so helpful to see them on their journey"*. Furthermore, Natia spoke about how supporting others had been helpful for herself in building her own self-esteem and confidence. Natia's comments emphasise mutuality and support in recovery. She spoke extensively about the impact others in treatment had on her recovery, both good and bad, as well as the impact she had on theirs. Mutuality and support are key tenets of the TC model, that change occurs with and through others.

Case Vignette Five: Ātaahua

At the time of her interview, Ātaahua (Māori *Tainui,* age range 25-30) had been in treatment for four months, and had started during her pregnancy at the Odyssey House Adult Programme. She then transitioned to the Family Centre to prepare for the birth of her baby. Ātaahua had four other children, all under age 10 and living in the community under care and protection orders. At the time of the interview her baby had been born, and she had just entered Level Three of treatment. Ātaahua came to the Family Centre to seek support for years of substance use, significant trauma, poverty, and parenting difficulties. She had attended the Odyssey House Adult Programme early in her pregnancy, but left treatment due to missing her children, and was now attending treatment under release conditions from prison. Ātaahua had support from her partner who was living in the community, as well as whānau support.

For Ātaahua recovery was "*finding yourself again, finding my actual self".* She emphasised the discovery and rebuilding of 'self' as being important in her recovery journey, and how the Family Centre supported her to do so, that "*They help you find yourself, who you really are, and yourself as a parent"*. Ātaahua's comment identifies the role of being a parent in her construction of self, and identity. Finding passions, engaging in cultural activities and parenting her child had been key factors associated with this self-discovery and development. Engaging in her culture was pertinent to Ātaahua's recovery. She emphasised how engaging in her culture had been important for her to rediscover herself.

Building trust in relationships had been a significant factor in Ātaahua's recovery. She spoke of the difficulty moving from the Adult Programme to the Family Centre, specifically due to the trusting relationships she had built with staff and other residents in the Adult Programme.

Having that communication and trust with people over there [Adult Programme], *and then not having it with anyone at the Family Centre yet, it was hard. I had found my family over there, and I wanted to be with them.*

Ātaahua expressed a deep sadness regarding her move to the Family Centre at first. She described the Adult facility as her 'family', illustrating the depth of her bonds with those at that facility. Her discussions were a salient point of difference from those of other participants. As someone with a trauma background, Ātaahua experienced difficulties opening up to others and building trusting relationships. Having found these supports at the adult facility but then having to move proved a significant challenge for her recovery.

Although challenging, moving into the Family Centre and building further trusting relationships with staff and residents was extremely beneficial and enabled Ātaahua to reach out for the support that she says is crucial for her ongoing recovery. She voiced how building trusting relationships was important in order to work through the significant trauma she had

experienced, something that she was struggling with at the time of the interview. She was receiving support from a clinical psychologist for significant past trauma, but was still struggling with learning to trust others and open up, noting that "*I'm trying to find that trust around my trauma. Being able to open up with someone, I think it's important for my recovery, I do need to let it out, I haven't really opened up about everything yet".*

Learning from other residents and watching their recovery journeys had been helpful for Ātaahua, because *"being able to learn from others, you are learning from me, and I am learning from you".* She noted how this observation and learning both motivated her recovery and gave her hope for change. She further emphasised the crucial role mutual support has in treatment and recovery.

Ātaahua spoke of the difficulty of being pregnant while in treatment, especially watching other families build relationships while she was still waiting for her child to be born. For Ātaahua, giving birth and bonding with her child was a key turning point for her in treatment and recovery. She spoke extensively on giving birth drug-free for the first time, and the impact this had on her own recovery and parenting. With previous births, Ātaahua had been using substances, and that following the birth of her children she had either left them or "*was just there to feed them and then the father did the rest".* She expressed how giving birth sober was scary and intense, especially due to complications experienced. However, the process changed her thinking around being a parent, that "*the process was feeling the pain and knowing that I did need change, I do need change".* Ātaahua spoke of the first 24 hours spent with her child being significant in her recovery, that *"this time I was with her 24 hours doing everything, everything was about her, I was actually present… It was awesome, unbelievable".* The time she spent bonding with her baby while drug-free helped her build an identity as a mother as well as contributing to her overall wellbeing and drive in recovery.

Case Vignette Six: Aria

At the time of her interview Aria (Māori *Ngati Porou, Tūhoe*/Cook Island/German, age range 25-30) had just entered Level Three of treatment and had been in the programme for three months. She entered the Family Centre with one of her four children, seeking support and treatment following ongoing substance use for near 10 years, as well as intergenerational trauma and hospitalisation for drug-induced psychosis. She had made previous attempts to remain abstinent in the community following the birth of her youngest child, but relapsed due to a lack of whānau support at the time, along with the stresses and grind of coping with poverty. Aria had previously sought treatment from the Odyssey House Adult Programme, for three months. Following this treatment, while living in the community, she relapsed and became aware of the support she needed for her recovery and the positive changes she wanted to make. Aria now had the support from some whānau, where the rest of her children were residing.

For Aria recovery was *"trying to become human again ... trying to get my whole life together, my wellbeing"*. She acknowledged that she was still trying to figure out what recovery was, noting that when she came into treatment, she thought recovery was just "*not using drugs".* Since progressing through treatment, she had discovered the holistic nature of her recovery, and how it connects, relates to and informs every aspect of her life.

Aria discussed how learning to manage distorted thinking and developing strategies to use when feeling overwhelmed was important to her recovery. She had developed some of these skills through learning from other residents.

> *Watching people change in here, for me seeing things that I don't notice in myself. I watched them progress and change things that used to be so massive for them, and it makes me reflect on myself and wonder how I have changed.*

Aria additionally described how the programme curriculum and staff support had been significant in both understanding the core of her substance use challenges and starting to manage her emotions. She also spoke of how she wanted access to specialised psychological support for childhood experiences so that these experiences didn't impact her relationships with others in the future. At the time of the interview, that support was not available.

For Aria, bonding with her youngest child was significant in her choosing recovery. She described how, with her other children, she had co-parented actively with the father of the children. Following an acute mental health episode and resulting hospitalisation, Aria became pregnant with her youngest child.

> *I raised her on my own, and this gave me this time where I was bonding with her, and it made me realise I don't want to* [use substances], *I choose this love over that love, and I wish I had done it with my other kids. I will forever be hurt over that. But when she was born, I was so connected to her, and I wanted to change.*

Aria expressed regret for her past substance use and the impacts that had on her children. Her language use, *"this love over that love",* highlights the significant role substances had played in helping her to live with her trauma and pain. She expressed the significant role bonding with her child had in motivating her to choose *"this love over that love"*. Bonding with her child following birth was a key turning point. Moving into the Family Centre, her relationship with her child had been significant in her recovery, contributing to her over all wellbeing and her construction of self and identity as a person and parent.

Engaging in groups and parenting day-to-day in the Family Centre had built Aria's confidence in being a mother. Her growing confidence helped her develop boundaries and seek support, which had had a large impact on her ability to balance recovery and parenting.

> *Now I've gained more confidence to express my needs and that's where my boundaries come into place too, being able to say no because I need that one-on-one time with my child. I used to just go with it, but now I express my boundaries, so that confidence has helped me with finding my balance.*

It was clear that Aria's child was her number one priority. Gaining confidence in herself, which was developed through her role as a mother, supported her to be able to prioritise her own and her child's needs, giving her the ability to better balance her recovery and parenting.

Case Vignette Seven: Isla

At the time of her interview, Isla (Cambodian, age range 31-25) had been in treatment for three months and had just entered Level Two of treatment. She entered the Family Centre with her youngest child, a toddler who was under care and protection conditions. She sought recovery and treatment for methamphetamine use and to regain custody of her child. Isla had previously been in residential treatment but relapsed due to an abusive relationship she was in at the time. This was the first time she had entered treatment with her child. Isla had support in the community from her family and partner.

For Isla, recovery encompassed not only herself, but the ones she loves, noting that *"Living the reality life again, being able to make the people you love smile again, and that's why I chose recovery over addiction, I wanted to exist again".* She voiced how she still had

so much to learn on her recovery journey, but that she finally felt good about herself and the changes she was making.

Isla described support from both staff and her peers as being significant in her recovery. She expressed how she had been able to open up with people for the first time and how watching individuals with similar experiences make significant changes in their life gives her motivation and belief in herself to do the same, that *"It makes me feel so much better knowing I'm not the only one. I find it inspiring too".*

Isla discussed rebuilding her relationships with her family as being very important for her recovery. She commented on the multi-family group run at the Family Centre as a great way of rebuilding those relationships and learning how to communicate more effectively. Rebuilding family relationships had *"made me crave recovery so much. Being able to make them smile again".* Isla discussed how the Family Centre had continued to support her to engage in her culture and religion, something that was very important to her. Furthermore, the curriculum had been pivotal in gaining insight into her substance use and in developing coping mechanisms.

Isla was open about the difficulties that all parents face, and for her recovery was about being a good parent for her children. Guilt and shame regarding her past parenting also appeared to interfere with the way in which Isla interpreted her parenting. In discussing changes in her relationship with her child, Isla wanted to improve her parenting.

Isla = Just be a great mum, not the best mum, but a good enough mum.

INT = What does that mean?

Isla = Well, I know I can't be a perfect mum, but there for them. I suppose no one can be a perfect mum. But I feel like I'm calmer. Now I can control my frustration with my children when it comes up. Breathing exercises help, it's really handy.

Although her past parenting appeared to influence her current view of herself, being with her child every day was supporting a shift in her parenting skills and her perceptions of her parenting. Isla expressed how her motivation for change was reinforced daily by the presence of her child, *"seeing him every day, it's like, wow it makes me more focused, more determined I'm not only doing it for myself, but I'm also doing it for my children".* She highlighted how having her child in treatment had helped her build capabilities as a parent, while also building her confidence and self as a person outside of the parenting role. She commented on the difficulty in finding a balance between being a parent and working on her recovery, and how learning to ask for support had helped her manage.

Case Vignette Eight: Niamh

At the time of the interview, Niamh (Māori *Ngāpuhi, Ngāti Kahungunu*/Irish, age range 25-30) was in Level One of the programme and had been in treatment for two and a half months. Niamh self-referred to treatment with one of their two children and was seeking recovery for long term poly-substance use, intergenerational substance use, severe emotional, physical and sexual trauma, and mental health difficulties. Niamh had attended several treatment programmes before the Family Centre. They had also maintained abstinence in the community for a year-long period following the birth of their first child, but began using substances again as a way of coping with their trauma.

For Niamh, their primary goal in recovery was centred around healing their past trauma, becoming themselves again, and starting to live. Niamh's comments highlight the good and the bad that they associated with substance use. They used descriptive language to highlight the role of substance use in numbing emotions and trauma. Their comments also portrayed how substances took away anything happy in their life.

I just don't want to be dull anyone, I want to start living. When you're on drugs you're on a fluffy white cloud, but once you're on it for so long you get into this dark area, nothing grows there, it gets darker and darker and takes away that fluffy cloud that you're on.

Niamh described specialist psychological support as crucial for their recovery, emphasising that without it, they would not be able to get better. They commented on the need for this support for processing trauma and developing self-worth, that *"People would say aren't your children enough to not be addicted… it's not a lack of love I have for my children, it's a lack of love I have for myself".* Niamh emphasised psychological support as being a crucial component in services such as the Family Centre. They also portrayed the turmoil and trauma associated with the use of substances.

Niamh discussed as fundamental the support from staff to engage in their culture and religion, further helping them in the rediscovery and construction of self. They noted the routine and structure in the house as very important to be able to manage their own recovery whilst also parenting. Niamh said that the house ran more smoothly when at full capacity, with 10 families, as the parents were all there to support each other in their recovery and parenting, while also fulfilling the day-to-day responsibilities in the house. Their comments spoke to the impact of relationships, and a sense of community in their recovery.

Niamh spoke of wanting to protect their child and wanting to break the intergenerational cycle of substance use and parenting difficulties in their family. They spoke of how their daughter was a daily reminder of why they were in recovery, that *"Everything I do is for my child. Over there they lose focus for why they are in here, a lot of them are here for their children, but they don't see them every day, so they lose focus".* They spoke about how being in the Family Centre had taught them how to be the mother that they had always wanted to be, and the purpose they had created for themselves in the process, noting that

"This place has taught me that you can actually parent your kids without needing drugs". Niamh discussed how before entering the Family Centre they played a "*sister"* role in their childrens lives, but now parenting day-to-day and spending quality time with their child had developed their relationship with their child, confidence and identity as a parent.

Case Vignette Nine: Sarah

At the time of the interview, Sarah (Pākehā, age range 36-40) had been in the Family Centre for just over two months and was in Level One of treatment. She self-referred to the Family Centre with her newborn child to seek recovery following near 20 years of poly-substance use, intergenerational substance use, significant childhood and adult sexual trauma, and mental health difficulties. Sarah had previously attended treatment programmes, but this was the first time she had attended treatment with one of her children. Sarah had two teenagers, and two school aged children who were living with family in the community. Sarah was motivated to stop using substances after she was caught stealing money to buy methamphetamine. At that point her values and the way she was behaving were conflicting, and she knew she needed support to change. She had remained abstinent in the community for one and a half years prior to entering the Family Centre, but noted that she was isolating herself at home the whole time, and to start living her life again she felt like she needed to attend treatment.

Sarah described recovery as "*knowing that I am putting myself first, I am right inside myself, working on myself every day…. To be honest, I'm not sure, I'm still discovering what it will look like".* Recovery for her appeared to centre around an internalised change in self, which was intertwined with making herself and her family proud. Sarah described recovery as being connected to both selfhood and relationships. Whilst her recovery focused on putting herself first and working on internalised change, her change was fundamentally influenced by and impacted on her children and family.

Sarah emphasised one to one psychological support as being crucial for the changes she had made so far in recovery. At the time of the interview, Sarah was receiving psychological support for mental health difficulties she had been facing for years, with the result that "*I wake up happy, before I used to wake up depressed, now I can see a future".* Sarah's recovery was centred around building her self-esteem and learning to love herself. She felt that *"I don't love myself yet, so I can't give my kids the love they deserve, I need to learn to love myself more, and I am learning that here. When I love myself, I will know I am ready to leave."* Sarah's discussion identified recovery as being both individualised and relational. She described how positive reinforcement and support from staff, peers, her children and whānau were contributing to her developing self-love.

For Sarah, being a parent centred around becoming a role model for her children and breaking the intergenerational cycle that she experienced, noting that *"I don't want to repeat the cycle, I have in the past, so I want to break that now. I wish I had seen it years ago, but now I want to break it, and I can, I am doing that now."*

She spoke of how being in the Family Centre had made her a more present mother in her children's lives, both her new-born in the Family Centre and her older children who lived in the community. She spoke of how being a parent was making her proud of herself and contributing to her overall wellbeing and self-worth.

Much of the discussion with Sarah centred around her new-born's wellbeing and making spaces child-friendly. She noted how the Family Centre was child-friendly and how it felt homely. However, she also commented that the Adult Facility (where they attend groups daily) needed more child-friendly facilities, such as safe areas for 'tummy time'. At the time of the interview, Sarah was struggling to find a balance between recovery and being a parent, as her child was too young to attend pre-school. Sarah was thankful for the support of her peers and staff in allowing her to attend groups with her new-born, but said it was very

difficult to take in information when her child was present. Her story illustrates some of the difficulties associated with both parenting and recovery, particularly in relation to balancing the two. Difficulty finding this balance was common for many of the participants who were in the beginning stages of treatment, as compared to the participants who had been in the programme for longer and had learned to balance the two through routine, confidence and support.

Case Vignette Ten: Hana

At the time of the interview, Hana (Māori *Ngāpuhi*/Samoan/Pākehā, age range 25-30) had been in treatment for two months. More than five years previously, Hana had attended the Family Centre programme with two of her older children for a short period of time and had also attended the Adult Programme. She had also engaged in Narcotics Anonymous and CADS in the past when she had been abstinent from drugs for a year. However, she discussed how she kept "*falling over"* due to the guilt and shame surrounding her children being taken out of her care. Hana had come to the Family Centre for her children, to break the intergenerational cycle of substance misuse in her family, and to stop using drugs that's she had been using for over 10 years. Hana was at the Family Centre with her two preschool aged children, her other two children being in whānau care.

Hana had difficulty articulating what recovery meant to her and she noted how in previous treatment attempts she didn't know what recovery encompassed. She had wondered *"when can I use again?",* and how growing insight into her difficulties had developed her understanding of the challenges she faced with methamphetamine misuse. Through multiple treatments and recovery attempts, she had developed awareness of what recovery meant to her, *"being prosocial, giving myself the chance to be a better person"*. Her story emphasised the impact of societal dialogues and stigma on the way in which she saw herself as needing to be 'better' as a person. She commented on how for the first time she had a desire and a

willingness to change, but that she was worried that "*Myself, I might get in the way. I'm scared of myself. I am the only person who can pick up drugs".* Her comment depicted the self-doubt she had in her recovery and a sense of hopelessness, due to multiple unsuccessful attempts at remaining abstinent.

Hana found it difficult to describe which parts of the Family Centre were contributing to her recovery, but described how she felt better and more herself. She did highlight the support she had received from professionals, both the staff and specialist psychological support, in helping her to understand the challenges she was facing, to develop strategies to manage her emotions and to build hope in her future. Hana emphasised the strengths-based, non-judgemental approach adopted by staff in the Family Centre, describing staff as *"understanding and patient"*, and how the Family Centre didn't feel like a *"rehab"*, but *"a big community, like a family".* Hana emphasised that *"they* [staff] *don't come down on us, we're not expected to be a certain way, we are not judged for our parenting"*.

Hana noted how the structure of the programme had been helpful in her gaining insight into herself and her behaviours. Specifically, she liked the rules in the house and the encounter system to help change behaviours that were not supporting her in her recovery, noting that now, *"when encountering others, I become more aware of my own behaviours, and I don't want to be a hypocrite, so I have to change them, which is good."*

Hana identified her children as her support for being in the Family Centre when she was struggling, that "*you know, they're not there cheering me on from the sideline, but simply them being there".* She discussed how merely having her children with her in treatment made recovery easier. She also described the immense guilt and shame she experienced for the impact her substance use had on her children. She noted how not having them all with her was incredibly difficult to process, where *"I have my two younger ones but not them* [older children]. *It's like a piece of the puzzle is missing, I'm grateful to have my two younger ones,*

but I don't feel whole". Hana's story portrayed the decision many parents face when choosing recovery, and the difficult decision many parents need to make in leaving their children to engage in treatment. Hana explained how being in the Family Centre with her children had made her a more present mother. She noted that they do more activities together and that their routine had improved.

Chapter Four: Findings

This chapter presents an analysis of the interview data. Through reading and re-reading both the transcripts and case vignettes multiple times and coding the texts, Three main themes were constructed to understand the experiences of participants - the Construction of Self, Therapeutic Milieu, and Relational Recovery. Each theme includes several subthemes that provide detail into the programme features which have supported recovery. Quotes from participants' interviews are used in the following discussion to demonstrate the themes. The themes are also explored in relation to the relevant literature. A map outlining the key themes and subthemes is provided in Figure 1. Themes and subthemes are described in Table 2.

Figure 1

Map of Core Themes and Subthemes

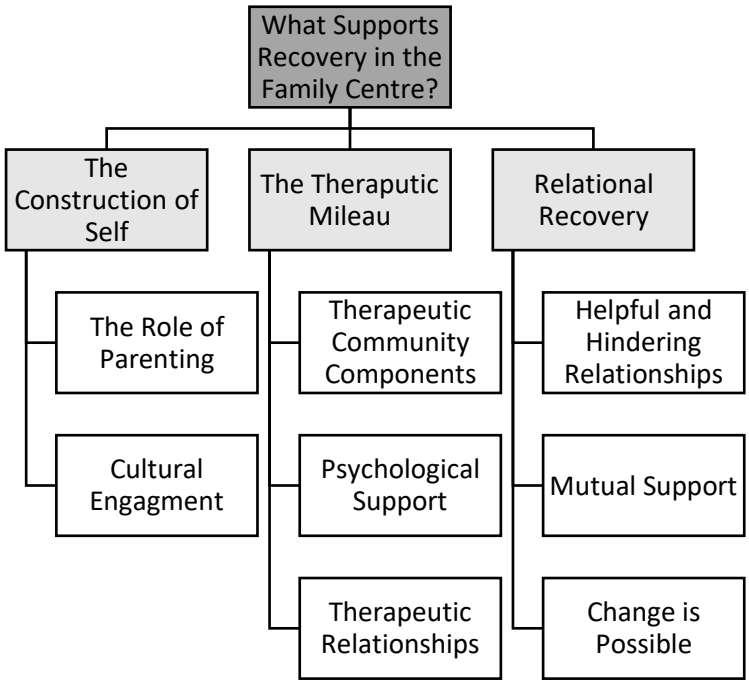

Table 3

Themes and Subthemes

Theme	*Subtheme*	*Description*
The Construction of Self	The Role of Parenting	Explores aspects that supported participants to construct and re-work a sense of self within the Family Centre.
	Cultural Engagement	
The Therapeutic Milieu	Therapeutic Community Components	Explores factors within the therapeutic environment that supported participants to gain insight and develop coping strategies and resources.
	Psychological Support	
	Therapeutic Relationships	
Relational Recovery	Helpful and Hindering Relationships	Explores the relational nature of recovery, the role social support plays in participants' recovery, and the value that this support brings.
	Mutual Support	
	Change is Possible	

Theme One: The Construction of Self

Theme One focused on the ways in which participants constructed and reworked their sense of self. The construction of self was enabled through identity-making, curating a sense

of purpose and building ideas of belonging. These processes were facilitated in two main ways (shown below as subthemes) through drawing on the role of parenting and participants' engagement in culture.

In the construction of self, the development of positive identities was significant, and participants spoke about recovery in relation to both self-construction and self-discovery.

> *Finding out who you are as a person without drugs and alcohol involved … it's about pulling yourself apart and rebuilding a better version. (Maia)*

> *Recovery is about finding yourself again, it's a lot to work through. But for me, it's about finding myself, my actual self. (Ātaahua)*

In talking about recovery as core to finding themselves, and finding out about themselves without drugs and alcohol, participants spoke about recovery as related to self-development, discovery, and construction. Within the concept of 'self', people hold multiple identities. Identity theory suggests that everyone claims particular identities based on their roles in society, the groups they belong to and the characteristics they use to describe themselves (Burke & Stets, 2009). A person's identity is a set of meanings that are tied to and sustain the 'self' as an individual; these meanings operate in various situations and guide people's behaviours (Burke & Stets, 2009).

Recovery was connected to participants' self construction in culturally pertinent ways. When describing her recovery, Isla said:

> *I just had to go through that path to be where I am today, that's how I see things. I'm a lotus flower, you know, they grow through the mud, that's how I see myself, I've gone through the dark and grown through it and I've come out into the light. (Isla)*

Her symbolism of the lotus flower is common in her Cambodian culture. It represents her journey of enlightenment, self-regeneration and rebirth. This quote depicts a journey through the dark, which represents her substance use, to the light, which signifies her recovery and growth.

Participants who had been in the programme for longer period of time seemed to have a greater insight into what they wanted their recovery to look like and were more likely to discuss aspects of self-construction or discovery as core to their definitions of recovery. Many participants discussed a growing sense of what recovery meant to them. For example, at the start of her recovery, Aria pointed to recovery being centred around *"not using drugs";* however at the time of the interview her understandings centred around recovery being all encompassing, and *"becoming human again".* Her story depicted how meanings of recovery can shift over time.

Within TCs, changes in identity are seen as core to the recovery process (De Leon et al., 2021). The recovery literature, including the recovery model CHIME (Leamy, Bird, Le Boutillier, Williams & Slade, 2011), highlights the importance of identity work and finding meaning in life. As discussed in the subthemes below, through drawing on the role of parenting, and engagement in one's culture, participants discovered and constructed positive identities, and fostered purpose in their lives, contributing to their recovery. Recovery and healing appeared to be influenced by an increasing awareness of a sense of self, which was fostered through belonging, purpose and identity.

The Role of Parenting

Participants spoke at length about reworking a sense of self while in the Family Centre. In creating a deeper sense of self, reflecting on their relationships with their child/ren and parenting played a significant role in all participants' recoveries. The Family Centre provided the opportunity for participants to provide consistent, present and nurturing parenting to their child/ren, developing their emotional connections and relationships with their child/ren. In doing so they developed and strengthened their role and identity as a parent, giving them purpose.

In discussing their changes in their identity as a parent, participants typically first reflected on their past parenting. They discussed how before treatment, or when they were using substances, their parenting was often merely functional - changing nappies, feeding and bathing their child. For some, their life was much more chaotic, where their substance use and associated lifestyle overshadowed their parenting experiences.

> *My first child, I had her, and I was on the run for three years, I would've got arrested if I stayed with her, so I just left her with her father and just left, I sort of disowned my children. (Ātaahua)*

> *We argued that I didn't have to be under Oranga Tamariki* [state child protection agency], *but I was just hiding it all, putting drugs before my kids. I gave birth high, that's how bad it was*. *(Rebecca)*

Their descriptions provide a key contrast to the parenting skills they developed and provided once they were in the Family Centre. In discussing their past parenting, all participants in this study articulated what they described as wrongs they had done and the

impact it had on their children. Many participants identified the grief, guilt and shame they still experience because of these actions.

> *I have times where I would break down and cry, I feel mad and shameful about the things I have done to them. I felt guilty for the things I had put them through because of my addiction. (Maia)*

This quote from Maia portrays her deep shame and guilt. This experience is commonly portrayed in the literature on parents who misuse substances (Corrarino et al., 2000; Liss et al., 2013; Silva et al., 2013), and often results in parents not seeking help (Liss et al., 2013). Following admission to the Family Centre, a shift in parenting occurred for all participants. They spoke of becoming more present and nurturing in their child/ren's lives, spending quality time together doing activities and developing relationships.

> *When I went to the park yesterday with* [fellow resident], *I was like, look at us, we're at the park and we're actually enjoying it. I wasn't looking at my watch, I was present, I wasn't waiting to go home and have my next puff. I was there and I was in the moment with my kids, I was happy to stand there for 30 minutes and push them on the swing because they wanted to, and they were having fun. I'm much more present with them now. (Rebecca)*

Since being in the Family Centre, Rebecca's parenting identity had come to the fore. Her role as a mother and engagement in this role were reinforced through the satisfaction and enjoyment that she gained through being present in her parenting. A shift in parenting was

also described by Niamh, who became more present in their daily interactions with their child.

> *Niamh= We do everything together, we play a lot, I enjoy her company, I'm being that mum that I always wanted to be. I feel so privileged that I get to do this with her.*
>
> *INT= Yeah, and how is that for you?*
>
> *Niamh = Well, it just makes me want to stay sober even more. Everything is blossoming, you can see your hard work is paying off. For example, the parents over there, they don't see it. But here you have it in front of you, you can see the progress every day, with you and your child.*

Participants discussed changes in identity when developing a sense of purpose, which they created through parenting in new ways. The new sense of purpose supported them to view themselves in different ways and had facilitated a shift in their recovery. Isla talked about this new sense of purpose.

> *I can do all the parenting things now, bathing, nappies, putting him to bed, not just dumping him for others to deal with, being a parent. I enjoy it. I enjoy those times because we can just talk and giggle … it's grown my confidence, as a person, and as a parent, a mother, and it drives me to be a mother, his mother. He gives me purpose. (Isla)*

Through engaging in daily tasks of parenting, Isla described developing a sense of competency in her skills to effectively parent her child and how she began constructing an identity as a mother. The Family Centre provides a highly structured environment where parenting is at the centre of daily experiences. This change in situation seemed to have influenced Isla's meaning-making process, bringing her role as a parent to the forefront of the ways in which she viewed herself.

Because people occupy multiple roles, they hold multiple identities. The meanings of these roles vary across social and cultural contexts and within individual families and communities. Situational changes strongly influence the changes in identity development for individuals (Burke & Stets, 2009). Participants may have experienced shifts in which of their various identities came to matter in the programme setting and outside of it; in terms of identity theory, some identities (like mother) became more central and salient. From this point of view, Isla decided to stop using substances when her identity as a substance user conflicted with other identities that were more important or acceptable to her, such as her identity as a parent.

Ātaahua also described a shift in her parenting when in the Family Centre:

Ātaahua = Yeah, it has, it's major, it built my confidence as a mother majorly. I just wish I had done it before. That support has really helped me build confidence as a mother.

INT = Has that confidence impacted your recovery?

Ātaahua = Yeah, hard out, being able to change my baby's bum, I never used to do that, my partner did while I would go out and get drunk. I do, I enjoy doing it. I talk to

her while I do it and she is laughing away. I was rushed when I was out there, but now I give her a cuddle and I tell her I love her, and she smiles away.

Mastering desired skill, including parenting skills, enhances self-efficacy (Coleman & Karraker, 2003; Vance & Brandon, 2017). Increased competence in the parenting role increases effective parenting practices and the quality of interactions between parent and child (Vance & Brandon, 2017). Bandura's (1977) Self-efficacy theory can be used to better understand these findings. Self-efficacy is considered an individual belief in their ability to successfully perform a behaviour (Bandura, 1977). Mastery experiences, the successful acquisition of a skill, are considered fundamental in increasing self-efficacy.

Ātaahua described feeling as though she was successfully mastering particular parenting skills; she was developing self-efficacy in her role as a parent (Troutman et al., 2012). The most salient feedback during the post-partum period is the infant's reaction (Troutman et al., 2012). Ātaahua's baby's reaction of smiling and laughing was used as a source of confirmation that she was mastering the skill. Furthermore, identity theory suggests that when a person performs well in a role, such as the parenting role, they not only have increased self-efficacy, but increased self-verification in their role (Burke & Stets, 1999). As Ātaahua developed self-efficacy through performing well in her role of a parent, she likely verified her role as a mother.

Ātaahua described moving beyond daily parenting tasks to form an emotional connection with her child. She gave birth to her child, in hospital, during her time in Family Centre, and discussed the day following childbirth.

That bond time, the comfort being with them, I've never felt that with my other babies. This time I was present with them and I'm not on the drugs. Now I feel focused and present. You know I just look at her and she is my everything. (Ātaahua)

Connecting with her child following birth was another significant turning point in her journey where her identity as a parent became more salient, important and acceptable, and a key driver in her motivation to fully engage in the recovery process. Mother-infant bonding, the emotional tie between a mother and infant following birth, is influential in the process of personal growth, identity formation and overall wellbeing (Graham, 2018; Myers, 1984). A stable and nurturing environment (Graham, 2018), interaction, skin-to-skin contact and proximity are also seen as important to support the bonding process (Karl et al., 2006), and this was the first pregnancy where Ātaahua was able to engage in these practices. Providing this environment could have allowed Ātaahua and her child to develop connections and supported her to develop her identity as a mother. Motherhood is central to recovery for many women, acting as a significant motivating factor to reduce use, seek treatment and maintain recovery (Brekke et al., 2020; Carlson et al., 2006; Schultz et al., 2018). The motivating role of motherhood was consistent across participants' stories.

For Aria, the emotional connection with her newborn had a significant influence on her recovery.

When she was born, I was so connected to her, and I wanted to change, I didn't want to keep using or selling drugs, I didn't want her to be exposed to that, and that's when I decided I needed to get my shit together. I made a referral to the Family Centre… I was distancing myself from my ex, I was in a safe environment with my sister who is completely drug-free and doesn't support drug use and would dob me in no matter

> *what. She encouraged me with, you know, if he* [ex-partner] *wants me to go out and use drugs on the weekend, while baby was with my mother. It just didn't sit well with me, and so I started distancing myself from my relationship with him and was like, I'm going to come into Odyssey. It was a big decision to make, but in my head, I was like, who do I love more, and the answer was that I did really love my daughter so much more, and so in the end the decision was really easy. I'm not even sure if I know what love is, but I know how I feel about my daughter and someone else raising my child, I wasn't going to let that happen. Having my daughter and having that bond time, I hadn't had that with my other children, and when I did, I was like wow, this is what I was missing out on.*

In developing a connection with her daughter, she became motivated to seek help and started to take steps to create a safe environment for her daughter. Once she moved into the Family Centre, her relationship with her daughter developed further. In discussions with Aria, it was apparent that through bonding with her daughter she developed purpose in life.

> *It gives me a sense of purpose, I don't just feel like a floater, I don't have negative thoughts about like where am I going, I feel like I have a path and I know what I am doing in my life. I am getting better, and I am trying to work on where I want to go. Whereas before I just would sell drugs and put myself in unsafe situations, because I just didn't know where I wanted to go. So, parenting her it gives me a purpose. I know what I want to do, I want to be a parent; I want to get my kids back, I want to start studying and doing something with my life. I want to get a diploma in performing arts, whereas before I just didn't want to do anything, I didn't have a passion. I have goals I want to achieve. (Aria)*

Having purpose in life and future-oriented goals extended beyond her role as a parent and positively influenced her other developing identities including her career identity. Developing identities across treatment experiences is strongly connected to a commitment to parenthood; parents' recoveries can become more meaningful with the opportunity to become a good parent to their children (Surratt, 2005).

As part of the treatment in the Family Centre, many participants choose to engage in the Circle of Security Programme (Cooper et al., 2005), which is a parenting programme based on attachment theory (Bowlby, 1951). The programme focuses on helping caregivers reflect on their child/ren's attachment needs and develop skills to promote a secure attachment with their child/ren. Attachment theory emphasises the importance of parental attention to the emotional needs of the child and highlights how this intimate and continuous relationship should lead to enjoyment and satisfaction for both the child and the mother (Bowlby, 1951). Aria talked about her change through this programme.

> [She used to] *bubble wrap my child and not let her explore, but since doing that* [circle of security] *I let her explore, and it makes me feel uncomfortable, but she knows that I'm right there and she comes back to me for comfort, and I'll show her that she is alright. She always looks around for me, so she knows that I am here. If she falls over, she knows I am there, whereas before she didn't explore.*
>
> INT= *Yeah that's great, so how are you finding that?*
>
> *Aria = I really love it. Because I have four children and I struggled to believe I was good enough and deserving to be their mother. So instead of trying to make changes I*

> *would use drugs to try and block out those thoughts and feelings, whereas now I feel the feelings, but have that there to reassure me that I am enough, and I am doing enough for my child. I am becoming aware of struggles where I could improve, also getting that gratification of the strengths that I have with her, so I am really enjoying that.*

Here, Aria explores how her emotional connection with her child had changed since being in the Family Centre. The growing relationship with her child and seeing changes in her own parenting supported a developing sense of self-efficacy in Aria's views of her own parenting. Furthermore, Aria's relationship and interactions with her daughter were drawn upon to confirm or disconfirm her identity as a mother. Positive reinforcement from the circle of security programme appeared to reinforce Aria's parenting identity. Previous research indicates that conceptualisations of self as a worthy and nurturing parent are linked to both completing treatment and maintaining and sustaining recovery (Coyer, 2003; Pirskanen et al., 2017; VanDeMark, 2007).

Identity theory focuses strongly on the meaning-making processes and behaviours of individuals, while also acknowledging the influence that other people have on identity construction and behaviour (Stryker, 1968). Participants reflected on interactions with others, including their children, staff and peers, which they drew upon in constructions of self and identity.

> *Well, I feel really confident in my parenting now. It was hard when I came in, you know everyone is watching your every move… am I being a good enough parent? I know I'm a good parent now, but it was hard at first, but having that feedback from people actually telling me I am a good mother. (Niamh)*

These discussions pointed to the large influence social networks and relationships play in participants' recoveries. Gaining feedback from others to confirm personal identity as a 'good mother' confirmed and strengthened parenting identity for Niamh. The Family Centre as a TC is a programme where continuous feedback from staff and other residents is an intrinsic component of the treatment process (De Leon, 2000). This continuous feedback appears to have supported identity development for Niamh.

For some participants, parental identity development was derived from becoming a role model in their children's lives. In discussing becoming a role model, some participants reflected on the ways in which they were parented or the ways in which they used to parent their children, in contrast to the ways in which they wanted to parent their children now. They sought purpose to become a role model and to break intergenerational patterns.

> *I'm a lot happier inside, knowing that I am doing this* [programme], *that I can see a future, I feel better every day that I am here, I want my children to see me do well, to have a job, be working, you know, be a role model. I didn't have that, my mum wasn't a role model, so I want to be that for my children. I don't want to repeat the cycle, I have in the past, so I want to break that now. (Sarah)*

Sarah's identity as a parent and positive role model to her children was a clear motivating factor in her recovery. In developing a sense of who she wanted to be as a parent, Sarah reflected on the ways in which she was parented as a child. It is commonly assumed that a parent with a history of childhood maltreatment is at risk of abusing and or neglecting their own child(ren) (Kaufman & Zigler, 1989); however, a number of protective factors can support parents to break these cycles. A stable living environment, including social support,

psychotherapy, and resources to support decreased stress, anxiety and depression are all protective factors associated with breaking the cycle of intergenerational transmission (Cerezo et al., 1996; Cowan & Cowan, 2001; Crouch et al., 2001; Dixon et al., 2009). While supporting the development of a parental identity, the Family Centre appeared to also be supporting parents to break these intergenerational cycles.

The Family Centre provided a structure and environment where individuals could develop a consistent positive approach to parenting, and where interaction with their children is emphasised in the treatment process. This environment allowed participants to be present, interact and strengthen their relationships with their children and reflect on these interactions in a positive manner. The ongoing process of interaction and reflection contributed to participants developing meanings and a sense of self, which contributed strongly to their overall wellbeing and purpose. Participants' discussions regarding their construction of self indicated recovery to be both deeply personal and relational. While recovery and change were related to the discovery and construction of one's identity and self, it was fundamentally influenced by those surrounding them. Participants' children were fundamental in their construction of self, and both peers and staff served as reinforcing factors.

Cultural Engagement

Motherhood or parenthood is not the only factor that can contribute to an individual's sense of self, with individuals typically building multifaceted identities which contribute to their overall sense of self. Participants spoke about how culture and religion supported the construction and sense of self. Five participants spoke about cultural engagement while in the programme, and how having cultural resources and support within the programme was beneficial to their overall wellbeing. Participants spoke about how engagement in cultural practices supported their connection to self and sense of self. This engagement was seen as crucial for their recovery and further reinforced their engagement in the Family Centre

programme. Both Māori and non-Māori participants spoke about how staff had supported them to engage in diverse religious and cultural customs and holidays as a part of their treatment, which they also identified as contributing to their programme engagement and general wellbeing.

Participants strongly identified cultural resources such as kapa haka, cultural guidance from staff, and cultural groups as being important in facilitating their recovery. For these participants, it was apparent that their cultural engagement was linked to a developing sense of self, feelings of belonging, and their overall wellbeing.

> *Having the culture here is helping me find who I was before. (Ātaahua)*

> *When we are singing, we know we are singing to our ancestors and as Māori, we feel them here. Being able to do that, and sing to them, and them being there, the feeling of you knowing when they are there helps you. (Ātaahua)*

> *When I was younger, I got taken from my whānau, so I never had a sense of belonging, I didn't know my whakapapa until two years ago. A close friend of mine passed away and I didn't want to walk onto his marae and not know my pepeha, so that's when I had to learn things, my whakapapa, my tupuna. It makes me feel more connected. But it's important for me to learn more and I have. (Hana)*

Within a Māori worldview, identity is centred around shared cultural values, membership and learning within the whānau, hapu, iwi and waka (Walker, 1989). Development of self-concept starts before birth and, as life circumstances change, individuals' identities continue to develop and adapt to the environment around them (Durie,

1997). Durie (1997) noted that even when identity may be lost, Māori identity can be rediscovered and redeveloped given the opportunity and support. For Ātaahua, reflecting on her identity prior to the use of substance, and constructing a new prosocial one, was facilitated through engagement in her culture.

Connection to tribal structures such as whakapapa, whānau and iwi as well as to land and tūrangawaewae provide Māori with security, a sense of belonging and stable self-identity (Durie, 2001, 2003). For Māori Tūrangawaewae is a place to stand, a places where Māori feel connected, belonging and empowered, a place where one has rights of residence and belonging through kinship and whakapapa (Cain et al., 2017). A secure and stable self-identity is fundamental for Māori mental health (Durie, 2001). The development and connection to one's identity are also fundamentally connected to wellbeing (Durie, 2003), with a stronger cultural identity being associated with improved wellbeing and reduced depressive symptoms (Williams et al., 2018). A secure identity can be supported through learning te reo Māori, having access to land, and connection with whānau (Durie, 2001, 2003). Knowledge of ancestry and iwi affiliation is thought to only be the first step of developing cultural identity, and connection to whānau, iwi and other important aspects of Māori tikanga and culture is also important (Durie, 2001). Within the Family Centre, participants were supported to discover and develop their identity through learning more about their whakapapa and tupuna, engaging in cultural groups such as kapa haka, and receiving support from cultural staff, which as a result supported a sense of belonging. The provision of cultural resources helped to keep some participants engaged in the programme.

> *Kaupapa Māori keeps me engaged in the programme. I didn't want to come here and do all of this without that. I came to the programme and was going to mention it when I came in, but they said that they already have it which was really great. So, I've got*

engaged with it, I've engaged with everything, just to get everything grounded back together, back then [before using substances] *I was sporty, into kapa haka, so getting everything back to how it was. (Ataahua)*

Identity is further recognised within links and relationships individuals have with others (Love, Malaulau & Pratt, 2004). Durie (1994) emphasised that interdependence, connection and whānau engagement are important for identity. Positive connections with whānau play an important role in a sense of security, belonging and overall wellbeing (Moeke-Pickering, 1996). As discussed in the subtheme 'The Role of Parenting' above, the relationships fostered with children in the programme inherently contributed to participants' identities and appeared to be a protective factor in supporting their recovery. Participants' relationships with parents and siblings were seldom discussed within interviews; for many, this may have been due to their destructive nature. The above literature does however note whānau importance in cultural connection, identity and wellbeing (Durie, 1998; Love et al., 2004; Moeke-Pickering, 1996), possibly pointing to the need for more inclusion of whānau components within the Family Centre programme.

Support for participants to engage in their culture extended beyond the core cultural groups which are integrated into the Family Centre programme. All participants were encouraged and supported by the Family Centre staff to explore their own cultural origins and practices.

I get support here to engage in my culture, there is a cultural day coming up and staff are supporting me to go and engage in that, which I am really grateful for. (Isla)

> *Odyssey are really trying to meet me halfway with my spiritual beliefs because I'm pagan… I got peer support to take me to Waitakere falls for Lammas which was really cool. A lot of my stuff is burning* [incense], *and I can't do that here. (Niamh)*

An individual's culture contributes to their identity and belonging, and therefore is key in supporting their overall construction of self. Participants' interviews identified that alongside core groups and cultural staff whom the Family Centre employ, the staff within the Family Centre are an additional facilitating factor in supporting participants to become or remain engaged in their culture. Some participants who were not Māori identified cultural components such as kapa haka as supportive factors in their recovery journeys and building confidence.

> *I do Kapa Haka as well and I think that really challenged me, so that was good. (Rebecca)*

Participants who identified as Pasifika (Samoan, Cook Island) did not identify their Pasifika cultural identity or engagement in Pasifika cultural resources as a key component in their recovery. The reasons for that were not explored. However, it is possible that because the three participants who identified as Pasifika also identified as Māori, and the majority of cultural activities within the Family Centre are linked to Māori cultural identity, participants spoke more about those and therefore their Māori identity. Perhaps these resources were supporting their cultural identity generally. However, the importance of culturally appropriate and relevant resources is identified as a key component of wellbeing for Pasifika people, particularly in mental health treatment (Kapeli et al., 2020; Kupa, 2009). There are important differences between Western and Pasifika understandings of mental health (Gunther, 2011),

and culture is seen as essential in understanding mental health (Kapeli et al., 2020). Supportive therapeutic interventions for the diverse Pasifika cultures require an understanding of their respective values, cultural beliefs and practices (Samu & Suaalii-Sauni, 2009). It is important to acknowledge that Pasifika are not a homogeneous group, and there is a need for Pacific ethnicity-specific service delivery (Kapeli et al., 2020). The lack of discussion of Pasifika practices within the Family Centre may identify the need for more Pasifika ethnicity-specific cultural aspects within the Family Centre programme.

Summary

The rediscovery and reconstruction of self appeared throughout most participants' definitions of recovery. Participants identified a need to find purpose and meaning in their lives. Parenting played a significant role in reconstructing their identities. Participants discussed becoming more nurturing and present in their child/ren's lives. They spent intentional and quality time together with their children, engaging in activities and developing their relationships and connections. In doing so, participants developed confidence in their parenting and purpose in their lives, and constructed positive and future-focused identities as parents. Relational feedback from their child/ren and professionals played a role in reinforcing and confirming these identities. Along with learning parenting skills, programme activities such as engagement, discovery and immersion in one's culture supported participants' recovery. Cultural practices, support and groups were seen as a need within recovery, for engagement within the Family Centre programme, general wellbeing, and to build a strong identity and a sense of belonging.

Theme Two: The Therapeutic Milieu

This theme focused on how participants experienced the therapeutic environment as supportive. It explores how participants described having gained greater awareness of themselves and their difficulties, and developing coping skills to manage challenging

emotions, behaviours, or situations. The theme speaks to participants' experiences in their therapeutic environment that supported them in their process toward recovery and wellness. Three subthemes describe how participants were supported to do so - TC Components, Psychological Support, and Therapeutic Relationships.

Therapeutic Community Components

This subtheme focuses on how participants experienced TC components as supportive of their recovery in various ways. In this milieu, participants became more aware of the difficulties they were facing in treatment in relation to their own thoughts, feelings and behaviours, and developed the motivation to change these. Participants also discussed the stability they gained from the routine and structure which is a core aspect of TC programmes, which supported participants to engage more actively in their recovery and parenting. Participants described three key aspects of the TC that supported their recovery in various ways - encounters, closed groups, and routine.

Encounters are a therapeutic tool used for residents to share feedback in a conducive and respectful manner. Encounters occur in an open forum, often with the whole community (all clients and staff) present. In an encounter group, an individual's behaviour that does not support the values of the community is challenged for the purpose of assisting them to stop an undesirable behaviour (De Leon, 2000; De Leon et al., 2021).

> *I understand our groups and things and how people challenge you on behaviours, you know if I flirt in here, it's probably ok, but out there it could put me in a really unsafe situation. Same with contracting, so that's when the encounters are really helpful. I understand the… method to the madness. Also, when encountering others, I become more aware of my own behaviours, which is good. (Hana)*

Hana's use of 'method to the madness' suggests that in some ways the process may not make sense, at least initially, but that its benefits become apparent as time goes on. Encounters occur in a controlled environment, supported by staff and supporting residents to remain constructive, rather than destructive, in their feedback. The controlled environment and support from staff likely supported participants to become more comfortable in delivering and receiving encounters. It was evident that many participants went through this process in becoming used to encounters.

> *Maia: I would confront them* [other residents] *about things, but I didn't realise it was confronting until they were like, this is my encounter from me to you for confronting, and I was like, what? That was just like normal behaviour for me, I didn't realise, at first I'd think they were just a pack of bitches, and I was like, you are all fake and out to get me, and then as the weeks went on I realised that if more than one person is saying that I'm doing this behaviour, then it must be me not them, and that's when I realised that's where I could get my feelings heard as well.*
>
> *INT: Do you think that the encounter system has been good for you?*
>
> *Maia: Yeah, it's made me change heaps, otherwise I wouldn't have changed, I would still be a cow, and I wouldn't take anyone else's feelings into consideration, I wouldn't because I've been encountered on my behaviours so many times, it's made me realise that something has to change, and I have to be mindful about the way I approach situations, so yeah, it's definitely helped.*

Insight in therapy is the conscious awareness and understanding of one's own symptoms or maladaptive behaviour (Markova, 2005). A lack of insight has been associated with poorer psychosocial functioning for individuals who are struggling with mental health conditions (Amador et al., 1994). Among people who misuse substances, increased insight can lead to higher levels of motivation and an increase in their willingness to change behaviour (Jung et al., 2011; Maremmani et al., 2012). This process was apparent for Maia. Through encounters she gained insight into her confronting behaviour and the impacts it was having on herself and others. Because of this insight, she developed the motivation to change those behaviours.

Closed groups were another tool that supported the development of insight. A closed group at the Family Centre is a therapeutic group where participants are made aware of behaviours they have displayed that are against the rules of the programme. Closed groups occur in a closed forum, with two staff members and four residents present, one resident from each level of the programme. Closed groups are used for more serious rule violations such as violence, threats of violence, theft, substance use, or sexual behaviours. Within a closed group, encounters are used to deliver feedback in a constructive manner. Both staff and other residents in the programme discuss the impacts the behaviour is having on the person and the community, help the resident to gain insight into their behaviour, and decide on a consequence for the behaviour. The resident is given an individualised project, typically with the goal of reflecting on the behaviour and developing adaptive coping mechanisms to manage it. Rebecca described the insight she gained into her substance use which was initiated through a closed group.

Rebecca = I had just read my RPP [Relapse Prevention Plan] *and then the closed group was straight after that, it had come out that I had been inappropriate with one of the males in the programme. But I learnt from that*.

INT = What did you learn?

Rebecca = I learnt that I was actually using that attention like a drug, the buzz I was getting off it was like a euphoric feeling. Because addiction can show in so many ways and that attention that I was getting it made me feel really good inside. It showed me that addiction can keep testing those boundaries in lots of ways. So that'll be something that I have to be careful of when I leave, that male attention. Not to just get caught up in those feelings, and that it's maybe not meaningful or real, it's just that buzz from the attention.

Through receiving constructive feedback, in a controlled environment, Rebecca was able to become aware of behaviours which mimicked feelings associated with the use of substances and which, in this way, perpetuated behaviour that could put her at risk of relapse. By gaining self-awareness into the emotions associated with male attention, and the impacts this behaviour was having on her recovery, she developed the motivation to change the behaviour, as it did not align with where she wanted to be in recovery. It also supported her self-awareness of the all-encompassing nature of her recovery. Maia also benefited from a closed group.

My last closed group before I hit Level Three, and then the lightbulb just went, ohhhh, I get it now, change now or I will be like this forever. Yeah, I just got it, I got out of

> *the closed group, because it was for venting on the floor and verbal threats, and then I realised why I was here, and then that's when it actually hit me, I needed to change and just surrender to the programme and get it done, and everyone else wasn't the problem, it was me, I was the problem, my behaviours were the problem.*

Maia's motivation for change increased when she noticed a discrepancy between her behaviour currently and how she wanted her behaviour to be, aligning with motivational interviewing theory (Miller & Rollnick, 1991). Increasing her insight into her behaviour and its impacts likely lead to an increase in motivation, as behaviour did not align with her goals at the time. The continuous feedback from encounters and closed groups developed participants' insight into the discrepancy between the way they wanted to be and their current behaviours.

Maia and Rebecca described encounters and closed groups as tools for increased self-reflection whereby they increased their awareness of their own behaviours and emotions, helping them to understand themselves and others better. Groups like the encounters and closed groups discussed are a quintessential tool of both traditional and modified TCs (De Leon, 2010). These tools gave participants the opportunity to learn and alter behaviours through receiving constructive feedback in a controlled environment, better equipping them for their lives in the community.

A further essential component of a TC is routine. It appeared that the highly structured environment of the Family Centre was a foundation for participants to engage in recovery. For some, a messy or irregular routine was an early warning sign that they may not be doing well.

> *It annoys me when I can see something popping up frequently, I put a lot of thought into things, and if it pops up in one place it will impact another too. Even when I was in isolation getting bored, I thought, oh, I can't be bothered doing my washing, and that's that selective effort. Only doing things when I want to. That's that using side of me, only doing things when I want to, putting effort only into things when I want to, and taking shortcuts. I can still see little hints of it left, the state of my mind with those little things, it makes me see when my mind is scattered. Those little things can create so much chaos, with a messy room, it makes you frustrated and annoyed and then blaming comes in, it all rolls into one thing after another. (Rebecca)*

For Rebecca, a messy routine or lifestyle was a metaphor for the way she was feeling; when her room was messy and washing wasn't being done, her state of mind was also scattered. The messy lifestyle was related to the way she lived her life while using substances. Living with structure and routine may be particularly important for individuals recovering from substance misuse, given the chaotic lifestyles many of the participants led prior to coming to treatment. All participants described the routine as being a basic component of their everyday life which supported them in staying balanced and gave them a sense of control. According to Bandura (1977), self-efficacy is a person's belief in their ability to control their functioning and events that impact their lives. Participants' experience of living in a structured environment marked by daily routine increased their sense of stability, which they reported as enhanced feelings of personal accomplishment and control. Aria discussed how developing structure and routine had been crucial for her to be able to focus on her recovery and treatment.

> *I actually really enjoy it, I need structure or otherwise, I will go AWOL, and so I like that we have this structure, it makes things more comfortable for me. Routine is really important in my recovery. (Aria)*

Aria discussed the significant impact structure and routine had on her wellbeing and recovery. These features supported Aria in feeling more in control of her life. They supported predictability in her life, which she had previously experienced as erratic. The desire for predictability and control is common for people who have experienced trauma, and routine can contribute to feelings of safety (Tompkins & Neale, 2018). A sense of safety was important to participants within the study, it made them feel at ease and supported them to better engage in their recovery.

> *Being somewhere safe where you can make those changes, that holds me accountable. It's safe. I don't have to worry about all those things that could happen out there…. Being in a safe place, everything stops, and you don't have to worry about anything anymore, it's time out to sort it out and focus on yourself. (Rebecca)*

For Rebecca, the Family Centre milieu afforded her stability and predictability. The environment reinforced Rebecca's sense of safety and contrasted with the insecurity and unpredictability of her past life prior to treatment. As participants commonly had extensive histories of trauma, a stable, predictable and routine environment was a fundamental aspect of a treatment environment (Tompkins & Neale, 2018).

Structure and routine were also identified as important in supporting participants to feel more confident in the parenting components of their recovery. Rebecca discussed the

process of finding routine, and how she learned to flourish in the role of being a parent in recovery.

> *It's hectic yeah, but I find it kind of easy now. I know a lot of the other mums struggle, but I'm kind of thriving in it now. I stick to the routine, when we are meant to function* [do house responsibilities], *when the kids need to be off the floor* [in bed]*, that's really helpful, because those boundaries gave me something to keep to and to put into place that's solid, so I find it easy to put my kids to sleep, I keep to my routine. (Rebecca)*

The development of a stable routine supported Rebecca's recovery by increasing her sense of control. It also supported her in developing confidence and stability in her parenting and therefore her recovery. Routine can support people in building self-confidence (Mercer & Woody, 1999); it gave Rebecca a sense of confidence in making positive changes. Routine was also seen as fundamental for Ātaahua, supporting her engagement in the programme. At the time of the interview, she had a newborn child.

> *I mean she is really awesome; I've got her in a routine, give her a feed, change her, burp her, and the n she'll go down for four hours, and bam, I've got time to do all the things I need to do. Then I know when she needs me because my boobs start. So yeah, I've got those four hours to do what I need to do, and I know she's my biggest responsibility, but yeah that routine is important. I feel like I've found a routine. (Ātaahua)*

For Ātaahua, routine also supported her sense of control over the responsibilities in her life. Prior qualitative research suggests that, from a professional perspective, routine is

crucial in supporting clients to better manage their children's needs, can improve parent-child interactions, and is preparing parents for their life outside of treatment (Wiig et al., 2018). Considering the literature along with participants' accounts indicates that the implementation of a stable routine should be a fundamental component in treatment for parents in AOD recovery. TCs are highly structured in terms of routine, rules, and daily schedules (De Leon, 2000). As indicated in participants' accounts, the stability and routine implemented within the Family Centre supported them in focusing on their recovery and parenting.

Further to the role the TC components had within treatment, some participants anticipated that the skills they had learnt from the TC would be useful when they move into the community.

> *INT = What do you think will be most helpful for when you move into the community?*
>
> *Rebecca = Not being scared to reach out, to keep in contact, because that's something I was bad at. The strategies, the weekly plans are a good idea to keep structure to my time. Yeah, there are lots of different things, even just the whole routine of things having a specific day when you do a whole house clean, keeping on top of tidying things up, the same routine, I'll be taking it to my own house. Even the encounter system, you can use that, but just not with the same wording, but it's a good way to get your feelings across, keeping that going, not to leave it behind when I leave.*

For these participants, the TC components and the skills learned through them are viewed as helpful and as transferable from the Family Centre to the community.

Psychological Support

Alongside the skills learned in the TC, psychological treatment was described by participants as crucial, particularly for those who had experienced trauma or had co-occurring mental health concerns. This subtheme focuses on the support psychologists provide to clients, enabling clients to process difficult experiences and become more aware of their difficulties, develop coping mechanisms, improve overall wellbeing, and move towards their recovery goals. Six of the participants were receiving specialist psychological support; four were engaged in support from a clinical psychologist through ACC for sexual abuse, while two clients were engaging with an intern psychologist employed directly by Odyssey for mental health concerns. All six of the participants spoke of the importance of processing and learning to manage trauma and mental health as a part of their recovery journeys.

> *I also have social anxiety. I'm working with the psychologist here doing CBT* [cognitive behavioural therapy], *cognitive distortions, thinking people don't like me and things. It's been helpful. When I first came in, I couldn't even sit in the dining room, and then every day I worked up by 10 mins to sit there longer, and now I can eat in there with everyone, for however long now. So, I've made huge progress. And my self-esteem, when I first came in it was really low, but she's really helped me, it's gotten better, I wake up happy, before I used to wake up depressed, now I can see a future. (Sarah)*

Along with supporting her overall wellbeing, through engaging with psychological support, Sarah developed her capacity and capabilities to engage in the Family Centre programme, and with her peers around her. Considering the relational nature of recovery, this support appears particularly important for her ongoing recovery.

Cognitive behavioural therapy (CBT) is a psychological approach to treatment based on the tenet that people's thoughts, feelings, physical sensations and behaviours are all interconnected and influence each other (Beck, 2011). CBT assumes that psychological problems are based, in part, on both faulty thinking styles and learned patterns of unhelpful behaviour (Beck, 2011). CBT is a commonly used non-pharmacological treatment approach for social anxiety, comparing favourably in its effectiveness to other psychological and pharmacological approaches including psychodynamic psychotherapy, mindfulness and selective serotonin re-update inhibitors (Mayo-Wilson et al., 2014). As such, CBT treatment typically involves efforts to change thinking styles, and break unhelpful behavioural patterns (Beck, 2011).

Sarah believed that people didn't like her and therefore avoided social situations. She was engaging in 'graded exposure', a component of CBT used to address social anxiety. This exposure supported her to be able to sit in the dining room comfortably and eat with the other residents. Alongside graded exposure, CBT treatment typically involves a combination of cognitive restructuring, relaxation training and social skills training (Beck et al., 2005; Eng et al., 2001; Foa & Kozak, 1986; Heimberg & Becker, 2002; Rodebaugh et al., 2004). The provision of psychological therapy enhanced programme engagement for Sarah, whilst also positively shifting the way in which she viewed herself and her future.

Psychological support was also considered important as a means of processing participants' past trauma. Natia was engaging in psychological support with a clinical psychologist for past sexual trauma.

Natia = My ACC counselling is really good, having access to that is so helpful

INT = Right, what do you find helpful about it?

Natia = Learning about myself and why I was doing the things I was doing [substance use, offending], *and what led to that, it all comes back to that trauma, so dealing with that trauma is helpful because you learn how to deal with those situations, and you know why you were doing what you were doing.*

Niamh also acknowledged the importance of psychological support in treatment of past trauma.

INT = So is the psychological support important for you?

Niamh = Yes, it's kind of why I'm here. I understand I have behavioural issues, so that will come into play. But also, I think that psychological therapy is key because of all of my trauma.

There is a clear link between craving substances, relapse, and PTSD symptoms, and it is common for individuals who have comorbid PTSD and Substance Use Disorders to crave substances when confronted with trauma symptoms (Gielen et al., 2016). For these individuals, substances are often used to be able to numb or cope with negative emotional responses (Gielen et al., 2016). Psychological support enabled Natia to become aware of and begin to heal core psychological, emotional and behavioural aspects underlying her trauma and mental health difficulties, which is key in the journey of recovery.

Sarah also spoke about the impact trauma had on her substance use and recovery.

Sarah = I still have a lot of work to do, I've lost myself basically. I don't know who I am really. I've just numbed everything out to get through, from my PTSD, but I'm learning to live in the day, learning to smile, I'm happy I am here, I'm happy this place is available for me and [daughter] *to get well. I'm lucky that I got here because there are so many mums that want to come here.*

INT = Mmm. It sounds like you are making progress. You spoke about PTSD, are you receiving support for that?

Sarah = I will start doing that and engaging in that help [clinical psychologist] *soon when I move to Level Two, which will be great, because that's what I need, because you know it's a safe place for me to be able to explore those things, to really discuss the trauma, so I don't go and use.*

For Sarah, trauma had overshadowed her life, and substances were a tool for her to cope with her past experiences. She spoke of the Family Centre being a safe place to explore her trauma. A structured setting and safe environment, such as the Family Centre, can provide a sense of safety and familiarity for clients with histories of trauma (Herman, 1992; Substance Abuse and Mental Health Services Administration, 2014).

Other participants acknowledged the difficulty associated with processing their trauma.

I haven't fixed everything; I've just learnt tools on how to deal with things. I still really need to work on my trauma, because I still haven't really opened up about that

with my psychologist, so he is pushing me, so its stuff like that, otherwise I'd just have it hanging over me forever. (Maia)

While acknowledging the need to process her trauma, Maia also spoke of the difficulty in doing so. Trauma therapy can be a challenging and lengthy process, particularly when individuals are asked to recall trauma memories in treatments such as exposure therapy (Rauch & Foa, 2006). As such, people may take longer to engage. This literature (Rauch & Foa, 2006) suggests that having access to this support at the start of treatment may be beneficial, as it could give participants more time to engage in and gain benefits from the treatment.

Participants who were engaging in psychological support spoke of it being core to their recovery journeys within the Family Centre. For these participants, psychological treatment was seen as addressing a need for them to overcome past trauma and fully engage in their treatment and recovery. Other participants acknowledged the importance of processing trauma, but also the difficulty in doing so. The availability of concurrent treatment for both trauma and substance use is acutely important, especially considering the reciprocal influence of these treatments, which have been separated historically (Chung et al., 2009; Dass-Brailsford & Myrick, 2010).

Sarah and Natia understood that much of their past alcohol and substance use resulted from experiences of trauma, and therefore understanding and processing their trauma was a fundamental aspect of their treatment. Further to supporting their ongoing recovery, engaging with this psychological support facilitated participants' engagement in the Odyssey House programme, which is particularly important considering that many of the TC concepts are based on learning through and with others (De Leon, 2000). Beyond the provision of evidence-based treatment of trauma, the therapeutic relationship plays a significant part in the

effective treatment and recovery of those who have experienced substance misuse and trauma.

Therapeutic Relationships

This subtheme focuses on the support that staff provided for participants, and the ways in which they supported participants in their recovery. All 10 of the participants identified the support that staff had provided to them as crucial in their ongoing recovery; however, they provided varying accounts of the ways in which staff were supportive. Rebecca spoke of the guidance and insight gained from staff support.

> *When I don't know the answer, I just go to staff. I'm like look, this is what is happening, this is my perspective, but what's going on, and I find that staff have seen it so many times before that you know what is going on, they're great, like that they'll steer you to many solutions and it'll give a lot of clarity, because sometimes you can't just see that simple solution. (Rebecca)*

Rebecca saw staff members as experts who provided direction and insight into challenges she was facing. Maia discussed the different types of support staff provided to her.

> *If it wasn't for them being so involved, I don't think I would have made it* [programme retention], *because it was a lot of their input that kept me here… Staff, them challenging me all the time.* [One staff member] *was the biggest one, always challenging me, and I was like, ahh, but it's been good for me. It's uncomfortable, but it helps. (Maia)*

Maia provided a nuanced account of the staff support that she received. For her, being challenged by staff was difficult, but helpful and supportive nonetheless. Whilst staff provided direct constructive feedback to her, which she found challenging, they also provided emotional support which grounded her in the programme. For her, that duel approach supported her recovery in different ways. Maia's and Rebecca's interviews suggest that the support staff provide is individualised to the resident and the situation each person is facing. Individualised support is particularly important given that each resident has different experiences, challenges and strengths. Participants described how staff had built strong therapeutic relationships with all the participants within the Family Centre, and offered emotional support while also facilitating the development of insight, guiding clients to learn more about themselves, and providing them with a different perspective and a source of motivation. Therapeutic relationships developed with staff contribute to engagement in early recovery, resulting in positive psychosocial and behavioural changes (Simpson & Joe, 2004). The relationships built with staff supported participants positive changes.

Helping participants to gain insight and concurrently develop their sense of self was seen as important to participants' recovery. To engender this self-development and promote psychosocial and behavioural change, it appeared that staff had supported this process through ongoing support, reflection, and feedback for residents. This support often took a strengths-based and non-judgemental approach, which Hana saw as imperative.

> *Hana = Well even though we are in rehab, staff aren't coming down on us, it's a big community, it's like a big family, it doesn't feel like we are in rehab, it's more family-orientated over here, the staff are understanding and patient, they're so supportive, and that's so helpful.*

INT = Yeah, so what do you find helpful about that?

Hana = If staff were coming down on us, I wouldn't want to be here. If we were expected to be a certain way, I wouldn't want to come here and be judged for my parenting.

It is common for mothers who face challenges from substance misuse to experience considerable shame and guilt (Corrarino et al., 2000; Hankin, McCaul, & Heussner, 2000; Kahler, McCrady, & Epstein, 2003; Silva, Pires, Guerreiro, & Cardoso, 2013), as was echoed in participants' stories about their past parenting. Stigma, shame and guilt have been identified as factors that inhibit the recovery process. These feelings can result in parents taking longer to seek treatment, and are also associated with a higher risk of relapse (Cattapan & Grimwade, 2008; Liss et al., 2012).

Platt (2012) describes a strengths-based approach as essential for engagement with parents in AOD recovery. The use of a strengths-based approach in substance use treatment has been identified as conducive to the recovery process. Strengths-based approaches focus on individuals' resilience and move away from solely symptom- or problem-focused work, focusing on the development of skills and empowerment (Markoff et al., 2005). Ātaahua spoke about this aspect.

Everyone looks at me now saying you've really changed, and those comments really help, they help me focus on myself and not everyone else, and I get that from staff, and that's a real motivation, hearing that from staff. (Ātaahua)

Ātaahua suggested that staff provided strengths-based care, affirming participants for positive changes they have made. Through providing support that was non-judgemental and positively reinforcing, staff in the Family Centre built strong therapeutic relationships. The therapeutic relationship, the trusting connection and rapport that a clinician and client establish (Cole & McLean, 2003), was considered important across participants' stories. Individuals tend to be more engaged in their service and have a stronger therapeutic alliance with their case manager when strengths-based approaches are adopted (Redko et al., 2007). Strong therapeutic relationships developed with staff contribute to treatment engagement and better adherence within a programme, and support individuals to remain in treatment (Keller et al., 2010). Strengths-based working alliances can help them to build trust, self-worth and self-esteem, which are all conducive to recovery (Redko et al., 2007), as the participants' stories attested. This strengths based care is also said to support parents to develop positive identities in recovery (Hine et al., 2018).

The therapeutic relationship was even more significant for participants due to their historic experiences of trauma (Cloitre et al., 2004). Relational trauma, the experience of exploitative and harmful relationships, can result in individuals avoiding intimacy in relationships and treating relationships with suspicion (Trickett et al., 2011; Zurbriggen et al., 2012). The cultivation of positive relationships, where trust dominates rather than suspicion, are essential in recovery from psychological trauma (Bell et al., 2019; Herman, 1998). Ātaahua spoke of the trust she had developed in some of her therapeutic relationships.

> *I can talk to* [staff member]. *I used to talk to* [previous staff member] *over there, I miss her so much. She was so genuine. Having those people who I can trust and express how I am really feeling is important for my recovery. If she* [previous staff member] *was still here, I would open up to her about my trauma. But my trust is*

slowly building with other people … The mothers and the staff are who I bond with. Because some of the staff I can trust. (Ātaahua)

Ātaahua emphasised the strong relationships she had built with certain staff members. These relationships centred around the development of trust, which was essential for her to open up and be honest about past experiences, and to fully engage in treatment, particularly when it came to discussions surrounding past trauma. For Ātaahua, the process of developing trust can be viewed as therapeutic in itself.

Staff were seen not only as supportive within the programme but as vital to recovery after treatment. Participants identified the need to engage with supports once they moved into the community and after graduating from the programme. Maia indicated staff as a key support for her when experiencing triggers once she is living in the community.

Maia = I do think it will be ok once I move into the community, as long as I keep putting my strategies in place, and reaching out - reaching out is the biggest one.

INT = Have you had a situation where you've been out or needed this support?

Maia = Yeah yeah, at my mum's, so I don't go back to my mum's anymore. I had all six of my kids at my mum's one weekend, and she just abused me the whole weekend, because she just couldn't handle the chaos… I just had to sit down with her and tell her this is how it is making me feel. I felt triggered, I felt like a smoke, there was just so much, I felt so stressed out, and so I cried, let it out, and then I said to the kids, ok, we are going for a walk, and we went for a long mindful walk. I concentrated on the trees and I called the house [Family Centre] *and checked in with staff and spoke to*

them, and then I came back and made a plan, and that plan was to not go back there, because I would end up using. So that's how I dealt with it. So, the things you learn here, they do work. And now my mum is using again, so yeah.

Along with the other strategies Maia had developed to manage triggers while in the community, the provision of support from staff was important. Having used these supports when in the community, Maia anticipated that staff would continue to be an important source of this support once she began residing in the community. Aftercare support within TCs is a key component to maintain recovery and positive lifestyles changes beyond graduation from programmes (De Leon et al., 2021). Aria spoke of this support.

Being engaged with my supports, peers in here that keep each other going, coming back here, and seeing certain staff members who I have bonds with to share certain things. (Aria)

Aria discussed how having strong therapeutic relationships with staff members and established existing support available will help her once she moves into the community. Aria's interview suggests that it is not just the provision of therapeutic support that is necessary following leaving treatment, but support from those with whom she had already developed strong and trusting relationships . Having access to this support would mean that participants did not have to rebuild trust with other professionals, or in other services, as they adapted to their lives in the community. Furthermore, having such relationships terminate because they leave the Centre could trigger a sense of loss that could discourage them from seeking similar relationships in the community.

This subtheme identifies the need for a strong therapeutic alliance between staff and residents and a strengths-based approach to support in therapeutic relationships. Support from staff, which was experienced as non-judgemental, strengths-based and individualised, was identified by participants to be helpful for their recovery and engagement in the Family Centre programme. Furthermore, participants anticipated that support from staff would continue to be important when they moved into the community.

Summary

Participants spoke extensively about aspects of the therapeutic milieu within the Family Centre that facilitated their recoveries. The TC model provided programme component benefits that supported increased participant insight into their difficulties and engagement in both parenting and recovery. For those who had experienced trauma, accessing psychological treatment was identified as a need for their recovery. Being responsive to the individual needs of those in treatment is crucial in recovery, and providing access to treatment for co-occurring mental health concerns within substance use treatment facilities promotes increased engagement in the service (Grella & Stein, 2006). Participants also spoke of gaining a better understanding of their alcohol and substance misuse histories, and the reasons for their use of substances. Participants provided nuanced accounts as to the support staff provided, however it was clear that supportive and non-judgemental staff care was seen as a need in participants' recoveries. The therapeutic milieu supported participants to better engage in the programme and their own recoveries. It supported participants to learn more about themselves and cope with challenging situations they faced within their recovery.

Theme Three: Relational Recovery

This theme focuses on the role that relationships played in participants' recoveries. Past and current relationships were influential on participants' substance use and recoveries. All 10 participants commented on how having the support of others in the programme had

been helpful for their recovery. Specifically, participants noted how they had learned a lot about themselves and their recovery and had gained motivation through connecting with others in treatment and the mutual sharing of experiences. Throughout participants' stories, they pointed to the impacts of others in the programme and to how recovery occurred through and with others. Three subthemes describe the ways in which relationships influenced recovery: Helpful and Hindering Relationships, Mutual Support and Change is Possible.

Helpful and Hindering Relationships

Overall, this subtheme emphasised the relational nature of recovery for all participants in this study. Past and present relationships had a significant influence on participants' experiences of substance use and recovery. Emerging literature now acknowledges recovery as occurring beyond an individualistic perspective, with interpersonal relationships regarded as potentially both supporting and hindering recovery journeys (Brekke et al., 2020; Pettersen et al., 2019). Within the recovery model, 'recovery capital', social capital (the development of positive social relations), is identified as a fundamental aspect of recovery (Cloud & Granfield, 2008). Participants identified several different types of relationships as supportive to their recoveries. These included relationships with peers in the programme, their whānau, and staff members. Fellow residents within the Family Centre programme played several positive roles in participants' recoveries, providing peer connection and anchor points.

> *They* [other residents] *are supportive, they keep me here, it's nice to have someone to talk to. When I want to leave, they support me. (Sarah)*

For Sarah, participants acted as an anchor for her in the programme, supporting her through difficult times. Ātaahua contrasted the positive support she received in the

programme to the negative relationships with her support people before the programme, signifying the helpful and hindering role relationships can play.

> *We seek support from others. We learn to manage in a proper way. I've found myself by talking to others* [residents in the programme]. *It's just the support really, I had support out there, but they supported me to take drugs, but this support is helping me find out who I really am. (Ātaahua)*

In making connections within the programme, Ātaahua was supported in her construction of self. As indicated in Theme One, relational feedback was significant in participants' self-development, and Ātaahua's story reinforced the role social connections play. Hana also spoke of the connection she had developed with other residents in the programme.

> *You know we are a big house of females, but it's not catty, they're supportive. I've built some good friendships. (Hana)*

Participants indicated the strong supportive role of positive relations in the programme. Alongside those within the programme, partner's and wider whānau were also discussed as a key source of motivation and support in participants' recoveries.

> *My partner, he was my motivation, telling me I could do this. Him giving me that positive vibe… It makes me focus on, you know, if he can do this out there on his own, I can do it in here. My mum and dad as well. Knowing my kids are out there waiting for me. (Ātaahua)*

For Ātaahua, her partner's recovery and her own were somewhat intertwined. Ātaahua's story pointed to a joint recovery journey. Observing her partner being able to make positive changes while living in the community served as direct motivation for her to do the same. Her whānau served as motivation for her to engage in recovery. Isla shared a similar motivation from family.

> *Now that I have had visits from my sisters too, and talked to my niece again, it's made me crave recovery so much, being able to make them smile again, my family. I've made amends. (Isla)*

For Isla, the rebuilding and healing of relationships was a confirmation that her recovery was progressing and served to reinforce the positive changes she was making. The importance of positive relationships was clear from participants' interviews. Participants' accounts align with an abundance of literature acknowledging that, within substance use recovery, positive social supports are a key protective factor and associated with recovery, abstinence and treatment retention (Dobkin et al., 2002; Stevens et al., 2015). The supportive role of relationships is explored in-depth in the next two subthemes.

Although relationships served as a positive, engaging and reinforcing role in participants' recoveries, they could also play a negative role. Participants often contrasted these supportive relationships to the hurt experienced in past relationships.

> *Being in a domestic violent relationship with the kids' father, trying to make him happy, having to go out and steal because there was no, well because the income*

wasn't great. It felt like I was going to lose everything, my house, my family, everything. (Estelle)

Relationships held prior to coming into treatment played a significant role in perpetuating Estelle's substance use and associated lifestyle. Her relationship with her partner appeared to act as a roadblock to her engaging in her recovery. The relationship motivated participation in activities that were unsupportive of recovery. It also evoked negative emotions, feelings of being controlled, and a negative perspective on her life and future. Negative intimate relationships were commonly discussed by participants. Rebecca discussed the impacts of intimate relationships on her substance use. She discussed a sense of being controlled in her relationship, and that it was inherently unsupportive.

Bad relationships, one bad relationship to the next bad one, living with people who were cooking, running around for this guy. And then one day I got in a really bad accident with [daughter] *in the car. We came away from it fine, but the car was wrecked, and I was seven months pregnant, it was a miracle that we survived, and that was the first eye opener… He was the father of the baby I was having, and the fact that he didn't even care when I got into the car crash, if we were ok or not, it was one of the workers who came and checked, he didn't give a shit. He just asked when I was going to pay for the car. (Rebecca)*

These negative relationships often directly influenced participants substance use.

I was in the community [and] *abstinent for a bit, but then I lapsed, my boyfriend was being very violent. That's my biggest trigger, it was unhealthy. (Natia)*

These women's experiences were not uncommon. Interpersonal trauma appeared across participants' stories as a precursor and maintaining factor in participants' substance use.

> *Well, I started using when I was dating my ex-partner, we were going through domestic violence, and I found out he was using, and he offered for me to use some, just for the hell of it, so I was curious, and then I just, it took every feeling away, and it made me want to have it again. So, when I was in my own moments, I would turn to that. I was using meth. Every time we had domestics I would go and find it, to shut down my feelings because I just wanted to have that happy feeling, and then I continuously was using it, and then putting it before everything else. I felt like I couldn't control everything, and that's why I would turn to it. (Isla)*

Isla's partner was a principal factor in initiating and perpetuating her substance use. Overtime, substance use and the way it made her feel began to control her. Participants' accounts align with recent research which acknowledges that negative relationships play a role in perpetuating substance use, or at the least, are a barrier to recovery (Brekke et al., 2020; Pettersen et al., 2019; Veseth et al., 2019).

Hindrances were not exclusive to the past. Despite the generally positive views of the programme, participants also provided nuanced accounts of relationships in the programme that failed to meet their needs. Natia spoke about the lack of peer support she had received, and how she were struggling with this.

> *It's not the programme, I wouldn't be struggling if I felt more supported by the upper structures* [residents in the later stages of the programme]… *It's not the programme, it's the lack of support from the peers. (Natia)*

Although most participants discussed their positive experiences of peer support in the programme, the experience was not universal, as Natia's story attests. Where there was a lack of support, participants spoke of unmet needs in their recovery. These accounts point not only to the hindrance of past negative relationships, but to challenges participants faced when there was an absence of positive and supportive peer relations.

A relational perspective assumes that relationships are the cornerstones of both substance misuse and mental health problems, and of subsequent recovery (Price-Robertson, Obradovic, et al., 2017). Interviews with participants in this study echoed the extensive constructive and hindering roles that relationships played in their recoveries. They also highlight the importance of fostering positive social connections within recovery, which will be further explored in the two subthemes below. Interpersonal relationships impacted participants' hope, identity and meaning, and were fundamental in their recovery (Price-Robertson, Obradovic, et al., 2017). These findings are additionally clear in Theme One, where children were identified as serving as a significant influence on participants' identity and meaning making. They are also present in Theme Two where staff played a significant positive role in participants' recoveries. The findings indicate the value of the notion of relational recovery. The following two subthemes further present relational recovery as being inherent to participants' recoveries within the Family Centre; they are focused largely on the ways in which peers in the programme facilitated participants' recoveries.

Mutual Support

In this subtheme, I focus on how mutual support aided participants in developing trust and connections with other residents in the Family Centre, and how these relationships supported their recovery. The development of supportive relationships was identified as important to recovery within the Family Centre as well as when participants moved into the community.

Mutual support and trust appeared to develop throughout programme participation, with participants who had been in the programme longer appreciating its supportive nature. These participants identified the need to build relationships, and the need to deepen them. Ātaahua, who had been in the programme for four months described this aspect.

> *I'm proud of bonding with the ladies because it's hard for me to trust, it took me a while over at the main house, and now I'm trying to find that trust back. I'm expressing myself and they're expressing themselves back, so I'm trying to find that trust. Being able to open up to someone who won't let it out. I think it important for my recovery. (Ātaahua)*

Ātaahua spoke of developing trusting relationships with peers through honest communication and sharing of experiences. Relationships with friends and peers can have a fundamental impact on how confident people feel in recovery (De Ruysscher et al., 2017; Topor et al., 2006), as was apparent across participants' stories. These relationships are a particularly important component of recovery, and many treatment programmes focus on social connection as a core principle (Bjørlykhaug et al., 2020; Kruk & Sandberg, 2013; Werner et al., 2007). Furthermore, high levels of trust within social networks are fundamental in recovery (Brekke et al., 2020; Weston et al., 2018), and are especially relevant to TCs, as

recovery is said to occur through and with people (De Leon et al., 2021). Niamh discussed the value of developing trust with other clients.

> *The other client,* [name], *is brilliant, she is great, she's hard but I need that. I trust her, which is unusual for me because I've never really trusted women before. (Niamh)*

The experience of trust was novel for Niamh, but it was apparent that this trust supported them to develop a supportive relationship with peers. For many participants, trust centred around the ability to share their experiences with others, and others not misusing such information or invalidating what they shared.

> *Aria = I am proud of the boundaries I have learnt to have in place, I am proud of some of the things I have been able to open up on and talk about, I'm proud of the fact that I have put myself out there in a lot of situations that I wouldn't have done before.*
>
> *INT = Wow, those are some big changes... How do you think you've made those changes?*
>
> *Aria = I think it's from people almost, talking to me and feeling comfortable talking to me, so I will share with them, so they know they are not alone. So that's what started it, I share what I did too. So, building those trusting relationships with people.*
>
> *INT = Do you find it helpful sharing your journey with other people?*

Aria = Yeah, I do actually, because it makes me realise that I'm not alone, there are lots of people in this world that are similar. That's a trigger for me when I think I'm the only person who has been through something… Being in an environment with other mums, I don't feel alone. I used to think, oh no one understands me, but being in an environment where other people understand me, it's good. (Aria)

The majority of Aria's recovery milestones centred around relational changes she had made and the positive impact relationships were having on her recovery. Connection with other residents was fundamental to these changes. For Aria, recovery was easier when it was experienced with others, as a shared journey. The sharing of experiences was genuinely supportive for Aria, which can be understood in light of sharing similar social identity. Social identity theory suggests that people are more likely to provide support to others who share the same identity as themselves (Tajfel & Turner, 1986). The mutual sharing of experiences by participants supported a deepening of connection with others. For Aria, sharing her experience also centred around compassion. She shared so as to feel less alone, and so others felt less alone also. Her story points to an experience of group strength where people feel stronger when they are with others and not alone.

Once trust was developed with others in the programme, relationships appeared to be more supportive, and participants were able to share and process many aspects of their recovery and provide reflection and feedback. Sharing of experiences can act as a healing experience for many, especially in processing guilt and shame (Bjørlykhaug et al., 2020; Kissman & Torres, 2004). Similar to Aria, Isla discussed how the sharing of experiences countered isolation.

INT = What is helping at the moment?

Isla = Support. Support and empathy.

INT = Mmmm, who from?

Isla = The mums and staff.

INT = Ok, how do the mums provide support?

Isla = Their stories are so similar, so I feel like I can share with them, it's nice knowing they can relate, and it makes me want to share more.

INT = Have you been able to share stories like that with others in the past?

Isla = It's a new thing for me, I didn't use to be able to dig in deep, but now I can, because of the similar stories, so I feel like I'm not alone. It makes me feel so much better knowing I'm not the only one. I find it inspiring too, it makes me motivated hearing their stories and seeing them move through the levels, it makes me more focused and want to achieve things.

Becoming vulnerable so as to build deeper connections was supported by the shared nature of many participants' experiences. Isla described an experience of universality countering isolation when other people understood her story. Isla's interview illustrates the power of having people with similar experiences living in the same community. It further shows the need for connection within her recovery. Aria's and Isla's stories, in particular,

align with Yalom's (1995) theory of group cohesiveness and its positive influence on group self-esteem, hope and general wellbeing (Marmarosh et al., 2005; Yalom, 1995). As residents in the Family Centre, they shared their stories of life and recovery and built strong and trusting social connections. They developed hope for themselves, their future and everyone around them, as further explored in the following subtheme.

Rebecca also pointed to the importance of the support provided by other residents. When discussing her moving into the community, she said she would miss that support.

> *I will miss all the people; I actually really like it. Different things that have popped up, with my mum and my son, I've really liked being able to come out of my room and find someone to talk to, or just sit with, or hear about what' s going on for them, or just that distraction or support or different perspective. I know we can call them, but I will still miss it. (Rebecca)*

She added that one of the best parts of the Family Centre was the *"support, peers, the opportunity to make friends who want to make changes as well and understand where you are coming from."* Having support available all the time from people who have shared experiences was helpful to Rebecca, as it countered feelings of isolation. She pointed to the value of mutual support when she was experiencing difficulties, where both providing and receiving support from peers was beneficial. Her story also points to the importance of the connections she developed while in the programme, and how they would continue to support her when she was living in the community.

Consistent with previous research (Bjørlykhaug et al., 2020; Turpin & Shier, 2017), mutual support was identified to play a number of roles within recovery, supporting participants through the sharing of experiences, prevention of isolation, development of trust

in relationships, receiving feedback, and gaining new perspectives. Participants' stories support 'relational recovery' and emphasise the importance of positive peer relations in supporting recovery.

Change is Possible

This subtheme focuses on the hope or optimism for change that participants developed largely through their relationships with other residents in the Family Centre programme. Hope can be understood as an individual's perceived ability to develop pathways to a desired goal, and motivation to use those pathways (Snyder, 2002). It emphasises a person's agency and capacity to work towards goals (Snyder, 2002) and is considered a key therapeutic factor and a vital component of recovery (Bjørlykhaug et al., 2020; Schrank et al., 2008). The development of hope was key to participants' recoveries and their belief that change was possible, particularly given that states of despair and hopelessness are common for individuals facing challenges with substance use, and with those who may have relapsed (Metzger, 1988). Niamh discussed the feeling of hopelessness following relapse.

> *When I relapsed, I was clean for two years before it. But then I got a DNA test for my daughter, and it wasn't my partner, so there was only one conclusion, it was too much for me. I started using again, I started thinking I'm so over this cycle, as soon as something traumatic happens I go back to it* [drug use]. *I'm not getting better, I'm staying in the same state all the time, I'm not growing, it's made me lose everything. (Niamh)*

For Niamh, experiences of trauma triggered relapse to substance use. Niamh felt like they were stuck in a cycle, unable to make lasting positive changes, and under the control of substances. Significant traumatic events had disrupted efforts in recovery and perpetuated

feelings of hopelessness; this seemed to impact the extent to which Niamh felt able to change, holding them back even when they wanted to change. Feelings of hopelessness weren't uncommon; Hana also discussed hopelessness around her ability to make lasting changes.

> *Hana = I don't know, anything can happen, I don't know what might happen. I hope I'm still on the path in recovery, but who knows, anything could happen, I do have this willingness and desire to change, its strong for me.*
>
> *INT = Ok, so you've got that desire, but you might be scared something will get in the way?*
>
> *Hana = Yeah.*
>
> *INT = What are you be worried about?*
>
> *Hana = Myself, I might get in the way. I mean I know it's all up to me at the end of the day, I can't say this happened and THAT or THEY made me use, but I'm scared of myself, because I'm the only person who can pick up drugs and alcohol.*

Hana spoke of feeling powerless over her substance use and saw herself as a barrier to lasting change. This experience of hopelessness was more common in participants who had been in the programme for shorter periods of time. However, many of those who had been in the programme for longer, described experiencing a sense of hope in the Family Centre. They felt more positive about the future, and that change was possible.

Learning from others was described by participants as an internal process of changing attitudes and beliefs where they would become more recovery-orientated and positive in their own outlook, future, and ability to change. Rebecca discussed the hope she had developed for her own and other recovering individuals' futures through observing people's recovery in the Family Centre.

> *Seeing them change as well, it gives me a sort of feeling of you know, people can change. Most of the people in the past, they just didn't change, and you know, I just thought it was my fault, I didn't know that people could change. I thought that people were deliberate in what they were doing, but it was just really that they didn't know what they were doing, or they didn't know how to change. (Rebecca)*

Experiencing people make positive changes in their lives was described by Rebecca as breaking the cycle of hopelessness that Rebecca experienced for herself and others. A sense of hope supports an individual's perception that something desirable might happen and that goals can be achieved (Snyder, 1994). A sense of developing hope was echoed throughout participants' stories.

Snyder (2002) theorised that hope is learned. In early childhood, this learning occurs through modelling by others and the teaching of a hopeful mindset. Emerging literature extends modelling, and highlights the external and contextual influences on hope, including the influence of those around us (Stevens et al., 2014). The people we surround ourselves with have a salient influence on the development of hope. For participants, surrounding themselves with people in recovery who were making positive change led to hope for recovery-orientated change. Participants' levels of hope were not only related to themselves,

but to perceived hope for those around them, as consistent with previous research (Stevens et al., 2014).

> *Being in a place living with people who have similar experiences, but have different thoughts and behaviours, it's hard, but it's good. Especially with people in different levels. You can see how you used to be, and who you want to be, and how people have changed. It gives you motivation to change. (Aria)*

Residents in higher levels served as an anchor for viewing positive change. They were a source of optimism and motivation that those positive changes were possible.

> *You look at some people and you're like, wow, they're so good, they're so strong, you're so good at holding other people accountable. They're motivating, it makes you want to be like that, it's so good to be around good people, and people here are like that. It's helpful to see them on their journey. (Natia)*

For Natia, other residents in the programme acted as role models for her to map her desired behaviour. They motivated positive change. Similarly, Ātaahua discussed the motivation gained through observing positive change in living with others in the Family Centre.

> *A bit of chaos, but awesome, something that keeps us motivated every day. I love watching the other families though, seeing them grow, it's amazing watching them move up the levels and then move out. It's amazing seeing the kids grow, seeing them grow and change, it's a really big change for us mums but also for the children, for us*

together growing in a safe environment and being able to take what we learn here back out there. (Ātaahua)

Rather than being alone on the recovery journey, Ātaahua reflected on a sense of family where people grow and change together. Her use of the language 'together growing' portrayed a sense of belonging with other residents in the Family Centre. Her words reflect the strong and intimate relationships built between residents within the Family Centre. Her statement suggested that simply being able to watch someone make positive changes supported hope and motivation, although this result was likely strengthened through a sense of connection with the other residents. When participants were making changes together, they were more hopeful; a sense of community emerged which supported participants to be more positive regarding the possibility of change and a different, more positive future. The Family Centre environment appeared to support participants in developing a sense of community and intimacy with other residents.

Alongside the influence of peers in the programme, Maia acknowledged the hope she developed through the relationship she was re-developing with her eldest daughter.

INT = Has your relationship changed [with her eldest daughter] *since you've been in here?*

Maia = Yeah, she's talking to me, she's come and stayed with me like twice. We hug. I can still hear resentment in her voice, but that will take years to rebuild. But she loves me, she's written me a letter to tell me she is proud of me. That's a start and I'm happy with that.

INT = That's great. How is that for you, for your recovery?

Maia = It's amazing, I mean I feel shameful, to even have my daughter have those feelings towards me, because I know I've been a shit parent. But it gives me hope, I've got the letters she written to me everywhere, so that when I'm having my shit days, I can see it and I'm like this is why.

While acknowledging the hurt and pain her substance use had caused to her children, Maia's relationship with her daughter served as a significant source of hope. Rebuilding her relationship with her daughter, and her daughter acknowledging the positive changes Maia has made in her recovery, made her more hopeful; in doing so it supported her drive and purpose in recovery.

Hope and sense of community are both factors identified to support recovery trajectories within residential drug and alcohol treatment (Kelly & Yeterian, 2011; Laudet et al., 2000; Stevens et al., 2018). For participants in this study, a sense of community was portrayed through togetherness and connection, where participants did not feel alone in their recovery. They felt a part of something, where people were collectively making changes in their lives together. The concept of a community seems fitting, given the participants' descriptions of shared recovery, positive change and mutual influence. The results support the use of treatment approaches such as TCs, which emphasise working with and learning from others as a core aspect of treatment to promote the development of hope as well as positive relations in recovery.

Summary

Theme Three highlights the relational nature of recovery for participants in the Family Centre. Past and present relationships were experienced as both supportive and

hindering to recovery. Through observation of positive role models and sharing of mutual experiences, participants developed social connections and a community with others in the programme. They developed hope for their own future, and trust in social relationships, something that many had struggled with prior to entering the programme. Considering the importance of positive social connections in recovery, which are highlighted both in past literature and within the study's findings, Theme three points to meeting the needs of social connection within the programme.

Chapter Summary

There is a lack of prior research investigating individuals' experiences within residential integrated treatment programmes for alcohol and substance misuse, and what factors facilitated their recovery. This study highlights several key factors that contributed to participants' recoveries within the Family Centre. Participants spoke extensively about the role their child/ren played within their recovery, supporting their construction of self through becoming present in their child/ren's lives, becoming role models, developing a sense of purpose, and increasing connections with their child/ren. These factors fundamentally supported parents' recovery, and interviews emphasised how intertwined participants' parenting and recovery processes were. Cultural immersion additionally supported participants' recovery, assisting them to reconstruct and rediscover themselves through enhanced knowledge, connection and belonging.

The Family Centre provided a therapeutic milieu that supported participants' recoveries. Within this, specialist psychological support for trauma and mental health difficulties, as well as strengths-based staff support, was seen as crucial. Furthermore, key TC components such as encounter groups, closed groups and the daily routine provided participants with a stable platform to engage in recovery while also supporting an increased awareness of their difficulties and the development of coping mechanisms.

Lastly, the relational nature of participants' recoveries was echoed throughout each participant's interview. The people surrounding participants were said to fundamentally impact their recovery, both positively and detrimentally. Peers within the programme played a key role in each participant's treatment and recovery journeys. Observing peers' recovery journeys supported the development of hope. Mutual support provided participants with social connections, making them feel less alone in their recovery and facilitating the development of trust in relationships. The results indicate several key clinical implications for treatment services as well as future directions of research.

Chapter Five: Implications, Limitations and Conclusions

This research focused on the recovery journeys of 10 mothers who were engaged in a structured programme at an integrated AOD rehabilitation facility, the Family Centre. The research aimed to identify factors, as identified by these participants, as supporting recovery-orientated change within the Family Centre, as well as participants' needs within recovery. This chapter will outline key conclusions from the research, as well as the clinical implications of the study. The limitations of the study and recommendations for future research will be outlined.

The three themes illustrated several aspects of the Family Centre programme which, for these participants, were supporting them to make positive changes within their recovery. Participants' stories were rich with nuances around their alcohol and substance use and recovery journeys. Their accounts of recovery align with past literature in acknowledging that recovery is far more than symptom reduction or abstinence from substances (De Maeyer et al., 2009; De Maeyer et al., 2011; Laudet & White, 2008; McQuaid et al., 2017). For example, stable recovery for those who misuse opiates is predominantly connected with establishing meaningful activities and purposes in life, and with social connection and participation, rather than with abstaining from or controlling substance use (De Maeyer et al., 2011).

Many of the participants' understandings of recovery evolved over time. When they first entered treatment, they acknowledged believing that their recovery was simply about abstinence from alcohol or other substances. However, as their recovery evolved, so did their definitions of recovery. Participants spoke about recovery as being all-encompassing and integrated into every aspect of their lives. Considering the all-encompassing nature of recovery, treatment needs to focus on more than symptom reduction, and a holistic perspective surrounding the whole person and their networks needs to be considered in

supporting individuals. Each theme, discussed in the sections below, specifies how participants were supported in their recoveries at the Family Centre, detailing the resources that participants accessed, engaged in and found helpful.

The construction of self focused on how participants were supported to discover and construct a positive recovery-orientated self. Firstly, participants identified that parenting was central to their construction of self. Their interviews reflected that, as they spent intentional time with their children, developed confidence in their role as a parent and built stronger connections with their child/ren, they started (re)constructing their identity as a parent. This identity contributed to participants' motivation and purpose, not just as a parent, but in their recoveries and lives. The daily tasks and activities of being a present and nurturing parent contributed to their recovery. The findings suggest that enhancing the role of parenting in those who are in recovery contributes to the construction of a positive, forward-thinking identity. These findings align with past literature, which identifies parenthood to play an important role in identity formation for recovery, acting both as a motivator and a protective factor (Coyer, 2003; Pirskanen et al., 2017; VanDeMark, 2007). The findings align with literature which acknowledges the importance of identity development in people's recovery (Leamy et al., 2011).

The findings also emphasise the centrality of parenting to recovery. Participants described the intertwining of parenting and recovery, each impacting the other in both positive and negative ways. When participants felt like they could not balance their parenting, they reported struggling. Furthermore, the experience of guilt and shame regarding their past parenting practices was echoed throughout each participant's story, often perpetuating their past use of substances. However, parenting also served as a primary source of motivation in their recoveries and positively influenced participants' recovery journeys. This finding is

consistent across previous research, with the parental role being a primary motivation for recovery (Brekke et al., 2020; Schultz et al., 2018).

Within the construction of self, cultural engagement was highlighted as central to participants' overall wellbeing, recovery and motivation in treatment, consistent with previous research (Kapeli et al., 2020; Kupa, 2009; Williams et al., 2018). Cultural safety and competence are of vital importance to substance misuse treatment services in New Zealand (Nelson, 2017; Te Rau Matatini, 2015). Participants of different cultural ethnicities and religions spoke of how the Family Centre supported them in engaging with their cultural and religious practices, emphasising the importance of this support and how, for many, they would not have engaged in the programme or their recovery without it. Engagement in cultural practices facilitated a better understanding and discovery of who they were and contributed to their overall wellbeing.

The therapeutic milieu focused on factors within the therapeutic environment that supported participants in gaining self-awareness and awareness of their difficulties, and developing coping mechanisms to manage challenging emotions, behaviours and situations. The Family Centre was seen as a safe and stable environment that provided such support.

Although this study was not solely focused on the TC model, participants identified several TC components which were supportive of different aspects of their recovery. In particular, encounters and closed groups were seen as significant tools for participants to develop insight into their substance use and associated thoughts, emotions and behaviours. Many participants identified an increase in motivation from the insight from such interventions. This finding is consistent with previous literature, which supports the provision of self-awareness interventions for AOD treatment (Apodaca & Longabaugh, 2009; Castine et al., 2019; Jung et al., 2011). Participants noted how these tools could be challenging and needed support to understand and accept. They emphasised the importance of gaining insight

into the recovery process, particularly concerning their behaviours that could put them at risk of lapse or relapse. The TC tools were seen as helpful in doing so.

Programme routine and stability afforded participants a sense of safety that they had not experienced before, allowing them to feel more in control and grounded and supporting of both parenting and recovery. Of course, routine and structure are not the only factor that contributed to participants feeling as though they can manage their parenting within their recovery. However, for many, establishing a stable routine in their lives was a significant contributing factor in being able to balance parenting with recovery. For many parents, the stress involved in managing both parenting and recovery is a point of relapse (Adinoff et al., 2014; Carlson et al., 2006; Hodgkinson et al., 2014). Therefore, supporting individuals in recovery, particularly those who are also parenting, to implement a stable routine in their lives was seen as an important need and aspect of recovery.

The therapeutic milieu included the importance of professional psychological support. For those who had experienced trauma or had co-existing mental health conditions, psychological services were required to meet recovery needs. Participants' accounts and existing research highlight the strong association between trauma and substance use (Gielen et al., 2016; Kingston & Raghavan, 2009; Reynolds et al., 2011; Todd, 2010). Substances were described by several participants as a way to cope with trauma experiences, which highlights the complex needs of individuals who seek treatment for alcohol and substance use, and the need for comprehensive and multidisciplinary treatment to meet these needs. An accumulating body of evidence identifies that individuals who receive a greater number of comprehensive services while in treatment show improved outcomes, particularly if the treatment is targeted to their specific needs (Friedmann et al., 2004; Grella & Stein, 2006; Smith & Marsh, 2002).

Historically, people have faced issues with treatments for alcohol and substance misuse and mental health difficulties being provided separately (Health and Disability Commissioner, 2020). Both literature and participants' accounts identified the need for mental health, alcohol and substance misuse and trauma to be treated concurrently. The six participants who were engaged with either a clinical psychologist or intern psychologist emphasised the importance of these services supporting their overall wellbeing and recovery. For them, psychological support was a significant factor contributing to their recovery and a need for them in their treatment.

Furthermore, beyond the access to psychological services, the findings highlighted participants' need for services to be trauma-informed. Participants spoke about the importance of predictability and routine in their lives, the development of trust and relationships, and the development of their identities, all factors that are associated with trauma recovery (Tompkins & Neale, 2018). The Family Centre was meeting some of the participants' needs regarding trauma.

Alongside psychological support, the therapeutic relationship was identified as particularly important. Aligning with past literature, which acknowledges strengths-based approaches as core to recovery-oriented practice (Davidson et al., 2008; Le Boutillier et al., 2011), staff support that empowered residents and supported an increased sense of self-efficacy was helpful for participants' recovery. Family Centre staff support was anticipated by participants as also important in their long-term recovery, including both community staff support and support from professionals with whom participants had established therapeutic relationships. Continuing care staff are fundamental for long-term support of individuals in recovery, particularly as lapse and relapse are common within recovery (Malivert et al., 2012; McLellan et al., 2005).

Relational recovery focused on the role relationships played in participants' recoveries. Past and present relationships were identified to be potentially both helpful and hindering to recovery. Within the programme, witnessing others' journeys of positive change supported participants to develop hope for their own future, and for the future of others. Participants shared their stories and journeys with other residents in the programme. The mutual support experienced with other residents provided participants with social connections, making them feel less alone in their recovery, and supported them to develop trust in relationships. These findings fit with recovery literature that describes recovery as a process of moving from isolation or disconnection toward support and feelings of connection (Leamy et al., 2011). The participants' experiences of alcohol and substance use and recovery were also greatly influenced by relationships with their children, family and professionals.

It was difficult to categorise many of the themes within this research, given that most of the themes and subthemes could have been categorised under relational recovery. Relationships extend beyond those with among residents in the programme and include relationships with professionals, children, and culture. The study's findings add to emerging literature indicating that recovery is a relational process (Maybery et al., 2015; Mudry et al., 2019; Price-Robertson, Obradovic, et al., 2017; Topor et al., 2011; Topor et al., 2006). Although recovery is a personal journey, it is strongly influenced by the people around an individual. In fact, many of the participants spoke about recovery not being solely about themselves, but about the recovery of themselves and their whānau together. I decided to separate the findings into separate themes and relate them to their relational nature, as other themes indicated important aspects of recovery that needed to be explored.

Implications

The study's findings inform several key treatment targets or factors that treatment facilities could implement to meet the needs of parents in recovery. The Family Centre was

seen as meeting the recovery needs of the participants within the study. Several interventions and resources could continue to be implemented, amplified or introduced within the Family Centre to enhance the clients' recovery experiences.

Firstly, regarding the role of parenting, the findings suggest the need for parenting to be a central aspect of treatment programmes. This finding can be implemented in several different ways. Within integrated programmes, such as the Family Centre, it might involve bringing in additional resources that enhance parenting knowledge. Increased child developmental resources and courses were requested by several participants. Psychoeducational groups such as the Incredible Years parent programme (Webster-Stratton, 2001) and Triple P parenting programme (Sanders, 1999) could be continued within the Family Centre service to provide a group-based forum for client learning. Textbook resources could also be made available onsite detailing parenting practices to support parents' knowledge. Increased parenting knowledge in topics such as child developmental stages, correcting children's behaviour, and how to foster positive parent-child interactions would support parental self-efficacy and confidence, supporting positive parenting practices (Hess et al., 2004; Morawska et al., 2009; Sanders, 2008). Furthermore, considering the importance of parenting to participants' recoveries, individual clinical support focusing on both AOD treatment needs and parenting needs would be beneficial. Staff would benefit from having the skills and knowledge to provide this support and could be trained accordingly if they required further familiarity or additional competence.

Enhancing the parent-child relationship was seen as significant as it led to these mothers developing strong parenting identities which were supportive of their recovery. Participants identified the Family Centre to be meeting these needs. Programmes such as Circle of Security (Powell et al., 2013), which supports parents to implement parenting that enhances the parent-child relationship, could remain available. Further groups and activities

which promote present and nurturing parent-child interactions could be integrated into the programme, as a significant component of recovery. For example, the scheduling of daily parent-child activities could be implemented into the programme. An additional recommendation is an environment, such as one the Family Centre provides, that places parenting at the core of treatment, promoting positive interaction, play and nurturing practices.

Almost all participants in this study mentioned that, without a programme like the Family Centre, they would not be motivated to seek treatment. Participants did not have alternative supports, such as whānau, available to care for their children if they were to attend residential rehabilitation. They were scared to leave their children, or be separated from them for months, and some who had been in treatments previously without their children had left those programmes due to missing their children. These barriers outlined the significant positive role of parenting. While participants were in the programme they indicated learning how to be emotionally present with their children and learnt how to parent their children and meet their day-to-day needs. The literature on the efficacy of integrated services (Andrews et al., 2018; Espinet et al., 2016; Luthar et al., 2007; Niccols et al., 2012; Noether et al., 2007) suggests the need for more programmes such as the Family Centre which meet the needs of parents in treatment and enhance the significant role of parenting in people's recovery.

For parents in treatment without their children, the results suggest that including parenting aspects such as family visiting, groups and resources into treatment could be supportive of recovery, although further research is needed to support this suggestion. Considering the vital role of parenting on recovery, the findings highlight the importance of exploring the role of parenting in individuals' lives, as well as its impacts on individuals' recovery, as a core component of assessment and treatment planning for all individuals who are a parent and in recovery.

Regarding the importance of culture, findings outline the need for recovery programmes, policies and practices to promote strong cultural identities. Within the Family Centre, clients currently benefit from support to engage in cultural groups, cultural practices such as karakia, waiata and kapa haka and having access to specialised support from cultural staff. Having cultural staff available could be seen as fundamental to treatment programmes, in order to provide this specialised care. Clinical staff could continue to be trained accordingly, so they can continue to provide culturally sensitive, competent and safe care.

Regarding the provision of therapeutic support, staff at the Family Centre were identified to have built strong therapeutic relationships. They provided support which appeared strengths based, supporting, empowering whilst also challenging participants to develop new ways of coping and behaving. Staff could continue to be trained and supported to provide strengths-based care to clients, whilst also supporting insight development to meet clients' needs in treatment. A competent level of knowledge regarding AOD, mental health difficulties and trauma informed care could be helpful in supporting this, and as such, training could be provided if further familiarity or knowledge is required.

The findings also reiterate the need for comprehensive aftercare services for individuals once they leave or graduate from residential treatment services. Currently, aftercare services are separate from the Family Centre programme; however aftercare staff attempt to build relationships with clients while they are still living at the facility. Findings suggest that aftercare support could be integrated into the Family Centre, where aftercare staff focus on building connections with individuals while they are in the programme, to develop trust, a therapeutic alliance and client confidence prior to them moving into the community.

Based on the findings, which emphasise the relationship between trauma and substance use, there is a need for access to specialist psychological support services within

residential AOD rehabilitation to support clients who are facing more severe mental health needs or have a history of trauma. Odyssey House employs predominantly registered AOD practitioners and social workers who provide therapeutic support to clients. These practitioners largely focus on the treatment of AOD-related treatment needs, as well as general wellbeing or mild mental health needs such as low mood and anxiety. In terms of psychological support, the Family Centre residents could benefit from the continued provision of specialised psychological services for those who have experiences of trauma and compromised mental health, as is needed to meet the complex needs of those in treatment.

Throughout the findings, the influence of relationships dominates. The findings suggest the need for treatment services to focus on the relationships surrounding the person as a fundamental aspect of treatment. They also suggest a need for greater integration of interpersonal factors when exploring experiences of recovery. The improvements participants identified within their relationships were directly related to improvements in their recovery, suggesting essential aspects of relationships such as communication, boundaries, trust, and support could be included as a component of treatment services, through psychoeducation, group treatment, individual treatment, or other therapeutic resources. The provision of mutual support groups where clients can share experiences should be continued. Importantly, in the provision of group therapy, residents would benefit from staff who are trained and supported to run groups that foster group cohesiveness. Currently, staff are assigned to particular groups, which could be continued wherever possible, to support the development of trust, group cohesiveness and self-disclosure (Morgan-Lopez & Fals-Stewart, 2008).

Limitations

There are several limitations to this study. The focus of this study was on exploring in depth the narratives of people in AOD recovery in a specific facility. As such, the results speak specifically to this group's experiences, rather than being intended to generalise

beyond this group. Further research exploring similar questions outside of this population would provide additional depth. The research focused solely on factors that contributed to recovery within the Family Centre. There are many other factors, besides what was discussed in this research, which are supportive of individuals' recoveries. Due to participants being in the programme, they focused their attention and discussions on the day-to-day factors that supported them while in the programme. Nevertheless, the study aimed to provide accounts of recovery within an integrated service and what participants found useful, and the study produced results that addressed these aims.

Although I aimed to recruit participants of all genders and cultures, due to the lack of male representation within the Family Centre at the time, no male participants were interviewed to explore their experience in the Family Centre. There is a dearth of literature that explores the role of fatherhood in recovery, and such research could provide further insight into the role parenting plays in fathers' recoveries.

Within this methodology, participants were asked to reflect on their experience of recovery within the Family Centre. Personal experiences are particularly difficult to communicate in a way that reflects their richness (Todres, 2007). A person's self-awareness, willingness to communicate and communication skills may impact their ability to convey their lived experience (Frost et al., 2014). The implications of impression management should also be raised, particularly given my previous employment at the Family Centre. It was possible that participants were overly positive about the Family Centre programme, or their recovery in general. Participants may have also been overly positive about the programme if they saw themselves as completely reliant on the programme for their wellbeing at the time. However, all the participants appeared open to discussing all elements of the programme and provided both support and ideas for improvement. Participants were also open about their

past alcohol and substance use, as well as difficulties they were currently facing in their recovery. Therefore, the implications of impression management are likely limited.

Due to the time restraints of the research, three participants had been in the Family Centre programme for under three months. Although these participants were able to articulate their experiences, they had some difficulty in communicating the core tenets of the programme which were supporting them, and therefore more probing and direction within interviews was necessary to gather some information. Some of the newer mothers in the programme discussed focusing on one core aspect of their recovery such as their parenting, their self-esteem, or implementing a routine before working on other factors of their recovery. That focus increases the likelihood that the results gave more insight into the earlier stages of recovery. Nonetheless, other participants had been in recovery for a longer period and were able to provide rich accounts of their experiences, insights and learnings that had supported them throughout their time in the programme and while in the community. I had endeavoured to gain insight into recovery across multiple stages of treatment to compare these stories across participants, but due to time restraints, it was not possible to complete this to the extent I had wished.

It was difficult to obtain nuanced accounts of treatment and recovery across different programme stages. For example, I was particularly interested in gaining insight into what would be supportive of recovery once participants left the Family Centre and were living in the community. This is important considering the long-term nature of alcohol and substance use recovery. There were however no participants who were living in the community at the time of their interview, and therefore this information could not be gathered. Two of the participants, who were about to move into the community, provided some insight. However, richer and more distinct accounts could have been provided by individuals who had resided in the community and were living the day-to-day reality of recovery out of treatment.

An additional limitation of the current research is the lack of active involvement of service users in the research design or in identifying and defining needs. Service users place high importance on the expertise of individuals with lived experience (Davies & Grey, 2017). The use of co-design based research could have been beneficial to address this limitation. Experience based co-design (EBCD) is a participatory approach which aims to improve health care settings through the collaborative co-design of service implementation by service users, carers and staff (Cooper et al., 2016; Donetto et al., 2014; Robert, 2013). In EBCD, there is collaborative design of the research. Then, following data collection, key themes or 'touch points' are presented back to staff, whānau and service users who can then prioritise the implementation of changes in their services, and put services users, whānau and staff at the forefront of implementation. An EBCD approach allows the views of all key stakeholders to be heard (Cooper et al., 2016). Likewise, participatory action research is a collaborative method of research which seeks to empower affected populations and communities through actively involving them in the research process through identifying problems, defining needs and developing potential solutions (Chevalier & Buckles, 2019; Livingston & Perkins, 2018).

Although the current research lacked active involvement of service users, the current research was an initial exploratory attempt to hold the spirit of these research designs within this research and give voice to service users' perspectives and understanding of key issues. Furthermore, as with EBCD approaches, the current research findings were fed back to service users, programme staff and management to facilitate alterations within the service if appropriate.

Directions for Future Research

To date, this study is the only research to my knowledge that has been conducted on integrated parent-child AOD treatment services in New Zealand. Further qualitative research would be beneficial, particularly interviews conducted at multiple points throughout

treatment to be able to understand the intricacies of recovery at each stage of the programme and as people move through treatment. That research would give insight into individuals' shifting trajectories of recovery throughout treatment, how goals and motivation change, and any changing needs or facilitating factors for each individual. By interviewing the same person multiple times across their treatment stay, or recovery, interviews could focus on what was supporting the person at that moment; as such discussions would likely be more in-depth, participants may be able to articulate their experience better, rather than reflecting on their entire time in treatment.

Furthermore, future research would benefit from interviewing parents who are living in the community following leaving an integrated facility such as the Family Centre. These participants may be able to reflect on the core components of the programme that have supported them, their wellbeing and recovery while living in the community and facing daily recovery. It is suggested that it takes around five years before recovery can be regarded as self-sustaining (Dennis et al., 2005), so longitudinal research with individuals who have been in recovery for longer periods would provide rich information.

Research should additionally explore the role of parenting for those who are in treatment without their children, and how parenting might play a role in their recovery. Further to this, considering findings suggesting the critical role that parenting does play in recovery, how can services which do not include children in treatment better meet the needs of those parents in recovery?

Further quantitative or mixed methods research would also be beneficial within a New Zealand context. These designs could gather more generalisable evidence of change and recovery within integrated treatment services, and further contribute to understandings of the role parenting plays in individuals' recoveries. Beyond the investigation of AOD services, an investigation into the role parenthood plays in mental health recovery would be beneficial.

Although participants identified some cultural elements which facilitated recovery, the present study was not solely focused on cultural aspects of the programme and their effectiveness. Further research should explore cultural resources and services within treatment programmes such as the Family Centre to further understand whether individuals' difficulties are understood within a cultural framework, whether staff work within a culturally appropriate framework, the cultural needs that should be met for Māori and Pasifika people in recovery, and what improvements could be made to programmes to make them more efficacious. This research undertaken within a kaupapa Māori and Pasifika framework would be beneficial. Within this, research could use key cultural models such as te whare tapa whā (Durie, 1998; Rochford, 2004) or the Meihana model (Pitama et al., 2017) as a way to assess fundamental aspects on individual and whanau wellbeing. Furthermore, there are minimal New Zealand specific studies on substance use and recovery, and therefore research undertaken often needs to rely on international literature and attempt to map that onto the unique population in New Zealand. Further research would develop the literature base and understandings specific to unique demographic and cultural idiosyncrasies within New Zealand.

The findings of the study emphasised the role staff played in participants' recovery journeys. Despite staff prominence in participants' narratives, it was beyond the aims and scope of this research to explore staff perspectives of recovery. Given staff's experience in working with individuals parenting while in recovery, future research could explore staff's perspectives of factors influencing client change and recovery within integrated services. That focus would give a nuanced account and could provide perspectives on the system and organisational factors that support staff to provide recovery-orientated support to individuals, barriers to doing so, and changes that may need to be made to improve service effectiveness.

Given the findings of this study, and the literature indicating both the impact of trauma and the need for trauma-informed care within AOD and parenting services, research evaluating the trauma-informed framework of organisations such as the Family Centre would be beneficial. Moreover, research to better understand how services can improve their trauma-informed care would additionally be beneficial.

Final Statement

Alcohol and substance use recovery while parenting is a complicated endeavour. This research acknowledges the complex histories of those who are parenting in recovery, the difficulties they must face when choosing recovery, and the multifaceted nature of their recovery journeys. Parents in recovery often face a tough decision - to take care of themselves, or to take care of their children. Societal expectations and stigma regarding parenting, along with the lack of treatment services available, contribute to individuals' difficulties in seeking support. The Family Centre offers an environment that enables parents to choose both themselves and their children and enhances their recovery and parenting in the process. Although challenging at times, parenting in recovery within the Family Centre brought strength to participants' recovery journeys, meeting their needs for recovery. I hope that this research provides pause for reflection for professionals and service providers when working with parents in recovery, highlighting its relational nature, particularly in relation to children. It is hoped that participants' voices will be heard and treatment services will better meet the needs of those parenting in recovery.

Beyond the role of parenting, participants in this study highlighted the significant role those around them have on their recovery. Children, partners, staff, whānau and fellow residents played a significant role in participants' recoveries. They supported the development of trust and hope, fostered social connection, supported and reinforced the development of identity, meaning and purpose. Johan Hari notably quoted "the opposite of addiction is not

sobriety – it's human connection" (Hari, 2015) and participants' stories of recovery from this study unquestionably support his claim. It is hoped that this study supports researchers, practitioners and society to reflect on the ways in which they view alcohol and substance misuse, its treatment, and people's recoveries. Beyond this, it is hoped that the current research can contribute to practice and support those who are in recovery by highlighting and changing the implementation of clinical practice to better support those who are parenting and in recovery.

References

Adamson, S., Deering, D., Hinerangi, M., Huriwai, T., & Noller, G. (2010). An evaluation of the Moana House residential therapeutic community. *Alcohol Advisory Council of New Zealand: Wellington, New Zealand*.

Adinoff, B. H., Denton, W., Lewis, D., Walker, R., & Winhusen, T. (2014). Family discord is associated with increased substance use for pregnant substance users. *Substance Use & Misuse*, *49*(3), 326-332. https://doi.org/10.3109/10826084.2013.840002

Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child development*, 49-67. https://doi.org/10.7312/stei93738-006

Ajzen, I. (1991). The theory of planned behavior. *Organizational behavior and human decision processes*, *50*(2), 179-211. https://doi.org/10.1080/08870446.2011.613995

Amador, X. F., Flaum, M., Andreasen, N. C., Strauss, D. H., Yale, S. A., Clark, S. C., & Gorman, J. M. (1994). Awareness of illness in schizophrenia and schizoaffective and mood disorders. *Archives of general psychiatry*, *51*(10), 826-836. https://doi.org/10.1001/archpsyc.1994.03950100074007

American Psychiatric Association, A. (1952). *Diagnostic and Statistical Manual of Mental Disorders* (Vol. 1). American Psychiatric Association Washington, DC.

American Psychiatric Association, A. (1968). *Diagnostic and Statistical Manual of Mental Disorders* (Vol. 2). American Psychiatric Association Washington, DC.

American Psychiatric Association, A. (1980). *Diagnostic and Statistical Manual of Mental Disorders* (Vol. 3). American Psychiatric Association Washington, DC.

American Psychiatric Association, A. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (Vol. 4). American Psychiatric Association Washington, DC.

American Psychiatric Association, A. (2000). *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR)*. American Psychiatric Association Washington, DC.

American Psychiatric Association, A. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (Vol. 5). American Psychiatric Association Washington, DC.

Andrews, N. C., Motz, M., Pepler, D. J., Jeong, J. J., & Khoury, J. (2018). Engaging mothers with substance use issues and their children in early intervention: Understanding use of service and outcomes. *Child Abuse & Neglect, 83*, 10-20. https://doi.org/10.1016/j.chiabu.2018.06.011

Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11. https://doi.org/10.1037/h0095655

Apodaca, T. R., & Longabaugh, R. (2009). Mechanisms of change in motivational interviewing: A review and preliminary evaluation of the evidence. *Addiction, 104*(5), 705-715. https://doi.org/10.1111/j.1360-0443.2009.02527.x

Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage and Family, 62*(4), 1192-1207. https://doi.org/10.1111/j.1741-3737.2000.01192.x

Arria, A. M., Derauf, C., LaGasse, L. L., Grant, P., Shah, R., Smith, L., Haning, W., Huestis, M., Strauss, A., & Della Grotta, S. (2006). Methamphetamine and other substance use during pregnancy: preliminary estimates from the Infant Development, Environment, and Lifestyle (IDEAL) study. *Maternal and Child Health Journal, 10*(3), 293. https://doi.org/10.1007/s10995-005-0052-0

Arsiniega, B. (2021). Race and Prohibition Movements. *Tennessee Journal of Race, Gender, & Social Justice, 11*(2), 3.

Atwool. (2010). *A report into the quality of services provided to children in care: Office of the Children's Commissioner*.

Bahr, S. J., Masters, A. L., & Taylor, B. M. (2012). What works in substance abuse treatment programs for offenders? *The Prison Journal, 92*(2), 155-174. https://doi.org/10.1177/0032885512438836

Baker, Piper, M. E., McCarthy, D. E., Majeskie, M. R., & Fiore, M. C. (2004). Addiction motivation reformulated: an affective processing model of negative reinforcement. *Psychological review*, *111*(1), 33. https://doi.org/10.1037/0033-295X.111.1.33

Bandura. (1971). *Social Learning Theory*. *General Learning Corporation*.

Bandura, A. (1969). *Principles of Behavior Modification*. Holt, Rinehart, and Winston.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological review*, *84*(2), 191-215. https://doi.org/10.1037/0033-295X.84.2.191

Bandura, A. (1997). *Self Efficacy: The exercise of control*. W.H Freeman.

Barnard, M., & McKeganey, N. (2004). The impact of parental problem drug use on children: what is the problem and what can be done to help? *Addiction*, *99*(5), 552-559. https://doi.org/10.1111/j.1360-0443.2003.00664.x

Bartram, M. (2020). 'It's Really About Wellbeing': a Canadian Investigation of Harm Reduction as a Bridge Between Mental Health and Addiction Recovery. *International Journal of Mental Health and Addiction*, 1-14. https://doi.org/10.1007/s11469-020-00239-7

Barwick, H. (2000). Improving access to primary care for Maori and Pacific peoples. *A literature review commissioned by the Health Funding Authority. Wellington: Ministry of Health*.

Bassuk, E. L., & Gerson, S. (1978). Deinstitutionalization and mental health services. *Scientific American, 238*(2), 46-53. https://doi.org/10.1038/scientificamerican0278-46

Baumeister, R. F. (1999). *The self in social psychology*. Psychology Press.

Baxter, J. (2002). *Barriers to health care for Maori with known diabetes: A literature review and summary of the issues*. Te Roopu Rangahau Hauora a Ngai Tahu.

Beck. (2011). *Cognitive Behavior Therapy Basics and Beyond* (2nd ed.). Guilford.

Beck, A. T. (1993). Cognitive therapy: past, present, and future. *Journal of consulting and clinical psychology, 61*(2), 194. https://doi.org/10.1037/0022-006X.61.2.194

Beck, A. T., Emery, G., & Greenberg, R. L. (2005). *Anxiety Disorders and Phobias: A Cognitive Perspective*. basic Books.

Bell, V., Robinson, B., Katona, C., Fett, A.-K., & Shergill, S. (2019). When trust is lost: The impact of interpersonal trauma on social interactions. *Psychological <edicine, 49*(6), 1041-1046. https://doi.org/10.1017/S0033291718001800

Benishek, L. A., Dugosh, K. L., Kirby, K. C., Matejkowski, J., Clements, N. T., Seymour, B. L., & Festinger, D. S. (2014). Prize-based contingency management for the treatment of substance abusers: A meta-analysis. *Addiction, 109*(9), 1426-1436. https://doi.org/10.1111/add.12589

Best, D., & Laudet, A. (2010). The potential of recovery capital. *London: RSA*.

Best, D., Rome, A., Hanning, K. A., White, W., Gossop, M., Taylor, A., & Perkins, A. (2010). *Research for recovery: A review of the drugs evidence base*. Crown.

Bill, W. (1957). *Alcoholics Anonymous Comes of Age: A Brief History of AA*. Alcoholics Anonymous World Services.

Bird, V., Leamy, M., Tew, J., Le Boutillier, C., Williams, J., & Slade, M. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian & New Zealand Journal of Psychiatry, 48*(7), 644-653. https://doi.org/10.1177/0004867413520046

Bjørlykhaug, K. I., Bank, R.-M., & Karlsson, B. (2020). Social Support and Relational Recovery in the Age of Individualism. *Journal of Recovery in Mental Health*, *4*(1), 35-55.

Blakey, J. M. (2012). From surviving to thriving: Understanding reunification among African American mothers with histories of addiction. *Children and Youth Services Review*, *34*(1), 91-102.

Bowlby. (1969). Attachment and Loss (vol. 1) Basic Books. *New York*.

Bowlby. (1982). Attachment and Loss: retrospect and prospect. *American journal of Orthopsychiatry, 52*(4), 664.

Bowlby, J. (1951). *Maternal Care and Mental Health* (Vol. 2). World Health Organization Geneva.

Bramley, D., Hebert, P., Tuzzio, L., & Chassin, M. (2005). Disparities in indigenous health: a cross-country comparison between New Zealand and the United States. *American Journal of Public Health, 95*(5), 844-850. https://doi.org/10.2105/AJPH.2004.040907

Braun, & Clarke. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, & Clarke. (2013). *Successful qualitative research: A practical guide for beginners*. sage.

Braun, Clarke, Hayfield, & Terry. (2019). Thematic Analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health social sciences*. Springer.

Brekke, E., Ness, O., & Lien, L. (2020). Relational recovery in co-occurring conditions: a qualitative study of first-person experiences. *Advances in Dual Diagnosis, 13*(2), 89-100. https://doi.org/10.1108/ADD-12-2019-0017

Broekaert, E. (2006). What future for the therapeutic community in the field of addiction? A view from Europe. *Addiction*, *101*(12), 1677-1678. https://doi.org/10.1111/j.1360-0443.2006.01646.x

Bronstein, A. C., Spyker, D. A., Cantilena Jr, L. R., Green, J. L., Rumack, B. H., & Heard, S. E. (2008). 2007 Annual report of the American Association of Poison Control Centers' National poison data system (NPDS): 25th annual report. *Clinical Toxicology*, *46*(10), 927-1057. https://doi.org/10.1080/15563650802559632

Brougham, D., & Haar, J. M. (2013). Collectivism, cultural identity and employee mental health: A study of New Zealand Māori. *Social Indicators Research*, *114*(3), 1143-1160. https://doi.org/10.1007/s11205-012-0194-6

Burke, P. J., & Stets, J. E. (1999). Trust and commitment through self-verification. *Social Psychology Quarterly*, 347-366. https://doi.org/10.2307/2695833

Burke, P. J., & Stets, J. E. (2009). *Identity Theory*. Oxford University Press.

Burke, P. J., & Tully, J. C. (1977). The measurement of role identity. *Social Forces*, *55*(4), 881-897. https://doi.org/10.2307/2577560

Bynum, W. F. (1984). Alcoholism and degeneration in 19th century European medicine and psychiatry. *British Journal of Addiction*, *79*(1), 59-70. https://doi.org/10.1111/j.1360-0443.1984.tb00248.x

Cain, T., Kahu, E., & Shaw, R. (2017). *Tūrangawaewae: Identity & belonging in Aotearoa New Zealand*. Massey University Press.

Campbell, J., & Carlson, J. R. (2012). Correctional administrators' perceptions of prison nurseries. *Criminal Justice and Behavior, 39*(8), 1063-1074. https://doi.org/10.1177/0093854812441161

Capaldi, D. M., Pears, K. C., Patterson, G. R., & Owen, L. D. (2003). Continuity of parenting practices across generations in an at-risk sample: A prospective comparison of direct and mediated associations. *Journal of Abnormal Child Psychology, 31*(2), 127-142. https://doi.org/10.1023/a:1022518123387

Carlson, B. E., Matto, H., Smith, C. A., & Eversman, M. (2006). A pilot study of reunification following drug abuse treatment: Recovering the mother role. *Journal of Drug Issues, 36*(4), 877-902. https://doi.org/10.1177/002204260603600406

Cash, S. J., & Wilke, D. J. (2003). An ecological model of maternal substance abuse and child neglect: Issues, analyses, and recommendations. *American Journal of Orthopsychiatry, 73*(4), 392-404. https://doi.org/10.1037/0002-9432.73.4.392

Casswell, S., You, R. Q., & Huckle, T. (2011). Alcohol's harm to others: reduced wellbeing and health status for those with heavy drinkers in their lives. *Addiction, 106*(6), 1087-1094. https://doi.org/10.1111/j.1360-0443.2011.03361.x

Castine, B. R., Albein-Urios, N., Lozano-Rojas, O., Martinez-Gonzalez, J. M., Hohwy, J., & Verdejo-Garcia, A. (2019). Self-awareness deficits associated with lower treatment motivation in cocaine addiction. *The American Journal of Drug and Alcohol Abuse, 45*(1), 108-114. https://doi.org/10.1080/00952990.2018.1511725

Cattapan, O., & Grimwade, J. (2008). Parental illicit drug use and family life: Reports from those who sought help. *Australian and New Zealand Journal of Family Therapy, 29*(2), 77-87. https://doi.org/doi.org/10.1375/anft.29.2.77

Cavaiola, A. A., & Smith, M. (2020). *A Comprehensive Guide to Addiction Theory and Counseling Techniques*. Routledge.

Cerezo, M. A., D'Ocon, A., & Dolz, L. (1996). Mother-child interactive patterns in abusive families versus nonabusive families: An observational study. *Child Abuse & Neglect, 20*(7), 573-587. https://doi.org/10.1016/0145-2134(96)00045-2

Chandler, R. K., Fletcher, B. W., & Volkow, N. D. (2009). Treating drug abuse and addiction in the criminal justice system: improving public health and safety. *Jama, 301*(2), 183-190. https://doi.org/10.1001/jama.2008.976

Cheng, T. C. (2010). Factors associated with reunification: A longitudinal analysis of long-term foster care. *Children and Youth Services Review, 32*(10), 1311-1316. https://doi.org/10.1016/j.childyouth.2010.04.023

Chevalier, J. M., & Buckles, D. J. (2019). *Participatory action research: Theory and methods for engaged inquiry*. Routledge.

Choi, S., Huang, H., & Ryan, J. P. (2012). Substance abuse treatment completion in child welfare: Does substance abuse treatment completion matter in the decision to reunify families? *Children and Youth Services Review, 34*(9), 1639-1645. https://doi.org/10.1016/j.childyouth.2012.04.022

Choi, S., & Ryan, J. P. (2007). Co-occurring problems for substance abusing mothers in child welfare: Matching services to improve family reunification. *Children and Youth Services Review, 29*(11), 1395-1410. https://doi.org/10.1016/j.childyouth.2007.05.013

Chung, S., Domino, M. E., & Morrissey, J. P. (2009). Changes in treatment content of services during trauma-informed integrated services for women with co-occurring disorders. *Community Mental Health Journal, 45*(5), 375-384. https://doi.org/10.1007/s10597-009-9192-9

Clarke, J., Winship, G., Clarke, S., & Manning, N. (2018). Democracy in mental health care: therapeutic communities and the new recovery movement. In *Essentials of Mental Health Nursing* (pp. 449 - 465). Sage Publications.

Clausen, J. M., Aguilar, R. M., & Ludwig, M. E. (2012). Fostering healthy attachment between substance dependent parents and their infant children. *Journal of Infant, Child, and Adolescent Psychotherapy, 11*(4), 376-386. https://doi.org/10.1080/15289168.2012.735183

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*(1), 11-27.

Cloitre, M., Chase Stovall-McClough, K., Miranda, R., & Chemtob, C. M. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 72*(3), 411. https://doi.org/10.1037/0022-006X.72.3.411

Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use & Misuse, 43*(12-13), 1971-1986. https://doi.org/10.1080/10826080802289762

Cole, M. B., & McLean, V. (2003). Therapeutic relationships re-defined. *Occupational Therapy in Mental Health, 19*(2), 33-56. https://doi.org/10.1300/J004v19n02_03

Coleman, P. K., & Karraker, K. H. (2003). Maternal self-efficacy beliefs, competence in parenting, and toddlers' behavior and developmental status. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health, 24*(2), 126-148. https://doi.org/10.1002/imhj.10048

Conger, K. J., Rueter, M. A., & Conger, R. D. (2000). The role of economic pressure in the lives of parents and their adolescents: the family stress model. In L. J. Crockett & R.

K. Silbereisen (Eds.), *Negotiating adolescence in times of social change* (pp. 201 - 223). Cambridge University Press.

Conners, N. A., Bradley, R. H., Whiteside-Mansell, L., & Crone, C. C. (2001). A comprehensive substance abuse treatment program for women and their children: An initial evaluation. *Journal of Substance Abuse Treatment, 21*(2), 67-75. https://doi.org/10.1016/S0740-5472(01)00186-6

Conners, N. A., Grant, A., Crone, C. C., & Whiteside-Mansell, L. (2006). Substance abuse treatment for mothers: Treatment outcomes and the impact of length of stay. *Journal of Substance Abuse Treatment, 31*(4), 447-456. https://doi.org/10.1016/j.jsat.2006.06.001

Connock, M., Juarez-Garcia, A., Jowett, S., Frew, E., Liu, Z., Taylor, R., Fry-Smith, A., Day, E., Lintzeris, N., & Roberts, T. (2007). Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation. In *NIHR Health Technology Assessment Programme: Executive Summaries*. NIHR Journals Library.

Cooper, G., Hoffman, K., Powell, B., & Marvin, R. (2005). The Circle of Security Intervention. . In L. J. Berlin, Y. Ziv, L. Amaya-Jackson, & M. T. Greenberg (Eds.), *Enhancing Early Attachments: Theory, Research, Intervention, and Policy* (pp. 127-151). Guilford Press.

Cooper, K., Gillmore, C., & Hogg, L. (2016). Experience-based co-design in an adult psychological therapies service. *Journal of Mental Health, 25*(1), 36-40. https://doi.org/10.3109/09638237.2015.1101423

Cordess, C. (1992). Pioneers in forensic psychiatry. Edward Glover (1888–1972): Psychoanalysis and crime - A fragile legacy. *Journal of Forensic Psychiatry, 3*(3), 509-530. https://doi.org/10.1080/09585189208409026

Corrarino, J. E., Williams, C., Campbell III, W. S., Amrhein, E., LoPiano, L., & Kalacbik, D. (2000). Linking substance-abusing pregnant women to drug treatment services: A pilot program. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 29*(4), 369-376. https://doi.org/10.1111/j.1552-6909.2000.tb02059.x

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin, 30*(3), 481-491. https://doi.org/10.1093/oxfordjournals.schbul.a007096

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical psychology: Science and Practice, 9*(1), 35. https://doi.org/10.1093/clipsy.9.1.35

Coulton, S. (2011). Alcohol misuse. *BMJ Clinical Evidence, 1071*.

Coupe, N. M. (2005). Whakamomori Māori Suicide Prevention. *Palmerston North: Massey University*.

Cowan, P., & Cowan, C. P. (2001). A couple perspective on the transmission of attachment patterns. *Adult Attachment and Couple Psychotherapy: The 'Secure Base' in Practice and Research*, 62-82.

Coyer, S. M. (2003). Women in recovery discuss parenting while addicted to cocaine. *MCN: the American Journal of Maternal/Child Nursing, 28*(1), 45-49. https://doi.org/10.1097/00005721-200301000-00013

Crapanzano, K. A., Hammarlund, R., Ahmad, B., Hunsinger, N., & Kullar, R. (2018). The association between perceived stigma and substance use disorder treatment outcomes: a review. *Substance Abuse and Rehabilitation*, 1-12.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Crothers, T. D. (1902). *The drug habits and their treatment: A clinical summary of some of the general facts recorded in practice*. GP Engelhard.

Crouch, J. L., Milner, J. S., & Thomsen, C. (2001). Childhood physical abuse, early social support, and risk for maltreatment: current social support as a mediator of risk for

child physical abuse. *Child Abuse & Neglect, 25*(1), 93-107. https://doi.org/10.1016/s0145-2134(00)00230-1

Cuffe, S. P., Waller, J. L., Addy, C. L., McKeown, R. E., Jackson, K. L., Moloo, J., & Garrison, C. Z. (2001). A longitudinal study of adolescent mental health service use. *The Journal of Behavioral Health Services & Research, 28*(1), 1-11. https://doi.org/10.1007/BF02287230

d'Arlach, L., Olson, B. D., Jason, L. A., & Ferrari, J. R. (2006). Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community, 31*(1-2), 121-131. https://doi.org/10.1300/J005v31n01_11.

Dass-Brailsford, P., & Myrick, A. C. (2010). Psychological trauma and substance abuse: The need for an integrated approach. *Trauma, Violence, & Abuse, 11*(4), 202-213. https://doi.org/10.1177/1524838010381252

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: a report from the field. *Schizophrenia Bulletin, 32*(3), 443-450. https://doi.org/10.1093/schbul/sbj043

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4), 459-470. https://doi.org/10.1080/09638230701482394

Davidson, L., Rowe, M., Tondora, J., O'Connell, M. J., & Lawless, M. S. (2008). *A practical guide to recovery-oriented practice: Tools for transforming mental health care*. Oxford University Press.

Davis, I., Landsverk, J., & Newton, R. (1997). Duration of foster care for children reunified within the first year of care. *Child Welfare Research Review, 2*, 272-293.

Davis, S. (1994). Effects of chemical dependency in parenting women. In *Addictive Behaviors in Women* (pp. 381-413). Springer.

Dawe, S., & Loxton, N. J. (2004). The role of impulsivity in the development of substance use and eating disorders. *Neuroscience & Biobehavioral Reviews, 28*(3), 343-351. https://doi.org/10.1016/j.neubiorev.2004.03.007

De Leon, G. (1995). Therapeutic communities for addictions: A theoretical framework. *International Journal of the Addictions, 30*(12), 1603-1645. https://doi.org/10.3109/10826089509104418

De Leon, G. (2000). *The Therapeutic Community: Theory, model, and method*. Springer publishing company.

De Leon, G. (2010). Is the therapeutic community an evidence-based treatment? What the evidence says. *Therapeutic Communities, 31*(2), 104.

De Leon, G., Perfas, F. B., Joseph, A., & Bunt, G. (2021). Therapeutic communities for addictions: essential elements, cultural, and current issues. In *Textbook of Addiction Treatment* (pp. 697-707). Springer.

De Maeyer, J., Vanderplasschen, W., & Broekaert, E. (2009). Exploratory study on drug Users' perspectives on quality of life: more than health-related quality of life? *Social Indicators Research, 90*(1), 107-126. https://doi.org/10.1007/s11205-008-9315-7

De Maeyer, J., Vanderplasschen, W., Camfield, L., Vanheule, S., Sabbe, B., & Broekaert, E. (2011). A good quality of life under the influence of methadone: A qualitative study among opiate-dependent individuals. *International Journal of Nursing Studies, 48*(10), 1244-1257. https://doi.org/10.1016/j.ijnurstu.2011.03.009

De Ruysscher, C., Vandevelde, S., Vanderplasschen, W., De Maeyer, J., & Vanheule, S. (2017). The concept of recovery as experienced by persons with dual diagnosis: a systematic review of qualitative research from a first-person perspective. *Journal of Dual Diagnosis, 13*(4), 264-279. https://doi.org/10.1080/15504263.2017.1349977

Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment, 28*(2), S51-S62. https://doi.org/10.1016/j.jsat.2004.10.013

Department of Corrections. (2010). Department of Corrections Annual Report 2010-11. Wellington: Department of Corrections.

Derauf, C., LaGasse, L. L., Smith, L. M., Grant, P., Shah, R., Arria, A., Huestis, M., Haning, W., Strauss, A., & Grotta, S. D. (2007). Demographic and psychosocial characteristics of mothers using methamphetamine during pregnancy: preliminary results of the infant development, environment, and lifestyle study (IDEAL). *The American Journal of Drug and Alcohol Abuse, 33*(2), 281-289. https://doi.org/10.1080/00952990601175029

Dixon, L., Browne, K., & Hamilton-Giachritsis, C. (2009). Patterns of risk and protective factors in the intergenerational cycle of maltreatment. *Journal of Family Violence, 24*(2), 111-122. https://doi.org/10.1007/s10896-008-9215-2

Dobkin, P. L., Civita, M. D., Paraherakis, A., & Gill, K. (2002). The role of functional social support in treatment retention and outcomes among outpatient adult substance abusers. *Addiction, 97*(3), 347-356. https://doi.org/10.1046/j.1360-0443.2002.00083.x

Dolan, R. M., Birmingham, L., Mullee, M., & Gregoire, A. (2013). The mental health of imprisoned mothers of young children: a follow-up study. *Journal of Forensic Psychiatry & Psychology, 24*(4), 421-439.

Donetto, S., Tsianakas, V., & Robert, G. (2014). Using Experience-based Co-design (EBCD) to improve the quality of healthcare: mapping where we are now and establishing future directions. *London: King's College London*.

Doyle, K. (2011). Modes of colonisation and patterns of contemporary mental health: towards an understanding of Canadian aboriginal, Australian aboriginal and Maori peoples. *Aboriginal and Islander Health Worker Journal, 35*(1), 20-23.

Dozier, M. (1995). symptomatology: Effects of dismissing attachment strategies. *Development and Psychopathology, 7*, 217-226.

Dudley, J. R. (2000). Confronting stigma within the services system. *Social Work, 45*(5), 449.

Durie. (1998). *Whaiora - Māori Health Development* (Vol. 2). Melbourne, Australia. Oxford.

Durie. (2001, 22 November 2001). Cultural competence and medical practice in New Zealand. Australian and New Zealand Boards and Council Conference, Wellington, New Zealand.

Durie. (2003). *Ngā kāhui pou launching Māori futures*. Huia Publishers.

Durie, M. (1999). Te Pae Māhutonga: A model for Māori health promotion. Health Promotion Forum of New Zealand Newsletter,

Dutra, L., Stathopoulou, G., Basden, S. L., Leyro, T. M., Powers, M. B., & Otto, M. W. (2008). A meta-analytic review of psychosocial interventions for substance use disorders. *American Journal of Psychiatry, 165*(2), 179-187. https://doi.org/10.1176/appi.ajp.2007.06111851

Dyba, J., Klein, M., & Wetzel, W. (2017). Parenthood, partnership and family constellations in methamphetamine users - an analysis of the advice documentation in outpatient addiction support. *Addiction Therapy, 18*(02), 73-78. https://doi.org/10.1176/appi.ajp.2007.06111851

Dyba, J., Moesgen, D., Klein, M., & Leyendecker, B. (2019). Mothers and fathers in treatment for methamphetamine addiction—Parenting, parental stress, and children at risk. *Child & Family Social Work, 24*(1), 106-114. https://doi.org/10.1111/cfs.12587

Dye, M. H., Ducharme, L. J., Johnson, J. A., Knudsen, H. K., & Roman, P. M. (2009). Modified therapeutic communities and adherence to traditional elements. *Journal of Psychoactive Drugs, 41*(3), 275-283. https://doi.org/10.1080/02791072.2009.10400538

Einbinder, S. D. (2010). A qualitative study of exodus graduates: family-focused residential substance abuse treatment as an option for mothers to retain or regain custody and sobriety in Los Angeles, California. *Child Welfare, 89*(4).

Eng, W., Roth, D. A., & Heimberg, R. G. (2001). Cognitive behavioral therapy for social anxiety disorder. *Journal of Cognitive Psychotherapy, 15*(4), 311-319. https://doi.org/10.1016/s0006-3223(01)01183-0

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science, 196*(4286), 129-136. https://doi.org/10.1126/science.847460

Espinet, S. D., Motz, M., Jeong, J. J., Jenkins, J. M., & Pepler, D. (2016). 'Breaking the Cycle' of maternal substance use through relationships: a comparison of integrated approaches. *Addiction Research & Theory, 24*(5), 375-388. https://doi.org/10.3109/16066359.2016.1140148

Evans, R., White, J., Turley, R., Slater, T., Morgan, H., Strange, H., & Scourfield, J. (2017). Comparison of suicidal ideation, suicide attempt and suicide in children and young people in care and non-care populations: Systematic review and meta-analysis of prevalence. *Children and Youth Services Review, 82,* 122-129. https://doi.org/10.1016/j.childyouth.2017.09.020

Eysenck, H. (1997). Addiction, personality and motivation. *Human Psychopharmacology: Clinical and Experimental, 12*(S2), S79-S87. https://doi.org/10.1002/(SICI)1099-1077(199706)12:2

Farmer, E. M., Burns, B. J., Chapman, M. V., Phillips, S. D., Angold, A., & Costello, E. J. (2001). Use of mental health services by youth in contact with social services. *Social Service Review, 75*(4), 605-624.

Fernández-Montalvo, J., López-Goñi, J. J., Illescas, C., Landa, N., & Lorea, I. (2008). Evaluation of a therapeutic community treatment program: A long-term follow-up study in Spain. *Substance Use & Misuse, 43*(10), 1362-1377. https://doi.org/10.1080/10826080801922231

Field, T. M., Scafidi, F., Pickens, J., Prodromidis, M., Pelaez-Nogueras, M., Torquati, J., Wilcox, H., Malphurs, J., Schanberg, S., & Kuhn, C. (1998). Polydrug-using adolescent mothers and their infants receiving early intervention. *Adolescence, 33*(129), 117-143.

Flanagan, N. (2020). Considering a participatory approach to social work–Service user research. *Qualitative Social Work, 19*(5-6), 1078-1094.

Flykt, M. S., Salo, S., & Pajulo, M. (2021). "A Window of Opportunity": Parenting and Addiction in the Context of Pregnancy. *Current Addiction Reports, 8*(4), 578-594.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: exposure to corrective information. *Psychological Bulletin, 99*(1), 20. https://doi.org/10.1037/0033-2909.99.1.20

Fraley, R. C., & Roisman, G. I. (2019). The development of adult attachment styles: Four lessons. *Current Opinion in Psychology, 25*, 26-30. https://doi.org/10.1016/j.copsyc.2018.02.008

Friedmann, P. D., Hendrickson, J. C., Gerstein, D. R., & Zhang, Z. (2004). The effect of matching comprehensive services to patients' needs on drug use improvement in addiction treatment. *Addiction, 99*(8), 962-972. https://doi.org/10.1111/j.1360-0443.2004.00772.x

Frost, D. M., McClelland, S. I., Clark, J. B., & Boylan, E. A. (2014). Phenomenological research methods in the psychological study of sexuality. In D. L. D. Tolman, L.D (Ed.), *APA handbook of sexuality and psychology: Vol. 1. person-based approaches* (pp. 121 - 141). American Psychological Association.

Fusco, R. A. (2019). Perceptions of Strengths-Based Child Welfare Practices Among Mothers With Drug Use Histories. *Journal of Family Issues, 40*(17), 2478-2498. https://doi.org/10.1177/0192513X19859392

Gamble, J., & O'Lawrence, H. (2016). An overview of the efficacy of the 12-step group therapy for substance abuse treatment. *Journal of Health and Human Services Administration*, 142-160.

George, O., Le Moal, M., & Koob, G. F. (2012). Allostasis and addiction: role of the dopamine and corticotropin-releasing factor systems. *Physiology & Behavior, 106*(1), 58-64. https://doi.org/10.1016/j.physbeh.2011.11.004

Gielen, N., Krumeich, A., Tekelenburg, M., Nederkoorn, C., & Havermans, R. C. (2016). How patients perceive the relationship between trauma, substance abuse, craving, and relapse: A qualitative study. *Journal of Substance Use, 21*(5), 466-470. https://doi.org/10.3109/14659891.2015.1063717

Gilbert, P. A., & Zemore, S. E. (2016). Discrimination and drinking: A systematic review of the evidence. *Social Science & Medicine, 161*, 178-194. https://doi.org/10.1016/j.socscimed.2016.06.009

Global Commission on Drug Policy. (2017). *The world drug perception problem: Countering prejudice about people who use drugs*.

Glover, E. (1932). On the aetiology of drug-addiction. *International Journal of Psycho-Analysis, 13*, 298-328.

Gluckman, P. D. (2017). *Youth suicide in New Zealand: A discussion paper*. Office of the Prime Minister's Chief Science Advisor.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. Simon and schuster.

Goh, E. T., & Morgan, M. Y. (2017). pharmacotherapy for alcohol dependence–the why, the what and the wherefore. *Alimentary Pharmacology & Therapeutics, 45*(7), 865-882. https://doi.org/10.1111/apt.13965

Gowing, L., Cooke, R., Biven, A. & Watts, D. (2002). *Towards better practice in Theraputic communities.*

Graham, A. (2018). Tika Tonu: Young Māori Mothers' Experiences of Wellbeing Surrounding the Birth of their First Tamaiti.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. NYU Press.

Granfield, R., & Cloud, W. (2001). Social context and "natural recovery": The role of social capital in the resolution of drug-associated problems. *Substance Use & Misuse, 36*(11), 1543-1570. https://doi.org/10.1081/ja-100106963

Grant, T., Huggins, J., Graham, J. C., Ernst, C., Whitney, N., & Wilson, D. (2011). Maternal substance abuse and disrupted parenting: Distinguishing mothers who keep their children from those who do not. *Children and Youth Services Review*, *33*(11), 2176-2185. https://doi.org/10.1016/j.childyouth.2011.07.001

Green, B. L., Rockhill, A., & Furrer, C. (2006). Understanding patterns of substance abuse treatment for women involved with child welfare: The influence of the Adoption and Safe Families Act (ASFA). *The American Journal of Drug and Alcohol Abuse, 32*(2), 149-176. https://doi.org/10.1080/00952990500479282

Greene, G. J., Lee, M. Y., & Hoffpauir, S. (2005). The languages of empowerment and strengths in clinical social work: A constructivist perspective. *Families in Society, 86*(2), 267-277. https://doi.org/10.1606/1044-3894.2465

Grella, C. E., Joshi, V., & Hser, Y.-I. (2000). Program variation in treatment outcomes among women in residential drug treatment. *Evaluation Review*, *24*(4), 364-383. https://doi.org/10.1177/0193841X0002400402

Grella, C. E., Needell, B., Shi, Y., & Hser, Y.-I. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of*

Substance Abuse Treatment, 36(3), 278-293. https://doi.org/10.1016/j.jsat.2008.06.010

Grella, C. E., & Stein, J. A. (2006). Impact of program services on treatment outcomes of patients with comorbid mental and substance use disorders. *Psychiatric Services, 57*(7), 1007-1015. https://doi.org/10.1176/ps.2006.57.7.1007

Gross, M. (2010). Alcoholics Anonymous: Still sober after 75 years. *American Journal of Public Health, 100*(12), 2361-2363. https://doi.org/10.2105/AJPH.2010.199349

Gunther, S. (2011). Disparity in mental health provision for Māori and pacific: A nursing response. *Whitireia Nursing Journal*(18), 39-43.

Hankin, J., McCaul, M. E., & Heussner, J. (2000). Pregnant, alcohol-abusing women. *Alcoholism: Clinical and Experimental Research, 24*(8), 1276-1286.

Hari, J. (2015). The likely cause of addiction has been discovered, and it is not what you think. *The Huffpost*.

Hawn, S. E., Cusack, S. E., & Amstadter, A. B. (2020). A systematic review of the self-medication hypothesis in the context of posttraumatic stress disorder and comorbid problematic alcohol use. *Journal of Traumatic Stress, 33*(5), 699-708. https://doi.org/10.1002/jts.22521

Hayward, R. A., & DePanfilis, D. (2007). Foster children with an incarcerated parent: Predictors of reunification. *Children and Youth Services Review, 29*(10), 1320-1334. https://doi.org/10.1016/j.childyouth.2007.05.005

Health and Disability Commissioner. (2020). *Aotearoa New Zealand's Mental Health Services and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*.

Heimberg, R. G., & Becker, R. E. (2002). *Cognitive-behavioral group therapy for social phobia: Basic mechanisms and clinical strategies*. Guilford Press.

Herbert, A. M. L. (2001). *Whanau Whakapakari: A Māori-centred approach to child rearing and parent-training programmes* The University of Waikato].

Herman, J. L. (1992). Trauma and Recovery. *NY: Basic books.–290 p*.

Herman, J. L. (1998). Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences, 52*(S1), S98-S103. https://doi.org/10.1046/j.1440-1819.1998.0520s5S145.x

Hermle, L. (1986). Die Degenerationslehre in der Psychiatrie. *Fortschritte der Neurologie· Psychiatrie, 54*(03), 69-79.

Hess, C. R., Teti, D. M., & Hussey-Gardner, B. (2004). Self-efficacy and parenting of high-risk infants: The moderating role of parent knowledge of infant development. *Journal*

of Applied Developmental Psychology, 25(4), 423-437. https://doi.org/10.1016/j.appdev.2004.06.002

Hiersteiner, C. (2004). Narratives of low-income mothers in addiction recovery centres: Motherhood and the treatment experience. *Journal of Social Work Practice in the Addictions, 4*(2), 51-64. https://doi.org/10.1300/J160v04n02_05

Hine, R. H., Maybery, D. J., & Goodyear, M. J. (2018). Identity in recovery for mothers with a mental illness: A literature review. *Psychiatric Rehabilitation Journal, 41*(1), 16. https://doi.org/10.1037/prj0000215

Hodgkinson, S., Beers, L., Southammakosane, C., & Lewin, A. (2014). Addressing the mental health needs of pregnant and parenting adolescents. *Pediatrics, 133*(1), 114-122. https://doi.org/10.1542/peds.2013-0927

Hogan, D. M. (2007). The impact of opiate dependence on parenting processes: Contextual, physiological and psychological factors. *Addiction Research & Theory, 15*(6), 617-635. https://doi.org/10.1542/peds.2013-0927

Hohman, J. A. B. M. (2012). The Impact of Methamphetamine Use on Parenting: Julie A. Brown and Melinda Hohman. In *Impact of Substance Abuse on Children and Families* (pp. 79-104). Routledge.

Holder, S. M., Peterson, E. R., Stephens, R., & Crandall, L. A. (2019). Stigma in mental health at the macro and micro levels: Implications for mental health consumers and professionals. *Community Mental Health Journal*, *55*, 369-374.

Horvath, A. T., & Yeterian, J. (2012). SMART Recovery: Self-empowering, science-based addiction recovery support. *Journal of Groups in Addiction & Recovery*, *7*(2-4), 102-117. https://doi.org/10.1080/1556035X.2012.705651

Houkamau, C. A., Stronge, S., & Sibley, C. G. (2017). The prevalence and impact of racism toward indigenous Māori in New Zealand. *International Perspectives in Psychology: Research, Practice, Consultation*, *6*(2), 61. https://doi.org/10.1037/ipp0000070

Huang, H., & Ryan, J. P. (2011). Trying to come home: Substance exposed infants, mothers, and family reunification. *Children and Youth Services Review*, *33*(2), 322-329. https://doi.org/10.1016/j.childyouth.2010.09.015

Hurt, H., & Betancourt, L. M. (2017). Turning one year of age in a low socioeconomic environment: a portrait of disadvantage. *Journal of Developmental and Behavioral Pediatrics: JDBP*, *38*(7), 493. https://doi.org/10.1097/DBP.0000000000000469

Ivers, J., Larkan, F., & Barry, J. (2018). A Longitudinal Qualitative Analysis of the Lived Experience of the Recovery Process in Opioid-Dependent Patients Post-Detoxification. *Journal of Psychoactive Drugs*, *50*(3), 231-239. https://doi.org/10.1080/02791072.2018.1435928

Jackson, M. (1988). Māori and the criminal justice system: He Whaipaanga hou - A new perspective. *Wellington, New Zealand: Department of Justice*.

Jellinek, E. M. (1960). The disease concept of alcoholism.

Jenkins, Harte, & Ririki. (2011). *Traditional Māori Parenting. A Historical Review of Literature of Traditional Māori Child Rearing Practices in Pre-European Times*.

Jones, M. (1984). Why two therapeutic communities? *Journal of Psychoactive Drugs, 16*(1), 23-26. https://doi.org/10.1080/02791072.1984.10524460

Jung, J.-G., Kim, J.-S., Kim, G.-J., Oh, M.-K., & Kim, S.-S. (2011). Brief insight-enhancement intervention among patients with alcohol dependence. *Journal of Korean Medical Science, 26*(1), 11-16. https://doi.org/10.3346/jkms.2011.26.1.11

Justice, L. M., Jiang, H., Purtell, K. M., Schmeer, K., Boone, K., Bates, R., & Salsberry, P. J. (2019). Conditions of poverty, parent-child interactions, and toddlers' early language skills in low-income families. *Maternal and Child Health Journal, 23*(7), 971-978. https://doi.org/10.1007/s10995-018-02726-9

Kahler, C. W., McCrady, B. S., & Epstein, E. E. (2003). Sources of distress among women in treatment with their alcoholic partners. *Journal of Substance Abuse Treatment, 24*(3), 257-265. https://doi.org/10.1016/s0740-5472(03)00033-3

Kalland, M., & Sinkkonen, J. (2013). Children exposed to parental substance abuse who are placed in foster care: An attachment perspective. In *Parenting and substance abuse: Developmental approaches to intervention* (pp. 344-364). Oxford University Press USA.

Kapeli, S. A., Manuela, S., & Sibley, C. G. (2020). Understanding Pasifika Mental health in New Zealand *A New Zealand Journal of Indigenous Scholarship, 9*(3). https://doi.org/10.20507/MAIJournal.2020.9.3.7

Karl, D. J., Beal, J. A., O'Hare, C. M., & Rissmiller, P. N. (2006). Reconceptualizing the nurse's role in the newborn period as an "attacher". *MCN: the American Journal of Maternal/Child Nursing, 31*(4), 257-262. https://doi.org/10.1097/00005721-200607000-00011

Kaufman, J., & Zigler, E. (1989). The intergenerational transmission of child abuse. *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect,* 129-150. https://doi.org/10.1017/CBO9780511665707.006

Kearney, M. H., Murphy, S., & Rosenbaum, M. (1994). Mothering on crack cocaine: A grounded theory analysis. *Social Science & Medicine, 38*(2), 351-361. https://doi.org/10.1016/0277-9536(94)90405-7

Keller, S. M., Zoellner, L. A., & Feeny, N. C. (2010). Understanding factors associated with early therapeutic alliance in PTSD treatment: adherence, childhood sexual abuse

history, and social support. *Journal of Consulting and Clinical Psychology, 78*(6), 974. https://doi.org/10.1037/a0020758

Kelley, S. J. (1992). Parenting stress and child maltreatment in drug-exposed children. *Child abuse & neglect, 16*(3), 317-328. https://doi.org/10.1016/0145-2134(92)90042-P

Kelly, J. F., & Yeterian, J. D. (2011). The role of mutual-help groups in extending the framework of treatment. *Alcohol Research & Health, 33*(4), 350.

Kendler, K. S., Maes, H. H., Sundquist, K., Ohlsson, H., & Sundquist, J. (2014). Genetic and family and community environmental effects on drug abuse in adolescence: a Swedish national twin and sibling study. *American Journal of Psychiatry, 171*(2), 209-217. https://doi.org/10.1176/appi.ajp.2013.12101300

Kennard, D. (1983). An Introduction to Therapeutic Communities, Vol. 1. *Philadelphia: Jessica Kingsley*.

Kerwin, M. E. (2005). Collaboration between child welfare and substance-abuse fields: Combined treatment programs for mothers. *Journal of Pediatric Psychology, 30*(7), 581-597. https://doi.org/10.1093/jpepsy/jsi045

Khantzian, E. J. (1987). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. In *The Cocaine Crisis* (pp. 65-74). Springer. https://doi.org/10.1176/ajp.142.11.1259

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry, 4*(5), 231-244. https://doi.org/10.3109/10673229709030550

Khoury, B., Langer, E. J., & Pagnini, F. (2014). The DSM: mindful science or mindless power? A critical review. *Frontiers in Psychology, 5*, 602. https://doi.org/10.3389/fpsyg.2014.00602

Kilpatrick, D. G., Acierno, R., Saunders, B., Resnick, H. S., Best, C. L., & Schnurr, P. P. (2000). Risk factors for adolescent substance abuse and dependence: data from a national sample. *Journal of Consulting and Clinical Psychology, 68*(1), 19. https://doi.org/10.1037//0022-006x.68.1.19

King, J., Dow, J., & Stevenson, B. (2016). Measuring outcomes for TC clients: higher ground drug rehabilitation trust. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Kingston, S., & Raghavan, C. (2009). The relationship of sexual abuse, early initiation of substance use, and adolescent trauma to PTSD. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies, 22*(1), 65-68. (10.1002/jts.20381)

Kiro. (2019). *Ngā mātua – Māori parenting', Te Ara - the Encyclopedia of New Zealand*. Retrieved 13 August from

Kissman, K., & Torres, O. A. (2004). Incarcerated mothers: Mutual support groups aimed at reducing substance abuse relapse and recidivism. *Contemporary Family Therapy, 26*(2), 217-228.

Kobak, R. R., & Sceery, A. (1988). Attachment in late adolescence: Working models, affect regulation, and representations of self and others. *Child Development*, 135-146. https://doi.org/10.2307/1130395

Kroll, B. (2004). Living with an elephant: Growing up with parental substance misuse. *Child & Family Social Work, 9*(2), 129-140. https://doi.org/10.1111/j.1365-2206.2004.00325.x

Kruk, E., & Sandberg, K. (2013). A home for body and soul: Substance using women in recovery. *Harm Reduction Journal, 10*(1), 1-16. https://doi.org/10.1186/1477-7517-10-39

Kupa. (2009). Te Vaka Atafaga: A Tokelau assessment model for supporting holistic mental health practice with Tokelau people in Aotearoa, New Zealand. *Pacific Health Dialog*, *15*(1), 156-163.

Kvale, S. (1996). *Interviews: An Introduction to Qualitative Research Interviewing*. Sage.

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the Craft of Qualitative Research Interviewing*. sage.

Langendam, M. W., van Brussel, G. H., Coutinho, R. A., & Van Ameijden, E. (2001). The impact of harm-reduction-based methadone treatment on mortality among heroin users. *American Journal of Public Health, 91*(5), 774. https://doi.org/10.2105/ajph.91.5.774

Larkby, C., & Day, N. (1997). The effects of prenatal alcohol exposure. *Alcohol Health and Research World, 21*(3), 192.

Lassiter, P., & Spivey, M. (2018). Historical perspectives and the moral model. In *Theory and Practice of Addiction Counselling* (pp. 27-46). SAGE Publications.

Laudet, A. B., Magura, S., Vogel, H. S., & Knight, E. (2000). Support, mutual aid and recovery from dual diagnosis. *Community Mental Health Journal, 36*(5), 457-476. https://doi.org/10.1023/a:1001982829359

Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. *Substance Use & Misuse, 43*(1), 27-54. https://doi.org/10.1080/10826080701681473

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services, 62*(12), 1470-1476. https://doi.org/10.1176/appi.ps.001312011

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry, 199*(6), 445-452. https://doi.org/10.1192/bjp.bp.110.083733

Leek, L., Seneque, D., & Ward, K. (2004). *Parental drug and alcohol use as a contributing factor in care and protection applications 2003*. Department for Community Development.

Leijdesdorff, S., van Doesum, K., Popma, A., Klaassen, R., & van Amelsvoort, T. (2017). Prevalence of psychopathology in children of parents with mental illness and/or addiction: an up to date narrative review. *Current Opinion in Psychiatry, 30*(4), 312-317. https://doi.org/10.1097/YCO.0000000000000341

Leitch, L. (2017). Action steps using ACEs and trauma-informed care: a resilience model. *Health & Justice, 5*(1), 1-10. https://doi.org/10.1186/s40352-017-0050-5

Lembke, A. (2012). Time to abandon the self-medication hypothesis in patients with psychiatric disorders. *The American Journal of Drug and Alcohol Abuse, 38*(6), 524-529. https://doi.org/10.3109/00952990.2012.694532

Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science, 278*(5335), 45-47. https://doi.org/10.1126/science.278.5335.45

Levine, H. G. (1984). The alcohol problem in America: From temperance to alcoholism. *British Journal of Addiction, 79*(4), 109-119. https://doi.org/10.1111/j.1360-0443.1984.tb03845.x

Liss, M., Schiffrin, H. H., & Rizzo, K. M. (2013). Maternal guilt and shame: The role of self-discrepancy and fear of negative evaluation. *Journal of Child and Family Studies, 22*(8), 1112-1119. https://doi.org/https://doi.org/10.1007/S10826-012-9673-2

Livingston, W., & Perkins, A. (2018). Participatory action research (PAR) research: critical methodological considerations. *Drugs and Alcohol Today*. https://doi.org/10.1108/DAT-08-2017-0035

Love, C. (2002). Māori perspectives on collaboration and colonization in contemporary Aotearoa/New Zealand child and welfare policies and practices. Positive Systems of Child Welfare Conference Waterloo, Ontario, Canada.

Love, C., Malaulau, M., & Praat, A. (2004). Understanding social wellbeing: Maori contributions. Social policy research and evaluation conference, What works,

Lundgren, L. M., Schilling, R. F., Fitzgerald, T., Davis, K., & Amodeo, M. (2003). Parental status of women injection drug users and entry to methadone maintenance. *Substance Use & Misuse, 38*(8), 1109-1131. https://doi.org/10.1081/JA-120017653

Lussier, J. P., Heil, S. H., Mongeon, J. A., Badger, G. J., & Higgins, S. T. (2006). A meta-analysis of voucher-based reinforcement therapy for substance use disorders. *Addiction, 101*(2), 192-203. https://doi.org/10.1111/j.1360-0443.2006.01311.x

Lussier, K., Laventure, M., & Bertrand, K. (2010). Parenting and maternal substance addiction: Factors affecting utilization of child protective services. *Substance Use & Misuse, 45*(10), 1572-1588. https://doi.org/10.3109/10826081003682123

Luthar, S. S., Suchman, N. E., & Altomare, M. (2007). Relational Psychotherapy Mothers' Group: A randomized clinical trial for substance abusing mothers. *Development and Psychopathology, 19*(1), 243-261. https://doi.org/10.1017/S0954579407070137

MacKillop, J., & Ray, L. A. (2018). The etiology of addiction: A contemporary biopsychosocial approach.

Mahmoud, K. F., Finnell, D., Savage, C. L., Puskar, K. R., & Mitchell, A. M. (2017). A concept analysis of substance misuse to inform contemporary terminology. *Archives of Psychiatric Nursing, 31*(6), 532-540.

Malivert, M., Fatséas, M., Denis, C., Langlois, E., & Auriacombe, M. (2012). Effectiveness of therapeutic communities: a systematic review. *European Addiction Research, 18*(1), 1-11. https://doi.org/10.1159/000331007

Mallard, S. R., Connor, J. L., & Houghton, L. A. (2013). Maternal factors associated with heavy periconceptional alcohol intake and drinking following pregnancy recognition:

A post-partum survey of New Zealand women. *Drug and Alcohol Review*, *32*(4), 389-397. https://doi.org/10.1111/dar.12024

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research*, *26*(13), 1753-1760. https://doi.org/10.1177/1049732315617444

Mann, K., Hermann, D., & Heinz, A. (2000). One hundred years of alcoholism: The twentieth century. *Alcohol and Alcoholism*, *35*(1), 10-15. https://doi.org/10.1093/alcalc/35.1.10

Maree Kopua, D., Kopua, M. A., & Bracken, P. J. (2020). Mahi a Atua: A Māori approach to mental health. *Transcultural Psychiatry*, *57*(2), 375-383. https://doi.org/10.1177/1363461519851606

Maremmani, A. G. I., Rovai, L., Rugani, F., Pacini, M., Lamanna, F., Bacciardi, S., Perugi, G., Deltito, J., Dell'Osso, L., & Maremmani, I. (2012). Correlations between awareness of illness (insight) and history of addiction in heroin-addicted patients. *Frontiers in Psychiatry*, *3*, 61. https://doi.org/10.3389/fpsyt.2012.00061

Markoff, L. S., Fallot, R. D., Reed, B. G., Elliott, D. E., & Bjelajac, P. (2005). Implementing trauma-informed alcohol and other drug and mental health services for women: Lessons learned in a multisite demonstration project. *American Journal of Orthopsychiatry*, *75*(4), 525-539. https://doi.org/10.3389/fpsyt.2012.00061

Markova, I. (2005). *Insight in Psychiatry*. Cambridge University Press.

Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, *21*(6), 779-788. https://doi.org/10.1016/0306-4603(96)00042-1

Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, *33*(1), 13-21. https://doi.org/10.1080/02791072.2001.10400463

Marlatt, G. A., & Donovan, D. M. (2005). *Relapse prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*. Guilford press.

Marmarosh, C., Holtz, A., & Schottenbauer, M. (2005). Group cohesiveness, group-derived collective self-esteem, group-derived hope, and the well-being of group therapy members. *Group Dynamics: Theory, Research, and Practice*, *9*(1), 32. https://doi.org/10.1037/1089-2699.9.1.32

Marsden, M., & Henare, T. A. (1992). *Kaitiakitanga: A definitive introduction to the holistic world view of the Māori*. Ministry for the Environment.

Massey, S. H., Neiderhiser, J. M., Shaw, D. S., Leve, L. D., Ganiban, J. M., & Reiss, D. (2012). Maternal self concept as a provider and cessation of substance use during pregnancy. *Addictive Behaviors*, *37*(8), 956-961. https://doi.org/10.1016/j.addbeh.2012.04.002

Matendechere, E. N. (2018). *A correlational study on self-forgiveness and the risk of relapse in adults recovering from alcohol addiction* Northcentral University].

Matua Raki. (2012). Supporting New Zealand's Therapeutic Community Workforce: An investigation of current needs. *Ministry of Health*.

Matusow, H., & Rosenblum, A. (2013). The most critical unresolved issue associated with psychoanalytic theories of addiction: Can the talking cure tell us anything about substance use and misuse? *Substance Use & Misuse, 48*(3), 239-247. https://doi.org/10.3109/10826084.2012.753548

Maybery, Reupert, A. E., Patrick, K., Goodyear, M., & Crase, L. (2009). Prevalence of parental mental illness in Australian families. *Psychiatric Bulletin, 33*(1), 22-26. https://doi.org/10.1192/pb.bp.107.018861

Maybery, D., Meadows, G., Clark, J., Sutton, K., Reupert, A., & Nicholson, J. (2015). A personal recovery model for parents with mental health problems. *Parental Psychiatric Disorder: Distressed Parents and their Families*, 312-323. https://doi.org/10.1017/CBO9781107707559.030

Mayo-Wilson, E., Dias, S., Mavranezouli, I., Kew, K., Clark, D. M., Ades, A., & Pilling, S. (2014). Psychological and pharmacological interventions for social anxiety disorder in adults: a systematic review and network meta-analysis. *The Lancet Psychiatry, 1*(5), 368-376. https://doi.org/10.1016/S2215-0366(14)70329-3

McComish, J. F., Greenberg, R., Ager, J., Essenmacher, L., Orgain, L. S., & Bacik, W. J. (2003). Family-focused substance abuse treatment: A program evaluation. *Journal of Psychoactive Drugs*, *35*(3), 321-331. https://doi.org/10.1080/02791072.2003.10400015

McFadden. (2016). *The New Zealand Drug Harm Index 2016*. Ministry of Health.

McGregor, S. L., & Murnane, J. A. (2010). Paradigm, methodology and method: Intellectual integrity in consumer scholarship. *International Journal of Consumer Studies*, *34*(4), 419-427. https://doi.org/10.1111/j.1470-6431.2010.00883.x

McKeganey, N., Barnard, M., & McIntosh, J. (2002). Paying the price for their parents' addiction: meeting the needs of the children of drug-using parents. *Drugs: Education, Prevention and Policy*, *9*(3), 233-246. https://doi.org/10.1080/09687630210122508

McLaughlin, H. (2010). Keeping service user involvement in research honest. *British Journal of Social Work*, *40*(5), 1591-1608.

McLellan, A. T., McKay, J. R., Forman, R., Cacciola, J., & Kemp, J. (2005). Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. *Addiction*, *100*(4), 447-458. https://doi.org/10.1111/j.1360-0443.2005.01012.x

McNeely, J., Cleland, C. M., Strauss, S. M., Palamar, J. J., Rotrosen, J., & Saitz, R. (2015). Validation of self-administered single-item screening questions (SISQs) for unhealthy

alcohol and drug use in primary care patients. *Journal of General Internal Medicine, 30*(12), 1757-1764. https://doi.org/10.1007/s11606-015-3391-6

McQuaid, R., Malik, A., Moussouni, K., Baydack, N., Stargardter, M., & Morrisey, M. (2017). Life in recovery from addiction in Canada. *Ottawa, Canada: Canadian Centre on Substance Use and Addiction*, 84.

Mead, S., & Copeland, M. E. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal, 36*(3), 315-328. https://doi.org/10.1023/a:1001917516869

Meixner, T., Milligan, K., Urbanoski, K., & McShane, K. (2016). Conceptualizing integrated service delivery for pregnant and parenting women with addictions: Defining key factors and processes. *Canadian Journal of Addiction, 7*(3), 57-65. https://doi.org/10.1097/02024458-201609000-00008

Melchior, M., Choquet, M., Le Strat, Y., Hassler, C., & Gorwood, P. (2011). Parental alcohol dependence, socioeconomic disadvantage and alcohol and cannabis dependence among young adults in the community. *European Psychiatry, 26*(1), 13-17. https://doi.org/10.1016/j.eurpsy.2009.12.011

Melnick, G., & De Leon, G. (1999). Clarifying the nature of therapeutic community treatment: The Survey of Essential Elements Questionnaire (SEEQ). *Journal of Substance Abuse Treatment, 16*(4), 307-313. https://doi.org/10.1016/s0740-5472(98)00036-1

Melnick, G., Leon, G. D., Hiller, M. L., & Knight, K. (2000). Therapeutic communities: Diversity in treatment elements. *Substance Use & Misuse, 35*(12-14), 1819-1847. https://doi.org/10.3109/10826080009148242

Mental Health and Addiction Inquiry. (2018). *Government Inquiry into Mental Health and Addiction*.

Mental Health Commission. (2012). Blueprint II: How things need to be. *Wellington, New Zealand, Mental Health Commission*.

Mercer, D. E., & Woody, G. E. (1999). *An individual drug counselling approach to treat cocaine addiction: The collaborative cocaine treatment study model* (Vol. 3). US Government Printing Office.

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education. Revised and Expanded from" Case Study Research in Education."*. Jossey-Bass Publishers.

Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. John Wiley & Sons.

Metzger, L. (1988). *From denial to recovery: Counseling problem drinkers, alcoholics, and their families*. Jossey-Bass.

Meulewaeter, F., De Pauw, S. S., & Vanderplasschen, W. (2019). Mothering, substance use disorders and intergenerational trauma transmisson: An attachment-based perspective. *Frontiers in Psychiatry, 10*, 728. https://doi.org/10.3389/fpsyt.2019.00728

Meurk, C., Carter, A., Partridge, B., Lucke, J., & Hall, W. (2014). How is acceptance of the brain disease model of addiction related to Australians' attitudes towards addicted individuals and treatments for addiction? *BMC psychiatry, 14*(1), 1-10. https://doi.org/10.1186/s12888-014-0373-x

Meyers, R. J., & Miller, W. R. (2001). *A community reinforcement approach to addiction treatment*. Cambridge University Press.

Meyers, R. J., & Smith, J. E. (1995). *Clinical guide to alcohol treatment: The community reinforcement approach*. Guilford Press.

Miller, & Rollnick. (1993). Motivational interviewing, preparing people to change addictive behavior. *Journal of Studies on Alcohol, 54*, 507-507. https://doi.org/10.1002/casp.2450020410

Miller, W., & Rollnick, S. (1991). *Motivational Interviewing*. Guilford Press.

Milligan, K., Niccols, A., Sword, W., Thabane, L., Henderson, J., & Smith, A. (2011). Length of stay and treatment completion for mothers with substance abuse issues in integrated treatment programmes. *Drugs: Education, Prevention and Policy, 18*(3), 219-227. https://doi.org/10.1186/1477-7517-9-14

Milligan, K., Niccols, A., Sword, W., Thabane, L., Henderson, J., Smith, A., & Liu, J. (2010). Maternal substance use and integrated treatment programs for women with substance abuse issues and their children: a meta-analysis. *Substance Abuse Treatment, Prevention, and Policy, 5*(1), 21. https://doi.org/10.1186/1747-597X-5-21

Mills, K. L., Teesson, M., Ross, J., & Peters, L. (2006). Trauma, PTSD, and substance use disorders: findings from the Australian National Survey of Mental Health and Well-Being. *American Journal of Psychiatry, 163*(4), 652-658. https://doi.org/10.1176/ajp.2006.163.4.652

Ministry of Health. (2006). *Te Kōkiri: The Mental Health and Addiction Action Plan, 2006-2015*. Ministry of Health.

Ministry of Health. (2010). *Drug use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey*.

Ministry of Health. (2014). *New Zealand Practice Guidelines for Opioid Substitution Treatment*.

Ministry of Health. (2016). *Amphetamine Use 2015/16: New Zealand Health Survey*.

Ministry of Health. (2018a). *Fetal Alcohol Spectrum Disorder*. https://www.health.govt.nz/our-work/diseases-and-conditions/fetal-alcohol-spectrum-disorder. Retrieved 28 August 2020 from

Ministry of Health. (2018b). *Mental Health and Addictions Workforce Action Plan 2017–2021*

Ministry of Health. (2020a). *Annual Data explorer 2019 / 2020: New Zealand Health Survey*

Ministry of Health. (2020b). *Mental Health Data Explorer 2016/17: New Zealand Health Survey*.

Ministry of Social Development. (2016). *Expert Panel Final Report: Investing in New Zealands children and their families*.

Moallem, N. R., & Ray, L. A. (2012). Dimensions of impulsivity among heavy drinkers, smokers, and heavy drinking smokers: singular and combined effects. *Addictive behaviors, 37*(7), 871-874. https://doi.org/10.1016/j.addbeh.2012.03.002

Moeke-Pickering, T. M. (1996). *Māori identity within whanau: A review of literature*.

Moore, J., & Finkelstein, N. (2001). Parenting services for families affected by substance abuse. *Child Welfare New York 80*(2), 221-238.

Morawska, A., Winter, L., & Sanders, M. (2009). Parenting knowledge and its role in the prediction of dysfunctional parenting and disruptive child behaviour. *Child: Care, Health and Development, 35*(2), 217-226. https://doi.org/10.1111/j.1365-2214.2008.00929.x

Morel, B. A. (1857). *Traité des dégénérescences physiques, intellectuelles et morales de l'espèce humaine [Treatise on physical, intellectual and moral degenerations of the human species]*. Paris: Baillière.

Morgan-Lopez, A. A., & Fals-Stewart, W. (2008). Analyzing data from open enrollment groups: Current considerations and future directions. *Journal of Substance Abuse Treatment, 35*(1), 36-40. https://doi.org/10.1016/j.jsat.2007.08.005

Moyle, P. (2013). *From family group conferencing to whānau ora: Māori social workers talk about their experiences: a thesis presented in partial fulfilment of the requirements for the degree of Master of Social Work in Social Work at Massey University, Manawatu, Aotearoa New Zealand* Massey University].

Mudry, T., Nepustil, P., & Ness, O. (2019). The relational essence of natural recovery: natural recovery as relational practice. *International Journal of Mental Health and Addiction, 17*(2), 191-205. https://doi.org/10.1007/s11469-018-0010-x

Murphy, C. E., Wang, R. C., Montoy, J. C., Whittaker, E., & Raven, M. (2022). Effect of extended-release naltrexone on alcohol consumption: a systematic review and meta-analysis. *Addiction, 117*(2), 271-281. https://doi.org/10.1111/add.15572

Myers, B. J. (1984). Mother-infant bonding: the status of this critical-period hypothesis. *Developmental Review, 4*(3), 240-274. https://doi.org/10.1016/S0273-2297(84)80007-6

Nakhid, C., & Shorter, L. T. (2014). Narratives of four Māori ex-inmates about their experiences and perspectives of rehabilitation programmes. *International Journal of Offender Therapy and Comparative Criminology, 58*(6), 697-717. https://doi.org/10.1177/0306624X13476939

National institute on Drug abuse. (2009). *Principles of Drug Addiction Treatment: A Research-Based Guide*.

National Institute on Drug Abuse. (2012). Principles of drug addiction treatment: A research-based guide. *NIH Publication No. 12–4180.*

Neger, E. N., & Prinz, R. J. (2015). Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations. *Clinical Psychology Review, 39*, 71-82. https://doi.org/10.1016/j.cpr.2015.04.004

Nelson, A. (2017). Addiction workforce development in Aotearoa New Zealand. *Drugs: Education, Prevention and Policy, 24*(6), 461-468. https://doi.org/10.1080/09687637.2017.1311841

Neppl, T. K., Senia, J. M., & Donnellan, M. B. (2016). Effects of economic hardship: Testing the family stress model over time. *Journal of Family Psychology, 30*(1), 12. https://doi.org/10.1037/fam0000168

New Zealand Drug Foundation. (2017). *Whakawātea te Huarahi: A model drug law to 2020 and beyond*.

New Zealand Drug foundation. (2019). *State of the Nation: A stocktake of how New Zealand is dealing with the issue of drugs*.

New Zealand Drug Foundation. (2020). *State of the Nation: A stocktake of how New Zealand is dealing with issues of drugs*

New Zealand Law Commission. (2010a). *Alcohol in our lives: Curbing the harm, A report on the review of the regulatory framework for the sale and supply of liquor*.

New Zealand Law Commission. (2010b). *Controlling and Regulating Drugs*.

Newton, T. F., De La Garza, R., Kalechstein, A. D., Tziortzis, D., & Jacobsen, C. A. (2009). Theories of addiction: methamphetamine users' explanations for continuing drug use and relapse. *American Journal on Addictions*, *18*(4), 294-300. https://doi.org/10.1080/10550490902925920

Niccols, A., Milligan, K., Smith, A., Sword, W., Thabane, L., & Henderson, J. (2012). Integrated programs for mothers with substance abuse issues and their children: a systematic review of studies reporting on child outcomes. *Child Abuse & Neglect, 36*(4), 308-322. https://doi.org/10.1016/j.chiabu.2011.10.007

Niccols, A., & Sword, W. (2005). “New Choices” for substance-using mothers and their children: Preliminary evaluation. *Journal of Substance Use, 10*(4), 239-251. https://doi.org/10.1080/146598904123313416

Nicholson, J. (2010). Parenting and recovery for mothers with mental disorders. In *A public health perspective of women's mental health* (pp. 359-372). Springer. https://doi.org/10.1007/978-1-4419-1526-9_19

Nicholson, J., Wolf, T., Wilder, C., & Biebel, K. (2014). Creating options for family recovery: A provider's guide to promoting parental mental health.

Noether, C. D., Brown, V., Finkelstein, N., Russell, L. A., VanDeMark, N. R., Morris, L. S., & Graeber, C. (2007). Promoting resiliency in children of mothers with co-occurring disorders and histories of trauma: Impact of a skills-based intervention program on child outcomes. *Journal of Community Psychology, 35*(7), 823-843. https://doi.org/10.1002/jcop.20184

O’Hagan, M. (2004). Guest Editorial: Recovery in New Zealand: Lessons for Australia? *Australian e-journal for the Advancement of Mental Health, 3*(1), 5-7. https://doi.org/10.5172/jamh.3.1.5

Oakley-Browne, M., Wells, J., & Scott, K. (2006). *Te Rau Hinengaro: The New Zealand mental health survey: Ministry of Health*.

Odyssey House. (2020). *Family Centre - Retrieved from https://www.odyssey.org.nz/our-services/pakeke/family-centre*.

Odyssey House Victoria. (2016). *What we do - residential, Retrieved from https://www.odyssey.org.au/what-we-do/rehabilitation/melbourne/*.

Office of the Children's Commissioner. (2020). *Statistical Snapshot: Pēpi Māori 0-3 months and the care and protection system*.

Oranga Tamariki. (2020). *Care and protection - Statistics, Quartly report*.

Oranga Tamariki. (2021a). *Care and protection - Statistics, Quartly report*.

Oranga Tamariki. (2021b). *Safety of Children in State Care - Biannual Report July 2020 to December 2020*.

Ouimette, P. C., Finney, J. W., & Moos, R. H. (1997). Twelve-step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. *Journal of Consulting And Clinical Psychology*, *65*(2), 230. https://doi.org/10.1037//0022-006x.65.2.230

Pajulo, M., Suchman, N., Kalland, M., & Mayes, L. (2006). Enhancing the effectiveness of residential treatment for substance abusing pregnant and parenting women: Focus on maternal reflective functioning and mother-child relationship. *Infant Mental Health*

Journal: Official Publication of The World Association for Infant Mental Health, 27(5), 448-465. https://doi.org/10.1002/imhj.20100

Paterson, R., Durie, M., Disley, B., Rangihuna, D., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He Ara Oranga: Report of the government inquiry into mental health and addiction*.

Perkins, S. C., Finegood, E. D., & Swain, J. E. (2013). Poverty and language development: Roles of parenting and stress. *Innovations in Clinical Neuroscience, 10*(4), 10.

Pettersen, H., Landheim, A., Skeie, I., Biong, S., Brodahl, M., Oute, J., & Davidson, L. (2019). How social relationships influence substance use disorder recovery: a collaborative narrative study. *Substance Abuse: Research And Treatment, 13*, 1178221819833379. https://doi.org/10.1177/1178221819833379

Pihama, L., Reynolds, P., Smith, C., Reid, J., Smith, L. T., & Nana, R. T. (2014). Positioning historical trauma theory within Aotearoa New Zealand. *AlterNative: An International Journal of Indigenous Peoples, 10*(3), 248-262. https://doi.org/ 10.1177/117718011401000304

Pihama, L., Smith, L. T., Te Nana, R., Cameron, N., Mataki, T., Skipper, H., Kohu, H., & Southey, K. (2017). Investigating Māori approaches to trauma-informed care. *Journal of Indigenous Wellbeing, 2*(3), 18-31.

Pirskanen, H., Holmila, M., Kataja, K., Simonen, J., & Tigerstedt, C. (2017). Parenthood re-discovered: Views of recovered parents. *Drugs: Education, Prevention and Policy, 24*(1), 23-31. https://doi.org/10.1080/09687637.2016.1206514

Pitama, S. G., Bennett, S. T., Waitoki, W., Haitana, T. N., Valentine, H., Pahiina, J., Taylor, J. E., Tassell-Matamua, N., Rowe, L., & Beckert, L. (2017). A proposed hauora Māori clinical guide for psychologists: Using the hui process and Meihana model in clinical assessment and formulation.

Platt, D. (2012). Understanding parental engagement with child welfare services: An integrated model. *Child & Family Social Work, 17*(2), 138-148. https://doi.org/10.1111/j.1365-2206.2012.00828.x

Popova, S., Lange, S., Probst, C., Gmel, G., & Rehm, J. (2017). Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis. *The Lancet Global Health, 5*(3), e290-e299. https://doi.org/10.1016/S2214-109X(17)30021-9

Powell, B., Cooper, G., Hoffman, K., & Marvin, B. (2013). *The circle of security intervention: Enhancing attachment in early parent-child relationships*. Guilford publications.

Price-Robertson, R., Manderson, L., & Duff, C. (2017). Mental ill health, recovery and the family assemblage. *Culture, Medicine, and Psychiatry, 41*(3), 407-430. https://doi.org/10.1007/s11013-017-9522-2

Price-Robertson, R., Obradovic, A., & Morgan, B. (2017). Relational recovery: beyond individualism in the recovery approach. *Advances in Mental Health, 15*(2), 108-120. https://doi.org/10.1080/18387357.2016.1243014

Rangihuna, D., Kopua, M., & Tipene-Leach, D. (2018). Mahi a Atua: A pathway forward for Māori mental health. *New Zealand Medical Journal, 131*(1471), 79-83.

Rauch, S., & Foa, E. (2006). Emotional processing theory (EPT) and exposure therapy for PTSD. *Journal of Contemporary Psychotherapy, 36*(2), 61-65. https://doi.org/10.1007/s10879-006-9008-y

Ray, L. A., Meredith, L. R., Kiluk, B. D., Walthers, J., Carroll, K. M., & Magill, M. (2020). Combined Pharmacotherapy and Cognitive Behavioral Therapy for Adults With Alcohol or Substance Use Disorders: A Systematic Review and Meta-analysis. *JAMA Network Open, 3*(6), e208279-e208279. https://doi.org/10.1001/jamanetworkopen.2020.8279

Redko, C., Rapp, R. C., Elms, C., Snyder, M., & Carlson, R. G. (2007). Understanding the working alliance between persons with substance abuse problems and strengths-based case managers. *Journal of Psychoactive Drugs, 39*(3), 241-250. https://doi.org/10.1080/02791072.2007.10400610

Reynolds, M., Hinchliffe, K., Asamoah, V., & Kouimtsidis, C. (2011). Trauma and post-traumatic stress disorder in a drug treatment community service. *The Psychiatrist, 35*(7), 256-260. https://doi.org/10.1192/pb.bp.110.030379

Richardson. (2018). *NZ Drug Foundation OIA up to 2018*.

Robert, G. (2013). Participatory action research: using experience-based co-design to improve the quality of healthcare services. *Understanding and Using Health Experiences–improving patient care*. https://doi.org/10.1093/acprof:oso/9780199665372.003.0014

Rochford, T. (2004). Whare Tapa Wha: A Mäori model of a unified theory of health. *Journal of Primary Prevention, 25*(1), 41-57. https://doi.org/10.1023/B:JOPP.0000039938.39574.9e

Rodebaugh, T. L., Holaway, R. M., & Heimberg, R. G. (2004). The treatment of social anxiety disorder. *Clinical Psychology Review, 24*(7), 883-908. https://doi.org/10.1016/j.cpr.2004.07.007

Roesner, S., Hackl-Herrwerth, A., Leucht, S., Vecchi, S., Srisurapanont, M., & Soyka, M. (2010). Opioid antagonists for alcohol dependence. *Cochrane Database of Systematic Reviews*(12).

Roget, N. A. (2009). *Encyclopedia of substance abuse prevention, treatment, and recovery* (Vol. 1). Sage.

Romme, M., & Escher, S. (2000). *Making Sense of Voices: A Guide for Mental Health Professionals Working with Voice-hearers.* Mind Publications.

Rosenhan, D. L. (1973). On being sane in insane places. *Science*, *179*(4070), 250-258. https://doi.org/10.1126/science.179.4070.250

Rossen, F., Newcombe, D., Parag, V., Underwood, L., Marsh, S., Berry, S., Grant, C., Morton, S., & Bullen, C. (2018). Alcohol consumption in New Zealand women before and during pregnancy: findings from the Growing Up in New Zealand study. *Alcohol*, *131*(1479).

Rothenberg, W. A. (2019). Intergenerational continuity in parenting: a review and theoretical integration. *Marriage & Family Review*, *55*(8), 701-736. https://doi.org/10.1080/01494929.2019.1589618

Russell, L. (2018). Te oranga hinengaro: Report on Māori mental wellbeing results from the New Zealand mental health monitor & health and lifestyles survey. *Health Promotion Agency/Te Hiringa Hauora*.

Rutherford, H. J., Gerig, G., Gouttard, S., Potenza, M. N., & Mayes, L. C. (2015). Focus: addiction: investigating maternal brain structure and its relationship to substance use and motivational systems. *The Yale Journal of Biology and Medicine*, *88*(3), 211.

Ryan, A. B. (2006). Post-positivist approaches to research. *Researching and Writing your Thesis: a guide for postgraduate students*, 12-26.

Ryan, J. P., Garnier, P., Zyphur, M., & Zhai, F. (2006). Investigating the effects of caseworker characteristics in child welfare. *Children and Youth Services Review, 28*(9), 993-1006. https://doi.org/10.1016/j.childyouth.2005.10.013

Sacks, Sacks, S., McKendrick, K., Banks, S., Schoeneberger, M., Hamilton, Z., Stommel, J., & Shoemaker, J. (2008). Prison therapeutic community treatment for female offenders: Profiles and preliminary findings for mental health and other variables (crime, substance use and HIV risk). *Journal of Offender Rehabilitation, 46*(3-4), 233-261. https://doi.org/10.1080/10509670802143680

Sacks, S., Sacks, J. Y., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified TC for MICA offenders: Crime outcomes. *Behavioral Sciences & the Law*, *22*(4), 477-501. https://doi.org/10.1002/bsl.599

Salvation Army. (2020). *Alcohol and other drug services, Retrieved from https://www.salvationarmy.org.au/need-help/alcohol-and-other-drug-services/*. Retrieved 14 August from

SAMHSA. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach.

Samu, K. S., & Suaalii-Sauni, T. (2009). Exploring the 'cultural' in cultural competencies in Pacific mental health. *Pacific health dialog, 15*(1), 120-130.

Sanders, M. R. (1999). Triple P-Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review, 2*(2), 71-90. https://doi.org/10.1023/a:1021843613840

Sanders, M. R. (2008). Triple P-Positive Parenting Program as a public health approach to strengthening parenting. *Journal of Family Psychology, 22*(4), 506. https://doi.org/10.1037/0893-3200.22.3.506

Sanders, M. R., & Woolley, M. (2005). The relationship between maternal self-efficacy and parenting practices: Implications for parent training. *Child: Care, Health and Development, 31*(1), 65-73. https://doi.org/10.1111/j.1365-2214.2005.00487.x

Saxon, A. J., Hser, Y.-I., Woody, G., & Ling, W. (2013). Medication-assisted treatment for opioid addiction: methadone and buprenorphine. *Journal of Food and Drug Analysis, 21*(4), S69-S72. https://doi.org/10.1016/j.jfda.2013.09.037

Schaeffer, C. M., Swenson, C. C., Tuerk, E. H., & Henggeler, S. W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. *Child Abuse & Neglect, 37*(8), 596-607. https://doi.org/10.1016/j.chiabu.2013.04.004

Schrank, B., Stanghellini, G., & Slade, M. (2008). Hope in psychiatry: a review of the literature. *Acta Psychiatrica Scandinavica, 118*(6), 421-433. https://doi.org/10.1111/j.1600-0447.2008.01271.x

Schultz, K., Teyra, C., Breiler, G., Evans-Campbell, T., & Pearson, C. (2018). "They gave me life": Motherhood and recovery in a tribal community. *Substance Use & Misuse, 53*(12), 1965-1973. https://doi.org/10.1080/10826084.2018.1449861

Schumacher, J. A., & Madson, M. B. (2014). *Fundamentals of motivational interviewing: Tips and strategies for addressing common clinical challenges*. Oxford University Press.

Siegel, S. (1983). Classical conditioning, drug tolerance, and drug dependence. In *Research advances in alcohol and drug problems* (pp. 207-246). Springer.

Silva, S. A., Pires, A. P., Guerreiro, C., & Cardoso, A. (2013). Balancing motherhood and drug addiction: The transition to parenthood of addicted mothers. *Journal of Health Psychology, 18*(3), 359-367. https://doi.org/10.1177/1359105312443399

Simpson, D. D., & Joe, G. W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment, 27*(2), 89-97. https://doi.org/10.1016/j.jsat.2004.03.001

Slade. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge University Press.

Smedslund, G., Berg, R. C., Hammerstrøm, K. T., Steiro, A., Leiknes, K. A., Dahl, H. M., & Karlsen, K. (2011). Motivational interviewing for substance abuse. *Campbell Systematic Reviews, 7*(1), 1-126. https://doi.org/10.1002/14651858.CD008063.pub2

Smith. (2012). *The Medicalization of Therapeutic Communities in the Era of Health Care Reform*. Taylor & Francis.

Smith. (2020). Sociocultural Model. In *A Comprehensive Guide to Addiction Theory and Counseling Techniques* (pp. 114-125). Routledge.

Smith, Diaz, LaGasse, Wouldes, T., Derauf, C., Newman, E., Arria, A., Huestis, M. A., Haning, W., & Strauss, A. (2015). Developmental and behavioral consequences of prenatal methamphetamine exposure: a review of the infant development, environment, and lifestyle (IDEAL) study. *Neurotoxicology and Teratology, 51*, 35-44. https://doi.org/10.1016/j.ntt.2015.07.006

Smith, B. D. (2003). How parental drug use and drug treatment compliance relate to family reunification. *Child Welfare, 82*(3).

Smith, B. D., & Marsh, J. C. (2002). Client-service matching in substance abuse treatment for women with children. *Journal of Substance Abuse Treatment, 22*(3), 161-168. https://doi.org/10.1016/s0740-5472(02)00229-5

Snyder. (1994). *The psychology of hope: You can get there from here*. Simon and Schuster.

Snyder. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry, 13*(4), 249-275. https://doi.org/10.1207/S15327965PLI1304_01

Solis, J., Shadur, J., Burns, A., & Hussong, A. (2012). Understanding the diverse needs of children whose parents abuse substances. *Current Drug Abuse Reviews, 5*(2), 135-147. https://doi.org/10.2174/1874473711205020135

Spohn, C., & Holleran, D. (2002). The effect of imprisonment on recidivism rates of felony offenders: A focus on drug offenders. *Criminology, 40*(2), 329-358. https://doi.org/10.1111/j.1745-9125.2002.tb00959.x

Stake, R. E. (2006). Stake, Robert E., Multiple Case Study Analysis. New York: Guilford, 2006.

Staton-Tindall, M., Sprang, G., Clark, J., Walker, R., & Craig, C. D. (2013). Caregiver substance use and child outcomes: A systematic review. *Journal of Social Work Practice in the Addictions, 13*(1), 6-31. https://doi.org/10.1080/1533256X.2013.752272

Stevens, & Arbiter, N. (1995). A therapeutic community for substance-abusing pregnant women and women with children: Process and outcome. *Journal of Psychoactive Drugs, 27*(1), 49-56. https://doi.org/10.1080/02791072.1995.10471672

Stevens, Buchannan, B., Ferrari, J. R., Jason, L. A., & Ram, D. (2014). An investigation of hope and context. *Journal of Community Psychology*, *42*(8), 937-946. https://doi.org/10.1002/jcop.21663

Stevens, Guerrero, M., Green, A., & Jason, L. A. (2018). Relationship of hope, sense of community, and quality of life. *Journal of Community Psychology*, *46*(5), 567-574. https://doi.org/10.1002/jcop.21959

Stevens, Jason, L. A., Ram, D., & Light, J. (2015). Investigating social support and network relationships in substance use disorder recovery. *Substance Abuse*, *36*(4), 396-399. https://doi.org/10.1080/08897077.2014.965870

Stewart, J., De Wit, H., & Eikelboom, R. (1984). Role of unconditioned and conditioned drug effects in the self-administration of opiates and stimulants. *Psychological review*, *91*(2), 251. https://doi.org/10.1037/0033-295X.91.2.251

Strathearn, L., Mertens, C. E., Mayes, L., Rutherford, H., Rajhans, P., Xu, G., Potenza, M. N., & Kim, S. (2019). Pathways relating the neurobiology of attachment to drug addiction. *Frontiers in Psychiatry*, 737. https://doi.org/10.3389/fpsyt.2019.00737

Street, K., Harrington, J., Chiang, W., Cairns, P., & Ellis, M. (2004). How great is the risk of abuse in infants born to drug-using mothers? *Child: Care, Health and Development*, *30*(4), 325-330. https://doi.org/10.1111/j.1365-2214.2004.00421.x

Stryker, S. (1968). Identity salience and role performance: The relevance of symbolic interaction theory for family research. *Journal of Marriage and the Family*, 558-564. https://doi.org/10.2307/349494

Substance Abuse and Mental Health Services Administration. (2013). National Survey of Substance Abuse Treatment Services (N-SSATS): . *Rockville, MD: Substance Abuse and Mental Health Services Administration*.

Substance Abuse and Mental Health Services Administration. (2014). *Trauma-Informed Care in Behavioural Health Services* (Vol. Treatment Improvement Protocol (TIP) series, No. 57).

Suchman, & Luthar, S. S. (2000). Maternal addiction, child maladjustment and socio-demographic risks: implications for parenting behaviors. *Addiction*, *95*(9), 1417-1428. https://doi.org/10.1046/j.1360-0443.2000.959141711.x

Suchman, Pajulo, DeCoste, & Mayes. (2006). Parenting Interventions for drug-dependent mothers and their young children: the case for an attachment-based approach. *Family Relations*, *55*(2), 211-226. https://doi.org/10.1111/j.1741-3729.2006.00371.x

Suchman, N., DeCoste, C., Castiglioni, N., Legow, N., & Mayes, L. (2008). The Mothers and Toddlers Program: Preliminary findings from an attachment-based parenting intervention for substance-abusing mothers. *Psychoanalytic Psychology*, *25*(3), 499. https://doi.org/10.1037/0736-9735.25.3.499

Sudhinaraset, M., Wigglesworth, C., & Takeuchi, D. T. (2016). Social and cultural contexts of alcohol use: Influences in a social–ecological framework. *Alcohol Research: Current Reviews*, *38*(1), 35-45.

Surratt, H. L. (2005). *Constructing the self as addict: Narratives of recovery and resistance among women in drug abuse treatment*. City University of New York.

Sussman, S., Dent, C. W., & Leu, L. (2000). The one-year prospective prediction of substance abuse and dependence among high-risk adolescents. *Journal of Substance Abuse*, *12*(4), 373-386. https://doi.org/10.1016/s0899-3289(01)00053-0

Svanberg, J. (2018). *The Psychology of Addiction*. Routledge.

Swift, R. M., & Aston, E. R. (2015). Pharmacotherapy for alcohol use disorder: current and emerging therapies. *Harvard Review of Psychiatry*, *23*(2), 122. https://doi.org/10.1097/HRP.0000000000000079

Sword, W., Jack, S., Niccols, A., Milligan, K., Henderson, J., & Thabane, L. (2009). Integrated programs for women with substance use issues and their children: a qualitative meta-synthesis of processes and outcomes. *Harm Reduction Journal, 6*(1), 32. https://doi.org/10.1186/1477-7517-6-32

Tajfel, H., & Turner, J. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. Austing (Eds.), *Psychology of Intergroup Relations* (pp. 7 - 24). Brooks/Cole.

Talamaivao, N., Harris, R., Cormack, D., Paine, S.-J., & King, P. (2020). Racism and health in Aotearoa New Zealand: a systematic review of quantitative studies. *The New Zealand Medical Journal (Online), 133*(1521), 55-55.

Taylor, J., Spencer, N., & Baldwin, N. (2000). Social, economic, and political context of parenting. *Archives of Disease in Childhood, 82*(2), 113-120. https://doi.org/10.1136/adc.82.2.113

Te Rau Matatini. (2015). *Te Hau Mārire: Addiction workforce strategic framework for people working with Māori experiencing addiction-related harm (2015–2025).*

Thoits, P. A. (1986). Social support as coping assistance. *Journal of Consulting and Clinical Psychology, 54*(4), 416. https://doi.org/10.1037/0022-006X.54.4.416

Tims, F. M., Jainchill, N., & De Leon, G. (1994). Therapeutic communities and treatment research. *NIDA Research Monograph, 144*, 1-1.

Todd, F. C. (2010). *Te Ariari O Te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems, 2010*. Ministry of Health.

Todres, L. (2007). *Embodied enquiry: Phenomenological touchstones for research, psychotherapy and spirituality*. Springer.

Tompkins, C. N., & Neale, J. (2018). Delivering trauma-informed treatment in a women-only residential rehabilitation service: Qualitative study. *Drugs: Education, Prevention and Policy, 25*(1), 47-55. https://doi.org/10.1080/09687637.2016.1235135

Topor, A., Borg, M., Di Girolamo, S., & Davidson, L. (2011). Not just an individual journey: Social aspects of recovery. *International Journal of Social Psychiatry, 57*(1), 90-99. https://doi.org/10.1177/0020764009345062

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). Others: the role of family, friends, and professionals in the recovery process. *Archives of Andrology, 9*(1), 17-37. https://doi.org/10.1080/15487760500339410

Trickett, P., Negriff, S., Underwood, M., & Rosen, L. (2011). Child maltreatment and social relationships. In M. K. a. R. Underwood, L. H (Ed.), *Social Development: Relationships in Infancy, Childhood, and Adolescence* (pp. 403 - 426). Guilford Press.

Troutman, B., Moran, T. E., Arndt, S., Johnson, R. F., & Chmielewski, M. (2012). Development of parenting self-efficacy in mothers of infants with high negative emotionality. *Infant Mental Health Journal, 33*(1), 45-54. https://doi.org/10.1002/imhj.20332

Trujols, J. (2015). The brain disease model of addiction: challenging or reinforcing stigma? *The Lancet Psychiatry, 2*(4), 292. https://doi.org/10.1016/S2215-0366(15)00050-4

Turpin, A., & Shier, M. L. (2017). Peer support and substance use disorder treatment: Benefits and barriers for intra-personal development in longer-term treatment programs. *Journal of Groups in Addiction & Recovery, 12*(2-3), 117-134. https://doi.org/10.1080/1556035X.2016.1258683

Ullman, S. E., Relyea, M., Peter-Hagene, L., & Vasquez, A. L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive Behaviors*, *38*(6), 2219-2223. https://doi.org/10.1016/j.addbeh.2013.01.027

United Nations Office on Drugs and Crime (UNODC). (2016).

Van Scoyoc, A., Harrison, J. A., & Fisher, P. A. (2017). Beliefs and behaviors of pregnant women with addictions awaiting treatment initiation. *Child and Adolescent Social Work Journal, 34*(1), 65-79. https://doi.org/10.1007/s10560-016-0474-0

Vance, A. J., & Brandon, D. H. (2017). Delineating among parenting confidence, parenting self-efficacy and competence. *ANS. Advances in Nursing Science, 40*(4), E18. https://doi.org/10.1097/ANS.0000000000000179

VanDeMark, N. R. (2007). Policy on reintegration of women with histories of substance abuse: A mixed methods study of predictors of relapse and facilitators of recovery. *Substance Abuse Treatment, Prevention, and Policy, 2*(1), 28. https://doi.org/10.1186/1747-597X-2-28

VandenBos, G. R. (2007). *APA Dictionary of Psychology*. American Psychological Association.

Vanderplasschen, W., Colpaert, K., Autrique, M., Rapp, R. C., Pearce, S., Broekaert, E., & Vandevelde, S. (2013). Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective. *The Scientific World Journal, 2013*. https://doi.org/10.1155/2013/427817

Velez, M. L., Jansson, L. M., Montoya, I. D., Schweitzer, W., Golden, A., & Svikis, D. (2004). Parenting knowledge among substance abusing women in treatment. *Journal of Substance Abuse Treatment, 27*(3), 215-222. https://doi.org/10.1016/j.jsat.2004.07.004.

Veseth, M., Moltu, C., Svendsen, T. S., Nesvåg, S., Slyngstad, T. E., Skaalevik, A. W., & Bjornestad, J. (2019). A stabilizing and destabilizing social world: close relationships and recovery processes in SUD. *Journal of Psychosocial Rehabilitation and Mental Health, 6*(1), 93-106. https://doi.org/10.1007/s40737-019-00137-9

Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine, 374*(4), 363-371. https://doi.org/10.1056/NEJMra1511480

Walker, R. (1989). Māori identity. In *Culture and Identity in New Zealand* (pp. 35-52).

Watson, L., & Parke, A. (2011). Experience of recovery for female heroin addicts: An interpretative phenomenological analysis. *International Journal of Mental Health and Addiction, 9*(1), 102-117.

Watts, G. (2012). Critics attack DSM-5 for overmedicalising normal human behaviour. *BJM*. https://doi.org/https://doi.org/10.1136/bmj.e1020

Webster-Stratton, C. (2001). The parent and child series: A comprehensive course divided into four programs—Leaders' guide. *The Incredible Years, Seattle*.

Welsh, W. N. (2007). A multisite evaluation of prison-based therapeutic community drug treatment. *Criminal Justice and Behavior, 34*(11), 1481-1498. https://doi.org/10.1177/0093854807307036

Werner, D., Young, N., Dennis, K., & Amatetti, S. (2007). Family-centered treatment for women with substance use disorders: History, key elements and challenges. *Substance Abuse and Mental Health Services Administration*.

Wesson, D. R., & Smith, D. E. (2010). Buprenorphine in the treatment of opiate dependence. *Journal of Psychoactive Drugs*, *42*(2), 161-175. https://doi.org/10.1080/02791072.2010.10400689

Weston, S., Honor, S., & Best, D. (2018). A tale of two towns: A comparative study exploring the possibilities and pitfalls of social capital among people seeking recovery

from substance misuse. *Substance Use & Misuse, 53*(3), 490-500. https://doi.org/10.1080/10826084.2017.1341925

Whiteley, S. (2004). The evolution of the therapeutic community. *Psychiatric Quarterly, 75*(3), 233-248. https://doi.org/10.1023/B:PSAQ.0000031794.82674.e8

Whiteside-Mansell, L., Crone, C. C., & Conners, N. A. (1999). The development and evaluation of an alcohol and drug prevention and treatment program for women and children: The AR-CARES program. *Journal of Substance Abuse Treatment, 16*(3), 265-275. https://doi.org/10.1016/s0740-5472(98)00049-x

Wiig, E. M., Halsa, A., Bramness, J., Myra, S. M., & Haugland, B. S. M. (2018). Rescue the child or treat the adult? Understandings among professionals in dual treatment of substance-use disorders and parenting. *Nordic Studies on Alcohol and Drugs, 35*(3), 179-195. https://doi.org/10.1177/1455072518773615

Wikler, A. (1948). Recent progress in research on the neurophysiologic basis of morphine addiction. *American Journal of Psychiatry, 105*(5), 329-338. https://doi.org/10.1176/ajp.105.5.329

Wilkins, C., Prasad, J., Wong, K., & Rychert, M. (2014). Recent trends in illegal drug use in New Zealand, 2006-2013. *Social and Outcomes Research and Evaluation, School of Public Health, Massey University*.

Williams, A. D., Clark, T. C., & Lewycka, S. (2018). The associations between cultural identity and mental health outcomes for indigenous Māori youth in New Zealand. *Frontiers in Public Health, 6,* 319. https://doi.org/10.3389/fpubh.2018.00319

Wilson, M. (1993). DSM-III and the transformation of American psychiatry: a history. *The American Journal of Psychiatry, 150*(3), 399-410. https://doi.org/10.1176/ajp.150.3.399

Wodak, A., & Cooney, A. (2006). Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. *Substance Use & Misuse, 41*(6-7), 777-813.

World Health Organization. (2008). *Principles of Drug Dependence Treatment: Discussion Paper*.

Wouldes, T. A., LaGasse, L. L., Huestis, M. A., DellaGrotta, S., Dansereau, L. M., & Lester, B. M. (2014). Prenatal methamphetamine exposure and neurodevelopmental outcomes in children from 1 to 3 years. *Neurotoxicology and Teratology, 42,* 77-84. https://doi.org/10.1016/j.ntt.2014.02.004. Epub

Wright, J., Barrison, I., Lewis, I., MacRae, K., Waterson, E., Toplis, P., Gordon, M., Morris, N., & Murray-Lyon, I. (1983). Alcohol consumption, pregnancy, and low birthweight. *The Lancet, 321*(8326), 663-665. https://doi.org/10.1016/s0140-6736(83)91964-5

Yalom, I. D. (1995). *The Theory and Practice of Group Psychotherapy* (4th ed.). Basic Books.

Yin, R. (2003). *Case study research: Design and method*. Sage Publications.

Yoos, H. L., Kitzman, H., Olds, D., & Overacker, I. (1995). Child rearing beliefs in the African-American community: implications for culturally competent pediatric care. *Journal of Pediatric Nursing, 10*(6), 343-353. https://doi.org/10.1016/S0882-5963(05)80031-4

Zlotnick, C., Tam, T. W., & Soman, L. A. (2012). Life course outcomes on mental and physical health: the impact of foster care on adulthood. *American Journal of Public health, 102*(3), 534-540. https://doi.org/10.2105/AJPH.2011.300285

Zubin, J. (1967). Classification of the behavior disorders. *Annual Review of Psychology, 18*(1), 373-406.

Zurbriggen, E. L., Gobin, R. L., & Kaehler, L. A. (2012). Trauma, attachment, and intimate relationships. *Journal of Trauma & Dissociation, 13*(2), 127-133. https://doi.org/10.1080/15299732.2012.642762

Appendix A

Interview Schedule

Demographic Data:

1. How old are you?
2. What cultural group/ethnicity do you identify with?
3. What is your gender?
4. How many children do you have? What are their ages?
5. How many children do you have present with you in Family Centre Facility?
6. Number of months stay in Family Centre Facility?
7. What programme level are you?

Semi-structured interview topics:

1. What is the meaning of recovery for you?

Prompts:

- What will be different for you?
- Some people call this recovery – what do you think about that?
- What will be different for you and your whānau?

2. Can you tell me a bit about your recovery journey, what bought you to the Family Centre?
3. What parts of the Family Centre Programme have been most helpful for you, in your recovery?
4. What steps have you taken to move towards your goals in recovery while in the Family Centre?
5. What changes have you noticed in yourself as a person since you came into Family Centre?

6. What changes have you noticed in yourself as a parent since you came into Family Centre?

Prompts

- Changes in relationship with child, if not discussed
- How would you describe the Centre's approach to helping with parenting?

7. Is there anything else that you think I should know about that would be helpful to understanding your experience in the Family Centre?
8. What do you think will help maintain your recovery?

General Prompts:

- Can you give me an example of that?
- Can you tell me a bit more about that?
- Can you tell me what happened in a bit more detail?
- How did X support you to make changes?
- Why do you think X is important?

Appendix B

Participant Information Sheet

Study title: Exploring recovery for parents with alcohol and substance misuse and dependency difficulties

Locality: Odyssey House **Ethics committee ref.:** 20/NTB/133

Sponsor: Massey University

Lead investigator: Laura Stanley **Contact Email Address:** laura.stanley.1@uni.massey.ac.nz

---

I would like to invite you to take part in a research study. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason, and it won't affect the care you receive. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This information sheet provides details about the research is being done and what participating would involve for you. We will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, or healthcare providers. Feel free to do this.

If you agree to take part in this study, you will be asked to sign a Consent Form. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

This document is 4 pages long. Please make sure you have read and understood all the pages.

Researcher

My name is Laura Stanley, and I am a Doctor of Clinical Psychology student at Massey University. As a part of my Doctoral research, I am completing research which aims to explore parent's recovery at the Odyssey House Family Centre.

What is the purpose of the study?

The Family Centre provides treatment programs to address addiction difficulties and parenting together. These programs have been successful in helping parents achieve long-term recovery. Currently, little is known about the experiences of a parent's recovery and what helps them make changes in recovery. This study aims to look at what has successfully contributed towards your recovery while at the Family Centre. The information from this study will increase our knowledge on how to best meet the needs of individuals who are in recovery and also parenting.

Who is participating?

If you are or have in the past been a client in the Odyssey House Family Centre programme you are invited to participate. 10 – 12 participants will be recruited. You must be 18 years or over to be part of this study. You are unable to participate in the current study if you have received treatment from the primary investigator (Laura Stanley) during your stay at the Family Centre.

What will my participation in the study involve?

If you choose to participate, you will be involved in one 1-2-hour interview with myself (Laura) at a time and place convenient to you. The interviews will not take place in participants homes. Before taking part in the interview you will be asked to complete a consent form.

During the interview, you will be asked to talk about your recovery journey and what things have contributed to your recovery while in the Family Centre. We will discuss topics including parenting in the Family Centre; however, we will not be discussing your child specifically.

Following the interview, I will transcribe your interview and, if requested, will send your transcripts for you to review. You will then have 10 working days to notify me if you would like to make any changes to the transcript.

As a thank you for your time and participation in the study you will get a $20 Pak 'n' save voucher. You will receive this gift card upon agreeing to participate; you will not be asked to give it back should you choose to stop the interview at any point or to withdraw your data.

What are the possible risks of this study?

We do not anticipate that the interview will cause any harm. However, if you become emotionally distressed during the interview process, I will support you during the interview, and will also provide you with resources for further help.

What if something goes wrong?

If you were injured in this study, which is very unlikely, you would be eligible **to apply** for compensation from ACC just as you would be if you were injured in an accident at work or at home. This does not mean that your claim will automatically be accepted. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery.

How does this study respect cultural Values?

We understand the importance of cultural values and beliefs in regard to parenting, Whānau and recovery, and will ensure these values be regarded throughout your participation, during data analysis, interpretation and reporting of results. Should you have any concerns regarding appropriate practice/ tikanga to address cultural issues arising from your participation in the study it is recommended that you consult with a kaumatua. We respect the importance of these values and beliefs so please inform us if you wish to have whānau support present or perform a karakia before and after participating in the interview.

Confidentiality

Everything discussed in the interview will be kept confidential. The only exception to this would be if I became worried about your safety, or your child's safety (for example, if you said you were planning to hurt yourself), in which case I would be required to take action to ensure you remain Safe. However, I would discuss this beforehand with you, and support you through the process.

Quotes from your interview may be used in my doctoral thesis, conference proceedings, reports and/or publications. However, extreme care will be taken to ensure that you cannot be identified by your quotes and your identity will also be protected through the use of a false name. No one, except for myself, will know that you have taken part in the study unless you tell them.

What are my rights?

If you change your mind and decide you do not want to take part in the interview you can tell me, and we can stop at any time. You do not need to provide a reason for wanting to withdraw. After completing the interview, you have up to two weeks to let me know if you have decided to withdraw from the study. You can also decline to answer any question during the interview and ask for the recorder to be turned off at any time during the interview.

Whether you choose to participate in this study or not, your treatment from Odyssey House will not be impacted in any way. The Primary Investigator (Laura Stanley) is employed through Odyssey House; however, no personal or identifying information gathered in this study will be shared with Odyssey House. They will only be able to view the study findings.

How will my data be managed?

Your data will be used to create a story of recovery journeys in the Family Centre. This information will be used in my doctoral thesis, conference proceedings, reports, and/ or publications. A summary of the findings can be sent to you if requested.

If you consent, your data may be used in further research projects over the years, with the approval of myself or other members of my research team, and with further ethical approval. This will not include any identifiable data.

The audio- recordings from your interview will be destroyed once I have transcribed your interviews. If you do not consent to you de-identified data being used in future studies, your transcripts and consent forms will be kept securely at Massey University on a password-protected computer file for a 10-year period, after which they will be destroyed.

Who do I contact for more information or if I have concerns?

If you have any questions, concerns or complaints about the study at any stage, you can contact:

Laura Stanley	**Veronica Hopner**
Primary Researcher	Supervisor
Massey University	Massey University
Email: Laura.Stanley.1@uni.massey.ac.nz	Phone: (09) 414 0800 ext. 43101
	Email: V.Hopner@massey.ac.nz

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050

Fax: 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@advocacy.org.nz

Website: https://www.advocacy.org.nz/

If you require Māori or other cultural support, talk to your whānau or Odyssey Cultural Support in the first instance, or you can contact the researcher on the details above.

You can also contact the health and disability ethics committee (HDEC) that approved this study on:

Phone: 0800 4 ETHIC

Email: hdecs@health.govt.nz

This project has been reviewed and approved through Northern B Health and Disability Ethics Committee. Ethics Reference: 20/NTB/133

Appendix C

Consent Form

Exploring recovery for parents with drug and alcohol misuse and dependency difficulties

Participant Consent Form

I have read or have had read to me in my first language, and I understand the Participant Information Sheet.		
I have been given sufficient time to consider whether or not to participate in this study.		
I have had the opportunity to use a legal representative, whānau/ family support or a friend to help me ask questions and understand the study.		
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.		
I understand that I am free to withdraw participation at any time before and during the interview, and to withdraw my interview or any part of it up to two weeks after the interview.		
I understand that my participation or non-participation will in no way impact my treatment or relationship with Odyssey House		
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.		
I agree to the interview being sound recorded:	Yes ☐	No ☐

I wish to review a copy of my transcript, and understand I must notify Laura within 10 working days if I would like to make changes, or the original version will stand:	Yes ☐	No ☐
I agree to my interview data to be used for future studies with the approval of Laura or the Massey University Supervision team for this project:	Yes ☐	No ☐
I wish to receive a summary of the results from the study.	Yes ☐	No ☐

Declaration by participant:

I hereby consent to take part in this study.

Participant's name:

Signature: Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name:

Signature: Date:

If you would like to review your transcript or receive a summary of the findings when the project is finished, please provide your email or postal address below:

Email / Postal Address:

Appendix D

Research Case Study

As a part of the Doctor of Clinical Psychology thesis, candidates are required to include a thesis case study which is examined as a part of the clinical component of the doctorate.

The present work outlines learnings I have taken from my experiences with my doctoral research, and how they apply to my work as an intern psychologist. The case study opens with an overview of my doctoral research, which focuses on what contributes to recovery for parents within an integrated parent-child rehabilitation facility, for alcohol and substance use. Attention is then paid to how my experience designing, conducting and analysing my doctoral research has informed and enhanced my work as an intern psychologist. Such reflections include skills for working with service users, the role of reflexivity, and the influence of parenting.

Doctoral Research Overview

My doctoral research focuses on understanding what contributes to recovery, for parents with substance misuse and dependency difficulties, whilst in a residential parent-child integrated treatment facility. The study had two primary aims, to identify what supports recovery, and the needs of those in recovery. The following section will provide an overview of the study background, rationale, aims, methodology and results. By providing information about how the research was conducted, it is hoped that the reflections on my role as an intern psychologist will be contextualised.

Study beginnings

This project was inspired by my academic and professional experience and interests. Before commencing the Doctor of Clinical Psychology programme, I worked in Odyssey House, a drug and alcohol treatment facility. It was here that I became passionate about working with and empowering people in their recovery journeys. During my experience working at Odyssey House, as well as my academic study, I became aware of the high rates of individuals suffering from substance misuse and dependency in New Zealand (Oakley-Browne et al., 2006), and the devastating impact this has on people, whānau and children. There was a dearth of research understanding the needs of individuals with children who are also facing addiction challenges, which struck me as an important gap in our understanding of these phenomena, especially considering the increased attention brought to this topic in public discourse. He Ara Oranga, the Mental Health and Addictions inquiry (Paterson et al., 2018) was significant in highlighting the widespread impact of mental health and addictions in New Zealand and harm to individuals, whanau and communities. The inquiry raised awareness of the significant need for more rehabilitation and treatment services in New Zealand.

While working in the Family Centre, I observed the gratefulness of clients for being able to work on their recovery while building strong connections with their children. At the same time, I observed parents from other services facing the strain of being separated from their children, while trying to focus on their recovery. It struck me as important to understand the aspects of the Family Centre programme that were contributing to parents' recovery and helping them and their children to live meaningful lives.

Study Rationale and Aims

In Aotearoa New Zealand, there is a lifetime prevalence of 12.3% and a 12-month prevalence of 3.5% for substance use disorder, and these are identified as some of the highest rates in developed countries (Oakley-Browne et al., 2006). New Zealand is also identified to have some of the highest rates of alcohol and drug consumption during pregnancy(Wouldes et al., 2014). Alcohol is the most commonly misused substance, with approximately 21% of New Zealanders reporting drinking at a hazardous level in recent years (New Zealand Drug Foundation, 2020). It is estimated that 1% of New Zealand adults used amphetamines in 2020, these rates are ranked among the highest in the world (New Zealand Drug Foundation, 2020; United Nations Office on Drugs and Crime (UNODC), 2016), and the impacts of use are substantial and widespread, particularly for certain communities (Ministry of Health, 2016).

Parents in recovery from substance misuse often have complex and unique needs that mainstream treatment approaches cannot always meet. Those who are parenting while in recovery experience substantial shame, guilt, and barriers to support (Corrarino et al., 2000; Hankin et al., 2000; Kahler et al., 2003; Silva et al., 2013). There is a multitude of parenting challenges during active recovery as parents manage a range of emotions and behavioural concerns related to their recovery, and also about their children. Treatment often focuses

solely on substance misuse and fails to pay attention to parenting, and most often, parents and children are separated during treatment.

Integrated treatment services, which include both drug and alcohol treatment and parenting support, have been developed to break the often intergenerational cycle of addiction and troubled parenting. The predominance of findings suggests the efficacy of integrated treatment services, in reducing substance use (Espinet et al., 2016b; Lowell et al., 2021; Moore & Finkelstein, 2001; Suchman et al., 2006). Research suggests that women, in particular, show higher rates of engagement, retention, and recovery when children are included as part of the treatment process (Lundgren et al., 2003). Mothers have also demonstrated improvements in living skills, including independent living, relationships and employment, when mother-child programs were offered (Espinet et al., 2016a; Lundgren et al., 2003). Improvements in psychological well-being, including depression and increased self-esteem, have also been indicated (Barnard & McKeganey, 2004; Espinet et al., 2016a; Stevens & Arbiter, 1995). Further to supporting personal recovery, integrated programmes are shown to improve parenting behaviour and skills (Barnard & McKeganey, 2004; Hiersteiner, 2004; Neger & Prinz, 2015).

Although literature highlights the efficacy of integrated services, there is a lack of understanding as to how parents conceptualise their experiences within these services as it relates to their recovery, and what programme components contribute to changes in recovery. Much of the literature quantitatively highlights the effectiveness of integrated services for parenting and substance misuse, and there is a lack of qualitative literature which understands the subjective experiences of parents within these integrated services. A large proportion of contemporary research focuses on a biomedicalised understanding of both alcohol and substance use disorders and recovery. It fails to take into account the complexity of recovery

and instead uses objective measures of abstinence that do not provide an adequate understanding of the phenomenon.

There is a dearth of research exploring parents' experiences in integrated programmes, which factors they find useful, what they engage in, how they engage in these services and how this impacts their recovery. Further understanding of the subjective experiences of parents in integrated treatment programmes is crucial, particularly concerning parenting practices. Research is needed to enhance knowledge of how integrated programmes are effective in aiding recovering parents, from the voice of service users themselves. By researching the subjective experiences of parents, we can better understand the needs of parents within these services, so that clinical service delivery can best meet the needs of these parents.

The research explores parents' experiences of their service use and the factors that have contributed to their recovery, while in a parent-child residential treatment facility, the Odyssey House Family Centre. The Odyssey House Family Centre is a 9 – 12 month residential programme inclusive of community integration. The programme addresses substance misuse and parenting concurrently, and children can live with their parent during treatment to (re)build strong attachment and connections. Given the uniqueness of the Family Centre, the research gains insight into the unique journeys of parenting while in residential drug and alcohol treatment. By further understanding the experiences of parents in integrated treatment programmes, the research aimed to enhance knowledge about how to best support the parents in recovery. Key objectives of the research include understanding:

iii) What are the needs of parents in integrated treatment for substance misuse and dependency?

iv) What are the unique factors that have facilitated parent's recovery within a residential integrated treatment facility?

Methodology

Participants

Participants comprised of 10 residents who were currently engaged in the Family Centre programme with at least one of their children. Guided by Malterud et al. (2016), 10 participants were considered an appropriate sample size due to the strength of the dialogue, dense sample specificity and quality of dialogue between the researcher and participants. Participants had been in the programme for two to twelve months.

Procedure

Using purposeful sampling (Merriam, 1998), participants were recruited who were, at the time of the interview, engaged in the Odyssey House Family Centre. I endeavoured to recruit participants who were in multiple stages of the programme to gain insight into what contributes to recovery at multiple stages within the programme.

All interviews took place at Nga Wai Otihi, the Odyssey House Main building. This location was chosen by all participants as it is private, safe, and comfortable, and allowed the participants to participate in the research without other residents or staff members seeing them.

Semi-structured interviews, each lasting approximately one-hour, were adopted to understand participants' stories of recovery within the Family Centre. The interviews were participant lead and conversational. To make the interviews conversational a broad interview protocol was adopted for topics to be discussed. Enquires included participants meaning of recovery, participants' recovery journey and what bought them to the Family Centre, goals in recovery and what steps participants had made towards these goals, what had supported participants to make changes towards their goals, recovery, milestones, Changes they have noticed in themselves as a person and a parent while in the Family Centre and what has

supported these changes, the role of parenting within recovery. General socio-demographic data was collected at the start of the interview

Interviews were audio recorded and the interviewer took additional field notes. Recordings were transcribed verbatim, with identifying information removed. Participants were given the opportunity to review their transcripts, and this process was completed by 5 participants. None of the participants wished to change any aspect of their interview transcript.

Ethics

This research was approved by the Health And Disability Ethics committee (HDEC) on 22 October 2020 (Reference 20/NTB/133).

Data analysis

This study used reflexive thematic analysis within a multiple case study methodology to explore participants experiences of recovery within the Family Centre. Taking a case study approach allowed for the exploration of each person's experience and is a valuable tool for detailing novel behaviours and for gaining a better understanding of human knowledge in complex real-world settings such as the Family Centre (Merriam, 1998; Yin, 2003). The case study approach is particularly useful as it aids in providing context to participants' stories, which is important considering the complex histories and factors associated with substance misuse, recovery and parenting they bring into this work.

Braun and Clarke's (2006) six phase process of reflexive thematic analysis was followed to analyze the data. Thematic analysis is a method for identifying, analysing, and reporting patterns or meaning across participants' stories. It allows for the examination across a complete data set producing patterns of meaning known as themes (Braun & Clarke, 2006, 2013). Reflexive thematic analysis was adopted for the current research as it emphasises the importance of the researcher's subjectivity as an analytic source, and the importance of

reflective engagement with theory, data and interpretation. This was particularly important, considering my historic role as a clinician at Odyssey House, and my role as a researcher within the project.

An inductive approach to data analysis was utilised to avoid potential assumptions and biases and to ensure the findings were grounded in participants' responses. In line with Braun and Clarke's (2006) thematic analysis method, transcripts and case vignettes were then read and re-read to support familiarisation with the data. Initial codes were then generated identifying important features of the data which helped to answer the research questions. Multiple sweeps were done to make sure all relevant features were captured. Initial themes were then constructed by grouping together relevant codes Themes were refined, separated and reorganized several times to ensure they accurately captured and reflected the data. Lastly, themes were named and defined with a written analysis completed to accompany each theme identified.

Findings

Three key themes were identified pertaining to parental experiences of recovery within the Family Centre. These themes were: 1) The Construction of Self 2) The Therapeutic Milieu and 3) Relational Recovery. Within each theme subthemes provided additional information, constructing more specific discussions around aspects of the themes and going into more detail about the defined features which have supported recovery.

Within theme one, participants spoke extensively about the role their child/ren played within their recovery, supporting their construction of self, through becoming present in their child/ren's lives, becoming role models, developing purpose, and increasing connections with their child/ren. These factors fundamentally supported parents' recovery, and interviews emphasised how intertwined participants' parenting and recovery were. Cultural immersion

additionally supported participants' recovery, assisting them to reconstruct and re-discover themselves through enhanced knowledge, connection and belonging.

The Family Centre was identified to provide a 'Therapeutic Milieu' that supported participants' recoveries. Within this, specialist psychological support for trauma and mental health difficulties, as well as strengths-based staff support, was seen as crucial. Furthermore, key Therapeutic Community components such as encounter groups, closed groups and the routine provided participants with a stable platform to engage in recovery whilst also supporting an increased awareness of their difficulties and the development of coping mechanisms.

Lastly, theme three highlighted the relational nature of recovery for participants. The people surrounding participants were said to fundamentally impact their recovery, both positively and detrimentally. Peers within the programme played a key role in each participant's treatment and recovery journeys. Observing peers' recovery journeys supported the development of hope. Mutual support additionally provided participants with social connections making them feel less alone in their recovery, and development of trust in relationships. The results indicate several key clinical implications for treatment services as well as future directions of research.

Clinical Psychology Internship

My internship was completed at an Adult Community Mental Health services providing assessment and treatment for adults (aged 18 – 65) with moderate to severe mental illness or severe psychological distress in the Counties Manukau region of Te Whatu Ora. Within the team, Clinical Psychologists provide evidence-based assessment and treatment of various presenting mental health problems, therefore, my reflections below are representative of this work. They include reflections on reflexivity, skills for working with service users and the role of parenting.

Reflexivity

Reflexivity was a fundamental skill I develop throughout my doctoral thesis that I use daily within my clinical practice. Within qualitative research, the researcher's age, gender, socioeconomic status, life experiences and beliefs influence how they conduct research from beginning to end. To harness a researcher's subjectivity, and understand how it related to the project, ongoing consideration, critique and reflection of the researchers' subjectivity is needed, through the process referred to as reflexivity (Braun & Clarke, 2013). Within my thesis, reflexivity was fundamental, particularly given my personal experiences working in the Family Centre. Ongoing reflection was necessary to ensure that my own beliefs, attitudes, and experiences of the Family Centre did now skew the participants' experiences and instead assure the voices of the participants informed the presentation of results, alongside my interpretation of these. Although I had always considered myself to be a reflective person, taking part in a more formal process of reflexivity throughout my research enabled me to become more thoughtful, intentional, and insightful in how I engaged in processes. I came more aware of my presence in the room with people I was interviewing, how my beliefs and prior experiences influenced my interviewing skills and well as my interpretation of what people said, to name a few. Reflexivity was additionally important during my data analysis and write up of my findings. Engaging in self-reflection and discussions with my thesis supervisors meant I was better able to avoid potential assumptions and biases and to ensure the findings were grounded in participants' responses.

The reflective skills developed within my thesis have been transferable into my clinical training and are a formal process of my Clinical Psychology Internship. Being reflective in clinical practice leads to further self-awareness, therefore, enhancing personal development. It makes me more aware of my strengths as well as areas for improvement, so I can continue developing my skills and knowledge. Further to this, it is important to reflect on

my own bias and preconceived understandings of difficulties as well as the therapeutic relationships I hold with clients to make sure I am providing the best care possible.

Following assessment and treatment sessions with clients, I make sure to set time aside to reflect on processes which took place in the room with the client. I reflect on the therapeutic relationship, the client's body language, tone, eye contact and any congruence or incongruence with this and what they have expressed. I also reflect on my role within the room. How I presented towards the client, my reactions or beliefs regarding the client's presentation or behaviour, and importantly and transference or countertransference with the client. Further to this, I reflect on the process within the room and any information that I may have missed or need to follow up on. Formal reflection from my thesis has made me more intentional and aware in this process, which has supported my clinical practice.

Weekly supervision with my clinical supervisor is additionally important in the reflection process. My supervisor and I often talk through any beliefs I have about a client, their presentation, and their needs, as well as how I could improve my therapeutic process. I find it helpful to have a second opinion to discuss reflections, assessment findings and treatment plans. Engagement in supervision, a growth promoting relationship has been one of the most valuable tools for my improvement and is key to my development as an intern psychologist.

While reflexivity holds an important role in my internship, it will continue to be important beyond my internship year in developing my skills and knowledge moving forward in my career.

Skills for working with service users

I began the data collection for my research in December 2020, and at the time had not completed any community placements. Although I had undertaken assessments within previous employment, the process of assessment differed largely from that of my research

and a clinical interview, and I had not completed any formal training in the clinical assessment process. Upon starting my research interviews, I had difficulty differentiating between a research and a clinical interview. On several occasions, in initial interviews, when participants shared their experiences or thoughts I found myself wanting to explore their thoughts or their beliefs, as I would have in the role of a clinician. I had to challenge myself throughout this initial interview process to stay in the role of a researcher. Moreover, ethically I needed to be exploring the purpose and aims of my research. At times in initial interviews, I also felt that I failed to explore participants' experiences at a deeper level, instead of taking what the participant said at face value and placing it into my preconceived notions of their experience. Learning this within the research process was incredibly valuable and has supported me in my therapeutic processes within my internship. Skills such as active listening, rapport building, micro-skills, open-ended questioning, developing a non-judgemental and empathetic response and validation were all developed as I progressed through my thesis interviews.

The research process gave me a space to practice my opening ended questioning, naive enquiry, and specific questioning. These skills have informed how I work with service users in my internship. I found that developing these skills has allowed me to deeper understand people’s experiences and how they relate to them, their difficulties, and their strengths as well as their beliefs. It additionally helped me to develop confidence in my ability to explore difficulties with clients and sit with vulnerability within the room. In my research interviews, participants were vulnerable to share several traumatic life experiences, as well as the guilt and shame they experience concerning how their substances use impacted their whānau and children. They often cried or were visibly upset discussing these events. Now, in my internship, I experience vulnerability or the sharing of traumatic experiences daily. I find that I can more easily sit with clients’ trauma and emotional experiences in the

room and hold a safe space for clients to be able to express and process these emotions. I further understand how to respond empathetically and in a validating manner and feel more confident in doing so.

In conducting my thesis interview I additionally developed skills to support the therapeutic relationship. My research interviews typically lasted one to one and a half hours, and before the interview, I had met the participant once or twice. It was important for me to build rapport quickly with the client to be able to explore experiences with the client, and for them to feel comfortable and confident in being vulnerable, to do so. Although within my internship we are usually not time limited in our ability to meet with clients, and can certainly meet with them more than once, it is important that we develop a strong therapeutic relationship with clients in the first session. As a clinician I want service users to have a positive experience with mental health services and feel motivated and comfortable to come back and seek support. This is particularly important as many clients have had unfavourable, traumatic, or difficult experiences with mental health services in the past. The development of skills in validation, empathy and non-judgemental stance and active listening supported me to develop strong therapeutic relationships where participants in my research, and now service users in my internship, feel safe and comfortable to share their lives and stories with me.

Furthermore, a significant finding of my thesis was the importance of strengths-based and non-judgemental staff support in recovery. Findings reinforce the importance of identifying clients' strengths and working with these as a core component of assessment and treatment. A non-judgmental approach is also particularly important in creating strong therapeutic relationships with clients, and my thesis reinforced the importance of this.

The influence of parenting

An objective of my doctoral research was to better understand the role of parenting in substance misuse recovery. Findings highlighted the significant role that parenting played in participants' recovery journeys. Children played as a significant motivator, and the role of parenting itself was drawn on to form positive and recovery orientated identities. At the same time, parenting was described as stressful, particularly in terms of managing both being a 'good' parent and engaging in recovery. Completing my research highlighted the fundamental and multifaced role of being a parent, and how although fulfilling, motivating and protective, it can provide a source of stress for clients. My research highlighted the importance of understandings the parenting role in every aspect of service users' lives as a part of the therapeutic process.

Through my time in my internship, I have seen how being a parent can simultaneously amplify and obstruct recovery. For example, at times clients had to miss scheduled therapy sessions last minute due to their child being unwell. Additionally, when collaboratively developing a sleep hygiene plan with a client, considerations and changes had to be made for their role as a parent. Sometimes it was not possible for them to sleep through the night, as their child might wake up, and therefore, problem solving had to be made around developing a sleep routine that considered their role as a parent. Parents often put their children's needs before their own, meaning that their recovery was shifted to the side. This was particularly relevant when both the parent and the child were accessing secondary mental health services.

Although managing the role of being a parent while in recovery was at times stressful for clients, it also served as a primary protective factor. Engaging with their child bought joy and pleasure to clients' lives. For some service users being a better parent or spending more time with their children was a goal of treatment. When discussing when clients' moods were the best, the times they spent with their children were often reported, and the role of

parenting could be used protectively within treatment plans such as behavioural activation to promote pleasurable activities.

Having insight into the role of parenting, from my research experience allowed me to have a more holistic understanding of the strengths and difficulties of being a parent. When doing assessments, it became core to my process to explore being a parent as well as clients' relationships with their children. Within therapy, the role of parenting was always on my radar. I make sure to take it into account when developing plans with clients, and actively problem-solve with them to support both the role of parenting and their recovery simultaneously.

Summary

My doctoral research has been influential in developing my skills as an intern psychologist. The time I spend conducting research interviews for my thesis supported the development of several key interview skills I use within my clinical practice. Moreover, it supported the development of insight into several important areas in service users' lives and recoveries. The knowledge from my thesis findings and the extensive literature review conducted allowed me to better understand the role of parenting for service users, meaning I feel more confident and comfortable exploring parenting in my clinical practice. In conducting reflexivity as a part of my thesis I became more reflective, supporting me to continue to develop my skills during my internship year.

References

Barnard, M., & McKeganey, N. (2004). The impact of parental problem drug use on children: what is the problem and what can be done to help? *Addiction, 99*(5), 552-559. https://doi.org/10.1111/j.1360-0443.2003.00664.x

Braun, & Clarke. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, & Clarke. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. Sage.

Corrarino, J. E., Williams, C., Campbell III, W. S., Amrhein, E., LoPiano, L., & Kalacbik, D. (2000). Linking substance-abusing pregnant women to drug treatment services: A pilot program. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 29*(4), 369-376. https://doi.org/10.1111/j.1552-6909.2000.tb02059.x

Espinet, S. D., Motz, M., Jeong, J. J., Jenkins, J. M., & Pepler, D. (2016a). 'Breaking the Cycle' of maternal substance use through relationships: a comparison of integrated approaches. *Addiction Research & Theory, 24*(5), 375-388. https://doi.org/10.3109/16066359.2016.1140148

Espinet, S. D., Motz, M., Jeong, J. J., Jenkins, J. M., & Pepler, D. (2016b). 'Breaking the Cycle'of maternal substance use through relationships: a comparison of integrated approaches. *Addiction Research & Theory, 24*(5), 375-388. https://doi.org/10.3109/16066359.2016.1140148

Hankin, J., McCaul, M. E., & Heussner, J. (2000). Pregnant, alcohol-abusing women. *Alcoholism: Clinical and Experimental Research, 24*(8), 1276-1286.

Hiersteiner, C. (2004). Narratives of low-income mothers in addiction recovery centres: Motherhood and the treatment experience. *Journal of Social Work Practice in the Addictions, 4*(2), 51-64. https://doi.org/10.1300/J160v04n02_05

Kahler, C. W., McCrady, B. S., & Epstein, E. E. (2003). Sources of distress among women in treatment with their alcoholic partners. *Journal of Substance Abuse Treatment, 24*(3), 257-265. https://doi.org/10.1016/s0740-5472(03)00033-3

Lowell, A. F., Peacock-Chambers, E., Zayde, A., DeCoste, C. L., McMahon, T. J., & Suchman, N. E. (2021). Mothering from the Inside Out: addressing the intersection of addiction, adversity, and attachment with evidence-based parenting intervention. *Current Addiction Reports, 8*(4), 605-615.

Lundgren, L. M., Schilling, R. F., Fitzgerald, T., Davis, K., & Amodeo, M. (2003). Parental status of women injection drug users and entry to methadone maintenance. *Substance Use & Misuse, 38*(8), 1109-1131. https://doi.org/10.1081/JA-120017653

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative health research, 26*(13), 1753-1760. https://doi.org/10.1177/1049732315617444

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education. Revised and Expanded from "Case Study Research in Education"*. Jossey-Bass Publishers.

Ministry of Health. (2016). *Amphetamine Use 2015/16: New Zealand Health Survey*.

Moore, J., & Finkelstein, N. (2001). Parenting services for families affected by substance abuse. *Child Welfare New York 80*(2), 221-238.

Neger, E. N., & Prinz, R. J. (2015). Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations. *Clinical Psychology Review, 39*, 71-82. https://doi.org/10.1016/j.cpr.2015.04.004

New Zealand Drug Foundation. (2020). *State of the Nation: A stocktake of how New Zealand is dealing with issues of drugs.*

Oakley-Browne, M., Wells, J., & Scott, K. (2006). *Te Rau Hinengaro: The New Zealand mental health survey: Ministry of Health*.

Paterson, R., Durie, M., Disley, B., Rangihuna, D., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He Ara Oranga: Report of the government inquiry into mental health and addiction*.

Silva, S. A., Pires, A. P., Guerreiro, C., & Cardoso, A. (2013). Balancing motherhood and drug addiction: The transition to parenthood of addicted mothers. *Journal of Health Psychology, 18*(3), 359-367. https://doi.org/10.1177/1359105312443399

Stevens, & Arbiter, N. (1995). A therapeutic community for substance-abusing pregnant women and women with children: Process and outcome. *Journal of Psychoactive Drugs, 27*(1), 49-56. https://doi.org/10.1080/02791072.1995.10471672

Suchman, Pajulo, DeCoste, & Mayes. (2006). Parenting Interventions for drug-dependent mothers and their young children: the case for an attachment-based approach. *Family Relations, 55*(2), 211-226. https://doi.org/10.1111/j.1741-3729.2006.00371.x

United Nations Office on Drugs and Crime (UNODC). (2016).

Wouldes, T. A., LaGasse, L. L., Huestis, M. A., DellaGrotta, S., Dansereau, L. M., & Lester, B. M. (2014). Prenatal methamphetamine exposure and neurodevelopmental outcomes in children from 1 to 3 years. *Neurotoxicology and Teratology, 42*, 77-84. https://doi.org/10.1016/j.ntt.2014.02.004. Epub

Yin, R. (2003). *Case Study Research: Design and Method*. Sage Publications.