EXPLORING COLLABORATIVE PEER RECOVERY COACHING IN THE CONTEXT OF SUBSTANCE USE DISORDERS: AN AUSTRALIAN WORK-BASED STUDY

A Thesis submitted by

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ABSTRACT

Substance use disorders stem from abuse and addiction to alcohol, tobacco, medications, and illicit substances. The prevalence of substance use disorder continues to significantly worsen. The economic, social and personal health costs of substance use disorder are well documented in the relevant literature. Clinical treatment and rehabilitation of substance use disorders are important and popular topics of study. Despite this, studies on peer-supported, recovery coaching, to mitigate substance use disorders, especially as it relates to professional practice, in Australia, are rare.

The purpose of this study is to investigate the effects and practice of a collaborative peer recovery coaching approach, in response to substance use disorders, as they relate to cultivation of recovery capital resources and goal attainment. This Australian work-based study aims to explore and seeks to contribute to professional practice, by investigating the experience the Collaborative Peer Recovery Coaching program, designed to assist clients in active addiction. The program is based the extant literature which provides an evidence-base, supporting the inclusion of its four practice delivery dimensions: being a collaborative; peer facilitated; recovery oriented; and coaching-based program.

The study is exploratory and adopted a constructivist, qualitative research design. In total, 18 participants were eligible to participate in this study. The data were in the form of transcribed video recordings of coaching sessions and documents associated with the evaluation of client progress. The analysis of the qualitative data included the use of assigning scores, as per the Assessment of Recovery Capital scale. Scoring is based on the number of recovery resource item responses, analysed from the observations of the recorded coaching sessions. A self-rating of goal attainment scores will also be evaluated.

Content analysis seeks to explore the extent to which: 1) clients can demonstrate improvements in recovery capital resources; 2) emergent patterns found across the recovery capital domains; and 3) participant self-rating of perceived goal attainment scores. The results suggest that improvements were shown across all ten recovery capital domains. Self-reported evidence of goal attainment scores, corroborated by the session data, also demonstrated positive results. The analysis of data revealed 13 treatment principles were utilised in the coaching program and had an effect. These insights informed the development of a recovery-oriented, case management tool, presented as the study artefact, called the Principle-centred Recovery Resource Register (P3R).

The empirical results reported herein, should be considered in the light of a number of limitations, including sample bias from a convenient sample. It is acknowledged that the sample represents; a) only those with addiction issues, that were attracted to programs of this nature, b) were associated with the organisation, recruited to this coaching program, c) and were limited to a geographic location. While the sample included a vast amount of data and 18 participants, the sample size does not allow for generalisation of the result findings.

Lastly, the study did not have a control group, and post-tests were not conducted. Therefore, the sustainability of the post-intervention results cannot be verified. Despite the limitations mentioned, it is proposed that the purpose and aims of the study, can make an original, previously unreported, and meaningful contribution, to professional alcohol and other drug practice.

CERTIFICATION OF THESIS

This Thesis is entirely the work of Maria Power, except where otherwise acknowledged. The work is original and has not previously been submitted for any other award, except where acknowledged.

Principal Supervisor: Dr Luke van der Laan

Associate Supervisor: Dr Lee Fergusson

Student and supervisors' signatures of endorsement are held at the University.

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I would like to acknowledge Dr. Douglas Massing for offering editorial feedback and recommendations. As well, Dr. Aleta Villanueva, Karyn Martyn and Alice Illes offered input in the last month of submission. I am grateful to them, for being giving of their time in reading the full thesis, with such a tight deadline.

I dedicate this to my father who has already passed. He set the example of grit, resilience, temperance, compassion, and perseverance, that I was able to follow. I dedicate this to my mother, as this was her dream for me from the beginning. If not for her journey to bring me here to Australia, this education would not have been possible. My mother stands proud and in anticipation of my doctoral graduation, despite battling cancer recently. With all that she has surmounted, I appreciate and love her, always.

I dedicate this to my clients, not only those that became the participants of this study, but all others. Each has taught me to keep on keeping on with my own recovery. To my clients, thank you for continuing to bless me with me with your honesty, your rawness and vulnerability. Your experiences offered me the humility of remembrance and I am forever in awe of the strength of a human's capacity for transformation, against all odds.

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ABBREVIATIONS

AOD	Alcohol and Other Drug/s
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
CC	Coach Competency or Coach/ing Competencies
CPRC	Collaborative Peer Recovery Coaching
CRM	Collaborative Recovery Model (Psychiatric/Clinical Setting)
DSM-V	Diagnostic and Statistical Manual (of Mental Disorders), 5th edn
IR	Insider Researcher
MH	Mental Health
MH/AOD	Mental Health and Alcohol and Other Drugs
NIDA	National Institute of Drug Abuse
P3R	Principle-centred Recovery Resource Register
PS	Professional Studies
QADREC	Queensland Alcohol and Drug Research and Education Centre
RC	Recovery Coach/es
RCR	Recovery Capital Resource/s
ROSC	Recovery Oriented Systems of Care
SUD	Substance Use Disorder/s
TA	Therapeutic Alliance
TP	Treatment Principle/s
USQ	University of Southern Queensland

GLOSSARY OF TERMS

Term	Definition
Assessment	The formal or informal information gathering session completed to appraise the effect of alcohol and other drugs (AOD) use in individual.
Alcohol and Other Drugs (AOD)	A term used in the mental health industry for the AOD sector workers that provide services to end-users with substance use disorders (SUDs) and/or issues with dependence to alcohol and other drugs.
Brief Intervention	A form of intervention used in AOD treatment settings utilising harm minimisation and/or harm reduction through safer drug use and relapse prevention plans. Brief intervention can last from 1 to 30 minutes in the form of motivational interview, problem solving, decision-balancing, goal setting and support groups, requiring an understanding of the process of AOD change.
Coaching	Partnering with clients using a thought-provoking and creative strategic process. The coaching approach inspires clients to maximise their personal and professional potential through attainment of mutually agreed upon goal outcomes. Eleven competencies set by the International Coaching Federation (ICF) operationalises the intervention used and described in this study.
Coach Competency **Also: Coaching Competencies**	Becoming an effective and confident coach require the development of a culmination of 11 sets of competencies. The competence a coach would display is rated by the International Coaching Federation (ICF) and to remain an accredited coach, examination requires a minimum of 75% score rating competency against these 11 competency standards, these coach competency standards are outlined in Chapter Three. Coach competencies comprise of skills, techniques and processes which need practice integration. These sets of competency-based skills are the responsibility of the coach to continuously improve and contribute to the ‘coach effect’.
Coach Effect	The coaching delivered by the coach-practitioner is dependent upon accreditations obtained, qualifications completed and score rating against the 11 coach competencies. There are 3 levels of ICF accreditation, the highest level, called the Master Coach.

has completed over 5000 hours of paid professional coaching.

Coaching Session	A scheduled coaching arrangement, called the Collaborative Peer Recovery Coaching (CPRC) session. Each CPRC session is an hour in duration, and has been recorded, with transcripts made to provide the evidence-base for this study.
Co-dependent	An individual is called a co-dependent when there is a dysfunctional 'helping' relationship with another. It is where one person supports or enables another person to continue their addiction and addictive behaviours. Co-dependent behaviours can exacerbate poor mental health issues.
Comorbidity Also: Co-occurring	The presence of one or more additional diseases or disorders, occurring with another primary disease or SUD.
Collaborative	The is first dimension of the CPRC program. The 'collaborative' approach has been described in treatment literature, as the therapeutic alliance. In CPRC, collaborative entails a healthy partnership, where the main aim is for the client to flourish, amidst existence of active addiction issues. The client is at the centre of the CPRC session, and the coach leads the 'coach-client collaboration' by using skills, competencies, and capabilities that ensure the fruition of goals set, in the first session.
Collaborative Peer Recovery Coaching (CPRC)	The recovery coaching program coined by the insider-researcher and the CPRC Practitioner of this study. This CPRC program consists of four practice dimensions: 1: Collaborative; 2: Peer; 3: Recovery; and 4: Coaching. The CPRC Practitioner (n = 1) of this study is accredited in coaching with the ICF, and recovery coaching with Recovery Coaches International. The 11 coach competencies discussed in Chapter Three, operationalises the CPRC program delivery.
Collaborative Peer Recovery Coach Practitioner (CPRC Practitioner)	The coach-practitioner that facilitated the CPRC program in this study has completed a Master of Public Health, in the field of AOD studies. She has also completed her degree in psychology and philosophy. She has logged over 1600 hours of coaching sessions and has been operating her MH/AOD coaching practice since 2010.
Collaborative Recovery	A Collaborative Recovery Model (CRM) is a practice model designed to incorporate processes that have been

Model (CRM)	shown to assist people living with mental illness issues. The CRM is designed to assist mental health workers provide services utilising the recovery-oriented framework.
Denial	Otherwise known as 'denial mechanisms' and falls into five categories: minimising; blaming; justifying; regressing or dissociating; and projecting. Each denial mechanism serves to keep the addiction firmly in place, keeping it active within the individuals' behavioural, cognitive, physiological, and social states and structures.
Diagnostics and Statistical Manual of Mental Disorders 5th edition (DSM-V)	DSM-V is a manual used by medical practitioners to diagnose and assess a series of mental disorders, to prescribe appropriately matched medications, accordingly. The DSM-V does not include information or any guidelines for treatment of stated disorder/s. However, it provides an accurate current diagnosis, as the first step to treating the mental disorder/s that the patient may present to the physician with. The DSM-V is the 5th and current edition, in worldwide use.
Insider-Researcher	Insider research has been described as research undertaken within one's practice, or in an organisation, group, or community, where the researcher is also a member. The research in this study was completed by an insider-researcher.
International Coaching Federation (ICF)	Established in 1996, the International Coaching Federation provides independent, accredited certification for professionally competent, practicing coaches. ICF credentials are awarded to professional coaches, who have met stringent education, experience and examination requirements. These need to be demonstrated through completion of an assessment and exam. Achieving credentials through ICF signifies a coach's commitment to integrity, where mastery of coaching skills, and dedication to clients are key.
Intervention	An intervention is a combination of strategic activities designed to assess, improve, maintain, promote, or modify behaviour among individuals or groups. Interventions can include educational, therapeutic, or coaching programs, policy changes, environmental improvements, or health promotion campaigns.
Medical Model	The current, predominant system in the AOD treatment and clinical sector is based upon an acute biopsychosocial

	assessment and symptom stabilisation process. This medical model is augmented with case managed treatment plans and appropriate medication/s prescribed by a suitably qualified treatment professional or doctor.
Mental Health (MH)	Mental health can be defined as the absence of mental disease in one's biological and psychological states. Social and developmental factors also contribute to an individual's mental state and ability to function within their living environment. There are various practitioners that deal mental health patients and clients. As a major shift occurred in care practices during the Australian Mental Health Reform in 2012, mental illnesses are now referred to as MH. Mental Health encompasses the clinical and treatment industry as a whole, with its' different sectors of practice, including MH psychiatric, and rehabilitation service providers.
Mental Health and Alcohol & Other Drugs (MH/AOD)	Continuing from the above definition, MH/AOD refers specifically to the issues experienced by those with substance use disorders. As AOD come under the jurisdiction of mental health in Australia, MH/AOD may also refer to the sector of workers and allied health practitioners that provide services to individuals that identify as needing support, to alleviate symptoms of their SUDs.
Peer	An individual delivering addiction recovery support that has had past issues with SUD and its associated mental health, comorbidity issues.
Peer-supported **Also: Peer-delivered**	A service delivered by those that identify as having had past issues with substance use disorder/s, with its associated mental health, and comorbidty issues. In this study, a formal, peer-delivered service entails abiding by recovery-oriented management strategies. Operating within a recovery-oriented systems of care (ROSC) framework, the peer-delivered service defined in this study, was delivered through Coaching with Substance, a registered charity and Public Benevolent Institution, with one qualified practitioner.
Principle-centred Recovery Resource Register (P3R)	The P3R is a case management register designed to guide practitioners to assess recovery-orientation for patients/ clients that present for coaching, intervention or treatment It has been developed from this research study and this register allows for recovery-orientation, using the 13 principles of

	treatment, reported by the U.S. National Institute of Drug Abuse (NIDA). The P3R is to be used for case management of adults with prolonged and serious substance abuse issues.
Poly-drug use	Ingesting more than one type of alcohol or drugs in any given moment. Poly-drug use is usually the norm, rather than the exception.
Queensland	A state in the country of Australia, and the location from which the insider-researcher conducted the study and operated the CPRC practice from.
Reflection	An academic form of synthesising knowledge for practice, used by postgraduate students that enrol in the Professional Studies (PS) program. As a reflective practitioner, reflexive learning is structured so that the PS student/learner will be provided the tools, resources, and supervisors who apply a 'hands on' approach to work-based learning (WBL) and action-oriented research. Reflection helps the student consider their own expertise, helping them develop learning objectives that matter to them, their organisation (work or practice-base) and scope of problem to solve.
Recovery	At the heart of recovery is the idea that instead of focusing on the disease or pathological aspect of addiction (medical model), emphasis can be placed on the potential for growth within the individual. Recovery potential can be developed and integrated with medical, clinical, and social work treatments or interventions.
Recovery Capital Resources (RCR)	There are ten recovery capital resources referred to in this study. They are 1. Sobriety; 2. Psychological Functioning 3. Physiological Functioning; 4. Community; 5. Social 6. Meaningful Activities; 7 Housing/Safety; 8. Risk Taking; 9. Coping/Life Functioning, and 10. Recovery Experience.
Recovery Coaching	A form of strengths-based coaching support, as individuals seek recovery from alcoholism, drug use, co-dependence and other types of addictive behaviours. Recovery coaching and the CPRC program is based on a recovery-oriented framework.

Recovery Coach	The coach-practitioner that practices a non-clinical, coaching support. Recovery coaches do not diagnose and are often peers, who are not associated with any particular method or means to recover.
Recovery-Oriented	Recovery-orientation enhances and protects transition from addiction to recovery, utilising a strengths-based and client-centred approach. In order to stabilise the transition from SUD symptom management to recovery-orientation, the practitioner needs to trust and believe in the ability of the end-user, to be able to surmount the various limiting social, familial and cognitive beliefs systems learned in addiction.
Recovery-Oriented Systems of Care (ROSC)	Coordinated network of community-based services and person-centred supports. This recovery-oriented care builds on the strengths and resilience of individuals, families, and communities, to achieve abstinence. ROSC services seek to improve health, wellness, and quality of life outcomes, amidst prevalence of addiction issues, or risk thereof.
Relapse **Also: Lapse**	To fall or slip back into a former state of drug or alcohol use (addiction). Relapses have negative connotation and usually signals failure by an organisation to deliver successful 'funding' outcome. Relapses can be deemed as 'un-fundable' outcomes for medical insurance, rehabilitation, or other legal reasons, such as child support, divorce proceedings or probation.
Relapse Prevention Management Plan (RPM Plan)	The proper management of substance use and/or abuse issues through compliance with medication regimes or prevention of relapse instructions. Relapse prevention is a form of illness management, with an emphasis on minimising symptoms. Relapse prevention plans are different to recovery-orientation, in practice. Therapists, medical practitioners, social workers, and clinicians use a relapse prevention management plan.
Substance Use Disorder Disorder (SUD) **Also: Chemical Dependence** **Also: Addiction**	A diagnosis given to an individual, meeting criteria according to the Diagnostics and Statistics Manual, 5th edition (DSM-V). A person with SUD will have physical and/or psychological addiction/s to psychoactive (mind altering) substances, such as narcotics, medications, alcohol, or nicotine. Described to have diagnostic symptoms, such as craving/s, withdrawal/s, and inability to stop amidst ongoing negative effects. Tolerance to substances increase over time

Therapeutic Alliance (TA)	A good therapeutic alliance is a relationship consisting of three essential qualities: an emotional bond of trust, caring, and respect; agreement on the goals of therapy; and collaboration on the "work" or tasks of treatment. The collaborative dimension of the CPRC program shares the same qualities as TA, applied in a coaching context.
Treatment Principle/s (TP)	Effective treatment programs typically incorporates many components, each directed to a particular aspect of substance use disorder symptoms and its consequences. Addiction treatment help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in family, at work, and in society. Treatment principles operate from a philosophy of harm minimisation and underpin delivery of all AOD services, models of care, policy and procedure planning, performance, supervision and AOD workforce training. The 13 treatment principles covered in this study from the U.S. National Institute of Drug Abuse guide providers and practitioners in achieving a sustainable and coherent, AOD service that yields successful client outcomes.
Work-Based Learning (WBL)	The type of research conducted in the Professional Studies postgraduate program at the University of Southern Queensland, Australia. Work-based research is conducted in practice or work settings, where an influx of constantly changing new challenges and opportunities occur. These work challenges arise organically and often pose unforeseen risks that require academic skills to be developed. In WBL, rigorous methodologies and principles are applied, that formalise academic learning and translational research, at a postgraduate level.

CHAPTER ONE: INTRODUCTION

1.1 Introduction

The core problem being addressed in this research is how to maximise the long-term and ongoing health and wellbeing outcomes of those undergoing addiction recovery coaching. Classified as substance use disorder (SUD) by the Diagnostics and Statistics Manual, 5th edition (DSM-V), it was estimated by Collins and Lapsley (2008) that the social costs of alcohol, tobacco, and drug addictions to Australians in 2004-05 were $56 billion. Substance use disorders has become a worldwide problematic issue reaching pandemic proportions (Inaba & Cohen, 2014). Addiction treatment and alcohol and other drug (AOD) rehabilitation fall under the jurisdiction of the mental health (MH) sector, with various service provision models (Meadows, et al., 2019).

Substance use disorders is a diagnosis given to those experiencing addiction issues and have been described in the Diagnostics and Statistics Manual, 5th edition (DSM-V) as maladaptive patterns of substance use that lead to significant impairment across familial, relationships, social, financial, cognitive, physiology and neurological areas of an individuals' life (Center for Behavioral Health Statistics and Quality, 2016). Those with addiction issues find that their SUD can a) result in a failure to fulfil major role obligations; b) create or contribute to physically hazardous situations; c) hinder abstinence despite persistent and recurrent physical, psychological, social, occupational, and financial problems; d) increase tolerance levels; e) bring withdrawal symptoms when abstaining; and f) cause strong craving, resulting in a high amount of consumption and a great deal of time spent in obtaining substance. The American Psychiatric Association (2013) affirmed that even if only two of the above are symptomatic patterns occur in an individual's life, this may already determine a diagnosis of SUD. Symptomatic definitions are covered in Table 1 with further diagnostics discussed in Section 2.2.1.

Addiction or SUD treatment and alcohol and other drug (AOD) services fall under the jurisdiction of the Australian mental health (MH) sector. The National Mental Health Commission provide evidence and advice on ways to continuously improve the lived experience of individuals and their families, supporting the Australian community with various MH service delivery models. The National Mental Health Commission (2018, p. 18) quoted: "The undeniable fact is that people with severe mental illness live between 10 - 32 years less than the general population*"*. To augment SUD, services can include brief intervention, therapeutic communities, rehabilitation, detoxification, therapy sessions, crisis centres, mental health hubs and counselling (Marel, et al., 2016). Not-for-profit organisations, government-based allied health workers, the medical workforce and private practitioners deliver AOD/MH services Australia-wide (Australian Health Ministers' Advisory Council, 2013).

Alcohol and other drug, comorbid with mental health issues were found to be the fifth burden of disease, out of 291 diseases studied amongst 187 countries that participated in the Global Burden of Disease Study (Whiteford, et al., 2013). Delivery of AOD services cause major implementation issues across the rehabilitation and treatment sector. Despite medical discoveries, innovation, and improvements to alcohol and other drug services, prevalence rates continue to rise. There are eight barriers discussed in the literature review that impede successful AOD treatment outcomes. These include (Section 2.4):

1) Lack of governmental funding and financial incentives for alcohol and other drug workers impede rewards and productivity, in an environment driven by crisis situations (Ritter, et al., 2014).
2) Missed opportunities for screening problematic alcohol and other drug behaviours allow SUD to remain untreated (World Health Organisation, [WHO), 2002).

3) Use of pathology-based tools, instead of focus on recovery-oriented measures (White, 2010) may cause further stigma in individuals seeking service (Louma, et al., 2007).
4) Denial mechanisms experienced by those with SUD may prevent them from accessing the appropriate services or may cause them to remain ineffective while still in active addiction and accessing treatment (Abadinski, 2018; Doweiko, 2006; Perkinson, 2008).
5) Perceived or actual stigma experiences by those with SUD may make them less susceptible to take up treatment and when in treatment, less engaged in the treatment process (Louma, et al., 2007).
6) Lack of practitioner ability to understand how to engage using a strong therapeutic alliance (Ardito & Rabellino, 2011).
7) Lack of consistent self-care practices by workers in the crisis-driven alcohol and other drug sector contributed to high rates of workforce burnout (Skinner & Roche, 2005).
8) Lack of peer-based, SUD specialty training (Gagne, et al., 2018) and practical coach competency building skills (Reiss, 2015).

In order to stabilise the transition from SUD symptom management to recovery-orientation, the practitioner needs to trust and believe in the ability of the end-user to be able to surmount the various limiting social, familial and cognitive beliefs systems learned in addiction (AIHW, 2015). Recovery-orientation drives outcomes through engagement, accountability, and motivation (Deane, et al., 2014). The introduction of coaching brings into focus a recovery-oriented intervention derived from sports coaching as the ability to achieve a winner's mindset using a results-based outcome. The use of coaching and its competencies and approach are now being used and applied in the phenomena of substance use and abuse mitigation (Eddie, et al., 2019; Jack, et al., 2018).

Coined by Loveland and Boyle (2005), recovery coaching specifically addresses the challenges of an individual facing addiction through practical implementation of performance-driven techniques. Using this recovery coaching modality, fuelled by the recovery-oriented system of care (ROSC) framework (Australian Health Minister's Advisory Council, 2013), a goal focused regime was derived. Collaborative Peer Recovery Coaching (CPRC), the intervention used in this study focuses on this distinctive ROSC framework, with ten RCR dimensions and 50 sub-questions in total. This RCR scoring metric provides the narrative from which this qualitative study will be based upon, to answer the research questions posed in Section 1.4.1.

A Collaborative Recovery Model (CRM) is a practice model designed to incorporate processes that have been shown to assist people living within enduring mental illness (Deane, Andresen, Crowe, Oades, Ciarrochi & Williams, 2014).The CRM is designed to assist mental health workers provide services under the broad ROSC model. Similarly, the role of a CPRC practitioner is to help clients' concentrate on cultivating internal and external resources, encouraging them to build or ignite these emotional, financial, cognitive, and social resource reserves. Originating from the ROSC framework and sharing characteristics of the CRM model, the CPRC program's focus is on the cultivation of RCR's that promote a better way of life, amidst existence of substance use disorder/s (SUD/s).

1.1.1 Structure of Study

To guide the reader, Figure 1 represents the structure of the thesis by presenting the scope of problem addressed by this study and its corresponding chapter titles.

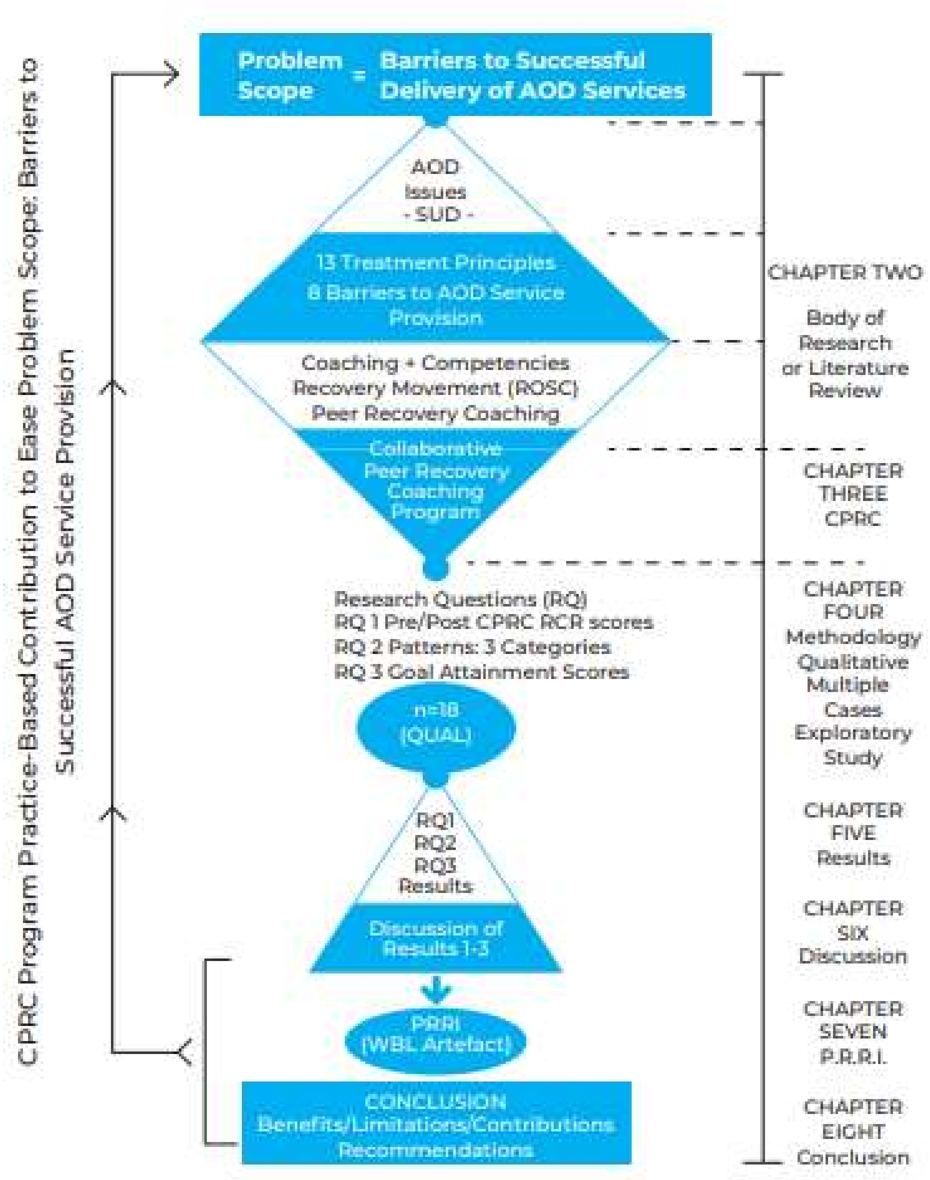


Figure 1 Conceptual Map of CPRC Study

A review of the literature will begin by stating various substances of abuse along with a short review of behavioural addictions and comorbidity issues associated with SUD. Workplace impacts will be briefly discussed to illustrate workforce implications of SUD. The thirteen (13) principles of treatment used in clinical and psychiatry settings (National Institute of Drug Abuse, 2018) will be reviewed next. This will be followed by eight (8) barriers that may impede successful delivery of alcohol and other drug services.

The coaching approach will be introduced in Section 2.5. In this section the coaching framework and coach competencies will be delineated. From this coaching and delivery of coach competencies standpoint, how recovery-orientation, the collaborative aspect and peer-supported delivery can be integrated together as a model of intervention, will be covered. Studies utilising recovery-oriented systems of care (ROSC), peer-delivered coaching that support goal attainment and behavioural change, will be analysed.

Chapter Three: Collaborative Peer Recovery Coaching (CPRC) will introduce the CPRC program as the chosen intervention. The CPRC program has been completed by an insider-researcher, and also the CPRC Practitioner (n = 1) in this study. This chapter will outline the four dimensions of the CPRC practice and discuss the coach competencies needed. It will be argued that the different competencies displayed by the coach, can lead to a coach effect.

Chapter Four: This chapter will discuss the work-based method utilised in this study, as offered by the Professional Studies program offered at the University of Southern Queensland (USQ). The methodology chapter will also discuss research design, data collection and data analysis processes.

The results of the CPRC scores will be reported as Result 1 in Chapter Five. Result 1 will be represented by the 50-point question responses, contained in the

chosen instrument used (called the ‘Assessment of Recovery Capital’ scale (Appendix A). Result 2 include reporting on the patterns observed, segmented in three categories (improved, did not improve or no negative change). Result 3 reports on self-rated goal attainment scores, ranging from 0-100%.

Chapter Six: Discussion will evaluate the three results. Inferences will include transcript examples that expand on the use of the four dimensions of the CPRC (collaborative, peer, recovery, and coaching) program. Improvements, if any on the RCR metrics will be discussed. Where utilised, the implementation of treatment principles or suggestions for future CPRC use will be integrated as salient points for discussion. Based on these discussion points, a work-based learning (WBL) artefact was developed, called the Principle-centred Recovery Resource Register (P3R). The P3R serves as a contribution of this study to practice-base, that provides professional knowledge, with preliminary AOD service delivery implementation suggestions.

As mentioned above, Chapter Seven: Principle-centred Recovery Resource Register (P3R) will be about the WBL artefact. In its initial development phase, the P3R emerged as a case management register for future AOD-practitioner use. It is hoped this case management register can support individuals with SUD and guide future practitioner delivery of any AOD/SUD/MH service. The P3R is based on cultivation of recovery capital resources to sustain long-term recovery, with the 13 principles of treatment foundational in its case management. The P3R has been gathered from peer-driven data used as the CPRC program was delivered from this study. Future users of the P3R must complete accreditation successfully.

The final chapter will conclude on the overall research outcomes, outlining how the research responded to the original research questions posited. Summary of the limitations of the study will be reiterated. In Chapter Eight: Conclusion, the triple-dividend contribution of the study will be evaluated as to how the study: 1. Contributed to AOD-practice; 2. Contributed a WBL artefact which may be useful for practice-

based implementation, and 3. Contributed to student learnings and academic development at a doctoral level. Recommendations will be made for practical use of research findings. Future research suggestions to be discussed in the final chapter will outline how other researchers may contribute to peer recovery coaching evidence-base in Australia, and consequently around the world.

1.2 Background, Scope, Purpose and Aims of Study

Inaba and Cohen (2014) outlined significant investments have been made to produce empirical literature intended to alleviate suffering, reduce mortality, and improve the quality of lives of individuals with SUD. Despite these significant investments, the United States of America (USA), continue to struggle to deliver high-quality healthcare and improve patient outcomes due to the systemic failure of the dissemination, adoption, and implementation of AOD/SUD evidence-based discoveries in a timely fashion (Inaba & Cohen, 2014). The same can be said for delivery of MH services in Australia, from which AOD/SUD service provision come under.

The 'Health of Queenslanders Report' stated 540,000 Queenslanders declared 'recent use' (use within the last three months') of an illicit drug (Qld Health, 2014, pp. 116-119). This equates to 15% of the Queensland (QLD) population having ingested drugs of abuse in the last three months and is equal to the Australian national prevalence (Qld Health, 2014). Cannabis is the most commonly used illicit drug (11% recent use prevalence), followed by ecstasy (2.7%), cocaine (2.3%) methamphetamine (1.9%), hallucinogens (1.4%) and heroin with 0.2% prevalence (Qld Health, 2014). With recent use prevalence rates rising, research on issues of alcohol and other drug should be a national and state funding priority and successful treatment outcomes should be reflected in AOD/MH reports. However, this has not been the case.

1.2.1 Lack of Australian Literature on Peer-Supported, Recovery-Oriented Coaching

Notable alcohol and other drug problems were witnessed in the criminal justice, court, legal, and hospital systems as prevalence rates for alcohol and other drug use worsened (Collins & Lapsley, 2008). Tangible and intangible alcohol and other drug costs and morbidity rates also began to rise. As the magnitude of social and economic challenges relevant to alcohol and other drug use continued to surface, the Australian workforce displayed compromised states of mental and physical well-being across many industries (Bush & Lipari, 2015; Najman, 2011; Pidd, Shtangey & Roche, 2008).

According to the Queensland Alcohol & Drug Research Education Centre (QADREC), studies regarding treatment of alcohol and other drug are still in the latent stages of research maturity and are often understudied, underfunded, and under-reported. (Najman, 2011). As mentioned in the Health of Queenslander Report (Section 1.2), persistent and ongoing concern about the detrimental impact of alcohol and other drug issues may not receive funding priority. According to Najman, the National Health and Medical Research Council (NHMRC) and Australian Research Council (ARC) have not allocated funding for alcohol and other drug research from 1980–1999. Therefore, in 2001, QADREC was established in collaboration with the Royal Brisbane and Women's Hospital, after receiving its first NHMRC and ARC grant.

Najman (2011) also noticed that there was little AOD-related curriculum content at the post-graduate or tertiary level. In collaboration with the Royal Brisbane and Women's Hospital, QADREC produced academic research on issues of AOD from 2001. Najman and his team of researchers began work that has now been published in major international journals. Najman (2011) elaborated that the negative and egregious effects of dependence on addictive substances and behaviours of

addiction reverberated throughout the nation. For this reason, QADREC started offering the only post-graduate study in the field of AOD studies, in 2008.

1.2.2 Purpose and Aims of Study

The purpose of the present study is to contribute to professional practice knowledge related to the implementation of an alcohol and other drug service based upon the recovery-oriented systems of care (ROSC) and the collaborative recovery model (CRM). The ROSC model has been defined as a person-centred, coordinated network of community-based services and recovery-oriented supports that builds on the strengths and resilience of individuals to achieve abstinence (Australian Institute of Health and Welfare [AIHW], 2015; 2018). Recovery-orientation relies on treatment and a medical model evidence-base, which enhances and protects the transition from addiction to recovery.

To further the aims of this study, it will be stated that traditional clinical talk therapy treats active addiction with a relapse prevention plan (Inaba & Cohen, 2014; Perkinson, 2008). Therefore, the treatment approach, with its strong research evidence-base and relevant efficacy rates to be discussed in the literature review, will provide the baseline knowledge for a suitably competent and qualified peer recovery coach to draw from.

Thus, another purpose of this study is to contribute peer-supported, recovery-oriented, addiction coaching literature for shared learnings. Consent has been granted by clients, who are eager to contribute to peer-driven research. As peers, verbalising their experiences have been driving factors in improving alcohol and other drug practice. As a mutual aim, the coach and client agree that lived experiences inspire others to seek recovery.

1.3 Anticipated Contributions of the Study

In executing this study, the researcher intended to contribute to triple dividend outputs. Instructions about the triple dividend outputs were given to students undertaking the Professional Studies program at the University of Southern Queensland, and forms part of their candidature presentation requirements (Fergusson, van der Laan, Shallies & Baird, 2020).

Ferguson et al. (2020) described the first part of the triple dividend to consist of contributing to practice-base knowledge. The second aim to aid in development of a work or practice-based artefact stemming from the research findings; and the last triple dividend aims to identify academic / personal skillsets to be developed, at a doctoral level. To meet the first part of the triple dividend, this study sought to contribute to professional practice knowledge that may provide insights into the practice of peer-supported, addiction recovery coaching. The study is contextualised around the issues faced by 18 participants in a particular Australian geographic location.

The contribution to the triple dividend from this study was the preliminary production of a case management register, developed according to the gaps reported from the results of the study. In the discussion of results, it was found that recovery orientation and continuous encouragement in meeting recovery goals were important. As the study progressed, a case management register (P3R) was developed and is in its pilot stage. It is hoped that P3R can be disseminated for use by other therapeutic providers, allied health workers and medical practitioners, working with people with SUD. Use of the P3R can provide data needed to measure RCR and treatment principles use in practice. In integrating the 13 principles of treatment, this study hopes to begin the collaborative process between alcohol and other drug teams, working towards a peer-supported, recovery-oriented practice. Chapter Seven offers suggestions in how to use the P3R which may guide future practitioners in employing

a uniform, principle-centred approach in the delivery of their chosen alcohol and other drug service.

The last triple dividend contribution was drafted at the beginning of the research undertaking and submitted for presentation, prior to being accepted as a doctoral candidate. In this report and presentation, the following were identified as anticipated contributions to the researcher's own professional and personal development goals:

- Problem Solving: increase quality of reflection in practice, utilising high ethical standards and codes of conduct within the field of recovery coaching.
- Critical Judgement: increase ability to refine judgment and facilitate client growth in increasing their recovery assets.
- Cultural Intelligence: strengthen evidence-based understanding of SUD.
- Problem Solving: consistent and ongoing application of strategic and logical thinking processes to be applied in a practice-based alcohol and other drug setting.
- Communication Skills: increase rapport building skills by matching and mirroring client language. Improve active listening skills.
- Reflective Learning: demonstrate stronger reflexive practices.
- Personal Potential: reinforce a deeper bond and therapeutic alliance through modelling of own daily self-care practices.
- Academic and Analytical Skills: development of dissertation writing skills by using academic language that is logical, informative, and concise. Improve data gathering and data analysis skills. Advance understanding of qualitative research processes, including robust methodology and better research design skills.

1.4 Methodology and Research Questions

This study will report multiple cases, as an exploratory, qualitative study (*n*=18), with constructivist approach. This study intends to examine the effects of the CPRC program (chosen intervention) on the recovery capital resources of those with substance use disorders (SUD). This research produced over 2000 pages of data, in the form of transcripts from the CPRC 10-12 sessions of 18 participants, engaged in the CPRC program from 2014 - 2016. The transcripts were collected from 216 hours of video recorded CPRC sessions, with the duration of coaching ranging from 3 to 10 months. Table 6 found in Section 4.4 of the Methodology Chapter (4), introduces the participants and summarise their presenting issues. Appendix B provides the pre- and post-CPRC RCR scores for each participant involved in this study,

The study sits within the Doctor of Professional Studies (Research) program at the University of Southern Queensland (USQ). The work-based learning (WBL) pedagogy is based upon a practice-based research framework, with the intention of making an original contribution to professional practice (Fergusson, van der Laan, White & Balfour, 2019; Stringer, 2007). One of its objectives is to pursue both work-based projects and research outcomes simultaneously (Fergusson, Harmes, Hayes, Rahman, 2020; Fergusson, et al., 2020). As this is a practice-based study, the practitioner is also the insider-researcher/student in the Doctor of Professional Studies (Research) program.

The student embarked upon learning formalised research methods to be applied within the scope of the insider-researcher's practice domain (Fergusson, et al., 2019b; Fergusson, et al., 2019d). As a learner/student of this doctoral studies program, the insider-researcher developed academic skills to be sharpened throughout the course of this doctoral journey.

The methodology used in this study is described in Chapter Four. In this chapter, the research design will be covered in detail. This includes how the participants were recruited, how data was collected and what data analysis procedures were implemented.

1.4.1 Research Questions

This study sought to respond to a work-based research problem that intends to make an original contribution to AOD service delivery and practice. The research question posed in the beginning of the study was:

> Will the use of the Collaborative Peer Recovery Coaching program affect recovery capital resource and goal attainment scores of individuals with substance use disorders?

With the above question as the foundation for this research's line of enquiry, sub-questions emerge warranting investigation of recovery-oriented assets or reserves, within these ten RCR dimensions (Groshkova, Best & White, 2013):

- abstinence or discontinuing of use of substances of addiction (RCR1)
- happiness and psychological wellbeing (RCR2)
- physical health, energy, and vitality (RCR3)
- citizenship and contribution to community (RCR4)
- high-level of social interaction and support (RCR5)
- productivity and opportunity seeking (RCR6)
- housing and ability to feel safe in one's domicile (RCR7)
- ability to manage finances and take calculated risks (RCR8)
- ability to cope/function well in a new life in recovery (RCR9)
- overall level of recovery progress (RCR10)

In answering the above questions, the study sought to respond to a series of sub-questions that provides a preliminary evaluation of the application of CPRC dimensions of practice. It is aimed that these findings can contribute to an understanding of how peer-supported, recovery coaching collaboration adds to the client's quality of life and recovery outcomes, after it was delivered.

1.5 Conclusion

This study conducted a preliminary evaluation related to the delivery of CPRC program and its potential effects on RCR and goal attainment capacity of the participants included in this study. These improvements and/or patterns of change were measured by RCR and self-rated goal attainment scores. Emergent patterns were categorised as: improved, no improvement, and no negative change. Participants presented with SUDs, along with a host of other co-morbidity issues (Table 6: Summary of Participants). Although co-morbidity and behavioural addiction form part of the SUD spectrum, the scope of this research will only focus on SUDs.

This chapter provided the necessary introduction to the problem being addressed by this research, including a background on the scope of the study. The purpose and aims of the study were discussed, along with outlining the anticipated contributions this research WBL project aimed to make. Figure 1 outlined the structure of the research.

Data collated from this study was derived from video logs and transcripts of CPRC sessions delivered to 18 clients (*n*=18). The duration of the CPRC program ranged from three to ten months and the research measures were informed by the pre- and post-CPRC, recovery capital resource scores (Dept of Health, VIC., 2013). Client RCR pre- and post-CPRC results originated from 216 hours of recorded coaching interactions, with over 2000 pages of transcripts yielded. This dataset intends to

contribute insights into the phenomenon of peer-delivered, recovery-oriented, coaching of participants with ongoing, persistent and chronic SUD issues.

The next chapter will provide a review of the extant literature as it relates to the prevalence of substance use disorders (SUD), Chapter Two will also cover principles of AOD treatment, barriers to successful treatment outcomes and set about to introduce coaching and the peer recovery coaching model. Research relevant that responds to the research questions posed in this study, will be covered

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter provide an overview of the literature informing the need for developing a uniform peer-delivered, recovery coaching approach to addiction treatment. The first section provides diagnostic classifications for SUD defined by the Diagnostics and Statistics Manual, 5th edition (DSM-V). As part of Section 2.2, relevant literature on legal and illicit substance use/abuse issues will be reviewed. Global studies will be included, to guide a comparison of AOD prevalence across nations. Then a brief discussion of existing medical, economic and cartel systems contributing to the AOD end users' propensity for chemical and behavioural dependence will be included in Section 2.2.1 - 2. The Illicit drug trade will be discussed, to help the reader recognise the "unseen and unheard' world of illicit drug traders, that profit from this detrimental proliferation of substances of abuse. Since the phenomenon of SUD includes behavioural addictions and comorbidity issues, both of these issues will be briefly discussed in Section 2.2.2 - 3.

A brief overview of detrimental impacts of SUD in the workplace will be discussed. After which, 13 principles of treatment will be discussed, intended to guide better implementation of drug and alcohol services in Australia (Section 2.3). After the discussion of treatment principles, barriers faced by the AOD practitioners are covered, then coaching and recovery coaching concepts and relevant research, will be introduced. Figure 2 is divided into five major sections, outlining how Chapter Two will be presented.

SUBSTANCE USE DISORDERS

LEGAL SUBSTANCE DEPENDENCE
Alcohol
Medication
Tobacco

DRUG SYNDICATED SALE OF ILLICIT SUBSTANCES
Heroin
Coccaine
MDMA
Raving Culture
Marijuna
Methamphetamine

PLUS:
COMORBIDITY
BEHAVIOURAL ADDICTIONS
SEVERE & COMPLEX
Inter linked Issues

Section 2.1-3
2.2.1 - 3

PROBLEM SOURCE

THIRTEEN PRINCIPLES OF TREATMENT

Treatment Principle Code
1 NEUROPLASTICITY
2 UNIQUENESS
3 IMMEDIACY
4 RECOVERY RESOURCES
5 1-YEAR OPTIMUM
6 ACTIVITIES
7 PHARMACOLOGY
8 ONGOING ASSESSMENT
9 COMORBIDITY
10 DETOX:1ST STEP ONLY
11 REWARDING
12 RELAPSE GUARANTEED
13 MULTIPLE SCREENS

Section 2.3

MITIGATION PRINCIPLES

BARRIERS TO TREATMENT SUCCESS

LACK OF	
Funding & Focus	AOD Specific Training
Screen for AOD issues	Self-care Practices

DENIAL MECHANISMS + PRIVACY
STIGMA
THERAPEUTIC ALLIANCE
FOCUS ON DISEASE or MEDICAL MODEL

Section 2.4

PROBLEM SCOPE

USE OF COACHING MODEL

- full accountability
- building capabilities and competencies as a coach
- authenticity and transparency encouraged
- use of video and audio recording for personal and professional development for both client and coach

FOCUS ON:

- strategy & peak performance
- goal attainment
- coach competencies
- motivation
- client autonomy
- victory mindset

Section
2.6.1
2.6.2
2.6.3

PEER RECOVERY COACHING

- Use of recovery movement systems of care (ROSC)

CAPABILITIES TO BUILD

1. Own Alcohol & Other Drug (AOD) knowledge-base to be Continually added to be developed
2. Own Recovery Capital Resources (RCR) and Client's RCR are both important to cultivate
3. Sharpen Storytelling Skills
4. Own & Clients' Resilience
5. Therapeutic Alliance
6. Strengthen own self-care practice and Positive role modelling behaviours to inspire client's capacity

Section 2.5
2.6.3-5

ADDRESSING PROBLEM WITH VIABLE APPROACH

***Figure 2**:* Literature Review Summary Map

2.2 Substance Use Disorder and Related Issues

A definition and related symptoms of substance use disorder (SUD) are a prerequisite for this literature review. The Centre for Behavioural Health Statistics and Quality (2016) reported in detail about the necessary changes made when the Diagnostics and Statistical Manual of Mental Disorders (DSM) was revised from its fourth (DSM-IV) to its fifth iteration (DSM-V).

The Centre for Behavioural Health Statistics and Quality (2016) defines SUD as a *maladaptive pattern of substance use leading to significant impairment or distress across some or all areas of an individuals' lifespan*. When presenting for an alcohol and other drug assessment, an accurate diagnosis can be reached if any two or three of 11 criteria outlined in Table 1 apply (Center for Behavioral Health Statistics and Quality, 2016). In Table 1, each category of substance is classified. Each category, such as stimulants, sedative/hypnotic etc., are described, along with matching symptoms that define the biological and psychological markers, characteristics and effects of SUD.

Table 1 provide the comprehensive diagnostics, used to assess for each substance of dependence, from three different sources (DSM-IV, DSM-V and National Survey for Drug Use and Health). Apart from meeting two or more of the criteria, occurring as a subset of issues, symptoms are recognised by current DSM-V diagnostics as psychiatric disorders, falling under the SUD category.

As outlined in Table 1, the history of iterative changes helps the suitably qualified physician or clinician to accurately diagnose the client's presenting issues. Once symptoms have been assessed and diagnosis given, appropriate course of medication can be prescribed and AOD case management can begin. Referrals can also be made for ongoing, relevant treatment.

Table 1:

DSM-IV to DSM-V Diagnostics Criteria for SUD

Substance	Symptom	DSM - IV	DSM - 5	NSDUH
Alcohol	Two or more symptoms	√	√	√
	Autonomic hyperactivity	√	√	√
	Increased hand tremor	√	√	√
	Insomnia	√	√	√
	Nausea or vomiting	√	√	√
	Transient visual, tactile, or auditory hallucinations or illusions	√	√	√
	Psychomotor agitation	√	√	√
	Anxiety	√	√	√
	Generalized tonic-clonic seizures (formerly grand mal seizures)	√	√	√
Cannabis	Three or more symptoms	√	√	√
	Irritability, anger, or aggression	√	√	√
	Nervousness or anxiety	√	√	√
	Sleep difficulty (i.e., insomnia, disturbing dreams)	√	√	√
	Decreased appetite or weight loss	√	√	√
	Restlessness	√	√	√
	Depressed mood	√	√	√
	At least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache	√	√	√
Cocaine	Dysphoric mood and two or more symptoms	√	(See Stimulant Use)	√
	Fatigued	√		√
	Vivid, unpleasant dreams	√		√
	Insomnia or hypersomnia	√		√
	Increased appetite	√		√
	Psychomotor retardation or agitation	√		√
Hallucinogens and Phencyclidine	No withdrawal diagnosis			
Inhalants	No withdrawal diagnosis			
Opioid	Three or more symptoms	√	√	√1 √2
	Dysmorphic mood	√	√	√1 √2
	Nausea or vomiting	√	√	√1 √2
	Muscle aches	√	√	√1 √2
	Lacrimation or rhinorrhea	√	√	√1 √2
	Yawning	√	√	√1 √2
	Pupillary dilation, piloerection. or sweating	√	√	√1 √2
	Diarrhea	√	√	√1 √2
	Fever	√	√	√1 √2
	Insomnia	√	√	√1 √2

(continued)

Source: Centre for Behavioural Studies, 2016.

Substance	Symptom	DSM - IV	DSM - 5	NSDUH
Sedative, Hypnotic or Anxiolytic	Two or more symptoms	√	√	
	One or more symptoms			√3.4
	Autonomic hyperactivity	√	√	√4
	Hand Tremor	√	√	√4
	Insomnia	√	√	√4
	Insomnia or hypersomnia	√	√	√4
	Nausea or vomiting	√	√	√4
	Transient visual tactile, or auditory hallucinations or illusions	√	√	√4
	Psychomotor agitation	√	√	√4
	Anxiety	√	√	√4
	Grand mal seizures	√	√	√4
Stimulant	Dysphoric mood and two or more additional symptoms	√	√	√
	Fatigue	√	√	√
	Vivid, unpleasant dreams	√	√	√
	Insomnia or hypersomnia	√	√	√
	Increased appetite	√	√	√
	Psychomotor retardation or agitation	√	√	√
Tobacco	Four or more symptoms	√	√	
	Irritability, frustration or anger	√	√	
	Anxiety	√	√	
	Difficulty concentrating	√	√	
	Increased appetite		√	
	Increased appetite or weight gain	√		
	Restlessness	√	√	
	Depressed Mood	√	√	
	Insomnia	√	√	
	Decreased heart rate	√		
Other Substance	A syndrome of substance-specific symptoms that causes clinically significant distress or impairment in social, occupational, or other areas of functioning	√	√	

DSM-IV = *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition; DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition; NSDUH = National Survey on Drug Use and Health.

NOTE: Caffeine is not included in NSDUH assessments in any form and is therefore excluded from this table.

[1] Specifically Asked for heroin
[2] Specifically Asked for pain relievers
[3] This is being changed to two or more symptoms in the 2015 redesign
[4] NSDUH assesses sedatives and tranquilizers in seperate modules; withdrawal symptoms are not assessed for tranquilizers.

Source: Centre for Behavioural Studies, 2016.

Addictive pharmacological drug use and especially tobacco use are receiving political scrutiny, heavy taxing, and regulation (Collins & Lapsley, 2008; Magnus, et al., 2012). Economic savings and health benefits from reduced tobacco, alcohol and medication use have been correlated to decrease in SUD related burden of disease and injury (FARE, 2019; Magnus, et al., 2012; Whiteford, et al., 2013). Section 2.2.1 will explore the legal and illicit trade as a backdrop of how the availability of these various catalyst substances propagate an individuals' susceptibility to develop SUDs.

2.2.1 Substances of Abuse

Drugs and drug use are popular and dynamic areas of study, as newer drugs are being discovered, and being introduced to youth and mainstream society (Abadinsky, 2018). Lim et al.(2012) verified that addiction and mental illness contributed to 183.9 million disability adjusted life years (DALY) in 189 countries studied in 2010. In epidemiology, one DALY is a 'healthy' year of life lost to disease or disability (Lim, et al., 2012). In discussing substance use disorders, the following are descriptions of the types of substances that are relevant.

Legal Substances Known for Abuse. In 2012one trillion dollars in revenue was shared by pharmaceutical conglomerates (Inaba and Cohen (2014). The National Institute of Drug Abuse (2015) reported around 40,000 a year die from prescription drug abuse effects. Inaba and Cohen (2014) further noted that four billion US prescriptions of highly addictive substances, such as methadone, opiates (Vicodin and Oxycontin), fentanyl, benzodiazepines (Xanax, Ambien and Valium), methaqualone (Quaalude) and barbiturates/sedative hypnotics were dispensed in 2012. Moreover, in the same year, emergency room visits for addictive central nervous system (CNS) prescription medications, arose from 472,000 in 2004 to 1,043,000.

The Australian Pharmaceutical Benefits Scheme (2019) reported 793 medicines in 2,066 forms, yielded $9.1 billion in revenue against 211 million

prescriptions subsidised in 2018-19. Like any of the commonly used substances of abuse, prescription medications will have negative effects for those that become dependent (FARE, 2019). The cumulative effects of drugs ingested, combined with repetitively ingrained behavioural habits of addiction, become hard to break over time (Abadinsky, 2018). Use and abuse of substances also severely compromises overall mental health and functioning (Maisto, Galizio, & Connors, 2015; Perkinson, 2008). It has been shown that any substance, if used long-term without the proper clinical guidance and regular ongoing assessment from a suitably skilled, medical practitioner, may be abused (Abadinsky, 2018; Perkinson, 2008). As such, these substances of abuse lead to multiple, ongoing negative ramifications not only in the individuals' lives but those of their family, and the community at large (Manning, et al., 2017).

Illegal Substances and the Illicit Drug Trade. All eighteen study participants have been directly affected by the illicit drug trade. Strategic placements of illicit substances remain an important backdrop to the phenomena of substance abuse (Alsema, 2015; Kim, 2014; Oh, 2000). Illustrative examples come from Australia, Europe, The Philippines, Mexico, Columbia, UK, Canada, and Ibiza. Knowledge of cartel systems aid in understanding how the global illicit drug trade promotes mass consumption and societal detriment, that extends beyond direct effects of drug use (Alsema, 2015; Kim, 2014). Cartels profit from the susceptibility of vulnerable end users. For example, teen uptake has been highly correlated to long-term dependence, extra negative effects and higher mortality rates (Oh, 2000). Therefore, hindering the proliferation of drugs, most especially to youths, is critical (Coleman & Haggell, 2007).

Heroin. The Medically Supervised Injection Clinic (MSIC Evaluation Committee, 2013) in Kings Cross, Sydney NSW reported 56,861 heroin visits in the 2002-03 annual period, reflecting heavy distribution by illicit drug traffickers in metropolitan cities of Australia. Among a total 3,810 intravenous drug user (IDU) registrations, 66% had already received drug treatment and rehabilitation in the past

(MSIC Evaluation Committee, 2003). The average duration of dependence for an IDU was around 12 years of continuous use (MSIC Evaluation Committee, 2003).

The European Monitoring Centre for Drugs and Drug Addiction (2016) estimated that the Balkan and northern routes are the main heroin trafficking corridors linking Afghanistan to the markets of the Russian Federation and Western Europe. The Balkan route traverses the Islamic Republic of Iran (often via Pakistan), Turkey, Greece, and Bulgaria across Southeast Europe to the Western, Eastern and Southern European markets, with an annual market value of some EU$20 billion. Drug dealing in Europe brings billions of euros a year to criminals and provides financing for other criminal activities such as terrorism, sex trafficking, armament trade and migrant worker smuggling (National Drug Intelligence Centre, 2001).

Stimulants: Methamphetamine and Cocaine. In Mexico, Kim's (2014) research led him to discover that the illegal drug trade cartels spent around USD$500 million a year in bribery monies alone, to facilitate alliances with the Mexican government and money-laundering institutions.

Alsema (2015) reported coca farming as the top crop produced in Columbia, where an aggregate area of between 69,000 - 112,000 hectares produced the country's cocaine supply. It has been estimated that around 300,000 Columbian farmers and their families, live off coca farming. It has been known that illicit drug traffickers operate a similar type of system in Australia (Caldicott, Pigou & Edwards, 2005).

Youth Uptake of Synthetic Drugs. Adolescents who abuse drugs act out by truancy, poor academic performance, unplanned pregnancy, inability to pursue further higher education, and resistance to acquiring more purposeful pursuits of contribution to family and society (NIDA, 2018). Adolescent illicit drug uptake is on the rise with the existence of "rave parties" throughout the United States, Australia,

Canada, Europe, Mexico, and Asia (Bellis, Bennett, Chaudry, & Kilfoyle, 2010; Kim, 2014; Oh, 2000; Weir, 2000). Drugs such as MDMA (3,4-methylenedioxy-methamphetamine), ketamine, GHB (gamma-hydroxybutyrate), Rohypnol, and LSD (lysergic acid diethylamide) have become an integral component of the rave culture (Teter & Guthrie, 2001). For example, in Canada, a survey into youth trends and values found that 5% of 3,500 subjects aged 16 to 29 had attended one or more raves in the past year and every year around 50,000 ravers are committed to 'raving' (Oh, 2000; Weir, 2000).

Bellis et al. (2010) interviewed 846 individuals (15 to 35-year-olds) in Ibiza, a famous hedonistic summer party destination. As Bellis et al. (2010) interviewed participants returning to the United Kingdom (UK) in Ibiza airport, they found that young respondents altered their patterns of drug, alcohol, and tobacco use, where 2.9% of users (9/313) used 5 or more days a week in the UK but while in Ibiza this rose to 42.6% (127/298). The participants in this study also reported risky behaviours, such as unprotected sex and having sexual intercourse, with more than one partner simultaneously.

Cannabis. In Australia, the National Drug Strategy 2016 Household Survey (AIHW, 2019) reported cannabis was the most commonly used illicit substance. Guerin and White (2018) surveyed more than 23,000 secondary students (aged 12 – 17 years old) and found that 18% admitted using cannabis (a slight increase from the 17% reported in 2014). Eight percent of the respondents had used in the month prior to the survey (up from 7% in 2014) and 5% of the young participants (n=1145, up from 4% in 2014) had used in the prior week.

2.2.2 Behavioural Addictions

Though not the focus of this study, brief discussion behavioural addictions are still relevant. A study completed by Albrecht, Kirshcner and Grusser (2007) described forms of addictive behaviours as follows:

1. Pathological gambling – the most common form of behavioural addiction. Diagnostic instruments for assessing excessive gambling are derived from the existing diagnostic criteria of the classifications of mental disorders (ICD-10, DSM-IV and V), in which pathological gambling was classified as an impulse control disorder but operationalised as an addiction.
2. Pathological buying – a tendency to spend, feeling an urge to buy or shop, post-purchase guilt, and family environment negatively affected.
3. Exercise addiction – overcommitting to physical activities to experience the dopamine 'high' brought about by excessive exercise performance, and not being able to cope without this intensity of exercise habits, with negative ramifications.
4. Workaholism – propensity to work overtime or more than the typical 38 hours of a normal work week, leading to symptoms of burnout. This 'burnout' phenomenon is explained in detail in Section 2.4.7 as one of the barriers to effective AOD service provision.
5. Computer and internet addiction – initially reported in children and teenagers who excessively played video games as an escape. Computer and internet addictive behaviours are a coping mechanism to allay peer pressure. Research on video gaming behaviour in adolescence, are now examining overall internet and social media addiction. A study by Kim et al. (2017) found that computer and internet addiction was significantly associated with depression and may be used as a means to escape negative emotions (*n* =1401).
6. Sex and porn addiction - high frequency of risky sexual behaviours, including loss of control and development of tolerance that lead to erectile, marital and familial dysfunctions. Sex or porn addiction issues find origin from adverse childhood experiences, such as childhood trauma or severe developmental issues.

2.2.3 Comorbidity Issues

Comorbidity, coexisting, co-occurring or dual diagnosis are well-known interchangeable terms described as the existence of substance use disorder/s (SUD/s) along with another medical condition (Marel, et al., 2016). According to Marel et al. (2016), a significantly high number of AOD end-users have poly-drug use, co-morbidity issues (<90%). It is important to consider comorbidity since the phenomena of addiction will invariably be related to comorbidity of other medical and/or MH issues. Marel et al. (2016) examined the effect of comorbidity issues and found that major depressive disorders were the second largest cause of disability burden of Queenslanders in 2010.

Depression coupled with substance use disorders contributed significantly to social harm. Those that declare SUD, also declared anxiety, and the Department of Social Services (2013) confirmed that 256,380 Australians declared a psychological impairment as their main medical condition for receiving disability support pension (DSP). This reiterates the importance of successful treatment outcomes so that detrimental costs of AOD/MH comorbidity issues to individuals and families can be mitigated.

2.2.4 Workplace Impacts of Substance Use Disorders

Bush and Lipari (2015) revealed that high levels of problematic drinking and illicit drug behaviours impacted workplaces across many sectors. Adverse effects have been documented for workers in the mining, hospitality (Eade, 1993), trades, medical, allied health, legal, and AOD field—effects that extend beyond the personal and familial. It also affects to the safety of other co-workers and the fortunes, liberty, and lives of legal/medical/trades clients/patrons/patients.

Pidd, Shtangey, and Roche (2008) presented a comprehensive examination of the prevalence and patterns of alcohol use among the Australian workforce. They

provided a companion report addressing 2004 National Drug Strategy Household Survey (NDSHS) data on drug use by the Australian mining workforce. They reported that alcohol use by workers in the mines is implicated in 5% of all Australian workplace deaths and 25% of all workplace accidents. Roche, Pidd and Bywood (2007) corroborated this with findings, indicating methamphetamine use by tradespeople in Australia contributed to work fatalities and traumatic injuries.

Carrington, Hogg, and McIntosh (2011) detailed adverse effects of substance use in the mining sector, affecting mining communities with high rates of SUD hospitalisation and mental health issues. Their study measured the serious social impacts of drug abuse by mining workers coping with 12-hour-day, two weeks in- and two weeks out-of-town shift schedules (called 'fly-in, fly-out' or FIFO). Negative community effects of SUD in this work sector include high levels of violence and crime. These SUD issues in the mining industry continue to escape industry, governmental and academic scrutiny (Carrington, Hogg & McIntosh, 2011).

A further example of the negative impact of workplace SUD was reported by Mote et al.(2002) in reference to SUD in the law sector. They found that lawyers displayed high rates of depression and estimated that it may be close to four times the rate of depression found in the general US population. This was the first study of its kind specific to law makers, legal administrative staff, and lawyers in America.

The National Institute of Drug Abuse (2015) indicated that American doctors, nurses, and allied health professionals constantly exposed to mind-altering medications develop greater propensity to self-treat. This self-treating dependence fostered a false sense of control and alleviated worker exhaustion after performing long, taxing hours in the hospital system (NIDA, 2018).

Lessening chemical dependence and addictive behaviours in the workplace should remain a national priority. Treatment provision should be guided by set principles. The next section proposes thirteen principles that should guide a uniform approach backed by a national framework for practice-based delivery for AOD services across clinical, not-for-profit, and community settings.

2.3 Thirteen Principles of Treatment

In Australia, around four million Australians experienced a mental illness in any given year (Marel, et al., 2016). As treatment of SUD fall under the mental health/illness sector for care, a majority concur that the need for action and mental health reform has been forthcoming and critical (Department of Health and Human Services, 2011). This rising prevalence of mental health issues commissioned reform through various reporting metrics that were drafted, implemented, and evaluated by Professor Allen Fells, AO in 2012, 2014 and 2018 (National Mental Health Commission, 2018). The said reports included nationwide report cards, mental health factsheets and departmental reports disclosing the mental health and suicide prevention reform details from its infancy (2012), during its development (2014) and as it further evolved (2018). The three separate reports from each timeframe highlighted the existing complexity, inefficiency, and fragmentation of the Australian mental health system (National Mental Health Commission, 2018). At time of writing, a uniform best-practice treatment model, is not yet available for implementation across the Australian AOD sector for all AOD workers.

In the U.S., the National Drug Abuse Treatment Clinical Trials Network in 1999 produced data for NIDA, from more than 20 years of research studies. Its intention was to aggregate data that sought to improve the quality of addiction treatment derived from community-based drug abuse treatment programs, and university-based research centres (NIDA, 2018). As this collaboration developed over the years, 11,000 participants contributed pharmacological, behavioural, and

integrated treatment intervention data across 20 trials. With this evidence-base, NIDA (2018) introduced 13 principles of treatment to address addiction issues as a whole of body threat, rather than simply a somatic, medical issue. Table 2 provides a short summary for each of the 13 principles from the NIDA research.

Table 2:

Thirteen Principles of Treatment Summary

#	Treatment Principle (TP) Code	Competency Summary for AOD Practice-Based Implementation
1	NEURO	Clearly communicate that recovery is a life-long and difficult process where altered brain states have long-term negative implications.
2	UNIQUE	Each person has unique needs and experiences requiring ongoing assessment. Must be matched to appropriate treatment, clinician temperament/cultural competencies.
3	IMMEDIACY	Immediate and responsive treatment is paramount as >70% of those that do need help need immediate critical care that it is readily available.
4	RESOURCES	All resources needed for recovery must be addressed, ensuring quality of life integration
5	ONE-YEAR	Research provides data that a year in AOD care or treatment is optimum. Long-term outcomes with severe and complex issues need at least three months in intensive care.
6	THERAPY	Behavioural and cognitive talk therapies must cover the full spectrum of life, including discussion of life purpose, meaning and all other aspects.
7	PHARMA	Pharmacology is deemed of importance in treatment of many patients by the medical profession.
8	ASSESS	Flexibility is needed to accommodate needs as it changes or evolves over time whereby continuous assessment is necessary to uncover needs, as they arise.
9	COMORBID	Comorbidity issues must be addressed and treated, such as depression, anxiety, and a host of other medical issues. Treatment should assess and address all issues at the outset.

10	DETOX	Withdrawal and detoxification are merely the beginning of the recovery process hence circumstances, ramifications and timeline of recovery must be addressed.
11	REWARD	Enticements, rewards, and motivation must be offered to increase the chances for ongoing treatment. Individuals must be kept engaged about recovery and excited about the future.
12	RELAPSE	As it is known that relapse is guaranteed, treatment plan must be continually adjusted for understanding of triggers that will help withstand urges and cravings.
13	SCREEN	Other medical issues are exacerbated by SUD, therefore testing of issues, such as HIV/AIDS, Hepatitis B/C, and tuberculosis should be provided, along with risk-reduction counselling.

Source: National Institute of Drug Abuse [NIDA], 2018.

Chemical dependence includes alcoholism and is a major health and social problem in the US (Inaba & Cohen, 2014). Not adhering to these sets of treatment principles impede successful treatment outcomes (Ritter, et al., 2014). The National Institute on Drug Abuse in the US researched a wide variety of effective approaches to treatment of alcohol and other drug addictions (Tai, et al., 2010). It is beyond the scope of this thesis to focus on any specific treatment modality. The next sections will consider previous research related to principle-based treatment that may mitigate negative impacts of SUD. From decades of research, NIDA (2018) concluded that these 13 treatment principles were foundational in AOD care that produces positive outcomes.

2.3.1 Treatment Principle 1: Neuro

Addiction affects brain circuitry, motivation, learning, memory and homeostasis (Pascual-Leone, et al., 2005). Symptoms stemming from SUD compromises aetiology of disease that affect the cardiovascular, epidermal, skeletal, lymphatic, nervous, hormonal, circulatory, digestive, immune, renal, urinary and muscular systems (Abadinsky, 2018; Pascual-Leone, et al., 2005). Prolonged SUD

erodes a person's self-control and as tolerance and/or cravings increase, so too may compulsive, violent, depressive, neurotic, and/or dysfunctional behaviours, increase (Doweiko, 2006). Drug and behavioural addictions become more complex and multidimensional over time, severing much-needed healthy synaptic connections (Inaba & Cohen, 2014).

Neuroplasticity is the ability of the billions of pre-frontal and limbic parts of the brain to be moulded via cortical and neurological pathways, such as when excretion or inhibition of dopamine, serotonin and/or oxytocin takes effect (Pascual-Leone, et al, 2005). It has been posited that the most pertinent understanding emergent in the field of present-day AOD treatment is concentrated effort in how to break, interrupt or ameliorate patterns interfering with biological homeostasis (Pascual-Leone, et al., 2005).

Volkow (NIDA, 2018) noted that future research should harness results from studies in genetics, gene expression, and neuroplasticity to guide in the integration of treatment practices that optimise and strengthen synaptic wirings. To better understand trauma-informed care and the long-term effects of SUD on the brain systems, the AOD end-user needs to be equipped with these types of information, as needed.

2.3.2 Treatment Principle 2: Unique

Evidence continues to validate the uniqueness of the individuals' multiple and complex needs as they enter the phase of early recovery (NIDA, 2018). These unique developmental attributes and characteristics should be matched with relevant other services as the relapse prevention and treatment plan is developed and as they are made known to the AOD worker. For this to happen, an ongoing assessment of unique needs, traits and experiences must be discussed in an ongoing basis (White,

2008; Wiener, 1999) This also relates to Treatment Principle 8: Ongoing, and Treatment Principle 9: Comorbidity.

In assessing the uniqueness of client situation, the interplay between client characteristics and their drug use portfolio must be explored. Once critical information has been gathered, clients must be matched to appropriate treatment settings and professionals. Clinician's temperament, background, expertise, and cultural competencies must be considered, when matching client for a long-term engagement with practitioner (Perkinson, 2008).

2.3.3 Treatment Principle 3: Immediacy

The National Centre for Education and Training on Addiction, led by researchers Kostadinov, et al. (2017) evaluated drug and alcohol first aid programs. They concluded that immediate and responsive treatment is essential. With over two decades of empirical data, NIDA (2018) found that 70% of those that may need help, may not be equipped with the cognitive, mental and emotional resources needed to seek it. Therefore, when treatment is sought, it is critical that it be readily available, and clients/patients are immediately engaged with the practice.

2.3.4 Treatment Principle 4: Resources

Cultivation of recovery capital assets assesses resources necessary to enhance quality of life and contribution to a greater good (Sterling, Slusher & Weinsten, 2008; White & Cloud, 2008). An AOD practitioner should focus the client on increasing recovery capital resources across ten dimensions: 1) sobriety; 2) psychological; 3) physical; 4) community; 5) social; 6) activities; 7) safety; 8) risks; 9) coping and 10) quality of recovery. With this strengths-based focus, tracking of recovery resources increases the client's motivation for transformational change.

2.3.5 Treatment Principle 5: One-Year

A year in continuum of alcohol and other drug care or treatment is optimum, with numerous research articles reporting that the more time spent in quality rehabilitative care, the better the long-term quality of life outcomes will become (Inaba & Cohen, 2014; NIDA, 2018; Tai, et al., 2010). Those with severe and complex issues need at least three months in intensive care (Marel, et al., 2016; NIDA, 2018). The duration of treatment is dependent upon the types of substance/s that the individual has been consuming (Best & Laudet, 2010. To assess duration for treatment, gathering details of first drug use, current dosage/s consumed and timeframe of use are useful (Best, et al., 2015). Recovery from SUD, like other chronic illness, require multiple and ongoing treatment, therefore leaving or discontinuing treatment prematurely, will lead to adverse effects (Best, 2012)

2.3.6 Treatment Principle 6: Therapy

Talk therapy should address all areas of life, encouraging proof of participation in various activities (Wiener, 1999). Cognitive therapies must cover motivating the client to be involved in the full spectrum of life, including discussion of life purpose, and meaning. Talk therapy should include incorporating actions that ensure clients attend to their financial, spiritual, social, cognitive, emotional, fitness, educational, career, business, and risk-taking needs and/or ventures (Groshkova, et al., 2013; Perkinson, 2008). Proof of participation in various activities form part of the conversation (Wiener, 1999).

2.3.7 Treatment Principle 7: Pharma

The medical model recommends relapse prevention pharmacotherapies, considering naltrexone, methadone, and buprenorphine of importance in treating SUD in patients (Marsh, O'Toole, Dale, Willis, & Helfgott, 2013). Combined with counselling and other behavioural therapies, pharmacotherapies provide relief or amelioration of psychological issues such, as anxiety or depression (Marsh, et al.,

2013; NIDA, 2018). Use of pharmacology and pharmacotherapies must be delivered by a suitably qualified clinician or physician.

2.3.8 Treatment Principle 8: Assess

Treatment must be flexible and continuously assessed over a longer-term period (see Treatment Principle 5: One-Year). As an example, Jenner and Lee (2008) investigated engagement and retention of stimulant users in a residential rehabilitation centre. They found that residents benefitted from an individually tailored, continuously assessed and flexible rehabilitation plan. This plan accounted for the newly abstinent user's potential for impulsivity, irritability, paranoia, intense cravings, and memory impairment (Jenner & Lee, 2008). Flexibility and ongoing assessment is vital. Flexibility in care accommodate needs, as they negatively change or positively improve, over time (Marsh, et al., 2013).

2.3.9 Treatment Principle 9: Comorbid

Most clients present with a form of diagnosable mental health disorders that interfere with progress, e.g., anxiety or depression will impede overall client functioning (Marsh, et al., 2013). Treatment should assess and address depression, anxiety, and other relevant medical issues at the outset (Marel, et al., 2016). This helps in managing clients' continuum of care (Marsh, et al., 2013). It is important that counsellors be alert for symptoms of mental health issues, as they help clients manage their ongoing recovery (Marel, et al., 2016). Depending on the severity of mental health issues, AOD workers should consider integrating strategies to address them into their case management approaches. A vetted referral pathway should be available to refer clients for medication management, or other specialised psychological, and/or AOD-related mitigation services (Marel, et al., 2016; Marsh, et al., 2013).

2.3.10 Treatment Principle 10: Detox

Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal, clearing the body of toxins to minimise physical harm, delirium and/or even sudden death (Center for Substance Abuse Treatment, 2006). Management of life-threatening intoxication requires specialist detoxification medical knowledge (Center for Substance Abuse Treatment, 2006). For many, detoxification represents their first point of contact with the treatment system, and a first step to recovery. Management of withdrawal symptoms and detoxification are an acute and emergent stage, where circumstances and ramifications that led to long-term drug abuse are not dealt with (Center for Substance Abuse Treatment, 2006).

Allied health and medical workers should take care to ensure the patient can easily get into a detoxification program. A detoxification program helps avoid the myriad of short-, mid- and long-term negative consequences associated with substance abuse (e.g., physiological, and psychological disturbances/disorders, criminal involvement, unemployment, etc.). Detoxification also helps stabilise the patient, when the intoxication crisis has passed.

2.3.11 Treatment Principle 11: Reward

For alcohol and other drug treatment to have its' full remedial effect, it needs to be stimulating, and rewarding, especially for those that may not have come voluntarily (Marsh, et al., 2013). Enticements must be offered to reward changes proposed to clients. Rewards increase the chances of ongoing treatment maintenance, to be viewed as worthwhile (Marsh, et al., 2013). Patients must be kept engaged in recovery and excited about the future it may bring. Therefore, it is the job of the AOD worker to develop alternative rewards that will reinforce reasons for transformational change, relapse prevention, and life management skills (Marsh, et al., 2013). The ideal provider of AOD care, must act as a cheerleader to reinforce the positive changes clients have made (Athanmen, et al., 2019).

2.3.12 Treatment Principle 12: Relapse

Relapse is likelier to occur than not, hence constant adjustment of the relapse prevention plan is needed (Marsh, et al., 2013). Helping the client identify one's own triggers can help in withstanding urges to use drugs and alcohol, or act out with other addictive behaviours, such as gambling, and overuse of pornography, sex, internet, food and credit/shopping (Centre for Substance Abuse Treatment, 2006). Interventions that target negative beliefs and thought patterns that cause difficult behaviours must be utilised. Interventions can be based in cognitive behaviour therapy, schema therapy, interpersonal therapy, narrative therapy, and other available approaches (Manning, et al., 2017).

There are also mindfulness-based and meditation interventions that AOD workers have used with promising results (Fernros & Furhoff, 2008; Haaga, et al., 2011; Hawkins, 2003; O'Connell & Alexander, 1995). Other relapse prevention management planning activities might include assistance with problem-solving, conflict resolution, assertion, anger management, grief processing, parenting skills, employment, or accommodation (Marsh, et al., 2013). Other clients, particularly young people, may benefit from the inclusion of key significant others, such as parents and/or foster parents or care givers (Marsh, et al., 2013).

2.3.13 Treatment Principle 13: Screen

A host of other medical issues are often exacerbated by SUD, therefore testing of HIV/AIDS, hepatitis B and C and tuberculosis should be encouraged, along with provision of risk-reduction talk-therapies and counselling (Tai, et al., 2010). Agencies have standard procedures that are used for initial alcohol and other drug assessment, most take considerable time and staff can be reluctant to burden the client with additional questionnaires (Center for Substance Abuse Treatment, 2006). However, it is useful for clinicians to screen for additional areas of comorbidity. Assessment involves using standardised assessment tools, such as questionnaires that have been

evaluated as reliable and valid (WHO, 2002). As part of overall treatment efficacy, providers should also inform patients that of therapies effective in combating other related comorbidty issues they are faced with, such as linking them to HIV treatment, LBBTQ counselling or pregnancy termination centres, if rape occurred etc. (Marel, et al., 2016).

Abadinski (2018), Inaba and Cohen, (2014), Doweiko (2006) and the National Institute on Drug Abuse (2018) agree that alcohol and other drug treatment must cater to all aspects of a person's overall wellbeing. Embedding treatment principles within any alcohol and other drug service model requires ongoing proficiency (Tai, et al., 2010). Continuous improvement should be actively sought to minimise barriers to treatment success. For this reason, it is important to explore what barriers do exist that impede sustainable AOD outcomes.

2.4 Barriers to Treatment of Substance Use Disorders

Eight barriers that impede successful treatment outcomes have been identified in this study and outlined in the next sections.

2.4.1 Barrier 1: Lack of AOD Funding Resources

Lack of funding for AOD studies at a postgraduate level was already mentioned as problematic in Section 1.2.1 by Najman (2011), and QADREC. A comprehensive 408-page report by the Ritter et al. (2014) concurred, that a consistent approach to alcohol and other drug treatment planning is needed. The national review of alcohol and drug treatment reported that:

> "We valued Australia's current investment in AOD treatment at around $1.26 billion per annum. Compared to the unmet demand, along with the prevalence rate of AOD problems in Australia and the estimated social cost per annum of $24 billion, according to Collins and Lapsley's research findings in 2008, the

investment in AOD treatment is significantly small." (Ritter, et al., 2014, p. 14).

According to this report by Ritter et al. (2014), each state and territory assume responsibility for treatment planning and as such, there has been no single congruent Australian national strategic alcohol and other drug plan being implemented across all sectors that deliver AOD services. Limited technical planning and misappropriated resources hindered nationwide implementation and delivery of services to areas, with the highest need. With this lack of clarity in regard to respective jurisdictional responsibilities, operating independently of one another, financial burdens severely compromise service provision, yielding outcomes that have been subpar. In looking at alcohol and other drug service demand, it was indicated in their report that:

> "Modelled projections of the unmet demand for AOD treatment (that is the number of people in any one year who need and would seek treatment) are conservatively estimated to be between 200,000 and 500,000 people over and above those in treatment in any one year. This has significant implications for treatment planning and purchasing." (Ritter, et al., 2014, p. 13).

In a dated study and the only one of its kind reported by the Department of Health NSW (2007), 34 treatment centres were carefully assessed against the aforementioned 13 treatment principles. The report found problematic themes across funding, impeding state-wide ability to provide necessary infrastructure and human resources (Department of Health NSW, 2007). Treatment recommendations against these 13 principles remain unmet.

Due to the issues of addiction lacking political and medical funding support in the US, their government estimated that 23.8 million people needed treatment for alcohol and illicit drug use but did not receive it (Inaba & Cohen, 2014). To confirm budgetary constraints for AOD issues, diabetes, heart conditions and cancers have a

combined budget of 238 billion for its treatment, compared to only 28 billion allocated for AOD care (Inaba & Cohen, 2014). Note that a smaller budget of USD$28 billion was spent to treat 40 million Americans to rehabilitate from their addiction issues, while almost double was spent (USD$44 billion) to treat diabetes that affected a smaller number of persons (26 million). Heart conditions affected 27 million individuals, though almost four times were spent on its treatment (USD$107 billion vs. USD$28 billion). As for cancers, more than double the amount spent on SUD, was instead spent treating cancers (USD$87 billion).

It is likely that a similar treatment shortage exists in Australia, as $1 billion was invested in specialist (55%) and generalist alcohol and other drug treatment (45%), representing 21% of all alcohol and other drug funding in Australia, in 2013 (Ritter, et al., 2014). Research in the USA indicated that for every $1 spent on treatment, $39 could have been saved on prison costs, absenteeism at work, non-productivity on the job, healthcare and hospitalisation costs and extra social services (Doweiko, 2006).

In the first and only dated evaluation document ever produced on the delivery of global AOD services by the World Health Organisation (WHO), it was concluded that: "…the extent and quality of care available to psychoactive substance users are often inadequate, particularly as some service providers may regard drug users as unworthy of help" (WHO, 2013, p. 6.). With rates of mortality and morbidity continuing to rise, the traditional approach must be re-examined in earnest, and other form of supports funded (Inaba & Cohen, 2014).

2.4.2 Barrier 2: Lack of Opportunistic AOD Screens

There are lack of opportunities to screen those that may have undiagnosed SUD issues. Currently, there are two tools predominantly being used to screen and assess individuals in the AOD clinical and rehabilitation settings. Administered in

general practice, emergency department settings, or other allied health setting by trained and qualified clinicians, these screening tools are:

1. The Alcohol, Smoking and Substance Involvement, Screening Test or ASSIST (World Health Organisation, 2002).
2. The Alcohol Use Disorders Identification Test or AUDIT (Saunders, Aasland, Babor, De La Fuente & Grant, 1993);

The Alcohol, Smoking, and Substance Involvement, Screening Test (ASSIST) has good reliability, specificity, sensitivity, and validity scores; it was developed by the World Health Organisation Alcohol, Smoking and Substance Abuse Involvement Screening Test Working Group (2002). The ASSIST screens for all levels of problem or risky substance use in adults (WHO, 2002). The full versions of ASSIST consist of eight questions covering tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (including ecstasy) inhalants, sedatives, hallucinogens, opiates and 'other drugs' entered into a preliminary case summary sheet (McNeely, et al., 2014). A score of 8-10 is deemed harmful use and a score of 13 is considered hazardous. McNeely et al. (2014) agree that opportunities for screening will help workplaces promote health, safety, longevity, and satisfying career outcomes, and limit accidents and hazardous incidents. Early detection, mostly at the onset of alcohol or drug abuse, is ideal and vital.

The Alcohol Use Disorders Identification Test (AUDIT) consists of a ten-item screening instrument requiring answers to questions using the Likert scale (Saunders, Aasland, Babor, De La Fuente, & Grant, 1993). After screening for hazardous drinking, the AUDIT results set the stage for introduction to rehabilitative treatment of alcoholism using the medical model (Department of Veterans' Affairs, 2009). More opportunities should be explored in administering the AUDIT tool outside of rehabilitation settings.

Focus only on the pathology of addiction possess negative consequences considered a barrier to successful treatment outcome. The next barriers to treatment, tie in hand-in-hand to this barrier of lack of opportunities to screen for AOD use and abuse issue. This barrier implies that focus on the disease model, denial mechanisms, privacy issues and stigma play a role. These barrier implications will be discussed in the next sections.

2.4.3 Barrier 3: Pathology-Based Screening May Prevent Honest Disclosure

The AUDIT and ASSIST tools are pathology-based tests with design flaws that might prevent honest disclosure at the outset. It is important to consider that the questions both screening tools ask, require honest and accurate responses (Saunders, et al., 1993) Unfortunately, its design may prevent truthful disclosure, due to a number of issues (WHO, 2002).

First is that rapport typically needs to be built before these types of highly personal questions, shown in Figure 3, can be broached and answered honestly (WHO, 2002). For example, if the case manager or provider of service administers this test, they need to have suitably established rapport. However, standard practice requires these assessment tools to be administered in the first meeting, preventing suitably established engagement and rapport to have naturally built (Department of NSW Health, 2007).

Another issue is that both the AUDIT (developed in 1993) and the ASSIST (developed in 2002) appear to be antiquated screening tools, that need a more contemporary understanding of the issues of SUD.

Figure 3 provide an example of the popular ASSIST screening tool focusing on the symptoms of SUD.

Question 4

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC)* led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7

Question 5

During the past three months, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8

***Figure 3**:* ASSIST Sample Questions

Source: Department of Health, VIC 2013.

Noted in own private practice as informed by client reactions, own reflections and feedback from networking with other professionals, the following flaws exist in the ASSIST and AUDIT screening tools and summarised as follows:

- Considering trauma, its co-morbidity, and associated complex issues, this tool tends to oversimplify what needs to be uncovered, with no rapport built.
- Fails to take into account the individual's perceived stigmas and feelings coming into treatment (Louma, et al., 2007).
- Gets in the way of Treatment Principle 3: Immediacy – as treatment is not provided without ASSIST and AUDIT filled. Most rehabilitation and clinical settings require diagnostics before care is provided (McNeely, et al., 2014; Saunders, et al., 1993).
- It is worded in a way that may cause offense (Louma, et al., 2007). As mentioned earlier, end-users of alcohol and other drug service would

find it hard to answer these questions without rapport having been built WHO, 2002). This deep probe into a person's life and SUD predispositions take time to build. It also takes time before an individual will reveal their true drug using patterns of behaviour, unless the practitioner is a peer and opens the conversation with their own past experiences, to soften the therapeutic interaction (White, 2010).

- Fails to encourage a person to engage and take responsibility for their own treatment and consequently, transformational change (Albrecht, et al., 2007).
- Exacerbates client issues, where the clinician or AOD worker is focused solely on loss of control, burden of SUD on lifestyle choices, along with other comorbidity associated with it (Marel, et al., 2016). This may take the attention away from wellness and what feels good, as the aim of the therapeutic intervention.
- Has a serious scoring flaw, in that - as per ASSIST instructions, if the client leaves the answer blank, then they are allocated a score of 0. This means that even if they were binge drinking but did not want to disclose this, it would be scored as if they did not have any drink at all (McNeely, et al., 2014). This would be an inaccurate picture of the current individual's physiological and psychological state.

Other factors to consider are that the strong denial mechanisms displayed by persons in active addiction will prevent accurate response/s in screening tools (Abadinski, 2018). Stigma is also an issue felt by clients, as they access service (Louma, et al., 2007). Denial mechanisms and stigma are covered other barriers to successful treatment outcome. It will be argued that with denial mechanisms in play, accurate answers may also not be forthcoming. Illustrated in Figure 3, the types of questions being asked, heighten denial patterns, mechanisms and stigma.

2.4.4 Barrier 4: Denial Mechanisms, Privacy and Sensitivity of Issues

Denial patterns are defence mechanisms employed by a person in active addiction, to avoid painful feelings of shame or guilt (Allsop, 2008). Denial mechanisms are also a delaying tactic, often employed subconsciously, by someone in active addiction (Perkinson, 2008). Denial mechanisms are used, so that people with SUD issues do not need to face the unpleasant truths and negative ramifications of their own drug and alcohol abuse (Allsop, 2008). Denial mechanisms are a means of coping with trauma and pain, where the consequences of alcoholism and drug use are deflected as not their own fault and blamed on upbringing, a partner or others using around them (Abadynski, 2018; Doweiko, 2006).

Denial is often an addict's first line of defence to continue with their drug and alcohol seeking and using behaviour (Doweiko, 2006). AOD workers are constantly faced with various denial mechanisms deployed by people with SUD (Marel, et al., 2016). Trauma that occurred in the individual's childhood or developmental stages (0-12 years old) lead to the limbic lesions and synaptic overuse (Allsop, 2008; Pascual-Leone, et al., 2005). This stunted adult brain development contributes to denial patterns being engaged later on to compensate for drug and alcohol use and consequently, abuse thereof (Allsop, 2008; Doweiko, 2006).

Denial mechanisms and privacy/sensitivity issues are closely knit and have an effect not only on the way a client would present their AOD issues, but on the way the health professions respond to comorbidity and mortality. For example, most medical, not-for-profit, and allied health professionals consider it highly insensitive and inappropriate to declare an individuals' cause of cancer, diabetes, and heart conditions to have stemmed from SUD (Inaba & Cohen, 2014). Family members share this sentiment (Inaba & Cohen2014). Doctors seldom attribute mortality rates to alcohol or drug factors, instead describing the cause of death as cancer, liver failure, or heart disease in that individual's death certificate (Abadinsky, 2018; Inaba & Cohen, 2014).

Adabinsky (2018) and the Australian Institute of Health and Welfare (2018) both found that medical professionals often, may not scrutinise whether patients suffer from chemical dependence. Abadinsky (2018) adopted an ethnographical account reflecting why professionals may consider the interplay of alcoholism, domestic violence, suicide, and other SUD topics to be 'sensitive' and a personal subject matter to even broach.

2.4.5 Barrier 5: Stigma Surrounding Addiction

Interwoven effects of addiction intensify denial mechanisms, making individuals give up their right to seek help, in fear of being subjected to stigmatising events (Louma, et al., 2007). Whether perceived, self-stigma or actual, stigma is a barrier to treatment, discussed in this section.

To understand stigma better, a prospective study by Louma et al. (2007) examined the impact of stigma in 197 patients entering treatment from 15 rehabilitation sites in the state of Nevada (US). Seven instruments were used:

a) *Quality of Life Scale* – QOLS (Flanagan, 1978) measures ability to perform tasks that contribute to better quality of life against 16 items via a seven-point Likert scale (1-7).
b) *Overall Mental Health* – The General Health Questionnaire (GHQ-12) are 12 statements (Vieweg & Hedlund, 1983), each question statement aims to detect mental disturbances and disorders (1 to 4-point Likert scale).
c) *Perceived Stigma* – The 12 questions of the Substance Abuse Perceived Stigma Scale (SAPSS) use a 1 (never) to 7 (always) Likert scale (Link, 1987). Sample questions include: "Most people would hire someone who has been treated for SUD to take care of their children" and "Most people do not think less of a person who has undergone SUD treatment".
d) *Secrecy Coping* (Link, et al., 1997) – Four yes-or-no questions, e.g., "Do you think it is a good idea to keep your history of substance use a

secret?". These types of questions assess secretiveness on a scale of 0 to 4.

e) *Stigma-related interpersonal rejection* – The Stigma-Related Rejection Scale (SRS) was modified from its original MH/AOD consumer version to focus on SUD behaviours, using a 7-point Likert scale (Wahl, 1999). Questions included one's perception of being less competent, critical comments made against participants, and perceived worry that one would be viewed unfavourably because of current or past SUD.

f) *Internalised Shame Scale (ISS)* – The ISS (Cook, 1987) has been found to be a reliable test (Cronbach's alpha of .95). Twenty-four question are negatively worded and six are positively phrased (30-items). Participant answers are on a Likert scale of 0 (never) to 4 (almost always).

g) *Experiential Avoidance and Psychological Flexibility* – The Acceptance and Action Questionnaire (AAQ) measured nine items regarding willingness to accept feelings deemed undesirable; it demonstrates excellent internal consistency (Hayes, et al., 2004. On a 7-point Likert scale, participants with lower scores reflect greater willingness to act, despite difficult feelings.

Louma et al. (2007) found little to no research that sought to examine the relationship between stigma and functional outcomes for those with SUD, entering a treatment setting. The study reported that 118 participants (60%) felt that they were treated unfairly due to their history of SUD, 90 (46%) felt that people were afraid of them and 88 (45%) felt their family would give up on them if they found out about their current AOD use (Louma, et al., 2007). Stigmatising experiences reported (SRS) were 'almost always' and 'always' hearing unfavourable and critical comments against their past or current use of alcohol and drugs (17%), especially pertinent if it was not their first-time receiving treatment.

With regards to perceived stigma (Link, 1987), 59% believed they were devalued or discriminated against because of their AOD use and treatment attendance (SAPSS scores vary across items). The strongest indicator of perceived stigma was that people would not trust the care of children to those with current or past SUD (69%) or to train or teach young children (59%).

2.4.6 Barrier 6: Lack of Therapeutic alliance

Emergent evidence on therapeutic alliance (TA) as studied by Ardito and Rabellino, (2011) through meta-analysis of ten studies from 1983–2011 reported emotional stability of the therapist, and continuity of same-therapist care positively correlate with efficacy in treating those with SUD.

Another study, this time by Urbanovski et al. (2015) were on 303 young adults aged 18–24 years old at a US Midwest rehabilitation centre receiving comprehensive treatments. The treatments comprised of attendance to 12-step approaches, CBT, family, and multiple didactic groups to manage anger, shame, trauma, parenting, eating, dual diagnosis and mental health issues, and pharmacology. The young residents had a buddy system to match new residents, with residents that had more time in the centre. All participants are invited to comply to a full schedule, comprising of meaningful activities to be completed, such as cooking, gardening and routine chores.

Therapeutic alliance was assigned and measured using three subscales assessing: a) agreement of tasks and goals of therapy; b) patient-counsellor bond and c) theory of consonant alliance using the Working Alliance Inventory (Horvath & Greenberg, 1986; Tracey & Kokotovic, 1989; Urbanovski, et al., 2015). Items were rated against a 7-point scale summed to total subscale scores, where alliance was assessed two weeks into residential rehabilitation, and usually in the second session. Results were tabulated and it was found that significant changes were recorded for all

five measures upon discharge. Therapeutic alliance was only associated with positive change in psychological distress when interaction was established with an AOD worker over time (Urbanovski, et al., 2015).

Urbanovski et al. (2015) and Ardito and Rabellino (2011) suggested that to establish therapeutic alliance and better serve the needs of vulnerable AOD end-users, treatment would need to change its focus from responding to crisis, to instead teaching the clients that treatment is a long-term, life-changing endeavour. This helps set accurate expectations (Treatment Principle 5: One year in Section 2.3) from the beginning, and helps the clinician shape the positive outcomes clients are seeking (Ardito & Rabellino, 2011, NIDA, 2018; Urbanovski, et al., 2015).

2.4.7 Barrier 7: Lack of Self-care Practices for AOD Workers Lead to Burnout

Burnout is a common phenomenon felt by those who work in SUD practices. Constrained government funding (mentioned in Barrier 1: Lack of Funding Resources) may have contributed to lower quality-of-care by compromising the ability of AOD clinicians, allied health, and/or drug and alcohol workers to apply the recommended improvements to standard-of-self-care practices (Department of Health NSW, 2007; Ritter, et al., 2014). It has been reported that consistent self-care practices bring about the necessary foundation needed to appropriately service this high-risk and crisis-driven population subset (Department of Health NSW, 2007). Due to being under-resourced at the practitioner level, many instances of burnout were recorded, evidenced in the unusually high staff turnover rates within the AOD rehabilitation setting workplace at that time (Department of Health NSW, 2007).

Skinner and Roche (2005) reported that burnout is often exacerbated by organisational mismanagement and lack of an adequate self-care practice. This can stem from lack of promotion and workplace practice of wellbeing activities, that can inflate organisational wellbeing issues. Stress and burnout are highly correlated to

high staff turnover and low job satisfaction. These burnout issues consequently lead to reduced workplace progress and performance. Burnout as a form of chronic distress response over a prolonged period, present with three core dimensions:

1. Exhaustion – both physical and emotional overextension of resources, which causes the worker to feel drained.
2. Cynicism – caused by dehumanising, or depersonalising client-worker interaction as a protective mechanism.
3. Reduced feelings of fulfilment – caused by low feelings of achievement, feelings of incompetence and low self-efficacy.

Skinner and Roche (2005) noted that while stress develops over time in the workplace, most people do not develop characteristics of the long-term burnout that is common in the AOD service sector. Six percent of Australians in the 2001 National Drug Household Survey (NDHS) reported being abused by those with AOD issues, whilst a staggering 55.8% of workers in the AOD field reported incidents of abuse in the workplace by those intoxicated by alcohol or drug use. These incidents of abuse place a high level of stress on workers and make them vulnerable to burnout. While symptoms may differ, contributing factors remain similar and are brought about by the following:

1. Complexity of AOD/SUD issues can lead to role ambiguity and lack of understanding in ability to engagement with target group.
2. Spurned by negative community attitudes, issues of stigma need to be addressed.
3. There is a need for continuous AOD specialty upskilling and training to ensure management of complex client presentations are understood and client successful outcomes met.
4. Adverse work conditions, such as overburdening clients with heavy administrative demands, further compound workload stress. For example: client crisis demands long and emotionally heavy workload; work goals and expectations have confusing timelines and competing

priorities; there may be dangerous work environments; and job instability can be felt by employees, due to pending fund cuts.

A study by Vilardaga et al. (2011) explored how a form of counselling called Acceptance and Commitment Therapy (ACT) may be related to reduction of burnout of urban addiction counsellors (*n* =699), after controlling for well-established worksite factors, such as co-worker support, salary, tenure, workload stress, and supervisor input. It was concluded that mindfulness and continuity of care by the same therapist adhering to consistent delivery of the ACT framework during treatment, improved burnout rates. The data presented, showed preliminary effects using the ACT model measuring against exhaustion, depersonalisation, low accomplishment, experiential avoidance, and low values commitment. A conclusion is that commitment to client values, diminished burnout rates. Retention of staff correlated to job satisfaction and performance. Prioritising the wellbeing of the AOD worker was foundational in retaining staff, and this includes teaching the ability to maintain equilibrium throughout the therapeutic interactions (Vilardaga, et al., 2011).

Dorji (2017) described 'self-care' as promoting one's own psychological, emotional, and physical wellbeing. Self-care is regarded as the most important consideration for helping professionals who practice in the field of AOD counselling. Therefore, encouraging practitioners to take responsibility for their own personal and professional self-care practices, are vital components recommended, for longevity in the field (Dorji, 2017).

2.4.8 Barrier 8: Lack of AOD-specific Training

Delivering AOD services are quite a demanding and complex field, requiring thorough practice-based knowledge across facets of psychology, physiology and cognition (Abadinsky, 2018). Deane et al. (2010) reported that up to 50% of medical professionals confess they lack the skills needed to deal successfully with the

complex and emotionally laden issue of SUD. Seventy-five percent (75%) of medical professionals admit they have had no training in identifying ways to be able to divert drug and alcohol patients to non-pharmacological approaches. Since most general practitioners, emergency professionals, and allied health workers are not trained to deliver brief intervention related to SUD, they are limited in their scope to encouraging or recommending appropriately specialised resources for those experiencing addiction issues.

Competencies and fields of knowledge needed for AOD practitioners to continuously develop to be able to deliver successful, long-term client outcomes, will include and are not limited to the following (Deane, et al., 2010; Tai, et al., 2010):

a) trauma-informed practice,
b) developmental, social and family systems
c) nutrition
d) exercise physiology
e) alternative holistic treatments
f) anatomy
g) substances and behaviours of abuse
h) integrative care, and
i) neurological and epigenetic studies

A promising area for further training by AOD workers, is in the subject of neuroplasticity. Pascual-Leone is considered a prominent researcher in the topic of neuroplasticity (Berenson–Allen Centre for Non-Invasive Brain Stimulation, 2019). Neuroplasticity is the ability of the billions of neuronal networks in the pre-frontal and limbic parts of the brain to be moulded in daily or consistent practice, in the same way addictive behavioural patterns are formed.

Pascual-Leone et al. (1991, 2005) started studying the phenomenon of cocaine use, by administering electroencephalographic (ECG) brain scans with

formative work started in 1997. They reported evidence that drugs of abuse cause neurological insults and structural abnormalities to the pre-frontal areas of the cerebral cortex, negatively affecting cognition and follow-through behaviours. The most pertinent understanding emerging in the field of AOD would now need to concentrate its efforts on how to break, interrupt or ameliorate these abnormal and/or fatalistic brain patterns.

As research advances into translational phases, neuroplasticity can provide knowledge related to Treatment Principle #1: Neuro. Clinical trials and research have been published, involving use of neuroplasticity tools and techniques, such as meditation (Haaga, et al., 2011), breath work (Fernros & Furhoff, 2008), yoga (Pozadski, et al., 2014), journaling (Fernros & Furhoff, 2008), memory retention, holistic planning (Zahourek, 2008), and strategic goal setting (White, 2010). Training in neuroplasticity and activities that lead to neuroplasticity, will equip the AOD worker with knowledge on how to help their clients change their brain circuitry, to improve health outcomes.

Specialist AOD training opportunities are limited for AOD practitioners (Najman, 2011). Compounded by the other seven barriers already discussed, it is evident that AOD/MH service delivery outcomes are dependent upon healthy and resilient workers, who have received appropriate AOD specialist training. There are multiple pressures facing an AOD practitioner today, as they continue to deal with life-threatening issues, such as death, suicide, grief, violence, self-harm, sexual abuse, and criminal behaviour repercussions.

This summary of the barriers to effective treatment informs and justifies the development of the peer-supported, recovery coaching program, reviewed next.

2.5 The Coaching and the Peer Recovery Coaching Model

Coaching involves a collaborative partnership for the purpose of attaining goals and the central function of a coach is to increase the capacity of an individual by the articulation and clarification of goals (Gavin & Mcbrearty, 2013). This part of the review will outline current literature on the coaching model, and coach competencies necessary for professional practice. This will lead to literature that delineates recovery orientation precepts, and advantages of a peer-delivered, recovery coaching model.

Coaching can underpin the delivery services that enhance optimal functioning associated with characteristics of flourishing or peak performance states (Fredrickson & Losada, 2005). To flourish is "to live within an optimal range of human functioning, one that connotes goodness, generativity, growth and resilience" (Fredrickson & Losada, 2005, p. 678). Coaching interactions encourage clients to flourish, by increasing their capacity for positive emotions (Gavin & Mcbrearty, 2013).

Other merits of the coaching approach include coaches who help clients become more engaged and interested in their overall quality of life, help them find meaning and purpose and support them in the cultivation of positive relationships, self-esteem, determination, vitality and optimism (Gavin & Mcbrearty, 2013). Gavin and Mcbrearty (2013, p. 17) argue that the: "use of the coaching model exemplifies winning and is synonymous with success, competition and sportsmanship". While Grant (2003, p. 254) elaborated that: *"*with a changed emphasis to increasing potential, finding strategic alliances and expressing the motivation to sustain ongoing actions, using a coach as an accountability partner enables attainment of personal goals*"*. To excel as a coach, competencies are needed for successful delivery of a coaching practice.

2.5.1 Eleven Coach Competencies to be Developed by an AOD Practitioner

In 2016, coaching was an industry with around 53,000 coach practitioners globally, of which the International Coaching Federation is the oldest and largest accreditation body. Of its 53,000 members, 45% were registered as either an Associate Certified Coach (ACC), Professional Certified Coach (PCC) or Master Certified Coach MCC (ICF, 2016).

Contributing to the coach effect, a verbal examination must be completed and a score of >75% must be successfully secured, demonstrating the 11 coach competencies at the ACC Level 1 (ICF, 2020). For PCC, Level 2, > 80% must be scored and >85% score must be achieved for Level 3: MCC. A complete list of coaching clients (>100 logged hours for ACC, Level 1), with contact details must also be supplied for audit and review, along with video logs or transcripts, if asked (ICF, 2020). To be valid, 80% of these logged coaching hours require that payment was made for professional coaching services rendered. Last requirement is 60-minute examination passed with a score of no less than 80%, in one sitting. Figure 6 – 8 illustrate competency requirements in Section 3.2.4. Coach competencies ensure a uniform, gold standard is delivered, whilst upholding Codes of Ethics and Conduct.

Table 3 summarise the 11 coach competencies, for accreditation and practice (ICF, 2020). The 11 coach competencies will be discussed as the 'coaching' dimension of the CPRC program in Section 3.2.4.

Table 3:

Summary of ICF's 11 Coaching Competencies

#	ICF Coaching Competency	Competency Summary
1	Behave ethically and meet professional standards	Clearly communicate the distinctions between coaching, consulting, psychotherapy, and other support professions and refer appropriately.
2	Establish and adhere to the coaching agreement	Discuss parameters of the coaching relationship (fees, duration, confidentiality etc)
3	Establish a strong sense of trust and intimacy with the client	Have genuine concern for client's welfare and behavioural style, demonstrating integrity, honesty, and sincerity. Ask permission to broach sensitive topics.
4	Possess a conscious, open, flexible, and confident coaching presence	Be highly intuitive, yet open to not knowing and taking risks. Uses humour effectively, shift perspectives and encourage commitment to action. Work effectively with strong emotions.
5	Practice active listening skills by focusing completely on what the client is saying and is not saying, understanding its full context	Attends to the client's and not one's own agenda. Hears client's concerns and beliefs, responding appropriately. Distinguish between words, tone, and body language. Understands the essence of the client's communication, allowing the client to vent without judgment.
6	Able to ask powerful questions that reveal the information needed for maximum benefit to the coaching relationship and the client	Asks questions that evoke discovery, insight, commitment, or action, is open-ended, creating greater clarity, moving the client toward what they desire and not asking questions that makes the client justify or look backward.
7	Use of direct communication that has the greatest positive impact on the client	Communicates respectfully, providing useful feedback. Reframe and help the client understand other perspectives. Clearly state coaching objectives, agenda, and purpose of techniques, using metaphors well

8	Create awareness to help the client achieve agreed-upon results	Go beyond what is said in assessing client's concerns, and identifying facts, opinion and disparities between thoughts, feelings, and action. Help clients to discover new thoughts, beliefs, perceptions, emotions that strengthen their ability to achieve what is important.
9	Create with the client opportunities for taking new actions that will most effectively lead to agreed-upon coaching results.	Help the client focus on and systematically explore specific concerns and opportunities that are central to agreed-upon coaching goals. Celebrate client successes and experimentations that challenge client's assumptions and perspectives.
10	Develop goals and maintain an effective coaching plan with the client.	Consolidate collected information and establish a coaching plan that develops goals with the client. Address concerns and areas for learning with goals with timelines that are attainable, measurable, and specific.
11	Able to manage progress and gold the client attention to achieve what is important with action.	Clearly requests of the client actions that move towards goal attainment. Acknowledge client for what they have done, not done, learned, or become aware of since the previous coaching session(s), positively confronting them for not taking agreed-upon actions.

Source: International Coaching Federation (2020)

Now that competencies needed for the coach-practitioner to develop have been summarised and explained as part of the coach effect, this review will move onto review of recovery concepts, recovery-orientation and peer-delivered coaching.

2.5.2 Why Recovery Coaching and Recovery-Orientation?

A recovery-orientation provides the practitioner and client with a united front from which to establish a therapeutic alliance. Use of recovery coaches can be a strategy to extend the capacity of health promotion services for sustaining and motivating behavioural change in people with SUD (Jack, et al., 2018; White, 2010). Other roles recovery coaches help individuals with, is to navigate through numerous

resources available for gaining employment, proper parenting, building recovery capital resources and addressing any legal or criminal issues (Eddie, et al., 2019).

As the seminal proponents of recovery coaching, Loveland and Boyle (2005) tell us that recovery coaches work with the client to help them find effective ways to increase their motivation for abstinence and productivity, while safeguarding the individual's fulfilment of potential through goal oriented, non-clinical intervention. Recovery coaches draw their legitimacy not from traditionally acquired educational credentials, but rather, through experiential knowledge and experiential expertise (Loveland & Boyle, 2005). Similar to coaching, recovery coaching is an ongoing professional relationship, set with defined mutual agreement that support individuals considering recovery from substance use issues (Jack, et al., 2018).

The recovery coach (RC) and client produce goal outcomes in specific areas of the client's life, while prioritising recovery from issues of chemical dependence. Recovery coaches build trust with clients by sharing their experiences of coping with SUD, role modelling of recovery behaviours, sharing problem-solving strategies, providing emotional support, and rewarding behavioural change milestones achieved (Jack, et al., 2018).

Crowe et al. (2007) attempted to address power imbalance in the delivery of health coaching in the medical sector. They have developed the Collaborative Recovery Model (CRM) to respond to the recovery paradigm and used CRM as an intervention for those with mental illness. In integrating CRM into everyday practice, health coaches were trained to re-orient to a focus on recovery instead of pathology. The process of CRM guides a coach through a systematised feedback loop, constantly focusing the coach to guide the client in sharpening their vision, values and achievement of goals set. This research study strengthens the merit of using a recovery-oriented approach. Further study on the Collaborative Recovery Model (CRM) should be contextualised specific to the delivery of alcohol and other drug coaching services.

Recovery coaching represents an intervention that can help individuals persist in the pursuit of individually chosen health and wellness goals. As studies regarding the use of recovery coaching are outlined in Section 2.5.4, it is hoped that the recovery-oriented systems of care (ROSC) model can be practiced in Australia. The collaborative recovery model (CRM), already being utilised in the mental health sector by clinicians, therapists, and counsellors, supports recovery orientation as a needed focus (Deane, et al., 2010). This study aimed to contextualise the currently used CRM for practice-based delivery of alcohol and other drug coaching services, with experiential knowledge at the heart of delivery (Deane, et al., 2010; 2014).

2.5.3 Why Peer-Supported Coaching Services?

According to White (2006), experiential knowledge in peers is information acquired about addiction recovery, through the process of one's own recovery or by being supported by others through the recovery process. Experiential expertise requires the ability to transform this knowledge into the skill of helping others to achieve and sustain recovery. Many people have acquired experiential knowledge about recovery, but only those who have the added dimension of experiential expertise, are ideal candidates for the role of recovery coach. That is, one must lead by staying in recovery. The dual credentials of experiential knowledge and experiential expertise are bestowed by local communities of recovery, to those who have offered sustained proof of their expertise, as a recovery guide. The recovery coach works within a long tradition of wounded healers or individuals who have suffered and survived SUD. The recovery coach will use their own vulnerability and the lessons drawn from own setbacks in sustaining recovery, to minister and guide others to pursue a path of recovery and healing (Loveland & Boyle, 2005).

Peer workers are increasingly being utilised in a range of alcohol and other drug/mental health clinical settings in the USA (Eddie, et al., 2019). Harvard Medical School has started to recognise the role of peers with their SUD lived experience

(Eddie, et al., 2019; Jack, et al., 2018). Eddie et al. (2019) systematically reviewed research on Peer Recovery Support Services (PRSS) by investigating the potential of peer supports at the Massachusetts General Hospital (Eddie, et al., 2019). They found seven randomised-control trials and eight single and multi-group studies. Outcomes reported were that participants were more likely to; adhere to inpatient PRRS duration; attend 12-step meetings, abstain from cocaine use, and showed a trend toward heroin abstinence (Eddie, et al., 2019).

In their systematic review of literature, Tracy et al., (Eddie, et al. 2019) conducted a randomised control study on 96 Veteran inpatients, dividing them into treatment as usual plus peer-led group; treatment as usual, with 8 weeks of clinician-delivered relapse prevention; and treatment as usual only. Treatment combined with peer-support was associated with greater mental health appointment adherence (52%) compared to treatment as usual only (38%). Those that accessed peer-support engaged better with their substance use treatment plan and those that received treatment as usual plus PRRS were associated with greater post-discharge attendance and likelier commitment to outpatient treatment than those that only received treatment as usual (Eddie, et al., 2019).

Another important finding in a quasi-experimental study by Blondell et al. (Eddie, et al., 2019) concluded that 90% of those who attended peer-support sessions found their interaction meaningful. Eddie et al., (2019) reported in their review that this study evaluated the work of nineteen (n=19) 12-step program volunteers (peers) as they visited and offered peer support to eighty participants (n=80), attending their SUD detoxification program.

'Peers reach out supporting peers to embrace recovery' (PROSPER) is a unique, strength-based recovery maintenance program based on holistic peer-to-peer social support in the Los Angeles area (Andreas, Davis & Wilson, 2010). Peers in the program include people in recovery who have been incarcerated, and their families

and significant others. The combined effects of substance abuse and incarceration can be overwhelming for individuals and families, as rising rates in relapse and recidivism indicate. PROSPER believes that social support through a peer-community approach can have a significant impact on this specific population of around 300,000 (50% incarcerated and 40% on parole in the state of California). A general self-efficacy test indicated positive and significant changes at six and 12 months, compared to data collected at the beginning of the program. Other findings included improvements in quality-of-life scores, social support, and daily functioning. Participants also reported feeling less stress during situations that they usually appraised as stressful.

In Australia, the mental health reform was based upon a collaborative recovery framework and a peer model. To date, there were no studies that have been found in the Australian setting, specifically examining the efficacy of peer-based recovery coaching in therapeutic settings. To align with the mental health reform, a new *Certificate IV in Mental Health Peer Work – CHC43515* was iterated for second release in December, 2015 (Australian Government, ND). As of May 2020, there were 22 Registered Training Organisations approved to deliver this ‘peer-based’ qualification across Australia. This course was designed to recognise workers with lived experience, though not specific to those with alcohol and other drug issues.

Sadly, peer work for AOD service provision is still widely stigmatised (Australian Health and Ministers’ Council, 2013). Nevertheless, lived experience or peer work is slowly being recognised as a noteworthy phenomenon, with peer-practices and considerations ready to be embedded within the day-to-day operation of AOD practices (Eddie, et al., 2019; Jack, et al., 2018; White, 2010; White & Cloud, 2008). As peer-based service models are steadily increasing outside of Australia, particularly for clients with co-occurring psychiatric and substance use disorders. There is a slow growth of “peer’’ research where the peer leads with a “been there before’’ attitude expressing to the end-user of the AOD service that they

are not alone in their struggles (Australian Health Ministers' Advisory Council, 2013). This encourages those going through active addiction to be inspired by the successes of the peer worker and instils the 'hope to overcome' attitude needed (White, 2010). This research aim to add to the peer recovery coaching practice-based literature, including a Collaborative Peer Recovery Coaching (CPRC) program presented in Chapter Three, as the chosen intervention for this study.

2.5.4 Summary of Relevant Coaching/Recovery Coaching Studies

This section will summarise relevant coaching and recovery coaching studies related to mental health, addiction recovery. In scanning the literature for relevant studies, the International Coaching Federation (ICF, 2017) research portal was used to collate and eliminate unrelated research items, cross-referenced with other relevant research libraries, such as PubMed. From this, a summary of coaching and recovery studies are presented in Table 4.

Table 4:

Summary of Coaching / Peer Recovery Coaching Studies with Commentary

	Study / Method	**Title**	**Methodology / Results / Details**	**Limitations and Comments**
1	Deane, F., Andersen, R., Crowe, T., Oades, L., Ciarrochi, J., and Williams, V. (2014) Mixed	A Comparison of Two Coaching Approaches to Enhance Implementation of a Recovery-Oriented Service Model	Transformational coaching (n=153) and skills condition coaching (n=143) Future research could utilise recordings of coaching sessions to clarify whether potential mechanisms for change are evident across various settings.	Transformational coaching for mental health issues merit further study. Study reinforced the implementation of a new coaching practice model to increased commitment to use of ongoing coaching.

2	Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoeppner, B., Weinstein, C., and Kelly, J. (2019) Systematic Review	Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching	Reviewed: 7x randomised control trials (RCT) where total n=6,544 -4x Quasi-experimental studies were included. -10x single/group prospective/retro-spective and cross-sectional studies.	Comprehensive and systematic review showed this novel peer recovery approach has yet to establish clear efficacy and effectiveness research base. Ethical and practical challenges remain.
3	Grant, A. (2003) Quantitative Dissertation	The impact of life coaching on goal attainment, metacognition, and mental health	10x 50min coaching session weekly, (n=20) post grad students, Solution focused therapy. Depression, anxiety, and stress were reduced notably.	Goal attainment increased, although no control group
4	Jack, H., Oller, D., Kelly, J., Magidson, J., Wakeman, S. (2018). Qualitative	Addressing substance use disorder in primary care: The role, integration, and impact of recovery coaches.	Interview with recovery coaches (n=5) and their clients (n=16). Goal of study was to better understand the merit of recovery coaching (RC) program in hospital.	RC strengths: accessibility, peer, motivating behaviour change. Challenges: lack of RC connection /clarity in coach role and tension between coach and primary care team
5	LePage, J and Garcia-Rea, E. (2012) Quantitative	Lifestyle Coaching's Effect on 6-Month Follow-Up in Recently Homeless Veterans with SUD: A Random Study	n=56 homeless veterans. 3 groups; with therapist and coached, therapist with only emotional support and no therapist.	Coached consumers had longer latency to relapse and relapsed at a lower rate than with no therapist

6	Lindgren, S. (2011) Qualitative Dissertation	Life coaching youth: A supportive youth coaching model	n=90, Coaching is appropriate process to support youth development.	Further training of coaches needed. Focus on youth development, concurrent with use of coaching needs parameters for practice
7	Powell, J. (2012) Mixed	Recovery Coaching with Homeless African Americans with SUD	Recovery coaching for African Americans who are chemically dependent, face homelessness and comorbidty issues.	Facilitated recovery for those who previously lacked the vision that recovery was possible.
8	Smyth, G. (2014) Qualitative	Coaching desistance? Life coaching for offenders in a 'who works' environment	Considers potential contribution of life coaching to work with offenders. Positive impact, against the theory of change, n=17.	The contribution to this process of engagement and the relationship between coach and client is also considered.

A study by Powell (2012) supports the proposition that the addictions field is slowly shifting from an acute care model to a recovery-oriented, client-centred and strengths-based model. The Association of Persons Affected by Addictions (APAA) in Dallas runs its centre with staff of around 39 people and a budget of around USD$1 million, to help homeless African-Americans with severe addiction issues. Powell (2012) points out that warmth and a loving environment should be exemplified in any treatment centre, instilling hope and breaking down barriers to participation. The APAA match clients with peer volunteers with similar experience and age, including incarceration histories and future aspirations. The recovery coaches that work with APAA, help secure housing and funding for ROSC services, while providing emotional support and any other needed services, as they arise.

Grant (2003) highlighted the positive effects of coaching on actual attainment of goals and mental health in his doctoral thesis (n=20). Grant's seminal study provided evidence that adults who received coaching over 13 weeks, had significantly lower levels of depression, anxiety, and stress.

Another coaching study on the efficacy of youth coaching practices, gathered data from coaches about the delivery of coaching services to young people (Lindgren, 2011). The evidence provided by Lindgren's participants (*n*=90) presented coaching as an appropriate process that supports young people's self-determination. She used a survey with 51 questions about youth coaching programs, training completed by the coaches, modes of delivery and specific outcomes. Lindgren (2011) revealed youths engaged in coaching tended to perform better academically and were more focused on health, social and well-being outcomes. Both Grant (2003) and Lindgren's (2011) studies showed that participation in coaching were associated with increased goal attainment, greater levels of insight and better quality of life.

LePage and Garcia-Rea (2012) conducted a randomised control study on the topic of recovery coaching, recruiting 56 substance dependent, homeless veterans. Urine samples were used to measure sobriety. LePage and Garcia-Rea (2012) divided the participants into three groups: (1) those with therapist and coaching, (2) those with therapists only and (3) no therapist at all. Both coached and non-coached groups had the same high relapse rates, while those that were coached had longer latency to relapse rates. It was inferred that treatment had no effect in lowering relapse rates. It was also found that those coached relapsed at a slower rate than those with therapist support, where only 5 out of 14 that were coached relapsed, compared to the 23 out of 28 who relapsed that belonged to the treatment only category.

Smyth (2014) studied how coaching boosted the self-confidence and self-worth of its offender participants. Coaching equipped the participants' better problem solving skills to deal with problems in and out of prison. Using a qualitative method, 17

offenders were interviewed, who had presented with depression, suicidal thoughts, addictions, and securing employment, business, and parenting issues. Data was corroborated by correctional staff and family members whichconfirmed accuracy of participant responses. Le Page and Garcia-Rea (2012) and Smyth (2014) concluded that therapeutic interventions concurrent with coaching and a focus on healthy behaviours, while capitalising on recovery capital resources, are all important components needed to be integrated for sustained, long-term recovery.

Deane et al. (2014) studied two different recovery coaching models by auditing 296 case files. Participants were divided into transformational coaching (n=153) and skills condition coaching (n=143). They found sufficient evidence suggesting transformational coaching for mental health issues, merit further study. The study concluded that transformation coaching model increased commitment to ongoing coaching and personal development. Deane et al. (2014) recommended use of audio or video recordings of coaching sessions for future research, to verify how specific mechanisms were employed to effect change. This study has video recordings of coaching sessions and aimed to evaluate effects of the CPRC program to effect change.

2.6 Conclusion

To begin the review of the literature, substances of abuse were discussed. Services delivering mental health (MH) and alcohol and drug (AOD) services were covered, providing definitions, diagnostics, and prevalence rates of substance use disorders (SUD). Thirteen treatment principles originating from the National Institute of Drug Abuse in the USA were delineated in Section 2.3. The treatment principles served as a preamble, prior to investigating eight barriers that may have hindered successful provision of AOD/MH services to its end-users. The literature review continued to provide an analysis of research published in the peer supports, recovery coaching and recovery-oriented systems of care domain (Section 2.5.4).

Coaching precepts from a non-clinical background and utilised as a complementary adjunct to existing AOD/MH service were introduced in this review. Critique of peer and recovery literature globally was provided in Section 2.5.4. This section of the literature review examined various effects of coaching on goal attainment and long-term mitigation of SUD issues. This has been relevant because the premise of coaching was based upon strategic achievement of goals, set by coach and client.

Following a discussion of the extant literature that explored the: a) nature of substance use disorders (SUD) issues, b) its' consequences, c) barriers that impeded successful treatment outcomes d) why coaching is a veritable complimentary approach and e) why peer recovery coaching can improve Australian alcohol and other drug treatment outcomes. This study sought to answer the following research question:

> How can participation in the CPRC program enhance recovery capital resources and promote attainment of goals in people with co-morbid, SUD?

Stemming from the main question above are sub-questions this study will investigate, in relation to increasing and measuring of recovery capital resources (RCR). These sub-questions are:

1. Evidenced in the participants' before and after RCR scores, how did CPRC affect the ten different RCR dimension?
2. As the coaching series developed, what change patterns occurred in relation to the effect of CPRC on participants' RCR scores?
3. Despite the ongoing existence of SUD issues, what effects did CPRC have on participants' ability to achieve pre-determined goals, set in the first coaching session?

Therefore, based on the review of the relevant literature covered in Chapter Two, the CPRC program was adopted to explore the questions posed above, for this

study. Chapter Three presents and justifies the merit of the CPRC program with its four dimensions and instructions for use in professional AOD practice.

CHAPTER THREE: COLLABORATIVE PEER RECOVERY COACHING

3.1 Introduction

To address treatment gaps for those that are recovering from substance use disorders (SUD), the literature review was based on professional practice and informed by the extant literature to introduce the reader to a form of coaching created and practiced by the insider-researcher. Derived from a peer-supported, recovery coaching model, the *Collaborative Peer Recovery Coaching* (CPRC) program was developed to explore the assumptions of the study, providing insights for practice-based application.

The first part of Chapter Three outlines how the insider-researcher derived the CPRC dimensions of practice. The first collaborative dimension, will define how collaboration is established, based upon what is known in treatment, as the therapeutic alliance of the coaching model. The client uses this as an impetus for change.

The peer dimension is the second dimension of the CPRC program. As Section 2.5.3 already discussed the peer work model, Section 3.2.2 elaborates on why peer-supported coaching can work, adding to the discussion the importance of peer delivery. Peer work and lived experiences were the foundation upon which the current mental health reforms and its' sets of peer-led consultation rounds have been based upon (National Mental Health Commission, 2018).

The third dimension is working with the reform in delivery of recovery-oriented systems of care framework, led by the Australian National Mental Health Strategy and the Australian Health Minister's Council, started in 2013. This move away from the pathology-based disease model can augment existing therapeutic interventions and current Australian models of AOD care. The latest mental health reform surrounding strengths-based, peer-led datasets will be discussed under this third, peer dimension.

The last, and fourth 'coaching' dimension, was borrowed from the sports coaching model. Section 3.2.4 will discuss the concepts of coaching, its set of pre-determined coaching competencies (ICF, 2020), and how this mode of coaching delivery affirms the coach-client bond. This section will also detail the competency rating score measures for each of the 11 coach competencies, presenting the first two scoring metrics, with its sub-sections. The level of competence a coach has developed provides the basis on how well the coach can help the client stay focused on collaboration, quality of life in recovery, the ongoing cultivation of recovery capital resources (RCR) and attainment of goals. This has been known as the coach-effect (Reiss, 2015).

3.2 Dimensions of Collaborative Peer Recovery Coaching

The CPRC program follows the national recovery-oriented framework provided for practitioners by the Australian Health and Ministers' Advisory Council (2013). This document sets forth frameworks which inform treatment, therapeutic, psycho-social and rehabilitation-based AOD professionals on how to support their end-users. At the time of writing, AOD services in Australia are still under the umbrella of mental health services. The researcher of this study delivers from this national framework a form of coaching, geared towards the specific needs of those with SUD/AOD issues. Dr Penny Brown (Australian Health and Minister's Council, 2013) expressed how now that this national recovery-oriented framework is in place, the real work of implementation can and must begin.

The CPRC program has four dimensions: 'collaborative' (first dimension): 'peer' (second dimension); 'recovery' (third dimension); and 'coaching' (fourth dimension), are its four pillars for practice. The 11 coach competencies operationalise its delivery, whereby the continuous improvement of one's competence as a coach, is the responsibility of the coach-practitioner. Figure 4 illustrate the dimensional aspects of the CPRC program.

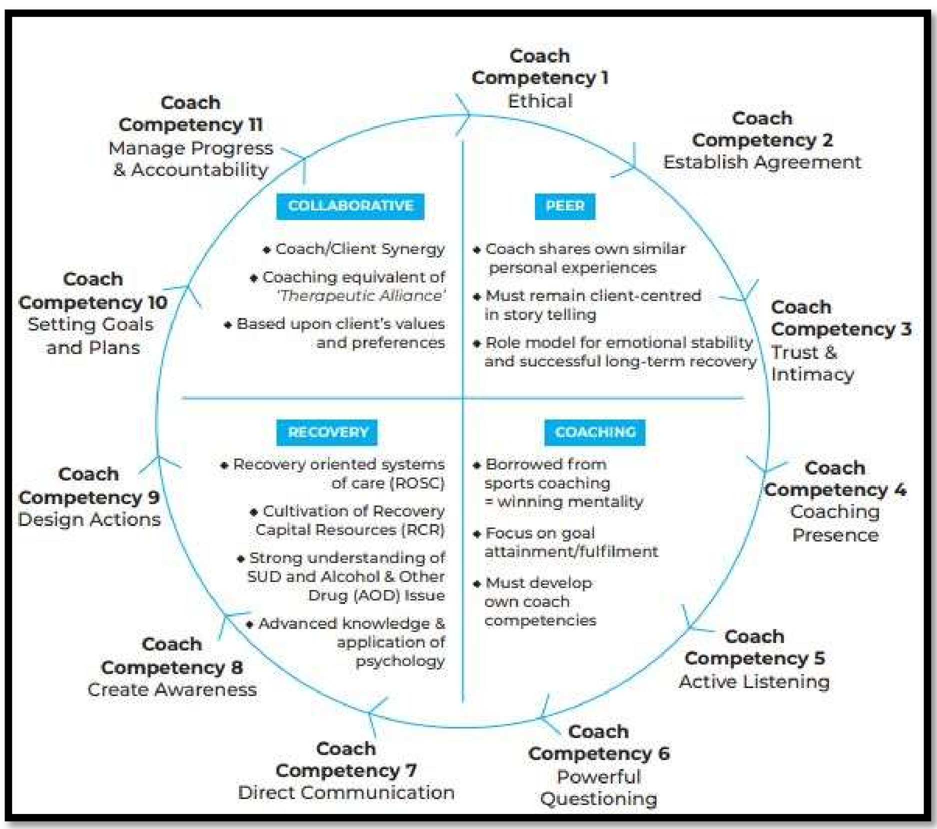


***Figure 4**:* The Collaborative Peer Recovery Coaching Program
Source: Developed for this study

This coaching program consists of 10-12 CPRC sessions, dependent upon the client's goals, availability and willingness to commit. The participation in the CPRC program is usually around 3 – 12 months, is self-funded by clients and with no grants given for participation. Session support are also given in conjunction to the CPRC sessions, via email, in social media groups and text messages, as needed. This chapter will outline the operationalisation of each dimension, with the intention to contribute to practice-based alcohol and other drug service delivery outcomes.

3.2.1 Collaborative Dimension

The literature covered in Section 2.4.6 described collaboration to be akin to what therapists refer to as the *therapeutic alliance* (Krupnick, et al., 1996). In the context of the CPRC program, 'therapeutic alliance' (TA) is the equivalent coaching term for the collaborative bond shared by the coach and client. This collaborative bond acts as a catalyst to deeper and deeper levels of engagement. Collaboration and synergy mean that each interaction and input from both coach and client, increases the learnings and insights, progressing the clients' goal attainment (Krupnick, et al., 1996).

Research as discussed in Section 2.4.6 *Barrier 6: Therapeutic Alliance* has shown that there is a positive correlation between the strength of the working therapeutic relationship, to how strongly a person recovers from their SUD issues. This correlation can be attributed to the strength and merit of their cooperative partnership (Krupnick, et al., 1996). When the therapeutic alliance is not strong and/or when the AOD worker shows symptoms of burnout (Barrier 6 and 7, Section 2.4.6 - 7) the efficacy of the coaching session remediation suffers.

Collaboration is a synergistic approach, reliant on the coach effect and coach's competency in keeping the client engaged with their recovery. Techniques were used by the CPRC practitioner to focus the client to stay true to their own values, while discovering their life purpose, even in active addiction. This level of rapport and engagement with the client encouraged a deeper dive into their world. With permission and consent, this collaboration was recorded and facilitated an interaction that is based upon what the client articulates to the CPRC practitioner, as their desired outcomes.

Techniques and activities activated by the CPRC practitioner include motivating the client to cultivate recovery capital resources, making of vision board/s, meditation, yoga practice, martial arts, journaling, lateral thinking, goal setting, and other activities that bolster the client's self-management skills. The CPRC practitioner acted as a guide in helping the client grow their own recovery assets, with the intention

of supporting them to gain a score of 50/50 in the assessment of recovery capital scale (Appendix A). A score of 50/50 means that the client has maximum resources for an ongoing, meaningful and fulfilling journey of recovery.

On the other hand, a score of 0/50 show that no recovery capital resources are yet evident. This RCR score is not assessed in the way the AUDIT, ASSIST or K10 assessment tools are administered, with its pathology-based focus. Instead of being administered prior to rapport being built or using it in an intrusive way to depersonalise client needs, the ARC scale is used as a conversation piece not given to the client to fill out. This builds a stronger collaborative partnership without threatening the therapeutic alliance, that is yet to be established. The CPRC connection is warm and authentic to mitigate barriers discussed in Section 2.7, do not continue to hinder SUD goal outcomes.

A likely reason therapeutic alliance is harder to build is because the average time a doctor or clinician spends with the patient can be around four to eight hours, a year. If awarded under the mental health plan, the social worker, case manager or therapist uses eight sessions (<1 hour per session) to effect change (Queensland Health, 2018). In contrast, time spent with a client throughout the whole CPRC program would be around 20 – 60 hours, over a span of up to 12 months. This would include conversations in between sessions via SMS, email and social media interactions. This is 2 to 14 times more 1-on-1 time that a clinician would be willing or able to spend with a patient. The average case load of AOD workers is between 20-50 cases every month, while psychiatrists spend 5-8 minutes 1-on-1 with patients in psychiatric facilities, in any given admission, dealing mostly with the patient's care team (Gold Coast Primary Health Network, 2016).

In contrast to the clinical setting workload per case, a CPRC practitioner is a non-clinical ally because what a client gets in the CPRC program is an active supporter, a confidant, and coach involved in many aspects of a client's life (White,

2010). This extra time and attention reinforce the importance of the 'collaborative' dimension of the CPRC program. As an AOD service, CPRC does not intend to replace clinical interventions but compliment recovery of clients with a recovery-oriented systems of care (ROSC) approach, delivered as part of a continuum of AOD services.

The CPRC Practitioner uses questioning techniques defined by the ICF (2020) in their competency evaluation schedule. Competency 6: *Powerful Questioning* and 11: *Manage Progress and Accountability*, are guides as to how to speak with the client competently so they unravel and understand their own trauma. Score measurements are detailed in Section 3.2.4. To incite collaboration, powerful questioning and management of client progress, assists the client to learn about their own set/s of maladaptive behavioural patterning. In working collaboratively with the CPRC practitioner, unhealthy coping and denial mechanisms can be reverse engineered to understand how they were used to deal with traumas experienced. At the core of CPRC is goal setting and ultimately the fruition of goals set in the first CPRC session. For this, a strong collaboration is need.

3.2.2 Peer Dimension

Those with lived recovery experiences know that help from peers with various aspects, such as housing, educational and work opportunities, lead to real changes that go far beyond accepting diagnosis and treatment. Currently, therapists still find it hard to speak from and divulge their own experiences, to guide the therapeutic mitigation and form the building blocks of a strong therapeutic alliance. According to the *Australian Health Ministers' Advisory Council* (2013, p. 11): "The concept of recovery was conceived by, and for, people with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of diagnosis". As people who have recovered often say: "We *are* the evidence!" (Campbell-Orde, Chamberlain, Carpenter, & Leff., 2005, p. 19). Lived experience is

at the heart of the national framework being used in delivering mental health (MH) services in Australia (Australian Health Ministers' Advisory Council, 2013).

Figure 5 illustrate their concept of the peer recovery model.

Figure 5: Mental Health Peer Recovery Model

Source: Australian Health Ministers' Advisory Council, 2013.

Experiences that are shared by both the practitioner and client cements the therapeutic bond (Australian Health Ministers' Advisory Council, 2013). If both can safely and openly talk about experiences, cathartic expressions will follow, based upon release of pains associated with long-term trauma (Australian Health Ministers' Advisory Council, 2013). Coach-practitioner explanation of first-hand experiences, aid in identifying denial mechanisms for participants, as they still display active addiction. As a peer with lived experience, the coach is not afraid of challenging the client, and discussing with them the various manipulative tactics they have employed.

This helps in given the client the ability to examine their own behaviours, so they can understand the mechanisms that have hindered their ability to fulfil goals previously set, on their own.

Covered in Section 2.5.3, peers are now utilised in hospitals to work hand in hand with medical professionals (Eddie, et al., 2019, Jack, et al., 2018). A systematic review of peer recovery coaching and support services by Eddie et al. (2019) at Harvard Medical School was completed on 15 studies. Outcomes reported were that patients accessing peer recovery support in groups, were more likely to implement peer recommendations. It was also found that there was a higher commitment to 12-step meeting attendance, and participants were likelier to remain abstinent from cocaine use. Another trend found was those with heroin dependence were likelier to remain abstinent, if supported by peers. These studies were discussed in Section 2.5.4.

Familiarity and rapport built within the coaching interactions, ensure the coach can bravely confront the client for each relapsing incident that merit challenging. Some of the participants have been tried for criminal charges and have had numerous traumatic incidents happen in their lives. Many have admitted to being diagnosed with severe mental illnesses and a host of other medical issues, such as fibromyalgia, autoimmune disorder and obesity, to name a few. It is paramount that the open-mindedness and sincerity shown by the CPRC Practitioner, inspires the client to achieve goals, they might not otherwise have the capacity or belief to achieve, on their own.

The *Collaborative Peer Recovery Coach* (CPRC) practitioner is mindful of the role family members play in the long-term success of their loved ones during recovery. Oftentimes, a CPRC Practitioner helps loved ones cultivate insight into the process of recovery as the person going through recovery may be unable to articulate their feelings and emotions in a healthy manner. The CPRC Practitioner acts as the buffer for both parties as they all try to process the whole recovery continuum, ensuring that

everyone can appreciate its complexity and depth. The willingness of the CPRC Practitioner to be available, can mean the difference between someone's successful re-entry into healthy and sober community life or a return to the downward spiral of addiction. As new practitioners enter the field of CPRC, each will bring their own cultural diversity, educational attainments and world views consequently matched to suitable clients. Peer work reinforces the second treatment principle, valuing clients' unique needs, backgrounds and varied experiences.

3.2.3 Recovery Dimension

Attention to peers and lived experiences are reflected in the growing interest in recovery with recovery-oriented supports (Loveland & Boyle, 2005; White, 2010). After the role of recovery coaches were defined in Section 2.5 and 2.5.2, it can be summarised that the recovery coach and client produce goal outcomes that prioritise recovery from substance use disorders (Loveland & Boyle, 2005). Recovery Coaches affirm that health and wellness are inherent in clients, therefore they are viewed as creative and resourceful (White, 2008). Recovery coaches do not promote or endorse any single or particular way of achieving or maintaining sobriety, abstinence, or serenity or of reducing suffering from addiction (White, 2010). The focus is on coaching our clients to create and sustain hope-filled and meaningful lives (Eddie, et al., 2019; Loveland & Boyle, 2005).

Recovery is a product of dynamic interaction among characteristics of the individual, characteristics of the environment and the characteristics of the exchange (Campbell-Orde, et al., 2005). Campbell-Orde et al. (2005) produced a compendium of recovery measures and described 'characteristics of the individual' to include self-agency, holism, hope, a sense of meaning and purpose. The 'characteristics of the environment' included access to basic material resources, ability to sustain healthy social structures and relationships, ability to participate in meaningful activities, and also have access to peer support, formal services and alcohol and other drug staff. The

last product of recovery mentioned was the 'characteristics of the exchange', this includes having the referent power to display and practice values of hope, choice, empowerment, independence and interdependence.

According to Campbell et al. (2005), a key difference between the traditional model being utilised and the orientation to recovery is the distribution of power. The medical model comprises of health practitioners who direct the system and set its direction and tone. Practitioners decide the most important elements and patients need to be compliant in accepting treatments offered. Evidence-based research awards direct funding to the medical model. Recovery-based programs, such as peer support, coaching and self-help development, see little opportunity to develop their evidence base.

Through the process of recovery coaching, clients deepen learning, improve performance, and enhance quality of life (Eddie, et al., 2019; Loveland & Boyle 2005; White, 2010). In each meeting, the client chooses the focus of conversation, while the coach listens and contributes observations and questions (ICF, 2020; White, 2008). This interaction creates clarity and moves the client toward action. Recovery Coaching accelerates the client's progress in recovery by providing greater focus and awareness of choices, actions, and responsibility (White, 2010). Coaching concentrates on where clients are now and what they are willing to do to enjoy a better tomorrow (Grant, 2003). These tenets of recovery coaching, along with the CPRC Practitioner's peer experience helps the client recognise that results are a matter of the client's intentions, choices, and actions taken toward building a strong foundation. The coach and client create a life worth staying sober, abstinent, and healthy for.

Recovery orientation is a concept being explored within the Australian field of therapeutic practice. Upon scanning literature regarding contemporary treatment practices, diagnostics and assessment questionnaires, the insider-researcher synthesised an approach that can work hand-in-hand with existing treatment models.

Rather than subscribing to the pathology or disease-based traditional medical model, (Barrier 3 covered in Sections 2.4.3), the third CPRC dimension is based upon the recovery-oriented system of care (ROSC) model.

Glover (2012) proposes five models that act as a framework reflecting the efforts that people must undertake to journey to a sustainable road to recovery. Glover's (2012) five steps include taking the client from: 1. passive to active sense of self; 2. hopelessness to despair; 3. being in another's control to gaining back personal control; 4. alienation to discovery; and 5. disconnectedness to connectedness. These same steps are used within the CPRC program to guide the client towards the fruition of their recovery goals.

Part of the third dimension of the CPRC program is amassing the recovery capital resources needed for sustainable, enjoyable, and fulfilling recovery. Recovery capital resource (RCR) scores helps the coach understand how to best support the client. Wherever the client stands in this RCR spectrum, the score at the end of the first session acts as a baseline. Goals formed in collaboration with the client in the first session are kept as the goalpost upon which the client aims toward. Goal attainment and increase in recovery capital resources are the ultimate goals, irrespective of SUD issues that the client may present with.

In seeking recovery, a client is faced with choices for therapeutic support, such as a psychologist, a counsellor, or a rehabilitation centre (known in Australia as therapeutic community). As part of supportive community with a ROSC model, participation in a 12-step program is encouraged by the CPRC Practitioner. Examples of these 12-step programs (Alcoholics Anonymous, 2014) are Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Sex Addicts Anonymous (SAA), Sex and Love Addicts Anonymous (SLAA), Al-Anon, Alateen, Sex Workers Anonymous (SWA), Overspending Anonymous (OA), Porn Anonymous (PA), Gamblers Anonymous

(GA), SMART Recovery Australia, Food Addicts Anonymous (FAA) and Online Gaming Addicts Anonymous (OGAA).

3.2.4 Coaching Dimension

Stemming from professional coaching, recovery-orientation and peer-supported care covered in the literature review, the CPRC program is a concept developed by the researcher that contributes to contemporary knowledge and practice-base literature. Coaching is the fourth dimension of the CPRC program, where competencies outlined by the ICF become the foundation from which the CPRC practitioner operates from. Exploring the possibilities for goal attainment is facilitated by the CPRC, as the coach sets the parameters for ongoing accountability (Allen, Manning, Francis, & Gentry, 2016). In the first CPRC session, the coach and the client should arrive at three goals mined from the goal areas in Table 5. Goals are then structured to meet the following criteria:

1. Must be inspirational for both coach and client to work on. Therefore, inspiration is heightened with the goal is worded positively, such as "*Learn prosperity mindset and have $10,000 saved*" vs. "*Do not file bankruptcy"*).
2. Must be extremely challenging for the client, hence employing a coach as an accountability partner, in the hopes of increasing their capabilities and expanding their current skillset and worldviews.
3. Must embed a deadline in the wording of the goal of exactly when must it be achieved. For example, "*By Spring 2018, I have a prosperity mindset and have saved $10,000 in my online savings account*"
4. Must have sufficient detail (specific, measurable, clear, and succinct), so that the client knows exactly, that it has been achieved.

An example of a goal that meets all of the criteria above, by a client was: "I am looking great in my brand new, size 8 designer bikini, as I sit by the beach this summer, enjoying the sun with my husband and kids'.

Table 5 summarise the goal setting areas, uncovered in the first CPRC session. The client picks three priority areas, that will form the working of their three goals, from this list.

Table 5:

Goal Setting Areas for CPRC Session #1

	GOAL AREA	GOAL AREA EXAMPLES
1.	Relationship	intimate partnership, past relationships, current relationship status
2.	Health	nutrition, medical conditions, sleep level
3.	Fitness and/or Sport	exercise regime, any sport or martial arts, yoga, dance, gym, etc.
4.	Financial planning	monies owing or debt, investment, savings, house
5.	Business	staff productivity levels, profit/loss, and cash flow
6.	Career	long term profession, corporate, executive or trade
7.	Job	work that brings in money, contracts
8.	Family	history and quality of parental, sibling and offspring relationships
9.	Social life	leisure groups, support networks and friendships
10.	Creativity	creative pursuits, such as art, writing, singing, dancing, poetry etc
11.	Community	Activities or donations that contribute to others in need
12.	Education	personal development (self-study), tertiary, vocational, post-grad
13.	Emotional	stability, confidence, self-esteem/awareness, emotional stability
14.	Hobbies	knitting, car repair, reading group, collecting comics/stamps etc
15.	Living environment	owned, rented, safety, recovery homes, treatment centres etc
16.	Transport	car, mobility and/or other ways of getting around
17.	Travel	travel aspirations/holiday goals, holiday memories to rekindle
18.	Spirituality	practice of spiritual values, quiet time, religious affiliation etc

An aspect of the fourth coaching dimension in the CPRC program, is the use of video (Jones, et al., 2015). The coaching model is borrowed from sports coaching and athletes are known to watch past games and competitor's videos, as instructed by their coach, to improve peak performance. To be accredited as a CPRC Practitioner, all CPRC sessions must be video recorded, where the camera only reveals the coach's identity, and never captures the client's facial identity. Audio recording can also be utilised, although from a reflection and continuous personal and professional development perspective, video logs improve CPRC Practitioner's coach competencies (Doncaster & Thorne, 2010). Utilising videos has enabled the insider-researcher to present accurate research data. It can contribute to contemporary social science researcher themes (henry & Fetters, 2012).

Video recorded CPRC sessions (60-90 minutes) are useful in investigating social, psychological, and behavioural interactions. Henry and Fetters (2012) explained that video recordings, accompanied by a relevant methodological orientation, provide unprecedented opportunities for those interested in qualitative research. Sensitive data collated by the CPRC insider-researcher regarding the phenomena of SUD, enables detailed scrutiny of activities and events, as they arise. This provides an opportunity for reflection that allows for further exploration of ways in which SUD can be mitigated. Unlike more conventional forms of qualitative data, such as note taking, interviews and filling interview forms and surveys, video recording provide an analytic resource that can be shown and shared with the research community (Heath, Luff, & Svenson, 2007; Jones, et al., 2015).

Video also provides an opportunity to inform practice in light of themes that may emerge (Jewitt, 2012). Perkinson (2008) noted that clinical treatments tend to focus on alleviating dysfunctionality and changing past conditioning. Therefore, use of video recording, without revealing client identity is of importance, as it helps break down specific dysfunctions and denial mechanisms, as they take place. This enables the coach to prepare for the CPRC session, prior to client arrival. The client can also

use the video logs to learn about their 'opponent' and used in line with the sports coaching analogy, their opponent is their own substance use disorder.

Coaching Competencies. Complex and often emotionally-laden video logs of the coaching sessions have been examined by the CPRC practitioner, to develop her own coaching competencies. The video logs allowed the CPRC practitioner to monitor and score her own competencies regularly. Reiss (2006) point out that professional coaching associations have an important role to play in cultivating high-quality training for new coaches. To ensure a high standard of coaching competencies was delivered for this qualitative study, an ICF accredited mentor coach was engaged to give feedback on participant sessions. Feedback was used for reflexive practices, in line with the CPRC practitioner's personal and professional development goals. It also formed part of ICF requirements for re-accreditation.

A total of 10, one-hour mentoring sessions were sought, and specific feedback received, using the video logs provided to the ICF accredited mentor. Using the metrics and score rating for the 11 coach competencies described in Section 3.2.4, the CPRC practitioner also participated in 5x 3 hour-long group mentoring sessions. In these group mentoring sessions, up to 15 different accredited ICF coaches gave and received coach competency feedback, to others in attendance.

To define what professional coaches accomplish within a coaching session, Associate Certified Coach accreditation requirements are included in Figure 7, to provide clarity on the coaching competencies and skills, a credential coach must display and develop (ICF, 2020). An Associate Certified Coach (ACC) need at least 60 hours of coach specific training with robust documentation. Ten hours of mentoring, continuing education unit (CEU) points, after initial accreditation, and a coaching log (full names, emails, and phone numbers) which demonstrates at least 100 hours of coaching sessions completed successfully (ICF, 2020). Associate Certified Coaches (ACC) requirements are shown in Figure 6.

Associate Certified Coach (ACC) Application Requirements

ACC ACTP Path	ACC ACSTH Path	ACC Portfolio Path
Completion of an entire ICF Accredited Coach Training Program (ACTP). Check for your program's approval here.	At least 60 hours of coach-specific training through an ACTP or ACSTH program. Check for your program's approval here.	At least 60 hours of coach-specific training with robust documentation.
Coaching log demonstrating 100 hours (75 paid) of coaching experience with at least 8 clients following the start of your coach-specific training. At least 25 of these hours must occur within 18 months of submitting your credential application.	10 hours of Mentor Coaching to be documented on your online application.	10 hours of Mentor Coaching to be documented on your online application.
Complete the Coach Knowledge Assessment (CKA).	Coaching log demonstrating 100 hours (75 paid) of coaching experience with at least 8 clients following the start of your coach-specific training. At least 25 of these hours must occur within 18 months of submitting your credential application.	Coaching log demonstrating 100 hours (75 paid) of coaching experience with at least 8 clients following the start of your coach-specific training. At least 25 of these hours must occur within 18 months of submitting your credential application.
	Complete the Coach Knowledge Assessment (CKA).	Performance evaluation (audio recording and written transcript of coaching session to be uploaded with your application).
		Complete the Coach Knowledge Assessment (CKA).

Figure 6: Associate Certified Coach (ACC) Application Requirements

Source: International Coaching Federation (2020)

Professional Certified Coaches require 125 coach specific training hours, ten (10) hours of mentoring, ongoing CEU accrued yearly and 500 hours of coaching log evidence (ICF, 2020). The highest level accredited for the ICF is coaching mastery (Master Certified Coach or MCC), incorporating the PCC requirements and adding an extra 2500 logged coaching hours, another 200 training hours more than a PCC, and ongoing CEU and mentoring by an ICF coach-mentor. Professional Certified Coaches (PCC), requirements are shown in Figure 7.

Professional Certified Coach (PCC) Application Requirements

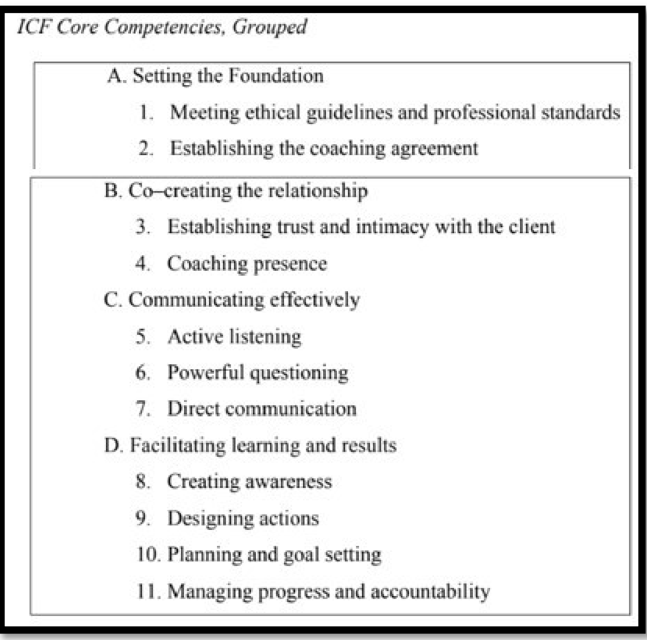
PCC ACTP Path	PCC ACSTH Path	PCC Portfolio Path
Completion of an entire ICF Accredited Coach Training Program (ACTP). Check for your program's approval here.	At least 125 hours of coach-specific training through an ACTP or ACSTH program. Check for your program's approval here.	At least 125 hours of coach-specific training with robust documentation.
Coaching log demonstrating 500 hours (450 paid) of coaching experience with at least 25 clients following the start of your coach-specific training. At least 50 of these hours must occur within 18 months of submitting your credential application.	10 hours of Mentor Coaching to be documented on your online application.	10 hours of Mentor Coaching to be documented on your online application.
Complete the Coach Knowledge Assessment (CKA).	Coaching log demonstrating 500 hours (450 paid) of coaching experience with at least 25 clients following the start of your coach-specific training. At least 50 of these hours must occur within 18 months of submitting your credential application.	Coaching log demonstrating 500 hours (450 paid) of coaching experience with at least 25 clients following the start of your coach-specific training. At least 50 of these hours must occur within 18 months of submitting your credential application.
	Performance evaluation (two audio recordings and written transcripts of coaching sessions to be uploaded with your application).	Performance evaluation (two audio recordings and written transcripts of coaching sessions to be uploaded with your application).
	Complete the Coach Knowledge Assessment (CKA).	Complete the Coach Knowledge Assessment (CKA).

Figure 7: Professional Certified Coach (ACC) Application Requirement

Source: International Coaching Federation (2020)

A summary of coaching competencies reflects the core coach competencies required for accreditation as an International Coaching Federation coach-practitioner. From its inception in 1995, the ICF sought to accredit coach training curriculum, enabling coaching skills to be taught at a consistently high-level, regardless of language spoken or location. Credentialed coaches are clearly displayed within the ICF Coach Member directory website and display credentialed coaches in an ICF directory, for consumer verification. The coach effect suggests that the amount of training

completed, the mentoring received, along with the number of hours of coaching experience logged contribute to higher score ratings in the coach competency metrics (ICF, 2020; Reiss, 2015). Without a membership and ongoing assessment with the ICF, for example, it will be hard to measure or rate their coaching competence to better ascertain the coach effect. Figure 8 gives a picture of the how the competencies are grouped, according to the ICF.


ICF Core Competencies, Grouped

A. Setting the Foundation
1. Meeting ethical guidelines and professional standards
2. Establishing the coaching agreement

B. Co–creating the relationship
3. Establishing trust and intimacy with the client
4. Coaching presence

C. Communicating effectively
5. Active listening
6. Powerful questioning
7. Direct communication

D. Facilitating learning and results
8. Creating awareness
9. Designing actions
10. Planning and goal setting
11. Managing progress and accountability

***Figure 8**:* Grouped ICF Core Coach Competencies

Source: International Coaching Federation (2020c)

To illustrate coach competency (CC) needed for credentialing and uniformity of coaching service provision, a short summary has been listed for quick reference. The ICF metric scoring is extensive and not within the score of this research, therefore only the first two scoring metrics are included, in the following pages. This information gives an example of competency lower-score cut-off needed to gain, and/or keep ICF accreditation and membership current. Lower-limit cut off scores

have been discussed previously and are as follows: > 75% (ACC), >80% (PCC) and >85% (MCC). Competency scores may be attributable to the coach effect, this requires further study not included in this research.

Coach Competency 1: Behave ethically and meet professional standards. The coach must ensure the client understands the difference between coaching and other modalities, such as counselling and psychotherapy. The coach must adhere to and exhibit congruent behaviours aligned with the ICF Code of Ethics. If needed to combine consulting or counselling with coaching, permission must be sought to do so, and coaches must be suitably credentialed in this field, adhering to its codes of conduct.

a	Understands and exhibits in own behaviours the ICF Standards of Conduct (see list)		Rating 1-10
	i.	is familiar with the ICF Standards of Conduct	______
	ii.	is clear on the personal application of each Standard of Conduct	______
	iii.	researches any Standard they are unsure about	______
		is willing to be responsible for regularly rating themselves against the Standards, and following up on any that are not being fully met	______
	iv.	acts in accordance with the ICF Standards of Conduct in all dealings	______
b	Understands and follows all ICF Ethical Guidelines (see list).		
	v.	is familiar with the ICF Ethical Guidelines	______
	vi.	is clear on the personal implications of each of the Ethical Guidelines	______
	vii.	researches any Ethical Guidelines they are unsure about	______
	viii.	is willing to be responsible for regularly rating themselves against the Guidelines, and following up on any that are not being fully met	______
	ix.	refuses to enter into any conversations or agree to any action with a client that may be considered unethical or illegal	______

Rating: 10 exceptional; 5 average; 1 requires serious coach supervision
Source: Coach Competencies: International Coach Federation internal website, 2020.

Coach Competency 2: Establish and adhere to the coaching agreement. It is important that the coach understands and effectively discusses with the client the guidelines and specific parameters of the coaching relationship. For this, the coach must cover what the client's responsibilities are and describe how challenging the coaching relationship can get as it stretches the individual to reach the next level of learning.

		Rating 1-10
a	Understands / effectively discusses with the client the guidelines / specific parameters of the coaching relationship (e.g., logistics, payment fees, scheduling, inclusion of others etc).	
i.	clearly explains all the features of the coaching series in the trial session	______
i.	encourages the client to ask questions and answers them appropriately	______
ii.	sets a fee that is appropriate to the type of goals, the income level of client and the experience of the coach	______
b	Reaches agreement about what is appropriate in the relationship and what is not, what is and is not being offered, and about the client's and coach's responsibilities.	
i.	discusses the T&C's, ensuring that the client is aware of their responsibilities	______
ii.	discusses the coach's expectations of the client including punctuality, actions between sessions, contacting the coach outside of sessions, payment method	______
iii.	explains their responsibilities as a coach including commitment/confidentiality	______

Rating: 10 exceptional; 5 average; 1 requires serious coach supervision
Source: Coach Competencies: International Coach Federation internal website, 2020.

Coach Competency 3: Establish a strong sense of trust with the client. The coach must exhibit genuine concern and respect for the client's welfare. This must be continuously demonstrated through integrity, honesty, and sincerity within sessions. The best coaches are aligned with the practice of these values in their own personal life, as well as in their professional practice.

		Rating 1-10
a	Shows genuine concern for the client's welfare and future.	
i.	gives the client complete attention	______
ii.	asks questions which express genuine interest in and concern for the client	______
iii.	gives examples of where coaching exercises can be used in other areas of life	______
iv.	listens to and acts on intuition as to whether a client is clear/ complete	______
v.	is certain that the client is aligned with the context	______
b	Continually demonstrates personal integrity, honesty, and sincerity.	
vi.	is open and honest with the client	______
vii.	is in a real conversation with the client, not following a script	______
viii.	makes sure the client is ready to move on before doing so	______
ix.	openly discusses whether the context of a session has been met or not	______
	provides follow up information and sources for client when unable to directly answer their questions	______
x.	newly creates content of every coaching session with each client	______

Rating: 10 exceptional; 5 average; 1 requires serious coach supervision
Source: Coach Competencies: International Coach Federation internal website, 2020.

Coach Competency 4: Possess a strong coaching presence. This is the ability to be fully conscious and in the moment. This means the ability to access intuition and create a spontaneous relationship with the client, employing a style that

is open, flexible, and confident. Coaches must demonstrate confidence in working with strong emotions, showing evidence of their ability to manage these emotions intelligently.

	Rating 1-10
a. Is present and flexible during the coaching process, dancing in the moment.	
i. is totally focused in the moment	______
ii. focuses on the client rather than themselves	______
iii. responds to what is happening, not how they think the coaching should go	______
b. Accesses own intuition and trusts one's inner knowing – "goes with the gut".	
i. listens to their inner voice and can express this to client in a way they will understand	______
ii. allows themselves to vocalise something in their intuition	______
iii. is committed to developing their intuition	______

Coach Competency 5: Practice active listening skills. This is the ability to focus completely on what the client is saying so that the meaning of what is said in the context of the client's desires are fully understood. The excellent coach also listens for what is not being said, reading the client accurately and making a conscious effort to attend only to the client's agenda and desired outcomes.

	Rating 1-10
a. Attends to the client and the client's agenda, and not to the coach's agenda	
i. focus of the conversation if kept on the client	______
ii. does not bring their own agenda into the conversation	______
iii. notices when their own agenda comes in, able to put aside and focus on client	______
stands for the client being great, not just on them achieving their goals	______
b. Hears the client's concerns, goals, values, and beliefs about what is and is not possible.	
i. notices when the client feels something is possible or not possible	______
ii. notices deeper beliefs/attitudes when a client thinks something is not possible	______
iii. discusses and clarifies what the client expects of the coach and coaching	______

Rating: 10 exceptional; 5 average; 1 requires serious coach supervision
Source: Coach Competencies: International Coach Federation internal website, 2020.

Coach Competency 6: Master powerful questioning. The coach asks powerful questions that evoke discoveries, commitment, action, greater clarity and better possibilities or new learnings. Better outcomes are achieved when coaches ask questions that move the client toward what they desire, instead of asking questions that get the client to justify.

a. Asks questions that reflect active listening and an understanding of the client's perspective. — Rating 1-10

i. asks succinct, specific questions ______
ii. gives the client his/her total attention before asking a question ______
iii. asks questions that relate directly to the client's perspective ______

b. Asks questions that evoke discovery, insight, commitment, or action (e.g., those that challenge the client's assumptions).

i. asks questions that call the client to think in a new way about themselves ______
ii. asks questions that call a client to take action or develop commitment ______
iii. encourages the client to create actions by asking action-orientated questions at appropriate times in conversations ______

Rating: 10 exceptional; 5 average; 1 requires serious coach supervision
Source: Coach Competencies: International Coach Federation internal website, 2020.

Coach Competency 7: Use direct communication. The coach uses language that has the greatest positive impact on the client, such as acknowledgement, praise, analogies, metaphors, and useful feedback. The coach communicates succinctly, helping the client get to the point without the need to engage in superfluous stories.

a. Is clear, articulate, and direct in sharing and providing feedback. — Rating 1-10

i. can express important issues in a short clear sentence ______
ii. provides enough detail so the client understands issues fully ______
iii. shares personal issues to aid understanding, where appropriate ______
iv. is articulate enough for the client to hear and understand without effort ______
v. gives feedback in a way that gives the client real value ______
vi. asks permission to give feedback on any area that is sensitive to the client ______
vii. gives feedback even when it is uncomfortable for them as a coach ______

b. Reframes and articulates to help the client understand from another perspective what he/she wants or is uncertain about.

i. says things back to the client in a more succinct form ______
ii. chooses alternative viewpoints that are appropriate to the situation ______
iii. checks in with client to ensure they are clear about an issue ______

Rating: 10 exceptional; 5 average; 1 requires serious coach supervision
Source: Coach Competencies: International Coach Federation internal website, 2020.

Coach Competency 8: Create clarity and awareness. Integrate all the pieces within all successive coaching sessions and then accurately evaluate and make interpretations that help the client gain ongoing awareness. A coach helps the client differentiate between the facts, perceptual interpretation, disparities between thoughts, feelings, and action. A coach makes the client distinguish between trivial and impactful effects.

a. Goes beyond what is said in assessing the client's concerns, not getting hooked by the client's description. Rating 1-10

i. listens to all aspects of the client – their energy, their emotion, body language, not just their words ______
ii. hears the major concern behind the client's conversation ______
iii. is objective with the client's story ______
iv. is aware of their own triggers or issues and puts those aside ______

b. Invokes inquiry for greater understanding, awareness, and clarity.

i. asks questions around the subject to prompt the client to investigate further ______
ii. works to set actions that further investigation by the client ______
iii. gives the client space to think and process insights for greater awareness ______

Rating: 10 exceptional; 5 average; 1 requires serious coach supervision

Source: Coach Competencies: International Coach Federation internal website, 2020.

Coach Competency 9: Design engaging actions. As the coaching sessions are all about accountability and moving the client to action, creating opportunities for ongoing learning within work/life situations are paramount. To cement concepts of action taking, small successes and capabilities must be celebrated.

Rating 1-10

a. Brainstorms and assists the client to define actions that will enable the client to demonstrate, practice, and deepen new learning.

i. encourages the client to set actions for themselves rather than depend on coach ideas ______ ______
ii. provides a broad range of ideas that inspire the client to come up with their own answers ______
iii. guides the client to transform their ideas and suggestions into specific actions ______

b. Helps the client to focus on and systematically explore specific concerns and opportunities that are central to agreed-upon coaching goals.

iv. constantly pulls client back to the core issues of coaching ______
v. ensures the actions are relevant to the current strategy ______
vi. asks questions which seek more detail and reflection ______
vii. keeps the client informed and aware of where they are up to in the coaching series and within each goal ______ ______

Coach Competency 10: Collaborative planning and goal setting. The coach collaborates with the client to develop and maintain a strategic coaching plan. All collected information must be consolidated to ensure achievement of goals, reflecting on major areas of learning and development. The goals must be inspirational, realistic yet challenging, measurable, specific, and have target dates. Early successes are accentuated to build the client's confidence and commitment to progress and where possible, flexibility must be employed.

a. Consolidates collected information and establishes a coaching plan and development goals with the client that address concerns and major areas for learning and development. — Rating 1-10

i. is able encourage client to generate a list of at least 15 different areas the client has in their life ______
ii. is able to work with the client to refine the list to the 3 different areas ______
iii. able to guide client to define most impactful SMART goals meets all of the requirements for primary goals ______

b. Creates a plan with results that are attainable, measurable, specific and have target dates.
iv. can set goals that meet all the requirements for primary goals – specific, measurable, inspiring, one focus, achievable, succinct ______
v. has confidence to guide client through goal setting process so that each goal meets all of the requirements for primary goals ______
vi. checks all primary goals with mentor between session 1 and 2 ______
vii. is able to introduce the concept of 'strategies' to the client and facilitate the creation of a plan to reach each goal ______
viii. is able to create a set of strategies that meet all requirements – specific, broad, clear, logically connected, positive ______

Rating: 10 exceptional; 5 average; 1 requires serious coach supervision
Source: Coach Competencies: International Coach Federation internal website, 2020.

Coach Competency 11: Manage progress and accountability. The coach must cultivate the ability to hold attention on what is important for the client, and to leave responsibility with the client to continue to take actions. Prior to sessions, preparation is key in being able to manage goal attainment with clients.

In summary, a trained and suitably accredited coach will have the ability to move back and forth between the big picture of where the client is heading, setting a context for what is being discussed and where the client wishes to go.

a. Demonstrates follow through by asking the client about those actions that the client committed to during the previous session (s). — Rating 1-10
i. checks in on the outcome of each action the client set ______
ii. checks in on the level of completion of each action, making sure the client did not miss any part of the action ______

b. Acknowledges the client for what they have done, not done, learned, or become aware of since the previous coaching session (s).
i. acknowledges the client for what they have done between sessions ______
ii. discusses what the client did not do in an objective manner ______
iii. discusses what the client learned or became aware of since the last session ______
iv. congratulates the client for the completion of challenging actions ______

In summary, a trained and suitably accredited coach will have the ability to move back and forth between the big picture of where the client is heading, setting the context for what is being discussed and where the client wishes to go. The crux of

developing competencies for a coach is to promote self-discipline and gain the skills to make the client accountable for what they say they are going to do (Reiss, 2015). High levels of coach competency rating scores will contribute to the 'coach effect', whereby each coach-practitioner will get different results, set different intended actions, and coach the client according to their skill and competency level. As in every session, a mutually agreed upon coaching goals are set with the client, including related time frames covered in section 3.2.4 and Table 5. An excellent coach will positively confront the client with the importance of completing agreed-upon actions, so that their progress is maximised (Reiss, 2015).

3.3 Conclusion

The dimensions of the CPRC program were delineated in this chapter as informed by the literature review. The CPRC program was developed by the researcher with the intention of contributing to contemporary knowledge and practice-base findings. With its four dimensions for practice, this chapter outlined how the CPRC program intervention may address gaps that hindered successful provision of alcohol and other drug treatment outcomes.

Stemming from professional coaching and recovery coaching precepts covered in the literature review, the CPRC program, with its' video recording and transcription system, is a research concept, worth investigating. This chapter outlined that the crux of the CPRC program as it was delivered in Australia, that promotes self-discipline, self-awareness and goal attainment. It was shown throughout Chapter Three that the various coach competencies that CPRC Practitioner must continuously improve and develop, to stay accredited as a coaching professional, accredited with the ICF. It has been argued that the coach competency ratings contribute to the coach effect.

Chapter Three provided illustrations and described each of the four dimensions of the CPRC program. Definitions of how collaboration was established, was

discussed. The collaborative component has similarities to the term: ‘therapeutic alliance’ in treatment and this was covered in this chapter. As the dimensions for CPRC practice was delineated, the peer dimension and its importance were elaborated upon. After highlighting that lived ‘peer’ experience and peer-led consultation rounds was started by the National Mental Health Commission (2018) to spearhead the Australian mental health reform, Dr Penny Brown asserted that collaboration between organisations, are as important as collaboration between client and practitioner. This study represents a first step in contributing to professional practice knowledge, related to the implementation of an evidence-based, peer recovery coaching intervention, in Australia.

The next chapter will focus on the research approach and methodology applied in this study.

CHAPTER FOUR: METHODOLOGY

4.1 Introduction

This chapter focuses on the methodological approach used by the researcher to analyse the impact of CPRC. This chapter will start with the work-based learning approach used for this Professional Studies doctoral program. What made this practice-based study unique and rich in content, was the video recordings and transcripts, which allowed a retrospective analysis of the coaching sessions that already occurred. This means that the participants were in their natural setting, providing authentic content, without fear or pressure to perform to a pre-determined set of research outcomes (Nassaji, 2015).

The data collection section will discuss the research design, how the data was manually collected to preserve the integrity of the question item scores, how it was analysed to tabulate before and after recovery capital scores, and what types of patterns that emerged. Video recording protocols, the transcription process and assessment of recovery capital (ARC) scale used for this study will be discussed. Following that, procedures for recruiting participants will be covered, along with providing a summary of the participants' details, and three goal areas.

This chapter will be concluded with detail on how the three results: Result 1: pre- and post-CPRC RCR scores; Result 2: patterns that emerged from coaching sessions; and Result 3: the self-rated goal attainment scores, were tabulated and analysed for discussion in Chapter Five and Six.

4.2 Research Design

This insider- research (IR) study utilised theoretical foundations of a work-based learning (WBL) research pedagogy, discussed in Section 1.4. Using an exploratory, practice-informed research, this study was conducted by an insider-

researcher (IR) using qualitative data derived from 18 participants. The multiple client cases (n=18) provided a constructivist account of each of the participant's experiences, whilst immersed in the CPRC program.

The trustworthiness of qualitative research is often debated because qualities of validity and reliability are hard to address in the naturalistic work setting (Nassaji, 2015; Shenton, 2004). While the results cannot be extrapolated over to the larger SUD population, what this study provides is a saturation into the CPRC coach-client interaction, as it naturally occurred. Work-based learning (WBL) and in this study, practice-based research, refer to doctoral learning that takes place, while the insider-researcher also plays the role of a practitioner (Fergusson, et al., , 2019a; Fergusson, et al.,, 2020; Lester & Costley, 2010).

Conventional empirical research developed rigorous principles to guide traditional research conduct (Creswell & Creswell, 2018). These conventions may inhibit transformational change (Unluer, 2012), therefore work-based has been developed against a different set of research principles and WBL characteristics (Fergusson, 2019; Stringer, 2007). In conventional research, insider-researchers appear in opposition to the traditional empirical model (Rooney, 2005; Unluer, 2012). Empiricists argue that the notion of 'bias' may play a part, when the insider-researcher is also the practitioner that has a direct involvement with the research process and case study participants (Rooney, 2005). To prevent any escalation of insider-researcher bias, video recordings and transcripts played a part in providing evidence-base that can aid in understanding the complex phenomenon of substance use disorders, as it occurred in the participants lives.

There were four advantages shown within this WBL research project for utilising a peer-practitioner to deliver the research. They were: a) the insider-researcher had affinity with the circumstances the case study subjects found themselves in (Fergusson, et al., 2020); b) as a peer, the insider-researcher had greater potential of

eliciting a richness, fidelity and authenticity of information exchanged with the client (Fergusson, 2019; Rooney, 2005); c) the validity of the client responses were increased because of the insider-researcher's honest and candid responses with her own past experiences deepened the coach-client therapeutic alliance (Henry & Fetters, 2012), and d) the peer-perspective offer an understanding of the symptomatic characteristics of the 'addicted' personality, for participant reflection and over time, learnings integrated to their day to day life.

The research design was based upon the research questions postulated in the introduction. This qualitative research responds to the research questions, for convenience has been again summarised below:

> Does the use of the collaborative peer recovery coaching (CPRC) program enhance recovery capital resources and promote attainment of goals in people with substance use disorders (SUD)?

Stemming from the main question are three sub-questions that relate to recovery capital resources (RCR):

1. Evidenced in the participants' before and after RCR scores, how did CPRC affect the ten different RCR dimension?
2. As the coaching series developed, what change patterns occurred in relation to the effect of CPRC on participants' RCR scores?
3. Despite the ongoing existence of SUD issues, what effects did CPRC have on participants' ability to achieve pre-determined goals, set in the first coaching session?

This qualitative research then sought to answer the question by dividing the results into three segments:

- Result 1: Pre- and post-CPRC RCR score: 0-50

- Result 2: Emergent patterns, being:
    - a) *improved,* b) *did not improve and* c) *no negative change*
- Result 3: Client-Rated Goal Attainment Score: 0-100%

4.3 Data Collection Procedures

The CPRC program was the chosen intervention and the Assessment of Recovery Capital (ARC) scale was used to collate a score of an individual's recovery strengths (Department of Health and Human Services, 2011). The ARC consists of 50 statements in ten RCR dimensions (Appendix A). Each of the dimension consists of five, 'yes' or 'no' statement-like items, assessing recovery strengths. A 'yes' response is equivalent to a 1, and a 'no' response = 0. Groshkova, Best, and White (2013) demonstrated moderate ARC test–retest reliability, and good concurrent validity with the World Health Organization (WHO) quality-of-life measure (WHOQOL-BREF) in a Scottish sample.

These 50-item ARC scale indicate strengths and resources needed to sustain long-term recovery and quality of life, whilst in active addiction and trying to remain abstinent from addictive substances. Like the WHOQOL-BREF, there are no cut off scores for the ARC. Higher scores (consisting of 'yes' answers) illustrate areas of strengths and lower scores ('no' answers) are possible weaknesses or areas for improvement. For instance, if a client scores 5 on the social support dimension, but scores 1 on the meaningful activities dimension, then this might indicate that the client is doing really well in terms of social support (RCR5) but is not engaged in enough meaningful activities that would help motivate for change (RCR6).

Feedback on the results of the ARC is helpful, in terms of the coach having the metrics to motivate clients in continuing any progress made. Motivation for change is particularly suitable for clients and has a holistic, client-centred focus. The ARC scale

was used, as a strengths-based tool for collating RCR scores. The ARC scale is already available in the Australian AOD treatment settings and its use documented well in the literature.

Since risk-of-bias (ROB) may play a major role within the scope of the insider-researchers' function (Shenton, 2004), safe-guard mechanisms were put in place to meet dependability and transferability criterion demonstrating the findings emerged from the data and not the researcher's ROB predispositions. Video recordings derive from it, various thematic perspectives (clinical, offender profiling, perpetrator behaviour, parent education and so on). The researcher was careful to document all methodological process undertaken to provide opportunity for a future investigator to repeat this body of research.

Credibility can be referred to, in a qualitative study, as the trustworthiness of the data, based on subjectivity, interpretation, and context (Shenton, 2004). To preserve the accuracy of the data, a true account was video recorded and triangulated with written transcripts to capture RCR and goal attainment scores. The researcher ensured the transcripts, upon numerous reviews and re-readings, reflected the unfolding of the coaching events as they happened, minimising any risk of bias that may occur. The transcripts and video logs helped the researcher keep to the integrity of the nuances, inflections and deeper meanings that happened during the coaching interactions and will be included in the results and discussion chapters (5-6). With the changing phenomena of addiction, combined with the coach effect (discussed in Section 3.2.4) can render the parameters by which 'reliability' is defined, problematic for this study, similarly the same results will be hard to obtain.

Verification of pre- and post-CPRC RCR scores will become easier to refer to and remember, as opposed to approaches used in the traditional case management folders or digital note logs. In note-taking, as used in therapy and conventional psychology sessions, there are fewer mechanisms that help the specialist remember

subtleties presented by the patient/client (Henry & Fetters, 2012). If many months or even years have passed when the client presents themselves back to the service, it will be difficult to ask them to keep re-telling their past hurts or recount back to the therapist/coach any of the trauma suffered (Heath, et al, 2007). Omission of data or inaccurate remembrance of interactions are always in question hence the video format is preferential to standard notes (Heath, et al, 2007; Henry& Fetters, 2012). Video helps remember the stress felt by client, or verbal cues presented, such as rising in pitch due to urgency, sarcasm, manipulation or lies (Jones, et al, 2015).

4.3.1 Video Recording Procedures

At the time of writing, over 1100 video recordings were recorded and used for self-reflection, self-awareness, and self-development. The coaching video logs formed the foundation for this research. Participants granted consent for these video logs to be used in research, by signing a coaching agreement (sample provided -Appendix D). These video logs were used to record and discuss participant progress and growth, where watching their own video logs helped them remember actions taken and reflections had, that made them cognisant of their own denial patterns. With consistent video reviews over time, greater awareness and lesser resistance was shown by clients', helping them aspire for long-term recovery and attainment of goals set in the first session (Henry & Fetters, 2012). The video logs served as an accountability tool, to ensure the three goals set, become realised over the course of the CPRC program.

In the pre-session and in the first coaching interaction, the CPRC Practitioner explains that recordings will aid in remembering actions taken, tasks set and mutually agreed upon goal outcomes. Just like sports coaching, recovery coaching also follows the same principle of transparency, hence the ability to be recorded is paramount in understanding and ensuring the client remain engaged in taking ownership of their own mutually agreed-upon goals set in the first session. The onboarding or assessment process further explains that the recordings constitute one of the main differences

between traditional therapeutic treatment and coaching. In the recruitment to coaching phase, it has been explained to the client that the video recordings will form part of their own personal and professional development. It was explained that volunteers, coach trainees, stakeholders, mentors, and research supervisors may view the CPRC recordings, and their participation contributes to the peer-driven datasets and learnings.

Video logs provide ongoing training, learning, feedback gathering, coach competency building tool and continuous professional development for all those who are provided access to the recordings. Clients are assured their identity is never revealed. Once the process of video recording has been acknowledged and consent given for use outside of coaching, coaching contracts are signed and the CPRC program begins.

Video or audio recording of the coaching interaction is completed via a mutually agreed upon digital or audio medium. Face to face sessions were conducted when the geographical proximity of the client allowed for this. The CPRC practitioner always carried an extra phone or digital device to record the coaching session, and this was uploaded as a private video on a video hosting cloud system. A link was given to the client for download and review, if requested.

4.3.2 Transcription and Transcriptionist Sourcing Process

Transcription of the video files preserves the integrity of the coaching sessions. The transcripts were a useful tool for convenient study of each coaching interaction and to ascertain the content of the video log without having to listen to the full 60 to 90-minute session. Professional transcriptionists were recruited via www.upwork.com, and transcriptionists vetted for their experience, client reviews, quality of work and service deliverability scores. Transcriptionists were interviewed and required to sign a confidentiality agreement.

Once they agreed to keep the files confidential, they were given a 7-minute snippet to transcribe as a sample of their ability. Those that submitted high quality transcriptions in a timely manner were engaged with contracts to transcribe the video coaching sessions. Cost of transcription was reduced by employing three postgraduate and undergraduate interns, studying psychology, human services, and social work to do transcription work, adhering to the same vetting procedures mentioned. There were nine (n=9) individuals that completed a 12-session, 1-hour coaching series, four (n=4) clients that completed 11 sessions, and five (n=5) who completed 10 sessions. In total, there were 202 coaching sessions that needed transcription, and these were scheduled to be completed over a period of one year by eight (8) transcriptionists.

4.4 Recruitment Process and Participant Summary

Participants were recruited from a pool of clients that have begun and completed the whole collaborative peer recovery coaching process anytime from 2014-2016. All participants experienced co-morbid depression, anxiety and mood disorder issues, and have severe and complex poly-drug and addictive behavioural issues.

Eighteen participants completed the CPRC program, and these individuals were included in this study to evaluate improvements and emergent patterns, upon completion. Those that began but did not complete 10-12 CPRC sessions, were not eligible and hence excluded from participating in the study.

For ease of reference, the participants are outlined in Table 6 with their alias, participant #, age, presenting issues, three goal areas and short commentary.

Table 6:

Participant Alias, Age, Presenting Issues, Goals and Summary

Alias	Age	Presenting Issues	Three Goals Set	Participant Summary
Michael #1	59	Tobacco Smoking, Malpractice, Co-dependence, pathological lying, porn.	Social connection work and financial goals	Michael once ran a rehabilitation centre, His licence to operate was revoked for malpractice. He constantly blamed staff and the State Tribunal's decision instead of recognising his own gambling issues, and manipulative behaviours concerning sexual allegations and porn overuse. He won't admit to anything but smoking a pack of cigarettes a day. It was clear in the coaching sessions that co-dependence and pathological lying were ongoing issues he has been battling with. His co-dependent children were heavily into overeating, drinking, and drugging. He admitted to heavy gambling and porn addiction later.
Angela #2	53	Adult children of alcoholic, co-dependent, past DV, marijuana and alcohol heavy use	Financial goal, heal/ forgive parents, help son	Angela is a mother of two adult children, an aged care worker and in her 50's as an avid squash player. Her son has had many problems with binge drinking and incarceration. She grew up with severely abusive and alcoholic parents and battled heavy alcoholism and marijuana use herself. She suffers self-esteem issues, though keen to develop personal development goals. She showed enthusiasm and rated highly in her self-reports. She worked hard to keep abstinent from her addictions. She worked through her issues, and actively engaged in completing her actions, such as attending AA meetings and writing her biography.
Mala #3	44	Co-dependent, domestic violence, food addiction	23 years in abusive relationship with addict	Mala comes from a Muslim family. She has been married to a severe addict for 26 years, and has suffered greatly, living in a domestically violent home. As a 44-year-old mother, she was raised with strict Muslim outlook, and taught to accept violence as part of her obligations. She has earning a high paying income as an optometrist for almost two decades. After training in personal development, she realised taking abuse was not good for her emotional wellbeing, and detrimental to her three children's upbringing. She wanted financial independence, be safe in her own home and be actively taking care of her health as she was overweight at time of CPRC.

Michelle #4	33	Injecting meth 20+ years, sexually abused by sibling who is a long-term heroin addict	abstinence; parenting skills; work and financial	Michelle has been injecting meth on and off since her 20's. Mother to a toddler, she continued to inject methamphetamine even in her pregnancy and the boy was born in withdrawal. Raised by dysfunctional parents, she was given money most of her life as a 'payoff' for the guilt the mother carried about the sexual abuse Michelle suffered from her heroin-addicted brother. Scared that her young son will grow up like her and her brother, she has made the decision to once and for all quit all her addictions. She moved to the researcher's vicinity seven months into CPRC and opted for aspiring to do meditation and yoga daily to help keep her on the straight and narrow.
Janet #5	46	Death, grief, alcohol and food, medication, depression	Practice as recovery coach, heal/forgive parents, family	Janet received a $190,000 inheritance upon his father's death when she was 19. Janet had severe attachment issues as her father kidnapped them in her childhood. She has a fear-of-abandonment issue, not resolved, nor does she seem to want to. She has two young children from 5 and 12 years old. Her mother has pronounced mental health issues and her sister abuses prescription pills and alcohol. It was easy to observe detrimental effects in her life from overwork, overeating and over-drinking. She suffers mental health deterioration, crying hysterically and screaming often.
Sandra #6	45	Co-dependent, anxiety, fibromyalgia, medication	Parenting time manage-ment, anxiety, confidence	Approaching her 50's, Sandra is a psychology university student. Her husband has Asperger's Syndrome and finds it hard to show emotion and tenderness towards her. She longs to understand psychology to decipher her husband's and two children's autism spectrums. She suffers from fibromyalgia. She is seeking balance to lessen her co-dependence. Prescription medication is her addiction, although she is still in denial. All her family members are also prescription medication-dependent. She has seven kids and is often anxious/teary from the of tasks she must deal with, day-to-day.
Lina #7	34	Co-dependence, past addictions	Work as AOD Coach in industry, earn / save / confidence	Lina works in a rehabilitation centre. Her daughter and ex-husband are in active addiction. Lina, at 34, is working hard to contain her daughter's addiction and prevent her from getting pregnant. Lina has extremely low confidence levels, having suffered a flesh-eating bacterial infection with lasting effects Lina has not had a major intimate relationship in many years because of her anxiety, low confidence and ex-husband

				always being around. She has had a colourful past with the ex-partner, and addiction was rampant in their lives.
John #8	51	Sex, porn, dating, relation-ship issues, food, violence, alcohol, drugs	Facilitator, heal/forgive parents, family	John had three charges to his name, two for assault and one for driving under the influence of alcohol and drugs. He was diagnosed and hospitalised for drug induced psychosis, having used cocaine, methamphetamine, and alcohol. He also gambled. He feels his work as a painter and plasterer is not good, but it helps support his 12-year-old daughter, whom he has part custody of. As a dapper and attractive man, he can play the field and always has a variety of choices on the 'Tinder' dating application. He wanted to build his abstinence to longer periods and learn social, emotional and wellbeing skills, so he can continue volunteering at his local Men's Shed.
Karina #9	48	Own child sexual abuse, daughter was abused, DV, AOD	Healing through Art, relationship, and self-esteem repair	Karina is single and looking for a potential lifelong partner. Having been sexually abused as a child by her father, she has no faith in men and has been in and out of numerous violent and abusive relationships. The same fate of sexual abuse was suffered by her daughter at the hands of her then partner and father of their child. Her son is verbally abusive towards her and currently not on speaking terms with her. Her parents died when she was in her 20's, hence she has always felt isolated and vulnerable. She is a breast cancer survivor and at 48 years old, art, playing guitar and singing is her release.
Betty #10	38	Sex work, foster care, sexual abuse, heroin meth, alcohol/ cigarettes	Recovery, financial Parenting/ self-care	Betty grew up in the foster care system. She was a sex worker in Kings Cross in her teens to early twenties, having been addicted to heroin for around eight years at that time. In those times, she would inject up to $2,000 worth of heroin in just one day and her health and well-being suffered greatly. She was gang raped by police when she was just 18 and grew up in the foster care system. She has a daughter under a Department of Child Services arrangement. She gave birth to another girl from a domestically violent relationship. She had an unplanned pregnancy during attendance to the CPRC program, and they chose to keep the baby.
Donna #11	51	Adult children of alcoholic, co-	Business studies, escape DV,	Donna was raised by alcoholic parents, who have now both passed-away. She allowed herself to be swept away by a man and in three short months together, permitted him to move into her home with her son, and supported him through a hernia operation. She

		dependent, DV, alcohol	abstinence from alcohol/medication	explains how tormented she is by his negative behaviours, but still chooses to let him continue to express these towards her. He has cheated on her many, using sex or hook up sites. She does not have the skills to draw boundaries or practice self-respect. She is unable to enforce discipline with her teenage son, who is truanting and dabbling with drugs. Donna would beg me to promise not to let her go back to him. But after a few weeks, he is back in her life again. Soon, a fight ensues, and the cycle repeats again.
Melissa #12	17	Meth use, criminal, truant, stealing, dealing, promiscuity	Forgiveness for alcoholic father/co-dependent mother, sobriety	Melissa's father called me one afternoon quite distressed at his Melissa, punching her bedroom wall, after yet another 'ice' rampage. Melissa's father was worried about her involvement with the wrong 'gang' of ice dealers and users. She would frequently steal from her parents and at one point, even stole her parents $20,000 car to buy a large amount of methamphetamine supply. Melissa's father works at the mines, drinking large amounts when he is home, and her mother is a severe co-dependent. Melissa's mother grew up seeing her family ruined by alcohol and both committed suicide from alcohol issues.
Nancy #13	55	Adult children of alcoholic, co-dependent, alcohol	Heal severe backpain and chronic worry	Nancy rang our agency because she needed help with her issues with alcohol. She suffered a dysfunctional childhood full of threats and trauma in the hands of her mother, who consistently belittled her and even killed her childhood pet dog. She wanted stronger self-control so that she can rein in her everyday habit of drinking about 2 bottles of wine a night. Her favourite drinking buddy was her then husband. A nurse for over four decades, she suffers chronic back pain, had broken ribs (reason undisclosed), and consumes strong pain relievers every day for this. She also has been on anti-depressants for the last seven years and has cut of her parents from her life as she hates them both.
Ayako #14	24	Porn use	Practice Christian values, align with beliefs	Ayako is a devout Christian from an Asian background who went to youth services and Sunday church regularly. She would consume porn a few hours a day. Having low self-worth, she would use masturbation to deal with frustration, boredom, loneliness and to relieve stress. She also uses it to calm down and to diffuse anger. She is concerned about her stress levels, not happy with the sleep she gets and does not exercise or do other self-care routines. She also wants to meet a Christian partner and live a life of integrity, devout to her Christian beliefs.

Duong #15	25	Internet, porn	Improve PhD standing	Duong is a gamer and an Internet addict completing his PhD in molecular science. He reports being online 6 hours a day, surfing the net, watching YouTube updating social media, gaming and just doing ‘trivial and useless things’, instead of working on his PhD. He feels very guilty for this and consequently is having problems with his PhD supervisor, and progressing his thesis. From a Vietnamese background, he started his PhD at a noticeably young age (21 years old) and admits to not having enough life experience. His parents have pushed him to this path, and he feels strong pressure to perform, using the internet as his coping mechanism at his young age.
Rachel #16	29	Alcoholic, PTSD, Post-natal depression, Child of AOD	Closer and more satisfying relationship financial, improve self-worth	Rachel is a mother of two, in her late 20’s, with a problematic drinking habit. Her husband urged her to call me and to get her drinking under control for the sake of the newborn (second child). She suffered post-natal depression on both childbirth occasions. She seeks to be more connected to those around her, but she takes her anger out on her husband and children, drinking copious amounts of alcohol on a day to day. She was devastated when her mother died ten years prior and her drinking started to become unhealthy from this point. She has worked in retail for around 14 years. Her future goals are to stay abstinent from drinking alcohol and become a recovery coach. She wants to be able to contribute to mortgage payments and help her husband run his trades business.
Patricia #17	22	Pathological liar, marijuana/meth addiction	Abstinence; finish university studies	The youngest of three siblings, Patricia was already smoking pot for over seven years by the time she engaged in the CPRC program. She spent time in Byron Bay, living the ‘hippy’ lifestyle, smoking pot with friends, partying and using other illicit drugs. She is currently studying a degree in naturopathy and is keen to have a YouTube channel where she can showcase her learnings and possibly make money online. The CPRC practitioner discovered, after corroborating with her father and brother that she is a pathological liar. She let her studies slide, she spent her study stipend on drugs and uses many illnesses (constant headaches, hair falling out etc) as excuses, to continue to get financial support from her father. At 22, she does dream of practicing yoga daily and being more aligned with her ‘natural therapy’ studies.

Cassie #18	41	Injecting meth use, brain / head injury from car accident 17 years ago	Understand family gambling and drinking behaviour	Cassie has been injecting methamphetamine for almost 16 years, having suffered a severe head trauma when she had a vehicle accident in her late teens. Her accident was traumatic, and she went through the front glass of her car when she smashed into a tree at 19 years old. She was in coma and unwell for a few months. She still 'lives' in those moments and have not quite recovered since that time. At around mid-twenties, she became involved with a violent and drug-induced man who started injecting her methamphetamine, and over time – they were injecting heavily together. She developed a gambling problem (pokies daily) and has been psychologically unwell since. She is emotionally unstable state, has violent tendencies, hoards excessively and always teary. Cassie was referred by a local charity to our service.

4.5 Data Analysis Procedures

4.5.1 Result 1: Pre- and Post-CPRC RCR scores

This qualitative research study presents peer perspectives, whilst the participants were engaged in the CPRC program. The 'Assessment of Recovery Capital' scale was used in this research, consisting of a 50-point yes or no questionnaire across ten dimensions. According to Groshkova, Best, and White (2013), and as further developed by Best et al. (2015), recovery capital comprises of ten resources that need addressing, in the spheres of:

1. sobriety
2. emotional stability
3. physical health
4. social support
5. community
6. meaningful activities
7. housing/safety
8. ability to cope and function
9. ability to take responsible risks and
10. ability to feel one's deeper sense of purpose in quality of recovery

A copy ARC scale, can be viewed as Appendix A, providing a full view of its question items and dimensions. After using Leximancer and Nvivo for six months, it was decided that a manual annotation of results would better serve the integrity of the qualitative data gathered.

The researcher formulated an excel spreadsheet to contain before and after CPRC, RCR scores. These are included in Appendix B as Tables 1-6. The excel spreadsheet allowed a convenient view of the pre- and post-CPRC scores for each question item. It also allowed to tabulate improvements in three categories, reported

as Result 2 in Section 5.3 and discussed as an integration of all pre- and post-CPRC RCR scores in Section 6.2.

To arrive at the pre-CPRC scores, 18 copies of the ARC scale were printed and each client's pre- and post-CPRC responses were scored. The insider-researcher concentrated efforts on one participant at a time, not proceeding to the next participant, until the ARC scale was completed in its entirety for pre-CPRC scores first. The advantage was that the researcher had tangible video logs and transcripts (Henry & Fetters, 2012), hence because of these logs, an accurate '*yes'* or *'no'* answer for each question statement was allocated. As there were no denial mechanisms in place that may impede accuracy of scores, the insider-researcher was able to make a reliable assessment.

The researcher spent around three months re-listening to the video logs and cross referencing the transcripts to assign an accurate: *yes or no* answer to each of the pre-CPRC, 50 RCR question items. Figure 9 illustrates how this was annotated manually and Tables 1-6 report these results for each participant (see Appendix B).

Once the pre-CPRC, RCR scores were completed for each participant, the insider-researcher repeated the same process, this time listening to the last session and appending a score for each of the 50 RCR question items, called the post-CPRC, RCR score. In doing this, the insider-researcher scanned the client files and the transcripts for clues as to the accurate depiction of where the client was in relation to a particular RCR question item, by the last session. This post-CPRC RCR scoring process took around four months to complete, in the third year of doctoral study.

4.5.2 Result 2: Emergent patterns

The second result will identify patterns, as the coaching progressed from the first session to the last session (Result 2 to be reported in Section 5.3 and discussed in

Section 6.2). Result 2 investigated three patterns the CPRC program had on the RCR scores. This emerging pattern was arrived at by manually annotating all participant pre- and post-CPRC scores on a spreadsheet. If the pre-CPRC score for a particular RCR question item was 0 = no, then post-CPRC was a 1 = yes, then that participant has improved, and belonged in the 'improved' category, coded yellow in Figure 9. For a complete visual on patterns, please see Figure 11.

Figure 9 illustrate a part of the spreadsheet used to categorise the three RCR1 and RCR2 patterns for Participant 1 - 4.

Duration | Age	4 mos	59yo	7 mos	56yo	9 mos	44yo	4 mos	33yo
n | CODE	**1**	**ROMI**	**2**	**KIBR**	**3**	**SASA**	**4**	**KAJA**
Recovery Capital Resource (RCR)	Before	After	Before	After	Before	After	Before	After
RCR 1 SOBRIETY	0	4	2	5	0	5	0	3
RCR 1.1: I am completely sober	0	0	0	1	0	1	0	0
RCR 1.2: I feel I am in control of my use	0	1	1	1	0	1	0	1
RCR 1.3: I have had no 'near relapses'	0	1	1	1	0	1	0	0
RCR 1.4: I have had no recent periods of use	0	1	0	1	0	1	0	1
RCR 1.5: There are more important things than using	0	1	0	1	0	1	0	1
RCR 2 PSYCHOLOGICAL FUNCTIONING	1	5	1	5	2	5	1	5
RCR 2.1: I am able to concentrate when needed	0	1	0	1	1	1	0	1
RCR 2.2: I am coping with stresses in my life	0	1	0	1	0	1	0	1
RCR 2.3: I'm happy with my appearance	0	1	0	1	0	1	0	1
RCR 2.4: In general, I'm happy with life	0	1	1	1	1	1	0	1
RCR 2.5: What happens to my future depends on me	1	1	0	1	0	1	1	1

Figure 9: Final RCR1 and RCR2 Pre- and Post CPRC Scores for Participant 1-4

The second category was allocated: '*did not improve'* (i.e., 0 = no at the beginning and also 0 = no, by the end of CPRC program), this was colour coded red in Figure 9. The third and last category was: '*no negative change'* (colour coded: green in Figure 9). This category signifies that the participant did not slide back to old patterns, having a score of 1 = yes, in the beginning and sustaining that score until the end of the CPRC program. This still represents a positive effect. Results will be

reported for emerging patterns in Section 5.3. Discussion of Result 2 will be integrated in Section 6.2.

4.5.3 Result 3: Self-Rated Goal Attainment Scores

Result 3 assess achievement of client goals. A peer-supported, recovery coaching approach is used, where the client chooses three priority goal areas for themselves. Table 5 in the CPRC chapter (Section 3.2.4) outlined the 20 goal areas assessed in the first session. Every first session looks at all these goal areas and a process of mining and defining is used, to ensure the client can pick three priority goal areas they would like to work on for the duration of the CPRC program.

At the end of the CPRC program, the client-generated a goal attainment score for each of the three goals, that range from 0 to 100%. To round and close of the completion of the CPRC program, the CPRC Practitioner asked the client how they felt they fared in relation to the three goals set, in the first session. This self-rating is a positive way to keep a tangible score. It affirms the client's efforts and supports the client to celebrate their successes in finishing the complete CPRC program. Correct formulation and wording of these three priority goals (detail in Section 3.2.4) in the first coaching session is key. At the end of the CPRC program, the client self-generated a score as part of their last coaching session.

4.6 Conclusion

This chapter focused on outlining the methodological approach utilised by the researcher to analyse the effect of CPRC program on RCR and goal attainment. This chapter summarised the work-based learning pedagogy adhered to by the insider-researcher, as a student of the Professional Studies doctoral program.

A discussion of the research design was included, and participant recruitment procedures followed. Data collection procedures were relayed for the reader to

understand video recording protocols and the transcription process used in this study. The Assessment of Recovery Capital (ARC) scale used for this study was covered, and a summary of the participants presenting issues and goals were presented. This chapter concluded with how the pre-CPRC, post intervention and self-rated goal attainment scores were tabulated. The three results will be reported in the next chapter.

CHAPTER FIVE: RESULTS

5.1 Introduction

Discussed in the data collection process outlined in Section 4.5, only individuals that completed the CPRC program were eligible to be part of this study. Therefore, this study consists of 18 participants (n=18) who completed the CPRC program from 2014 - 2016. The CPRC program took place over three to ten months for each participant, with the average duration being 6.2 months. The chapter allow the reader an inside look into the CPRC program, as it unfolded in its natural setting.

In the writing of this results chapter, transcriptions of the coaching sessions will be used to illustrate the CPRC interactions. Aliases were used to de-identify participants or any other individuals mentioned, such as family members. The lead time from first contact to engagement in the CPRC program took one to six months to establish. There were numerous communication exchanges prior to the first CPRC session being formally set. To convey the level of rapport established with each of the 18 participants in this study, an average of 12 emails and nine SMS messages were sent and at least two, 30 to 90-minute phone calls were made to engage the client in the program. As discussed in Section 2.4.6, therapeutic alliance and rapport takes time to build, especially for those with pre-existing substance use disorder/s (SUD).

This chapter reports and describes three different result outputs. The first set of results entailed scoring the outcome of the CPRC program on RCR dimensions. The scoring was captured based on an assessment of each of the RCR question items, with a score represented by 0 for ‘no’ or 1 for ‘yes’. With 18 participants and five question items, the total qualitative representative score for each of the ten RCR dimensions can range from 0 – 90. The ‘Assessment of Recovery Capital’ scale contains 50 question items (Appendix A). Each participant received a pre-or post-CPRC score from 0 to 50. A total score of 50 indicates the maximum number of recovery capital assets each participant can accumulate during the CPRC program.

There are three results to be reported in this chapter. These three results will be reported as follows: Section 5.2: Result 1: Pre- and Post-CPRC scores; Section 5.3: Result 2: Emergent Pattens for CPRC sessions 2-11; and Section 5.4: Result 3: Perceived Goal Attainment Scores.

5.2 Result 1: Recovery Capital Resource Scores

Mentioned in detail in the data collection section of the methodology chapter (Section 4.3), scores were appended after listening to the recordings then cross-checking transcripts and client folder / file notes. There were two instances these scores were measured, first instance was in the beginning, recorded as a pre-CPRC and referred to as the pre-CPRC score. The second instance was at the last CPRC session, called post-CPRC score. Scores will be annotated in brackets as: pre- or post-CPRC RCR# and question item # = score, for example: pre-CPRC = 1, post-CPRC = 1 for RCR5.4.

5.2.1 Pre- and Post-CPRC Score for Sobriety (RCR1)

Relapse or lapse means falling or slipping back into a former state of chemical dependence (Maisto, et al., 2015). Relapse management is one of the core functions of the CPRC program. This RCR dimension and the five questions associated with RCR1 helps the clients gain more focus in their ability to sustain increasing periods of abstinence.

Table 7 illustrates the question items for RCR1: Sobriety, guiding the presentation of data associated with the RCR1 dimension and scores.

Table 7:

Recovery Capital Resource Dimension 1

Recovery Capital Resource (RCR): RCR 1 SOBRIETY
RCR 1.1: I am currently completely sober
RCR 1.2: I feel I am in control of my substance use
RCR 1.3: I have had no 'near things' about relapsing
RCR 1.4: I have no recent periods of substance intoxication
RCR 1.5: There are more important things to me in life than using substances

Source: Department of Health, VIC., (2013).

Relapse management techniques helps the client plan for any seen or unforeseen situations that may occur. Stop-gap coping mechanisms are discussed in the CPRC sessions to help prevent onward trajectory of events that continue to lead to ongoing relapsing behaviours. The reason clients engage in the CPRC service is to manage their SUD symptomology, hence none of the participants were completely sober (RCR1.1) at the beginning of the CPRC program.

A common phenomenon discussed previously as a potential barrier to treatment (Section 2.4.4) are denial patterns entrenched within individuals in the active addiction phase. The client will usually not be forthcoming with disclosing their alcohol, medication or illicit drug consumption until rapport has been deeply established. This process of establishing rapport looks different for each client (Treatment Principle 2: Unique Needs). Even if rapport has been established prior to engagement in the CPRC program, therapeutic alliance can take up to six CPRC sessions before coach-client alliance can gain a stronger foothold. It is a safe to believe that clients will withhold vital information about their SUD in the first half of the CPRC program. This is most especially true in the first CPRC session.

At the start of the CPRC program, all clients yielded a score of 0 in *RCR1: I am completely sober*. Five participants ended the CPRC program by not relapsing back into their addiction (#2Angela, #3Mala, #7Lina, #8John, #16Rachel). Other question

items measured in this dimension were clients feeling they were in control of their SUD (RCR2).

Example of focusing the client on this question item was elaborated in the CPRC session below. In this session, it was decided that only a maximum of two drinks will be consumed, even if the occasion was a family birthday celebration deemed important to John.

Session 8

John: *I really don't drink anymore but on Leanne's birthday, it would just be better if I do because it is a family affair. What can I do?*

Maria: *In this case, do you feel it is worth giving your priority up for this?* (allowed time for John to gather his thoughts). *If you were to do this, what would be sufficient for you to do what you feel is your obligation to family without falling into the trap altogether?*

John: *Yeah, I get it, feels like I am throwing it all away, maybe I will just have a few drinks and enjoy time with family instead of making drinking the focus.*

Maria: (more time to let this sink in) *Just remember, many sessions ago, we discussed that this is the recurring theme in the family gatherings. I realise it is easy to fall back, but a decision needs to be made. We already spoke about this and many times you have already decided this was not healthy for you.*

John: *Never easy, is it? I will try two drinks and talk to you about how I did - in our next coaching session* (sounding confident and hopeful).

RCR1.3 question item looks at relapses and breaks down the situations that cause 'near' relapses, this means the person did not relapse but was close, whereas RCR1.4 is a statement that indicates an actual relapse moment, if the answer was 0 or no. Part of coaching and flourishing, discussed in Section 2.5 and 3.2.4, requires sticking to the relapse prevention plan. Successful relapse management implies that as time passes, the client can start to foresee future relapse situations that may occur.

Client insight strengthens their ability to be able to avoid these 'trigger' situations altogether and inevitably avoid relapsing (RCR1).

Angela has spent a lifetime drinking (53 years old) and occasionally smoking marijuana. Her parents were severe alcoholics. In CPRC session #1, Angela recounted some of her alcohol and other drug experiences:

Session 1

Angela: *I have been drinking quite a lot but also it is this whole denial thing you have been telling me about and I did grow up in an alcoholic family. I cannot even function well anymore* (sighs and teary), *I have been living on my own for the last 20 years.*

Maria: *Do you have children?*

Angela: *Yeah, my boys are grown now, one is 34 and the youngest is 20.*

Maria: *Let's talk about your current using? What do you do around that now?*

Angela: *I used to smoke (cannabis) every day, when I was younger and drink quite a lot, but I have been pretty good for 10 years now with that. I still drink but I don't think it's a lot.*

In CPRC session above, the duration of use (when it started) and dose of substances taken are usually not disclosed in its full severity yet. Explained as part of Barrier 4: Denial Mechanisms, it is not recommended to try to pin the client down for their active addiction usage and behavioural patterns, as it will incite the use of denial mechanisms (Allsop, 2008). It is also not the focus of recovery-oriented care. In traditional therapy, assessment tools, such as AUDIT and ASSIST are administered to ascertain SUD (Department of Veterans' Affairs, 2009; McNelly, et al., 2014). This makes the client defensive and creates tension, shame and/or guilt (discussed in Section 2.4.3). Making the client feel guilt or shame about their use at the outset does not help them because it is already implicit that those with substance use disorders (SUD) will still be in active addiction or will relapse, at some point in the future.

In Angela's case, drinking and smoking cannabis regularly is where she is at and she needs support to surmount these habits. In the end, helping them admit that they have a chemical dependence is a motivator. This realisation becomes powerful, when they begin to verbalise the negative ramifications of their own alcohol and other drug use, to the CPRC Practitioner. This level of trust takes time to establish (Ardito & Rabellino, 2011) and the peer experiences shared by the CPRC Practitioner helps the client open up, over time.

As more CPRC sessions were completed, Angela discussed playing squash more often and we were engaged in conversations about healing, transformation and wellness (pre-CPRC = 0; post-CPRC = 1 for RCR1.5: There are more important things to me in life than using substances). Each CPRC interaction strengthened Angela's resolve to not fall back to smoking cannabis and drinking daily as her mechanism or habitual pattern used to wind down. Instead, CPRC sessions worked on concentrating her efforts on activities and thoughts that build on her recovery.

Angela indicated that 'bourbon and beer' was her form of relaxation as it helped calm her nerves, especially on the weekends. There was a strong justification that how she drank was 'different' to the way her parents drank. Having experienced violence growing up, she does not consider the way she drinks as dangerous. She presented as being in control of her alcoholism and sober from drinking. (pre-CPRC = 1; post-CPRC = 1 forRCR1.2: I am currently completely sober and pre-CPRC = 1; post-CPRC = 1 for RCR1.3:I have had no 'near things' about relapsing).

Unfortunately, her past behaviours prior to starting the CPRC program still had ongoing negative ramifications. She admits in later sessions that because of her continuous substance abuse, she realised how this affected her parenting, especially in her children's younger years. Through the course of her inability to parent her children appropriately, she had to go through the heartbreak of seeing her son incarcerated

while her other son was involved in numerous unhealthy intimate relationships, theft, violence, and bad company.

Session 4

Angela: *Scott has had a rough patch; he has been in jail now twice. He has been mixing with the wrong sorts and none of his so-called friends really care and let him take all the blame for their deals.*

Maria: *Where is he now?*

Angela: *He is still inside.*

The fact that her son is in jail left, Angela feeling like a failure as a parent and this brings about her drinking episodes. We focused a lot of the remainder of the sessions on defining what wellness, healing and forgiveness means to her. It was important that she took action to incorporate practices that allowed her to release resentment and feelings of unworthiness felt, while growing up with violent and severely alcoholic parents. As she began to understand about her own coping tools to deal with her childhood pains, she was able to release more of the resentment she felt over the years. At the end of seven months of coaching, she no longer drinks alcohol in an unhealthy manner, nor does she smoke marijuana regularly (pre-CPRC = 0; post-CPRC = 1 for RCR1.5: There are more important things to me in life than using substances). She ended CPRC enjoying a regular weekly game of squash with her peers. The excerpt below was from her last CPRC session.

Session 12

Maria: *You came into this saying you wanted personal growth, how are you feeling about all the growing you have been doing?*

Angela: *It feels like I only started…*

Maria: *Look, you have given up so much, poor decisions, no follow through and you even threw away the Angela with no self-worth. Doesn't it feel amazing? C'mon, you have to recognise these are massive wins, right?*

Angela: *I always don't, I know now that was what I was conditioned to believe growing up. Like you said, I kept doing life the way I know how.*
Maria: *Let's break it down. Drinking a few bottles of bourbon was a thing, right? For a long while there. And it no longer is, right?*

Angela: *It's not easy but yeah, I did it!* (smile starts to beam out of her face).

Maria: *Exactly, that's why I want to really congratulate you. For you to really relish this moment and take it all in.*

Four participants (Angela, Sandra, Lina, and John) started CPRC feeling in control of their AOD use (pre-CPRC = 1; post-CPRC = 1 for RCR1.2). Lina, John, Karina, and Duong (pre-CPRC = 1; post-CPRC = 1 for RCR1.5) perceived there were more important things to using and drinking. By end of the CPRC, 12 participants felt they improved their control over their alcohol and other drug use (RCR1.2). Another set of 12 participants felt there were more important things in life other than 'drinking and drugging' (RCR1.5).

Having no recent periods of 'use' (pre-CPRC = 1; post-CPRC = 1 for RCR1.4: I have had no recent periods of substance intoxication and pre-CPRC = 1; post-CPRC = 1 for RCR1.3: I have had no 'near things' about relapsing) was displayed by John, as he felt they had control over preventing relapse and confessed at the beginning of his CPRC session that he does not drink or use. In session 1, John revealed his perceptions on recovery.

Session 1

Maria: *With the drug use and psychosis in the past? What age was that?*
John: *I was 19.*

Maria: *Aah, when was the last hints of drinking or using?*

John: *I would say about a year and a half or so ago. Now, I am looking deep into my spirituality into my inner work. I also look and study stuff about energy, and just keep reigning in all the resources I can find to help me grow.*

Maria: *Wow, that's amazing and a massive achievement from what you have been through.*

In John's first session, he was well presented and considered himself to be a handsome man. He was articulate and 32 years old at the time. As denial mechanisms and self-preservation played a big part, in the sessions that followed, it became apparent that there was drinking involved and occasional marijuana drug use. He confessed that it was to open his mind and he used cannabis to get in touch with his inner world. By the middle of the coaching series, even if says that he does not drink or do drugs, he admitted that he still engaged in other behaviours that were problematic. Some of these behaviours were having too many chocolates or desserts and excessive use of Tinder, an online dating site for casual sex, and what John described as meaningless meet ups.

John and Angela slowly began to realise that observing their chemical dependence, without fear of outside judgement helped them verbalise it in the coaching sessions. Being able to say it out loud, and work on processing these relapsing behaviours, helped them greatly. Over the course of their CPRC program, John (5 months) and Angela (7 months), found that their life need not revolve around their old drinking, drugging, and co-dependent behaviours. They both found other positive outlets in their lives (pre-CPRC = 0; post-CPRC = 1 for RCR1.5: There are more important things to me in life than using substances).

By the end of the coaching series, seven (n=7) participants, exhibited improvement through understanding of their own triggers and felt they had much better control over relapsing behaviours (RCR1.3). Fifteen (n=15) participants have had no recent periods of relapse and sixteen (n=16) participants finally had the breakthrough

of not feeling like they were stuck in the cycle of addiction (RCR1.5). All participant scores have been recorded in Tables 1-6 (Appendix B). Based on the data presented, the pre- and post-CPRC RCR scoring of all participants are reported in Table 8.

Table 8:

Summary of Scores for RCR1 Sobriety

Recovery Capital Resource **RCR 1 SOBRIETY** Question Items:	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the end of CPRC
RCR 1.1: I am currently completely sober	0	5
RCR 1.2: I feel I am in control of my substance use	4	16
RCR 1.3: I have had no 'near things' about relapsing	2	7
RCR 1.4: I have no recent periods of substance intoxication	1	15
RCR 1.5: There are more important things to me in life than using substances	4	16
TOTAL SCORE: for RCR 1 SOBRIETY DIMENSION	**11**	**59**

Note: 18 participants x 5 question items, score range 0-90

5.2.2 Pre- and Post-CPRC Score for Psychological Functioning (RCR2)

When it comes to psychological health and functioning, the score for RCR2 was the second lowest of all ten dimensions at 24 out of 90, prior to CPRC program being applied. It improved to 76 out of 90 at the end of the recovery coaching series, making it the most improved dimension across participants.

All participants improved their ability to concentrate on tasks (RCR2.1), handle stresses in life (RCR2.2), perceive life to be generally happy (RCR2.4) and become more in control of what happens to their own future (RCR2.5). This is an improvement because at the start of the CPRC program, only #8John seemed able to cope with life's stresses. In the end, all participants improved their psychological functioning using the five metrics of this dimension. Table 9 illustrate the items RCR 2: Psychological Functioning, guiding the presentation of data associated with the RCR 2.

Table 9:

Recovery Capital Resource Dimension 2

Recovery Capital Resource (RCR) **RCR 2 PSYCHOLOGICAL FUNCTIONING**
RCR 2.1: I am able to concentrate when I need to
RCR 2.2: I am coping with stresses in my life
RCR 2.3: I am happy with my appearance
RCR 2.4: In general, I am happy with life
RCR 2.5: What happens to me in the future mostly depends on me

Source: Department of Health, VIC., (2013).

Rachel is the prime example as she started the coaching series with a score of zero, showing an improvement in all five question items. She was drinking quite heavily (pre-CPRC = 0; post-CPRC = 1 for RCR2.5: What happens to me in the future mostly depends on me) and was coaxed by her husband to engage help because she was suffering from post-natal depression (pre-CPRC = 0; post-CPRC = 1 for RCR2.4: In general, I'm happy with my life). She clearly expressed that she wanted to gain clarity about her addiction and to seek balance, as she felt she was spiralling out of control with her drinking (pre-CPRC = 0; post-CPRC = 1 for RCR2.2: I am coping with stresses in my life).

She was retreating into alcohol as she felt she was not able to cope from the death of her mother some ten years back: "*It killed me when Mum died, I felt dead*

since." This was affecting her ability to parent her own child properly. Her siblings also abused alcohol and she saw her parents sneaking alcohol from each other. A deeper investigation was needed, that enabled her to understand her drinking triggers. After identifying what sets Rachel off on the path of a drinking rampage, we were able to embark upon a journey of self-discovery which liberated her from her 'learned' addictive tendencies.

Session 7

Maria: *We haven't seen each other for a long time. Let us get your goals up and see where you are placed with each one. The first one is where you wanted to be confident, happy, and relaxed. How is that sitting with you right now?*

(Rachel had a small relapse, but Rachel picked herself up and threw herself into her husband's business. Client cancelled scheduled sessions twice and it has been 37 days since the last CPRC session. There has been a few short calls and 6 SMS interactions in between sessions).

Rachel: *I am in a really good place with that.*

Maria: *Amazing, I love it. We will get into the details of all of that. With your second goal, I am worthy just the way I am. Where are you placed with that?*

Rachel: *Yes, I really noticed a huge change in the way I feel about myself. I am starting to see a big difference. It is becoming more and more natural to feel worthy nowadays.*

Maria: *Beautiful, good! Last goal is: I found a career where I can be sincere and communicate with people on a deeper level. With that one, we were exploring the book 'What Colour is Your Parachute?' How did that go?*

Rachel: *That is such a long book, I have to take it out of the library and actually read it, instead of browsing what little I can online. Me and my husband have been really talking about a business idea and now that I am really in a position to run it with him, we are really talking about that. You see, this is quite new territory for both of us and we are not even sure where it will take us. So, whether this is something I am going to be involved in the business or not, is something we are seriously considering.*

She had a profound insight in session seven, when she expressed that her childhood dysfunctions were again playing out in her own relationship with her husband and projected out as her relationship with her siblings. Over the course of the CPRC program, she re-learned how to be more relaxed, be less judgemental and be more authentic in expressing herself in a healthy manner. This helped her psychological functioning greatly. Rachel started to be able to concentrate better after the CPRC program was completed (pre-CPRC = 0; post-CPRC = 1 for RCR2.4: In general, I am happy with my life).

In the first session, she was rather vague in her speech and it was apparent, and she even admitted that she felt cloudy. As CPRC continued, we were able to discuss that this is the effect of alcohol in her body and is commonly known as brain fog. Therefore, when she consumed less alcohol, the brain fog diminished, and she was able to concentrate better (pre-CPRC = 0; post-CPRC = 1 for RCR2.1: I am able to concentrate when I need to). This was her remark in Session 8:

> '*This is amazing, I never really thought I can even think this way, I was always blacking out… more often than not, I was mostly out of it… that is probably why my husband thought I really needed help … I wasn't really a good Mum… so now I get what you are saying about how I died with my Mum ten years ago… I didn't need to'*

As she increased her ability to cope with grief and various stresses (pre-CPRC = 0; post-CPRC = 1 for RCR2.2), she was not so enmeshed with her emotional feelings of unworthiness. She once thought people are talking about her, where she said:

> '*It feels like everyone was talking about me, I was filled with shame and thought all conversations (*as a grocery store clerk*) was about me. I really felt they were taking a jab at me, I just wanted to die*'.

The subject of many CPRC sessions was about how it consumed her and made her feel intense worry if she perceived people talked about her. This exacerbated her

feelings of low self-worth and made her feel anxious all the time. All these thought patterns changed over the course of her CPRC program attendance. After the CPRC program ended, she does not mind if people do talk about her: She was feeling so much clearer of that by the end of the CPRC program. She was able to contribute by running her husband's trade business and this was quite an achievement for her, especially as she said: "*I always thought I was just a checkout chick*." Table 10 summarise the data scores for all participants, giving a total pre-CPRC score of 24 and a post-CPRC score of 80.

Table 10:

Summary of Scores for RCR2 Psychological Health

Recovery Capital Resource **RCR 2 PSYCHOLOGICAL** Question Items:	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the end of CPRC
RCR 2.1: I am able to concentrate when I need to	6	12
RCR 2.2: I am coping with stresses in my life	1	18
RCR 2.3: I am happy with my appearance	2	14
RCR 2.4: In general, I am happy with life	8	18
RCR 2.5: What happens to me in the future mostly depends on me	7	18
TOTAL SCORE: for RCR 2 PSYCHOLOGICAL DIMENSION	**24**	**80**

Note: 18 participants x 5 question items, score range 0-90

5.2.3 Pre- and Post-CPRC score for Physical Functioning (RCR3)

This dimension yielded the second highest score prior to receiving CPRC. More than half of the participants (collective score of 35 out of 90) already possessed some level of physical functioning needed to do the tasks mentioned in RCR3. All

participants showed improvement in this dimension with a cumulative score from 35 going up to 76, before and after CPRC, respectively.

Physical functioning (RCR3) involves external resources and tangible assets needed to cope with being able to do day to day activities, such as sleeping well, use of private or public transport and having the energy to complete tasks set, including going to work, if they have a job. An improvement was when 13 participants were now able to cope with their day-to-day tasks (RCR3.1). This was a major impact from only seven participants, noting that they were able to function well enough to be able to deal with achievement of everyday tasks, at the beginning of their CPRC program. Table 11 summarise RCR 3 items.

Table 11:

Recovery Capital Resource Dimension 3

Recovery Capital Resource (RCR) **RCR 3 PHYSICAL FUNCTIONING**
RCR 3.1: I cope well with everyday tasks
RCR 3.2: I feel physically well enough to work
RCR 3.3: I have enough energy to complete the tasks I set myself
RCR 3.4: I have no problems getting around
RCR 3.5: I sleep well most nights

Source: Department of Health, VIC., (2013).

Another question item within dimension three (RCR3.5) was sleep. Sleep is an all-important homeostasis the body needs to reset every night, to be able to function well the next day. None of the participants, because of their drug induced-behaviours were able to get a good night's sleep when they began CPRC. In dealing with the CPRC Practitioner, 13 participants were now able to sleep well at night, affecting their day-to-day functioning abilities positively (RCR3.1-3.5).

Michelle is the prime example of improvement for this dimension, going from a score of 1 (for RCR3.4: I have no problems getting around), as she was loaned money by her mother to be able to buy a brand-new car, to a score of 5 for all RCR4 metrics, after five months of coaching.

As an intravenous injector of methamphetamine, she knew her 18-month-old son, Josh was greatly affected by her injecting behaviour. The main crux of what Michelle was able to slowly understand was how her brother's actions of sexual interference with her when she was eight years old, totally compromised her childhood innocence and ability to trust men. Growing up with two brothers who injected heroin, did not give her the ability to know how to live an abstinent and healthy life. She always felt betrayed and deep sorrow for the loss of her innocence, from such a young age.

She was unable to provide a stable home environment for herself and Josh, finding it difficult to keep a house in order and needing to inject methamphetamine daily to be able to do things around the house (pre-CPRC = 0; post-CPRC = 1 for RCR3.3: I have enough energy to complete the tasks I set myself). She was unable to take on work responsibilities, as her life revolved around finding her next 'fix' (pre-CPRC = 0; post-CPRC = 1 for RCR 3.1: I cope well with everyday tasks). She relapsed every time we had coaching sessions. To help Michelle open up, the CPRC Practitioner also talked about her experiences in how she was able to increase her ability to trust men and what methods she used to do this. This helped Michelle to not feel so much shame and guilt, around her inability to have healthy relationships.

Michelle recounted that yoga and meditation was her saving grace (post-CPRC = 1 for RCR3.3: I have energy to complete tasks set), even if she was reluctant at first to set the goal of engaging in a daily yoga and meditative practice (pre-CPRC = 0, post-CPRC = 1 for (RCR3.1: I cope well with everyday tasks and RCR3.3). Her path to recovery included physical practice of meditation and yoga, as well as eating well.

Session 5

Michelle: *I have been doing research on clean energy foods and nutritious foods. I am a lot more aware now of superfoods that I should be eating, I'm still eating a lot of chocolate, but I am a lot more conscious about what I put in my body. I have been eating oats for breakfast and stuff like that -instead of lollies* (laughs).

Maria: *Wow amazing, good yeah! You can say then that your relationship to your 'healthy' goal, is more aware of super foods? Because that's important!*

Michelle: *I'm trying to get myself into a mentality that if I wouldn't let Josh eat it, I shouldn't eat it. I am really (expletive) about what I give Josh, and that he eats healthy food. I'm trying to get myself into that mentality, too.*

Maria: *Beautiful, good, and then what about other aspects of your body? The goals you set around that?*

Michelle: *I am invigorating and healing my body daily with one hour of yoga. That was the goal we set. You know what though, my yoga hasn't been that good in the past fortnight. I haven't done any to be honest, but I have been reading that intro to yoga book. It talks about stresses and how yoga helps the body. I think where I am falling down is maintaining motivation, I have always been like that, I was gung-ho at the start, then I lose interest.*

Maria: *Well, we're almost halfway there and your motivation is high. It's just your follow-through, it's your action taking that's not high. I mean you really want this you want this more than anything. You've declared to everyone in the Facebook groups that you want it. You just need to know how to put one step in front of the other.*

Michelle: *I think I need to re watch my goals video again and that Ted Talk with Anthony Robbins about how to achieve any goal in your life.*

In the end, she felt she was unable to remain abstinent on her own. She expressed her concern and talked about moving to the Gold Coast. She felt at that time that the people in her small town were 'friends' that were all using methamphetamine. She felt this will be a great move for her and her son. It will also help her as she continues to struggle with guilt, as she was injecting methamphetamine when she was pregnant. Her son was born in withdrawal and has been on steroids ever since birth.

He was two years old at the time of coaching. We discussed how she did not have any non-injecting friends and she felt moving to the Gold Coast would support her recovery. By Session 12, she visited Gold Coast and then proceeded to make her move from another state. She re-engaged in another round of the CPRC program when she reached the end of this particular coaching series. Table 12 outlines all participant scores for the RCR3: Physical Health.

Table 12:

Summary of Scores for RCR3 Physical Health

Recovery Capital Resource **RCR 3 PHYSICAL HEALTH** Question Items:	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the end of CPRC
RCR 3.1: I cope well with everyday tasks	7	18
RCR 3.2: I feel physically well enough to work	7	13
RCR 3.3: I have enough energy to complete the tasks I set myself	8	17
RCR 3.4: I have no problems getting around	13	15
RCR 3.5: I sleep well most nights	0	13
TOTAL SCORE: for RCR 3 PHYSICAL HEALTH DIMENSION	**35**	**76**

***Note*:** 18 participants x 5 question items, score range 0-90

5.2.4 Pre- and Post-CPRC score for Community (RCR4)

Oftentimes overlooked for successful recovery is RCR4 community involvement dimension. It is vital for an individual to feel a certain sense of pride and belonging in in their community. Across all question items, each participant was able to recognise that a community exists outside of their own drug using and drinking behaviours (RCR4.5). A realisation was also had in the importance of belonging

(RCR4.1) and ability to contribute to the health and well-being of others (RCR4.2 and RCR4.4). The cumulative 'before CPRC' dimension score (arrived at by adding all the 5 question item scores for RCR4 dimension for all the 18 participants, with 90 as the highest possible score) was 30. This has more than doubled by the time all the coaching sessions were completed with a score of 75. Table 13 illustrate the items for RCR 4: Community in guiding the presentation of data associated with the RCR 4 dimension and scores.

Table 13:

Recovery Capital Resource Dimension 4

Recovery Capital Resource (RCR) **RCR 4COMMUNITY**
RCR 4.1: I am proud of the community I live in and feel part of it – sense of belonging
RCR 4.2: It is important for me to contribute to society or be involved in activities that contribute to my community
RCR 4.3: It is important for me to do what I can to help other people
RCR 4.4: It is important for me that I make a contribution to society
RCR 4.5: My personal identity does not revolve around drug use or drinking

Source: Department of Health, VIC., (2013).

The CPRC excerpt was near the end of Rachel's CPRC program. She talked about the difference for her, in relation to this RCR 4 Community dimension.

Session 11

Rachel: *What scared me was all the change. Because you know, if you build yourself and you know who you are, you can be confident. I was successful in my professional life. I was smart and an extrovert. I was really good with people and in groups where I felt myself being really confident in public. I was a good leader. I think. I want to regain all that back. Actually, I feel like I might have. I feel better about myself in public. It feels like I am starting to belong in my workplace, too.*

Maria: *There you go, very good, yeah.*

Rachel: *I was good, but I realised that my personality changed since drinking. I lost myself somewhere. I was a bit afraid of the next steps. How can I be successful again? How I can be back to my professional life and how can I find myself again. And now I think I know that I'm in a good way now. I know my strength. I know my obstacles, but I need more self-development. With self-development, I will be ready to live my life. It's not really changing to a new personality, because it's not different person, it's still me.*

Maria: *It's still you, yeah? It's like you have evolved. Like you have grown to be a bigger version of yourself and you are listening to your higher calling. Because now you've got all the experience. You've got more stability and more control. You have gained back your leadership skills. So, it's actually that you ARE a better version of yourself, don't you think?*

Rachel: *I can still be better. I can still seek balance between my professional and my private life. Out there, I just lost my confidence. Because previously, I put out a brave professional front, and not really talk about my personal life. Probably because I had so much to hide. I feel really happy in my family life right now… But, I'm trying to still find myself in my professional life and my public life. I do feel like I can work on having everything back on track. That I can regain my confidence and be really balanced. I just want to be good out there, that's what I really want to do.*

In the CPRC sessions, Rachel lamented that she did not share anything with her husband, friends, family, or work colleagues. It became apparent that she has been repressing all her 'addictive behaviours' and referred to them as her 'dirty little secret'.

As for Ayako (see Ayako summary, participant #14 in Table 6, Section 4.4), one of her goals is being more involved in her church community by discipling a few youths in her home cell, church group (pre-CPRC = 0; post-CPRC = 1 for RCR4.1: I'm proud of my community and I belong). She has been using porn, of at least a few hours a day, for the last decade. The session below was about finding a community on Facebook or outside of her church group goal, where she can share her feelings regarding her porn addiction, without stigma or fear of being judged by a community of church members.

Maria: *So really, the secret you feel, is that you must find a really good group of support around you?*

Ayako: Y*eah, for sure. And just learning from people that have gone through it all. I want to be in a group of people I can talk to, about my issues.*

Maria: *For sure, having that group will really help you. Away from the church group. We discussed the church fellowship is useful for you and you love it there. But from what we have discussed, it is not the place to talk about the issues we are talking about now, is it?*

Ayako: *No, I feel more guilty if I start talking about my problems there, not when it is this personal. Also, I know that in that online group, over time, I can be an example, too. I want to recover so that I can then help someone else to recover. So, I think I really want to go to a SA meeting* (Sexaholics Meeting) *this Sunday*?

Table 14 give an outline of scores of all participants in this study for RCR4.

Table 14

Summary of Scores for RCR4: Community

Recovery Capital Resource **RCR 4 COMMUNITY** Question Items:	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the end of CPRC
RCR 4.1: I'm proud of the community I live in and feel part of it – sense of belonging	3	14
RCR 4.2: It's important for me to contribute to society or be involved in activities that contribute to my community	7	15
RCR 4.3: It is important for me to do what I can to help other people	8	16
RCR 4.4: It is important for me that I make a contribution to society	9	15

RCR 4.5: My personal identity does not revolve around drug use or drinking	3	15
TOTAL SCORE: for RCR 4 COMMUNITY DIMENSION	**30**	**75**

***Note*:** 18 participants x 5 question items, score range 0-90

5.2.5 Pre- and Post-CPRC Score for Social Support (RCR5)

As the CPRC continued, this social dimension showed one of the least improvements after the CPRC program was applied. In comparison to the other nine (9) dimensions, this had the second lowest score, finishing at 72. After considering that all participants started off poorly and only had a cumulative social score of 17 at the beginning of the coaching program, it does appear that RCR5 was still considerably impacted. Table 15 is a summary of items for RCR5: Social for convenient reference.

Table 15:

Recovery Capital Resource Dimension 5

Recovery Capital Resource (RCR) RCR 5 SOCIAL
RCR 5.1: I am happy with my personal life
RCR 5.2: I am satisfied with my involvement with my family
RCR 5.3: I get lots of support from friends
RCR 5.4: I get the emotional help and support I need from my family
RCR 5.5: I have a special person that I can share my joys and sorrows with

Source: Department of Health, VIC., (2013).

Enhanced family involvements (RCR5.2) improved from a score of 1 to 16, (n=15 improved, post-CPRC). Receiving support from friends increased from 2 to an end of score of 13 (RCR5.3: I get lots of support from friends), while more emotional family support was felt by 12 participants (RCR5.4: I get the emotional help and support I need from my family). Participants were relatively happier with their personal affairs, scoring from 5 to 17, (n=12 improved, post-CPRC for RCR5.1).

Of the cohort, only Duong started CPRC being already satisfied with his family involvement (pre-CPRC = 0, post-CPRC = 1 for RCR5.2). Duong mentioned his father has not been emotionally available with him while growing up and this trait is typical of a male, Vietnamese father. Duong, Melissa and Patricia (the younger cohorts, 17-24 years old) felt they received ample financial support from family members to begin with (pre-CPRC = 1, post-CPRC = 1 for RCR5.4: I get the emotional help and support I need from my family). What was found was that gratitude or appreciation for the financial help given, were rarely expressed back to their parents, by Duong, Melissa and Patricia.

Melissa, the youngest cohort (17 years old) has had a very problematic childhood with two uncles committing suicide from alcoholism (pre-CPRC = 0, post-CPRC = 1 for RCR5.4: I get the emotional help and support I need from my family). Her father works in the mines and is also a heavy alcoholic with sex addiction issues (pre-CPRC = 0, post-CPRC = 1 for RCR5.4: I get the emotional help and support I need from my family). Melissa has been heavily involved with criminal activities. At one point, she and her friends stole $20,000 worth of jewellery and her mother's car to do 'drug runs'.

The CPRC session and conversation outlined next was with Melissa's mother, Justine. Deeply entrenched with her 17- year old's recovery and participation in the CPRC program, this CPRC session gives context around the level of support Melissa should be guided with, to get her out of the criminal system.

Maria: *Thanks for talking to me today, I can imagine all this is worrying you no end.*

Justine: *This has been going on for so long now. It just reminds me of my brother, although a little different but still the same. He killed himself (*starts to cry for a long time*). I had a nightmare about her the other day, I saw her die too. She had an accident.*

Maria: *So, what are we feeling here? Feeling of grief? Feeling of frustration?*

Justine: *I am not really good at teenagers, you know.*

Maria: *Let's start there. What happened when you were a teenager? Is that a good place to start? What happened there, that you want to repress it? I know there is such a big age gap (*41 years between mother and daughter*).*

Justine: *She knows I care for her.*
Maria: *Does she? How do you express this with her?*

Justine: *It is really hard to talk to her.*

Maria: *I can imagine. How did it get this way? Where did it all start?*

*(*A conversation ensued about her teens. Justine is now 53 years old. I let her speak about how her alcoholic parents have treated her, her feelings of abandonment, her inability to express herself. This became the knowledge-base and experience from which she has learned to treat her 17-year-old daughter).

Maria: *All this has been passed down, I mean your father also died from alcoholism, so did your brother. Sounds like you are in the same boat with Peter. He works in the mines, he is also heavily drinking and seems like not available for you, too. So, with all this in mind. How can we go about understanding all this? Most of all, how can we go about fixing it. Melissa is in a bad way, that much we know. So, what can we do to start taking responsibility for each of our emotional needs? Who supports you? Because if no one supports you, how are you able to support Melissa through this?* (more coaching ensues, in line with strategic plan).

As for Patricia and her father, Tim, who is an affluent businessman and offered financial support to her daughter often, we had a CPRC session over the phone to discuss his unhealthy way of showing affection. Patricia expressed that her father showed no depth in emotional support, and she complained often about how all she gets is money. She explained that it was emotional bonding time that she really wanted (pre-CPRC = 0, post-CPRC = 1 for RCR5.4: I get the emotional help and support I need from my family).

The session included next, was collateral information gathered from Tim. He referred his 21-year-old daughter, Patricia for coaching. He was quite worried and rightly so. In treatment, collateral information means gathering information in a therapeutic session to build or improve the case management of a client from a loved one.

Maria: *What we need to do is we really must stop all of the financial support. We still have the love in our heart and we still wish her well and we still pray for her. But the key is, every time she calls, you tell her you love her, and mean it. Of course, that much we know you're sincere about. But the only way we can change the course of the trajectory of her life - is to not engage with or give in to her ability to buy drugs.*

Tim: *Well, what do we do about her needs? Her actual needs.*

Maria: *Let's look at the other option. She is yearning for connection. She is not getting it in a healthy manner – so she is acting out. Isn't the whole point of her coaching and yours is to get through this dark phase and understand it all? Isn't your intent to make ways for right change?*

Tim: *So, don't support her financially? I need to provide for her.*

Maria: *Connect with her deeper and finally - give her the emotional support she needs and has been yearning for. Understand her better, ask her where she spends the money, listen to her. Ask her to do a log of where money is spent. Have lesser confrontational interactions.*

Tim: *I thought I have been doing that?*

Maria: *Why don't we finally give her the time she needs, instead of depositing money on her account every month? Your attention, your love, and conversations she has been craving for with you. I have been coaching her, I can see and feel exactly where she is reaching for with you. Does that make sense?* (We speak about specific actions to take and Tim writes them down)

This interaction was about how he can set boundaries around his 21-year-old daughter, as well as learn to give the emotional support his daughter needs. This discipline of setting boundaries would allow Patricia to realise the nature of her drug

addiction (pre-CPRC = 0, post-CPRC = 1 for RCR5.2: I'm satisfied with my involvement with my family).

Table 16 summarise the data scores across RCR5 question items, giving a total pre-CPRC score of 17 and a post-CPRC score of 72.

Table 16:

Summary of Scores for RCR5: Social

Recovery Capital Resource **RCR 5 SOCIAL** Question items:	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the end of CPRC
RCR 5.1: I am happy with my personal life	5	17
RCR 5.2: I am satisfied with my involvement with my family	1	16
RCR 5.3: I get lots of support from friends	2	13
RCR 5.4: I get the emotional help and support I need from my family	3	15
RCR 5.5: I have a special person that I can share my joys and sorrows with	6	11
TOTAL SCORE: for RCR 5 SOCIAL DIMENSION	**17**	**72**

Note: 18 participants x 5 question items, score range 0-90

5.2.6 Pre- and Post-CPRC Score for Meaningful Activities (RCR6)

Being engaged in meaningful activities gives depth and fulfilment to one's life experiences, giving the ability to sustain long-term recovery. These meaningful activities include being active in sports and leisure (RCR6.1) being engaged in personal development and education (RCR6.2), as well as career progression (RCR6.4) and involved in activities without the need to be on drugs or drinking

alcohol. This dimension, like all other RCR dimensions has enriched the individual's life, as they found meaning in the various activities of their choosing. Similar to other dimensions, participants have shown positive effect whereby the cumulative score for the 'Meaningful Activities' dimension increased from a pre-CPRC score of 33 to 77 at the end of their CPRC program. Table 17 show RCR 6 question items.

Table 17:

Recovery Capital Resource Dimension 6

Recovery Capital Resource (RCR) **RCR 6 MEANINGFUL ACITVITIES**
RCR 6.1: I am actively involved leisure and sports activities
RCR 6.2: I am actively engaged in efforts to improve myself (training, education and/or self-awareness)
RCR 6.3: I engage in activities that I find enjoyable and fulfilling
RCR 6.4: I have access to opportunities for career development (job opportunities, volunteering, or apprenticeships)
RCR 6.5: I regard life as challenging and fulfilling without the need for using drugs or alcohol

Source: Department of Health, VIC., (2013).

This was very important to Angela, and she would always divert to 'activities' to gain some sort of momentum to get her back on track to recovery. Squash was one of her outlets and she felt she was not playing squash as much as she wanted (pre-CPRC = 0, post-CPRC = 1 for RCR6.1: I'm actively involved leisure and sports activities). Out of the 18 participants, Angela was the only one already engaged in what she considered, meaningful activities (pre-CPRC = 1, post-CPRC = 1 for RCR6.3: I engage in activities that I find enjoyable and fulfilling).

As the coaching progressed, she began doing it not only out of obligation but because she wanted to feel more fulfilled. Angela began to realise that exercise has its health benefits, apart from just getting her out of trouble with drinking. She realised that squash helped her cultivate a sense of enjoyment for the sport. This

means not being so over-competitive with her squash partners but instead, instil a spirit of a more meaningful connection with them. As the CPRC Program progressed, nine participants (Angela, Mala, Sandra, Karina, Donna, Melissa, Nancy, Duong and Patricia) were able to become actively involved in leisure or sports activities.

John was already doing physical exercise regularly forr RCR6.1: I'm actively involved in leisure and sports activities, therefore he scored pre-CPRC = 1 or 'yes' and retained that post-CPRC. For RCR6.2, 11 participants improved their standing. For RCR6.3, five participants felt they were now engaged in fulfilling activities. For RCR6.4, nine participants felt they were accessing career development opportunities. As for the last question item, ten participants felt they regarded life quite fulfilling to live without the need for alcohol and drugs (RCR6.5). These results of improvements for RCR6 are reported in Table 18.

Table 18:

Summary of Scores for RCR6: Meaningful Activities

Recovery Capital Resource **RCR 6 MEANINGFUL ACTIVITIES** Question items:	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the end of CPRC
RCR 6.1: I am actively involved leisure and sports activities	1	10
RCR 6.2: I am actively engaged in efforts to improve myself (training, education and/or self-awareness)	6	17
RCR 6.3: I engage in activities that I find enjoyable and fulfilling	13	18

RCR 6.4: I have access to opportunities for career development (job opportunities, volunteering, or apprenticeships)	8	17
RCR 6.5: I regard life as challenging and fulfilling without the need for using drugs or alcohol	5	15
TOTAL SCORE: for RCR 6 MEANINGFUL ACTIVITIES DIMENSION	**33**	**77**

Note: 18 participants x 5 question items, score range 0-90

5.2.7 Pre- and Post-CPRC Score for Housing and Safety (RCR7)

The ability to have housing and feel safe within it, is one of the important aspects highlighted by the Australian National Recovery Framework (Australian Health Ministers' Advisory Council, 2013). The cumulative score for the safety and housing dimension before they engaged a recovery coach was quite low for all participants at 21. The score at the end of the recovery coaching program (80) was the third highest dimension, showing instances of improvement. Table 19 outline the five RCR 7 items to guide presentation of results data summary.

Table 19:

Recovery Capital Resource Dimension 7

Recovery Capital Resource (RCR) RCR 7 HOUSING & SAFETY
RCR 7.1: I am proud of my home
RCR 7.2: I am free from threat or harm when I am at home
RCR 7.3: I feel safe and protected where I live
RCR 7.4: I feel I am able to shape my own destiny
RCR 7.5: My living space has helped me to drive my recovery journey

Source: Department of Health, VIC., (2013).

Notably, all participants felt safe from threat and harm (RCR7.2) and felt free to shape their own destiny with original scores being 5 and 7, respectively. There were ten participants that felt an improvement because they were proud of where they lived

after CPRC (RCR7.1). Eleven participants also felt safe and protected living in their own home, when they did not prior to CPRC (RCR7.3). Fourteen participants now felt they were able to recover instead of slip back to relapsing behaviours, whilst in their home or because they moved into a new home (RCR7.5).

Mala was from a devout Muslim background. She engaged my services as a coach and confessed that she has never disclosed the various elements of domestic violence she experienced in her 25 year-marriage to anyone outside of family and extended family members. She was emotionally distressed and in tears during the first meeting and prior to committing to the CPRC program. Her fifth session reflected aspects of how domestic violence and her husband's addiction affected her.

> **Mala:** *I guess our relationship right now as has been for the last 3 or 4 months, a very shallow relationship, but it's okay* (sad tone and teary). *It is pretty cold. There's been a lot of things that happened, and I think it is really time for me to move on. Imagine how hard it is to move on thought, we have been married for 23 years and together for over 25.*
>
> **Maria:** *Okay, talk me through this more.*
> **Mala:** *I'm on the stage where I know that it's not fixable. It's so sad and I dread telling the kids. It consumes me, what needs to happen from this point.*
>
> **Maria:** *Yeah. It totally makes sense. You're the only one that knows this. It feels lonely keeping this knowledge to yourself.*
>
> **Mala:** (Starts to cry) *You know for ten years I've known about his drug problem. Ten years I have been saying to myself that no matter what happens, whatever it takes I'll support him. I totally get where he's coming from and that's okay, that's his life. But now, I know I cannot do it anymore (sobbing uncontrollably).*

By the 11th month and at the last or #12 CPRC session, Mala has already moved into her own modest home. The coaching sessions were about using the coach as a sounding board and support to be able to recount all the ups and downs of finding her little haven (RCR7.1: I am proud of my home).

MALA: *...so he does it in my face* (the drugs) *that was really confronting. I would still tell the kids that he is a loving person, that he is generous. I keep on excusing his behaviours. I keep telling myself I don't hate him, but I do. My kids told me the other day that they don't hold anything against me. I thought to myself - they know so much!*

MARIA: *Well, that's the thing with drug use. It does affect the kids. The violence affects them, the fighting affects. He provided everything with what best he could. The three kids go to good schools and you all really live well.*

MALA: *It was a hard decision, the hardest – to disappoint my parents and to face my community. I thought I couldn't get through it all!*

MARIA: *You've started to have full ownership of your life. You're more than entitled to do what you feel is right. Coz you've learned. In the beginning, I could really sense your frustration. I could feel your brokenness. But you persevered and you severed a 26-year tie. You took back your power, you took control of your finances. So, let us look at how you did in achieving that goal? Living on your own, fully independent, and financially secure because you got $10,000 saved in the bank?*

MALA: *I'd say that's a 100% for me. Freedom really does come to mind.*

Table 20 summarise the RCR7 scores for all participants - where the pre-CPRC score was 21 and post-CPRC score jumped to 80.

Table 20:

Summary of Scores for RCR7: Housing and Safety

Recovery Capital Resource **RCR 7 HOUSING and SAFETY** Question items:	Represents sum of ***18 participants scores*** (range 0-18), with: **<u>0 = No, 1 = Yes;</u>** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **<u>0 = No, 1 = Yes;</u>** Measured at the end of CPRC
RCR 7.1: I am proud of my home	4	14
RCR 7.2: I am free from threat or harm when I am at home	5	18

RCR 7.3: I feel safe and protected where I live	4	15
RCR 7.4: I feel I am able to shape my own destiny	7	18
RCR 7.5: My living space has helped me to drive my recovery journey	1	15
TOTAL SCORE: for RCR 7 HOUSING and SAFETY DIMENSION	**21**	**80**

Note: 18 participants x 5 question items, score range 0-90

5.2.8 Pre- and Post-CPRC Score for Risk Taking (RCR8)

The cumulative score for the risk-taking dimension were the highest for all dimensions at 41 at the start of the CPRC program. For risk taking, most participants already felt they do nothing to hurt or damage others (RCR8.4). Participants in this study, because of attendance in the CPRC program were now willing to explore how to take full responsibility for their actions (RCR8.5).

Nine participants' felt they did not have the privacy they need (RCR8.3) before the coaching sessions began, with n=3 improving in this question item. During the course of collaborating with their peer recovery coach, n=14 showed improvement in their perception of money (RCR8.1). As well, almost all (n=17) felt they have changed their perspective in viewing their decision-making regarding resources, feeling they now possess the resources they need to work towards and strive to make important decisions (RCR8.2).

Table 21 illustrates the items for RCR 8: Risk Taking, guiding the presentation of data associated with the RCR 8 dimension and scores.

Table 21:

Recovery Capital Resource Dimension 8

Recovery Capital Resource (RCR) **RCR 8 RISK TAKING**
RCR 8.1: I am free from worries about money
RCR 8.2: I have the personal resources I need to make decisions about my future
RCR 8.3: I have the privacy I need
RCR 8.4: I make sure I do nothing that hurts or damages other people
RCR 8.5: I take full responsibility for my actions

Source: Department of Health, VIC., (2013).

Janet showed improvement, from a score of 0, pre-CPRC to an increase of 4, post-CPRC. She had a specific goal of increasing the equity of her home and buying it from the owner of the house, as they have been renting this home for over ten years and developed a relationship with the owners of the property.

Session 1

Maria: *Yeah, well let's go back to the financial goal and let's just see if we can word something about that. So, something that's inspirational to you and quite challenging, as well. So, shares, property, and business. Remember, the gyst of all this is abundance mentality, isn't it?*

Janet: *I am bit scare coz I'm really not sure.*

Maria: *Put it this way, if money comes in easily, like it did with your inheritance, it's not really coming from that place of abundance and a sense of knowing you are in charge of your financial path. What we are doing here, for the course of the coaching journey, is we want you to know exactly how to take control of your finances.*

Janet: *Okay. I can see a hundred thousand.*

Maria: *Well, let's put that down. Building a hundred thousand in equity for your house. I know you're renting right now but you can negotiate with the owner, as you said you already know them, having rented from them the last eight years, right?*

Janet: *Okay, well, I'm scared. This is really a little bit frightening. Because I'm not used to thinking like this, I mean-- I've never. This is quite a challenge for me.*

Maria: *Stay with me, that hundred thousand signifies or represents your abundance mentality--your prosperity consciousness. I want you to feel very confident in this. Coming from that strength, this is the seed that helps build abundance mentality for you.*

Janet: *I can't do it.*

Maria: *Why?*

Janet: *I really (expletive) up around it, I know I have. I don't give to myself. I'm a miser. I'm a real miser. I don't allow great stuff in my life. Everything I do, it's (expletive).*

Maria: *Well, then at least you know and can admit that. This right here is extremely challenging for anyone to do.*

Janet: *It's really challenging. I'm comfortable in misery and strength and struggle.*

Maria: *I mean, isn't that where all the problem started. Meaning, you've got so many regrets about finances and self-deprecating thoughts about money?*

Janet presented as a woman that was extremely self-deprecating, and this shows with her self-talk. She was referred by her husband who was worried about her mental health and drinking. She would throw fits, screaming and crying almost daily. She was screaming and crying for most of her first CPRC session. She expressed a lot of anger for life and there was deep resentment that we worked through in that session. When we met again for CPRC #4 session, a spark was ignited inside her.

Session 4

Janet: *hmmm, what is my relationship to my first goal: I am allowing myself to feel abundance and have the 100,000 by May 1st?.*

Maria: *What's that one word, one phrase that captures where you're at with that particular goal right now?*

Janet: *Possibility? When I write that goal, it meant nothing to me at the time but since we've done that, I've seen opportunity. So, it's like something sprouted inside me. I think in many way,s I saw hope. It is like I CAN make something of that.*

Maria: *Perfect! There are opportunities sprouting. That's a great start.*

Janet: *Funny how I just started start seeing this now because I realised I keep dwelling in severe regret. Now, I force myself out of thinking that way (smiles).*

The journey to changing her mindset started to take form when she started to see the connection between her ability to make decisions and take appropriate risks relied heavily on making time for herself (self-love and self-care). For this, we set an action set to practice yoga together, twice a week at her place. She was able to balance her yoga practice, with picking up her kids and running their business (pre-CPRC = 0, post-CPRC = 1 for RCR8.5: I take full responsibility for my actions). It also meant that she and her husband had to close the business for one day in the week, instead of working 24/7, 7 days a week (pre-CPRC = 0, post-CPRC = 1 for RCR8.2: I have the resources to make decisions). She started to see that the undue pressure she gave herself, caused her to be very wound up and screaming at people was her release.

Table 22 show a summary of RCR8: Risk Taking scores for all the participants in this study.

Table 22:

Summary of Scores for RCR8: Risk Taking

Recovery Capital Resource **RCR 8 RISK TAKING** Question items:	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the end of CPRC
RCR 8.1: I am free from worries about money	4	14
RCR 8.2: I have the personal resources I need to make decisions about my future	5	17
RCR 8.3: I have the privacy I need	9	13
RCR 8.4: I make sure I do nothing that hurts or damages other people	12	15
RCR 8.5: I take full responsibility for my actions	11	15
TOTAL SCORE: for RCR 8 RISK-TAKING DIMENSION	**41**	**74**

***Note*:** 18 participants x 5 question items, score range 0-90

5.2.9 Pre- and Post-CPRC Score for Coping and Life Functioning (RCR9)

Coping and life functioning dimension included examining how participants dealt with a range of professional people (RCR9.1) and asked if they let other people down (RCR9.2). For this dimension, the score increased more than twice as much from beginning (33) and end point (75), with 12 to 18 participants showing improvement across the coping dimension and all of its five question items. This dimension also looked at daily eating and nutrition (RCR9.3: I eat regularly and have a balanced diet), ascertaining if individuals look after themselves regularly (RCR9.4: I look after my health and wellbeing) and meet their obligations on time (RCR9.5: I meet all of my obligations promptly).

Outlined in Figure 9 are itemisation of RCR9 dimension.

Table 23:

Recovery Capital Resource Dimension 9

Recovery Capital Resource (RCR) **RCR 9 COPING & LIFE FUNCTIONING**
RCR 9.1: I am happy dealing with a range of professional people
RCR 9.2: I do not let other people down
RCR 9.3: I eat regularly and have a balanced diet
RCR 9.4: I look after my health and wellbeing
RCR 9.5: I meet all of my obligations promptly

Source: Department of Health, VIC., (2013).

Overall, for this coping and life functioning recovery capital dimension (RCR9), twelve participants made sure they were more conscious of their eating habits and improved their overall diet by learning about proper nutrition (RCR9.3). Ten participants felt they already did not let other people down and met their obligations to the best of their ability (RCR9.5). They were six participants feeling they do not meet obligations promptly (RCR9.5), while four that felt they still let other people down (RCR9.2). Two participants felt they were not happy dealing with professionals (RCR9.1), while three individuals did not find improvement in eating a balanced, nutritious diet (RCR9.3).

The most noticeable improvement was when all participants started looking after their health and well-being (collective score pre-CPRC = 3, post-CPRC = 18 for RCR9.4: I look after my health and wellbeing). Prior to CPRC, only John, Duong and Karina were able to do look after their health. All participants' results are detailed in Appendix B.

Sandra improved in this category, as one of her goals was to improve her diet and eat better. She is a mother of 7 children and her husband and two children have

Asperger's Syndrome. Suffering from fibromyalgia, she has been abusing anxiety and pain medications for the most part of her life (pre-CPRC = 0, post-CPRC = 1 for RCR9.4: I look after my health and well-being). At 46 years old, she lives a very hectic life, serving her seven children and husband's needs, almost always before her own (pre-CPRC = 0, post-CPRC = 1 for RCR9.2: I do not let other people down).

Sandra embarked upon going back to university as a mature aged student studying a Bachelor of Psychological Science degree. She enrolled just prior to committing to the CPRC program. She expressed this qualification will help her gain understanding of her personal situation. After graduating, she planned to work in corrections or human services as a way to contribute to the income of her household. As she had this intention, her score remained a yes = 1, for this question item (pre-CPRC = 1, post-CPRC = 1 for RCR9.5: I meet all of my obligations promptly). She has a meek personality and often in an anxious state. Her first session below talks about the relevant goal to this RCR9 dimension.

> **Maria**: *Sure, you mentioned before how you wanted to lose ten kilograms. This is the requirements of a goal. Just to remind you, your goals must be inspiring to both of us! It needs to push you to your next level, therefore really challenging you. Also, the measure and the timeframe must be expressed within the goal. Are you ready?*
>
> **Sandra**: *Yeah* (hesitantly). S*o, I really want to fit into my fabulous blue dress again. And wear this to Latino dance night Earl!*
>
> **Maria**: *Great, so let's stick to that - as I saw how your eyes lit up when you said that. Here it is: My fabulous blue dress looks perfect when I'm dancing with Earl - something like that?*
>
> **Sandra**: *For sure!*

As the sessions progressed, she was able to go about managing her schedule better. She arranged for date nights and she started to realise how much she really has taken on in life, with her studies and the seven children. The interaction below shows

the depth of the conversations in CPRC Session #6. It was about improving her eating habits and looking after her well-being with exercise.

Session 6

Sandra: *I haven't really done exercise but if I have the time, I'll do it. I can't really run anymore. It's so hard. I used to be quite active and used to play net ball, but I probably can't do that anymore either with my fibromyalgia.*

Maria: *Is it because the joints really hurt and it's uncomfortable?*

(More in-depth discussion is had about the pain and her fibromyalgia condition)

Maria: *Being sedentary and not moving usually, stops us in your tracks and the habit kicks in more and more. Remember, the point of having me as your Coach is to point out where I see it might not be working, If I don't stretch you with that - our mind will beat us. You've got to sweat and let out the toxins, it's got to come out one way or the another. Either in your workout, or as a worsening medical condition. What needs to change here?*

Sandra: *I know it so well, but three weeks pass, and I have done no exercise because I have been really busy.*

Ten months of working closely together, allowed us to explore where her beliefs came from. She discovered that her sharp pains are due to over-reliance on anxiety and pain medications for 18 years. The way her husband was unable to give her emotional responses due to his Asperger's Syndrome, was connected to her inability to receive emotional support, learned from her parents in her childhood. Over time, she started to realise the chain of events that led her to take anxiety pills, stemmed from her inability to receive love.

Table 2 (Appendix B) outline all of Sandra's RCR scores and Table 24 summarise the RCR9 scores for all participants in this study.

Table 24:

Summary of Scores for RCR9: Coping/Life Functioning

Recovery Capital Resource **RCR 9 COPING and LIFE FUNCTIONING** Question items:	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the end of CPRC
RCR 9.1: I'm happy dealing with a range of professional people	7	16
RCR 9.2: I do not let other people down	10	14
RCR 9.3: I eat regularly and have a balanced diet	3	15
RCR 9.4: I look after my health and wellbeing	3	18
RCR 9.5: I meet all of my obligations promptly	10	12
TOTAL SCORE: for RCR 9 COPING and LIFE FUNCTIONING DIMENSION	**33**	**75**

Note**:** 18 participants x 5 question items, score range 0-90

5.2.10 Pre- and Post-CPRC Score for Recovery Experience (RCR10)

In line with recovery-orientation according to the Australian National Framework (Australian Health Ministers' Advisory Council, 2013), this last dimension is the reflection of their overall quality of recovery experience. The cumulative score overall for this dimension increased from 21 to 71, providing at least a three-time, increase from its original score (Table 26). There was an increase in this dimension because it is the quality of the recovery experience that coaching sought to improve. Allowing the client to focus on purpose and meaning is the foundation of the complete coaching program (RCR10.1).

Table 25 illustrates the question items associated with RCR10 scores.

Table 25:

Recovery Capital Resource Dimension 10

Recovery Capital Resource (RCR) **RCR 10 QUALITY OF RECOVERY**
RCR 10.1: Having a sense of purpose in life is important to my recovery journey
RCR 10.2: I am making good progress on my recovery journey
RCR 10.3: I engage in activities and events that support my recovery
RCR 10.4: I have a network of people I can rely on to support my recovery
RCR 10.5: When I think of my future, I feel optimistic

Source: Department of Health, VIC., (2013).

It is the job of the CPRC Practitioner to engage the client to remain optimistic and hopeful about sustaining a successful long-term recovery (RCR10.5). Inspiring a future oriented, hope-filled interaction from beginning to end can be one of the differences between the therapeutic approach and the peer recovery coaching model (Loveland & Boyle, 2005).

Karina showed improvement in RCR10.3: I engage in activities that support my recovery and RCR10.4: I have a reliable network that supports my recovery, pre-CPRC = 0, post-CPRC = 2. She heard about the coaching service at a workshop facilitated by the researcher regarding addiction recovery techniques. She communicated through social media and a few months later was ready to commit to her coaching journey. She uses art as her way to release the pains she experienced being sexually abused by her father when she was quite young. The same tragedy happened to her daughter and this was something very shattering for her to discuss and process. One of the problems we worked on intensively is her way of helping other people before herself. Her last relationship, like most of any of her past relationships, was extremely abusive. She wants to work on healing and forgiving her past, so she does not loop through the same experiences, over and over again.

Session 3

Karina: *I get so scared. I mean – I did what I can, and I know it was too late, but I am still wrecked with guilt about it all (her ex-partner sexually abused her daughter at 6 years old and it continued for 3 years until she and her children left).*

Maria: *You've seen it with your own eyes. It is normal to go through these intense moments of disorientation and sorrow. It is totally normal, you went through it and the horror of what you know you wanted never to happen to anyone else, actually happening. I can't even begin to describe to you how much pain I feel just hearing this.*

As there was a lot of unresolved and repressed pain, she smokes marijuana, drinks heavily, was involved in mostly casual relationships and had a co-dependent relationship with toxic men. The transcript that follows looks at Karina's actions that improved her result in this RCR10 domain.

Session 7

Maria: *How many brothers and sisters do you have again?*

Karina: *One sister and one other brother.*

Maria: *Okay, let us revisit the reason behind why you want to heal the relationship with your sister and brother?*

Karina: *My other brother is in such a bad way and he cannot handle anything. He is always drinking, and we have really fallen away quite a lot. It hurts to talk to him because I still feel he wasn't really there for me* (at the time of the sexual abuse) *when I needed him.*

Maria: *Okay, so let's write down some actions, shall we? Like we have been talking about before, we need some models, sibling relationships to benchmark. So, action #4: find a sister-sister and sister-brother relationship that you love and dig into that story. Action #5: tell me why you've chosen that particular sibling-relationship, let us really discuss that in the next session.*

Karina: *Can't wait.*

Maria: *Of course, because in the past instead of unburdening or taking a layer off which makes us feel exposed and vulnerable. What happened with you is you delved deeper into your negative habitual patterns and learnt behaviours. And in the healing process, part of healing is actually taking a layer off and feeling exposed. Then we work on this and process it. That way, it doesn't have quite a sting. Where we don't need to drink or use drugs or be in constant bad relationships to keep reliving the pain, of what you have been used to.*

Karina: (listening and processing intently, while crying)

Forgiveness and release of past trauma had a bearing on how Karina moved from displaying symptoms of her SUD, to a need to keep persisting prioritising her recovery work (RCR10.2). As she worked up courage to handle her own heavy traumas, her first step was repairing her sibling relationships. We decided it was an easier starting point to develop and practice her ability to learn how to forgive. Once she was able to do this, Karina worked her way to facing her own trauma, of being abused as a child.

Her feelings of guilt and shame towards feeling as if she allowed her daughter to also fall into the same circumstances she was in. Her post-traumatic stress symptoms were always brought up when she remembers her abuse and her daughter's. It took her time to work her way to doing her own self-healing, self-regulation and self-forgiveness work, in earnest. The CPRC sessions were used as a sounding board and a way to understand and resolve what she went through. The CPRC session below was another moment of release and realisation for Karina.

Session 4

Karina: *Loneliness. I get so overwhelmed with it. I don't know why.*

Maria: *It is just reminding you. These are all memories that are unprocessed. I know your Art is there and that is amazing for you. But just remember, you were left by your mother, father, husband, son, daughter, brother, and sister. You were also abused when you were too young to know any better, by a person that is meant to love you and care for you as a Father. There is a lot there. A*

lot! The loneliness will always sit underneath all that. But you know, solitude is good. When you drop the fear, being alone is actually a way for you to start the real work of loving yourself and being one with yourself.

Karina: *Yeah, I get so upset on my own. I can hear my thoughts. I get so consumed. I can hear what everyone is saying. I can hear myself say that everyone I love is taken from me. It always makes me cry (starts crying again softly). And this guy, of course - we had a wonderful time but just like that, don't hear from him again. He's gone. I am always left to ask myself. Why? Not again* (continues sobbing).

Each session was a work in progress. It was a careful follow through from the goal originally set, then adhering to the strategies discussed in the second session. Each CPRC session became a step closer to a realisation by Karina, that the quality of her life depended on her ability to reflect upon her actions and explore her limiting beliefs. A big moment came for her as she decided she doesn't need to respond to her ex-husband, and she can take full control of her decisions. In the CPRC session that follow, she made the decision that would mean missing an important occasion, her son's wedding.

Session 11

Karina: *... yeah and that is why I didn't want to go to his wedding* (son's).

Maria: *Because obviously he's going to be there* (her ex-partner and the perpetrator of child sexual abuse to her daughter and father of the son having the wedding). *It's just like a trap!*

Karina: *Yeah.*

Maria: *It will be so emotional for you and you may just fall right into that one. But it depends on you, it depends on how strong you are. It can be a great thing or an ugly thing. The choice is exactly in your hands. No more time to play the victim card, right?*

Karina: *I don't want to, that's why we need to get this sorted.*

Maria: *It can be that you take this and birth your forgiveness for him in real time. That way, you can say things to him that you never had the courage to*

before. Or just embrace the whole situation and really set clear proper boundaries without the need to be there to prove a point.

Karina: *I don't know, I know I will never go back to him. I mean, it can be beautiful. Is it my time for finally reclaim my peace? Is that the moment where what I have felt I lost all those years, I can gain back? If I can just stand strong.*

Maria: *Is it just you that's invited? What a big decision? Have you wrapped your head around it all yet? I mean, if you can pull that off, it'll be the greatest thing that you can do for yourself or it could be the start of another downward spiral and another round of relapse.*

How this session ended was a role-play of possible wedding scenarios. After the role-plays and more coaching, she decided to simply send a heart-felt present (a camera he was asking her for). She realised that she does not need to sacrifice her own recovery anymore (RCR10.3: I engage in recovery activities). Her decision to prioritise herself was demonstrated, as she realised she did not want to jeopardise her recovery by walking into a wedding with people that drank alcohol and used illicit drugs (pre-CPRC = 0, post-CPRC = 1 for RCR10.2). She knew she was not yet that strong in her recovery and she wanted to remain optimistic about her path (pre-CPRC = 0, post-CPRC = 1 for RCR10.5). It was a strong decision and one which took of full integration of learnings from the previous CPRC sessions, after eight months of working together.

Table 26 summarise the scores for all participants for RCR10: Recovery Experience.

Table 26:

Summary of Scores for RCR10: Recovery Experience

Recovery Capital Resource **RCR 10 QUALITY OF RECOVERY** Question items:	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the beginning of CPRC	Represents sum of ***18 participants scores*** (range 0-18), with: **0 = No, 1 = Yes;** Measured at the end of CPRC
RCR 10.1: Having a sense of purpose in life is important to my recovery journey	7	15
RCR 10.2: I'm making good progress on my recovery journey	3	15
RCR 10.3: I engage in activities and events that support my recovery	2	14
RCR 10.4: I have a network of people I can rely on to support my recovery	0	12
RCR 10.5: When I think of my future, I feel optimistic	9	18
TOTAL SCORE: for RCR 10 QUALITY OF RECOVERY DIMENSION	**21**	**74**

Note: 18 participants x 5 question items, score range 0-90 for total score.

5.3 Result 2: Patterns Found for CPRC Sessions #2-11

To identify patterns, 'Result 2' has been segmented into three categories:

a) improved

b) did not improve

c) no negative change

Explained in Section 4.5.2 of the Methodology chapter, Result 2 concentrated on categorising each question item to either one of the three categories mentioned. An

increase from 0 to 1 or from a 'no' response pre-CPRC to a 'yes' response post- CPRC program, belong to the 'improved' category. This category holds answers to the research questions posed.

The second category represents 'did not improve', where a 0 = no response was recorded pre-CPRC, and did not show improvement by the end of the CPRC program, staying a '0' or no. The third and last category represents '*no negative change'*. This means the participant did not slide back to old patterns, having a score of 1 = yes, pre-CPRC and sustaining that score until the completion of the CPRC program.

Figure 9 (Section 4.5.2) illustrate how these categorised were manually annotated and arrived at. Figure 11 (Section 6.2.10) offer a view of these three categories. The next session (5.3.1-10) will only report these three categories. A full discussed about the full effect of the CPRC program, on all RCR scores for all the participants in this study will be covered in Chapter Six: Discussion. For easy access and convenience, Figure 10 is shown on the next page that gives RCR8-10 results for Michael to Janet (Participants #1-5).

RCR 8 RISK TAKING	1	4	2	5	2	5	2	4	0	4
RCR 8.1: I am free from money worries	0	0	0	1	0	1	0	1	0	1
RCR 8.2: I have the resources to make long-term decisions	0	1	0	1	0	1	0	1	0	1
RCR 8.3: I have the privacy the I need	1	1	1	1	0	1	0	0	0	0
RCR 8.4: I ensure nothing I do hurts/damages others	0	1	1	1	1	1	1	1	0	1
RCR 8.5: I take full responsibility for my actions	0	1	0	1	1	1	1	1	0	1
RCR 9 COPING & LIFE FUNCTIONING	0	1	3	5	3	5	1	4	1	5
RCR 9.1: I'm happy dealing w/ a range of professionals	0	0	1	1	1	1	0	1	0	1
RCR 9.2: I do not let other people down	0	0	1	1	1	1	1	1	0	1
RCR 9.3: I eat regularly & maintain a balanced diet	0	0	0	1	0	1	0	1	0	1
RCR 9.4: I look after my health & wellbeing	0	1	0	1	0	1	0	1	0	1
RCR 9.5: I meet all of my obligations promptly	0	0	1	1	1	1	0	0	1	1
RCR 10 QUALITY OF RECOVERY	1	5	1	5	1	5	0	2	0	3
RCR 10.1: A sense of purpose in life is important	1	1	0	1	1	1	0	1	0	1
RCR 10.2: I'm making good progress in my recovery journey	0	1	0	1	0	1	0	0	0	1
RCR 10.3: I engage in activities that support my recovery	0	1	1	1	0	1	0	0	0	0
RCR 10.4: I have a reliable network that supports my recovery	0	1	0	1	0	1	0	0	0	0
RCR 10.5: When I think of my future, I feel optimistic	0	1	0	1	0	1	0	1	0	1
TOTAL SCORE	**7**	**42**	**23**	**49**	**14**	**49**	**6**	**38**	**5**	**40**
	8 35	**7**	**1 26**	**23**	**1 35**	**14**	**12 33**	**6**	**10 35**	**5**
Duration | Age	4 mos	59yo	7 mos	56yo	9 mos	44yo	4 mos	33yo	7 mos	45 yo
n | CODE	1	ROMI	2	KIBR	3	SASA	4	KAJA	5	KAJO

Figure 10: Final RCR8 -10 Pre- and Post CPRC Scores for Participant 1-5

5.3.1 Emergent Patterns found within RCR1 Sobriety

Relapse management is one of the core functions of the CPRC program. This RCR dimension related to relapse management, helps the coach and client gain more focus in their ability to sustain longer and longer periods of abstinence (Maisto, et al., 2015). As the nature of relapses were already explained as TP 12: Relapse will occur, this dimension showed a pattern of having the highest number of '*did not improve'*. This means the participant started out with a 'no' answer and it remained unchanged throughout the application of CPRC.

Notably, RCR1 ended with 48 improvements in the yellow category. This will be discussed in greater detail in Chapter Six: Discussion.

Table 27 outline patterns found within RCR1.

Table 27:

Patterns Found within RCR1: Sobriety

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 1 SOBRIETY	**31**	**48**	**11**
RCR 1.1: I am currently completely sober	13	5	0
RCR 1.2: I feel I am in control of my substance use	2	12	4
RCR 1.3: I have had no 'near things' about relapsing	11	5	2
RCR 1.4: I have no recent periods of substance intoxication	3	14	1
RCR 1.5: There are more important things to me in life than using substances	2	12	4

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.3.2 Emergent Patterns found within RCR2 Psychological

As shown by RCR2.2 (Table 28), participants were not able to cope with stresses in their life, hence engaged the CPRC service because they were using drugs or drinking as a form of dysfunctional coping mechanism. By the end of the CPRC program, 17 participants were now able to cope with stresses. These 17 participants were able to find the necessary inner resources to cope with stress, due to the different techniques practiced during the CPRC program, that were part of their recovery and wellness goals.

Through powerful questioning (Coach Competency #6, Section 3.2.4), the CPRC Practitioner helped the participant understand the detrimental role alcohol and drugs played in exacerbating stress levels, whilst trying to cope with the effects of SUD in their day-to-day life. The level of empathy showed by the CPRC Practitioner as a peer, contributed to RCR2.2 becoming the most improved question item. This

dimension showed the second highest improvement with 56 instances, increasing from 'no' to 'yes' and will be discussed in Chapter Six.

Table 28 summarises the Did Not Improve, Improved, and No Negative Change category scores for RCR2.

Table 28:

Patterns Found within RCR2: Psychological Health

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 2 PSYCHOLOGICAL	**10**	**56**	**24**
RCR 2.1: I am able to concentrate when I need to	**6**	**6**	**6**
RCR 2.2: I am coping with stresses in my life	**0**	**17**	**1**
RCR 2.3: I'm happy with my appearance	**4**	**12**	**2**
RCR 2.4: In general, I am happy with life	**0**	**10**	**8**
RCR 2.5: What happens to me in the future mostly depends on me	**0**	**11**	**7**

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.3.3 Emergent Patterns found within RCR3 Physical Health

This recovery capital dimension of physical health placed second to last, showing one of the least improvements, out of all ten RCR's (see Table 29). Participants, perhaps in denial, expressed already possessing most of the attributes of this dimension prior to starting the coaching intervention.

It was indicated that there were 35 instances that the participants' in this study already possessed the question items indicated for RCR3. As for question items with no improvement, 14 instances were recorded. Five participants felt they were not physically well enough to work (RCR3.2), nor felt they were sleeping well at night

(RCR3.5), before and after the CPRC program. In question item RCR3.4, 13 participants indicated experiencing 'no negative change' as they were able to travel or get around freely at the start, and also by the end of the CPRC program.

Table 29 summarise the instances of Improved, Did Not Improve and No Negative Change category scores for RCR3.

Table 29:

Patterns Found within RCR3: Physical Health

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 3 PHYSICAL HEALTH	**14**	**41**	**35**
RCR 3.1: I cope well with everyday tasks	0	11	7
RCR 3.2: I feel physically well enough to work	5	6	7
RCR 3.3: I have enough energy to complete the tasks I set myself	1	9	8
RCR 3.4: I have no problems getting around	3	2	13
RCR 3.5: I sleep well most nights	5	13	0

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.3.4 Emergent Patterns found within RCR4 Community

RCR4.5 recorded the most improvement, with 12 participants viewing that their SUD behaviour does not identify them anymore. As for question items that did not fall from a yes to a no, there were 30 instances across this 'community' dimension where nine participants already felt they were making a contribution (RCR4.4), that it was important to help others (n=8, RCR4.3), and that it was important that they engage in activities that contribute (n=7, RCR4.2). For RCR4, three participants felt they did not improve their capacity to contribute to their community (RCR4.2 and 4.2), nor

establish an identity that does not revolve around their addictive patterns (RCR4.5). Table 30 summarise the frequency of each of the three categories.

Table 30:

Patterns Found withinRCR4: Community

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 4 COMMUNITY	**15**	**45**	**30**
RCR 4.1: I am proud of the community I live in and feel part of it – sense of belonging	4	11	3
RCR 4.2: It is important for me to contribute to society or be involved in activities that contribute to my community	3	8	7
RCR 4.3: It is important for me to do what I can to help other people	2	8	8
RCR 4.4: It is important for me that I make a contribution to society	3	6	9
RCR 4.5: My personal identity does not revolve around drug use or drinking	3	12	3

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.3.5 Emergent Patterns found within RCR5 Social

The fifth social dimension ranks fourth in the number of improvements (48) shown across all ten RCR dimensions. The most notable improvement was the family reconciliation that occurred in 15 participants' lives, as they actively made positive strides to communicate better with their family members (RCR5.2). It ranks second when it comes to 'no negative change' category where participants did not show any improvements in 22 question items.

Table 31 summarise the frequency of each change category.

Table 31:

Patterns Found within RCR5: Social

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 5 SOCIAL	**22**	**48**	**20**
RCR 5.1: I am happy with my personal life	1	12	5
RCR 5.2: I am satisfied with my involvement with my family	2	15	1
RCR 5.3: I get lots of support from friends	5	11	2
RCR 5.4: I get the emotional help and support I need from my family	7	5	6
RCR 5.5: I have a special person that I can share my joys and sorrows with	7	5	6

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.3.6 Emergent Patterns found within RCR6 Meaningful Activities

This recovery capital dimension of meaningful activities showed improvement in 44 instances. It was shown that 11 participants involved themselves in further study (RCR6.2) and ten (10) participants cultivated the belief that life is more fulfilling without the need to abuse medications, alcohol, and illicit substances (RCR6.5). There were a minimal number of instances throughout CPRC that did not show any improvement, as eight (8) participants did not engage in any physical activity (RCR6.1) and three participants felt that life is not fulfilling if they did not engage in their addictive behaviours (RCR6.5).

For example, 13 participants felt they were already engaged in activities that they found fulfilling (RCR6.3) and eight participants felt they had access to development opportunities throughout their coaching (RCR6.4). The 'no negative change' category showed that there were already 32 question items that clients

possessed. Table 32 outlines all the summary of 'improved', 'did not improve' and 'no negative' change categories for this dimension.

Table 32:

Patterns Found within RCR6: Meaningful Activities

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 6 MEANINGFUL ACTIVITIES	**13**	**44**	**32**
RCR 6.1: I am actively involved leisure and sports activities	8	9	0
RCR 6.2: I am actively engaged in efforts to improve myself (training, education and/or self-awareness)	1	11	6
RCR 6.3: I engage in activities that I find enjoyable and fulfilling	0	5	13
RCR 6.4: I have access to opportunities for career development (job opportunities, volunteering, or apprenticeships)	1	9	8
RCR 6.5: I regard life as challenging and fulfilling without the need for using drugs or alcohol	3	10	5

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.3.7 Emergent Patterns found within RCR7 Housing and Safety

This recovery capital (housing and safety) is the most improved dimension of all, improving in 59 instances. Notably, none of the participants felt free from threat or harm at their domicile anymore (RCR7.2), where they felt their recovery was supported after learning and implementing strategies in their CPRC sessions. As well, 11 participants felt they improved their capacity to shape their own destiny (RCR7.4) and felt the place they live in supported them in being able to shape their recovery journey (RCR7.5).

As for the 'improved' category shown in Table 33, it has one of the lowest numbers of no improvement recorded, with only ten instances not improving, where four participants felt they were not proud of their home (RCR7.1) and three felt protected or safe within it (RCR7.3) in the duration of their coaching interaction with the insider-researcher and coach. Table 33 summarise the frequency of each change category.

Table 33:

Patterns Found within RCR7: Housing and Safety

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 7 HOUSING and SAFETY	**10**	**59**	**21**
RCR 7.1: I am proud of my home	4	10	4
RCR 7.2: I am free from threat or harm when I am at home	0	13	5
RCR 7.3: I feel safe and protected where I live	3	11	4
RCR 7.4: I feel I am able to shape my own destiny	0	11	7
RCR 7.5: My living space has helped me to drive my recovery journey	3	14	1

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.3.8 Emergent Patterns found within RCR8 Risk Taking

This eighth RCR dimension had the highest number of instances a participant already showed that they possessed RCR9. No Negative Change category report this, where 12 participants already felt they do not do actions that hurt or damage others (RCR8.4) and 11 participants felt they already took full responsibility for their actions throughout the coaching interactions (RCR8.5).

It showed the least improvement of all dimensions, improving in 33 instances. The most improved question item was where participants felt they improved on the resources they need to make long-term decisions (n=12, RCR8.2), these included having more financial capacity (n=10, RCR8.1) and internal resources for sustainable recovery. As for not improving their score, five participants felt they did not improve on their privacy issues (RCR8.3) and four participants did not increase their finances or felt free from financial worries (RCR8.1). Table 34 summarise the frequency of each change category.

Table 34:

Patterns Found within RCR8: Risk Taking

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 8 RISK TAKING	**16**	**33**	**41**
RCR 8.1: I am free from worries about money	4	10	4
RCR 8.2: I have the personal resources I need to make decisions about my future	1	12	5
RCR 8.3: I have the privacy I need	5	4	9
RCR 8.4: I make sure I do nothing that hurts or damages other people	3	3	12
RCR 8.5: I take full responsibility for my actions	3	4	11

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.3.9 Emergent Patterns found within RCR9 Coping and Life Functioning

When coached to employ 'approach coping style' to be discussed in Section 6.2.9, the client is made aware of their old pattern of 'avoidance coping'. The score for RCR9: Coping and Life Functioning was improved in 42 instances. This recovery capital dimension belonged in the bottom three of number of improvements across all question items (42/90 improved).

Notable improvements were shown in RCR9.4 and RCR9.3 where the importance of looking after their health and wellbeing became apparent as 15 participants made improvements (RCR9.4) within this question item after implementing their coaching strategies on how to do so. Table 35 summarises the frequency of each change category for RCR9.

Table 35:

Patterns Found within RCR9: Coping and Life Functioning

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 9 COPING and LIFE FUNCTIONING	**15**	**42**	**33**
RCR 9.1: I am happy dealing with a range of professional people	2	9	7
RCR 9.2: I do not let other people down	4	4	10
RCR 9.3: I eat regularly and have a balanced diet	3	12	3
RCR 9.4: I look after my health and wellbeing	0	15	3
RCR 9.5: I meet all of my obligations promptly	6	2	10

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.3.10 Emergent Patterns found within RCR10 Recovery Experience

This last recovery capital dimension ascertains the quality of recovery experience. This dimension ranked third amongst the number of improvements shown across the ten dimensions (53). Twelve participants improved in three question items from within this dimension. Twelve participants felt they made good progress in their recovery (RCR10.2) because they were engaged in activities that supported their recovery (RCR10.3), and that they have a reliable network that supports their recovery strategies and goals (RCR10.4). Last of all, nine participants felt optimistic about their future after receiving coaching (RCR10.5) and eight felt a sense of purpose has been

born after accessing the coaching intervention (RCR10.1). Table 36 summarises the frequency of each change category.

Table 36:

Patterns Found within RCR10: Recovery Experience

Recovery Capital Resource (RCR)	Did not improve	Improved	No Negative Change
RCR 10 QUALITY OF RECOVERY	**16**	**53**	**21**
RCR 10.1: Having a sense of purpose in life is important to my recovery journey	3	8	7
RCR 10.2: I am making good progress on my recovery journey	3	12	3
RCR 10.3: I engage in activities and events that support my recovery	4	12	2
RCR 10.4: I have a network of people I can rely on to support my recovery	6	12	0
RCR 10.5: When I think of my future, I feel optimistic	0	9	9

Notes. 1. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer).
2. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer).
3. No negative change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer).

5.4 Result 3: Perceived Goal Attainment Scores

Three goals were recorded for all 18 participants in the first CPRC session. Chapter Three detailed how the three goals were arrived at, using a process called mining against goal areas (Table 5). Once the three goals have been identified, certain goal eligibility criteria has to be met. This helps define the wording of the goals. Self-rating of these goals are given by the client, thatrange from 0-100%.

With a total of 54 goals set (3 goals for each of the 18 participants), two of the participants perceived achieving the goals completely and another two participants

self-rated at 90-95%. Approximately 25% of participants perceived goals were relatively achieved with a self-rating of 70-85% and only 10% scored below 65% achievement. A summary of participants' goal areas or perceived achievements self-ratings are outlined in Table 37. A discussion of these results will be covered in the next chapter, Section 6.3.

Table 37:

Summary of Participant Self-Rated Goal Attainment Scores

# ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
1 Michael	Co-dependence, Pathological lying, barred from counselling practice	Career / Financial	70%	Creativity	85%	Social / Friends	90%
2 Angela	Child of alcoholic parents, past DV, use of alcohol/marijuana	Emotional	100%	Family	70%	Business	80%
3 Mala	23 years in DV marriage, emotional eating, co-dependent	Living / Home	100%	Fitness	60%	Nutrition	70%
4 Michelle	20+ years injecting meth, sexually molested by	Family	100%	Health	70%	Fitness	80%

	brother in childhood						
5 Janet	Depression, anxiety, emotional eating, medication, and alcohol addiction	Living / Financial	100%	Health / Fitness	65%	Community	60%
6 Sandra	Co-dependent, medication addiction fibromyalgia	Fitness / Emotional	70%	Business	85%	Career	80%
7 Lina	Past AOD use, teen child is meth addict (co-dependent)	Financial	90%	Travel	60%	Emotional	90%
8 John	Past AOD, anger management, violent past behaviour	Relationship	80%	Health	70%	Financial	90%
9 Karina	Own sexual abuse as kid, own daughter suffered sexual abuse by own Father in childhood	Income	80%	Creativity	70%	Family	90%
10 Betty	Grew up in foster care, gang-raped, past heavy heroin use.	Career	75%	Community	85%	Emotional	70%

	Current alcohol- use high.						
11 Donna	Parents were heavy drinkers, in DV relationship, also heavy drinker	Fitness	100%	Education	80%	Emotional	95%
12 Melissa	Teen truant, juvenile delinquent. Strong meth use. Two generations of alcoholism	Family	70%	Health	65%	Social	60%
13 Nancy	Adult children of alcoholic parents, past DV issues, heavy drinking, and chronic back pain.	Health /Fitness	80%	Family	50%	Emotional	70%
14 Ayako	Porn addiction, spiritual dissent	Emotional	90%	Spiritual	100 %	Financial	100%
15 Duong	Internet and porn addiction and procrastinati on	Career	50%	Emotional	50%	Education	80%

16 Rachel	Alcoholic, PTSD, and post-natal depression	Emotional	100%	Relation-ship	95%	Spiritual	95%
17 Patricia	Marijuana / meth use, pathological lying	Health / Fitness	70%	Creativity	70%	Education	70%
18 Cassie	Injects meth – heavy user, obesity, and emotional eating issues. Severe head trauma from car accident in early 20's	Health / Nutrition	60%	Fitness	75%	Emotional	70%

Now that these self-ratings have been reported for Result Three, Chapter Six, Section 6.3 will discuss and provide more context on these ratings.

5.5 Conclusion

This chapter reported on Result 1, being pre- and post-CPRC RCR scores. The RCR scoring was captured based on the Assessment of Recovery Capital (ARC) scale. This chapter provided a qualitative assessment of each of the RCR question items represented by 0 for no or 1 for yes.

Three emergent patterns found during the CPRC program have also been reported as Result 2. In reporting patterns, these were divided in three categories being: a) improved; b) did not improve, and c) no negative change. Lastly, goal attainment scores were also reported as self-ratings by participants.

The next chapter will discuss, evaluate, and draw inferences on the various effects the CPRC program had on the participants lives, while being supported to help manage their SUD issues.

CHAPTER SIX: DISCUSSION

6.1 Introduction

This chapter will discuss how recovery capital resource scores improved for those that attended and completed the CPRC program. Various effects were noted and the sum of the recovery resource assets out of a 50-point score will become the contextual narrative for discussion. This chapter will elaborate on how pre-determined goals set were achieved, despite the prevalence of substance use disorders and related alcohol and other drug use issues. The aim will be to integrate the collaborative, peer, recovery, and coaching dimensions of the CPRC program to contribute insights for wellness coaches and other MH/AOD practitioners in the sector. In keeping the client stay recovery-oriented (Sheedy & Whitter, 2009), focus of each CPRC session sought to increase the participants' capacity to seek ongoing transformative change (Deane, et al., 2014). It will be mentioned that development of one's own coach competencies is important, leading to a coach effect (Reiss, 2015).

Coming from a strengths-based and solution focused lens, recovery can become a liberating experience (Queensland Health, 2016). Recovery-orientation (Onken, Craig, Ridgway, Ralph, & Cook, 2007), peer-delivery (Eddie, et al., 2019) and the coaching approach (Gavin & Mcbrearty, 2013) set the tone from which the CPRC program was developed. When viewed as moving through and beyond the limitations of chemical dependence, the R or recovery dimension of CPRC is most relevant. These are covered in RCR1: 'Sobriety' and RCR10: 'Quality of Recovery'.

In the discussion of the results, the 13 treatment principles will be considered to address any oversight that act as barriers to successful alcohol and other drug treatment provision, mentioned in Section 2.4. Suggestions about the potential of the CPRC program to augment some these systemic issues, will be asserted. Discussion regarding Treatment Principles #7: 'Pharmacology', #10: 'Detox' and #13: 'Screens' will be

sparse because the insider-researcher and also coach-practitioner of this study has had little training in these fields.

6.2 Discussion of RCR Score Results and Patterns Found

In discussing the first and second result, this section will incorporate aspects of the CPRC program that led to a) improvement, b) did not improve, or) no negative change, whilst participating in the CPRC program. Evaluation of results, evidenced in the pre- and post-CPRC RCR scores, will hold two-fold implications: 1.to enrich client experience and 2. for coach-practitioner development. Results One and Two will be discussed, reporting improvements felt by the participants' (*n*=18) using the video logs and transcripts of the CPRC sessions, as a guide. All results discussed in this section are reported in Appendix B (Tables 1-6).

6.2.1 RCR1 Sobriety Scores and Patterns

Sustained and meaningful recovery is frequently preceded by an episodic pattern of between two to five relapse episodes (Doweiko, 2006). Research on alcohol treatment indicates that those with alcoholism require more than three to four treatment episodes over a period of approximately nine years before achieving stable abstinence (Sterling, et al., 2008). As the 'disease model' views addiction as a type of chronic illness, there is a growing awareness that formalised treatment needs to be better connected to an overarching concept of recovery (White, 2010). This was discussed in the literature review and R dimension of CPRC, known in alcohol and other drug industry as recovery-oriented systems of care (ROSC). Within the ROSC framework (see Section 2.5, 2.5.2, and 3.2.3) symptom reduction and abstinence are no longer viewed as an adequate endpoint (Yates, 2014).

The first step in collaboration requires developing goals with the client (Perkinson, 2008). In the first session, three goals are set and clients are given a copy of a coaching folder, along with CPRC session videos for review and self-accountability purposes. Video recordings prompts the remembrance of the exact

details of any problematic behaviours that occur, which the client can address or change.

In measuring the improvements related to RCR1: 'Sobriety', there were 48 improvements from a score of 0 to a 1, across the five RCR1 questions items, called the 'improved' category. The most number or tally of those that fell into the 'improved' category was reported in RCR1.4: 'I have had no recent periods of substance intoxication'. In this question item, 14 participants relayed that they have not taken any substances in the last month. This was achieved by talking about drug use or alcohol intake regularly, undertaking a functional analysis of each relapsing or triggering responses. Functional analysis requires letting the client speak freely about their triggers. These triggers may be situations, people (peer-group), actions or sensory outputs that reinforce or lead to a relapsing behaviour (Loveland & Boyle, 2005).

A critical antecedent examined were reasons why cravings occurred. Craving associations can often be gleaned from each client interaction, and when recorded as video logs, help with memory recall on the CPRC Practitioner's part. This encourages a reflexive practice (Fergusson, van der Laan, & Baker, 2019) and used as discussion points to progress the clients to a mutually agreed upon goal outcome. Often, these associations of antecedents and consequences can be pinpointed to a specific past traumatic experience (Loveland & Boyle, 2005). Once specific antecedents and consequences are pinpointed, these can be processed together within the CPRC session.

Collaborative Dimension of CPRC. Within the CPRC sessions, functional analysis of behaviours or problems were essential in developing an effective problem-solving plan for John and Angela (reported in results section of RCR1, Section 5.2.1). As a CPRC Practitioner, coaching competence (CC) was shown by communicating and asking questions powerfully (CC#6: Powerful Questioning). To create awareness (CC#8: Creating Awareness), part of the competent delivery of coaching (Section

3.2.4), requires going beyond what the clients' concerns were. This means considering all aspects of the clients' body language, tonality and inflection, and not just the words used (ICF, 2020).

An example used in RCR1 for John, was the choice to drink at his sister's birthday party (Section 5.2.1). In this session, John chose to have two drinks and had outlined a clear plan with the CPRC Practitioner. This plan included what his drinking can look like, before making the decision to stop at his limit of two alcoholic beverages. In an earlier CPRC session, he decided he wanted to understand his established responses underlying his thoughts and feelings (i.e., triggers), especially around family gatherings. In John's case, the CPRC functional analysis was completed in two phases. The first phase was the analysis of antecedents of the behaviour and second phase required speaking about any perceived and real consequences of client behaviour (Loveland & Boyle, 2005). As this was explored together in the CPRC sessions, John was able to be more in charge of his behaviour/s, formulating action/s in an informed, strategic manner. The video logs, case notes recorded, and around an hour of time spent in preparation prior to John's session helped the CPRC Practitioner support John and his recovery goals.

It can be observed that CPRC requires ample time for thorough preparation. Prior to the CPRC session, the CPRC Practitioner studied the chain events that may have caused relapsing behaviours to occur. Case formulation and functional analysis often require reflection so that triggers can be identified, preventing future relapse. Once preparations and reflections are completed, this functional analysis work, continues in collaboration with the client whilst in the CPRC session.

Recovery Dimension of CPRC. The 'recovery' dimension requires a thorough understanding of AOD contexts and is the narrative from which all discussions in this chapter stem from. Theoretical and practical understanding of AOD and SUD issues, enabled John to understand his own triggers and cravings. This

includes gaining clarity around goal attainment and possible consequences of decisions made. Discussed in Sections 2.2.1 and 2.2.3, most individuals wanting to stay clean are unable to do so because family members and social networks are still engaged in drinking alcohol, taking illicit drugs, and abusing medications (White, 2010). Others simply do not have the courage, parental modelling, or emotional construct to aspire for a better quality of life, outside of being sober (Daley, 2014).

Peer Dimension of CPRC. Peer support specific to recovering from AOD issues, shares common aims with the therapeutic convention but employ different approaches. The research shows that both are necessary, although the academic literature available are still limited for peer supported, recovery coaching (Eddie, et al., 2019; NIDA, 2018). The therapeutic convention recognises those with SUD sustain biological and psychological effects in need of disease management and cognitive therapeutics (Marel, et al., 2016).

As a peer, open acknowledgement of any relevant past experiences may serve as a catalyst when illuminating some of the next steps available to the client. Discussed as Barrier 5: Stigma (Section 2.4.5), the stigma associated with illicit drug use, alcoholism, domestic violence, self-harm, sexual abuse (both as a victim and perpetrator) and suicide ideation/completion are still considered illegal, taboo, perverted or even deviant topics for honest discussion (Inaba & Cohen, 2014). Therefore, having the support of a non-clinical peer is vital (Eddie, et al., 2019). The CPRC program allows a space for expressions of trauma to be verbalised, without the feeling stigma or judgement.

For John, the peer-delivered coaching he received, compelled him to take control and prevent relapses. He admitted lying about not drinking or using drugs. It became apparent to both John and the coach that by the middle of the coaching program, his addictive tendencies have been transferred over to the excessive use of a

dating site, called Tinder. He was also commented about his over-reliance on eating sweets, such as cakes and donuts.

Angela has spent a lifetime drinking and occasionally smoking marijuana, having had parents that were alcoholics. It was discussed that playing squash enabled her to take her focus away from drinking alcohol and smoking marijuana regularly (RCR1.5). Part of the actions she undertook within CPRC, was to read articles about recovery and research celebrities she looked up to that were able to turn away from alcohol and drugs. She used these stories as inspiration, to affirm she is on the right thing. What follows is an excerpt from her 6th CPRC session:

Session 6

Maria: *Goal three for you is my life is now transformed and free from all addictions to alcohol and other drugs. Where are you placed with that?*

Angela: *I think I really can't do what I normally do but I know that is just self-sabotage*

Maria: *Exactly, and as I was listening to you, you reminded me what you wrote in your preparation questionnaire. You answered in that section about: How do you tend to self-sabotage? Remember, you wrote: 'by drinking'. Still remember that?*

Angela: *Yeah, probably (sheepish).*

Maria: *Well, look at you now, building your 'no more drinking muscle'. It has been what, 90 days without drinking? How do you feel?*

Angela: *Well, I remember when I was still sneaking in drinks… I didn't tell you! And I really felt like crap.*

Maria: *I hear you. Have you felt you had more energy now, to go to squash regularly?*

Angela: *Yeah.*

Maria: *Stay with that because it looks like it is really helping you. I know for me journaling helped. You writing your book, whether you realise it or not, that would just be so satisfying and would have taught you so much, right?*

Angela: *I hope so. It sure helps, as I write about what I have gone through (starts to tear up) it really keeps me up and I feel so much anger. How can they do that to me? (…she continues on to share a traumatic experience)*

Maria: *I really admire you for sharing that. Congratulations! You are on your road to healing, well and truly.*

Angela: *I see that now, I am in control now, aren't I? I used the drugs and alcohols to cope. I mean this is big! Three months is a heck of a long time to not be drinking. I have only smoked (cannabis) two times I think, and that was to help me sleep. Then I threw away my stash* (laughs!). *I did not think this was ever possible, especially to feel happy that I am not drinking anymore, or smoking!*

Angela was one of the five participants that remained abstinent by the time she reached her 12th and final CPRC session. Her CPRC program spanned across seven months. In the course of her CPRC program, she expressed her inability to parent successfully, having been raised by severely alcoholic parents. Her ex-husband was a heroin addict and her son spent years in and out of jail. Acts of forgiveness and learning to release resentment or feelings of unworthiness during CPRC sessions helped her develop the ability to do 'release and forgive' types of exercises on her own. The CPRC Practitioner tended to use humour (CC#4, see Table 3 and Section 3.2.4) to diffuse the heaviness of some of the darker topics delved into. Angela admitted laughter allowed cathartic release of the trauma built up over the decades.

6.2.1.1 Use of Treatment Principles in CPRC related to RCR1

During the course of reporting the results and discussion, the researcher found that the treatment principles (TP) covered in Section 2.3 played an intuitive part in the way she functioned as the CPRC Practitioner. In relation to RCR1: 'Sobriety', relapse management (RCR1-4) and RCR1.5: 'I have a life outside of drinking and drug using behaviours', TP 12, is the most helpful and relevant. Treatment Principle 12:

'Relapses' entails explaining that relapses are part of the recovery journey and is it almost guaranteed and inevitable that relapses will occur, while in treatment.

With this principle and expectation, part of the ongoing CPRC sessions will be to help Angela understand the reasons why she kept drinking, even if she was not verbally admitting it out loud in the beginning phases of the CPRC program. During CPRC sessions, talking about past drug and alcohol intake was normalised. This was done so that when relapses do occur, conversations about relapses can be opened and explored in real-time. Destigmatising of the shame based around relapsing behaviours, allows its phenomena to be carefully examined, when it does occur. This was evidenced when nine participants started to feel more in control of their AOD use, as they were now able to talk about it (RCR1.2).

Treatment Principle 12 is most applicable to the 'did not improve' category result. In this study, there were 38 instances where abstinence was not sustained for RCR1. This category had the highest amount of did not improve score for RCR1 because management of SUD, requires the implementation of the 12th treatment principle. Covered previously, it can take up to nine years or episodic patterns of relapses before abstinence can be sustained long-term (Dennis, et al., 2008).

The peer, recovery and coaching approach helped the participants be more proactive in taking better control over their own relapsing behaviours (RCR1.2). Some ways this was done was when they were encouraged to journal, meditate, practice yoga, and by the use vision boards (Coach Competency #9: Taking Actions, see Table 3 in Section 2.5.1, and explained in Section 3.2.4). As these activities were implemented, 15 participants consequently have had no recent periods of relapse (RCR1.3) and 16 participants had the breakthrough of not feeling like they were stuck in the downward cycle of addiction (RCR1.5). Taking actions will continue to be discussed more in RCR6: 'Meaningful Activities' (Section 6.2.6). Another set of 15 participants felt they had more control of the situations that were presented to them

regarding their SUD behaviours (RCR1.2). These are notable impacts, worth exploring with future research that compares CPRC with other therapeutic approaches, using a randomised design.

6.2.2 RCR2 Psychological Functioning Scores and Patterns

In collaborating with a client, an analysis of the participant's situation is critical in understanding psychological functioning (RCR2). In analysing antecedent factors in Rachel's situation, two components were involved: (1) understanding the context around the behaviour; i.e., who, what, where, and when, and (2) the person's internal thoughts and feelings associated with the behaviour (Loveland & Boyle, 2005). For SUD, these two components were also referred to as external and internal triggers that lead them to relapses (Perkinson, 2008).

The CPRC Practitioner's job is to ask questions (CC#6: Powerful Questioning, see Table 3 in Section 3.2.4) until a clear picture of the negative behaviour emerges. In formulating the case and completing an analysis of Rachel's situation, these questions were noted to be asked, as the CPRC Practitioner prepared for each session:

> Who was Rachel with when she drinks? Does she drink often? In what doses? Who does she drink with? (get names) Who does she think of when she drinks? What painful memories does this give her, that she is soothing?

When examining this question of who affects her most, Rachel's comment: '*It killed me when Mum died, I felt dead since*' had the most effect. Both her parents suffered alcoholism, affecting her ability to parent her own child properly (Daley, 2014). This affected her cognitive capacity and psychological functioning (RCR2). Rachel displayed post-natal depression on both child-birthing occasions. Upon reflection, it seems that her siblings were also affected, and this had a whole-of-family effect in her inability to parent in a healthy manner (Daley, 2014). Continuing the functional analysis, the next step was looking at 'what' questions, such as:

> What were you doing when the behaviour occurs? What were your infants doing? Does it trigger you when you hear them cry? Does it make you panic? What turn of events lead to having a bottle of alcohol, while at home? At what point does Rachel blackout?

As these antecedents were investigated using the video logs of the CPRC session and notes taken from each session, Rachel was invited to engage in a collaborative conversation about the phenomenon of her drinking behaviours. In explaining what is being done, another coaching competency (CC) is applied that allows the CPRC Practitioner to manage each session (CC#11: Manage Client Progress). Part of competent coaching requires the CPRC Practitioner to ask questions that support the client to set actions that are suitably challenging (CC#11, Section 3.2.4, and Table 3). This skill in managing the progress and line of questioning, enabled Rachel to slowly understand her drinking triggers.

After identifying what sets Rachel off on the path of a 'drinking rampage', the work in each CPRC session allowed her to self-discover, in the hopes of liberating her from 'learned' addictive tendencies. As the CPRC Practitioner progressed in understanding Rachel, more questions had to be asked (CC#6: Powerful Questioning) about the details of her drinking behaviour, to understand the effect of RCR2.1: I am able to concentrate when I need to and RCR2.2: I am coping with stresses in my life.

> Where does the behaviour occur? Was she alone in the bedroom with the little kids? Where is her husband? Where does she drink when he is already home? Where is she hiding the alcohol around the house? Where does she pick to hide the alcohol if her husband discovers her hiding places? Where else does she drink (the porch, the bed, the bathroom, the kitchen etc.) where did you go when you drank alcohol on to soothe the pain you feel every time thoughts about your Mother's death come up? When does she drink? First thing in the morning? When the babies cry? When the babies are asleep? When she feels

sad? When does she feel sad? When she feels depressed? When does she feel depressed, i.e., afternoon, 2pm? When she feels anxious? When does she feel anxious? When she feels angry? When does she feel angry?

Rachel began drinking by 8.30am as soon as her husband leaves for his trades work. She was able to drink until 3.00 or 4.00 pm. This behaviour caused her to be anxious, lazy, angry, and almost always sad. In examining the where and when, she was able to understand her drinking cycles. Sober times were introduced by the CPRC practitioner to be integrated to her day-to-day living. As she began studying all aspects of her drinking, Rachel was able to shift her focus to other, more meaningful wellbeing activities. As she continued to do this in every session, she was able to improve her psychological functions, on all five question items.

The results for RCR2: 'Psychological Functioning' strengthen the merit of the peer recovery-oriented, collaborative approach. This was demonstrated when all 18 participants showed improvement across any or all three of the five question items (RCR2.2: 'I am coping with the stresses in my life', RCR2.4: 'In general, I am happy with my life' and RCR2.5: 'What happens to me in the future mostly depends on me'. When examining improvements within psychological functioning (RCR2), there can be a maximum of 90 points scored, if all participants said yes to all five question items (18 x 5 = 90).

For RCR2, the pre-CPRC score was 24, finishing strongly post-CPRC with a score of 80. In this dimension, the greatest impact was shown in participants' ability to handle stress, because at the start of the CPRC program, only John was seemed able to cope with life's stresses. After working with the coach using the CPRC dimensions, 17 participants improved their ability to handle stresses better (RCR2.2).

Other notable score increases was positive changes in the way participants viewed their capacity to take charge of their future (n=11, where RCR2.5, pre-CPRC

= 7, post-CPRC = 18) and see life generally as a happy experience (n=10, where RCR2.4 pre-CPRC = 8, post-CPRC = 18). The rest of the participants for these two question items remained the same, with no negative change. As for RCR question items that showed no improvement (coded red in Figure 9 and Figure 11), six participants did not improve their concentration (RCR2.1) and four were not happy with their appearance. In the end, all participants improved their psychological functioning using the five questions for RCR2: Psychological Functioning.

6.2.2.1 Use of Treatment Principles in CPRC related to RCR2

Treatment Principle 1: 'Neuro' means an explanation of the negative ramifications of SUD on the brain is needed to be relayed to the client. As the actual improvements in the domain of psychological health is about the brain and psychological function, Treatment Principle 1 is the most relevant to RCR2. For example, Rachel was able to concentrate better after the coaching series was completed. It has been known that SUD become more complex, while healthy synaptic connections are severed over time (Pascual-Leone, et al., 2005). The work of recovery aids neuroplasticity in moulding cortical and neurological pathways together, allowing natural excretion or inhibition of dopamine, serotonin and/or oxytocin to have its healthy long-term effects.

In the beginning, Rachel was always vague in the CPRC sessions and commented on feeling cloudy. This is usually the effect of alcohol in the body, also commonly known as 'brain fog' (Abadinsky, 2018). Rachel began by drinking all day, going through post-natal depression twice. Over the course of CPRC, she shifted her focus on other activities like helping run the administrative tasks for her husband's business (pre-CPRC = 0 for RCR2.5: What happens to me in the future mostly depends on me), being a thoughtful and caring mother to her two little boys (pre-CPRC = 0 for RCR 2.4: In general, I am happy with my life) and becoming more aware of self-care by having a massage or reading self-help books. As her quality of life improved, she

felt more in control of her future (pre-CPRC = 0, post-CPRC = 1 for RCR2.5: What happens to me in the future mostly depends on me).

As Rachel expressed wanting to work on diminishing brain fog and having the ability to concentrate on her children and husband's business better (RCR2.5), the CPRC Practitioner made efforts to interrupt or ameliorate fatalistic patterns interfering with her biological and pharmacological responses. As neurological and structural abnormalities are suffered by those that sustain long-term SUD, pre-frontal and vascular areas of the cerebral cortex are also negatively affected, making follow-through behaviours difficult. The CPRC program allowed Rachel to improve her psychological functioning as collaboration with the peer coach increased her confidence in the overall coaching process.

From the CPRC Practitioner's coach competency perspective, the ability to explain the effects of SUD on the brain demystifies the disease management aspect. It also normalises behaviours known to Rachel as guilt or shame-inducing. This resulted in Rachel achieving an RCR score of 49/50. This was a remarkable improvement on her part because she started the CPRC program with a score of only 8/50. Her self-rated goal attainment scores for her emotional health, intimate relationship and spirituality goals were 100%, 95%, and 95%, respectively. Table 6 outline all of Rachel's RCR scores, found in Appendix B.

6.2.3 RCR3 Physical Health Scores and Patterns

Mentioned in Section 2.2.1 to define SUD, symptoms of drug and alcohol use negatively affects various physiological systems (Pascual-Leone, et al., 2005). As an example, the Center for Behavioural Health Statistics and Quality (2016) reported that SUD can create physically hazardous situations and increase tolerance for the substance to achieve intoxication. Ongoing alcohol and other drug use exacerbate

negative physiological symptoms and can be known to increase carcinogenic effects (Inaba & Cohen, 2014).

Demonstrated in animal models, and human brain imaging studies, dopamine receptors express physiological plasticity in individuals when certain stimulant drugs are taken repeatedly (Inaba & Cohen, 2014). Examples include prescribed medications, such as beta-blockers, antidepressants, sedatives, and opioids for pain, as well as commonly abused drugs, such as alcohol, cocaine, and nicotine (Inaba & Cohen, 2014). In Michelle's case, her dopamine receptors have been eroded by her intravenous injection of methamphetamine over 15 years. She was unable to fight the effects and birthed her son in methamphetamine withdrawal as she continued to inject while pregnant.

The reason for her behaviours were deeply ingrained neuroplasticity manifested over time by her compulsive drug-seeking behaviour. Her reward system was under-developed early on, during child development due to parental neglect. Her reward and brain systems were further compromised, when she was sexually interfered with by her older brother. Her intravenous drug use activated strong rewards, hence she needed to produce more drug-seeking behaviours to repeat these strong, rewarding feelings. The dopamine release caused by her injecting methamphetamine was greater than that of her body's natural reward systems (Sampedro-Piquero, Santin, & Castilla-Ortega, 2019). The drug experience becomes associated with environmental cues and acquires increasing salience. Michelle had greater potential for relapse, even years after the last dose of drug injection.

Over the course of the four months, Michell was able to cope better with cleaning the house and parenting her son by allowing her to understand that parenting and domestic skills are learned behaviours (post-CPRC = 1 for RCR3.1: I cope well with everyday tasks). She also started becoming well enough to attempt studies (post-CPRC = 1 for RCR3.2: I am coping with the stresses in my life) and felt energised

with more sober days away from injecting, than before started the coaching journey (post-CPRC = 1 for RCR3.3). Consequently, as we worked toward more days without injecting, her sleep began to stabilise and by the end of the first round of 12 coaching sessions, she was sleeping deeper and felt more rested (post-CPRC = 1 for RCR3.5: I sleep well most nights).

When Michelle increased her natural reward seeking behaviours, her injecting behaviours lessened. Methamphetamine, classified as a stimulant, has been known to damage the liver, the cardiovascular system, and the central nervous system (Radfar & Rawson, 2014). Clandestine laboratories make methamphetamine with fatal substances, such as battery acid, drain cleaner and rodent poison (Owens, Mason & Marr, 2017). As a result of high toxicity levels and organ or systemic damage sustained by Michelle from injecting methamphetamine regularly over the course of 12 years, she gave birth to her son in methamphetamine withdrawal. In the CPRC sessions, Michelle found it particularly useful verbalising her guilt, as she recalled how her son was born, shaking from symptoms of drug withdrawal. This level of authentic sharing reinforced the therapeutic alliance (1st dimension of CPRC: Collaboration) already well established.

Michelle took four months of speaking to the CPRC Practitioner, learning about the books she has authored, purchasing two of these and reading both before she engaged in the coaching program. It took time for her to become familiar with the CPRC Practitioner’s story, to establish the trust she needed and make a decision to commit to her recovery. As the CPRC Practitioner encouraged her and modelled contentment in a life of recovery, Michelle decided to engage in her own transformation. These aspects solidified the collaborative and peer dimension of the CPRC program. As this gentle and reassuring approach by the CPRC steadily continued, she was able to slowly understand the physical aspects of SUD and was therefore able to consciously improve her integration in four aspects:

1. RCR3.1: I cope well with everyday tasks

2. RCR3.2: I feel physically well enough to work
3. RCR3.3: I have enough energy to complete the tasks I set myself
4. RCR3.5: I sleep well most nights

As she relapsed, she was able to arm herself with coping mechanisms to replace the denial mechanisms she usually operated from. When she learned to practice forgiveness, being her second goal, she slowly came to grips with her trauma, pushing forward to deal with and/or manage her pain without the use overuse of methamphetamines. Overall, she reduced her injecting dosage and had three months of abstinence which lessened physiological consequences effects on her sleep. Her pre-CPRC RCR score was 6 and she finished the CPRC program with a score of 38/50 (see Table 2, Appendix B).

6.2.3.1 Use of Treatment Principles in CPRC related to RCR3

Treatment Principle 9: Address Comorbidity Issues and Ensure Referrals are Vetted. Comorbidity issues are important aspects to discuss for RCR3: 'Physical Functioning' because SUD influences the body's physiology (Marel, et al., 2016; Pascual-Leone, et al., 2005). As research has confirmed, the phenomena of addiction will invariably be related to comorbidity of other medical and/or MH issues (Marel, et al., 2016). Part of a collaboration between coach and client requires addressing comorbidity issues that interfere with SUD mitigation. Treatment Principle 9 requires alcohol and other drug workers to consider integrating strategies to address comorbidity with the client. This includes making referrals for suitable SUD medication or access to other specialised psychological services (Marel, et al., 2016). In Michelle's case, making plans specific to her nutrition and wellness goals addressed comorbidity and this was discussed in the transcriptions used to report of her results in Section 5.2.3.

6.2.4 RCR4 Community Scores and Patterns

There is a sense of community and a strong feeling of belonging deeply entrenched within drug using and alcohol drinking circles (Maisto, et al., 2015). To better understand RCR4: Community, and its' alcohol and other drug context, this section will discuss specific communities that participants in this study felt they belonged with.

Promulgated by the global drinking culture, alcohol is seen as beneficial for hastening social connections, reducing anxiety, and supporting workplace or familial social interactions (Pizam, 2010). Prior to engaging in recovery coaching, drinking communities elicited a sense of belonging for participants and all were proud to partake in. It is interesting to note that this is the sentiment being portrayed in RCR4: 'I am proud of the community I live in and feel part of it', which offers a sense of belonging. Therefore, unless this sense of belonging with the drinking culture is replaced with a healthier sense of belonging to a different community (gym, yoga, sport, business group, etc.), it would be hard to break away for the participant.

Alcohol is promoted as an important social lubricant in community functions (Pizam, 2010). In the same way, illicit drugs promote a 'drug culture' of its' own (Kim, 2014). Cartel systems profit from the proliferation of their substances through intricate systems involving many sectors (Alsema, 2015; Kim, 2014). Cartel systems utilise hospitality staff and security personnel employed in the licensed establishments to ensure cycles of addiction continue (Pizam, 2010; 2012). Other sub-communities pertaining to a community of illicit drug users are those who frequent 'raves', dance parties, and/or or music festivals (Oh, 2000).

Drinking and illicit drug taking communities, rave cultures, adult entertainment circles, and clandestine networks, as discussed in Section 2.2.1, have members who derive a sense of identity while belonging to these types of groups. In investigating results for RCR4.5: My personal identity does not revolve around drug use and

drinking; it is important to examine the current communities the participant feel they belong to. In the CPRC sessions, functional analysis requires the CPRC Practitioner to use the video logs, to learn more about the community belief systems ingrained in the client's weekend or day-to-day functions. Conversations around communities are paramount to be able to support the client in changing destructive 'sense of belonging' beliefs. In starting the work of breaking down the perceived importance of this sense of community belonging (Gordon, et al., 2011), abstinence remains the beginning point. In the CPRC sessions, clients are allowed a place where they can understand where drinking and drug taking beliefs stemmed from.

Coaching competence enables the CPRC Practitioner to actively listen to what is being said, noticing the client's deeper beliefs and attitudes, while working together to change them. Coach competency 5 is highlighted to describe how the CPRC Practitioner listens to the participants:

Coach Competency 5: Active Listening: '*Ability to focus completely on what the client is saying and is not saying, to understand the meaning of what is said in the context of the client's desires, and to support client's self- expression.'*

Active listening and collaboration are important components in aiding the client to meet set goals and make plans to avoid the multitude of venues in their area of residence or work that serve or sell alcohol. This can include avoiding family and friends' homes, while still in early recovery. As exposure to events and places that serve alcohol is normal and common, more effort is needed on the part of the client to consciously employ a strategy with the CPRC Practitioner to stay on course with their recovery goals.

Twelve participants were able to recognise that a community exists outside of their usual drug using and drinking communities (pre-CPRC = 3, post-CPRC = 15 for RCR4.5: My personal identity does not revolve around drug use or drinking). Another

set of twelve participants were able to enhance their sense of belonging to another community (gym, yoga, squash, Men's Shed, etc.) other than their usual drinking, gambling or places where they took drugs. The cumulative 'pre-CPRC' score was 30 and this has more than doubled by the time all the coaching sessions were completed, with a score of 75.

Rachel's narrative was reported in detail in the results section (5.2.4). In summary, by the end of her completing four months of the CPRC program, she claimed that she: ''felt more connected to others" (pre-CPRC = 0; post-CPRC = 1 for RC4.1: I am proud of the community I live in and feel part of it – a sense of belonging). Her transformation started when her intention of feeling more connected was sharpened (pre-CPRC = 0; post-CPRC = 1 for RC4.5: My personal identity does not revolve around drug use or drinking).

As Rachel was able to share some of her successes and even 'failures' in social and work connections, it became easier for her to understand how closed off she was in sharing her alcoholism or post-natal depression with anyone else. This was because her community comprised of people she would intermittently drink with and although she and her husband felt they belonged in this group, it felt superficial. Rachel and her husband started to realise, there was not much depth in the conversations within these drinking interactions, therefore they decided to concentrate on their finances and work hard on their business together (pre-CPRC = 0; post-CPRC = 1 for RC4.2: It is important for me to contribute to society and/or be involved in activities that contribute to my community).

6.2.5 RCR5 Social Scores and Patterns

Social cues and interactions stem from family dynamics (Ritanti, Wiarsih, Asih & Susanto, 2017). The family context holds information about how SUDs develop and are maintained. This knowledge of family dynamics are needed by the CPRC

Practitioner to help the clients identify what can positively or negatively influence the mitigation of client alcohol and other drug issues (Lander, Howsare, & Byrne, 2013). For this, family systems and attachment theories are frameworks for understanding how SUDs affect the social dynamics of participants involved in this study. Treatment Principle 2 provide more insight into the uniqueness of the individual, in relation to their family dynamics.

6.2.5.1 Use of Treatment Principles in CPRC related to RCR5

Treatment Principle 2: Recognise Unique Needs. Unique family relationships form a subsystem within which larger family and social systems develop from, that the participant feels they belong in. Part of the work of the CPRC Practitioner is to comprehend the uniqueness of the family systems the client grew up in. Once this is completed, collaborating with the client to help them identify their own attachment styles, helps discern belief systems that were handed down to them.

As the coach and client talk about the client's family unit, we can start to examine if they are happy with their personal life (RCR5.1), and what social support/s they actually have (RCR3: I get lots of support from friends). The hard questions that need to be asked (CC#6: Powerful Questions) include whether these 'friends' are people in recovery or in active addiction? If still in active addiction, a necessary question is, if this is appropriate and vital in the client's life; and if it resonates with their decision to become sober? The same question needs to be asked about their choice of a significant other (RCR5.5: I have a special person that I can share my joys and sorrows with), especially if this partner is still in active addiction.

Attachment is formed based upon the infant to carer relationship at a pre-language level, where infants learned to communicate and relate to their social environment (Lander, et al., 2013). If the child experiences the primary caretaker as inconsistently responsive, an insecure attachment may form that can result in a variety of problems including anxiety, depression, SUD pre-disposition and a failure to thrive

(Lander, et al., 2013). A parent with a SUD who is mood altered, preoccupied with getting high, or spending significant amounts of time recovering from the effects of substances may miss the opportunities to foster healthy attachment (U.S. Department of Health and Human Services, 2016). Without a healthy attachment system, a child is much more vulnerable to stress, and therefore more susceptible to having problems with trauma, anxiety, depression, and other mental illness/es (Lander, et al., 2013). Attachment theory posit that the quality of the parents' attachment systems developed in infancy, may also affect their ability to form healthy attachments to their own children (Lander, et al., 2013).

This has been pronounced in the cases mentioned in the results section (5.2.5). As a teenager and young adult, Melissa and Patricia's parents were brought in for their own CPRC sessions. This supported Melissa and Patricia in their goals, and helped the CPRC Practitioner to reconcile family dynamics.

Melissa's mother, Justine, reported in Section 5.2.5 that she spent her childhood watching her parents preoccupied with drinking. From this, she missed opportunities to foster a healthy attachment, and this can be observed in the way she has parented Melissa. Melissa presented to coaching at 17 years old and by this time, she had already spent her teens truanting from school. Over the years, she has progressively become more disturbed, getting picked up by police regularly for drug misdemeanours, and taking methamphetamines regularly with a socially disruptive network of predatory young men, most with criminal records (pre-CPRC = 0, post-CPRC = 0 for RCR 5.2: I'm satisfied with my involvement with my family). Being involved with these men has been a learned behaviour for Melissa as her father was also a heavy alcoholic and her mother had a father and brother commit suicide from alcoholism.

As intricate attachment systems are built on thousands of reciprocal and implicit interactions between infant and parent, social interactions into adulthood will

be affected (Lander, et al., 2013). Eye contact, tone, volume and rhythm of voice, soothing touch, and the ability to read the needs of the infant, are all intricate building blocks of attachment (Lander, et al., 2013). The relational and familial attachment system provides modelling of social norms into adulthood (Daley, 2013; Lander, et al., 2013). Poor outcomes result when children are reared by parents with SUDs. In this study, fifteen participants were not in contact with and/or still harboured deep resentment for their parents and siblings (RCR5.2 and 5.4).

Rachel demonstrated tendencies to cover up her mother's drinking by cleaning up after her mother when she passed out. Her mother was constantly sick and often hung over. In the end, her mother died from alcoholism and Rachel was filled with guilt, thinking that it was her fault, that she did not do enough to keep her mother alive.

Nancy and most of the participants in this study harboured deep, unverbalised resentment and unforgiveness for their parents. In the ninth CPRC session, Nancy finally articulated that acceptance is the most she is willing to give, instead of forgiveness. Her written goal was: *I have a solid foundation therefore I am healed and have forgiven all of my past experiences.* In session 8, she changed the wording of this third goal to: *I have a solid foundation therefore I am healed and have accepted all of my past experiences.*

Session 8

Maria: *So, back down to goal three, how are you in relationship to that goal now? This is how we worded it then: I now have a solid health foundation therefore I am healed and have forgiven what has happened in the past.*
Nancy: *I am accepting.*

Maria: *So, more accepting that the idea of actual forgiveness?*

Nancy: *No, forgiveness is just not possible at the moment.*

Maria: *So, what are we accepting then?*

Nancy: *I can accept my past.*

Maria: *Okay, more accepting of my past?*

Nancy: *Yeah, instead of running from it.*

Nancy showed the least improvement in this dimension because her unforgiveness remained intact, affecting RCR5.2 – 4). Her overall score increased from a score of 1 (pre- and post CPRC = 1 for RCR5.5) to 2. This increase was for RCR5.1: I am happy with my personal affairs/life. Within the coaching, Nancy was able to find happiness in her relationship and her work. Her status with her significant other was sustained during the CPRC program, hence remained a score of 1 (RCR5.5).Table 38 summarise her scores for RCR5 and her full pre- and post CPRC RCR scores are reported in Appendix B as Table 5.

Table 38:

RCR5: Social Pre- and Post-CPRC Summary of Scores for Nancy

Recovery Capital Resource (RCR)	Pre-CPRC	Post-CPRC
RCR 5 SOCIAL	1	2
RCR 5.1: I am happy with my personal life	0	1
RCR 5.2: I am satisfied with my involvement with my family	0	0
RCR 5.3: I get lots of support from friends	0	0
RCR 5.4: I get the emotional help and support I need from my family	0	0
RCR 5.5: I have a special person that I can share my joys and sorrows with	1	1

For children of parents with SUD, research reported an increased risk of developing SUD (Lander, et al., 2013). This was also the case for Betty, whose parents were severe drug takers and alcoholics. So much so, that she was given up to the foster care system. Sometimes her parents would remember her and take her back in but mostly, her developmental growth was full of unhealthy attachments to parents and foster carers' that, according to her, did not have her best interests at heart. Her

formative years were fraught with stories of neglect, bullying and sexual abuse. As the family remains the primary source of attachment, nurturing, and socialisation (Lander, et al., 2013) it is relevant to question item RCR5.2: I am satisfied with my involvement with family.

Sheedy and Whitter (2009) reported that the level of social support that an individual receives has been directly associated with engagement indicators and treatment completion. Recovery-oriented social supports may foster greater self-efficacy and longer abstinence. In addition, it has been shown that social support, particularly through social and family networks produces positive health implications. Further research is needed to better understand how coaching and peer recovery supports influence de-escalation of substance use disorders (SUDs) and social transitions between the stages of SUDs.

6.2.6 RCR6 Meaningful Activities Scores and Patterns

Recovery from addiction requires major changes in thoughts, feelings, and behaviours (Pascual-Leone, et al., 2005). Using Angela as an example, she started to understand this concept as she became more engaged in activities that helped recovery momentum. Upon reflecting and listening to the video logs, we spoke about how squash was one of her outlets and she knew she was not exercising and moving as much as she intended (RCR6.1). As she loves this sport, it was encouraged that she resumes regularly playing squash. She agreed to go back and set her eyes on playing squash 3-4 times a week. In the beginning, she began doing it not out of obligation or as she simply put it: "*I need to do something and keep myself busy*''.

Table 39 provides a summary of Angela's RCR6 scores, for easy reference in. Table 1 (Appendix B) report in all her pre- and post-CPRC RCR scores.

Table 39:

RCR 6 Meaningful Activities Pre- and Post-CPRC Summary of Scores for Angela

Recovery Capital Resource (RCR) RCR 6 MEANINGFUL ACTIVITIES	Pre-CPRC	Post-CPRC
RCR Score: Pre-CPRC and Post-CPRC	2	5
RCR 6.1: I am actively involved in leisure and sports activities	0	1
RCR 6.2: I am actively engaged in efforts to improve myself (training, education, and self-awareness)	0	1
RCR 6.3: I am engaged in fulfilling/fun activities	1	1
RCR 6.4: I can access career development opportunities	0	1
RCR 6.5: I regard life as fulfilling without drugs or alcohol	1	1

In modelling behaviour, another barrier to successful treatment (Barrier #7: Burnout and lack of self-care practices for the alcohol and other drug worker in Section 2.4.7) was mitigated when the CPRC Practitioner engaged in her own self-care practices. She then uses these experiences as discussion points with clients. Doing the activity together also has an effect. As a peer, conversations about the effects of yoga and her meditation activities helped the clients decide which meaningful activities they can choose, to yield health, cognitive, economic, and social benefits.

Zhuang and Zhao (2013) evaluated the effects of a six-month yoga intervention on mood status and quality of life among women undergoing detoxification for heroin dependence in China. It was reported to be effective in improving quality of life for female heroin addicts, using a randomised control group to compare effect. Posadzki, Choi, Lee, and Ernst (2014) completed a systematic review on the effects of yoga on alcohol, drug, and nicotine addiction. After qualifying eight randomised control studies, it was found that hatha yoga, Iyengar yoga, nidra yoga, pranayama, or cognitive behavioural therapy (CBT) plus vinyasa yoga, led to significantly more

favourable results for addictions compared to various control interventions. Pozadski, et al., (2014) concluded that various yoga practices:

> "… may also promote personal development; increase emotional stability, life satisfaction and self-awareness; improve mental, physical and social health; or strengthen initiative, motivation and confidence to improve maturation, intention, attitude and behaviour necessary to overcome addiction." (p. 1)

Meditation is a practice which entails detaching from thoughts while observing and calming the self. There had been several systematic reviews documenting correlations between different forms of meditation and successful addiction rehabilitation (Alexander, Robinson, & Rainforth, 1994; Cheng, 2016). Regardless of the specific teaching, meditative practices are wellness tools used in the CPRC sessions to teach the client how to put time and distance between themselves and their addictive impulses (Hampton, 2018). This pause between urge and action may encouraged neuroplasticity and new wellness behaviours (Hampton, 2018).

6.2.6.1 Use of Treatment Principles in CPRC related to RCR6

Treatment Principle 1: Neuroplasticity. The CPRC Practitioner passes research studies completed about neuroplasticity to the client (Treatment Principle 1: Neuroplasticity). This helps the clients gain practical understanding of how meaningful activities will aid their recovery journey. In all cases, meditation and yoga were completed together in the CPRC sessions and/or outside of the sessions by the client. This gives them a practical experience of how yoga and meditation can be incorporated in their life (see Michelle and Janet's examples in Section 5.2.3 and 5.2.8, respectively).

Cheng's (2016) reviewed 27 studies on effects of meditation on alcoholism. He found that meditation lowered drinking motivation, encouraged better alcohol

disengagement, and greater alcohol-associated self-efficacy. Importantly, it was found that meditation benefits alcohol-induced depression and anxiety and resulted in a significant reduction in alcohol consumption across the aggregate studies. Although it is a potential measure for pathological alcohol dependence and relapse, further well-designed empirical research is necessary to collect evidence that pairs stillness practices, with the use of a peer recovery coach.

Treatment Principle 1: Therapy. This dimension also consolidates the sixth treatment principle, that strongly suggest talk therapy should address all areas of life, encouraging proof of participation in various activities (NIDA, 2018). This is what RCR6 encourages and what the CPRC Practitioner advocates in practice. RCR6: Meaningful Activities showed improvement in 44 instances. It was shown that 11 participants involved themselves in further study (RCR6.2) and ten (10) participants cultivated the belief that life is more fulfilling without the need to abuse medications, alcohol, and illicit substances (RCR6.5).

6.2.7 RCR7 Housing and Safety Scores and Patterns

Housing plays a vital role in one's ability to feel safe as they recover from SUD and is the essence of RCR7: Housing and Safety dimension (Best & Laudet, 2010). Stress factors, such as inability to find a place to live with those that support their recovery (RCR7.5), inability to pay rent and the threat of being rendered homeless due to leaving a home that has perpetrated domestic violence on a person, can all lead to stress that triggers substance misuse and relapse (Sinha, 2018).

People not feeling safe in their own homes typically find it difficult to address their substance use (U.S. Department of Health and Human Services, 2016). A place one can proudly call home (RCR7.1) helps individuals start of a path toward recovery. Conditions experienced by those with SUD make it difficult to maintain a stable home without additional supports. The CPRC Practitioner speaks with the client

about accommodation needs to ensure their physiological and mental health can be addressed (Dohler, 2016).

Recovery-oriented Systems of Care (ROSC) represented by the recovery dimension of the CPRC program, embrace the idea that severe substance use disorders are most effectively addressed through a chronic care management model that includes longer-term, outpatient care; recovery housing; and recovery coaching (U.S. Department of Health and Human Services, 2016).

Integrating an understanding of ROSC was a key component of Mala's growth as she began CPRC with no resources in the seventh dimension and ended her coaching journey possessing a score of 5 for '*RCR7 Housing and Safety'* recovery capital resources. Mala ended up saving her money from her job as an allied health professional (pre-CPRC = 0; post-CPRC = 1 for RCR7.4: I feel that I am able to shape my destiny), she felt relief and joy about her newfound freedom and safety (pre-CPRC = 0; post-CPRC = 1 for RCR7.2: I'm free from threat/harm at home and RCR7.3: I feel safe and protected where I live).

Prior to this moment, she has never been in charge of any household money, except for her own earnings. Her husband gave her enough stipend to keep on top of domicile duties (RCR7.5). She was not even allowed to see the bank statements, be privy to any financial information or included in major business or financial decisions (RCR7.4).

Covered in more detail in Section 5.2.7, Mala's devout Muslim background made it difficult for her to share the various elements of domestic violence she experienced, in her 25 year-marriage. In distress for her future housing safety and financial needs, she set one of her goals to be fully independent, living in her own home and financially in charge of her own monetary assets.

Table 40 outline Mala's scores for this RCR dimension and Table 1 in Appendix B reports all her RCR scores.

Table 40

RCR 7 Housing and Safety Summary of Pre- and Post-CPRC Scores for Mala

RECOVERY CAPITAL RESOURCE (RCR) **RCR 7 HOUSING and SAFETY**	**Pre-CPRC** **0**	**Post-CPRC** **5**
RCR 7.1: I am proud of my home	0	1
RCR 7.2: I am free from threat/harm at home	0	1
RCR 7.3: I feel safe and protected where I live	0	1
RCR 7.4: I feel I am able to shape my destiny	0	1
RCR 7.5: My living space has helped me 'recover'	0	1

The therapeutic alliance cultivated by the CPRC Practitioner with the client included visiting her home, meeting her now ex-husband and strategically planning with Mala all the details of her move. Having a coach, helped forge the conversations that allowed Mala to share a great deal of dysfunction going on behind closed doors. To give context and shared previously in the results section, she estimated around $10,000 was spent on marijuana, medication, adult services, and alcohol by her husband. Being able to plan around these revelations, as they were verbalised, helped her integrate her understanding of her husband's perpetrator behaviour.

Giving the client actions (CC#9: Designing Actions) to complete at the end of each CPRC session is part of the CPRC agenda. For Mala, understanding behaviours of domestic violence, financial violence, and emotional abuse, became part of her ongoing learning and development. Developing her own competence for designing actions, the CPRC Practitioner was able to prepare for Mala's sessions. This included a list of helpful actions that would enable Mala to plan and enact the exact steps for her to be able to move into her own home (RCR7.1, RCR7.3, RCR8.5).

6.2.7.1 Use of Treatment Principles in CPRC related to RCR7

Treatment Principle 3: Immediacy. In understanding RCR7, safety factors and immediacy of service go hand in hand. Treatment Principle 3 posit that immediate and responsive treatment is paramount because 70% of those that may need help, may not be equipped with the foresight needed to seek it (NIDA, 2018). Those that do seek treatment are usually in a crisis and forced to partake in services that are readily available and can have them immediately integrated into the alcohol and other drug practice.

The CPRC Practitioner is prepared and educated on the context of immediacy and for this, has established social media groups to allow participants the least amount of administrative documentation to get started. Constant administrative assessment testing and processes may hinder client motivation to access service.

6.2.8 RCR8 Risk-Taking Scores and Patterns

As this dimension showed the least improvement of all RCR dimensions, financial aspects relevant to RCR 8.1: I am free from worries about money and RCR 8.2: I have the personal resources I need to make decisions about my future, will be discussed, that speaks about their ability to take care of their own financial resources. Within RCR8, the most improved question item was where participants felt they improved on the resources they need to make long-term decisions (n=12, RCR8.2).

Addiction issues leave a lasting impact on finances with financial costs, challenges and consequences that persist into recovery. In this study, five participants felt they did not improve on their privacy issues (RCR8.3) and four participants did not increase their finances or felt free from financial worries (RCR8.1). Truelink (2018) concluded that during recovery, financial challenges continue and is among the biggest obstacles for those in recovery and reported:

"Being able to make typical day-to-day purchases, like buying a transit pass or gas for a car, is necessary for people recovering from an SUD in order to re-enter the workforce and rebuild many other aspects of their life." (Truelink, 2018, p. 4.).

In a survey of 149 people with loved ones suffering from SUD, 82% said their loved one experienced adverse financial effect due to SUD. Truelink (2018) reported that (*n* =149):

- 65% borrowed and/or asked for money from me or others;
- 50% neglected necessary bills/had bills go into collection (e.g., utilities, rent, student loan, taxes, etc;
- 48% depleted their savings (e.g., spent money from savings accounts or retirement accounts, etc.);
- 43% had additional medical or legal expenses (e.g., treatment or hospital bills; lawyers' fees, bail/bond payments, etc.);
- 42 % sold their assets to gain access to cash for drug-taking or alcohol (e.g., took items to a pawn shop, sold online, etc.);
- 39% were negatively impacted by their low credit score;
- 34% overdrew their bank accounts;
- 23% took out a pay advance, quick cash loan, high-interest loan, credit card advance, etc., and
- 11% filed for bankruptcy.

In working with the clients, recovery coaching treats the whole person, recognising the significant financial challenges, that often are not recognised nor addressed. Preparation for and learning financial literacy is littered with a variety of issues, such as those reported by Truelink (2018). Addiction issues can create serious financial strains, that often persist into recovery.

Michael often faced numerous financial challenges mentioned above, consequently, he was always late with coach payment fees. His savings were depleted, he had outstanding debts to employees and sub-contractors; and cannot access credit after his rehabilitation clinic was closed due to clinical misconduct. We worked closely together to combat these financial issues and negligent behaviours, bringing more awareness to these matters. Apart from improving RCR8.4, he also improved his ability to become more responsible (pre-CPRC = 0, post-CPRC = 1 for RCR8.5). He did this by being held accountable for decisions he has made. His negligence and morally unethical practices were documented by his clients and legal action taken against him by his State Tribunal. We looked at his documented cases filed by his employees and clients , given to him by the State Tribunal. One by one, we sought to understand the reasons behind why he felt he needed to do these nefarious behaviours.

By the end of the CPRC program, he was more contrite about his behaviours and tried his best to understand why he must not continue his disreputable actions. Michael also looked at improving his financials, so that he can make better financial decisions about his future (pre-CPRC = 0, post-CPRC = 1 for RCR8.2). He accomplished this by swallowing his pride and accepting work at his local Officeworks store, to start saving money. He also was closer to breaking his denial patterns about his gambling behaviours.

Financial difficulties profoundly affect the individual in recovery, and often affects family members, who has frequently provided financial support in the hope of helping their loved one get healthy. This was the case for Justine and her husband when they continued to bail their daughter, Melissa, out of juvenile custody. Tim, Patricia's father was giving his daughter $4000 a month to live. She used this money on illicit drugs instead of studying. Michelle was able to ask her mother for money for a car and most of her expenses. Again, this money was used to buy and inject methamphetamine.

As reported in Section 5.2.8, Janet received a $190,000 inheritance when she was 19 years old and spent most of this on alcohol and drug taking. Despite running their business for almost eight years, she still does not own a house. In meeting her goal of buying her rented home and increasing its equity, actions were set within the CPRC sessions. These actions included studying the movements of real estate in her area and learning how to possess a prosperity mindset (RCR8.1, 8.2 and 8.5). She also listened to a lot of abundance and prosperity mindset audio books to help her meet her financial objectives. In the end, she met her goal of acquiring the property and built over $100,000 in equity. She was tremendously grateful for the work that was done during the 7 months together and for having completed the CPRC program.

Risk-taking, stem from childhood attachment styles, that when unmitigated, develop into tendencies to act out in the adolescent years and beyond (U.S. Department of Health and Human Services, 2016). Adolescence is one of the most critical stages in a person's development. During this phase, adolescents change physically, psychologically, and socially, especially in terms of their self-perception and risk expectations of taken in adolescent social life (Hanson, et al., 2011).

In a research discussed in Section 2.2.1, where 846 individuals, from 15 to 35-year-old, were to have significantly altered their patterns of drug, alcohol and tobacco use and displayed behaviours that can be adopted as adult lifestyle patterns (Bellis, et al., 2010; Hanson, et al., 2011). These types of riskier behaviours are often characterised by the use of illicit, psychoactive substances in adulthood (Lander, et al., 2013).

6.2.9 RCR9 Coping/Life Functioning Scores and Patterns

There are two coping styles useful in understanding those with SUD, approach, or avoidance coping (Forys, McKellar, & Moos, 2007). In working with participants in this study, they would either approach a problem or make active efforts to resolve

it. Approach coping means working with the CPRC Practitioner to problem solve and overcome challenges. Avoidance coping would be to use drugs or alcohol as an avoidance strategy to try to reduce distress or depression When coached to employ approach coping style, the client is made aware of their old pattern of avoidance coping. At various points along the CPRC journey, all 18 participants showed improvement across the RCR9 coping dimension, in any one or more questions items. Rachel improved on all five question items.

As Rachel's diagnosis was alcoholism, research on a 16-year longitudinal study involving 2,376 participants by Moos and Moos (2005) examining long-term alcohol abuse outcomes were relevant. They concluded that individuals who adopted less of an avoidance coping style at a one-year follow-up were more likely to be stably remitted over the 16-year follow-up period. Lemke and Moos (2003) completed a study on approach and avoidance coping style, and they found that at a one-year follow-up, those that employed approach coping predicted less substance use at a five-year follow-up. It was found in a seminal ten-year study, upon following up these two coping styles, that approach coping at two years after treatment predicted better physical functioning at ten-years post-treatment (Finney & Moos, 1992).

Working collaboratively with the CPRC Practitioner, a sweep of each recovery capital resource question item was discussed in the coaching sessions. For this study, the metrics used in the 'Assessment of Recovery Capital' scale for RCR9 dimension examine how people deal with a range of professional people (RCR9.1). It also asks whether other people are let down by the participant's action (RCR9.2). The third question is about healthy eating and nutrition (RCR9.3: I eat regularly and have a balanced diet). RCR9.3 allows the CPRC Practitioner to broach the topic of what the clients eat and perhaps more insight into how they eat. Another way to test if a participant deploys avoidance or approach coping is in the way they meet their obligations (RCR9.5: I meet all of my obligations promptly).

Although not measured directly in this study, the culmination of cultivating all recovery capital resources makes for self-efficacious behaviours. Thus, indirectly, self-efficacy is a desired outcome for participants in this study. For RCR9, the most noticeable improvement was when all participants are now looking after their overall well-being (RCR9.4). After engaging with their CPRC Practitioner, the collective score post-CPRC was 18, increasing from a score of 3 (John, Duong, and Karina). The CPRC program ends at the last session with a celebration. Unlike therapy, this end point affirms the participants' achievement in fulfilling the goals set in the first session with the CPRC Practitioner. This celebratory session praises the client's self-efficacy efforts, encourages their strengths, and lifts their hopes and aspirations for a better quality of life, post-CPRC.

Interventions, when focused on developing and enhancing self-efficacy may provide a valuable contribution to client wellness and clinical practice (Kadden & Litt, 2011). In theory, all treatments for SUD are expected to enhance self-efficacy. In practice, this is harder to establish and measure. The original concept of self-efficacy has been coined by Bandura (1986). Kadden and Litt (2011, p. 1123): noted these self-efficacy concepts to be:

> "1. Performance attainment;
>
> 2. Vicarious experiences of observing the performance of others;
>
> 3. Verbal persuasion to try to convince people that they possess certain capabilities; and
>
> 4. Physiological states based on which people judge their capabilities, strengths, and vulnerabilities".

Of the above four sources of efficacious behaviour, Bandura (1977; 1986) noted "performance accomplishments" to be most influential. He affirmed that the strongest increase in self-efficacy was developed through repeated successful experiences. The researcher agreed with these notions, therefore acknowledged each one of the participants' wins, no matter how small. Bandura (1986) postulated that

increasing levels of self-efficacy give rise to progressively higher performance accomplishments (Kadden & Litt, 2011). Thus, self-efficacy and performance enhance one another.

6.2.9.1 Use of Treatment Principles in CPRC related to RCR9

Treatment Principle 2: Uniqueness. As each individual present with specific needs, strengths, goals, health attitudes, behaviours, and expectations for recovery, it was discovered that, indeed, pathways to recovery are highly personal and unique (NIDA, 2018). In reviewing the CPRC sessions, the CPRC Practitioner impressed upon the client how to redefine their SUD identity, unique to their strengths and values. The modelling performed by the CPRC Practitioner, mentioned by Bandura (1986), being: "the vicarious experiences of observing the performance of others" (Kadden & Litt, 2011, p. 1123) helps validate and support clients' struggles. In the context of this study, the lived experiences shared by the CPRC Practitioner were seen as models of behaviours, thereby acknowledged by clients to the coach, as inspirational. This became their encouragement, in aspiring for their own transformation.

Bandura (1986) noted that necessary life skills and strong coping efficacy are likely to mobilise the effort needed to successfully resist relapsing situations (Kadden & Litt, 2011). In the event of relapse, a person with high-efficacy regards slip as a temporary setback and without berating oneself, must gain back control. Kadden and Litt (2011) concluded that low self-efficacy leads to likelier outcomes of continuous relapsing behaviours. As self-efficacy is a strong predictor of healthier coping mechanisms (RCR9), higher levels of performance, and perseverance in the face of difficult problems (Kadden & Litt, 2011). Bandura (1977) concluded that belief in one's performance efficacy, i.e., the belief that desired results can be achieved by one's own efforts, is necessary to mobilise and sustain coping behaviours (RCR9).

6.2.10 RCR10 Quality of Recovery Scores and Patterns

As we approach the last RCR dimension, it has been discussed that SUD has a broad range of direct and indirect consequences in all aspects of the participants' life. The complexity and depth of the overall quality of life in recovery (RCR10) effects depend on the specific drug(s) used, dose, method of administration, and other sociological, neurological, psychological, economic, and physiological mix of factors (Abadinsky, 2018). Acute effects can range from subtle molecular changes to overdose and death (Inaba & Cohen, 2014; NIDA, 2018).

Recovery outcomes affected inability to: attain educational qualifications; (RCR6.2), access employment (RCR6.4), secure safe housing (RCR7.3), sustain healthy relationships (RCR5.5), and constant involvement with the criminal justice system (RCR4.5). These consequences can all contribute to the quality of recovery for (RCR10). In CPRC, the client is the centralised point of information. Collaboration, then, is focusing in on how the client wants to receive care.

As chronic drug use can affect physical and mental health, the CPRC program aimed to increase the quality of the participants' recovery experiences (RCR10). This meant helping clients deal with and cope with practical aspects of day-to-day living (RCR9), support them in various life functions, as well as help them find a sense of purpose and ownership (RCR10.1, pre-CPRC = 7, post-CPRC = 18). Other question items included:

- the progress clients are making in their recovery (RCR10.2, pre-CPRC = 3, post-CPRC = 15);
- how engaged clients are with activities that promote recovery (RCR10.3 pre-CPRC = 2, post-CPRC = 14);
- the type of network clients has that support their recovery journey (RCR10.4, pre-CPRC = 0, post-CPRC = 12); and

- how optimistic they feel when they think of their future (RCR10.5, pre-CPRC = 9, post-CPRC = 18).

6.2.10.1 Use of Treatment Principles in CPRC related to RCR10

Treatment Principle 8: 'Flexibility' requires continuously assessing the progress of the client, while being flexible to their ongoing needs. As researchers are beginning to understand the effects of chronic drug abuse on, and other relevant topics such as: epigenetics; brain energetics; synaptic plasticity; and less-studied cell types; such as glia, that act to support neurons (Pascual-Leone, et al., 2005), it may be concluded that the culmination of all the effects of SUD has diverse indirect consequences. These influences may be affecting: a user's nutrition (RCR9.3); sleep and circadian rhythms (RCR3.5); decision-making and impulsivity (RCR2), violent tendencies (RCR7.2) and risks for trauma (RCR5.4), injury (RCR8.4), and/or communicable diseases (RCR3.2).

Treatment Principle 4 Cultivate Recovery Resources. In examining, RCR10, the overall quality of life is contingent upon identifying with the CPRC Practitioner, a series of personal assets and resources which enabled substance dependent individuals to positively transform their lives (Cloud & Granfield, 2001). Moos and Moos (2005) observed that recovery resources based on scores derived from eight longer measures of personal and social resources predicted positive outcomes in a sample of treatment naïve alcoholics. These findings were completed in a 15 years post-study of cohorts.

Furthermore, Moos and Moos (2005) observed that admission levels of recovery capital-like measures protected against end-of-treatment cravings, in a sample of alcohol dependent patients. They found craving for alcohol lessened, even if strongly predicted at 3-month relapse point. Comparably, the CPRC Practitioner concurs that recovery can be measured by the quantity and quality of RCR resources a person can bring to bear on the initiation and maintenance of recovery (RCR10). For

this reason, a strengths-based, recovery-oriented tool, called the 'Assessment of Recovery Capital' scale was adopted for this study. Recovery-orientation encourages giving up the source of pleasure or stress relief (substances of addiction) and being rewarded for these recovery-oriented behaviours.

Treatment Principle 11: 'Reward'. Part of RCR cultivation requires clients to be rewarded and taught to remain excited about long-term recovery. Regardless of the treatment approach, relapse rates remain high because Treatment Principle 12 espouses that relapse is a guaranteed phenomenon. To counter this, disease management should remain as exciting and rewarding (NIDA, 2018). Like patrons in a drinking established, enticements must, too be offered to increase the chances for ongoing commitment to treatment (Marsh, et al., 2013). For Karina, achievement of having an art therapy business was exciting. At the end of all she has been through, she now wants to help those that also when through what she went through, using Art as a therapeutic tool. Ideally, therapists act as cheerleaders and role models, reinforcing the positive changes clients have made and continue to help clients to find alternative rewards (Marsh, et al., 2013). Twelve participants felt they made good progress in their recovery (RCR10.2), remained engaged in activities that supported their recovery (RCR10.3) and worked on keeping a reliable network that supported their recovery goals (RCR10.4). Nine participants felt optimistic about their future after receiving coaching (RCR10.5) and eight felt a sense of purpose has been born after accessing the coaching intervention (RCR10.1).

Figure 11 provides an overall visual representation. There were three categories: 'improved' was coded yellow; 'did not improve', coded red; and 'no negative change' was colour coded green. The RCR dimensions and question items run down the page and the participants results (*n* = 18), run across the page horizontally. Figure 9 and 10 (in Section 4.5.2) provide a closer look at how Figure 11 has been arrived at**.**

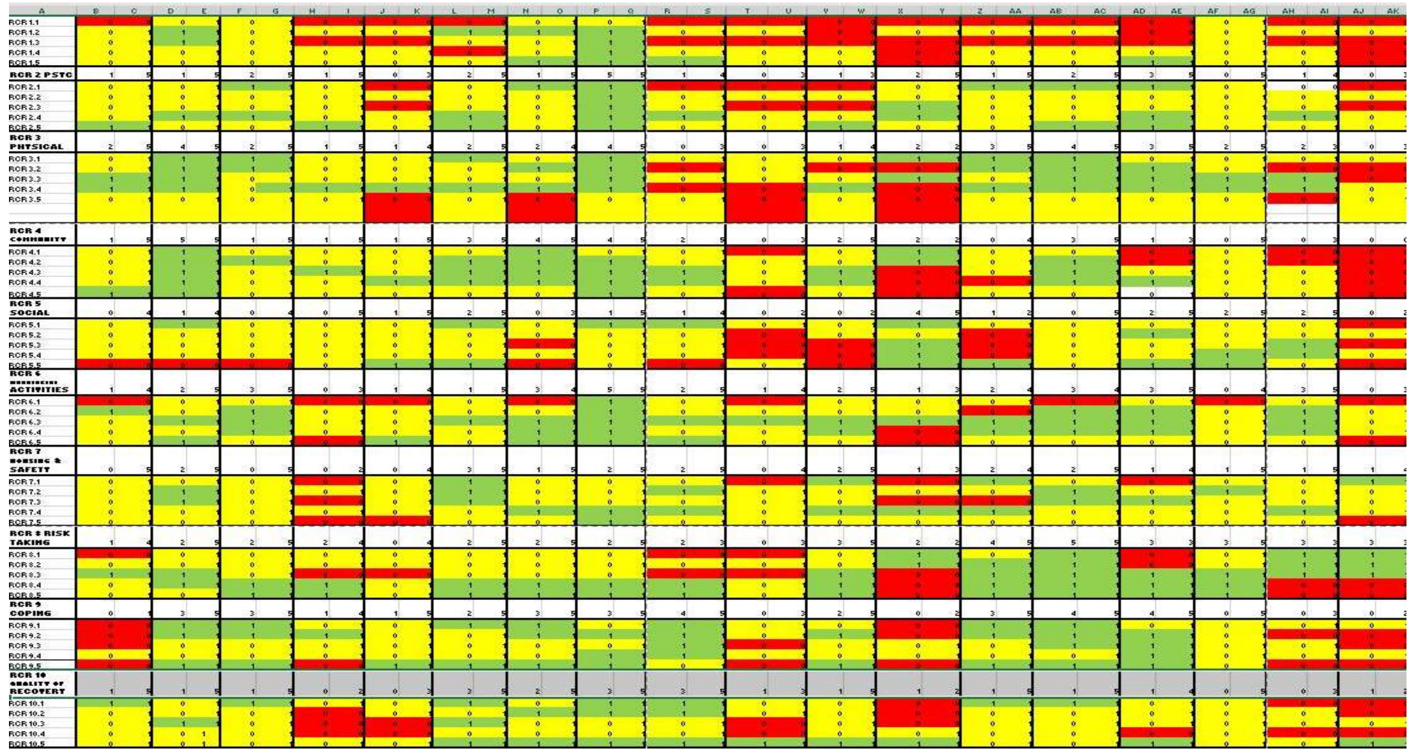


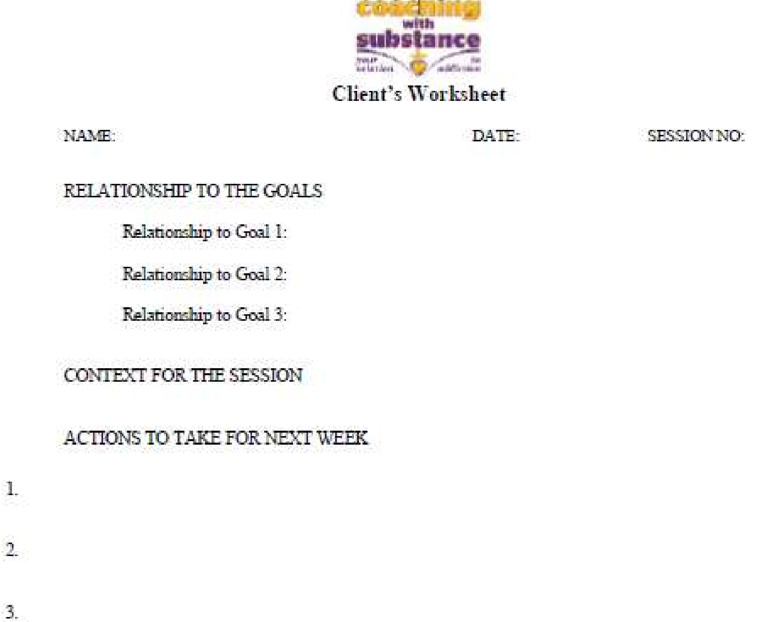
Figure 11: RCR Patterns: Improved, Did Not Improve, No Negative Change

Notes. 1. Improved (pre-CPRC = 0 or 'no' answer, post-CPRC = 1 or 'yes' answer) - Coded Yellow.
2. Did Not Improve (pre-CPRC = 0 or 'no' answer, post-CPRC = 0 or still 'no' answer) - Coded Red.
3. No Negative Change (pre-CPRC = 1 or 'yes' answer, post-CPRC = 0 or still 'yes' answer) Coded Green.

Source: Developed for this study

6.3 Discussion of Perceived Goal Attainment Scores

The attainment of goals are focal points in each session. Figure 12 show the CPRC session worksheet as an excerpt of the 31-page folder given to the client prior to starting the CPRC program.



coaching with substance

Client's Worksheet

NAME: DATE: SESSION NO:

RELATIONSHIP TO THE GOALS

Relationship to Goal 1:

Relationship to Goal 2:

Relationship to Goal 3:

CONTEXT FOR THE SESSION

ACTIONS TO TAKE FOR NEXT WEEK

1.

2.

3.

Figure 12: Client CPRC Session Worksheet

Source: Coaching with Substance, 2013.

Each CPRC session comprises of discussing each goal set in Session 1, then seeing where the client is in relation to a goal. This process can be seen in Figure 12 as Relationship to Goal 1, 2 or 3. The CPRC Practitioner then proceeds to discuss whether actions from the previous session/s were completed, or not. As the coaching continue, more actions are noted for the client to accomplish, prior to the next session. Once CPRC sessions 1-11 are completed, the last CPRC session becomes a celebration. This is where the self-rating is completed with the coach, by the client. Figure 13 provides the worksheet used in the last CPRC session. This worksheet is included in the client folder, given to them in session 1.

Completion Report

DATE: SESSION NO.: 12

ACKNOWLEDGEMENTS

1. The three main things I learnt about myself during coaching were:

2. Three things I want to acknowledge myself for:

3. Three things I want to celebrate:

4. Three things I want to acknowledge my coach for:

RELATIONSHIP TO THE GOALS:

Relationship to Goal 1:

Relationship to Goal 2:

Relationship to Goal 3:

CONTEXT FOR THE SESSION

GOAL OUTCOMES

Goal 1. %

Goal 2. %

Goal 3. %

I will next call my coach on:

Figure 13: Completion Report – Last CPRC Session

Source: Coaching with Substance, 2013.

Outlined in the last session completion report (Figure 13), the client rates their goal fulfilment in relation to how they felt they have achieved their pre-determined goals set from the first CPRC session. A self-rating of 100% meant the client was confident they achieved the goal. This rating is totally subjective to the clients' perception at the time of coaching. The completion report formalises the end of the

CPRC program and encourages celebration. As the last collaborative effort, a review of the CPRC program is completed together and feedback is given to coach about the complete experience (see discussion points in Figure 12-13).

Through the process of CPRC, clients deepen their learning, improve their performance, and enhance their quality of life. In each session, the client chooses the focus of conversation, while the coach listens and contributes observations and questions (Coaching Competence #4-10). With a total of 54 goals set (three goals for each 18 participants), around 15% were perceived by the participants as achieved completely and 18.5% were achieved at self-ratings of 90-95%.

It is important to note that a CPRC Practitioner does not promote a particular way, force attendance to Anonymous groups (e.g., Alcoholics Anonymous) nor impose a particular theory or religious belief. The CPRC Program is led by the client, and they choose or decide their way of maintaining sobriety. As goal attainment is the intention explained in session #1, there is a sense of certainty and clarity, as the CPRC Practitioner moves the client toward action. In this way, the CPRC program tended to accelerate the client's progress in recovery, by providing greater focus and awareness on choices, actions, and responsibility.

The last session also acts as a closure to the CPRC, giving the participant a definitive beginning and end point. This last session is a well-deserved celebration, where the coach and client look back at all the learnings and the struggles the client has overcome. Again, this last session serves as a reward and acknowledgement of the clients completing something they have started. From this section, self-rating percentages are discussed, for all of the 18 participants.

Goal Attainment Summary for Michael. Michael set a goal for his career that also yielded a financial increase in his assets, which he reported 70% accomplishment. For his creativity goal of finishing a book, he was able to finish 8

chapters and rated this goal at 85%. As for his third goal of attending social gatherings in his line of interest (politics and coaching), he was able to make a few new friends and he rated this 90% complete by the end of the coaching series. Table 41 summarise his goals and scores.

Table 41:

Result 3: Self-Rated Goal Attainment Score by Michael

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Michael	Love / porn addiction, Pathological lying, barred from counselling practice	Career / Financial	70%	Creativity	85%	Social / Friends	90%

Goal Attainment Summary for Angela. Angela was able to improve her emotional wellbeing by transforming her addiction to alcohol and marijuana, rating herself 100% fulfilment of this goal area. She set a second business goal, where she received clarity on why and how earning an extra $50,000 per year would benefit her life and because of this clarity, she was able to rate herself 80% for learning how to achieve this goal. At the end of the coaching series, she realised that she needed more time to be able to set out a strategic plan her second goal. She became mindful of her current time commitments. As for her third goal of dealing with her negative experiences growing up as a child of alcoholic parents, she was able to begin this process and rated herself 70% for this (goal area = family). It can be noted that she improved from 1 to 5 for her pre- and post-CPRC score in both RCR2 Psychological and RCR10 Quality of Recovery Experience. As a whole, she improved her overall

RCR score from 23 to 49 after 7 months of attendance in the CPRC program. Table 1 in Appendix B report all her RCR scores (pre- and post-CPRC).

Table 42 is a summary of her self-ratings for her three goals.

Table 42:

Result 3: Self-Rated Goal Attainment Score by Angela

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Angela	Child of alcoholic parents, past DV, use of alcohol/ marijuana	Emotion	100%	Family	70%	Business	80%

Source: Developed for this study

Goal Attainment Summary for Mala. Mala was able to achieve a milestone in her life by moving out and ending a 23-year domestically violent relationship and rating herself 100% achievement of this difficult goal. She also set a fitness goal, setting herself a 60% achievement for this goal about having a: "panther-life body, lithe and lean". As for her last goal of learning to stop emotional eating, she was able to rate herself 70% in completing this goal. Showing resilience, she was able to climb five notches, going from a 0-5 in two RCR dimensions (RCR1 Sobriety and RCR7 Safety and Housing). Her RCR score improved from 14 to 49/50, by the end of the coaching series. It took her 8 months to complete the CPRC program.

Table 43 show a summary of Mala's self-ratings and her three goal areas.

Table 43:

Result 3: Self-Rated Goal Attainment Score by Mala

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Mala	23 years in DV marriage, emotional eating, co-dependent	Living	100%	Fitness	60%	Nutrition	70%

Goal Attainment Summary for Michelle. Table 44 summarises Michelle's goals, presenting issues and self-rating for how she perceived she achieved these three goals.

Table 44:

Result 3: Self-Rated Goal Attainment Score by Michelle

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Michelle	20+ years injecting meth, sexually molested by brother in childhood	Family	100%	Health/ Nutrition	70%	Fitness	80%

Michelle was able to repair her family relations. As was giving RCR5 all her efforts with one of her goals being, forgiving family members, she scored 100% achievement for this. She was also able to start to cultivate a daily yoga practice, rating herself 80% for doing so. As for nutrition, she decided to eat less junk food and wanted

to be more mindful of how balanced her eating choices were. For this, she was able to achieve at a self-rating of 70%. She showed vast improvement in three areas of her recovery capital resources (RCR2 Psychological, RCR3 Physical and RCR4 Community) by beginning with only one resource and increasing these dimensions to finishing with all five of the resources needed. Her recovery capital scores showed vast improvement from a low 6/50 to 38/50 overall, after five months of coaching.

Goal Attainment Summary for Janet. Janet came in quite problematic and in the first session, was screaming and crying all the way through. Referred by her husband, she suffered trauma and deals with extreme mood swings and anger outburst. For CPRC, she was made able to concentrate all her efforts in increasing her home equity to $100,000. She accomplished this over time, by offering the owner of the house they have been renting for 8 years from, to buy their place. After much work, she proudly achieved 100% on this goal. As for three RCR dimensions, she was able to increase these from a score of 1 to 5, these dimensions were: RCR4 Community, RCR5 Social and RCR9 Coping. Her RCR scores jumped from 5 to 40 after seven months of working with her coach. In the end, she expressed 60 and 65% achievement of her community and health goal, respectively. Table 45 summarises Janet's issues, goals, and self-rating.

Table 45:

Result 3: Self-Rated Goal Attainment Score by Janet

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Janet	Depression, anxiety, emotional eating, medication, and alcoholism	Living / Finance	100%	Health / Fitness	65%	Community	60%

Goal Attainment Summary for Sandra. Sandra achieved her goals comfortably, rating herself 70% for her health and fitness goal of looking stunning in her favourite blue dress, 85% for her business goal of earning extra $40,000 a year and 90% of learning how to become a powerful motivational speaker. She was able to increase from a score of 1 to 5 in RCR: 'Meaningful Activities'. She improved in three question items (scored 2 pre-CPRC to 5 post-CPRC) in four dimensions, these improvements were in: RCR2; RCR5; RCR8; and RCR9. Sandra was able to develop her recovery capital resources from 21 to 48 overall.

Table 46 is a summary of Sandra's presenting issues, goals, and goal attainment scores.

Table 46:

Result 3: Self-Rated Goal Attainment Score by Sandra

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Sandra	Co-dependent, medication addiction fibromyalgia	Fitness / Emotion	70%	Business	85%	Career	80%

Goal Attainment Summary for Lina. Lina was able to rate herself a high rating of 90% achievement for her financial and emotional goals for being able to save money and increase her confidence levels to the highest it has even been. A lower achievement rate of 60% was because she was not able to travel as planned with her sons to Thailand for Christmas but moved it back to March instead. She was able to improve her recovery capital resources from 1 to 5 in two dimensions, being: RCR2 Psychological and RCR7 Safety and Housing. Lina increased her recovery

capital resources from 20 to 46 over seven months of working with a recovery coach. Summarised in Table 47 are Lina's goals, presenting issues and scores.

Table 47:

Result 3: Self-Rated Goal Attainment Score by Lina

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Lina	Past AOD use, teen child is meth addict (co-dependent)	Financial	90%	Travel	60%	Emotion	90%

Goal Attainment Summary for John. John has been having difficulty finding the right woman and therefore was pleased when he was finally able to date the woman he perceives might be his soulmate. He scored himself 80% for his relationship goal. As for eating healthy, he rated himself 70%. For his financial goal, he almost achieved his $12,000 savings goal, thereby rating himself 90%. He attended coaching for five months. He was able to improve his RCR5 Social dimension score from 1-5 and showed improvements in two other dimensions with a score that jumped from 2 to 5 (RCR7 Housing/Safety and RCR8 Risk Taking). John showed the least improvement in RCR scores, going from 33 to a perfect score of 50 after eight months of applying the CPRC program in his life. To his credit, he scored a perfect score, and he had the highest RCR assets to begin with. He was the most motivated of all participants in achieving goals and increasing his recovery assets.

Table 48 show his goals, rating scores and presenting issues.

Table 48:

Self-Rated Goal Attainment Score by John

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
John	Past AOD, anger management, violent past behaviour	Relation-ship	80%	Health	70%	Financial	90%

Goal Attainment Summary for Karina. Karina was able to increase her income, hence rated herself 80% close to achieving this goal. Table 49 summarise her goals and scores.

Table 49:

Self-Rated Goal Attainment Score by Karina

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Karina	Own sexual abuse as kid, own daughter suffered sexual abuse by own Father in childhood.	Income	80%	Creativity	70%	Family	90%

For attending art classes to improve her skills and network with life-minded individuals, she was able to do this 70% and for her family goal of being closer with siblings, she was able to rate herself 90% for achieving this well. As for recovery capital resources, she increased this from a score or 18 to 42 over just four months of

getting coached, increasing from a 1 to 4 in two dimensions (RCR2 Psychological and RCR5 Social).

Goal Attainment Summary for Betty. Betty improved her career outlook by enrolling in a Diploma of Community Services course (75%) and volunteering for a charity (85%). She also worked on cultivating her inner being by remaining sober and learning about enlightenment (90%). She has shown a dramatic increase in her RCR by progressing from a score of only 2 to 31/50 after participating in nine months of CPRC sessions. Her greatest increase was in RCR7: Housing and Safety (0 - 4) and second biggest increase was RCR6: Meaningful Activities (0 - 4).

Table 50 outlines her original presenting issues, her goal areas, and her self-rated goal attainment scores.

Table 50:

Self-Rated Goal Attainment Score by Betty

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Betty	Grew up in foster care, gang-raped, past heavy heroin use. Current alcohol- use high.	Career	75%	Community	85%	Emotional	70%

Goal Attainment Summary for Donna. Donna was able to score herself highly in the achievement of her three goals. She indicated 100% achievement of her fitness goal, as she was able to reach her goal weight. Table 51 summarise her SUD issues, goal areas, and goal scores.

Table 51:

Self-Rated Goal Attainment Score by Donna

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Donna	Parents were heavy drinkers, in DV relationship, also heavy drinker	Fitness	100%	Education	80%	Emotional	95%

She also scored herself highly (95%) for her goal of being a person of integrity and 85% for almost completing her Certificate IV in Small Business course, as planned. Her recovery capital resources were also enhanced going from a score of only 14 to increasing to 41 after five months of being coached by the insider-researcher. Her improvements were shown in the last dimension from a score of 1 to 5 and also third physical RCR dimension where she scored from 1 to 4.

Goal Attainment Summary for Melissa. As Melissa was quite young (17 years old), she scored herself low because she admitted she was not able get away from her using friends (60%). She also felt she didn't improve her nutrition (65%) and was not able to cherish her family, as well as she could have (70%). She yielded the second lowest RCR score post-CPRC at 27, from a score of 15, pre-CPRC. She was not as engaged, as the coach hoped her to be and attended six months of the CPRC program. Table 52 summarise Melissa's SUD presentations, goals, and self-rated scores. Her full pre- and post CPRC RCR scores are reported in Appendix B as Table 4.

Table 52:

Self-Rated Goal Attainment Score by Melissa

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Melissa	Teen truant, juvenile delinquent. Strong meth use.	Family	70%	Health	65%	Social	60%

Goal Attainment Summary for Nancy. Nancy was able to reach 80% of her fitness goal by becoming more active in the gym and engaging a personal trainer. Nancy was able recognise the hurt her mother has inflicted on her and its effects on her life growing up. Starting the CPRC Program at 55 years old, she admitted that she felt it was too late for her forgive her parents. She concedes that it was helpful to understand her childhood better. She rated herself 60% achievement in forgiveness, as part of her family goal. Table 53 summarise her presenting issues, goal areas and goal attainment scores. Table 5 report her pre- and post-CPRC RCR scores (Appendix B).

Table 53:

Self-Rated Goal Attainment Score by Nancy

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Nancy	Adult children of alcoholic parents, past DV issues, heavy drinking, and chronic back pain.	Health /Fitness	80%	Family	60%	Emotional	70%

As for her last goal, Nancy was able to be less worried and doubtful of herself, lowering her drinking considerably and achieving this goal at 70%. Her recovery capital resources score improved from 17 to 42 after being coached over a course of seven months. Her biggest increase was shown in the second (Psychological) and tenth (Quality of Recovery Experience) dimension, jumping from a score of 1 to 5.

Goal Attainment Summary for Ayako. Ayako was able to understand her self-esteem issues that lead her to watching excessive amounts of porn thereby rating herself 90% fulfilment on this goal. Her recovery capital resources showed an increase going from 24 to 47/50, with the most increase shown in the fifth RCR dimension (social) going from 0 to 5. Her second highest increase was turning a 1 into a score of 5 for the tenth RCR dimension (Quality of Recovery Experience). With her porn addiction affecting her religion and fellowship with her Christian church group, Ayako worked hard to lean on the scriptures and was able to find the strength to turn away from porn achieving 100% on this. Table 54 presents Ayako's issues, three goals and self-rated scores associated with each goal.

Table 54:

Self-Rated Goal Attainment Score by Ayako

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Ayako	Porn addiction, spiritual dissent	Emotional	90%	Spiritual	100%	Financial	100%

Goal Attainment Summary for Duong. Duong increased his recovery capital resources from a score of 22 to 41/50, improving an original score of 1 to a 4 across the seventh (Safety and Housing) and tenth (Quality of Recovery Experience) RCR dimension. He rated himself with the lowest goal achievement percentages, with only

50% awarded twice for his career (completing his PhD) and emotional goal of understanding his procrastinating behaviour. For his third goal, he gave himself a score of 80% achievement for being more organised and relinquishing the powerful hold of his internet addiction on his study time. Duong's presenting issues, goals and self-rated goal attainment scores are outlined in Table 55.

Table 55:

Self-Rated Goal Attainment Score by Duong

ALIAS	PRESENTING ISSUES	GOAL #1	%	GOAL #2	%	GOAL # 3	%
Duong	Internet and porn addiction, heavy procrastina-tion	Career	50%	Emotion	50%	Education	80%

Goal Attainment Summary for Rachel. Rachel was struggling with her post-natal depression and drinking and expressed high fulfilment of all goals set with her coach. Table 56 summarise Rachel's three goals areas, her presenting issues, and self-rated scores.

Table 56:

Self-Rated Goal Attainment Score by Rachel

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Rachel	Alcoholic, PTSD, and post-natal depression	Emotion	100%	Relation-ship	95%	Spiritual	95%

One of Rachel's goals was to be more authentic and accepting of her past and she was able to achieve this wholly at 100%. Her relationships improved, and she scored her achievement of this with a 95%. As well, she awarded herself 95% fulfilment of her third goal, being cultivating a clear, happy, and relaxed mind, instead of one filled with mindless chatter.

Goal Attainment Summary for Patricia. Patricia rated herself 70% achievement for all three goals. Table 57 outlines Patricia's three goal areas, presenting issues and self-rated goal attainment scores.

Table 57:

Self-Rated Goal Attainment Score by Patricia

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Patricia	Marijuana / meth use, patholo-gical lying	Health / Fitness	70%	Creative	70%	Education	70%

Patricia wanted to practice yoga daily, to have her own YouTube channel and to do well in her naturopathy studies. As for recovery capital resources, her score increased from 12/50 to 37/50 after participating in five months' worth of coaching sessions. Her highest improvement was shown across the seventh dimension of RCR7 housing and safety, increasing her score from a 1 to 5. She also showed improvement from 1 to 4 in the second dimension (RCR2 Psychological).

Goal Attainment Summary for Cassie. Cassie showed the least improvement of recovery capital resources (scored from 5 to 23), perhaps because she only attended for a short duration of three months (least duration of all participants). She also showed

relatively low achievement of goals in comparison with her cohorts, where she indicated a score of 60% for achieving her health and nutrition goal, 75% for completing her fitness goal and 70% for stabilising her emotional state through daily meditation. These scores, goal areas and issues are summarised in Table 58.

Table 58:

Self-Rated Goal Attainment Score by Cassie

ALIAS	PRESENTING ISSUES	GOAL # 1	%	GOAL # 2	%	GOAL # 3	%
Cassie	Injects meth – heavy user, obesity, and emotional eating issues. Severe head trauma from car accident in early 20's	Health / Nutrition	60%	Fitness	75%	Emotion	70%

6.4 Conclusion

This chapter discussed how each RCR dimension was improved through the application of the CPRC dimensions, in private AOD practice. Results were discussed according to pre- and post-CPRC RCR scores that range from 0 to 50. This chapter carefully evaluated how the three pre-determined goals set were achieved, despite participants being in active addiction. The recovery-oriented narrative, integrating how the collaborative, peer, recovery, and coaching dimensions were used in the CPRC program, contributed insights for MH/AOD practice. It has been argued that recovery-orientation, cultivation of recovery capital resources and goal attainment focus of each CPRC session improved the participants' overall qualities of recovery (Deane, et al.,

2014). It was also discussed that coach competencies played a part in goal fulfilment, as the coach and client worked collaboratively, and as peers.

Coming from a strengths-based and solution focused lens, recovery can become a liberating experience (Queensland Health, 2016) thus, recovery-orientation (Onken, Craig, Ridgway, Ralph, & Cook, 2007), peer-delivery (Eddie, et al., 2019) and the coaching approach (Gavin & Mcbrearty, 2013) were evaluated in this chapter. It was discussed that the RCR scores improved post-CPRC, compared to the pre-CPRC scores. Result 2 reported patterns of improvement, where the highest instances of improvement, was shown in the seventh dimension (RCR7: Housing and Safety). It may be concluded that housing and the ability to feel safe in it is a contributing factor to ongoing recovery, and this was consistent with findings highlighted within the Australian National Recovery Framework document (Australian Health Ministers' Advisory Council, 2013).

It was covered in this section that the CPRC program aimed to build an ongoing professional relationship, set with defined mutual agreement that supports individuals considering recovery from substance use issues as proposed by White (2010). The recovery coach and client produced goal outcomes in specific areas of the client's life, while prioritising recovery from substance use disorders (SUD). The results affirmed that goals are within reach for each client. The CPRC Practitioner held the client accountable in taking a goal and recovery-oriented stance. It was discussed how the self-rating of goal attainment scores gave the participant dignity and a sense of self-efficacy, while in attendance to the CPRC program. The last session acted as a closure to the CPRC program and a way to celebrate with the participant a definitive beginning and end point. This was where the coach and client looked back at their collaboration, taking in all the learnings. At the end of the program, the participant was rewarded with completion of something they have started. This is in line with Treatment Principle#11: Treatment Must be Rewarding and Exciting.

In the discussion of the results, the 13 treatment principles were incorporated in the discussion to address any oversight that act as barriers to successful alcohol and other drug treatment provision, mentioned in Section 2.4. This led to the researcher to formulate a case management register to fill the gaps for successful client AOD outcomes. The researcher aims to contribute this work-based artefact, to help guide future Australian alcohol and other drug workers to offer a recovery-oriented and treatment principle-centred, case management register.

Currently, Recovery Oriented Service Self-Assessment Toolkit (ROSSAT) exists in Australia for practitioner use to meet the needs of mental health patients (Deane, et al., 2010). In the USA, The Recovery-Oriented Systems Indicators (ROSI) act as a self-report survey designed to assess the recovery orientation of community mental health systems for adults with serious and prolonged psychiatric disorders (Dumont, et al., 2017). Already mentioned in the review of the literature, the ROSSAT and ROSI will be discussed in the next chapter again, as a preamble to why the artefact, called: Principle-centred Recovery Resource Register was developed. This artefact serves as the original contribution of this study, aiming to provide a convenient register, to be able to effectively manage the cases of alcohol and other drug clients.

CHAPTER SEVEN: WORK-BASED LEARNING ARTEFACT

7.1 Introduction

This study developed an artefact called the Principle-centred Recovery Resource Register (P3R) to guide future alcohol and other drug practitioners. The artefact emerged from the research in the form of a register, used as a case management assessment tool, to be used by practitioners to support individuals with substance use disorders. Based on the continued assertion in the literature regarding goal attainment (Gavin & Mcbrearty, 2013; Reiss, 2015) and cultivation of recovery capital resources (Groshkova, et al., 2013; Sterling, et al., 2008; White, 2008; Yates, 2014), as key components to a sustainable and fulfilling long-term recovery (White, 2010), development of the P3R, was warranted.

At the time of writing, there have been 1,128 hours of CPRC video logs recorded, of which, 216 videos were eligible to be used in this study. The Principle-centred Recovery Resource Register was formulated based on the observations from the study. These peer-experiences resulted in development of the P3R, with the intention of utilising uniform, best-practice standards stemming from the 13 principles of treatment. Thus, seeking to support the successful goal outcomes of clients accessing AOD treatment interventions. This register uses the 50-item RCR question items and the 13-item treatment principles, to lead the recovery orientation of individuals, committed to recover from SUDs. The PPRI serves as a case management register, which guide the practitioner stay focused on important recovery indicators, while delivering a principle-centric, AOD intervention (Australian Health Ministers' Advisory Council, 2013).

As barriers to alcohol and other drug treatment continue to impede long-term recovery, the P3R can provide a simple and convenient register of recovery assets for ongoing assessment by practitioners. This chapter will outline preliminary suggestions

for alcohol and other drug practice implementation. To guide the future practitioner, Section 7.3.1 focuses on treatment principles and Section 7.3.2 covers recovery-orientation. Section 7.3.3 relays how coach competencies are foundational in the delivery of a peer-based, recovery coaching collaboration and contribute to the coach effect.

7.2 Principle-Based Recovery Resource Register

The Collaborative Peer Recovery Coaching program is guided by the Collaborative Recovery Model (Deane, et al, 2010; Deane, et al., 2014), the seminal work of Loveland and Boyle (2005) in the Manual for Recovery Coaching Manual, and the National Framework for Recovery-oriented Mental Health Services: Guide for Practitioners and Providers (Australian Health Ministers' Advisory Council, 2013).

The latter sets forth frameworks informing mental health practitioners, on how to focus on recovery and dignify lived MH experiences of Australians. Reiterated throughout the thesis, those with substance use disorders have differing sets of identified challenges (Treatment Principle 2: Unique), falling outside the scope of general mental health service delivery. For this reason, the researcher of this study saw an opportunity to contextualise these MH frameworks, principles, and models of service delivery to meet the specific needs of those experiencing SUD issues.

Dr Penny Brown expressed the following in the foreword of the National Framework for Recovery-oriented Mental Health Services: Guide for Practitioners and Providers: "now that this document has been released, the real work of collaboration and implementation can begin" (Australian Health Ministers' Council, 2013, p. iii). The researcher regards this quoted statement highly and since reading this national guideline, has begun the work of collaboration with other stakeholders in the AOD sector. Dr Brown continued that the next stage is to:

"…make the framework live; to embed its principles into everyday practice and service delivery around the country. We want a system that puts people with a lived experience at the heart of everything we do and offers consistently high-quality care that has long-term improvements on people's lives." (Australian Health Ministers' Advisory Council, 2013, p. iii)

Figure 14 outline the treatment professionals involved in the AOD continuum of care that can benefit from utilising the P3R, as a case management register.

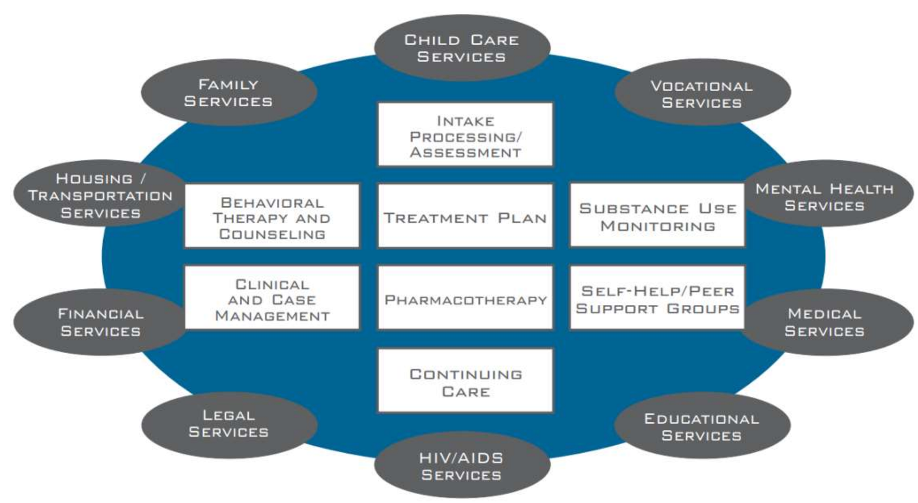


Figure 14: Comprehensive alcohol and other drug Treatment Services
Source: NIDA, 2018.

Practitioners, such as ones illustrated in Figure 14, comprise of roles delivered while working in intake, treatment planning, screening/monitoring, pharmacology, counselling, clinical case management, and continuing care (NIDA, 2018). Other professionals directly or indirectly support alcohol and other drug clients include (Tai et al., 2010):

- family support services;

- childcare services;
- vocational training;
- mental health services;
- medical care;
- educational services;
- legal services;
- housing services (including emergency care and foster care); HIV/AIDS services, and
- financial literacy and support.

The Gold Coast area delivers the components shown in Figure 14, delivered by separate entities. The city of Gold Coast has a population of around 500,000, with a strong tourism community of around 13 million per annum (Gold Coast Legal Centre, 2016). The Gold Coast catchment area has four rehabilitation centres with 270 beds delivering traditional therapeutic care. There are eight AOD family support and counselling centres, two domestic violence services, four youth services, two injecting users support services and three indigenous service support agencies. Other adjunct services include six neighbourhood centres, 19 Alcoholics Anonymous (AA) meeting venues, eight food aid services and 11 emergency or refuge-type accommodation for AOD service users (Gold Coast Legal Centre, 2016).

A disadvantage of several organisations delivering what was outlined by NIDA (2018) as a comprehensive treatment model, is that these organisations, social workers, medical practitioners, allied health workers and therapists/clinicians may not meet regularly to share useful knowledgebase. This makes service provision fragmented and lacking the much-needed continuum of care the clients need (Gold Coast Primary Health Network, 2016). There are also severe shortages in the number of rehabilitation treatment places available with waitlist lasting many months, especially for those that

provide for the needs of youth and those with severe and complex co-morbid issues (Gold Coast Primary Health Network, 2016).

In line with the stepped care model, barriers, gaps, and recommendations related to delivery of AOD and MH care were (Gold Coast Primary Health Network, 2016):

- re-design of AOD services with a stepped care model and a 'no wrong door' policy to better match services to individual needs.
- improve the coordination of primary medical services with local allied health and not-for-profit providers thereby increasing efficiency and effectiveness of health services, moving towards better addressing the health and wellbeing of residents in the region.
- enable people still using substances to access services.
- increase capacity of detoxification, residential rehabilitation, and aftercare services to provide flexible support and follow up for clients.
- flexible outreach treatment services.
- focus on vulnerable target groups including young people and people with families, and
- provide training, referral pathway education and resources for General Practitioners to support patients with substance use issues.

Figure 15 depicts a simplified stepped care model for primary mental healthcare services that better caters for and meets individual needs.

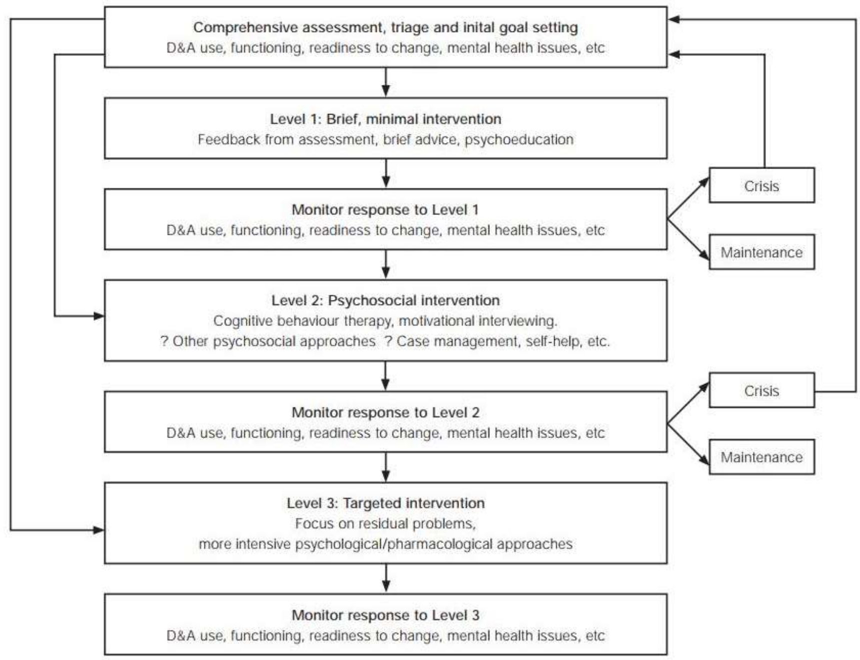


Figure 15: Simplified AOD Stepped Care Treatment Model

Source: Gold Coast Primary Health Network, 2016.

Guidelines for implementation that follow will provide suggestions for dealing with different clients, as they present their issues. When clients present for treatment or coaching, they must be defined and differentiated to a matching intervention needed, as not all needs require formal intervention. In coaching, the CPRC practitioner provides guidance on how to manoeuvre systems of care available to them. It is the role of a CPRC practitioner to make the clients familiar with the comprehensive 'menu' of evidence-based services, corresponding to their needs (severity of needs range from early prevention, low severity, complex, severe, chronic, acute, etc.).

7.3 Suggested Implementation Guidelines

Abadinski (2018), Inaba and Cohen (2014), Doweiko (2006) and the National Institute on Drug Abuse (2018) agree that alcohol and other drug treatments must cater to all aspects of a person's overall wellbeing, instead of being delivered by different entities and organisations, making access difficult for end-users of service. Embedding treatment principles guide practitioners to train for ongoing proficiency using a uniform approach. Thus, continuous improvement for the implementation of treatment principles should be actively developed in collaboration with a care team, supervisors, mentors, and the client, to prevent barriers to treatment success.

The alcohol and other drug field is a demanding and complex field of work and study. The practitioner requires thorough practice knowledge across facets of psychology, physiology, neuroscience, and cognition (Abadinsky, 2018). As well, this field is fraught with crisis-driven confrontations (Skinner & Roche, 2005). To withstand AOD workplace pressures and stressful client interactions, self-care is a key component to be implemented regularly by the alcohol and other drug practitioner. Wellbeing practices enable the practitioner to mitigate Barrier #7: Burnout due to lack of self-care practices, as discussed in Section 2.4.7.

Better training initiatives that develop knowledge base for efficacy has shifted from practice efficacy and comparing success of treatment types to understanding mechanisms underlying successful recovery (Athamneh, et al., 2019). Lack of training and competence by the practitioner speak directly about barrier to treatment #8: 'Lack of AOD-specific training's adverse effects', reviewed in Section 2.4.8.

In outlining treatment principles for best practice, it will be described how the 13 treatment principles observed from the data (see Chapter 6: Discussion; Section 6.2.1 - 10) emerged, to inform the development of the P3R, leading to the following preliminary suggestions for professional practice implementation.

7.3.1 Treatment Principles in Practice

Treatment professionals should adhere to uniform treatment principles for positive impacts to be felt by clients accessing AOD-related services (NIDA, 2018). The P3R can help practitioners, by offering a convenient case management register that guides recovery orientation in practice. Upon activation of the collaborative process, the treatment or coaching professional can alert the client to any one of the recovery capital resource assets, available to them to cultivate. The P3R contains the 13 treatment principles and 10 recovery capital resource dimensions in one document for easy viewing. Table 59, 60 and Appendix C, give a sample of the P3R, designed to prompt the practitioner on the recovery assets, important for transformational change.

Table 59:

Principle-Centred Recovery Resource Register Sample: RCR1-6 and TP 1

RECOVERY CAPITAL RESOURCES	TP1 NEURO: Effects on Brain Function (short/long-term), mechanics neuroplasticity	Date/s discussed
RCR1 SOBRIETY	TP1	
1 Sober 2 In control 3 Nearly used 4 Used Recently 5 Other things are important	RCR1	
RCR2 PSYCH	TP1	
1 Concentrate 2 Cope w/ Stress 3 Happy w/ Appearance 4 Overall Happy 5 Future	RCR2	
RCR3 PHYSICAL	TP1	
1 Daily Tasks 2 Physically Well 3 Have Energy 4 Can Get Around 5 Can Sleep	RCR3	
RCR4 COMMUNITY	TP1	
1 Proud 2 Contibute 3 Wants to Help Others 4 Does Help 5 Identity without use	RCR4	
RCR5 SOCIAL	TP1	
1 Personal 2 Family 3 Circle of Friends 4 Family - Emotional Needs 5 Intimacy	RCR5	
RCR6 ACTIVITIES	TP1	
1 Exercise 2 PD / Education 3 Fun Activities 4 Career 5 Abstinent	RCR6	

Source: Developed for this study

Suggested Implementation of Treatment Principle 1: Neuro. With literature already mentioned in Section 2.3.1, research has yielded significant data about the effects of drugs on the brain and the biological processes involved in developing SUDs (Pascual-Leone, et al., 2005). There are numerous neurological processes involving major changes to multiple interconnecting circuits in the brain (Sampedro-Piquero, et al., 2019). It is important to discuss these processes with the client and any suitable current research findings on the subject of neuroscience (see Table 59).

Depending on the client's presenting situation, one example might be to discuss how drugs of abuse affect and mimic chemical signals in the brain's neurotransmitters (Ackerman, 2020). The client can be informed that dopamine levels rise when activated with drug use, thus rewarding brain circuitry with feelings of euphoria (Sampedro-Piquero, et al., 2019). The conversation about neuroplasticity can continue with the discussion of the negative impacts of repeated drug use, which reduce sensitivity to dopamine surges (Ackerman, 2020). It can be explained that this neurobiochemistry builds drug or alcohol dependence and increases tolerance (Ackerman, 2020).

Once this has been discussed, it can be emphasised how the 'feel good' substance use effects can dull the nervous system temporarily (Pascual-Leone, et al., 2005). In early recovery, depression-like symptoms can manifest, hence a daily activity schedule (Recovery Capital Resource #6: Meaning Activities) is important to follow for reversal of drug symptoms and for neuroplasticity to begin to take positive effect (Ackerman, 2020).

Suggested Implementation of Treatment Principle 2: Unique. Evidence continues to validate the uniqueness of an individual's multiple and complex needs, as they enter the phase of early recovery (NIDA, 2018). In working with clients, their unique developmental attributes and characteristics is best understood with careful notetaking skills, coupled with voice and/or video logs appended to digital client file

whenever possible. In case hard copy files are still used, a document with digital location of stored files should be noted for easy review in the client folder. When data is collated, the client can be matched with other relevant services as the relapse prevention and treatment plan is being developed (Henry & Fetters, 2012). Ongoing assessment is critical, as circumstances change quite rapidly for clients in active addiction or new recovery phase (<one year); this will be discussed in Treatment Principle 8: Ongoing Assessment and Treatment Principle 9: Comorbidity.

The interplay of effects and impacts felt in the overall quality of client lives will vary. Therefore, consequences of each SUD behaviour need to be understood and each layer of the practitioner's understanding relayed exactly to the client for collaborative understanding and for the deepening of the therapeutic alliance (Von Greiff & Skogen, 2019). This allows for the collaboration to continue to evolve.

Suggested Implementation of Treatment Principle 3: Immediacy. In line with the evaluation completed on alcohol and other drug first aid workshops, it was concluded that immediate and responsive treatment is of paramount importance (Kostadinov, et al., 2017). Corroborated by two decades of empirical data, it was found that 70% of those who may need help, may not be equipped with the foresight needed to seek it. In addition, circumstances around issues of SUD may interfere with and seem to prevent seem to prevent seeking of help (legal issues, domestic violence issues, presence of mental illness, budgetary constraints, transport problems, etc.). It follows from these constraints and barriers that immediacy is key (NIDA, 2018). When treatment is finally sought, those who seek it need to be offered a remedy through engagement with services, as soon as available.

Each agency, organisation, or practice needs to prepare to operationalise the principle of immediacy. From a practice perspective, the timelines, organisational chart and intake processes may require more flexibility (Byrne, et al., 2020). The volunteer workforce and placement students may need to be on standby to immediately

meet demand, as the client presents for service. Byrne et al., (2020) reported that the least amount of paperwork and re-telling of story is important to facilitate effective engagement. From a client standpoint, the preparation that the practitioner or agency has in place is important. This means, as they present to service, they are given the timelines that will assist them to meet their presenting needs. This level of engagement needs to be established and clearly explained. For example, letting them know the costs of service, the time and capacity to deliver service, and if unsuitable, a list of referrals better suited to their situation. The practitioner should also provide qualifications and client testimonials, if asked.

Suggested Implementation of Treatment Principle 4: Resources. As covered in the use of the 'Assessment of Recovery Capital' scale used in this study and guiding the P3R, a crucial element of treatment is speaking firmly with the client about how cultivation of recovery capital resources results in better quality of life in recovery. This conversation should be at the beginning or soon as practical, in any short, mid-, or long-term interaction with those presenting for service. During treatment, all resources needed for recovery must be addressed across the duration of treatment (Groshkova, et al., 2013); the PPRI serves as a guide. A check-in for 10-20 minutes, across a recovery capital resource domain will be worthy of discussion. In this conversation, the interplay of each dimension against overall quality of life in recovery should be discussed (NIDA, 2018). If time is limited, should be tabled for future discussion in ensuing sessions (NIDA, 2018; White & Cloud, 2008).

An alcohol and other drug practitioner should focus the client on increasing recovery capital resources, as opposed to the negative effects of the symptoms of SUD in their life. A scan with the client of the ten RCR dimensions, being: RCR1: Sobriety; RCR2: Psychological; RCR3: Physical; RCR4: Community; RCR5: Social; RCR6: Activities; RCR7: Safety; RCR8: Risks; RCR9: Coping, and RCR10: Recovery Quality will increase motivation for transformational change (White, 2010). This will be most especially true, if the practitioner presents well, is modelling the behaviours

coached and can talk positively about their own RCR cultivation practices, as a peer. A practitioner's inability to practice self-care was evidenced in the literature as a barrier to successful treatment outcomes in Section 2.4.7 as Barrier 7: Burnout and Lack of Self-care Practices (Skinner & Roche, 2005).

Suggested Implementation of Treatment Principle 5: One-Year. Research continues to reveal that continuity of care is paramount (NIDA, 2018). Evidence corroborated that alcohol and other drug treatment of less than three months in duration does not bring any foreseeable results for patients in rehabilitation treatment settings (AIHW, 2018; Marel, et al., 2016; NIDA, 2018).

This principle includes impressing upon the client the understanding that a quick fix is not available to them. One-year in treatment is also evidenced in the comprehensive treatment care model and stepped-care model summarised in Section 7.1 (Figure 14 and 15). Clients should be told about or shown (e.g., actual articles emailed or handed to them) research that concludes that continuing a year in alcohol and other drug treatment or care is optimal (Tai, et al., 2010). Once severity and complexity of issues are established, these findings must be communicated immediately to the client and the timeline must be clearly explained to them in a way they can understand (White, 2010). Stigma is common, and practitioners can sometimes tend to undermine the capacity of clients to understand their situation (Louma, et al., 2007). When this doubt from the practitioner surfaces, it is felt by clients, and their ability to get well is affected by the practitioner's negative belief structure (Louma, et al., 2007).

The greater the impact the client wants on recovery outcomes and goal fulfilment, the higher the frequency of care (days in treatment) needed, all being relative to the dosage and duration of chemical dependence (Marel, et al., 2016). Recovery from SUD is similar to management of any other chronic illnesses, both

requires multiple and ongoing treatment, where leaving treatment prematurely lead to adverse effects (Best, 2012; Best, et al., 2015; Best & Laudet, 2010).

Suggested Implementation of Treatment Principle 6: Therapy. Talk therapy is an essential component of treatment (Perkinson, 2008; Wiener, 1999). There are numerous modalities that deliver talk therapy, such as: motivational interviewing, cognitive behavioural therapy, Gestalt therapy, somatic therapy, Adlerian therapy, art therapy, dialectical behavioural therapy, acceptance and commitment therapy, animal assisted therapy, strength-based therapy, the Gottman Method, transpersonal therapy, and many more (Perkinson, 2008).

Coaching is one of the many talk therapy modalities, and peer recovery coaching is a subset within coaching, specific to treatment of SUD. Whichever modality is used, it should address all areas of life (NIDA, 2018). Proof of participation in various activities forms part of the conversation and must motivate the client to grow in their involvement with their own financial, spiritual, social, cognitive, emotional, fitness, educational, career, and/or business advancement (Groshkova, et al., 2013; NIDA, 2018).

Suggested Implementation of Treatment Principle 7: Pharma. Pharmacotherapies must be delivered by skilled and specifically qualified practitioners. The phenomenon of addiction dictates that a pharmaceutical pill may have the propensity to be abused (Australian Pharmaceutical Benefits Scheme, 2019). Discussed in Section 2.1, pharmacological interventions are temporary responses used as a harm reduction technique, to avoid further toxicity (Inaba & Cohen, 2014). For full remediation of SUD, encouraging the natural remedies is ideal to negate the addictive feedback loop and allow neuroplasticity for wellness instead of illness to develop (Zahourek, 2008). It can be recommended to see a dietitian or nutritionist and referral to a specialist should be made to ensure the management of client medication

is suitable to their long-term wellness goals (Marsh, O'Toole, Dale, Willis, & Helfgott, 2013).

Suggested Implementation of Treatment Principle 8: Assess. Ongoing assessment of the unique needs, traits and experiences of the client must be discussed regularly. Probing into client issues, gives the practitioner insight into the multifaceted and complex issues to be resolved together (Maisto, et al., 2015; Perkinson, 2008). Critical information gathered must be utilised to formulate an appropriate case management plan. The practitioner must reflect upon their own temperament, background, expertise, and cultural competencies to match their capacity to the client's needs (White, 2010).

Flexibility must be shown in meeting client outcomes by individually tailoring a plan that considers any potential for client impulsivity, irritability, paranoia, intense cravings, and memory impairment (Jenner & Lee, 2008). Ongoing assessment is needed to accommodate needs as they occur and as they negatively change or positively improve over time. Video logs can be useful for retention of information (White, 2010).

Suggested Implementation of Treatment Principle 9: Comorbidity. Treatment should assess and address depression, anxiety, and a host of other medical issues at the outset (NIDA, 2018). Discussion with the client should broach whether other mental health issue/s may interfere with progress and continuum of care (Marel et al., 2016). This includes any suspected undiagnosed anxiety or depression issues that may impede overall client functioning. The peer role is important; how the practitioner was able to deal with depression, anxiety, or other issues matched to clients' issues, can be a precursor to client admission of how severe their issues may have become for the client (Eddie, et al., 2019). Practitioners must develop literacy, comprehension, and articulation of client mental health disorder symptoms, to better support clients in management of these issues.

Depending upon the severity of presenting neurotic behaviours, alcohol and other drug workers should consider integrating strategies to address them prior to client sessions. Engagement with a clinical supervisor or practice mentor will enable the practitioner to regularly assess their performance. A referral pathway must also be vetted and continually updated so that clients can be handed over for medication management or other specialised psychological or alcohol and other drug-related mitigation pathways (Marel, et al., 2016).

Suggested Implementation of Treatment Principle 10: Detox. Those in contact or delivering service to alcohol and other drug end-users are required to have a current referral list of reputable detoxification facilities. Detoxification comprises of a set of interventions that minimise harm, death, or coma from dangerous toxicity levels and to manage subsequent withdrawal symptoms. Clearing the body of toxins through detoxification centres and clinics, can represent a first point of contact with the treatment system, for many (Center for Behavioural Health Statistics and Quality 2016).

AOD-specific emergency intake and acute care clinics provide specialist detoxification services. Management of intoxication issues require medical knowledge; additional qualifications for detox providers are foundational psychology training and post-graduate study of managing withdrawal symptoms related to alcohol and other drug and SUD issues. Most emergency rooms, medical and surgical wards in hospitals, and acute care clinics do not provide AOD detoxification services (Marel, et al., 2016).

Suggested Implementation of Treatment Principle 11: Reward. It is relevant to talk to the client about the capacity of the brain to readapt to the absence of drugs (Pascual-Leone, et al., 2005). When these readaptation instances occur, the client must be immediately rewarded and taught to instantly reward themselves. Preparing

rewards for clients falls on the practitioner to begin with, so that relapses can be averted.

Practitioners must offer enticements that can increase the chances for a committed, fulfilling, and worthwhile ongoing engagement with the service provider or AOD professional (Marsh, et al., 2013). Collaboration or therapeutic alliance must bring joy, hope, and optimism into the clients' lives. It is the job of the alcohol and other drug worker to keep developing alternative non-pharmacologically based rewards that will reinforce reasons for transformational change, relapse prevention and life management skills (Marsh, et al., 2013). For this to happen, the practitioner must act as cheerleader to sustain and reinforce positive changes.

Suggested Implementation of Treatment Principle 12: Relapse. Interventions that target solutions are important, and can be based in cognitive behaviour therapy, schema therapy, interpersonal therapy, narrative therapy, and other approaches based on client-centred delivery (Centre for Substance Abuse Treatment, 2006). AOD workers have used mindfulness- and meditation-based interventions that preliminary research results have found promising (Fernros, & Furhoff, 2008; Haaga, et al., 2011; Hawkins, 2003; O'Connell & Alexander, 1995). Other relapse prevention management planning might include assistance with problem-solving, conflict resolution, assertion, anger management, grief processing, parenting skills, employment, or accommodation (NIDA, 2018). Other clients, particularly young people, benefit from the inclusion of key significant others, such as parents or foster carers', while engaged in treatment (Lander, et al., 2013).

Reference to P3R can help the practitioner take into necessary consideration that relapse is a learning process for the patient or client. It can allow a shift in focus for the practitioner. This essential change in orientation can enable both practitioner and client to understand that each relapse, if processed effectively, will bring about transformative change. Destigmatising of alcohol and other drug issues will encourage conversations that increase client awareness. This new awareness can allow

identification of clients' own psychological, environmental, and social cues that need addressing, to progress with resolution of deep-seated issues they present (White, 2010).

In encouraging flow of conversation in relation to relapse, explanation of how addiction develops and is rewarded will help clients implement actions that determine self-efficacy. This involves empowering clients to be involved in stress release and to cultivate the ability to exercise self-control to improve neuroplasticity, over time. Important to note and discuss can be that the amygdala (the brain's danger switch) can control emotional responses, causing an addicted person to feel severe stress when not using the drug. Like all healing processes, time, diligence, and consistency aid the body's own natural healing homeostasis. Instead of vilifying relapse behaviours, it is useful instead, to talk about their triggers and reinforce that constant preoccupation and craving will occur.

Suggested Implementation of Treatment Principle 13: Screen. In looking at a host of other medical issues exacerbated by SUD, the practitioner must ask whether the assessment tools and ways of communicating with the client encourage treatment engagement. Feelings of shame, guilt, oppression, fear, hatred, anger, or sorrow should be carefully managed. Practitioners should ask how clients are supported, and would like to be supported, including referring access to risk-reduction talk-therapies and counselling related to their presenting issue. This can include referral to an HIV/AIDS case manager; refugee centre; sex worker mediator; abortion clinic; lesbian, gay and transgender service provider; etc. (NIDA, 2018).

Burdening clients with additional questionnaires can become problematic. Warning them ahead of time of the considerable effort needed in filling in forms can help. If administrative help is needed, a referral can be given to volunteer groups or time can be allotted to help them with this task. To uphold overall treatment efficacy, practitioners must inform clients of any insights on known therapies and referral

pathways (Marel, et al., 2016). Certainty in referrals given, conveys confidence. Ways this confidence can be relayed include elaborating on how the referral link was established and giving positive feedback about the linked service from other clients referred.

As referrals are given, access can be granted to other treatment professionals, and with client consent, all parties can annotate notes, as required. In one glance, RCRs, TPs and dates when each topic was broached, can be viewed quickly. Further dates can be discussed with the client for future sessions and fields expanded digitally to accommodate more writing space. Conversations can flow easily with accessible RCR and treatment principle (TP) prompts. In hard copy format, dates can be inserted with RCR and TP circled or highlighted with color-coding preferences identified by practitioner, once discussed when clients.

Digital copies can be shared and stored electronically. The P3R can be shown or given to the client, ensuring collaboration is activated. The P3R can prompt conversations to support the client in their recovery-oriented journey. As each treatment principle is as important as each other, discussion of all the treatment principles and all recovery capital resources needed to sustain long-term recovery are vital conversation pieces in successfully transforming SUD.

Table 60 is a sample of how the P3R can be used to track change. Referring to Table 59, 60 and Appendix C will provide a how notes and dates and short comments can be entered into, conveniently. Convenient view of treatment principles and recovery orientation, that was already discussed or can be further discussed with the client allows for recovery-oriented and principle-centric focus.

Table 60:

Principle-Centred Recovery Resource Register Sample: RCR1-10 and TP1-2

RECOVERY CAPITAL RESOURCES	TP1 NEURO: Effects on Brain Function (short/long-term), mechanics neuroplasticity	Date/s discussed	TP2 UNIQUE: Match needs, dependent upon dosage, usage, symptoms, family etc	Date/s discussed
RCR1 SOBRIETY	TP1 neuroplasticity ✓	4/3 30 mins	TP2 schedule	
1 Sober 2 In control 3 Nearly used 4 Used Recently 5 Other things are important	RCR1 ③ ④ ① ③ ⑤	1/2/20, 4/3, 10/3, 4/4	RCR1 ← see previous elaborate ②	4/4, 6/5, 6/6
RCR2 PSYCH	TP1 more exercises to help understand		TP2 ✓	
1 Concentrate 2 Cope w/ Stress 3 Happy w/ Appearance 4 Overall Happy 5 Future	RCR2 for RCR2.1 ⑤	1/2	RCR2 ④	1/2
RCR3 PHYSICAL	TP1		TP2 dosage effects	
1 Daily Tasks 2 Physically Well 3 Have Energy 4 Can Get Around 5 Can Sleep	RCR3		RCR3 on ⑤	
RCR4 COMMUNITY	TP1 ✓		TP2 Family – unique step x2	6/5
1 Proud 2 Contibute 3 Wants to Help Others 4 Does Help 5 Identity without use	RCR4 ←		RCR4 Nothing yet – own needs	6/5
RCR5 SOCIAL	TP1 Brain function	2/2	TP2 Family sisters	6/5
1 Personal 2 Family 3 Circle of Friends 4 Family - Emotional Needs 5 Intimacy	RCR5 ③ Friends? must not use	2/2	RCR5 ④ ? Need support 2/2	④ Emotional need 4/4 'probe'
RCR6 ACTIVITIES	TP1		TP2 ✓	
1 Exercise 2 PD / Education 3 Fun Activities 4 Career 5 Abstinent	RCR6 must exercise	10/3	RCR6 ② Psyc degree at ④ Career	6/6
RCR7 SAFETY/HOME	TP1 Research neuro		TP2 ✓	
1 Proud 2 No Threat 3 Safe at Home 4 Can Shape Destiny 5 Conducive to recovery	RCR7 Safe @ home kids ?	6/2	RCR7 ① need to work on	entitlement? 10/3
R8 RISKS	TP1		TP2 ✓	
1 No $ Worries 2 Have Resources 3 Has Privacy 4 No Damage 5 Responsible	RCR8 Need $$ refer Financial advice @	6/2 Mercy	RCR8 ① ③ ④ ⑤	2/2, 6/5
R9 COPING	TP1 journal neuro	6/2	TP2 coping strategies	5/9
1 Deal with Professionals 2 Has Integrity 3 Nutrition 4 Wellbeing 5 Meet Obligation	RCR9 5 obligations ?		RCR9 ① ②	
R10 QUALITY	TP1		TP2 ✓	
1 Purpose 2 Progress 3 Activities 4 Has 'Clean' Network 5 Optimistic @ Future	RCR10		RCR10	

7.3.2 Recovery-Orientation Competence in Practice

Having a recovery orientation, as covered in the literature review and Chapter Three; CPRC, shifts the focus from the pathology of addiction to enhancing clients' internal and external assets required to initiate and sustain long-term recovery (Best, 2012). The current mental health system is based on professional expertise, with limited interaction with consumers and family members despite evidence-based practice guidelines instructing to the contrary (Campbell-Orde, et al, 2005). It is taught based upon a medical model which presents mental illness in the brain or neurological disorder (Treatment Principle 1: Neuro). Neurological disorders or diseases have an effect on the physiology of the body, for which pharmacological treatments are prescribed as part of long-term maintenance of SUD (Campbell-Orde, et al., 2005).

The recovery model, on the other hand, is one that has grown out of the lived experiences of people who have been diagnosed with mental illness (Australian Health Ministers' Advisory Council,2013). The recovery pathway for the CPRC program puts emphasis on peer support (second dimension, or the P in CPRC). Those who have undertaken the journey of recovery can pass on their learnings, give advice, and teach lessons learned through trial and error (Campbell-Orde, et al., 2005). Although not limited to CPRC practice, a practitioner choosing the recovery approach must work with the individual to increase their quality of life and ensure activities are integrated into daily living. In using the P3R as a case management tool, the 'Assessment of Recovery Capital' scale can be used to ask questions for discussion. At this stage of development, there is no P3R clinical guide or analysis package yet to be utilised with this register. The development of a practice-based manual is planned as part of a post-doctoral timeline. More practitioners and their respective client data are needed, to start this translational research project.

The concept of cultivating recovery capital resources (RCR) and having a recovery orientation reflects a shift in focus from the pathology of addiction to a focus

on the internal and external assets required to initiate and sustain long-term recovery from alcohol and other drug problems (Best, 2012). The Australian national framework model developed recovery processes to inform clinical practice (Australian Health Ministers' Advisory Council, 2013). These four processes are finding hope, re-establishing positive identity, building a meaningful life, and taking responsibility and control. These same processes are used within the CPRC coaching frameworks and form part of the 'collaborative', 'peer' and 'recovery' dimensions.

7.3.3 Developing Competencies as a Coach that Contribute to the Coach Effect

Coaching requires ongoing proficiency for maximum engagement, that enables attainment of client goal outcomes (Gavin & Mcbrearty, 2013; Grant, 2003).One important aspect of recovery from addiction is the growth gained from the coaching, akin to personal development (White, 2010). Coaching principles are based upon peak performance techniques and the competencies required for practice has been summarised in Sections 3.2.4 and 2.5. To ensure uniformity in best practice, 11 competencies were developed by the International Coaching Federation (Reiss, 2015).

A detailed composite of the 11 coaching competencies were outlined as the fourth dimension of the CPRC program in these sections. The rating of the coach against these coach competencies, as they develop their coaching practice comprise the 'coach effect. To summarise what has been discussed in Section 3.2.4 and in the literature review, to practice as an accredited ICF coach at the first level (ACC), a score of 75% must be achieved at the Coach Examination Assessment, against the 11 coach competency ratings provided. There are three levels of ICF accreditation, and a Level 3 Master Certified Coach will have over 5000 hours of coach recorded hours logged. This score rating (0-100%) explain the phenomena of a 'coach effect', whereby the competence of the coach, with their relevant coach competency rating, will have an effect on the client interaction, depth of engagement, and attainment of goals (Reiss, 2015). Each coach will bring to the session, a different level of coach competence,

qualifications, skillsets, and peer experiences. All of these capabilities and individual attributes contribute to an overall coach effect.

Coach competency is needed to advance, not just the coaching profession but one's coaching practice (Reiss, 2015). The use of the P3R require adherence to a set of ethical guidelines and uniform best-practice standards (Reiss, 2015). A credentialed coach knows to uphold practice conventions and accept the responsibility to continue to develop their coach competencies to a higher standard. Maintaining coaching competence, strengthen the credibility and growth of the peer-supported, recovery coaching field. Part of this include being able to relay to the client, the difference between recovery coaching and the therapeutic model.

Distinguishing Coaching from Therapy. Coaching and therapy must be distinguished and articulated to the client as different in approach (CC#1: Meet Professional Standards). This can be done by explaining to the client that coaching is focused on the future and the attainment of meaningful goals while therapy deals with healing personal traumas stemming from past dysfunction and developmental conflict (Reiss, 2015).

The focus in therapy is often on resolving difficulties from the past, that hamper an individual's emotional functioning in the present (Abadinsky, 2018). Resolving difficulties can improve overall psychological functioning and equips the patient in dealing with current life and work circumstances, in more emotionally healthy ways (Campbell-Orde, et al., 2005). In contrast, while positive emotions and healthy states may be a natural outcome of coaching, the primary focus of coaching is on creating goals, strategies and track actions (or non-actions), to ensure actual achievement of goals set (Loveland & Boyle, 2005). The emphasis in a coaching relationship is on action-taking between sessions, accountability for goals set, discussion of actions completed or not completed, and ongoing follow-through (White, 2010).

7.4 Conclusion

The chapter discussed a novel contribution to AOD practice: development of a case management and formulation analysis tool, called the Principle-centred Recovery Resource Register (P3R). Implementation of the register developed from this research, may aid individuals with SUD. Research has found that goal attainment (Gavin & Mcbrearty, 2013; Reiss, 2015) and cultivation of recovery capital resources (Groshkova, et al., 2013; Sterling, et al., 2008; White, 2008; Yates, 2014) are essential for long-term recovery (White, 2010).

Hence, this register was formulated from the 13 principles of treatment promulgated by the National Institute of Drug Abuse (2018) and with a recovery orientated focus (Deane, et al., 2014; Humphreys, et al., 2014; White, 2008). Those wishing to use the P3R ought to read the *Principles of Drug Addiction Treatment: A Research-Based Guide,* re-published in 2018 by the National Institute of Drug Abuse. The chapter included preliminary suggestions for use of the P3R; further research and evidence is needed to continue to develop this case management register.

The peer-supported, recovery-orientation lens offered a different approach to the conventional medical and disease management model. Although the approaches have dissimilarities, the 13 treatment principles should remain intact and applied in all practice settings. The P3R should also be developed in line with each coach-practitioner's capabilities and skillset. Having a full set of videos and transcripts of peer-supported, recovery coaching session recordings is rare. This study can provide an opportunity to be involved in investigation of translational research with other fields of professional practitioners interested in peer delivered, AOD/MH recovery coaching.

CHAPTER EIGHT: CONCLUSION

8.1 Introduction

This doctoral study examined the coaching processes used by a CPRC Practitioner aimed at helping participants build a sustainable and long-term future in recovery from alcohol and drug dependence. This concluding chapter provides a summary of the research findings, contributions and limitations in investigating the merits of recovery-oriented, peer-delivered coaching related to the participants in this study.

Significant numbers of deaths from substance use disorders have caused major systemic disruption to health, political, economic, and legal systems (Collins & Lapsley, 2008). As a most preventable and treatable disease, an innovative and recovery-oriented, coaching intervention that has the capacity to report higher rates of overall well-being, for those with SUD, is needed (AIHW, 2019). Specific and actual coach-client interactions, especially with participants suffering SUD, remain largely under-investigated. This research contributed to the evidence-base, on peer recovery coaching in Australia.

One of the aims of this study was to integrate the collaborative, peer, recovery, and coaching (CPRC) aspects as an approach, and to contribute practice-base insights for use within the AOD sector in Australia. This was achieved by investigating the effects of peer recovery coaching in goal accomplishment and increasing recovery resource assets.

With 18 participants, this qualitative study used recovery capital resources with ten dimensions and 50 question items, called the Assessment of Recovery Capital (ARC) scale (Appendix A). The findings indicated that the CPRC program improved the recovery capital resources of the participants involved in the study, over the

duration of the intervention. It did not, however, provide evidence of the sustainment of these results, beyond the intervention timeframe.

In section 8.3, triple-dividend contributions to AOD practice, work-venue, and academic development are concluded. Since a limitation of this study included no other intervention or practitioners, these improvements are not representative of the population of people with SUD against a randomised, control group. The way the data was collected and the form it was collected with, was also a limitation, therefore will be summarised in Section 8.4. Lastly, section 8.5 concludes on the research findings and its overall impacts, including recommendations for practical use, and suggestions for future research.

8.2 Research Outcomes

The literature reviewed some of the prevailing political, generational, economic, and social factors, verifying how hard it is for the drug user to abstain from this strong and vehement force (Chapter 2). Research found that shared lived experiences can became the foundation for a strong therapeutic alliance, despite long-term, ongoing negative effects felt in the lives of those with SUD. Similar to other peer and recovery-oriented study findings mentioned in the literature review, this research found that peer delivery and recovery-orientation (Deane, et al., 2014; Eddie, et al., 2019) were key aspects for impactful and transformational change.

Findings from this qualitative research found that participants responded positively to peer-based, recovery-oriented coaching. The results show (Table 61-63 and Table 1-6 in Appendix B) that completion of the CPRC program, suggested improvements in recovery measures for participants in this study, across a range of RCR dimensions. This study corroborates findings that there is a need for the AOD field to shift from a professionally directed, acute-care model, with its' focus on

isolated treatment, toward a more long-term, sustainable, recovery-oriented approach (White, 2010).

A focus on recovery is a focus on cultivation of recovery assets (Cloud & Granfield, 2001). Recovery is the process by which people with SUD rebuild and further develop connectedness with themselves, with others and with their environments or recovery assets (Cloud & Granfield, 2001). Recovery also takes place in community (RCR4) and an interactive process that involves transactions between the person (RCR1-3, RCR6, RCR8), their immediate support system (RCR5, RCR7), their treatment system (RCR9-10), and other relevant variables (Onken, et al., 2007).

This study responded to a research problem and made an original knowledge contribution professional practice, related to the research question:

Does the use of the Collaborative Peer Recovery Coaching program affect recovery capital resources and goal attainment scores of individuals with substance use disorders?

The proposed research question was contingent upon observing any improvements pertaining to recovery-oriented resource assets and goal attainment scores. In order to answer the main research, it was necessary to answer the following research sub-questions:

1. How did CPRC affect the ten dimensions of RCR, as evidenced in the participants' before and after RCR scores?
2. As the coaching series developed, what improvements, or change patterns emerged, related to participation in the CPRC program, on the participants' RCR scores?
3. Despite the ongoing existence of SUD issues, what effects did CPRC have on participants' ability to achieve pre-determined goals, set in the first coaching session?

Recovery capital resources are not a fixed value, sustained over given periods of time, as they diminished during active addiction and increased during sustained recovery (Loveland & Boyle, 2005; White, 2010). Recovery capital is built on the idea that addiction treatment starts with detoxification or intervention and continue to include developing and strengthening access to resource assets, for long-term recovery to be sustained (Loveland & Boyle, 2005).

This study explored the notion of cultivating recovery capital resources, reporting improvements, if any, across the 50 RCR question items, for all the participants involved. Reported as Result 1, Table 1 to 6 summarise the pre- and post-CPRC RCR scores for each participant, found in Appendix B. The score was based upon the number of instances the participant recorded a 'yes' response, as yes = 1). Table 61 provide a summary of cumulative, pre- and post-CPRC RCR scores from all the participants involved in this study.

Table 61:

Pre- and Post CPRC Cumulative RCR Scores

Pre-CPRC RCR Score	Post-CPRC RCR Score	Recovery Capital Resource (RCR)
11	**59**	**RCR 1 SOBRIETY**
0	5	RCR 1.1: I am currently completely sober
4	16	RCR 1.2: I feel I am in control of my substance use
2	7	RCR 1.3: I have had no 'near things' about relapses
1	15	RCR 1.4: I have had no recent periods of substance intoxication
4	16	RCR 1.5: There are more important things to me in life than using substances
24	**80**	**RCR 2 PSYCHOLOGICAL FUNCTIONING**
6	12	RCR 2.1: I am able to concentrate when I need to
1	18	RCR 2.2: I am coping with the stresses in my life
2	14	RCR 2.3: I am happy with my appearance
8	18	RCR 2.4: In general, I am happy with my life

7	18	RCR 2.5: What happens to me in my future mostly depends on me
35	**76**	**RCR 3 PHYSICAL HEALTH**
7	18	RCR 3.1: I cope well with everyday tasks
7	13	RCR 3.2: I feel physically well enough to work
8	17	RCR 3.3: I have enough energy to complete the tasks I set myself
13	15	RCR 3.4: I have no problems getting around
0	13	RCR 3.5: I sleep well most nights
30	**75**	**RCR 4 COMMUNITY**
3	14	RCR 4.1: I am proud of the community I live in and feel part of it -sense of belonging
7	15	RCR 4.2: It is important to contribute to society
8	16	RCR 4.3: Its important I do what I can to help others
9	15	RCR 4.4: It is important that I make a contribution
3	15	RCR 4.5: My identity does not revolve around using
17	**72**	**RCR 5 SOCIAL**
5	17	RCR 5.1: I am happy with my personal affairs/life
1	16	RCR 5.2: I am satisfied with my family involvement
2	13	RCR 5.3: I get lots of support from friends
3	15	RCR 5.4: I get emotional support/help from family
6	11	RCR 5.5: I have a special person I share life with
33	**77**	**RCR 6 MEANINGFUL ACTIVITIES**
1	10	RCR 6.1: I am active with sports & leisure activities
6	17	RCR 6.2: I am engaged in education/self-development pursuits
13	18	RCR 6.3: I am engaged in fulfilling & enjoyable activities
8	17	RCR 6.4: I can access career opportunities
5	15	RCR 6.5: I regard life as fulfilling w/out using
21	**80**	**RCR 7 HOUSING & SAFETY**
4	14	RCR 7.1: I am proud of my home
5	18	RCR 7.2: I am free from threat/harm at home
4	15	RCR 7.3: I feel safe & protected where I live
7	18	RCR 7.4: I feel I am able to shape my destiny
1	15	RCR 7.5: My living space has helped me 'recover'

41	74	RCR 8 RISK TAKING
4	14	RCR 8.1: I am free from money worries
5	17	RCR 8.2: I have the resources to make long-term decisions
9	13	RCR 8.3: I have the privacy the I need
12	15	RCR 8.4: I ensure nothing I do hurts/damages others
11	15	RCR 8.5: I take full responsibility for my actions
33	**75**	**RCR 9 COPING & LIFE FUNCTIONING**
7	16	RCR 9.1: I am happy dealing w/ a range of profession9als
10	14	RCR 9.2: I do not let other people down
3	15	RCR 9.3: I eat regularly & maintain a balanced diet
3	18	RCR 9.4: I look after my health & wellbeing
10	12	RCR 9.5: I meet all of my obligations promptly
21	**74**	**RCR 10 QUALITY OF RECOVERY**
7	15	RCR 10.1: A sense of purpose in life is important
3	15	RCR 10.2: I am making good progress in my recovery
2	14	RCR 10.3: I engage in activities that support my recovery
0	12	RCR 10.4: I have a reliable network that supports my recovery
9	18	RCR 10.5: When I think of my future, I feel optimistic
266	**742**	**TOTAL: PRE-CPRC / POST- RCR SCORE**

Notes: 1. Score means the number of instances that there were a 'yes' response (yes = 1).
2. 18 participants x 5 question items, per RCR dimension (18 x 5 items x 10 RCR = 900)
2. Maximum number of participants that can be recorded for each question item is 18.
2. Therefore, each of the ten RCR dimension have pre- and post-CPRC range = 0-90
3. Therefore, TOTAL pre- and post-CPRC RCR across the ten dimensions, range = 0-900

According to the reported results and discussion, the CPRC Practitioner helped the individuals navigate the recovery capital resources available to them. Outcomes show the pre-intervention recovery capital resources scores was recorded at 266, while post-CPRC, RCR score was 742. This post-CPRC, RCR score was improved almost 3 times from the original, pre-CPRC, RCR score. Examples of results were helping

clients gain employment, insights and resources on improved parenting skills, access to financial literacy, and addressing any legal or criminal issues faced. This increase in recovery assets had positive effects, and overall optimistic functioning impacts in the lives of the participants involved in this study, as discussed in Chapter Six.

Result 2 reported patterns of improvement, no improvement and no negative change. The highest instances of improvement were shown in the seventh dimension (RCR7: Housing and Safety), where 50 question items, showed instances of improvement from an original, pre-CPRC, RCR cumulative score of 21, to 75 post-CPRC. The ability to have housing and feel safe within the comfort of one's home is a contributing factor to ongoing recovery, and was also highlighted as important, in the Australian National Recovery Framework document by the Australian Health Ministers' Advisory Council (2013).

Table 62 show the ranking of instances of improvement compared to other RCR dimensions.

Table 62:

Most Improved RCR Dimensions

Recovery Capital Resource (RCR)	# of instances Improved	Overall Ranking
RCR 7: HOUSING AND SAFETY	59	1st
RCR 2: PSYCHOLOGICAL HEALTH	56	2nd
RCR 10: QUALITY OF RECOVERY	53	3rd
RCR 1: SOBRIETY	48	4th
RCR 5: SOCIAL	48	4th

Notes. 1. 'Improved' RCR must have recorded a pre-CPRC score of 0 or 'no' answer, then post-CPRC, a '1' or 'yes' answer, for each question item, relevant to the RCR dimension.
2. There is no range for 'Improved' category, as ranking was dependent upon the instances of improvements recorded, for each of the participants (*n*=18).
3. See Figure 9 for sample of how the 'improved' category, was tallied.
4. See Figure 11 for visual representation of the three categories reported, 'improved' was coded in yellow.

Table 63 report the instances of 'improved' responses, showing question items that received the highest number of instances, where there were an 'improved' response.

Table 63:

Most Improved RCR Question Items

Recovery Capital Resource (RCR) Question Item	# of instances IMPROVED	Overall Ranking
RCR 2.2: I am coping with stresses in life	17	1st
RCR 9.4: I look after my health and wellbeing	15	2nd
RCR 5.2: I am satisfied with my family involvement	15	2nd
RCR 1.4: I have had no recent periods of intoxication	14	4th
RCR 7.5: My living space helps me drive my recovery	14	4th

Notes. 1. 'Improved' RCR question item must have recorded a pre-CPRC score of 0 or 'no' answer, then post-CPRC, a '1' or 'yes' answer.
2. There is no range for 'Improved' category, as ranking was dependent upon the instances of improvements recorded, for each of the participants (n=18).
3. See Figure 9 for sample of how the 'improved' category, was tallied.

Result 3 assessed the achievement of client goals, as a self-rating by the client. As a response to the third sub-question, result 3 has been reported from the total of 54 goals set (3 goals for each of the 18 participants). It was found that around 15% were perceived by the participants as achieved completely (100% goal attainment rate) and 18.5% achieved self-ratings of 90-95%. Overall, 90% of the goals showed relatively high percentage of achievement (self-rated 70-100%), as only 10% scored below 65% achievement. This may have been achieved because coaching involved a collaborative partnership, for the purpose of attaining goals and is considered the central function of the CPRC program. Table 37 in Section 5.4 summarise all the participants' self-rated, goal attainment scores.

Session transcripts provided examples of how the articulation and clarification of goals, were a key component in each CPRC session. The goal setting exercise in the first session and the strategy session as the second CPRC session, served to increase the capacity of each client, to achieve goals set. In CPRC practice, peer-supported, recovery coaching underpins delivery of services that enhance optimal functioning associated with characteristics of personal growth. Specifically, Fredrickson & Losada (2005) called them 'flourishing' states.

Based upon the Collaborative Recovery Model (CRM), peer-support literature, recovery coaching precepts, and the Recovery-Oriented Systems of Care (ROSC) framework, the 'Collaborative Peer Recovery Coaching' program was delivered as the coaching intervention for this study. The findings affirm the merit of using peer-supported coaching, with a recovery-oriented approach, for the participants that attended the CPRC program. Now that the resource outcomes have been summarised, original contributions of the study, follow next.

8.3 Contributions of Study

This study conducted within the Professional Studies faculty at The University of Southern Queensland stemmed from work-based learning and research, seeking to address complexities, challenges, and future practice-based demands (Fergusson, Aldred, & Dux, 2018). Teddie and Tashakkori (2009) point to work-based transformative researchers, whose purpose is to advocate and offer support, for a stigmatised population, rather than simply to generate new knowledge. The motivation for undertaking this research has a transformative component. It is to improve alcohol and other drug service provision and outcomes, while empowering peers with SUD. The findings from this dataset, derived from this preliminary study of the CPRC program, provided deeper insights into the influences of peer-supported, recovery coaching for problematic AOD behaviours, within the Australian context.

8.3.1 Contribution to Alcohol and Other Drug Practice

The USQ Professional Studies learning contract specifies delivery of a work-based project that yields a triple dividend (Fergusson, Aldred & Dux, 2018). The triple dividend aims to provide a three-fold benefit to practice-base (Section 8.3.1), the WBL organisation (Section 8.3.2), and to the student (Section 8.3.3). This doctoral study addressed the triple dividend delivery by:

a. being of benefit to a real-world challenge, described as an addiction epidemic (Abadinsky, 2018; Inaba & Cohen, 2014), by offering an intervention that may improve AOD service delivery engagement and outcomes, as reflected in the participants' improvements in recovery capital resource assets;
b. contributing insights into the mechanisms (denial, cravings, triggers etc.) and behavioural patterns (co-dependence, neuroplasticity, reward centres etc), of those with substance use disorders, as evidenced in the video logs and transcriptions used, to illustrate the CPRC sessions.
c. provision of a peer supported, recovery coaching service that serves as an adjunct intervention, that can be provided, as part of a comprehensive treatment continuum.
d. providing a work-based artefact, in this instance, a case-management register, called the Principle-centred Recovery Resource Register (P3R). The P3R can aid in recovery orientation and uniform delivery of any AOD service, that address barriers, discussed in the literature review.

This study represents the first peer recovery coaching study in Australia providing rich, participant-oriented data on improvement of recovery resource 'assets' and goal attainment capacity. Those seeking AOD services see recovery as a personal journey, facilitated or impeded by the practitioner, through an interplay of complexly linked interactions (Deane, et al., 2010).

This study focused attention on the value of peers and lived experiences, as coach and client collaborate to produce goal outcomes in specific areas of the client's

life (White, 2010). This study contributed insights into the phenomena of recovery of SUD, through the use of the CPRC program with four practice dimensions, they are:

- Collaborative
- Peer-supported
- Recovery-Oriented
- Use of Coaching approach

Collaborative. In each meeting, the client chose the focus of the conversation, while the coach listened and contributed observations and powerful questions (ICF, 2020; White, 2008). This coaching interaction created clarity and moved the client toward action. The CPRC practitioner accelerated the client's progress in recovery by providing greater focus and awareness of choices, actions, and responsibility. Coaching concentrated on where clients were, and what they were willing to do to enjoy a better tomorrow. These tenets of recovery coaching, along with the CPRC Practitioner's peer experience, helped the client recognise that the results are a matter of the client's intentions, choices, and actions taken toward building a strong and sustainable recovery. The coach and client collaborate to create a life worth staying sober, abstinent, and healthy for.

Peer-Supports to Build Recovery Capital Resources. In this study, the use of a peer-CPRC Practitioner enhanced the engagement, collaboration, recovery capital resources and goal attainment capabilities of the participants involved in the CPRC program. Few individuals hospitalised for or having participated in therapy or rehabilitation programs, further attend post-discharge, peer recovery support services (Eddie, et al., 2019). Peer-supported, recovery coaching represents a potential method for promoting recovery-orientation and post-treatment engagement (Jack, et al., 2018).

Recovery-Oriented Focus. The ten recovery capital resource dimensions, used in this study, measure the sum of recovery capital resources needed for a fulfilling and sustainable recovery. They are:

1. abstinence or discontinuing of use of substances of addiction (RCR1)
2. happiness and psychological wellbeing (RCR2)
3. physical health, energy, and vitality (RCR3)
4. citizenship and contribution to community (RCR4)
5. high-level of social interaction and support (RCR5)
6. productivity and opportunity seeking (RCR6)
7. housing and ability to feel safe in one's domicile (RCR7)
8. ability to manage finances and take calculated risks (RCR8)
9. ability to cope and function well in life (RCR9)
10. overall high-level of recovery progress (RCR10)

The CPRC Practitioner in this study encouraged and acknowledged the recovery capital resources inherent within clients. The CPRC sessions focused the recovery-orientation to ensure individuals maximised health and wellbeing, through an audit of internal and/or external resources needed, to sustain sobriety that can lead to a better quality of life (White, 2010).

As this research study progressed, the culmination of knowledge regarding the 13 principles of treatment, helped with the formulation of a case management register, to be used for ongoing management of AOD clients.

8.3.2 Contribution to Workplace and Work-Based Learning

To address barriers to successful treatment outcomes, an artefact, stemming from the results reported in this study, led to the development of the '*Principle-Centred Recovery Resource Register'* (P3R). The P3R contributes an original, AOD case management register, incorporating the 13 principles of treatment and ten dimensions

of recovery capital resources, useful for successful client outcomes. The P3R is adaptable to those practicing known modalities, such as; Motivational Interviewing, Cognitive Behaviour Therapy, Gestalt Therapy, Therapeutic Communities delivery, group or individual counselling and/or any other services offered to a person with SUD issues.

It is hoped that recovery-orientation will help support those in treatment measure and discuss recovery capital resources needed for long-term recovery to successfully attain recovery goals and have a better quality of life, abstinent from substances of abuse. As covered in detail in Chapter Seven, the use of the P3R can guide practitioners in activating principles of treatment in the delivery of therapy or a coaching session. A uniform approach to recovery-orientation (White, 2010) and use of evidence-base treatment principles have been shown to enhance quality-of-life outcomes for those with active addiction issues (NIDA, 2018). The P3R may be used in case management of AOD clients, within any of the AOD programs that fall under the comprehensive treatment model (Tai, et al., 2010).

As the literature suggested, the CPRC Practitioner affirmed the participants' innate health and wellness, amidst the existence of their SUD issues. (Loveland & Boyle, 2005). The CPRC Practitioner viewed the clients as creative and resourceful, focusing them on creating and sustaining hope-filled and meaningful lives. Through the process of engaging in the CPRC program, clients deepened their learning, improved their performance across their chosen goals, and enhanced the quality of their recovery, through the cultivation of recovery capital resources.

Lack of training opportunities reveal a problem with the ability of practitioners to gain competence needed for sustaining a successful AOD practice (Deane, et al., 2014; Deane, et al., 2010). While not replacing any further study needed, the P3R developed in this study contributed a register, to guide case management. With the P3R, a case manager, clinician or coach, can maintain concentrated efforts toward

recovery orientation, focusing the client on internal and external resources or recovery assets needed to recover from SUDs.

Another contribution of this study are provision of transcripts and video logs of the CPRC coaching sessions, as the participants completed the CPRC program. These peer-driven session logs can be used as training material for future coach and clinical practitioners. Already mentioned, there is a need for accreditation and a uniform approach, formalising the ethical delivery of an AOD, peer-supported, recovery coaching service to this vulnerable population.

8.3.3 Contribution to Self

In the introduction to this study, Section 1.3 drafted the preliminary academic and personal development skillsets, to be acquired. These anticipated contributions were identified at the beginning of the program, were presented for doctoral candidature, to a panel. Upon completion of the Doctor of Professional Studies, these academic learnings that have improved the student’s capabilities and personal potential, have been summarised as follows:

Problem-Solving Skills. Logical thinking and problem-solving skills were enhanced, as consistent and ongoing application of strategic and logical thinking processes were applied within the field of peer-supported, addiction recovery coaching. This focus on strategy and logic, included increasing the quality of reflection in the practice setting. As we, high standards of ethical conduct were implemented, to better serve this vulnerable population.

Critical Judgement and Academic Skills. As the study culminated over a period of six years, critical thinking and academic analysis, were consistently developed. The various processes and tasks completed whilst conducting research reports, helped formulate an analytical approach to study findings. The demands of the

doctoral program refined critical judgment skills, facilitating client growth which increased discernment and evaluation of client recovery assets. Dissertation writing skills were developed through the use of academic language that is logical, informative, and concise. Data gathering and data analysis skills were increased, as an advanced understanding of qualitative research processes, including robust methodology and better research design, were developed.

Communication Skills. Coaching competence included use of communication skills, such as active listening and increased rapport building skills. All aspects of coaching competence as covered in Section 3.2.4, underwent a continuous revision and improvement, as 206 hours of coaching sessions were delivered, for qualitative analysis in this study.

Reflective Learning. At the core of the DPRS program is a "reflective practice", reflexivity allowed enhancement of organisational learning, including a critical examination of AOD service barriers (Fergusson, van der Laan, & Baker, 2019). Investigating and probing deeper into client AOD issues, increased alignment of personal thoughts that meet organisational and client outcomes. Development of a learner profile also improved professional reflection, during the course of this study (Fergusson, et al., 2019b).

Personal Potential. Personal potential was sharpened through the reinforcement of a therapeutic alliance or collaborative synergy with clients. Modelling my own recovery and daily self-care practices to client and with clients, was another aspect of personal growth. Reflection of my own potential as a researcher, practitioner, peer and coach has helped me find and live my life purpose.

8.4 Limitations

The findings of this study have to be seen in light of some limitations that will be summarised in this section. Due to lack of research funding resources, this self-funded study utilised a convenient sample, recruited from the work-venue's social media networks, database and referrals list. The association between exposure to the CPRC program and recovery outcomes may be different for those who completed this study, compared with those who belong in the target population. Selection bias has limiting effects, as the association between a risk factor (SUD) and health outcome/s (goal/s attainment and improvement in RCR scores) may differ, if this study had another intervention control group, set up, where randomised trials are ideal. Hence, the generalisability of the improvements felt by participants from this convenient sample, will not be representative of the broader target population. As an example, cultural diversity can play a part in outcomes experienced by participants from another cultural heritage, such as from Asian or Middle Eastern background. This must be taken into consideration for it different effects, dependent upon culture and upbringing.

A further limitation could be that recovery capital resource scores on the 'Assessment of Recovery Capital' scale (Appendix A) does not function like a Likert scale, according to an effect indicator model or validation scale. Moreover, the ARC scale used for this study, need more psychometric validation and field-testing work to further evaluate its' ten RCR dimensions. For this reason, the RCR domains used in this study may not be amenable to standard psychometric assessment methods and results extrapolation. Future studies should use a control group. Post-intervention RCR results should also be measured six-months and/or one year after the intervention, if time, resources and participant recruitment consent allow. A self-report by the client against the 'Assessment of Recovery Capital' (ARC) scale will be useful in future studies. A self-report was not completed for this study. Study results should be interpreted with caution, as it stands, this study still provided tentative support for RCR improvements, for the participants involved.

8.5 Recommendations and Future Studies

Use of the National Framework for Recovery-Oriented Mental Health Services Guide. It is recommended that AOD practitioners and service providers model their practice against the Australian National Framework for Recovery-Oriented Mental Health Services (Australian Health Ministers' Advisory Council, 2013) and the Collaborative Recovery Model (Deane, et al., 2010, 2014). Other practitioners in Australia, utilising traditional treatment models would benefit from further training in providing recovery-oriented systems of care (ROSC) services.

Research on Peer-supported Interventions. The research demonstrated that the use of the peer-supported coaching modality can increase individuals' motivation and propensity to achieve goals set. Coaching can underpin the delivery of services to enhance optimal functioning associated with characteristics of flourishing or peak performance states (Fredrickson & Losada, 2005). The study explained that attainment of client goals and cultivation of recovery assets are the key impacts made from participation in the CPRC program. It is recommended that further studies be conducted that examines coaching interactions that encourage the person to flourish by increasing client capacity for positive emotions and self-efficacy (Bandura, 1977; Gavin & Mcbrearty, 2013).

Prioritising AOD Funding for Successful Intervention Outcomes. Inaba and Cohen (2014) outlined investments have been made in clinical science to produce empirical literature intended to alleviate alcohol and other drug suffering, reduce mortality, and improve quality of lives. Despite these significant investments, nations continue to struggle to deliver high-quality healthcare and improve patient outcomes related to addiction. These unmitigated service issues may be due to the systemic failure to disseminate, adopt, and implement evidence-based discoveries, in a timely fashion (NIDA, 2018). It is recommended that research and government funding should prioritise effective combinations of intervention components, that

improve AOD intervention effectiveness through use of coaching, peer-support and recovery orientation. This can be measured by participant engagement and long-term behaviour changes.

Recovery-oriented Research Themes. Missing from the current literature is a description of what actually happens in treatment. The CPRC coaching conversations in this study offered insights to specific CPRC practitioner and client interactions. Further research in Australia should include integration of building recovery capital resource assets. Use of the P3R, developed from this study, show merit in its aim to improve AOD intervention outcome/s. Therefore, further research is needed to validate the peer supported, recovery-oriented coaching hypothesis as it relates to long-term recovery, with a larger sample size, representative of the Australian target population.

Development of own Coach Competency and AOD-specific Knowledge. Development of coach competencies enhances ability to practice, engage and facilitate successful goal outcomes for clients (Reiss, 2015). In the case of this study, coaching competencies and delivery of the CPRC program is specific to meeting the needs of those presenting with SUD issues. As covered in Section 2.4.8 as Barrier 8: Lack of AOD-specific training is already faced by the Australian AOD workforce. Deane et al. (2010) revealed that almost half of the medical professionals in practice confess they lacked the skills needed to deal successfully with the complex issues faced by clients with AOD/SUD issues. Seventy five percent of medical professionals admitted they received no formalised training in identifying ways to be able to deal with and understand those with SUD (Deane, et al., 2010).

Coach Competency and Treatment Principles-centric Training for AOD Practitioners. It is recommended that clinicians and medical professionals, receive priority coach competency and treatment principle implementation training, on how to divert drug and alcohol patients to non-pharmacological approaches, such as peer-

supported coaching. As most general specialists, emergency professionals and allied health workers are not trained to deliver brief AOD intervention, they remain limited in their scope to encourage or recommend appropriate courses of action for those in vulnerable circumstances, experiencing addiction issues.

Uniform Implementation of Treatment Principles In AOD Practice. This study recognised coaching is an area in which there have been no clear, uniform practice guidelines. Through the identification of treatment principles used by the U.S. National Institute of Drug Abuse (2018), it is recommended that awareness amongst AOD practitioners who coach, regarding the complexity of alcohol and other drug challenges evident in the field of coaching psychology, should be raised. To prevent or combat further symptomologies of SUD, it is recommended that the Principle-centred Recovery Resource Register (P3R) developed from this study, be used as a case-management register, to audit cultivation of recovery capital resources. This audit and discussion of recovery assets should be delivered against a uniform set of treatment principles.

AOD Translational Research Collaboration. Future research may reap benefits from using the P3R in case management of clients in an alcohol and other drug practice setting. Use of the P3R will validate the recovery-oriented framework with larger sample size, if compared with treatment as usual. Having a follow-up period, a year later may also help in triangulating the results of whether recovery-orientation and peer recovery coaching affect long-term recovery outcomes. In addressing the need to identify coach-practitioner AOD skills, the National Framework for Recovery-Oriented Mental Health Services (Australian Health Ministers' Advisory Council, 2013) should be utilised, and further studies conducted to enable a global code of ethics in coaching psychology to be implemented Australia-wide. Thorough understanding of SUD challenges, along with the implementation of optimal coaching competencies, will serve and benefit clients accessing AOD services.

8.6 Conclusion

This chapter summarised how the CPRC program affected the recovery capital resources and goal attainment capabilities of participants wanting to sustain their recovery from alcohol and drug dependence. Research results (Chapter Five and Six) show that the use of the ARC scale helped the CPRC practitioner and the client, remain focused on recovery assets, needed for sustainable, life-affirming recovery. The CPRC program adhered to the Australian National Framework for Recovery-Oriented Mental Health Services framework and coaching model. The peer support received, along with the collaborative approach (or therapeutic alliance) and use of the CPRC dimensions for practice improved the lives of individuals, whose aim was recovery from SUD issues.

According to US national datasets, treatment of one chemical dependence becomes problematic, as addiction symptomologies are composed of a number of multi-faceted, deeply embedded complex issues (Abadinsky, 2018). Substance abuse has devastating effects on the cognitive, social, developmental, psychological, biological and neurological functions (Inaba & Cohen, 2014). Not without its limitations, the coach-client interactions on the phenomena of SUDs, along with its RCR and goal attainment score outcomes from this study, has been summarised below:

- Use of a recovery coaching model yielded promising improvements in participants' lives and supported attainment of client goals.
- Recovery Capital Resources (RCR's) captured the effects of internal and external long-term recovery indicators, as shown in instances of improvements, related to RCR scores.
- The collaborative approach and peer delivery of the CPRC program have been useful to the participants involved in this study, evidenced by promising, self-reported goal attainment scores and high number of instances of post-CPRC, RCR score improvements.

- Coach competence may be correlated to coach effect and goal attainment score. This requires further study and was not covered in this research. Ratings of actual coach competence scores should be investigated, to measure coach effect, with multiple practitioners and control group set up.
- AOD-specific training is needed. Coach competency and/or therapeutic principle-based practice delivery skillsets are the responsibility of the coach and/or clinical practitioner, to continuously develop.
- As documented in the video logs and transcripts of sessions, peer-practitioner knowledge of AOD issues, supported the clients' understanding of their own SUD issues.
- Use of video logs and transcriptions enhanced interpretation and remembrance of the context-rich data that formed the coaching interaction and discussions, which transpired during each CPRC session. These peer-driven datasets can be used for training and accreditation.
- Use of P3R can encourage collaboration and translational research, where recovery-oriented research findings that can contribute to successful client or patient outcomes, can be disseminated, adopted and implemented.
- Focus on lived experience and peer-expertise, can contribute to strategic organisational and practice-based development outcomes, for AOD service provides and practitioners.

It has been highlighted how the insights from this study can help understand AOD client perspectives, regarding their recovery journey. Recommendations and future studies finalised the conclusions in this chapter. As recommended, future longitudinal cohort studies, with a control group, can help explore the preliminary benefits of a peer-supported, recovery coaching intervention. Further understanding of the full effects of peer-supported, recovery-oriented coaching approach on clients' show promise. Hence, translational research, further AOD-specific training and collaboration with AOD professionals is needed. It is hoped that use of P3R would encourage recovery-orientation and integration of these RCRs in client's daily life.

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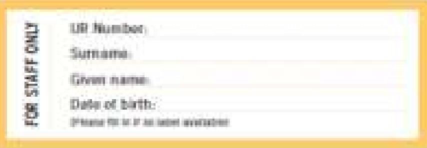
APPENDICES

Appendix A: Assessment of Recovery Capital Scale

OPTIONAL MODULE 8: ASSESSMENT OF RECOVERY CAPITAL


FOR STAFF ONLY
UR Number:
Surname:
Given name:
Date of birth:

1. SUBSTANCE USE & SOBRIETY	YES
I am currently completely sober	
I feel I am in control of my substance use	
I have had no 'near things' about relapsing	
I have had no recent periods of substance intoxication	
There are more important things to me in life than using substances	
TOTAL	/5

2. GLOBAL HEALTH (PSYCHOLOGICAL)	YES
I am able to concentrate when I need to	
I am coping with the stresses in my life	
I am happy with my appearance	
In general I am happy with my life	
What happens to me in the future mostly depends on me	
TOTAL	/5

3. GLOBAL HEALTH (PHYSICAL	YES
I cope well with everyday tasks	
I feel physically well enough to work	
I have enough energy to complete the tasks I set myself	
I have no problems getting around	
I sleep well most nights	
TOTAL	/5

Source: Dept of Health,VIC 2013.

4. CITIZENSHIP /COMMUNITY INVOLVEMENT	YES
I am proud of the community I live in and feel part of it – sense of belonging	
It is important for me to contribute to society and or be in involved in activities that contribute to my community	
It is important for me to do what I can to help other people	
It is important for me that I make a contribution to society	
My personal identity does not revolve around drug use or drinking	
TOTAL	/5

5. SOCIAL SUPPORT	YES
I am happy with my personal life	
I am satisfied with my involvement with my family	
I get lots of support from friends	
I get the emotional help and support I need from my family	
I have a special person that I can share my joys and sorrows with	
TOTAL	/5

6. MEANINGFUL ACTIVITIES	YES
I am actively involved in leisure and sport activities	
I am actively engaged in efforts to improve myself (training, education and/or self-awareness)	
I engage in activities that I find enjoyable and fulfilling	
I have access to opportunities for career development (job opportunities, volunteering or apprenticeships)	
I regard my life as challenging and fulfilling without the need for using drugs or alcohol	
TOTAL	/5

7. HOUSING AND SAFETY	YES
I am proud of my home	
I am free of threat or harm when I am at home	
I feel safe and protected where I live	
I feel that I am free to shape my own destiny	
My living space has helped to drive my recovery journey	
TOTAL	/5

Source: Dept of Health,VIC 2013.

8. RISK TAKING	YES
I am free from worries about money	
I have the personal resources I need to make decisions about my future	
I have the privacy I need	
I make sure I do nothing that hurts or damages other people	
I take full responsibility for my actions	
TOTAL	/5

9. COPING AND LIFE FUNCTIONING	YES
I am happy dealing with a range of professional people	
I do not let other people down	
I eat regularly and have a balanced diet	
I look after my health and wellbeing	
I meet all of my obligations promptly	
TOTAL	/5

10. RECOVERY EXPERIENCE	YES
Having a sense of purpose in life is important to my recovery journey	
I am making good progress on my recovery journey	
I engage in activities and events that support my recovery	
I have a network of people I can rely on to support my recovery	
When I think of the future I feel optimistic	
TOTAL	/5

Source: Dept of Health,VIC 2013.

Appendix B: Summary of Results: Recovery Capital Resources

Table 1: *RCR Results for Participant 1 Michael, 2 Angela and 3 Mala*

RCR	MICHAEL		ANGELA		MALA	
	Before	After	Before	After	Before	After
RCR 1 SOBRIETY	**0**	**4**	**2**	**5**	**0**	**5**
RCR 1.1	0	0	0	1	0	1
RCR 1.2	0	1	1	1	0	1
RCR 1.3	0	1	1	1	0	1
RCR 1.4	0	1	0	1	0	1
RCR 1.5	0	1	0	1	0	1
RCR 2 PSYC FUNCTIONING	**1**	**5**	**1**	**5**	**2**	**5**
RCR 2.1	0	1	0	1	1	1
RCR 2.2	0	1	0	1	0	1
RCR 2.3	0	1	0	1	0	1
RCR 2.4	0	1	1	1	1	1
RCR 2.5	1	1	0	1	0	1
RCR 3 PHYSICAL HEALTH	**2**	**5**	**4**	**5**	**2**	**5**
RCR 3.1	0	1	1	1	1	1
RCR 3.2	0	1	1	1	1	1
RCR 3.3	1	1	1	1	0	1
RCR 3.4	1	1	1	1	0	1
RCR 3.5	0	1	0	1	0	1

RCR	MICHAEL		ANGELA		MALA	
	Before	After	Before	After	Before	After
RCR 4 COMMUNITY	**1**	**5**	**5**	**5**	**1**	**5**
RCR 4.1	0	1	1	1	0	1
RCR 4.2	0	1	1	1	1	1
RCR 4.3	0	1	1	1	0	1
RCR 4.4	0	1	1	1	0	1
RCR 4.5	1	1	1	1	0	1
RCR 5 SOCIAL	**0**	**4**	**1**	**4**	**0**	**4**
RCR 5.1	0	1	1	1	0	1
RCR 5.2	0	1	0	1	0	1
RCR 5.3	0	1	0	1	0	1
RCR 5.4	0	1	0	1	0	1
RCR 5.5	0	0	0	0	0	0
RCR 6 MEANINGFUL ACTIVITIES	**1**	**4**	**2**	**5**	**3**	**5**
RCR 6.1	0	0	0	1	0	1
RCR 6.2	1	1	0	1	1	1
RCR 6.3	0	1	1	1	1	1
RCR 6.4	0	1	0	1	1	1
RCR 6.5	0	1	1	1	0	1
RCR 7 HOUSING and SAFETY	**0**	**5**	**2**	**5**	**0**	**5**
RCR 7.1	0	1	0	1	0	1
RCR 7.2	0	1	1	1	0	1

RCR	MICHAEL		ANGELA		MALA	
	Before	After	Before	After	Before	After
RCR 7.3	0	1	1	1	0	1
RCR 7.4	0	1	0	1	0	1
RCR 7.5	0	1	0	1	0	1
RCR 8 RISK TAKING	**1**	**4**	**2**	**5**	**2**	**5**
RCR 8.1	0	0	0	1	0	1
RCR 8.2	0	1	0	1	0	1
RCR 8.3	1	1	1	1	0	1
RCR 8.4	0	1	1	1	1	1
RCR 8.5	0	1	0	1	1	1
RCR 8.5	0	1	0	1	1	1
RCR 9 COPING AND LIFE FUNCTIONING	**0**	**1**	**3**	**5**	**3**	**5**
RCR 9.1	0	0	1	1	1	1
RCR 9.2	0	0	1	1	1	1
RCR 9.3	0	0	0	1	0	1
RCR 9.4	0	1	0	1	0	1
RCR 9.5	0	0	1	1	1	1
RCR 10 QUALITY OF RECOVERY	**1**	**5**	**4**	**5**	**1**	**5**
RCR 10.1	1	1	0	1	1	1
RCR 10.2	0	1	0	1	0	1
RCR 10.3	0	1	1	1	0	1
RCR 10.4	0	1	0	1	0	1

RCR	MICHAEL		ANGELA		MALA	
	Before	After	Before	After	Before	After
RCR 10.5	0	1	0	1	0	1
RCR 10.1	1	1	0	1	1	1
TOTAL SCORE	**7**	**42**	**23**	**49**	**14**	**49**

Notes.

1. Michael Age (59): 3 Category Scores — Red (8); Yellow (35); Green (7);
2. Angela Age (56):3 Category scores — Red (1); Yellow (26);Green (23);
3. Mala Age (44): 3 Category scores — Red (1); Yellow (35);Green (14);
4. Coaching Duration (month) — Michael (4); Angela (7); Mala (4)
5. Improved category, coded yellow — Pre-CPRC 'no' = 0; Post-CPRC 'yes' = 1
6. Did Not Improve category, coded red — Pre-CPRC 'no' = 0; Post-CPRC 'no' = 0
7. No Negative Change category, coded green — Pre-CPRC 'yes' = 1; Post-CPRC 'yes' = 1

Table 2: *RCR Results for Participant 4 Michelle, 5 Janet and 6 Sandra*

RCR	MICHELLE		JANET		SANDRA	
	Before	After	Before	After	Before	After
RCR 1 SOBRIETY	**0**	**3**	**0**	**3**	**1**	**3**
RCR 1.1	0	0	0	0	0	0
RCR 1.2	0	1	0	1	1	1
RCR 1.3	0	0	0	0	0	1
RCR 1.4	0	1	0	1	0	0
RCR 1.5	0	1	0	1	0	1
RCR 2 PSYCHOLOGICAL FUNCTIONING	**1**	**5**	**0**	**3**	**2**	**5**
RCR 2.1	0	1	0	0	0	1
RCR 2.2	0	1	0	1	0	1
RCR 2.3	0	1	0	0	0	1
RCR 2.4	0	1	0	1	1	1
RCR 2.5	1	1	0	1	1	1
RCR 3 PHYSICAL HEALTH	**1**	**5**	**1**	**4**	**2**	**5**
RCR 3.1	0	1	0	1	1	1
RCR 3.2	0	1	0	1	0	1
RCR 3.3	0	1	0	1	0	1
RCR 3.4	1	1	1	1	1	1
RCR 3.5	0	1	0	0	0	1

RCR	MICHELLE		JANET		SANDRA	
	Before	After	Before	After	Before	After
RCR 4 COMMUNITY	**1**	**5**	**1**	**5**	**3**	**5**
RCR 4.1	0	1	0	1	0	1
RCR 4.2	0	1	0	1	1	1
RCR 4.3	1	1	0	1	1	1
RCR 4.4	0	1	1	1	1	1
RCR 4.5	0	1	0	1	0	1
RCR 5 SOCIAL	**0**	**5**	**1**	**5**	**2**	**5**
RCR 5.1	0	1	0	1	1	1
RCR 5.2	0	1	0	1	0	1
RCR 5.3	0	1	0	1	0	1
RCR 5.4	0	1	0	1	0	1
RCR 5.5	0	1	1	1	1	1
RCR 6 MEANINGFUL ACTIVITIES	**0**	**3**	**1**	**4**	**1**	**5**
RCR 6.1	0	0	0	0	0	1
RCR 6.2	0	1	0	1	0	1
RCR 6.3	0	1	0	1	1	1
RCR 6.4	0	1	0	1	0	1
RCR 6.5	0	0	1	1	0	1

RCR	MICHELLE		JANET		SANDRA	
	Before	After	Before	After	Before	After
RCR 7 HOUSING and SAFETY	**0**	**2**	**0**	**4**	**3**	**5**
RCR 7.1	0	0	0	1	1	1
RCR 7.2	0	1	0	1	1	1
RCR 7.3	0	0	0	1	1	1
RCR 7.4	0	1	0	1	0	1
RCR 7.5	0	0	0	0	0	1
RCR 8 RISK TAKING	**2**	**4**	**0**	**4**	**2**	**5**
RCR 8.1	0	1	0	1	0	1
RCR 8.2	0	1	0	1	0	1
RCR 8.3	0	0	0	0	0	1
RCR 8.4	1	1	0	1	1	1
RCR 8.5	1	1	0	1	1	1
RCR 9 COPING and LIFE FUNCTIONING	**1**	**4**	**1**	**5**	**2**	**5**
RCR 9.1	0	1	0	1	1	1
RCR 9.2	1	1	0	1	0	1
RCR 9.3	0	1	0	1	0	1
RCR 9.4	0	1	0	1	0	1
RCR 9.5	0	0	1	1	1	1

RCR 10 QUALITY OF RECOVERY	**0**	**2**	**0**	**3**	**3**	**5**
RCR 10.1	0	1	0	1	1	1
RCR 10.2	0	0	0	1	0	1
RCR 10.3	0	0	0	0	1	1
RCR 10.4	0	0	0	0	0	1
RCR 10.5	0	1	0	1	1	1

RCR	**MICHELLE**		**JANET**		**SANDRA**	
	Before	After	Before	After	Before	After
TOTAL SCORE	**6**	**38**	**5**	**40**	**21**	**48**

Notes:

1. Michelle Age (33): 3 Category Scores — Red (12); Yellow (33); Green (6).
2. Janet Age (45): 3 Category Scores — Red (10); Yellow (35); Green (5).
3. Sandra Age (46): 3 Category Scores — Red (2); Yellow (27); Green (21).
4. Coaching Duration (month/s) — Lina (7); John (7); Karina (10)
5. Improved, coded yellow — Pre-CPRC ‘no’ = 0; Post-CPRC ‘yes’ = 1
6. Did Not Improve category, coded red — Pre-CPRC ‘no’ = 0; Post-CPRC ‘yes’ = 0
7. No Negative Change category, coded green — Pre-CPRC ‘no’ = 1; Post-CPRC ‘yes’ = 1

Table 3: *RCR Results for Participant 7 Lina, 8 John and 9 Karina*

RCR	LINA		JOHN		KARINA	
	Before	After	Before	After	Before	After
RCR 1 SOBRIETY	**2**	**5**	**4**	**5**	**1**	**3**
RCR 1.1	0	1	0	1	0	0
RCR 1.2	1	1	1	1	0	1
RCR 1.3	0	1	1	1	0	0
RCR 1.4	0	1	1	1	0	1
RCR 1.5	1	1	1	1	1	1
RCR 2 PSYCHOLOGICAL FUNCTIONING	**1**	**5**	**5**	**5**	**1**	**4**
RCR 2.1	1	1	1	1	0	0
RCR 2.2	0	1	1	1	0	1
RCR 2.3	0	1	1	1	0	1
RCR 2.4	0	1	1	1	1	1
RCR 2.5	0	1	1	1	0	1
RCR 3 PHYSICAL HEALTH	**2**	**4**	**4**	**5**	**0**	**3**
RCR 3.1	0	1	1	1	0	1
RCR 3.2	1	1	1	1	0	0
RCR 3.3	0	1	1	1	0	1
RCR 3.4	1	1	1	1	0	0
RCR 3.5	0	0	0	1	0	1

RCR	LINA		JOHN		KARINA	
	Before	After	Before	After	Before	After
RCR 4 COMMUNITY	**4**	**5**	**4**	**5**	**2**	**5**
RCR 4.1	1	1	0	1	0	1
RCR 4.2	1	1	1	1	0	1
RCR 4.3	1	1	1	1	1	1
RCR 4.4	1	1	1	1	1	1
RCR 4.5	0	1	1	1	0	1
RCR 5 SOCIAL	**0**	**3**	**1**	**5**	**1**	**4**
RCR 5.1	0	1	1	1	1	1
RCR 5.2	0	1	0	1	0	1
RCR 5.3	0	0	0	1	0	1
RCR 5.4	0	1	0	1	0	1
RCR 5.5	0	0	0	1	0	0
RCR 6 MEANINGFUL ACTIVITIES	**3**	**4**	**5**	**5**	**2**	**5**
RCR 6.1	0	0	1	1	0	1
RCR 6.2	0	1	1	1	0	1
RCR 6.3	1	1	1	1	1	1
RCR 6.4	1	1	1	1	0	1
RCR 6.5	1	1	1	1	1	1

RCR	LINA		JOHN		KARINA	
	Before	After	Before	After	Before	After
RCR 7 HOUSING and SAFETY	**1**	**5**	**2**	**5**	**2**	**5**
RCR 7.1	0	1	0	1	0	1
RCR 7.2	0	1	0	1	1	1
RCR 7.3	0	1	0	1	0	1
RCR 7.4	1	1	1	1	1	1
RCR 7.5	0	1	1	1	0	1
RCR 8 RISK TAKING	**2**	**5**	**2**	**5**	**2**	**3**
RCR 8.1	0	1	0	1	0	0
RCR 8.2	0	1	0	1	0	1
RCR 8.3	0	1	0	1	0	0
RCR 8.4	1	1	1	1	1	1
RCR 8.5	1	1	1	1	1	1
RCR 9 COPING and LIFE FUNCTIONING	**3**	**5**	**3**	**5**	**4**	**5**
RCR 9.1	1	1	0	1	1	1
RCR 9.2	1	1	1	1	1	1
RCR 9.3	0	1	0	1	1	1
RCR 9.4	0	1	1	1	1	1
RCR 9.5	1	1	1	1	0	1

RCR 10 QUALITY OF RECOVERY	2	5	3	5	3	5
RCR 10.1	0	1	1	1	1	1
RCR 10.2	1	1	1	1	1	1
RCR 10.3	0	1	0	1	0	1
RCR 10.4	0	1	0	1	0	1
RCR 10.5	1	1	1	1	1	1

RCR	**LINA**		**JOHN**		**KARINA**	
	Before	After	Before	After	Before	After
TOTAL SCORE	**20**	**46**	**33**	**50**	**18**	**42**

Source: Developed for this study

Notes:

1. Lina Age (34): 3 Category Scores — Red (4); Yellow (26); Green (20).
2. John Age (32): 3 Category Scores — Red (0); Yellow (17); Green (33).
3. Karina Age (48): 3 Category Scores — Red (8); Yellow (24); Green (18).
4. Coaching Duration (month/s) — Lina (7); John (5); Karina (8.5)
5. Improved category, coded yellow — Pre-CPRC 'no' = 0; Post-CPRC 'yes' = 1
6. Did Not Improve category, coded red — Pre-CPRC 'no' = 0; Post-CPRC 'yes' = 0
7. No Negative Change category, coded green — Pre-CPRC 'no' = 1; Post-CPRC 'yes' = 1

Table 4: *RCR Results for Participant 10 Betty, 11 Donna and 12 Melissa*

RCR	BETTY		DONNA		MELISSA	
	Before	After	Before	After	Before	After
RCR 1 SOBRIETY	**0**	**3**	**0**	**2**	**0**	**1**
RCR 1.1	0	0	0	0	0	0
RCR 1.2	0	1	0	0	0	1
RCR 1.3	0	0	0	0	0	0
RCR 1.4	0	1	0	1	0	0
RCR 1.5	0	1	0	1	0	0
RCR 2 PSYCHOLOGICAL FUNCTIONING	**0**	**3**	**1**	**3**	**2**	**5**
RCR 2.1	0	0	0	0	0	1
RCR 2.2	0	1	0	1	0	1
RCR 2.3	0	0	0	0	1	1
RCR 2.4	0	1	0	1	1	1
RCR 2.5	0	1	1	1	0	1
RCR 3 PHYSICAL HEALTH	**0**	**3**	**1**	**4**	**2**	**2**
RCR 3.1	0	1	0	1	1	1
RCR 3.2	0	1	0	0	0	0
RCR 3.3	0	1	0	1	1	1
RCR 3.4	0	0	1	1	0	0
RCR 3.5	0	0	0	1	0	0

RCR	BETTY		DONNA		MELISSA	
	Before	After	Before	After	Before	After
RCR 4 COMMUNITY	**0**	**3**	**2**	**5**	**2**	**2**
RCR 4.1	0	0	0	1	1	1
RCR 4.2	0	1	0	1	1	1
RCR 4.3	0	1	1	1	0	0
RCR 4.4	0	1	1	1	0	0
RCR 4.5	0	0	0	1	0	0
RCR 5 SOCIAL	**0**	**2**	**0**	**2**	**4**	**5**
RCR 5.1	0	1	0	1	1	1
RCR 5.2	0	0	0	1	0	1
RCR 5.3	0	0	0	0	1	1
RCR 5.4	0	0	0	0	1	1
RCR 5.5	0	1	0	0	1	1
RCR 6 MEANINGFUL ACTIVITIES	**1**	**4**	**2**	**5**	**1**	**3**
RCR 6.1	0	0	0	1	0	1
RCR 6.2	0	1	0	1	0	1
RCR 6.3	1	1	1	1	1	1
RCR 6.4	0	1	1	1	0	0
RCR 6.5	0	1	0	1	0	0

RCR	BETTY		DONNA		MELISSA	
	Before	After	Before	After	Before	After
RCR 7 HOUSING and SAFETY	**0**	**4**	**2**	**5**	**1**	**3**
RCR 7.1	0	0	1	1	0	0
RCR 7.2	0	1	0	1	0	1
RCR 7.3	0	1	0	1	0	0
RCR 7.4	0	1	1	1	1	1
RCR 7.5	0	1	0	1	0	1
RCR 8 RISK TAKING	**0**	**3**	**3**	**5**	**2**	**2**
RCR 8.1	0	0	0	1	1	1
RCR 8.2	0	1	0	1	1	1
RCR 8.3	0	0	1	1	0	0
RCR 8.4	0	1	1	1	0	0
RCR 8.5	0	1	1	1	0	0
RCR 9 COPING and LIFE FUNCTIONING	**0**	**3**	**2**	**5**	**0**	**2**
RCR 9.1	0	1	0	1	0	0
RCR 9.2	0	1	1	1	0	0
RCR 9.3	0	0	0	1	0	1
RCR 9.4	0	1	0	1	0	1
RCR 9.5	0	0	1	1	0	0

RCR 10 QUALITY OF RECOVERY	**1**	**3**	**1**	**5**	**1**	**2**
RCR 10.1	0	1	0	1	0	0
RCR 10.2	0	1	0	1	0	0
RCR 10.3	0	0	0	1	0	0
RCR 10.4	0	0	0	1	0	1
RCR 10.5	1	1	1	1	1	1
RCR	**BETTY**		**DONNA**		**MELISSA**	
	Before	After	Before	After	Before	After
TOTAL SCORE	**2**	**31**	**14**	**41**	**15**	**27**

Notes:

1. Betty Age (38): 3 Category Scores — Red (19); Yellow (26); Green (20).
2. Donna Age (45): 3 Category Scores — Red (9); Yellow (17); Green (33).
3. Melissa Age (17): 3 Category Scores — Red (23); Yellow (24); Green (18).
4. Coaching Duration (month/s) — Betty (10); Donna (5); Melissa (4.5)
5. Improved category, coded yellow — Pre-CPRC 'no' = 0; Post-CPRC 'yes' = 1
6. Did Not Improve category, coded red — Pre-CPRC 'no' = 0; Post-CPRC 'yes' = 0
7. No Negative Change category, coded green — Pre-CPRC 'no' = 1; Post-CPRC 'yes' = 1

Table 5: *RCR Results for Participant 13 Nancy, 14 Ayako and 15 Duong*

RCR	NANCY		AYAKO		DUONG	
	Before	After	Before	After	Before	After
RCR 1 SOBRIETY	**0**	**3**	**0**	**3**	**1**	**2**
RCR 1.1	0	0	0	0	0	0
RCR 1.2	0	1	0	1	0	0
RCR 1.3	0	0	0	0	0	0
RCR 1.4	0	1	0	1	0	1
RCR 1.5	0	1	0	1	1	1
RCR 2 PSYCHOLOGICAL FUNCTIONING	**3**	**5**	**4**	**5**	**3**	**5**
RCR 2.1	1	1	1	1	0	1
RCR 2.2	1	1	1	1	1	1
RCR 2.3	0	1	1	1	1	1
RCR 2.4	1	1	1	1	1	1
RCR 2.5	0	1	0	1	0	1
RCR 3 PHYSICAL HEALTH	**3**	**5**	**4**	**5**	**3**	**5**
RCR 3.1	1	1	1	1	0	1
RCR 3.2	1	1	1	1	1	1
RCR 3.3	0	1	1	1	1	1
RCR 3.4	1	1	1	1	1	1
RCR 3.5	0	1	0	1	0	1

RCR 4 COMMUNITY	**0**	**4**	**3**	**5**	**1**	**3**
RCR 4.1	0	1	0	1	0	0
RCR 4.2	0	1	1	1	0	0
RCR 4.3	0	1	1	1	0	1
RCR 4.4	0	0	1	1	1	1
RCR 4.5	0	1	0	1	0	1
RCR 5 SOCIAL	**1**	**2**	**0**	**5**	**2**	**5**
RCR 5.1	0	1	0	1	0	1
RCR 5.2	0	0	0	1	1	1
RCR 5.3	0	0	0	1	0	1
RCR 5.4	0	0	0	1	0	1
RCR 5.5	1	1	0	1	1	1
RCR 6 MEANINGFUL ACTIVITIES	**2**	**4**	**3**	**4**	**3**	**5**
RCR 6.1	0	1	0	0	0	1
RCR 6.2	0	0	1	1	1	1
RCR 6.3	1	1	1	1	1	1
RCR 6.4	1	1	1	1	1	1
RCR 6.5	0	1	0	1	0	1

RCR	NANCY		AYAKO		DUONG	
	Before	After	Before	After	Before	After
RCR 7 HOUSING and SAFETY	**2**	**4**	**2**	**5**	**1**	**4**
RCR 7.1	1	1	0	1	0	0
RCR 7.2	0	1	1	1	0	1
RCR 7.3	0	0	1	1	1	1
RCR 7.4	1	1	0	1	0	1
RCR 7.5	0	1	0	1	0	1
RCR 8 RISK TAKING	**4**	**5**	**5**	**5**	**3**	**3**
RCR 8.1	0	1	1	1	0	0
RCR 8.2	1	1	1	1	0	0
RCR 8.3	1	1	1	1	1	1
RCR 8.4	1	1	1	1	1	1
RCR 8.5	1	1	1	1	1	1
RCR 9 COPING and LIFE FUNCTIONING	**3**	**5**	**4**	**5**	**4**	**5**
RCR 9.1	1	1	1	1	0	1
RCR 9.2	1	1	1	1	1	1
RCR 9.3	0	1	1	1	1	1
RCR 9.4	0	1	0	1	1	1
RCR 9.5	1	1	1	1	1	1

RCR 10 QUALITY OF RECOVERY	**1**	**5**	**1**	**5**	**1**	**4**
RCR 10.1	1	1	1	1	0	1
RCR 10.2	0	1	0	1	0	1
RCR 10.3	0	1	0	1	0	1
RCR 10.4	0	1	0	1	0	0
RCR 10.5	0	1	0	1	1	1

RCR	**NANCY**		**AYAKO**		**DUONG**	
	Before	After	Before	After	Before	After
TOTAL SCORE	**17**	**42**	**24**	**47**	**22**	**41**

Source: Developed for this study

Notes:

1. Nancy Age (55): 3 Category Scores — Red (8); Yellow (25); Green (17).
2. Ayako Age (24): 3 Category Scores — Red (3); Yellow (23); Green (24).
3. Duong Age (28): 3 Category Scores — Red (9); Yellow (19); Green (22).
4. Coaching Duration (month/s) — Nancy (8); Ayako (3.5); Duong (7)
5. Improved category, coded yellow — Pre-CPRC 'no' = 0; Post-CPRC 'yes' = 1
6. Did Not Improvecategory, coded red — Pre-CPRC 'no' = 0; Post-CPRC 'yes' = 0
7. No Negative Change category, coded green — Pre-CPRC 'no' = 1; Post-CPRC 'yes' = 1

Table 6: *RCR Results for Participant 16 Rachel, 17 Patricia and 18 Cassie*

RCR	RACHEL		PATRICIA		CASSIE	
	Before	After	Before	After	Before	After
RCR 1 SOBRIETY	**0**	**5**	**0**	**3**	**0**	**1**
RCR 1.1	0	1	0	0	0	0
RCR 1.2	0	1	0	1	0	1
RCR 1.3	0	1	0	0	0	0
RCR 1.4	0	1	0	1	0	0
RCR 1.5	0	1	0	1	0	0
RCR 2 PSYCHOLOGICAL FUNCTIONING	**0**	**5**	**1**	**4**	**0**	**3**
RCR 2.1	0	1	0	0	0	0
RCR 2.2	0	1	0	1	0	1
RCR 2.3	0	1	0	1	0	0
RCR 2.4	0	1	1	1	0	1
RCR 2.5	0	1	0	1	0	1
RCR 3 PHYSICAL HEALTH	**2**	**5**	**2**	**3**	**0**	**3**
RCR 3.1	0	1	0	1	0	1
RCR 3.2	0	1	0	0	0	0
RCR 3.3	1	1	1	1	0	0
RCR 3.4	1	1	1	1	0	1
RCR 3.5	0	1	0	0	0	1

RCR 4 COMMUNITY	**0**	**5**	**0**	**3**	**0**	**0**
RCR 4.1	0	1	0	0	0	0
RCR 4.2	0	1	0	0	0	0
RCR 4.3	0	1	0	1	0	0
RCR 4.4	0	1	0	1	0	0
RCR 4.5	0	1	0	1	0	0
RCR 5 SOCIAL	**2**	**5**	**2**	**5**	**0**	**2**
RCR 5.1	0	1	0	1	0	0
RCR 5.2	0	1	0	1	0	1
RCR 5.3	0	1	1	1	0	0
RCR 5.4	1	1	1	1	0	1
RCR 5.5	1	1	0	1	0	0
RCR 6 MEANINGFUL ACTIVITIES	**0**	**4**	**3**	**5**	**0**	**3**
RCR 6.1	0	0	0	1	0	0
RCR 6.2	0	1	1	1	0	1
RCR 6.3	0	1	1	1	0	1
RCR 6.4	0	1	1	1	0	1
RCR 6.5	0	1	0	1	0	0

RCR	RACHEL		PATRICIA		CASSIE	
	Before	After	Before	After	Before	After
RCR 7 HOUSING and SAFETY	**1**	**5**	**1**	**5**	**1**	**4**
RCR 7.1	0	1	0	1	1	1
RCR 7.2	1	1	0	1	0	1
RCR 7.3	0	1	0	1	0	1
RCR 7.4	0	1	1	1	0	1
RCR 7.5	0	1	0	1	0	0
RCR 8 RISK TAKING	**3**	**5**	**3**	**3**	**3**	**3**
RCR 8.1	0	1	1	1	1	1
RCR 8.2	0	1	1	1	1	1
RCR 8.3	1	1	1	1	1	1
RCR 8.4	1	1	0	0	0	0
RCR 8.5	1	1	0	0	0	0
RCR 9 COPING and LIFE FUNCTIONING	**0**	**5**	**0**	**3**	**0**	**2**
RCR 9.1	0	1	0	1	0	1
RCR 9.	0	1	0	0	0	0
RCR 9.3	0	1	0	0	0	0
RCR 9.4	0	1	0	1	0	1
RCR 9.5	0	1	0	1	0	0

RCR 10 QUALITY OF RECOVERY	**0**	**5**	**0**	**3**	**1**	**2**
RCR 10.1	0	1	0	0	0	0
RCR 10.2	0	1	0	1	0	0
RCR 10.3:	0	1	0	1	0	1
RCR 10.4	0	1	0	0	0	0
RCR 10.5	0	1	0	1	1	1

RCR	**RACHEL**		**PATRICIA**		**CASSIE**	
	Before	After	Before	After	Before	After
TOTAL SCORE	**8**	**49**	**12**	**37**	**5**	**23**

Notes:

1. Rachel Age (29): 3 Category Scores — Red (1); Yellow (41); Green(8).
2. Patricia Age (21): 3 Category Scores — Red (13); Yellow (25); Green (12).
3. Cassie Age (43): 3 Category Scores — Red (27); Yellow (18); Green (5).
4. Coaching Duration (month/s) — Rachel (4); Patricia (4.5); Cassie (3)
5. Improved category, coded yellow — Pre-CPRC ‘no’ = 0; Post-CPRC ‘yes’ = 1
6. Did Not Improve category, coded red — Pre-CPRC ‘no’ = 0; Post-CPRC ‘yes’ = 0
7. No Negative Change category, coded green — Pre-CPRC ‘no’ = 1; Post-CPRC ‘yes’ = 1

Appendix C: Sample: P3R RCR1-10 and TP1-2

RECOVERY CAPITAL RESOURCES	TP1 NEURO: Effects on Brain Function (short/long-term), mechanics of neuroplasticity	Date/s discussed	TP2 UNIQUE: Match needs, dependent upon dosage, usage, symptoms, family and medical history, etc
RCR1 **SOBRIETY**	TP1		TP2
1 Sober 2 In control 3 Nearly used 4 Used Recently 5 Other things are important	RCR1		RCR1
RCR2 **PSYCH**	TP1		TP2
1 Concentrate 2 Cope w/ Stress 3 Happy w/ Appearance 4 Overall Happy 5 Future	RCR2		RCR2
RCR3 **PHYSICAL**	TP1		TP2
1 Daily Tasks 2 Physically Well 3 Have Energy 4 Can Get Around 5 Can Sleep	RCR3		RCR3
RCR4 **COMMUNITY**	TP1		TP2
1 Proud / Belongs 2 Contributes 3 Wants to Help Others 4 Does Help Others 5 Identity established, without use	RCR4		RCR4

RCR5 SOCIAL	TP1		TP2
1 Personal 2 Family 3 Circle of Friends 4 Family - Emotional Needs 5 Intimacy	RCR5		RCR5
RCR6 ACTIVITIES	TP1		TP2
1 Exercise 2 PD / Education 3 Fun Activities 4 Career 5 Abstinent	RCR6		RCR6
RCR7 SAFETY/HOME	TP1		TP2
1 Proud 2 No Threat 3 Safe at Home 4 Can Shape Destiny 5 Conducive to recovery	RCR7		RCR7
R8 RISKS	TP1		TP2
1 No $ Worries 2 Have Resources 3 Has Privacy 4 No Damage 5 Responsible	RCR8		RCR8
R9 COPING	TP1		TP2
1 Deal with Professionals 2 Has Integrity 3 Nutrition 4 Wellbeing 5 Meet Obligation	RCR9		RCR9
R10 QUALITY	TP1		TP2
1 Purpose 2 Progress 3 Activities 4 Has 'Clean' Network 5 Optimistic @ Future	RCR10		RCR10

Appendix D: Agreement and Client Consent Form

Coaching Agreement with Client

Dated: ________________________

Between:

…………………………………………………………………………………
………………………………
(Coach – Name, Address, Postcode and Contact No)

…………………………………………………………………………………
………………………………
(Email address, Phone and Mobile)

…………………………………………………………………………………
………………………………
(Client – Name, Address, Postcode and Contact No)

…………………………………………………………………………………
………………………………
(Email address, Phone and Mobile)

Recital:
I agree to provide 'You' personal coaching services to facilitate your achievement of specific and agreed goals ("Coaching") through a series of regular conversations or meetings with You ("sessions") on the terms and conditions below. I agree that our coaching sessions will be video recorded without showing client identity and may be used for training, research and/or supervision purposes.

Agreement:
You and I agree to be bound by the Terms and Conditions of Coaching attached and the details relating to 'You' personally, and the Coaching and the Sessions specified below.

Period of Coaching is the elapsed time to complete a series of ____________________ Sessions ("Period")

Commencement date for Coaching:

Total Fee for 12 Sessions: (fee) (plus GST) = $
("Fee")

Payment Arrangement: …………………………………………………………

Coach's full name and signature:………………………………………………...
Signature

Client's full name and signature:………………………………………………...
Signature

Terms and Conditions of Client Coaching
(Attachment to coaching agreement)

Sessions – A Session may be carries out over the phone or in person at mutually agreed places and times during the Period.

Duration of Sessions – A Session will take place each week for approximately 1 hour per week throughout the Period or at such other times as is agreed during the Period. You must be on time for all Sessions, whether these take place using the phone or in person.

Session Times – Times for Coaching Sessions may only be changed by you if you give me no less than 24 hours' notice. If you cancel more than 3 Sessions during the Period then I may terminate this Agreement on notice to you (and the provisions below relating to termination shall apply). A Coaching Session may be deemed to have taken place if less than 24 hours' notice is given. If I cancel a Session then the Session will be rescheduled at an agreed time.

Use of video logs and coaching session information – as specified prior to recording of videos, you agree to be recorded and for the recordings to be used for client development, research and/or training purposes, as long as the identity of the client is never revealed.

Payment for Coaching – Payment for Coaching shall be by way of cheque, direct debit, credit card or cash prior to coaching session booked.

Preparation for Sessions – You must perform all actions forming part of the Coaching Sessions and also carry out any act matter or thing in preparation for future Sessions as determined by me. You must advise me as soon as you become aware that these actions will not or cannot be performed. If you refuse to carry out such actions then this agreement shall be terminable by me (and the provisions below relating to termination shall apply).

Coaching Methods – You acknowledge that the Coaching Sessions may be personally, emotionally and physically challenging and that there may be occasions on which you will feel emotional challenges –including frustration, annoyance or stress. You must make all efforts and schedule all Sessions at such times to ensure your peak physical, mental and emotional state and condition necessary for the conduct of the Session and shall (if necessary) take all steps to cancel any Session in the event of mental, physical or emotional stress or distress (or other ailment or condition) caused either directly or indirectly in relation to the Coaching Sessions. You shall indemnify me in the event of any such claim.

No Warranties Given – I make no representation or warranty to you that any of the Coaching methods or the Sessions will work for your particular circumstances. You will not hold me responsible for the failure (in whole or part) to achieve any of your goals.

Intellectual Property Rights – You have no right to use or reproduce any of the processes, techniques, presentations, methodologies, precedents and materials used by me in the Coaching activities ("Materials"). You must not at any time use or reproduce the Materials in any manner, shape or form (except for your own personal use) and shall ensure than none of your servants, agents or any related bodies corporate use or reproduce the Materials in any manner, shape or form. You shall indemnify and keep me indemnified in respect of any loss or damage caused or sustained by me in the event of your breach of this paragraph.

Confidential Material – As part of the Coaching I may need to obtain your personal details or confidential material relating to you personally. I shall use reasonable endeavors to ensure that such material shall not be disclosed to any third party without your consent.

Coach is Independent Contractor – You acknowledge that I have been engaged by you solely as an independent contractor. I act at all times as an independent contractor and have no authority to bind or represent any other party in any way. You shall not hold any party liable for any act matter or thing done or to be done by me in the course of the Coaching or the Sessions.

Termination of Agreement – I may terminate this Agreement before the end of the Period on written notice to you if:

i. you fail to perform or observe any of the terms of this Agreement and fail to remedy such breach within 5 business days of notice from me to remedy that failure;

ii. you fail to perform any term of this Agreement which is incapable of remedy;

iii. an insolvency event occurs in relation to you (for instance, you become bankrupt or some arrangement or court order is made or proposed in relation to all or any of your assets); or

iv. any cheque drawn or endorsed by you for the purposes of this Agreement has been dishonoured and you fail to honour such cheque within 5 working days of a notice from me to honour the said cheque.

Procedure on Termination – If the agreement is validly terminated prior to the end of the Period then you must immediately pay me the balance (if any) of the fee for the unexpired period of Coaching, together with any other monies owed by you under this agreement. Upon termination I shall immediately cease to be liable to you in respect of the Coaching and the Sessions.

Interest for late payment of monies – If you fail to pay the amounts owing under procedure on termination then you shall in addition pay me interest at a rate of 10% per annum of all monies outstanding, calculated on and from the date on which the monies were due to me. Such monies together with interest owing shall be a debt due from you to me.