# NARRATIVE STUDY OF HOW NON-QUALIFIED VOLUNTEERS AND EX-DRUG USERS MAKE THE TRANSITION TO PAID EMPLOYMENT IN THE SUBSTANCE MISUSE FIELD

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**Abstract**

This thesis explores how non-qualified ex-user and carer drug workers have made the transition from alcohol and drug use to paid employment in the substance misuse field. The key aims of the research were to:

- explore issues that affect the transition experiences of ex-users, carers, peer mentors, students, and paid workers;
- examine influencing factors that determine ex-users' and carers' decisions to disclose or not their background to colleagues and service users at different stages of their transition;
- explore how ex-users perceive their identity, or feel themselves to be perceived, within the context of the substance misuse field;
- understand how non-qualified, ex-user or carer drug workers make the transition from service user to paid employee in the substance misuse field, in order to facilitate greater understanding of their experiences in becoming and developing as drug practitioners; and
- make recommendations regarding training, employment, and staff development for my own organisation; to enhance my own practice; and to influence wider policy and practice principles.

Most ex-user narratives already available 'end' at the point where treatment ends leaving much to be discovered regarding what happens next. Understanding the next stage of transition journeys will be valuable in enhancing recovery and treatment outcomes; and determining how best to recruit, induct, train, supervise and support ex-user drug workers in gaining paid employment within the substance misuse field. As a practitioner-researcher I adopted a narrative approach to gain insight into substance misuse practitioners' experiences, perceptions and attitudes. Participants were recruited through a service user-designed questionnaire and 11 non-qualified ex-users/carers identified themselves as willing to participate in narrative interviews to share their journey of becoming practitioners (consent forms were used and identifying information anonymised through pseudonyms). I used process-mapping to develop participant-structured narratives, so that each participant 'plotted' key events along their journey (chronologically) while telling their story. I asked questions to clarify and gain insight into their self-identified significant events over two interviews, each lasting 1-2 hours. From these narratives and process-maps, I identified and analysed three orientations: transition, disclosure and professional identity.

Key transition findings included the influence of key-workers in encouraging clients to become drug workers; difficulties, barriers, expectations and opportunities; and motivation to become drug workers (for example, 'giving something back', status and remuneration). The findings suggest that participants based disclosure decisions on previous experiences, that is, positive responses were more likely to result in future disclosures; there was limited (if any) guidance available to volunteers and staff; and disclosure was viewed as an individual, selective decision. In terms of professional identity, the findings highlighted different perceptions of what it meant to be a professional; the role boundaries, qualifications and status play in determining professional identity; and tensions between 'textbook' and 'ex-user' drug workers. A number of recommendations were identified, focusing on how ex-drug users can be better trained and supported in making the transition to substance misuse practitioner. The recommendations not only consider factors such as education and volunteering but, more specifically, how to utilise disclosure effectively and safely; inter-professional working; ex-user and carer motivation; and personal and professional boundaries.

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## Chapter 1 Introduction

### Background

This study seeks to explore how people with life experience of substance use make the transition to paid employment in the drug and alcohol field. This is directly relevant to my role as training coordinator as I am responsible for delivering training courses (including the nationally accredited Level 3 Award in Tackling Substance Misuse) to people working or volunteering in the drug and alcohol field. Such people include those from an ex-user or carer background as well as practitioners who may already have other qualifications or experiences. I am aware from my previous roles as a substance misuse practitioner and team manager that numerous service users and ex-service users express an interest in becoming drug workers following treatment. For many ex-users the route into employment involves a combination of treatment, volunteering and education.

Over many years of being involved in the substance misuse field, I have worked with numerous clients, volunteers and colleagues at various stages of their transition journey. I have supported clients to initiate this transition process; established peer mentoring programmes to enable 'stable' clients to take their first steps towards volunteering; trained/supervised ex-user and other volunteers; and employed and promoted ex-users within drug teams. These experiences have whetted my appetite to find out more about what is involved for these individuals and to discover what might facilitate this process more effectively.

Whilst it may appear that such transitions are relatively smooth and a 'natural' progression, I am conscious that there is often more to this process than first meets the eye. I therefore feel that the journey ex-users go through to establish themselves as substance misuse practitioners is worthy of investigation. Indeed, not all ex-users who set out to become drug

workers 'make it' – some get stuck at the volunteering stage, unable to obtain paid employment in their desired career; some obtain employment within a related field but not directly in the substance misuse field; some relapse and return to substance use and/or treatment; and others make the transition successfully but then find it difficult to gain promotion. All the participants in this study did 'make it' (albeit to differing degrees and over widely varying timescales) but all described difficulties and barriers, opportunities and successes along the way, detailing complex routes into and through volunteering, education and employment.

Throughout my career I have heard polarised views about the 'type' of person who makes the 'best' drug worker; some say ex-users have the most relevant experience while others suggest only professionally qualified people should be employed in paid roles. There remains insufficient evidence to support either claim. When I reviewed research literature from related fields, I found a few studies that explored notions of user involvement and lived experience (for example, Fox 2011, Gosling 2010, Lakeman 2010, Lindow & Rooke-Matthews 1998), but none investigated actual transition journeys that non-qualified volunteers or ex-service users make to become practitioners. This reflects a lack of awareness of who these individuals are; how they became practitioners; and how they see themselves, that is, do they identify themselves as 'ex-users' or as 'drug practitioners', and how do they feel they are perceived by others within the substance misuse and related fields? Given the number of questions this raises, it is worth exploring the notion of whether or not there is such a thing as a typical drug worker or typical transition route into employment within the substance misuse field.

While there are several studies relating to how people become qualified professionals in a variety of sectors, for example, teaching (Connolly & Clandinin 1999, Felstead et al. 2010, McCulloch et al. 2000) and nursing (Barton 2007, Kelly 1991), I found little research

exploring the transition ex-users make to become drug workers. Where there are studies relating to ex-substance users' stories (for example, Addenbrooke 2011; Hurwitz et al. 2007; Jason et al. 2008; Sinisi 2009) these tended to focus on the earlier stages of recovery, meaning their narratives often ended at the point where treatment ended, or they explored the transition from drug user to volunteer but not from volunteer to drug worker, leaving much to discover about 'what happened next'. This highlights a significant gap in the available literature as without access to later transition narratives, how are ex-users to know what to expect once active treatment has ended; and how are services to support this process?

Since the most recent National Drug Strategy was published in 2010, notions of recovery have been at the forefront of substance misuse services' policies, practices and targets (DH 2010), with many agencies now employing 'recovery champions' in either paid or voluntary capacities (Best & Laudet 2012). However, there remains limited understanding about exactly what factors facilitate this recovery process (Best & Laudet 2012) even though practitioners and researchers continue to advocate the development of recovery capital that is "idiosyncratic and personal" (Best & Laudet 2012, p6). It has been suggested that stable employment and accommodation are key components of sustained recovery for many ex-users (McIntosh & McKegeney 2001, 2002, White & Cloud 2008). When it comes to ex-user employment within the substance misuse field itself, there is little evidence or guidance about how to increase the likelihood of successful transition (Adfam 2012).

Best et al.'s (2008) study of 107 ex-heroin users (which included many ex-user drug workers in the sample) offered evidence to suggest that the factors enabling individuals to become drug-free are often different from the factors that help maintain abstinence. Because of this distinction, it becomes important that both narratives of achieving abstinence and narratives of sustained abstinence are made available. Best et al. (2008) suggested that

"workers in the field who are open about their previous experiences constitute a research resource that has not been tapped adequately" (p624). Certainly, there is a tradition of interest in drug user narratives and a history of involving drug users in research, but this study builds on these notions to involve ex rather than current substance users, and therefore complements the literature already available. This study's participants are all ex-users or carers who have made the transition to volunteering and/or working in the substance misuse or another closely related field. By listening to, and learning from, the narratives of their experience, I hope to add to the evidence-base of what works and what does not work when recruiting, training, supporting, supervising and promoting ex-user drug workers.

When reviewing literature within the substance misuse field (for example, through the Drug Reference Library, National Treatment Agency for Substance Misuse (NTA) and Department of Health websites), I have not been able to discover any information about the number or percentage of ex-user drug workers who work in drug and alcohol services. Nor, was I able to identify a breakdown of how many nurses, social workers, counsellors, volunteers, and so on, make up the substance misuse sector's workforce. It would appear that such statistics are not gathered. Clearly, given the wide range of routes it is possible to take into the drug field; that there is no 'set' qualification to be eligible for employment; and the diversity of service settings across the statutory and voluntary sectors, gathering such statistics would be challenging. In addition, many ex-user drug workers do not disclose their background so they would in any case be invisible within such quantitative research. Also, many individuals could fall into more than one category (for example, it is possible for someone to have the dual-status of qualified counsellor and ex-drug user). Therefore, 'number-crunching' the different 'types' of drug worker becomes a side issue, but the stories of such ex-user drug workers who share their experiences of achieving and sustaining recovery become essential if we are to understand transition processes, disclosure decisions and professional identity issues.

Without insight into how ex-users make and sustain the transition from drug user to drug worker, we cannot fully understand these practitioners' training, development and support needs. There are significant gaps in the evidence-base not only regarding such opportunities for new and existing substance misuse practitioners, but also the theoretical base regarding identity development and disclosure within the context of health and social care employment. For example, much available literature relates to personal rather than professional identity development (for example, Erikson 1980, Giddens 1991, McAdams 1988, McAdams & Janis 2004) while disclosure theories often refer to disclosure within social contexts rather than professional disclosure between colleagues and/or clients in the workplace (for example, Berg 1987, Chaudoir & Fisher 2010, Derlega et al. 1993, Jourard 1971).

**Research Aims**

The aims of this research were initially developed through reviewing the available literature, analysing the initial data, and reflexive questioning. This generated emergent themes relating to what influences participants' decisions to attempt the transition from substance user or carer to drug worker. These emergent themes subsequently resulted in some potential key aims for analysis: exploring issues that affect their experience as ex-users, carers, peer mentors, volunteers, students and paid workers; examining influencing factors that determine ex-users' and carers' decisions to disclose or not their background to colleagues and service users at different stages of their transition; and exploring how ex-users perceive their identity, or feel themselves to be perceived, within the context of the substance misuse field.

However, I felt that as a practitioner-researcher, I needed to bring my own experience of working and delivering training in the substance misuse field to the study and to consider the issues from a range of perspectives. The aims, therefore, were refined as follows:

- To understand how non-qualified, ex-user or carer drug workers make the transition from service user to paid employee in the substance misuse field in order to facilitate greater understanding of their experiences in becoming and developing as drug practitioners.
- To make recommendations regarding training, employment and staff development for my own organisation, to enhance my own practice and to influence wider policy and practice principles.

The key intended outcome of the above aims is that the experiences of ex-users/carers making this transition will be enhanced as a result of the improved understanding and more effective policies and practice. In order to achieve this, the following objectives were identified that would assist the research process:

- To review literature relating to user involvement, training and employment within the substance misuse field;
- To gain an understanding of ex-Level 3 substance misuse students' experiences before, during and following their completion of this course, including how these experiences influence their identity (self and perceived); and
- To examine the transition that non-qualified drug workers and volunteers (including ex-users) make in order to/attempt to gain paid employment in the substance misuse field.

I had initially become involved in delivering the Level 3 substance misuse qualification in an evening class while working full-time as team manager of a structured day programme for current and ex-substance misusers. I had been keen to take on this role because when I had recruited staff to the day programme, I had often interviewed candidates who had the

potential to become effective practitioners but who, on paper at least, did not have the necessary credentials in terms of relevant qualifications and experience. I felt that enabling individuals with an interest in substance misuse work to access related training would not only enhance individual employment prospects but contribute to strengthening the workforce as a whole. This concurred with the national strategies at the time, with the National Treatment Agency for Substance Misuse (NTA) introducing the concept of Drug and Alcohol National Occupational Standards (DANOS) in an attempt to professionalise the workforce (Skills for Health, 2003). I was therefore keen to explore how such qualifications as the Level 3 substance misuse course impacted on the employment experiences of drug and alcohol workers, for example, do qualifications: affect the likelihood of gaining employment; enhance skills once in post; and/or increase opportunities for promotion?

Even in the early stages of the research, it was clear that there was more to the transition process than volunteering and education. Factors affecting decision-making, disclosure and identity were also of interest especially as there appeared to be a wide variety of views and experiences among different individuals at varying stages of the transition journey with many overlapping factors between disclosure, transition and professional identity.

It also transpired that the more I reflected on the aims of the study and initial data analysis, the more questions arose, for example, whether ex-users' decision to attempt the transition was related (or not) to a motivation to 'give something back' or to consolidate their own treatment outcomes (at least in earlier stages of their transition journey). How disclosure decisions are reached by substance misuse workers (individually or where a service developed a 'norm' of either disclosure or non-disclosure) was questioned time and again by participants resulting in yet more questions about how ex-users might feel about such decisions. I also hoped this study would provide greater insight into how ex-service users reflected on their transition; how they perceived themselves in light of their current roles;

and how they felt they were perceived by colleagues and clients within the context of their working lives.

This study will contribute to the substance misuse field's understanding of what makes a 'good drug worker' so that relevant support and training can be offered. At a local level, I will make recommendations to influence my own practice and the practice of my colleagues, and to enhance the experience of future substance misuse students. At a national level I hope policy decision-makers will consider the implications for recruiting and managing ex-user volunteers and paid workers more effectively within the substance misuse field. Previously under-researched principles and practices will be investigated, as they specifically relate to substance misuse practitioners, for example, disclosure decision-making; identity development and perception; the meaning of what it is to be a professional in the substance misuse field; and the stages an ex-user may go through to become a drug worker (including how recovery is sustained and employment achieved in the later stages).

**Structure of the Thesis**

This thesis is presented in six chapters. A literature review has been included in this thesis, however, I felt it more appropriate to incorporate a review of the relevant literature into each chapter rather than having a separate literature review chapter. This suits the hermeneutic approach I have adopted in the analysis of the findings, interweaving the different parts with the whole so that the literature interweaves with the component parts of the thesis; the methodological approach adopted; the findings and discussion of each orientation; and the conclusions reached. While it may be more conventional to present a separate chapter for the literature review (Ridley 2008), I feel that this hermeneutic perspective offers an effective rationale for incorporating citations throughout the discussion chapters (Ridley 2008) so that they appear and can be reflected on alongside the

participants' voices. Wolcott (1990) also suggested that it may be inappropriate to "lump (dump?) it [literature review] all into a chapter that remains unconnected to the rest of the study" (p17). Furthermore, guidance offered by Crossley (2000) suggested that in narrative analysis it is more desirable to establish "connections between ... analytic findings and the debates and issues ongoing within the narrative psychological literature" (p105). It could, after all, be considered that existing literature are pre-understandings (see page 25) that I and others bring to the interpretation of participants' data.

In this chapter, I have set out the aims of the research and the contribution it will potentially make to the substance misuse field, stating how my prior experience influenced the research process and questions to be investigated. I have also outlined the context in which I work as a substance misuse practitioner, trainer and researcher. In chapter 2, the methodology and underpinning philosophical standpoints are explored with the way in which the data was generated and analysed through hermeneutic principles, co-construction and reflexivity discussed in terms of its emergent nature.

Chapters 3, 4 and 5 present the three orientations which emerged from the data analysis: transition, disclosure and professional identity. Each of these orientation chapters is structured in 2 parts with the participant findings – Adam, Debbie, Elizabeth, Harry, Jamie, Kieran, Luke, Michael, Nicola, Phil and Richard - presented first, followed by discussion of the participants' narratives in cognisance of the relevant literature relating to the participants' narratives. These chapters are longer than might usually be expected in a PhD thesis because narrative methodology elicits thematic complexities and depth in the participants' own words.

In chapter 6, the conclusions reached as a result of reflecting on the findings are presented including how the aforementioned orientations interlink. I also offer recommendations for my own and others future practice, policy development and areas for further research.

## Chapter 2 Methodology

### Introduction

This chapter explores the methodology of the study; philosophical principles underpinning the approach adopted; methodological decisions and practical approaches utilised; and why these were chosen. In other words, I will 'tell' the narrative of the research in a not dissimilar way to the narratives told by participants in this study. I will explain the methods used and how they enabled the meeting of the project aims; ensured high ethical standards; and operated within wider hermeneutic and constructionist frameworks. In presenting the rationale for these decisions, I will outline the link between theory and practice and demonstrate elements of the trustworthiness of the findings and their interpretation.

At the start of this study, I proposed that the research would seek: to understand the experiences of non-qualified drug workers and volunteers in their journey to become and develop as drug practitioners; enable me to make recommendations regarding training, employment and staff development for my own organisation; enhance my own practice; and influence wider policy and practice principles. Having previous experience of undertaking research with a service user steering group and of working within the substance misuse field, I was keen to explore the aims in a way that enabled participants to tell their own stories of how they became and developed as drug workers. I felt such an approach would give the greatest insight from ex-user drug workers' perspectives to inform my own and others practices. In the early stages of the research project, I attempted to identify what methodological approaches would be most suited to enable the voices of ex-user drug workers to be heard. Because I was interested in the *personal experiences* of individual ex-users rather than statistics relating to the number or 'type' of ex-users who become drug workers, it was clear to me that a qualitative study would produce the richest data and provide the greatest level of insight. This is because qualitative research often focuses on

interpretation and examines complex events to create meaning within their wider context (Chase 2005). In addition, qualitative approaches are well placed to examine research processes and findings from the perspective of the people being studied rather than from the starting point of the researcher (influenced by previous literature) as might be expected in more positivist and other theoretically driven approaches (for example Rice & Ezzy 1999).

Of the range of qualitative approaches available, I almost immediately 'discovered' the use of narrative within the context of research studies. I was drawn to a narrative approach because it allows the researcher (and participants and readers) to identify and reflect on the meanings associated with people's experience rather than so-called 'factual events' (Polkinghorne 2007). It was the meaning the participants attached to their transition to become drug workers that I was more interested in rather than chronological facts and figures.

I therefore identified and reflected on a number of aspects of narrative that I considered as strengths. Firstly, narrative offers flexibility, that is, there are a range of ways to think about and analyse narratives (Phoenix et al. 2010) which enables the reader to find alternative meanings and develop new perspectives (Goodley et al. 2004). This means it is not just my interpretation as the researcher that matters, but also the interpretation and/or re-interpretation of the narrators as they tell and/or reflect on their stories; and the interpretation of any other readers of the study. I feel the opportunity for reflexivity and personal interpretation creates empowerment and identity development through the interactive nature of the narrative process. Elliott (2005) also suggested that:

> "The strength of a more qualitative narrative approach to research is therefore not just that it gives a voice to those with marginalized identities…, but that it allows for a specific focus on the construction and maintenance of those identities" (p178).

Andrews et al. (2004), building on the work of Mishler (1986) and Bruner (1990), proposed that "[i]n performing narratives we can create new possibilities for identities and actions" (p116). I envisaged that utilising a narrative approach would create opportunities for the participants to develop a sense of self-identity through sharing their transition story (Rice & Ezzy 1999). Because many ex-user drug workers have prior experience of telling stories about their substance use but less of talking about becoming a drug worker, being involved in this research may allow the participants to combine the disparate parts of their life to create a whole narrative and new meaning. This indicates a further strength of narrative approaches in that by telling stories, participants are able to draw together their life events (Kleinman 1988) and enable people to make connections between them through reflexivity. It could be considered that human beings are story-tellers by nature (Lieblich et al. 1998) so using narrative interviews is "consistent with how most people make sense of their identity and their experiences" (Rice & Ezzy 1999, p131).

It is notable that narratives are composed within their given context to tell us about the group to which individuals belong as well as the narrator themselves. This is because narratives develop through the interaction between the teller, those with whom they share their stories and the context in which they live (Riessman 2008, Phoenix et al. 2010), while the analysis of such stories is simultaneously effective in "preserving the individuality of stories" (Hinckley 2008, p73). This does not mean I can take one person's story and assume their experience can automatically be transferred to others, but it does mean that I can, through analysis and reflexivity, develop insight into the narrator's world.

A further strength of narrative is that "stories are more persuasive than reasons" (Polletta 2012, p238), that is, if a person simply states a held belief, this is likely to be less convincing than if the person tells the story of how they developed that viewpoint. However, this can also be a weakness of narratives as it may be possible to persuade

another to accept a weak reason with a 'good' story (Frank 2010). It is important to acknowledge other weaknesses of qualitative research, with those of a positivist standpoint suggesting the data generated and subsequent findings are subjective; reliant on memory "which is selective" (Robson 2011, p374); and with recollections altered by how "the biographer perceives these experiences today" (Rosenthal 1993, p65). As I am interested in how individuals make sense of their experiences over-and-above the actual experiences themselves, I feel subjective outcomes to be as relevant, if not more relevant, than objective 'facts' and support the view that narratives have an evaluative or subjective dimension that fits within hermeneutic traditions (Elliott 2005). I agree that memory is selective – we choose the stories we tell based on the things we remember; how we think others will respond to our disclosures; past experiences that put us in a particular light both for ourselves and for those with whom we interact; and the meaning we attach to these events. People remember the things that were most pertinent, life-changing, or that resonate with us in light of our current situation. It is equally true that how we remember past events is influenced by what has happened to us since. Individuals adopt a particular lens through which they view their past lives and experiences (Gubrium 1993). Husserl suggested that it is possible to 'bracket' our own experiences from those of others so that we can adopt an objective position (Bauman 1978). Others, including Heidegger and Gadamer disagree, instead believing, as I do, that it is impossible to separate our pre-understandings from our current experiences and anticipated futures (Gadamer, 1975, Bauman 1978). Rather, our experiences and those of others fuse to create new experiences and meanings for both parties. This is important because it is through such interaction that individuals develop alternative identities and understand how they relate to others.

I anticipated that a narrative approach would enable participants to reflect on the meaning behind 'the facts' and add to their own interpretations and understanding. Therefore, participants would be drawn into the research, making their experience and narratives

more vivid (Riessman 1990) and stimulate further reflection. Narrative is therefore about more than a record of events occurring over a period of time. Narratives enable narrators, listeners and researchers to draw connections and to identify what is important and unimportant, what is applicable to others in a similar situation and what is not; attribute motives and emotions; and make meaning as well as represent the individual's reality (Gabriel 2004).

Sparkes and Smith (2008) draw on many scholars as well as their own research to summarise what they consider to be the strengths of narrative, for example: the use of narrative in social action; helping people make sense of their lives; enabling people to understand each other; allowing people to question previous understandings; being effective in social and individual transformations; facilitating recall; provoking ethical reflection; helping people to organise their experiences; jointly constructing selves and identities within a wider context; offering a source of self-continuity; enabling researchers to become storytellers so they experience and write about their study in a different way; creating effective social and personal change; seeing things from another's perspective; making connections across different viewpoints and exploring social inequalities. It is an extensive list.

As well as appreciating the evidence-base of the effectiveness of narrative, I had previous experience of narrative in the context of substance misuse services where service users were encouraged to tell their story of substance use, treatment and recovery. Furthermore, story-telling has a long history in the drug field whether through clients answering practitioners' questions in assessment interviews or their involvement in mutual aid groups. In other words, I was familiar with narrative as a means of assessing client need and as a therapeutic intervention but not as a means of generating research data. By identifying narrative as a research approach, I was able to bring together both my worlds – research and substance

misuse. Because of how early in the process I had chosen narrative as the research approach, when it came to writing the thesis, I struggled to recall what had come first – the aims or my interest in narrative? Reading back through my research journal, I found the aims had been identified first but, on reflection, I consider my existing interest in and experience of narrative influenced my choice of research questions. This is supported by Brewer and Hunter's (1989) view that "the selection of methods is more likely to reflect researchers' different conceptions of what constitutes a *good* piece of research is more likely to be evoked by those styles that resonate with one's own methodological predilections" (p26, emphasis in the original).

Having embarked on the research process, the study questions evolved through interaction with the participants, reflective practice and initial analysis, to create further issues for consideration, namely: factors influencing ex-users' decision to attempt this transition; issues affecting their experience as ex-user, peer mentor, student and paid worker; decisions to disclose, or not, their background to colleagues and clients; and perceptions of identity within the context of substance misuse services. In developing this study, I have also been influenced (in terms of approaches to narrative research) by a number of key texts, most significantly Lieblich et al. (1998), Carlander et al. (2011), Gubrium (1993), and Riessman (1990, 1993, 2008).

Rather naively, I had assumed in the early stages of this research that I could simply 'give voice' to the participants by presenting their stories holistically and embarked on a literature search of narrative studies as I thought this would guide me in this endeavour. Initially, many authors suggested that 'giving voice' was not only possible (for example, Andrews et al. 2004 p121, Coffey & Atkinson 1996, p78; Gergen 1999, p97; McAdams 2001, p114;) but that it is a "central, if not *the* central, concern underlying narrative studies" (Ewick & Riley 1995, p199). However, the presentation of these voices is in fact

their *re-presentation* because they have been interpreted in the process. As Riessman (1993) described it: "We cannot give voice, but we do hear voices that we can record and interpret" (p8).

Through further literature searching in relation to methodological approaches and modes of interpretation, I discovered the world of co-construction (for example, Riessman 2008; Speedy 2008; Squire 2008) and hermeneutics (for example, Fleming et al. 2003; Gadamer 1975, 1976; Koch 1999; Warnke 1987), realising as I reflected on seminal works that people do not have "prefabricated stories" (Rosenthal 1993, p65) already written in their heads just waiting to be told. Rather, these stories emerge through interaction with others, resulting in a form of co-construction or co-production (Presser 2008) to "create their stories within the social process of mutual orientation according to their definition of the interview situation" (Rosenthal 1993, p64). For example, the stories people tell about their substance use will depend on who is present in a mutual aid meeting or the rapport between a client and practitioner in an assessment interview. In this study, the transcripts generated through interviews are not solely the creations of the participants themselves, but were co-created through the interaction between the researcher and participants (Polkinghorne 2007). The stories told, and my interpretation of them, were further determined by hermeneutics, that is, individual segments of the participants' narratives were influenced by the context of their whole lives and vice versa, while the pre-understandings that both I and the participants brought to the interview influenced what stories they told; how they told them; and how I responded to and interpreted them. It became apparent that many stories can be told with "no 'single' truth, but rather a multiplicity of truths" (Webster & Mertova 2007, p92) and "no single 'correct' interpretation" (Janesick 2000, p393).

Individuals attach different meaning to stories depending on the context of the telling and the hearer of the teller's tale creating a fusion of meaning-making of both participants and researcher based on pre-understandings and how we relate the parts of the narratives to the whole story. Other readers of the narratives may later add their own layer of interpretation as the pre-understandings they bring and the context of their reading provide another opportunity for meaning-making. The process of analysis in the context of hermeneutics is never-ending (Fleming et al. 2003).

**Hermeneutics and Interpretation**

Hermeneutics has been defined as: "the nature and means of interpreting a text" (Schwandt 2001, p112) and a way of "bringing to understanding" (Palmer 1969, p13) while Widdershoven (1993) suggested, from a broader perspective, that, "[f]rom a hermeneutic point of view, human life is a process of narrative interpretation" (p2). As a result, hermeneutics are not only considered useful when analysing data (Robson 2011) but is a means of interpreting, understanding and determining the course of our lives as a whole and a "personal, partial, and dynamic" process (Lieblich et al. 1998, p10). McLeod (1997) takes this further to define interpretation as an approach that provides:

> "alternative meanings, or new frameworks for feelings, behaviours, or personality. It may establish connections between seemingly isolated statements or events; interpret defences, feelings, resistance, or transference; or indicate themes, patterns or causal relationships in behaviour and personality, relating present events to past events" (p113).

Hermeneutic principles are therefore central to all interpretation, linking the parts to the whole in a circular motion (Kelly 2006). As a result, understanding always requires interpretation, and meaning-making only occurs through the fusion of interpretation and the 'object' under study (Warnke 1987). Although Gadamer did not set out to "provide a method for interpretation" (Koch 1996, p176) when he developed his ideas in relation to

hermeneutics, Kincheloe and McLaren (2005) suggested researchers can use a hermeneutic circle as a methodology to "engage in the back-and-forth of studying parts in relation to the whole and the whole in relation to parts...[to] produce profound insights that lead to transformative action" (p312). Based on this description, it is possible to consider hermeneutics' role in creating narratives through narrators' interaction with listeners, and by narratives being analysed through similar interactions. In this way both parties make sense of the story-telling process with the resultant personal, multi-layered meaning created through the narrative being valued for its unique perspective (Paley 1998).

Whilst there is significant overlap between the principles of phenomenology and hermeneutics, the two are not the same (Fleming et al. 2002), but have resulted in what Heidegger referred to as "hermeneutic phenomenology" (Palmer 1969, p125). Heidegger advocated the hermeneutic circle whereby people bring their pre-understandings to new experiences and are transparent in how these fuse together to form a mutual experience for both parties, that is, "a "fusion of horizons," an integration of differing perspectives in a deeper understanding of the matters in question" (Warnke 1987, p170). Heidegger stated that, "[i]nstead of bracketing and setting aside such biases, an attempt is made to explain them and to integrate them into the research findings" (Robson 2011, p151). This approach is also advocated by Koch (1996) who suggested that,

> "Stories are told by self-interpreting patients, who have brought to them their pre-understandings. At the same time, I bring my pre-understandings and prejudices to the research process. No attempt is made to disguise them. My own mode of thought is something that cannot be eliminated or bracketed, I participate in making data" (p178).

Heidegger demonstrated how pre-understandings merge with current understanding to create new understandings. While pre-understanding, or prejudice as it is often referred to, usually has negative connotations, Heidegger and Gadamer suggested that it is possible

to "prevent this from developing into a vicious circle" (Alvesson & Sköldberg 2000, p84) by constantly moving backwards and forwards between our own world and that of another person. Through reflexivity, it is possible to "successfully come to an understanding of the unfamiliar reference system, something which also leads to the gradual revising and/or enriching of our own: there is a fusion of horizons'" (Alvesson & Sköldberg 2000, p84). Therefore, the hermeneutic circle brings together prior and current understandings as well as the different perspectives of the listener and teller, making these central to interpretative processes. Gadamer (1975) suggested that, "to acquire a horizon of interpretation requires a fusion of horizons" (p398). In other words, interpretation cannot happen without the bringing together of pre-understandings of both listener and teller.

Gadamer further developed Heidegger's thinking through the use of a complementary perspective (Alvesson & Sköldberg 2000, Crist & Tanner 2003) by fusing pre-understandings with new experiences as well as moving from the whole of the story to its component parts (Crotty 1998). The researcher is firmly placed within the hermeneutic circle (Koch 1996) to bring their pre-understandings to the current experience while also recognising the pre-understandings participants bring to their narrative. Koch and Harrington (1998) suggested the hermeneutic circle is "a metaphor for describing the movement between the part and the whole" (p887) while Schwandt (2001) proposed that "coming to understand the meaning of the whole of the text and coming to understand its parts were always interdependent activities" (p112).

In this study, narratives were created through the interaction of the participants with the researcher and analysed through the interaction of the researcher with the transcripts and process-maps, the latter of which guided the narratives (see pp44-49). The use of process-maps within this context digresses from narrative's usual oral tradition, offering an alternative way of structuring the stories, guiding the chronological order of events and

perhaps altering the narratives and their interpretation in the process. As a result of the story's co-construction, the narrative, and indeed the individual's life, can be transformed, while the researcher gains deeper insight into the world of the participant. Further interpretation occurs when readers of the researcher's 'findings' interact with the aforementioned co-constructed narratives, meaning that analysis is never finalised because "everything is and always will be open to reinterpretation" (Zuckert 1996, p95). This means a transformation can occur beyond that of the individual narrator's life, that is, the understanding of the 'audience' is altered through their reinterpretations.

Koch (1996) suggested an overlap between "fusion of horizons" (Gadamer 1975, p398) and co-construction whereby the data must be considered in its context and through the merging of participant's and researcher's perspectives. Such co-construction can only be achieved through reflexivity and through the active involvement and interpretation of both participants and researcher. In order to fully understand how this contributes to data analysis and enhances the study's credibility, Koch (1996) recommended the use of a reflective diary throughout the research; a piece of advice I followed (see appendix I). Through reflective practice, I endeavoured to be transparent about how my role as the researcher and the pre-understandings I brought to the interviews, data collection and analysis have fused with the experiences and narratives of my participants (Koch 1994, p985). Koch (1996) also suggested that understanding could be developed through another fusion of horizons, that is, the merging of "data sources" (p181) so that journal reflections, prior experience, participant narratives, and the literature review could interweave to create further opportunities for interpretation and insight.

In addition, participants' pre-understandings fused with their current experiences as drug workers and as research participants/narrators to influence the stories told during the study (see also Gubrium 1993). It has been suggested that, because hermeneutics is central to

how we narrate our lives, the stories themselves are interpretations (Abma 1999) and that in the telling we alter our lives (Widdershoven 1993). This is partly because "life informs and is formed by stories" (Widdershoven 1993, p2) but also because "the meaning of life cannot be determined outside of the stories told about it" (Widdershoven 1993, p2). However, as a researcher, I am re-telling the participants' narratives rather than telling my own story and it could be considered that through interpretation I am separating my voice from the participants' voice (Chase 2005) because I may have different interpretations from that of the participants themselves. Similarly, readers of this thesis (who may identify with the participants' stories) could have alternative interpretations (Chase 2005). The risk of allowing other people to interpret one's personal narrative is that if the interpretation does not concur with the narrator's own interpretation, "the individual's own understanding of their experience is inevitably compromised" (Smyth & Murray 2000, p321, quoted in Elliott 2005, p141). Yet, in narrative analysis terms at least, this is the role of the researcher – to systematically interpret other people's interpretations (Riessman 1990, 1993).

**Narrative and Identity Construction**

Narratives are constructed during interviews, that is, co-constructed between the narrator and listener through their interaction – "in the constructionist view, as the word suggests, meaning is not discovered but constructed" (Crotty 1998, p42). Similarly, our experiences are constructed within the wider context of our lives while also being unique to each individual through perception and meaning-making so "meanings are constructed by human beings as they engage with the world they are interpreting" (Crotty 1998, p43). In epistemological terms, this is referred to as constructionism and constructivism (Crotty 1998). Gergen (1999) suggested some authors use the terms interchangeably while others (for example, Crotty 1998, Sparkes and Smith 2008) emphasised the differences between

them. I recognise differences between constructivism and constructionism, but also acknowledge their overlaps.

According to Crotty (1998), constructionism (also known as social constructionism) considers the collective generation of meaning within the cultural or social context while constructivism refers to the unique meaning-making of individuals. Constructionism suggests that the context of our lives determines who we are. We create a collective identity that shapes our lives within a given context, which in turn, shapes our stories. This implies that it is possible to generalise one person's experience to that of others. Crotty (1998) described constructionism as being:

> "the view that *all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context*" (p42, italics in the original).

Constructionism emphasises the influence of culture on one's actions because it shapes the way in which we see things and gives us a particular lens through which we see the world (Crotty 1998). However, it must be acknowledged that although our culture influences experience, each individual attaches their own meaning to how they interact with the world in which they live. Constructivism, on the other hand, is focused on the "inner world" (Sparkes & Smith 2008, p297) and suggests each person's experience is unique because the meaning each person attaches to their life events and interactions with others is different from everyone else's. This implies that it is not possible to generalise from one person's experience to others (even if that experience may resonate with others in similar situations (Carlander et al. 2011)) and suggests each person's way of making sense of the world is as valid and worthy of respect as any other, so that no one can criticise or dispute another's experience or telling of their experience. Sparkes and Smith (2008) described

constructivism as an internal, personal process involving the stories people tell about themselves to develop their identity so that the emphasis is on "personal experience and the active engagement of the individual person in the process of self-construction" (p297). Where my understanding of constructivism deviates from some authors (for example McAdams) is with the suggestion that the story "is there all along, inside the mind" (McAdams 1993, p20, quoted in Sparkes & Smith 2008, p298). This goes against hermeneutic principles of a "fusion of horizons", but also contradicts McAdams' own assertion that identities are "psychosocial constructions" (McAdams 1993, p12, quoted in Sparkes & Smith 2008, p298). I interpret the "psycho" component as being "in the mind" but the "social" implies a move towards a "relational, sociocultural phenomenon" (Sparkes & Smith 2008, p298). For me, identities cannot be formed *only* as an internal phenomenon, but must include some element of external interaction.

While there are such distinctions between constructionism and constructivism, links clearly exist, meaning that while each individual does have a unique story to tell (constructivism) based on their individual experience and psychology, they cannot escape the context in which their life has developed (constructionism). This means both constructionism and constructivism have relevance for how people develop and tell their narratives, resulting in a model where individual experience remains but allows the context to influence rather than determine unique meaning-making. This means constructivism does not negate the influence of the social (constructionism) in developing stories and identities but sees narratives as essential for making meaning explicit (Sparkes & Smith 2008). Narratives are rarely monologues without an audience; they are told to people, through interaction and within a given context. Therefore, while a person may develop an inner sense of self (constructivism), they also have an interactive, narrative self (constructionism). In this research I will use the term constructionism because of its more interactive nature and how the narratives were developed in this study.

Because of the interactive nature of narrative development and the fact that identity formation is not constituted in an exclusively internal way, it is likely that there will be common themes that resonate with others experience. Kirk and Miller (1986) note that some social scientists consider that every individual will have an "alternative interpretation of everything" (p15), meaning that participants' accounts within qualitative research "cannot be reconciled with anyone else's" (p15). However, I believe it is possible to resolve the tension between constructionism's individuality and the desire to use this study's findings to offer meaningful recommendations for other ex-users and service providers because this study provides "sufficient descriptive data to make such similarity judgments possible" (Lincoln & Guba 1985, p298) and demonstrates "an adequate level of detail" (Seale 1999, p108) to enable the reader to reach their own conclusions. This means that, while the participants' narratives and the meanings they attach to their transition journeys remain unique, the existence of common themes and interpersonal understanding facilitate the transferability of experience (Lewis & Ritchie 2003), further supporting the development of recommendations. This position is further endorsed by the view that:

> "Reality is always viewed through particular perspectives; hence our accounts *represent* reality they do *not* reproduce it" (Hammersely 1992 pp50-51, quoted in Silverman 2001).

The narratives told in this study were co-constructed "by the researched and the researcher" (Goodley et al. 2004, p155) and told in the way they have because of the context in which they took place. For example, had the participants been asked to plot their transition journey by a colleague or client within the context of their work or volunteering role, or by their partner or other family member in their home-life, rather than by their ex-tutor as part of a research study, the narratives may have been constructed and told differently. The fact that participants had the opportunity to reflect on their process-maps and return for a

second interview to add to, or revise, what they had shared in their first, meant further re-construction was possible based on the participants' own interpretation.

Furthermore, the role of the researcher is crucial in the construction process. McLeod (1997), in his study of narrative and psychotherapy, suggested that the therapist's role cannot be neutral as the story told is co-constructed between them and the client. Such principles apply equally to the role of researcher when working with participants to enable them to tell their story. I cannot be 'neutral' but I can be transparent about the pre-understandings I bring to the research process and the stance I adopted when introducing the study, generating the data, reading the transcripts and analysing the findings. For example, when reading the transcripts, I was aware of identifying themes that "jump out" (Riessman 1993, p57) because of my pre-existing interest in certain topics such as disclosure. This means that I was drawn to elements of the narratives relating to such issues and this informed the focus of my reflections.

**Narrative research**

In exploring the literature in relation to narrative (for example, Elliott 2005, Gubrium 1993, Holstein & Gubrium 2012; Lieblich et al. 1998; Riessman 1990, 1993, 2008), I also became aware of little consensus regarding narrative principles and methods with a range of approaches being deemed to be narrative (Elliott 2005). Some authors suggested there is "no single narrative analytical method" (Phoenix et al. 2010, p3) and others consider it as a "family of approaches" (Robson 2011), rather than one specific methodology or type of analysis (Robson 2011, p374). Furthermore, many authors use 'story' and 'narrative' interchangeably (for example, Riessman 2008) while others suggested that although it was hard to separate the two terms, they are distinct entities. Sparkes and Smith (2008), for example, suggested that stories are the "actual tales people tell" (p311) while narrative:

> "comprises various particular stories and...has, for example, a plot - a sequence of events that is temporally ordered – characters, a consequence, a point, intentionality, and a teleological quality or a valued ending" (p311).

This study's participants were not only asked to tell how they made the transition from substance user to drug worker, but to simultaneously 'plot' their journey using a 'process-map' (see pp44-49 & appendix H) to structure their transition story and represent their "plot-over-time" (Speedy 2008, p6). These stories were, therefore, recorded in a sequence of events, meaning their stories became narratives. While not all stories are narratives, all narratives are told as stories. Robson (2011) suggested that "a distinction is made by some researchers between narrative as an account by an individual of their own experience and story-telling as its retelling by others" (p374), the suggestion being that the original 'first-person' telling by participants is a narrative while the researcher's 'third-person' re-telling and/or interpretation is a story. In presenting the findings, the first-person accounts, in the participants' own words, are alongside my interpretations, resulting in a combination of narrative *and* story. For the purposes of this research I will therefore, like Riessman (2008), use 'narrative' and 'story' interchangeably.

Just as 'story' and 'narrative' are often used interchangeably, so, too, are the terms 'narrative research' and 'narrative inquiry'. Narrative research "incorporates biographical, autobiographical, life history and oral history approaches" (Robson 2011, p374). While it was not my intention to study the participants' entire life histories, I was interested in exploring a particular period of their lives, namely, the time between being a substance user and becoming a paid worker in the drug field.

Alternative definitions of narrative inquiry include, "the production, interpretation and representation of storied accounts of lived experience" (Shacklock & Thorp 2005, p156). This definition gained relevance to this study when I realised, through reflecting on the

narrative process, that the stories did not pre-exist in the form they were told before the interview – they were *produced* during and as a result of the interview. Furthermore, the stories were open to *interpretation* – not only in terms of how I interpreted them but how the participants themselves interpreted their narratives as they reflected on what they shared. Finally, the stories were a *representation* of their transition rather than the only narrative available, that is, their stories offered not only a representation of the facts of the participants' transitions, but also included the meanings participants attached to these events. This makes the data generated richer and more relevant to how individuals make sense of their lives, rather than a simple chronological list of events. Furthermore, the participants interpreted their narrative as they told their story, revising it, offering alternative examples and perspectives. As Riessman (1993) said, "[n]ature and the world do not tell stories, individuals do. Interpretation is inevitable because narratives are representations" (p2).

The above view is supported by another definition of narrative inquiry as "the making of meaning through personal experience by way of a process of reflection in which storytelling is a key element" (Connelly & Clandinin (1988), quoted in Cortezzi 1993, p17). Thus, it is the meaning attached to storied events that take precedence over the 'facts' of what happened. The meaning is affected by the sequence in which events happen so narrative becomes a useful tool for making sense of "the temporal ordering of events that are associated with change of some kind" (Hyden 1997, p50). Narrative inquiry would therefore seem the optimum methodological choice in studying the changes ex-users go through when making the transition to drug worker. Because narratives are chronological, meaningful and social (Elliott 2005), they are effective in representing patterns over a period of time; offering the interpretation of the participants themselves; and social in their construction, that is, the story-teller tailors their narrative to suit the actual or potential audience.

Subjectivity is a recognised element of stories (Lieblich et al. 1998). Humans think in terms of their own experiences and what these mean to them rather than thinking in objective terms. This is perhaps one reason why no ex-user drug worker can ever have the exact same experience of drug use as their clients, but subjectivity also allows a person to try and look at things from another's perspective – empathy. Subjectivity is also why a person might describe the same event in their life but do so in a different way, with a different focus depending on the context of the telling. We choose the stories we tell, how we tell them and to whom.

The fusing of narratives with interpretative stories is supported by hermeneutic principles. Elliott (2005) offered a clear link between hermeneutics and narrative through the following definition:

> "a narrative can be understood to organize a sequence of events into a whole so that the significance of each event can be understood through its relation to the whole. In this way a narrative conveys the meaning of events" (p3).

The part each event plays in giving meaning to the participants' whole transition narrative and vice versa can be made plain through analysis of narrative reflection. Thus, if I had hoped at an early stage in the research to find a textbook that would offer a 'how-to guide' to tell me how to carry out a narrative analysis of my data, I was to be disappointed. There was no recipe to follow (Phoenix et al. 2010) because, as I soon discovered, there was no "standard set of procedures for actually carrying out narrative analysis" (Robson 2011, p375). Elliot (2005) was emphatic on why it was impossible to have a standard approach to carry out narrative inquiry:

> "if we focus on research lying broadly within the hermeneutic or interpretive tradition, which emphasizes the evaluative dimension of narrative evidence, the idea that narrative analysis might represent a set of procedures becomes problematic. Interpretive analysis demands that we understand how the subjects of our research

> make sense of events and experiences and requires dense, detailed, and contextualized description" (p37).

However, the lack of a 'recipe' did not give me carte-blanche to make the steps up as I went along. As Gubrium and Holstein (1998) stated, when it comes to narrative or interpretive analysis, it is not the case that "anything goes" (p173). Suggestions included holistic analysis (analysing the narrative as a whole) and thematic or sequential analysis (breaking the narrative into segments in order to identify themes) (Robson 2011). With hermeneutic principles underpinning this study, it became clear that a combination of both holistic and thematic analysis would have roles in exploring patterns within the context of the whole narrative.

The best guide I identified to assist me in the research study's narrative, was Lieblich et al. (1998) who offered a simple definition of narrative research as being: "any study that uses or analyzes narrative material" (p2), and identified "four modes of reading a narrative" (p13), namely, holistic-content, holistic-form, categorical-content, and categorical-form. The authors described holistic-content as focusing on the content of whole stories; holistic-form as focusing on the plot or structure of whole stories; categorical-content as being similar to content analysis; and categorical form as focusing on linguistic characteristics (Lieblich et al. 1998). Having reflected on these approaches in light of underpinning hermeneutic principles, I rejected using categorical-content as too quantitative, and categorical-form as too semantic. I was not interested in number-crunching how many times a participant made a particular comment, being more concerned with the meaning they attached to the point they were making or the emphasis they placed on it. Similarly, I was not concerned with the specific wording used, more the content and implications underpinning this. As a result, I turned my focus to holistic-content and holistic-form. I found holistic-content reading to be especially useful because this approach "analyzes the meaning of the part in light of

content that emerges from the rest of the narrative or in the context of the story in its entirety" (Lieblich et al. 1998, p13). For me, this offered an ideal approach to implement hermeneutic principles. Although I retained my main focus on holistic-content reading, holistic-form approaches had relevance as I was interested in "the plots and structure of complete life stories" (Lieblich et al. 1998, p13) or, at least, the life story as it relates to the transition from drug user to drug worker as this highlights key events and turning points.

Carlander et al.'s (2011) study of "self-image close to death" utilised Lieblich et al.'s (1998) holistic-content reading approach to narrative analysis, meaning I could use it as an exemplar for carrying out my own data generation and analysis. This study resonated with me because it considered how individual events relate to the whole of the participants' lives (past, present and future); there was no pre-prepared interview-schedule so the narrative interviews were participant-led; participants were encouraged to reflect on their involvement in the interview, allowing them to make sense of their experiences; the participants' stories were considered to be unique while also acknowledging patterns or themes emerging from the data; and each participant's story was represented as an ensemble, that is, the story was read under the heading of their name rather than separated into excerpts under the heading of given themes.

**Sample**

I utilised purposive sampling for this study because this approach enabled me to identify "participants who share a particular trait or experience that is of interest to the researcher" (Hinckley 2008, p77). I was interested in identifying ex-user and carer drug workers from among ex-students who had completed the Level 3 substance misuse course in Greater Manchester. As the participants were already familiar with me, as their ex-tutor, I anticipated that pre-existing trust and rapport would facilitate greater openness in the narrative process.

While I could have simply approached ex-students I knew to have a background of substance use in person or by telephone, I chose to send questionnaires (see appendix A) and letters (see appendix B) to their postal address as the initial contact (see also Nettleton et al. 2005). This was because I was concerned that if I approached individual ex-students directly they might have felt obliged to take part or would have insufficient time to fully consider their decision to be involved. By approaching them indirectly, if they decided against being involved, they could simply not return the questionnaire without having to tell me this in person or give a reason for declining the invitation. Also, if a participant had not disclosed their past substance use while on the course, I would not have known to approach them and, without the questionnaires, they might not have identified themselves as being willing to be involved.

The questionnaires (which were part of a separate but linked study) were designed by a service user steering group (Wilson 2006) and sent to all ex-substance misuse students who had consented to have their contact details on the training team's database. Fifty-three people returned completed questionnaires, of which eleven were eligible and willing to be involved in the narrative interviews. The response of eleven consenting people fits the sample size norm for narrative studies of between six and twelve (Paley 2005). Discussion with my supervisory team at Manchester Metropolitan University confirmed the appropriateness of this sample size as it provides sufficiently rich data to meet the needs of qualitative studies, while also being a manageable sample size given this is an educational project being undertaken on a part-time basis within a set timeframe.

Ten participants described themselves as ex-substance users and one self-identified as a carer of poly-substance users (ex-partner and brother). Eight were male and three female. Of the ex-substance users, five described themselves as having been poly-substance users, three heroin, one alcohol and one amphetamine. The ex-students had completed the Level

3 substance misuse course between 2004 and 2009 and so represented a number of student cohorts (there having been at least two intakes each year). Because of the range of cohorts from which the sample was taken, their anonymity was enhanced. In addition, all participants' names, places of residence/work or other identifying features were altered.

**Ethics**

The Ethics Committee of the British Psychological Society (2009) defined ethics as: "the science of morals or rules of behaviour" (p6). Such rules apply to research as much as to other interventions offered in physical and mental health services. It is, therefore, essential that all research is carried out ethically and in line with national guidelines (DH 2005). At the most basic level, researchers are responsible for the "[i]dentification of appropriate informed consent procedures and willingness to deal with ethical issues as they present themselves" (Janesick 2000, p385). The main ethical concerns in relation to qualitative studies are managing power differentials, confidentiality, informed consent, the right to withdraw consent, and ensuring no harm is done to participants (Braun & Clarke 2013). In aiming for high ethical standards, I adopted an approach suggested by Goodley et al. (2004) that, "[g]ood research (in an ethical and collaborative sense) involves negotiating these concerns and allowing collaboration and participation to shape the project" (p155). Therefore, a prime consideration was to conduct the research *with participants* rather than *on subjects*. Denzin (2005) argued that, "collaborative methodologies" (p936), including narrative studies, contribute to ethical research practice because of their participatory, reflexive and subjective approach. This study's participants were 'co-researchers' as they set the interview agenda and presented their narrative journey through process-mapping in a way that "best captures the social setting yet will not compromise or harm any members in the study" (Janesick 2000, p385).

All research in the NHS is reviewed independently by a Research Ethics Committee, to protect the interests of participants. This study was granted ethical approval by North West 7 Research Ethics Committee in March 2010. It was also reviewed favourably by Greater Manchester West Mental Health NHS Foundation Trust's Research and Development Group and Manchester Metropolitan University's Independent Reviewer for the Faculty of Health, Psychology and Social Care Ethics Committee (see appendices C, D and E).

It could be considered that as a researcher I am in a more powerful position than the participants, just as when in the role of course tutor, I am in a more powerful position than the students. I therefore made the decision that the sample would be made up exclusively of ex rather than current students, even if the latter met the criteria of being ex-substance users. This meant I avoided participants feeling pressured into being involved because they might fear repercussions if they either decided against participating in the study, or if they said something during their interview they thought I might not agree with or find critical. Even though I knew I would not take their decision or comments into consideration when assessing their work, the students may have had concerns. It was highly likely, after all, that they might discuss their experience of being a student on the substance misuse course as part of their transition journey. Also, by having a time lapse between completing the course and being a participant, ex-students had the opportunity to consider how their qualification had facilitated, or not, their career progression since completing the course; and this information could contribute to their narrative.

Another way in which I attempted to shift the balance of power in favour of participants was to enable them to set the agenda, that is, they were asked to 'plot out' their transition journey from substance user to drug worker on a process-map and were told I would only ask questions about topics they raised in this exercise. I emphasised that they should only

put topics on the process-map they felt comfortable discussing with me. This approach initially caused some difficulties when seeking ethical approval. The ethics committee, understandably, wanted to know what questions I was going to ask and the lack of a pre-prepared interview schedule caused them some anxiety. I was determined to have a participant-led study and to retain the process-mapping approach, but to satisfy the ethics committee I offered suggested examples of the types of questions and topics I anticipated arising from the interviews. Many of these examples did in fact come up. Similar concerns have arisen for other narrative researchers, for example, Clandinin and Connolly (2000) suggested the "process of obtaining ethical approval…places narrative inquirers in a catch-22 position...[because] some aspects of the inquiry are no longer able to be negotiated" (p170).

Having an interview schedule, I felt, would have disempowered participants as it would have been me setting the agenda and deciding on their behalf what I felt was important to discuss, and yet I can also see from the ethics committee's perspective, that the lack of a schedule meant they had no assurance that I would ask appropriate questions; catch-22, indeed. Having resolved this dilemma satisfactorily through offering examples of anticipated topics, such as, barriers and difficulties experienced along their transition journey; pivotal stages/turning points; decision-making; availability of opportunities; and the role of significant others, I then considered how best to assure participants' confidentiality.

Confidentiality is a core ethical requirement (Braun & Clarke 2013) for conducting any research project. Ethical and legal practices were followed throughout the study and all information about participants handled in confidence. This meant all data gathered from the questionnaires and process-mapped interviews were stored in a lockable filing cabinet within the training team office and only accessible by the researcher; all audio-recordings

were stored in a lockable filing cabinet and 'wiped' following their transcription; the computer used to analyse the data is encrypted and password protected; and the data gathered only stored for as long as necessary for the completion of the study and then destroyed.

The participants were given pseudonyms to protect their anonymity (Braun & Clarke 2013) and I altered other identifiable information, for example, their place of work, town/country of origin. I sent the transcripts and process-maps to participants to check they were comfortable with how their narratives had been represented and received no requests for alterations to preserve their anonymity or correct any misinterpretations. Through consulting with the participants in this way, I attempted to clarify that the participants shared with me similar "expectations about how their stories are going to be used" (Elliott 2005, 149) and so felt more confident in undertaking further analysis, having 'got it right' in these early stages of interpretation.

Narrative studies have their own unique ethical issues to consider and these influence the way in which the research is conducted and the data analysed. For example, it is necessary to reflect on "how our expectations of and ethical stances towards a story may alter its crafting and reception" (Adams 2008, p185). This meant the research aims expressed to the participants verbally and/or through participant information sheets (see appendix F) as well as the ethical position adopted, for example, confidentiality protocols and boundaries, influenced the narratives people subsequently shared and how they were interpreted.

The ex-students were asked to complete consent forms (see appendix G) and return these with their completed questionnaires. Prior to beginning the interviews, I checked each participant was still happy to take part and reminded them they could withdraw from the study at any point without explanation. All eleven participants agreed to continue. The

interviews took place at mutually convenient locations - five participants requested I interview them at their usual place of work; four attended the training team offices; one requested the interviews take place at their home; and one attended the training team office for their first interview but their place of work for the second. All interviews were carried out in a private room without anyone else present apart from the researcher and the interviewee.

By enabling participants to set the agenda, I endeavoured to minimise the potential for causing any distress through raising sensitive issues. I was also able, through the preliminary analysis of the ex-user/carer section of the questionnaires, to identify in advance of the interviews, some issues of concern to participants and to assess where they were at on their transition journey. This meant I was able to determine (as far as possible) the likelihood of sensitive issues arising from the narrative interview. However, participants experiencing distress as a result of the interview was still possible so participants were informed that they could access support through NHS counselling services or their own clinical supervision. During her first interview, one participant (Debbie) did become upset and was offered the opportunity to stop the interview or take a break. After switching off the recorder for a period of time, during which I supported her through listening empathically, Debbie said she felt comfortable to continue, stating at the end of the interview that "it's been quite therapeutic actually". This reflects Elliott's (2005) view that,

> "it is not necessarily harmful for research subjects to experience distress in the course of an interview, and it may in fact be therapeutic or reassuring for a respondent to be given a safe space in which to talk about an upsetting event or experience" (p137).

I identified other potential benefits for participants in being involved, including the opportunity to reflect on their experiences (Elliott 2005); to influence future training and development plans; and to make recommendations towards policy and practice

development within the substance misuse field. In obtaining participants' views and narratives of their experiences, I then had an ethical "obligation to treat participants respectfully in the process" (Elliott 2005, p140). However, Elliott also proposed that there is more to this process than 'taking' their experience as data because the nature of narrative studies is such that "the potential of research to be a significant transformative experience must also be recognized" (Elliott 2005, p140). This 'transformative experience' can apply equally to participants and researchers.

**Methods**

The narrative data was generated with the participants using a combination of process-mapping and qualitative interview techniques, that is, while a participant 'mapped out' their transition journey chronologically from substance user to drug worker using flipchart paper, pens and post-it notes, they told the story of their experiences. In response to their verbal and written communication, I asked for points of clarification or interjected with, for example, 'tell me more about that time' or 'what happened next?' These questions enabled me to check my understanding and gain greater insight into their self-identified significant events over two interviews, each lasting 1-2 hours. The interviews were audio-taped and transcribed verbatim. The participants decided for themselves where to start their story (some started as far back as childhood, even though they were asked to plot their journey from drug user to drug worker), what information they included about themselves, their families, drug workers, colleagues, significant people, turning points, difficulties, opportunities, and so on.

It was not expected that participants would be one hundred percent accurate in their recollection of dates but would attempt to get things in the 'right order'. A typed copy of their process-map was sent to participants directly after their first interview so they were able to review this and make any amendments or additions to it and then had 6-10 weeks

to reflect on the process of devising their map and on what they had/had not said in their first interview and so "deepen their subsequent responses" (Polkinghorne 2007, p481) in the follow-up interviews. Because I also reflected on the participants' narratives, and was interested to find out more about specific elements of their stories, I tended to ask more questions in the follow-up interview than in the initial one. The first question I asked each participant at their second interview was: "would you like to change/add anything to your process-map or to anything you said in your first interview?" Participants were given the option of a third interview if they thought of anything further they would like to add or clarify. While no participants formally requested a third interview, a number maintained informal telephone contact to let me know of further developments in their story.

**Process-mapping**

Process-mapping, sometimes also called 'node-linked mapping' (Dansereau et al. 2000) and 'mind-mapping' (Wheeldon 2011), has an evidence-base in education (for example, Farrand et al. 2000), business (for example, Anjard 1996), research (for example, Wheeldon 2011) and substance misuse services (for example, Campbell et al. 2007). Dees et al. (1994) described how the 'nodes' in the process-maps are represented as boxes containing the participant's thoughts, actions, or feelings while the links are represented as lines with arrows labelled to show the direction of influence, chronology and/or the interrelationships among the nodes' contents (Dees et al. 1994). Figure A provides an example of a simplified version of Jamie's process-map (see appendix J for all the participants' full, original process-maps).

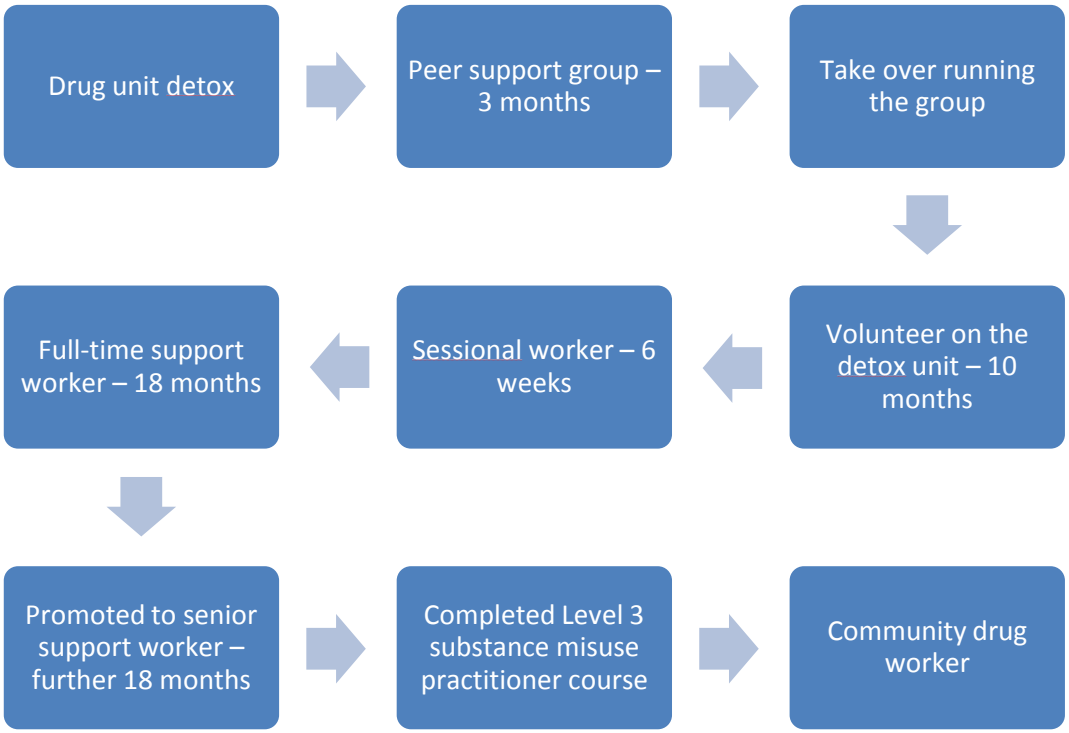


**Figure A: Example of simplified process-map – Jamie**

There are different types of process-maps used by practitioners and clients within the substance misuse field – guided-maps and free-maps being the main options (Campbell et al. 2007). Guided-maps are already partially or fully populated, that is, they have a pre-existing structure and topic outline to guide the client's cognitive processes and interactions with their key worker. Free-maps, on the other hand, essentially "start life as a single blank sheet of paper" (Tattersall et al. 2007, p32) and are then collaboratively (Czuchry & Dandereau 1999) populated with nodes and links to represent events, thoughts and feelings (in the nodes) and how these connect together (through the links). In this study, the participants and I used sheets of flip-chart paper, post-it notes and marker pens to develop free-maps. I typed up the maps directly after the interview to provide a permanent record and sent it to the participants for verification. I chose to use free-maps rather than guided-maps so the participants decided what to discuss and could identify and reflect on the connections during the process-mapping exercise while working in partnership with the researcher (Dees et al. 1994). Once the "starting node" (Pitre et al. 1998, p539) is

identified, other nodes are added and linked together as a form of emplotment so that the participants decided what to include and arranged the different events in order for it to make sense (Newbern et al. 1999).

The evidence suggests there are a range of benefits to using this technique, for example, Wheeldon (2011), who used process-mapping as a means of generating research data, stated that by developing a "graphic construction of experience, researchers can get another view of how participants see the world" (p510). As one of my research aims was to explore ex-user drug workers' transition journeys, mapping can be seen as effective in developing this insight, for example,

> "By focusing on individualistic accounts of knowledge, experience, and perception, meaning is discovered through social interactions and the ways in which an individual constructs, frames, and describes one's past" (Wheeldon 2011, p509).

Both Farrand et al. (2002) and Wheeldon (2011) argued that maps assist recall, prompt greater depth and detail in those recollections, make connections between key pieces of information, and facilitate the gathering of "more personalized data from research participants" (Wheeldon 2011, p510). Given that a criticism of qualitative interviews is that participants' memories are selective and fallible, any technique that enhances this is surely welcome. Furthermore, Wheeldon (2011) suggested that through mapping, participants engage at a deeper level in the research process, reflect on the information they share and offer conclusions regarding their experiences. Because reflections and conclusions are not solicited by researcher questions, but emerge from the participants' maps, this reduced the possibility that I might ask leading questions that introduce bias to their story. As Wheeldon (2011) explained, "[b]y specifically focusing on user-generated representations of experience, mind maps allow individuals a unique role in research" (p519-520), making this "qualitative data collection tool...attractive" (Wheeldon 2011,

p519). It has also been suggested in the substance misuse field that the use of mapping facilitates greater investment in the treatment process (Czuchry & Dansereau 1999). I also hoped this approach would facilitate greater participant investment in the research process. Further advantages of process-mapping include: their ease of compilation; facilitating the organising of thoughts and feelings about an event systematically; providing a clearer view of an experience; putting experiences into context; and providing the opportunity for participants to realise "how much had happened" (Wheeldon 2011, p518). In the context of the substance misuse field it is suggested that,

> "When a visual record of past and current discussions is provided, communication gaps are less likely because both client and counselor can refer to the simple language and structure of the map to help explain and clarify their thoughts and expressions. New ideas can be easily (and visually) linked to old ideas, increasing the likelihood that they will be remembered and better understood" (Joe et al. 1997, p306).

The evidence from a number of studies of using process-maps in the substance misuse field suggests the technique: enables drug users to see connections between cause and effect (Campbell et al. 2007); acts as a memory aid between key-worker sessions (Dansereau et al. 1993); visualises relationships between ideas, feelings and actions, allowing clients and practitioners to explore complex issues (Dansereau et al. 2000, Dansereau & Dees 2002); enhances communication and facilitates problem-solving (Dansereau & Dees 2002); provides a record of the therapeutic process (Dees et al. 1994); and takes conversations to a deeper level, enhances clients' attention span, encourages greater participation in treatment and provides a forum for personal expression (Czuchry & Danseareau 1999). In addition, Dansereau et al. (1994) emphasised how maps can be "navigated more easily than written notes or memories of previous conversations" (p519), not only making the process of involvement easier, but also the process of reflection.

I feel the above benefits for clients and practitioners within the context of substance misuse key-worker sessions apply equally to ex-user drug workers engaging in narrative research. Furthermore, because the participants were already familiar with process-maps, either through using maps with their own drug worker and/or using them with their clients it was easier for them to engage in process-mapping in the research context. Before the interviews, the participants had been informed that this technique would be used and so arrived reassured that they knew what was going to be involved. Once in the interview room, the maps provided a focus for the participants and allowed them to decide what they were and were not willing to discuss. Having embarked on telling their transition story, the participants were enabled through the process-maps to explore the complexity of their journeys. Without the benefit of the maps, the participants may have found the interview experience more "emotionally daunting" (Dees et al. 1994, p517). This may be because maps can reduce how self-conscious they feel during an interview (Dansereau et al. 1994), that is, by focusing on the activity of co-creating the maps, the participants feel less in the 'spot-light' themselves. Furthermore, as well as the process-maps assisting in the generation of data, the analysis of the data was facilitated by the visual representation provided by the process-maps (Tattersall et al. 2007). While re-listening to the audio-recordings, I simultaneously reflected on the narrative transcripts and the process-maps, moving between the two documents to see how the whole picture (represented by the completed maps) related to the parts (emergent themes from the narratives and key events identified in the nodes).

Pitre et al. (1998) described how "collaborative mapping... results in a shared visual representation" (p542) while Dees et al. (1994) stated that this technique is "a mutual partnership activity" (p522). This makes process-mapping an ideal method of data generation and analysis in this study because it is compatible with underpinning principles of co-construction and hermeneutics. By utilising this approach, greater insight and

understanding can be developed through enhancing participants' ability to remember past events and assisting them in better understanding how these link to their current situation (Joe et al. 1997). The process-map acts as a conduit for mutual understanding, bringing the researcher and narrator closer together and facilitating co-constructed knowledge as part of the process of analysis and within a constructivist perspective (Hollingsworth & Dybdahl 2007). Furthermore, it supports the view that "participants' intentions and interpretations are as important as the researcher's" (Hollingsworth & Dybdahl 2007, p151).

Reviewing the process-map enabled participants to reflect (perhaps for the first time) on their different experiences; how these connect together; and the way in which they combine within the context of their whole life. Wheeldon and Faubert (2009) advocated that mapping facilitates reflexivity for both researchers and participants. I certainly reflected on the process-maps to identify follow-up questions to ask the participants and found the maps made the analysis process more effective. Many participants also noted how they thought differently about their transition journey when looking over their process-maps. Phil, for example, stated he had not considered the significance of his disclosure decisions until he saw this represented on his process-map.

Eden (1992) suggested that mapping "may represent subjective data more meaningfully than other models" (p261-2). As this study is interested in exploring subjective experiences of ex-user drug workers and the meanings they attach to their transition, disclosure decisions and identities, mapping is ideally suited as a method to facilitate this understanding. Tattersall et al. (2007) stated that while there is guidance regarding how to generate process-maps there are "no set rules" (p32). I was therefore able to reassure participants that there was no 'right or wrong' way to develop their maps, thus retaining the desired participant-led research.

**Interviews**

There are generally considered to be three different types of interview – structured, semi- or partially-structured and unstructured (Braun & Clarke 2013). Structured interviews are most closely associated with quantitative studies and are deemed to risk influencing participants "into following a predetermined thematic or chronological route" (McCormack 2005, p148), making it inappropriate for narrative research. Hinckley (2008) stated that semi-structured interviews "allow the researcher to act outside an originally planned question script" (p78), suggesting in-depth interviews usually fall into this category as it is possible for researchers to "pursue more information on topics or events that are brought up by the participants" (Hinckley 2008, p78). It has been argued that "interviews that attend to individuals' narratives would produce data that are *more* accurate, truthful, or trustworthy than structured interviews that ask each respondent a standardized set of questions" (Elliott 2005, p23, emphasis in the original). Elliott (2005) argued that structured questioning can suppress story-telling and Riessman (1993) stated that, "[r]espondents (if not interrupted with standardized questions) will hold the floor for lengthy turns and sometimes organize replies into long stories" (p3). This proved to be the case in my interviews as participants shared their stories while they constructed their process-map.

Although the interview approach adopted might be described as unstructured because there was no interview schedule, the process-maps did give the interviews some degree of structure; it is just that it was the participants who structured their stories through maps rather than the researcher. The second interviews were more structured than the first as I introduced several questions based on preliminary analysis of the first interview transcripts and process-maps. Brown (2009) suggested that there is another layer of interviewing between partially-structured and unstructured, namely, "minimally structured" (p243) and I feel this to be the 'layer' that most closely describes my interview approach. Mishler (1986) endorsed this view by suggesting that story-telling might be facilitated by "using relatively

unstructured interviews where respondents are invited to speak in their own voices, allowed to control the introduction and flow of topics and encouraged to extend their responses" (p69).

Due to the collaborative nature of the study which aimed to involve participants as co-researchers, I felt it entirely appropriate that participants took the lead in setting the interview agenda. Riessman (1993) advocated that, "[i]nterviews are conversations in which both participants – teller and listener/questioner – develop meaning together, a stance requiring interview practices that give considerable freedom to both" (p55). The absence of an interview schedule and use of process-maps allowed this freedom and facilitated hermeneutic interaction where meaning-making evolved as a result of narrative conversation and reflecting on the map content and node-links. Furthermore, by adopting a narrative approach to the interviews, participants became more actively involved in the study and were able to decide what they "believe[d] to be the most salient information" (Elliott 2005, p135) to share. I then contributed to their narrative interview through responding to their tales and maps; their emotions and disclosures, meaning the stories were jointly constructed (McCormack 2005).

The interviews were conducted, and the stories therefore constructed, through the interaction between the researcher and the narrator. How I introduced the purpose of the study, my previous working relationship with the participants, the questions I asked, the use of process-mapping, how I responded to their stories, and so on, all influenced the stories told, how they were structured and the meanings attached to them. Co-constructed stories are therefore about more than just giving voice to the participants. The process-mapping technique attempted to "restructure the interviewer-interviewee relationship, so as to empower respondents" (Mishler 1986, p118), making it more likely that, because narrative

methods are used, they will tell 'stories' in their own words (Nettleton et al. 2005) rather than simply respond to questions.

Another study that resonated with my predilections was Gubrium's (1993) in-depth biographical study of nursing home residents which was designed to encourage participants "to tell their stories, to speak of life and to convey in their own terms the meaning of the qualities in their facilities in relation to the significant matters of long stays" (pxv). Gubrium (1993) utilised an interview guide but suggested that this "receded into the background as residents set their own narrative agendas" (p14) so as to facilitate greater participant autonomy and empower his participants to take charge of their own narrative, rather than this being determined by the researcher. Unlike Gubrium, I did not have an interview guide, using process-mapping instead to draw out their story, but, like Gubrium, I wanted the participants to set the agenda rather than determining it myself. Gubrium's study and analytical approach enabled his participants to tell their life story in relation to where they are *now*, that is, from the perspective of the nursing home. Similarly, I asked my participants to share their stories of becoming drug workers. Bringing their story up to the point at which they are now as drug workers, influences the lens through which they see their past life in the same way Gubrium's residents saw their past lives through the lens of being in a nursing home.

The interviews provided a forum for participants' stories that were more than a chronological record of events. Gubrium (1993) stated that narrative interviews offer the ability to focus "on subjective meaning [that] helps to uncover lifelong biographical linkages and locate them in relation to interpretations of current experience" (p7). This relates to what Riessman (1993) said about the importance of subjectivity in demonstrating the context of the narrative, the individual perspective and the value attached to the experience. Heidegger and Gadamer (Palmer 1969) also valued subjectivity because of

its ability to assign meaning to individuals' experience rather than 'objective facts'. Individuals' experiences are more than just 'the facts' - they are influenced by our past, our beliefs and our aspirations. This means several people can all experience the same event, but experience it in different ways, and therefore tell their story of it differently, depending on their perceptions and interpretations. This means the stories I was told in these interviews might have been told in a different way, on a different occasion, in a different place, at a different time, to a different researcher, but the story would have been no less true on each occasion.

**Analysis**

Although I include this separate section on analysis, in reality the analytical process took place throughout the study - during the interviews, while listening to the audio-recordings, reading (and re-reading) the transcripts, and writing (and re-writing) the narratives that emerged from the transcripts. Indeed, analysis is continuing as this thesis is read by others. Numerous options are available when deciding on the type of analysis to carry out with narrative studies; narrative analysis and thematic analysis being perhaps the most obvious. Davidsen and Reventlow (2011) stated, "[t]he aim of narrative analysis is to take the full narrative account and analyse it as a whole" (p961) while a thematic or content mode of analysis "seeks central themes, typologies or instances of paradigmatic categories within the narratives told" (Sparkes & Smith 2012, p55). However, "there is as yet no single analytic approach that can provide the definition for narrative analysis" (Elliott 2005, p36) and thematic analysis alone may not fully complement the hermeneutic philosophy underpinning my research. It was my intention to interpret the participants' stories as a whole and identify themes and patterns within the context of the whole narratives, making holistic-content analysis an ideal choice as it combines the best of both narrative and thematic analytic worlds by focusing on the content of whole stories (Lieblich et al. 1998, Carlander et al. 2011). I allocated the participants' stories to thematic chapters (inspired by Gubrium

1993) and included reflections on these themes, links and commonality between the different stories, as well as any differences and contradictions. This meant that even when I identified emergent themes, I interpreted them in the context of their whole story and made explicit how and why I interpreted these segments in that way, reflecting back on the original polarised question of who makes the 'best' drug worker; ex-users *or* 'professionals'. The holistic-content analysis process was inspired, primarily, by my reading of Lieblich et al. (1998) and Carlander et al. (2011) and although I describe the process as if it were a linear, step-by-step performance, it was in fact iterative and cyclical with the steps overlapping and the analytic components moving back and forth between the different stages and emergent data; much like the hermeneutic circle. First, I listened to the audio-recording of the narrative interviews in their entirety, simply listening to them from beginning to end without transcribing at this stage, but absorbing the story as a whole and noting initial impressions. I then transcribed the recordings, making further notes of initial interpretations, tone, pauses, and so on. I chose to transcribe the data myself as I see this as a key part of the analysis (Riessman 1993). This was a lengthy process but a useful one as it enabled me to really get to know the data. I then listened to the recordings again but this time with the transcripts and process-maps in front of me, making further notes. By this point, I was starting to see how particular events described by a participant related to their whole narrative and vice versa. Based on an analysis approach used by Carlander et al. (2011) I developed a table to record this information with the headings of 'narrative', 'initial impressions', 'interpretation' and 'initial theme' (See Figure B for a section example of Jamie's table).

| Narrative | Initial impressions | Interpretation | Initial Theme |
|---|---|---|---|
| Em, [I started with the] support group…on a Thursday night which you didn't have to attend in them days so it wasn't compulsory. So, em, I decided to attend it anyway. Em, and I enjoyed it. It were quite good. Em, I liked to see people who was clean coming back each week. So, when you left the unit, you could come back as an ex-patient and do the support group every week to get a bit of support from people as well, you know. So I decided to do that when I left the unit, once I'd finished me detox. | Jamie starts his story while still in an aftercare support group following his inpatient detox | There is an overlap between Jamie's treatment and peer mentoring involvement | Positive experience of treatment & aftercare |

**Figure B: Example from Jamie's table**

A similar technique was used by Riessman (1990, 1993) where she created 'rough' transcriptions followed by retranscriptions in tabular form to break the structure of the narrative into what happened, its orientation (setting), any complicating action, how the narrator evaluated its meaning, and what action they took to resolve that element of their story. The table enabled the story to be presented as a whole while showing clearly how emergent themes developed. I felt using tables was important, not so much so I could show I had been systematic in my analysis, but so I could demonstrate reflexive processes and how my experience contributed to the co-production of the narratives.

Following this stage of the analysis, I returned to analysing the narrative as a whole by writing a summary 'story' of each narrative in an attempt to capture its overall essence and meaning. Throughout, I read relevant literature and wrote reflexively on the emergent data, other studies and methods used in my research diary. This complements the notion

that "[a]n approach to qualitative analysis informed by an interest in narrative is therefore frequently accompanied by a more reflexive methodology" (Elliott 2005, p152). As a result, the transcriptions, narratives, initial interpretations, literature and reflexivity fused to create the resultant narrative findings (Carlander et al. 2011).

In addition, the step-by-step approach of holistic-content reading of the transcripts within the context of narrative and research processes is supported by underpinning hermeneutic principles whereby the whole relates to the parts within it, which then relate to the whole, albeit a 'whole' which may have altered in the process (Gadamer 1975, 1976). While acknowledging that neither Heidegger (Crotty 1998) or Gadamer (Koch 1996) set out to create a particular methodological or analytical approach, in adopting this pattern of analysis I was able to gain insight into how participants' whole journey related to its thematic parts and vice versa.

Having used the tables to identify initial themes, I then reviewed the tables to identify key themes, that is, themes "were selected on the basis of their issue-relevance" (Mishler 1999, p153), and were the ones that appeared repeatedly; were relevant to the research questions; and/or were expressed with greatest emphasis. While there were potentially many alternative orientations that could have been selected (such as recovery, motivation, volunteering, work experience), the three main orientations identified for the focus of this study were transition, disclosure, and professional identity. It also became apparent as I explored these orientations that the alternative themes identified could be considered as contributing factors within these broader issues, for example, recovery is a component of transition.

Transition was perhaps the most obvious orientation (given the nature of the initial research questions), and therefore, the first to be identified. Furthermore, the process-maps offered

visual representations of the transition journeys each participant made, highlighting the stages they went through, including barriers and opportunities along the way. It would have been possible to allocate *all* the participants to the orientation of transition, however, the people selected (Adam, Debbie and Richard) offered multiple, data-rich stories under this heading while those who were not selected here, offered more and/or stronger stories in relation to alternative orientations. The next orientation to be identified was disclosure; this issue being raised by all the participants within the context of their decision-making as their transition journey progressed. The participants (Elizabeth, Harry, Jamie and Luke) were selected for this orientation because they represented a range of perspectives and experience along the 'disclosure continuum' but all expressed clear decision-making principles and processes that resonated with disclosure theories (for example, Chaudoir and Fisher 2010, Jourard 1971, Omarzu 2000) and current concerns within the substance misuse field (DH 2010, Adfam 2012). In addition, Kieran's non-disclosure narrative provided a contrast to the other participants' perspectives. The final orientation selected was professional identity as this drew out from the participants what making the transition meant to them as individuals in terms of how they saw themselves or felt they were seen by colleagues and clients. Again, all participants shared their perspectives of their own professional identity, but, the three participants allocated to this orientation (Michael, Nicola and Phil) each expressed in some detail the consideration they had given to the meaning they attached to their roles, returning to the experiences of professional identity on multiple occasions throughout their interviews.

The above allocation process was achieved through extrapolating 'transition stories', 'disclosure stories' and 'professional identity stories' from each participant (see Appendix J). First, I simply 'copied and pasted' the elements of each participant's story that related to these individual topics before editing so as to enable the story to 'flow', for example, by removing some pauses, extemporaneous sounds (eh, erm, and so on) and in a few cases

changing the order of the story but not changing the words or meaning. Following this exercise, I identified which participants I felt offered the most meaningful representation for each of the three orientations in terms of their range of experiences; their distinctiveness and similarities; and the depth of their reflections on their experiences. This approach echoes that adopted by Gubrium (1993) whereby the narratives of his nursing home residents were "organized by horizons of meaning ... in terms of the different linkages they make with lifelong experiences" (pxv-xvi). In the context of this study, this meant that I allocated participants to the three orientations depending on how they expressed the meanings they attached to these themes during their interviews and in their process-maps.

Gubrium (1993) maintained the integrity of his participants' stories by presenting them unitarily and allocating each participant to different orientations based on their "horizons of meaning" (p166) thereby linking whole stories to key themes, rather than fracturing (Riessman 1990) the stories into excerpts. Once assigned to such orientations, Gubrium (1993) allowed participants to narrate their own story "in their own voices" (pxvi).

In terms of presenting the analysis within each orientation, I was keen to show "how their lives as a whole related to their current situation" (Gubrium 1993, p13). This meant that when presenting the participants' stories, I detailed the links between where the participant is now, to where they were at different stages of their journey and how such experiences influenced how they view their past and how their past has influenced their present (and future). What emerged from the data is how ex-user drug workers have formed their identity. By telling their story in a holistic way, it is possible to present how participants relate to and reflect on their past life to give a measure of unity and purpose in their current life.

My presentation differs from Gubrium (1993) in the way he sometimes included the interviewer's questions whereas I removed my own words from the discourse, preferring to focus on the words of the participants. Within the orientations, Gubrium (1993) occasionally referred to other participants who had similar views or experiences to the main story presented. This is something I have also done but to a greater degree as I have included several extracts from other participants where they support, or contrast with, the experiences described by the 'main' narrator. By presenting additional quotations from other participants within these orientations, I was able to connect common and contrasting themes across the narratives thereby demonstrating a mixture of shared and unique experiences. This also enables the reader to gain insight into each individual's experience within the context of their transition journey rather than reading about how each individual's experiences fitted into the themes identified by the researcher. Similarly, Carlander et al. (2011) presented direct quotes from the participants interspersed with paraphrases and interpretations to show the results of their analysis alongside the participant's individual voice.

This may have been the first time the participants had been asked to describe 'what happened next', after recovery, to enable them to become drug workers. Several participants commented that the process was useful and therapeutic, allowing them to reflect on this element of their journey and encouraging them to think about their identity within the current context of their lives. This enabled me to identify how emergent issues are influenced by past experiences, for example, how the participant's own experience of treatment influences their current practice. What they told themselves about this transition and their identity is as important as what they told me.

**Trustworthiness**

It is the researcher's responsibility to maintain "the trustworthiness of the research process and the truthfulness of his or her analysis" (Fleming et al. 2002, p119). This implies the necessity of clearly setting out the steps of the data generation and analysis; specifying underpinning ethical practice and theoretical principles; being transparent about the pre-understandings I brought to the analysis; and clarifying how decisions were reached at each stage of the research process. At school, my maths teacher stressed the importance of showing our 'working out'. For me, demonstrating trustworthiness and validity in research is akin to showing my 'working out' in maths.

In positivist terms, generalisability, reliability and validity are considered "a scientific holy trinity" (Kvale 1996, p229). In narrative studies and other qualitative approaches, these concepts can prove problematic for a number of reasons. For example, "[a] personal narrative is not meant to be read as an exact record of what happened, nor is it a mirror of the world 'out there'" (Webster & Mertova 2007, p89), meaning that the narrative is open to interpretation rather than purely factual. Also, narrative studies' small sample sizes may be deemed insufficient to be generalisable; while the use of narrative means there are no standard interview schedule to provide consistency across participants (Elliott 2005). However, Riessman (1993) suggested that, "traditional notions of reliability simply do not apply to narrative studies, and validity must be radically reconceptualised" (p65). In reconceptualising such notions the perceived problems become less of an issue. For example, from a narrative perspective, having no standardised or leading questions, means "participants are empowered to provide more concrete and specific details about the topics discussed and to use their own vocabulary and conceptual framework to describe life experiences" (Elliott 2005, p23), in fact, making the narratives "*more* accurate, truthful and trustworthy" (Elliott 2005, p23, emphasis in the original). Riessman (1993) suggested that,

> "[v]alidation, the process through which we make claims for the trustworthiness of our interpretations, is the critical issue. "Trustworthiness" not "truth" is the key semantic difference: The latter assumes an objective reality, whereas the former moves the process into the social world." (p65)

The validation of the data within the social world (also discussed by Lieblich et al. 1998) is certainly more compatible with principles of co-construction and hermeneutics while the notion of trustworthiness has superseded more traditional, quantitative concepts of verifiability, reliability, replicability and generalisability. This does not mean that such concepts have been discredited entirely in qualitative studies (Morse et al. 2002), but the techniques used to demonstrate a study's quality have changed. Trustworthiness can, for example, be determined by evaluating the accuracy (Christians 2008) of the narratives. I followed Riessman's (1993) good practice principles of sharing the transcripts and process-maps with the participants (Riessman 1993) to establish accuracy and it was then possible to move onto "meaningful analysis" (Webster & Mertova 2007, p89). In addition, peer review through my university supervisors enabled me to assess the persuasiveness and believability of the participants' emergent narratives by answering the question, "[i]s the interpretation reasonable and convincing?" (Riessman 1993, p65)

Holmes (1998) argued that there are two types of truth – emotional truth and factual truth – and suggested that while factual truth may be assessed scientifically, emotional truth is judged on the basis of "whether the story rings true, feels right, is satisfying, coherent, or touches the listener emotionally" (Holmes 1998, p178). Such concepts resonate with the reality that the meanings we attach to our daily experiences stem from "narrative knowledge, that is, knowledge deriving from our and other people's experience and disseminated through stories" (Gabriel 2004, p183). This does not mean we must always accept stories on face value. It is appropriate to ask questions to facilitate verification and clarification, and explore any contradictions (Gabriel 2004). This was one reason for

interviewing the participants more than once as it gave me the opportunity to reflect on their first interview transcripts and process-maps and prepare follow-up questions for the second interviews. I could then probe further into their experiences to seek confirmation and additional details of previous disclosures. This also meant I was able to ascertain whether or not my interpretations had been accurate, that is, were my "reconstructions... recognizable as adequate representations" (Riessman 1993, p66) making my interpretations credible? It also meant the participants could reflect on their narratives, perhaps then being able to add an extra layer of memory or insight at the next interview.

Because trustworthiness, rather than one objective truth, emerges from co-constructed narrative analysis, "there are degrees of validity rather than a claim being determined to be either valid or not valid" (Polkinghorne 2007, p474). This means "a conclusion is valid where there is sufficient evidence and/or reasons to reasonably believe it is so" (Polkinghorne 2007, p474). The narratives in this study were believable because participants shared specific and detailed examples from their life story to evidence their experiences of particular events, issues and transitional states. Even though the participants were atypical in their identity as ex-user drug workers and were treated, volunteered and worked in a range of services, the experiences resonated with each other through certain common themes and concerns.

Lieblich et al. (1998) suggested that as well as the necessity of research demonstrating trustworthiness, plausibility and credibility, studies should also demonstrate relevance. Having reflected on the participants' narratives, I feel the study is "important and contributes to the field" (Lieblich et al. 1998, p172), especially as previous studies have tended to focus on drug users' experience of substance misuse and treatment rather than the next transitional phase of sustaining recovery and moving into employment. This study

therefore builds on previous findings and offers relevant conclusions pertinent to developing drug services.

Polkinghorne (2007) advocated the use of personal reflection and inductive analysis to facilitate validity in narrative studies. Koch (1994, 1996) suggested that the maintenance of a reflective diary throughout a research project contributes to the analysis process while Braun and Clarke (2013) suggested inductive analysis is possible through collating data "*by participant,* rather than *by question*" (p227). Having kept a journal and reflected on the research process to assist in the interpretation of emergent data (see appendix I for an example of an extract from my reflective diary), I know how beneficial this can be in making meaning from the narratives and how writing can facilitate hermeneutic thinking by making my pre-understandings transparent. By reflecting on my interpretations of the narrative transcripts, I was able to explore the range of possible interpretations and how the key elements of the narratives related to the context of the co-constructed narrative as a whole. I also collated the data 'by participant', that is, I recreated the narratives holistically for each person. Even when exploring specific themes, for example, disclosure, I extrapolated these elements from the narratives to create personal 'disclosure' stories for each participant rather than allocate excerpts into separate themes (see appendix J).

I did not set out to develop generalisations from this study (see Nettleton et al. 2005, Webster & Mertova 2007) as I recognised the unique experiences of ex-user drug workers while also identifying commonalities and thematic patterns across their experiences. I, therefore, did not intend to "[prescribe] how things are or ought to be" (Webster & Mertova 2007, p90) but did hope the study would resonate with other ex-user drug workers' experiences or offer alternative perspectives so that "upon reading the story, they gain a new understanding of an experience" (Webster & Mertova 2007, p99). As part of the research process, one participant, Richard, read a draft article I wrote relating to

disclosure and reflected on his own experience of disclosure and how he trains ex-user volunteers within his service. As a result he is developing a volunteer training session exploring disclosure decision-making, a topic not previously covered. Clearly, the disclosure discussions resonated with Richard and his reflections on this are now being applied in practice. For me, this is evidence of validation in action. The concepts of validation and reliability are often associated with the generalisability of qualitative data beyond the study's sample (Lewis & Ritchie 2003). As mentioned above, I did not set out to offer generalisations but I did want to demonstrate that through reflection it is possible for people to identify areas of transferability (Lewis & Ritchie 2003). This means that it is possible to offer recommendations for other ex-users (and the service providers for whom they volunteer/work) to then interpret for themselves, meaning that the analysis and meaning-making continues beyond the dissemination of the thesis as "readers must always make their own judgements about the relevance of findings for their own situation" (Seale 1999, p108).

This chapter has described the methodological steps and underpinning principles that enabled me to investigate the research questions in an ethical and appropriate manner. In chapters 3, 4 and 5, I explore the findings of this research within the orientations of transition, disclosure and professional identity respectively, relating each to the pertinent literature available.

## Chapter 3 Orientation: Transition

### Part 1: Findings

#### Introduction

This chapter explores the findings in relation to the orientation of transition. In light of the participant-led research design and hermeneutic principles underpinning this study, it is the participants' stories that foreground the findings' presentation. As the stories were structured through process-mapping (see pp44-49 and Appendix H), the participants told their stories chronologically, enabling each individual to plot their transition journey as they moved from stage to stage. The three stories selected for the focus of this chapter belong to Adam, Debbie and Richard as they illustrate a range of experiences. Adam moved from residential rehabilitation to voluntary and statutory sector employment; Richard volunteered and then worked in the same service where he was in treatment and remained in the voluntary sector throughout; and Debbie remained frustrated by the barriers she faced in trying to make the transition to drug worker within either sector. Excerpts from other participants' stories are included alongside these central voices where they further illuminate emergent themes.

#### Adam's transition story

At the time of the interviews, Adam, an ex-heroin user, was in his mid-30s and working in a statutory sector (NHS) Community Drug Team (CDT). Adam completed a residential rehabilitation programme in 1998, directly afterwards working in a manual occupation while volunteering in the same rehabilitation unit where he was in treatment. Following this, he gained paid employment in a prison-based voluntary sector agency before moving to work in an NHS shared care programme. Two years later, Adam returned to the voluntary sector in supported housing for people with drug and alcohol problems and then entered his current employment in the NHS.

**Decision-making**

Adam described how he first decided to become a drug worker, acknowledging it had not initially been his intention and that he was as driven by moving *away* from his previous employment as *towards* his aspirations to be a drug worker.

> "It was my actual key-worker at the time, she put the idea into my head really. She said, it's something to be interested in because we do volunteer work here. It can be a natural progression. And she kind of sold it to me because of the type of person I was and my character. And it's looked upon as quite good that people from a substance user background, who've been through that experience can be used as [volunteers]. But, also, there's plenty of jobs, which there was in them days, so that's probably when the idea was put in my head. Since I've been doing this, it's something quite common you hear and I said it myself. It's something about, because of the experience of being actually within that and going through that treatment process, it's also the putting back, applying your own skills to that as well. Because I'd worked previous to that, I'd always been employed from quite a young age, I'd always managed to hold down full-time employment. But that was always in the building trade, quite heavy manual work. My whole family had been building trade, one way or another. And I thought, well, I don't want that [anymore], but all I knew was the building trade. So, for me, it was about changing career. It was about turning over a new leaf, being able to put back and just basically getting out of manual work."

It could be considered that Adam's transition started some time before he was aware of his decision to become a drug worker, that is, he was already on a transitional journey by engaging in treatment and being a stable and reliable patient in the residential rehabilitation unit. Therefore, there was no discernible 'starting point'. His key-worker may have already recognised Adam's skills and personal qualities, identifying him as someone with 'potential', even before Adam had thought about post-treatment options. Without interviewing Adam's key-worker from this period, we cannot know what qualities she saw in Adam to prompt her to encourage him to become a drug worker or if she considered herself to be instrumental in starting his transition journey. Further research may be warranted in this area. Adam, however, had his own ideas about how he was perceived within the unit – stable, responsible, a good listener, supportive, and able to separate "me

own stuff out of it". In this treatment setting, there was a system of cultivating clients with valued attributes meaning Adam had already become a 'senior' resident:

> "[Rehab] was 12 months back then but I think I probably did 11, 11 and a half months, so I kind of did the full [lot]. So, by then I'd already made the decision about the road I was going to go down. I needed to be 6 months from rehab, but I think I was still on aftercare, so you could be a volunteer then. I think a lot of trust was given as well, the responsibility and trust as I became more senior and was seen as quite a stable client really within treatment. My responsibilities went higher, and I'd actually got quite good at it. So, then just the listening skills and people skills I probably developed while I was in there, peer support."

Adam was not the only participant to describe how the notion of becoming a drug worker had been worker-led rather than self-led. Michael's probation officer had commented that she "would probably see [me] in a meeting...and I thought that's a bit of a boost" while Jamie explained how a facilitator (herself an ex-user) had "sneakily" persuaded him to adopt the role of support group facilitation as a post-treatment activity, while other staff later offered him volunteering and paid employment opportunities – "It never even entered me head to be a volunteer, it was staff. They said, 'well, you're doing alright, why don't you become a volunteer on the unit.'" Therefore, it was staff who recognised participants' potential and gave them permission to aspire to these transitions. Without such endorsement, some individuals may not have seen their own potential nor had the confidence to make these early steps towards paid employment. The fact that becoming a volunteer post-treatment was seen by staff and clients as a "natural progression" further advocated such aspirations, almost suggesting it was expected that those who were 'doing well' in treatment *should* 'put back'. Having made the decision to become a drug worker, Adam then explored his options of how he was going to achieve this goal:

> "Part of me probably thought I wanted to go and maybe do university or something like that, but, because when I'd left rehab I'd started work I'd got used to having the wage. It was another way in, doing the volunteering route first rather than education. For me, it was voluntary, cos I worked full-time as well and I liked having the money, cos I had me flat to run and things like that. I'd never done education. I

> left school without any exams and I wasn't familiar with the education system and it was easier and the finances were there as well. Perhaps if I'd looked into it a bit more I might have been able to have gone down that way."

Adam saw his transition options as limited to either volunteering *or* education but not both due to financial practicalities. He was also not confident that he could access education due to his previous lack of educational attainment. This contrasts with Kieran's experience where he accessed a university course as a mature student but Adam was not aware of such routes into education at this time, opting instead to gain experience through volunteering. This was also the approach advocated by his rehabilitation key-worker. It is also likely, although Adam does not mention this, that he had witnessed other ex-user volunteers while in treatment, thereby offering him role models.

Adam was aware of the progression route along which he had started to travel, noting the increasing trust invested in him and the greater responsibilities he had earned through his evolving skills and reliability. Adam was also told that this rehabilitation unit had a policy requiring ex-service users to have a six-month gap following successful completion of treatment before they could become official volunteers. Other participants also commented on 'rules' set by various organisations, a national 'guideline' of the 'two-year rule' that suggested ex-users should be drug-free or out of treatment for this length of time before gaining paid employment. Many service users and service providers refer to this 'two-year rule' without any one organisation or governing body claiming it as emanating from their policies. It appears, therefore, to be a concept that was unofficially adopted by many substance misuse services without knowing its origins. A range of views were expressed by participants regarding this 'two-year rule', for example, at two ends of the spectrum:

> "I applied to [voluntary sector rehab] … And I'd only been out of rehab for six months at that point. And, of course, you know the rule of working in the [drug field] when you've been there yourself, it's got to be two years before you're let loose. But, he said he was going to give me a chance." (Phil)

> "there is within drug services this notional idea [of] two years clean and back in as a drug worker. I don't think so. I've spoke to nurses and staff on site that have been visiting and talking with staff as well, it's gotta be roughly about five years." (Kieran)

Despite the requirement to take a break between treatment and volunteering, stable clients like Adam (that is, clients who have achieved a period of abstinence in their substance use and positive behaviour change in other aspects of their lives) were still encouraged to be working towards qualifications that would enhance later job prospects. Therefore, alongside the aforementioned responsibilities, senior residents took part in training relevant to the skills needed to work within the drugs field while still in treatment:

> "I worked through treatment, [became a] senior, then did a basic counselling course. I think that was a 12 week course so it was entry level 1, and then I finished rehab [in] March I think it was. I started level 2 but I didn't complete that, probably did three quarters cos I had a full-time job, [manual occupation], as well in the day time. That was part of leaving rehab, to get full-time employment and a place to live. I just decided to stop that [counselling course], to concentrate on work and volunteering. I did that for about 12 months. [I was thinking] longer term because I was wanting to leave treatment behind, [thinking of the] rest of my life, and where I'd see things going."

Adam knew, at this early transition stage, that he wanted to move on from his status as service user (leaving treatment behind) and, despite taking advantage of opportunities presented to Adam during and directly following treatment, he felt it advisable for ex-users to take a break before making the transition to paid employment within the substance misuse field (echoing the rehabilitation unit's own policy on this), and, in hindsight, he recognised the importance of education to complement personal and voluntary experience:

> "I think you need time out. You need time out because, looking from my own experiences, if you go through rehab, I think you need that gap, you definitely need a gap, whatever time that is, before you start making that [transition], because I think you still need to go find yourself and make sure that you can cope, and be able to cope with life, running a flat, working, whatever. How you make the change, you could still do education and stuff, and go and get qualifications, university and college, but still you need that break, that gap of working, and having where you want to go and what you want to do, at least some idea of where you want to head

> towards, to work towards, having a plan. I think nowadays you'd need a mixture. I think it'd be difficult if you just went on volunteering actually. I'd definitely say get some qualifications, if you could, ideally, experience and qualifications, as much as you can."

Adam described his observation of some volunteers who behaved as though they were still clients, suggesting he does not agree that volunteering can act as a form of relapse prevention and/or treatment extension:

> "I did see other people who volunteered, but it was like they were still in treatment. They kind of went up there and kind of when they were talking to the staff, it was kind of treatment talk, but it was about their selves."

This is in direct contrast to Jamie's experience:

> "It [volunteering] was keeping me safe as well at the time cos it was [pause] how can I [put it]? I still had that, [it was] possible that, relapse scenario in me head, that I debated that if I wasn't doing anything maybe I could easily have slipped back into it. It worked out to be [like relapse prevention]."

For Adam, he needed a clearer 'divide' between being a client and a volunteer. He also advocated employment outside the drug field while volunteering in it as this enabled him to take a break between treatment and drug work while also gaining the skills he needed to cope with day-to-day living. When Adam felt ready to gain paid employment within the drug field, his first instinct was to seek employment where he was already a volunteer. However, although Adam was valued as a peer mentor and volunteer at the rehabilitation unit, this did not guarantee paid work within the same treatment setting, something he had initially expected was his due:

> "[I did] volunteer work and then, I think, a full-time job came up at the rehab, [after] a year, year and a half. So I applied for that job but was unsuccessful. [I didn't get the job because], personally, I think I went in a little bit over-confident, cos I'd done quite well and I was a prominent member when I was in the rehab. I knew the staff and they knew what I was like, and I went in, probably part of me thinking, I'll get this job cos I'd done volunteering. I remember the feedback I got [was] that I didn't sell myself as much. [At the time I was] gutted. I remember now, cos it was very

> much, I've done this and, I do my volunteer work, I've got a full-time job, you know, and I can do that rehab job, but, again, it was very much, em, a massive learning curve to go up."

**Difficulties**

Despite this 'knockback' in the early stages of his career Adam did not give up, continuing as a volunteer until applying for a job with another voluntary sector agency. Having acknowledged the steep learning curve from his recent interview experience, he had to climb an even higher curve in his first paid post because it was a new service within a very different environment and staffing culture from the one he was used to in residential rehabilitation:

> "[T]hen I got a job. I applied for a full-time job in the field. It was [prison] for [voluntary sector agency]. What was me job title then? Something like drug treatment worker. It was setting up the TC [Therapeutic Community], drug treatment at [voluntary sector treatment provider]. It was very difficult because we had a lot of problems with the prison staff as well and the culture of working alongside them. I mean, the first couple of months, it was [a pretty steep learning curve]. I think that's probably made me, made a lot of me within that. I did go through an awful lot then. I realised from that, you know, that I don't need to go through this and I learned to ask for help, support and use management sometimes. But I didn't do it at the time, but, that's where I was then, and, it was a very steep learning curve. I was probably there 12 months. The prison officers really looked at us like the Care Bear bunch."

Adam was not the only participant to share difficulties within their first paid post or as a result of a culture clash with non-ex-user colleagues. Phil described being treated with suspicion by police officers when working in an arrest referral role – "The police didn't want us there...so we were treated with disdain," while Luke described tension between himself as an ex-volunteer and qualified staff:

> "When I first started...and I became part of a team, there was a little bit of a class issue, around, sort of, experience and education...three of them had been to university and, like, were qualified social workers... And quite naively, when I sat down to talk to them and just getting to know you, they were actually digging, you know, 'what's your experience?' And, 'how long have you been doing this?' And when I told them dead honestly, you know, they used it against me."

Having sharpened his drug worker teeth in a hostile environment, Adam was keen to move to a more positive workplace and it was here that Adam started to make different decisions about what he told colleagues and clients about his past:

> "I applied for a job then at [town] as a [shared care] worker... I got the job. Oh, it was unbelievable. I was so desperate to get out of that [prison-based job]. The feeling when I got that job, I've never felt anything like it since, just so relieved. When you're in that, sometimes, you don't realise, do you, until you're on your way out and you look back and go, 'my God, how did I do that?' Then that was my first [job] in the NHS, so, I had to do my interview. I had to do a presentation as well. I think because I so much wanted to get out of there, you know, I planned and I planned, going over it and I was asking people I know, staff, what did they think, this? What did they think, that? And people'd tell me all these different tips and, then I was successful in getting that. So, in the process of going to that [shared care], that's when I personally made the decision, not to disclose. It felt like because I was going into the NHS, cos of the kudos of working for the NHS, I felt like I didn't want to use this badge of 'I'm an ex-user'. I wanted to see if I could do it on my own. Cos I'd done 12 months here, you know, and I could mention about voluntary work, so I wanted to do it on that."

Adam used the learning curve from his first job interview to prepare better for subsequent interviews while also being motivated to move away from a difficult job in the hope of gaining a more rewarding position. He also referred to the 'kudos' of working for the NHS, suggesting he saw this as higher status than his previous role in the voluntary sector. However, having been challenged in his first post, Adam then found the stable shared care clients not challenging enough and became frustrated by the lack of training opportunities offered here:

> "I think it was about two years at [shared care] and again, I got all my clinical work. The reason I left [shared care] is because [it was] a bit boring cos it was longer-term clients and I didn't find that as much of a challenge any more and, it felt like there just weren't very much happening there, and I didn't get any training. So, I applied to non-stat, for [voluntary sector supported housing] and that's when I joined the Level 3 [substance misuse course]. It was supported housing in [town] as a support worker. And, obviously, my connections from when I worked [in prison] and the experience I've got from [shared care], they snatched my hand off really. And I got training. I mean, I actually took a pay-cut to come here [supported housing provider]."

Adam found the client work more rewarding in this voluntary sector role while also appreciating the staffing mix where both ex-users and qualified staff were seen as having equally valued contributions in effective working. Adam also appreciated greater access to training available in this setting, something also mentioned by Nicola, although her positive experience was in the statutory sector (NHS):

> "I'm always on training. Always [laughs] I love it, just for the knowledge. Obviously, if there's training there, it's needed so you're going to need to know about it. If it's not now, it's in the future and it's just good to have knowledge. Like that stimulant training I were on the other day, lucky cos, I went back and I had an assessment put on me desk and she were a heroin user but more crack cocaine so I'm doing a bit of that, but without training … you were limited to what you could do, because we'd had no training. But, now we've had the training, it's like you can go that little bit further. Training's important; you definitely need it in this job."

**Motivation**

Although Adam enjoyed the role and working environment in the voluntary sector, he was aware that this was not as well paid as statutory provision. This was reinforced by his experience of other students on the substance misuse course who he saw as less proficient than himself but who were earning significantly more. He was motivated by financial gain to recompense the skills and experience he had developed. While he was previously motivated by the need for job satisfaction and access to training, resulting in a return to the voluntary sector, he was now motivated to have his skills and experience recognised by financial reward and status attainment. It is often stated that ex-users are motivated to 'give something back' but these findings suggest there is more to it that such altruistic motivation:

> "And then I did the level 3 [substance misuse course]. I shouldn't really say this [laughing] but, I'm doing the level 3 and I'm listening to other people in the class and, obviously, worked out where they worked and if I put it really blunt, I just thought, bloody hell, you know, where you're working, the level of work you're doing and some of the statements you're coming out with, that's quite terrible, that. You probably earn a lot more. And, basically, it was money. You're probably earning a lot more money than me and if that's [your level of knowledge], then I

> thought, well, I can easy get back and do that NHS work...I was quite open with the managers and things like that and, literally, it's because I know I can get more money. I mean, I still enjoyed the work I did. I could have naturally stayed there another 12 months or so, but I understood, obviously, the NHS was better paid, more opportunities and again the kudos of NHS."

Financial reward, role status and job satisfaction are as important aspirational factors for ex-users as they are likely to be for individuals from other backgrounds. Certainly, Adam was not alone in discussing such considerations. Nicola, for example, described her need to find paid employment – "I had to get a job...I didn't carry on volunteering once I finished the Level 3...I needed the money" and although Michael was initially grateful for a low-paid job to enable him to get off welfare benefits, he was keen to move into a more financially rewarding post:

> "I was approached by the rehab and they asked me to work for them as a project worker, which I snapped their hands off really. The money was absolutely [laughs] I remember the money, it didn't matter about the money. It didn't matter, I was moving on, getting off benefits, which was a real, that was another boost, you know, coming off benefits and stuff like that, getting off the sick and all that stuff. I went to work for them and learned an awful lot of stuff. I was there for 12 months, basically doing bits of group-work, overnight stays and stuff like that, just a normal project worker. Anyway, I went to work in the rehab ... [I] did lots of training, always doing training. Give me some training, I'll do that, and then, decided that the money was absolutely nonsense really. It was absolutely awful. So, I started applying for jobs. I thought, well, I've got some experience now and I wanted to move back home to be honest."

**Future aspirations**

When Adam returned to the NHS, he gained what he considered to be significant qualifications directly relevant to his role as well as his future aspirations:

> "Getting my level 3, that was my first biggest certificate...Then, from that, I've done all my other bits of courses – diploma in management, because I'm fed up of client work now. I'm still doing it but what I wanna do now, for my sins, [is] get more into [management]. I mean now I've got my line-management responsibilities and caseload management responsibilities, but I don't want that, I don't want caseload management. I'd like to spend all me time as a team leader. It wasn't about money. It never has been, I mean it was here [voluntary sector supported housing] because I

> was at the non-stat agency. But, it's more job satisfaction. I work with clients now and the challenge is going each year, so to speak. I'd rather be more of a management role and look at bringing staff on and using all my experience."

Adam gained the substance misuse award and management diploma while working full-time, thereby achieving Adam's original aim of maintaining financial security, this being an over-riding consideration above educational ambitions. Adam's description of his future management aspirations supports the idea that making the transition from drug user to drug worker is about more than simply 'giving something back'. There are personal goals to be satisfied. Adam is now in a contrasting situation compared to his early career as a drug worker. Then, he had volunteering and personal experience of substance misuse but no qualifications to help him become a drug worker. Now, he has a management qualification, but limited management experience which restricts his promotion opportunities.

> "I need more [management] experience. I mean I've got my diploma in management. I've done the paper but I feel I need to do a bit more practical level now of management and getting more involved with that. I suppose, in my ideal world, I'd like to go for a small non-stat service with maybe a team of 10, 12, and be a team leader and then look at bringing on my skills with that, and then maybe become a manager of that service. I couldn't imagine myself just suddenly going, 'you've got to run a whole service', but maybe a team within a service, or a smaller service. And I suppose money-wise, it doesn't really matter as long as me standard of living's not affected too much."

Luke has similar ambitions:

> "Only recently I've started to think I might like to be a team leader. You never think like that when you start out, but, in two, three years' time, I can't see why I couldn't be a team leader if that's what I want to do. I've never really thought like that before."

Adam concluded his transition narrative by reflecting on how he feels things have changed since he managed the transition from drug user to drug worker:

> "I think it'd be harder now to get paid employment. I think there is jobs coming up, but I think you'd have to be a lot more [qualified and experienced]. If it were me now, when I started out, I don't think I'd have got [a job] because there's fewer jobs and more people going for them. I think it'd be more difficult."

Adam is not alone in feeling it would be harder now to get a 'toe in the door' of drug work. Elizabeth stated, based on her experience of trying to move from homelessness to drug work, "I have found it quite hard, em, to move on in this field, to be honest." Jamie also shared his concerns of too much competition due to increased numbers of volunteers in the drugs field:

> "There weren't that many volunteers about when I first started and I think if I'd been in that same situation now, I don't think I'd get anywhere. That's my personal view on it. I don't know if I'm wrong or not...It's a bit wrong, letting people be volunteers if you're not going to let them get that experience or give them the chance of getting a job if that's the type of job they're wanting to get. It's using them really, isn't it?"

**Key aspects of Adam's story**

For Adam (and other participants), being prompted by a key-worker who saw their potential to be good drug workers, was an important first step in instilling confidence and inspiration to become drug workers. Had his key-worker not taken the lead in instigating this and had there not been a service ethos supporting volunteering as a post-treatment norm, would such transition options have even been considered by Adam? It is clear from Adam's description of treatment processes and post-treatment volunteering, that the rehabilitation team had given some thought to this transition route; establishing structures to identify potential peer mentors and volunteers early in their treatment journey; and providing them with training opportunities and responsibilities to enable them to gain skills and experience needed for future transitions. The rehabilitation team also considered ex-clients' personal needs and life skills by advocating a break between treatment and volunteering and by supporting clients, like Adam, in gaining employment and housing outside the substance misuse field, a system Adam found beneficial. However, when it came

to gaining paid employment in the field, there was less preparation available for Adam's first job interview and how realistic it might be for him to expect to get the first job he applied for. This expectation initially backfired as he went into his first interview "over-confident" and failed to "sell himself". While Adam's initial motivation was 'putting something back', this was not the only driving force. His commitment was to gain status; put treatment behind him; and be recognised for the quality of his work through being appropriately financially rewarded. Equally, he wanted employment in a service where he had access to training, acknowledging that education was something he had missed out on earlier in life, and that experience and education are equally important. Adam also demonstrated his positive approach to both education and experience when he talked about appreciating the skill and background mix within the teams where he worked. It is clear from Adam's transition story that his journey is not over yet. Adam has future aspirations as a manager, so although this study looks into the transition from drug user to drug worker, there is much to be considered in terms of promotion opportunities for ex-users within the substance misuse field.

**Debbie's transition story**

At the time of the interviews, Debbie, a single mum in her early-40s, had recently ended her four-year volunteering involvement with a statutory sector organisation (NHS). She explained that she decided to leave this position as a result of her frustration at not gaining paid employment within this service. Debbie had started volunteering in this agency's structured day programme while still in community-based treatment (methadone maintenance) in a nearby city's CDT, becoming methadone-free within six months of becoming a volunteer. However, Debbie experienced difficulties with some staff members in the structured day programme and so, after 18 months, asked to transfer to the service's needle exchange programme based in another area of the city. Having left the needle exchange in frustration a few months prior to her first interview, Debbie was considering her

options within the drugs field. She expressed distress at having applied for 150 jobs within the substance misuse field (four of which had been for the service where she was a volunteer) and only being interviewed for one (in the voluntary sector), for which she was unsuccessful. By the time of her second interview, Debbie was applying to be a volunteer in a voluntary sector drug agency. In a telephone call following her second interview, Debbie informed me that she had obtained a six-month paid contract in this voluntary sector drug service.

**Decision-making**

Like other participants (for example, Adam), the idea of volunteering was first suggested by a drug worker. But, for Debbie, the initial decision to become a volunteer in a drug service was motivated by her desire to become prescription drug-free. She had been on a methadone maintenance prescription for 18 years and felt stuck. Debbie saw volunteering as a way to keep busy while reducing her methadone usage.

> "I was introduced to [structured day programme] from a drug worker. He told me about volunteering. I'd stopped using street heroin and just sticking to me methadone but I wanted to get off it and I just thought this was a good way of possibly getting off methadone and finding something to do. So I came down to [city] where [they] took me on, trained me and, as for the methadone, I was clean within 6 months on me own."

**Difficulties**

Although Debbie had initially been enthusiastic in her role as a volunteer, after several months, she experienced difficulties with some staff members. However, these problems were not as significant to her as the issues she was dealing with at home, with the break-up of her relationship. This motivated her to remain within volunteering but she asked to transfer to another service within the same organisation to escape the aforementioned staffing issues. A further motivation to remain as a volunteer within the same organisation

stemmed from her awareness that the NHS would fund her enrolment in the Level 3 substance misuse course:

> "So, then I was bullied. Can I say that? [whispers] I felt I was hounded out of there [structured day programme]… bullied…[I] moved to [needle exchange]. Sounds black and white, don't it? I was really hurt. I felt [starts crying][pause] angry, upset, em, disappointed. [But] I needed, I wanted to become a drug worker, and I don't think I [pause] I didn't need it to stay clean. I just needed it. I needed [pause] I just wanted a change and it's more hands-on. Em, so, in a way I was glad. I was sorry to leave there [structured day programme] but I was glad in the end. I needed to be doing something, Sheila, with going through hell at home. I thought I don't want to be sat at home plus I wanted to do the Level 3 [substance misuse course] as well. So I thought well, carrying on there, they'll pay for it which really, they've had plenty out of me, you know I ran the place on me own when Tony [paid worker] wasn't in. Services for services [laughs]"

Although Debbie had received initial volunteer training when she started at the structured day programme, she did not receive any further induction or training relevant to her new role in the needle exchange programme. It might have been assumed by the service that, as Debbie had herself been an injecting drug user, she did not need further guidance on what equipment or advice to give. From Debbie's description, however, she worried about this deficit, concerned she did not give enough accurate information to clients using the service. It was only when she completed the 'harm reduction' module on the substance misuse course that she gained knowledge and confidence to engage more fully with the clients:

> "So, at the needle exchange, I learned about needle exchange, nothing about [harm reduction] though, I was never taught... When I was an injecting drug user there was no needle exchanges; there was no harm reduction advice. That's why I nearly lost me leg ...I learned everything on your course about harm reduction. I didn't know until I done the harm reduction module on the course, all I did was an exchange, em, just give it 'em; ask them for returns; that was it. So there was loads of things that I didn't know and I was embarrassed. So that's why I never said nothing. I thought, 'Oh God'. Once I did the course [Level 3 substance misuse], I knew where I stood. I knew what was [right] and I tried to implement that into the needle exchange as often as I could. I was at [needle exchange] 2 years 5 months, just under 4 years altogether as a volunteer."

Having become established as a volunteer in the needle exchange programme and having completed her substance misuse qualification, Debbie felt ready to apply for paid posts in the drugs field:

> "I had applied for altogether 4 jobs within [city] Drug Service. I know I wouldn't have got the job, but, I would have liked to have had the interview experience. And the last time I applied for one at [CDT] and all's I wanted was an interview and, you know, I thought if this doesn't I'm going. I've had enough. Got an email – 'you don't meet the criteria' and then I just phoned up, Tony wasn't in so I said to Gary [another paid worker] 'tell him [Tony] I'm not coming back'. He said, 'Why, what's up?' I said, 'I'm not coming back, no explanation, I've had enough,' and put the phone down. Just didn't go back! I'd applied for 4 jobs over a few months. I mean I had my Level 3 and everything but I didn't even get an interview. I applied for that STaR [Support, Time and Recovery] worker job that came up again cos the NHS emailed me and said this job's available again. I applied for it again and I didn't even hear nothing back from that. So, I wasn't bothered about that. It was too far anyway but, Sheila, I would just have been happy with the interview experience. You know, cos then I would have known what to expect again if another one came up. Em, but that's it, I thought I'm pissing in the wind here [laughs]. They said I didn't meet the criteria of having paid experience, em, managing a caseload and care plans. And a lot of the time it's driving. You need a car but they said desirable, not essential. So, it was, like, care plans and caseload. As a volunteer I was not allowed to develop these skills...I understand you're limited as a volunteer but, believe me, as a volunteer, I knew more about the clients than the staff did."

Debbie was not the only participant to find that the application and interview process acted as a barrier. Nicola also described early frustration when applying for paid work in the substance misuse field:

> "Then I had a nightmare with application forms [laughs]. Could I fill out application forms? Oh, my God. I was on the phone to [friend] ten to twenty times which was just to help me. The first one I did, oh, I can't believe I actually sent it in. It was absolutely diabolical. Then I went for a STaR worker at [town] where I work now, and they knocked me back. And then I went for another one, got knocked back again. I got the interview. It just went shite. I was sick of it by then. It gets to the bit where you're so fed up."

Harry also found he was not able to make the transition to paid work as easily as anticipated:

> "I was getting more and more frustrated at [non-substance related job] and I hated that. I was on anti-depressants over it, it were that bad ... Yeah. I look back and there's a lot of frustration along the way."

Debbie found her volunteering experience did not match the job specifications of the posts she applied for because she was not permitted to manage a caseload as a volunteer. She had expected that having volunteered for four years she would be rewarded with paid work. When this did not materialise, she felt disillusioned and questioned the ethics of the substance misuse field:

> "I felt used and exploited in the end. And that's one of the reasons why I left. Still be there now doing the same thing and not getting anywhere. I might as well have been at home, Sheila, with me kids. [I'm ambitious], totally, I just needed me foot in the door. If I was financially well off, I'd have volunteered for the rest of my life but I needed to be paid. I just feel [pause], I feel like they use volunteers because they've got a lot of knowledge from their background and then once they've learned from us, and that's great to improve services but these are people, Sheila, what, do they think that they haven't got feelings? They have. And then it's, like, 'see ya' and move onto the next one. It's like setting people up to fail and it's so disheartening. It's horrible, especially when you're determined and think, yeah, I'm going to do this. Like I said, there's only so far you can go unless someone's willing to give you a chance. Services need to just stop using people. Just stop discriminating against them once it comes to paying them. Cos, I think a lot of ex-service users are vital to services. I'm not saying they're all good. There's good and bad on both sides but you know the majority of people I've met [pause] I think they feel threatened sometimes, maybe because sometimes the volunteers are doing a better job than them. They think 'they might come along and take my job', you know. There's suspicion there, between workers and volunteers, yeah, it's a combination of loads of different things, Sheila, you know. It's just that at the end of the day you've got to earn your trust which is understandable but, for God's sake, you know, it's every little thing's scrutinized and 'what's she up to? She's up to summat, her. How's she building up or he's building up such good rapport? Summat's going on.'"

Such tension between staff and volunteers, between ex-users and non-ex-user staff was also commented on by Elizabeth who witnessed negative attitudes towards substance users – "I still have this feeling that there's judgement about people who are addicts. I hear comments in work, you know, [laughs] and I think if they only knew."

Another way of Debbie getting 'her foot in the door' included sessional work through an employment agency. However, further barriers included the practices of such employment agencies when they require payment up-front for Disclosure and Barring Service (DBS) checks (which replaced the Criminal Record Bureau (CRB) in 2013) and other financial considerations whereby, if Debbie was to be able to come off welfare benefits, she needed regular rather than intermittent paid work (such as that offered through agency work):

> "When I finished my Level 3, [I applied for jobs in the voluntary sector]. I applied for a few straight after that... Em, where else? Em, I think altogether I've applied for about 150 jobs. [All drug jobs], or something to do with [it] and I've had one interview out of all that. And it's mainly because I've not got paid experience. Or I've not got experience in doing care plans or having a caseload. There's agencies that phone me up but they want money off me for a CRB and they take a percentage out of you. It's no good. I can't do two weeks here, two weeks there. It's got to be something steady. Even [if I got] a 6 month contract, Sheila, what's going to happen at the end of that? I can't even get a job at Tescos, Sheila, there's none anyway, they're fully staffed. I'm just a bit in limbo at the moment. Stuck and I just don't know what to do."

On top of such practical barriers, Debbie felt there were negative attitudes towards employing ex-users in drug services, impacting on her motivation to apply for drug worker posts. Her fear that no-one will give her a chance was based on her perception that employers consider ex-users a relapse risk due to some lapsing once working in the drug field:

> "[I feel] lost, not me passion though. I've give up to tell the truth. I don't think, how I feel at the moment, that anyone is going to give me a chance. If there was a million jobs that came up I just don't think they'd employ ex-users now because, and I've known this for a couple of years, maybe a handful or more who've lapsed, so they're tarring everybody with the same brush instead of treating people as individuals."

**Motivation**

Like Adam, the motivation to become a volunteer was as much about moving away from an undesirable situation as it was about gaining a new status. In Adam's case, it was moving

away from manual labour, in Debbie's it was moving out of prescribed treatment and away from an unhappy relationship. Debbie expected her unpaid labour in the drug service should be rewarded, meaning she felt entitled to get funded to do a qualification that might increase her chances of gaining paid work in the substance misuse field. In the meantime, Debbie felt her skills and personal experience of substance use were effective and appreciated by most clients and some staff members:

> "Mainly, I just did a lot of one-to-one talking with people, you know, maybe it didn't seem to other practitioners that I was doing anything, but feedback what I got from the clients was, 'I'd rather talk to Debbie,' 'Debbie, can I have a word?' 'Why am I feeling like this?' 'Why is this happening to me?' Could be they'd rather speak to me than one of the paid staff because I'd been through it myself. Could be because I was able to empathise and showing a bit of compassion. The impression that I get is a, uh [sighs], lot of people think that drug users are thick, but it's far from it, Sheila. You can see through people. It might take you a little bit of time sometimes, but you sometimes, you instinctively know who you can approach, you know, and, hopefully, well I think that I was approachable. I had the same at the [needle exchange] off the manager saying, 'we don't want to lose you', this, that and the other. 'You know you're brilliant with the clients'. They always come in and say, 'Debbie, this, Debbie, that' and Tony [paid worker] as well. So maybe it's a few things, init?"

**Future Aspirations**

Despite the barriers, Debbie remained committed to gaining further voluntary experience or future paid employment, if not directly in the substance misuse field, then in a related one:

> "There's lots of other places that I could take my skills, it doesn't have to be the drug field, what you do in shelters and that. So, em, I have given up but I haven't given up, if you know what I mean. I've not put all this hard work in just to walk away from it, Sheila, I've just got to keep trying. I am gonna try and get just voluntary, even if it's only one day a week. I've been told to go down to [mental health service], Salvation Army cos they always need help. Got me skills there [laughs]. Summat different, init? So, it's about not giving up, really, you never know what happens... Em, a friend told me to go down to [drug service], they do [recovery group]. He said, 'tell 'em I sent you and ask how you can be trained up' and went, 'Debbie, you can go and deliver this to women's groups'. So I'm thinking of going down tomorrow, even if I have to pay for it me-self."

Although Debbie had four years' volunteering experience and reported applying for 150 jobs without success, she continued to see volunteering as the route into paid employment. She further reflected on how realistic her expectations were in anticipating gaining paid work and considered her previous experience as a drug user to have influenced this:

> "I'm gonna have to break through the volunteer route, I think, but still apply, right, so, em, try for paid work. Do you know what it is, Sheila, as well, you know when you've been on drugs, everything's instant and it's really hard to learn patience. But this, it was all, like, dead exciting. I thought, 'wow, this is great'. I was so happy. Fucking people fuck it up for you [cries]. D'you know that sometimes I really regret coming off drugs, Sheila, cos I think, if I'd only stayed at home, stayed on the methadone, my family wouldn't have split up, you know. I never realised how much they meant to me, Sheila. I know they meant the world to me but I feel like everything's my fault. I've wrecked everything. I was so selfish. He [ex-partner] was, like, 'you're neglecting me'. I said, 'have this little bit of patience with me, just got to get through this', and he wouldn't. [When I first became a volunteer], I was ecstatic, over the moon. And I met other workers that was ex-users and it really inspired me. I'm not saying it would for everybody but for me, I thought, I can do this. Maybe I set my goals too high. Patience! [laughs] And it's pressure, with being on benefits, you know, I've tried to get off benefits and once your children are over 10 now you have to sign on and it's the worst thing in the world. Oh, nothing is ever good enough. To fill in the thing three times a week, it's not good enough, you need to ask friends and family. There's only so many friends and family you can ask about jobs but it's not good enough. If it's like this next time you come your benefits are going to be stopped. Oh my God. In comparison, coming off drugs was a walk in the park. Honestly. Flipping, you know what? I think we've been shielded, been in this bubble for years. Life's flipping hard. I don't just mean financially, just life in general, dealing with emotions. It's overwhelming, Sheila. It's like, 'ugghh'. I'd lock myself away, me, for weeks at a time, 'leave me alone'. But that's just my way of coping. Better than going out and using again. I need summat to do and I need challenging. I like being challenged [laughs], I do. I need to get off me backside and go out, Sheila, cos I know nothing's going to land in me lap. Life don't work like that. You've got to work hard for what you get. I need to motivate me-self and I am. I'm starting again to get [motivated]. Cos me self-esteem and me self-worth was knocked, right down there [hand towards the floor]."

Despite Debbie's difficulties in making the transition to drug worker, which she felt were related to her personal experience of substance misuse and her having voluntary rather than paid experience, other participants, for example Luke and Jamie, saw both these attributes as desirable and, indeed, gave them an advantage over workers who entered the substance misuse field via an educational route:

> "I think that if you've come from volunteer to paid, then you're very fortunate. If you've just gone into paid employment straight away and you've not had the life experience either then...your two worlds will never really make sense to each other... If you'd started to do it early on, it's really beneficial. Some workers feel intimidated, that's very individual on the worker but I saw it a lot...workers were uncomfortable in a roomful of clients. I could just see it. You know, they didn't want to be there." (Luke)

> "not every staff member, even though they're good at their job, they still [sighs] don't know, might not have an understanding. You've got different staff, you know what I mean, that have got that understanding but there's a lot that haven't. And I think even though a lot of people have just been trained and stuff like that in substance misuse, I still think that understanding bit of it isn't there…[I'm not saying] staff that have never used drugs don't know what they're on about, cos they do…you get brilliant staff who know everything about everything and they're up-to-date and they're really good at their job and they can really motivate clients to change and stuff like that, but when it comes down to the drug use, they're still a bit naïve." (Jamie)

Debbie alluded to the need to address other issues apart from employment when making the transition from a drug-using to a drug-free lifestyle - "life's flipping hard" - that is, the emotional roller-coaster of this process; the challenges that life poses with and without substance use; maintaining motivation throughout a prolonged period, especially when obstacles mean goals are not immediately or easily met. Similar perspectives were offered by Michael and Richard:

> "Defence mechanisms, you know, the denial and justifications and rationalisation and, you know, what to do with that. And just get down to the onion, you know, peeling stuff away. You get down to fear and shameful feelings at the end of the day. I remember someone asking once, will I ever get used to feeling that? I was, no, you'll just learn how to deal with it." (Michael)

> "I thought I'd be further along than this [in my personal life]. You know, em,…but it, sort of like, just dealing with things as they come." (Richard)

In Debbie's second interview, her attitude was more positive as a result of approaching a voluntary sector drug service and becoming involved in an advocacy group. The prospect of gaining a new voluntary position infused Debbie with renewed motivation and confidence so that her whole demeanour was transformed. However, she also reconsidered

her future employment options, deciding that the statutory sector was a 'non-starter' for ex-users, stating the roles available there would not suit her approach:

> "I'm going back to volunteering. Em, I'm going to volunteer for [voluntary sector agency] to deliver [treatment programme] to women. I'm also involved with [an advocacy group], on the committee with that, but it's not challenging enough. It's just going to meetings now. But I need to do something for meself, Sheila. So, I'm looking forward to that. I've just got to take me application form up. I don't know what to write on it, to tell you the truth. So, I'll just have to see what happens from there, summat different. Me confidence has gone back up. I just need something to do, Sheila, and, like, I didn't want to give this up. I really didn't. I've put fucking four years of my life into this, you know, then just to walk away. But I know now it'd never happen with the NHS, a job. And, to tell you the truth, I don't want to be, like, a prescriber. I don't want to do that. Cos I think the focus of the support for service users it's gone with prescribing. There's not enough time. It's a couple of minutes and then all the admin work with it. It's, you know, 'there's your script, see ya'. I don't want that. So, maybe I can put more of me-self into motivating people. I just hope it works out, volunteering with [voluntary sector organisation]. Fingers crossed they'll take me on."

Debbie's commitment to volunteering as her 'route' towards employment echoes Harry's experience. He had originally hoped to gain employment on the basis of his educational achievements alone, but found he needed volunteering experience in the drug field to get on:

> "I was studying with yourself and I think I talked to you a little bit about how long it might take and you suggested volunteering. The problem I were having were, I were still involved a little bit with me degree, studying with yourself, the football team was still going on a bit and there was just no time for volunteering around this point. When I got qualified from yourself, I had all this paper I needed but when I went for a couple of interviews, it were just experience that were letting me down...[So] for me, volunteering was the only way."

It is also clear that in the intervening period between her first and second interview, Debbie had taken time to reflect on her aspirations and how these have been affected by her experience as a service user and volunteer. The importance of positive role models and seeing others manage the transition from drug user to drug worker was significant here:

> "I keep putting massive goals in front of me, Sheila, and it's wrong. I need to set little goals for me-self to get to that. But I thought I'd done that but I didn't. It just wasn't meant to be. That's how I have to look at it. [When I became a volunteer], and then when I saw ex-service users who'd become drug workers, that was a key factor. It really motivated me cos I really thought, 'I can do this', you know. When you're not around people like that, Sheila, what've come through the other side cos you don't think, people move away. If they do come off it or if they stay in the area, you never see 'em, you know, so that motivated me. Just again, because I've been stuck in the same lifestyle for so long, I wanted, I just really wanted to change me life and that."

**Key aspects of Debbie's Story:**

Throughout Debbie's story, she returned time and again to difficulties and barriers experienced in her transition journey. These contrast with her initial positive experience as a new volunteer when still in treatment. For Debbie, and the workers who suggested volunteering as an option, there was no expectation that there be a time gap between treatment and volunteering. However, Debbie felt it was important that she not volunteer in the same agency where she was in treatment herself – a different boundary consideration than that described by Adam. Debbie does not consider any other route into employment outside of volunteering. She valued the training she engaged in (her volunteer induction and substance misuse qualification) but did not consider full-time education as a viable, financially practical option. The range of difficulties experienced by Debbie are emotional, personal, practical and financial as well as influenced by her expectations of becoming a drug worker and how other practitioners interacted with her. At no point did Debbie talk about support being offered by the services where she volunteered to address these problems. Indeed, Debbie identified a lack of understanding of what ex-users go through on their journey beyond treatment – this being a key aspect of the transition process little witnessed by substance misuse services.

As Debbie reflected on her experiences and the difficulties that prevented her from making the transition to paid work, she noted that her expectations may not have been wholly

realistic. She considered that this may have been affected by her drug-using experience where she expected instant gratification and had been unaware of how difficult daily life was when not using drugs. However, other drug users have successfully made the transition to paid employment in shorter timescales than the four years Debbie described. Might this relate to Adam's suggestion that it is harder for ex-users to make the transition in the current financial climate compared to when he made the transition? Adam became a volunteer in 1998, while Debbie did not do so until approximately ten years later. This may mean drug services have to re-consider how best to recruit, induct, support and train potential ex-user drug workers.

**Richard's transition story**

At the time of the interviews, Richard, an ex-poly substance user in his early-40s, was working in a voluntary sector treatment programme. Richard had himself completed this treatment programme before engaging in their aftercare service and subsequently becoming one of their volunteers. After volunteering here for a year, he was offered a paid post and continued to be employed within the same setting. Between Richard's two interviews, he relocated to another geographical setting within the same organisation.

**Decision-making**

Richard began his transition story while still using illicit substances and in the criminal justice system. Richard qualified his reason for starting at this point, stating that in prison he gained a passion for learning that influenced his later education and recovery decision-making:

> "A significant period of me life really was in prison, so that's played a part in where I am today. I did a lot of reading [in prison]. And I would read different books and I guess that sort of broadened my imagination if you like and stretched the brain cells. Then, I guess, it was treatment from that date. The tools I learned [included] talking, very first one. I learned just to express, really, how I felt. And they listened.

> Not just the treatment centre but the people who were around, so my peers as well. Until I was 38 I never uttered a word about that [childhood experiences]. I started that process. Well, I put down the drugs on that day and that was a good start. I was ready for something else, I guess. So, I was in primary treatment for 8 weeks. And then I went into aftercare so then I was clean. One of the first things I did was go to college. And that seemed to ground me. So it was 3 days a week health and social care and it just seemed to give me some focus. That was it then, nothing got in the way of college, you know, friends, girls, nothing. It was Monday, Tuesday and Wednesday, I went to college and, you know, obviously I'd not been to any type of education since I got expelled from the approved school as well and that was when I was about 14."

Although Richard stabilised his lifestyle through treatment and education he was reluctant initially to become a volunteer. However, he eventually agreed and relished the training offered alongside this involvement:

> "I'd just finished treatment. I wasn't long out of treatment. I was in college, so, I wasn't recruited, I was just asked to go on it. They asked me three times, I said, 'no'. But they kept asking me. Every couple of months, they'd ask me again, so, eventually, I just said, 'yeah'. I just felt the timing was right, so, I always knew it was coming. It was just when the time was right to do it really. They just put me on, just doing it; learn on the job, doing it, just sat in groups. And I was already having confidentiality training and other professional training through the health and social care, and then, of course, coming on the substance misuse course. And there was assertive training. So, there was a little bit of academic training as well. No specific volunteer programme then."

Richard was 'head-hunted' initially as a volunteer but then, without needing to apply, he was offered a paid post within the same service. Other participants reported being offered employment without an application process, for example, Michael and Jamie. Meanwhile, other participants experienced opportunities that facilitated their passage into paid employment, for example, Luke and Harry:

> "And then the coordinator said there's this job coming up but it's only for six months and you should go for it cos you'd probably get it. I was like, 'I won't get that'. 'You will because, obviously, you've got the skills, but it's for six months so no one's going to go for it. I bet you'll get it cos hardly anyone's going to go for a six-month contract.' So I went for it and got it." (Luke)

> "I did about 4, 5 months and [manager] tipped me off that there was going to be a full-time place. She'd like me to apply. I applied and got it. I mean, 'tipped off' sounds a bit sinister [laughs]... I just said, 'let me know if there's anything coming up here'. And that's when she said, 'we're applying for funding for [new post]. There's a good chance that there's going to be some positions, we'd like you to go for it'. I didn't apply for anything else because this was what I had my heart set on." (Harry)

**Difficulties**

Despite working in the same service where he was in treatment and having access to education Richard experienced some barriers along the way related to his previous substance use and offending behaviour. However, he was determined to overcome these:

> "The most recent [barrier], I guess, was to finish the diploma I had to go join the BACP, the British Association of Counselling and Psychotherapists. To finish me course I had to do a placement of 100 hours, one-to-one counselling with clients. To actually start a placement on a one-to-one basis, I had to be a member of BACP. I put in me application form with everyone else from college. Two of us, they said, 'no,' but you can appeal. So, we both appealed and then it came back and they said, 'yes' to the other person and 'no' to me. So, I rang 'em up panicking. Everyone else was starting their placement. I rang 'em up panicking and I spoke to this lovely woman and she said, 'well, the only thing you can do is come down to [town] and be seen by a panel'. You know, like an appeals panel and within 2 days she'd organised 4 key people within the BACP which is quite a lot of doing I think. And she rang me back up with a date to go down to the BACP for this appeals panel and I went down. I took someone with me and, em, I enjoyed it. I enjoy that sort of thing where you just got to be honest. It was quite serious and then they started asking me about me drug use and why I wanted to be a counsellor and he said to me, and this struck me, but he actually said to me, and this was a counsellor with 40 years experience, he said he could not understand how someone with 20 years' history of drug use could suddenly change and he asked me what it was, and I wasn't being flippant and I did pause, but I believe it was that therapeutic process, the therapeutic process. And I was able to express that to them. He said to me, 'go out, we'll call you back in'. So I went out and I wasn't nervous at all and I don't know why, and he come in and he said to me, 'Right, Richard', he started calling me Richard at that point, and he said, 'Alright, Richard, what are you going to do if we don't let you in?' And the question sort of hit me by surprise but what I said to him was that, if they'd said yes or if they'd said no, it wouldn't really make a big difference to the grand scheme of things so I wasn't really bothered and I said that to him and then this big grin came on his face and then he said, 'Right, we'll let you join'."

Richard was also accepting of others' guidance that training as a social worker may not be viable because of his criminal record. This was a similar experience to that described by

Michael who said, "I applied to be a social worker which I was accepted onto [laughs] but when they saw my criminal record obviously they decided it wasn't a good idea; too high risk and not too far away from probably chaotic behaviour". Like Michael, Richard felt there were other, more attainable, ways of reaching his goal of becoming a drug worker, primarily through his own drive and determination:

> "I remember having aspirations of going to do a social work degree, that's what I wanted to do. But I had a word with a few people and it wasn't really fitting really. After speaking to people it wasn't really fitting. [They were] just saying to me, 'I'm not saying you can't do it, but you're gonna struggle getting into university because of your 20 years of using and being in prison. It didn't feel right and then someone mentioned the substance misuse level 2."

It was at this point in Richard's journey that he became involved in substance-specific education, using the Level 2 substance misuse course as a stepping-stone to the Level 3, alongside counselling qualifications. By this stage in the transition process, Richard had a definite plan regarding how he was going to achieve his ambition:

> "So while I was doing your substance misuse level 2, I worked out a bit of a 2-year plan and that was to do your substance misuse level 2, the counselling skills which was a year and then the substance misuse level 3. So it took me about 2 and a half years to fulfil that bit of a goal and it bleedin' happened, you know, and in the end, you know, I'd done your course, did the counselling skills as well and it just seemed like the most obvious, right thing to do was the diploma as well."

Not all participants had such definitive plans as Richard. In fact, some had no intention to become a drug worker at all and left their career progression to chance, for example, Jamie:

> "I never set out to be a drug worker, not at all, never. Even when I was [a support worker], if you'd said you'll be doing shared care, working with G.P.s and stuff like that in another three years, I'd have been like, 'yeah, whatever'. I would have said you were talking rubbish. Now I've realised when it's all on paper [process-map] like that, you don't realise how much you do. And I was trying to work it out. I done all that since [doing a detox]. It's not even ten years yet and I've done quite a lot. You don't realise how much you've done, I don't think, until you look back at it all. So, when I [see] that [process-map of his transition journey], I was, you've come a

> long way really. If someone had said to me before I did me detox or while I was doing it, in nine, ten years you'll have done this, that and the other, and you would end up here, I wouldn't have believed it for a minute. I've probably got one of the most responsible jobs in the whole family. I think it's that kind of need in me, to keep me going. To keep me fulfilled, I think, so, yeah, quite pleased with my little self."

Not only was Richard committed to education, he was also a regular volunteer within the treatment programme and reflected on how far not only he himself had come, but also reflecting positively on how his (and his manager's) input has facilitated the development and expansion of this service. While Richard is proud of his achievements, he reflects on a need to remain grounded to avoid over-confidence:

> "Well, I did volunteer for about a year on [treatment programme] when it was here in a little room downstairs with a couple of clients. I have absolutely no doubt what I've done for [treatment programme] and what Kyle's [manager] done collectively for the [treatment programme], cos it's absolutely massive now and it's all over the place. And I've got no doubt about what I've done and Kyle for that. I think these lot forget but that's alright [laughs], I've definitely stuck with it. Now I'm [treatment programme] coordinator for [two towns]. It's a massive achievement, in't it? You know, doing all this stuff, I constantly have to keep myself grounded, constantly."

Richard continued to work in the same organisation where he was in treatment, something he was comfortable with as all the other staff members are from a similar user-background to himself. He considered his substance misuse qualification to have prestige and felt privileged to have done this at the time and in the way he did. For Richard, it was the ability to simultaneously combine daily practice with education and reflection that enabled him to feel confident in his position as a drug worker:

> "I've been working now full-time for 3 years. And I seem to think that because me diploma was 2 years ago, I must have been on the level 3 sometime rounds about then and I got the job round about then. So I ended up getting a job when I was doing the level 3. [It was] massive, doing the Level 3, because at the same time everyone was scrambling to do the Level 3, you know. Me and Kyle had already done it and, you know, only the other week I was listening to some CDT workers who were scrambling to do it and they've got to do it by distance learning. So, they're all struggling with it pretty much, so, I just count myself lucky to have had the opportunity to do it then with you. It really gave me a lot of confidence, the Level 3. I guess the biggest thing about doing the Level 3 was actually being in college and

then doing it the next day, straight away. What brought them two things together was the reflective diary."

Meanwhile, for others, it was a relevant qualification that was the achievement that cemented their transition to recognised drug worker status, not just in their own eyes, but from colleagues' perspective as well. For example, Luke stated:

"I've done the level 3 now, so it's pretty much once you've done your level 3, people know that you've hit your [competences]... people know you've got your ten DANOS [Drug and Alcohol National Occupational Standards] points which you should be having. And, a lot of them, although they've worked in the field for ten years, they've not done that course so they don't have the ten DANOS points. So, I don't think people are so quick to judge. I feel that now. It feels different now."

**Motivation**

Despite Richard's initial reluctance to volunteer in the drugs field, he saw becoming a drug worker as a natural progression for himself. It was not, however, a conscious decision, more of a 'gut instinct' that required work and dedication to achieve:

"I always knew, I just always knew I would work [in this field], but I don't remember making the decision to do this. I just always knew really. It was the natural thing for me to do anyway, making the transition from drug user to drug worker. Well, the first thing is you've got to stop using. You've got to stop using drugs and, for me, prescribed drugs as well. But that's my own personal opinion. Then you've got to be patient as well and then, for me, not rushing it, not rushing the change, or trying to control the change and just do what you need to do. And commitment as well, you know, turning up. It's a big part of that change, I think, that transition. So, it's not just about getting twenty grand a year or whatever, you need to have as much passion and commitment to volunteering. That was important, I think, to me. You know, being as committed and passionate then when I wasn't getting paid as committed and passionate now when I do get paid twenty-odd thousand a year or whatever. I'm still, sort of like, being that same person, if you like. And the money's great and I'm dead lucky, but, at the same time, it's not just bleedin' fell in me lap. It's not fell in me lap."

Richard was able, at this time, to tap into the study skills and focus he had developed in prison and found he could rise to the challenge of studying at a higher level. He felt there

was a different type of motivation at work here and is prouder of engaging in education on a voluntary basis, rather than coerced into it through the criminal justice system. It may be that the kudos of doing education in college, rather than in a prison setting, is a similar motivating factor to the one Adam described when comparing statutory with voluntary sector service provision (see p72). For both Adam and Richard, status mattered:

> "And I found out I could sit down and do assignments, and I knew I wasn't stupid because of education in prison and the odd little things that I did, it was no real surprise, but it was nice for me to be able to do it [education] outside, on the street, by me own volition and actually go to college as well. I was there by choice and I enjoyed it. I think that was the main difference. It wasn't a chore. It wasn't even a chore doing the assignments. So I went back to college and I ended up getting a distinction."

**Future aspirations**

Richard did not see himself continuing forever in his current role unlike Nicola who cannot imagine doing a different role: "I've never, ever thought about changing jobs, ever, I can't imagine doing anything else." Richard had aspirations of moving on from client work to deliver training. Although he already had a training remit through working with volunteers and had done some personal presentations with a range of professionals, he saw these as side-lines rather than his main role and he wanted to shift the focus more towards training as his main occupation. This is similar to Michael's aspiration: "And what would I like to do next? I don't know, probably training. All old drug workers go into training [laughs]." However, it is clear from the way Richard talked that he has more of a tangible plan and motivation regarding training than Michael. Indeed, since being involved in this study, Richard did a teacher training course that included a placement with a substance misuse service in a trainee trainer role, alongside his full-time job. He had already approached his director to discuss a proposal to develop this idea, demonstrating Richard's own initiative in creating opportunities to meet his desired goals:

> "Something I've been thinking of doing, is training. And I've done odd bits for [treatment programme] because we have to train other volunteers and that's been quite successful really in itself. So I've got experience of training up the volunteers and doing stuff like boundaries and that sort of in-house training. So I did a proposal of maybe taking on a trainer's role within the organisation and it would be in-house, but also, for outside agencies as well, so, police, probation, hospitals, prison officers, but obviously, they'd have to pay for that. So, I did this proposal; ...sent off the thing to the managing director who's the top man, he invited me out to lunch and bought me lunch and we sat down and talked about it. He definitely was interested in it and he wanted to hear what I had to say... So, he said, 'ok, well, first thing to do is to get your diploma out of the way and then, apply for college', which is fantastic for me. So back to college in September and the course is called certificate in training development. And it's a year and it trains me actually to deliver training so they'll pay for that which is great. [So], I'd like to get more involved in the training side of things. I don't know, I just seem to be dead comfortable with talking to [people]. Like when I was talking, when I was invited to do them three police conferences and training days, and I was just comfortable with doing it and not ramming it down their throats, but really cos I'm very articulate and having had that experience as well and bringing the two together really. Does that make sense? And, why not exploit that in me-self and use that? I've got a skill, why not use it? And I'm sure that's where I'm going to be headed whether I do this training the trainers or whatever. I'm sure that's where I'm going to be headed. I don't know why, but I just seem to be very comfortable speaking to fifty doctors about this stuff, so why not sort of like exploit that, use that."

When Richard met for his second interview, he had re-located to a new geographical base and described how he was getting on with the challenges of his new role and working within a new team of staff and volunteers:

> "I'm fitting into two different services cos we've got the [towns 1 and 2] services and they're very different teams, very different buildings, even different clients. The clients at [town 1] just seem more manageable than the clients at [town 2] and the workers do as well. I'm just enjoying that, just sort of fitting in, just seeing where I fit in, you know, watching the dynamics that are already happening. But it's good, it's really good. [The service in [towns 1 and 2] are run by the same organisation [name], so there's [three voluntary sector organisations] who are partnered up and are doing [towns 1 and 2] and, obviously, they've brought us in to deliver the [treatment programme] so, they're, you know, [sighs]. I can imagine that the senior managers have told the area managers that, you know, they want the [treatment programme], they've paid for it. So they've got to give me support cos they've paid for it. So, it sounds like that's filtered down to the staff. And I have had one or two, not cold shoulders, but, you can tell one or two people are a bit threatened and that's normal, init? But, it's going great. And I'm doing it on me own as well, so, I'm enjoying that as well. [Staff] weren't very welcoming. I think they're a bit anxious cos there's a couple of group workers [and] quite a few groups already up and running with these group workers, so, I can imagine, I don't think I'd be very comfortable, me, if [employing agency] brought someone in to do a group."

**Key aspects of Richard's transition story:**

Throughout Richard's story, the link between experience and education is tangible. He got a taste for education in prison and this has remained with him, despite negative experiences of education in childhood. While Richard relished a challenge, especially where education is concerned, he kept within his comfort zone by continuing to work for the same organisation where he was in treatment and a volunteer, although he recently re-located to a different base. Even when considering his future as a trainer, it is within this organisation that he is trying to create the opportunities to make this happen. What is also of interest is that Richard did not have to apply to become a volunteer or paid worker within this organisation – he was recruited by them. The closest Richard got to being interviewed was when he appealed against BACP's decision. Despite Richard's belief in his own self-efficacy and recognition of the achievements he has made for himself and his organisation, he is determined to remain grounded (a term he used many times in his interviews), often worrying that he was getting above himself. Perhaps this is reflected in his initial reluctance to become a volunteer and linked to his comment about needing to be patient and put in the effort over time to achieve his goals, something also referred to by Debbie, although her comment was in hindsight rather than part of a plan like Richard's. Over all, it is clear that Richard is proud of how he has managed his transition:

> "I don't regret anything. I don't regret any part of me volunteering, or any part of me courses I did, any of the people I met, any of the decisions I made."

## Part 2: Discussion

### Transition components

In the earlier stages of transition, many participants referred to their motivation to "put back" (Adam), but this was not the only driving force - status, financial security, respect for one's skills and experience are amongst factors influencing how far participants felt they had come and their future aspirations. For example, Michael described how he relished his first paid post but soon wanted to move to a more financially rewarding one (see p74). Although Michael was not one of the three 'main' transition narratives, I begin this chapter by highlighting a number of key elements from his story that are not reflected in the three main transition narratives but which arose not only in Michael's narrative but also in participants allocated to the other orientations of disclosure (for example, Jamie and Luke, and professional identity, for example, Nicola and Phil). First, Michael's transition from welfare benefits to paid work; second, he was approached to be a paid worker by the rehabilitation unit – their recruitment practice meant he did not have to apply; and third, his first paid role was restricted to working in the secondary unit, not the primary. In order to reflect on the above components and how they have affected Michael's career, I will explore each point in turn.

#### 1. Transition from Welfare Benefits to Paid Employment

Making the transition from welfare benefits to paid employment can be a huge life-change for ex-drug users, especially if they have not worked for some time or had been claiming sickness benefits, resulting in anxiety and feeling disconnected from their previous identity where there was at least comfort in knowing where they stood (Rattansi & Phoenix 1997). For example, there are associated status, financial and mental health concerns in attempting this transition. Despite this, Michael was keen to move from benefits to employment not only because paid employment would be more financially rewarding but also as it gave him a

more respected status with his family. Debbie, on the other hand, having not yet made the transition to paid work, described the stress of having to demonstrate to the job centre that she was 'actively seeking work' while trying to remain committed to volunteering, studying and being a parent. Similarly, Jamie described his anxiety about making the transition to paid work, especially as he was a sessional rather than full-time employee, and he worried he would have a reduced standard of living compared to previously having his rent and council tax paid alongside incapacity benefits. These are three quite different experiences of making the transition from benefits to paid employment so I would consider it important for service managers to discuss such practical considerations with volunteers when they are at the point of planning their transition to paid employment.

**2. Recruitment Practices within Drug Services**

Luke's recruitment to his first paid post was through a short–term contract and Harry's successful application was within the service where he volunteered. In Michael's case, he remained in contact with the rehabilitation unit where he was in treatment through their aftercare programme and was volunteering elsewhere when he was approached by the rehabilitation unit and offered a job without an application process. Like Michael, Adam had been identified as having drug worker potential within a residential rehabilitation unit, but, unlike Michael, when a vacancy arose, Adam had to apply but was unsuccessful. What we will never know is, if Michael had had to apply, would he have been successful? The rehabilitation unit's recruitment strategy could be seen to have influenced the rest of Michael's transition journey as, without this initial employment, it is less likely he would have gained subsequent posts. Luke, Harry and, to an even greater degree, Michael can be seen to have been given a 'leg up' into employment in ways that actively discriminates in favour of ex-users.

Michael was not the only participant in this study to have been given such opportunities. Richard also did not need to apply for either his initial post or subsequent promotions while Jamie did not need to apply to become a sessional worker, even though subsequent permanent posts did require an application form and interview. Both Richard and Jamie began their careers in the same service where they were in treatment and had been volunteers. Perhaps there is something rewarding, even validating, for staff to see ex-clients becoming volunteers and then paid workers – ultimate proof they have done a good job. If the rehabilitation unit Adam attended had the same recruitment strategy as Michael's, his early transition journey may have been smoother and his learning curve less steep, even if the longer-term outcome for both Michael and Adam have ended up the same – both are now drug workers within CDTs.

There are a number of key questions here, firstly, was it fair that Michael, Richard and Jamie got jobs without applying when Adam, Debbie and Nicola had to apply, sometimes without success? Secondly, and looking at things from the other side, did it disadvantage Michael, Richard and Jamie by denying them experience of application processes that would have stood them in good stead for later employment opportunities? It would appear not, as all were successful in gaining future employment, but this was not true for others in a similar position, for example, Nicola described how her lack of experience with application forms and interviews initially acted as a barrier to gaining employment (see p80).

Because many ex-drug users face barriers and discrimination in a range of employment sectors, it might be considered appropriate to redress the imbalance by finding ways of offering employment without resorting to traditional recruitment practices of advertisement, application and interview. Based on the experience of these participants, it would appear that some agencies agree with such positive discrimination.

### 3. Paid Role restrictions

Michael stated that while he was sought out to work in the residential rehabilitation unit, his role was restricted to working with clients who had already made progress in their treatment journey, that is, he was permitted to work in the secondary stage of the treatment programme but not the primary. To clarify, when an individual enters this type of residential programme, there are often specific phases through which an individual must travel. Primary treatment is the initial first few weeks of treatment, when clients are perhaps at their most vulnerable due to the recency of their substance misuse and chaotic lifestyle. Secondary treatment is the stage that clients progress to when they are more settled in the rehabilitation unit; have stabilised their physical health, mood and behaviour; and have demonstrated their engagement in one-to-one and group-work settings. By this stage, individuals have gained confidence and skills. Michael seemed to accept that, as an ex-user, it was appropriate for service managers to insist he work only in the secondary stage; the implication being that either he or the clients were too vulnerable for him to work in the primary stage. This is a variation on the theme of having a gap between treatment and paid employment (NTA 2010).

**Identity and Meaning in Transition**

It could be considered that individuals are different from their previous identities (McIntosh & McKegeney 2002) but they may also be seen as different from their colleagues *and* different from their clients. As Debbie put it, at the volunteering stage of the transition process, she was "a bit in limbo". May (2001), in his research on young people's transition to adulthood, referred to young people trying to make the transition from school to employment as being in "no man's land" (p76) so this is a transitional phenomenon that resonated with other potentially vulnerable or socially excluded groups. Being 'in limbo' or 'no man's land' builds of the concept of liminality which has been described as "an experience of in-between and uncertainty" (Bruce et al. 2014, p36) or, based on the work

of Van Gennep, "a betwixt space – which, in turn, creates this lack of belonging or sense of placelessness" (Palmer et al. 2009, p38). This can leave ex-drug users vulnerable because "[d]anger lies in transitional states, simply because transition is neither one state nor the next, it is indefinable" (Allatt 1997, p90). This is not an experience that is unique to ex-substance users but one that is recognised in other populations, for example, "the danger which the ageing person moving between social statuses, or in transition, poses – and the threats to which they are exposed" (Hockey & James 2003, p199) and asylum seekers who are "in the 'liminal stage', following a 'rite of separation' and prior to a 'rite of incorporation'" (Hynes 2011, p30).

Ageing individuals and asylum seekers are no more homogenous groups than are ex-substance users. Hockey and James (2003) suggest that:

> "though people may share the same nominal identity they may have very different experiences of it, for it is in and through social interaction with others that the individual comes to an understanding of the social identity which he or she inhabits." (p201).

Therefore, while the participants in this study share the same 'nominal identity' of ex-users, they may have different experiences and attach different meaning to their life events. This does not mean that there is no relevance for individuals in finding out about other people's experiences for there may well be shared issues that affect how they then view their own experience in hindsight. It is therefore important to reflect on what meaning individual ex-substance users attach to the transitions they have made/are making. For example, for Debbie, volunteering and aspiring to paid employment meant "getting off methadone"; for Jamie, it meant avoiding relapse; for Nicola, it meant working with a client group she felt "passionate" about; while for Adam and Luke, it meant "putting something back". Such meaning-making demonstrates just how much participants had 'riding on' the success or

failure of their transition and how potentially vulnerable such individuals were if they did not get a positive response from colleagues and clients along the way. As can be seen from the above, there were a variety of meanings attached to becoming a drug worker. This is consistent with the notion that meaning-making is subjective and is based on how individuals evaluate their own transition (George & Hickman 2011).

**Turning Points**

It can be considered that a human being's life course is made up of a series of turning points and transitions (Palmer et al 2009) and that "turning points are helpful in understanding stability and change in human behaviour over the life course" (Sampson & Laub 1993, p240). For many ex-users, the notion of turning points or rites of passage (Barton 2007, Palmer et al 2009) determines the way in which they manage their transition; the extent to which they feel they have been successful in achieving their goals; and their sense of self or identity once they have made progress towards their desired transition outcomes. Within the context of the principles of liminality, Palmer et al. (2009) suggested that there are:

> "individual differences in the experience of the turning point, including the development before the transition, the timing of the transition for the individual, the individual's experience of navigating the transition, and the context in which the transition occurs" (p41).

Palmer's view is supported by the underpinning life course perspective (Bengtson et al. 2005) which suggests that there are five principles – interconnectedness; social and historical context; transitions and their timing; personal agency; and human development as a life-long process. Certainly, for drug users and ex-users, there may be interconnections with other users, drug workers and family that influence their life journey while the social and historical context in which they live affects the options available to them in terms of any

sanctions, treatment and future aspirations. Furthermore, the actual transition process, including the above turning points, may be determined by how much time has elapsed since they were an active drug user; how long it takes to manage each transition step; and their expectations regarding timing of the overall transition. The concept of personal agency suggests that individuals can plan for and therefore determine much of their own journey, echoing the experiences of many of this study's participants, while the concept of life-long development suggests that for ex-users there are more turning points to come in their future careers and lives.

Some participants in this study talked about many turning points in their lives (for example, Elizabeth and Michael). However, the turning points referred to by Elizabeth and Michael related to experiences when they were still using chaotically. For Elizabeth, the turning point was her teenage daughter leaving the country, while for Michael, it was being left for dead after a drug deal went wrong. Such dramatic events were not included in the post-treatment narratives. Here, the transitions were more 'gentle', slower paced, often planned, and, even, "mundane" (Gubrium 1993, p xvi; Hinckley 2008, p29; Holstein & Gubrium 2000, p24, p169). This 'mundane' element of later stages of transition to be a drug worker is rarely found in the genre of recovery narratives available in newspapers, on the shelves of book shops (for example, Addenbrooke 2011; Hurwitz et al. 2007; Jason et al. 2008; Sinisi 2009) or on recovery websites (My Recovery My Choice (2012); Stories of Recovery (2013)). In many, stories focus on the more dramatic stages around the time of 'hitting bottom' rather than what happens next. It is the next stage of the journey that is less familiar to current drug users so if such experiences were shared this could potentially be even more useful. New service users already know what it is like to be a drug user but they may not yet have experience of navigating treatment, volunteering and paid drug work. An element of danger may emerge from, for example, the trepidation with which individuals face up to underlying issues whilst in treatment; risks associated with the

potential for relapse; stigma attached to being seen as a substance user *and* as an ex-user; and fear of rejection when applying for jobs. However, greater danger may result from having to adapt to day-to-day living without the use of substances as a coping strategy. If ex-user drug workers are to be role models, their stories need to continue beyond dramatic turning points, treatment and recovery processes in order to support others to develop the work *and* life skills needed to be drug workers. In other words, ex-user drug workers need to offer constructive insight into how they practically and emotionally achieved their goals, rather than tokenistic statements, for example, "he began to educate himself and is now a drug and alcohol worker" (Darren's story on the User Voice website (2013)). This statement does not tell us how Darren achieved this. What education? What employment? How much work was involved? How long did it take? These are questions ex-users attempting the transition are likely to have, amongst others, and it is this kind of narrative that would be useful to guide future transitions.

**Starting Points**

It may be considered that to enter a process of transition, participants must have a 'starting point' from which to begin the journey even if this point is different for each person. Without identifying this starting point, how can we compare the person they were at the beginning with the person they become? How can we measure how far they have come or understand the route they have taken? However, many participants had identified transitional aims and mapped out potential routes while still in treatment; even before taking (perhaps almost imperceptible) steps in the desired direction, making the starting point indistinct.

Adam reported his transition journey being instigated by his key-worker while Debbie's community drug worker suggested volunteering as a useful diversion to help her avoid illicit heroin use on top of her methadone prescription. For Nicola, it was her partner's key-

worker; for Phil, it was his vicar, and so on. The role of drug workers or other inspirational role models in instigating and/or facilitating the transition is important – without such role models many would not have ventured on this route let alone succeeded in achieving their ambitions. Although referring to transitional experiences of young people rather than problematic substance users, Barry's findings (2001) echo the significance of such role models:

> "many commented on the value of professional workers having experienced in the past similar situations and feelings to those of their clients in order to have an effective and constructive relationship with them" (p70), and that, "those with experience of, for example, social workers or care workers in the past seemed more likely to want to pursue a career in this field" (p71).

Furthermore, drug workers not only encouraged ex-users to start this transition, they 'taught' them necessary skills for the role of drug worker even if not purposefully 'teaching' each individual. This process often began during treatment where drug users 'recognise good practice when they see it' and so endeavour to emulate this when making the transition to volunteering, continuing to develop their skills when gaining paid employment through observing "role models from the multi-professional context, styling themselves on traits they observed from experienced clinical staff" (Barton 2007, p344).

In addition to Adam being influenced to make the transition *towards* being a drug worker, he was also influenced by his prior experience to *move away* from substance use and previous employment in the building trade, a key concept described by Hayes and Hough (1976) as "to move *towards* some attractive position or *away* from an unattractive one" (p92, emphasis in the original). This was a motivation shared by other participants who saw themselves as making the transition *away* from a previous identity, role or experience. For example, Debbie wanted to move away from prescribed medication; Nicola wanted to move away from unskilled, irregular employment; Elizabeth wanted to move away from

administrative work, and so on. The notion of moving away from "unattractive positions" was also referred to by McIntosh and McKegeney (2002) as ex-drug users made the "attempt to dissociate themselves from their old friends and haunts" (p101). The suggestion here is that for ex-drug users to develop new identities, they first need to move away from the old, including associates they used to identify with. This often required a physical move to a new area to prevent relapse so they could live "somewhere where they were not recognised and where their past was concealed" (McIntosh & McKegeney, 2002, p102). This resonates with Elizabeth's attempts to keep her past identity "hidden".

It would undoubtedly be considered by most, if not all, that moving away from problematic substance use is a 'good' thing. However, this does not mean that ex-users making the transition should simply ignore their past identity as if it never existed. Nor should mentors assisting this process fail to offer support to address this loss of role. As Bridges (2003) said,

> "Even in these *good* changes, there are transitions that begin with endings, where you have to let go of something... The failure to identify and get ready for endings and losses is the largest difficulty for people in transition. And the failure to provide help with endings and losses leads to more problems" (p8, emphasis in original).

In a similar vein, Bauer and McAdams (2004) noted that, "not all life transitions – not even the voluntary ones – leave the individual with a strengthened sense of meaning or happiness in life" (p574). Therefore, ex-users need support to reflect on, and come to terms with, their previous identity as drug users as failure to do so might increase risks of relapse or act as a barrier to successful completion of the transition journey to their new identity. Bridges (2003) goes on to explain what he sees as three stages of transition – "letting go" (as referred to above); the "neutral zone" (p8), which is akin to what both Bridges and Debbie described as being in "limbo"; followed by "new beginnings" (p9). Many of this study's participants were simultaneously working on "letting go" of their "old sense of

identity" (Bridges, 2003, p8), while working as a volunteer in "no-man's-land" (Bridges 2003, p8) and aspiring to gain skills and confidence needed for "new beginnings". Ex-users must cross a boundary between volunteering and paid employment if they are to move away from the "dissatisfying situation" (Hayes & Hough 1976, p92) of being seen as a drug user (what McIntosh and McKegeney (2002) referred to as a "spoiled identity" (p57)) and the 'dissatisfying' position of not being paid for one's labour, while attempting to become successful as paid drug workers with a "new identity" (Bridges 2003, p5) and receiving financial remuneration.

In addition to the theme of participants moving away from problematic substance use, it is also significant that participants were moving away from prior unsatisfactory employment. Although previous employment did not provide job satisfaction, they did have employment experience to positively influence their ability to become drug workers with transferrable skills and work experience standing them in good stead when making subsequent transitions. This is supported by Bynner's (1998) research which found that "[w]ithout employment experience early on in their career, employability becomes even more difficult to achieve" (p48), meaning *any* prior experience of employment (however unsatisfying) will be beneficial in countering other barriers participants might face in the employment market. Only Richard and Kieran reported no previous employment experience. They relied on other factors to facilitate their transition to paid employment, namely, Richard volunteered and worked in the same service he was in treatment and gained a counselling diploma, while Kieran undertook a degree as a mature student. Despite the benefits of educational attainment and volunteering experience in increasing employability, Bynner and Pan (2002) advocated that, "the best form of vocational preparation continued to be work itself" (p17). And yet, it is likely that few employers in the substance misuse field would offer a job to ex-drug users if they had not first demonstrated competence in the field through training and volunteering. The optimal combination would, therefore, appear to be prior work

experience (in an unrelated occupation, perhaps before problematic substance use); relevant education and/or qualifications; and volunteering experience in the substance misuse or other related field, such as homelessness (Bynner et al. 2002, Bynner & Roberts 1991).

**Volunteering as a Recognised Route into Employment**

Most participants (Adam, Luke, Harry, Jamie, Michael, Debbie, Elizabeth, Nicola and Richard) saw volunteering as a recognised transition route from treatment to employment and all engaged in volunteering activities in the substance misuse or related field. Although Kieran and Phil did not mention volunteering as a transitional requirement, Kieran had prior volunteering experience in youth work and Phil had informally volunteered through his church. It became apparent that volunteering is not just recognised as an important stepping-stone for gaining paid employment by the ex-users themselves (Wilson & Musick 1999), but was valued by potential employers as much as, if not more than, relevant qualifications (Student Volunteering UK 2001). The notion that ex-users' volunteering in the substance misuse field is purely about "giving something back" (Best & Laudet 2012, p5) is not wholly accurate, although Wilson (2000) noted that "activities that seem to be truly selfless are the most esteemed" (p218). It may be for this latter reason that ex-service users select this accepted narrative to express their motivation for volunteering, expecting this will gain social approval (Wilson & Musick 1999) in addition to other positive outcomes associated with volunteering. It is, however, more likely that any volunteering arrangement will be reciprocal resulting in perceived and actual benefits not only for individual volunteers, but for service users, the organisation for whom they volunteer, and the wider community (Wilson & Musick 1999).

A perceived outcome associated with ex-user volunteering within the substance misuse field relates to the recovery process. While White and Cloud (2008) advocated volunteering as

a way of facilitating recovery, there is more to volunteering in the drug field as a transition route than first meets the eye. Participants expressed a range of views regarding the role volunteering played in their transition, for example, Jamie suggested volunteering was, for him, an extension of treatment and a key part of his relapse prevention programme (see p67). There may be advantages and disadvantages to utilising volunteering as a form of treatment extension. For example, Wilson and Musick (1999) suggested a positive association between volunteering and mental health because it is a "self-validating experience ...[and] provides a sense of control over one's life and one's environment, thereby alleviating depression" (p154). Self-validating experiences; opportunities to build trust; gaining control; and alleviating depression may be particularly important during earlier stages of recovery, whether that recovery is from mental health or substance misuse problems. Even if ex-users are not intending to use volunteering as a means of accessing continuing support, it is inevitable (and appropriate) that they experience personal benefits. However, these positives may need to be balanced against issues relating to intimacy in terms of relevant boundaries between service users and volunteers or if ex-service user volunteers need reciprocal help. Adam suggested such help may be inappropriate once a person has made the transition from service user to volunteer and yet, on balance, it may be considered that if volunteers are struggling with addiction-related issues then it is better for them to get help rather than risk relapse. Recovery is after all a dynamic process. The concept of feeling that one is making a difference is important for ex-user volunteers as this contributes to motivation and enables them to move away from the "spoiled identity" (McIntosh & McKegeney 2002) they had before treatment and find a role for which they are "getting satisfaction" (Rochester et al. 2010). Therefore, where a person's treatment stops and their recovery starts is not clear. There are many overlaps especially in the earlier stages of the transition journey. As previously mentioned, some service users started informal volunteering roles while still officially 'in treatment' meaning their experience is more akin to a treatment-volunteering continuum rather than adopting defined roles where

one day the individual is a service user and the next they are a volunteer. They may, in fact, oscillate between the two statuses resulting in blurred roles and boundaries. In such circumstances, transition processes from treatment to volunteering need to be individually-tailored in a similar way to the support needs model outlined by Hughes (2001) in which "interactive collaboration" (p86) was advocated.

**Transition Rules**

The views discussed above reflect different 'transition rules' participants experienced in a range of agencies and types of service. For example, before being permitted to volunteer in the same rehabilitation unit where he had been in treatment, Adam was required to take a six-month break whereas Jamie went straight from being an in-patient in the detoxification unit to being a volunteer. The organisation where Richard was in treatment tried to encourage him to become a volunteer straight after treatment, but Richard asked for this to be deferred. The onus was on Richard to self-assess his readiness to make the transition from service user to volunteer, rather than guidelines being in place. However, while transition 'rules' vary from agency to agency, the outcomes achieved were experienced as equally positive, in the above examples at least. There may be no 'right or wrong' approach to transition timings and processes as long as everyone involved (clients, volunteers and paid workers) are clear about expectations and requirements. In addition to services having volunteering policies, for many years in the drug field, there has been a 'rule' expecting ex-users to have a two-year break between drug use and drug work. However, when investigating this further, the information on the origins and implementation of this 'policy' was either absent, vague or contradictory:

> "the requirement by some employers – including some drug treatment services – that people need to be drug free for a specified length of time before they can be considered suitable to take up employment or volunteering opportunities, commonly applied as the so-called "two year rule". However, this was never actually a 'rule'; never having been endorsed as national policy by any government department or

> by the NTA, and the application has proved to be of little use in terms of a universal rule to determine an individual's appropriateness or readiness for employment or volunteering" (National Treatment Agency for Substance Misuse (NTA), 2010).

When working in the substance misuse field, I observed and heard anecdotally inconsistent interpretations meaning that some ex-users were required to be two years 'post-treatment', while for others it meant two years since 'illicit use' but not prescribed substitute medication, and for some it meant being allowed to volunteer in the drug field for two years directly after treatment before being able to gain paid employment. In other words, the 'rule' was interpreted differently from area to area, from agency to agency and from ex-user to ex-user. Some participants referred to this 'rule' either in terms of following it or breaking it. Phil, for example, talked about being given "a chance" six months after treatment and felt two years might be necessary for some people, but not for him. Others (like Jamie) felt that if he had not been allowed to volunteer and work in the field for two years post-detoxification, he would have been at greater risk of relapse. However, others (like Kieran) felt two years was not long enough, this view being based on his experience of working with another ex-user who relapsed once in paid employment. The consensus (if there is one) is that each ex-user should be assessed on their own merit rather than implementing an arbitrary timescale which may or may not be relevant depending on the unique circumstances of ex-users themselves.

There are advantages (pros) and disadvantages (cons) to having a gap between treatment and employment. In terms of 'pros' a gap might allow time for ex-users to develop skills and confidence; test the sustainability of their abstinence; and address underlying issues. However, it must be noted that a time delay is only beneficial *if* the aforementioned considerations are addressed, that is, if support is available to enable ex-users to gain skills, confidence, coping strategies and sustainability of abstinence. It is when ex-users are left 'in limbo' with time on their hands and no support that a time delay is not helpful.

Resultant 'cons' include a lack of support to address issues; ex-users becoming frustrated in 'no man's land'; and increased risk of relapse because their time is not filled meaningfully. As well as needing to assess their readiness for employment on their own merits, tailored support packages to facilitate individual transitions should be implemented. The NTA (2010), for example, advocated that:

> "Drug services should, as part of an individual's care plan, assess a service users' employment related needs and identify the support they need and, when appropriate, encourage and support people in recovery to get a job or volunteering opportunity".

This reflects Adam's experience of being identified during treatment as someone with drug worker potential; he was encouraged to seek educational opportunities and volunteering experience before applying for paid work in the drug field. Other sectors advocate the need to support individuals to manage transitions, including into paid employment. For example, Hughes (2001) suggested that services should adopt a "philosophy of transition support [that] accepts that *all* people need support – just in varying degrees and in different areas of life" (p85) and such support should be "designed to meet individual needs of people" (p85).

**Volunteering and working in the same agency that the ex-user was in treatment**

The study found little agreement on the appropriateness of ex-users volunteering and/or working in the same service they were in treatment. At one end of the spectrum (see Figure C) Richard continued to work in the same service he was in treatment and viewed this as a "natural thing for me to do". At the other end Kieran did not feel it appropriate to encourage ex-users' employment, a contradiction to his own situation but also a reflection that he did not address his substance use in services, viewing himself as not in the same category as ex-users who required treatment. Along this continuum, of the seven participants who mentioned this as an issue, we find next to Richard, Jamie who volunteered

and worked in the same service he was in treatment but now works elsewhere; then Harry who returned to 'give talks' in the inpatient unit where he did his detoxification; then Adam, who felt it appropriate to volunteer in the same rehabilitation unit after a six month break, followed closely by Michael, who returned to work in the same rehabilitation unit where he was treated after volunteering elsewhere. Next, is Debbie who felt it inappropriate to volunteer or work in the same agency but she was still in treatment elsewhere for the first six months of volunteering, before a rather longer gap on the continuum to find Kieran who not only saw working or volunteering in the same agency as inappropriate, but considered working in any drug service 'risky'.

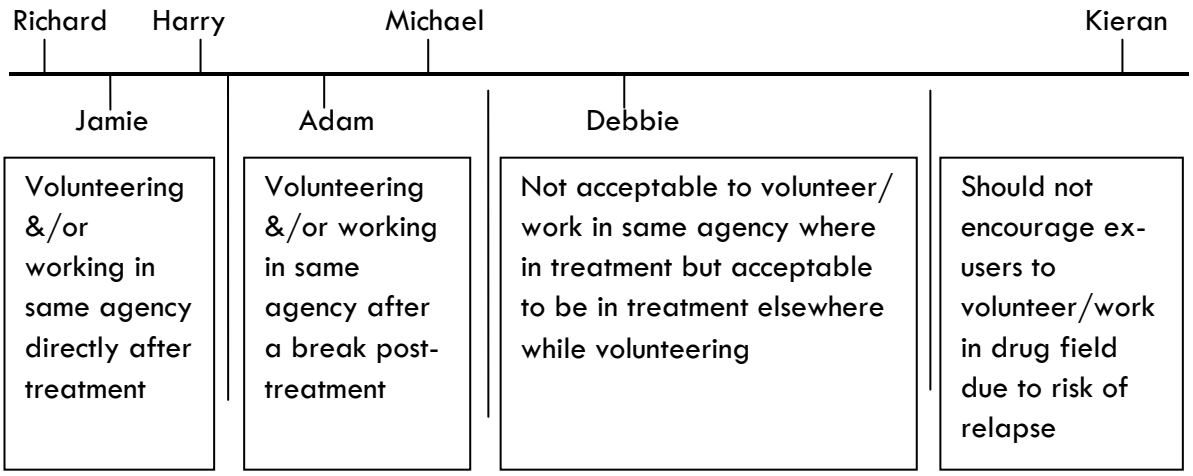


**Figure C: Continuum of attitudes to volunteering/working in the drug field**

There are few policies available in relation to the appropriateness of ex-users volunteering or working within the same agency where they were in treatment. An assessment of the advantages and disadvantages, however, is important for each individual within the context of that particular service environment so it is acknowledged that:

> "A special set of challenges and opportunities present themselves for someone in recovery who returns to the service he or she was treated at to work as a volunteer. On the one hand, their experience of the service and existing relationships with both staff and clients will be extremely useful; on the other hand, they will have to work

hard to establish new relationships and a new role within the organisation" (Adfam 2012, p17).

**Volunteering Role Restrictions**

Although participants welcomed the experience gained through volunteering, many also commented on role restrictions, some of which affected employment prospects. For example, Harry, Debbie and Nicola all shared such experiences with Harry not allowed to work in the needle exchange because "it might set off his triggers"; while Debbie was not permitted to do care plans and Nicola noted that as a volunteer, "there were limited things that you could do." Without opportunities as volunteers to undertake particular duties, ex-users may find they are unable to compete in recruitment against people with paid experience. In addition to other pre-existing barriers, for example, previous convictions, this may compound their difficulties in making the transition to paid drug worker status. Despite this, it is clear volunteering continues to be seen by ex-users as a realistic way (perhaps the *only* way) of gaining experience that will enhance employment prospects.

**The Role of Education in Transitions**

Although volunteering was considered a recognised route out of treatment and into employment, there were other factors facilitating this transition, most notably, education. All the participants had successfully completed the Level 3 Substance Misuse course, many believing this to be a decisive factor in their achievement of future employment, for example, Harry and Nicola. The Level 3 Substance Misuse course was considered by many participants to be the 'gold standard'. For example, it was a deciding factor for Adam in moving to a voluntary sector post as this employer was willing to fund the course and he referred to it as "my first biggest certificate".

For many participants, it was the combination of experience and qualifications that assisted their transition. Such views are supported by research evidence. For example, disadvantaged young people in one study stated they, "wanted firstly to improve their chances of a career by going to college to gain the qualifications that they regretted not working harder towards at school" (Barry 2001, p71). Another study suggested young people are motivated to "acquire qualifications and gain work experience that will enhance their employability in the longer term" (Bynner et al. 2002, p67). Such experience is equally relevant for ex-users. Bynner (1998) contended that education plays a part in facilitating access to employment and is significant in determining identity development.

In addition to qualifications assisting people to gain employment in the first place, another study exploring young people's transition from school to employment, provided evidence of "a strong association between higher levels of qualifications and higher levels of earnings" (Elias & Pierre 2002, p39). Ex-user drug workers with financial aspirations, for example, Michael, saw gaining qualifications as key to achieving better paid employment. Many also remained positive about the usefulness of their "expertise by experience" (James 2007) seeing this as something that complements the attainment of relevant qualifications:

> "Skills gained through informal learning (e.g., 'life experiences') were seen as generally more relevant to adulthood than those gained through formal channels (e.g., academic attainment), although qualifications were, in retrospect, viewed as important for future employment" (Barry 2001, p77).

The attainment of relevant qualifications, including diploma and degree level courses, added to participants' employability; demonstrated commitment to continuing learning; and suggested ex-users are not content to rely exclusively on personal experience of substance use in order to work in the drug field. Both Nicola and Adam described being identified by their clients as "textbook" drug workers and yet, every participant could be described as such, given that each engaged in education related to their employment. It is, however, a

matter of perception. The implication is that clients view "textbook" drug workers as less credible than "experts by experience" (James 2007) and yet these very experts by experience valued the additional knowledge and skills attained through education and training. Even Harry, who felt ex-users have an advantage over non-ex-users, advocated classroom-based learning and research into underpinning theories to enhance practice.

If ex-user drug workers value education and training, and employers view qualifications as desirable when appointing paid workers, it is necessary to consider how service providers can support access to relevant courses. In recent years, with the economic recession, some drug services are making decisions to restrict funding for accredited courses, such as the Level 3 Substance Misuse course, to paid employees (this is based on my own experience of working and delivering training in the drug field where students from several different services make up the course cohort) meaning many volunteers are either unable to do the course or must self-fund which may impact on volunteers' ability to make transitions to paid employment. Over time, if funding for training becomes further restricted, the number of volunteers accessing such courses may decrease, making them part of the increasing group without qualifications (Hendley & Pascall 2001). This is especially concerning as many missed out on prior educational opportunities due to problematic substance use. As a result, many volunteers may remain stuck 'in limbo', no longer owning the identity of a drug user, but not having attained the identity of a drug worker either.

Michael felt strongly that volunteers should be supported to access education and gain a breadth of experience as volunteers. Commitment to supervision and training on a par with paid staff is supported by Adfam (2012) who suggested: "volunteers are employees just like paid staff, and just like paid staff they need on-going support and supervision" (p10). The reality, however, is that, with budget constraints, commitment to volunteer training may wane, resulting in less development opportunities. Even if numbers of volunteers increase,

this may be because it is considered a cheaper option than employing paid staff and, therefore, services may invest less in volunteers through supervision, support and training. Many unpaid volunteers in receipt of welfare benefits cannot afford to pay for accredited courses, resulting in a lack of qualifications that becomes a significant barrier to future employment. Without agency support, this could prevent volunteers making the transition to paid employment. Michael, Jamie and Adam all reflected that they felt getting on the employment ladder was harder today than it had been when they were making the transition ten years ago. Even with a qualification the transition appeared more challenging now than in the past, for example, Debbie and Elizabeth, who were still 'in transit' felt that achieving the next step into paid employment directly in the drug field in the current economic and political climate was "quite hard" (Elizabeth) and that services were "setting people up to fail and it's so disheartening" (Debbie). Despite these difficulties, both Elizabeth and Debbie are determined to succeed with Elizabeth applying for jobs in the drug field and Debbie stating, "I haven't given up... I've not put all this hard work in just to walk away from it". Determination in the face of significant difficulties was discussed by Barry (2001) who found people remain "optimistic about their chances of finding and sustaining such a job" (Barry 2001, p65).

**Over-Optimistic Transition Expectations?**

In some sectors, for example, young people and people with mental health problems, it has been suggested that expectations regarding the transition to employment may have been over-optimistic, especially in the early stages of applying for paid posts (Barry 2001, Lindow & Rooke-Matthews 1998). Ex-service users did not expect to 'walk into' a paid post on the back of their ex-user status alone. In a study relating to people with mental health problems seeking employment within the same field, Lindow and Rooke-Matthews (1998) stated:

> "People did not expect to be employed only on the grounds of having used mental health services. They did expect to have an equal chance in selection procedures and to have any added value gained from their experience of mental distress respected by colleagues and employers" (p2).

In some cases, however, it was perceived that "widespread institutional discrimination" (Lindow & Rooke-Matthews 1998, p2) was sometimes the reason why their employment aspirations were unrealistic. In contrast, several participants in the current study expressed confidence in gaining well-paid posts within months of completing treatment or being successful in their first application. Adam, for example, was "gutted" when he did not get the first post applied for and Debbie felt that, because of her previous experience of drug use, she had been unrealistic to expect to get a job straight away: "when you've been on drugs, everything's instant and it's really hard to learn patience." On the face of it, it might seem strange that Harry struggled to accept that it might take time to gain employment once he had his Level 3 substance misuse qualification, feeling the eight or nine months he was volunteering one or two days per week on top of his paid employment was a long time (see p86). However, contributing factors to this frustration include the 'juggling act' Harry had maintained for several years while doing his psychology degree, informal volunteering with a drug users' football team and giving talks to the detoxification unit, culminating in completing the Level 3 substance misuse course. It, therefore, took Harry approximately six years to complete his degree and Level 3 substance misuse course, on a par with or in excess of the time it may take someone to complete professional qualifications such as nursing or social work. In other words, by the time Harry discovered his qualifications were not enough on their own to get paid employment, he was already six years into his transition journey, so it is perhaps, then, less surprising that he found the further months frustrating. Similarly, Luke spent three years combining volunteering, agency work and studying for counselling qualifications, before doing a further eighteen months in full-time paid employment in the voluntary sector while continuing his counselling studies, and yet he

was challenged by university-educated colleagues for not having enough qualifications or experience to do the 'same' job as them when he moved to statutory drug services.

Adam volunteered and started a counselling course alongside working in a manual occupation and found this a challenge, eventually dropping the counselling course to concentrate on his other commitments. Richard described balancing volunteering, and then paid work, with doing his counselling diploma, having private counselling clients and doing two substance misuse courses, while Nicola and Debbie shared their experiences of juggling parental responsibilities with volunteering and studying. These narratives demonstrate that the transition from drug use/treatment to paid employment in the drug field is more complex and demanding than a linear route via volunteering where a job is guaranteed at the end. For ex-users making the transition to drug worker status we need, therefore, to consider "how they navigate the complex demands of different contexts" (Eccleston et al. 2010, p6-7). The metaphor of navigation (Bauer & McAdams 2004) is useful as ex-users must find their way (usually without a map) through various options, routes and obstacles as they progress. There is no one way to achieve their desired transition. Furthermore,

> "transitions become problematic if a viable identity in one context does not transfer to another. Having to reconstruct an identity narrative can disrupt a viable way of being in a context, making transitions demotivating and stressful" (Eccleston et al. 2010, p9).

For many ex-drug users, their identity as an ex-user does transfer to working in the drug field. But this relies on the willingness of colleagues and clients to accept them in this new guise – Debbie, Luke and Elizabeth, for example, shared experiences of their new identity being resisted, suspected and even rejected.

**'Normal' vs. Complex Transitions?**

It is not just ex-users making the transition to drug workers who find transition processes complicated. Even in so-called 'normal' transition events such as adolescents leaving school, Evans and Furlong (1997) suggested, "the 'life course' ... is now becoming much more complex and differentiated" (p33) and Furlong et al. (2005) noted that, "youth transitions have become increasingly protracted and complex" (p12), resulting in increased vulnerability, social exclusion and marginalisation. If this is the complex transition experience for young people without additional disadvantages, for individuals with backgrounds affected by substance use, crime, gaps in education and employment history, and other traumatic experiences, the transition process is likely to be more challenging, meaning they are more likely to be:

> "experiencing complicated transitions in which they struggled to reach the normal goals associated with adulthood (for instance, many had been unable to find lasting, rewarding employment)" (Webster et al. 2004, p1).

It might be considered that drug-related convictions are a complicating factor likely to affect employment prospects. For example, Webster et al. (2004) noted that, "[a] criminal record, if admitted, can in effect debar ex-offenders from legitimate employment" (p20). While still a factor for some participants, this did not appear to be the *primary* concern of those with previous convictions. Other factors, such as staff attitudes and financial consideration, were reported by these participants as having greater impact on their career pathways. Six participants reported having criminal records, but what may have reduced the impact of disclosing their record was their decision to work where they had previously been in treatment (Jamie, Michael and Richard) or where the service expected volunteers from an ex-user background to have drug- or alcohol-related convictions (Debbie, Luke and Phil) and so were tolerant of this. In such settings their prior involvement in crime was either already known and/or any criminal involvement seen as associated exclusively with *past*

substance use. However, some participants did experience difficulties relating to previous convictions – Debbie (who felt it was an issue when applying for jobs); Luke (when he transferred from the voluntary sector to the statutory sector under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE)); Michael (when he applied to do a social work degree); and Richard (when he applied for registration with BACP). Luke and Richard were able to overcome initial difficulties in these settings, while Michael had to choose an alternative career path and Debbie remained unemployed.

The fact that some ex-users continued to feel judged on their past rather than their present behaviour, and that there remains the actual or perceived risk of relapse, resonates with Webster et al. (2004), who described such stigmatising complications as follows:

> "The metaphor of the 'vicious circle' goes some way to understanding the effects of heroin use on extended transitions. It does, however, imply that once out of the 'circle' (that is, becoming drug-free) the problem is resolved once and for all. Our evidence of repeated relapse suggests that this is not the case and that a metaphor of 'cork-screw' drug-crime careers might be more apposite" (p22).

This implies that ex-substance users may struggle to move away from past drug use or criminal identity. If they have previous convictions and wish to work in the caring profession, they cannot hide their past identity because it would be discovered during the recruitment process through the DBS. Therefore, if an employer, educational establishment or other authority has a negative view of previous drug-related convictions this can act as a significant barrier to future goals. However, if they can overcome such barriers, for example, through working with a sympathetic employer; being flexible to alternative career pathways; or challenging discrimination or adverse decisions appropriately, the rewards can be worth the effort. Webster et al. (2004), however, considered that, based on their study of young people's "poor transitions", including those of substance users, most

ex-user narratives focused on the early stages of recovery and on the struggles and difficulties rather than later successes:

> "The 'decision' to 'get clean' and 'go straight' is only the first step in a long, arduous, risk-laden struggle back to a 'normal life'... This necessitates facing – and overcoming – the cumulative personal, social and economic consequences of their long-term careers of crime and drug use and explains why many in this sub-sample had biographies that were replete with instances of failed attempts at desistance" (p22-3).

Webster et al. (2004) described how complex circumstances contribute to elongated and challenging transitions so that even years after their problems were at their height, the impact continued to be felt. In the context of poverty, long-term or intermittent unemployment, crime, ill-health and substance use, the result for many was "cumulative experience [where] earlier transitions compounded current situations and possibilities" (p35). In other words, such individuals' pasts continued to haunt them. Despite many barriers and set-backs along their journey, they remained resolute in their ambitions to become drug workers (Barry 2001).

**Transition Opportunities and Strategies**

Despite such continuing complexities, some participants encountered opportunities along the way that facilitated smoother transitions than might have been anticipated. Luke, for example, was supported by his volunteer coordinator to apply for a temporary drug worker post while Harry was alerted by his manager to a new post where he was volunteering (see p90). Given Luke's and Harry's experiences, such employment strategies might be considered mutually beneficial, that is, volunteers are given the opportunity to apply for positions that are less likely to be attractive to people already in paid employment thereby reducing the competition and increasing their chances of being successful in their application, while the agency can seek applications from a range of candidates including people already known to them through volunteering. This is not to

suggest such services are breaking equal opportunities in employment legislation, but does imply that volunteering may be more likely to lead to paid work within the same agency if short-term contracts and encouragement to apply are available. Of the eleven participants in this study, five gained paid employment in the drug service where they were either in treatment or a volunteer or both (Luke, Michael, Jamie, Richard and Harry), while a further two applied unsuccessfully for paid posts where they had either been a client (Adam) or a volunteer (Debbie).

**Transition Status**

The participants' status and their perception of status during this transition are of interest. In the same way that Barry (2001) considered that for young people "being 'an adult' and 'feeling adult' are two different concepts to them" (p65), for ex-user drug workers, being 'a professional' and 'feeling professional' are not the same. Furthermore, being seen as having (or not) a professional status by other colleagues may not be compatible with their own view of themselves and the status they feel they have attained. Such considerations may be affected by how far along their transition journey they are. For many ex-user drug workers, a professional status is conferred by gaining paid employment, for example, when moving from volunteer to paid worker. This coincides with Barry's (2001) findings in relation to young people whereby employment was the "status symbol" (p65) that allowed entry into the adult world. For this study's participants, gaining paid employment in the substance misuse field allowed entry into the professional world. For many people, including ex-users:

> "Aspirations for the future were predominantly centred around having the status and stability of a good job and a family of one's own, aspirations which were seen by many to be the culmination of the period of transition" (Barry 2001, p79).

Therefore, improved status can be seen as the anticipated reward for making a transition from one state to another. For many participants in this study, being a volunteer was seen

as an acceptable status during transition but only paid employment would do in order to feel they had fully achieved their transition goals. In comparing the findings of this study of ex-substance users with the young people in Barry's (2001) study, there are similarities with Barry's view that, "[y]oung people are neither totally children nor totally independent adults, but straddle the two in a somewhat 'chaotic' phase of semi-independence" (Barry 2001, p13) so ex-user drug workers are neither totally 'ex-users' nor 'professional practitioners' as they 'straddle the two in a somewhat chaotic phase of being ex-user volunteers'. As already mentioned within the context of liminality, for some participants being a volunteer resulted in feeling in limbo or no man's land so that they are neither "one thing nor another; or maybe both" (Turner 1967, p96, quoted in Bruce et al. 2014). As Barton (2007) in her study of nurses making the transition to a qualified status put it, they experienced a period of "duality" (p343). Because they found it difficult to "disengage" (p343) entirely from their previous role they had the dilemma of having two statuses simultaneously while having neither one status nor the other. However, Barton asserted that disengaging from a previous role was necessary for individuals to make the successful transition to their new role. This would be equally applicable to participants in this study as they must leave the role of substance user or service user behind if they are to successfully make the transition to volunteer and paid worker. This could be considered an even more challenging prospect given that being a substance user provided the initial status for entry into the drug field in the first place.

Within the same study of nursing students, Barton (2007) talked of, "rites of passage" (p345), suggesting individuals benefit from, or even need to be transformed by, such a process in order to move "from one condition of life experience into another, from one stage of life, or state of social status, to a more advanced one" (Barton 2007, p339). Barton further suggested that if a rite of passage is not apparent, then individuals risk not being accepted by those already in 'more advanced' status groups. This may have been a

contributing factor to Luke feeling not accepted initially by his new colleagues. They did not recognise volunteering as a valid 'rite of passage', seeing it as inferior to their own 'professionally qualified' transition journey, thus they considered Luke to be "[c]rossing a professional boundary (without a rite of passage) [which] ran the risk of censure due to a social or cultural transgression" (Barton 2007, p345). It is unlikely that Luke had even considered that he might be crossing such a boundary or transgressing any social or cultural norms. For Luke, his transition felt like a 'natural' progression but this view was not shared by his colleagues.

Within the substance misuse field, gaining employment is seen as a significant treatment outcome for ex-service users (McIntosh & McKegeney 2002, White & Cloud 2008). Krause's (1996) study of people's transitions and life experiences after a Spinal Cord Injury (SCI) also found their results "validate the importance of employment as a central rehabilitation goal" (p252). However, Krause reported that, "benefits of employment extend well beyond simple economics" (p252) suggesting a combination of employment, education and positive social networks culminated in "enhancing their overall quality of life" (p252).

Having been a volunteer for several months or even years, individual ex-substance users may attain a 'high' status as a respected and reliable volunteer. However, in making the transition to paid employment, they became 'the new kid on the block', reverting to a 'lower' status of 'inexperienced' new worker. Similar status transitions exist when children move from being 'big kids' in primary school to being 'little kids' when they move to high school. Luke, for example, related how his volunteer coordinator was "basically bigging me up" in the voluntary sector, but this contrasted sharply with how he was treated after making the transition to the statutory sector (see p71). In a similar vein, Jamie achieved 'high' status as a trusted volunteer and support worker in the detoxification unit where he

was in treatment. However, when he moved to a community service and they wanted him to 'cover' the drop–in rather than have a full caseload, he rejected their attempts to revert him to a role he considered 'lower' status and insisted on doing the job he had been employed to do. Having a particular job title does not, therefore, guarantee others will accept an individual's new status. It is possible that other factors contribute to how a person feels in that new role and how they are seen by others. For example, participants stated they were more likely to introduce themselves as ex-users and disclose more frequently in earlier stages of their career, meaning they retained ex-user status. It was also more likely that their first posts were as support workers rather than substance misuse practitioners, thereby conferring a relatively lower status compared to professionally qualified staff and affecting how they were perceived by colleagues and clients.

**Motivation and Transition Capital**

Throughout the transition to become drug workers, key motivational factors included access to training (for example, Adam); being equally committed whether in voluntary or paid posts (for example, Richard); and having rewarding or interesting jobs (for example, Nicola). In order to make this transition, participants needed a range of skills, but also needed experience to develop these skills or social capital. Eccleston et al. (2010) asserted that:

> "Identity is therefore constructed through complex interactions between different forms of capital (cultural, social, economic and emotional), broader social and economic conditions, interactions and relationships in various contexts, and cognitive and psychological strategies" (p9).

This view compares favourably with the notion of 'recovery capital' which is considered to be necessary for drug users to make the transition to a drug-free life (Best et al. 2011; Cloud & Granfield 2008; Groshkova et al. 2012; White & Cloud 2008). White and Cloud (2008), for example, defined 'recovery capital' as, "the breadth and depth of internal and

external resources that can be drawn upon to initiate and sustain recovery from severe AOD [alcohol and other drug] problems" (p22). White and Cloud (2008) break this definition down into physical (health, housing, clothing, food, financial security) and human capital (values, knowledge, self-esteem, optimism); family (supportive family, relationships) and social capital (networks, non-using friends); and cultural and community capital. Such attributes are relevant to ex-drug users making the transition to paid employment within the drug field. Indeed, one could coin a similar term of 'transition capital', and define it as, *the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain transition from problematic substance use to drug worker*.

For participants in this study, their "recovery capital – both its quantity and quality – plays a major role in determining the success and failure of natural and assisted recovery" (White & Cloud 2008, p24) and, by extension, plays a "major role" in the success or failure of their transition to paid employment. Several participants described, for example, supportive family and drug workers; previous work experience; educational attainment; and financial reward indicating the influence such factors played not only in their initial recovery but their new identity as drug workers.

**Future aspirations**

While ex-users, like Michael, were willing to accept low wages in earlier stages of their career, this was not to be accepted for long. Although grateful for the experience and training opportunities, Michael had higher aspirations and priorities; he wanted to provide for his family. Jamie echoed such aspirations, saying that, "getting a decent wage" was important and that, "I wanted to lead a productive life where I just didn't want to struggle [financially]". While Adam was willing at one stage in his career to take a 'pay-cut', aspiring to higher wages motivated him to return to the statutory sector. Some participants stated their contentment with their current role and could not imagine an alternative career,

for example, Nicola (see p94). Future aspirations were at the forefront of others' minds and they were considering what steps were needed to achieve these goals. It may be considered that one's life journey, and therefore one's identity development, does not stop evolving until the day we die, that is, one's transition "is never finished; it is in fact an infinite process" (Gadamer 1975, p298). Similarly, for participants in this study, the transition journey has not ended: "It leads to feeling always 'in process,' which Heidegger suggests means that one's encounter with the world is always dynamic and full of possibility" (Freeman 2007, p928).

While this might result in some people feeling they have not yet achieved their transitional goals or desired identity status, it can also conclude that as one goal is achieved, individuals strive towards future aspirations, that is, continuing their journey through "multi-transition turnings" (Bridges 2003, p82). For example, Luke, Michael and Adam aspired to move into team leader or management roles while Elizabeth was keen to gain employment within a residential rehabilitation unit and Richard was moving to a training role. To achieve such ambitions, further training and experiential opportunities are required, for example, Elizabeth sought an additional volunteering role in the drugs field to get the experience she felt she needed, while Richard enrolled on a 'train the trainers' course. Such aspirations confirm participants' motivation is often about more than 'giving something back'. Yet, this is the accepted rationale for making the transition from drug user to drug worker. Indeed, this is often *the* story expected by others (colleagues *and* clients), almost implying that to have less altruistic motivation is unacceptable. Many participants referred to this accepted rationale (for example, Adam, Jamie and Luke), even while acknowledging their motivation had also been to support their own recovery (Debbie and Jamie, for example, suggested being a volunteer had been key to their treatment or relapse prevention programme). But the 'accepted' and 'expected' rationale is not unique to this study. For example, one of four interviewees (Chris) on the "My Recovery, My Choice" website (2012) states, "I'm

working now with users and ex-users … I'm kind of giving something back". This concept was also referred to by the NTA, who stated that, "[m]any people with a history of addiction are often highly motivated to work or to 'give something back' through volunteering" (NTA, 2010). In a similar vein, Addenbrooke (2011) stated in her collection of addiction survivor narratives that, "[t]hey all wanted to give something back, which is in itself a gain" (p10).

**Ambivalence**

Such dedication is not universal and some may feel ambivalent about their role. For example, Jamie stated:

> "[heavy sigh] I do get cross from time to time, to be honest. I feel, to be honest with you, Sheila, that I've never really got away from drug use. Even though I'm not using drugs anymore I've never really got away from it which sometimes it gets me. It doesn't get me down, it just, I don't know, it's a bit weird. I suppose, the way I see it, all them years I used drugs and I got drug-free and I'm still dealing with drugs in some form or another [laughs] which is a bit, if you take it the wrong way, if you think about it too much, I suppose, it could destroy you as well, in a way. Well, I thought about this and I thought, 'what else could I do now?' There's nothing else I would do now, I don't think. You know, if I decided to change the way I work, what else could I do? Don't know. Don't know, haven't got a clue."

It is not so much that he is content in his role, rather, there is an element of being trapped in it, suggesting his ex-user identity is something of a "burden" rather than always a "benefit" (see Hammack 2010). Jamie does not have qualifications or experience to make the transition into an alternative career. What is also of concern is Jamie's lack of support to cope with these feelings. Such ambivalent feelings are not mentioned in more traditional 'recovery narratives' where only the positive side of becoming a drug worker after treatment is acknowledged, for example, recovery stories on the internet (My Recovery My Choice 2012; Stories of Recovery 2013), in drug services (many now have recovery message boards in their reception area where clients can post their stories), magazines (from Drink and Drug News to the popular press) and books (for example, Addenbrooke

2011; Hurwitz et al. 2007; Jason et al. 2008; Sinisi 2009). As previously mentioned, such narratives emphasise how the individual became involved in drug use, the traumas they went through and describing how they 'hit rock bottom' before experiencing a turning point, entering treatment and becoming abstinent. Very little, if anything is said about life from this point or how they achieved a "new identity" (McIntosh & McKegeney 2002) or how they feel in these new roles.

The transition process was not always smooth. Many participants shared experiences of problems along the way. For example, Debbie described a lack of induction, training and supervision in her four years of volunteering, while Phil reported having no supervision or training for the six years in his first paid post in a residential rehabilitation unit and Jamie stated that although informal support was available while a volunteer and sessional worker, he described how he "never got supervision" until he became a support worker. As volunteers were not mentioned in guidelines such as "Quality in Alcohol and Drug Services (QuADS)" published in 1999 by Alcohol Concern and Drugscope, and the "Supervision and Appraisal Briefing" (Virgin 2004) published by the NTA, it is unsurprising that service providers did not include them in their supervision schedules or training needs analyses. However, if volunteers are considered 'unpaid staff' (Adfam 2012), these guidelines can just as easily apply to volunteers as paid workers. Clearly, unpaid volunteers may benefit from supervision and training in order to gain the skills and confidence needed; if they are to maintain appropriate boundaries and understand the organisation's policies and procedures; and if they are to be enabled and encouraged to make future transitions into paid employment. As Øvretvet (1997) stated more generally, "[a]dequate supervision arrangements are especially important to improving quality and to supporting staff undertaking emotionally-demanding work" (p28).

If drug services do not adequately support volunteers and new workers (whatever their backgrounds) then they are potentially being set up to fail. Such failings create negative reinforcement, that is, if an ex-user leaves their role or, worse still, relapses, then sceptical workers and service managers can say, 'I told you so' as this reinforces their view that employing ex-users is 'risky'. Alongside such service-wide reinforcement, is the personal reinforcement telling individual ex-users that it is *they* who failed rather than the service that let them down. For me, this is a dangerous message likely to undermine future progress and recovery for that individual and increase risk factors so relapse becomes a self-fulfilling prophesy (see Figure D).

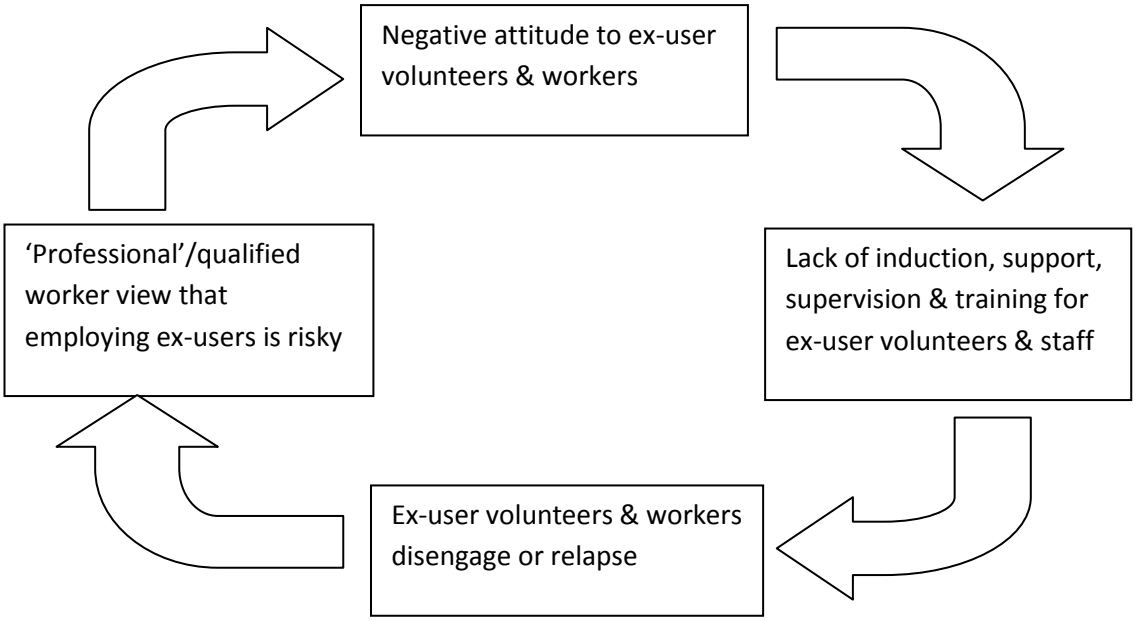


**Figure D: Self-fulfilling prophecy of risk of relapse**

For some participants, such negative attitudes expressed by some non-ex-user colleagues resulted in additional stress as they made their transition into the drug field or when changing roles/agencies within that process. The reaction to these experiences varied from being determined to prove these colleagues wrong (for example, Luke and Adam) to leaving the service (for example, Elizabeth and Debbie). While these negative views persisted for some, others saw themselves as more equipped to work with the client group

than staff from non-ex-user backgrounds (for example, Luke and Jamie) because they had personal experience of substance misuse as well as experience as a volunteer (see p85).

Whilst mistrust may exist on both 'sides', for many participants in this study, their expressed ideal team consisted of a mix of workers from 'qualified' *and* ex-user backgrounds. Michael, for example, felt that people from a range of different backgrounds have knowledge and skills to contribute to service delivery and stated, "All ex-service users? Oh, no. I think you need some normals in there [laughs]." Michael's use of the word "normals" also reflects many ex-users' view of non-ex-users as "normal", while also implying that participants (including Michael himself) are not normal, but remain stigmatised by their past substance use (Goffman 1963).

To address such othering (see also p257), where individuals define themselves through comparing their own role and attributes with those of others, it is important to provide opportunities for workers from a variety of backgrounds to work together to share their range of often complementary skills and therefore offer effective services. Such multidisciplinary working has been described as:

> "Interprofessional [which] refers to relations between different professional groups. These might include medicine, nursing, professions allied to medicine, social work, police, probation, management and administration amongst others. Each one will have a distinctive professional culture which depends, by degrees, on established professional bodies and training and accrediting organisations" (Biggs 1997, p186-7).

Ex-service users are not included in this list perhaps because they are considered to be an "out-group" (Biggs 1997, p186), that is, a group of workers who do not meet the eligibility criteria to join the 'professional in-group'. In order for ex-users to make the transition to be accepted as an equal within the team – an issue for many participants, including, for example, Luke - it is suggested that: "Interprofessional collaboration might centre on how

far the unique contributions of each discipline are enhanced and rivalry reduced" (Biggs 1997, p188).

Luke described the process of being accepted by his colleagues in the statutory sector as taking "a good year", even though it took much longer for there to be "an appreciation of each other's expert contributions" (Engel & Gursky 2003, p48) as this did not occur until the instigation of the 'recovery agenda' (DH 2010) which meant his counselling qualifications and experience of working with service user groups were both recognised. Mathias et al. (1997) suggested that in relation to inter-professional work, "everyone's contribution is of equal importance and each person has a distinct role to play" (p124). In the substance misuse field, this should include equal contributions from ex-user drug workers.

**The Value of Volunteering in the Transition Process**

Returning to Luke's earlier comment, "if you've come from volunteer to paid, then you're very fortunate", he suggested that even qualified workers would benefit from volunteering before gaining paid employment as this enhances their ability to form effective relationships with clients. This commitment to volunteering also reflected Adam advocating that individuals gain "ideally, experience and qualifications, as much as you can" and echoed Debbie's situation whereby having gained her substance misuse qualification, she still felt it is most likely she would make the final transition to paid employment through volunteering ("I'm gonna have to break through the volunteer route") while Harry felt he would not have achieved paid employment without being a volunteer first (see p86). The suggestion is that volunteering continues to be seen as the main route into employment. The participants realised they were not going to become paid drug workers overnight (even if this had been their early hope) and they were going to have to "work hard for what you get" (Debbie). This often involved attaining relevant qualifications while volunteering. For many participants, these two roles (student and volunteer) also coincided with that of paid

employment outside the drug field and/or family commitments. Linked to this 'multi-tasking' is the realisation that making the transition to drug worker is not just about dealing with the tasks of gaining educational awards and practical experience. Debbie, Michael, Richard and Adam also reflected on the need to address emotional needs and coping strategies (see p85).

The emotional and practical elements of the transition process adds a further layer of complexity, meaning ex-users are not only juggling the afore-mentioned volunteering, studying, work and family commitments, but emotions and personal issues. Because of this, Michael's "onion" analogy (see p85) is useful as there are many layers to this transition process, reflecting the complexity of the issues involved. These issues are inter-connected, potentially painful and/or difficult for individuals as they continue on their journey. With this in mind, the notion that the transition to drug worker "just seemed to work, it just happened" (Jamie) becomes less realistic and does not fully reflect the work that went on 'behind the scenes' in order to make the transition seem 'effortless'.

It could be considered that ex-users do not openly share their difficulties for fear of being negatively judged by other colleagues. This concern is also expressed by survivors of mental health problems when working within mental health services (Lindow & Rooke-Matthews 1998) who felt, "they were devalued and treated as more vulnerable than their colleagues and subjected to increased surveillance" (p1), so, both types of ex-service users had to demonstrate they are able to cope without support so others will not consider them to be vulnerable or a risk in case this perpetuates a cycle of mistrust. And, yet, if ex-user workers do not share the struggle of life post-treatment/post-recovery, other ex- and current service users might think they are 'doing something wrong' if they feel they are not doing as well as these role models. This is a further reason for sharing the reality of making the transition from treatment recipient to paid worker, rather than simply stating that it has

been done, as if by magic, as seen in many publically available recovery narratives. All the hard work is not done during treatment; a significant level of effort is required to manage the next stage successfully. As Richard said, "it's not bleeding' fell in me lap."

**Transition Focus**

As already stated, the norm in many recovery narratives is to focus on earlier stages of treatment, or indeed, to share 'rock bottom' experiences of substance use itself. This was a factor for some of this study's participants, including Elizabeth and Michael who, as members of twelve-step groups, are perhaps more familiar with this type of narrative (Denzin 1987). Even though all participants were asked to 'map out' their transition from ex-user to drug worker, many started their story from much earlier in their life history (for example, Kieran began his narrative in infancy). As the researcher, I did not attempt to stop such narratives once they had started, feeling this would potentially silence the participant and I was also aware that their 'back-story' was likely to have a bearing on their later transitional experience (Gadamer 1975; Gubrium 1993). After all, no one enters an interview (or any other experience) as a blank slate: our prior experience influences our current experience and future aspirations (Clandinin & Connelly 2000).

While Richard was aware of the "massive achievement" of becoming a drug worker, he remained concerned about the need "to keep myself grounded, constantly", a concept he returned to often during his interviews. Elizabeth used a similar expression, referring to her personal need "to be vigilant daily". The implication is that ex-users need to remember where they have come from, where their journey started. It is only through such reflection (or vigilance) that they can remain focused on not returning to this place while balancing this with a recognition of just how much they have achieved in getting to where they are now. Although some participants' focus was initially on more traditional elements of recovery, process-mapping techniques enabled participants to explore 'what happened next' and to

appreciate, perhaps for the first time, just how far they had come since being in treatment. There is clearly more to their transition narrative than their recovery story, the focus needs to shift so that stories of later transitions and achievements can also be told and given equal appreciation.

**Transition Rewards**

What became apparent from these participants' transition narratives is the overall positive interpretation attributed to their experiences which fits with the suggestion that:

> "people who interpret their life transitions in terms of growth will have higher levels of not only satisfaction with the transition but also personality development more generally" (Bauer & McAdams, 2004, p574).

Even when some of the participants' transitions had not gone according to plan, there remained a high degree of pride in the achievements to get to the stage they are now, for example, Jamie concluded his interview by saying he felt "quite pleased with my little self", as well as optimism for the future, for example, Luke has started to consider promotion options (see p75). The aspirations and anticipated or actual rewards do not remain static for individuals; these may change over time and through experience. Also, the range of rewards associated with making the transition from substance user to practitioner, and beyond, may be afforded different weightings by each individual and are likely to vary as the journey progresses. Individual perception of these rewards, no matter what stage they are at, are of paramount importance whether ex-user drug workers feel more motivated by status, avoiding relapse and maintaining their own recovery, financial remuneration, or the more traditional "giving something back" (Best & Laudet 2012, p5). All motivation and rewards should be recognised and valued by themselves as ex-user drug workers *and* by other practitioners.

**Transition Planning**

For Jamie, who stated, "I never set out to be a drug worker, not at all, never", his transitional journey has exceeded his expectations (and the expectations of those around him). It is perhaps surprising that Jamie did not plan his transition at all. The idea of becoming a group co-facilitator and volunteer came solely from his drug worker, followed by prompts from a range of influential staff within the agency where Jamie had been in treatment to become a sessional worker, then a support worker. This led to Jamie seeing himself as a "yes person", that is, whenever a mentor or colleague suggested he do something, he said, 'yes'. Had these prompts not been there, Jamie felt relapse would have been almost inevitable as "the only alternative would have been…nothing [laughs], back to drug use. There was no plan B, definitely not. There was no plan B at all." This is in direct contrast to other participants who had definite plans, for example, Richard who "worked out a bit of a 2-year plan" where he combined education with volunteering to achieve his goal of becoming a paid worker.

Other participants, such as Debbie, also had a plan (even if it was less fully formed (see p79) to continue volunteering for long enough to become entitled to funding for a course she felt would help her get paid employment. Debbie's motivation to volunteer was not only about the traditional 'giving back' but being rewarded with future opportunities and personal fulfilment. Similarly, Nicola, having identified her goal of becoming a drug worker, did her research – "I asked my mate at [drug service]...and she advised me to go to [voluntary sector agency] and that's where I started". She then completed her level 2 substance misuse certificate while also volunteering, before progressing onto the Level 3 and applying for paid employment. Nicola's plan demonstrated structured progression and was successful.

**Transition Conclusion**

What became apparent in analysing the participants' transition narratives was that while there were some shared experiences, each journey was unique. This means there is no such thing as a typical ex-user drug worker any more than there is a typical non-ex-user drug worker. It could also be considered that our identities are in transition as they evolve over time and it has been acknowledged that identity formation is a lifelong process (for example, Davies 2002a, McAdams 2001). There are many core elements that remain constant to provide us with stability and a sense of self (Brown 1999) but there are other identifying factors that are in flux and are influenced by how we interact with others; by the stories we tell; and by the stories we hear. This is equally true for ex-user drug workers.

What motivated the participants to become abstinent was different to what motivated them to become peer mentors or volunteers and was, again, different from what motivated them as drug workers. For example, while 'giving something back' may have been a driving-force in earlier transition stages, this changed as further aspirations came to the fore. Consequently, many ex-users were not happy to remain in volunteering positions or low paid jobs as they seek and/or need other rewards than altruistic ones, that is, remuneration and status. The benefits of volunteering as a stepping-stone to becoming drug workers are, therefore, not one way (that is, not simply the ex-users 'giving something back'). The process is more reciprocal in nature with ex-user volunteers and workers also benefitting from the relationship. Just because 'giving something back' narratives are dominant in substance misuse services (for example, Best & Laudet 2012), it must not be assumed these are the only narratives.

In interviewing participants about the later stages of their transition journey, it soon became apparent that their transition to drug worker did *not* 'just happen' by some lucky chance,

even if this was not fully acknowledged by the ex-users themselves. There was a lot of hard work in their endeavours, with multiple steps and difficulties negotiated along the way, for example, managing the transition from welfare benefits to paid employment; coping with life outside of the drug service where they volunteered or worked; and making decisions about disclosure, including disclosing any previous convictions.

Many participants in this study advocated the role of education in facilitating their transition to paid employment, including the Level 3 Tackling Substance Misuse qualification, the course through which I knew the participants and that made them eligible for involvement in this study. This education complements their personal experience, not just of substance use, but of life in general. For ex-user drug workers, the optimal combination appears to be prior work experience; relevant education and/or qualifications; and volunteering experience in the substance misuse or other related field, such as homelessness. The transition journey is not just about developing skills and confidence needed to work with substance users, it is also important to provide ex-user drug workers and volunteers with opportunities to address underlying emotional and practical issues.

From the data analysis and much of the literature relating to identity formation, it could be considered that individuals make the transition from a previous identity to a 'new' one. Within the context of drug use, McIntosh and McKegeney (2002) suggested that the transition is from a "spoiled identity" involving substance use and associated stigmatising problems, to a "new" identity which does not. The term "spoiled identity" was previously utilised by Goffman (1963) who suggested that stigmatised individuals engage in a "moral career" (p45) that may determine the options available to them; how much of their 'stigma' is made public; and how they are viewed by others. In unpacking this term further, I reflected that, while I am not comfortable with the term 'spoiled' as this label is likely to compound their experience of stigma (and, within this study's context, implies that an

individual's past identity was dictated exclusively by substance use), I accept that this terminology reflects, in general, moving from a negative identity to one which is predominantly perceived as positive. Goffman (1963) further proposed that individuals mix with "post-stigma acquaintances" (p49) who may not have known them in their pre- or stigmatised identity (probable for ex-users working with non-ex-user colleagues in the substance misuse field, unless the ex-user is working in the same service where they were in treatment themselves). However, I feel it is likely to result in a post-stigmatised identity that carries forward prior stigma from which it is difficult to break free. Once a drug user becomes an ex-drug user, their subsequent identity is not entirely new; it is not a complete re-invention of oneself, but brings with it past experiences and identities (including those deemed to be spoiled) that fuse with their present identity. It would be incongruent to ignore the person they used to be as if that identity never existed. Indeed, for many, it was beneficial to bring the experiences – both negative and positive – to their current situation, while also recognising that these experiences may have been re-interpreted in light of more recent events.

It is clear that the transition towards, and the attainment of, a 'new' identity does not happen overnight. One is not seen as a drug user one day and an ex-user the next, even if a person has stopped using substances and has proclaimed this to the world. It is probable that others will continue to see that person as a drug user for some time after actual use has stopped. This may reflect similar explanations of desistance from crime whereby an individual cannot simply describe themselves as desisting; they can 'only' be considered to be maintaining crime-free behaviour (Maruna 2001) over a period of time. Such a description implies that just as offenders can change to a non-offending lifestyle, becoming ex-offenders in the process, so too can drug users move towards an ex-user status. However, desistance or abstinence is not a stand-alone event but, having made the decision to stop using drugs (or not committing crime), individuals engage in an on-going process that

is necessary to maintain this lifestyle (Maruna 2001). For this reason, the acquisition of a new identity (in this case an ex-user identity) and having that identity recognised by others (for example, colleagues) is a complex and prolonged process. It can be frustrating too, for the ex-user already sees themselves as a non-user as a result of their abstinence, but this may not as yet be accepted by others, resulting in tension between that individual and their family, friends, colleagues or service providers. While ex-offenders and ex-substance users might prefer their decision to not commit any further crime or use any more drugs recognised immediately, Maruna (2001) questions the possibility of such a "termination event" (p22) and suggests that:

> "*Desistance* might more productively be defined as the long-term abstinence from crime among people who had previously engaged in persistent patterns of criminal offending" (p26, italics in the original).

The prolonged wait for recognition of "long-term abstinence" leaves the ex-user once again in 'limbo' – no longer part of the drug-using world, but not yet accepted in the drug-free world. There is after all no specific timescale that determines whether or not someone has been abstinent for long enough to be accepted as a non-offender or a non-user, meaning that where their past offending or substance use is known, these individuals are always considered ex-offenders and ex-users with the continuing stigma that these labels imply. It could also be considered that ex-users rely on their 'spoiled identity' during this liminal state as they may not as yet have acquired the skills, qualifications and/or experience to enable them to develop the credibility they need for later roles. For example, Adam stated that during this period he disclosed his past substance use to clients because, "that was all I had. I had no qualifications." Many participants also talked about the perception that they were considered to be a relapse risk, or, as Debbie put it, "you're tarred with the same brush because of maybe a handful...of people have lapsed".

Furthermore, being a volunteer is not the end of the journey for most, so it is likely that volunteers will see this status as a temporary identity form. Their commitment to this identity will therefore be limited and their aim to move to a more desirable and financially rewarding status will motivate further identity development. Financial reward and respected status have been identified in this study as being important to ex-user drug workers because they provide access to security and a desired identity.

From the narrative analysis another influence on identity development was identified as that of the role models ex-users come into contact with throughout their recovery journey. Many key-workers 'sowed the seed' of becoming a drug worker and so instigated the journey to become a drug worker while that individual was still in treatment. This worker was pivotal in their clients' future transition journey, through recovery and into employment. Without this prompt, many ex-user drug workers, for example Jamie, would not have considered this career as an option. While this influence might start with a key-worker in treatment, it continues through the role of volunteer coordinators, and through colleagues and managers once in paid employment. It is through such role models, as much as if not more than through training and education, that ex-users learn how to be competent substance misuse practitioners. While in treatment themselves they may have learned from observing and interacting with their own key-worker what skills and attitudes are effective in working with drug users. Through modelling such behaviours, ex-users put these principles into practice, combined with their own experiences and attributes, to create their own unique style of engaging clients in addressing their substance misuse issues. It is notable that key-workers do not suggest becoming a drug worker as a career choice to every drug user who enters treatment. These workers appear to use assessment skills to identify an individual's potential, highlighting personal attributes they feel would correspond with skills needed to work with drug users, and resulting in a nurturing process that encourages their clients to

take the first tentative steps on the transition route to employment in the drug field. Certainly, Adam, Jamie, Richard, Michael and Luke all reported this as their experience.

The transition is not always just about moving away from substance use, there are other considerations, for example, moving away from previous unsatisfactory employment while simultaneously bringing the skills gained from this experience to their current role. Elizabeth, for example, although keen to move away from previous employment in administration, reflected on how she used these skills in her work within supported housing. People bring their 'baggage' with them, but it is note-worthy that this is not always a negative connotation; protective as well as risk factors, strengths as well as difficulties pre-exist recovery processes. The assumption that everything before recovery was negative and everything that comes after is positive is not wholly accurate and should therefore be challenged.

While it is broadly acknowledged that moving from a drug user identity to an ex-user/drug worker identity is a positive transition, it is also essential to consider that ex-user drug workers face the *loss* of their previous identity (Bridges 2003). Without support, the level of risk and vulnerability for that individual may increase. Ex-user drug workers have given up more than the substance itself; they have given up previous lifestyles and identities for which they may go through a grieving process relating to the loss of friendships, family, status, home and so on. If services where ex-users volunteer or work assume they only experience 'positive' feelings now they are substance-free, then they underestimate how anxiety-provoking, making any change can be. The role of volunteers and drug workers can also be stressful in their own right, but if individuals are experiencing other challenges and losses during this transition, then anxieties can be compounded.

Some participants in this study made the transition to volunteer and/or work in the same service where they had been in treatment. While on some levels this may have made their transition journey smoother (for example, they were already known within the service and they knew how the service operated), in other ways it made the process more of a challenge (for example, being already known meant staff and service users saw them in their 'old' identity and may not accept the 'new', or it may have been assumed that the ex-user did not need an induction). In addition, volunteering or working where one was in treatment means their past substance use is already 'out', limiting how much control they have over personal disclosure. Clearly, each individual and the service where they work need to consider the advantages and disadvantages of volunteering and/or working in the same agency where they were in treatment. There is not necessarily a right or wrong answer to this decision as long as it is managed appropriately.

Some of the participants (for example, Debbie and Adam) expected that after a few months of volunteering, they would gain paid employment, only to be disappointed when this did not transpire. It is the responsibility of service providers to be clear about the reality of such prospects so as to avoid leaving volunteers feeling frustrated and unappreciated. Because some drug users have been used to 'instant gratification' the length of time it can take to achieve desired employment goals may not be understood in advance. Despite such concerns, volunteering remains one of the most common ways in which ex-substance users (and indeed many others) 'get their toe in the door' before successfully applying for paid employment. When employment opportunities arise in the same service where someone is volunteering, because the volunteer (for example, Harry) already knows the ethos and working practices of the agency, it is possible that they have an advantage over external candidates because they are better placed to discuss these during the interview. However, the opposite can also be true as a volunteer might assume that because "I knew the staff and they knew what I was like" (Adam), the volunteer

candidate may fail to 'sell themselves'. For others in the cohort, for example, Jamie, Michael and Richard, there was no need to go through an application process when making the transition from volunteer to paid employment within the same service. Within these services, the transition from volunteer to paid worker was seen as a 'natural progression' and their time as volunteers gave the employer the opportunity to assess their suitability for a paid post over an extended period of time. The service where Luke volunteered advertised a six-month contract rather than a permanent position, probably limiting the number of external candidates, thereby reducing the competition, and increasing the chances of Luke making a successful application. Luke certainly saw this employment strategy as a way of increasing opportunities for volunteers and reflected that he might not have got the job if it had been advertised as a longer contract.

Although volunteering is often seen as a stepping-stone *into* paid employment, it can also be seen as a stepping-stone *out of* treatment. What this suggests is that there are more steps to the transition process than might first meet the eye resulting in a more complex transition experience. Early stages in the journey 'out of' treatment may overlap with their transition 'into' peer mentoring and/or volunteering. By this stage, ex-users are likely to be more confident in their recovery progress as well as in their ability to help others. The individual is therefore moving closer to their identity as a volunteer while simultaneously moving away from their identity as a service user, and may next consider future aspirations. An individual may continue to volunteer while also doing paid sessional work (as both Jamie and Luke did, for example), creating a further overlap between the different transitional stages before full-time employment is attained. Alongside such employment transitions, it is also likely that education and/or training will be accessed. Each transition journey differed depending on the individual, the obstacles they faced along the way and the opportunities that were created.

Where ex-users do not tell others about the complexity of their journey, tension is created between ex-user drug workers and qualified staff because the latter mistakenly feel that ex-users have 'walked into' a paid job on the same pay scale when they have done 3-4 years at university and the ex-users have not. This was something keenly felt by Luke but which was not an accurate reflection of the transition journey that he or other participants had made. The transition journey of ex-users that continues the timeline beyond the usual recovery narrative needs to be more widely available and respected by clients and colleagues alike.

As mentioned above, volunteering can be seen as a way of cementing recovery and as an extension of treatment. Not all agree this is appropriate (for example, Adam felt there should be a clearer distinction between treatment and volunteering) but the introduction of peer mentoring/navigator roles in recent years can act as an additional transition stage. This stage can provide support and relapse prevention for ex-users in the early stages of their recovery while also offering opportunities for skills development, responsibility taking and meeting their need to 'give something back'. If an ex-user is struggling with their recovery journey, it may be considered less of a 'fall from grace' to step back from being a peer mentor to being a service user should this become necessary. The transition therefore becomes a more gradual process, perhaps less daunting for both ex-users and service providers. This also reflects the dynamic nature of recovery where there are no clear 'cut-off points', that is, one is not a supported service user on Monday and a volunteer without any support needs on Tuesday. Another element of this transition journey that needs to reflect individual ex-user's situation is the length of time the process might take. This certainly varied greatly for this study's participants. The concept of the so-called "two year rule" (NTA 2010) was viewed as ineffective and indeed, not a 'rule' at all. Like the support needs of the individual making the transition, the time needed for the process must be individually assessed and negotiated.

Volunteering is supported in a broad context by government policy who as part of their Big Society agenda state the government is "encouraging volunteering" (Conservative Party 2010) as well as with specific reference to drug and alcohol services (Inter-ministerial Group on Drugs 2012). In this regard, being a volunteer does have a respected status (Wilson & Musick 1999) and can certainly be seen in more positive terms than a drug user status. The participants in this study did, however, also report there were often restrictions regarding their roles as volunteers. Such restrictions may be designed to protect the volunteer and/or the clients; for insurance or governance purposes; or to protect the specialist role of paid drug workers. Whatever the reason for not permitting volunteers to carry out such tasks as assessments and care plans, there is a potential impact on their future job prospects, namely, that when they are in competition for jobs against others who have previous paid experience, they are unlikely to be successful because they have no experience of doing such duties. Many participants also reported that they had either no or limited access to supervision when they were a volunteer, although most stated that informal support was available.

It is clear from the participants' narratives that they value both qualifications and experience in equal measure. They did not want to rely exclusively on their personal experience of substance use. Ex-user volunteers have aspirations to gain qualifications, or indeed have already gained these and this reinforces the notion that their skills and knowledge base is broader and has more depth than a simple label of 'ex-user' would imply. Such labels are therefore unhelpful in predicting the quality of their interactions with clients and professional identity. Similarly, so-called 'textbook' drug workers, that is, individuals who have become drug workers through educational routes, may also have greater breadth and depth of experience that is not reflected in this label. Many participants called for mutual respect for, and between, 'ex-user' and 'textbook' drug

workers. The knowledge, skills and experience mix this brings can only enhance treatment experiences of service users and job satisfaction of substance misuse practitioners.

Although some participants stated they had not planned to become a drug worker, for example Jamie, others did have a plan they hoped would result in the achievement of their goal. What becomes obvious when reviewing the participants' transition narratives and process-maps is what a "massive achievement" (Richard) it is to make the transition from substance user to paid drug worker. Some participants commented that they had not realised just how far they had come until they saw the process-map of their journey laid out in front of them (for example, Debbie and Jamie).

In addition, a number of difficulties experienced by participants were verbalised, for example, negative staff attitudes towards ex-user drug workers and volunteers, previous convictions, economic climate, role restrictions, and national strategies influence on the availability of volunteering programmes and paid posts, as well as potentially unrealistic expectations regarding how smoothly the transition might be achieved. Many participants stated their motivation to make the transition to drug worker stemmed from their desire to 'give something back' – a phrase I have heard often in the substance misuse field. However, when the participants went into further detail about their motivation, it soon became apparent that there were wider, deeper and less altruistic considerations, for example, the motivation to be financially rewarded and maintain a good standard of living; the desire to be respected for the skills they had to offer; the kudos of working for a particular service; and the attainment of recognised qualifications. These additional motivational factors do not detract from the participants' original motivation of 'giving back', but do acknowledge that ex-users will not continue to be satisfied to act as volunteers or work in lower paid jobs: they have more ambitious aspirations.

## Chapter 4 Orientation: Disclosure

## Part 1: Findings

### Introduction

In this chapter the findings in relation to disclosure are presented and discussed. The mapping approach within a narrative methodology (see pp44-49) enabled me to analyse the stages at which each participant disclosed (or not) past substance use. This included situations in which they disclosed more or disclosed less (in terms of breadth and depth); to whom they disclosed (clients, colleagues or both); situations in which their substance use was 'out' by the nature of their role (including if they volunteered or worked in the same agency where they had been in treatment) or because they had been 'outed' by a colleague or client; and how previous disclosure experiences (positive or negative) influenced future disclosure decision-making.

I include excerpts from all participants (including Kieran whose story is one of non-disclosure), but the four stories selected for the focus of this chapter belong to Elizabeth, Jamie, Harry and Luke as they illustrate a range of disclosure choices. Elizabeth, for example, had early negative experiences of disclosure and subsequently did not disclose to colleagues or clients, while Harry had only positive experiences and continued to share his background with clients and colleagues. Luke, meanwhile, selectively disclosed to clients if he felt this would benefit them, but did not disclose to colleagues because he did not "think it's anyone's business". Jamie shared similar views to Luke regarding disclosure to colleagues, but after initially being 'out' due to volunteering and working in the same service he was in treatment, Jamie had mixed (positive and negative) experiences of sharing information with clients. Each 'story' has been sub-divided into background, early disclosure, later disclosure and key elements.

**Elizabeth's story**

At the time of the interviews, Elizabeth, an ex-drinker in her early-50s, was working in supported housing. She started her story with, and indeed focused much of it on, her experience of using alcohol problematically and her subsequent treatment through her General Practitioner (GP), counsellor and Alcoholics Anonymous (AA), describing how she needed to 'hit bottom' before recognising she had a problem and seeking help. Having been sober for two years, Elizabeth began volunteering in a homeless centre and used this unpaid experience to gain sessional work before working full-time with homeless people in supported housing. Elizabeth continued to work in this role, but was seeking paid employment in the substance misuse field, recently applying to volunteer in a CDT to gain further experience and help her make this next transition as well as applying for paid posts in the substance misuse field. Elizabeth's primary aspiration was to gain employment in a residential rehabilitation unit, preferably within the twelve-step tradition as it was this approach she had experienced herself.

**Early disclosure experience**

In her first volunteering placement Elizabeth had difficulties, following disclosure of her past alcohol problems:

> "The day centre [where I volunteered], I found very judgmental. The manager there was very judgmental. She's not there now, but, I was truthful about it, that I was in recovery. I think it was about two years, when I moved over here and, I asked her for a reference. She says, 'oh, you know, you won't get a job if you, you know, if you've been an alcoholic' and all this negative stuff. I think how she expressed it was, 'oh, my God, you've got to be careful if you've got that background'. I felt at that point I'd never get rid of this background, and maybe that pushed me into not divulging much about myself. And I just felt she was judging me, to be honest. And really, I suppose, in a way, I was only two and a half years sober, so they're a bit wary, aren't they, in case you relapse. But I did find it quite frustrating, you know, that someone at that level spoke to me [like that]. What annoyed me more than anything was she said that to me in front of all the other staff, you see. And this was why I asked her if I could have a meeting with her and her superior. And I went through it... she was very apologetic and I just hope she did it without the intention

> that I thought and she maybe learned by it, you know, not to disclose these things in front of people. It's private. I didn't use her for a reference and I still got the job."

This negative experience influenced Elizabeth's decision not to disclose in the future, fearing she would be similarly judged elsewhere:

> "But, by then I got a job with [voluntary organisation] and, started doing cover work with [supported housing] cos I knew by then that I would like to work in this field cos I'd experienced it. I just thought I could give something back really and enjoy what I'm doing. And I do enjoy it. But, I've never ever told anyone in [supported housing] that I'm a recovering alcoholic. I've told two people but they're friends that I trust. I don't know if I'd have got the job, to be honest, but that's my bit. I know now that they are actually employing ex-service users so it was all about me judging me. And I find it quite hard sometimes because it's like a whole part of my life I can't mention to people. When they're talking about nights out I can't talk about the past because I've had good times as well and I sometimes go to say something, so I've always got to be on my guard, so my choice. I don't know if it's a good choice but at the time it was good for me. And it still works. I'm used to it now. I don't even think now about it. They all know that I [don't drink]. I think some of them suspect, to be honest, but it doesn't matter what they think. They just know me as Elizabeth doesn't drink, so that's basically fine. Some may have guessed."

Elizabeth described how she remained conscious of what is and is not 'safe' to share with her colleagues, a form of self-censorship. She saw this as her choice, recognising it as a self-imposed decision that goes against her awareness that her organisation does employ other ex-users and acknowledging that her decision not to disclose brings its own stresses (being "on my guard") as well as its rewards (feeling safe). Elizabeth also reflected that some colleagues may have guessed and yet neither party brought up the topic – the proverbial elephant in the room. Elizabeth was not the only participant to suggest that clients or colleagues may have guessed – Michael, Jamie, Luke and Adam also referred to this. It is interesting that while Elizabeth stated she did not disclose, she had told friends outside of the work environment on the basis that she trusts them, implying, perhaps, that it was colleagues that she did not trust. Even when opportunities arose to discuss her own experience of AA with clients, she resisted:

> "I worked at [project] for three years and I used to key-work an alcoholic and he just had a lot to offer if he could get help and he tried [voluntary sector agency] and different things and I just said, 'have you ever tried AA?' and he said, 'I've tried but it's a lot of crap'. And I said, 'why don't you give it another try?' you know, 'go to a different meeting'... I took him in some books and we used to chat quite a bit. I mean, I was sitting with him, I felt how he felt, you know, the anxiety, the fear, and he said to me, 'have you been to AA? Do you go to AA?' I says, 'No, no, I'm just quite empathic and understanding' and that was the nearest I got. But, no, I've never told anyone. It's quite hard as well because I've never really disclosed anything about myself, so I've never asked anyone for support in that area. For example, one of my fears if I do disclose anything, you know, say if I'm off sick, what are they going to think? Now, that's me. Do they automatically, cos I've heard them, do they automatically think, 'oh, she's back drinking' and this kind of thing. And again, it's trust."

The reason for not telling the client in this context appears to be two-fold. First, she did not want to breach professional boundaries (something Adam, Nicola and Phil also mentioned) and, second, she feared this information might get back to her colleagues and result in them being suspicious of her. The example Elizabeth gives of being worried that if she goes off sick, her colleagues will think she is drinking again resonated with Jamie's experience when he returned from long-term sick leave to find a rumour circulating that he had relapsed. This suggests that Elizabeth's concerns were not unfounded. Similarly, Adam was concerned he might be viewed negatively because of his ex-user status. This concern stemmed from disclosure experiences in his first paid post in the voluntary sector resulting in him making different disclosure decisions when he moved from the voluntary to statutory sector:

> "And I remember, like, some of the [clients] used to say to you and it felt like they were trying to, not entrapment, but, like, manipulate, you know. Asking, 'what did you do?' Try and get a bit personal, asking about me personal… they were pushing the boundaries and asking, like, you know, what I used to do and what experience… It felt then like being on dodgy ground, this" (Adam, in first post)

> "I didn't want anyone to find out I'm an ex-user cos they might judge me... I wanted to be able to first of all, go into the job and, you know, not say I've got this because I used to be a service user. You know, I wanted to go in and prove that I could do the job without formal qualifications and then earn respect from my colleagues and be a valued member of staff" (Adam, when moving to second post)

Debbie described her mistrust of colleagues in stronger terms and how this affected her decision to disclose to clients:

> "I don't trust them [ex-colleagues] as far as I could throw them. I mean I was quite an open person but I don't think like that anymore. I don't tell people me past, cos you get judged. And in the end, if new clients came I never disclosed. I only disclosed if they came in saying, 'you don't understand, you ain't got a clue' and that's when I'd say, 'yeah, I do.' Otherwise I kept my mouth shut."

**Later disclosure decisions**

Elizabeth was at the stage of her transition journey where she was seeking employment in the substance misuse field, rather than supported housing. This potential move encouraged her to reconsider her disclosure decision and she weighed up the pros and cons of future disclosure:

> "Then I thought I would like to counsel people who had alcohol issues or work in that kind of area. It wouldn't bother me that anybody knows but I feel when you're working with someone it's about them. It's not really about me. But if it could help, you know, I would say, I would understand it. I maybe would [disclose], depending on the job, depending on the policies, and depending on how other colleagues would take it. I'm not ashamed of it, I don't think. I think one of the things for [organisation] is it's not really relevant and it doesn't really matter to them cos it is housing and we refer out. But I think now that I'm kind of stepping out, I probably would at interviews. If, and I think, [voluntary sector drug service] they actually specify at the bottom of their application form that they'll look at ex-service users and that, to me, is a positive thing. So I can be honest. So, I think now that I'm trying to look outside of the homeless sector then I possibly would. I actually understand now that there's a lot of ex-service users working within that kind of thing now anyway so it's nothing new to them."

Elizabeth implied that there is safety in numbers if she disclosed in the drug field, recognising there are more ex-user practitioners in this field compared to housing.

However, when Adam worked in supported housing he felt able to disclose:

> "Thinking about it, it didn't feel as bad talking with the staff members. You know, there's a lot of ex-service users work there [supported housing] as well so it didn't feel as bad and, obviously, I disclosed to some staff members. I told them. I disclosed a lot more. It felt comfortable there to do that." (Adam)

Elizabeth remained hesitant about disclosure, changing her mind, citing trust issues and giving examples of work-based situations where she was aware of some colleagues' judgmental attitudes to substance users. Elizabeth's non-disclosure also meant she was unable to challenge such views as she feared this would 'blow her cover':

> "I find it hard to trust people, to be honest with you. I have to get to know somebody really well before I can disclose anything about me and it's quite sad, because at work people don't really know me, well, they do but without my past history. I just feel it keeps me safe, and I think because I hear so much backchat... And anyone can drink again or take drugs again or anyone can start drinking at fifty years old, you know. So, it's a case of I don't want folk judging me in that way. I just want them to know how I'm doing now and if it's necessary and I trust them enough, I'll tell them. I still have this feeling that there's judgement about people who are addicts. I hear comments in work, you know, [laughs] and I think if they only knew. You know what I mean? And I think, maybe it's best just to keep safe. [When I hear those kind of things] I want to shout out, 'well, I've been in recovery 10 years'. [Sighs]. I'll tell you, I kinda keep my head down cos I don't want to say too much in case they say, 'well, how does she know that?' Cos I know because I've been there but what this course helped me with, I'm able now to say things because I've been on the course and it's opened up a door for me to actually express feelings about certain things, you know, to a certain level anyway, but, it's not coming from me as a person, it's general, it's the training which is good. [It] gives me a bit of confidence. I don't think the barriers will stop me. I mean, I actually went for that interview at CDT last week and I felt really comfortable with the lady that was interviewing me but I still didn't disclose anything. And I know in the application they did ask if you had any problems with drugs or alcohol and I totally missed it out. So that I could possibly discuss it if they brought it up, but nobody brought it up."

Elizabeth did not suggest that she lied about her background, she simply remained evasive. In the above example, she achieved this by avoiding answering the question. For other participants, for example Phil, if employers did not ask, they did not disclose:

> "I didn't disclose here [probation hostel], but, they didn't ask about it. From memory, there was nothing on the application form and it's not a talking point, 'oh, by the way…' So, it just didn't arise. It's just that there was no actual opportunity to [disclose] on the application form or at the interview" (Phil)

Even though Elizabeth is having second thoughts about her decision not to disclose, when she did attempt such a disclosure at a job interview, she instantly regretted the decision:

> "I have found it quite hard to move on in this field, to be honest. It's quite hard to. I went for that interview at [drug service] which I didn't get. But, it was a lot less money anyway. But I was glad [cos] it was like proof that I have got what I need now to start looking in that area. But I told the truth about myself and I wished I hadn't. It was probably just personally for me. I felt I was quite vulnerable then and let too much go, trusted too much. I think what worried me as well, we refer there. I go up there with clients as well, you know, and maybe for their reviews and things and that kind of worried me when I came out and then I thought, 'they're professionals', never disclose again, you know, all this rubbish that runs in your head. So, I don't know. I'd be very wary about exposing myself again if I went for another interview."

While Elizabeth continued not to disclose at work, she did disclose her problematic alcohol use and AA experience while attending the Level 3 substance misuse course, again the 'safety in numbers' consideration affected her decision-making as well as there being less risk attached to disclosing in this setting – her livelihood was not riding on her participation here. Interestingly, she was able to challenge another students' negative attitude to AA while on the course, something she had not felt able to do in her workplace:

> "[I don't disclose at work] because it's my livelihood. You see, it's one of my things, I have to feel financially secure so, [on the Level 3 course], I just felt it was nice to be honest. It was just nice to be Elizabeth, it's part of Elizabeth. It's not hidden anymore. It was good just being able to talk about it and use it in class. I found everyone really accepting of you [on the course]"

**Key aspects of Elizabeth's disclosure story**

Elizabeth's disclosure story may have been different if her first disclosure experience had not been negative. This resulted in a heightened sense of potential consequences of disclosure so that when she weighed up the pros and cons of disclosure, the risks always seemed to outweigh potential benefits. Elizabeth was contemplating a move to work in the substance misuse field rather than housing but remained hesitant about taking the 'risk' of disclosure. Elizabeth established a protective barrier of non-disclosure designed to protect her from others' judgments and allowed her to move on from the label of addiction. Her perception was that if she didn't tell anyone, they would not be suspicious of her, while at the same time, she remained distrustful of most of her colleagues. Elizabeth had no way of

knowing if her fears had foundation within her current or future employment. She was aware that her own organisation employed other ex-users and that some drug services actively encouraged ex-users to apply for voluntary and paid posts, but this knowledge did not enable her to change her disclosure decision. On the one occasion when she disclosed her background in a job interview, she regretted this decision. Even though she did not report any negative consequences to this self-disclosure, she was so fearful that the interview panel might think badly of her or that word would get back to her own employer (inter-agency referrals operated between both agencies) that she did not contact the interview panel for feedback.

This fear extended to disclosure with clients in case staff members become aware of the information. Whereas other participants if asked by clients would disclose, Elizabeth would deny this aspect of her life; again, for her, potential risks outweighed possible benefits to herself or her clients. This also meant that when she heard colleagues make derogatory comments about the client group, she felt unable to challenge it in case the workers suspected she was talking from personal experience. Elizabeth talked about being "on my guard" and keeping a part of her life "hidden", suggesting a stressful existence whereby she cannot 'be herself' but always maintain a different identity from her own. She recognised this as a self-imposed decision and while, on one level, it kept her safe, on another, it created difficulties. Elizabeth believed that if she made the transition to working in the substance misuse field, she would feel more comfortable in disclosing. This links with other participants' view that where several ex-users are employed in a service, it is safer to be 'out' about one's background.

**Harry's disclosure story**

At the time of the interviews Harry, an ex-heroin user in his late-30s, had worked in a voluntary sector drug service for a few months. Harry's story started in treatment and he

described how, having been on a methadone prescription for 2 years, he became frustrated with a lack of local services to help him become abstinent. As a result, Harry funded his own 2-week inpatient detoxification and set up an addicts' football team to support himself and others in treatment. Throughout, Harry maintained full-time paid employment in an unrelated field and at this time had no aspirations to become a drug worker. However, he became inspired to make this transition when concerned families asked him to help their drug-using loved ones. He also did a psychology degree which gave him insight into his own and others' behaviour. In addition, Harry returned to the unit where he detoxified to 'tell his story' to current residents and was encouraged by the manager there to do the Level 3 substance misuse course. Once Harry finished his studies, he sought volunteering opportunities in the substance misuse field, initially in one voluntary agency before transferring to another. Having applied unsuccessfully for posts in his first voluntary placement and the detoxification unit where he was treated, Harry was encouraged to apply for a post in his second volunteering placement. Having been a volunteer there for 4-5 months, he gained paid employment and continued to work for this agency.

**Early disclosure experience**

Before Harry had even decided he wanted to be a drug worker, he was disclosing his drug using background through returning to the detoxification unit where he had been in treatment to tell his story. In this situation, Harry was introduced as an ex-resident with the purpose being to act as a role model to the current client group, that is, Harry would not have had a role if he had not disclosed his own drug use:

> "I went back to [detoxification unit]. I went back a few times just to give a talk really cos I was an ex-resident and just to try and inspire people really, just tell them about my journey. And I ended up doing that a few times, but then I started going back more and more really. And they let me sit in on a lot of groups and I think that's when it started. After each group, they'd all sit down and talk to me

about what was going on in the group, what had happened. I think I gave them just an idea of my use and my chaotic lifestyle and [sighs] I can't say this for definite but I'm sure I was given some guidance about what I'm to say and not to mention certain things."

Harry referred to getting guidance on what he could and could not tell clients, the implication being that he was to tell the positives of becoming substance-free rather than any negative aspects of his recovery journey. Harry also described how he made decisions regarding disclosure by assessing whether disclosure would benefit the client, this being something many participants referred to (for example, Adam, Michael, Luke). He was, however, wary of disclosing if he felt disclosure would benefit him as a worker, that is, if he felt he would be using disclosure instead of using professional skills. A further dilemma for Harry was that while he did sometimes use disclosure to build rapport and instil hope, he was not comfortable with the label of 'ex-service user' either, a sentiment shared by Phil who stated:

"I don't mind people knowing, Sheila, but I don't always bring it up as a topic. I don't want to spend the rest of my life going, 'I had a drug and alcohol problem'. Em, I'm not going to put a label on myself. If somebody asks or if [phew] I can say a little bit about myself which is going to help somebody else, fair enough." (Phil)

This combination of pros and cons suggests disclosure decision-making is not straightforward with many considerations to weigh up in a short timeframe before making an individual decision within a given scenario:

"I certainly have no problem disclosing to colleagues, no, about me past. Again, when you're working with clients, is it going to benefit them or is it going to benefit me? But yeah, I have disclosed before, yeah. It's not a problem. If I feel it's appropriate, if it'll benefit somebody. Even to the point of maybe if somebody's got no hope and so negative, you know, maybe to the point of giving them hope, I've used it a couple of times like that. I mean, I don't want to wear the tag of ex-service user either really, you know, cos I'd like to think that I might have made a pretty good worker even if I hadn't been a service user. I know [volunteer] is [an ex-user] cos I'm his supervisor. No one's disclosed up front. I think we're the only ex-service users here. Obviously, you learn about people from other people, don't you? And I think unless somebody's not disclosed it to anybody, then, as far as I know, we're the

only ones. I find that ninety-five per cent of my clients say that's what they want to do. You know, this service user, ex-service user [label], I struggle with that term cos I wasn't really a service user. I used a G.P. and I accessed a detox unit for two weeks but I don't feel I was a service user in that I was using services for a long time. But, that never comes up really in introductions. As you know, if you work in a project, word gets round certainly among clients who you know already. But, I never feel the need to use it. I think I ultimately have to think, 'am I using this to get myself out of a sticky situation?', you know, when I've got nothing else to offer them, 'am I going to disclose this because I can't help them in any other way?' On the other side, when I have used it, it's sometimes when I've felt that there's absolutely no hope in that person at all, you know, and they don't have any reason to carry on or make changes, not believing it's possible, I think. But, like I said, I don't have a set formula. It very much depends on the person, you know and I have to be aware of whether that's gonna become an issue, you know. But, touch wood, it hasn't and in a small service like this, [town] is a small town as well, the drug using population, alcohol using population, all tend to know each other. So, I think that information is pretty much out there and if they don't know in the first group, they tend to have found out by week two or week three. They often know it, Sheila, yeah. It's rare these days that I have to make that decision, you know, with a new person."

In the above description, Harry alluded to the fact that in a small town and, indeed, in a small service, disclosure is often made via clients who already know his background. This meant that once Harry had carefully calculated his pros and cons and decided to disclose to an individual client, this person may then inform others, resulting in a wider group of clients being aware of his substance use without Harry having the opportunity to do a similar calculation. This loss of control of their personal story was mentioned by Michael and Adam where breaches of confidentiality had both positive and negative consequences.

"Even if I don't tell them, they guess. They just know. Sometimes one of the things about the clients is how they know. 'Have you ever used this?' and that sort of thing And I'm not going to lie to them. I just give a shrug of the shoulders and they get it. They're not daft... Most of my clients know. In fact, on occasion, they've come in and said, 'you're a user,' 'you're an ex-user'. And I'm like, 'who told you, then?' I won't deny it. People, they know people who I know." (Michael)

"A funny thing happened there when I left there [NHS post] and I had quite a good relationship [with other staff members], as you do with any job. Me current partner worked there as well. She doesn't work there now, so, you know how it is in the substance misuse field, people know people, know people, know people. So when I went working there and I did disclose to some clients and that client then went and told her key-worker who was still there. And she rings up me partner cos me colleague, we got on really well and we'd have a laugh and a joke, but I'd never

disclosed it. She'd got this information that a client's turned round and said, 'oh, by the way, did you know Adam is an ex-user? He told us, he's an ex-user.' So my colleague, she's like, what do I do with this information? 'Oh, God, I don't know if this is right or wrong'. So, she's, 'does Adam's partner know? Does she know he's an ex-user?' I remember she actually told me how she thought, 'why didn't you tell me? Cos I thought we got on that well you'd have told me.' She actually rung me partner and said, 'I don't know what to do with this' and my partner said, 'Don't worry, I already know.' It's just one of them things. So she were more gutted that I didn't tell her. She said, 'why didn't you tell me?' and all that, 'well I chose not to'. I didn't really think that clients would take it back and tell their worker. It were like they were telling tales I think. And then, at first, I was a bit like, oh [groans], you know, all this time I'd worked and people had known and then it was, well, I've moved on from that now." (Adam)

**Later disclosure decisions**

Harry contradicted his previous assertion that disclosure should not be used instead of worker skills by acknowledging occasions where he used his personal experience as "something to support other tools" to break down barriers between worker and client:

> "I think if I were [sighs] to say [being an ex-user is an extra tool] that'd reinforce, go against what I said a minute ago in that I don't want to use it when I've got nothing else left to use. I see it more as something to support the other tools, could work alongside them. I think [sighs], I wouldn't like to see it as a tool, but, I do the structured treatment, the one-to-ones and I don't often use it in that way. It's often more appropriate in the group cos we're in a therapeutic community. And, like I said to them, 'this is my group, this is your group.' I'm just part of the group myself. And I think when people are sharing very sensitive stuff about their past and I think it's more appropriate to say, probably. Is there ever a way of knowing if it's worked? I certainly don't use it in the way of, right, I'm doing this now in this group to help their recovery that step further. I think where it can work is in a group setting, the empathy side of it, definitely, the sharing side of the group setting as well, but, you know, I think there has to be a professional distance. I can't just sit there as an ex-service user and be part of the group. But, I think, it can bring up [hope], for certain people, you know, I'm here now and I'm not trying to say, 'I know what you're going through cos I don't, only you can know that. But I know what I was going through,' that kind of thing. I think it can just, build a bit of [rapport] and break down a few barriers."

Not only had Harry encountered no difficulties when disclosing his past use, he found clients appreciated his experience and have, as a result, sought him out to be their key-worker, a similar experience to that expressed by Michael:

> "You will get people, service users, saying I want to work with him cos he knows where I'm at and stuff like that." (Michael)

Similarly, Richard found disclosure to be useful:

> "I guess the way it works for me, is it just takes down a lot of barriers of judgment, if you like, and inclusion and more of a balance within the coordinator and the facilitators as well." (Richard)

Harry went on to suggest that clients viewed his personal experience as preferable to having a key-worker with an education background or who have less 'life experience':

> "I've never found any negativity. I tend to find people judge you on your knowledge base and maybe the way you present yourself. If you're giving a report on a client, you know, they base it on that, that's what I've found. It isn't a problem. I think it's been positive. Certainly, when I'm supervising [volunteer], I think he feels more of a rapport with me because maybe I've been through that. I suppose one example, a client that I worked with, who's actually now volunteering at [voluntary sector drug agency]. He's doing really well. And he was very, very chaotic, and did a lot of crime, a lot of drug use, and I hadn't been working here long and we were re-allocated service users to work with in structured day care. And, for some reason, he asked to work with me, which I were a bit taken aback at. I wanted to know, so I asked him in the first session why he'd chosen me. And he says, 'I'm the biggest blagger going.' And he were one of those people who could talk you into bleedin' giving him a hundred pounds if he wanted [laughs]. Maybe that's why he's a volunteer now... Another comment was, 'you won't take any bullshit'. And if they've got that into their head, that's great cos it gives me an in-road. But whether it's true or not, I don't know. We've also had a situation when I first started working in the drug structured day care, I found a lot of clients, they asked if I could be their worker, simply based on the fact that I'm an ex-service user me-self. They had a feeling that the two people who were working here before were very young, and, in their minds, they felt they didn't have life experience, all they'd done, in their words, was read it out of college books. You know, they don't know what it's about, so, rightly or [wrongly], the service users' perception [was] that I could help them more because I was an ex-service user. Rightly or wrongly, that gave me a way in and that gave me an almost instant rapport with them and so, it was certainly a positive in that way. They tended to respect what I was saying because they felt that I'd been there and done it, so, in that respect it was a positive... And I still, rightly or wrongly, feel that if you've got two workers and they're both exactly the same with skills and everything, if one's been an ex-service user, I feel they have the slight, slight advantage. I think I draw on that experience, you know. It's just another tool to use in therapy."

Harry acknowledged the benefit he got from being seen in a more positive light by the clients (as someone who has greater insight, empathy, and experience) was based on client

perception rather than necessarily the reality of the qualities of individual workers. He was, however, happy to use this perception to his advantage when building rapport with clients. Harry did not counter such client perceptions of non-ex-user drug workers not being as effective as ex-users, unlike Debbie who did challenge such views:

> "I've explained to them, 'look, just because someone hasn't got a drug-using background, you know, there's some brilliant workers out there'" (Debbie)

Harry did disclose his past to some people when he completed the Level 3 course but had not planned to do so when starting his degree:

> "I did speak about my background [on Level 3 course]. I got talking to [student]. I think we both disclosed together. I certainly didn't experience any difficulties from it. I don't know if I disclosed to everyone but it weren't a secret. But it didn't cause me any trouble, not at all. So, next step is the addiction degree. [Disclosing my ex-user status on the addiction degree], it's not something I've thought about. Thinking about it now, I probably wouldn't purposefully disclose it, I don't think. I think if it came up and it were appropriate, then I probably would. And I could probably, not because I feel the stigmatisation but just to go in there and learn as an equal really. I think it's all part of my identity. But, I think, as in life, we don't disclose everything to people we've just met, do we? You know, somebody might have suffered from depression for a lot of years, you know, but in the first group they won't sit there and disclose that, so I don't think it's separate identity but I think you choose when you use it, you pick and choose."

While Harry would disclose in an educational setting if "it were appropriate", there seemed to be less emphasis compared to his level of disclosure in the workplace. Perhaps, for Harry there was less reward associated with disclosure when attending training courses than when building rapport with clients. Elsewhere in Harry's story he described how he had not told his previous employer (outside the drug field) about his substance use, ensuring his GP put depression on his sick note rather than heroin use. In this situation, Harry considered disclosure to be a risk rather than a benefit. These three aspects of Harry's disclosure decisions – disclosure with clients, some disclosure on courses and no disclosure in non-drug

related work – echoed what Harry described as the way one would "pick and choose" when to disclose.

**Key aspects of Harry's disclosure story**

Disclosure meant various things to Harry at different stages of his transition. For example, while continuing to work in an unrelated post, Harry kept his drug use and treatment hidden, while simultaneously disclosing at the detoxification unit where he was treated. Harry referred to disclosing his ex-user experience as positive, especially in relation to how he felt it benefited clients. He stated he is cautious about disclosing to 'benefit' himself as a worker, that is, to make his job easier or if he had exhausted his toolbox of skills. He acknowledged, however, that he had used his background to build rapport, and felt ex-user drug workers have an advantage over non-ex-users when it came to developing trusting relationships with clients. Harry appeared relaxed about clients and colleagues knowing about his past without him having personally disclosed to them, seeing this breach of confidentiality as an acceptable outcome of working in a small town where once you tell one person, everyone knows. Despite this openness and potential loss of control of his own information, Harry saw disclosure as something he was selective about, that is, he could "pick and choose" when, to whom and how much he disclosed, without having a "set formula" to determine these decisions.

**Jamie's disclosure story**

At the time of the interviews Jamie, an ex-stimulant user with dyslexia in his early-40s, was working in a statutory sector (NHS) CDT. His story started when he finished an inpatient detoxification and was involved in their support group as part of his aftercare package. After a few weeks of attending this group, Jamie and another ex-resident were asked to co-facilitate this group before a few months later being asked to become a volunteer on the unit. Ten months on, Jamie was asked to join the paid sessional team and 6 weeks later,

was encouraged to apply for a full-time support worker role. Eighteen months on, he was promoted to senior support worker, continuing in this role for a further eighteen months. Jamie then applied to be a drug worker in a community-based service within the same organisation, where he continued to work, latterly within shared care.

**Early disclosure experience**

For Jamie, there was no need to disclose his background in the early stages of his transition to become a drug worker because he initially volunteered and then worked in the same service where he was in treatment meaning all the staff already knew his background and the clients were introduced to him in his ex-user role. When Jamie left the unit to work in a community setting, he stated he did not disclose but then retracted this by saying he did if asked. For Jamie, there was a difference between disclosing informally when asked compared with using disclosure as part of how he introduced himself to clients:

> "When I filled out the application form for the [support worker] job, I just put in that I'd worked up from being basically a service user in the support group, to volunteering, to then going on the [sessional team]. I just said that I'd been an ex-service user in the support group, facilitated the support group and then being a [sessional] worker, volunteer obviously, and where I was volunteering at and that was it basically. When I first started volunteering, everyone knew I was an ex-user, didn't they, because of the support group. Since I left the unit, I've never divulged, well, I have done if they've asked. I've never, ever, ever [pause] I can't remember ever saying, Sheila, I don't say, 'my name's Jamie and I'm an ex-user'. I never do it like that. They shouldn't ask, you know, but what's the point of telling lies? It's not right, cos you'd be putting that thing across that you're a liar [laughs]. So, how can you expect people to work with you if you're lying? You can't really, can you? [intake of breath] I don't think you should shove that 'I'm an ex-user' thing down people's throats, really. It can reel against you, Sheila, where it can make you, sort of like, 'oh, he thinks he's great, him, because he used to use, and he's turned his life around', nah, nah, nah. So, no, I don't go down that road."

**Later disclosure decisions**

More recently, Jamie saw disclosure as less relevant and described being advised by a manager not to disclose when applying for promotion:

> "[When I applied for recent job opportunity], did I put I was an ex-user? No, I didn't, no. I put it from I was a volunteer, blah, blah, blah. I think I have done it on one or two occasions and not put it on others. At one point, cos I went for a couple of jobs and I think at one stage I got told not to put it on about being an ex-user by me manager. I can't really remember what the reason was but they said, don't put that on, just don't put that on. Just go with the flow, like, get experience and stuff like that. He gave me a new way of doing me personal statement. He just went, 'oh, do it this way now'. He gave me a new way of doing it I think. Volunteer, done this, done that, put all me experience and stuff like that. I wouldn't say now [my past use] is relevant, no, definitely not. If I was applying for anything else now, I wouldn't put it on. I didn't put it on there cos I didn't think it was relevant anymore."

In contrast, Michael continued to disclose on application forms:

> "I just say I'm in recovery myself. Em, yeah, that's something, I might not need to do that now. Is it a selling point? [pause] Yeah, it is. I'd probably do it [disclose]. Em, but it'd be very brief. I remember, em, on early applications, I found it really hard, recovery then. You tend to focus on that a little bit. Em, so, you focus on that. Things are quite different; they're obviously quite different now. I've got a lot more experience of working with drug users, yeah, in a professional capacity, so, I tell them what I do. But, I would mention it. It's never stopped me from getting an interview. I don't think it has."

As Jamie only disclosed when asked, this limited his ability to act as a positive role model for clients. Jamie considered this role as being further limited because his clients did not know what he was like when he was using and although he did not directly say this, the implication was that clients will never get to know such details because he would never tell them. For Jamie there were boundaries to the breadth and depth of disclosure similar to those of Adam:

> "I can't see how you can be an actual role model, Sheila, for someone unless being an ex-user, but, I think, for you to be a role model for someone, they've got to know how you used to be, to get that full benefit. I mean, I had one of me clients a couple of weeks ago asking me how I got to where I am now, and asking me how did you do this, how did you do that? And I told him. But, does he see me as a role model? I don't know. I can't really ask him." (Jamie)

> "I like to have the worker boundary there... I like to be clear-cut and even now, when, em, clients ask me, which they always do, don't they? And my next question is 'why?' 'Why do you need to know?' That comes out and sometimes it depends on the

> client and the situation. I can generally tell if someone, there's a reason why they want to know, a bit more to it rather than a general, 'do you have experience?' And sometimes, a comment might be, 'yeah, I have experience of drugs' or it might be, 'well I drink coffee, I take paracetamol', you know, or it's, 'why, why do you need to know?' And then, 'well, I just want to know if you've got the experience, do you know what it's like taking drugs?' And sometimes it's, em, well, 'maybe ask me, you know, we'll work together first, see how it goes, and perhaps ask me again in six months or so'." (Adam)

When Jamie went on long-term sick leave rumours circulated that he had relapsed. In another example, Jamie described how he was expected to behave in a different way from his 'professional' colleagues because it was known he was an ex-user:

> "I was off sick last year. I was quite ill [laughs]. I was off sick for about 6 months and, eh, it went round the [service], well I got told, some of my clients told me that there was a rumour going round that I'd gone back to using. So, I was like, 'really?' And they went, 'yeah, that's what everyone was saying, that you'd start using again'. I don't know. I was like, 'really?' I was quite shocked in a way, I was. I was quite shocked. For them to think [that], that they talk about you like that, you know what I mean? I thought it was a bit weird, to be honest, that they still see you like [that], it's a bit odd, like people expect you to [relapse], you know what I mean? It's been nearly ten years for me and people, like, there must be people who still expect that you're going to relapse at some point which is a bit odd. [laughs] I've even had a client, oh [sighs], about a year and a half ago, who had social services involvement and she was my client. And she turned round to me cos I'd phoned social services and spoken to them to tell them that she hadn't provided urine samples like she was supposed to be doing. And she had a go at me, basically, because she said, 'I've heard you're an ex-user and you should know better than to phone people' and blah, blah, blah. And I was, 'oh, really?' [laughs]"

These examples suggest that even if a worker has been substance-free for a considerable time they cannot fully move on from their identity as a drug user. Even when Jamie had not directly disclosed his past, clients guessed and passed judgment on his behaviour as a result – something that would not have been an issue for workers from a different background. While the above examples indicate that Jamie was not allowed by others to move on, Jamie himself had chosen to return to his drug user identity by giving 'talks' to nursing students about his experience as a service user. Interestingly, Jamie talked exclusively

about his in-treatment experience and did not mention his ten years' post-treatment experience as a drug worker:

> "I do presentations at the university, nursing students, and I'm there two hours, talking for an hour and then questions and answers for an hour. It's nursing students and it's about my experience of being a substance user and how you get treated by health care professionals, you know, getting discriminated against and stuff like that. The way people perceive you to be as a substance user. It goes down quite well, actually. I got a thank you card off them all last time I did it. I used to do it all the time, to be honest. I've not done it since I've been at [drug service]. I've not done it for the last three, four years and then I've just started again. I'm doing [it] more as a favour than me wanting to do it really. It's not something I wanted. I'm just doing it [because] someone's asked me to do it so, yeah, I'll do it. It's me being the yes person though, isn't it? It's just that if I can help them out I'll do it, you know... I didn't [tell the students I'm a drug worker] in me last one, no. I didn't get asked. I thought, because they were nursing students, it was their opportunity to ask questions and I was to answer them for an hour. So, before I'd finished talking, I said to them, 'right, when I come back I want loads of questions' and that's what I expected one of the questions to be. They never asked what I do now, not one of them said, 'what do you do now?' Cos I'm sure I don't look like a drug user now. Not one of them asked and there was a class of about thirty. Not one of them asked, 'are you still using now?' Or, 'are you working now? What do you do for a living?' None of them. Unless they still see me as a drug user [laughs]."

Jamie felt that once others, including healthcare professionals and substance misuse clients, knew his background, he was perceived differently. He had mixed responses from clients (positive and negative) but predominantly negative responses from colleagues. However, he disclosed less to colleagues so it is possible that if he had disclosed more widely to this group, he might have experienced a similarly balanced range of responses. The reason he gave for this reduction in disclosure to colleagues is that they did not ask whereas clients did:

> "I think once healthcare professionals know you've been a substance user, they look at you in an entirely different way. I don't think it's got anything to do with me anymore. Well, it has cos it's a big part of me life [laughs]. [I] shouldn't have said that really. But, I don't think it's got anything to do with them really. Although it's a big part of me and the person who I am as well, it's been so many years now. I think [phew], to be honest, I don't really know, it's hard to say, isn't it? With clients, if they ask me, like if I was struggling in a clinic with a client, and as soon as this client walked in, she went, 'you're an ex-user, you, aren't you?' And I don't actually get

that. So, I went, 'yeah, why?' She went, 'I can tell by your arms'. I said, 'yeah, yeah', and that broke the barriers straight away and we started chatting and she was asking me about my experience and what do I think she should do about this and that. Then I will, but, if I'm trying to get something across, I won't go, 'I'm an ex-user' and nah, nah, nah. I won't do it like that, Sheila. I will try and do it without saying I'm an ex-user. Really, I'll only say if they ask me, then I'll tell them. But if they don't ask me, I won't. I mean, one client said, 'what's all that on your arms?' So, I thought, he doesn't know what they is on me arms so I'm not going to tell him. I said, 'what you being nosey for?' That's what I said to him. But, I thought, if you don't know what they are, you know what I mean? To me, it's quite obvious what they are, so, if he doesn't know what they are, I'm not going to tell him. [Other workers] never ask, never, which is a bit odd. I don't know, but, I've never had anyone say, 'what's all that, Jamie?' Some service users don't know what they are, which surprised me, so, I imagine if a lot of service users don't know what they are, then you'll get a lot of workers who don't know what they are as well, really. It's how they perceive you really, Sheila, isn't it? If they know you to be an ex-user, then they'll probably say to you, but if they don't know you as a person, anyway, say if, some new member of staff came here and started working, I don't think they'd have a clue really... I don't disclose to other staff. Why should I? I don't usually get professionals in my job asking me, 'am I an ex-user?'"

**Key aspects of Jamie's disclosure story**

In the early stages of Jamie's career in drug services, he did not need to debate any disclosure decisions – his background was already known as he volunteered and then worked in the same service he had been in treatment. On leaving this unit, Jamie stated he did not disclose about his past but then acknowledged that he would disclose to clients if they asked. For Jamie, there was a difference between volunteering the information and responding honestly if asked. Later in Jamie's career, he was advised by a manager not to disclose his substance use when applying for promotion, the implication being that he did not need to disclose now he had experience working in the field. While Jamie remained comfortable sharing limited information about his past with clients who asked (or at least disclosure was preferable to lying), he did not disclose with workers on the basis that they did not ask. This pattern was also reflected in Jamie's experience of giving talks to nursing students, in that, he had been asked to share his experience of using substance misuse services so this is what he restricted the content of his story to, meaning he did not discuss

the ten years since becoming drug-free. Because the nursing students did not ask what he does now, he did not tell them, leaving a significant chapter of Jamie's story untold.

**Luke's disclosure story**

At the time of the interviews Luke, in his late-20s, was working in a statutory (NHS) CDT. Luke described how although he had previously been in drug treatment as a teenager, once an adult he travelled for a year as an alternative to treatment to overcome his poly-substance use and while away achieved abstinence and volunteered in a school-building project. This gave Luke the motivation to seek volunteering opportunities on his return to the UK and within two weeks, had started a voluntary sector drug agency's volunteer training programme. Luke had some difficulties with a member of staff in his first volunteering placement, but after transferring to another base within the same organisation, he thrived under the guidance of the coordinator there who encouraged Luke to seek paid employment in the drug field. Luke was already considering how to make the transition to paid employment and started working towards a counselling diploma as well as gaining experience through agency work in a homelessness hostel. His breakthrough came when the volunteer coordinator encouraged him to apply for a six-month contract in the voluntary sector, in which he was successful and which subsequently became a permanent post. Following a change of service contract, Luke was then TUPE'd across to work in the NHS.

**Early disclosure experience**

From the beginning of Luke's volunteering in the substance misuse field, he was open about his past substance use and offending behaviour:

> "On the [volunteering] application form, I just said I wanted to give something back because I've got experience around substance misuse and that was all. But I just disclosed my three offences on there. [They had] no [issues], not at all, that was really reassuring cos I thought ok then, well they're going to be ok with you having experience around drugs but are they going to let me volunteer and potentially,

> work in this field in the future? I got a taste for volunteering and then I was, like, yeah, I'd like to work in this field one day."

Like some other participants (for example, Adam, Jamie and Michael), Luke was aware that many clients guessed his past without him disclosing anything. He was also conscious, like Jamie, that clients would often ask about his background while co-workers avoided the topic:

> "Because a lot of volunteers have had experience with or they've experienced it themselves and I think service users are kind of aware of that in a roundabout way, without you actually saying it. And I think it's also like that thing where you, you know when someone's been there. Or they've been involved in it. And I think you see that in other people. And I definitely do. I can spot someone, most of the time anyway. Clients asked me all the time, but, workers never would. But, I felt that workers made an assumption, and they wouldn't ever name it. But, I felt like I was being judged or they were assuming I did, and that's the difference. Whereas, service users would just say, 'so, have you used drugs before?' or 'did you used to use drugs?' and I'd say, 'yeah, well, that's why I'm here now.' I was open with clients, sometimes with workers, depending on the worker, you know, and how they made me feel. But, definitely there was an assumption a lot of the time."

Luke saw the potential benefits of disclosing to clients as being a motivating factor by acting as an "incentive" for clients. This may also reflect the desirability of greater disclosure with clients rather than with workers – there is no similar incentive for non-ex-user colleagues. This may be a similar position to the one adopted by Richard where he is more comfortable (and there is potentially more reward) in disclosing to clients than disclosing to colleagues:

> "[I've not told my new colleagues] about my past. I've not said anything. It's just not come up. Just not come up. I've told more of the clients. I'm more comfortable telling the clients than them for some reason." (Richard)

The potential rewards for disclosing to clients are similarly more tangible for Luke:

> "I think once I'd sort of named it and sort of put it out there, I think it's a great incentive. You know, if someone is in that situation themselves and people would say it to me all the time, 'oh, I want to get into volunteering once I've got drug-free and cleaned it all up and I've sorted my head out, I want to do something like that'. And to see someone else doing it, I think it proves it, doesn't it, that they can do it. And I think that the people who don't say it, or don't admit it, it's up to you, it's entirely up to you, but I think in a lot of ways you might actually be doing someone a favour by just being honest, cos it will really motivate others, some people anyway, definitely."

Despite Luke being happy for clients to know he used substances in the past, he was not comfortable with them knowing further details. Luke had clear ideas about his personal and professional boundaries in this regard, this also being a concern for Michael and Nicola:

> "Usually I don't [disclose], but they get onto it by the way I talk, and they'll start saying 'have you used?' And what do you do? Do you sit there and say, 'no, I haven't', or do you say, 'I might have but it's nothing to do with you'. You know, sometimes I leave it in the air. Sometimes I do disclose. I have disclosed on occasions when I feel it's necessary, if I feel they're going to make a right change or learn from my experience. I never tell them details or anything like that. If it will benefit them, I will disclose, well, not disclose, well, no, identify in a fashion. I say, I never tell exact details or anything like that. I think they know anyway, most of my clients know." (Michael)

> "Well, you'd be breaking boundaries, aren't you, if you start talking about yourself and your past, and how many kids you've got and where you live and stuff like that [laughs]. It's not about [me], I'm not here to talk about me." (Nicola)

Luke, however, also recognised that limited disclosure gave him credibility with clients and enabled him to avoid the awkwardness of being evasive. Alongside these considerations, Luke also reflected on what he perceived as the client's motivation for wanting to know about his past and how Luke felt the client might benefit from such disclosure:

> "It's funny cos I wouldn't like tell them my story. But they'd only want to know key facts; they wouldn't want to know much detail. They wouldn't ask a lot of questions. All they wanted to know was: were you a drug user or not? And that was it. And why you were doing it [volunteering] and that was it. And, as long as you told them those two things, then they'd go, 'that's brilliant, that's what I want to do as well'. And that was it. That's the extent of it. Nothing too prying. It just felt just right and that. I can handle that. It was just being there, didn't need to know my actual

> background. End of story. 'You don't need to know which drugs I used'. 'You don't need to know how I funded my habit'. 'You don't need to know how I got drug-free'. Yeah, it's credibility. Because I think if I had avoided that or not answered the question, what kind of message are they going to get? Oh, he thinks he's too good to talk to. And I'll just tell anyone anything if they ask me the right questions. I can't even imagine how awkward it would have been to try and get out of that without just being obvious that you were anyway cos you didn't want to answer the question. So, you may as well just answer the question [laughs] unless you're really good at lying which I'm not. So, I'm not going to lie. And I always thought, well, I won't lie, and I think it's important to just maybe have used it once when I have told some service users, on a one-to-one, my background, and, I've also said to others. Cos it's all about how it feels and what's their agenda. Why do they want to know? And if it felt like it was something useful and it was tapping into something for them or myself, if it felt like it would help the situation, then I would tell them. However, if it was a situation where it felt like, hang on, what do they want to know that for? It doesn't feel right here. Is this about gossip? Or is this just curing curiosity for them? It'd be, come on, we're not here to talk about me. Come on, let's get on with this. Let's do this and move it on to something else, distract them. But, I think you get a sense of that at that time. Why do they want to know? And if it's going to help them, yeah, I'll tell them, if it's going to break down some sort of barrier."

In terms of guidance regarding disclosure when Luke became a volunteer, it was suggested that sharing personal information was inappropriate. Despite this Luke felt selective disclosure was acceptable on the basis that it was his own information and therefore a personal decision:

> [When I was training as a volunteer], I think I was advised it's probably best not to tell them stuff about yourself. But, I thought, well, I can tell them that, you know. [I didn't tell my colleagues I disclosed] and I don't know, they could have been [aware], but, you know, it's up to me, isn't it at the end of the day? Why have you got a problem with that? It's my life, it's my story. And I think, I told people if I thought it was relevant and it might be useful. Anyone else, I'd just change the subject... Some [services] have a don't ask, don't tell policy [around past drug use], but [sighs] I don't know. If you're asked outright, you know, it depends who's asking. And I can agree in some respects, but, then, I don't think it actually does the service as a whole any favours because, lots of people, lots of clients will find it hard to connect with workers as it is. And if a worker's being like that with them, it makes things even worse. And I think it does a lot for relations if clients can identify with some members of the workforce more than others."

Other participants, for example Adam, took the 'middle-ground' when it came to how truthfully he responded to client questions and the extent of any personal disclosures:

> "I generally don't [say] to clients, I don't say, 'yes, I am an ex-user' or, 'no, I'm not'. It's just a little bit of a game and I think it comes from me. It's like I want to prove to you that I can do my job as a worker, in the client-worker relationship, that you don't need to know if I've taken drugs or not and sometimes when people have naturally left me as a key-worker, I've gone, 'yes, I have' and things like that. And some were, 'oh, yeah, I could tell' and some were, 'no, I couldn't tell that', you know."

**Later disclosure decisions**

While Luke's criminal record had not been a problem when he started as a volunteer and then gained paid work within the same organisation, it did become an issue when he was obliged to disclose during an interview when he transferred to the NHS:

> "[My criminal record] never seemed to be a problem, however, it did become a problem later on, only at the NHS. I went for the job [with voluntary agency where already a volunteer] but it was a temporary six months thing I went for and I got it but then it just turned into full-time. [When the voluntary agency lost the contract to the NHS], I got TUPE'd over. But, right at the final hour, I had an H.R. [Human Resources] meeting and I had to disclose my criminal activity and then everything was on hold then. Cos I was in this meeting, welcome to the NHS, and then they just said is there anything you need to disclose to us and I thought they must know already cos surely they'd asked to see my records from [voluntary sector agency]. And I thought, oh, they don't know. They obviously don't know. I picked that up. I thought they've not got my file and [voluntary sector agency] probably aren't allowed to say anything. And, for a split second, I thought, I can't even say it. I can't say anything. And then, I just said it, I went, 'yeah, well, I've got these two [previous convictions]' and then it was just this weird reaction. The service manager was actually supportive. I'm glad they were there to intervene cos the H.R. manager was just, like, God, if it was just her, I thought, no, I'll never get the job. She was really a stickler for it. And the service manager just, sort of, leapt in to my defence and went, 'well, you know, it is a drug service and, you know, you will come across workers who've got a history of drug use themselves'. [She] put her pen down and she was, like, looking at the service manager and, 'oh, right, ok, well, I'll need to ask a few questions around this.' I do think that I might not have got the job if I'd applied externally. Well, it was just a case of there weren't much communication. It was a waiting game. And then about a month later, the service manager says that H.R. had spoken to someone else and that TUPE law overrides it and you're protected under TUPE law."

This experience influenced Luke's future decision-making regarding disclosure to colleagues and was further compounded by early experiences of working within his new NHS team:

> "[T]hey had all worked in substance misuse for maybe, like, ten years and they'd all been, I think, three of them had been to university and, like, were qualified social workers already, and then changed to this field. And they had some sort of qualification where they'd been to university. And quite naively, when I sat down to talk to them and just getting to know you, they were actually digging. You know, 'what's your experience?' And, 'how long have you been doing this?' And when I told them dead honestly, you know, they used it against me. Yeah, cos, it was a bit like, you've been doing this job, but you've only been working for 18 months in the industry and that was it. And they didn't even want to count the volunteering. Yeah, that was quite a difficult time as well. I didn't [disclose my past drug use], and I don't think they necessarily would know, maybe they would, I don't know, but, there were certain snobbery about where I'd come from and how I'd got into it. They weren't happy that I was in the same job as them. And cos of the experience I'd had with the H.R., I thought I'm never bringing that up again in here. God! You know, I don't know how much other managers are privy to that information. I don't think they are. But, I know that just the main manager knows everything. But then certain things come up, like, there's a lot of staff do's. There's a staff do every month or something and I don't drink. And then everyone loves a drink [laughs]. I don't know whether people are a bit, mmm, putting two and two together. I'm assuming. Cos, you know, people don't mention it either which is strange. I mean, if I ever thought it was relevant, and it was anyone's business, like, on a wide scale, then, yeah, I might tell them. But I don't think it's anyone's business and, to be honest, they might know, maybe they just know. Even now, well, it's mainly, like, around social events and stuff, you know, if there's a Christmas party coming up. And, I say, 'oh, I've drove.' And they're, like, 'what do you mean you drove?' And I'm, like, 'cos I'm not drinking'. 'Why aren't you drinking?' And some of them just don't get it. And they, like, keep going, 'Huh? Why don't you drink?' And they'll say something really stupid [laughs]. But, it doesn't bother me at all. Cos, you know, luckily, I like the person who said it. But, someone else'll just hit the nail on the head straight away and go, 'oh, yeah, right'. And they've obviously got it. Cos they might know someone else who, you know, doesn't drink for that reason or something like that."

The above excerpt suggests that the views of Luke's colleagues' (in and out of work), continued to affect how he interacted with them; his perception of them; and his disclosure decision-making.

**Key aspects of Luke's disclosure story**

When Luke first applied to be a volunteer in a voluntary sector drug service he had no qualms about disclosing his previous substance use on his application form, seeing this as a valid rationale for his motivation to engage in this role and later welcoming the credibility it gave him with clients. However, once a volunteer, he was advised not to disclose personal information, a piece of guidance he chose to ignore on the basis that he felt the benefits of

disclosure outweighed potential risks. Despite Luke's generally positive experiences when disclosing to clients, this did not apply equally to his relationships with colleagues and statutory service employers where he felt assumptions were made about his background and ability to be an effective practitioner. In other words, the benefits of disclosing to clients were, in Luke's experience, much greater than the benefits of disclosing to colleagues.

**Non-disclosure narratives**

These four disclosure narratives contrast with Kieran's non-disclosure stance in that he stated:

> "[I've never been open about my past with my colleagues], not at all. Not at all... I think really, which is quite interesting, when I got the thing [letter responding to Kieran's completed questionnaire] back I was quite surprised you asked to come over. And the only reason I said, 'yes' was cos I had previous history with you. That's the only reason, Sheila, if it was anybody else I'd have said, 'no', cos I've never told any of this to anybody at all."

Kieran remained adamant that disclosure was inappropriate because any individual ex-user drug worker's experience is different from everyone else's, including their client group:

> "There's a notional idea of you have to be an ex-user to understand a user. Again, that's a complete [pause], I think it's totally irrelevant. My experience is different from everybody else's. It doesn't bear any resemblance to it. It's like us saying, oh, I've had this past experience, you can disclose. It's the only trade in the world where you can disclose, well, I've done this in the past."

Kieran stated his belief that disclosure crosses boundaries resulting in what he described as "over-identification":

> "We've all our dirty little secrets tucked in and nobody ever gets to see except me. So you come in with that in your head and you're in this kind of environment and you look around and you think you know what? You project it and this is this notional idea of over-identification with the service users, if you like to call it. It's what this is all about. And it's why people screw up. Well, I think anyway. People think, you know what, I can really identify with you. I really understand it and I can do it in

> here all day long with all the clients. Yeah, I really understand, I get that. I feel that. I know that, da, da, da, da. But I don't. I don't cross that boundary."

For Kieran, therefore, there was no perceived benefit to clients (let alone to himself as a worker) from disclosure, resulting in him not sharing personal information. Kieran did not get as far as weighing up the positives and negatives of disclosure, as other participants did, as the whole concept was irrelevant to him. Had the participants, including Kieran, had access to support and guidance, it is debatable how this might have affected disclosure decisions.

**Disclosure findings summary**

Negative experiences of disclosure resulted in less future disclosure. More specifically, if the negative experience had been with clients, then there was less disclosure to clients (for example, Adam) while if the negative experience had been with colleagues, then it was with colleagues that disclosure was less likely (for example, Luke). Through such experiences, participants learned what levels of disclosure felt safe, what types of disclosure benefited themselves as workers or their clients in terms of inspiring recovery, and enabled each person to assess relative risks and rewards of disclosure in any given situation. Disclosure decisions were, therefore, made selectively on an individual, ad hoc basis, with participants responding to what 'felt right'. Participants reported limited, if any, guidance on disclosure decisions, meaning they had to work out for themselves how to share personal information while balancing this with the desire to maintain professional boundaries.

## Part 2: Discussion

### Disclosure – decisions and goals

Most participants disclosed their past substance use in their first volunteering or paid roles (Adam, Debbie, Elizabeth, Luke, Nicola, Phil) or, in some cases, were volunteering or working in the same agency they were in treatment, so their status as an ex-user was already known (Harry, Jamie, Michael, Richard). The only participant who stated he never disclosed his status in either voluntary or paid employment was Kieran. Three participants – Adam, Debbie and Elizabeth – described early disclosure experiences as predominantly negative, that is, the outcome for them suggested "disclosure is not always advantageous and carries with it the possibility of social rejection and discrimination" (Chaudoir & Fisher 2010, p252). For Harry, Jamie, Luke, Michael, Richard, Nicola and Phil, early disclosure experiences were predominantly positive and usually resulted in them being comfortable with future disclosure. While early disclosure or 'being out' about one's past drug use was the norm amongst participants, there was much variety regarding whether they continued to disclose once they moved into subsequent posts or had gained qualifications; how much they disclosed to colleagues, clients or both; and how they decided if it 'felt right' to disclose.

Luke, Adam and Phil, for example, all stated they chose not to disclose their past use to colleagues in their second paid posts (each moved from the voluntary to statutory sector) although they would on occasion disclose to individual clients if it felt "appropriate" (Phil). A key theme emerging from previous research as well as from the current study relates to "appropriateness of self-disclosure within the context of specific social-situational conditions" (Chelune 1979, p245). Participants assessed appropriateness based on such factors as wanting to "really motivate others...if it felt like it would help the situation, then I would tell them" (Luke); or "if it will benefit them" (Michael); and so on. Alongside such client-centred approaches, each individual balanced their clients' needs with their own

boundary considerations, for example, “I wouldn’t, like, tell them my story. But they’d only want to know key facts” (Luke) or, “You’ve got to really know what you’re up to, where your boundaries are” (Jamie).

An individual’s motivation to disclose and their desired outcomes of disclosure influence not only the decision to disclose or not but its “depth, breadth, duration, and emotional content” (Chaudoir & Fisher 2010, p240). Some participants were clear about what they aimed to achieve through disclosure, for example, Richard used disclosure to promote equality with clients, volunteers and paid workers in his agency’s group-work programme while for Luke, it was to identify which clients might benefit from a personal disclosure to help them engage in services. Therefore, disclosers assess the “reward value – the extent to which the information provides positive and/or negative outcomes for either the discloser or the target” (Derlega & Grzelak 1979, p152). When participants decided to disclose, it was predominantly because they identified benefits for themselves (disclosers), their clients (targets), or both. Reward value was not the only component identified by Derlega and Grzelak (1979) when determining the nature of self-disclosure. They also noted the amount of information (breadth and depth) shared by the discloser; how accessible the information was (that is, how readily the discloser shares personal information); how truthful the discloser was; whether they voluntarily disclosed the information (or did they need to be pressed to disclose); whether the disclosure supported social or cultural norms; and how effectively the disclosure meets the discloser’s desired goals.

These components had different implications for each participant. For example, the reward for Harry in disclosing past drug use came through clients giving him “respect...because they felt that I’d been there and done it” and benefited his clients by trying to “inspire people”. The amount of information shared was decided on an individual basis depending on what “felt comfortable” (Michael) in terms of depth and breadth with “nothing too prying” (Luke).

The accessibility and voluntariness of disclosure was affected by the participants' role as well as individual decision-making. For example, Richard introduced himself to new group members as an ex-service user who had been through the same treatment programme whereas Jamie and Phil would only share information "if asked". Being truthful about their background was important to many participants, for example, Jamie, Michael and Phil, while Elizabeth, even if asked directly by clients, would deny her ex-user status.

Some participants suggested that certain agencies had a cultural norm for ex-users to be open about past substance use, particularly for those participants who volunteered or worked in voluntary sector drug and alcohol services. For example, even though Adam did not disclose when he worked in the statutory sector, when he moved to the voluntary sector it was the norm to be open, because "there's a lot of ex-service users work there as well so...I disclosed a lot more. It felt comfortable there to do that" (Adam). Michael came from a twelve-step fellowship background where part of the twelfth step suggests members "carry this message to alcoholics and to practice these principles in all our affairs" (Alcoholics Anonymous 2014), the result of which, for Michael, meant that sharing his recovery was a social norm and he stated, "I don't hide the fact that I do twelve-step, or anything like that. I'm hoping that I'm an example just by my presence" (Michael). Within this context, it could be considered that Michael's stigmatised or spoiled identity as an ex-user (Goffman 1963, McIntosh & McKegeney 2002) is being utilised as a positive attribute, resulting in continued disclosure. For Richard, working in the same service he was in treatment and within an all-ex-user team, the cultural and social norms emphasise shared experience that included disclosure so that, "we talk in terms of 'we', so this is what we do if we're talking about fear or one of the subjects that we're talking about on [treatment programme]". These examples suggest disclosure decisions are well-considered and reflected upon with participants taking time to weigh up the pros and cons of disclosure in terms of when, where, how, how much, what level of detail, and so on. However, in reality,

when working in busy drug services, there is often little opportunity to be so reflexive. As a result many decisions to disclose were on-the-spot responses rather than planned approaches, an example perhaps of how "little explicit attention was paid to the goals of disclosing" (Miller & Read 1987, p42). In other words, disclosers may have vague ideas about what they hope to achieve from disclosure but have not fully reflected on specific goals. For others, there is an element of ambivalence towards both disclosure and being identified as an ex-user, for example, Phil suggested that he has mixed feelings about whether or not to disclose his past use (see p158). On the one hand, he does not object to people knowing about his past and so will answer honestly if asked, but on the other hand, he does not want to be labelled by his past. Similarly, Jamie (see p164) felt it was important to respond honestly if asked, but did not feel it appropriate to volunteer the information, that is, he only disclosed if a client expressed an interest in knowing. Therefore, disclosures are made in response to the needs of and/or interactions with others (see Berg 1987).

Participants, therefore, often 'took their lead' from those with whom they interacted, particularly clients, as it was "the previous actions, communications, needs and wishes" (Miller & Berg 1984, quoted in Berg 1987, p102) of others that influenced their disclosure decision-making. For example, if ex-user workers assessed a client 'needed' the worker to be a role model or to offer hope, they would be more likely to disclose their past substance use in order to meet this need (for example, Michael, Luke and Harry). Similarly, if clients asked workers about their past use, they were more likely to respond affirmatively rather than lie (for example, Jamie, Michael and Phil).

If individuals experience positive responses to disclosure, the likelihood of future disclosure increases in terms of frequency, breadth and depth (Chaudoir & Fisher 2010). Conversely, if individuals experience difficulties relating to disclosure, they may be less likely to respond

with further disclosure (for example, Debbie and Elizabeth) because "people may fear that they will now be judged negatively or 'discredited'" (Chaudoir & Fisher 2010, p248). Chelune (1979) referred to weighing up positive and negative aspects of disclosure as, "[t]he reward/cost outcomes of social interactions" (p252) and saw these as "motivational units that result in evaluations and forecasts about future exchanges" (p252). This means where rewards exceed costs, disclosure is more likely and results in effective relationships, whereas if costs exceed rewards, disclosure will be less likely and may result in relationship breakdown. Based on this assessment, "[a]n individual regulates the extent to which he or she is open (discloses) or closed (avoids disclosure)" (Derlega at al. 1993, p68). This was true for this study's participants as they reached disclosure decisions based on individual assessments, even if it only took a matter of seconds to reach a decision. Luke, for example, assessed disclosure appropriateness thus: "if it felt like it would help the situation, then I would tell them [clients]" but if "it felt like, hang on; what do they want to know that for? It doesn't feel right here," he would not disclose.

What becomes apparent in this example, is just how subjective this assessment is and how difficult it is for ex-user drug workers to predict how their disclosure will be received or how beneficial it may be. Many participants' decisions to disclose could be seen as falling into the more intuitive end of the "Cognitive Continuum" (Cader et al. 2005, p402) which suggests that the more intuitive the decision-making process, the less precise, more rapid, inconsistent and non-cognitive the decision-making process is and, by extension, the less reliable its outcome in terms of achieving a positive response is likely to be. When reflecting on the descriptions participants gave about the circumstances in which they decided to disclose, none described an analytic or scientific process (at the other end of the Cognitive Continuum) (Cader et al. 2005). Although not specifically relating to disclosure, Cognitive Continuum Theory has an evidence-base that demonstrates decision-making processes in a range of settings, including healthcare. The two main concepts within this

theory are analysis and intuition with analysis being more likely where an individual is undertaking "well-structured tasks" (Cader et al. 2005, p399) and there is time and opportunity to construct a thoroughly considered response. The closest example to a more analytic approach is Richard's aforementioned use of disclosure within groupwork settings. At the other end of the spectrum, as a result of ill-structured tasks (Cader et al. 2005, p399), intuition is more likely to occur, often where a rapid response is required because there is limited time and opportunity available to decide and act. The latter scenario could be true for drug services because of the less structured, more informal nature of many psychosocial interventions offered within these settings, including those interactions where there is the potential for disclosure. This seems to resonate for many participants given their comments about disclosing in response to client questions if it *felt* appropriate (intuition) rather than as a structured, analytic response.

However, no practitioner makes decisions exclusively through either analysis or intuition as individuals oscillate between the two cognitive processes (Cader et al. 2005). This theory has relevance for the participants' disclosure decision-making as, depending on the given situation, an individual may have the opportunity to analyse the appropriateness of disclosure as part of a well-structured task. For example, Adam decided within structured assessment interviews to inform clients he would not disclose but they could discuss this once they had established a working relationship. Conversely, Debbie, Luke, Jamie, Phil and Michael all reported feeling required to respond with personal disclosures in an unstructured situation when it either "felt just right" (Luke) or as a defence mechanism in response to such client comments as, "'how would you know?' 'Well, I do actually'" (Phil). These examples demonstrate a rapid response to client concerns where individual workers felt obliged to disclose. If ex-user drug workers have no opportunity to reflect on disclosure decision-making prior to being 'put on-the-spot', they are more likely to respond intuitively

rather than as a result of a considered, balanced analysis where they have weighed up the pros and cons of disclosure.

Even where an individual anticipates or hopes for a positive response, and "[d]espite the benefits of self-disclosure, individuals incur risks in sharing upsetting personal experiences with others" (Derlega et al. 1993, p111). For some individuals, such as Elizabeth who usually does not disclose her past, they may perceive the risks as being greater; have lower acceptability of taking such risks; or of tolerating feelings of vulnerability that may result from disclosure (Derlega et al. 1993). If Elizabeth felt her "level of vulnerability is tolerable" (Derlega 1993, p69), then she may have lowered her boundaries to disclose (as she did in a recent job interview). However, if Elizabeth did not feel able to accept these risks, boundaries remained in place and information is not shared, evidenced by her continuing decision not to disclose to colleagues (Derlega et al. 1993). Furthermore, when Elizabeth felt her disclosure in a job interview was, in hindsight, too risky, she decided to re-establish her original boundaries and returned to her prior decision not to disclose (see p155). Elizabeth's narrative demonstrates that she continued to feel she "risk[s] experiencing negative outcomes or even becoming the [target] of prejudice" (Chaudoir & Fisher 2010, p236), even though this discrimination did not become a reality, that is, she did not report any direct negative consequences as a result of disclosing in the job interview. This fear was based on her early negative experience of disclosure when as a new volunteer she felt judged and had her confidentiality breached. Elizabeth's perception of disclosure, therefore, remained one of predominant risk as she continued to see her disclosure decision-making through the lens of her prior negative experience (see Gubrium 1993). As identified by Chaudoir and Fisher (2010), "the outcomes of a single disclosure event can affect subsequent disclosure processes" (p240). This is clearly true for Elizabeth's disclosure decision-making. Furthermore, "single disclosure events are components of a

larger, ongoing process of "stigma management" – coping with the psychological and social consequences of their identity" (Chaudoir & Fisher 2010, p240).

Again, this has relevance for Elizabeth, whereby she found numerous ways of coping with and managing what she considered to be the psychological and social consequence of her previous identity. When she first experienced negative reactions to her past, Elizabeth felt "frustrated" and "annoyed" which was to be expected given that "when disclosers receive anything less than fully supportive reactions or are socially rejected, disclosure can be detrimental to well-being" (Chaudoir & Fisher 2010, p247). To manage these feelings, she raised her concerns with a senior manager, expressing a hope that her manager "maybe learned by it". For subsequent jobs in the homelessness field, Elizabeth's coping strategy was to avoid disclosure, an approach she considered to be the ultimate risk management plan, that is, "I just feel it keeps me safe". Chaudoir and Fisher (2010) described this as, "avoidance-focused coping strategies" (p241) and further suggested that, "intentional efforts to suppress information about one's concealable stigmatized identity can actually lead people to become preoccupied with thoughts about their identity" (p245). This can be seen to apply to Elizabeth as she stated, "I've always got to be on my guard".

In contrast, when doing the Level 3 substance misuse course, Elizabeth felt able to disclose (see p155) because she did not perceive the potential cost of disclosure as being so great in this educational context compared to her employment context. Here, it felt less risky to disclose so her management plan moved from being risk-averse to not only risk-accepting, but having specific goals of being herself and accepted by course colleagues. This relates to the suggestion that "a tension exists between disclosure and privacy" (Derlega et al. 1993, p86) and to Chaudoir and Fisher's (2010) description of how "approach vs. avoidance goals fundamentally shape the way individuals perceive and react to their environments" (p241).

Individuals assess their disclosure 'dilemma' – "[t]he more risk, the tighter the boundaries are controlled" (Derlega et al. 1993, p70). While another function of disclosure includes the aim of relieving distress (Omarzu 2000) by talking to another person about past or present problems, it may be considered inappropriate for ex-user drug workers to disclose to current clients in this way. However, utilising supervision and gaining team support may be entirely appropriate. In the absence of such support, the lack of any "appropriate disclosure recipient" (Dergela et al. 1993, p87) with whom to share personal information may result in psychological distress and/or physical health problems (Pennebaker et al. 1988), especially if the issue that is withheld is traumatic or difficult (for example drug use). It has been suggested that where people, including ex-drug users, choose not to disclose, they view themselves or their withheld experiences negatively (Derlega et al. 1993), implying similarly negative connotations for their self-esteem and self-worth. This situation may arise when there is a lack of any appropriate disclosure recipient.

Whether individuals have a positive attitude to disclosure (approach) or negative attitude to disclosure (avoidance) (Chaudoir & Fisher 2010) will be influenced by past experiences of disclosure to determine future disclosure decisions and include the "reaction of the confidant" (Chaudoir & Fisher 2010, p240) to further influence the likelihood and extent of any future disclosure. This reinforces the fact that disclosure is an interactive process and that each disclosure experience is unique, that is, an individual may tell the same story about themselves but even if they disclose their narrative in exactly the same words and manner, how the confidant responds will be different from previous responses. However, this does not mean disclosers have no influence over how disclosures are received. Chaudoir and Fisher (2010) described how disclosers can positively influence, to a lesser or greater degree, how individuals respond to their personal disclosure, suggesting that by teaching skills in communication and self-regulation disclosers might "improve the chances of eliciting positive, supportive responses from their confidants" (p252). This may be equally

applicable to the training needs of ex-user drug workers so they become more skilled and confident in their method of disclosure within the drug field and achieve more rewards than costs as a result.

The above range of contributing factors (rewards and costs, context and environment, disclosure skills and recipient reactions) means that "disclosing a concealable stigmatized identity may be a highly complex process because it can yield the potential for both benefit *and* harm" (Chaudoir & Fisher 2010, p236, emphasis in the original). Disclosure is therefore neither a good nor a bad thing to do. When individuals make disclosure decisions, they need to consider the benefits and harms for each situation rather than having a 'blanket policy' of either disclosing or not disclosing, that is, they need to adopt a selective disclosure strategy.

**Selective disclosure decisions**

Disclosure decisions are not necessarily fixed decisions. For example, Adam, when he moved to the voluntary sector, disclosed to colleagues and told "one or two people in my team" on returning to the statutory sector. He continued to disclose on occasion to clients, even though he saw himself as someone who "like[s] to keep me cards close to me chest". Similarly, Phil worked in both voluntary and statutory sectors and in both settings his colleagues were aware of his background while he also discussed his past with selected clients – "I'll self-disclose where it's appropriate". Luke did not disclose to colleagues although he wondered "whether people are a bit, mmm, putting two and two together" but would disclose to clients as long as they "only want to know key facts". This level of disclosure Luke felt to be appropriate "cos it will really motivate others".

Such experiences reflect disclosure theories (Chelune 1979; Collins & Miller 1994; Derlega & Grzelak 1979; Derlega et al. 1993) where participants selected to whom they were

comfortable disclosing, having assessed their perception of risk for themselves and benefit for the client. The extent to which they disclosed - "I won't go into specifics" (Michael) - sets the 'ceiling' of their disclosure and not going above this boundary is intended to keep themselves and their clients safe (Derlega & Grzelak 1979, p163). This means on a day-to-day basis individuals are constantly balancing what level of disclosure is appropriate within any given context so "they will selectively reveal or withhold information depending on how heavily they are relying on disclosure to obtain their goal" (Omarzu 2000, p177). Disclosure is therefore a matter of choice or selection. For some participants, their choice in the early stages of their career as a drug worker was limited by their lack of other experience or qualifications, meaning they felt they had to disclose their past substance use because they had no other story to tell in order to justify their role (for example, Adam). In some cases, personal choice was denied them by their past already being known through volunteering or working in the same service they had been in treatment, or by the nature of their role which exclusively related to an ex-user status (for example, Harry and Jamie). There are therefore limits to just how much choice regarding disclosure people have in reality. This is especially true as, in addition to such limitations, there are social norms within some services where it is expected that ex-users will share their own experiences of substance use, what is referred to as "visible recovery" (Sinclair 2012). In recent years, visible recovery has become manifest in the form of "recovery 'champions' as charismatic and connected community figures who are visible examples of success" (Best & Laudet 2012, p5).

However, even though ex-users are encouraged in many settings to be open about their own recovery, this does not mean they are encouraged to share *everything*. Michael stated, "I'll tell them my life story if they want to hear it. They don't [laughs]. I'll tell them certain things, you know". Michael's point is an important one in that others do not want to know *everything* about an individual. As well as the discloser being conscious of what is

appropriate in terms of depth and breath, the recipient or confidant is also conscious of this. If a discloser reveals too much personal information for a given context, the recipient may be left feeling awkward or embarrassed or make negative judgments about that person's boundaries (Collins & Miller 1994). However, if an individual feels they have been personally selected as the recipient of a particular piece of personal information, then the recipient may "feel trusted and liked and more apt to evaluate the discloser favorably" (Collins & Miller 1994, p459). Individuals will therefore select which stories to tell; how much to share; and who to disclose such information to depending on the nature of the relationship and the context of the conversation.

Given the potential risks associated with disclosure, "it seems reasonable that people will be selective when sharing intimate information with others" (Collins & Miller 1994, p466). The balancing of risks with potential benefits of disclosure is likely to be the deciding factor when disclosure decisions are made. For example, drug workers (whether from an ex-user background or not) want to make a good impression to build rapport and trust with clients and colleagues and will therefore be selective about what information they share in what circumstances (Derlega et al. 1993). This is what Chelune (1979) referred to as "impression management" (p254) and Omarzu (2000) called "strategic disclosure" (p177). Derlega and Grzelak (1979) described such selective disclosure strategies as a means of "social manipulation" (p161), that is, to "increase control over their own and others' outcomes" (p161). On the face of it, this sounds potentially harmful for disclosure recipients and the possibility that such disclosure could be misused is real. However, the intention may not be to deliberately mislead or control another in a damaging way, but to put a positive 'spin' on the nature of treatment and recovery to instil hope and act as positive role models, a combination of what Derlega and Grzelak (1979) described as "[s]elf-disclosure... to gain others' social approval or to make others feel good about themselves" (p161). Maybe this is why many ex-users tell the positive elements of their recovery story alongside their 'rock

bottom' story to show the contrast in their experiences but do not share the details of how much hard work it is to achieve and sustain a meaningful life post-treatment. It is selling the recovery message without saying what investment is needed.

Selective disclosure can also be considered in terms of regulation, that is, "persons can regulate the degree of intimacy that they prefer to maintain by emphasizing the boundary aspects of their relationship" (Derlega & Grzelak 1979, p163). This means ex-users can select in advance of client/colleague interactions which stories they are willing to share. For Nicola, this meant, "I wouldn't personally go into any depth with it", while for Michael, his response to questions would "be very brief", and Richard and Debbie both described how they shared "snippets" rather than talk about their pasts at length. Nicola, however, felt self-disclosure needed tighter regulation and stated she made clear to clients that, "I'm not here to talk about me" as "you'd be breaking boundaries, aren't you, if you start talking about yourself and your past". As well as selecting what to disclose, the participants also selected who to disclose to with many assessing this based on perceived benefits of disclosure to the recipient. For some participants, the selection process was about which groups of people they were willing to disclose to, that is, some were happy to disclose to clients but not colleagues (for example, Luke and Debbie); some were happy to disclose to all colleagues but only some clients (for example, Michael and Phil); and some were more likely to disclose in voluntary rather than statutory agencies (for example, Adam and Phil).

A further consideration was selective timing, that is, some participants disclosed "if the time is right" (Richard) while Adam did not respond to questions about his past at the beginning of his working relationship with new clients, saying, "we'll work together first, see how it goes, and perhaps ask me again in six months or so". Richard did not describe how he decided "if the time is right" perhaps indicating he is reacting to the situation or responding to perceived needs of clients at any given time so it is the interaction between Richard and

his clients that determined the appropriateness (or not) of disclosure. For Adam, the decision appeared to be more pre-determined with his decision based on his belief that any disclosure on his part early in his working relationship with a client may influence how the client then perceived him. Adam did not want to be seen primarily as an ex-user, he wanted to be judged on his skills and knowledge as a drug worker. In other words, because he wanted to be recognised for his present identity as a drug worker rather than his past identity as a drug user, this regulated his disclosure decision-making.

Many participants referred to selective disclosure in terms of assessing the benefits for clients and were reluctant to own any benefit (apart from building rapport and breaking down barriers) for themselves. Indeed, Harry implied self-disclosure was acceptable if it was intended to benefit the client but not if the motivation was to make his role as a drug worker easier (see p158-159). And yet, some of the literature stated that, "[a]nother purpose of self-disclosure is social validation, getting feedback from others about our thoughts or feelings or getting help with problems in our lives" (Derlega et al. 1993, p3). This may mean it can be as acceptable for ex-user drug workers to benefit from selective disclosure as much as their recipients, that is, gaining 'feedback' from service users can reinforce or validate the achievement of becoming a drug worker and 'getting help' from colleagues and/or supervisors to support their continuing recovery. However, different rules apply to working in the drug field so it would not be acceptable for ex-user drug workers to be 'getting help' directly from their client group even if this may be happening in subtle, indirect ways with clients helping ex-users remain motivated to be role models and live positive, meaningful lives.

Because personal and professional boundaries exist within drug services for the protection of clients, volunteers and workers alike, disclosure may not always be appropriate. Therefore, the concept of selective non-disclosure or selective privacy may override that of

selective disclosure. Privacy may be considered a passive non-action. However, privacy can be defined as "a dynamic process involving selective control over a self-boundary either by an individual or by a group...[and]...an *interpersonal boundary process* by which a person or group regulates interaction with others" (Altman 1975, p.6, quoted in Derlega et al. 1993, p67, emphasis in the original). In other words, it may take as much consideration, interaction and reflection to decide *not* to disclose as it takes to disclose. This is particularly true if individuals select a disclosure strategy on some occasions, with some people, but select a non-disclosure strategy in other situations, with other people. Chaudoir and Fisher (2010) noted that:

> "[i]n practice, disclosure is a complex behavioral process that involves sustained self-regulatory efforts – exerting self-control in order to make disclosure decisions, communicate effectively, and cope with the outcomes of disclosure" (p237).

This implies that disclosure is not a simple event occurring in isolation of previous experience, the context of the situation and the reaction of the recipient. Conversely, it is a challenging cognitive and emotional process requiring careful consideration and reflection.

**Disclosure – risks, rewards and reciprocity**

As part of the selective disclosure decision-making process, individual ex-user drug workers assess the risks and rewards of each disclosure while simultaneously assessing what and how much to share based on the interaction between themselves as discloser and their recipient(s). This may include their perception of the appropriateness of reciprocating when a client or colleague discloses personal information to them as ex-user drug workers. Certainly, drug workers, whatever their background, expect their drug-using clients to divulge sensitive personal information as part of the assessment process (see Derlega & Grzelak 1979). Such clients may then expect a degree of reciprocity (see Chelune 1979) from the drug worker. In addition, a worker may feel it appropriate to respond with

disclosures of their own because their client is being 'open' about their drug-using history. This resonates with the available literature as, "disclosure is a highly reciprocal process wherein one person's disclosure can engender disclosure from another" (Chaudoir & Fisher 2010, p244).

Between his first and second interviews, Richard re-located to facilitate groups in a new geographical location and within a multi-agency setting where the staff team comprised ex-user and non-ex-user drug workers. This was the first time he had to decide whether or not to disclose his past use (see p170) and had disclosed to clients but not colleagues. For Richard, there was perhaps less perceived reward and more risks to disclosing to his new colleagues in comparison with disclosing to clients where he had prior positive experiences. And yet, non-ex-user colleagues might benefit from Richard's 'lived experience' (numerous research studies have explored or demonstrated the effectiveness of lived experience, for example, Abma 1999, Ellis & Flaherty 1992, McLaughlin 2009) where "people give meaning to their experiences by telling stories" (Abma 1999, p170) and which may, in turn, benefit the wider client group through having workers with greater insight and understanding than before. The term 'lived experience' was adopted originally in this context by mental health services (Scottish Recovery Network (2004)) who advocated the involvement of clients in research, service design and delivery, and peer support. As many drug services have similar principles, the ethos of 'lived experience' is equally applicable here and becoming increasingly valued (Best & Laudet 2012). Other workers' practice may be improved through hearing about lived experience, but the rewards may be perceived as indirect or less obvious while anticipated or actual risks may be more direct in the form of discrimination. This contrasts with Richard working in a service staffed exclusively by ex-users where reciprocity might be considered more acceptable because of "peer support" (Best et al. 2011).

However, even in this setting, Richard was conscious of the need to limit what he disclosed, partly for his own safety but more for the benefit of his clients so "we won't constantly just go on about ourselves because they'll switch off, they won't come back". Richard, therefore, felt it inappropriate to reciprocate on an equal footing because the focus should remain on the clients and not him as an ex-user drug worker. There are significant differences between reciprocity in a social context where "recipients of a self-disclosure input will respond by disclosing about themselves at a comparable level of intimacy" (Berg & Derlega 1987, p4) and reciprocity in a working environment where 'intimacy' is seen as unprofessional. For example, it was deemed inappropriate that participants match disclosure 'like-for-like' as this crossed the invisible line that marks the boundary between acceptable and unacceptable working practices. In this context, it was inappropriate for there to be equal reciprocity because "[u]nequal power relationships – legitimized by social norms – create situations where some persons are expected to disclose more information about themselves than others" (Derlega & Grzelak 1979, p163). In this case, the "some people" who are expected to disclose are current rather than ex-substance users within the context of treatment and recovery services. However, there is potentially another layer in this disclosure hierarchy where ex-drug users are expected to disclose *some* personal information about their past but non-ex-substance users are not, even when they have relevant life experience. Such workers may not have used substances problematically in the past, but they may have experienced, for example, mental health problems or be survivors of abuse, both of these being common concerns for substance users as well. Therefore such disclosures could offer further role models for substance misuse treatment recipients.

There may be benefits for clients to find out their drug worker has "been there" (Harry), as this instils hope and provides a positive role model, but if the worker were to match disclosure like-for-like, boundaries would be crossed. These boundaries are a consideration for all drug workers, not just ex-users, if disclosure is extended to include other pertinent

issues. Therefore, guidance and training related to boundaries and disclosure should be offered as standard to all drug workers irrespective of their backgrounds. There are particular issues for ex-user workers in the substance misuse field especially if, like Michael and Elizabeth, workers continue to attend twelve-step meetings where the emphasis is on mutual aid, that is, mutual reciprocity of disclosure (see p221). This results in a dilemma when it comes to making disclosure decisions. For example, when Michael attended a meeting (see p222) where a client was present, he disclosed but did "not go into details" resulting in setting a lower disclosure "ceiling" (Derlega & Grzelak 1979, p163). Therefore, the level of disclosure reciprocity for Michael in the workplace; in meetings where he knows another member as a client; and in meetings where no known clients are present had to be adjusted. Further complications arose if he received a referral to the service where he worked from someone he previously disclosed to in mutual aid meetings. This meant levels of reciprocity must be re-adjusted again and new boundaries negotiated.

When clients disclose their backgrounds, for example, during an assessment, Michael and Jamie felt 'obliged' to respond honestly when asked about their own experiences. This confirms the interactional nature of disclosure decisions and relates to the disclosure theory of reciprocity (Chelune 1979). Omarzu (2000) suggested that, "[r]eceiving disclosure also seems to be an experience that produces a sense of obligation" (p176). Such decisions to disclose are being made at the same time as Jamie acknowledged clients may be pushing boundaries by asking about his past perhaps implying that Jamie is not wholly comfortable with disclosing. Chelune (1979) explored reciprocity of disclosure as a norm within interpersonal relationships, building on the work of Jourard (1971) to posit that, "disclosure begets disclosure" (Chelune 1979, p249). He suggested we learn to reciprocate through modelling others' disclosures and through "social exchange" (Chelune 1979, p249). For drug service users who are expected to disclose personal information as part of the assessment process, there may be an expectation that their drug worker will reciprocate

with disclosures of their own. Any disclosure should, Collins and Miller (1994) argued, be appropriate in terms of breadth and depth – too little disclosure and others (including service users) may not trust the worker; too much, and professional boundaries are compromised. This links to Omarzu's (2000) description of a "subjective utility versus subjective risk" (p179) decision-making process, where individuals may disclose less (or less frequently) if they perceive greater risk while individuals may disclose more (or more frequently) if they perceive greater benefit (or utility) to such disclosures. For example, Elizabeth disclosed less based on her perception of discrimination, while Harry disclosed more based on his perception of client benefits.

Michael is comfortable disclosing his past drug use on application forms and in conversation with colleagues and clients; "I think the service users appreciate the views of an ex-user worker". Debbie, however, was less comfortable discussing her past, especially with colleagues, as she perceived the risk of disclosure to be greater than perceived benefits. There were occasions where she used her background to validate her role, and establish trust and common ground, but it could be considered that Debbie was 'pushed' into reciprocating by some clients' challenging behaviour (Omarzu 2000), whereby Debbie felt she needed to disclose in order to gain credibility (see p153). In such situations she had to balance the rewards and risks of disclosure, perhaps unconsciously recognising "[s]elf-disclosure cannot only be used to achieve social rewards, it also carries with it a social risk" (Omarzu 2000, p177). Every time ex-user drug workers disclose, they take a risk including the risk of being rejected; of losing personal integrity or control; and/or causing distress for the recipient (Omarzu 2000). While Debbie and Elizabeth had negative experiences of disclosure because both perceived the risks to outweigh potential benefits, others, for example Harry, spoke positively of the response he got when disclosing (see p157 and p158).

Clearly, such prior experiences of disclosure – positive or negative - strongly influenced future disclosure decision making (Chaudoir & Fisher 2010, Chelune 1979; Derlega & Grzalek 1979). Within the drug field, it could be considered the norm for disclosure to occur between clients; between workers; and between clients and workers, as such interactions help facilitate rapport-building and trust development, promoting both recovery and teamwork. Indeed, patterns of interactive disclosure could be seen as "attempts to maintain equitable social exchange or a 'norm of reciprocity'" (Berg 1987, p112). However, while it might be the norm to disclose, there are also norms about how much disclosure is appropriate in what context. These unwritten rules "can also have powerful effects in controlling a person's behavior because violation of the norms may lead to negative sanctions" (Chelune 1979, p254). In other words, if an ex-user drug worker revealed too much information about themselves, this could be considered as "being on dodgy ground" (Adam) or as Jamie put it, "I don't think you should shove that 'I'm an ex-user' thing down people's throats". This suggests that if an ex-user drug worker reveals or reciprocates too much information about their transition (Chelune 1979), then instead of achieving the goal of inspiring the client and making a good impression (Berg 1987), the worker's effort back-fires causing a rift between themselves and the client, resulting in de-motivation potentially for both client and worker. There are therefore "social rules" (Chelune 1979, p254) determining how much information is appropriate to reciprocate, including within drug services. If norms are broken or disregarded this might result in "negative sanctions" (Chelune 1979, p254) or leave "the recipient embarrassed and unsure how to respond" (Collins & Miller 1994, p459). This means ex-user drug workers must calculate an appropriate level of reciprocity to avoid breaking these unwritten disclosure rules. For example, Luke described his disclosure as being limited to the fact that he used to be a substance user with no mention of his "actual background" while Michael will "never tell exact details".

Where ex-user workers, such as Elizabeth, chose not to reciprocate, their aim was to "maintain their privacy" (Cheulne 1979, p247) rather than build closer working relationships with clients. Jourard (1971) suggested that, "therapists, in order to maximise disclosure in their patients, will be obliged to go beyond impersonal 'technique' and 'be themselves'" (p17). However, for workers who choose not to disclose, this can lead to interactions between them and their clients where "impersonality begets impersonality" (Jourard 1971, p17), the opposite of disclosure leading to disclosure. Such impersonality may be considered by some to be a barrier to building rapport while others view it as an appropriate boundary. But the choice is not one of either disclosure or non-disclosure. As we have already seen, selective disclosure; decisions regarding depth, breadth and duration of disclosure (Chaudoir & Fisher 2010); assessment of risks and benefits; context-specific disclosure; reciprocity versus privacy; and the concept of having a disclosure "ceiling" (Derlega & Grzelak 1979, p163) offer individuals opportunities to make disclosure decisions based on a disclosure continuum rather than limiting the choice to either disclosure or non-disclosure. In reality, non-disclosure is a "selective" decision as much as disclosure, and as no one can ever disclose everything about themselves, there will always be a 'disclosure ceiling' rather than 'full disclosure'.

It has been suggested that there are three key elements to disclosure decision-making – appropriateness, perception of motives for disclosure, and discloser characteristics (Chelune 1979). In other words, individuals – both disclosers and recipients – assess how appropriate it is to disclose, to a particular person, within a given context. Furthermore, the recipient makes a judgment regarding *why* they think a person is disclosing a particular piece of information to them. For example, within substance misuse services, if a client perceives an ex-user drug worker's disclosure as being designed to support and motivate them, this is likely to be seen favourably. If, however, the client feels the disclosure is designed to coerce them into a particular type of treatment or that the worker is 'showing

off', this will be viewed with suspicion or even contempt. Discloser characteristics may also be a factor in that recipients may be more open to listening to someone of the same gender, age and/or racial background who has used the same type of substances as themselves and who shares their experience in a way that resonates with the recipient. These key elements affect the norm of reciprocity because how much a person reciprocates will not only be affected by the interaction between the individuals, but also by the nature or stage of the relationship. In the context of drug services, the level of disclosure may be affected by whether the client has just met the worker at an assessment interview or has a longer term treatment relationship with them. A further element affecting reciprocity in the drug field includes the context within which the interaction takes place. Furthermore, personality characteristics, including whether a drug worker had an open or boundaried approach to disclosure influenced reciprocity, for example, it might be considered that Harry and Richard had open approaches to disclosure, while Elizabeth and Kieran appeared boundaried or even closed (Chelune 1979).

This contrast between open and closed approaches may affect the working relationship between worker and client. Disclosure could be used as a technique to build rapport and to encourage clients to answer sensitive questions in assessment interviews. Collins and Miller 1994, noted that, "the easiest way to get others to talk about themselves is to talk about oneself" (p468); in other words, "you tell me and I'll tell you" (Jourard 1971, p25-26). Certainly, several participants suggested they disclosed their ex-user status as a means of building trust and rapport. Disclosure could be mutually reciprocated because the client models the disclosure behaviour of the worker and/or the worker models the behaviour of their client. In other words, if more information is shared by the worker, can more information be expected from the client and vice versa? Equal reciprocity may be deemed inappropriate in the work context as there may be less "social obligation to return a disclosure of comparable value (or intimacy)" (Miller & Read 1987, p45). However, some

degree of self-disclosure is deemed useful, including in the early stages of relationship development. Derlega et al. (1993) postulated that, "[i]t is hard to imagine how a relationship might get started without such self-disclosure" (p1-2). Getting the level of disclosure 'right' is a delicate balance (Chaudoir & Fisher 2010), assessed on an individual basis and through responding to the responses of the recipient without "a set formula" (Harry).

Some participants suggested that disclosure indicates a crossing of boundaries. For example, even though Nicola did not experience any difficulties disclosing when she was a volunteer, she decided not to disclose her background once in paid employment, citing professional boundaries as the reason for this (see p171). However, it is noteworthy that "[s]elf-disclosure between individuals is not equivalent to having a close relationship" (Derlega et al. 1993, p2). This means disclosure need not be seen as an unprofessional breach of boundaries between workers and clients provided an appropriate *level* of disclosure has been accurately assessed and implemented, that is, if selective disclosure rather than equally reciprocal disclosure is effectively utilised.

**Disclosure – for optimum effectiveness**

Disclosure is "not an easy task" (Chaudoir & Fisher 2010, p243) so how do individuals develop a strategy that enables them to achieve their desired disclosure goals and optimum outcomes without experiencing unacceptable negative consequences? In the context of ex-user drug worker disclosure, it is not just the feelings of the client that must be considered. Drug workers' roles, feelings relating to their 'new' identity and the transition they have made must also be carefully deliberated. Ex-user drug workers may feel uncomfortable when disclosing information about their past substance use or offending behaviour. Such discomfort may arise from the reactions of recipients to whom they made initial disclosures, whether clients or colleagues. Other factors affecting the level of discomfort in disclosing or

the outcome of any disclosure include how prepared (or not) the individual was for the disclosure conversation; their skills in articulating their personal information in a positive manner; what goals they hope to achieve with disclosure; what risks they perceive are involved in disclosure; and how disclosure may affect their identity as a drug worker. In order to be seen as an effective drug worker, individual ex-users may feel it necessary for their client group to see them as credible and likeable and may consider disclosing their past history of substance use as a means of optimising this aim. As Holstein & Gubrium (2000) stated in their discussion of Alcoholics Anonymous narratives, "the 'voice of experience' is credible because it appeals to having 'been around'". In this study, Harry, for example, found that as a result of disclosure he gained respect and trust from his clients (see p161).

Collins and Miller's (1994) suggestion that, "the link between self-disclosure and liking is mediated by the formation of positive beliefs about the discloser" (p458) supports Harry's aforementioned experience. This is further corroborated by,

> "some experimental evidence that people form more positive impressions of others who are willing to share personal information about themselves, compared with others who are less open" (Collins & Miller 1994, p458-9).

This suggests that ex-user drug workers like Harry who disclose personal information are more likely to bond with their clients than practitioners like Elizabeth and Kieran who do not. However, there are limits to how effective disclosure is likely to be. Collins and Miller (1994) advocated that there is a balance of disclosure, that is, "liking is expected to be strongest when the level of disclosure is moderate and weakest when the level is either extremely low or extremely high" (p460).

In other words, if a person discloses too little or not at all they are often liked less by others while, at the other end of the spectrum, if they disclose too much, too soon or too often they will also be less liked by others. This implies the need for an optimal level of disclosure with *enough* information shared to develop an effective relationship. Selective disclosure can be a useful tool to determine this optimal level. However, the amount of disclosure is not the only component determining how the disclosure will be received, for example, appropriateness of the disclosure in its context; the perception of a personal connection between the discloser and the recipient; the content, quality and quantity of the information disclosed; personal factors such as gender; the receptivity of the confidant to the information disclosed (Collins & Miller 1994) all contribute to the disclosure interaction and outcome. For this study's participants, it might be appropriate (or even a norm in some services) to disclose their status as an ex-user in the context of their role as a drug worker or volunteer. If they were to similarly disclose in another occupational or social setting, such disclosure might be deemed less appropriate. Elizabeth, for example, currently employed in supported housing, felt it was inappropriate to disclose in this context but that when applying for jobs in the substance misuse field it might be more acceptable (see p153).

Functional theory of disclosure (Derlega & Grzelak 1979) suggests that disclosure aims to achieve "one or more of five basic functions: self-expression, self-clarification, social validation, relationship development, and social control" (Omarzu 2000, p177). When participants discussed why they disclosed their past history of substance use, relationship development was the predominant reason given (for example, "it can just build a bit of [rapport] and break down a few barriers" (Harry), this being the "function" most closely associated with benefits to clients. In terms of what is considered acceptable in the drug field, disclosure in order to act as a role model to current service users is the norm. In a similar way to the accepted narrative of transition to become a drug worker being to 'give something back' (for example see Addenbrooke 2011), the accepted goal of disclosure

(and therefore the accepted narrative of disclosure) is to benefit the clients through relationship development. This does not, however, mean the other functions - self-expression, self-clarification, social validation, and social control (Derlega & Grzelak 1979) - are not factors in the participants' decision-making; it is simply that these stories are suppressed by being seen as less acceptable than relationship development. And, yet, disclosure that seeks approval by others and aims to represent one's identity to others, for example, are perfectly normal in everyday social interactions (Omarzu 2000). When we interact with others, we tell our narratives in ways we hope will put us in a favourable light (McLeod 1997) and will give an accurate reflection of who we are (or who we are trying to be). Ex-user drug workers are no different in this regard.

While self-disclosure can be beneficial for both teller and recipient (Derlega et al. 1993), it is also possible that individuals "use self-disclosure for social control, selectively presenting information about ourselves to create a good impression" (Derlega et al. 1993, p3). This was referred to by some participants in terms of breaking down barriers and letting clients know they understood the clients' situations through having similar experiences. The relationship can thus be seen as "*mutually transformative*" (Derlega et al. 1993, p6), so workers gain from the interaction as well as clients. Some people may view disclosure as "a more effective strategy" (Omarzu 2000, p182) and more useful in some situations than others. When deciding whether or not to disclose, or to what level, individuals must decide how they will communicate their personal information and what they hope to achieve from disclosure or non-disclosure. Indeed, "disclosure goals shape both the content of the disclosure event and the reaction of the confidant" (Chaudoir & Fisher 2010, p240) in that an individual will choose their words carefully to impart the information depending on their desired outcome. For ex-user drug workers, therefore, there would be little or no benefit if they were to talk about their past drug use in a way that glamorised or suggested life as a drug user had been better than the life they are living now. Goals outlined by the

participants included: "motivate others" (Luke), "to help engage with the client" (Phil), and "trying to help" (Nicola). The way in which individuals disclose their personal histories, the language and tone they use, will thus reflect the goals or benefit to clients. Participants who selectively disclosed when they felt it to be appropriate genuinely believed that in doing so they would improve client treatment outcomes.

**Disclosure – guidance and support**

Many participants discussed a lack of induction, training and supervision during their early days as volunteers or sessional workers, meaning limited access to support to carry out their role, almost assuming that because they had been a substance user, they automatically knew how to be a drug worker/volunteer. Luke was the only participant to report receiving any guidance on disclosure when he started as a volunteer, and was advised not to disclose personal information as part of a wider "don't ask, don't tell policy". However, Luke felt it was his information to disclose and gave as his rationale for sharing his ex-user status, his assessment that by disclosing elements of his past, "in a lot of ways you might be doing someone a favour by being honest, em, cos it will really motivate others." He did not, however, let his volunteer coordinator know he had breached the agency's boundaries, leaving him no back-up if he had needed support following disclosure. Other participants, for example, Michael and Harry, also felt disclosure was a personal decision rather than an agency one. The participant's decision to disclose was made by the ex-user on their own; often based on gut instinct or as a defence mechanism, without forward planning and without having the opportunity to discuss this with trusted colleagues or supervisors. For example, Phil disclosed in response to, "'how would you know?'" while Jamie would "only disclose when people ask," and Richard would disclose "if the occasion comes up".

It has already been noted that selective disclosure can offer treatment benefits for current clients therefore enabling ex-user drug workers to disclose appropriately and skilfully

becomes paramount so "they may be better able to garner positive responses from their confidants" (Chaudoir & Fosher 2010, p242). It has been suggested that to improve communication with and get more positive responses from confidants people should develop "approach-focused disclosure goals" (Chaudoir & Fisher 2010, p243), and "a more effective 'roadmap' or self-regulatory strategy for how to achieve the outcomes they want" (Chaudoir & Fisher 2010, p243). Skills identified by Chaudoir and Fisher (2010) included, "balancing the depth, duration, breadth and emotional content of their messages" (p243). This contrasts with avoidance-focused disclosure goals where individuals "find little benefit – and possibly harm – in their disclosure experiences" (Chaudoir & Fisher 2010, p252).

It has already been noted how both Elizabeth and Kieran demonstrate avoidance-focused disclosure goals (see p153-155, and p175-176 respectively). Had Elizabeth and Kieran had access to training and support that encouraged approach-focused disclosure goals and the skills necessary to elicit positive responses from their clients and colleagues, their experience of disclosure might have been different (Chaudoir & Fisher 2010). Yet, none of the other participants had training and support regarding disclosure either. Many did have initial positive experiences of disclosure on which to build; treatment backgrounds that encouraged peer support and reciprocal disclosure; perceptions that benefits of disclosure outweighed risks; and/or a belief that disclosure helped their clients in their own treatment journeys. Even with these attributes, further training and support might have helped participants feel more confident in disclosure decision-making by facilitating consistent communication with and reactions from clients and colleagues. As Chaudoir and Fisher (2010) suggested, "intervention efforts that focus on teaching individuals effective communication skills may improve the chances of eliciting positive, supportive responses from their confidants" (p252). Having a positive approach to disclosure (rather than avoidance-focused) may also affect *how* one discloses (Chaudoir & Fisher 2010) and may result in more skilled disclosure and, therefore, a better response to the disclosure from the confidant

(Chaudoir & Fisher 2010). This supports the notion of offering induction, training and supervision to ex-user drug workers regarding skills necessary for appropriate disclosure, for example:

> "interventions that help disclosers set approach-focused goals and equip them with effective communication and coping skills may help disclosers gain greater control over the outcomes of their disclosures" (Chaudoir & Fisher 2010, p252).

There is evidence of commitment to supporting ex-service user volunteers with disclosure decision-making in some drug services, for example, Adfam (2012) suggested that:

> "For a volunteer with a substance-using past, self-disclosure may present some significant challenges. Developing guidance on self-disclosure is the prerogative of every organisation, and advice on when (or if) to disclose to clients will vary. Volunteers have told us that self-disclosure has helped them build relationships with clients, but it's for every volunteer and their manager to decide exactly how disclosure should happen" (p19).

**Reflective practice**

Although not specifically reported in this way by the participants, such decision-making about disclosure appears to involve reflective practice, or as Derlega and Grzelak (1979) term it, "critical self-evaluation" (p157), whereby each person reflected on their past experience as a substance user and what responses they got from previous disclosure(s) (Chelune 1979). This determines present and future decisions about what and how much to communicate to others. How they view themselves as ex-user drug workers, or feel they are perceived by others, is strongly influenced by disclosure experiences and reflective practices. Disclosure, especially selective disclosure (Chelune 1979), serves a purpose and is based on the discloser's subjective view when assessing the appropriateness of sharing personal information. Disclosure concerns were raised by each participant in this study, with individuals working out their own level of disclosure by reflecting on their perceived benefit or risk to the worker/client relationship.

This relates to what Chelune (1979) called, "[t]he reward/cost outcomes of social interactions" (p252). If, on reflection, the cost of disclosure is too great, that is, if they perceive the relationship with that client may be damaged, they may decide not to disclose. Also, the decision to disclose is based on individual interactions (Chelune 1979) between worker and client, and is not usually decided by the worker in advance, dependent rather on the evolving relationship (Derlega & Grzalek, 1979), and by weighing up costs and benefits of disclosure.

**Disclosure decisions – in transition**

Decisions relating to disclosure were affected by how far participants had come on their transition journey, that is, how much time had elapsed from being a drug user to being a drug worker affected selective disclosure decisions. For example, Michael stated, "I just don't feel comfortable with it much anymore, disclosing. I'll say my experience is [pause], but I won't go into specifics, ever." Meanwhile Jamie said that while he had disclosed his person history of substance use on early job applications, he has not done so on more recent applications because, "I didn't think it was relevant anymore", and Phil said, "I think I no longer have that label. It was a novelty to begin with. Not now." This suggests that for ex-user drug workers, there are two stages that influence levels of disclosure – 'early disclosure' decisions and 'later disclosure' decisions – whilst not forgetting the third option of 'non-disclosure'.

In the earlier stages of participants' careers, disclosure about past drug use was more likely to occur when working with clients because it felt appropriate to gain credibility in the absence of other experience or qualifications. Adam, for example, felt he needed to disclose his past substance use in order to "justify what I did". However, he felt, even at this early stage in his drug worker career, that disclosure held some risks with which he was not comfortable, resulting in him feeling that he was "on dodgy ground". This meant that when

Adam gained a new statutory sector post, he "felt like I didn't want to use this badge of 'I'm an ex-user'... I wanted to see if I could do it on me own". Some ten years on, his views became stronger and he asserted, "It seems a bit cringe-worthy to me sometimes when people rely on this [ex-user] label" and Michael also implied that, in his opinion, there should be limits to the level of disclosure within the service setting by saying, "There is another chap here who discloses all the time. Nah, bollocks to that."

There were greater levels of disclosure during the early stages of the participants' transition to become drug workers, with all but Kieran disclosing their use in their first volunteering or paid roles. Once they had more experience or other qualifications, like the Level 3 Substance Misuse course, the perceived need to disclose reduced. Indeed, for Elizabeth having the Level 3 qualification meant she was able to attribute her knowledge to attending the course rather than her own experiences as a substance user, thereby enabling her to maintain her 'non-user identity' in the workplace. Other participants simply felt they did not need to rely on their own experiences of substance use to the same extent as they had when first working in the substance misuse field. They wanted the skills they had developed over years of practice to be recognised as well, for example, Harry felt "I'd have made a pretty good worker even if I hadn't been a service user".

**Decision-making principles**

In attempting to clarify the multiple disclosure decisions, I reflected on these steps and mapped the various components of the process to create a visual summary (see Figure E).

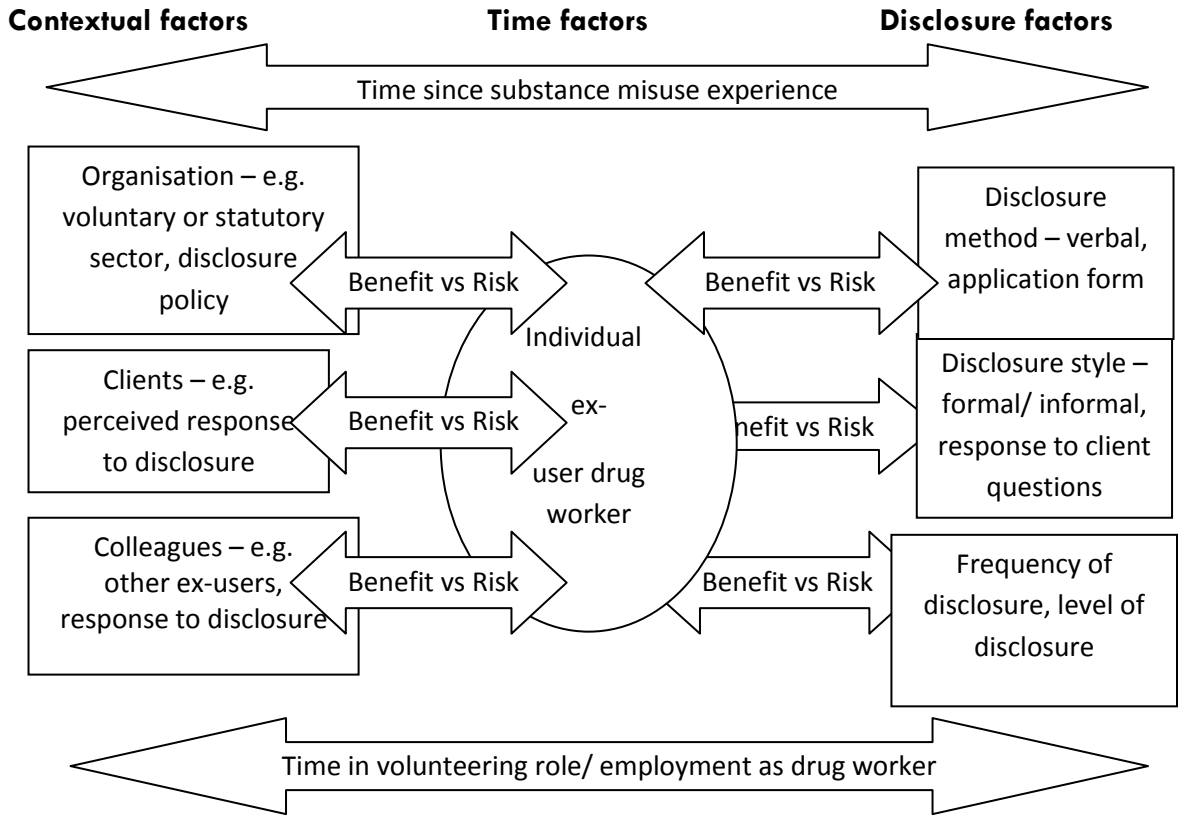


**Figure E: Key factors in disclosure decision-making by ex-user drug workers**

It has already been suggested that self-disclosure is linked to individuals' desire to be liked by others (Collins & Miller 1994). For participants in this study, this implies they may be seen more favourably by their clients if they disclose their own past use, in comparison with ex-users who choose not to disclose or non-ex-user drug workers. However, this does not suggest that disclosure is always appropriate, so the notion of being "selective about to whom to disclose" (Collins & Miller 1994, p459) remains key, as does how much to reveal and when. Disclosing too little information may cause suspicion while too much may leave the worker vulnerable, boundaries compromised, or clients overwhelmed (Collins & Miller 1994). Many participants talked of disclosure decision-making as "risky" (see Collins & Miller 1994, p466), suggesting that, when deciding whether or not to disclose, or how much to disclose, individuals must (often in a split second) assess potential rewards and risks of sharing before any disclosure, as "once we disclose, we can't take it back" (Collins & Miller 1994, p471).

Within the context of personal and professional relationships, it is suggested that individuals set boundaries regarding breadth and depth of disclosure, depending on the nature of their relationships (Derlega & Grzelak 1979). Some people struggle with their ability to "regulate self-disclosure" (Derlega & Grzelak 1979, p163) resulting in them being identified as disclosing too much or too frequently. As previously discussed, too much disclosure can be counter-productive for both discloser and recipient, increasing levels of risk for both parties (Collins & Miller 1994). Some participants saw 'over-disclosure' as "cringe-worthy" (Adam), suggesting it is inappropriate. But if there is no support and guidance available and the ex-user drug worker perceives their personal experience of disclosure as positive, it is understandable that such levels of disclosure would continue. The responsibility to raise any concerns regarding disclosure boundaries and disclosure decision-making lies within services, especially through supervision and training (Chaudoir & Fisher 2010).

The conclusion reached for most of the participants appears to be that "[a]lthough self-disclosure about sensitive topics may pose risks, sharing this information with an appropriate disclosure recipient can be beneficial" (Derlega et al. 1993, p87). But, in the absence of structured support and guidance, ex-user drug workers may struggle to make such decisions or to get positive outcomes from disclosure interventions.

Disclosure Conclusion

The lack of disclosure guidance constitutes a significant gap in the induction programme for all substance misuse practitioners. Service providers seemed to assume ex-users (or, indeed, any other drug worker) automatically know what and how to disclose safely. What became apparent from the participants' experience of disclosure was that there was no obvious right or wrong answer to disclosure dilemmas. Some participants related tales of

responding to personal questions as a 'knee-jerk' reaction or on the basis of 'gut instinct' without considering the implications of such disclosure. Without forethought any disclosure intervention remains unplanned, and without understanding underpinning theories and principles of disclosure the practitioners do not have access to an evidence-base. Almost all other interventions offered within drug treatment are part of a 'plan', for example, a care plan or recovery action plan. If we are to consider disclosure as an intervention (and I do consider it to be so) then disclosure decisions need to be better planned and have a clear rationale for the disclosure or non-disclosure decision.

Another factor to consider within the context of drug services is the link between disclosure and professional identity. What information volunteers or workers disclose about themselves influences how they see themselves and are seen by others, that is, their identity is formed and re-formed through their interaction with others. Through disclosing personal information, including past substance use, ex-users are interacting with their clients in narrative form, telling their substance use and/or recovery story. In doing so, they selected which stories to tell; how much of the story to tell; and who to tell. Of the participants who did disclose, the stage of their transition journey influenced such decisive factors meaning they were more likely to disclose their past substance use earlier in their journey than later, for example, this was true for Adam and Phil. This suggests that at this stage, these volunteers and practitioners saw their identity more strongly in terms of ex-user than professional worker. As disclosure is more likely in the early stages when ex-users are closer to their own recovery experience and before ex-users have developed further experience and confidence, they are potentially more vulnerable to any negative disclosure responses and consequences.

For others, there was no decision to make in their first volunteering or paid role because their identity as an ex-user was already known, for example, Jamie and Debbie. They

could not 'take back' the information once it was 'out there' but they could decide how much detail to go into when discussing it with individuals or groups of clients. Michael made an interesting point in his narrative by distinguishing between 'disclosing' and 'identifying'. He made it clear that he was comfortable with 'identifying' himself as an ex-user with clients and colleagues but he did not feel the need to disclose any further details. The 'ceiling' for his disclosure was set. Luke shared similar sentiments but for Elizabeth, Nicola and Kieran even this level of disclosure was too much. They saw any personal disclosure as either too risky or inappropriate as it breached professional boundaries. There were, therefore, multiple pros and cons, benefits and risks to consider when making disclosure decisions, and sometimes, there was no clear-cut answer. It must not be assumed that disclosure is always a benefit as individual practitioners need to reflect on the potential risks to themselves and their clients. The participants found their own balance by implementing boundaries to keep themselves safe while also utilising their personal experience as ex-substance users.

In reviewing the participants' disclosure narratives, it also became apparent that some agencies had a 'norm' of disclosure whereas others did not. Some of these distinctions came from the 'status' of the service, for example, whether it was voluntary or statutory sector, and how the participants felt about their role within each. This may not have stemmed from a particular 'rule' within these service settings, but the 'norm' was consciously or unconsciously perceived by practitioners. For some, including Adam, it was the fact that there were other ex-users working in a voluntary sector service who were open about their own past that supported the norm of disclosure and led to disclosures of his own. This supports the notion of disclosure reciprocity in that having been disclosed to, Adam felt obliged to disclose in return even though in his previous job he had made the decision not to disclose.

Disclosure has long been a norm within many drug and alcohol programmes, most famously in Alcoholics Anonymous where there is a tradition of telling one's addiction and/or recovery story, often parodied as, "My name is ... and I am an alcoholic". With the advent of Recovery Champions, a new norm of disclosure has evolved within a wider range of treatment services, in both voluntary and statutory sectors. The rationale for this is the notion of "visible recovery" (Sinclair 2012) whereby ex-user volunteers and drug workers are encouraged to share their narratives as a means of inspiring others. While this is a laudable aim, I have yet to read on any recovery websites, notice boards, articles or books, guidance for ex-users about how to get the most out of disclosure or how to keep themselves safe in the process. It is almost as if it is assumed that people know intuitively how to disclose. A review of the literature (for example, Berg 1987, Chaudoir & Fisher 2010, Derlega et al. 1993, Omarzu 2000), however, indicates just what a complex process disclosure actually is. Furthermore, the participants described a range of attitudes towards disclosure from their own perspectives as well as from that of other ex-user drug workers, professional drug workers and clients. Some suggested limited disclosure was acceptable but too much disclosure was not; others reported that they only disclosed if asked but would not volunteer the information while still others felt it was appropriate to be open as long as they were not expected to go into too much detail.

It was interesting to note that a number of the participants felt more comfortable disclosing to clients than they did to colleagues. From the experiences of these participants it can be interpreted that such practitioners felt there were more benefits to disclosing to clients and more risks associated with disclosing to colleagues. Staff attitudes to working with ex-user drug workers may be an important factor here, but it might also be that non-ex-user colleagues simply do not know how to respond to such disclosures and ex-user drug workers perceive there to be a tension between themselves and colleagues so that they suspect their lived experience will not be valued. The ex-users' reciprocity of personal information or

professional viewpoints may, therefore, be adversely affected, further compounding any inter-professional discord.

There is a balance to be struck between disclosure and privacy. Disclosing too much information, too soon, in an inappropriate context; or to someone who does not want to hear that disclosure or who would misuse personal information can carry negative consequences for the discloser and/or the recipient. Disclosing too little information, being defensive or failing to disclose when such an intervention would be appropriate can also carry risks and potentially undermine the developing professional relationship between worker and client. Disclosure does not always mean that a boundary has been crossed. Many participants had experience of managing disclosure balance decisions; of working out how much information was appropriate to disclose. For example, Richard learned to only disclose "snippets" as any further disclosure might cause the clients to "switch off". However, it is not just the needs of the clients that should influence whether or not disclosure is appropriate; it is also the needs of the volunteer or worker. Each individual has their own views of what they are and are not comfortable disclosing; their own perceptions of risks and benefits associated with disclosure. It must also not be assumed that just because they have disclosed their status when interviewed for their post or to selected colleagues, that they are happy for all colleagues and clients to know their background or that they are obliged to go into details. As Luke put it, "'You don't need to know which drugs I used', 'You don't need to know how I funded my habit'. 'You don't need to know how I got drug-free'". It is the individual's information to share (or not), rather than the agency for whom they volunteer or work. Certainly, Luke concluded that, "it's up to me, isn't it, at the end of the day?"

## Chapter 5 Orientation: professional Identity

## Part 1: Findings

### Introduction

In this chapter the professional identity findings are examined. There were two overriding factors when determining participants' professional identity at different stages of their transition to become substance misuse practitioners – how they see themselves and how they feel they are seen by others (colleagues or clients). Linked with this was the concept of what the term 'professional' meant to each individual in terms of status, qualifications, roles and boundaries. The three main stories I have selected for this section are Michael, Nicola and Phil because of their variety of professional insight and identity formation. Michael, having been abstinent for approximately twelve years saw himself as being "in recovery" and while he generally considered himself on a par with professionally qualified workers, such as nurses, felt he may not be considered as such by non-ex-user colleagues.

Meanwhile, Nicola felt strongly about professional boundaries and, having gained the Level 3 Substance Misuse qualification, felt this gave her the professional status needed for her role. Phil altered his perception of professionalism throughout his career, feeling that this fluctuated depending on whether he worked in the voluntary or statutory sector.

### Michael professional identity story

At the time of the interviews Michael, an ex-poly-substance user in his mid-40s, was working in a CDT. A voluntary sector provider had recently won the contract from the statutory sector (NHS) resulting in a change of management and job role for Michael. His story started while he was still in a residential rehabilitation unit, at which point, he already knew he wanted to become a drug worker. Michael, however, decided he wanted a 'break from

addiction' so entered the education system to gain the A' Levels he had failed to achieve at school and began volunteering in the homelessness sector. At this stage Michael applied unsuccessfully to do a social work course and returned as a support worker to the residential rehabilitation unit where he had been in treatment. After a year, he sought employment in the community, subsequently working for six years in supported housing for drug and alcohol users. Following this, Michael gained his current employment in the CDT.

**Professional role models**

In terms of exploring what it means to work professionally and to develop a professional identity of their own, many participants including Michael (but also Adam, Elizabeth, Harry, Jamie, Luke and Nicola) encountered inspirational workers early in their careers, often while still a client or a volunteer. It was perhaps such early influence that gave participants insight into the type of worker they aspired to be. In Michael's case, the volunteer coordinator of the homeless service where he volunteered shortly after completing treatment was this role model:

> "I went to work for a homelessness organisation. The volunteer coordinator there was absolutely brilliant; she knew how to encourage you. She knew how to develop your skills, taught me about the importance of networking, talking to people. That's where I learned to accept that people are at different places and primarily they came in there for their housing problems, not their drugs. But I'd ask if their drug problem was affecting their housing. It always was." (Michael)

> "I did stay in touch with [detoxification manager] and she became very much a mentor to me, academically certainly, her enthusiasm. I think later, when I'd left [detoxification unit] she was always interested in what I was doing and she wanted me to keep in touch. She were very encouraging in that way. She was very interested in people's recovery. She cared about people and I think that was core really." (Harry)

> "When I moved to [town 2], the coordinator was amazing, [sighs], it was a type of person I'd never met before; they didn't appear to be from a particular sort of educated background themselves. They were working in a coordinator role and they were just like me. They'd come up through the voluntary sector themselves and they'd spent the years putting all the hard work in and there was just something that

clicked anyway, on a personal level, in that we got on great. But, she wasn't like a service manager. She wasn't like a person in a position of power. It felt like she was more on a level with you even though she was a coordinator. There was just something that I aspired to in a sense, cos I thought it's very understated and I can see how you relate to people easily, and certainly clients. And I thought, sometimes, that's how I feel. I feel like I'm more on a level with people of all sorts of backgrounds and I felt instantly connected to her." (Luke)

**Professional qualifications and training**

Initially, Michael was keen to gain a recognised, professional qualification and to this end applied to undertake a social work course. However, the professional standards set by the university would not accept him at that time because of his previous convictions and the relatively short period of time since he had been an active substance user:

"I think around the same time, I applied to be a social worker which I was accepted onto [laughs] but when they saw my criminal record obviously they decided it wasn't a good idea, too high risk and not too far away from probably chaotic behaviour. I think that would have been about 18 months [since I used], probably more like two years. He said, 'we'd really like you on the course but we can't with that [previous convictions]. We took advice and we can't with that criminal record, you're not far enough away from it'. I was disappointed. I think at that part of my recovery I could take stuff like that and roll with it. That weren't meant to be then. To be honest, when I see the kind of things that social workers do, did I really want to do that? I had this plan that I wanted to do drug work but I didn't want to do it straight away. I wanted a break from it. But if they'd have accepted me [on the social work course], I would have done it. They said that [I could re-apply in a couple of years]. At the stage of recovery it was a setback as well as a knockback. It was a setback and that's how I was feeling at the time. But I thought something'll come up and I'll just carry on with [volunteering]."

Having reconciled himself not to qualify as a social worker, Michael gained employment in the residential rehabilitation unit where he had been in treatment. Notably he did not need to apply for this; he was approached by the service. Given this took place approximately twelve years ago, I wonder if such an arrangement would be sanctioned in the current job market where employers must show they are conforming to equal opportunities policies and legislation. Michael reflected that he made a number of mistakes early in his career within

the rehabilitation unit but was also able to access a lot of training while in their employ, indicating his commitment to continuing professional development:

> "A couple of months after that I was approached by the rehab and they asked me to work for them as a project worker. Anyway, I went to work in the rehab. This was the second stage as well. Not the primary unit. I don't think they wanted ex-peers in the primary unit, not straight away anyway. How did I make the transition? It's really weird. I was on the other side of the fence being in meetings, discussing clients and stuff like that. They were really supportive actually. Did I find it difficult? Yeah, I did. I made some right cock-ups there that didn't go down very well [laughs]. I got pulled up for that."

Michael was not the only participant to talk about mistakes or breaches of boundaries in their early career - this was also an issue for Jamie and Richard. All three participants who reported such mistakes early in their careers were volunteers or workers in the same agency where they had themselves been in treatment. If they had been working or volunteering in another agency where they were not already known, it is debatable whether the same level of tolerance to such mistakes would have been available so that they were offered a degree of latitude to learn and develop:

> "I learned all this [boundaries] while I was being a volunteer. The best way to go about it, the way I learned that, Sheila, was because clients were using on the unit, smoking weed, and I caught them smoking weed [laughs]. And it was at the time when if you was caught smoking weed, it was discharge. That was it. You was finished. And I caught a few of them smoking in the garden, so I said, 'Listen, put it out and I won't say nothing this time. But if I catch you again.' But, you know, as soon as me back was turned, so, I caught them again. And I went then and told staff. But, I said, 'Listen, I hold me hands up [laughs], I did catch them before but I gave them the benefit of the doubt.' And I thought, oh, they're not going to have me back here and that's when I learned then. So, if you're going to do it, you gotta do it properly, so giving someone a chance and then they took no notice basically. And I could have endangered my volunteering on the unit because I was putting not only clients but staff at risk as well. On reflection now, at the time I didn't realise what I was doing. I thought I was finished and when I came in the next day and I said, 'listen, I understand if you don't want me here anymore.' And they said, 'don't be daft, don't be daft. In the end it all got sorted. Use it as a learning curve.'" (Jamie)

> "I can think of the odd mistake [I've made earlier in my career], insignificant mistakes, but even then, it's all been learning. At one point [when I was a volunteer], I got suspended for chatting up a receptionist in the local CDT. It was the [treatment

> programme] coordinator at the time found out that I was chatting up this girl and I was suspended. At that point I was taken into the office by [two managers] and they sat me down and told me straight, 'you've got loads of potential, and we've got big plans for you, but this will mess you up'. I took that on board really. So, I don't regret that happening cos I learned from it." (Richard)

What is significant from the above excerpts is that the participants reflected on and learned from these mistakes. They, and other participants, also showed commitment to training that would assist them in their personal and professional development:

> "I've done all the normal courses, the one-day courses, there's hundreds, like mental health, inclusion and different things, well, I like using my brain... When I went for [volunteering interview at CDT] she was quite impressed, I think, with what I've achieved in the last five and a half years I've been in [organisation] cos I've studied every year for something." (Elizabeth)

> "So, next step is the addiction degree. I just wanted to do summat, a higher level of motivational interview training, anyway, than I've done. And I knew that were a big module on it, so I knew I'd get that training. That highest level, so that were important. I think probably vanity, to get another degree and I think that it's quite a broad spectrum of learning rather than picking something specific like CBT or something like that. I think it'll give me a better understanding of everything really. Ultimately, it'll be good for my CV as well." (Harry)

**Status**

While Michael was grateful to the rehabilitation unit for giving him the opportunity to 'get his toe in the door', his aspirations were greater than those that could be fulfilled within this service. Michael was keen to gain higher employment status and greater financial reward in recognition of the skills and experience he had by this stage accrued. This ambition resulted in him applying for a community-based, supported housing job within the voluntary sector that was better paid and with better working conditions. However, it was here that Michael encountered discrimination against ex-users from the service manager and some tension between staff from different backgrounds:

> "I was quite good at me job. I didn't get on with the manager that was basically why I left. I don't really want to go into the manager cos he was a knob. I don't think he liked ex-users to be quite honest, even though he was working in that sort of industry, supported housing. He would fund other people [to do the Level 3 substance misuse course] but not ex-users. He actually said at one point, 'I'm getting away from employing ex-users', that's how bad it was. He said ex-users were hard work. "

At this stage of his career, Michael was clearly identified as an ex-user by his manager, a status not respected by this individual. Similarly, Jamie, Debbie and Luke all felt there were times in their careers when they were harshly judged by colleagues because of their ex-user or non-qualified status:

> "[I don't get discriminatory comments], not to my face, no... There's a couple of people that, basically, in our office now, where if there comes a situation, they'll always ask another professional, who's got a qualification. They'd never come to the unqualified, ever. I've got me Level 3 [substance misuse course], but they'll never [ask me], and that sticks out a little bit for me. If you don't come from a nursing background or you've not got a degree or something like that behind you, you're no one. Well, you're not no one but they don't class you in their league, basically. I wouldn't say all nurses are like that, but, there's one particular nurse here who, I mean, it's not just me, it's to other people as well, is that they'll only ask certain questions to other qualified staff. They won't ask un-qualifieds." (Jamie)

> "But, you're tarred with the same brush because of maybe a handful - and I'm not just talking about the service I was in, I think it's also happened in the voluntary sector - of people [who] have lapsed so they're automatically now thinking if we take on an ex-user, they'll end up back on drugs in twelve months time." (Debbie)

> "Certain individuals had an issue with the fact that I was doing the same job as them and I'd only just been doing it for 18 months and that was it. And they didn't even want to count the volunteering, so that was quite a difficult time as well. There were a certain snobbery about where I'd come from and how I'd got into it. They weren't happy about that I was in the same job as them." (Luke)

**Staff teams**

In Michael's experience, there was a split within the staff teams, resulting in day-to-day tensions within the working environment but also with social situations outside of, but related to, work. This social divide between workers who drank alcohol on staff nights out and ex-

users who did not created further tension between these different staff groups and was also raised by Elizabeth (see p151) and Luke (see p174):

> "In [supported housing], there was a bit of a split between [the staff], half were ex-users and half not ex-users, especially people with the twelve-step stuff, which is what I did. There seemed to be a step where people think you're mad if you don't drink, especially in these services. They have a problem with it." (Michael)

For Michael, there was a specific issue that other staff members have with his particular route of recovery, a sentiment shared by Elizabeth:

> "I think they were anti-twelve step to be honest. I think especially at [supported housing], I think they had this [view] that the twelve-steps were, the beliefs were, nothing. And [I would] just turn round and say, 'sorry for recovering' [laughs], 'it's not doing any harm'. 'What's the problem with it?' And they'd come out with all the usual stuff, God and all that sort of stuff." (Michael)

> "I still have this feeling that there's judgement about people who are addicts. I hear comments in work, you know, [laughs] and I think if they only knew. I want to shout out 'well, I've been in recovery 10 years'. I think this is what I find quite frustrating, that because we work with a lot of people who don't make recovery, and they're put in that cycle, aren't they, and they don't actually see masses of, millions outside that actually do recover and that kind of frustrates me. I can get quite angry at some of the comments. Well, one, worker but he hasn't got a clue about [twelve-step] but I've heard him comment on AA which is dear to my heart and he's just so misinformed, you know, he'll say to people, 'if you drink again you can't go back to AA, it's abstinence'. That's a total lot of rubbish. You can go and be pissed out your head [laughs] and you're accepted. Folk want you to recover. I do want to turn round and say, 'well this is my tenth year in recovery'." (Elizabeth)

Negative attitudes towards twelve-step groups were something Michael continued to experience when he moved to work in the NHS. There was suspicion about why he still attended weekly meetings having been substance-free for twelve years. For Michael, attendance at meetings assisted in sustaining his recovery, however, if clients were present at such meetings, this affected how much he was able to share about himself. This had the potential to be a boundary issue for Michael as there was always the possibility that

someone attending a meeting may not be a current client but could become one in the future:

> "And then, you'd get people saying, 'why are you still doing that?' 'Why shouldn't I?' The most consistent thing about my recovery is I go to meetings and that's twelve-step. It hasn't done me any harm whatsoever. 'But you're still going?' 'Well, you know, when things are difficult for Michael, Michael thinks like you do, believe it or not'. I've certainly not heard anything from people here about twelve-step. If I see a client at a meeting I've just got to be a bit wary about what I say, not go into any details. Usually, I can use meetings in different ways depending on what's going on. I can unload in meetings, no problem, I'll talk about how I feel in a meeting but if there's someone there, I'll give them messages. I don't hide the fact that I do twelve-step. I'm hoping that I'm an example just by my presence."

Michael concluded this excerpt by indicating that he was happy to be identified as an ex-user as this also gave him the status of 'role model' to current clients. In order to act as such a role model, it is necessary for workers like Michael to disclose their past to their client group, thereby demonstrating the close link between disclosure and identity.

**Voluntary and Statutory Sector Services**

In making the transition from working in the voluntary sector to the NHS, Michael became aware of different standards and procedures, levels of work required and accountability. He also felt these higher levels of accountability were not necessarily matched with higher levels of support to deal with extra job role demands:

> "I'm here doing prescribing, the last three years, this was quite a culture shock for me. I work hard [laughs]. In [supported housing] I did not work as much as here, especially when it's NHS with all the rules and regulations, all the bureaucracy and stuff like that. It was quite a shock to the system. I remember I was terrified of making mistakes, really, really beating myself up about making mistakes. It seemed like you're on your own, not as much as other places I've worked. I think [supported housing] would support you. Here, you'd be supported but you don't get any praise here. Sometimes you need to be told you're doing a decent job. But it's quite hard. It's quite stressful."

Michael felt that a mixed staff team was the most effective but with risks associated with employing any staff member, especially ex-users if they relapse:

> "I think the service users appreciate the views of an ex-user worker. They know by example. Don't get me wrong, I'm not one of them who thinks it should only be staffed by ex-users. I think that's totally messed about because people have got a lot to offer, all different people. All ex-service users? Oh no. I think you need some normals in there [laughs]. Employing normal people's risky, isn't it? If I think of some of my colleagues [laughs], they're drinking every night. It's not good for you. Everybody's got problems. I've known people to relapse, actually. [Ex-colleague], he relapsed. He's not in a good way. It's not a good experience to have a colleague using in the office. It's not good for anybody. He'd never have admitted it. He didn't tell anyone even though he was having supervision. Not a good experience at all. I don't think he could cope."

Like Michael, Kieran also experienced what can happen when a colleague relapses, seeing this as a damaging experience for the individual and the agency as a whole:

> "[When] people fall off the wagon it completely shatters an agency. If you've got someone who slips up or relapses, it's just horrendous for them and for us." (Kieran)

For Michael the consequences following a colleague's relapse became personal as rumours circulated about which staff member had relapsed and at one point Michael was erroneously identified as that person. In this situation, Michael felt helpless. Because of confidentiality boundaries he could not divulge the name of the person who had relapsed but could only deny the accusation and hope he was believed. By clients and colleagues knowing his substance-using past, he retained this ex-user identity in their eyes:

> "A client actually accused me [of] using. 'You're the one who's relapsed'. And you have to play dumb, don't you? 'I don't know what you're talking about'. But there are always rumours flying about. I think that accusation went to a social worker. She rang up and said he's accused you of using. I said, 'no, I'm not.' I said, 'why has he said that?' 'Well, he's heard that someone's been using in [supported housing] and he says it's you.' There was nothing I could do."

Despite such issues, Michael remained comfortable with colleagues knowing his ex-user identity. However, if he heard colleagues make derogatory comments about clients ("calling them scum"), he challenged these. This was different from Elizabeth who felt unable to challenge because her ex-user identity was hidden from her colleagues.

Michael was conscious of a 'divide' between nurses and non-nurses within the service where he worked. Jamie also saw himself (and felt he was seen by others) as being different from qualified staff based on his previous experience as a service user and as a drug worker (see p167). However, Michael felt this divide was lessening and that his Level 3 substance misuse qualification was as relevant to the job as other qualifications:

> "Qualifications, doing the Level 3, training, you've got to be keen as mustard. It's all qualifications, init? The Level 3 gives you your professional, qualified status. I've done lots of training, and stuff that I've picked up from doctors here, workers here; their experience. I know there is that divide [between nurses and other drug workers]. It's not as relevant. My manager isn't a nurse. That's old school, that. The older workers are like that, I think. What's changed it? I don't know, people who aren't nurses do as good a job as what they do probably, I think so. I think I do my job as well as a mental health nurse can do the job, or a medically qualified person can do the job. I know it. I know about prescribing. I know about how drugs work. I know all that sort of stuff."

In terms of identifying himself as an ex-user, Michael saw this as less relevant than he did earlier in his career, seeing himself as having "moved on":

> "I would disclose early on. You'd be, 'I'm in recovery' but later on, it's not as relevant. It's like twelve-step, early on I used to hammer it, and I was quite in your face with it. But, now, no, I've moved on. I do one meeting a week and that's enough for me."

**Support, supervision and role**

Michael valued team support as a way of coping with job-related stress and felt supervision ought to be offered more regularly to help with caseload management. His

professionalism extended to ensuring that he puts his emotions to one side so he can concentrate on client work, while also recognising that if he gets stressed this may affect his working relationship with clients. Whatever the situation, he wanted to be seen as reliable and not let clients down:

> "They're [colleagues] very good at listening to Michael get it off his chest. They don't go [groan], they just let me do it. Supervision, when I can get it, but it's been in disarray [laughs]. I think people are getting stressed out. I'm getting [supervision] but probably not as much... I don't like doing sick. I've got to be sick, very sick, extremely sick. If it's emotional stuff, I can shelve it and work. Probably has an effect on the clients, I bet it does. No doubt it'll have an effect on them. But I do try and come in. I'm not like these who'll take a month off cos I'm stressed out. I don't go and see a doctor and say I'm stressed. I might go to my sponsor and say I'm stressed out. I might go home and tell it to my wife or talk to colleagues. It's not cos I'm unfeeling. It's cos I've not left all my feelings around anymore. I've learned how to do that."

The service provider recently changed where Michael worked resulting in a change in job description and role responsibilities. He worried that his role was being de-skilled because his qualification did not meet the new service's requirements within shared care. This frustrated him as he had carried out these duties for some years and felt skilled in this area, especially when he was aware of some qualified colleagues who did not have the same level of experience he had and had made 'basic' mistakes. However, in the eyes of the new management team, he did not have the necessary credentials to continue in this role:

> "They've taken away the prescribing role. I can't see how they're going to do that when [I] work in shared care. It's basically the doctors. There's some very experienced doctors out there, but, generally the doctors aren't experienced and they rely on you to know the guidelines. Anything to do with prescribing, you're going to speak to the doctor cos [you're] not qualified. You've made the decision I ain't qualified. Last week, a new colleague, came from [voluntary sector agency], she altered a script and signed it. I would never do that. I mean, that's not right [laughs], that's my NHS training. I'd never do anything like that. I'd sit with the doctor and say this is what I'd do re: titration and get the doctor to alter it and sign it. But she did it. But, I think she were a nurse. Don't know [if she's a nurse practitioner], but she's in trouble. Basically what's happened is, I said to her, 'no, don't do it, get that changed'. But she's not done that, probably cos she's stressed half to death. We can all cut corners. I cut corners if I wanted to, dodgy. I tend not to do it, and so, I think I said to her, 'don't get them the script, just get it changed'.

> They said, 'you're not qualified to do that'. I said, 'how am I not qualified to do that?' This is in the interview, in this enquiry. I said, 'I was just giving her advice. What? I can't say to my colleague, go and get that changed?' 'That's got to come through a nurse, why not see a nurse?' I said, 'what nurse?' In this system round here, a nurse had exactly the same role as I had. There's no hierarchy here. You can be a team leader but nurses were working the same way I was. Nurses aren't trained how to dispense methadone, are they? 'You've got to see a nurse'. 'But what nurses are they?' 'Well, I'm always available'. 'Are you?' Well, I rang you two weeks ago for some direction on a couple of clients who I feel shouldn't be in the service, but they didn't get back to me. In fact, I had to contact them again requesting the same thing, and they've still not got back to me. I'm sat there thinking, getting very, very nervous, going, ok, 'so anything to do with the clinical side of it, I'm not doing it?' And it was almost like, 'no, you're not'. I'm in shared care. Some of the doctors' surgeries I go to, some of them are very competent when it comes to drug users and they can probably stand alone, prescribe quite easily, and know the guidelines and stuff like that. But, there's one doctor at the one clinic, he's only qualified himself five years, so, I'm basically going [through] the guidelines saying, 'well, this is the risk, this is what we're trying to achieve and this is how we do it'. I think I'm quite good at that and no one's died yet. But, that's quite weird to me cos basically I know it's the doctor's decision at the end of the day. So, I assess them. I'd ask questions, which you need to do, cos if I were here, I'd be asking me questions [laughs]. I'd be asking questions. I think I'm experienced enough to titrate the scripts safely. I think it's de-skilling my role. I talked to management about it, and she said, 'well, there's nothing we can do'. She's worked here for eight years. The nurse we've got [laughs], she's lovely, but she's not good at prescribing. She's got the qualification, but what training has she had around addiction? Nothing. I said, 'I've had more training than you've had around this'."

In the above excerpt, it is possible to get a real sense of Michael's frustration by the way in which he almost re-enacted the dialogue between himself and his colleagues and managers. It was apparent that no matter how much previous experience he had, Michael was not considered to have the professional status required to take on a fuller role with prescribing. Michael continued to see his identity as an ex-user drug worker as a positive thing in terms of how it is perceived by most workers and service users, even though he latterly disclosed less than he did when he was first employed within the substance misuse field (see p165). This experience was shared by Harry and Phil:

> "They [clients] tended to respect what I was saying because they felt that I'd been there and done it, so, in that respect it was a positive." (Harry)

> "they [clients] respected the fact that I'd done a rehab, so, they assumed that because I'd done one that I understood how they felt, which, up to a point, I did." (Phil)

**Professionalism**

While Michael stated he was not certain what being professional means, he did outline some key concepts whereby he viewed professionalism as working within the service's guidelines, adhering to appropriate boundaries, and being reliable. However, he was aware of times when he crossed professional boundaries with clients but less so with professionals from other agencies. A concern expressed by Michael regarding boundaries was that when stressed, his boundaries may be adversely affected:

> "Being professional is doing the business at hand, isn't it? It's doing the work in a way that follows boundaries, the rules, the guidelines, all that sort of stuff, working with other agencies. I'm probably very unprofessional with the clients [laughs]. I'll go down to their level. Some people would think that's unprofessional. I do swear [laughs], you know, to emphasise a point, I do swear. People would say that's unprofessional. So I would say I'm not very professional sometimes... whatever company you're working for, they expect different things, don't they? It's their standards. That's probably totally wrong. I don't know what professional means. It's presenting, isn't it, it's how you present yourself to the people you work with. It's doing the work, efficient. Do what you're supposed to do. If we say we're going to do something, we do it. That can be difficult when you get stressed out. You forget. I forget. The first thing that goes with me is boundaries. It's not a back-burner, but it goes if you don't have time to do it. You'd be doing a referral three weeks after you said you were going to do it, you know. I always turn up on time. It's my duty to do that. If I say I'm going to be there, I'll be there unless there's a good reason why I can't be there."

This notion of reliability as a key element of professionalism was also mentioned by Richard:

> "Another thing that's part of my own professionalism is if I say I'm going to do something, I do it. Reliable, yeah, that's professional to me. If I tell someone that I'm going to do something, then, you know. So that tells me I have to be careful before I agree to do something, so being sure that I can do it before I agree and then making bloody sure that I get that done for that person. That's professional to me. Doing what you said you were going to do." (Richard)

Further interpretations of professionalism include:

> "It's a few things in one. I don't think there's a little, nice sound-bite that picks it up [sighs]. It's respecting boundaries; it's being professional to clients and staff alike. It's being very self-aware. It's being emotionally mature as well. I think it's about the job you're in as well. I think this isn't just a job to me, it's a way of life. It's more than a job. And you have to have the right mind-set to be professional in that. Obviously, there's structural things as well like professional supervision, properly reflecting on your practice, all those things. It's a way of being with people as well. You could put someone in here with ten doctorates and they could still be a crap worker [laughs]. Not that I have a problem with people who have qualifications who are good workers. I always want to learn. I always want to keep getting better, keep developing. Never become a dinosaur." (Harry)

> "I think [professionalism] is a bit of an odd description because it's so lame. Anyone can call themselves a professional. I think it, what it means to me is, it's a responsibility. It's about upholding the profession and it's not doing anything to put that profession into jeopardy, like a code of conduct as well. If you're identified as and labelled as a professional, make sure you don't do anything to bring it into disrepute." (Luke)

**Identity**

Michael was proud of what he had achieved throughout his recovery; alluding to the idea that becoming a drug worker helped his recovery (Jamie also mentioned this). What was clear from Michael's narrative was that he continued to identify himself as being *in recovery,* a notion Harry dismissed because he saw himself as having a *recovered* identity rather than a lifelong label of being *in recovery:*

> "I feel very fortunate, quite privileged. I've come from a place which was quite dark with no future. Whereas I feel like I've got a worthwhile job, quite a well-paid job as well. But, it's quite fulfilling, interesting. I meet a lot of interesting people. I've a future. I feel quite fortunate. I connect with anybody. I do stop short of recommending [twelve-step] to clients. I won't specifically say, 'why don't you go and do this stuff'. I say, 'you can'. There's a difference. It's been good for me recovery as well, by the way, really good. I think it's contributed to my recovery. I could lose an awful lot. I've gained an awful lot as well. One day at a time. One day at a time. I still do that one. If anybody says to me, 'how have you done twelve years in recovery?', I say, 'one day at a time, simple as that'. There's no difference between me and the people I'm sat in front of, could be a little more skilled at staying away from drugs than they are. I don't have to tell them what to do. I've done it, painful as it's been sometimes. One day at a time. As I say, somebody has

> given that to me. I've learned from other people's experiences, not necessarily people in recovery either, by the way. There's been a lot of people who've contributed to [my recovery], some really, really good staff." (Michael)
>
> "I ban the word from my groups, the word 'alcoholic', and the labelling of yourself that you'll always be an addict. I think it's a self-fulfilling prophesy. It's derogatory, you know. I think somebody that's been clean for a certain amount of time and they're self-reliant, then they're not in recovery any more, they're recovered. And I think having to wear this almost like ball-and-chain around you is [pause], does it encourage? Do people ever become self-reliant with it? You know, if they can't go to a meeting, what happens? You know, doesn't there come a time when you draw a line in the sand and say, 'yeah, I've had issues, but, I've dealt with them and I've moved on?' Ultimately, that's what recovery is to me." (Harry)

Other participants, for example, Jamie and Richard, talked about being proud of their achievements and how this affected how they saw themselves and how they are seen by others in their personal and professional lives (see p92). Debbie also reflected with pride on the skills she felt she brought to her volunteering roles:

> "I think I'm skilled, you know, with people. I think one of me strengths is, because I'll talk to anybody, I'll sit down and listen, me listening skills are good and sometimes people don't want anything else. Just listen. So, it's being professional. God, I could go on forever. Non-judgmental, empathic, compassionate, passionate about your work and why you're doing the work, a stickler for the rules, your boundaries which you have to stick to and don't go over, not even bend."

**Key Aspects of Michael's Professional Identity Story**

Michael's professional identity narrative started with his experience of being inspired by a role model (volunteer coordinator) and ended with Michael seeing himself as a role model for substance users, almost as if his experience post-treatment had come full-circle. While he acknowledged some early mistakes in his career, he latterly saw himself as a competent and qualified practitioner, even if this is not how he was always perceived by colleagues – his level 3 substance misuse qualification not sharing the same status as nursing. Similarly, other practitioners continued to see him as an ex-user, something not necessarily valued by some colleagues. There was therefore a disparity between how Michael saw himself in his role as a drug worker and how others saw him. He was not uncomfortable being identified

as an ex-user, but implied this experience should be valued as much by colleagues as by clients. In contrast, Michael valued the contribution to service delivery some non-ex-user drug workers make (as long as they are skilled and experienced), believing services should be staffed by a combination of qualified and ex-user workers. Although Michael saw himself as a professional drug worker, he was aware of times when he breached boundaries and was conscious of the potential clash between his role as a drug worker and his continued attendance at twelve-step meetings. Ultimately, Michael identified himself as being 'in recovery' rather than having 'recovered.' As a result, Michael combined his identity as an ex-user with that of a drug worker and did not perceive there to be a conflict in simultaneously adopting both identities.

**Nicola's professional identity story**

At the time of the interviews Nicola, a single mum in her early-30s, had worked in a statutory sector substance misuse service (NHS) for a few months. Nicola had not herself been a problematic substance user but both her partner and her brother were. She started her story when her partner was in treatment and she went with him to appointments at the CDT. Nicola was inspired by her partner's drug worker to become one herself. She then became a volunteer in a voluntary sector drug service and through this enrolled in the level 2 substance misuse course before progressing onto the level 3. Due to financial considerations, Nicola had to stop volunteering and returned to employment in retail while applying for drug worker posts. Nicola struggled at first to gain paid employment in the substance misuse field due to her lack of experience with application forms, interviews and employment. She was, however, successful in gaining a needle exchange post within the NHS before transferring to a CDT in shared care.

**Professional Identity Role Model**

Nicola was strongly influenced by her then partner's drug worker when it came to her developing ideas of what it meant to be professional. This worker offered her inspiration in determining the type of drug worker she aspired to be herself – friendly, respectful, knowledgeable, but working within recognised boundaries:

> "My ex-partner was a user. He was a client and I could never, ever get to grips with him, ever. I could never, ever understand him and I didn't even know what heroin was until I met him. And I learned so much all about his using and he was going down the CDT and I was going with him. And I watched the drug worker working with him and I thought I'd love to do that. He were just so knowledgeable, and he just knew everything. Because I didn't even know what colour methadone were at that time. I knew nothing and I were just amazed by how much he knew about drugs and I thought I want to know as much as him. And it was just the way he spoke to [ex-partner] and the way he were like his friend. Cos people just think of drug users as scum basically, but just the way he interacted with him, the way he talked to him, the way he made us both feel comfortable. And he were meant to be there, not just to pick up his script. He treated [ex-partner] with respect. It were just brilliant. So, I always treat them, not as a friend, but not as a client. I don't think you can do this job if you're not friendly. And there is friendly but being professional with it. I don't clinicalise it. I don't make them feel like they're sat in the doctors. I always make them feel comfortable. You can still keep to your professional boundaries. You can still be doing that without going in thinking you're better than them."

**Professional Qualifications and Training**

Nicola set out her route into paid employment systematically, as she felt she first needed to gain experience as a volunteer before seeking educational opportunities to assist her in making progress toward this goal. While still a volunteer, Nicola recognised there were limits to what she was allowed to do (like Debbie) but felt she was equally respected by the client group as the paid employees. However, due to changes in her personal circumstances, Nicola had to alter her career plan and temporarily obtained unskilled employment (curtailing her volunteering role) while applying for work within the drug field:

> "I did the Level 2, and then I went and did the Level 3 straight after. [Voluntary sector agency] paid for the Level 2 for me. Well, they paid half of it and the college paid the other half. I think [manager] did [give a reference]. He doesn't work there anymore but I still go down and see them when I'm in [city]. They're

> brilliant. I was in there volunteering nearly every day [laughs]. Cos I just wanted to learn and even from the staff, I mean, [worker] who worked there, he's so clued up; it's amazing. I had loads of clients I'd speak to at [voluntary sector agency] and build up a bit of a rapport with them and they get to trust you. And they start telling you things, don't they? Well, a lot do. I don't mean I had the same responsibility as paid staff, I mean it was the same respect. Cos, I did have responsibility if I wanted to fill out forms with clients, but if you wanted an assessment, then you'd have to [be paid staff]. So, the level of responsibility changes, but you weren't treated like a volunteer, [there was] respect. But there were limited things that you could do. I was doing the volunteering, then the Level 2, and then the volunteering again, but I had to drop one volunteering day cos it got a bit too much. So, I were just doing the Mondays and then the [Level 3] on Wednesdays and there were lots of work. But once I did that, I got lots more confidence about me and I felt like I knew what I were talking about [laughs], cos I didn't have a clue at the start... then, I ended up on me own with the kids, so I had to get a job, so, I stopped volunteering, but I was still doing the Level 3. [I finished the level 3 and worked in a shop while applying for drug-related jobs]"

When Nicola applied for jobs within the drug field, she was comfortable sharing her carer's role as her motivation for gaining employment. She saw her family connection to substance use as a norm so was comfortable to identify herself in this way. Nicola also acknowledged that, because of professional boundaries, it would be inappropriate for her to work directly with a family member and would disclose this to her manager if such a situation arose:

> "I said at my interview, cos [they] said, 'what made you get into drugs?' and I said, 'well, my ex-partner was a user' and he was at the time. [Manager] did ask then if I was still with him. He said, 'it won't affect your [application]', and I just went, 'no'. And then, [name] who was my manager and [colleague], they all knew anyway. It wasn't an issue, just everyday life, isn't it? You work with substance misuse, it's just everyday life. I deal with it [my brother] myself. I'd say something if he actually walked in [service] cos I wouldn't be able to see him really cos of professional boundaries and confidentiality."

Nicola believed she would not have obtained paid employment without having completed the Level 3 substance misuse course. She saw this as giving her a recognised qualification needed to make the transition to drug worker status – the perceived difference between retaining the identity of a volunteer/carer and moving onto the identity of drug worker. Nicola was not the only participant who saw the attainment of the Level 3 Substance Misuse qualification as significant in terms of how colleagues perceived them and how they

perceived themselves through new skills developed on the course (see also Richard's story on p92-93):

> "I wouldn't have got it without the Level 3. I don't think they'd even have touched me without it. I don't think they'd have shortlisted me without it, to be honest, cos now everyone's got to do the level 3. I didn't know it at the time but you can put in all your experience but if it says it on the job descriptions, you've got to have [qualifications]. And I've shortlisted me-self and if you haven't got the qualification they ask for. You definitely need summat like that to show that you've actually got up off your own back and I think the fact that I paid for it me-self swung it for me as well cos it showed me commitment." (Nicola)

> "Getting the Level 3 [substance misuse qualification], oh, God, you get that respect, you get that respect for doing the course. Because there's a lot of people who work where I work and they've been doing it for ten years and not done anything like that. They've just moved from being a social worker or a nurse, and my role is probably better. It's more accurate and relevant and I've even been asked questions they're stuck on their homework and that obviously goes to show that. I've not told them I've done the course, but they've found out that I've done the course. So, people have obviously said, 'oh, Luke's done it'. There's not that many who have done it, there's four, and the rest have still to do it." (Luke)

**Support and Supervision**

Following her induction into her first paid job (in the NHS), Nicola quickly felt at home in this working environment. Her induction involved opportunities to shadow colleagues and from then, Nicola continued to relish training opportunities (similarly motivated to Michael):

> "The induction had finished on the Wednesday, so it were a Thursday. And it's just, like, there weren't many people buzzing about and I just felt like a lost soul, stood there. It was, like, oh, God. And then, I got introduced at the team meeting and I felt like I'd been there all my life. I had to work in [neighbouring service] and I was on the alcohol side shadowed someone for a few days. So I was shadowing someone doing a comprehensive assessment and doing needle exchange, but I could do that anyway. We were going on outreach which I used to love cos you get to see clients in their own homes, see how people live sometimes. I'm always on training, always [laughs]. I love it, just for the knowledge. If there's training there, it's needed so you're going to need to know about it. If it's not now, it's in the future and it's just good to have knowledge. Training's important, you definitely need it in this job."

Nicola's passion and commitment to training was echoed in her passion and commitment to working with the client group. However, although Nicola enjoyed her first post (within a

needle exchange), she was keen to transfer to structured drug treatment services to achieve her original ambition of emulating her ex-partner's CDT worker:

> "[When] I got the job and I were I love it, I love it, I love it. And I did love it for the first twelve months. But then managers changed, people left, people went on long-term sick. I were covering [service] on me own for about six months, needle exchange, assessments [laughs], … But I've always wanted to do the tier 3 side of it ever since I walked into that CDT. I thought just to give somebody that time, who's got nothing on the outside, that's what I wanted to get into. Tier 2, [you] did the assessment and they proper open their hearts to you in the comprehensive assessment and then, what do you do? You go and pass it on to someone else and then you never see that person again. Now [in shared care], I get to do the follow-through. I love it. How long have I been in shared care now? About two months... It's, challenging, rewarding. I love it. I do. I proper, proper love it [laughs]."

The contrast of Nicola's enthusiasm manifested itself in her feeling "disheartened" when her clients were not making the progress she felt they were capable of. She also expressed concerns about her most vulnerable clients and found herself worrying about them outside of work. Despite these frustrations, Nicola felt it important to continue to work professionally; to recognise her own limitations; and to accept the boundaries of her role. Although Nicola 'loves' her job, she became frustrated with 'demanding' clients, alluding to the possibility that they reminded her of her own brother. While Nicola is conscious of how clients prompt personal reminders, she did not mention taking such concerns to supervision:

> "When things don't work out with clients, I feel disheartened. Cos you can only help a client if they want to be helped, I think. You can put everything in place for them, you can bend over backwards for them, you can pick 'em up and bring them into appointments, you can do everything, but within a day, if a client doesn't want it, it's disheartening and I just think, well, that's one of many. There's more people that appreciate the help. But you get the odd one that doesn't. But you've still got to keep working with them. You've still got to be professional. You've still got to keep offering the advice and the referrals, but there's a limit to how far you can go. I was still pretty gullible when I first started here. Cos when I first started here at [service], I used to want to help everyone. But I think you get to know your clients as well so you can tell when they are telling the truth and you can tell when they are lying. Like I say, I was pretty gullible, but when you start hearing excuses, it comes back. [Ex-partner] used to say that, our [brother] says that. But, it's just like for every single excuse, they bounce off each other. I know one client said to me the other week, 'you've heard that before, haven't you?' I went, 'a million times' [laughs] and he just went, 'aw, alright then' [laughs]. And I think if you've got a good rapport with

> your clients as well, and I have got a good rapport with mine, so it's fine... And I feel sorry for clients at [town], your homeless ones. I often think of a couple of them when I've driving home at night, especially when it was snowing. Where are they going to go tonight? There's no shelter and the closest one, they've no money to get there. We can't give them money to get there no more. And that's the time when I feel sorry for them. You're limited to what you can do."

**Staff Teams**

Nicola believed she brought compassion to her role and was frustrated when other workers misused their power:

> "I feel sorry for clients who've got workers that play God with their scripts. There's no need for it at all. That really does wind me up [laughs]. It winds me up to death. There's absolutely no need. [They're] one of those that just want to get them in, get them scripted, get them reduced, get them out within six months and some of them are not like that. You can't do that with some of them. [They've] come in to get them all clean and that's it which isn't necessarily a bad thing, but if you've got the right attitude to go with it. And I just think if he had some knowledge, perhaps if he went to live on the streets or with a user's family for a week, I think [their] perception would change like that [snaps fingers]. Cos, you get to see the other side of it, don't you? I'm actually glad that I've lived the life that I have cos I'd hate to be like [them]."

Another participant who was sometimes frustrated with his non-ex-user colleagues was Jamie. However, it was not because they misused their power; it was because, unlike clients who would ask Jamie questions about his past use, they failed to be open to learning from Jamie as an ex-user practitioner (see p167-168).

**Professionalism**

Nicola worked hard to overcome any prejudice her clients experienced when they attended shared care surgeries. Despite difficulties with some colleagues' negative attitudes, Nicola believed that by presenting herself in a professional manner, for example, treating clients with respect while liaising with reception staff, she positively influenced how other staff saw her and her clients:

> "[In shared care], I've got three surgeries. There's one, they just look down on them, and I haven't got the time of day for her [receptionist], to be honest. She won't phone me and tell me they're [clients] there. I work at the back end of the surgery so I've got a massive corridor and I don't know what clients are there all the time. And she'll leave them sat there. The clinic next door are absolutely fantastic with me and [the] clients and they phone me and so I think it's just people's perceptions of drug users again, isn't it? I think it's seeing how another professional is with certain clients. And you can actually talk to them and see how they talk to you and be nice. If you give a client attitude, you're going to get it back. You talk to 'em nice and they'll calm right down and they'll talk to you. And I think she's clicked on to that. But the other one, stuck up."

Nicola was uncertain if she would disclose if she herself had used drugs rather than her partner and brother. She was concerned about potential risks associated with such disclosures and implied that those who disclose blur boundaries between the professional and the client. For Nicola, there was a difference between being a 'friendly professional' and a 'professional friend':

> "[When it comes to disclosing] about your past, I think you have to be really careful with a client. I don't know, I don't think I'd actually tell a client if I'd been on heroin. I don't think I'd actually tell them I was an ex-user. I'd just tell them I had no experience, but that's just me, cos I've never been there. But, other people when they just go on, it's like you're trying to be their friend. And they'll get into their drug use and you'll get into your drug use. And then you'll have a conversation about drug use. But, actually you're the professional and they're the client. I think there's certain things that you could say, like, 'I have experienced such a thing myself, so I do know what you're talking about'. But then you leave it at that. I don't think you should go into any depth with it. I think [people who do] leave themselves wide open, to be honest. If that client doesn't like you, you've had it [laughs]. That's my personal opinion."

Nicola believed it was more challenging to deal with family members' substance use than with her clients' addictions. Her professional identity, compassion, and the boundaries she puts in place at work are harder to maintain in her personal life:

> "I've tried to help [my brother] so many times and he just gives you all that and then you don't see him for about four weeks, two months even and then he'll come back again when he thinks he's had enough. I can cope with it all week, all day at work, but you're my brother. It is harder being family, with your brother, definitely. If

there's one client who's unhelpable, it's definitely him. I pity the key-worker who's got my brother [laughs]. I really pity the key-worker who's got my brother."

Nicola's own struggles to cope with her brother's and partner's substance use motivated her to offer support to her clients' partners:

"When they say, 'they don't understand'. Well, bring them to the next key-work session and I'll try and make them understand. I say you can bring whoever you want as long as you're alright with me talking about it. There's the family support group that runs up at [street] on a Wednesday through [voluntary sector agency]. They sign the consent form so I can speak to the wife and I say if you've got any problems, anything you want to ask me, just phone up. Don't be sat at home. Cos I've been that person sat at home, wondering what's going on."

However, Nicola continued not to disclose her own personal experience of being a carer when working with her clients' significant others:

"I just say I know what you're going through and I know how hard it can be. They've never asked [about my background]. I know how hard it can be when you're not the user and your partner is. So, I'll tell them there is support out there and I'll signpost them to where's needed. [If asked] I'd probably say I've been there a long time ago, with an ex-partner, but that's all I'd say, keep it simple. Some people if they're going for assessment won't let their partners in. I always ask the clients do they want their partners to go in. I don't go, 'oh, come in'. But most of my clients bring their partners, probably twenty bring their partners. If they're both clients I won't see them together. It's always men that are in treatment and the wife and I think it was because they let me go in with [ex-partner] as well. I think knowing the strain on the relationship, not trusting him with his drug use, actually being able to go into the room cos, obviously, once you're in the room, you're open to say whatever you want cos they've given permission for that person to be there, so anything negative I have to say, I say within reason. If it's all good news, then I'll big it up, meth reduction, your urine sample's come back clean, massive thing for clients cos they [partners] think they're sneaking off and using. But, you can see it in their eyes when you say it's come back negative. They just go like that [relief], and just a little twinkle [laughs]."

Although Nicola felt the support she offered had a positive impact on both clients' substance use and their personal relationships, Nicola had not disclosed the work she did with these

couples to her manager, suggesting they would not be interested as it is not something for which the service has targets:

> "My manager doesn't know I work with couples. As long as everything's [monitored] cos of this payment by results, that's all they're interested in, TOPs [Treatment Outcome Profiles], keeping people in treatment."

**Identity**

Nicola remained clear about her professional boundaries and connected this with limiting any personal disclosures. Because Nicola did not disclose her personal experience of being a carer some clients saw her as a "textbook drug worker", an identity not exactly matching her background. However, she did not disabuse them of their erroneous assessment of her status as this would have required her to breach her own professional boundaries:

> "You'd be breaking boundaries if you start talking about yourself and your past, and how many kids you've got and where you live and stuff like that [laughs]. I'm not here to talk about me, it's to sort you out basically. What did they call me? Textbook drug worker [laughs]. My client the other day said that. Textbook drug worker, I don't know what I'm talking about. I've lived a life of a drug user but not took drugs, do you know what I mean? I don't know everything but I've lived and I've seen whatever he does. The only difference with me and someone who has taken drugs is the physical side of them. That's the only thing I see as different. They know the physical effects of withdrawing off heroin. I've never experienced that myself. I've witnessed it and I can tell them all about it. But the aching legs, the cramps, I don't actually know how bad them are to make them not able to do the back end of a detox or need to go off and score. I can't tell them exactly how it is. But I could tell 'em how it looked. So, I said to the client, 'let's work together. Everybody's here to help you if they've got personal experience or they're textbook as you say'. He were alright after that."

The term 'textbook drug worker' was also raised by Harry and Adam with the former seeing this as a potential drawback for some non-ex-user colleagues, while the latter had been 'accused' of being such a worker because he had not disclosed his background - "you've got yours through university and you've learned yours in a book" (Adam).

Even when ex-user drug workers (or in Nicola's case, a carer) did not disclose their past, assumptions were made about workers with varying degrees of accuracy. The concept of a

textbook drug worker implies this is their only experience. By extension, this suggests ex-users only have knowledge of substance use and no other education or experience. This was not the case for this study's participants as all had completed the Level 3 substance misuse qualification; Kieran and Harry both had degrees; Richard, Phil, Elizabeth and Luke had done counselling courses; Adam had a management diploma; and most had undertaken a wide range of other non-accredited training. The reality, therefore, was that the participants had a combination of both life and 'textbook' experience.

Nicola remained committed to her substance misuse practitioner role and could not conceive of any alternative career path for herself. In this regard she was similar to Jamie who also had "no plan B" if things had not worked out in the drugs field:

> "I can't imagine doing anything else. No, there's nothing else out there anyway [laughs], nothing at all. I'd probably still be in limbo. I just knew as soon as that day I walked into CDT, I said, 'I'm going to be a drugs worker.'"

Nicola saw employing carers in the drug field as a positive thing as they have a lot of experience to offer. However, she felt that each applicant should be assessed on their individual merit when working out who is appropriate for this role; the timing of such a transition; and their ability to be professional once in the role:

> "If somebody was to say to me that employing carers was risky in the drug field because of potential boundary issues, I'd tell them it was a load of crap because they've got insight, haven't they? They've lived it. But, I reckon they've also got the passion and the understanding. [Waiting a couple of years to become a drug worker] would show a commitment, I suppose, after two years if they still want to do it. But, then why make somebody wait two years if they really want to do it? It depends; everyone's different, aren't they? Everyone's experience is different. I mean, you've got ones who have pushed their family away. I think [laughs] if there's two sides, I think they might need the two years. But it's different for everybody. They need to be empathic or they couldn't do the job. It's about being professional. Professional, it's someone that knows what they're doing and can do it how it should be done whether or not that's how they want it to be done. It's about sticking to those professional boundaries and telling them all the time. So, no stepping across the boundaries, if a client starts asking you about your life, 'we're not here to talk

about me, we're here to talk about you'. And you'll get the odd one who'll say, 'it's alright for you to talk about me, why can't we talk about you'. 'Well, I'm not in treatment, you are. So, I need to know all about you so you can get the best out of treatment'. They can trip you up sometimes. It is about being professional with your clients, in and out of work as well. It's not just in normal work hours, is it? Cos you work for the NHS it's about being a professional in and out of work [sighs]. My family, they were all shocked [when I became a drug worker]. They're still shocked now. Other people say, 'you're a drug worker?!' I don't know why they're shocked. It's just, 'you don't look like a drug worker' [laughs]. 'Well, what does a drug worker look like?'"

Ultimately, Nicola believed it was not possible to be an effective drug worker if passion for working with the client group is absent:

> "You couldn't do this job if you didn't have [passion]. If you didn't have passion and it weren't what you wanted to do, and you didn't love the clients, you wouldn't be able to do it."

**Key Aspects of Nicola's Professional Identity Story**

Throughout her narrative, Nicola expressed commitment to maintaining professional boundaries in and out of work, the latter of which was particularly challenging because of family and friends' continued involvement in substance misuse. For Nicola, having boundaries meant she did not disclose her past involvement with substance use as a carer. This resulted in clients, on occasion, 'accusing' her of being a 'textbook drug worker'. The implication of this label was, on the whole, negative in the eyes of the client group and led to Nicola feeling disrespected. The reality was that most drug workers, including those from an ex-user background, had some experience of education to complement their personal experience and many participants expressed the desirability of having a combination of both experience and education in order to be competent substance misuse practitioners, for example, Adam (see pp69-70).

**Phil – professional identity story**

At the time of the interviews Phil, an ex-poly substance user in his late-50s, was working in a statutory sector (NHS) CDT. Phil started his story while still in treatment in an inpatient detoxification unit and residential rehabilitation centre. Following this, Phil became involved in informal volunteering through an inspirational vicar and within six months of leaving the rehabilitation centre, had gained paid employment within a different rehabilitation unit. Phil remained in this role for six years, despite his reservations about what he considered to be unprofessional practices by the centre's manager. Phil then worked for two years in a probation hostel but as he was not working directly in the drug field, applied for a voluntary sector drug worker post within criminal justice. While in this post, Phil started working towards counselling qualifications. When his employment contract came to an end, he applied for and continued to work in a criminal justice post within the NHS.

**Professionalism**

Phil started his drug worker career in a residential rehabilitation unit and although he enjoyed the experience, he also realised in hindsight that there were some unprofessional practices occurring. From these experiences, he learned what it meant to be, and not be, professional, and this influenced his future practice and decision-making:

> "We moved down to work at [rehab] and, in many ways, it was probably the best, most enjoyable six years of my life. The drawback in the end was working with other Christians. I'll never work with other Christians again because they're so judgmental, so hypocritical. The team leader, I've got to question her professionalism in many ways. But, it was early days for me. I mean, I couldn't work in a place like that now, there were so many unprofessional things going on that I see now that I didn't at the time. At this point I had my wife and children, the eldest of which was 9. And we took one of the residents on holiday. There was no problem with it in term of anything happening, but he'd actually had allegations made about him sexually abusing his children in [town] and because I knew him, [client] is a nice lad. But, nothing happened, but, I realise now obviously, it was a tremendous risk to take. Nothing was said. It was actively encouraged by the staff. No risk assessment. The team leader was taking residents to her house. Some afternoons, she'd say, 'oh, come and have a brew at my house'. There were a lot of unprofessional goings-on.

> No boundaries. For me, looking back, it was a good learning experience, I suppose. I loved the contact with the members and to see them in the environment almost 24 hours a day and befriend them in a professional capacity is brilliant."

Phil compared good practice in terms of induction where he is currently employed with a lack of induction when he entered his first paid post in the rehabilitation unit, identifying what is and is not appropriate. In the early stages, this meant he had to realise for himself what the boundaries between him as a worker and the clients ought to be. Furthermore, he had to quickly establish his new identity as a worker, having been a resident (albeit at a different rehabilitation unit) just six months before. Even in this setting where he had no induction or supervision and was surrounded by what Phil considered unprofessional practice, he already saw himself as a professional and was determined to introduce personal boundaries that enabled him to achieve this professional identity:

> "There was no induction as we would have here [current CDT post]. It was very much get on with it. And one of the things, very early on, I had to realise I wasn't a resident; I was a member of staff. Because only six months before, I'd been a resident in a programme and there was I with a set of keys. I think I managed it quite well because I'd known other people in that situation who have actually gone the other way and become more like residents. And I suppose, even then, I wanted them to realise, yes, ok, I've been a resident, but I'm not a resident now. So, I'm a member of staff and I'll give you respect if you give me respect. And there were those who acknowledged that I'd been in rehab, it was no secret. They tried to use that, to take advantage of it, to get their way. But I was ok with that. So, it was realising my place and not over-stepping the line, being professional about it. They had to realise that as well. Well, you'd go on the occasional [voluntary sector organisation] training day but to actually work in the rehab, it was only watch what the others do and there was no programme. I was very, very aware of the fact that because I was new, because I was just out of rehab, being a resident only a few months before, and that it was a transition from being a resident to being a member of staff, that I didn't put my resident's head on. So, I was aware of what could be manipulative behaviour, but, I was on the other side of the fence now, so, I had to be professional in that sense. I was a worker, not a resident. To me, it was common sense. I used a lot of my own experience to be able to put myself in their position. And I think, as it turned out, they didn't try and manipulate me very much. If anything, they respected the fact that I'd done a rehab, so, they assumed that because I'd done one, that I understood how they felt, which, up to a point, I did. But, then everybody's different. So, it was just common sense, what to do, what not to do. The staff were crap [laughs]. I mean, it was unprofessional. There was no supervision. I first had supervision at [area] probation. [I] didn't have supervision at [rehab], really bad. But I didn't know what supervision was then."

Phil was not the only participant to disclose a lack of induction, support and supervision, especially in the early stages of their careers. Debbie described how a lack of support left her feeling like she was "white-knuckling it" while Jamie stated:

> "[there was] no induction. I don't know if they thought because I'd done me detoxes on the unit three times, I knew how it all run, you know, how everything works, so, maybe they thought I didn't need an induction. I don't know, but I didn't get one."
> And:
> "I never got supervision, you know. No, I never got supervision. I only got supervision when I became a support worker. [When I was a volunteer and a [sessional] worker I didn't get supervision], not professional supervision, but there was always times when I could go back to staff and have a chat but I never got planned, structured supervision. I mean, there was always staff there that I could to talk to if we had a problem."

Phil's immediate experience in his next post (a probation hostel) was no more positive than his experience in the residential rehabilitation centre – on his first day he witnessed a resident being verbally abused by a staff member and did not feel able to challenge this. What this experience reinforced for Phil was that this was not the way he wanted to work with clients. Instead, he saw the professional approach as being one where clients were not judged for their past behaviour and were treated with respect:

> "My first morning there, I was shocked because at least at [rehab] they treated the residents with respect and courtesy, and my first morning there started with being showed round by another [colleague] who [when] a lad came out of the kitchen and [colleague] said to him, 'get your fucking chores done or I'll rip your head off' [laughs]. This is to a resident. I thought, 'what have I come to now?' Out of the frying pan and into the fire. I didn't challenge it at the time. It was my first day. I went home thinking, 'what have I come into?' You'd never dream of talking to a resident like that. Well, he wasn't like that all the time. I don't know how much of that was to impress me. I was just the complete opposite [from colleague]. But, people pick up on that. They'll pick up on the way you approach them, the way you talk to them, they'll respond to that. So, if they had a problem, they'd rather come and talk to me, not him. In all the years I've been working in criminal justice now, I've never been threatened or assaulted. There's no reason why I should be. Because I'd come from [rehab], there was one or two problems with the manager, but it was a loving environment, a caring environment. Because one of the things I firmly believe in is giving people respect, no matter what they've done. We've all done things. I've done things I'm ashamed of, I'd rather not have done and people in the past have judged me for that. But, I don't think we should go around judging people in that way and certainly not speak to them like that."

Other similar examples were shared by Debbie and Elizabeth:

> "when I went back into the office [the staff were] bickering and calling clients, it just used to get me so mad, you know. And confidentiality, where's that? You know, shouting across the office about people's personal business and, you know, on some levels, there were things I shouldn't have known. When you know certain things about people, it can put a little bit of a barrier up, whereas you've got to keep your opinions to yourself. I understand that. But they were shouting things across the office." (Debbie)

> "Because I hear so much backchat, for example, I didn't know this client but seemingly they're doing really well in London and in recovery. They've got a job, and especially my manager poo-poos it, you know, it's like, 'oh, right, right, right, we'll wait and see'. And that kind of judgment to me, it makes me angry and I don't want to say, actually it can happen." (Elizabeth)

Phil, like Adam, felt that another way to maintain professional boundaries was to keep work and home lives separate:

> "I am quite good at shutting out. I'll leave my home life at home and then just as when I leave work I don't worry about work." (Phil)

> "I try and keep it very clear. So, home life's home life, you know, work is work and social life's social life. You know, I was in treatment, I'm not in treatment anymore and early on, I did see other people who volunteered, but it was like they were still in treatment. They kind of went up there and when they were talking to the staff, it was treatment talk, but it was about their selves. Whereas I became quite clear, for me, I'd done that. I won't forget that, I don't think I'll ever forget it, but, you know, I'm not in treatment anymore and things like that. Whereas I think, I can be quite good with me boundaries, you know." (Adam)

**Professional Qualifications and Training**

At this stage in his career (working in a probation hostel), Phil had no qualifications but was keen to take advantage of training and supervision they offered. However, having worked in the probation hostel for two years, Phil wanted to move back to work with substance users and returned to the voluntary sector where he became inspired by his new manager who he saw as being "a real professional". Although Phil appreciated the access to

training in the probation service, once in this voluntary sector agency, he was able to undertake accredited counselling courses and so could achieve the qualifications he desired:

> "At this point I had no qualifications. I got supervision there [probation]. To begin with that was more like you were always with another member of staff who was mentoring you, but you got on and did it [and] a lot of training. That was a real boon, that, a lot of training. When I moved there [voluntary sector], in the project there was [manager] and another project worker and myself. And I think we were all finding our feet really. But she was a brilliant manager, regular supervision, a real professional, but your friend as well. But, it was a professional friendship, you didn't over-step that boundary. But, if you had any problem, you can just kind of approach her, excellent. And, again, at [voluntary sector agency], they're pretty good for the training; they paid for the Level 2 and Level 3 counselling. I think it depends [on] the process of different organisations and their different ways of inducting the staff. When I came here, the induction was pretty good, probably one of the best, where I was given a month to find my feet, make contact with outside agencies, go and visit them. I think the worst one was probation where I turned up one day and I was doing the job same morning. I just learned from [shadowing colleague], but, it's accepting that every organisation's different."

Phil saw this voluntary sector agency as being more professional than the rehabilitation unit where he first worked. He continued to be inspired by his manager who encouraged him to gain higher level qualifications in counselling and offered regular supervision and support:

> "It was good because [voluntary sector agency] was a lot more professional than [rehab], but like the poor relation to probation, being a charitable organisation. I learned a lot from Diane [manager], and I think Diane, for me, is the epitome of what is professional and I learned so much from her and it was her who encouraged me to go for the counselling diploma. It lasted five years before they lost the contract. And I really enjoyed that. She was very, very supportive as a manager, regular supervision. The sort of person you could go to if you had a day-to-day problem."

When Phil was completing his counselling qualification he encountered some negative attitudes towards the client groups he worked with. Phil saw such judgmental attitudes as being contrary to the professional ethos and underlying principles of counselling practice:

> "I'd just started my Level 3 counselling. I did two placements, one at [town 1 probation hostel] and [town 2 probation hostel]. I was working with people, not the

> same people I'd worked with, but the same type of people I'd worked with. And it was quite interesting to see some of the reactions on the counselling course, which again bothers me. 'Oh, I couldn't work with drug users', 'Ooh, he killed his mother, how could you work with him?' and it's, why is somebody training to be a counsellor when they [are judgmental] and it really, really annoys me when I hear things like that from professionals. You can't really decide what client group you're gonna choose, you should be able to sit down and work with anybody."

**Staff Teams**

In a similar way to that described by Adam when he started working in a prison (see p71), when Phil changed role to become an arrest referral worker, he experienced professional culture clashes between substance misuse practitioners and police officers:

> "Now, what had happened was that the probation partnership came to an end. [another voluntary sector organisation] got the contract... I was encouraged to apply for a new post that was coming up in Arrest Referral in [town]. And myself and a colleague in the office applied for it. We set the scheme up. The police didn't want us there. Civilians hadn't been in the custody suite before, let alone a cell. And so we were treated with disdain and made to stand in the corner [laughs]. You were very aware that it was their environment so you had to be careful. I think I told some of them that I'd been a substance user. To begin with we were treated like outcasts. But as time went on, you'd stand at the custody desk, chat to the sergeant. It took a little while but we broke down the barriers. And then they accepted us for what we were there for. We still came across shocking attitudes towards people with drug problems. Some of them were ok, but some weren't. There were some really good ones. What you had to be careful of was you didn't start a parallel process of becoming sarcastic like they did. And I really believe, with the police, I had to be on the ball the whole time, that I didn't fall into the trap of becoming sarcastic and critical of the people that I was there to help and support. We broke the barriers. And it took a lot of work between the two of us to chip away at it. They thought we were do-gooders. But it was interesting. It was an eye-opening experience." (Phil)

While Phil continued to enjoy working with drug users in his current NHS job, he was frustrated with ever-increasing amounts of paperwork. Phil described himself as a person-centred counsellor and although he did not think this caused him to be especially frustrated with the levels of accountability, he acknowledged his disappointment in having to spend time doing paperwork when he could be working with clients. This experience was in direct contrast to a complete lack of paperwork and accountability in his first paid post but his view was that the situation had gone to the other extreme where there was too much, the

implication being that he had moved from an agency where there was unprofessionalism to one where he perceived there to be 'over-professionalism'. The result of this polarisation was that Phil confessed he did not always 'do things by the book' thereby breaking his own boundaries:

> "I thought it was horrible to hear the service manager saying your monitoring comes before the clients. I think it's sad. It's all time that's taken away from being there to support people. I accept the way the system is. We've got to provide statistics, but, it's gone to extremes. I don't think it's because I'm person-centred. I don't always do things by the book. I know we have to be accountable but, there's too much of it. I think, for me, it's become kind of disappointing and a lot of that is around the way things are today. I understand the need for paperwork, risk assessments, but I think it really has got to the stage where I can't spend the time with my clients that I want to."

**Voluntary and Statutory Services**

Although Phil's current colleagues were aware of his past substance use and he had disclosed to several clients, Phil felt he had moved on from his substance use and did not want to continue to have the label of ex-user:

> "I don't want to spend the rest of my life going, 'I had a drug and alcohol problem'. I'm not going to put a label on myself. If somebody asks or if I can say a little bit about myself which is going to help somebody else, fair enough. But, with clients, you don't go, 'oh, by the way, I used to,' cos it totally takes the focus off them and puts it on you. To help engage with the client, I have self-disclosed, but usually only in the situations where you get the comments, 'how would you know?' 'Well, I do actually'. It's an amazing reaction you get when you do self-disclose. Looking back I can put myself in that position where one of the best counsellors was an ex-drinker and he'd self-disclosed and then I'd just felt a lot more trusting of him because of that. I don't think it's necessary, I don't, obviously, believe that somebody has to go through it themselves to be a good listener, be a good helper but, I think it can help. I thought I was less likely to be judged. He might understand where I was coming from. I didn't disclose here [probation hostel], but, they didn't ask about it".

When applying for jobs, Phil perceived statutory agencies as more professional than voluntary sector - "you might look at [area] probation as being a more professional body than [voluntary sector agency]" - resulting in him making the decision to disclose to voluntary sector agencies but not when applying in the statutory. Such perceptions perhaps stem from

his initial experience in the voluntary sector (rehabilitation unit) but did not necessarily reflect his later experience of working in either sector, for example, he described a lack of induction and professionalism in the probation hostel (statutory sector) while being inspired by the "epitome of professionalism" in the probation partnership service (voluntary sector) and although he did not disclose his past substance use when he started in his CDT role (statutory sector) he had later disclosed to colleagues here. Although Phil had experience of professionalism within the voluntary sector, he remained convinced that, overall, the statutory sector is more professional and accountable, although he also suggested this can sometimes be experienced as a 'blame culture' where "they're looking for a neck to chop" if something goes wrong:

> "I know, I whinge and complain about this, that and the other, but, I actually enjoy working here. I enjoy working with the client group. I enjoy working with my colleagues. It is different. It's more professional, a lot more professional. I'm also acutely aware of the fact that at times you've really got to cover your back especially within the NHS Trust. If anything goes wrong, if someone dies, or someone's injured, then the file disappears and there's an enquiry. And they're looking for a neck to chop. I think in the statutory sector, accountability is much more important, much higher than in the private sector. Well, I haven't worked in a voluntary agency for years, maybe it's changed."

Luke also commented on differences he perceived between the voluntary and statutory sector:

> "I think how different the non-stat and stat drug services are, and how much more easier and accepting it is to come from a voluntary background for certain services and the real beef, if you like, started when I went to the [NHS organisation]. I'm sure it's not just [NHS organisation]. I think, actually, on reflection, [voluntary sector agency] was full of ex-volunteers. All the staff had been a volunteer at some point; even the manager was a volunteer. They started [as a volunteer] and eight years later they were a manager. So, that really just spoke highly of the voluntary background and of [voluntary sector agency] and what they're about. I think it's great. When I worked for the NHS, well, I'm still working for them, it is full of people who have either been a nurse at some point and moved on, just people with completely different backgrounds. In a lot of respects I'm proud to be there. There aren't actually that many who've made that crossover, and I think it is a hard, a difficult one to make. So, yeah, I feel proud that I'm there... And I think it's funny because the people who work for the statutory, there is a little bit of an arrogance about it. Just ever so slightly because you think, rightly so in some respects because, at the end of the day, it's the National Health Service, and it's what they probably

> aimed for, if they're going to work in the drugs field, they want to work for that, within that field in some respects. And, I think maybe, I think in the non-stat, people always used to say, 'God, I'd love to work for [the NHS], they get paid so much' or things like that... That's a little bit of a power imbalance in some respects and the type of people, obviously, that work in the different backgrounds generally. It's not always the case, cos I know there is a mixture but, the majority seems to be people who have ended up working in drug services, for the NHS for whatever reason. Your qualifieds have had, probably, different life experiences. From the very beginning, you've been in a position where you could go on to further education straight away and when they work for non-stat, but I think it comes later on. They're a lot older when they do it. It's almost like education versus something else, where it seems to be they were focused about doing all the education, getting the qualifications early on, but I was just doing something else [laughs]. The reality is you do need that bit of paper sooner or later, you do need something. I didn't have anything. I think there is a little bit of a change in culture, specifically where I work. It's finally [laughs], they're almost going back to what the non-stat services have been doing always. Where now, they're basically saying, we have to start doing things like groups, we have to start doing some kind of psychosocial interventions instead of just key-working." (Luke)

**Status**

Phil had mixed opinions about risk in employing ex-users as drug workers. Interestingly Phil had some sympathy with the two-year 'rule' for "proving yourself" before making the transition to paid employment, but this 'rule' had not applied to him as he was out of treatment for six months before gaining paid employment. By "proving yourself", Phil seemed to imply an ex-user must remain substance-free and show they can cope with stress:

> "From my own experience, I'd say, 'no, it's not risky' [to employ ex-users], but having seen other people in that situation, I'd say, 'yes, it is risky'. I don't think you can [assess who's risky and who isn't]. I think, realistically, you've got to have a period of time where you prove yourself, if you like. Remain drug or alcohol free, because it's a stressful job, now more so with all the bloody paperwork. I never find the stress with the clients or service users; they're not the stress, it's either the managers or staff or the paperwork or caseloads or whatever, but, not the actual people that I'm working with. But, I think, you do need a two-year period for proving yourself before. I'd probably have felt a bit resentful [if I'd had to wait two years] but I'd have accepted it." (Phil)

Phil's view of what makes an effective professional comprised a range of qualifications, experiences and attributes, especially in terms of how they interact with the client group. Phil saw it as imperative that workers have access to "proper" training so they not only

have the label of professional but also the ethical approach to be able to act in a professional manner. While at the time, Phil saw himself as a professional when he was working in the rehabilitation unit, he later considered this may not have been the reality, perhaps particularly in terms of how he was seen by other agencies' practitioners. Having now worked in a range of services, Phil was more aware of what constituted professional practice, and what does not, and continued to balance his professional boundaries with his person-centred sensibilities:

> "I suppose a professional is someone who has the knowledge, experience and qualifications to act in an ethical, professional manner. I'd expect somebody to demonstrate they were being professional by their actions, their behaviour with clients. It's the interaction with clients, the way you speak, the way you use your body language and talk to people. I don't think you can be how you are with somebody unless you've had the proper training and qualifications, and the knowledge of ethics. When I worked in rehab I think I regarded myself as a professional but, with hindsight, I wasn't a professional and, I think I conducted myself in a professional way, but, there are a lot of things now that I would really challenge, particularly about [voluntary sector organisation]. [When I started working in rehab] I knew about professionalism in terms of my conduct with people, but, my knowledge. I was there to learn and it was a bad, bad learning experience. I've learned from it. I never had supervision in all the six years I worked there. So, when I went to probation, it was my first introduction to things like supervision and being able to sit down with my manager for an hour, hour and a half. It's about boundaries, very much about boundaries. It's about retaining your professionalism and it's like a professional friendship but coming across as a friend but you're not their mate, you're not their buddy, but I'm a professional so, I can't overstep this boundary."

Like other participants (for example, Michael, Luke), Phil thought a mixed staff team was the most effective to meet clients' needs through pooling knowledge and experience. However, where staff had negative attitudes towards the client group, he saw training as having limited effectiveness in addressing such prejudice:

> "I don't have any problem with workers who don't have any experience of substance use. A brain surgeon doesn't have to have had a brain tumour operation to become a successful surgeon. I've had a lot of very good drug workers who have never experienced addiction themselves, so, no problem with that. I think it's good to get a mix. If a worker is prejudiced toward drug users, it's not a question of training,

> it's within the person. It's a prejudice that hasn't been dealt with. If I do hear anything [derogatory] I cringe when I hear it. And over the years, I've heard some really horrible statements. Not just things that are said but the way things are said, talking down to service users. Training, I suppose, wouldn't go amiss, but, I think it's a deeper problem than that. When I worked at [town] I didn't like sex offenders particularly, but, I worked with them and I was able to remain non-judgmental cos you put the issue to one side and work with the person sat in front of you. And people who can't separate the behaviour from the person, that's when they start to become judgmental and they're not doing any favours to the person they're working with."

For Adam, it was working side-by-side with colleagues from different backgrounds that broke down such prejudices and enabled effective co-working:

> "I suppose staff-wise, it was very mixed. It was more or less 50:50 give or take a percentage, but a lot more mixed. I mean people who'd been involved in drugs, people who'd been involved in alcohol, so it was just seen as the norm. I remember some staff members who had not been involved with substance use tapped into that as well. My colleague, who I worked very closely with, she'd never been involved in any sort of substances, but she'd kind of gone the other way. She'd done a lot of educational stuff, so, that mix worked well, cos she'd tap into me and be asking me certain questions, and vice versa." (Adam)

**Identity**

In terms of being identified as a professional drug worker, Phil was in the process of registering with the Federation of Drug and Alcohol Professionals (FDAP), seeing this as an appropriate way to gain recognition of his professional status as a qualified drug worker. The level 3 substance misuse course helped him achieve the FDAP criteria but also enabled him to develop skills required for his day-to-day job (also mentioned by Luke (see p93) and Harry):

> "I'm now going for FDAP. I think it's good to have a yardstick. Going back years and years, all sorts of people coming into the field, different ideas, different approaches, different techniques, so, at least now you've got a measuring stick. I think it's good. I agree with the other aspect of, wherever possible, I will go the extra mile for the clients... I think the Level 3 [substance misuse course] counted more to me in terms of FDAP, it's a recognised qualification for drug workers, that was useful. It was also useful because I learned a lot on the course and I still revisit things like the care plans, risk assessments. I know they are constantly changing but it's good to look back and make sure I'm still doing things the way that I should be doing. So, that helped me to be more professional, really, the course itself. And I

enjoyed it. It was also a good feeling to have to come to college every week and have that feedback and interaction with other students." (Phil)

"This certainly spring-boarded me, having this qualification because I found when I was applying for full-time work, they were looking for Level 3 qualifications. Always, they were always looking for it and even though I had the psychology, they wouldn't recognise it really, as a professional qualification. So, this was so important to me, gaining employment. Not just the piece of paper, so I could get through to the interview stage but the practical skills as well. I use them every day, I still do now and always will, huge, massive. Initially, this is Level three and that's what people are asking for. And I think I can remember saying, you went round on the first group and asked everybody why they were here and I can remember saying, 'I just want the piece of paper'. But, on so many levels, Sheila, it's given me the tools to be able to do me day-to-day work, stuff like care planning, risk assessment, just everything really." (Harry)

**Key Aspects of Phil's Professional Identity Story**

Phil's career started with him experiencing some colleagues' unprofessional practice although this only became fully apparent with the benefit of hindsight. Looking back, he contrasts his initial experience in a voluntary sector residential rehabilitation unit and probation hostel with his later more positive experience with more professional and inspirational managers and colleagues in both the voluntary and statutory sectors. Through experience, Phil developed an understanding of what, for him, constituted professional and unprofessional practice. Although Phil experienced a polarisation of professionalism and unprofessionalism in both voluntary and statutory sectors, Phil remained convinced that he was more likely to encounter higher levels of professionalism and accountability in statutory provision. However, he did not always see this as a positive thing because, with accountability, came additional monitoring requirements and what he perceived as a culture where managers were "looking for a neck to chop". Because of his perception that statutory services were more professional, Phil altered his disclosure decision-making about his past use so he did not identify himself as an ex-user when applying to statutory drug services but he did when applying to the voluntary sector. Although he was comfortable sharing his background with colleagues and clients, he preferred not to retain an ex-user label as his career progressed. For Phil, the concept of professionalism focused on

respectful interactions with clients, experience, qualifications and ethical practice. Phil saw the value of having national occupational standards for substance misuse practitioners, welcoming his Level 3 substance misuse qualification as this enabled him to register with FDAP and be recognised as a professional by other professionals.

## Part 2: Discussion

### Introduction

When discussing professionalism in this study, many participants referred to their own skills, competence and boundaries as their meaning of 'being professional', for example, Jamie (see p217). For this study's participants, career and identity choices required their active participation. Even Jamie, who described himself as a "yes person" because he said, "yes" to the opportunities offered to him through his treatment providers, was not passive in his identity development. He could, after all, have said 'no' and his narrative clearly demonstrates he was active in making the most of the available opportunities.

### Professional or Occupational Group?

It is questionable if substance misuse practitioners are in fact categorised as professionals. This status is not universally accepted for drug workers or even for nurses, although the term "*nursing profession*" (Kelly 1991, p185, italics in the original) is often used by the media and general public. Similarly, ex-user drug workers in this study referred to nursing colleagues as being 'professionally qualified' (for example, Jamie, Luke and Michael). If nursing does not meet the criteria for professional status, how can substance misuse practitioners?

Historically, substance misuse services were either provided through mutual aid (for example, Alcoholics Anonymous and Narcotics Anonymous which were not professionally developed but continue to have their own principles and traditions) or through the medical model by doctors who already had recognised professional status. Given the range of worker backgrounds attracted to modern substance misuse services, the occupational-professional continuum is perhaps a better reflection of reality. This means no matter the occupational or professional status of individual workers, they are still expected to practice

in a safe and professional manner by adhering to their service's code of conduct and policies, as well as national standards and guidelines, while also committing to their own professional development (for example, through training and supervision). The term 'professional' is therefore more than a label or identity conferred on individual workers.

In the context of ex-user drug workers, identity is influenced by the 'content' of their role and their 'common experiences' with their clients. The notion of identity as a "useful tool for dividing up the social world" (Widdicombe 1998, p192) is an interesting one in substance misuse services as it suggests a division between ex-user drug workers and practitioners from other backgrounds. Some participants disagree with such divisions and labelling, for example, Adam said, "I didn't want to use this badge of 'I'm an ex-user'" and Harry stated, "I don't want to wear the tag of ex-service user either really cos I'd like to think that I might have made a pretty good worker even if I hadn't been a service user."

These examples show how individuals might resist being given just *one* label or identity, especially if that label is 'ex-user' or they do not want to be categorised as different from 'qualified' colleagues. Furthermore, once ex-user drug workers have been employed in the substance misuse field for a period of time, they may have multiple identities within the workplace, including ex-user, volunteer, support worker, drug worker, senior practitioner, team leader and manager. In addition, other identities in their personal lives may be simultaneously relevant, for example partner, parent and friend. Mishler (1999) referred to such identity interactions as the "dynamics of sub-identities, or multiple selves, or 'shifting social identities'" (p14). The idea of dividing drug workers into different categories depending on whether they had used substances problematically or achieved certain qualifications, moves away from the NTA's competence-based professional identity where any individual can attain 'competent status' irrespective of their personal or professional experience (Skills for Health 2003).

For ex-user drug workers, their continuing identity construction is affected by the impact of their role on clients and colleagues while also being affected by how these same clients and colleagues respond to them. As a result, how participants see themselves and how they are seen by others will change over time and be altered in different contexts and relationships. Furthermore, how participants view their past identity (as a substance user) will be affected by their present experience (as a drug worker) while their past experience (of substance use) will affect how they view their present identity as either a professional and/or ex-user drug worker (Gubrium 1993), for example Michael (see pp227-228).

It has been argued that identity is constructed narratively (Sparkes & Smith 1999), that is, the stories we tell about ourselves influence and, indeed help determine, our identities and how we position ourselves within our social world (Misher 1999). The stories participants chose to tell when being interviewed about their transition journey from substance user to practitioner were selected to present themselves in a particular (usually positive) light, and to present "their new definition of self" (McIntosh & McKegeney 2001, p102).

As already discussed, many participants mentioned their initial motivation for becoming a drug worker was to 'give something back'. This may be considered as "generative efforts" (McAdams et al. 1997, p688) contributing to a "commitment story" (McAdams et al. 1997, p688) that not only assist people to develop the identity to which they aspire but also positively benefit others and is consistent with sentiments expressed by participants in this study who are concerned for the welfare of other substance users.

**Professional hierarchies – perceptions of positive and negative identities**

Some consider there is a hierarchy of substance misuse practitioners within the drug field. However, this hierarchy is viewed differently depending on what attribute is valued. In some cases, one's position on the hierarchy is validated so that "one's claims for a positive

identity may be justified by contrasting it with another's negative identity" (Mishler 1999, p136). For example, many participants reported they gained credibility with clients where it was known they had a history of substance misuse. This is a view supported by McIntosh & McKegeney (2002) who suggested three advantages to employing ex-substance users (in paid or voluntary roles): first-hand understanding, credibility and inspiration, and is further supported by participants in this study, for example Harry and Phil (see p227).

Therefore, if one feels that having lived experience of substance use improves competence, knowledge and understanding, this attribute is valued as a positive identity and ex-user drug workers view themselves, and feel they are viewed by their clients, as superior to non-ex-user drug workers who in comparison 'only' have 'textbook' learning, the latter being viewed by some as a negative identity. For example, Harry felt "service users' perception [was] that I could help them more because I was an ex-service user"; Nicola was called a "textbook drug worker" in derogatory manner by a client, and Adam was told, "you've got yours through university and you've learned yours in a book".

Other practitioners may feel that having a qualification, such as nursing or social work, better serves the client group. In this case, the attribute of being 'qualified' is seen as more valuable and contributes to a positive identity, resulting in these qualifications having higher status on the hierarchy in comparison with lived experience which becomes viewed as a negative identity. Furthermore, some non-ex-user workers not only considered ex-user drug workers and volunteers as lower on the hierarchy but "risky" (for example, Kieran) or "unqualified" (for example, Jamie). Even ex-user drug workers themselves did not always want to be recognised for their lived experience but preferred the status of "professional" (for example, Adam). The notion of a hierarchy of workers within drug services is likely to be facilitated by comparing one 'type' of worker with another.

Some participants suggested having a qualification was the deciding factor in terms of whether one was considered a professional or not. However, a further hierarchy is evidenced here, whereby qualifications such as nursing or social work degrees are accredited at a higher level by professional bodies and are therefore often held in higher esteem than, for example, counselling diplomas or the Level 3 Award in Tackling Substance Misuse. Luke, for example, described how he experienced "snobbery" from his colleagues because he had not been to university meaning he "encountered resistance and hostility from professionals in the workplace" (Barton 2007, p343). Luke, however, also reported that later in his career, he felt his Level 3 Substance Misuse course was respected. Michael was conscious of a "divide" between nurses and non-nurses within the service where he worked (something also referred to by Adam, Jamie and Luke), but he felt this divide was decreasing and that his Level 3 substance misuse qualification was as relevant to the job as any other qualification (see p223).

Another way of looking at this type of hierarchy involves "othering" (Baldwin 2008, p105, Anthias 1999, p176) where individuals make "comparison between one's own identity and those around one" (Baldwin 2008, p105). In a similar way to the hierarchy described above, individuals compare their own identity with another person to accentuate their differences, resulting in seeing others as either higher or lower in status than themselves or, indeed, seeing an individual as a member of an "out-group" (Turner 1991, quoted in Biggs 1997, p187). Baldwin (2008) described such hierarchies and othering in the context of healthcare services:

> "In order to maintain an expert position, for example, it is important that others are 'incompetent' and do not have the expert knowledge that one professional group is said to hold by virtue of training, socialisation or research development, and key elements of professional identification. This devalues the other by underplaying what they may be able to bring to the healthcare interaction" (p107).

Baldwin's (2008) study explored Child and Adolescent Mental Health Services (CAMHS), but the above description could equally apply to substance misuse provision and resonates with some experiences shared by this study's participants. In Jamie's example on p219, he described his experience of 'qualified' staff viewing 'non-qualified' staff, including ex-user drug workers, as less competent in comparison to themselves. Certainly, there are some tasks only nurses can fulfil by virtue of their training. However, it is likely that ex-user drug workers will have knowledge and understanding only they can have by virtue of their lived experience. To create effective teams, bringing both components together as different but equal facilitates what many participants (for example, Phil and Adam (see p250-251) described as a 'skills mix' to optimise service delivery. As identity development theories use comparison as a key component (Baldwin 2008), is it inevitable that workers from different backgrounds adjust their view of others to provide greater validation for their own role while simultaneously devaluing the contribution of others? This may be true for some practitioners, but not all. Phil, for example, thinks a mixed staff team is the most effective way to meet clients' needs through pooling knowledge and expertise, and he shared his experience of working in a staff team where professionally qualified and ex-user staff members worked closely and effectively together. Even though there are differences in qualification and experience, there are other similarities so that "identity is that which we share with other people *and* that which distinguishes us from other people" (Presser 2008, p3).

Recruitment policies and practices need to reflect the value of 'mixed teams' and should be reinforced by teamwork that facilitate equal respect between practitioners from different backgrounds so there is "an appreciation of each other's expert contributions" (Engel & Gursky 2003, p48). Currently in the substance misuse field, reference is often made to 'Experts by Experience' (service users/ex-service users) and 'Experts by Training' (qualified professional practitioners) (James 2007). Although the term "Experts by Experience" has

been used in mental health provision for some years (for example, Faulkner 1998), it is only relatively recently that it has gained common currency. While mental health services were among the first to adopt it as part of their national practice (for example, Lakeman 2010), many other health and social care sectors have also incorporated "Experts by Experience" principles, for example the disability sector (Fox, 2011), nursing (Muir & Laxton 2012), social work (Fenge et al. 2012; Skilton 2011) and substance misuse (Holmes & Williams 2009). The Care Quality Commission (2013) also advocated the involvement of "Experts by Experience" as a model of good practice within their national strategy. Many service providers now use the term "Experts by Experience" interchangeably with that of "Service User Involvement" (McLaughlin 2009), giving these principles a longer and stronger heritage.

**Valued Status?**

Drug workers are keen to achieve a valued status through their role on both a personal (with family and friends as mentioned by Nicola see pp238-239) and professional basis (as mentioned by Luke (pp247-249)). Achieving status, however, does not occur automatically and requires the individual to not only adopt a particular role but to be valued by others within this role. In their study of teachers, McCulloch et al. (2000) suggested that, "[i]f, by and large, teachers do not feel fulfilled in their work, trusted and valued; if they do not *feel* professional, then can teaching really be seen as a profession?" (p118)

The same feelings could apply to substance misuse practitioners. If ex-user drug workers do not feel trusted or valued by non-ex-user colleagues and clients, and/or drug workers do not feel professional, can substance misuse practitioners as a whole be viewed as a profession? The need for respect and cohesion between all substance misuse practitioners, whatever their background, gains greater emphasis in this context (Leathard 2003, Mathias et al. 1997), challenging mistrust and resulting in recognition of the contributions made by

all workers, including ex-users. In reality, many participants felt there have been times in their careers when they were judged by colleagues because of their ex-user or non-qualified status and/or their lived/volunteering experience was not valued, for example Debbie and Jamie (see p219).

Examples of negative attitudes toward practitioners from outside the dominant professional backgrounds include Phil and Adam who described difficulties when starting in new roles where drug work was not the primary role of the service - Adam worked as a drug worker in a prison while Phil became an arrest referral worker based in a police station. Both reported their experience of professional culture clashes between substance misuse practitioners and criminal justice workers with the role of drug worker not being valued by criminal justice staff, at least initially. It does not appear that this was necessarily because Adam and Phil were ex-users, although both had disclosed this to some prison and police officers respectively. There was distrust on both sides because the drug worker roles were new in these settings resulting in a lack of understanding and individuals feeling threatened. This is not unusual as,

> "By and large, workers are most comfortable working with others of their own profession/discipline as they share the same goals, priorities and a familiar structure" (Mathias et al. 1997, p127).

Initial tensions between different disciplines may therefore be expected. A willingness to communicate and agree goals, priorities and ways of working together will be necessary to address any concerns and move towards more comfortable working practices. However, there are other potential sources of tension between different practitioners. For example, another way of attributing value to a job status is through power and remuneration (Baldwin 2008). In the context of substance misuse services, it could be seen that having an equally responsible role as other practitioners and being on a similar pay scale indicates

ex-users are considered equally valuable. However, where this happened, participants, for example Luke (see p213), reported this was not always respected by professionally qualified workers who felt they should be on a higher pay band, resulting in further "divisions between qualified and unqualified staff" (Davies 2002a, p32).

**Integrated identity**

An individual is more than their job title. Their identity, especially if viewed from a hermeneutic perspective, is an integrated whole comprising several parts that fuse together to form a complex mix of attributes, beliefs, experiences, perceptions, personality traits and ambitions, and is told through a series of meaningful narratives, or as McAdams and Janis (2004) put it:

> "The idea that one's life, as complex and dynamic as it increasingly appears to be, might be integrated into a meaningful and purposeful whole may represent, therefore, an especially appealing possibility to the self-reflective emerging adult" (p162).

The notion of being self-reflective is one encouraged within the substance misuse field. For example, maintaining a reflective diary is a requirement of the Level 3 Tackling Substance Misuse course and Richard noted the importance of this in integrating his learning with his practice (see pp92-93). But an integrated identity requires more than simple reflective practice. It requires sharing our experience with others and in the telling not only do we describe but we create our identity because,

> "[t]he personal narrative is a special kind of story that every one of us constructs to bring together different parts of our selves into a purposeful and convincing whole...[and] we do not 'discover' ourselves in narrative, rather, we make or create ourselves through narrative" (Crossley 2002, p67).

Identity creation through narrative is particularly important for ex-substance users due to the transition process they have navigated to move away from their previous "spoiled

identity" (McIntosh & McKegeney 2002), and the role of disclosure in formulating their new identity. Indeed, narrative links the three orientations together. As Crossley (2002) stated, "[t]hrough narrative we define who we are, who we were and who we may become in the future" (p67).

**Identity development**

Identity development can be seen as a reflexive and two-way interpretive process. For ex-user drug workers, how they interpret their new identity will be determined by this interpretive process and will be influenced by the stage they are at when making identity claims. For example, earlier in transition journeys they may project an 'ex-user' or 'recovering addict' image "painting a dramatic picture with themselves as the heroes at the centre of the narratives" (Addenbrooke 2011, p10), while later they may distance themselves from their "spoiled identity" (McIntosh & McKegeney 2002) and portray what they consider to be a more 'professional' image. For example, Michael explained how he regularly disclosed his 'recovery' status early in his career but no longer sees this as being as relevant due to his other professional experiences (see p223). Here, the link between identity and disclosure is clear and is supported by a range of literature describing how our identities are influenced by the narratives we tell about ourselves (for example, Anthias 1999, Baumeister & Wilson 1996, Ben-Ari 2008, Bruner 2004).

**Professional identity**

Lindquist et al. (2006), in their study of physiotherapy students noted, "[h]ow graduating physiotherapists identify themselves as professionals and the extent to which each professional identity fits with expectations of health care now and over future years is of interest to educators and to future employers" (p274). I feel this importance can also be applied to practitioners in the substance misuse field, especially during the current economic and political climate which is seeing a number of pertinent changes, for example, the

recovery focus of the current National Drug Strategy (DH 2010), the incorporation of the NTA's substance misuse specific role into the more generic Public Health England in April 2013, and continuing economic recession. How ex-users see themselves as they make the transition from service user to substance misuse worker influences their interaction with other practitioners and clients as well as influencing how the 'profession' is seen as a whole. Connelly and Clandinin (1999) in their study of teaching practice noted the relevance of "ways that define who we are, what we do, and why, ways that retain our professional identity" (p115). This is also important for substance misuse practitioners but is harder to define, given the variety of roles, service providers and range of worker backgrounds. Teachers may develop a shared understanding of what it means to be a teacher, but is it possible to create and maintain a collective identity (Felstead et al. 2010) for substance misuse practitioners? Baldwin (2008) suggested that, "generic job titles with no relation to professional background and training will also reflect the intention to control a role more directly and concentrate on role performance rather than allowing the creation of a professional identity" (p114). Such generic drug worker roles might be considered congruent with DANOS (Skills for Health 2003) which are equally applicable to practitioners no matter what their initial training or background.

Some participants shared Baldwin's (2008) view that, "professional identity can be difficult to articulate" (p359), for example, Michael (see p226). In addition, Baldwin (2008) suggested that, "[n]o two individuals will share exactly the same interpretation of their professional identity because they will have experienced and interpreted the pressures in different ways" (Baldwin 2008, p359). Such perspectives may also be valid for substance misuse practitioners, including those from an ex-user background as even if two drug workers are working in the same organisation they may have different experiences of their role and interpret their professional identity in varying ways. Such differences may stem from the reality that even if two people have completed the same training courses or

worked in the same types of service, they will interpret that training and work experience differently because they bring different experiences and perceptions with them. In a similar vein, even if two ex-user drug workers previously used the same substances or engaged in similar treatment programmes, they will interpret their experiences in unique ways, again through bringing different experience and perceptions to that use/treatment and creating different experiences and perceptions as a result of that use/treatment. This can be seen in terms of hermeneutics as the multiple experiences fuse to create new perspectives or horizons, meaning that no experience or interpretation is 'fixed' but evolves through the bringing together of one's subjective view of past, present and future events (Presser 2008). By extension, this means all substance misuse practitioners, including those involved in this study, bring unique approaches to their role and professional identity. Therefore, it cannot be assumed that all practitioners are the same or work in the same way. This may be especially significant if agencies implement employment strategies, policies and protocols that treat all ex-user employees in stereotypical fashion, making judgments on their knowledge and skills-base or assumptions about their motivation for taking on the role of volunteer or paid employee. Just as national guidelines (for example, NTA 2007) advocate a tailored approach to working with individual clients, so should services tailor their approach to supporting ex-user drug workers and volunteers in their transition to new identities as professional drug workers.

Barton (2007) in her study of student nurses suggested that during the transition from one status to another "the student nurse practitioners moved into a professional and clinical limbo" (p343) so that "their uncertainties regarding their professional identities also became more pronounced" (p343). This is similar to the transition experience of many of this study's participants where, for example, Debbie described being in "limbo" as a volunteer, which may account for a lack of understanding regarding professionalism or having a professional status within the substance misuse field.

**Professional role models**

In terms of exploring what it means to work professionally and to developing a professional identity of their own, many participants including Michael, Adam, Elizabeth, Harry, Jamie, Luke and Nicola, encountered role models early in their careers, often while still a volunteer or even a client. For example, Michael and Luke were inspired by volunteer coordinators who were "brilliant" (Michael) and "amazing" (Luke) in their ability to encourage; develop skills and support their aspirations (see p215-216). Early influence gave participants insight into the type of worker they aspired to be. For example, Nicola was influenced by her then partner's drug worker when it came to developing ideas of what it meant to be professional – friendly, respectful, knowledgeable, but working within recognised boundaries (see p230). The power of role models continues beyond this early influence so ex-user drug workers, like the nurses in Barton's study (2007) when they were new to their role, "began to select role models from the multi-professional context, styling themselves on traits they observed from experienced clinical staff" (p344). Some of this study's participants echoed this experience, for example, Harry referred to the manager where he did his detoxification as a "mentor" (see p215) while Jamie stated he got "loads of advice from workers here who've never touched a drug in their lives". The participants not only sought role models from ex-user backgrounds but also practitioners from a range of backgrounds. As long as the role model demonstrated what they considered to be good practice, ex-user drug workers were keen to emulate this and learn from their experience. In this way both inter-professional and peer learning is facilitated.

**Voluntary & Statutory Sectors**

Most of the study's participants (Adam, Debbie, Kieran, Luke, Michael, Nicola and Phil) had experience of working and/or volunteering in both statutory and voluntary sectors. Elizabeth, Harry and Richard had only volunteered and worked in the voluntary sector while Jamie is the only participant to have volunteered and worked exclusively in statutory

services. For those participants with experience of both sectors, they noted differences in terms of professional status, practices, worker profiles and attitudes, for example, different life experiences and educational opportunities.

**Professional qualifications and training**

Initially, both Richard and Michael were keen to gain social work degrees as a recognised, professional qualification. While Richard decided against applying to do this qualification, feeling there was little point in pursuing his application because of previous convictions, Michael did apply. However, Richard's suspicions were accurate and the university's professional standards would not accept Michael because of his previous convictions and the relatively short period of time since he had been an active substance user (see p216).

Many participants showed commitment to training to assist them in their personal and professional development, for example, Elizabeth described many short courses she had completed (see p218) while Harry continued to value accredited training as this not only gave him much-needed skills but satisfied his "vanity, to get another degree". The attainment of the qualification was as important to Harry as the education process itself. The Level 3 Tackling Substance Misuse course was seen as pivotal in facilitating the transition to paid employment for many participants, for example Nicola (see p232) who believed she would not have obtained paid employment without it and Harry for whom it "spring-boarded me". Without the recognition this qualification conferred, they both felt the outcome of their job applications would have been very different.

Other participants noted the advantage having the Level 3 substance misuse qualification gave them not only when applying for jobs but once in them. This, again, relates to the notion of a hierarchy between practitioners. In the excerpt on p232, Luke highlighted his experience of this while also "othering" colleagues from nursing and social work

backgrounds to place them lower on the professional hierarchy. Notably, he described such colleagues as having "just moved from being a social worker or a nurse, and my role is probably better", implying their qualifications do not fully prepare them for their role with substance users while suggesting that in comparison his experience and qualifications did. This contradicts previous claims that higher level qualifications, such as nursing degrees, have more value than the Level 3 substance misuse course, affirming such differentials are perceptual rather than factual. Even though the participants were aware of benefits in undertaking a qualification such as the Level 3 Tackling Substance Misuse, further training and experience is necessary to maintain high standards of professionalism. Ghaye and Lillyman (2010) advocated that, "[c]ontinuing professional development is essential to all healthcare staff whatever their professional background or place of work" (p106). This applies equally to ex-user drug workers and volunteers as other practitioners. Yet, some participants suggested that because of their 'non-qualified' or 'volunteer' status, there were some training events for which they were not eligible, for example, Debbie stated she was not allowed to attend 'mapping' training as she was a volunteer. However, others talked of their appreciation of the range of training available to them throughout their careers, both as paid and unpaid workers, for example, Michael "did lots of training" and Nicola was "always on training".

**Induction, support, supervision and role**

As has previously been discussed, induction, support, supervision and clear role profiles are essential for both volunteers and paid employees. It has been noted that "[a]s the first stage of training for a volunteer it [induction] represents an important chance to have organisational structures explained, values conveyed and instilled and generally to be put at ease" (Adfam 2012, p10) and that effective supervision and appraisal policies are necessary to ensure a competent and confident workforce (NTA 2004). However, Adfam (2012) found evidence that "[i]nduction is an area where volunteers often report mixed

experiences" (p10). This was also true for this study's participants. For example, Jamie reflected that because he was volunteering where he had been in treatment, staff assumed no induction was needed. However, understanding how things operate from a client's perspective is different from how things operate from a worker's (whether paid or unpaid). Indeed, Jamie struggled initially with boundaries, giving some clients "the benefit of the doubt" after catching them smoking cannabis. At this point in his career, it was through such mistakes he learned how to implement appropriate boundaries rather than through induction or training.

Similarly, Debbie described how a lack of structured support when she was a volunteer left her feeling that she was "white-knuckling it". The implication of such negative experiences for volunteers like Jamie and Debbie could have been very serious for themselves but also for the clients they were supporting. Potential consequences include inappropriate interventions undermining clients' recovery; poor boundaries leaving volunteers vulnerable; bringing the service into disrepute; volunteers being dismissed or leaving their posts; and volunteers becoming stressed and as a result experiencing a relapse. It was not only volunteers who reported inadequate induction. Phil stated, "I think the worst one was probation where I turned up one day and I was doing the job same morning. I just learned from [shadowing colleague]". In contrast with the above negative experiences, participants appreciated effective induction, supervision and training when they did experience them, for example, although Phil described a lack of induction and supervision with some employers, he also had positive experiences in others (see p241-242) where there were opportunities for "mentoring", "regular supervision" and time to "find my feet".

Once established in paid roles, even if they are getting regular supervision and colleague support, individuals' roles can be affected by management changes and increased caseloads. Michael's stress levels were affected by a lack of role clarity and changes in

service delivery leaving him feeling de-skilled because his qualification did not meet a new service's treatment protocols within Michael's shared care role. Given the legal considerations associated with prescribing, it is questionable whether Michael should have had responsibility for prescribing decisions in the way he described his previous role (see p224-225), however, Michael felt competent in this area and when comparing himself with the nurses who are qualified for this prescribing role, he saw their level of competence as inferior.

**The meaning of Professionalism**

Professionalism was very important to participants. For example, Nicola used her standards to influence her colleagues' practice by challenging any prejudice her clients experience when they attend a multi-disciplinary service. Despite some colleagues' negative attitudes, Nicola believed her professional manner positively influenced how other staff saw her and her clients (see p235). Not all participants were as confident as Nicola in their understanding of the meaning of professionalism. For example, Michael stated he was uncertain what being professional means, but did outline key concepts whereby he viewed being professional as working within the service's guidelines, adhering to appropriate boundaries and being reliable. This notion of reliability as a key element of professionalism was also mentioned by Richard who stated, "if I say I'm going to do something, I do it. Reliable, yeah, that's professional to me". Although Michael was concerned he may have crossed professional boundaries on occasion (see p226), the fact that he was aware of this suggests he knew what both professionalism and boundaries meant within the context of his role.

Harry suggested that professionalism is more than a "nice sound-bite" and described the need to be "emotionally mature", while Luke stated professionalism was both a "lame" description and "a responsibility". It becomes apparent that the notion of being a

professional is open to interpretation with the meaning attached being complex and individually understood. From both Harry's and Luke's understanding of professionalism (see p227), it can be seen that there is more than one definition so that qualifications do not determine professional status any more than particular experiences, nor do adhering to boundaries carry more weight than having a given professional status. It is a combination of all these elements and more besides.

**Recovery identity**

As well as having a professional identity, ex-user drug workers have a 'recovery identity'. This concept relates to whether or not they disclose personal information and, if so, to what extent. It also relates to whether they identify themselves (and introduce themselves to clients and/or colleagues) as a 'professional' or as being 'in recovery'. White (2006) suggested that it is only in recent years that it has once more become acceptable for ex-users to be open about their drug-using past. It could be argued that this acceptability was reinforced by the 2010 National Drug Strategy which advocated the role of Recovery Champions (Inter-ministerial Group on Drugs, 2011). For many years, some ex-user drug workers kept their past substance use secret because of associated stigma. However, it is suggested that as there is now a "new recovery advocacy movement calling upon recovering people to put a face and voice on recovery, many...[drug workers] are again going public with their recovery status" (White 2006, p159). This may be a huge culture shift for some workers within the drug field if they have hidden their ex-user identity for many years meaning if they were to 'come out' at work to colleagues and clients who were previously unaware, there might be implications (positive and negative) for both individual workers and their colleagues/clients with whom they interact. Furthermore, such workers may have little practice in disclosure decision-making or techniques and without adequate guidance and support, may feel vulnerable as they adopt, and are seen as having, a different identity. However, not all ex-user practitioners felt their ex-user identity was no

longer stigmatised, for example, Debbie said, "I feel like I don't fit anywhere. I'm not a drug user anymore so I don't fit in that world. And in the non-drug using world, I'm an ex-druggie, so I don't fit in with that because of the stigma".

Further concerns continue about attitudes not having changed in all services so that it may not be as straight forward as everyone being able to be open because of the 'recovery agenda'. Some felt that other staff members had issues with their particular route of recovery for example, Michael described some colleagues as being "anti-twelve-step" while Elizabeth felt frustrated by a colleague's lack of understanding of what twelve-step programmes involve because "he hasn't got a clue" and gave clients misinformation (see p220). Both Michael and Elizabeth saw themselves as being *in recovery*, something in contrast, Harry adamantly refuted; he is *recovered* (see p228). It may seem like semantics to make such a distinction between 'recovery' and 'recovered', but for Michael and Harry, and many other ex-substance users, the difference affected the meanings they attached to their recovery journeys; their subsequent transitions to become drug workers; and how they interacted with clients and colleagues. Whether describing oneself as being 'in recovery' or 'recovered', McIntosh & McKegeney (2002) described a process of ex-users re-building their lives and adopting new identities:

> "The various components of their reconstructed lives promoted in the individuals a positive sense of themselves as people who could make a valuable contribution to society and who could build and maintain effective relationships with others. In short, they helped the recovering individuals to regain their self-respect and sense of worth" (McIntosh & McKegeney 2002, p122-3).

McIntosh & McKegeney talked about restored identities as if ex-user drug workers return to identities that pre-date their substance use. This contrasts with Sparkes and Smith's (1999) study of young men (mostly former athletes) following Spinal Cord Injury (SCI) where he

asserted that after experiencing a SCI, it is important that individuals seek 'new' rather than restored identities. Men with SCI cannot return to their former identity as while they may regain some mobility they will not return to their former athletic bodies. Aspirations for new rather than restored identities are also relevant to ex-user drug workers, at least as far as employment or professional identity is concerned. While they may wish to re-establish social roles such as son, daughter, partner, parent, and so on, they may not want to return to other prior identities or job roles. They are more likely to want a new, different sense of self. It is also possible, if not probable, that had they not experienced problematic substance use, they would not have aspired to become substance misuse practitioners. The transition to a drug worker identity is, therefore, a *new* career pathway that does not restore their former work identity.

For individuals who are a significant way along their recovery journey, the opportunity to reflect on their achievements to date, how they feel about their 'reconstructed lives' and to acknowledge various turning points and obstacles along the way can offer useful insight into their motivation for recovery and for becoming the type of drug worker they aspire to be. This process is not unique to ex-substance users, but is something that Eccleston et al. (2010) referred to in the following way:

> "Processes of 'becoming somebody' are sometimes a response to particular events, and sometimes events arise out of shifts and developments in identity and agency. For example, the evolution of a professional or occupational identity in a particular field, navigating uncertain labour and educational systems, changes in cultural identity for asylum seekers or migrants taking up educational opportunities in a new culture or for women returning to education after time at home might trigger a turning point or life event, or arise from one" (Eccleston et al. 2010, p7).

This study's participants could be considered to be aiming to become 'somebody' with new abstinent and professional identities through responding to particular events (for example, substance use and treatment) and/or experiencing a range of turning points along the way.

Reflective practice is facilitated by having someone to share one's narrative with and may in turn influence their identity. Frank (1995, p137) quoted in Sparkes and Smith (1999) suggested, "[p]eople who tell stories of illness are witnesses, turning illness into moral responsibility" (p89). In a similar vein, ex-users who tell their addiction and/or recovery stories also adopt the identity of witnesses, seeing their lives now as involving a moral responsibility to "give something back" (Best & Laudet 2012, p5).

**Professional boundaries**

Many participants referred to the importance of boundaries when it came to demonstrating professional approaches to their job roles. However, few reported formal boundaries training as part of their induction, whether as volunteers or paid employees, and some referred to learning about boundaries through 'trial and error'. As Michael described it, "I made some right cock-ups", while Jamie and Richard shared examples of early mistakes (see p217-218). As Michael, Jamie and Richard were volunteers or workers in the same agency where they had themselves been in treatment, a degree of tolerance to such mistakes allowed them to reflect on and learn from these mistakes. Other participants stated they were clear about boundaries from the beginning, for example, Luke stated he, "kept it all very boundaried" while Debbie said it was about being "a stickler for the rules".

Boundaries between work and home and between worker and client are not the only boundaries to be taken into consideration. There may be boundaries between workers to differentiate their distinct roles. However, within some substance misuse services and indeed many other health and social care fields, there has been a blurring of boundaries and professional roles. This has been welcomed in some arenas, but distrusted in others (Davies 2002b) with some qualified workers seeing colleagues with different qualifications or without qualifications as "meddling" (Davies 2002b, p33) in their role. It may be appropriate for workers to cross professional boundaries if there is an acceptable "rite of

passage" (Barton 2007, p345) through education and training, volunteering or paid employment experience, induction and supervision. Whether opportunities exist for such rites of passage will depend on the approach adopted by particular agencies and the attitudes of individual staff members and managers. Barton (2007) suggested these rites of passage do not guarantee successful achievement of acceptance into a desired professional identity, but stressed that such transitions are socially, culturally and professionally negotiated.

**Professional versus unprofessional practice**

It was not just through making mistakes or crossing boundaries that ex-user drug workers learned about the meaning of professionalism and boundary-keeping, it was through witnessing the mistakes of others. For example, Phil (see p240-241) described how he observed his first manager crossing boundaries with clients. By reflecting on these experiences, he learned what it meant to be, and not be, professional, and this influenced his future practice and decision-making. Phil was not the only participant to contrast professional and unprofessional practice. Elizabeth and Debbie both shared incidents where they witnessed what they considered unprofessional practice, for example, having heard other practitioners breach client confidentiality or talk in negative or judgmental terms about their client group (see p243). These examples directly contrast with the role models who inspired ex-users to become the type of drug worker they wanted to be. Instead, they learned what type of drug worker they did *not* want to be.

**Emergent identities**

As the participants told their narratives, they were, unconsciously perhaps, relating parts of themselves to the whole of their experience and vice versa, bringing their pre-understandings to their current experience and viewing their past through the lens of their current identities (Gubrium 1993). It would therefore be impossible to create a process-

map that visually represented all hermeneutic aspects of a person's life that contribute to the construction of their identity because the possibilities are infinite – the map would be too complicated. This complexity makes a mockery of the notion of simply labelling or stereotyping individual practitioners as 'ex-user' or 'professionally qualified' because "the self is actively narrated, dynamically accomplished as narrative practice provides the ever-developing stories that constitute our selves" (Holstein & Gubrium 2000, p124).

Narrative identity formation is relevant to both professional and personal identity development, making it as relevant for drug workers (whatever their background) as it is for drug users who tell their stories during their treatment and recovery journeys. McIntosh and McKegeney (2000) found that ex-substance users went through a number of stages to achieve their new "non-addict" identity:

> "firstly, in relation to the reinterpretation of aspects of their drug using lifestyle; secondly, in relation to the reconstruction of their sense of self and thirdly, in relation to the provision of convincing explanations for their recovery" (p1501).

This is perhaps why ex-user drug workers can be so effective in their role; they bring their pre-understanding of being a substance user to their new identity as a drug worker, but through reflexivity, they have reinterpreted their past experience in light of their current role. It is also relevant for qualified practitioners such as nurses and social workers in that, again through reflective practice, they reinterpret their nursing and social work training through the lens of their experience of working with substance users. It is reflective practice that makes such principles possible. The formation of a new identity is therefore a gradual, emergent process. A person is not one day a nurse, social worker or drug user and the next a drug worker, but over a period of time, the drug worker identity emerges, retaining elements of the previous identity while discarding others (Josselson 1987).

McAdams (1988) referred to such processes as "story revision" (p18) that result in "identity transformation" (McAdams 1988, p18) with some changes being dramatic and others so subtle, they are almost imperceptible. Whatever the scale of the change, McAdams (1988) suggested that, "[b]y integrating past, present and an anticipated future, identity provides human lives with unity and purpose" (McAdams 1988, p28). It may not just be about revising stories; it may be about selecting which stories to tell (Presser 2008) as this also influences one's identity formation and how one is seen by others. So, just as disclosure is selective, so is narrative, and, by extension, so too is identity development.

**Professional Identity Conclusion**

Policies and protocols relating to professionalism within individual drug agencies may include codes of conduct; requirements for supervision and appraisal; standards for service delivery; and multi-disciplinary working agreements while individual job descriptions will specify roles and responsibilities. However, being a professional or having a professional identity is about more than codes of conduct and job descriptions. It is about belonging to a recognised and respected professional group (Felstead et al. 2010); practicing in a way that demonstrates integrity and commitment (Giddens 1991); and taking responsibility for one's own professional development and decision-making (Ghaye and Lillyman 2010).

The participants in this study gave a number of different interpretations regarding what it meant to them to be 'professional,' for example, being reliable was important to Richard and Michael, while Nicola and Adam emphasised the importance of boundaries. For Harry, key factors included self-awareness; reflective practice; and commitment to continuing professional development and learning. Meanwhile, Luke felt professionalism was about being responsible and not bringing the service into disrepute, and Phil focused on the need to act in an ethical manner. What becomes clear from these different interpretations is that being 'professional' is about more than adopting a particular identity or job role. Having a

professional identity is not akin to wearing a particular hat; it evolves over time through effort and reflective practice. It is, therefore, unhelpful to label people with a particular identity as if this is a static entity instead of a life-long process (Davies 2002a, McAdams 2001). As a result, identity can be considered as a way of *being* and a way of *doing*. As Harry said, "this isn't just a job to me, it's a way of life. It's more than a job. And you have to have the right mind-set to be professional in that."

'Professional identity' may be considered a transition goal, but the dynamic nature of identity formation (McAdams & Janis 2004) reflects changes over time and circumstance meaning the process is as important as the resultant identity. Transition overlaps with identity formation and is, therefore, complex; affected by how individuals interact with their clients and colleagues. Indeed, identity development is also influenced by, if not determined by, prior experiences and pre-understandings (Alvesson & Sköldberg 2000) the ex-user brings to their drug worker role. Furthermore, our perception of identity changes over time as our past fuses with our present and influences our futures. In addition, we have multiple identities in our professional and personal lives which, again, affect our interactions with others; how we are seen by others; and how we see ourselves. At different stages of our lives, some parts of our identities will take priority over others, for example, early in recovery an individual might fore-ground their ex-user status but later project their professional identity more strongly (as Michael did, for example). Identity construction, including professional identity, occurs through interaction with others so it is in fact co-construction much like the development of narratives. In this way, the participants created their identity through the stories they told about themselves and their experiences, not just in this research but in the way they engage with clients and colleagues. Their identities may be seen differently from the perspective of colleagues compared to the perspective of clients where lived experience is more valued by clients than by other workers. Also, because no two people interpret their experience in the same way, no two people can ever

have exactly the same identity, meaning there is no value in labelling someone as an ex-user and expecting them to be the same as other ex-users. This applies equally for 'textbook drug workers', nurses, social workers, and so on.

Despite the complexities of identity formation described above, for many participants it was the 'simple' things that they felt influenced their professional identity status, for example, being seen as a 'competent' practitioner. However, for Harry and Adam, this involved having to prove themselves to colleagues over extended periods of time. Luke and Phil felt having a qualification enabled them to 'prove' their competence in accordance with DANOS and led to them registering with FDAP as they felt this national body conferred professional status irrespective of their background. Many felt qualifications were an important means of improving their status especially where their Level 3 Tackling Substance Misuse qualification was held in high regard.

It became apparent from the participants' narratives that a hierarchy exists within many substance misuse teams and that this is not necessarily helpful as it results in some roles being seen as less valuable than others. The notion of 'othering' (Baldwin 2008) where individuals and groups are seen as 'other' or 'less than' the group making the judgment results in the creation of an 'out-group' (Biggs 1997) that is not accepted as equal, causing damage to individual self-worth; team cohesion and inter-professional practice. Jamie described, for example, being treated as less knowledgeable than nursing staff even though he had worked in the substance misuse field for several years by the time he joined this team. Other participants, for example, Adam and Phil described a 'culture clash' between themselves and prison officer and police colleagues respectively. Such 'othering' did not just exist from qualified staff toward ex-users; it was also apparent in ex-user drug workers' views of qualified staff who were seen by some (and by clients) as 'textbook drug workers', for example, Harry. However, all the participants could be considered 'textbook

drug workers' because they have qualifications in addition to personal experience of substance use. The tensions created by 'othering' generally did not sit comfortably with the participants and many advocated that mixed teams consisting of both 'experts by experience' and 'experts by training' (Fox 2011) provide the optimal team profile.

The descriptions given by many participants, for example Adam, Jamie, Phil and Nicola, provided insight into how much they valued professional role models who showed them in practical terms what type of drug workers they aspired to become. Indeed, many explained how they started learning this while still in treatment (for example, Jamie), or were being supported by managers or volunteer coordinators in the early stages of their volunteering roles (for example, Michael). This meant that when they became drug workers, they brought with them a pre-understanding of what it meant to be professional.

Much of the literature refers to notions of restored or new identities (for example, McIntosh & McKegeney 2002). The hermeneutic circle would suggest that the reality is a combination of both restored and new identities as the pre-understandings from an individual's past fuses with the new experiences of the present and anticipated future goals, so that any 'restored identity' is in fact 'new'. No one can develop a brand new identity that does not incorporate elements of their past experience and this is also true for this study's participants as they bring their experience of substance use to their role of drug worker.

## Chapter 6 Conclusion and Recommendations

### Aims revisited

This study set out to understand the experiences of non-qualified drug workers and volunteers in their journey to become and develop as drug practitioners. This has primarily been achieved through an exploration of the participants' experiences of transition, disclosure and professional identity, alongside a range of related literature. Traditionally, stories from the substance misuse field explore drug users' experience of using drugs and their immediate experience of treatment and recovery, that is, how they achieve abstinence. Perhaps because many participants were more familiar with telling their story of substance use and treatment, many included these experiences in their narrative, even though they were asked to tell their story from the point at which they started making their transition to drug worker. Because this study aimed to explore what happens after this initial stage of their transition journey, that is, how participants sustained recovery and established 'new' or 'restored' identities, I focused the re-presentation of the narratives on how they achieved and sustained their identity as substance misuse practitioners.

### Transition

What became apparent in analysing the participants' transition narratives was that while there were some shared experiences, each journey was unique. This means there is no such thing as a typical ex-user drug worker any more than there is any such thing as a typical non-ex-user drug worker. The uniqueness of the transition experiences and the individuals themselves therefore makes a mockery of the polarised views of 'who makes the best drug workers' as described in the introduction. Defining ex-users as the 'best' or professionally qualified as the 'best' type of person to be substance misuse practitioners do not take their diversity and individuality into consideration. This means each person, no matter their background, should have their competence assessed on their individual merit.

Many participants in this study advocated the role of education in facilitating their transition to paid employment, including the Level 3 Tackling Substance Misuse qualification. This education complements their personal experience, not just of substance use, but of life in general. For ex-user drug workers, the optimal combination appears to be prior work experience (including in unrelated occupations, perhaps before or during problematic substance use); relevant education and/or qualifications; and volunteering experience in the substance misuse or other related field, such as homelessness. The participants' narratives show how complex their transition journeys were *after treatment was completed* with multiple personal and professional barriers vying for position against a range of educational and employment opportunities. The usefulness of these 'what happens next' narratives provide substance misuse services with insight, to more effectively guide ex-users through the processes of recruitment, induction, training, support, supervision and promotion.

In many participants' stories, key issues surfaced repeatedly, including the role key-workers had in instigating the notion of becoming drug workers while they were still in treatment. Such encouragement led to ex-service users expecting to make the transition to drug worker. What varied greatly between participants was the level and type of support available to assist them in this transition and how long it might take to achieve. Where ex-users were supported by their key-workers to make the transition into employment, it is clear existing drug workers perceived ex-users as potential colleagues with appropriate skills and attributes to offer.

**Disclosure**

No participants in this study (except Luke who was advised not to disclose at all) reported receiving guidance regarding disclosure decisions when they became volunteers or paid workers. This was a significant gap in the induction programme for all substance misuse practitioners. Service providers may assume ex-users (or, indeed, any other drug worker)

automatically know what and how to disclose safely. It became apparent from the participants' experience of disclosure that there is no obvious right or wrong answer to disclosure dilemmas.

Furthermore, the participants described a range of attitudes towards disclosure from their own, other ex-user drug workers', professional drug workers' and clients' perspectives. Some suggested limited disclosure was acceptable but too much disclosure was not; others reported they only disclosed if asked but would not volunteer the information, while still others felt it was appropriate to be open as long as they were not expected to go into detail. It is apparent from the participants' disclosure narratives that what and how much they disclose affects how they see themselves and how they are seen by others. This means disclosure decisions contribute to individuals' personal and professional identity.

**Professional Identity**

What becomes clear from the different interpretations is that being 'professional' is about more than adopting a particular identity or job role. Professional identities evolve over time through effort and reflective practice. It is, therefore, unhelpful to label people with one identity; as if this is a static entity instead of a life-long process (McAdams 2001, Davies 2002a). This is on a par with the aforementioned inappropriateness of trying to state one 'type' of drug worker is better than another 'type' – there is no one label held by an individual.

'Professional identity' may be a transition goal, but the dynamic nature of identity formation (McAdams & Janis 2004) reflects changes over time and circumstance; meaning the process is as important as any adopted status. The process of transition as it overlaps with identity formation is, therefore, complex; affected by how individuals interact with clients and colleagues. Indeed, identity development is also influenced by, if not

determined by, the prior experiences and pre-understandings (Alvesson & Sköldberg 2000) the ex-user brings to their drug worker role. Furthermore, our perception of identity changes over time as our past fuses with our present and influences our future aspirations. In addition, we have multiple identities in our professional and personal lives which, again, affect our interactions with others; how we are seen by others; and how we see ourselves. Because this study has explored the way in which an individual's past fuses with their present and anticipated future, it has been possible to identify key issues that affect their transition journeys, their disclosure decisions and professional identity. This means that we have a new, and better, understanding of what it means to embark on this journey so that drug and alcohol service and training providers should be able to learn from these experiences and offer suggestions to improve ex-users' experiences of making the transition to substance misuse practitioners.

**Link between transition, disclosure and professional identity**

Although I presented the findings under their respective headings of transition, disclosure and professional identity, within these distinct sections, I frequently cross-referenced to the other orientations to demonstrate how closely these issues interlink. If we take each interlinking factor in turn, it becomes clear that transition, disclosure and professional identity cannot be considered as distinct entities, but are in fact interdependent. It might be considered that there are three key elements regarding how these orientations interlink – reflexivity, interaction and narrative, each of which incorporate hermeneutic principles.

**Reflexivity**

When any individual embarks on a period of transition; formulates an identity; or decides to disclose personal information it is essential they reflect on the processes involved in order to understand, develop insight into, and make meaning of these life events. Without reflexivity, individuals remain unaware of how their identity is developing or how they

interact with the world in which they live. Elliott (2005) suggested that, "in relation to individual identity, in the simplest terms, reflexivity might be understood as a heightened awareness of the self, acting in the social world" (p153).

For this study's participants, reflecting on how they interacted during the interview and on their process-maps and transcripts, offered them the opportunity to gain insight into their transition journey, disclosure decision-making and professional identity. McLeod (1997) suggested that an individual "is aware of telling stories and (even at the same time) reflecting on the meaning and significance of these stories (client reflexivity)" (p117). This means that even as the participants were engaging in the narrative process, they were simultaneously reflecting on this experience and amending their narratives as a result. This links with "the concept of 'narrative editing' to underline the reflexivity of individual narrators: their ability to manage their own narrative performances and to suggest appropriate ways in which their stories may be heard and interpreted" (Elliott 2005, p129). In other words, through reflexivity, a narrator decides what stories to tell (disclosure); how they want to present themselves (identity); and this requires that an individual "constantly monitors, manages, modifies and revises the emergent story" (Gubrium & Holstein 1998, p170) as they continue on their transition journey. Reflexivity is, therefore, a key part of the participants' narratives of transition, disclosure and identity formation, especially as our narratives can change the course of our lives. With reflexivity comes interpretation and understanding or, as Widdershoven (1993) put it:

> "Our story is part of a history of interpretations, which changes the meaning of our life. By telling a story about our life, we change our life. In doing so, the story itself becomes richer, as it is filled with life experience. Thus experience and story may be said to c*ommunicate* with one another" (p13).

**Interaction**

How we interact with others and how they interact with us determines to a lesser or greater degree the success (or otherwise) of our transition journeys; how much or how little we disclose about ourselves; and how we see ourselves (and/or are seen by others). For this study's participants, this meant their interactions with clients, colleagues, friends and family influenced their life course and career options, while being involved in this study affected the narrative of their experiences so far. Squire (2008) noted the importance of "[i]nteractions between storyteller and listener, researcher and research participant in the co-construction of stories" (p41) while Sparkes and Smith (2008) went further to suggest that, "selves and identities are constructed and performed in and through narratives" (p296) and that these stories are "jointly constructed and take place within the flow of interaction" (p296).

Many authors, for example, Hepworth (2000), Holstein and Gubrium (2000) and Polkinghorne (2007), have discussed how identity, self-image and narratives are co-created not only within research studies but in day-to-day living. But it is not just how we interact with others, but how we interact with ourselves, what we tell ourselves *about* ourselves, and how self-aware we are through reflexivity that influences our identity. This is sometimes referred to as "internal dialogue" (Sparkes & Smith 2012, p246). In other words, there are complex processes of interaction simultaneously taking place for each individual, internally and externally, and within "a specific interpersonal context" (Lieblich et al. 1998, p9). Therefore, not only did I learn about participants' lives through interacting with them as they shared their process-maps and transition narratives, but "[t]hey learn by hearing themselves tell their stories, absorbing others' reactions, and experiencing their stories being shared" (Frank 1995, p1).

Through interaction, individuals acquire identities that may include being labelled as a particular 'type' of person. This may be a label they give themselves or are given by others. In some cases, this may be derogatory so that "individuals come to see themselves in the negative terms society assigns to them, and they develop the consequential self-concepts and negative self-feelings" (Holstein & Gubrium 2000, p53). For many participants in this study, this had been experienced at a number of stages in their transition journey, for example, Debbie continued to feel negatively labelled as a result of her ex-user identity. For others, it may be that society assigns them a positive identity so while it is still the case that "the individual comes to accept the identity and label, seeing himself or herself through others' associated eyes" (Holstein & Gubrium 2000, p53), the results build, rather than damage, self-esteem. For example, Jamie's colleagues encouraged him to see himself as a potential professional drug worker meaning he was able to adopt this identity.

**Narrative**

Narrative can be considered to link the three orientations of transition, disclosure and professional identity together within hermeneutic approaches as "through narrative we define who we are, who we were and who we may become in the future" (Crossley 2002, p67). In other words, it is through narrative we bring our pre-understandings from our past to fuse with our present experiences and it is the combination of these past and present events that shape our future aspirations and decisions. Furthermore, the whole narrative of our transitions influences what stories we tell, and what stories we tell influence our transitions. Storytelling in this context can be seen as a form of disclosure with individuals revising their stories (Draucker & Martsolf 2008) in light of how others respond to the content and manner of information sharing. Disclosure is therefore a key element of narrative throughout life-long transitions and identity development because what we tell others about ourselves directly relates to how we see ourselves and how we are seen by

others. Indeed, it could be considered that "[n]arrative practice lies at the heart of self construction" (Holstein & Gubrium 2000, p104).

Many ex-user drug workers developed their expertise in sharing their narratives (Gergen & Gergen 1991) through their own experience of treatment services where they were encouraged to tell their story of addiction, treatment and recovery. This means the participants in this study (with the exception of Kieran who never accessed services) already had experience of telling their story and so were able to present a "coherent identity" (Andrews et al. 2004, p113). Through their narratives, participants made "identity claims" (Andrews et al. 2004, p113), that is, they did not have a static, absolute identity that was universally accepted by others (or even by themselves). Rather, they *laid claim* to their identity as drug workers and were obliged to work hard to maintain this identity through interaction with clients, colleagues and managers. Part of the analysis of the participants' narratives involved reading for such identity claims (Andrews et al. 2004), that is, assessing how credible the claims are; how believable the narratives; how well the stories resonate with others' experiences; how consistent the stories are; and how much sense they make.

Not only were the interview-generated narratives jointly constructed between the interviewer and interviewee (McCormack 2005) but the interviewees brought with them pre-narratives that had previously been jointly constructed during their experience of drug use, treatment, volunteering and drug work. Interactions as a "collaborative enterprise" (Holstein & Gubrium 2012, p7) therefore co-create many personal narratives, not just in the stories disclosed by participants within this study, but also in the co-produced identities of substance user, service user, volunteer and drug worker earlier in their transition journey. Basset and Stickley (2010) suggested that, "narrative has become essential for people to have an identity" (p2) as without telling personal stories, it is impossible for individuals to understand themselves or for others to see who they are. Narrative is also the means by

which individuals share changes in their identity as well as the identity they carry forward from their past. This may be what Basset and Stickley (2010) meant when they described narrative as:

> "a way of balancing both the self that is constant and the self that is changing as we are able to make sense of ourselves through the stories that we tell ourselves (and others) about ourselves. The narrative, therefore, is a product of our constructing, deconstructing and reconstructing ourselves and our identities. It is fine that our stories change over time, and so they should, as we change and grow as people" (p2).

Certainly, it can be seen that the participants in this study shared narratives of how they changed from drug user to drug worker and how they grew into the role of substance misuse practitioner through constructing, deconstructing and reconstructing themselves and their identities. Individuals, including ex-user drug workers, view themselves in light of their prior experience and future aspirations so their identities integrate a range of aspects of their lives to create a sense of unity and direction. The creation of a "self-narrative" (McLeod 1997, p44) can assist people in bringing together many fragmented elements from different life stages and experiences. Identity can, therefore, be seen as developing within the context of whole lives by incorporating selected parts over time, through interaction with others and within complex social contexts. Without engaging in narrative, this study's participants may not have made the transition or adopted their current identities.

However, the past identities that individuals bring forward to fuse with their current and future identities have been edited and re-interpreted during their transition (Crossley 2000). In other words, people actively select which elements of their past they are willing to share in their narratives and which they are not (a form of selective disclosure). It could be argued that we create our identities through many self-narratives or through a "storied self" (McLeod 1997, p44) and in telling, and reflecting on, our own stories we discover and construct our identity and self-image (Carlander et al. 2011). For ex-user drug workers,

their narratives of substance use are told from the perspective of where they are now as drug workers, that is, their narratives have been edited and are shared for a specific purpose and to present themselves in a particular light. This could be seen as a way to "continually restory our pasts" (Mishler 1999, p5, quoted in Riessman 2003, p341) so that our narratives determine our identity status at any given point in our personal history. For example, stories told by participants as drug workers about their transition journey are likely to be different from the stories they used to tell when they were still using or in treatment. Gubrium and Holstein (1997) described such narrative links as "horizons of meaning" (p148) and advocated that through the context of narratives "stories [are] assembled by meaningfully linking together life experiences" (Gubrium & Holstein 1997, p148). This means that people change their perspective of past events in light of the lens through which they currently see their world, creating new meanings to attach to these experiences. For this study's participants, this resulted in them telling stories about their past experiences as substance users and volunteers while also expressing what these experiences mean to them now as drug workers. This concurs with "Gadamer's philosophical theory of interpretation...[which] requires that we try to see what the experience has to say to us, that we try to apply it to our present situation" (Widdershoven 1993, p13). Certainly, it is apparent that ex-user drug workers use their past personal experience of substance use to influence their current practice as drug workers.

In telling only selected stories from one's past, however, one must leave certain stories untold. Some narratives are therefore lost, meaning that aspects of an individual's previous identity may also be lost (Holstein & Gubrium 2000). For Adam, Nicola and Elizabeth who rarely disclosed, and Kieran who never disclosed, this meant the ability to demonstrate a "shared discourse of identity" (Holstein and Gubrium 2000, p117) with their clients was lost. For other participants who selectively disclosed only the elements of their past that put them and/or recovery in a positive light, then the narratives may be skewed and so not

necessarily reflect the full story of their transition journey. This may give an inaccurate impression of exactly what was involved in managing the transition. This does not mean that an ex-user drug worker should be compelled to share every detail of their life, simply that there needs to be sufficient levels of disclosure for the listener to understand the transition process and how identity changes through reflective practice, narrative and interaction with others. The stage an individual is at on their transition journey may also affect the identity disclosure choices made. For example, Adam chose to disclose his experience as a substance user earlier in his career when he was comfortable with this identity, but once he wanted to be seen as a professional, he distanced himself from such disclosures by sharing alternative narratives of volunteering and paid work experience. Both his substance use narrative and volunteering/drug worker narrative were his own, but they had different purposes, relevance and meaning at these different stages. Equally, motivation varies at these different transition stages, that is, individuals may be motivated to adopt particular identities, engage in certain activities (for example, education) and tell selected narratives depending on the desired outcomes. There is no one ex-user narrative. In summary, it can be seen that an individual's narrative is at the very heart of their life, and life itself is understood through narrative interpretation. Widdershoven (1993) advocated that storytelling is underpinned by hermeneutic principles so that:

> "the meaning of life cannot be determined outside of the stories told about it. Consequently life cannot be regarded as an independent touchstone for the adequacy of a story. Neither, however, can the meaning of a story be determined without any reference to human life as it is lived. Thus a story is never a pure deal, detached from real life. Life and story are not two separate phenomena. They are part of the same fabric, in that life informs and is formed by stories" (p2).

**Strengths and Limitations of the Study**

The main strength of this study was the participants themselves: their willingness to share details of their transition from substance user to substance misuse practitioner was

exceptional. The quality of their narratives was further enhanced because each individual set their own agenda through the use of process-mapping, making the interviews participant-led. In practical terms, the approach enabled participants to plot out their transition journey while verbally describing their experiences at each stage, the visual cues from their process-maps prompting further memories and insights. This resulted in rich, in-depth narratives emerging from the interaction between me, as the researcher, their process-map and their own storytelling. It is this co-production of their narratives that provided the depth and breadth of their unique experiences.

Another strength came from the purposive sampling technique which meant I could target people I knew were information-rich and eligible for the study. As I already had a professional relationship with each participant from being a tutor on the Level 3 Tackling Substance Misuse course, trust and rapport was already established. I had continued to have informal contact with some of the participants following their successful completion of the course but others I had not seen since they received their certificates.

A further strength came from the nature of the data analysis. I transcribed the narratives verbatim myself, seeing this as essential since without immersing myself in the data from the beginning, analysis opportunities are lost. Throughout the analysis process, I reflected on the narratives by relating the different themes (parts) to their wider story (whole) utilising hermeneutic principles while also comparing their verbal narrative with their visual process-map. Each step of the narrative analysis was logged; read and re-read; the recordings listened to again with the transcripts and process-maps in front of me; the narratives edited and reflected on time and time again.

At each stage of the analysis process, I engaged in reflective practice through my research journal; peer review through tutorials with my university supervisors; and consulted

participants on the accuracy of their process-maps and transcripts. By combining these approaches with holistic content-reading, participant involvement and hermeneutic principles, I worked to ensure the study's quality and trustworthiness.

As with most qualitative studies, a potential limitation is the small sample size. I set out with the intention of recruiting 8-12 participants for this study so was pleased when 11 consented to take part. This was partly to conform to the research norms for this type of narrative study (Sandelowski 1995) and also because I work full-time in addition to doing this research part-time, I had to be realistic about how much time was available to undertake the interviews and analyse the data. I feel the number of participants is acceptable given the vast amount and depth of data the eleven narratives generated.

While I see the purposive sampling approach as a strength, I also recognise its limitations. For example, there were no participants from other substance misuse courses or drug workers who had successfully made the transition without gaining this or a similar qualification. The sample also does not include ex-users who have not managed to make the transition (but who wanted to); ex-users who did not complete the course; or ex-user drug workers who have since relapsed. Non-ex-user drug workers are not represented in the cohort so the study can offer no comparison with other qualified staff. It is also possible that my previous role as a tutor with the participants may have led to the over-emphasis of the extent to which participants described the role of training in their transition narrative. Although, this may have introduced a different focus at times within some participants' narratives, it was useful to find out about this element of their journey as one of the research aims was to influence my own practice as a training coordinator.

As already stated, I did not intend to generalise (Carlander et al. 2011) the findings from this study to *all* ex-user drug workers (which could be considered a weakness), however, I

feel confident that readers will find that the narratives and their analysis resonate with their own experience as ex-user drug workers or their experience of working alongside ex-user colleagues (which could be considered a strength).

**Recommendations and Implications for Stakeholders**

I have identified a number of recommendations for practice and policy development within the substance misuse field and for ex-users making the transition to work in their field by reflecting on the findings relating to transition, disclosure and professional identity. Before presenting the many recommendations that have emerged from this study, it is important to highlight three key points that I feel warrant priority consideration:

- There should be no 'set' rules regarding whether or not an individual discloses their past substance use with disclosure being considered as a complex decision-making process not a simple 'yes' or 'no' decision. Instead, guidance and training should be offered regarding disclosure for all staff and volunteers from their earliest involvement (induction) with the service, for example, how to get the most out of disclosure, managing responses to others' disclosures, selective disclosure, how to set a disclosure 'ceiling', reflecting on disclosure decisions, disclosure goals, pros and cons, risks and benefits, professional and personal boundaries, confidentiality and privacy.
- Volunteers should have access to a range of learning and skills development opportunities in their volunteering role but also through fieldwork placements on nationally accredited substance misuse courses. Because of this research the Level 3 Tackling Substance Misuse course has already added the option of undertaking an Assessment and Care Planning placement as the lack of this experience had previously acted as a barrier for many volunteers when seeking paid employment.

- Service managers need to understand that motivation is not a fixed entity, including for ex-user volunteers and drug workers, meaning their initial motivation of 'giving something back' may change over time and other motivational and aspirational factors need to be considered and supported.

Because potential actions to enhance practice emerged from the analysis of the findings, I initially considered simply presenting the recommendations under the heading of each of the three orientations. However, I not only found that many overlapped, but that there were other more general considerations that were of equal relevance, for example, training and/or support needs. I have also identified a number of recommendations that are specific to ex-users which may be considered distinct from (but which complement) those aimed at service providers. The remaining recommendations are therefore presented in five categories: 1) Narrative and disclosure; 2) Induction, support, training, supervision and promotion; 3) Transition; 4) Motivation and identity; and 5) Ex-user transition strategies. All categories also include suggestions for further research.

**1. Narrative and disclosure-related recommendations:**

There is a lack of opportunities for ex-users to tell their transition narrative alongside their recovery narrative. Many of the participants were well-versed in their story of substance use and treatment but, for some, this was the first time they had narrated their later transition experiences. The participants had, however, made a range of disclosure decisions in their working lives and in this research, in terms of how much they disclosed and in what context. While there is not necessarily a 'right or wrong' to disclosure, it is apparent that this personal decision-making lacks guidance and support within the context of substance misuse services. This gap potentially leaves ex-users vulnerable if they do not find an appropriate level of disclosure to suit themselves, their clients and the service where they work/volunteer. The following recommendations aim to balance the importance of

narrative disclosure in enabling ex-users to act as role models, with the need to assist ex-users in selective disclosure decision-making so as to safeguard their own and their clients' wellbeing:

- Ex-substance users need to be offered more opportunities and support to tell their 'later' transition stories, not just their recovery narratives as this will provide them with the opportunity to identify and reflect on how far they have come on their own transition journey as well as enable them to act as role models by informing other ex-users about later-stage transition processes.
- Disclosure should be considered to be an intervention in its own right with a clear evidence-base, goals and rationale for utilising this intervention. This will enable drug workers to optimise the effectiveness of disclosure decisions.
- Disclosure should be explored as part of a wider discussion regarding professional and personal boundaries to keep both service users and volunteers/workers safe.
- The purpose and process of disclosure has been discussed in detail within this research with disclosure occurring regularly as a personal decision within drug services but often with limited guidance or support. Anecdotally, many participants viewed disclosure of past substance use as being beneficial for clients. However, there is little evidence to support or refute this. Further study is therefore needed to develop such an evidence-base for disclosure as an intervention within the substance misuse field.

**2. Induction, support, training, supervision and promotion recommendations:**

Within their transition narratives, many of this study's participants expressed concerns about inconsistencies and gaps in their induction, support, training opportunities, access to supervision; barriers to employment and promotion; and unrealistic expectations (on both the part of ex-users and service providers). By reflecting on their experiences, I have

identified a number of key factors that may contribute to a more positive experience of volunteering and employment opportunities and that would also, ultimately, enhance service delivery:

- A flexible, tailored, asset-based approach is needed in the recruitment, induction, support, training, supervision and promotion opportunities for all substance misuse practitioners, including those from an ex-user or carer background – this is because many participants identified a lack of such factors in their own experience, highlighting how these acted as barriers to their smooth transition.
- While flexibility is important to respond to individual ex-user transition needs, so too is consistency, transparency and parity to ensure fair access to a range of opportunities. Some participants felt they were treated unequally by colleagues compared to other practitioners and volunteers, leaving them feeling exploited or resentful.
- There should be clear role descriptions for all peer mentors and volunteers so ex-users know what is expected of them and they know what they can expect from the service as many felt their expectations and desire to be more involved did not match up with the tasks they were allowed to do.
- SMART goals should be agreed between the service and ex-user volunteers regarding roles, future roles and opportunities. This will enable ex-user drug workers and service providers to be clear about what can be expected from each other, and is particularly important in light of the findings where participants described uncertainty in their roles and/or had unrealistic expectations about how their career might progress.

- Supervision, appraisal and personal development plans should be available as standard for unpaid volunteers as well as paid staff to enable any difficulties to be identified early; to clarify and agree development needs and strengths.
- Ex-user peer mentors and volunteers need to be offered access to relevant education to enable them to gain the qualifications needed to make the transition to paid employment and/or gain promotion where desired.
- There should be inter-professional training available so paid staff and volunteers receive the same quality of training (subject to their needs and service objectives) and so there can be shared understanding and peer learning. This should include training for staff and volunteers regarding their respective roles and support needs.
- Training for staff and volunteers should include the meaning and practice of being 'professional' as well as practice principles, code of conduct, supervision, appraisal, multi-disciplinary working, reliability, roles and responsibilities. This will offer clarity and understanding of service expectations and contribute to all drug workers being seen as 'professional' within wider health and social care provision.
- Offering substance misuse qualifications higher than Level 3 needs to be considered so they are on a par with other national professional standards as this may address some of the tensions identified by participants in this study (for example Luke) that are associated with the existing 'hierarchy' of 'professionals'.
- Voluntary and statutory services should have policies and practices in place to increase standards and values in recruiting, supporting and training volunteers.
- The questionnaires utilised to identify the sample for this study have been analysed as a separate piece of work. These offer an evaluation of the impact of the Level 3 Tackling Substance Misuse course and provide further insight into the experiences not just of ex-users but of practitioners from other backgrounds. This will be

presented as an evaluation report to my service managers and disseminated to other substance misuse service managers in the North West.

3. **Transition-related recommendations:**

Although many of the above induction, support, training, supervision and promotion recommendations could be considered as relevant to transition goals, there are additional factors that may improve the transition experience of ex-user drug workers. For some of the participants in this study, their transition was achieved 'more by luck than by design' because of a lack of role clarity; multiple barriers to achieving key milestones; and inconsistent 'rules'. To address such concerns, the following recommendations have been devised:

- There need to be clear pathways (incorporating SMART (Specific, Measurable, Achievable, Resourced, Time-framed) goals for ex-users making the transition from treatment to volunteering but also when making the transition from volunteering to paid employment so everyone becomes clear and realistic about what is involved. This will address some of the complexities inherent in the transition process.
- Service providers need to be aware of difficulties and barriers facing ex-users, for example, previous convictions; moving from being in receipt of benefits to paid employment; lack of employment history; lack of job application and interview experience; lack of qualifications; stigma; and so on. Having identified such barriers, it is essential that service providers then work with ex-users to develop strategies and models of good practice that will overcome such concerns while also offering support in both practical and emotional terms as they attempt the transition.
- Although treatment may be complete for ex-users making the transition to volunteer or paid worker status, support is still needed and should be tailored to that individual. The role of peer mentor or navigator should be considered as a useful

stepping-stone in this transition. Service managers need to recognise there are no 'cut-off points', that is, the individual is not a service user with support needs one day and a volunteer without support needs the next.

- The 'two-year rule' is defunct (if it ever really existed) and should therefore not be referred to formally or informally. Instead, ex-users should be assessed on their individual merits and given a choice of roles from a continuum of opportunities suited to their stage of recovery, skills and confidence; for example, peer mentor, volunteer, recovery champion, sessional worker, support worker, generic drug worker, and so on.
- Ex-user drug workers should be encouraged to identify and utilise transferable skills in recognition of the fact that they do not arrive with a 'blank slate' as volunteers but have a range of existing attributes to offer.
- From this current study, the role of inspirational substance misuse practitioners became apparent as instigators of ex-users' transition processes. Exploring their role in identifying service users 'with potential'; nurturing their ambitions; and facilitating the transition process, will be useful to develop an understanding of these key components and developing further opportunities, guidelines and enhanced practices.
- Further studies into the later stages of the transition process, that is, once structured treatment has ended and peer mentoring/volunteering has begun, is necessary to understand these transition processes and to share the experiences of managing and sustaining significant life and career changes. The sharing of such narratives needs to become as commonplace as the sharing of earlier recovery journeys.
- While the purposive sampling used in this research was useful to identify eligible participants, it resulted in other possible stories not being told, for example, ex-users who did not complete the transition, ex-users who relapsed, and ex-users who

did other courses or who achieved drug worker status without qualifications. Undertaking additional study to include a wider cohort will provide further insight into a range of transition journeys.

**4. Motivation and Identity-related recommendations:**

It became apparent from the participants' narratives that there are a range of motivational factors relevant to individuals attempting the transition to drug worker, including not only the traditional 'giving something back' but also motivation in relation to identity status, financial reward and job satisfaction. In addition, there were several considerations that influenced identity status, for example, educational attainment, job title, and respect. Furthermore, how ex-users see themselves and how they feel they are seen by others affects how they feel about themselves, their job or volunteering role and future ambitions; such factors have implications for practice and how individuals are supported throughout:

- Service managers need to be aware of identity formation issues when ex-users make the transition to paid employment via volunteering so they recognise that during this period of being in 'limbo' there are likely to be additional support needs and they can take appropriate steps to work with ex-users throughout this challenging time.
- Service managers and substance misuse practitioners need to recognise the value of *both* education and experience – practitioners are not either 'textbook drug workers' or 'experts by experience'; both can complement the other.
- Mutual respect between practitioners is needed – respect for education and respect for experience - as each worker has valuable contributions to make to service delivery. Indeed, having a 'mixed' team was cited by many participants as the optimal resource where there is open dialogue to facilitate skills-sharing.

- Service managers should consider the pros and cons of positive discrimination, for example, through the employment of recovery champions. Many ex-users do not want to get a job solely on the basis of their ex-user status; they want their personal attributes and skills to be the deciding factor.
- Reflective practice should be encouraged for all substance misuse practitioners as this facilitates greater personal and professional insight and assists in the development of effective practice and boundaries.
- A greater understanding of what motivates ex-users at different stages of the transition journey is also necessary. This will identify what guidance, support, opportunities, and so on, may be necessary to facilitate such aspirations. This research has identified a range of motivational factors challenging the exclusivity of the 'giving something back' story. Further work is needed to better understand the breadth and depth of ex-users' motivations.

**5) Ex-user transition strategy recommendations:**

There are many stakeholders included in all of the above recommendations, for example, service providers, training providers, researchers and ex-substance users. However, it is important to elicit from this study recommendations specifically focused at ex-users as this may facilitate their transition to paid employment in the substance misuse field and enable them to be self-determining rather than solely relying on service providers to make structural changes. While the suggestions are based on the experiences described by this study's participants, they are, of course, open to the personal reflections and interpretations of other ex-users reading this thesis. These recommendations are therefore not intended to be used as a 'how to' guide, but rather highlight issues for ex-users to consider as they undertake their recovery journey:

- Ex-users may need to seek out a mixture of volunteering, education and paid employment opportunities. Many participants in this study suggested this as the optimal combination that enhanced their employment prospects. The volunteering need not be directly in the substance misuse field – participants found that related fields, such as homelessness, can act as a gateway into the substance misuse field at a later date. While access to education (whether substance misuse, counselling, psychology, social work or another related qualification) may be prohibited by course fees, there are local and national grant-making bodies that are available and many training providers are happy to assist the application process, for example, with a letter of support, or may be willing for payments to be made in instalments. Some voluntary and statutory services are also able to fund or part-fund courses for committed volunteers within their service. Any employment, even that which is unrelated to the substance misuse field, can provide opportunities to develop transferable skills and can enhance job applications especially if there are other gaps in an individual's employment record – no experience is without value. Such a combination as described here can only complement an ex-user's lived experience of substances.
- When applying for volunteering and paid posts within the substance misuse field, ex-users should highlight the transferable skills, as well as the lived experience, that they can bring to their role(s). This is likely to create greater opportunities and may enhance how others (colleagues and clients) perceive their abilities.
- Ex-users may need to be prepared to defend any previous convictions when applying for volunteering or paid posts, that is, they may need to explain the context of drug-related offences. Such convictions need not prohibit employment, but some prior offences may continue to constitute a barrier, especially in certain sectors, such as teaching, nursing or prison-based services. In this case, ex-users may wish to reflect on the viability of challenging adverse decisions (making use of

relevant support with this) or consider whether an alternative career path may need to be pursued.

- Ex-users should reflect honestly on what they need to do (for example, education, voluntary experience, addressing personal issues, skills development, and so on) in order to achieve their goals and should be realistic with regards to the length of time it is likely to take. It may be worth considering that if it takes social workers and nurses 3 years to gain their qualifications before starting paid employment, a similar timescale involving a combination of volunteering and training might need to be anticipated by ex-users.
- Ex-users need to give consideration to their disclosure decision-making as early as possible in their recovery journey. This can be done through reflective practice; weighing up the pros and cons; and/or talking the options through with a trusted friend, drug worker, counsellor, sponsor or fellow volunteer/peer mentor. It has already been recommended that disclosure be covered in a new volunteer's induction or training programme but if this is not the case, ex-users should ask for this to be added to the programme or for the opportunity to discuss this in supervision or team meetings.
- Once in peer mentoring or volunteering roles, ex-users should ask their volunteer coordinator or manager for the opportunity to negotiate a personal development plan which sets SMART goals; clarifies their roles and responsibilities; and creates opportunities for training, future aspirations and career pathways.
- Ex-users, indeed any other volunteer and paid employee, should make good use of the support, supervision and training available within their organisation. As regular supervision is considered to be a model of good practice, if supervision is not offered as standard to volunteers, ex-users should ask for this to be made available.

- If ex-users are involved in sharing their recovery story with current service users, the story of their later transition into volunteering and employment should be given equal emphasis to that of their earlier experience of substance use and treatment. This may not only inspire others to make the transition but also offer a more realistic awareness of what is involved in achieving such goals.
- Ex-users, including ex-user volunteers and drug workers, may wish to seek out opportunities to be involved in further research. This could be as either researchers or as participants in a range of relevant studies.

I set out to identify areas for practice improvements and feel the above recommendations, if adopted, will facilitate this, not only for my own practice but for that of local and national service providers. I also hope ex-user drug workers and potential ex-user drug workers will read and reflect on versions of this study to influence their own ambitions, transition journeys, disclosure decisions and professional development. For this to be possible, it is important that service users, peer mentors, volunteers, substance misuse practitioners and service managers have access to the findings and recommendations in a digestible form.

**Dissemination**

Dissemination of this research is required to allow substance misuse practitioners, service providers, policy-decision-makers and academics access to enable them to utilise these findings. It is my intention to present this research to my employers; to make the final research report available in the Trust Knowledge and Information Library; and to utilise the findings to enhance the training delivery within my team. Through journal articles (both academic and 'professional') and national and local recovery conferences, I will disseminate the findings so this may influence wider policy and practice. Many participants have asked for a copy of the final report and this will be forwarded to them.

A review of the effectiveness of these recommendations will be carried out in 5 years as this will be essential to review how policies and practices have developed and/or to assess the impact of any changes.

**Final words**

This study has explored the experiences of ex-users and carers as they make the transition to substance misuse practitioners. The transition narratives have taken the reader through a range of barriers (for example, negative staff attitudes, lack of prior work or educational achievement, previous convictions) and opportunities (for example, positive role models, access to support and training, volunteering, employment). Along each journey, participants have made decisions about what, how much and to whom to disclose personal information; often based on their perception of the risks and benefits of such disclosures. As the reader has followed the narratives, it has been possible to observe how each participant's identity has evolved depending on their transition stage and disclosure decisions. The interlinking of transition, disclosure and identity development has undoubtedly created a unique experience for each individual.

I feel this study to be especially pertinent at this time as many substance misuse services are recruiting 'Recovery Champions', welcoming applications exclusively from ex-users, the result of which is 'disclosure by default' as all colleagues and clients know they are ex-users from the definition of their role. While 'Recovery Champions' are a welcome addition to employment opportunities for ex-users, there may be implications for their confidentiality, identity and professional relationships yet to be considered. By reflecting on the implications of this study, I hope it will be possible to influence the experiences of ex-users as they make the transition to become drug workers whether they make the transition into employment via the route of recovery champion or other volunteering or educational

opportunities, while also enabling services to better support all substance misuse practitioners throughout their careers.

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# APPENDIX A

# Questionnaire

## Narrative Study of How Non-qualified and Ex-drug Users Make the Transition to Paid Employment in the Substance Misuse Field

- Please read each section and all questions carefully.

- While I would welcome a full response to all the questions, if there are any elements of the questionnaire that you are not comfortable with, you have the option to leave them unanswered – please mark these questions with 'N/C' (Not Comfortable) so that I know that you have not inadvertently missed out this question.

- If you feel any of the questions do not apply to you/your situation, please mark these questions with 'N/A' (Not Applicable).

- Please remember that you do not have to give your name so feel free to be frank about your experiences. If you do choose to give your name on the detachable sheet at the end of the questionnaire, the information you give will be treated in the strictest confidence.

- If you feel there is insufficient space to give as full an answer as you would like to an individual question, please use the last page to add further information, marking each additional comment clearly with the section and question number.

- If you require assistance with any aspect of the questionnaire or have any questions regarding the project, please contact me on 0161-772 3788 or 0771-751 3710. If I am not available when you ring, please leave a message and I will get back to you as soon as possible.

**Thank you**

**Sheila Wilson**

**Section 1 Course and Personal Details:**

1. **Which course did you complete?**

| |
|---|
| ☐ Level 3 Certificate (Advanced) in the Management of Substance Misuse |
| ☐ Level 3 Award in Tackling Substance Misuse: Practitioner |

2. **When did you complete this course?**

| | | | | | |
|---|---|---|---|---|---|
| ☐ 2004 | ☐ 2005 | ☐ 2006 | ☐ 2007 | ☐ 2008 | ☐ 2009 |

3. **Age when completed the course:**

| | | | |
|---|---|---|---|
| ☐ 20-24 | ☐ 25-29 | ☐ 30-34 | ☐ 35-39 |
| ☐ 40-44 | ☐ 45-49 | ☐ 50-54 | ☐ 55-59 |

4. **Gender:**

| | |
|---|---|
| ☐ Female | ☐ Male |

5. **Ethnicity:**

| | |
|---|---|
| ☐ White | ☐ Black Caribbean |
| ☐ Black African | ☐ Black Other (please specify) |
| ☐ Indian | ☐ Pakistani |
| ☐ Bangladeshi | ☐ Chinese |
| ☐ Other/self-identification (please specify) | |

6. **Employment status:**
**Employment Status when you started the course (please tick all that apply):**

| | | |
|---|---|---|
| ☐ Unemployed | | |
| ☐ Volunteer:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Trainee:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Sessional worker:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Part-time:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Full-time: | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |

7. **Employment status when you completed the course (please tick all that apply):**

| | | |
|---|---|---|
| ☐ Unemployed | | |
| ☐ Volunteer:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Trainee:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Sessional worker:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Part-time:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Full-time: | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |

1

**8. Employment status now (please tick all that apply):**

| | | |
|---|---|---|
| ☐ Unemployed | | |
| ☐ Volunteer:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Trainee:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Sessional worker:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Part-time:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |
| ☐ Full-time:- | ☐ In drug/alcohol field | ☐ Not in drug/alcohol field |

**9. Other Qualifications (please tick all that apply):**

| | | | |
|---|---|---|---|
| ☐ None | ☐ NVQ Level 1 | ☐ NVQ Level 2 | ☐ NVQ Level 3 |
| ☐ GCSE | ☐ A Levels | ☐ Diploma | ☐ Degree |
| Other (please specify) | | | |

**10. Length of time volunteering: If you have been/are a volunteer in the substance misuse field, for how long have you done so?**

| | | |
|---|---|---|
| ☐ Less than 1 year | ☐ Between 1 & 3 years | ☐ Between 3 & 5 years |
| ☐ Between 5 & 7 years | ☐ Between 7 & 9 years | ☐ More than 9 years |

**11. Length of time in employment: If you have been/are employed in the substance misuse field, for how long have you done so?**

| | | |
|---|---|---|
| ☐ Less than 1 year | ☐ Between 1 & 3 years | ☐ Between 3 & 5 years |
| ☐ Between 5 & 7 years | ☐ Between 7 & 9 years | ☐ More than 9 years |

**12. How would you describe the 'route' you took into the substance misuse field? (please tick all that apply to you)**

| |
|---|
| ☐ I have another relevant professional qualification, e.g. nursing/social work |
| ☐ I have experience of working/volunteering in a similar field, e.g. homelessness |
| ☐ I am an ex-service user who is offering my experience to help others |
| ☐ I am a carer of a service user/ex-service user who is offering my experience to help others |
| ☐ I am/was a volunteer working towards paid employment in the substance misuse field |
| ☐ Other (please use your own words to describe how you came to work/volunteer in the substance misuse field) |

2

**Section 2 Course Experience**

1. **What <u>new</u> skills did you gain through your participation in the course? (please tick as many boxes as apply)**

| | | |
|---|---|---|
| ☐ Assessing Need | ☐ Interview techniques | ☐ Reflective practice |
| ☐ Writing a care plan | ☐ Monitoring a care plan | ☐ Amending a care plan |
| ☐ Engaging clients in the care planning process | ☐ Partnership working | ☐ None |
| ☐ Other (please specify) | | |

2. **What <u>existing</u> skills do you feel you have <u>developed</u> through your participation in the course? (please tick as many boxes as apply)**

| | | |
|---|---|---|
| ☐ Assessing Need | ☐ Interview techniques | ☐ Reflective practice |
| ☐ Writing a care plan | ☐ Monitoring a care plan | ☐ Amending a care plan |
| ☐ Engaging clients in the care planning process | ☐ Partnership working | ☐ None |
| ☐ Other (please specify) | | |

3. **What <u>new</u> knowledge did you gain through your participation in the course? (please tick as many boxes as apply)**

| | | |
|---|---|---|
| ☐ Biological Issues | ☐ Psychological Issues | ☐ Sociological Issues |
| ☐ Prevention | ☐ Harm Reduction | ☐ Models of Care |
| ☐ Pharmacological Treatment | ☐ Psychosocial Treatment | ☐ Types/levels of assessment |
| ☐ The Treatment Continuum | ☐ Care Planning Approaches | ☐ Evidence-based practice |
| ☐ NTA/DAAT issues | ☐ Alcohol Issues | ☐ Criminal Justice Issues |
| ☐ Dual Diagnosis Issues | ☐ Shared Care issues | ☐ Young People's Issues |
| ☐ None | Other (please specify) | |

4. **What <u>existing</u> knowledge do you feel you have developed through your participation in the course (please tick as many boxes as apply)**

| | | |
|---|---|---|
| ☐ Biological Issues | ☐ Psychological Issues | ☐ Sociological Issues |
| ☐ Prevention | ☐ Harm Reduction | ☐ Models of Care |
| ☐ Pharmacological Treatment | ☐ Psychosocial Treatment | ☐ Types/levels of assessment |
| ☐ The Treatment Continuum | ☐ Care Planning Approaches | ☐ Evidence-based practice |
| ☐ NTA/DAAT issues | ☐ Alcohol Issues | ☐ Criminal Justice Issues |
| ☐ Dual Diagnosis Issues | ☐ Shared Care issues | ☐ Young People's Issues |
| ☐ None | Other (please specify) | |

5. **What skills gained and/or developed through your participation in the course have you used since? (please tick as many boxes as apply)**

| | | |
|---|---|---|
| ☐ Assessing Need | ☐ Interview techniques | ☐ Reflective practice |
| ☐ Writing a care plan | ☐ Monitoring a care plan | ☐ Amending a care plan |
| ☐ Engaging clients in the care planning process | ☐ Partnership working | ☐ None |
| ☐ Other (please specify) | | |

6. **What knowledge gained and/or developed through your participation in the course Have you used since? (please tick as many boxes as apply)**

| | | |
|---|---|---|
| ☐ Biological Issues | ☐ Psychological Issues | ☐ Sociological Issues |
| ☐ Prevention | ☐ Harm Reduction | ☐ Models of Care |
| ☐ Pharmacological Treatment | ☐ Psychosocial Treatment | ☐ Types/levels of assessment |
| ☐ The Treatment Continuum | ☐ Care Planning Approaches | ☐ Evidence-based practice |
| ☐ NTA/DAAT issues | ☐ Alcohol Issues | ☐ Criminal Justice Issues |
| ☐ Dual Diagnosis Issues | ☐ Shared Care issues | ☐ Young People's Issues |
| ☐ None | Other (please specify) | |

7. **If you have used any of the skills/knowledge mentioned above in your job/volunteering role, please describe, in your own words, how you have used these:**

8. **In which type of service did you undertake your placement?**

| | |
|---|---|
| ☐ Community Drug Team | ☐ In-patient Detox |
| ☐ Young People's Service | ☐ Criminal Justice (community) |
| ☐ Criminal Justice (prison) | ☐ Dual Diagnosis |
| ☐ Community Alcohol Team | ☐ Structured Day Programme |
| ☐ Needle Exchange/drop-in | ☐ Outreach Service |
| ☐ Housing/homelessness | ☐ Residential Rehab |
| ☐ Other (please specify) | |

9. **Since completing the course, how would you rate your confidence levels in your job/volunteering role?**

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| Greatly increased | Increased | Same as before the course | Decreased | Greatly decreased |

10. **If you have started a new job or gained a promotion since completing the course, do you think your completion of the course was a factor in your achievement?**

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree |

11. **Do you feel the skills/knowledge covered on the course are transferable to other professions/roles?**

☐ Yes ☐ No

12. **Do you have a Personal Development Plan (PDP) in your current place of work/ volunteering?**

☐ Yes ☐ No

**If yes, has participating in the course enabled you to achieve any of your development goals?**

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree |

**Comments:**

13. **On a scale of 1-9 (where 9 is the most knowledgeable), how much do you feel you know about DANOS (Drug and Alcohol National Occupational Standards)?**

1 2 3 4 5 6 7 8 9 (please circle)

14. **Have you discussed DANOS with your line manager/supervisor, e.g. as part of your PDP or in supervision?**

☐ Yes ☐ No

5

15. **Please read the list of DANOS Practitioner Competencies on the next page - and use the left hand column to tick all the issues you feel were covered in the course.**

16. **Which of the DANOS competences do you feel are the most relevant to your job/volunteering role (please write your top 5 DANOS units below in order of greatest relevance (1 being the greatest relevance))?**

| Top 5 relevant competencies | DANOS Unit Code Number |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |

17. **What skills, knowledge, attributes and/or competencies are not included in DANOS that you think are important in order to be a 'good drug/alcohol worker'?**

| DANOS UNITS | |
|---|---|
| AA1 | Recognise indications of substance misuse and refer individuals to specialists |
| HSC233 (AA2)* | Relate to, and interact with, individuals |
| HSC330 (AA3)* | Support individuals to access and use services and facilities |
| HSC3111 (AA4)* | Promote the equality, diversity, rights and responsibilities of individuals |
| GEN21 (AA5)* | Interact with individuals using telecommunications |
| HSC35 (AA6)* | Promote choice, well-being and the protection of all individuals |
| HSC226 (AB1)* | Support individuals who are distressed |
| AB2 | Support individuals who are substance users |
| AB3 | Contribute to the prevention and management of abusive and aggressive behaviour |
| HSC335 (AB4)* | Contribute to the protection of individuals from harm and abuse |
| AB5 | Assess and act upon immediate risk of danger to substance users |
| HSC356 (AB6)* | Support individuals to deal with relationship problems |
| AB7 | Provide services to those affected by someone else's substance use |
| HSC395 (AB8)* | Contribute to assessing and act upon risk of danger, harm and abuse |
| HSC387 (AB9)* | Work in collaboration with carers in the caring role |
| HSC388 (AB10)* | Relate to families, parents and carers |
| HSC33 (AC1)* | Reflect on and develop your practice |
| GEN36 (AC2)* | Make use of supervision |
| AC3 | Contribute to the development of the knowledge and practice of others |
| GEN33 (AC4)* | Enable other workers to reflect on their own values, priorities, interests and effectiveness |
| GEN35 (AC4)* | Provide supervision to other individuals |
| AD1 | Raise awareness about substances, their use and effects |
| ENTO L10 (AD2)* | Enable learning through presentations (Facilitate learning through presentations and activities)** |
| ENTO L13 (AD3)* | Enable group learning (Facilitate group learning)** |
| AD4 | Develop and disseminate information and advice about substance use, health and social well-being |
| AE1 | Test for substance use |
| AF1 | Carry out screening and referral assessment |
| AF2 | Carry out assessment to identify and prioritise needs |
| AF3 | Carry out comprehensive substance misuse assessment |
| AG1 | Develop, implement and review care plans for individuals |
| AG2 | Contribute to care planning and review |
| AG3 | Assist with the transfer of individuals between agencies and services |
| AH1 | Prescribe controlled drugs for substance users |
| AH2 | Prepare for, and administer medication to individuals, and monitor the effects |
| AH3 | Supply and exchange injecting equipment for individuals |
| HSC225 (AH4)* | Support individuals to undertake and monitor their own health care |
| CHS12 (AH5)* | Undertake treatments and dressings related to the care of lesions and wounds |
| CHS19 (AH6)* | Undertake physiological measurements |
| AH7 | Support individuals through detoxification programmes |
| AH8 | Pharm 07 Receive prescriptions from individuals; Pharm 08 Confirm prescription validity; Pharm 09 Assemble prescribed items; Pharm 10 Issue prescribed items; Pharm 11 Prepare extemporaneous medicine for patient use (Dispense medicines and products)** |
| AH9 | Supervise methadone consumption |
| AH10 | Carry out brief interventions with alcohol users |
| AH11 | Prepare prescriptions for controlled drugs |
| AH12 | Enable individuals to take their medication as prescribed |
| AI1 | Counsel individuals about their substance use using recognised theoretical models |
| AI2 | Help individuals address their substance use through an action plan |
| AI3 | Counsel groups of individuals about their substance use using recognised theoretical models |
| AJ1 | Help individuals address their offending behaviour |
| AJ2 | Enable individuals to change their offending behaviour |
| HSC347 (AK1)* | Help individuals to access employment |
| HSC348(AK2)* | Help individuals to access learning, training and development opportunities |
| AK3 | Enable individuals to access housing and accommodation |
| HSC345 (AK4)* | Support individuals to manage their financial affairs |
| HSC346 (AK4)* | Support individuals to manage direct payments |

*The codes in brackets indicate the previously used DANOS unit codes

**The title in brackets indicate the previously used DANOS unit title

7

**Section 3 Ex-Service User/Carer Experience**

**Please only complete this section if you ticked either "I am an ex-service user who is offering my experience to help others" or "I am a carer of a service user/ex-service user who is offering my experience to help others" in Question 12 of Section 1. If you ticked neither of these, please go to Section 4.**

1. **During the course, did you disclose your ex-user/carer status to other course members?**
   ☐ Yes ☐ No
   **If yes, did you experience any difficulties as a result of this disclosure?**
   ☐ Yes ☐ No
   **If yes, please describe these difficulties:**

2. **During the course, did you disclose your ex-user/carer status to the course tutors?**
   ☐ Yes ☐ No
   **If yes, did you experience any difficulties as a result of this disclosure?**
   ☐ Yes ☐ No
   **If yes, please describe these difficulties:**

3. **Did your ex-user/carer status restrict your placement options?**
   ☐ Yes ☐ No
   **If yes, please describe how/why your options were restricted:**

**4. Did you disclose your ex-user/carer status to your placement host agency?**

□ Yes □ No

**If yes, did you disclose this information to:**

| | |
|---|---|
| □ Placement supervisor only | □ Selected Staff team only |
| □ All staff members | □ Service users |

**If you disclosed your ex-user/carer status to any of the above during your placement, did you experience any difficulties as a result?**

□ Yes □ No

**If yes, please describe these difficulties:**

**If you did not disclose your ex-user/carer status to any of the above during your placement, why did you decide not to do so?**

| |
|---|
| □ Host agency were already aware of my situation |
| □ Did not feel the host agency needed to know |
| □ Was worried that if the host agency knew, they would refuse to give me a placement/would discriminate against me |
| □ Other reason, please describe: |

**3. Is your usual place of work/volunteering aware of your ex-user/carer status?**

□ Yes □ No

**If yes, who is aware of your situation (please tick all that apply)?**

| | |
|---|---|
| □ Line manager/supervisor only | □ Selected staff members only |
| □ All staff members | □ Service users |

**If you have disclosed your ex-user/carer status to any of the above, have you ever experienced any difficulties as a result?**

□ Yes □ No

**If yes, please describe these difficulties:**

9

**If you have not disclosed your ex-user/carer status to any of the above, why did you decide not to do so?**

| |
|---|
| □ Organisation were already aware of my situation |
| □ Did not feel the organisation needed to know |
| □ Was worried that if the organisation knew, they would have refused to give me a job/volunteer placement and/or would discriminate against me |
| □ Other reason, please describe: |

4. **Do you feel that your ex-user/carer status has (please tick all that apply):**

| |
|---|
| □ been a significant factor in preventing you from obtaining employment in the substance misuse field |
| □ been a significant factor in preventing you from accessing training in the substance misuse field |
| □ been a significant factor in preventing you from obtaining promotion in the substance misuse field |
| □ been a significant factor in enabling you to obtain employment in the substance misuse field |
| □ been a significant factor in enabling you to access training in the substance misuse field |
| □ been a significant factor in enabling you to obtain promotion in the substance misuse field |
| □ not been a significant factor either way |

**Please use your own words to describe your experience of the above:**

8. **Have you ever experienced any difficulties during your work/volunteering role as a result of your ex-user/carer status?**

☐ Yes ☐ No

**If yes, were these difficulties because of:**

| |
|---|
| ☐ Work colleagues' attitudes/behaviour/response to you? |
| ☐ Line manager's attitude/behaviour/response to you? |
| ☐ Other professionals' attitudes/behaviours/response to you? |
| ☐ Service users' attitude/behaviours/response to you? |
| ☐ Situations bringing up past issues for you? |
| ☐ Volunteering/working in the same service/geographical area where you were a service user? |
| ☐ Employer's/colleagues' attitudes to any previous conviction(s) you have? |
| ☐ Your own past experience was a barrier to you understanding another service user/carer's situation |
| ☐ Other, please describe: |

**If you have experienced any of the above difficulties, were these:**

| |
|---|
| ☐ An isolated incident that has been resolved |
| ☐ An isolated incident that has not been resolved |
| ☐ An on-going issue, but not one that is causing you significant problems |
| ☐ An on-going issue that is causing you significant problems |
| ☐ Other, please describe: |

**Please give an example of a difficulty you have experienced:**

9. **Have you ever experienced any positive situations during your work/volunteering role as a result of your ex-user/carer status?**

□ Yes □ No

**If yes, were these positive situations because of:**

| |
|---|
| □ Work colleagues' feedback to you? |
| □ Line manager's feedback to you? |
| □ Other professionals' feedback to you? |
| □ Service users' feedback to you? |
| □ Situations where you were able to use your personal experience to help others? |
| □ Other, please describe: |

**Please give an example of a positive situation you have experienced:**

10. **How often do you share your personal experience with service users (please tick one response only)**

| |
|---|
| □ Almost every working day |
| □ Perhaps once or twice a week, if I feel it is particularly relevant to a service user |
| □ Only occasionally, if a service user asked directly |
| □ Almost never, my focus is on the needs of the service users, not my past |
| □ Never, the service users are unaware of my ex-user/carer status |
| □ No need to disclose, all service users already aware of my ex-user/carer status |

**Please give an example of a situation when you have disclosed you ex-user/carer Status, indicating whether doing so had a positive or negative result:**

**Section 4 Course Recommendations**

1. **Was the course:**

| Too long? | | | | About right? | | | | Too short? |
|---|---|---|---|---|---|---|---|---|
| 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |

| Too indepth? | | | | About right? | | | | Not indepth enough? |
|---|---|---|---|---|---|---|---|---|
| 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |

2. **How did you find out about the course?**

| | |
|---|---|
| ☐ Educational establishment | ☐ Place of work |
| ☐ Course leaflet | ☐ Local press |
| ☐ A student who has already completed the course | ☐ Volunteer placement |
| ☐ Other (please specify) | |

3. **Would you recommend the course to colleagues?**
   ☐ Yes ☐ No
   **If no, why not?**

4. **On the course application form, it states that applicants should usually be drug free for at least two years. Please tick one of the responses below:**

| |
|---|
| ☐ I agree that the two year rule should remain |
| ☐ I think that the rule should be changed to 6 months drug free |
| ☐ I think that the rule should be changed to 1 year drug free |
| ☐ I think that the rule should be changed to 3 or more years drug free |
| ☐ I think that the rule should be removed |
| ☐ I think everyone should be assessed individually, on their own merit |

**Please use the space below to share your views on the above response:**

5. **The above 'two year rule' often applies to job applications in the substance misuse field. Please tick one of the responses below.**

| |
|---|
| □ I agree that the two year rule should remain |
| □ I think that the rule should be changed to 6 months drug free |
| □ I think that the rule should be changed to 1 year drug free |
| □ I think that the rule should be changed to 3 or more years drug free |
| □ I think that the rule should be removed |
| □ I think everyone should be assessed individually, on their own merit |

**Please use the space below to share your views on the above response:**

6. **One of the reasons for introducing DANOS and substance misuse specific qualifications was to increase the professional status of drug/alcohol workers. Do you feel that this qualification has changed your professional status?**

□ Yes □ No

**If yes, is this because:**

| |
|---|
| □ Other professionals recognise qualifications as being more important than experience |
| □ It is important to have a qualification to demonstrate your knowledge, skills and experience |
| □ A recognised qualification increases the chance of success when applying for substance misuse posts and promotion |
| □ Other (please specify): |

7. **Since completing the course have you undertaken a further course of study?**

□ Yes □ No

**If yes, what type of course is it?**

| |
|---|
| □ An additional specialist unit on the Level 3 Substance Misuse course |
| □ Another accredited substance misuse course |
| □ A non-accredited substance misuse course |
| □ A non-substance misuse course |
| □ A Substance Misuse Specific Degree |
| □ Other (please specify): |

**8. Would you be interested in undertaking a further course of study in substance misuse?**

☐ Yes ☐ No

**If yes, would you be interested in:**

| |
|---|
| ☐ Additional specialist units |
| ☐ A Level 4 Substance Misuse qualification |
| ☐ A Substance Misuse Specific Degree |
| ☐ Other (please specify): |

**9. What other recommendations would you suggest to improve the course content, structure and delivery?**

**14. Please use this space to add any further comments you have regarding the issues covered in this questionnaire or to add any supplementary information from previous questions**

15

**Section 5: Personal details**

Please remember that you do not have to give your personal details unless you are happy to do so but if you wish to be involved in the narrative study, please note your contact details below.

Any details you give will be treated with the strictest confidence. These personal details will be detached from the questionnaire prior to them being analysed.

Name (please print): .....

Preferred contact number (home/work/mobile): .....

Preferred postal address (home/work): .....

.....

.....

Post code: .....

**Thank you for taking the time and effort to complete this form. Please now return in the envelope provided at your earliest convenience and by 30th April at the latest.**

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# APPENDIX B

## Participant Letter

Greater Manchester West
Mental Health NHS Foundation Trust

Alcohol & Drugs Directorate
The building formerly known as Bunnyhops
Bury New Road
Prestwich
Manchester
M25 3BL

Tel: 0161 772 3782
Fax: 0161 772 3820

31st March 10

Dear

It is now some time since you successfully completed the Level 3 (Advanced) Certificate in the Management of Substance Misuse: Practitioner Skills at Manchester Metropolitan University (MMU) or the Level 3 Award in Tackling Substance Misuse within the GMW Mental Health NHS Foundation Trust.

At the time, you were asked to complete unit, placement and course evaluation forms, the feedback from which was very helpful in developing and improving the course content and structure.

You may also have been involved in completing a questionnaire for my MSc in Practice Development (Substance Misuse) in 2005, the title of which was "User Involvement, Training and Employment in the Substance Misuse Field". If so, thanks again for taking the time to be involved in this previous study. The findings were extremely useful in developing greater insight into the training needs of new and existing practitioners and in re-formulating the above qualifications.

I am now undertaking a PhD research project entitled "How Non-qualified volunteers and ex-drug users make the transition to paid employment in the substance misuse field". This new study will be based on the analysis of qualitative questionnaires with all ex-Level 3 students and narrative interviews with ex-students who have taken a non-qualified, volunteering and/or ex-user route into the substance misuse field.

A key element of the project is to gain information regarding such students' experience of volunteering and/or employment before, during and following the completion of the above courses. It is important for me to find out whether or not you feel the course, as well as your background (existing qualifications, volunteering, work experience, employee status, etc), has influenced your practice and/or employment opportunities.

If you wish to be involved in the questionnaire stage of the study, please read the enclosed participant information sheet and simply complete and return the questionnaire in the stamped addressed envelope provided (personal information is on the detachable section at the back of the questionnaire).

For the narrative interviews, I will select 6-12 questionnaire respondents who come from either a non-qualified volunteer and/or ex-user background to be interviewed, using a process-mapping approach (please see attached information sheet for further details). If you are willing to be involved in this second stage of the study and meet the additional eligibility criteria of being from a

non-qualified volunteer or ex-drug user background, please also complete and sign the written consent form and return it with your questionnaire in the stamped addressed envelope. Any information given will be treated in the strictest confidence and the final report will be anonymised so that no information will be directly attributable to you or your organisation.

If you would like to ask any questions regarding this project prior to completing the questionnaire or giving your consent to being involved in the narrative study, please ring me on 0161-772 3788 or 0771-751 3710.

Please complete and return your questionnaire and, where applicable, your consent form by the 30th April 10. Following this date, I will identify a sample group of respondents (6-12 individuals) for the narrative interviews and will contact you to let you know whether or not you have been included in the sample group.

Thank you for taking the time and effort to be involved in this project. I look forward to hearing from you.

Yours sincerely

SHEILA WILSON
Training Coordinator

# APPENDIX C

# LREC Ethical Approval Letter

National Research Ethics Service

**North West 7 Research Ethics Committee - Greater Manchester Central**
3rd Floor
Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161-625-7825
Facsimile: 0161-237-9427

19 March 2010

Ms S Wilson
4 Hyde Grove
Sale
Greater Manchester
M33 7TE

Dear Ms Wilson

| | |
|---|---|
| **Study Title:** | **Qualitative narrative study of how non-qualified and ex-drug users make the transition to paid employment in the substance misuse field.** |
| **REC reference number:** | **10/H1008/12** |
| **Protocol number:** | **1** |

Thank you for your letter of 05 March 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. Where the only involvement of the NHS organisation is as a Participant Identification

Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

The consent form should be amended to read:- I confirm that I have read and understand the information sheet dated 22 February 2010 (version 5). A copy of the final document should be provided to the Committee for information.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

| *Document* | *Version* | *Date* |
|---|---|---|
| Covering Letter | | 07 January 2010 |
| Copy of Unfavourable Opinion Letter | | 13 November 2009 |
| REC application | 2.5 | 07 January 2010 |
| Protocol | 1 | |
| Investigator CV | S.Wilson | |
| Letter of invitation to participant | | 19 February 2010 |
| Follow up Letter | 1 | 19 March 2010 |
| Interview Schedules/Topic Guides | 1 | |
| Questionnaire | 1 | |
| CV - Dr C Wibberley | 1 | |
| Participant Information Sheet | 5 | 22 February 2010 |
| Participant Consent Form | 4 | 28 February 2010 |
| Data collation and analysis | | 28 February 2010 |
| Response to Request for Further Information | | 05 March 2010 |

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators

- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

| 10/H1008/12 | Please quote this number on all correspondence |
|---|---|

Yours sincerely

K. Osborne.

p.p. **Professor S J Mitchell**
**Chair**

Email: kath.osborne@northwest.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Professor V Edwards-Jones
MMU, Ormond Building
Lower Ormond Street
Manchester
M15 6BX

Ms K Harney
Greater Manchester West Mental Health NHS Foundation Trust
Harrop House
Prestwich Hospital
Bury New Road
Prestwich
Manchester
M25 3BL

# APPENDIX D

# GMW Ethical Approval Letter

**Greater Manchester West** NHS
**Mental Health NHS Foundation Trust**

**Submission Point for Electronic Approval of Research**

Research & Development Office
Room 109, Harrop House
Bury New Road
Prestwich
Manchester M25 3BL

Tel: 0161 772 3591/3954
Email: kathryn.harney@.gmw.nhs.uk
jennifer.higham@.gmw.nhs.uk

24 March 2010

Mrs Sheila Wilson
Training Co-ordinator
Alcohol & Drug Directorate
Workforce Development & Training Team
Chapman-Barker Unit
Prestwich
M25 3BL

**Information for ID Badge if required:**
Research Project Ref No: 614
Expiry Date: 30 June 2014
**You must take this letter with you.**

Dear Mrs Wilson

**Re: Research Governance Decision Letter**

**Project Reference: 614**
**Unique SPEAR Identifier: 0917**
**Project Title : Qualitative narrative study of how non-qualified and ex-drug users make the transition to paid employment in the substance misuse field.**

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study. Please note when contacting the R&D office about your study you must always quote the project reference numbers provided above.

Trust R&D approval covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

Please take the time to read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&D Office should you require any further information. You may need this letter as proof of your approval.

May I wish you every success with your research.

Yours sincerely

S M. Colgan

Dr Stephen Colgan
Medical Director and R&D Lead

Research Governance Sponsor, MMU
Enc: Approval Conditions Leaflet, Induction & ID Badge Information, TrustTECH Leaflet

# APPENDIX E

# MMU Ethical Approval Letter

MANCHESTER METROPOLITAN UNIVERSITY
FACULTY OF HEALTH, PSYCHOLOGY AND SOCIAL CARE

*M E M O R A N D U M*

***FACULTY ACADEMIC ETHICS COMMITTEE***

Manchester Metropolitan University

To: Sheila Wilson

From: Prof Carol Haigh

Date: 02/12/2013

Subject: Ethics Application

Title: A narrative study of how non-qualified volunteers and ex-drug users make the transition to paid employment in the substance misuse field.

---

With regard your original ethical approval application dated 2009 all relevant issues have been considered and any risks associated with the study are minimal.

Prof Carol Haigh and Prof Jois Stansfield
Chair and Deputy Chair
Faculty Academic Ethics Committee

# APPENDIX F

# Participant Information Sheet

Greater Manchester West NHS
Mental Health NHS Foundation Trust

Alcohol & Drugs Directorate
The building formerly known as Bunnyhops
Bury New Road
Prestwich
Manchester
M25 3BL

Tel: 0161 772 3782
Fax: 0161 772 3820

**Participant Information Sheet (Version 4, November 26th 2009)**

**Study title:** Narrative study of how non-qualified volunteers and ex-drug users make the transition to paid employment in the substance misuse field.

I would like to invite you to take part in the above research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. If you have any questions about the information included in this document, I would be happy to discuss them with you. Please also feel free to discuss this study with others if you wish.

Part 1 tells you about the purpose of the study and what will happen if you take part. Part 2 gives you more detail about how the study will be carried out. Please ask if anything is not clear.

**Part 1:**

**Purpose of the study**

I (Sheila Wilson) am employed by Greater Manchester West Mental Health NHS Foundation Trust as a Training Coordinator within the Alcohol [+] Drug Directorate, based at Prestwich Hospital. I am also a part-time PhD student at Manchester Metropolitan University for which I am required to undertake a research study relating to my practice within the NHS.

As a training coordinator in the substance misuse field I am particularly interested in the process individuals go through in order to become a drug or alcohol practitioner. While there is much literature regarding practitioners from related professional backgrounds, e.g., nursing, there is limited information regarding the transition non-qualified volunteers and ex-substance users make to paid employment. Therefore, I am particularly interested in exploring the latter route into the substance misuse field.

The aims of the study are:

1. To understand the experiences of non-qualified drug workers and volunteers in their journey to become and develop as drug practitioners by:

- Using questionnaires to gain an understanding of ex-Level 3 substance misuse students' experiences before, during and following their completion of this course

- Using narrative interviews to examine the transition that non-qualified drug workers and volunteers (including ex-users) make in order to/attempt to gain paid employment in the substance misuse field, including how this influences their identity (self and perceived)

2. To make recommendations regarding training, employment and staff development for my own organisation, to enhance my own practice and to influence wider policy and practice principles

**Why have I been invited to take part?**
I welcome completed questionnaires from all ex-students who have completed either the Level 3 Certificate in the Management of Substance Misuse or the Level 3 award in Tackling Substance Misuse. This includes ex-students from a non-qualified volunteering, ex-substance user or related professional background in order for a greater understanding of the range experiences to be made and will enable me to meet the second overall aim of the project.

Following the analysis of these questionnaires, I will contact a small number of individuals from a non-qualified, volunteering or ex-user background to be involved in the narrative interviews.

**Do I have to take part?**
It is up to you to decide to join the study. Returning your completed questionnaire will imply your consent to be involved in this initial stage of the research. If you agree to take part in the subsequent narrative study you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason. If you withdraw from the study, only the information gathered to that point will be included in the study.

**What will my participation involve?**
Completion of the questionnaire should take approximately one hour. Following the initial analysis of these questionnaires, you may (if you have given consent) be contacted to participate in a narrative interview, using process-mapping techniques to set out your journey to become a substance misuse worker. Approximately 2 months later a follow-up interview will be arranged, the purpose of which is to clarify and build on any issues raised in the initial interview. If you wish for a third interview to take place, this can be arranged after the second interview (within an approximate 2 month timeframe). Each appointment will last 1-2 hours, will be audio-taped and will take place at a mutually agreed venue, e.g. either your usual place of work/volunteering or at the Training team office.

Step 1: Completion of questionnaire
Step 2: invitation/consent to narrative interview (see letter re eligibility criteria/sample size)
Step 3: narrative interview using process-mapping techniques
Step 4: interview transcripts & process maps given to participants to check for accuracy & to provide an opportunity for reflection and preparation for follow-up interview
Step 5: follow-up interview
Step 6: further meeting if requested by participant to add any further information to the data already given.

**Expenses & payments:**
Unfortunately, as this is primarily an educational study, there is no budget within the training team to meet out-of-pocket expenses.

**What are the possible risks/benefits to being involved?**
Process-mapping and being asked questions about the journey you took to become a substance misuse worker/volunteer may raise difficult issues which could cause distress. To minimise this risk, support/counselling can be accessed through the NHS or through your own clinical supervision. Benefits of being involved include the opportunity to reflect on your experiences, to influence future training and development plans, and to make recommendations towards policy and practice development within the substance misuse field.

**What happens when the research study stops?**
Participant will be given a copy of their process-map (if requested) and will be offered a summary report of the completed study findings.

**What if there is a problem?**
Any complaint about the way you are dealt with during the study or distress experienced will be addressed. Please see Part 2 for further details.

**Will my taking part in the study be kept confidential?**
Yes, I will follow ethical and legal practices and all information about you will be handled in confidence. Please see Part 2 for further details.

**Part 2:**
**What if there is a problem?**
Any complaint about the way you are dealt with during the study or distress experienced will be addressed. If you are concerned about any aspect of the study, please speak in the first instance to the researcher (0161 772 3788). If you remain unhappy and wish to make a complaint, please contact Claire Watson (Workforce Development Manager) on 0161 772 3782. Details of the full complaints procedure can be found at www.gmw.nhs.uk

**Will my taking part in the study be kept confidential?**
Ethical and legal practices will be followed throughout the study as well as following its completion and all information about you will be handled in confidence. This means that:

- All the data gathered from the questionnaires and process-mapped narrative interviews will be stored in a lockable filing cabinet within the Training team office; will only be accessible by the researcher (and the authorised persons described below);
- All personal information (e.g. participant name, place of work) included in the report will be altered so that it cannot be attributable to an identifiable individual
- The computer used to analyse the data is password protected
- The data gathered will only be stored for as long as is necessary for the completion of the study and will be destroyed after a maximum of 12 months following the study's end

If you join the study, the data gathered (questionnaires and narrative interviews) will be looked at by the researcher. The data (once anonymised) may also be looked at by authorised people from the Trust's Research and Development Team, Research Ethics Committee and Manchester Metropolitan University to check the study is being carried out correctly. All authorised people have a duty of confidentiality to you as a research participant and will do their best to meet this duty. Participants have the right to check the accuracy of data held about them and correct any error. Therefore, you will be able to check the accuracy of the narrative interview transcripts and process-maps

**What will happen to the results of the research study?**
The results will be collated and analysed to form a PhD report and will be made available through the Ian Smith Drug Reference Library and Manchester Metropolitan University Library. A copy of the summary report will be offered to participants.
Narrative participants will be given the opportunity to comment on the analysis of the data and this commentary will be included in the final report and reflected on by the researcher. Journal articles based on the research study are also planned to be submitted to key substance misuse publications. The results will also be used to develop recommendations regarding future training and personal development policies and practices within the substance misuse field.

**Who is organising and funding the research?**
Greater Manchester West (GMW) Mental Health NHS Foundation Trust

**Who has reviewed the study?**
All research in the NHS is looked at by an independent group of people called a Research Ethics Committee, to protect your interests. This study has been reviewed by and given a favourable opinion by North West 7 Research Ethics Committee. It has also been favourably reviewed by GMW's Research & Development group and by Manchester Metropolitan University's Independent Reviewer within the Faculty of Health, Psychology and Social Care.

**Further information and contact details:**
If you require any further information, please contact:

Sheila Wilson
Alcohol [+] Drug Directorate
Workforce Development & Training Team
Prestwich Hospital
Bury New Road
PRESTWICH
M25 3BL

Tel: 0161 772 3782
Mob: 0771 751 3710
Email: Sheila.Wilson@gmw.nhs.uk

# APPENDIX G

# Consent Form

Greater Manchester West
Mental Health NHS Foundation Trust

Alcohol & Drugs Directorate
The building formerly known as Bunnyhops
Bury New Road
Prestwich
Manchester
M25 3BL

Tel: 0161 772 3782
Fax: 0161 772 3820

**Consent Form (version 3, November 09)**

**Study title:** Narrative study of how non-qualified volunteers and ex-drug users make the transition to paid employment in the substance misuse field.

**Study Number:**

**Name of Researcher:** Sheila Wilson

**Participant Identification Number:**

| | **Please initial box** |
|---|---|
| I confirm that I have read and understand the information sheet dated 26th November 2009 (version 4) for the above study. I have had the opportunity to consider this information, ask questions and have had these answered satisfactorily. | |
| I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason and without my rights being affected | |
| I understand that data collected during this study will be anonymised by the researcher and May be looked at by authorised people from GMW, MMU and the Research Ethics Committee | |
| I agree to take part in this study | |

Name of participant: ..... Date: .....

Signature of participants: .....

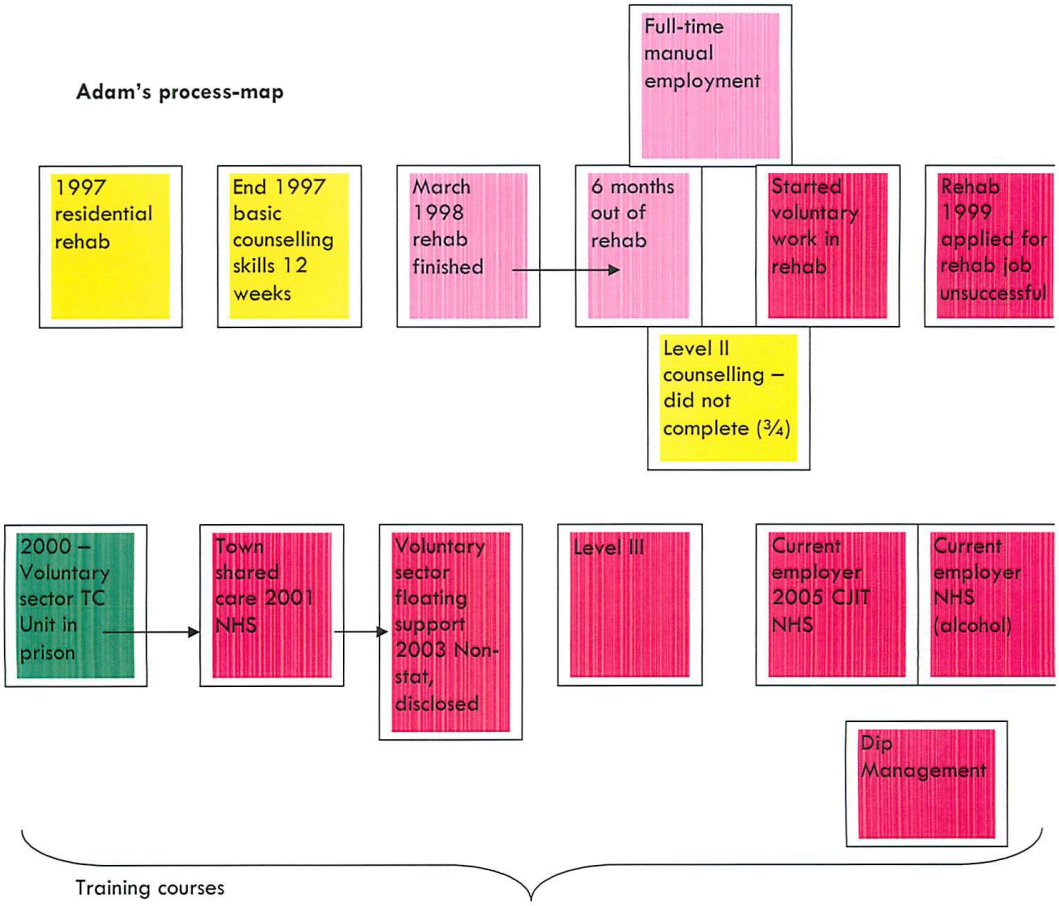
Name of person taking consent: ..... Date: .....

Signature of person taking consent: .....

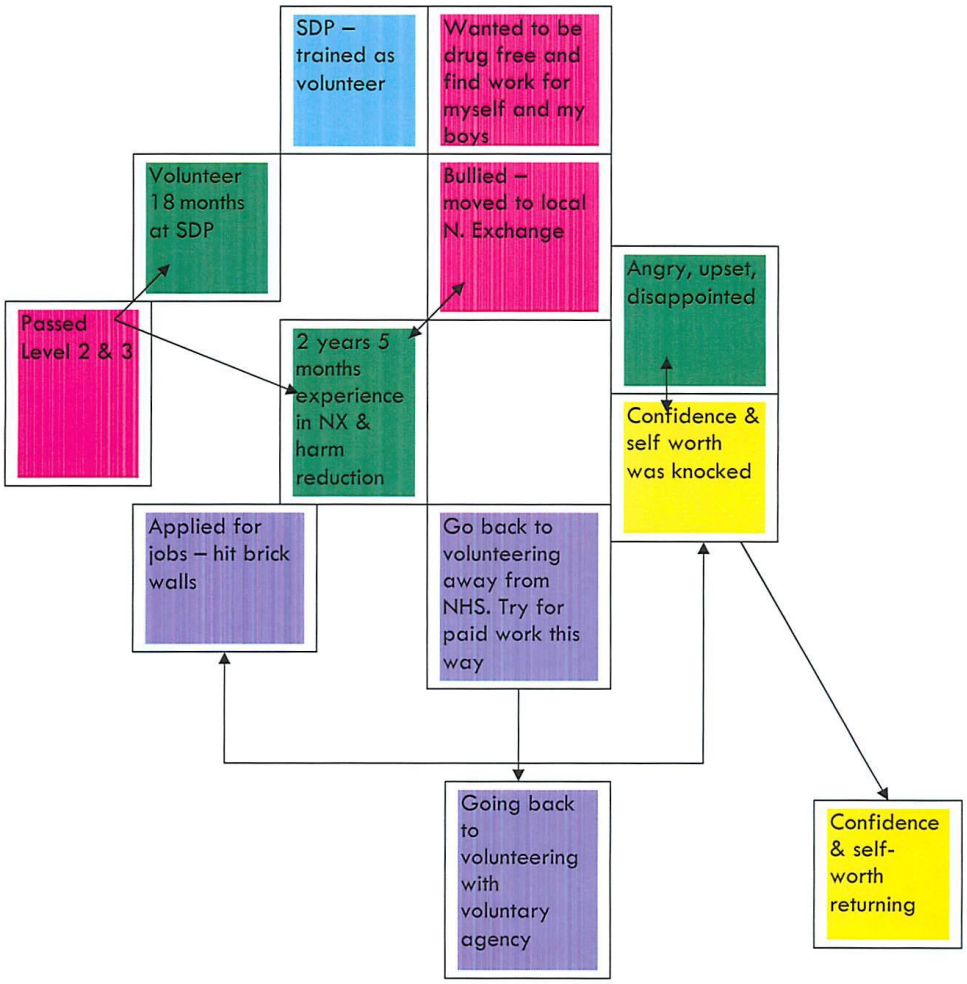
When completed, one for the participant, one for the researcher site file.

# APPENDIX H

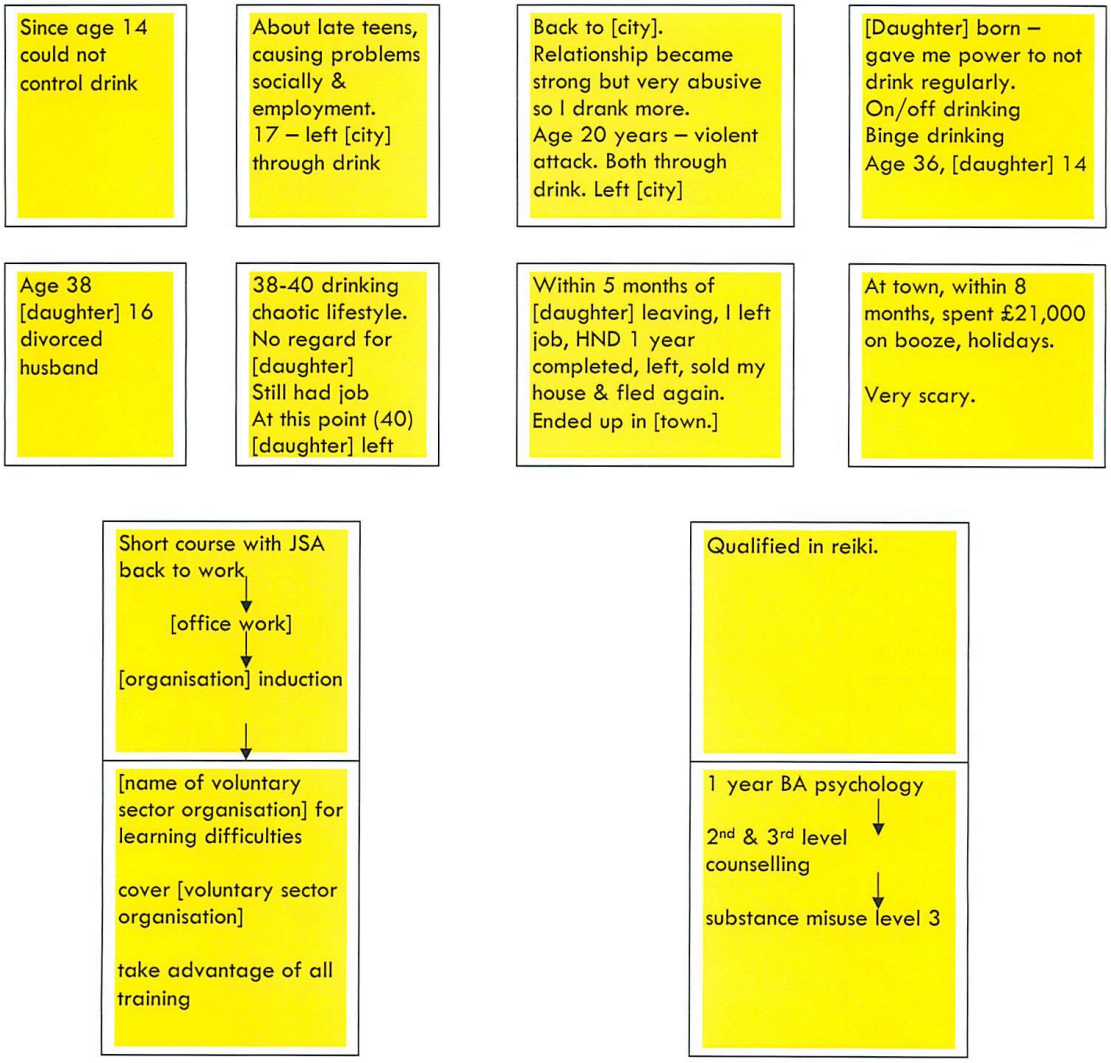
## Participant Process-Maps

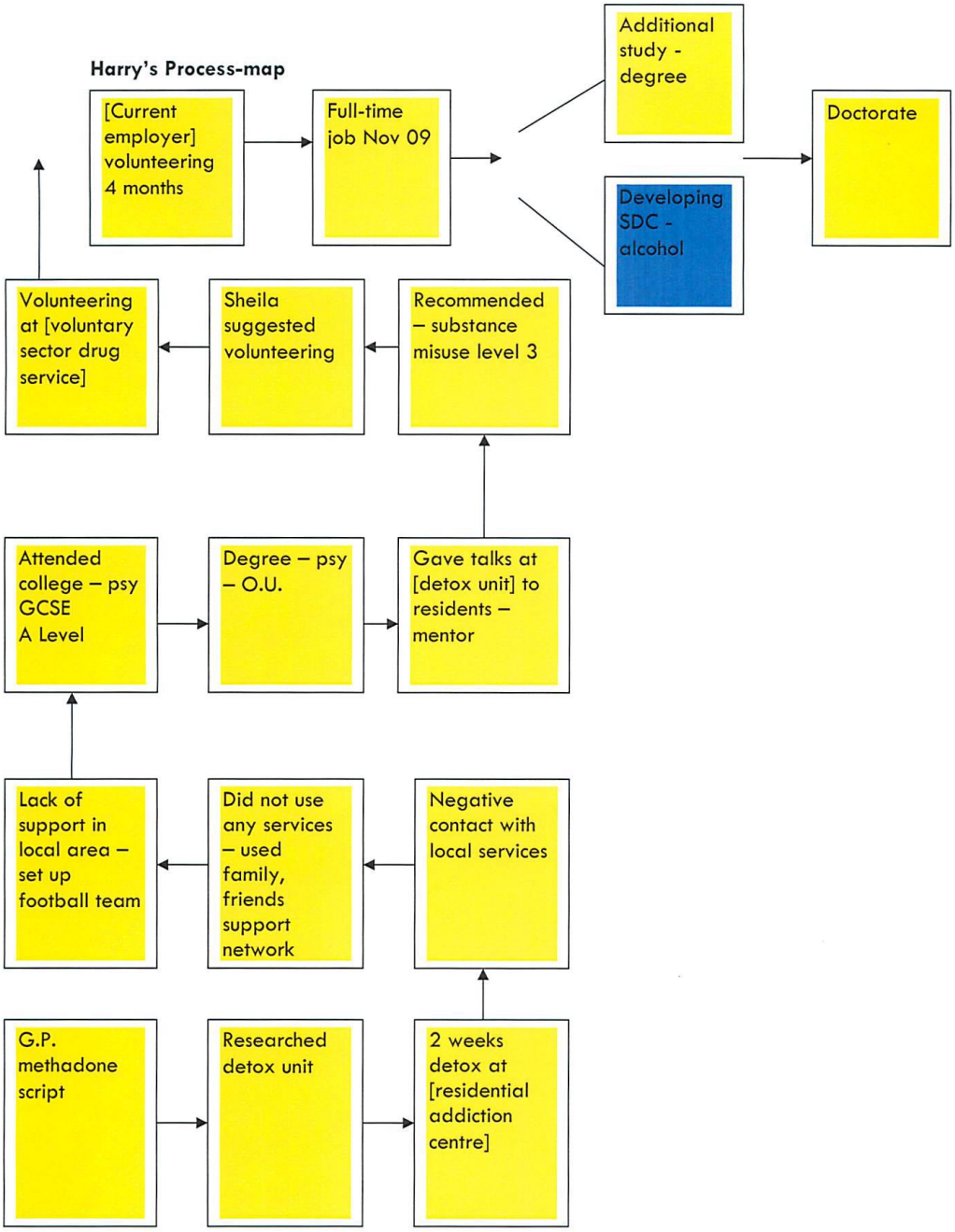

Adam's process-map
1997 residential rehab
End 1997 basic counselling skills 12 weeks
March 1998 rehab finished
6 months out of rehab
Full-time manual employment
Started voluntary work in rehab
Rehab 1999 applied for rehab job unsuccessful
Level II counselling – did not complete (¾)
2000 – Voluntary sector TC Unit in prison
Town shared care 2001 NHS
Voluntary sector floating support 2003 Non-stat, disclosed
Level III
Current employer 2005 CJIT NHS
Current employer NHS (alcohol)
Dip Management
Training courses

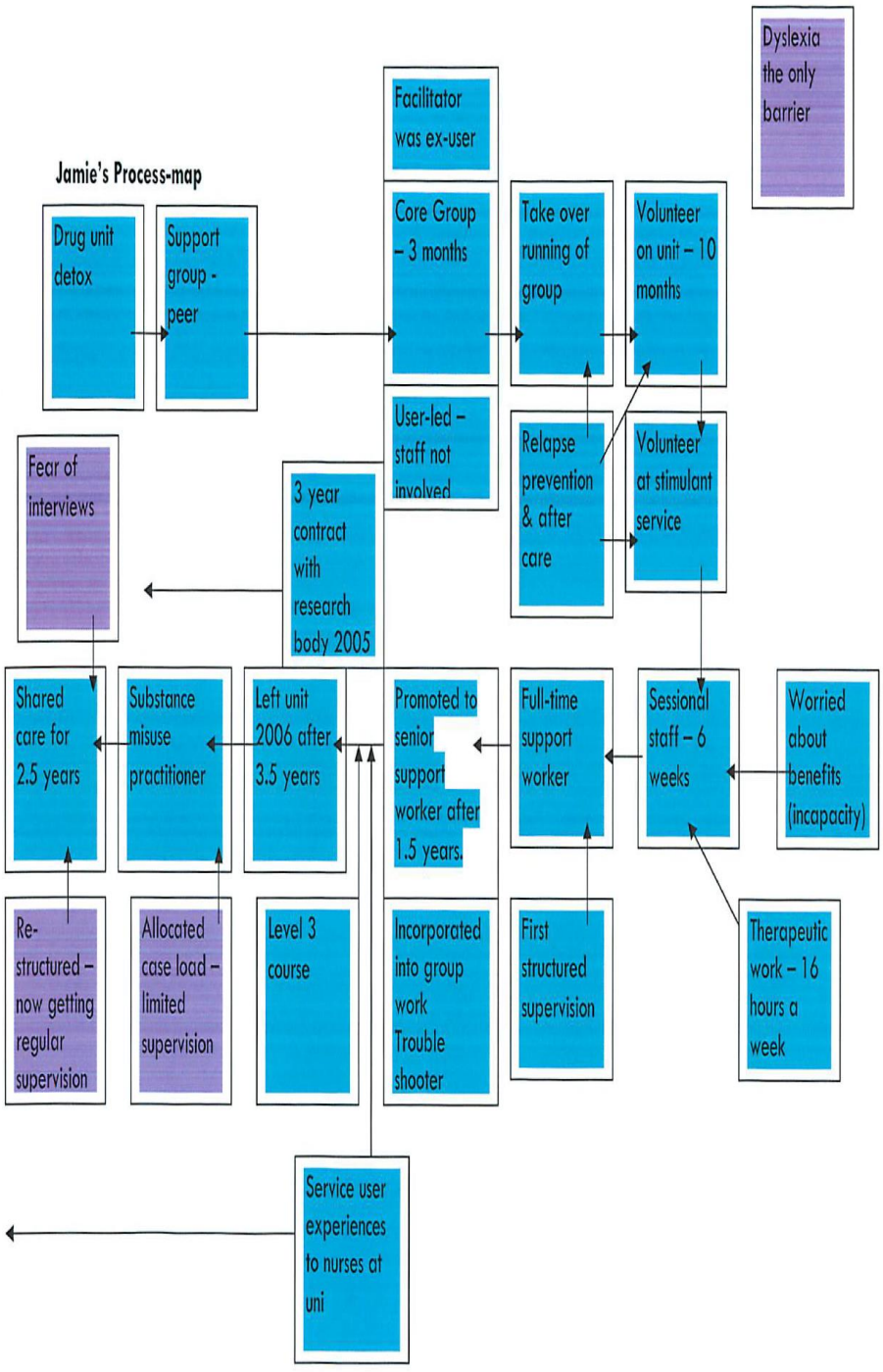
**Debbie's Process-map**



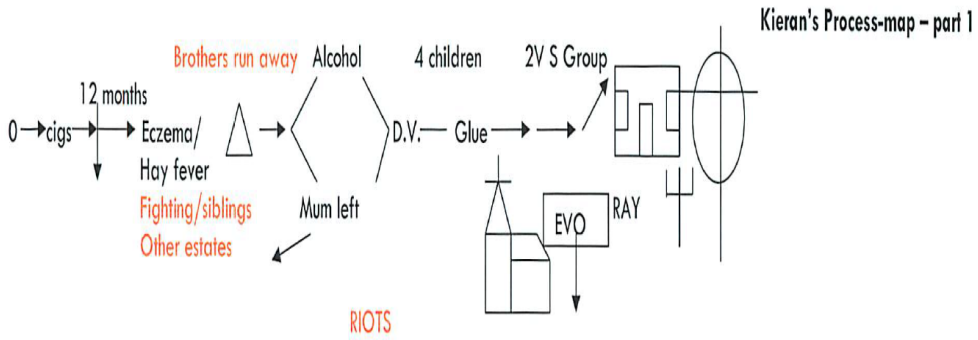
**Elizabeth's Process-Map**

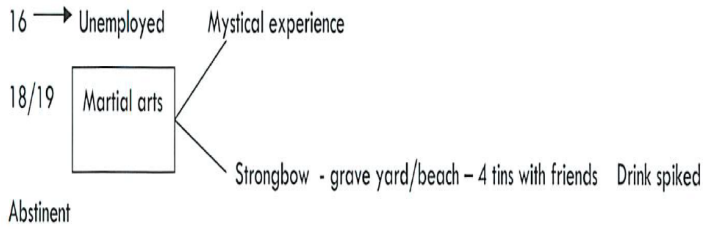


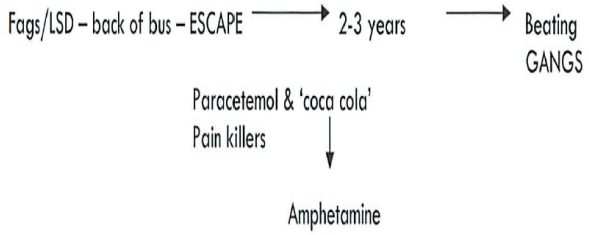

Harry's Process-map
[Current employer] volunteering 4 months
Full-time job Nov 09
Additional study - degree
Doctorate
Developing SDC - alcohol
Volunteering at [voluntary sector drug service]
Sheila suggested volunteering
Recommended – substance misuse level 3
Attended college – psy GCSE A Level
Degree – psy – O.U.
Gave talks at [detox unit] to residents – mentor
Lack of support in local area – set up football team
Did not use any services – used family, friends support network
Negative contact with local services
G.P. methadone script
Researched detox unit
2 weeks detox at [residential addiction centre]

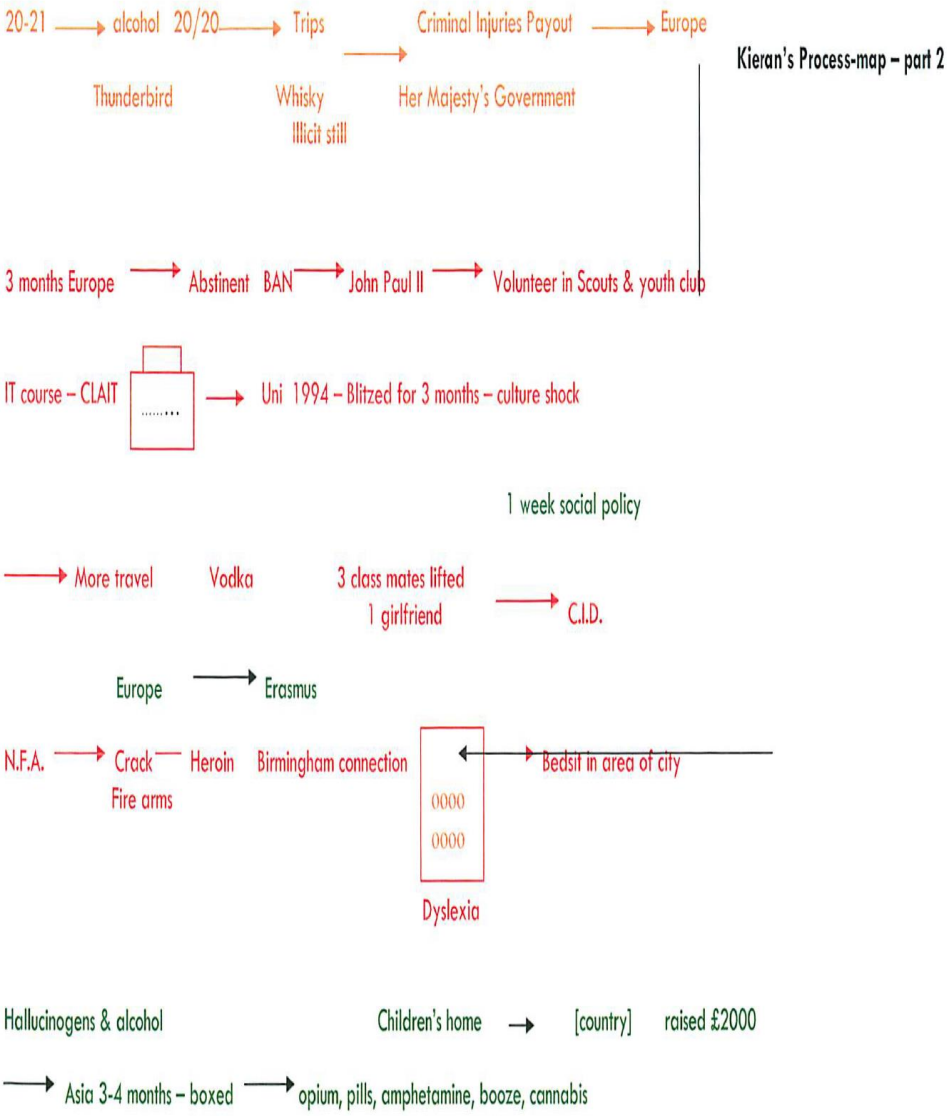

Jamie's Process-map
Drug unit detox
Support group - peer
Facilitator was ex-user
Core Group – 3 months
Take over running of group
Volunteer on unit – 10 months
Dyslexia the only barrier
User-led – staff not involved
Relapse prevention & after care
Volunteer at stimulant service
Fear of interviews
3 year contract with research body 2005
Shared care for 2.5 years
Substance misuse practitioner
Left unit 2006 after 3.5 years
Promoted to senior support worker after 1.5 years.
Full-time support worker
Sessional staff – 6 weeks
Worried about benefits (incapacity)
Re-structured – now getting regular supervision
Allocated case load – limited supervision
Level 3 course
Incorporated into group work Trouble shooter
First structured supervision
Therapeutic work – 16 hours a week
Service user experiences to nurses at uni

**Kieran's Process-map – part 1**





20-21
alcohol
20/20
Trips
Criminal Injuries Payout
Europe
Kieran's Process-map – part 2
Thunderbird
Whisky
Illicit still
Her Majesty's Government
3 months Europe
Abstinent
BAN
John Paul II
Volunteer in Scouts & youth club
IT course – CLAIT
Uni 1994 – Blitzed for 3 months – culture shock
1 week social policy
More travel
Vodka
3 class mates lifted
1 girlfriend
C.I.D.
Europe
Erasmus
N.F.A.
Crack
Heroin
Birmingham connection
Bedsit in area of city
Fire arms
0000
0000
Dyslexia
Hallucinogens & alcohol
Children's home
[country]
raised £2000
Asia 3-4 months – boxed
opium, pills, amphetamine, booze, cannabis

**Kieran's Process-map – part 3**

More travel – arrested 3 times. But abstinent → back in home country → drink, LSD, cannabis, pills

Back in the UK – lost time – BLUR

£500 → Europe Alcohol 60 days

Europe – 3-4 litres red wine → Home country → UK area of city →

Play team → Probation → ISSP → YOT → After school club

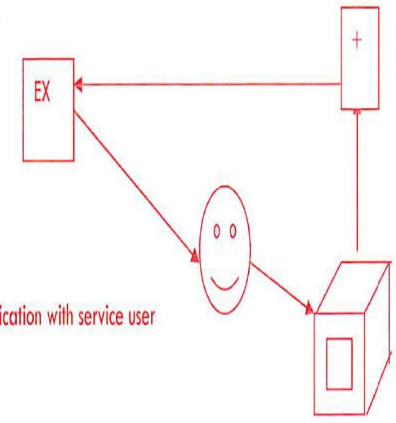
Selling body for medical research – Part-time Young Person's Service → current employer

Substance Misuse course

→ SOO=> - Selling a dream -> positions risk

V

U

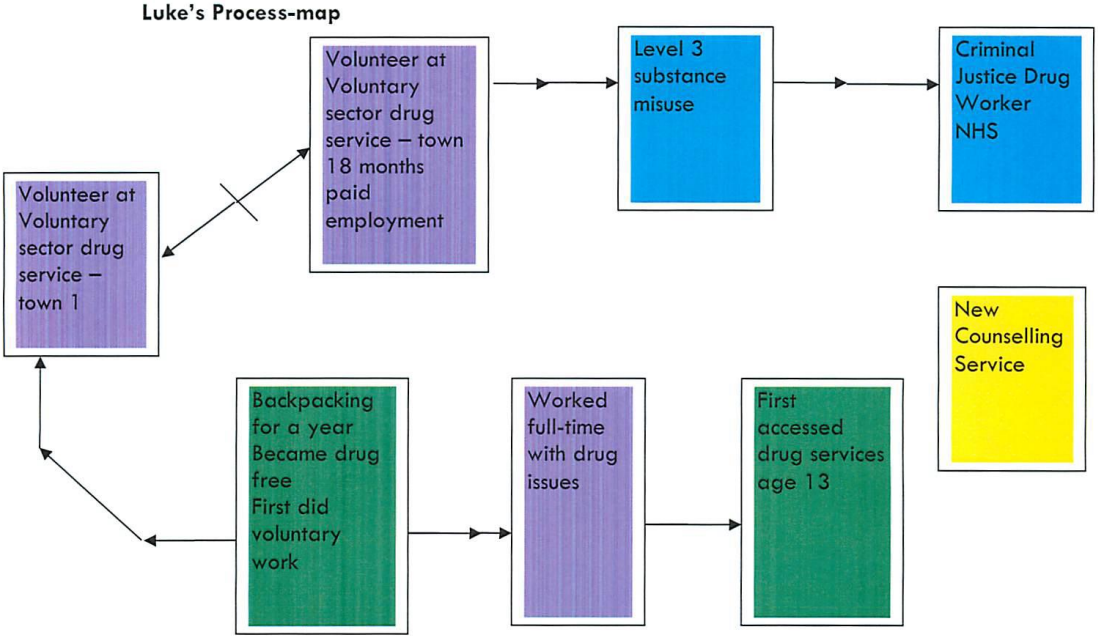



T.A.

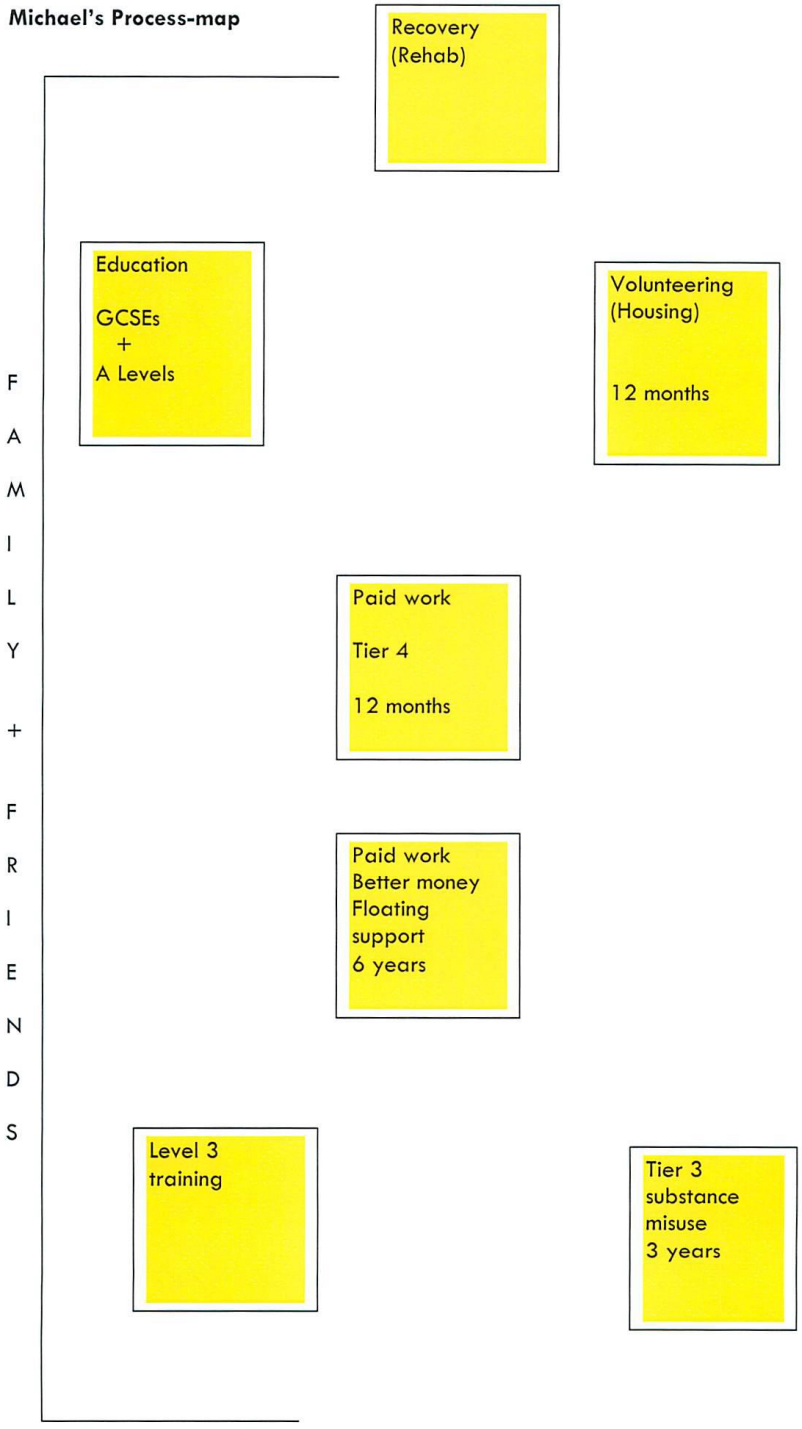
Over identification with service user

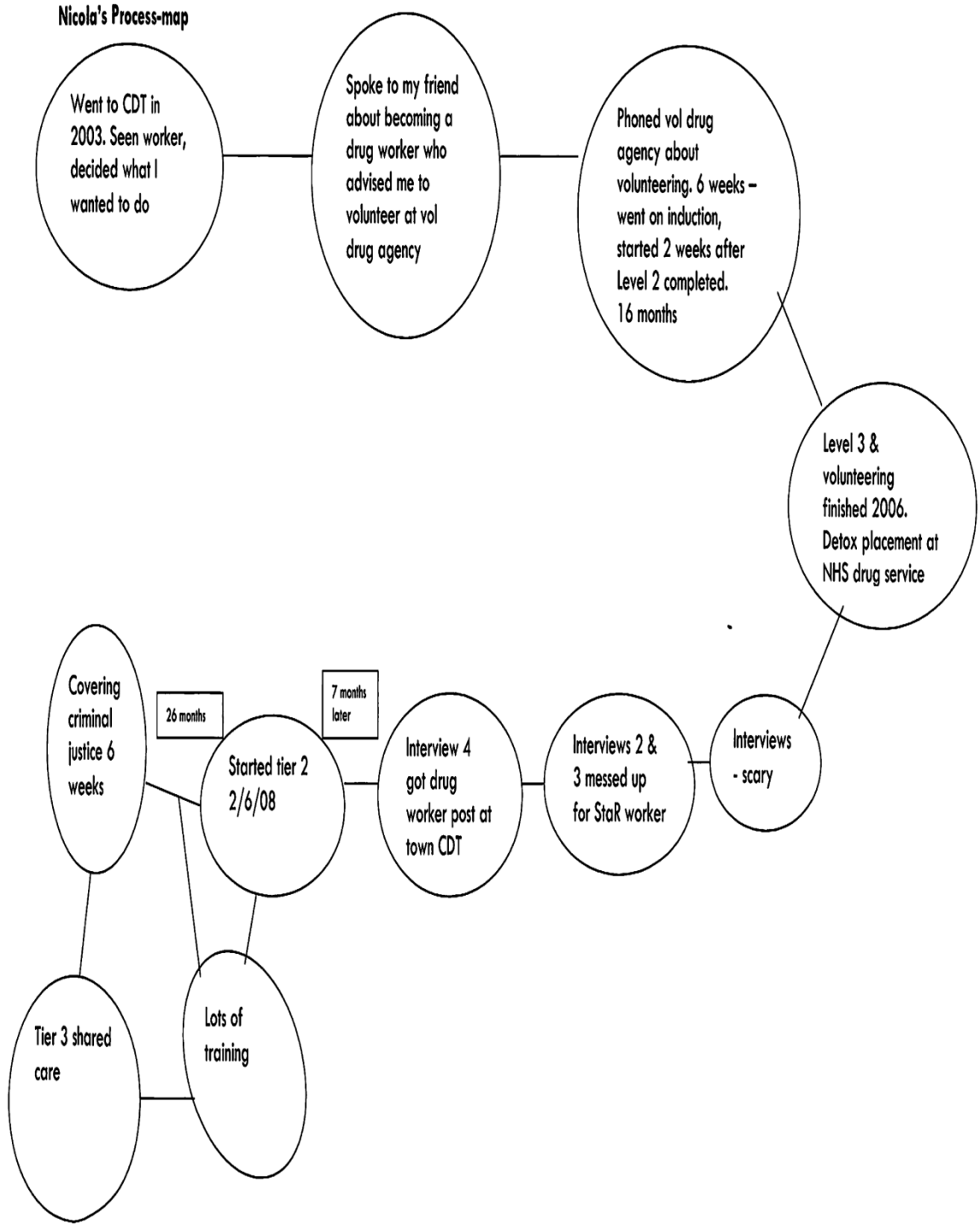
Underestimates impact of course & work

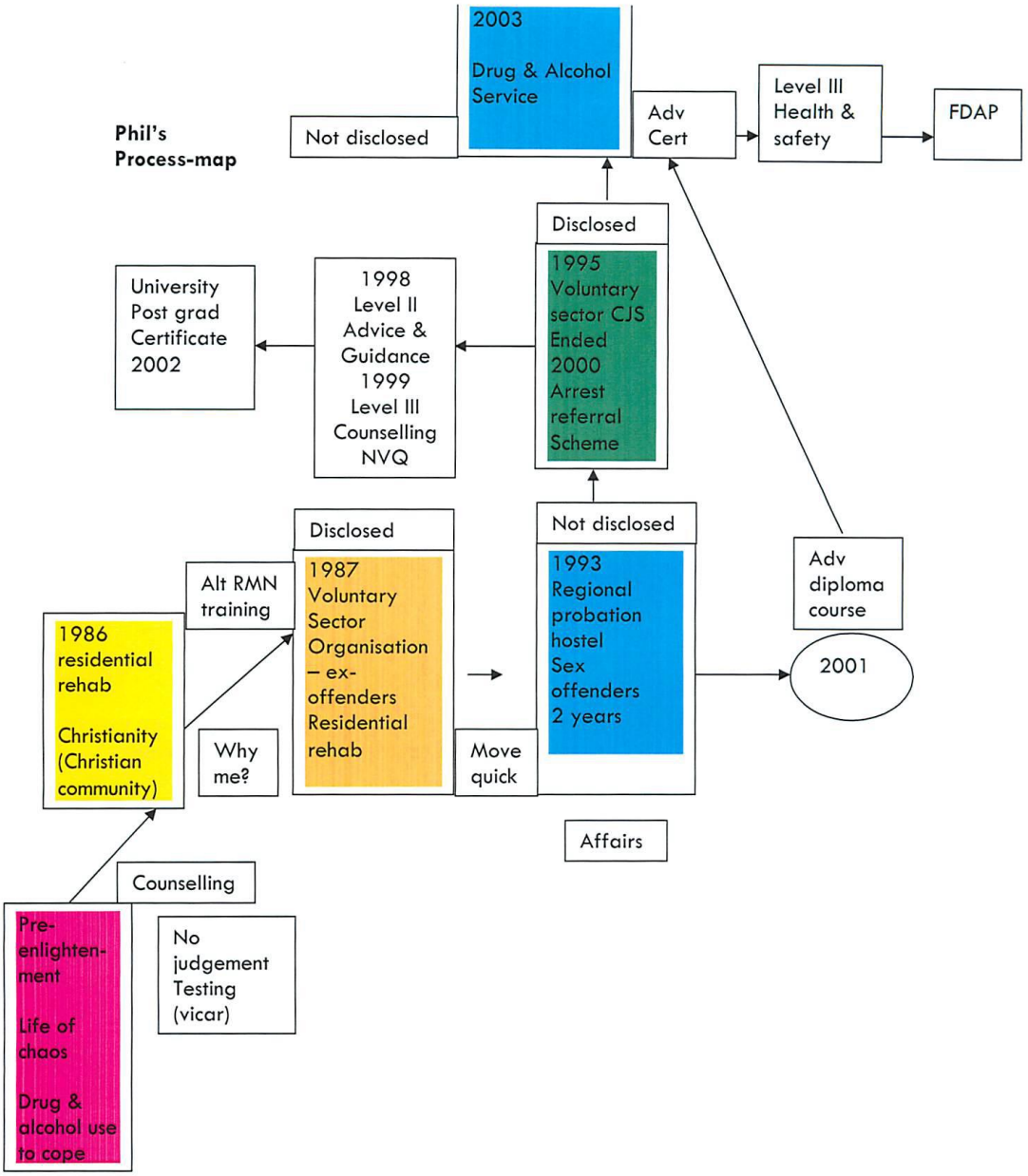
**Luke's Process-map**

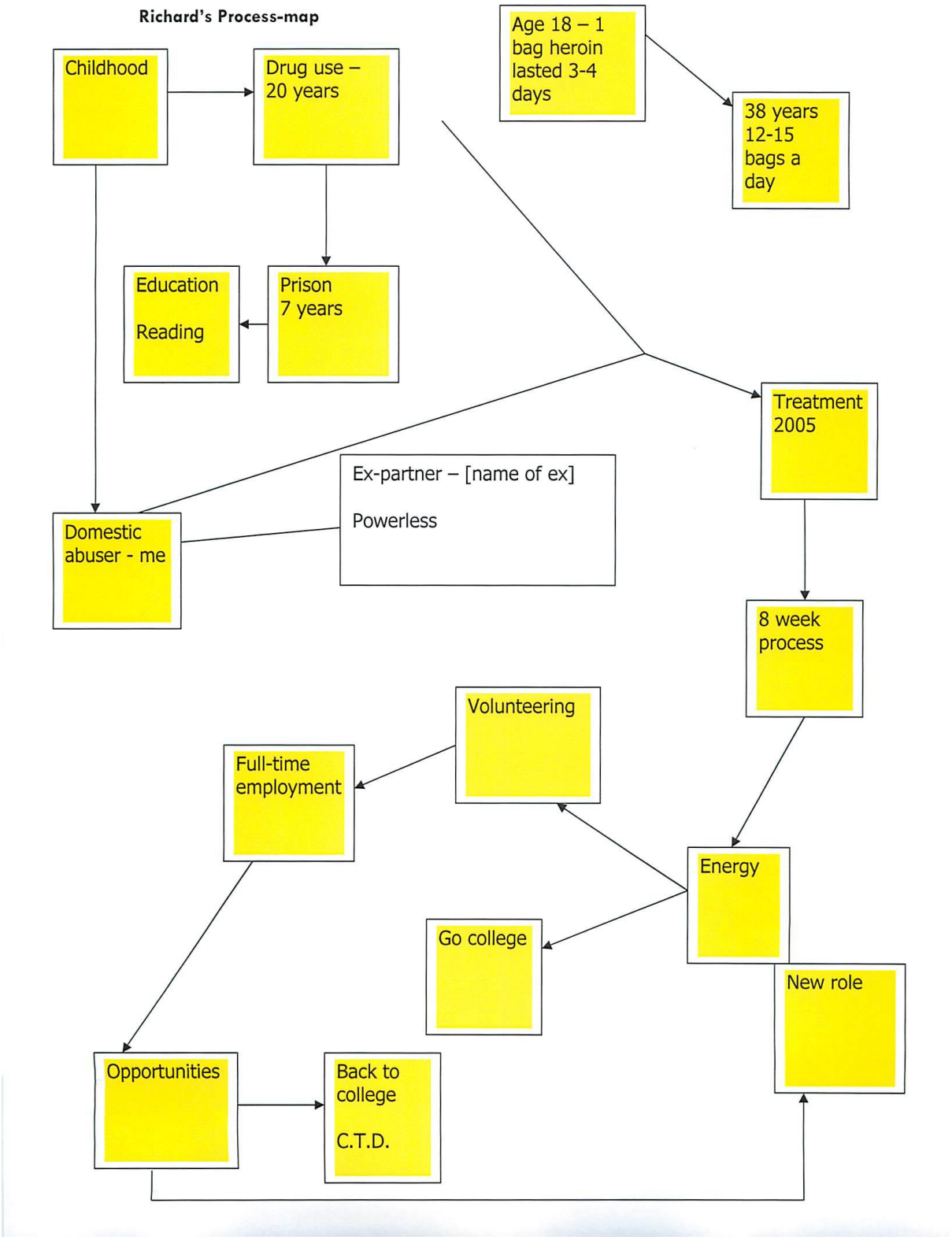


**Michael's Process-map**




Nicola's Process-map
Went to CDT in 2003. Seen worker, decided what I wanted to do
Spoke to my friend about becoming a drug worker who advised me to volunteer at vol drug agency
Phoned vol drug agency about volunteering. 6 weeks – went on induction, started 2 weeks after Level 2 completed. 16 months
Level 3 & volunteering finished 2006. Detox placement at NHS drug service
Interviews - scary
Interviews 2 & 3 messed up for StaR worker
Interview 4 got drug worker post at town CDT
7 months later
Started tier 2 2/6/08
26 months
Covering criminal justice 6 weeks
Lots of training
Tier 3 shared care


Phil's Process-map
2003
Drug & Alcohol Service
Not disclosed
Adv Cert
Level III Health & safety
FDAP
Disclosed
1995 Voluntary sector CJS Ended 2000 Arrest referral Scheme
University Post grad Certificate 2002
1998 Level II Advice & Guidance 1999 Level III Counselling NVQ
Disclosed
1987 Voluntary Sector Organisation – ex-offenders Residential rehab
Not disclosed
1993 Regional probation hostel Sex offenders 2 years
Adv diploma course
2001
Alt RMN training
1986 residential rehab
Christianity (Christian community)
Why me?
Move quick
Affairs
Counselling
Pre-enlighten-ment
Life of chaos
Drug & alcohol use to cope
No judgement Testing (vicar)


Richard's Process-map
Childhood
Drug use – 20 years
Age 18 – 1 bag heroin lasted 3-4 days
38 years 12-15 bags a day
Education
Reading
Prison 7 years
Treatment 2005
Ex-partner – [name of ex]
Powerless
Domestic abuser - me
8 week process
Volunteering
Full-time employment
Energy
Go college
New role
Opportunities
Back to college
C.T.D.

# APPENDIX I

## Excerpt from Reflective Diary

| Narrative | Reflections |
|---|---|
| The staff didn't really get involved. I suppose being an ex-client of the unit and then the staff know you anyway, so, you get that…the trust build up, I think, between us and they know we're not going to mess about. | The staff trusted the co-facilitators to run the group<br>Is this an argument in favour of ex-user volunteering where they were in treatment? There was already trust between staff & peer mentors, the peer mentors already knew the rules & how to implement them. Staff only became involved when requested by the peer mentors & this was not often needed – things were managed well by the peer mentors |
| Jamie didn't think it would have been right to have paid staff facilitate the groups | Jamie respected & valued a service user only space. He saw divisions between staff & clients. Debbie described similar divisions – something I have also witnessed in drug services and yet I have also had positive experiences of 'professional'/ex-user co-facilitation in detox-preparation groups and other support groups |
| Jamie used to take his work id badge off before facilitating the support group | Why did Jamie feel the need to take off his work badge when going into the group? In what role did he take part in the group – as ex-user drug worker or as peer mentor? If he retained his professionalism in the group, why take off the badge – surely everyone knew he was now a worker. To identify himself more closely with the group members? To remove any barriers? |
| Jamie feels that staff without personal experience of substance use have less understanding (naive) | Jamie suggests that without personal experience of substance use, drug workers may have limited understanding, even if in other respects they are good workers - similar to what Harry said<br>Without personal experience of using drugs, workers may not fully understand the implications of substance use & so come across as naive – this impacts on the relationship between staff & clients |
| Jamie won't pass on his understanding to non-ex-user workers unless they ask | The onus is on the workers to ask pertinent questions – Jamie is not the token ex-user whose role is to educate the other workers. A bit like when some agencies always gave the female clients to female workers or black clients to black workers – tokenism & exploitation |
| Jamie gained facilitation skills through the group – as an attendee and as a facilitator | A fine balance between challenging & safety – highly skilled & yet the co-facilitators had had no formal training only what they had picked up when group members themselves. It is difficult to manage groups with people at different stages of recovery. Harry also does this. Two types of learning for Jamie – observing the worker & doing the facilitation role. Indicates reflective practice on Jamie's part – he was able to |

| | |
|---|---|
| | learn from a positive role model & with experience to later see below the surface of a co-facilitator who had ulterior motives for being involved in the group |
| "when I started being a volunteer and working with professionals, I thought I'd left all that devious stuff behind and all that, and it still goes on" | While Jamie was used to such behaviour among drug users, he had not expected such behaviour from people who were drug-free professionals & volunteers in the field. This is perhaps similar to something Debbie talked about – expecting drug workers to be above such low behaviour – both Debbie & Jamie have been disappointed in this. On reflection, this might also demonstrate how ex-users hold their drug workers in high esteem, seeing them as role models, only to be let down in some cases when they do not live up to such expectations. Jamie may have also considered me, as his course tutor, to be a role model, influencing his decision to take part in the study but also causing him some anxiety in case I let him down by not taking his narrative seriously. |
| [Becoming a volunteer], it wasn't planned by me. That was just another thing that sort of happened basically. It never even entered me head to be a volunteer or… It was staff". | Unlike other ex-users who knew early on that they wanted to be a drug worker, this was not an ambition of Jamie's (Harry similarly had no early ambitions but Adam and Debbie did). It was the staff's suggestion that Jamie progress onto a volunteering role – from resident, to aftercare group member, to group co-facilitator, to volunteer within a matter of months |
| Jamie started volunteering on the unit at weekends... "no induction. It were just, sort of like, … I don't know if they thought because I'd done me detoxes on the unit I…well three times, I knew how it all run, you know, how everything works, so maybe they thought I didn't need an induction." | Jamie started offering informal support to current residents, accompanying them on leave, listening to them, etc – however, there was no induction and no mention of any guidance about this role and how to keep himself and others safe. The assumption that Jamie knew all this because he had detoxed on the unit himself seems naive and more than a little risky. Similar assumptions were made about Debbie when she started volunteering at a NX |
| "I was off sick last year. I was quite ill [laughs]. I was off sick for about 6 months and, eh, it went round the [service]…well I got told, some of my clients told me that there was a rumour going round that I'd gone back to using." | The immediate assumption re Jamie's sick leave was that it must be because he had relapsed. Had Jamie worked anywhere else, particularly if people were not aware of his background, this would not have been the rumour. The irony is that Jamie was off work following a [serious health complaint] – he later comments that this was down to smoking (a perfectly legal substance) but is it possible that his many years of amphetamine use had contributed to his [serious health complaint] – it's not the first time a person's past has returned to bite them on the bum! Ex-user drug workers still identified by others in terms of their drug use – it was |

| | |
|---|---|
| | inconceivable to this client that there was any other cause for Jamie's sick leave – he is only seen as an ex-user so any problems he has must be drug related? If people are talking about Jamie behind his back like this, what does it mean for his confidentiality – he has as much right to his privacy as any other worker. How did Jamie's colleagues respond to questions about his sick leave? Might Jamie have thought that I suspected his sick leave had been relapse related? This may have affected how he told this section of his transition story to me. |
| "I've even had a client, oh, about a year and a half ago, who had social services involvement. She was my client and she turned round to me cos I'd phoned social services and spoken to them to tell them that she hadn't provided urine samples like she was supposed to and she had a go at me, basically, she said, 'I've heard you're an ex-user and you should know better than to phone people'" | Jamie had not disclosed his drug using background to this client – she had 'heard' he was an ex-user & still expected he would behave differently as a drug worker when it came to liaison with social services – she expected non-ex-user drug workers to tell SS that she was still using, but she expected Jamie to lie for her, because they shared a drug using back-ground. If this is clients' expectation, it places ex-user drug workers in very difficult positions when it comes to maintaining professional boundaries while also building rapport. |
| "It's a bit different, being an ex-user rather than a professional, yeah. I've found, Sheila, you've got to learn yourself how to put a line there... Cos with us having that fine line, I think, isn't it? I learned it as a volunteer (through catching service users smoking weed on the unit and initially giving them the benefit of the doubt) …"so, I caught them again. And I went then and told staff. But, I said, 'Listen, I hold me hands up [laughs], I did catch them before but I gave them the benefit of the doubt', you know what I mean? And I thought, oh, they're not going to have me back here and that's when I learned then"... "I thought I was finished... and when I came in the next day and I said, 'listen, I understand if you don't want me here anymore'. And they said, 'don't be daft, don't be daft. You sorted it out, in the end it all got sorted. Use it as a learning curve'." | While Jamie does not like being seen as different from his colleagues, he feels that there is a difference, perhaps because he has had to learn the hard way about boundaries. The above example indicates that it is perhaps harder for ex-users to keep such boundaries if clients are more likely to push boundaries with ex-users than with other workers – do they think they can get away with more? Had Jamie not made this mistake early in his volunteering career, how would he have learned about boundaries – there appears to have been little guidance/induction/training about such matters prior to this incident. Jamie did however expect to have to face the consequences for his actions/inaction, knowing that it could have resulted in his being asked to leave – it was therefore brave for Jamie to admit his mistake. The implications for Jamie to have lost his volunteer role at this time could have been catastrophic – he has already said how important this was in keeping him safe from relapse. Jamie developed insight through reflective practice & this has helped him maintain boundaries with his clients. Jamie was given a second chance – the rest of the team were also given a second chance – to guide Jamie better – Richard was also given a second chance when he made an early mistake. Had they not been ex-users or vols at the time would they have had harsher consequences? |

# APPENDIX J

## Jamie's disclosure, transition and professional identity stories

**Jamie's disclosure narrative**

When I filled out the application form for the support worker job, I just put in what I'd worked up from being basically a service user in the support group, to volunteering, to then going on the [sessional team]. I just said that I'd been an ex-service user in the support group, facilitated the support group and then being a [sessional] worker, volunteer obviously, and where I was volunteering at and that was it basically. When I first started volunteering, everyone knew I was an ex-user, didn't they, because of the support group. Since I left the unit, that was in 2006, I've never divulged, well, I have done if they've asked. I've never, ever, ever [pause] I can't remember ever saying, Sheila, I don't say, my name's Jamie and I'm an ex-user. I never do it like that. They shouldn't ask, you know, but what's the point of telling lies? It's not right, cos you'd be putting that thing across that you're a liar [laughs]. So, how can you expect people to work with you if you're lying? You can't really, can you? [intake of breath] I don't think you should shove that 'I'm an ex-user' thing down people's throats, really. It can reel against you, Sheila, where it can make you, sort of like, oh, he thinks he's great, him, because he used to use, and he's turned his life around, nah, nah, nah. So, no, I don't go down that road.

[When I applied for recent job opportunity], did I put I was an ex-user? No, I didn't, no. I put it from I was a volunteer, blah, blah, blah. I think I have done it on one or two occasions and not put it on others. At one point, cos I went for a couple of jobs and I think at one stage I got told not to put it on about being an ex-user by me manager. I can't really remember what the reason was but they said, don't put that on, just don't put that on. Just go with the flow, like, get experience and stuff like that. He gave me a new way of doing me personal statement. He just went, oh, do it this way now. He gave me a new way of doing it I think. Volunteer, done this, done that, put all me experience and stuff like that. I wouldn't say now [my past use] is relevant, no, definitely not. If I was applying for anything else now, I wouldn't put it on. I didn't put it on there cos I didn't think it was relevant anymore.

I can't see how you can be an actual role model, Sheila, for someone unless being an ex-user, but, I think, for you to be a role model for someone, they've got to know how you used to be, to get that full benefit. I mean, I had one of me clients a couple of weeks ago asking me how I got to where I am now, and asking me how did you do this, how did you do that? And I told him. But, does he see me as a role model? I don't know. I can't really ask him.

It was only when I've come down to the [sessional] work when I had to start doing notes. That's the first time in me life where I had to turn round and say, 'I'm dyslexic'. I can't spell and it were terrifying [laughs], terrifying, it was, dreaded thinking about my dyslexia. I found it a real challenge being [open] to professionals, and still now, I feel dead embarrassed about it, really. [sighs] So, it was, sort of like, [phew] I've got to tell them how bad I am really, otherwise [laughs] I'm going to come a cropper. I don't think I [disclosed my background or dyslexia to other students on the course]. I only disclose it, Sheila, when people ask. It's that trust thing again, Sheila [laughs]. It's that lack of trust thing, yeah, I've got to feel it's alright. If I don't know anybody I feel really, really difficult about disclosing me dyslexia to them. So, I just didn't say anything except to you. I felt dead nervous anyway. I always feel really nervous about telling people all the time. But I felt it was really important that you read that assessment that I had with me. So, you could tell that I'm

not lying to you. You've got to read it so you know I do need that bit of extra time. I really thought it was really important that you read that. It was the first time I'd ever been in that situation, Sheila, I was proper nervous about it. It was horrible. [laughs] It was horrible.

I was off sick last year. I was quite ill [laughs]. I was off sick for about 6 months and, eh, it went round the [name of service], well I got told, some of my clients told me that there was a rumour going round that I'd gone back to using. So, I was like, 'really?' And they went, 'yeah, that's what everyone was saying, that you'd start using again'. I don't know. I was like, 'really?' I was quite shocked in a way, I was. I was quite shocked. For them to think [that], that they talk about you like that, you know what I mean? I thought it was a bit weird, to be honest, that they still see you like [that], it's a bit odd. Like people expect you to [relapse], you know what I mean? It's been nearly ten years for me and people, like, there must be people who still expect that you're going to relapse at some point which is a bit odd. [laughs]

I've even had a client, oh [sighs], about a year and a half ago, who had social services involvement. And she was my client. And she turned round to me cos I'd phoned social services and spoken to them to tell them that she hadn't provided urine samples like she was supposed to be doing. And she had a go at me, basically, because she said, 'I've heard you're an ex-user and you should know better than to phone people' and blah, blah, blah. And I was, 'oh, really?' [laughs]

I do presentations at the university, nursing students, and I'm there two hours. I'm there talking for an hour and then questions and answers for an hour. It's nursing students and it's about my experience of being a substance user and how you get treated by health care professionals, you know, getting discriminated against and stuff like that. The way people perceive you to be as a substance user. It goes down quite well, actually. I got a thank you card off them all last time I did it. I used to do it all the time, to be honest. I've not done it since I've been at [drug service]. I've not done it for the last three, four years and then I've just started again. I'm doing [it] more as a favour than me wanted to do it really. It's not something I wanted. I'm just doing it [because] someone's asked me to do it so, yeah, I'll do it. It's me being the yes person though, isn't it? It's just that if I can help them out I'll do it, you know. [I don't really know if I'd put the nursing presentations on an application form], Sheila, to be honest. I don't really, really know until that actual time arises. I'd really have to think about it, cos I don't know how long it's going to last. I didn't [tell the students I'm a drug worker] in me last one, no. I didn't get asked. I thought, because they were nursing students, it was their opportunity to ask questions and I just was to answer them for an hour. So, before I'd finished talking, I said to them, 'right, when I come back I want loads of questions and answers' and that's what I expected one of the questions to be. They never asked what I do now. And not one of them said, 'what do you do now?' Cos I'm sure I don't look like a drug user now. Not one of them asked and there was a class of about thirty. Not one of them asked, 'are you still using now?' Or, 'are you working now? What do you do for a living?' None of them. Unless they still see me as a drug user [laughs].

I think once health care professionals know you've been a substance user, they look at you in an entirely different way. I don't think it's got anything to do with me anymore. Well, it has cos it's a big part of me life [laughs]. [I] shouldn't have said that really. But, I don't think

it's got anything to do with them really. Although it's a big part of me and the person who I am as well, it's been so many years now. I think [phew], to be honest, I don't really know, it's hard to say, isn't it? With clients, if they ask me, like if I was struggling in a clinic with a client, and as soon as this client walked in, she went, 'you're an ex-user, you, aren't you?' And I don't actually get that. So, I went, 'yeah, why?' She went I can tell by your arms. I said, 'yeah, yeah', and that broke the barriers straight away and we started chatting and she was asking me about my experience and what do I think she should do about this and that. Then I will, but, if I'm trying to get something across, I won't go I'm an ex-user and nah, nah, nah. I won't do it like that, Sheila. I will try and do it without saying I'm an ex-user. Really, I'll only say if they ask me, then I'll tell them. But if they don't ask me, I won't. I mean, one client said, 'what's all that on your arms?' So, I thought, he doesn't know what they is on me arms so I'm not going to tell him. I said, 'what you being nosey for?' That's what I said to him. But, I thought, if you don't know what they are, you know what I mean? To me, it's quite obvious what they are, so, if he doesn't know what they are, I'm not going to tell him. [Other workers] never ask, never, which is a bit odd. I don't know, but, I've never had anyone say, what's all that, Jamie? Some service users don't know what they are, which surprised me, so, I imagine if a lot of service users don't know what they are, then you'll get a lot of workers who don't know what they are as well, really. It's how they perceive you really, Sheila, isn't it? If they know you to be an ex-user, then they'll probably say to you, but if they don't know you as a person, anyway, say if, some new member of staff came here and started working, I don't think they'd have a clue really.

I've had contact with social services and stuff like that. With them I don't really know, Sheila, if they are aware. I don't think they are aware that I'm an ex-user. I don't know. I don't disclose to other staff. Why should I? I don't usually get professionals in my job asking me, 'am I an ex-user?'

**Jamie – transition story**

[I started with the] support group on a Thursday night which you didn't have to attend in them days, it wasn't compulsory. So, I decided to attend it anyway and I enjoyed it. It were quite good. I liked to see people who was clean coming back each week. So I decided to do that when I left the unit, once I'd finished me detox. My decision to change was the detox. That was my change. I think everyone has got it in them at some point in their lives that they'll make change. They'll change the way they are. Everyone's got something that'll make them change. They've got it in them. They might not know what it is, but, I believe that everybody's got something in them that if it's there for them, they'll get.

The facilitator at the time was an ex-user, and she got a job in the community and she had no one else to do the support group. So she asked me and this other guy, did we want to take over the support group for her. She'd been doing it for a number of years and she didn't want to see it fade, so we agreed to carry it on. I think I were a group member for only a matter of about three or four months. As she was coming up to the time she was going, she didn't come to the support group. So, I took over unknowing that was what she was doing. She didn't say that's what she was doing. She was just letting us do that. She did it sneakily. She must have had it planned for a good while cos what she's do is, she was on

shifts while the support group was on so she'd come in and say, 'oh, I can't do it, it's a really busy shift today, and could you just do it between you'. If it'd have been me solely at the beginning, it might have been different but seeing as there was three of us, it was shared. The responsibility wasn't ours solely to get it up and going for it to be successful, when it was the three of us. And it worked quite well doing it, cos we was all going together anyway and getting support at the beginning, so we knew how it all worked. Then I got confident about talking about how I felt, and being open about all me difficulties that I was having. I think it was attending that group that gave me that skill [to facilitate]. The lady who did the group before, she was great at it. She knew how to keep it going, she knew how to get the conversation going. She knew when a person had had enough. People might go round in turns and some'd be crying and all that, and say it's always been like this for me, so it used to go round and when people that had had enough, she'd seem to know and move on to the next person and, 'how have you been?' and it just flowed. She was good at it. That's how it worked out.

[Becoming a volunteer], it wasn't planned by me. That was just another thing that sort of happened basically. It never even entered me head to be a volunteer or - It was staff. They said, 'well, you're doing alright. Why don't you become a volunteer on the unit?' I think, it all stems back to the support group. If someone hadn't have asked me to do that, I wouldn't have done it. If I hadn't have done that, I wouldn't have done none of this [support worker], definitely not. I think, Sheila, to be honest, cos it went well when that facilitator left, it carried on to be good and there were loads of people coming back every week I think they seen it as, 'oh, they're doing alright here'. Maybe they could do better on the unit'. I don't know what they were thinking but they asked us to volunteer, me and this other guy. It just started off on weekends. I just started going in on Saturday and Sunday, basically, taking clients to shops, going in the gym, taking clients for walks, sitting in the lounge chatting to people. [There was] no induction. I don't know if they thought because I'd done me detoxes on the unit I, well three times, I knew how it all run, you know, how everything works, so, maybe they thought I didn't need an induction. I don't know, but I didn't get one. It worked fine for me at that time, Sheila, it worked really well for me. I don't know why but it just clicked and I did ok. I think [I did] about ten months.

I think I'd been volunteering for about 10 months and then I got offered to go on the [sessional team], cos I was doing more volunteering then on the unit. I was there not every day but maybe every other day. So I was doing quite a lot. I was at the stimulant service and that included weekends as well. I was always on the unit. I was doing ok, coping alright and I really enjoyed it. I really got loads of feedback from the clients and staff so I really focused. I don't know why but I just focused on it. And it was keeping me safe as well at the time cos it was [pause] how can I [put it]? I still had that, [it was] possible that, relapse scenario in me head, that I debated that if I wasn't doing anything maybe I could easily have slipped back into it. It worked out to be [like relapse prevention] that way [laughs], Sheila, it worked out to be like that. But, like I say, it wasn't planned. It just seemed to work. It just happened.

I always seemed to get to where I wanted to go, I don't know why. Well, there was no way out of it cos it was, sort of like, well, I can't fail now. Cos the only alternative would have been nothing [laughs], back to drug use. There was no plan B, definitely not. There was no

plan B at all. So it was all like, it was also like embarrassment as well, Sheila, I suppose the embarrassment of, [pause] cos once I got so far and started on the [sessional team], it was like [intake of breath], there was no way I could relapse now and come back here as a patient. I would say though, Sheila, thinking about it on reflection, that to go straight, volunteer for a while, definitely, but, to go straight from detox, six months volunteering, to fulltime employment is hard for somebody who hasn't worked for years, definitely.

As I step back and reflect on it, it worked out pretty well for me. [How it happened was], 'do you want to do this?' Funnily enough I didn't have to apply [for sessional work]. As far as I know, I'm the only person that never had to, unless there were people before me that I don't know about but people since always had to. I didn't have to do an interview for the post at all. It was 'you're on the [sessional team] now' [laughs]. But I was mostly concerned about me benefits as well cos really I [sighs] was unsure, 'is this going to work out for me?' Am I going to lose me benefits? Am I going to have to start paying full rent?' So, I was pretty concerned really. Cos I was getting me rent paid, me council tax and all that paid for. So, I was thinking, 'well, if I don't make enough money here, I'm gonna basically be struggling and that's one thing I agreed to me-self, Sheila, that I never wanted to struggle. You know I didn't want to get a job where I was going to struggle. That was my purpose of being, I don't know, I wanted to be drug-free but I didn't want to suffer. If I was going to be drug-free, I wanted to lead a productive life where I just didn't want to struggle, you know? Like penny-pinching and that. Like saying, I can't do that. I've got to do that because when I was using drugs [laughs] it wasn't like that so I didn't want to change, being drug-free. I know it might sound daft but I didn't want to be drug-free and then suffer. It sounds weird but I didn't want to do that. Basically, I was a bit scared. I really just kept all that to me-self basically. It was just one of them things that I didn't want to talk about. I just dealt with it. I sussed it out anyway that I could do [sessional work] as therapeutic work, that's how I did it, so I could work 16 hours a week. I was working the 16 hours but I was still doing the volunteering as well, anyway, so I was doing more. So, I had that therapeutic work, cos I'd been on incapacity benefit. Then, the way I dealt with it was by doing all the shifts I could. The only way I could not do that was by [laughing] working more and getting a decent wage. And once you're in that trap, you're in it because you get used to the money then. So, really, my time on the unit just increased [sighs] a hundred-fold. [I was sessional staff for] about 6 weeks [then] a full-time support worker position came available.

[I was a support worker for] about 3 years. I went up a grade I think after about a year and a half, 2 years of me being there, something like that. It's hard to keep time lines and all that business. [I was promoted] because I had developed [service user advocacy] on the unit. So I incorporated [service user advocacy] into the group programme basically, and still doing the support group every Thursday. I only got supervision when I became a support worker. [When I was a volunteer and a sessional worker I didn't get supervision], not professional supervision, but there was always times when I could go to staff and have a chat but I never got planned, structured supervision. I mean, there was always staff there that I could turn round to talk to if we had a problem and stuff.

I was doing quite a lot of stuff then. It was a really busy time that actually, a lot to take in really. With me dyslexia as well that was a killer [laughs]. It was a killer. Cos I'd never, in all me years, Sheila, I've always through school, I've always wriggled out doing written

work and stuff like that. I'd always wriggled out of it some way or other. And it was only when I've come down to the sessional work when I had to start doing notes. When I first started on the [sessional team] and I realised I had to do client notes [phew] I went to pieces. I really struggled but the thought of, 'oh, my God, I've got to write', cos I couldn't do it. That's the first time in me life where I had to turn round and say, 'I'm dyslexic, I can't spell' and it were terrifying [laughs], terrifying, it was. [I] dreaded thinking about my dyslexia. I found it a real challenge [saying] to professionals, and still now, I feel dead embarrassed about it really. But I got support because the team at the time, it was still the nurses who I'd done me detox with and they was dead supportive of me, they was great. So, they supported me all the way, so, I was confident.

The Level 3 is [my] only major training. I've had loads of one day training sessions and stuff like that but the substance misuse course is the only training I've had. But I deferred because of me dyslexia. I had to do me Level one literacy first before they'd put me in for it. I was in full-time employment, cos I had to do Thursday morning at college for nine months, something like that I think it was. Nightmare, but I did it. Well, I passed it. I passed the test really. When I went on to the Level 3, [sighs] I found the biochemistry bit, about the neurotransmitters and stuff, really, really difficult to get me head round. I found it really difficult. I just couldn't grasp the concept of it. It's the terminology of it all. It's not my kind of terminology. Wow, I couldn't read out the words to be honest. I'd be, 'what does that say?' [laughs] So, that was pretty difficult, Sheila. The rest of it I found quite easy in me head. Putting it down on paper was something else. In me head, it was all there, you know what I mean? But, comes to putting it on paper and wording it how it should be worded was incredibly difficult. As it went on, as I got used to it, it was more, I did get used to it all, how it should be done. But, as it went on, I didn't have to ask anyone, I was just doing it myself. Because I'd never done any of that sort of work before, Sheila, how to set work out, it must have learned me how to put stuff like that into reports and that. I wouldn't say I'm brilliant at it, but, I know how to set it out now. So, I have learned by it, definitely.

I left the unit. I went as a substance misuse practitioner in the community. [sighs] No induction, well, the induction was go and spend a day here, a day there and that was it. I suppose, Sheila, if you passed the interview and got the job, you're expected to know how to do that job anyway, that expectation is there when you got the job. Because you've got to have experience of care planning and stuff like that, so, it's how you put it on your application form that you follow care plans. I didn't say anything about writing them, but I put, what a care plan is and stuff like that, so, as long as you mention that. I'd been on the unit, paid, about three and a half years. It seems longer than that but it's not. So, I'm now classed as a [drug worker], shared care, been doing that, oh, about two and a half years.

It was quite a jump to [the drug worker]. See, the notes what you had to do for in-patients were basic. I felt that was a challenge when I got to community. It was like, 'oh, my god', cos, I didn't have a clue. I knew about drug work but when it came down to prescriptions and you know what I mean, writing prescriptions and it was a nightmare. It's chaos, basically [laughs]. At the time, the [service] was mad. I mean, at first what they had me doing was drop-in three days a week and then I was doing case work 2 days a week [sighs]. I hated it in the drop-in. I hated it. Cos, it felt like same old thing again, you know? It was, sort of like, 'what am I doing here?' even though I was getting paid for it. . But I said,

'no, I didn't come here for that. I didn't come here to sit in the drop-in. I came here as a drug worker. I'm not sitting and manning the drop-in'. I don't know why they did that but I said, I've not come here for that. Well, there was one other drug worker in there and it was volunteers. But, I was, 'no, I didn't come here for that. I didn't come here to sit in the drop-in. I did that when I was a volunteer. I've come here as a drug worker. That's what my job role is, as a drug worker'. They moved me out because, I don't know if it was sickness or shortness of staff or maternity leave, so basically, they had to fill the gap, so it was, 'well, get stuck in then'. [I was] still in [service] but it was doing actual case work then. I didn't realise how scary it was gonna get [laughs] at the time really [sighs]. It were sink or swim, basically. I suppose all through me life really, Sheila, around me dyslexia, I've learned to deal [with it].

I did go for a [senior] position, but I didn't get it. I didn't get through the interview which was a bit of a bummer. I'm crap at interviews. I just went to pieces [laughs]. I hate interviews. I really do. How I managed to get the job I'm in now, I'll never know, cos I thought I did really rubbish, I hated it. You ask me about policies, drug strategies and that, I'd go to pieces. It's just like, with me dyslexia, if you were to ask me to write anything on the spot, I can't do it. I just can't do it. Even though I seem alright with you, inside, I'm shaking to tell you the truth. [laughs] It's just the way I am, Sheila.

I was off sick last year. I was quite ill. I was off for about 6 months and it went round the [service], some of my clients told me that there was a rumour going round that I'd gone back to using. So, I was like 'really?' And they went, 'yeah, that's what everyone was saying, that you'd start using again'. I was like, 'really?' I was quite shocked in a way. For them to think [that] and that they talk about you like that, you know what I mean? I thought it was a bit weird, to be honest, that they still see you like [that], it's a bit odd. Like people expect you to [relapse], you know what I mean? It's been nearly ten years for me and people still expect that you're going to relapse at some point which is a bit odd.

There weren't that many volunteers about when I first started and I think if I'd been in that same situation now, I don't think I'd get anywhere. That's my personal view on it. I don't know if I'm wrong or not. I think there's that many volunteers now at [service], they've got about 30 volunteers, and I just feel if I were in that situation now, there's no way I'd get where I am now, definitely not. I'm glad I'm not in their shoes cos I don't know if I'd get where I wanted to go. It's a bit wrong, letting people be volunteers if you're not going to let them get that experience or give them the chance of getting a job if that's the type of job they're wanting to get. It's using them really, isn't it?

The only friends I have are non-drug using friends. [I] don't have much contact with anyone really out of work, apart from me lad, I see him a lot. I have got friends, but, I don't go out socialising much. It's a bit odd cos all me friends were drug users, so, I was always doing summat, out with somebody, doing something or other. From being a drug user, I had to get rid of all them lot. So, them lot went out the window basically, and [sighs] me new set of friends that I've accumulated, are all professional workers.

[heavy sigh] I do get cross from time to time, to be honest. I feel, to be honest with you, Sheila, that I've never really got away from drug use. Even though I'm not using drugs anymore I've never really got away from it which sometimes it gets me; it doesn't get me

down, it just, I don't know, it's a bit weird. I suppose, the way I see it, all them years I used drugs and I got drug-free and I'm still dealing with drugs in some form or another [laughs] which is a bit, if you take it the wrong way, if you think about it too much, I suppose, it could destroy you as well, in a way. Well, I thought about this and I thought what else could I do now? There's nothing else I would do now, I don't think. You know, if I decided to change the way I work, what else could I do? Don't know. Don't know, haven't got a clue. But you can make that work to your advantage or disadvantage. It could really do your head in, with your caseload and the stress of it all. And you could turn around and say, 'I don't need all this. I got away from drug use to get away from all that, why am I continuing to have that as a part of me life now?' The stress of it all has surfaced. It has surfaced but not for a long time and I've just put it back down. I wouldn't say it's there all the time. It's just there in the background and you utilise it when it works for you. You need to move on, so to speak, and say I've had enough of this now, and move on from it.

I never set out to be a drug worker, not at all, never. Even when I was [a support worker], if you'd said you'll be doing shared care, working with G.P.s and stuff like that in another three years, I'd have been like, 'yeah, whatever'. I would have said you were talking rubbish. Now I've realised when it's all on paper like that, you don't realise how much you do. And I was trying to work it out. I done all that since [doing a detox]. It's not even ten years yet and I've done quite a lot. You don't realise how much you've done, I don't think, until you look back at it all. So, when I [see] that, I was, you've come a long way really. If someone had said to me before I did me detox or while I was doing it, in nine, ten years you'll have done this, that and the other, and you would end up here, I wouldn't have believed it for a minute. I've probably got one of the most responsible jobs in the whole family. I think it's that kind of need in me, to keep me going. To keep me fulfilled, I think, so, yeah, quite pleased with my little self.

**Jamie – professional identity narrative**

When we've taken over [the support group], they leave us to our own devices. I just don't think it would have been right [to have staff in the groups], Sheila, I don't, because it's us and them. It shouldn't be like that but I suppose that clients still see staff as us and them. And clients probably see me now as he's one of the staff and people just seem to clamp up a little bit. Cos, even when I was working, I used to go in and take the badge off, [facilitate the group] without my badge on. I'd still keep that professional stuff there but go back, giving advice about when I was using and how I've got round that difficult part. That's how I used to go in with it.

My understanding, I suppose, cos not every staff member even though their good at their job, they still [sighs] might not have an understanding. You've got different staff that have got that understanding but there's a lot that haven't. And I think even though a lot of people have been trained in substance misuse, I still think that understanding bit of it isn't there. I sound like I'm [saying] that staff that have never used drugs don't know what they're on about, they do, but, you get brilliant staff who know everything about everything and they're up-to-date and they're really good at their job and they can really motivate clients to change and stuff like that, but when it comes down to the drug use, they're still a bit

naïve, I think. You can tell [laughs] by the way some people talk, you just know they've just not got that real understanding [intake of breath]. It's not my role [to make them understand], it's not. It's not, at all. I mean, people ask me, and I tell them, but, apart from that, it's not my role to do that. I've always been like that, Sheila. I won't do that until I'm asked. If someone asks me, 'oh, Jamie, what do you think of that?', then I'll tell them, I'll give them my point of view across, but unless they do, no [laughs]; they have to ask.

The other person [who co-facilitated the support group], I thought it were going quite well until he started to mess about with some of the female clients. On the surface, I was looking towards him because, it's weird, but, he could spell, so he could write the group rules and, like, our expectations of people attending the group and boundaries and stuff like that. And because he could spell I was, sort of like, co-dependency, so to speak. I was looking to him to do that because I couldn't do it really [sighs]. And then he started messing about and this and that with female clients and started lying to me. Then it all came out and when it all came about, it was this female client, well, she was an ex-client at the time she was coming to the support group, and she came before the group and started saying she was making allegations, how he was coming up to see her and they were having a drink together and they was having a sexual relationship, 'Oh, really, he's using me and this is happening', and I was, like, 'oh, right' [laughs] and when he comes in tonight will I get help from the support group with him, and I was, 'oh, God' [laughs]. So, that was my first experience of anything like that. Obviously, I'd to divulge that. He got told not to come back. I've seen him since. I've seen him walking past this service. I don't know what he's up to or anything. Two of us ended up being volunteers. I believe that [the other co-facilitator] got a job in services in [town] or somewhere. That's what I heard. I believe he's doing alright. But, yeah, that was difficult. I later found out from the ward manager [laughs] that he'd been trying to say that I was doing stuff as well, to try and get me ousted, to try and get me into trouble. I mean, he was up to other stuff as well. I thought I was his friend and we were doing it together, but, no, he was trying to get me. He was trying to get me into trouble, so to speak. I was shocked really [laughs]. I was shocked, thinking, oh, that's what he's like. That's what he's really like. Not only was he having relationships with a female client, ex-service user, whatever, he was also trying to get me into trouble. [sighs] Well, to be honest, Sheila, even though I've got experience of being street-wise and stuff like that all through me drug using life, when I started being a volunteer and working with professionals, I thought I'd left all that devious stuff behind and all that, and it still goes on [laughs]. And I found, well, obviously, I know better now. [laughs] I expected that you'd be able to trust people and stuff like that in what you did. And I've learned over the years that people'll just drop you like a brick when trouble hits [laughs], yeah.

Some held it against you, being an ex-user, to be honest, Sheila, they do. Most of the time I've got good communication skills with the clients and I get on well but there's always one or two who don't like it. Em [sighs] I don't know [why people don't like it], Sheila, to be honest. I really don't know. I really, really don't know. I've even had it recently as well. Not that something was said to me personally. I was off sick last year. I was quite ill [laughs]. I was off sick for about 6 months and it went round the [service], some of my clients told me that there was a rumour going round that I'd gone back to using. So, I was like, 'really?' And they went, 'yeah, that's what everyone was saying, that you'd start using again'. I don't know. I was like, 'really?' I was quite shocked in a way, I was. I was quite shocked. To think

that they talk about you like that, you know what I mean? I thought it was a bit weird, to be honest, that they still see you like. It's a bit odd. Like people expect you to [relapse]. It's been nearly ten years for me and there must be people who still expect that you're going to relapse at some point which is a bit odd [laughs].

I've even had a client, oh [sighs], about a year and a half ago, who had social services involvement. And she was my client. And she turned round to me cos I'd phoned social services and spoken to them to tell them that she hadn't provided urine samples like she was supposed to be doing. And she had a go at me, basically, because she said, 'I've heard you're an ex-user and you should know better than to phone people'. And I was, 'oh, really?' [laughs]. So, it's a bit how people perceive you.

It's a bit different, being an ex-user rather than a professional. I've found, Sheila, you've got to learn yourself how to put a line there in a way, which you won't cross, cos you've got to work with clients anyway. I see it as the best way to work with people is to be on their level. Don't be something you're not, and just work with them how you should, cos they're just normal people. But if you treat them any differently from that or you get too friendly, then they expect things from you as well, cos with us having that fine line, I think, isn't it? I learned it as a volunteer. I learned all this while I was being a volunteer. The best way to go about it, the way I learned that, Sheila, was because clients were using on the unit, smoking weed, and I caught them smoking weed [laughs]. And it was at the time when if you was caught smoking weed, it was discharge. That was it. You was finished. And I caught a few of them smoking in the garden, so I said, 'Listen, put it out and I won't say nothing this time. But if I catch you again.' But, you know, as soon as me back was turned, so, I caught them again. And I went then and told staff. But, I said, 'Listen, I hold me hands up [laughs], I did catch them before but I gave them the benefit of the doubt.' And I thought, oh, they're not going to have me back here and that's when I learned then. So, if you're going to do it, you gotta do it properly, so giving someone a chance and then they took no notice basically. And I could have endangered my volunteering on the unit because I was putting not only clients but staff at risk as well. On reflection now, at the time, I didn't realise what I was doing. I thought I was finished. I thought I was finished and when I came in the next day and I said, 'listen, I understand if you don't want me here anymore.' And they said, 'don't be daft, don't be daft. You sorted it out, in the end it all got sorted. Use it as a learning curve.' I felt terrible. I thought, you idiot. We got taught about boundaries and stuff like that. I mean, they did it in a verbal way. They said, Jamie, don't do duh, duh, duh. And it was just a learning thing. It wasn't like I got sat down and right, Jamie, it's like this. It was just staff chatting and if you see anyone doing this, let us know, and all that. I know that I should really have reported it, but I thought I'd give that person the option not to do it again. And I gave them that chance of remaining on the unit really, as they would have got discharged but I gave them that chance, that option of not doing it again basically and that was it.

I never got supervision, you know. No, I never got supervision. I only got supervision when I became a support worker. [When I was a volunteer and a sessional worker I didn't get supervision], not professional supervision, but there was always times when I could go back to staff and have a chat but I never got planned, structured supervision. I mean, there was always staff there that I could turn round to talk to if we had a problem and stuff.

[Volunteers] need support through that supervision and, obviously, it's great to get that support from managers and other colleagues and stuff like that, but, ultimately, it's the ex-service user employee's responsibility to keep themselves safe. And it all goes down to, Sheila, how you do your detox, right. You've got to disengage from old friends and associates. [Working with drug users now], it's different because they're not me friends [laughs]. They're not me friends and associates. If you don't you're not going to be able to maintain it. It'll come up and bite you on the backside before, even a couple of years down the line. I mean, now, [sighs] I suppose I could go and score now if I wanted to but because I've disengaged with meself, it'd be hard for me to go and do it. But, if you're knocking about in them kinds of circles, you'd find it a bit of a struggle. Stress. You're already there so it's miles easier if you distance yourself from it. It's harder if you don't, for me anyway. The way I think is you don't do it. As I explained before, Sheila, when you start this as an individual, you've got to sort yourself out and know your boundaries. And knowing there's people when them boundaries are really needed. You've got to really know what you're up to, where your boundaries are. And if you don't you're setting yourself up to fail. I think people should be aware as well about what you're up to, really, before you start.

[Being professional], it's all down to [having] someone you can trust in what they say really, to put your trust in them. To me, you should have that certainty that you're going to be respected and I found it doesn't work like that, does it? [laughs] It does with some people, but I have found where people can protect themselves and when things are at stake for them, they protect themselves and they'll just leave you flat and dry, really. It's just open and honest, that's what I expect from everyone, me, and I don't like someone who should be a professional person and they end up not being like that at all. I do find it hard to deal with really, especially, when they start playing games and saying things to protect themselves. That's when it started to hit home a little bit, thinking you've really got to watch what you're doing because if you make mistakes more than likely people won't back you up. They'll protect themselves. It also learned me to basically think about what I was doing before I did it. So, a quick learning curve really. It was positive but I expected really to be supported better than that and not just [phew] you're on your own, kid [laughs] You made that decision, sort it out. And that's what it was like.

So, I left the unit in 2006. I went as a substance misuse practitioner in the community. [sighs] No induction, well, the induction was go and spend a day here, a day there and that was it. Well, suppose, Sheila, if you passed the interview and got the job, you're expected to know how to do that job anyway. So, that expectation is there when you got the job because you've got to have experience of care planning and stuff like that. So, it's how you put it on your application form that you follow care plans. I didn't say anything about writing them, but I put what a care plan is and stuff like that, so, as long as you mention that.

And it was only when I've come down to the [sessional] work when I had to start doing notes. That's the first time in me life where I had to turn round and say, 'I'm dyslexic, I can't spell' and it were terrifying [laughs], terrifying, it was. [I] dreaded thinking about my dyslexia. I found it a real challenge being [open] to professionals, and still now, I feel dead embarrassed about it, really. [sighs] I suppose it goes back to childhood really, the way I was treated in school, cos it was not how it is these days. I got slapped on the back of me legs because I couldn't read a book. So, that's how it's stuck with me, I think. That's how I

was treated at school, 'you're thick'. I got excluded from everything, basically. So, it was [phew] I've got to tell them how bad I am really, otherwise [laughs] I'm going to come a cropper. When I first started on [sessional work] and I realised I had to do client notes [phew] I went to pieces. I really struggled but that thought of, 'oh, my God, I've got to write', cos I couldn't do it. And all the way through it, it's been the same thing, more or less. But I got support, really, because the team at the time, it was still the nurses who I'd done me detox with and they was dead supportive of me, they was. They was great. So, they supported me all the way, so, I was confident. I could say, 'listen, I need help with this'. So, they gave me the help. My confidence has got bigger over the years but that fear has always been there. On the computer, I'm alright as long as I've got the time.

[When I started as a community drug worker, it was, 'that's your job and you do it'. [Supervision was] very few and far between. Not a lot of it. It's only been, basically, recently that I've started getting proper supervision [laughs]. They've re-structured us now so they've got two team leaders, and everyone is getting supervision now. Before that it was just left up to the manager, basically.

[I give presentations to] nursing students about my experience of being a substance user and how you get treated by healthcare professionals, getting discriminated against and the way people perceive you to be as a substance user. It goes down quite well, actually. I got a thank you card off them all last time I did it. I used to do it all the time, to be honest. I've not done it since I've been at [drug service]. I've not done it for the last three, four years and then I've just started again. I'm doing [it] more as a favour than me wanted to do it really. It's not something I wanted. I'm just doing it as someone's asked me to do it so, yeah, I'll do it. It's me being the yes person though, isn't it, like I said. It's just that if I can help them out I'll do it. I didn't [tell the students I'm a drug worker] in me last one. I didn't get asked. I thought, because they were nursing students, it was their opportunity to ask questions and I just was to answer them for an hour. So, before I'd finished talking, I said to them, 'right, when I come back I want loads of questions and answers' and that's what I expected one of the questions to be. They never asked what I do now. Not one person asked it. Not one of them said, 'what do you do now?' Cos I'm sure I don't look like a drug user now. Not one of them asked and there was a class of about thirty. Not one of them asked, 'are you still using now?' Or, 'are you working now? What do you do for a living?' None of them [pause] unless they still see me as a drug user [laughs]. I don't know, unless they thought I must still be using. Don't know. So, it's interesting what people think. I think once healthcare professionals know you've been a substance user, they look at you in an entirely different way. I don't think it's got anything to do with me anymore. Well, it has cos it's a big part of me life [laughs], shouldn't have said that really. But, I don't think it's got anything to do with them really. Although it's a big part of me and the person who I am, even though it's been so many years now.

[Other workers] never ask, never, which is a bit odd. It's how they perceive you really, isn't it? If they know you to be an ex-user, then they'll probably say to you, but if they don't know you as a person, say if, some new member of staff started working here, I don't think they'd have a clue really. I've had contact with social services and with them I don't really know, Sheila, if they are aware. I don't think they are aware that I'm an ex-user. I don't

know. Why should I [disclose]? I don't usually get, like, professionals, you know, in my job asking me 'am I an ex-user?'

[I don't get discriminatory comments], not to my face, no. I've only had on the unit once there was a student and he had a bit of a shock, basically, cos he turned round and said, 'I don't know how you can work with these people, you know what I mean? People who burgle houses and all that, how can you work with these people day in, day out?' And I turned round and said, 'I am one'. He went, 'oh, right, I didn't mean it like that.' Like I say, he was a student. But apart from that, no, em, not really. [intake of breath] I've had no one say to me face anyway. It's hard to say. I mean, there's a couple of people who, I don't know, I think I'm quite a good judge of character, me-self, and there's a couple of people that, basically, in our office now, where if there comes a situation, they'll always ask another professional, who's got a qualification. They'd never come to the unqualified, ever. I've got me Level 3, but they'll never [ask me], and that sticks out a little bit for me. If you don't come from a nursing background or you've not got a degree or something like that behind you, you're no one. Well, you're not no one, but they don't class you in their league, basically. I wouldn't say all nurses are like that, but, there's one particular nurse here who, I mean, it's not just me, it's to other people as well, is that they'll only ask certain questions to other qualified staff. They won't ask un-qualifieds. But when I'm stuck with someone I can get loads of advice from workers here who've never touched a drug in their lives. We've got a lot of good staff here who are very well informed, who know their stuff. They do know their stuff. There's lots of good workers out there. Even if you've not got [a nursing] qualification, to be employed here you still must have that level of knowledge to be here in the first place and it's just not recognised. It's not. You're just not involved by that qualified nurse. It's not personal. They see us as unqualified. Everyone picks up on it, it's not just me. It's one of those things. It's hard to change people's attitudes, isn't it? As long as I can do my job and be effective, it doesn't bother me in the slightest. I think me wanting to do the Level three, came about in supervision when I was on the unit. And I think your first intake, when one of me colleagues did it, and I wanted to do it. But I deferred because of me dyslexia, so, I had to do me Level one literacy first before they'd put me in for it. The Level 3 is the only major training [I've done]. I've had loads of little one day training sessions and stuff like that but the substance misuse course is the only training I've had [laughs].

My [personal experience] was valued on the unit, most definitely. It was valued all the way up. Some staff'll come to me and say, 'what do you think about this, Jamie?' It's mostly me knowledge about the unit really, about detox cos I'm quite knowledgeable about detox even though I've not been there for four years. I still know it all really, how it works. Sometimes they'll come up to me and ask me about treatment – 'what do you think about this?' And I say, 'if they can't detox, how about you let them do stabilisation and have them out and back in again. See how they cope' and stuff like that. [In shared care], I do two surgeries, em, one surgery, it's really good. It's doing really well. I've even got the doctor where she has a two hour session open every Monday for any client who's attached to that service, to the surgery, to go in and she'll see 'em, basically. So, I have a really good relationship with her, always in and out of her office and talking to her and that, two hours, when I'm there. The other one, I only see the doctor now and again, basically, so I don't have much contact with 'em, but I don't think she is aware or if she is she's not said anything.

I do feel now and again to be honest with you, Sheila, that I've never really got away from drug use. Even though I'm not using drugs anymore I've never really got away from it which, I don't know, sometimes it gets me, well, it doesn't get me down, it just, I don't know. It's a bit weird, I suppose, the way I see it, all them years I used drugs and I got drug-free and I'm still dealing with drugs in some form or another [laughs] which is a bit, if you take it the wrong way, if you think about it too much, I suppose, it could destroy you as well, in a way. Well, I thought about this and I thought what else could I do now. There's nothing else I would do now, I don't think. You know, if I decided to change the way I work, what else could I do? Don't know. Don't know. Haven't got a clue. But you can make that work to your advantage or disadvantage. I mean, the way I started thinking about this was because someone put it into me head a little bit, another worker who's a ex-user, and he said, 'I'm sick of it, Jamie, it's just drugs, drugs, drugs, all this. I can't get away from it' [laughs] and I thought about this and I thought, 'oh, yeah, I know what you're on about there a little bit.' It's that realisation, Sheila, that if you really think about it, then that's the way it is because from leaving school to starting smoking cannabis and then through me drug using life and then from being drug-free, then moving on to being where I am now, it's just talking about drug use or preventing drug use, so, that's how it's been. It can make you sink or swim, can't it? It can work both ways really. I use it all in a positive way, so, I've gone from a really bad time in me life, to picking me-self back up again and getting out of it and moving on. Or, you could use it in a negative way and say, I need to get away from all this now, I need to focus on summat else and get away from it completely, cos it could really do your head in, with your caseload and the stress of it all. And you could turn around and say I don't need all this. I got away from drug use to get away from all that, why am I continuing to have that as a part of me life now? The stress of it all. It has surfaced. It has surfaced but not for a long time and I've just put it back down. I wouldn't say it's there all the time. It's just there in the background and you utilise it when it works for you. You need to move on, so to speak, and say I've had enough of this now, and move on from it.