Helpful Ingredients in the Treatment of Long-Term Substance Use Disorders: A Collaborative Narrative Study

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ABSTRACT: Relatively few individuals with a substance use disorder (SUD) seek or receive treatment, and knowledge about the effective ingredients in SUD treatment, from the perspective of those who receive it, is scarce. Our study purpose was to explore the experiences of those with long-term SUDs and the aspects they found helpful during treatment and long-term recovery. Semi-structured interviews were conducted with 18 participants, each of whom had been diagnosed with a long-term SUD, and who had been abstinent for at least 5 years. A resource group of peer consultants in long-term recovery from SUDs contributed to study planning, preparation, and initial analyses. Participants preferred individualized, long-term treatment, and support from both therapists and other clients. They further acknowledged the importance of their own sense of responsibility for their treatment and recovery success. Greater focus should be placed on viewing long-term SUD as a long-term condition, similar to somatic diseases, and SUD treatment services should place greater emphasis on developing partnership care models, long-term monitoring and support, and actively engaging recovered clients in the care of others in SUD treatment.

KEYWORDS: substance use disorder, treatment, client experiences, collaborative research

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Introduction

Persons diagnosed with a substance use disorder (SUD) tend to suffer from poor physical and mental health, in addition to experiencing adversity in different arenas of life.[1,2] Such issues seem to be even more prominent among those with SUDs and co-occurring mental illnesses.[3,4] From a global perspective, although the incidence of SUDs has increased,[5] we continue to see that relatively few of those with an SUD seek treatment. Data from Western countries such as Norway and the United States indicate that only about 5% to 20% of those with an SUD receive treatment.[6,7] This could be due to both a lack of available treatment options and the fact that many who are active substance users do not believe they need, or would potentially benefit from, treatment.

Several treatment approaches have been developed, including opioid maintenance treatment (OMT), detox programmes, drug-free outpatient treatment, harm-reduction services, long-term residential programmes, cognitive behavioural treatment, and motivational enhancement treatment. There are also several 12-step self-help programmes, including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Dual Diagnosis Anonymous (DDA). Although 12-step programmes are generally considered complementary to formal treatments, and their effectiveness has not been fully documented,[8] they are widely used, particularly in the United States.

Substance use disorder treatment and support services (e.g. 12-step self-help programmes) are generally effective and help clients reach stable abstinence and recovery.[9,10] The impact of motivation and readiness to change has been examined in several studies, which indicate that pretreatment motivation increases the probability of treatment retention[11,12] and seems to be a strong predictor of treatment outcome.[13,14] Furthermore, several studies suggest that motivation to cut down or abstain from substance use develops over time.[15-17] However, research also indicates that just as many individuals with SUD appear to recover without treatment.[18] The intuitive notion that the longer their period of nonuse, the less likely an individual will be to relapse, is confirmed by research showing abstinence of 5 years is critical for stable recovery.[19-21] The role of OMT in recovery is debated internationally, but the view among clinicians and health authorities in Norway is that individuals using only prescription OMT are in recovery status.[22,23]

Previous qualitative studies examining clients' perspectives on the factors that helped them during long-term SUD treatment suggest that therapeutic relationships with staff and mutual support among clients are the most important,[24-26]

along with support from family and friends.[27] In particular, studies about opioid addiction treatment experiences indicate that OMT experiences differ based on the medication used.[28] Participants in two studies experienced improved quality of life and a sense of freedom, as long as they followed the OMT treatment regimens (although having flexibility to be independent of supervision was also seen as important).[29,30] The importance of building trusting relationships with OMT staff, and the need for flexible and individualized support, has been put forward in other studies.[31,32] Experiences with 12-step-based self-help groups suggest that connectedness and support are most important to young adults,[33] while middle-aged adults view helping others as most important in their recovery.[34] Finally, those who have been on the 'recovery journey' longer, place greater emphasis on nonabstinence-related goals such as employment, education, family reunification, spirituality, and giving back.[21,35] In contrast, those who have spent shorter periods actively addressing their substance use problems are more focussed on abstinence-related goals, and they experience periods of decreased happiness and lowered self-esteem.[36,37]

It is already well known that factors such as pretreatment motivation, readiness to change, and/or receiving various forms of assistance from others are beneficial for behaviour change. We predominantly lack knowledge, however, about the experiened impact of different aspects of treatment on the initiation and maintenance of abstinence and recovery. Globally, few studies have examined the treatment experiences of both genders, individuals who used a diverse set of substances, and those who received a variety of SUD treatments. Thus, our overall research goal is to gain insight into how individuals with long-term SUD stop using substances over time. In this study, we specifically aimed to explore what those in long-term recovery found most helpful during their SUD treatment.

Methods

The study design was descriptive and exploratory, using individual semi-structured interviews to generate knowledge about individuals' experiences. A phenomenological narrative approach was applied in analysing the transcribed interviews. The details of the research design, context, recruitment, sample, and data collection have been described elsewhere.[15]

A collaborative research design

Clinical research into SUD and mental health disorder treatment is considered, by an increasing number of service users, to be disempowering and poorly reflective of service users' priorities.[38-40] Having firsthand experience with the health condition being investigated, and/or the treatments being evaluated, can increase the quality, relevance, and utility of study findings.[41] Thus, a resource group of peer consultants who had experienced long-term recovery from SUD was established when study planning was initiated in August 2015. The resource group's mandate was to contribute to the project by reviewing both the study aims and research questions, and preparing the thematic interview guide. The resource group also contributed to analyses during an initial reading of the interview transcripts, and worked alongside H.P. to establish the initial themes. Members of the resource group (Morten Brodahl, Stig Haugrud, Tore Klausen, and Jeanette Rundgren) are affiliated with the Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders. In addition, Victoria Benson, who is affiliated with the Programme for Recovery and Community Health at Yale University, contributed to the later stages of analysis and provided feedback on article drafts.

Context

The sample for this qualitative study was recruited from the Comorbidity Study: Substance Dependence and Concurrent Mental and Somatic Disorders (COMORB study), a longitudinal study of two cohorts from Norway concerning mental[42,43] and somatic[44] comorbidities, respectively. The two cohorts were (1) an 18-year follow-up of the Dual Diagnosis Study on psychiatric comorbidity in a heterogeneous sample of patients with SUD and (2) a 20-year follow-up of the study on OMT, in which somatic morbidity among dependent opioid users was assessed before, during, and after treatment. These two cohorts were merged for joint data collection in 2015, consisting of self-report assessment (N = 148). The current qualitative study recruited participants from the 2016 joint cohort.

Recruitment and sample

Of the participants (N = 148) who participated in the two cohorts during the 2016 follow-up, 35 met the inclusion criteria of the current study. Those who were excluded still had problematic substance use at follow-up or reported nonproblematic use within the previous 5 years. A purposive, criterion-based sampling procedure[45] was used to recruit a heterogeneous sample of 18 participants who had been in stable recovery for at least 5 years. Stable recovery was defined as abstaining from all substance use, being in OMT with prescribed medication, or engaging in unproblematic use of legal substances. Both being in stable recovery and having nonproblematic use of legal substances were assessed through self-report questionnaires. To obtain information-rich data that would provide insights and an in-depth understanding,[46] variance in gender, types of substances used, and experiences with different treatment types were sought.

The participants were 10 men and 8 women, ages 35–68 (mean: 54) years. They reported an active period of problematic substance use of 13–36 (mean: 21) years, followed by a period of abstinence of 5–18 (mean: 12) years. Six of the participants had mainly used heroin, five had primarily used alcohol, five had a history of mixed substance use, one had only used amphetamines, and one had only used cannabis. Eight of the participants were totally abstinent at the time of the interview;

10 reported nonproblematic alcohol use. Ten of the participants had been diagnosed with major depression and/or anxiety, as was assessed using the Composite International Diagnostic Interview (CIDI).[47]

With regard to their treatment experiences, all who had used heroin received OMT, and all but one of them had started methadone therapy during residential treatment. Those who had been dependent on alcohol or a mixture of substances had received long-term SUD treatment in institutions that used either a 12-step approach or the Therapeutic Community model, or had attended self-help groups such as AA or NA. A total of 16 participants had received long-term residential SUD treatment, and reported a total of three to eight institutional stays. Two participants had only been admitted to a detoxification unit or received another type of short-term treatment. Four of those six participants who attended 12-step programmes did so as part of residential treatment follow-up care.

Data collection

Given the time-consuming nature of our interview methods and group discussions for data analysis, 18 participants were considered both practical and sufficient. An interview guide comprising issues relevant to the study aim was developed. Face-to-face interviews conducted by H.P., lasting approximately 1 hour, were conducted with each of the 18 participants in their homes. Participants were asked to consider their experiences of abstaining from long-term substance use, including both their decisions and reasons for abstaining or using moderation, and their strategies and requirements to stay abstinent. The intention was to let participants reflect freely on their experiences and to ask clarifying questions without making interpretations.[48] The same questions with designated prompts were used with most of the participants. The exception was that the two participants who had only received short-term treatment were asked less about their treatment experiences than the others. The interviews were recorded digitally, and verbatim transcription was completed before the next interview.

Narrative analysis

If the intention of research is to influence and contribute to changes, it can be effective to touch the receivers emotionally.[49,50] Narratives which can contain emotional elements that unfold through diverse expressions, form the grounds for various interpretations among the recipients. As such, a narrative analysis seemed advantageous in this study. Informed by phenomenology,[51] the interview transcripts were initially read with an open mind to bracket the researchers' preconceptions and focus attention on the information conveyed by the participants. In the initial analysis, each member of the resource group, in addition to H.P. and S.B., individually read the transcripts after every four to five interviews. Overarching themes conveying issues related to reasons and strategies for abstaining were established. These themes were subsequently discussed and summarized in successive meetings between the resource group and H.P. Finally, we concluded by merging the findings into the main theme that included all 18 interviews. The main theme concerned what helped the participants during their SUD treatment experiences. Subsequently, 96 meaning units, consisting of sentences or paragraphs from the main theme, were identified and translated from Norwegian to English by H.P.

The next step involved moving from interview data to coherent revelatory descriptions employing empathic bridges within the narrative structure.[50,52] Essential to the narrative construction was maintaining focus on the basic narrative elements of metaphor, plot, character, and point of view[53] while summarizing each participant's story using a first-person perspective. Two of the peer consultants (M.B. and V.B.) developed nine narratives each, based on the meaning units that conveyed information about helpful ingredients in SUD treatment. Each interview contained recurrent expressions about treatment experiences but varied with respect to how much the participants emphasized treatment as important for their recovery. The main challenge for the peer consultants when writing the narratives was to establish a coherent story based on the meaning units. Since none of the peer consultants had any previous training in writing narratives, H.P. and L.D. gave advice during the initial phase of writing (e.g. how to establish a time line and how to shorten long sentences); the latter half of the writing was undertaken independently by the peer consultants. Furthermore, the established narratives were examined by H.P., who compared them with the overall interview information. Next, H.P. and L.D. developed 3 of the 18 main narratives, based on which of three treatment types the participants had experienced (OMT, long-term residential treatment, and self-help groups). These narratives were constructed using one participant from each of the three treatment types as a starting point, and then adding text from the interviews with the other participants who reported consistent treatment experiences, by using a cut and paste method to insert relevant meaning units. The main narratives were then reviewed by M.B. and V.B., and returned to H.P. for completion.

The last step in the narrative analysis was to closely examine the three treatment-type narratives for similarities and differences across their themes. This last step involved an iterative process of reading and commenting by the team members who had experience with SUD and SUD treatment but no formal training in qualitative analysis (M.B. and V.B.), and the researchers with no SUD experience but extensive experience with qualitative research methods (L.D. and H.P.). This method of developing consensus among team members with different backgrounds contributed to safeguarding the trustworthiness of the findings.[54]

Ethical considerations

The COMORB study was approved by the Regional Committee for Medical and Health Research Ethics, South-East Region (REK-no. 2014/1936). All survey participants gave written, informed consent and were informed that they could withdraw from the study at any stage. Consent covered the possibility that participants might be contacted for a further, in-depth interview. To insure anonymity, fictitious names are used when quoting participants and no identifiable participant information has been used herein.

Results

The following narratives use a first-person perspective to demonstrate how these participants described their treatment experiences. Each of the 18 interviews included expressions about which aspects of treatment were helpful; most, but not all, of their views are represented in these narratives.

Narrative 1: Kent (age 50 years) had used a mixture of heroin and other substances for 25 years and had been abstinent for the past 10 years. He had two grown children and was married to a woman who had a nearly identical substance use and recovery history. Kent had received long-term residential treatment on several occasions. He explained,

> Regardless of treatment or not, I believe you have to be very motivated in order to quit substance use. It is crucial not to use residential treatment just to gain weight or to relax. A lot of people have such attitudes. I remember from my days, from the start of each winter, most treatment centres experienced a great influx of people for admission. Towards the spring, when the weather became nicer, it was the opposite: everyone requested a discharge back to the streets. In my opinion, you really need motivation to benefit from residential treatment.
>
> I clearly recall my first treatment episode in the late 1980s. I had sparse knowledge about elementary chores of daily living, such as buying clothes or groceries. During my residential stays, I gained such knowledge. I learned about a lot of practical matters and their importance, because at some point in life you have to manage on your own, and having done some practical training, it made it easier for me to move on in the right direction. Because I stayed in residential treatment for longer periods, I also gained knowledge about handling all seasons. I had memories from the different seasons as an addict. Being institutionalized, I got to experience being sober for the first time over Christmas. To me, that was, in itself, an unusual and pleasant experience. Even if I didn't succeed in becoming stable and abstinent during most of my residential stays, I picked up something useful along the way. In particular, I recall being discharged from my last residential treatment, where I left feeling more self-confident than I had ever felt before.
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> I preferred individual conversations when attending treatment. During group discussions, when several were in attendance, I could not reveal a lot of my inner thoughts because one of my greatest challenges in life has been to share my feelings with other people. It actually felt more feasible to talk with my close family than to the treatment providers. But the good thing was that if you managed to open up, you received valuable feedback from the others. A lot of the group discussions were challenging, but seen in perspective, I realize that I came into contact with both my own and other participants' processes during such meetings.
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> More specifically, one of the treatment stays was helpful, because one of the treatment providers went out of his way to understand me and meet my needs. I had the feeling that he was there just for me. Of course he was not, but that was how I experienced our interactions. He was different from most of the other professionals in that he didn't care too much about the formal procedures at the centre. He focused on the years to come and at the same time he allowed me to bring back good memories from the years prior to my substance use career, such as the fishing trips or experiencing my very first bike ride.
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> But most important was when I finally realized that I was responsible for my own recovery. Nobody could ever help me if I didn't take on the heavy work myself. I also strongly believe that residential treatment is necessary if you are addicted. Polyclinic treatment doesn't fill the needs because you are not able to establish the necessary distance from people and places. I am aware that addiction services still offer a weekly polyclinic appointment, but if you still engage in the same 'playground', you don't have a chance to get new 'playmates'. I strongly believe you need a change of scenery to become abstinent.

Narrative 2: Anna (age 60 years) developed a heroin addiction after suffering from severe long-term pain following back surgery and had been abstinent for the past 17 years. She had been to residential SUD treatment several times before receiving OMT. She explained,

> I have had, and still have, serious physical health issues. That was also the main reason why I started using heroin in the first place and was using it regularly for more than 30 years. When being discharged from the hospital after back surgery, I simply didn't receive proper pain-relieving medication. I felt kind of left on my own.
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> Subsequently I asked for treatment, and yet it took three years before they gave consent to give me methadone. The reasons given were that they wanted to find out how motivated I was. But when you are really in the gutter, you don't apply just for fun when you finally get the chance to try something that can save you. After I decided to apply, I was thinking, 'If methadone does not help me, there is really no hope'. I was really just grasping at straws, because I felt totally helpless.
>
> Methadone was a medicine that really helped me from the beginning. I remember well, because the first time I received it I had severe withdrawal symptoms and felt both physically and mentally sick. I recall the treatment providers asking me to empty the bottle and I thought that those drops wouldn't help me much – I would have preferred to inject it. But after just 10–15 minutes, I had a sensation of free breathing and being able to relax. The stress and the anxiety went away and it was as if I had reached some kind of comfort and well-being without having taken any substances. Also, the cravings for substances were gone, and after some time I was able to envision a better future for myself. From then on, I actually felt that I got a second chance.

> Then after being institutionalized for some months, I told the treatment providers that I didn't want to leave because I felt I needed more time, and because I began experiencing some side effects of the medication, and I still suffered physical pain. Because I had experienced several residential stays previously without methadone treatment that had proven unsuccessful, I needed to build up my strength to be able to meet people again, and to face daily living. Considering I had been in my own bubble for all those years, it took some time to rearrange my habits. Thinking back, it was due to both my stubbornness and my courage to challenge the service providers that I got the best out of the treatment. I think if you are invited to share in the decisions about your treatment, then I believe this responsibility is of such significance that it can prevent relapse as well. Eventually, the doctors adjusted my medications and the treatment providers accepted my argument for an extended stay at the institution. My experience is that most of those starting up with methadone have to attend either residential treatment or receive other kinds of support, because they don't manage on their own. Having the opportunity to share my experiences with other people in treatment was, to me, the best support.
>
> The methadone treatment programmes are basically established as a 'one size fits all' style. But I think people experience methadone quite individually, because we have different backgrounds. A youngster developing into severe heroin use and entering methadone treatment may have other needs and experiences compared with myself, having had most of my adult years living in drug use circles before entering treatment.

Narrative 3: Susanne (age 58 years) was divorced from a husband who also had addiction problems; she had two adult daughters. Susanne was addicted to cannabis and alcohol for nearly 30 years and had been abstinent for the past 8 years. She had received short-term detox treatment before entering a 12-step programme. She explained,

> I remember thinking that even though acknowledging that my marijuana and alcohol use was way out of control, it was not in my mind to seek help because this was something I should manage on my own. I think it's the very notion of always managing on your own that confines your possibilities. But I believe defining addiction as an illness has a beneficial effect psychologically, because it takes away a heavy burden from many of us suffering from such problems. We carry a lot of guilt and shame after making bad choices throughout life. In my case, it was about being a bad mother and a bad wife. I was neglecting people close to me when smoking, and often lost control when I drank.
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> To me, the key to stable abstinence has been the membership in AA, with regular meetings all these years. It hasn't been a quick fix, but it has been crucial to realize my own powerlessness and why I didn't manage daily living. I had to give answers to such issues about myself and then share them with my sponsor in the programme. She was a quite straightforward woman, no kidding around, and we developed a good relationship. She confronted me in several ways, and I had no other possibilities than to face my challenges. Besides, I had to do services, which implied I had to engage in helping newcomers entering the programme. I was fully engaged, and the first person I helped really managed to quit drinking, so I had kind of success, and it strengthened me as well.
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> What I found in AA was a down-to-earth approach with concrete working tasks. I see it as a simple programme for difficult people. Initially in my career as an abstainer, I was searching for who to blame. But trying to find out who, outside of myself, was responsible for my addiction issues ended up in nothing. I realized that I had to be responsible for my own choices. The fortunate thing with admitting that you are addicted, is that some of the addiction problems actually let go.
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> At one of the AA meetings, I met a guy who told me his story, which was much worse than mine. At that time I still had a home and a steady job as a teacher in a public school. In contrast, this guy had been living on the street and had endured a very difficult life. Listening to his story made me kind of humble, because until then, I had mostly felt terribly sorry for myself and then I had to admit that somebody had actually been through more challenging times than I had. I recall this episode as a pivotal discovery for my own recovery.
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> AA was really important to me in the beginning of my abstaining career, by providing a social network other than what the milieu of substance users represented. It is not that easy, as a 49-year-old, to cut off contact with all your friends and acquaintances. Then you are suddenly on your own. For me, it could have become very lonely, because my husband had left, and both my daughters were drifting away from me. And besides, AA implies a social network where you meet recognition and are seen as the person you are. Often during meetings, I can still enjoy a good laugh when someone tells her story that seems almost equal to mine. But also, I have an arena where I can sit down just to talk if I have a bad day. A lot of non-addicted people have attended our meetings expressing a wish to have a similar place to visit once in a while.

Discussion

The primary study findings include similarities across the narratives, including the advantage of receiving long-term care, whether through prolonged stay in an institution or ongoing self-help group attendance. Participants also appreciated the individualized accommodations they received in successful treatment and were also aware that they bore personal responsibility for their own treatment success. The three narratives also reflected an appreciation for hearing the stories of, and receiving support from, other clients, which they reported had helped them confront and address their own issues.

The narratives also differed insofar, as the participants' experiences reflected their various SUD treatment types. For instance, using heroin and entering OMT implied a focus on the effects of methadone, which was not part of the experiences of those in non-medical treatments. Furthermore, long-term residential stays seemed to provide valuable training in practical skills, which was not mentioned in the narrative about participating in a self-help group. Finally, the impact of a social network on SUD recovery emerged as being crucial among those attending self-help groups, both during regular attendance and when they kept in contact later in recovery; in contrast, there was less focus on the social aspect in the narrative reflecting OMT experiences.

These findings will be discussed according to the recovery management (RM) model, which offers a relatively new perspective on SUD treatment by calling for nothing less than substantive, systemic transformation. Recovery management's focus is on viewing SUDs as long-term disorders, in the same manner as we view other long-term disorders such as diabetes, asthma, and hypertension. In short, RM argues that SUDs need to be addressed in a manner distinct from the current acute care model used in most SUD treatments. Recovery management can be seen as a philosophy of organizing SUD treatment and recovery support services to enhance early pre-recovery engagement, recovery initiation, long-term recovery maintenance, and quality of personal/family life in long-term recovery.[55]

Despite research showing that long-term SUD treatment is thoroughly beneficial,[56,57] the acute care model remains the prevailing paradigm, with its main objectives being gradual decrease in inpatient stay and increased cost-effectiveness. Furthermore, high turnover in the SUD treatment workforce, and consequently disrupted relationships, is another barrier to long-term care and follow-up.[58] Findings from this study show that both long-term stay at an institution and several residential stays over years were valued by our participants. The benefits of permanent or enduring meetings with a 12-step group were also underscored. The participants emphasized the helpful aspects of long-term care, which were relatively independent of which substance(s) they had used or what treatment type they had received. The exception to this was methadone treatment, about which reports of the immediate effects were seen as a turning point, although long-term follow-up and support were often also needed. This is consistent with research showing that beneficial outcomes of SUD treatment increase in proportion to treatment duration[59-61] and that SUD care should not last for fewer than 3 months for nonmethadone treatment and not less than 1 year for methadone treatment.[62] Considering that our participants had problematic substance use for an average of 21 years, it is unsurprising that their narratives underscore the significance of also needing several years for recovery. This long-term perspective is also in accord with the main principle of RM[55] but has not been reflected in previous qualitative studies of clients' treatment preferences.

Of similar importance, person-centredness and individualization of services have emerged as cornerstones of effective SUD treatment[63,64] and are highlighted as leading principles in national SUD treatment guidelines.[62,65] The narratives in this study reveal that these participants appreciated the service providers who used a 'personal connection', or saw the clients as individuals beyond their substance use problems. These aspects of effective treatment further reflect RM principles that client choice and individualized matching afford the best prospects for successful long-term SUD recovery.[55]

Although the narrative about OMT underscores the immediate and positive effects of medication, it also points to the importance of being invited to share decisions about treatment, including both discussion about medication options and treatment durations. These findings are consistent with previous research on client perspectives about which aspects of OMT are helpful.[30,31] Furthermore, individualizing OMT treatment is challenging because many service users still view monitoring and supervision as the main characteristics of these services.[29]

The recovery story as a personal battle in which individuals mobilize internal resources to manage daily living is well established in Western cultures.[66,67] Reflecting this personal battle, the narratives herein convey aspects of how the participants, as service recipients, feel they have a personal responsibility to make the best of their treatment. One participant explained that being invited to share in her treatment decisions gave her a greater sense of responsibility. Another participant reported finally recognizing that he was responsible for his own recovery. This sense of personal responsibility for the recovery process is also articulated in the philosophy of 12-step programmes.[68] Comparing treatment approaches used for those with long-term disorders with those with SUDs, we find that in the former there is substantially greater focus on collaborative care and that patients are empowered to assume responsibility for the long-term management of their disorders.[69] The dominant view among clinicians providing SUD treatment is that one is not responsible for the disease, but for one's recovery.[70] Furthermore, it is important to underscore that personal responsibility is context specific in the sense that health risk and illness development, SUD included, are also rooted in the social determinants of health (e.g. income, occupation, education, gender, ethnicity, and general living conditions).[71] According to RM's principles, the transition from a professional-directed treatment plan to a client-directed recovery plan encourages client responsibility. On the other hand, this must be balanced so that clinicians, rather than withdrawing from care, function as counsellors or consultants (i.e. instead of the sole expert). The transtheoretical model of change (TTM)[72] is the most widely used motivational theory of behaviour change in SUD research and treatment. In this respect, client responsibility can be seen as similar to transferring from the action stage to the maintenance stage of the TTM, which is associated with the initiation of substance use behaviour when abstinence has been reached but not firmly established. Furthermore, clients who are active in their treatment rate their experience more positively, remain in treatment longer, and achieve better recovery outcomes.[73,74] To our knowledge, this is the first study to assess client preferences and to underscore the importance of personal responsibility in SUD treatment.

Based on these narratives, hearing other clients' stories is important for recovery among those attending self-help groups. This has also been shown in previous studies[75,76] and is unsurprising, since social processes such as observation, imitation, and the expectation of peers are some of the basic factors in the

12-step programme philosophy.[68] However, these narratives also show that when participants are in long-term residential treatment programmes, participating in group discussions or activities with peers often allowed them to share experiences, consistent with previous qualitative findings.[24-26] Although previous studies included younger clients with shorter substance use histories than ours and were conducted in the United Kingdom, United States, and Norway, respectively, the findings are similar. This indicates that hearing stories and exchanging experiences with peers can be just as helpful for clients in reaching recovery as traditional contact between the client and a professional therapist. The efficacy of peer support in SUD treatment has also been supported in recent reviews.[77-79] Being recognized was seen by our participants as an important step towards abstinence and recovery; this was accomplished mainly through contact with other clients during treatment. This supports RM's philosophy concerning the importance of re-engaging those in recovery and developing a peer-recovery support network.[55]

The study findings reveal a number of important factors in SUD treatment, going beyond established constructs, such as pretreatment motivation and readiness to change, given our focus on the clients' treatment experiences. Individuals who abstain from substance use are seldom included as participants in research projects, emphasizing the importance of our heterogeneous study sample. The study sample consisted of persons in recovery in a Norwegian context. As mentioned previously, SUD development is influenced by contextual factors and social determinants of health, which is the case also with SUD recovery. Thus, that our study sample is not representative of the full range of clients with SUD treatment experiences may limit the transferability of our findings. Furthermore, since recruitment was based primarily on logistics, findings may not fully capture the breadth of experience. In addition, a potential source of bias may be that the meaning units were translated from Norwegian to English by only one person, rather than through a process of cross-translation and back-translation undertaken by multiple people.

One major limitation was that we used participants' retrospective recall of their experiences, which is problematic, given the fallibility of memory. Reports of events occurring several years earlier are influenced by frequent rehearsal. However, exploring these experiences directly through participants' narratives, through research collaboration with a team of former substance users, enabled us to focus deeply on the meaning of participants' treatment experiences and recovery. Furthermore, collaborating with those with firsthand SUD experience to guide preparation, data analysis, and write-up, contributed to internal data validity as well as a broader interpretation of the findings. This was an exploratory study, and as such, data interpretation should be considered within the context of qualitative research.

Conclusions

Our findings are generally consistent with previous reports of the factors that individuals with long-term SUDs find helpful in their treatment. The importance of individually tailored treatment and sharing experiences with, and receiving support from, other clients have been reported in both qualitative and quantitative studies. However, the importance of long-term treatment and clients' personal sense of responsibility have not been previously emphasized in qualitative studies of clients' treatment preferences. Moreover, these findings strongly support the basic elements of the RM model,[55] as opposed to the traditional acute care SUD treatment model. Ultimately, it is important to develop services to reach people at the early and middle stages of SUD, using case management or assertive outreach, service delivery at nonstigmatized service sites, and extended clinic hours. Services should employ greater collaborative, or partnership models of care, and develop client-directed recovery plans. Furthermore, services need to emphasize continuity of rapport building and maintenance through a primary recovery support relationship over time, and actively engage recovering clients to give back as peer mentors. Finally, to secure continuity of care, primary responsibility for posttreatment contact should be that of the treatment institution, not the client.

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Author Contributions

HP collaborated with the resource group on preparing the study and the writing of the interview guide, conducted the interviews, and collaborated with S.B. and the resource group on initial data analysis. HP, MB, VB, and LD conducted the later data analysis. HP had the primary role in drafting the manuscript, with inputs from MB, VB, LD, AL, IS, and SB. All authors read and approved the final manuscript.

Author's Note

AL, IS, SB, MB, VB, and LD contributed equally to this work.

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