Trust and collaboration between patients and staff in SUD treatment: A qualitative study of patients' reflections on inpatient SUD treatment four years after discharge

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Abstract

Background and aim: Substance use disorder (SUD) is multifactorial, complex, and involves the severe problematic use of alcohol, prescription drugs, and other substances. People with SUD have long histories of perceived stigma, marginalisation, exclusion, social isolation, and shame. Moreover, patients with SUD are often treated as untrustworthy and incapable of actively participating in their treatment planning, even by healthcare and social services workers. **Methods:** Through in-depth interviews with former patients who have undergone SUD treatment, we explored their reflections on the treatment content. Interpretative phenomenological analysis revealed that some informants experienced aspects of the treatment as valuable, whereas others considered the same treatment useless or harmful. **Results:** Essential aspects of treatment were developing self-esteem and optimism about the future, developing strategies for coping with stress and challenging emotions and situations, developing relationships with family and friends, and preparing for life after inpatient treatment. Relationships with staff were described as crucial in all parts of the treatment. **Conclusion:** In conclusion, we suggest that a transition to a more collaborative treatment philosophy would be ethically and professionally valuable for providing support and treatment and enhancing patients' perceptions of empowerment, inclusion, participation, and well-being on their terms, in cooperation with supportive others.

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Substance use disorder (SUD) is multifactorial, complex, and involves the severe problematic use of alcohol, prescription drugs, and other substances (Duncan, 2020). Some people with SUD keep their consumption at tolerable levels for extended periods, whereas others stop using, and some seek professional support and treatment to prevent or control their substance use and create better lives (Toneatto, 2013). For some, SUD entails lifelong struggles with substance use, suboptimal mental and physical health, complicated relationships, unemployment, poverty, poor housing, and the need for comprehensive professional support (Duncan, 2020). The World Health Organization (WHO) utilises a comprehensive, multidisciplinary approach for understanding the development and maintenance of SUD – a biopsychosocial model that Norwegian health authorities have adopted. The approach assumes that biological and psychological processes constantly interact with the relational, social, financial, political, and cultural elements of our surroundings (Duncan, 2020; Skewes & Gonzalez, 2013).

People with SUD generally have long histories of perceived stigma, marginalisation, exclusion, social isolation, and shame. Uncontrolled and continuing substance use, despite severe consequences for users and their close family members, are often seen as signs of incompetence, low morale, and weakness (Goffman, 1968; Livingston et al., 2012; Wiechelt, 2007). Patients with SUD often have experiences of being treated as untrustworthy and incapable of actively participating in their treatment planning, even by healthcare and social service workers (van Boekel et al., 2013; Welle-Strand et al., 2021).

In Norway, support and treatment for SUD are provided in both local-community and specialised healthcare facilities. To receive specialised treatment, users' SUD must be diagnosed according to ICD diagnostic criteria (WHO, 2015). Opinions differ as to whether a diagnosis decreases or increases stigma and shame; however, an SUD diagnosis may contribute to understanding the compulsive aspect of the problem and reveal the complexity of a life with SUD. Understanding and acknowledging this complexity is also appropriate for understanding people with SUD who stop using substances without support or treatment from professionals – so-called natural recovery (Duncan, 2020; Henden, 2016; Mudry et al., 2019; Toneatto, 2013). According to the diagnosis, SUD is often characterised by a lack of control over the use of alcohol or other substances, which significantly damages an otherwise safe and healthy life. In SUD, compulsive use of substances continues despite severe negative consequences for mental and physical health, education and work, relationships with family and friends, economic security, and participation in society (Duncan, 2020; WHO, 2015). For most people with SUD, substance use temporarily helps them feel better about and able to cope with, for example, trauma and adverse childhood experiences, attention deficit hyperactivity disorder (ADHD), anxiety, depression, challenging emotions, family demands, loneliness, and dire living conditions (Felitti & Anda, 2010; Gil-Rivas & McWhorter, 2013; Kassel et al., 2013; Topor et al., 2021). Frequent use of substances may lead to a worse life situation, with substances causing more problems than they solve.

The search for a better life is often called recovery, which has long been established in the SUD field and involves several approaches. The traditional model is the *clinical recovery* model of 12-step programmes, which requires lifelong abstinence from all substance use

(Recke, 2015). In recent decades, the concept of *personal recovery* has emerged, focusing on individual perceptions and descriptions of the current situation regarding well-being, community belongingness, and a positive sense of identity, including perceptions of a better life while living *with* core symptoms (Veseth et al., 2019). It entails a change of focus from "cure" to "coping" (Bjornestad et al., 2020; Laudet & White, 2010; Leamy et al., 2011; Neale et al., 2015; Slade et al., 2017). The *social recovery* approach emphasises the importance of meaningful and supportive relationships with family, friends, and professionals, as well as other aspects, such as poverty, discrimination, and community participation, which are all vital in a person's recovery process (Bjørlykhaug et al., 2021; Brekke et al., 2017; Pettersen et al., 2019; Tew et al., 2011; Topor et al., 2009). Price-Robertson et al. (2017) underpin the value of relational and social perceptions of recovery, claiming that an individualised understanding of recovery leaves the responsibility for quality of life and well-being to the user alone, instead of viewing people as situated in relational, social, and cultural contexts. Personal, social, and relational concepts of recovery may all embody a change of focus from the paternalistic approach involving a powerful specialist with a sometimes-arrogant attitude to patients, towards a practice that increases patients' empowerment and cooperation.

A growing body of research has investigated people's recovery processes without professional treatment and support, and follow-up studies have measured the outcomes of treatment (Andersson et al., 2020; Bjornestad et al., 2020; Hennessy, 2017; Johannessen et al., 2019; Mudry et al., 2019; Orford, 2008; Pettersen et al., 2018). To our knowledge, few qualitative studies have drawn attention to former patients' reflections on their treatment several years after leaving treatment programmes, focusing on factors related to the treatment and not to patient demographic factors (Brorson et al., 2013). Most studies

have explored people's experiences while still in treatment, examining their satisfaction with their treatment. This study explored informants' reflections on the research questions using in-depth interviews. The questions were: "Looking back on the inpatient treatment and the following years, how do informants reflect on their treatment? What elements of treatment do they consider useful, useless, or harmful?" The study aimed to gain more knowledge about former patients' perceptions of the content of treatment. Reflecting on possible connections between treatment content and subsequent life may improve the overall quality of SUD treatment.

Methods

Research context

In Norway, SUD is considered one of a range of physical and mental diseases that all require multidisciplinary specialised inpatient or outpatient treatment, and Norwegian health authorities manage and pay for such treatment. The informants in this study were 11 former patients who had undergone long-term inpatient treatment at the Tyrili Foundation – a non-government organisation that runs eight SUD treatment centres in Norway. The foundation's treatment approach is humanistic and adopts a biopsychosocial framework.

Recruitment

This study was a qualitative sub-study of the Tyrili Cohort 2016 study, which used quantitative methods to examine the quality of life, cognitive functioning, psychological distress, and experiences of trauma of 138 patients (Bergly & Sømhovd, 2018; Bergly & Sømhovd, 2021; Fjærli et al., 2021; Sømhovd et al., 2019). Most of these patients consented to participate in further sub-studies, and 25 informants completed all the surveys and tests and were chosen to participate in this sub-study. Selecting those who had met all the Tyrili

Cohort 2016 requirements allowed us to compare the results from both the quantitative and qualitative data. Fifteen of the 25 former patients responded to our invitation to participate in the study. Due to personal difficulties (a new-born child, substance use, or other reasons), four former patients could not keep their appointments; hence, the empirical data were drawn from in-depth interviews with 11 informants. The number of informants was not pre-determined. We had the option of continuing the recruitment process and including informants even if some data from the main study were missing; however, the transcription and transcript reading indicated that 11 interviews would be sufficient in order to answer the study aim (Kvale & Brinkmann, 2009; Magnusson & Marecek, 2015). The informants were recruited by telephone, messenger, or mail by one of the researchers.

Informants

The informants were six women and five men aged 30–45 years. They all had histories of severe substance use problems over many years. Most had started using substances between the ages of 12 and 15 years, and heroin and amphetamines were their primary substances, combined with cannabis, prescription drugs, and alcohol. Nine informants described adverse childhood experiences and explained that they used substances to deal with these experiences. They all claimed to have entered inpatient treatment to receive help and support in stopping their use of substances, improving their mental health, and obtaining education or a job. The average inpatient treatment stay was nine months. Table 1 provides some background information about the informants' life situations at the time of the interviews.

Interviews

We performed in-depth interviews in a conversational format as a framework for the co-production of meaning and knowledge (Kvale & Brinkmann, 2009). The researchers identified examples of meaning and learning by carefully listening to the informants with curiosity and respect, and by providing acknowledgement and responses. We used an interview guide that began with an open-ended question: "Can you please tell us about your life since leaving the treatment centre?" We followed up by asking:

> When looking back on the inpatient treatment and the following years, what elements of treatment do you think have been valuable, useless, or harmful? What particularly contributed to helping you reach your goals and improving your well-being and quality of life?

Both authors conducted the first three interviews to coordinate and adjust the interview guide. The second author alone conducted seven interviews, and the first author conducted one. Each interview lasted between one and one-and-a-half hours. The interviews were conducted in the informants' homes, workplaces, or cafés during the summer and autumn of 2020. Four of the interviews were conducted by telephone due to the coronavirus pandemic. The interviews were recorded and transcribed by the authors.

Analysis

Qualitative research requires reflexivity and transparency regarding the interview situation and analysis, choices made during the process, and possible consequences (Alvesson & Sköldberg, 2009; Simon, 2014). We used interpretative phenomenological analysis (Smith et al., 2009) to systemise and interpret the dialogue between the researcher and the informant. This approach embraced the informants' reflections and interpretations as well as the researchers' reflections during the interviews and while reading the interview transcripts. We considered this analysis relevant because it provided opportunities to focus on interpersonal

Table 1. Information about the informants' life situations.

Fictive name	Substance use after discharge	Living situation, important relationships	Work/ education	Health	Economy
Anders, 42	Nothing	Own apartment with partner and children	Full-time job	ADHD-medication,	Paid job
Anne, 29	Some episodes/ short periods	Alone in rented apartment Contact with family	Trainee	Depression treated with medication	Temporary disability benefit
Hanna, 39	Longer periods	Rented apartment Contact with children and siblings	Between part-time jobs	Depression, anxiety, trauma, treated with medication	Disability benefit
Ingrid, 31	Some episodes	Rented apartment boyfriend, contact with family and friends	Full-time job		Paid job
Jonas, 37	Some episodes	Own apartment with partner and children	Full-time job	Periods with depression treated with medication, OMT	Paid job 50% / temporary disability benefit 50%
Linda, 31	Longer periods	Rented apartment, boyfriend, contact with siblings	Full-time job	Anxiety, traumas treated with medication, somatic disease	Paid job
Peter, 29	Longer periods	Rented apartment with partner	Between jobs	ADHD, traumas, anxiety, depression treated with medication	Temporary disability benefit
Robert, 34	Some episodes	Rented apartment with partner and children	Full-time job	Anxiety, traumas, ADHD treated with medication, somatic problems	Paid job, debt settlement
Sara, 45	Frequently	Institutions and half-way houses Sporadic contact with family		Depression treated with medication	Temporary disability benefit
Stig, 38	Frequently	Institution, contact with family		Overwhelming emotions, trauma treated with medication, OMT	Disability benefit

(continued)

Table 1. (continued)

Fictive name	Substance use after discharge	Living situation, important relationships	Work/ education	Health	Economy
Tina, 30	Frequently	Own apartment	Participate in several activities organised by NGOs	Depression, anxiety, suicide, Somatic disease, OMT	Disability benefit

Note. ADHD = attention deficit hyperactivity disorder; NGO = non-government organisation; OMT = .

relationships in treatment, everyday life, and the interview situation. The analysis began with careful listening to the recorded dialogues. Thereafter, both authors read the transcripts several times to identify the informants' experiences, emotions, and reflections and then discussed them. Next, we investigated the participants' interpretations of their own stories and special events, because considerations of the treatment content arose at different points in the interviews (not only regarding questions about the treatment). Finally, we focused on the researchers' interpretations of the dialogue and the informants' interpretations. Both the common features of the informants' reflections and their unique stories and exceptions were of interest (Smith et al., 2009). We used the NVivo 11 software, designed for coding and analysing qualitative data, to systemise the data and select excerpts that shed light on aspects of the treatment and the following years. After careful examination by the authors, the following themes emerged: (1) treatment content and relationships that were considered valuable, (2) treatment content and relationships that were considered useless or harmful. We used these themes during the next examination to further explore and understand the informants' perceptions and reflections while maintaining awareness of the details of their stories. During this process, new, narrower subthemes emerged: developing self-esteem and optimism about the future, developing strategies for coping with stress and challenging emotions and situations,

developing relationships with family and friends, and preparing for life after inpatient treatment.

Ethical considerations

Ethical issues were considered during the recruitment, interviews, analysis, and data interpretation. Conducting in-depth interviews about personal experiences and perceptions requires great awareness of and respect for the informants' emotions and boundaries (Farrell, 2007). The informants were encouraged to contact their therapist, family, or friends if they needed anyone to talk to about stressful thoughts and emotions prompted by the interviews. The excerpts in this article were translated by the authors and anonymised, but they retain the content and meaning of the original narratives. The informants provided written informed consent before the interviews. They were informed of their right to withdraw and assured of data privacy. The Norwegian Centre for Research Data approved the qualitative sub-study (reference number 800600).

Findings

The analysis revealed that some informants considered aspects of the treatment content valuable, whereas others found it useless or harmful. We present the findings under two headings, the first of which refers to treatment content and relationships that were considered valuable, with subheadings: (1) developing self-

esteem and optimism about the future, (2) developing strategies for coping with stress and challenging emotions and situations, (3) developing relationships with family and friends, and (4) preparing for life after inpatient treatment. The second main heading refers to treatment content and relationships that were considered useless or harmful.

Treatment content and relationships that were considered valuable

Developing self-esteem and optimism about the future.. Relationships with treatment staff were mentioned as essential during treatment and constituted positive experiences to refer to after the treatment stay. Several informants discussed situations and relationships that made them feel important, trusted, valued, and cared for and how these precious experiences influenced the years after they left the treatment centre.

Ingrid, 31, lived in an apartment and had a paid full-time job. Although she had a couple of episodes of substance use after she left the treatment centre, she emphasised the staff members' attitudes and the importance of being treated with respect, which she thought contributed to keeping the treatment centre safe and free of substance use. Ingrid stressed that this was essential for establishing and maintaining relationships in general:

> You know, the staff were so sympathetic that none of us wanted to use substances at the centre. We all respected the place and those who worked there, not because they were strict but because they were so human. They treated us with respect, the same way they treated each other … I still carry this feeling with me four years after leaving … I think that being treated with humanity at the centre helped me trust other professionals later on because I used to think of all professionals as enemies.

Stig, 38, described his life situation after he left inpatient treatment as demanding, but he still had some optimism about the future. He arrived at the countryside treatment centre in the winter; it was near the mountains and used sledge dogs as part of the treatment:

> We went with the dogs far up into the mountains. The trust the staff showed me … I came from years of substance use, then detox … but they let me handle my own sledge with six dogs. I was so proud! … Somehow, I want to achieve that feeling again. That's why I never give up trying to become sober.

Hanna, 39, talked about her struggle with mental health and how she repeatedly used substances in an attempt to cope with her pain in recent years. She nevertheless emphasised the importance of meeting someone who believed she would manage to quit using substances and who cared for her:

> The staff didn't give up on me. They gave me chances. I ran away and used substances, and they welcomed me back. They cared for me and believed in me … Even after I left treatment, I could call my therapist and talk about how I felt and managed life outside. That helped me a lot … The fact that the staff believed in me still helps me to feel that I am worthy and important to my children.

Positive feelings of belonging during inpatient treatment mainly concerned being part of a patient group. Jonas, 37, explained that the group of patients made him feel that he belonged and was valued:

> To relate to others, they expect something from you in a good way … The other patients knew something about my struggles and feelings. They recognised them in themselves, so we could help each other … They trusted you and believed in you. Together with the other patients, I created new memories and

experiences. I realised that I could feel fine without substances, which was helpful. I sometimes catch up on that feeling, even years after leaving.

As the informants said, building self-esteem and hope for the future closely related to the attitudes of staff and the feelings of belonging to a group with fellow patients.

Developing strategies for coping with stress and challenging emotions and situations.. The informants described elements of the individual and group treatment that related to coping with trauma, anxiety, depression, criminality, gaming, and substance use. Jonas, 37, said that he experienced demanding periods during the first three years after leaving inpatient treatment. He had been depressed and struggled with anxiety and trauma, and he had used substances a couple of times to cope with his depression. In recent months, he had managed to stop using substances all by himself by employing the strategies he learned during treatment: "Those therapy groups about coping with substance cravings were helpful, and I have used some of those strategies in recent years".

The informants talked about their psychological processes in group and individual conversations with psychologists or other treatment staff. They emphasised positive experiences of being seen and understood and claimed that these prompted concrete actions. Robert, 34, was satisfied with the help he received from the psychologist: "We had days in the therapy group that were okay … when the subject was interesting. But the psychologist helped me the most. She arranged for ADHD screening and medication, which allowed me to work after I left treatment".

Most informants had experienced psychological health struggles caused by adverse childhood experiences and substance use over many years. It took several months of treatment for Ingrid, 31, to feel safe enough to enter into a therapeutic working alliance with the staff:

They helped me with the anxiety and depression that I struggled with during the first six months of treatment. Suddenly, I started to cry, and I couldn't stop. They taught me some methods that I still use when I get anxious at work.

It seems clear that these informants worked collaboratively with both staff and fellow patients to develop strategies for coping with stress, psychological problems, and substance cravings. They described different struggles and developed different strategies for coping with them, explaining that they were helpful in dealing with demanding life situations after leaving the treatment centre.

Developing relationships with family and friends. The informants described their relationships with family and friends as demanding, damaging, or valuable. Some informants agreed to include family members in their treatment programmes, but others refused. The family members who participated joined meetings, workshops, and family therapy sessions. Tina, 30, grew up with two parents who had SUD and severe mental health problems. Her father died during her late teens, but her mother became sober and received psychiatric treatment. Sara's mother visited her several times at the treatment centre and participated in family therapy sessions and workshops: "We had many difficult themes to talk about, you know … my childhood … It was so hard for both of us to talk about it … Today, we have a better relationship, and she is important to me" (Sara, 45).

Those informants who had children while in treatment emphasised that wanting to be a sober and good parent provided strong motivation to complete the treatment and stay sober. Jonas, 37, stated:

We had treatment groups focusing on being a mum or dad. They made me aware of how important I am to my children … When you have children, you have an obligation to stay

sober. I stay sober for my partner and my children.

Establishing new friendships often seemed important but demanding. Some informants reconnected with former friends, and some found closer relationships with colleagues after leaving the treatment centre. Most of the informants explained that they had to end their friendships with people who used substances to stay sober, like Hanna, 39:

> I have cut off contact with old friends many times, but it gets very lonely, so I start to see them again and then begin to use substances again. It's tough … I have tried to do it differently this time, but it is very demanding. It was necessary to cut off all contact with the "bad" people, but so hard to connect with new ones.

Loneliness is a challenging emotion and life situation for people after they leave inpatient treatment. These informants stressed the importance of working on relationships with family and friends during inpatient treatment, even though it was usually painful.

Preparing for life after inpatient treatment..
Looking back on the past four years, most informants were satisfied with the help they received to prepare for life after treatment. They emphasised learning daily routines and adjusting to circadian rhythms, getting a job, engaging in new activities, finding accommodation, and dealing with personal finances.

Linda, 31, had been unemployed with no regular daily activity over the past few years. In the interview, she proudly stated that she had held a full-time paid job for the last six months. She talked about the valuable experiences of participating in daily routines at the centre:

> I loved working with dogs … I learned to get up in the morning and work through the day, even though I sometimes hated it. I must admit that it was a skill I needed to learn …

I have been quite unstable when using substances, and jobs … you know … it is hard to combine them. However, thanks to the skills I learned during inpatient treatment, I have now been both sober and in paid work for the last six months.

Robert, 34, expressed great satisfaction with his life. He lived with his partner and their children and had a full-time paid job. He emphasised the importance of having specialised staff members to help patients find jobs and reduce debts:

> I received help getting a job. I didn't dare make the phone calls myself, but one of the staff helped me. I still have that job! … I had so much debt when I came in for treatment. One of the staff members helped me with debt agreements. They have been hard to pay off, but I will be debt-free in less than a year.

Tina, 30, had struggled terribly with mental health issues and substance use in recent years. She had recently moved to a new town and felt lonely. Nevertheless, she was satisfied that she had learned skills during the treatment stay: "I learned to snowboard and surf, and I loved it. There are excellent opportunities to do such activities where I live. Maybe I will meet some new people while doing them".

One of the treatment centres had the main focus on the final months of inpatient treatment, and the patients lived in apartments connected to the centre. Anders, 42, had undergone inpatient treatment several times and needed independent treatment more than residential care: "Living in the apartment, with the staff available, was extremely important for me. Learning to be alone, feeling lonely, preparing my meals, prioritising money – such things … without using substances to cope with the struggle".

Preparing for life after treatment involved not only practical issues but also attitudes towards cultural norms and rules. Most informants explained that, during inpatient

treatment, they gradually adjusted to more acceptable norms through experiences of belonging to and participating in groups in new social contexts after living for years in sub-cultures where the rules of the street or prison naturally coloured their attitudes, stances, and values. The informants described the process of developing their identities as sober people and adjusting to culturally accepted norms and attitudes as long and painful. Robert, 34, had been in prison several times before entering treatment and struggled with criminal habits. He reflected on how he changed his attitudes towards crime:

> When I arrived in treatment, I had a negative attitude towards the whole society. I wanted to keep earning fast money through crime, even if I stopped using drugs. Oh, I had many discussions about this with the staff and other patients. Finally, I agreed to quit crime, get a job, and earn legal money, which I now do.

Treatment content and relationships that were considered useless or harmful

Most of the informants talked about positive experiences of receiving help during their treatment, although most had struggled with mental health and substance use problems over the last four years. Nevertheless, some had had negative experiences with the staff and found it difficult to connect more closely with them, like Peter, 29. At the time of the interview, he was between jobs and described his struggles with mental health and substance use. He was rather dissatisfied with most of the treatment content and, in particular, with the staff:

> They had this top-down attitude, like they were walking on high heels all the time. They had hang-ups about stupid rules, treating us, the patients, like children … I think most professionals are useless when it comes to treating people with SUD as equal human beings … If the staff had been more

cooperative, I would probably be in a better life situation today.

Anne, 29, felt that she was not heard or respected by the staff:

> The staff forced me to move to another treatment centre because I used substances too many times, but I wanted to continue my process at the first centre. I felt let down and less worthy because they did not listen to me … Despite that, today, I manage my life and am satisfied with it.

Most of the informants talked about episodes of substance use during the treatment stay and mentioned group sessions on their return to the treatment centre after such substance use, either inside or outside the treatment centre. All the patients and staff had meetings, and the patients had to talk about and reflect on their substance use, with the rest of the patients and staff giving feedback. The male informants found this method helpful and fair; they valued listening to other patients' critical and supportive voices. However, the female informants criticised this practice. Tina, 30, expressed it as follows:

> Receiving positive feedback is nice, but breaking people down …? There was possibly some reason for doing that, but it made no sense. I was not proud of myself for using substances, but the others' mean comments made it much worse. I, and many others, have experienced bullying in school, and I had flashbacks to those days … Those meetings did not help me stop using – actually, the opposite!

Some of the informants were disappointed about the last period of inpatient treatment, as Sara, 45, explained:

> I felt so lonely. I worked so hard on myself in treatment, and I changed my whole life and way of thinking, but it all went back to the same old shit during the last treatment period

… I couldn't control myself, and the craving was so intense it was like a hole that sucked you in. It was not easy to ask for help, and I felt that they had forgotten me … I did not receive the help and support I expected, and I have used a lot of substances since leaving the treatment centre.

These informants expressed experiences of not being seen, respected, and supported as damaging to their recovery processes.

Discussion

Crucially important in the informants' narratives were staff attitudes: whether they treated patients with respect, trust, and collaboration, or with a disrespectful top-down attitude that reinforced feelings of powerlessness. The findings are discussed in relation to two aspects of the patients' treatment: gaining a broader understanding of SUD as multifactorial and complex (Duncan, 2020) and gradually introducing more collaborative practices in local and specialised healthcare and social services.

The importance of a coherent treatment approach

Inpatient SUD treatment has the potential to provide a protected temporary home in which to build trusting relationships and find room for personal and interpersonal development (De Ruysscher et al., 2020; von Greiff & Skogens, 2014). The informants stressed that the staff and fellow patients were crucial for facilitating the development of strategies for coping with stress and emotions; maintaining contact with family and friends; and offering practical support in finding jobs, accommodation, and aftercare.

The importance of these different aspects of treatment varied according to the needs for support that the informants identified during their treatment processes. This depended on the staff members' ability and willingness to listen carefully to each patient and collaborate

with them on individualised treatment plans, indicating the value of coherent, personalised treatment content that meets diverse needs and aligns with an understanding of recovery as a relational and social process (Laudet & White, 2010; Price-Robertson et al., 2017; Wangensteen & Hystad, 2021). The crucial turning point for some informants was developing new strategies for coping with, for example, substance cravings, trauma, ADHD, depression, and anxiety. For others, it was the establishment of daily routines; the adoption of circadian rhythms; and (in the final phase of treatment) finding a job, safe housing, and a predictable income (Bergly & Sømhovd, 2021; Johannessen et al., 2019; Nettleton et al., 2013). Some informants claimed that their contact with family and friends during treatment contributed to sustaining those relationships after leaving the treatment centre. Research has confirmed the importance of supportive family and friends during SUD treatment (Pettersen et al., 2019; Tew et al., 2011; Topor et al., 2006), and opportunities to work on troubled relationships and feelings of abandonment, grief, anger, and loneliness during treatment may be crucial in the recovery process (Birkeland et al., 2021; Orford et al., 2009; Selbekk et al., 2015). Patients who have children are often overwhelmed by feelings of grief, shame, and guilt, and contact with children may be an important motivation for seeking treatment (Brekke et al., 2020; Panchanadeswaran & Jayasundara, 2012; Wangensteen et al., 2020; Wiig et al., 2018).

The informants' narratives confirmed former research emphasising the importance of developing new social and practical skills together with experiences of joy and happiness in treatment settings (Hystad & Bergly, 2021; McKay, 2017). These are often perceived as commonplace and less valued than therapeutic interventions, but to many patients they are extremely valuable (Skatvedt & Schou, 2010). Although most informants described the treatment content as helpful in preparing them for life after inpatient treatment, the transition

from a sheltered inpatient environment to an independent life was challenging for most, and should probably be given greater attention by staff (Robertson & Nesvåg, 2019; Vanderplasschen et al., 2013).

According to the informants' reflections and former research, undergoing long-term inpatient treatment is highly demanding, and several of the informants discussed the benefits of working in groups with other patients (Nettleton et al., 2013; Orford et al., 2006; Robertson & Nesvåg, 2019). Patients are usually in a state of change, during which mental, physical, and social processes should lead to improved cognition, more appropriate attitudes, and new strategies for dealing with emotional pain and challenges. A treatment centre is an artificial setting: different people with unique backgrounds and needs are brought together and expected to develop individual aims and plans, but simultaneously work together in groups. Nevertheless, being in a sheltered environment where patients are allowed to "be themselves", with all their vulnerabilities and struggles, in their search for better lives may provide the necessary safety for developing and strengthening personal resources across several areas of life (De Ruysscher et al., 2020; Robertson & Nesvåg, 2019). Inpatient treatment aims to increase perceptions of belonging, acceptance, and reciprocity and to decrease feelings of loneliness and isolation. Being in a group of people who struggle with the same problems and are also searching for better lives facilitates connections (Kurtz, 2015; von Greiff & Skogens, 2014), since the group provides an outlet for patients to develop their empathy, receive and give advice and support, and improve their social skills during conversations and activities. Social support from fellow patients and staff is associated with improved mental health (Bjørlykhaug et al., 2021; Cloud & Granfield, 2008).

Nevertheless, one should not ignore the power of a group. In the same way that a group provides belonging and social support, it can also foster bullying, exclusion, and

oppression, as some of the female informants explained. Also, working with patient groups requires attentive and participatory staff who can prevent unwanted cultures from developing in a treatment unit (Radcliffe & Stevens, 2008; Valeri et al., 2018; Wendt & Gone, 2018).

Building personal relationships and social skills often entails some adjustment to cultural norms and rules. The informants described their journeys through inpatient treatment and into "normal" life as a mixture of struggle, pain, success, and setbacks. Moving from a substance-use-related culture to a sober culture seemed challenging because street attitudes and rules rarely function in other social contexts (Robertson & Nesvåg, 2019; Tew, 2013). Developing self-esteem and identity as a sober person requires the courage to adjust to cultural norms without necessarily becoming "like everyone else". Self-esteem and optimism about the future contribute to feelings of empowerment by enabling patients to look forward to participating in working life, leisure activities, support groups, organisations, and democratic processes (Johannessen et al., 2019; Veseth et al., 2019; Wangensteen & Hystad, 2021). Nettleton et al. (2013), however, asserted that these expectations of "normality" may be perceived as constraints by people in recovery. The standards of "normality" are too difficult to achieve for many of them, and years of stigmatisation and marginalisation can hinder the development of a "normal" identity, which requires a far more diversity-oriented society than the one existing today (Livingston et al., 2012; Nettleton et al., 2013; Wiechelt, 2007). SUD treatment should probably, to a larger degree, take into account that a "normal life", with its expectations of zero substance use and participation and coping in all arenas in society, is not compatible with some individuals' aims for improved quality of life and well-being while still using substances (Hystad & Wangensteen, 2021). The struggles many of the informants described during the years following inpatient treatment

may be understood in terms of normative ideals of a successful life.

The importance of trust and collaboration between patients and staff in SUD treatment

Relationships with staff were described as extremely important to most informants, who highlighted feelings of connectedness, trust, and respect. Trusting relationships with treatment staff seemed to be a prerequisite for completing demanding processes, such as working on traumas, adjusting to societal norms, reconnecting with family, building self-esteem while searching for a better life, and improving well-being. These processes entail understanding recovery not as an "inner" experience but as something developed with others (Brekke et al., 2017; Ness et al., 2014; Price-Robertson et al., 2017; Tew et al., 2011; Topor et al., 2006). Being treated with trust, optimism, and respect may be essential for establishing self-esteem and a more positive identity (Topor et al., 2006), and meeting professionals who demonstrate these qualities in practice is a significant experience that can contribute to more trusting relationships with professionals in later life.

However, the findings stressed the staff members' power and influence over the treatment process. For some of the informants, negative experiences with staff decreased their self-esteem and optimism about the future; consequently, they felt abandoned and lonely. In their literature review, in line with our findings, Ljungberg et al. (2016) concluded that non-helpful relationships with professionals are perceived as impersonal, involving disrespectful attitudes and a lack of negotiation about treatment progress and content, which may lead to patients experiencing the same stigma inside the treatment centre as they do outside.

Strengths and limitations

The informants were all patients at the Tyrili Foundation. Including informants from several inpatient treatment settings could have improved the transferability of the results. On the other hand, Tyrili follows the same national guidelines as other specialised SUD treatment facilities in Norway (Helsedirektoratet, 2017); hence, we consider the findings interesting and valuable for those who engage in different parts of SUD treatment. The age diversity of the informant group reflects the patient group in Tyrili. Regarding gender, the patient population in Tyrili includes about 75% men. In our data material, there are more than 50% women, which was not intentional but reflects former experiences in which women are more willing to participate in qualitative studies. An informant group with diversity in terms of ethnic and cultural backgrounds could have revealed other experiences and reflections. Both authors were, at the time of the study, employed in Tyrili's Research and Development Unit. We did not participate in the treatment programmes, but our in-depth SUD treatment knowledge made it possible to ask direct and supplementary questions. Research in one's own organisation may lead to informants not talking about difficult experiences or matters worthy of criticism (Coghlan & Brannick, 2014). However, we found that the informants were open and honest in their stories, as indicated in our findings.

Conclusions and implications for practice

Inpatient SUD treatment provides opportunities to increase one's life situation and well-being. Even though most of the informants were satisfied with the treatment, there should always be room for improvement and a willingness to improve.

According to the informants' stories about and reflections on their inpatient treatment, we make recommendations that may contribute to achieving a more inclusive and collaborative approach to inpatient treatment, whether it is called recovery or not. First, SUD and recovery

should be understood using a coherent, integrative approach to interpersonal, social, and cultural processes. Patients' perspectives and understandings of their backgrounds, coping strategies, vulnerabilities, resources, aims, and treatment should be constructed through collaboration with staff and fellow patients, and patients should be treated with respect. Group processes should foster an inclusive, safe, and caring environment in which to strengthen personal, relational, social, and practical skills and resources (Radcliffe & Stevens, 2008; Tew et al., 2011; Wendt & Gone, 2018). Second, treatment should build on existing resources and possibilities, contrasting with the problem–disease focus that often characterises inpatient treatment. By focusing more on "coping" than "curing", the steps of treatment and subsequent adjustment, with all the ups and downs they involve, will hopefully be experienced as steps on the road to a better life, rather than a series of failures and defeats (Hennessy, 2017; Hystad & Wangensteen, 2021; Tew, 2013). Third, professionals should consider how they can cooperate with patients, family, friends, and other professionals to find the best ways to support patients. They should acknowledge patients' perceptions of well-being and quality of life in a broad sense, not in terms of narrow standards of normality (Brekke et al., 2017; Ness et al., 2014; Nettleton et al., 2013).

The transition to a more collaborative treatment philosophy must be ethically and professionally valuable if it is to provide support and treatment that enhances patients' perceptions of empowerment, inclusion, participation, and well-being on their own terms in cooperation with supportive others (Kvia et al., 2020; Ness et al., 2014; Price-Robertson et al., 2017; Robertson & Nesvåg, 2019). This will entail a paradigm shift involving professionals in listening more carefully to patients, playing more cooperative roles, respecting patients' aims, and acknowledging that staff members are experts in facilitating treatment but not in other peoples' lives (Anderson, 1997). For some people with SUD, inpatient treatment is a crucial life intervention that can potentially save lives and increase people's quality of life and well-being; hence, the treatment approach and transparency are of the utmost importance.

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