Supporting family members' and friends' individual recovery with a locally co-designed peer-led recovery program in Darwin

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PREFACE:

This report presents findings from the "Supporting family members' and friends' individual recovery with a locally co-designed peer-led recovery program in Darwin" project. The projects included the development of a local, consumer-led empowerment and recovery program for Families and Friends of people with Alcohol and Drugs (AOD) issues in Darwin, its implementation and evaluation.

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Executive Summary

According to the *2020 National Carer Survey*, in the Northern Territory (NT), nearly 10% of Families and Friends (FFs) supported a person with Alcohol and Drugs (AOD) issues. Supporting someone with AOD issues is a unique role. They are often less satisfied with their role than other Families and Friends who look after people with different challenges. This is because drug use is one of the most stigmatised behaviours, and Families and Friends of a person with AOD use issues are often blamed by others or perceived as 'contaminated'. These perceptions ultimately overlook the complexities of substance use and addiction and can lead to discrimination, which is problematic at an individual and population level. These difficulties can significantly burden quality of life, implying maladaptive coping strategies, reduction in personal opportunities, suboptimal individual health, and an elevated level of stress and strain. In addition, Families and Friends usually prioritise the persons' needs they support over their own needs. Thus, they often sacrifice their own social inclusion and neglect their own health and wellbeing needs. Therefore, FFs frequently need a recovery plan of their own to improve their quality of life.

The Circles of Support (CoS) program developed by the NT Lived Experience Network (NTLEN) provides a safe, supportive, and confidential space for the Families and Friends of someone with AOD issues to access support and information. Participants learn about (1) Mental health, alcohol and drug-related misuse and co-occurring issues; (2) Recovery and ways to support recovery; (3) Identifying and responding to a crisis; (4) Ways to support own wellbeing and practice self-care; (5) Managing overwhelming emotions and responses; (6) Setting boundaries on relationships; (7) Effectively communicating your needs and rights; (8) Responding to stigma and discrimination; and (9) Navigating the mental health and alcohol and other drug service system.

The primary aim of this project was to co-design a local consumer-led recovery and empowering program and implement and evaluate it. The main evaluation objectives were to assess the appropriateness and effectiveness of the Program among Families' and Friends' recovery, mental health, and wellbeing. A suitable evaluation approach was co-designed in collaboration with the evaluation team, NTLEN and other LE representatives. It applied a mixed-methods approach, including individual interviews and a pre and post-program survey with program participants, a consultation workshop, and/or individual interviews with sectoral stakeholders, including program facilitators. The sampling method was purposive. A consultation workshop (n=7) was held in April 2022 with local lived experience (LE) representatives and stakeholders to inform the program content, design and evaluation approach. Three CoS programs were delivered between April 2022 and September 2022 in various locations, including Winnellie, Casuarina and Palmerston. Each program was delivered over nine weeks in a three-hour session. In total, nineteen participants (n=19) were involved in this pilot program. Among them, 16 participants, including two facilitators (n=16), filled in the pre-program and ten (n=10) the post-program survey. In addition, seven (n=7) participants and four (n=4) facilitators were interviewed.

The participants in the CoS Program had similar socio-demographic backgrounds in relation to gender and age as in previous large-scale national studies. However, the education level and employment rate in this sample were higher. While the population in the NT is very diverse, in this program, most of our participants were Australian-born, non-Indigenous people speaking English at home. Only 25% of the participants were born overseas, 12% identified as Aboriginal and Torres Strait Islander, and 6% were part of the LGBTQI+ population. The qualitative interviews highlighted the complexities this vulnerable and highly stigmatised population experienced in their journeys. This included responsibilities for various persons, difficulties navigating services and getting support, having lived experience of their own challenges, violence, no respite, and hard work seldom acknowledged by many.

About half of the participants perceived their general health and wellbeing as moderate at the program start, which improved by the end of the program; however, these changes were not

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statistically significant. Moreover, participants scored significantly lower on the total stress scale in the post-program surveys. The most frequent stress indicators among them were trouble focusing on things, sleeping difficulties, and being upset with the changes in their loved one's behaviours. Most participants did not present physical symptoms of stress as often as in a previous study. However, the emotional symptoms were frequent, similarly to large-scale studies, such as loneliness, feeling overwhelmed, upset and irritable. These still indicate the impact of stress on their quality of life. While we found favourable changes in the frequency of these indicators, they were not statistically significant. In the individual interviews, participants further described their challenges of caring for someone with AOD issues. They shared their feelings of loneliness, shame, fear, uncertainty, grief, and hopelessness through their own stories. We also got insights into what areas of their lives were impacted by the persons' AOD use issues. This included social participation, financial situation, own needs, broader family unit and their own mental wellbeing. They often felt unsupported and undervalued by services and the wider society. Stigma was one of the most critical challenges they faced, which was more significant for people from CALD backgrounds.

While participants expressed how valuable it is to have fun and do things they enjoy, similar to previous studies, they presented indicators of neglecting some of their fundamental needs. They reported adopting healthy habits and doing pleasurable activities less frequently than other indicators. In the pre-program survey, more than 80% of the participants thought their support was valuable and helpful. While in the beginning, respondents scored high on the personal recovery scale, about 40% reported that they did not have the tools to live the life they wanted, and 25% did not like themselves and did not know when to ask help. Also, about 40% of the participants would not ask for help when needed and were not hopeful about possible changes in their own family context, such as fewer experiences of stress. Participants showed sound stress management skills and understanding of stressors; however, about 32% did not think they could handle it if it got worse. Regarding their social participation, our data showed that 75% of them had friends, though only about 50% reported friends who did not experience similar sources of stress. In addition, half of the respondents did not feel Ok with their family situation. However, participants showed improvement on these items by the end of the program; but this was not statistically significant. We found a significant increase only in the total empowering and recovery scale and social recovery subscales. Participants shared their positive experiences with the CoS peer-led program during the interviews, including authenticity, safety, confidentiality, and empathy. Most were satisfied with the program, indicating it 'completely' met their needs. The program made them feel connected, accepted, and understood. They also developed hope, self-gratitude, courage, and optimism. They learnt about self-reflection, setting boundaries, separating the person from the issue, advocacy, communication, and system navigation. The program generally empowered them, and some also expressed the importance of participating in the evaluation interviews to raise awareness and spread the word in the community about the positive impacts of the program. Participants also shared how they had already implemented key learnings into their daily life.

These results highlight the need for a more targeted approach in recruitment to access, involve and support more males, youth, LGBTQI+, Aboriginal and Torres Strait Islander people and individuals with CALD backgrounds. People with lower education levels, domestic duties or unemployment status also need to be targeted more directly. FFs' experiences are challenging and burden many areas of their life. This should deserve attention, so they can feel accepted, understood, and supported. Our findings also draw attention to the importance of programs aiming to increase FFs' connectedness, hope and empowerment in efforts to decrease the emotional indicators of distress and support as part of their mental wellbeing and recovery. Targeting FF's recovery, including modules about self-love and self-care, is important. It also draws attention to improving help-seeking behaviours, and it is vital for exploring the reasons and barriers behind not asking for help. This may be influenced by stigma, shame and prioritising the person's needs. Thus, implementing broader education activities in the community to neutralise conversations about various forms of addiction should be a priority. Due to the small sample size, applying mixed-methods approaches are critical.

1. Project Overview

Families and Friends supporting individuals with challenges

Many terms describe the experience of looking after and supporting someone through challenges relating to alcohol and other drug (AOD) issues, mental health concerns, related service use, and periods of healing and personal recovery. This may include: 'Family/Carer' (both in combination and separately), 'Supporter' (Byrne et al., 2021), 'Caregiver' (Youth Affairs Council of Western Australia, 2020), 'Affected Family Members' (AFMs) (McCann & Lubman, 2018) and 'Significant Others' (Network of Alcohol and Other Drugs Agencies). Many studies refer to this role generically as a 'Carer', defining an individual "who provides unpaid care and support to a family member or friend who has a disability, mental illness, drug and/or alcohol dependency, chronic condition, terminal illness or who is frail" (Carers NSW, 2020, p. 1). The most recent *National Lived Experience (Peer) Workforce Development Guidelines* preferentially suggest using the term 'Family/Carer' as the most appropriate term for those who have experience supporting another through such challenges (Byrne et al., 2021). We subsequently use the term 'Families and Friends' to align with the language used in the Information Services and Support Project (Family and Friends) Grant Program provided by the Alcohol and Drug Foundation (ADF) that allowed the current critical project to be conducted (Tari-Keresztes, Armstrong, et al., 2021).

In 2018, 2.65 million people in Australia were Families and Friends of someone who had some form of mental health challenges, AOD issues, disability, chronic conditions, severe illness, or needed care because of ageing. About one million people have a primary caregiver, which often equates to more than a full-time job (Australian Bureau of Statistics, 2019). However, they seldom do it as their paid employment. It is estimated that if paid workers replaced this, it would cost $77.9 billion annually (Deloitte, 2020). The age-related data shows that 45% of the Families and Friends are between the age of 45 and 64, and 62% are between 35 and 64. Most (60%) are female (Australian Bureau of Statistics, 2019). The *Carer Wellbeing Survey* draws attention to this population's poorer wellbeing, a gap that becomes more significant as Families and Friends get older. The most disadvantaged cohort of Families and Friends are aged between 45 and 64 years (Centre for Change Governance & NATSEM University of Canberra, 2021). According to the 2020 National Carer Survey, most Families and Friends of people living with mental health and AOD challenges had a high school education and did not participate in paid employment. The typical participant supported an adult son with a physical disability who could be left alone for a long. This role typically involves more than 40 hours of care per week. In most cases, they provide this support for 20 years without getting any significant respite from this responsibility (Carers NSW, 2020).

The *2020 National Carer Survey* included 109 (1.4%) respondents from the Northern Territory (NT). In this dataset, supporting someone with a physical disability, dementia, frailty due to ageing, sensory impairment, and mental health challenges were the most common types of conditions necessitating support and care. In addition, nearly 10% of these Families and Friends supported a person with AOD issues. The most common relationship between the respondents and the person they cared for was a child (more than 50%), followed by parents and parents-in-law (about 30%). Nearly 50% of these Families and Friends described that they were not asked about their needs when accessing aged care and NDIS services, and only about 30% of people were questioned about their needs when a mental health service was accessed. The Family and Friends inclusion and support were significantly lower than the previously mentioned services when engaged by general practitioners (GP), family doctors and the hospital. Among the respondents, the five most common impacts on career

trajectory were quitting working, reduced working hours, being less prepared to meet demands at the job, outdated skills, and lack of knowledge and confidence to apply for jobs (Carers NSW, 2020).

Perceived stigma among Families and Friends of people who have AOD issues

Supporting someone with AOD issues means a unique role that involves problems specific to this particular set of Families and Friends (Mental Health Carers NSW, 2018). Families and Friends of a person with AOD issues are significantly less satisfied with their role than other Families and Friends who look after people with different challenges (Centre for Change Governance & NATSEM University of Canberra, 2021). Drug use is one of the most stigmatised behaviours and is often perceived as a weakness of the individual, an undesirable attribute or behaviour that should be controlled (Corrigan et al., 2006; Goffman, 1963; Marshall, 2013). AOD users are subsequently viewed as lacking self-control, weak-willed (Tindal et al., 2010) and blameworthy (Obot et al., 2004). They are often portrayed as dangerous (Taylor, 2008), linked with crime and fear of HIV and Hepatitis C (Tindal et al., 2010). These perceptions ultimately overlook the complexities of substance use and addiction and can lead to discrimination (Link & Phelan, 2001), which is problematic at an individual and population level.

Simultaneously, Families and Friends of a person with AOD use are often blamed by others or perceived as 'contaminated' (Corrigan et al., 2006). They can also experience stigma such as secondary (Ogunmefun et al., 2011), courtesy (Goffman, 1963), associative (Mehta & Farina, 1988) or affiliated stigma (Mak & Cheung, 2008). This refers to the public stigma felt by Families and Friends, which manifests as a sense of shame and inferiority (Corrigan et al., 2006). Interventions aiming to reduce the stigma perceived by Families and Friends should include messages about 'recovery is possible'and 'no one is to blame' (Koschorke et al., 2017)

Jones and colleagues (1984) developed a model that includes six dimensions of stigma. One is concealability, which can hide the condition (Jones et al., 1984). Some Families and Friends in a study (Marshall, 2013) withheld information from other family members as a valuable way of managing and avoiding stigma and negative judgements. Although other studies have also described that concealing may lead to further stress for Families and Friends, as maintaining a secret of this nature may be difficult (Quinn & Chaudoir, 2009). In addition, some Families and Friends report withdrawing themselves from social participation to avoid conversations about the person they look after and to keep a level of secrecy about the AOD issues and related challenges they face. However, staying away from social situations and social distancing may also lead to social isolation, decreased quality of life, and less access to social support (Bogart et al., 2008; Marshall, 2013). Similarly, stigma directly impacts psychological wellbeing and can lead to mental health and related challenges (Major & O'Brien, 2004). Yet, little is known about stigma experiences among Families and Friends of persons with AOD issues.

Families' and Friends' quality of life: Social interaction, mental health and wellbeing

Families and Friends devote ample time and effort to support people with various AOD and mental health challenges and thus make a significant contribution to society. On the other hand, they experience notable challenges themselves. Recognising they might become carers for many reasons, such as a health condition, an accident, or a dramatic event, often finding themselves in this role because of their relationships with the individuals they support. This might involve a partner, parent, child, grandparent, siblings and friends (Hill et al., 2016). Helping an individual may impact many areas of the Families' and Friends' lives. For instance, their study, paid employment, quality of life, social participation, physical and mental health, and wellbeing (Hill et al., 2016; Sanders, 2020).

Being a Family or Friend of a person experiencing challenges offers rewards such as feeling good about themselves, giving purpose to their life, learning new skills, improving resilience and strengthening the relationship (Sanders, 2020). However, it also presents multiple challenges (Centre for Change Governance & NATSEM University of Canberra, 2021), as they may face several complex issues. For instance, when the caregiver role intersects with AOD use, Families and Friends deal with multiple stigmas around AOD use, mental health and caregiving. They are often wrongly labelled as enablers because of false beliefs about AOD use. For example, individuals need to be left alone to rock the bottom before help-seeking, which does not reflect the complexities of AOD use issues (Mental Health Carers NSW, 2018). This can be further exacerbated by stress, depression, anxiety, worry, financial struggles, inadequate sleep, social isolation, frustration, low self-esteem, anger and self-care issues (Mind, 2013). While Families and Friends experience significant challenges, a recent study found that only 22% wanted to leave this responsibility to someone else (Centre for Change Governance & NATSEM University of Canberra, 2021).

In a previous, large-scale, longitudinal study (Orford, 2010), Families and Friends shared their experiences supporting individuals with AOD challenges. They described that the individuals' AOD issues impacted them through different forms of aggression, stress derived from antagonistic relationships, and conflicts over money. In addition, they expressed they felt worried, threatened in life, and uncertain. They also expressed poor mental health, wellbeing, stress, anxiety and depression (Lee et al., 2011). Many cases manifested in panic attacks, suicidal ideation, sleeping issues, high blood pressure and chest pain (Orford, 2010).

The abovementioned difficulties can lead to a significant burden on quality of life, implying maladaptive coping strategies (Sanders, 2020), reduction in personal opportunities, suboptimal individual health (Hussain et al., 2016), and an elevated level of perceived stress and strain (Buhse, 2008; Centre for Change Governance & NATSEM University of Canberra, 2021). Consequently, Families and Friends may also use substances themselves (Heitz, 2016). When they do, they are at a higher risk of depressive symptoms and co-existing issues, such as anxiety disorders, chronic diseases and harmful substance use (e.g. prescription and psychotropic drugs (Family Carer Alliance, 2016). This may create a toxic cycle that increases their vulnerability because of the cumulative impacts of the conditions (Lesser, 2021). The literature is scant on substance use issues among Families and Friends, which requires enhanced pragmatic and research responses(Mental Health Carers NSW, 2018).

Studies also suggest that many individuals with AOD issues simultaneously suffer mental health challenges (Mental Health Carers NSW, 2018). Such co-morbidity requires dual diagnosis and respective integrated service delivery. Yet, many Families and Friends supporting individuals with dual diagnoses feel unsupported due to limited access to appropriately integrated mental health and AOD services. Indeed, some AOD services refuse to treat people with mental health challenges, and community mental health services are often reluctant to respond to clients with co-morbid AOD issues (Better Health Channel, 2021; Marel et al., 2016). This creates a significant problem for the individual and their Families and Friends.

In addition, Families and Friends usually prioritise the persons' needs they support over their own needs. Thus, they often sacrifice their own social inclusion (Hill et al., 2016) and neglect their own needs and health (Marshall, 2013). According to the Care Wellbeing Survey, they are three times more likely to experience chronic loneliness than an average non-family or friend in Australia (Centre for Change Governance & NATSEM University of Canberra, 2021). Therefore, Families and Friends frequently need a recovery of their own to improve their quality of life (Bradshaw et al., 2016).

Formal and informal support for Families and Friends

While providing understanding and support for individuals with AOD issues through their journeys is crucial, providing similar help for Families and Friends who experience distress is also vital. They deserve attention for what they experience on the journey when walking alongside them (Bradshaw et al., 2015; McArdle & Stull, 2018).

A national initiative, a network of support services called *Carer Gateway*, was implemented in April 2020 from Commonwealth Government funding to provide free online, telephone and in-person support and advice for Families and Friends of people living with meant health and AOD challenges. This aims to reduce stress and build resilience that Families and Friends may experience in this role involving various services such as accessing relevant information, advice and referral, counselling, peer support and available targeted financial packages. These services focus on education, paid employment, respite, transport and in-home support (Carers NSW, 2021; Carers NT).

According to the *Carers Wellbeing Survey*, only 19% of Families and Friends can organise another family member or friend to help them if they need a break or respite. Also, receiving support from carer support groups (33%) was the most common type of support they accessed in the last 12 months, followed by psychological support (31%) and respite services (31%). Some also accessed financial support services (29%) and skills training (22%). Accessing support is vital since data shows that Families and Friends having access to formal and/or informal support report significantly higher wellbeing and quality of life (Centre for Change Governance & NATSEM University of Canberra, 2021). However, the 2020 National Carer Survey findings highlighted that Families and Friends are rarely asked about their own needs, and services are more likely to meet the individuals' needs only (Carers NSW, 2020).

Peer support groups for Families and Friends of persons with mental health and AOD challenges provide a safe, inclusive, non-judgemental space where they feel understood, accepted and supported by peers with similar LE. Numerous support groups, forums and resources are offered by member organisations of [Carers Australia](#) and other relevant agencies and initiatives, for instance, [Self Help Addiction Resource Centre](#) (SHARC), [Head to Health](#), [Family Drug Support](#), and [Wellways](#). In the support groups, people often share their knowledge of local services, exchanging tips and advice on dealing with challenging situations. Peer support can be available face-to-face, but some services offer online peer support, making the program more accessible and convenient for those who live in more isolated locations or have limited time due to the demands of their caring role ([Carer Peer Connect](#)). Also, some places offer exceptional support for Families and Friends affected by someone's drinking, drug use or gambling that involves specialist skills and personal understanding to support and empower Families and Friends ([Self Help Addiction Resource Centre](#)). Learning modules, resources, and toolkits are also available for professional peer workers working with Families and Friends of individuals dependent on drugs and/or alcohol [Network of Alcohol and Other Drug Agencies](#) (NADA). In the NT, support for Families and Friends of people living with mental health and AOD challenges is available through local organisations, for example, [Carers NT](#), [Mental Health Fellowship of Australia NT](#) (MIFANT), [Sabrina's Reach4Life](#), [Multiple Sclerosis Society of South Australia and Northern Territory](#) (MS), and [Association of Alcohol and Other Drug Agencies NT](#) (AADANT).

Evidence-based peer education, recovery and empowering programs in Darwin

While the *National Framework for Recovery-oriented Service Delivery* (Australian Health Ministers' Advisory Council, 2013) advocates for recovery-oriented peer practices, NT peers have been poorly utilised in psychosocial support activities. In addition, the NT Government has no history of financially supporting an independent LE advocacy body and certainly not at a level commensurate with other

state and territory jurisdictions. This contrasts expectations outlined in national policies and reforms (Department of Health, 2017). This shortfall led to the planning of a series of peer education and recovery programs that were implemented and evaluated in Darwin, NT. This helped address the gap in peer-led psychosocial support programs and assisted in building a deplete evidence base in the NT. For instance, the (1) Darwin Peer-Led Education Pilot (PLEP) and its follow-up evaluation led by the Northern Territory Mental Health Coalition (the Coalition); (2) Two Ways Mentoring Program led by TeamHealth; and (3) NT Peer Workforce project led by the Top End Mental Health Consumer Organisation (TEMHCO). The research team of this report were involved in the evaluations of these programs (Tari-Keresztes et al., 2020; Tari-Keresztes, Girdler, et al., 2022; Tari-Keresztes, Gupta, et al., 2022; Tari-Keresztes, Smith, et al., 2021).

The PLEP was implemented in three stages. Stage 1 involved socialising the first My Recovery program facilitated by Wellways, who travelled from Victoria to the NT to assist with the delivery. Stage 2 involved the Train the Facilitator program, which was again delivered by Wellways. Stage 3 involved local facilitators offering the program.

The facilitators, during the program delivery in Stage 3, identified some barriers, such as:

- absence of visual activities,
- lack of content exploring the relationship between wellbeing, culture and spirituality in general,
- westernised lens for the interpretation of risk and protective factors for mental health and wellbeing, history of mental health treatment, power relationship and communication types and explanation of discrimination and right,
- need for participants to feel comfortable in a classroom-type environment, and
- reliance on reading and writing skills (Armstrong, 2021).

In addition, as the involved peer facilitators grew in their skills and knowledge, they started implementing minor adjustments and providing supplementary resources. Extension Stage 3 intended to run another round of the Train the Facilitator program; however, this was cancelled due to COVID-19-associated business risks. This change presented the opportunity for the local peers, who had grown their knowledge and skills, to co-design their own local recovery program, and corresponding 'Train the Facilitator' and 'Foundations in Peer Work' programs to make the content more accessible and contextual to the diverse population in Darwin. The program had been co-designed, but due to a lack of funding, it was not implemented after completing the pilot project (Armstrong, 2021).

The empirical studies about the NT's emerging peer education and recovery programs have focused on personal or direct LE only (Tari-Keresztes et al., 2020; Tari-Keresztes, Gupta, et al., 2022; Tari-Keresztes, Smith, et al., 2021). Akin to the national trends (Byrne et al., 2021), the evidence base relating to Families and Friends is scant. However, knowledge generation and prioritising data collection and analysis are vital in informing future policies, practices, and guidelines. *Mind Australia's Research and Evaluation Framework* also highlighted the need to research Families and Friends. One of the identified research priorities that emerged through consultation and the development of the framework related to Families' and Friends' LE and sensitive practices (Mind Australia & Centre for Health Policy Programs and Economics Melbourne School of Population Health The University of Melbourne, 2021).

2. Research Question

Project Objectives

The primary aim of this project was to co-design a local consumer-led recovery and empowering program and implement and evaluate it. The main evaluation objectives were to assess the appropriateness and effectiveness of the Program among Families' and Friends' recovery, mental health and wellbeing.

It also aimed to:

- Explore the most common stressors and their impact on Families' and Friends' mental health and wellbeing
- Identify the main characteristics in the supporting role among Families and Friends of persons with AOD issues
- Evaluate the Program's impact on Families' and Friends' individual recovery, mental health and wellbeing
- Make recommendations to address the gaps in the existing psychosocial support activities for Families and Friends in the NT context
- Provide an opportunity for both collaborating partners to build their research capacity in the NT emerging lived-experience space
- Stimulate further funding and collaboration to make the Program sustainable

A suitable evaluation approach was co-designed in collaboration with the evaluation team, NTLEN and other LE representatives. It applied a mixed-methods approach, including individual interviews and pre and post-program surveys with program participants, a consultation workshop, and/or individual interviews with sectoral stakeholders, including program facilitators.

The project applied an incremental approach involving four stages as follows:

- Stage 1: Development (literature review, consultation workshop with key stakeholders)
- Stage 2: Program delivery (program implementation and survey study with program participants)
- Stage 3: Evaluation (individual interviews with program participants and facilitators and data analysis)
- Stage 4: Review (reflection, discussion with the project team, report writing)

Research design

The sampling method was purposive. A consultation workshop (n=7) was held in April 2022 with local lived experience (LE) representatives and stakeholders to inform the program content, design and evaluation approach. The CoS program was advertised and delivered in small groups between April 2022 and September 2022. NTLEN Peer Facilitators had three workshop groups in nine sessions; each lasted 3 hours. The program was offered in various locations, such as Winnellie, Casuarina, and Palmerston and in multiple formats, but the evening workshop seemed more attractive for this population and had better attendance. In total, nineteen participants (n=19) were involved in this pilot program. Among them, 16 participants, including two facilitators (n=16), filled in the pre-program and ten (n=10) the post-program survey. In addition, seven (n=7) participants and four (n=4) facilitators were interviewed.

The literature review aimed to identify relevant programs, evidence-based practices, and survey tools to inform the consumer-led peer program development, the evaluation approach, and the co-design process. The survey explored Families' and Friends' stressors and characteristics relating to

their experiences in pursuing a supporting and caring role, as well as those relating to the quality of life. In addition, the individual interviews aimed to understand participants' Family/Carer journey and the peer program's impact on their individual recovery, and personal mental health and wellbeing.

The survey (Appendix A) included items on sociodemographic background, health and wellbeing, perceived stress, and personal empowerment. Similarly to large-scale national studies (Carers NSW, 2020; Centre for Change Governance & NATSEM University of Canberra, 2021), we asked the participants about their age, gender, country of birth, primary language spoken at home, Aboriginality, level of education, employment status, marital status, number of children, and relationship to the person they care for.

Participants were also asked to rate their health and wellbeing on a 5-point Likert scale (Heiestad et al., 2020; Piko & Keresztes, 2007). To identify the everyday stressors among Families and Friends, we applied the Caregiver Self-Assessment Questionnaire (CSAQ). This scale consisted of 16 dichotomous items (no=0, yes=1), which provided a total scale of min=0 and max=16 points. This self-assessment scale also included two additional items. These showed the current stress (Q17) (1=not stressful, 10= extremely stressful) and health levels (Q18) (1=very healthy, 10= very ill).
The interpretation of the scores was as follows:
- 'yes' to either or both Q4 (feeling overwhelmed) and Q11 (having crying spells); or
- total 'yes' score over 10; or
- score six or higher on Q17 (current stress level) OR Q18 (current health level) (Epstein-Lubow et al., 2010).

We used the revised version of the Recovery Assessment Scale – Domains and Stages (RAS-DS) (Hancock et al., 2019) to measure empowerment and personal recovery. The revision was made after the consultation workshop, incorporating the LE representatives' views to ensure the research tool was strengths-based, recovery-oriented and appropriate for the FFs population. This scale included 38 items. Participants were given a 4-point Likert scale to indicate their answers (1=untrue, 2=a bit true, 3=mostly true, 4= completely true). In the data analysis, the answer categories were re-coded into two broader categories, namely 'untrue', including the untrue and a bit true answer categories and 'true', involving answers such as mostly true and completely true. To gain the total recovery scores (min=38, max= 152), all 38 items were added up. This scale consisted of four subscales: functional, personal, clinical, and social recovery. Subscale mean scores and percentage scores were also calculated. However, because of the different numbers of statements in each domain, percentage scores provided more accurate information across the domains (Hancock et al., 2019).

The individual interview explored participants' backgrounds, wellbeing, the reason for participating in the program, and the main characteristics and stressors regarding the Family/Carer role. It will also assess their overall experience with the program, modules and activities while identifying the possible areas for improvement and challenges associated with the peer program (Appendix B). All interviews were transcribed verbatim to support the analysis process.

The evaluation team analysed the transcribed qualitative data with NVivo software, applying thematic analysis approaches. The quantitative survey data was coded into SPSS and analysed using the same software, applying appropriate non-parametric tests because of the small sample size.

3. Methodology

3.1. Data collection & recruitment

Initial engagement: An allyship between the evaluation team and Northern Territory Lived Experience Network

The _Northern Territory Lived Experience Network_ (NTLEN) is a volunteer-driven and recently founded initiative. The founding members were linked to the recent PLEP project. The network aims to provide a collective and independent voice for (a) people with "lived" or "living" experience of challenges related to mental health and suicide, (b) Families and Friends who provide support and care and may also experience their own challenges, and (c) people with LE of trauma and AOD use.

NTLEN developed an allyship with the evaluation team, including Dr Noemi Tari-Keresztes, Professor James Smith and Dr Himanshu Gupta, through the evaluation of the PLEP project. The evaluation team, in collaboration with NTLEN members, namely Ms Noelene Armstrong and Ms Lauren Keys, successfully secured a competitive grant funded by the Alcohol and Drug Foundation (ADF) to implement the pilot project and evaluation entitled "Supporting family members' and friends' individual recovery with a locally co-designed peer-led recovery program in Darwin". While there were some unavoidable delays at the start of the project, this period created an opportunity for the project team to strengthen this relationship and to create a dedicated Research Fellow role at Flinders University for Dr Noemi Tari-Keresztes, which was explicitly focused on LE, a first of its kind in the NT. This has enabled further collaboration aimed at improving the mental health and wellbeing of people with LE challenges in the NT.

Project roles and responsibilities

The agreed project responsibilities for NTLEN were:
- Co-designing program adaptations to suit the needs of Families and Friends. However, they ended up creating a new program for Families and Friends instead of trying to adapt the local program designed for individuals with AOD and mental health issues. The identified needs for Families and Friends were significantly different, and they determined an adaptation wouldn't work
- Recruiting participants for the program and evaluation through the delivery of information sessions and network
- Supporting program delivery for Families and Friends of people with lived experience of AOD issues
- Helping the evaluation team in the development of the survey instruments and interview schedule for data collection
- Assisting the evaluation team in the report writing and knowledge translation
- Co-presenting and disseminating the final results with the evaluation team
- Co-publishing the findings with the evaluation team in high-quality peer-reviewed journals

The agreed project responsibilities for the evaluation team were:
- Overall project management and administration
- Facilitating the ethics application development and submission
- Developing the instruments and interview schedule in support of NTLEN
- Collecting data for the evaluation
- Undertaking the data analysis

- Leading the report writing and knowledge translation in partnership with NTLEN
- Leading the development of presentations and publications in collaboration with NTLEN

Ethics Submission

An essential part of conducting research and evaluation with a high level of integrity involves obtaining ethics approval from a certified Human Research Ethics Committee (HREC). An ethics proposal was prepared to undertake a study assessing the appropriateness and effectiveness of the locally developed peer-led recovery and wellbeing program on individual recovery and mental health and wellbeing among family members and friends of individuals with alcohol and drug issues. The ethics application was submitted to the NT Department of Health and Menzies School of Health Research HREC on 1 October 2021. After receiving two conditional approvals (Table 1.), full approval (Appendix C) was obtained on 28 February 2022 (HREC Reference number: 2021-4164).

Involvement of Peer Work students

The PLEP project was well supported by a Steering Group (SG) consisting of local service providers, mental health and AOD peak bodies, agencies supporting the local workforce, funding bodies, education representatives and LE representatives, including individuals with their own challenges, and Families and Friends of people who have mental health challenges and/or AOD issues. The SG not just steered the pilot but they collaborated to influence the NT Government (NTG) to include a skill set in Peer Work in its JobTrainer[1] reskilling list, which provided a stimulus for the first NT-based, Registered Training Organisation (RTO), Response Employment and Training (RET) to deliver the Certificate IV in Peer Work. This course is offered by a VET lecturer, Ms Noelene Armstrong, from NTLEN. The course has brought an opportunity to engage some of these Peer Work students in the '*Supporting family members' and friends' individual recovery with a locally co-designed peer-led recovery program in Darwin*'. They spent their work placement hours with a family-to-family peer program development and then program delivery in mentorship with Ms Noelene Armstrong.

Composition of the project team

Addressing concerns raised by HREC, considering personal circumstances, incorporating the opportunities that stemmed from the delivery of Certificate IV in Peer Work, and recognising that the best practice in evaluation processes that are focused on LE is required to include people with LE as part of the project team, the project team was finalised as follows:

- Dr Noemi Tari-Keresztes, Research Fellow (Lived Experience), Flinders University
- Ms Noelene Armstrong, Senior Peer Worker, NTLEN and Vocational Education and Training (VET) Lecturer, Response Education & Training (RET)
- Prof James A. Smith, Deputy Dean Rural and Remote Health NT, and Matthew Flinders Professor (Health and Social Equity), Flinders University
- Dr Himanshu Gupta, Honorary Senior Lecturer, Flinders University
- Sam Goding, Peer Facilitator, NTLEN and Peer Work student, RET
- Sal-Amanda Endemann, Peer Facilitator, NTLEN and Peer Worker NT AIDS and Hepatitis Council (NTAHC)
- Kim Mulholland, Cultural Advisor, IvolveGen

Sustained Engagement

An evaluation team member (NTK) and an NTLEN representative (NA) had regular meetings

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[1] JobTrainer is an initiative to provide free or low-fee training courses as part of the Economic Response to COVID-19 through the Australian Government partnering with the state and territory governments. https://nt.gov.au/learning/adult-education-and-training/free-training-courses

throughout the project, kept the remaining project team members updated and requested input and feedback on certain project elements (refer to further details in Table 1). This approach (1) deepened the trust and rapport between the project partners, (2) supported the development of the Circles of Support program, and (3) a co-design of recovery-focused, strengths-based survey instruments and the appropriate evaluation approach (see Table 1 in Appendix D)

3.2. Participants

Participant recruitment

The participant recruitment was facilitated via social media and printed flyers in collaboration with relevant local community groups, lived experience networks, initiatives and service providers through the project team networks. Public information sessions were also organised (n=3) for the Darwin community. These sessions were scheduled ahead of each program start, offering participation in the Program, which was facilitated through a self-nomination process using the following inclusion criteria:

- At least18 years of age
- Living in Darwin and/or Palmerston
- Being a carer for people with lived experience of AOD use issues
- Able to provide informed consent

However, the project team experienced significant challenges in accessing the highly stigmatised and vulnerable population of Families and Friends of individuals with AOD issues. Thus, NTLEN asked for further support from community groups and service providers within their network to promote the program. In addition, they introduced a new recruitment approach to meet these challenges. They delivered 2-hour community literacy session series (n=3) for anyone to attend, including some useful alcohol and drug health education, information about stages of change, and the stages of change model for families developed by Family Drug Support. Thus, participants heard how the program supports families to move toward the 'coping stage', and these attendees acted as a 'mouthpiece' for the Circles of Support program in the community. These sessions also provided Professional Development opportunities for the local staff working with individuals experiencing AOD issues and their families.

Participation in the evaluation was voluntary. The evaluation was initially introduced to the program participants by NTLEN (rather than university affiliates), explaining the intent of the evaluation. Interested program participants were invited to participate in a survey, including a pre and post-program questionnaire and an individual interview at program completion. Potential participants were provided with a Participation Information Sheet (PIS) (Appendix E) at this stage.

The project team also invited local key stakeholders (n=7), with LE of being a Family or Friend of someone with challenges, for a consultation workshop to develop a consumer-led local peer support program and co-design the survey instruments. The workshop took around 4 hours, facilitated by an NTLEN representative (NA) and an evaluation team member (NTK). As part of the consultation, program facilitators (n=4) were invited to participate in individual interviews to reflect on the program implementation, challenges, opportunities, key lessons and program impact on their own recovery and mental wellbeing.

Initially, NTLEN planned to adapt the local peer program developed in Stage 3 of the PLEP (currently named Recovery Together) for the population of Families and Friends of persons with AOD issues.

However, from key learnings of the PLEP project, and as the Peer Facilitators grew in their skills and knowledge, the network encouraged NTLEN members to identify further needs and issues relating to the Families and Friends of people with AOD issues. Thus, the applied approach was consumer-led and deliberately embraced LE representatives' expertise. This co-design approach was also used for the evaluation process, including developing survey instruments to ensure they were strengths-based and recovery-oriented. The changes were made in agreement with LE representatives. Their views were privileged, heard, valued, discussed and incorporated.

Participant involvement

The quantitative data collection was facilitated by Peer Facilitators, who were supported by the evaluation team. Based on the experiences gained through various stages of the PLEP project (Armstrong, 2021; Tari-Keresztes et al., 2020; Tari-Keresztes, Smith, et al., 2021), recruitment to the quantitative survey occurred in the following way: Interested participants filled in the questionnaire at the program start. Peer Facilitators collected the surveys and kept them in a secure place at RET. Then, interested participants filled in the post-program surveys on the last day of the program. The Peer Facilitators gave them the pre-program survey; thus, these participants had the opportunity to compare their answers at the program start and completion to reflect on their own journey in the program. Those who agreed, provided these surveys (n_{pre}=16 and n_{post}=10) to the evaluation team for data analysis and filled in a Consent Form (CF) (Appendix F); otherwise, they were given the opportunity to keep their questionnaires. This was an important step for providing a safe and trusting evaluation environment.

Peer Facilitators informed the Program Participants about an individual interview with an evaluation team member (NTK) at the end of the Program. For those who agreed, an online interview was organised. The interview lasted approximately 45-60 mins after the participants provided recorded or written consent. The interview participants received a $30 grocery voucher (that cannot be used to purchase alcohol, tobacco, or gambling products) to acknowledge their time and contribution to the study.

During the analysis process, participants (n=7) and facilitators (n=4) involved in the individual interviews were grouped. All was denoted as program participant (PP), and a number was also allocated to protect their anonymity in the presentation of the findings.

3.3. The Circles of Support Program

Co-designing a consumer-led local peer program for Families and Friends by NTLEN to support their mental wellbeing and recovery was the first milestone of the current project. The program was named *Circles of Support* (CoS) by the consultation workshop participants.

The program provides a safe, supportive, and confidential space for the Families and Friends of someone with AOD issues to access support and information.
Participants learn about:
- Mental health, alcohol and drug-related misuse and co-occurring issues;
- Recovery and ways to support recovery;
- Identifying & responding to a crisis;
- Ways to support own wellbeing and practice self-care;
- Managing overwhelming emotions and responses;
- Setting boundaries on relationships;
- Effectively communicating your needs and rights;
- Responding to stigma and discrimination;
- Navigating the mental health and alcohol and other drug service system;

The Program was visual and included plenty of break times. It was strengths-based and had personal stories and discussions. Each session consisted of a participant's reflection and feedback time (e.g. what they liked or thought could be done better) that helped NTLEN with the quality improvement of the program. The CHIME framework underpinned the program, which brought the principles of recovery, such as Connectedness, Hope and optimism, Identity, Meaning and Empowerment, to the learning environment (Leamy et al., 2011). This model was also identified as one of the most significant elements of the peer-led education and recovery program in the PLEP project (Tari-Keresztes et al., 2020; Tari-Keresztes, Smith, et al., 2021).

The program consisted of seven modules as follows: (1) 'Settling-in', (2) The unique experience of 'informal carers', (3) Understanding Recovery, (4) Effective communication, (5) Responding to stigma, (6) Navigating the system, and (7) celebrating our journey together.

In Module 1, participants received an overview of the program and a snapshot of upcoming program content, and they recognised diversity within the group. They learned about stages of change, stages of change for families, and limits of influence. They also practised self-care, which is reconnecting their values. In addition, they discussed the group values and agreement. The objectives of this module were to (1) understand what the program is like, (2) get to know the facilitators and other participants, (3) create a safe group environment, (4) take away some knowledge and (5) become more intentional about self-care practices.

Module 2 was about the unique experience of 'informal carers', including peer ways of working, a deeper exploration of stages of change, an introduction to mental health and AOD, and separating the person from the symptoms and behaviour. The self-care practice in this module was gratitude. This module aimed to strengthen ways of working together as a group, separate the symptoms and behaviour that the loved one displays from who they are as a person, and acknowledge that the loved ones can experience grief.

The participants gained a better understanding of recovery in Module 3. They learned about the bio-psycho-social-spiritual model and social determinants of health to understand risk factors. They learned about the CHIME model for recovery and the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing model to understand protective factors and self-evaluate what they can do better to support their own wellbeing.

Effective communication was also part of the support program in Module 4. This consisted of the following:
- complexities in communication;
- relationship defaults;
- communication and conflict styles;
- rights;
- needs;
- boundaries;
- empowerment triangle;
- effective communication; and
- safety.

The self-care in this module was about identifying personal strengths. The objectives in Module 4 were the following:
- understand your own default role in relationships and communication style during the conflict;
- recognise how thinking and feelings influence your pattern of communication;
- identify personal boundaries which align with your values; and
- develop skills to support effective communication.

Circle of Support provided information about how to navigate the service system. This was included in Module 6 with further understanding of the learnings, such as tools to support motivation to change AOD behaviours and how to navigate and access the service system. In this module, self-care was

about setting goals and recognising strengths in others. The module aimed to:
- provide a better understanding of the service system;
- have access to tools and resources to support their loved ones; and
- feel hopeful for the future.

The closing session, Module 7, was about celebrating the journey by offering a program review and visualising a hopeful future. It also involved celebrating activities, such as a note of thanks and graduation. At the end of the program, participants were invited for a discussion session, reflecting on the modules and activities and providing feedback. This allowed the Peer Facilitator team continuous improvement.

Overall, the Circles of Support program aimed to:
- Improve participants' mental health and AOD literacy, particularly related to change behaviours and the limits of control for Families and Friends who support individuals with AOD issues.
- Provide substantive knowledge of recovery and have participants contextualise the information for the benefit of their own wellbeing.
- Develop comprehensive knowledge of roles and relationship dynamics, how this impacts communication and ways to enhance communication for Family and Friends.
- Provide basic information primarily to navigate the carer service system and resources and, in the second place, with a lesser extent, to the consumer service system.
- Enhance understanding of how to explore self-care as it relates to themselves.
- Increase overall self-awareness of their own journey, including emotional/behavioural responses.
- Validate the importance and value of Family and Friends providing care and support to feel empowered.

4. Key Findings

4.1. Families and Friends' profiles in the Circles of Support program

Results – Participants' sociodemographic background

In Program 1 (n=7), most participants were female (71.4%), and aged 35-64 (71.5%). All participants had English as a first language, and there was only one participant who was not born in Australia but in another English-speaking country. However, NT has a diverse population; in the first program, no people identified as Aboriginal and/or Torres Strait Islander. All participants had at least a Year 12 education level, and 57.2% hold Bachelor's or Postgraduate degrees. Some were students (14.3%) or retired (14.3%), and 57.2% had employment or self-employment. One participant expressed that they were semi-retired and studying, which was influenced by ill-health. Regarding relationship status, in this group, most participants were in a marriage or de facto relationship (57.1%) and had one or two children (57.2%). In many cases, a Family and Friend looked after more than one person (42.9%). Participants' relationships with the person they cared for were usually partners (28.6%) or parents (28.6%), followed by children and siblings (14.3%-14.4%). (Table 2)

Table 2. Sociodemographic background CoS Program 1 (n=7)

Variables	Frequency (%)
Gender	
Male	28.6
Female	71.4
Age Category	
18-24 yrs	14.3
25-34 yrs	0.0
35-44 yrs	28.6
45-54 yrs	14.3
55-64 yrs	28.6
65+ yrs	14.3
Country of birth	
Australia	85.7
Other	14.3
The main language spoken at home	
English	100.0
Other than English	0.0
Aboriginal and Torres Strait Islander	
No	100.0
Aboriginal and Torres Strait Islander	0.0
Highest level of education	
Less than Year 12	0.0
Year 12 or equivalent	28.6
Vocational education (VET)	0.0
Diploma course	14.3
Bachelor's degree	28.6
Postgraduate degree	28.6

Variables	Frequency (%)
Employment	
Employed	42.9
Self-employed	14.3
Domestic duties	0.0
Student	14.3
Unemployed	0.0
Unable to work	0.0
Retired	14.3
Other	14.3
Relationship status	
Single	42.9
Relationship	0.0
Married/ de facto	57.1
Other	0.0
Number of children	
0	42.9
1	14.3
2	42.9
Relationship with the person they care for	28.6
Partner	28.6
Parent	14.3
Child	14.3
Sibling	14.3
Other	
Caring for more than one person	
Yes	42.9
No	57.1

Program 2 (n=6) was more diverse than the first regarding some sociodemographic variables. As Table 3 shows, most participants were female, aged between 35-64 years, but 33.3% of the participants were Aboriginal and Torres Strait Islander people; one participant was on a disability pension, and another was born in a non-English language country. Also, in this group, the number of participants with children was higher than in the previous group. However, in this program, most participants cared for one person only, who were mainly partners (33.3%) and siblings (33.3%).

Table 3. Sociodemographic background CoS program 2 (n=6)

Variables	Frequency (%)
Gender	
Male	33.3
Female	66.7
Age Category	
18-24 yrs	0.0
25-34 yrs	16.7
35-44 yrs	16,7
45-54 yrs	33.3
55-64 yrs	16.7
65+ yrs	16.7
Country of birth	
Australia	83.3
Other	16.7

The main language spoken at home	
English	100.0
Other than English	0.0
Aboriginal and Torres Strait Islander	
No	66.7
Aboriginal and Torres Strait Islander	33.3
Highest level of education	
Less than Year 12	0.0
Year 12 or equivalent	0.0
Vocational education (VET)	50.0
Diploma course	0.0
Bachelor's degree	50.0
Postgraduate degree	0.0
Employment	
Employed	66.7
Self-employed	16.7
Domestic duties	0.0
Student	0.0
Unemployed	0.0
Unable to work	0.0
Retired	0.0
Other	16.7
Relationship status	
Single	50
Relationship	0.0
Married/ de facto	33.3
Other	16.7
Number of children	
0	16.7
1	16.7
2	16.7
3	33.3
4	16.7
Relationship with the person they care for	33.3
Partner	16.7
Parent	16.7
Child	33.3
Sibling	
Other	
Caring for more than one person	
Yes	16.7
No	83.3

In Program 3 (n=5), again, we experienced more gender, age, and country of birth diversity. This group included a person from a non-English speaking country, a non-binary participant and a person with domestic duties (Table 4).

Table 4. Sociodemographic background in the total sample 3 (n=18)

Variables	Frequency (%)
Gender	
Male	20.0
Female	60.0
Other	20.0
Age Category	
18-24 yrs	0.0
25-34 yrs	20.0
35-44 yrs	20.0
45-54 yrs	40.0
55-64 yrs	0.0
65+ yrs	20.0
Country of birth	80.0
Australia	20.0
Other	
The main language spoken at home	
English	100.0
Other than English	0.0
Aboriginal and Torres Strait Islander	
No	100.0
Aboriginal and Torres Strait Islander	0.0
Highest level of education	
Less than Year 12	0.0
Year 12 or equivalent	40.0
Vocational education (VET)	0.0
Diploma course	20.0
Bachelor's degree	40.0
Postgraduate degree	0.0
Employment	
Employed	80.0
Self-employed	0.
Domestic duties	20%
Student	0.0
Unemployed	0.0
Unable to work	0.0
Retired	0.0
Other	0.0
Relationship status	
Single	40.0
Relationship	0.0
Married/ de facto	40.0
Other	20.0
Number of children	
0	25.0
1	25.0
2	25.0
3	25.0
4	0.0

Relationship with the person they care for	
Partner	20.0
Parent	40.0
Child	0.0
Sibling	40.0
Other	0.0
Caring for more than one person	
Yes	20.0
No	80.0

The below table (Table 5) summarises participants' sociodemographic background on the total sample:

Table 5. Socio-demographic background CoS program (n=)

Gender	
Male	25.0
Female	68.75
Other	6.25
Age Category	
18-24 yrs	6.3
25-34 yrs	6.3
35-44 yrs	25.0
45-54 yrs	31.3
55-64 yrs	18.8
65+ yrs	12.5
Country of birth	
Australia	75.0
Other	25.0
The main language spoken at home	
English	100.0
Other than English	0.0
Aboriginal and Torres Strait Islander	
No	87.5
Aboriginal and Torres Strait Islander	12.5
Highest level of education	
Less than Year 12	0.0
Year 12 or equivalent	18.8
Vocational education (VET)	25.0
Diploma course	6.3
Bachelor's degree	37.5
Postgraduate degree	12.5

Employment	
Employed	62.5
Self-employed	12.5
Student	6.3
Unemployed	0.0
Unable to work	0.0
Retired	6.3
Other	12.5
Relationship status	
Single	43.8
Relationship	0.0
Married/ de facto	50.0
Other	6.3
Number of children	
0	25.0
1	12.5
2	31.3
3	18.8
4	12.5
Relationship with the person they care for	25.0
Partner	31.3
Parent	12.5
Child	25.0
Sibling	6.3
Other	
Caring for more than one person	
Yes	25.0
No	75.0

Results – Participants' journey

The individual interviews provided a better understanding of participants' journeys of being FFs of individuals with AOD and related issues. The below quotes from participants show how they contextualised the complex experiences and learnings they gained regarding multiple people in their life.

Most participants cared for various persons in their journey that had experiences of AOD issues, mental health challenges, co-occurring conditions, and domestic and family violence.

"I have a dual sort of role. I am the carer for a mentally ill adult [child]…for about 15 years now, and I also am the carer for an alcohol-dependent partner who is a binge drinker… I support [them] as well… since we met." (PP1)

"[I] experienced domestic violence. My partner [had] drug and alcohol…issues, and I also have a [sibling who] has… alcohol and drug use [issues] and [I] support my family with that… (PP11)

"[my child has] a diagnosis [that] is a [mental health issue]….[but] my [other child] was living in the house when [my child] was [in] earlier phases of the illness… [and] a number of friends who for one reason or another…I think it was more along the lines of perhaps alcohol and drugs and other illnesses… depression and anxiety, who encouraged [them]

to go to one of [support program] (PP8)

"[I] have had varying carer responsibilities… In the capacity of having AOD and mental health issues… [one of my children] had a drinking problem and had been smoking marijuana and then had been using [another drug] … that was going back seven years ago now… And [they are] currently sober, so that's good, but had varying degrees of caring responsibilities…like taking [them] to mental health appointments, taking [them] him to alcohol and other drug appointments… [my other child] fluctuates between smoking marijuana and drinking alcohol… [they haven't] engaged, really with any service provider. So my main caring role is just… keeping tabs on [them] and encouraging [them] to seeking…support… And then my other [child], [they are] mainly been smoking marijuana. [They] probably smoked at the longest… For the longest time, so since [they were] 14….[they are] still in active addiction." (PP9)

It was also described how difficult it could be to get support:

"[my sibling] started to experience psychosis… resulted in [them] going to hospital… So in one of [their], psychosis was triggered by using [drug]… And there was difficulty getting… support for [them]." (PP7)

"we were hearing from them, well, [they are] not a harm to [themselves] and [they are] not a harm to anyone else, so we can't do anything about it, which, you know, I completely understand people's rights, but it's very frustrating… so we kind of struggled through that for a period of time" (PP8)

Some participants shared that their journeys were also characterised by their own challenges:

"Having been a person with…issues with dependency, I have been in relationships where I've been the partner of and loved one of people with drug dependency issues. I also am a parent, and my [child] has had long-term issues with dependence" (PP2)

"I have a lived experience with alcohol, anxiety and depression… Has been dealing with my family members, two family members in my case, with issues with mental health and alcohol". (PP4)

"I'm a recovering alcoholic myself. I hit the wall…and put myself into rehab… and I haven't had a drink since… My husband was bipolar, and he was a functioning alcoholic… My [kid] was badly affected… [they were] heavy drinker… [and] my own father was a violent alcoholic." (PP5)

Many times, FFs' journey walking alongside the individuals has been long and intense without a break, implying risks to their own mental health and wellbeing, ultimately impacting the whole family. Still, there was a sense their hard work was undervalued, and that little was known about their experiences.

"I've been mentoring people on and off for most of my life…informally…" (PP5)

"I try to [have a break], then some days there are no breaks because you have to [be] there as a carer…. I'm a rescuing type of person as well; I like to help people. You don't always give yourself the breaks that you probably need" (PP1)

"It's a healing process for all of us…. [the] whole family dynamics got affected by [this issue]" (PP10)

"even though my [child] is [a grown up], I'm still completely consumed by [their] life… and sometimes [my child] has been my carer, and other times I provide [them] with care… I'm the person [they turn] to for everything… So, we're heavily reliant on each other" (PP2)

"…being a carer is an actual experience. It's not just something that you do. It should be acknowledged and that it does take a lot of time … and energy, which I think is something that's missed, you know, from people that don't have to deal with this kind of world" (PP9)

Interpretation

The participants in the CoS Program had similar socio-demographic backgrounds in relation to gender and age as in previous large-scale national studies (Australian Bureau of Statistics, 2019; Carers NSW, 2020; Centre for Change Governance & NATSEM University of Canberra, 2021). However, the education level and employment rate in this sample was higher, with 56.7% having a Bachelor or postgraduate degree, and 75% employed or self-employed. While in the first program, around 40% of FFs cared for more than one person, in the total sample, this was 25%. FFs in this sample were parents (31.3%), siblings (25%) and partners of a person with AOD and related challenges. While the population in the NT is very diverse, in this program, most of our participants were Australian-born, non-Indigenous people speaking English at home. Only 25% of the participants were born overseas, 12% were Aboriginal and Torres Strait Islander, and 6% were part of the LGBTQI+ population.

Moreover, the qualitative data highlighted the complexities this vulnerable and highly stigmatised population experienced in their journeys. This included responsibilities for various persons, difficulties navigating services and getting support, having lived experience of their own challenges, violence, no respite, and hard work that are not acknowledged by many.

Our results highlight the need for a more targeted approach in recruitment to access, involve and support more males, youth, LGBTQI+, Aboriginal and Torres Strait Islander people and individuals with CALD backgrounds. People with lower education levels, domestic duties or unemployment status also need to be targeted more directly. FFs' experiences are challenging and burden many areas of their life. This should deserve attention, so they can feel accepted, understood, and supported.

4.2. Families' and Friends' mental wellbeing and perceived stress

Results – Statistics of participants' self-perceived health and stress in the Circles of Support program

While no participant evaluated their health and wellbeing as being poor, 43.8% of the program participants rated it fair and moderate at the program start and 30% at the end of the program (Table 6). However, this was not a statistically significant increase.

Table 6. Self-perceived health (SPH) among CoS participants (n_{pre}=16 and n_{post}=10)

Variables	Frequency (%)
Self-perceived health (SPH)at the program start	
Poor	0.0
Fair	6.3
Moderate	37.5
Good	50.0
Excellent	6.3
Self-perceived health (SPH)at the end of the program	
Poor	0.0

Fair	10.0
Moderate	20.0
Good	60.0
Excellent	10.0

Note: p>0.05 (NS)

On the scale created from the answer categories about general health and wellbeing (min=1 and max=5), they scored 3.56 (SD=0.73) at pre-program and 3.70 (SD=0.82) post-program. Again, this was not a significant change (see Table 7).

We also aimed to explore participants' stress levels and stressors. Participants' mean score was 7.18 (SD=1.83) at the program start on the CSAQ scale (Epstein-Lubow et al., 2010), and at the end of the program, this significantly decreased to 5.50 (SD=3.46). Based on these scores, participants' stress levels were not considered extremely high since scores over 10 indicate a chance of a high level of stress. However, answers given to the CSAQ current stress levels questions are also considered significant indicators of high stress levels. These participants scored 6.57 (SD= 0.97), indicating elevated stress levels (Table 7) but again, the statistical analysis of these variables was not significant pre- and post-program.

Table 7. Families' and Friends' self-assessed stress levels and health mean scores (n_{pre}=16, n_{post}=10)

Variables	Mean	SD
Pre-program		
Self-perceived health (SPH)	3.56	0.73
Self-assessed stress scale (CSAQ)	7.18*	1.83
Pre-program		
Self-perceived health (SPH)		
Self-assessed stress scale (CSAQ)	3.70	0.82
	5.50*	3.46

*Note: p>0.05 (NS), *p<0.05*

We also analysed the frequency of each item on the CSAQ (Epstein-Lubow et al., 2010) pre and post-program. At the program start, most participants had trouble focusing on their actions, had sleeping difficulties and were upset with changes in their situation and behaviour. Physical and psychosomatic symptoms were less frequent among participants, such as back pain and illness, including headache, stomach problems and colds. However, loneliness, feeling overwhelmed, upset, and irritable were also frequently indicated feelings, which are also considered significant indicators of high stress levels. Conversely, more than 50% expressed satisfaction with their families' support and felt useful and needed. Many participants considered the living situation inconvenient or a barrier for care. While we can see changes in the frequency of these variables at the end of the program, these were not statistically significant (Table 8).

Table 8. The frequency of stressors and indicators among participants (n_{pre}=16, n_{post}=10)

Variables	Frequency (%) Pre-program	Frequency (%) Post-program
Had trouble keeping my mind on things what I was doing	56.3	33.3
Felt that I couldn't leave my relative alone	37.5	11.1
Had difficulty making decisions	31.3	12.5

Felt completely overwhelmed	50.0	33.3
Felt useful and needed	53.3	66.7
Felt lonely	40.0	33.3
Been upset that my relative has changed so much from his/her former self	60.0	44.4
Felt loss of privacy and/or personal time	25.0	44.4
Been edgey or irritable	53.3	44.4
Had sleep disturbed because of caring for my relative	46.7	33.3
Had a crying spell(s)	31.3	33.3
Felt strained between work and family responsibilities	25.0	44.4
Had back pain	37.5	33.3
Felt ill	37.5	55.6
Been satisfied with the support of my family has given me	56.3	37.5
Found my relatives' living situation to be inconvenient or barrier to care	40.0	11.1

Note: p>0.5 (NS)

Participants' perceived challenges

The individual interviews gave insights into the challenges participants experienced in their journey. Aggression, violence, relationship issues and hurtful communication were mentioned frequently.

"my own father was a violent alcoholic…and then he would start to get angry about something, and you know, throw things around the kitchen… bash up my mother." (PP5)

"My AOD partner has safety issues when it comes to self-care after drinking too much. [They] can be negative in the relationship…alcohol liberates the hurtful communication in [them] …." (PP1)

Fear was another experience that some participants shared:

"You live in fear… I remember running out of the house with my younger brother… Sleeping in parks… just being on the street for hours until, you know, he has gone home to bed." (PP5)

Some participants also felt isolated, poorly supported, ununderstood, and hopeless about their future. Their social life was impacted significantly. Many times, they had no one to talk to about the challenges they experienced and did not know where to seek help from. However, some successfully set boundaries in their relationships, which allowed them to have fulfilling lives despite the challenges.

"Our social life is certainly different because [my] alcohol-dependent [partner] can't be relied on to socialize in acceptable and safe ways all the time…. It has impacted definitely relationships, our access to social opportunities as a couple and yeah, I've set some boundaries there so that I still have a fulfilling life for an extrovert." (PP1)

"It's kind of isolated me from being able to socialize, you know, not having money because they've not been in work. So then, whatever money I earn, I support the whole family with. Therefore, you know, don't really socialize" (PP9)

"I felt incredibly isolated… and I didn't really know where to turn for help…. I did find it incredibly isolating… I did not know what the future possibly could look like… And I think just probably like it an overall feeling of just being overwhelmed" (PP8)

"You don't have someone that you can talk and explain them…[I] didn't know even with the law and all that how I can help [them], you know that. And it was…in my head that I have to do the right thing. I couldn't, you know, it was not up to me to help [them] and all that, yeah. It was very hard." (PP11)

"[my friends] don't really understand the stage that I'm at with mine… within the family…[we are] quite a close-knit family, but in saying that, I never really brought my issues to the table with what I was experiencing with my children… I don't feel really aligned to anyone in my friendship or family group that you know; I would feel supported by…" (PP9)

Conversely, having close friends and family helped participants to be understood, supported, and feel included. In the case of own lived experiences, drug-free friends also make good foundations.

"I need my friends. They are good listeners… [but it] depends on the friend. You know, there are some friends that don't get it at all…. You mainly have to rely on yourself… [but] My friends listen when I talk about my carer experiences. I've been a carer this week. I've been in [a] carer role." (PP1)

"My social life is…fairly strong. I have built myself a really strong foundation within a non-drug-using social community…. I've got a best friend out of [a support] group, and we see each other or we contact each other every single day…; my social life is still all safely wrapped around drug-free people only… my social life is my peer group." (PP2)

"[I have a friend who is in] a similar situation…we support each other, and we can understand each other." (PP11)

"We're very grateful because we've… got really good family support and friends. And so they were good listeners…" (PP10)

Getting support was even more complicated when it came to co-occurring issues, and mental health services were reluctant to help, which confirms previous evaluation findings relating to LE of mental health challenges in the NT that emphasised the importance of better co-ordinated care and integrated service delivery between AOD and mental health systems (Tari-Keresztes et al., 2020).

"… as soon as we were asked about whether [they] had drug use and we were turned away from services when we shared that information…" (PP7)

Mental health challenges are well-known for people supporting someone with AOD issues. Still, participants often prioritised the other persons' needs and neglected their own. However, there were also some participants who did succeeded in addressing their own mental health and wellbeing.

"I hadn't really engaged with anything for myself before, and it's all about trying to support them and get them supported through whatever means." (PP9)

"At the start, I thought that I don't…I can't have this opportunity [to seek help for myself] because I have to support them, so it's not easy, and it's hard people to understand you…and what's happened, you know… every day is different and …you always have to worry and…your priority is to help them" (PP11)

"Most days, I prioritise myself pretty well. Make sure that I do have a priority on [my]self because you need to put all oxygen mask to help others. And everyone knows the risk for mental illness for carers is very high." (PP1)

Supporting someone with AOD and related challenges significantly reduces their opportunities in many ways. Social participation and finances are among the most common ones. As a consequence,

they often feel grief.

> "I can't be… living my best life when I'm caring for my family because sometimes [their] needs cut over the top of yours… Then you have to drop every holiday, everything you planned to do and succumb to their needs. You experience grief." (PP1)

> "It's a lot [of challenges] … first of all economic, you know the money is the [biggest] issue and making it worse because you don't have the money, you have to pay for, you know, doctors and all that" (PP11)

> "[my mum] had to work part-time in a factory…shift work in a factory to help support us because even though [my father] had a good job…the money was spent in the grog" (PP5)

Feeling shame and being stigmatised often led participants to withdraw from social interactions, particularly to avoid judgement by others. This is often exacerbated and/or further influenced by cultural norms, values, and beliefs.

> "but then also trying to explain it to family or like this sort of shame and guilt and all the things that come around it… I just found it really difficult to talk to [them] about the situation… that was quite sort of distressing as well" (PP8)

> "With my culture…is hard to understand anything about mental health and all that… for us is stigma… and it's very hard for [my family] to understand [these issues]" (PP11)

> "I feel like there there's a huge stigma around writing people off, as in terms of thinking that once someone's got a drug issue or mental health issue, that's it. They're just stuffed, and it's all downhill from there." (PP3)

> "The journey was a roller coaster…because I think lack of knowledge and also denial with the family and cultural acceptance… that was the biggest hurdle… how could you have [these issues]? And you are the [parent] you should fix this…this kind of pressure was really heavy on me…" (P10)

The below participant described how AOD use could impact the whole family unit and broader social environment.

> "the impacts are enormous, and you grow up sort of disassociating, numbing yourself… that vicious cycle of the domino effect of how everything affects everyone else. We're talking about one person, but there's family, siblings, relatives, friends, everyone involved, and all of these people are impacted, and they, in turn, can impact other people mildly or quite severely." (PP5)

It does not matter if it is a lived or living experience; it has long-term impacts:

> "…it was very early on…. My [parent] has been sober for 35 years, and my [sibling] has been sober for two years… Even though it's lived experience…I remember at all… [however] it was from a long time ago." (PP4)

Despite the support, persons with AOD issues may not reach their full potential in recovery journey. Participants needed to manage these uncertainties.

> "It's a big responsibility that all the time you're aware you may not succeed, you may end up watching them deteriorate, go down the wrong path and perhaps even die or be being incarcerated… they can turn into a person you never imagined they could, especially if we're talking about drugs, become violent, etcetera…" (PP5)

Walking alongside these persons often impacted participants' own mental wellbeing, and some applied maladaptive coping strategies to eliminate the desperation, manage distress and cope with the situation.

"I started drinking… because of avoidance… but alcohol is not very good…" (PP10)

"Your life becomes too unmanageable and stressful if you are always responding to the same SOSs.." (PP5)

"I guess the most challenging thing is my own wellbeing having to continually support others through their journey… I was on suicide watch. Pretty much for a month. Was supporting one of [my children] through whatever [they were] going through so. And just feeling isolated because feeling like, you know, nobody else has experienced all my friendship groups and not experiencing what I'm experiencing. So not really being able to talk to them about, but also not having the time because focusing on trying to help these people along" (PP9)

"I remember deliberately drinking in the kitchen in front of him when I was about 18, thinking, well, if you can't beat them, join them." (PP5)

Some participants recognised that they need professional help to maintain their own mental wellbeing; however, they expressed that there is minimal support available to them. Indeed, most had never experienced any formal peer support relating to their journey of caring for a person with AOD and related issues.

"I, fortunately, have a very good counsellor who I saw [previously]… So I reconnected with [them]…. still do, to be honest with you, about once a month, once every six weeks" (PP8)

"I've had received counselling through [a service] and but that's it; otherwise, no support enough and recently I thought I have a need for support…" (PP1)

"Upon pressure of times, you know…we have [employee assistance program] counselling service through our work provided. And just maybe a couple of times I mention[ed] it as part of my counselling session about other stuff, but not anything dedicated to that cause [of caring for someone with AOD issues]." (PP9)

Now, this is my first experience in a peer support group..." (PP1)

The below participants expressed how difficult it is to walk alongside a loved one when you have your own challenges, which can even risk your own recovery:

"…my personal challenges were with the burden of being an addict myself and realizing that…you know I had role-modelled a drug-taking lifestyle…. I'm feeling like a hypocrite for expecting [my child] to straighten [their]life out 20 years earlier than I have…. that's really difficult… And that making it very difficult for me and risking my recovery by living with a drug taker in the household…." (PP2)

People with AOD issues may be in denial, which presents further challenges for participants who want to help and support the persons' recovery.

"the main challenges and there are a few people who I'm helping informally, is denial…The biggest challenge is that somebody considers you their friend, their mentor, someone they can come to. But when you finally broached the subject that it's the alcohol or the drugs that are causing the problem… then if you go even further and say that there are underlying problems that are causing you to use. You're getting on very touchy ground, and people can't face that, and you could end up being the enemy. You

know, they want to shoot the messenger." (PP5)

Because of the denial, discussion with the persons about their AOD issues is difficult, which presents further challenges to FFs. They need to be strategic in those conversations.

"After all, you can't really communicate; you are just talking to the drink or the drug…"Don't you talk to me about that. You don't know about my life."… So you do need to avoid those conversations because you lose them. And what a fragile thread you had with them" (PP5)

Despite the challenges, some participants experienced opportunities and rewards in their journeys, such as learning how to separate the person from the AOD issues, role modelling a drug-free lifestyle, especially they had their own challenges, being actively involved in the person's recovery and providing emotional support.

" I have a really, really trusting relationship... close relationship, with [my family members I support]… People say why do you stay? You know, [they don't] drink all the time. [They are] really good [parents]… when [they are]not on the binge" (PP1)

" I've decided a couple of years ago…not to say 'oh you should get drug free' and simply [role model] the change in life and my actions speaking louder than words. And it's been hugely rewarding having [my child] wanting, seeing that and wanting to follow suit… [I am] is lucid and present, and that's a huge reward. And [my child has] probably got the best carer aspect of all. Because I have walked that path…and so I properly know. Yeah. So that's been rewarding" (PP2)

" [we] are very heavily involved, and [our child] wants us to be heavily involved in, you know, [their]… appointments, understanding [the treatment] … so I guess it's more that emotional support in a caring role" (PP8)

Among the opportunities and rewards, changing worldviews about addiction, becoming an advocate for mental health challenges and AOD issues, and learning to be present were also mentioned.

[I] try to educate...where possible…[and this] has provided rewards in terms of, you know, compassion for people who are experiencing these things. So those kind of rewards… I feel like there's an advocacy role locally. If I can make some changes there…that's been rewarding. I also think it's another reward is just being the advocate for [my child]" (PP8)

"[caring for my family] is given me a bit of worldview, [about addiction], and you know how to support people going through addiction, but it's also helped me to manoeuvre the system, both the mental health system and that AOD system, which hasn't always been an easy thing to do.." (PP9)

"Walking gently side by side with my [child]… not controlling… just being an avid listener…. or just being present. We don't even have to talk… When the first conversation that we had, I tried to answer them but then at the end [they] just wanted me to listen…. [They] just wanted me to be there for [them]" (PP10)

Interpretation

About half of the participants perceived their general health and wellbeing as moderate at the program start, which improved by the end of the program; however, these changes were not statistically significant. While their CSAQ total stress levels were not considered extremely high, their answers to the CSAQ current stress level questions and certain items of the CSAQ scale showed significant chances of high stress levels. Participants scored significantly less on the total CSAQ stress

scale in the post-program surveys. The most frequent stress indicators among them were trouble focusing on things, sleeping difficulties, and being upset with the changes in their loved one's behaviours. Most participants did not present physical symptoms of stress as often as in a previous study (Orford, 2010). However, the emotional symptoms were frequent, mirroring those of large-scale studies (Centre for Change Governance & NATSEM University of Canberra, 2021; Mental Health Carers NSW, 2018), such as loneliness, feeling overwhelmed, upset and irritable. These still indicate the impact of stress on their quality of life (Hill et al., 2016; Sanders, 2020). While we found favourable changes in the frequency of these indicators, they were not statistically significant.

In the individual interviews, participants further described their challenges of caring for someone with AOD issues. They shared their feelings of loneliness, shame, fear, uncertainty, grief, and hopelessness through their own stories. We also got insights into what areas of their lives were impacted by the persons' AOD use issues. This included social participation, financial situation, own needs, broader family unit and their own mental wellbeing. They often felt unsupported and undervalued by services and the wider society. Stigma was one of the most critical challenges they faced, which was more significant for people from CALD backgrounds.

Our results highlight the importance of programs aiming to increase FFs' connectedness, hope and empowerment in order to decrease the emotional indicators of distress and support for their mental wellbeing and recovery. These findings suggest that applying mixed-methods evaluations in small sample-sized pilot studies is crucial to better understanding their experiences and needs.

4.3. Families' and Friends' empowerment and recovery

Results – Statistics of participants' empowerment and recovery

We explored participants' functional, personal, clinical and social recovery with the revised version of RAS-DS (Hancock et al., 2019). First, we analysed the frequency of each domain item and then used the scale to compare means and percentage scores. At the start of the program, we applied this instrument to create the baseline data for the post-program survey, which aimed to identify the CoS program's impact on participants' mental wellbeing and recovery. Participants had to report their answers on a 4-point Likert scale (1=untrue, 2=a bit true, 3=mostly true, 4=completely true). The answer categories were re-coded into two broader categories, namely 'untrue', including the untrue and a bit true answer categories and 'true', involving answers such as mostly true and completely true.

The functional recovery scale included six items about doing things that participants value. Most of them indicated their need to have fun and do important things at the program start. The majority also considered the support they provide as valuable and helpful. While most participants described that it was vital for them to have healthy habits and do things that give great pleasure, the frequency of these items was relatively lower than the others (Table 9).

The second subscale was the personal recovery involving 18 items. Most participants described all these items as essential for them and looked forward to doing and having those things. Their answers indicated a propensity towards self-awareness, good coping strategies, future orientation, development of goals, and comprehensive knowledge of available services. They also considered their mistakes as an opportunity to learn. Relatively fewer participants expressed self-love ('I like myself'), reported that they would ask for help when needed and had an idea about what they want to do in the future. Also, the lowest frequency was about 'having tools to live a life they want to (Table 9).

The clinical recovery scale included seven items. While participants' answers show good stress management skills and awareness of various stressors, they were less hopeful about changes in their family situation regarding decreasing stress or periods of stress. They also reported less frequently that they have the tools and plan to reduce distress (Table 9).

Social recovery is the last subscale of the RAS-DS scale, involving seven items. While the results show that participants' have supporting social connections and friends with and without similar challenges, only about 50% felt OK with the current family situation(Table 9).

At the end of the program, we saw some favourable changes in these frequencies, but these were not statistically significant (Table 9).

Table 9. The frequency of true answers on recovery factors (revised RAS-DS) among participants in the CoS program (n_{pre}=16, n_{post}=10)

Variables	Frequency (%) Pre-program	Frequency (%) Post-program
Functional Recovery (Doing things I value)		
It is important for me to have fun	75.0	80.0
It is important for me to have healthy habits	68.8	70.0
I do things that are important to me	81.3	100.0
I continue to have new interest	75.1	80.0
I do things that are valuable and helpful to others	87.5	100.0
I do things that give me a feeling of great pleasure	68.8	68.8
Personal Recovery (Looking forward)		
I can handle it if I get stressed again	100.0	93.8
I can help myself feel less stressed	87.6	90.0
I have the desire to succeed	100.0	100.0
I have goals in life what I want to reach	87.6	90.0
I believe that I can reach my current personal goals	81.3	70.0
I can handle what happens in my life	87.5	100.0
I like myself	75.0	80.0
I have a purpose in my life	86.7	80.0
I have people in my life who like and value me	93.8	90.0
I have tools to live the life I want to	68.8	90.0
I have an idea of what I want to do in the future	75.1	80.0
Good things will happen to/for me	93.8	100.0
I am the person most responsible for my own life	93.8	100.0
I am hopeful about my own future	87.6	88.8
I know when to ask for help	75.0	90.0
I ask for help when I need it	62.6	60.0
I know what helps me to feel good	87.5	90.0
I can learn from my mistakes	93.8	100.0
Clinical Recovery (Mastering my levels of stress)		
I can identify when I am stressed	87.5	100.0
I have my own plan to reduce my levels of stress	68.8	77.8
There are things that I can do to help reduce my levels of stress	87.5	90.0
I know that there are services that can/could help me	81.3	90.0
Although my experiences of stress may get worse, I know I can handle it	68.8	100.0
My experiences of stress interfere less and less interfere with my life	60.0	70.0

My experiences of distress seem to be a problem for shorter periods of time each time they occur	75.0	80.0
Social Recovery (Connecting and belonging)		
I have people that I can count on	87.5	80.0
Even when I don't believe in myself, other people do	93.8	90.0
It is important to have a variety of friends	87.5	50.0
I have friends who have also experienced similar sources of stress	75.0	70.0
I have friends who haven't experienced similar sources of stress	56.3	70.0
I have friends that can depend on me	87.6	80.0
I feel OK about my family situation	50.1	55.5

Note: p>0.05

We compared participants' average and percentage scores on each subscale and calculated their total revised RAS-DS scores at the program start and end of the program. The total mean score was 121.43 (SD=16.60) pre-program and 122.13 (SD=16.70) post-program on a scale with a max 152 score. Based on the average and percentage scores, they scored the highest on the personal recovery (looking forward) and the least on the clinical recovery (mastering levels of stress) domain. Comparing the pre- and post-programs scores, we found significant changes in the total empowerment and recovery scale and social recovery domain. In both cases, participants scored significantly higher on those scales at the end of the program.

Table 10. Families' and Friends' empowerment and recovery mean scores in the CoS program (n$_{pre}$=16, n$_{post}$=10)

Variables	Mean Pre-program	SD	Mean Post-program	SD
Total score *(REVISED RAS-DS)*	121.43*	16.60	122.13*	16.70
Subscale total scores *(REVISED RAS-DS)*				
Functional recovery *(Doing things I value)*	19.40	4.06	20.56	3.39
Personal recovery *(Looking forward)*	58.71	8.34	58.87	8.35
Clinical recovery *(Mastering my levels of stress)*	21.73	4.52	21.88	3.10
Social recovery *(Connecting and belonging)*	22.33*	3.63	22.73*	3.11
Subscale average scores *(REVISED RAS-DS))*				
Functional recovery *(Doing things I value)*	3.23	0.66	3.44	0.56
Personal recovery *(Looking forward)*	3.26	0.46	3.27	0.46
Clinical recovery *(Mastering my levels of stress)*	3.10	0.64	3.12	0.44
Social recovery *(Connecting and belonging)*	3.24*	0.51	3.40*	0.58
Subscale percentage scores *(REVISED RAS-DS)*				
Functional recovery *(Doing things I value)*	80.83	16.94	86.11	14.12
Personal recovery *(Looking forward)*	81.54	11.58	81.77	11.60
Clinical recovery *(Mastering my levels of stress)*	77.61	16.18	78.17	11.07
Social recovery *(Connecting and belonging)*	76.19*	14.50	81.19*	12.98

*Note: p>0.05 (NS), *p<0.05*

Results - Participants' experiences in the Circles of Support program

Participants shared their experiences with the CoS program in the qualitative interviews. Since peers are rarely utilised in psychosocial support activities in the NT, being in a peer-only environment was a unique and powerful experience for participants.

They described the power of the peer-to-peer approach as follows:

"I felt part of something; I felt worthwhile. I felt better when I left, and I just kept going… [it was] a fabulous experience. I've learned an awful lot both for me personally and as going on to be a professional. And for me as a person in what is still a personal recovery, if you like, because even though I don't drink. I still have so many issues, insecurities" (PP5)

[it] was…safe and supportive experience with the program and all that. I mean, it was the best thing they can [do]" (PP11)

"Well, first [because] I've never been in a peer support program, I thought it might be a little bit more therapeutic, and we might actually have some group counselling… but it came very clear that was not the case for this. [Peer support] is… allowing us to set our own thinking parameters, our goals and frame new thinking and new strategies around what we have inside…. not giving answers and not hoping to counsel at all… and that's been really valuable because everyone's journey as a carer is unique." (PP1)

Participants experienced authenticity and appreciated the learnings they gained through the program.

"the shared experience… authentic willingness to share straight up and not be professional experts… to acknowledge the experience that we have and value as well and try and leverage that…" (PP1)

"I really enjoyed the exercises that we did, you know, it wasn't just a death by PowerPoint; there [were] videos, [there were] exercises. It was all very useful information, even though the NT doesn't have, you know, something like [the] Family, drug support" (PP9)

The peer environment was perceived as a safe and confidential space for all participants.

"it's a safe, comfortable zone… the facilitators and the peers are on the same level. It's merely a sharing of information experience from people that have the lived experience of stuff that others have gone through, and they wanna…talk about that." (PP2)

"just having other people in the room… some of the things that I struggled with and some of those feelings of, like, shame and guilt and loss and all of those things. It was really lovely to be in an environment where everybody had those feelings regardless… So, if I'm dealing with [a clinician], I can go and have a chat to my friends about what the [they]said. But I'm not gonna go and have a chat to my friends about what a [people] with lived experience has said so; it brings about… just a trusting kind of relationship." (PP8)

This allowed participants to be honest, feel emotions and practice empathy.

"we are speaking the same language. Their eyes don't glaze over with disinterest or ignorance… It's not that we feel sympathy for each other and it's empathy and that they know." (PP5)

"I found being in the environment in the peer-to-peer, there's just there's a very refreshing kind of honesty that comes from that… which then I think allows some well better reflection, better self-reflection, better reflection on other people's lived experience, which then grows all those you know, good emotional traits. I was talking about, like, resilience and compassion and empathy and those sorts of things" (PP8)

Based on participants' feedback, the program satisfied their needs and provided valuable support, something they had never experienced before.

> "I completely and utterly satisfied… it's gone above and beyond what I thought I'd get from the program" (PP2)

> "This [program] is priceless… "(PP10)

> " [the facilitators] they gave us so many research and recommendation tips to cope, self-care, knowledge, support. It was 100, 1000% very positive for me to attend this program" (PP11)

Many of them referred to the lack of peer support activities and the need for them in the NT.

> " [it is] definitely [a] worthwhile program and something that should be funded and you know should be out there… " (PP9)

> "… there is no support at all for carers [in the NT] …Well, this is the first of its kind. And there's a lot of carers here. You don't even know that they [are] carers… [peer support] has been everywhere else in Australia for a long time, but just not the NT and why? So, there are some really strong models that are working elsewhere, right? Not here. We've never heard of it till now" (PP1)

They also wished they could have had this knowledge and the CoS program offered to them earlier in their recovery journey.

> "The biggest learning was that I wish I'd known all of this a lot earlier in my life. That things could have been different" (PP5)

> "I was sitting there, and I'm like, wow, I wish I had that knowledge [earlier]… " (PP10)

Participants dedicated their time, stepped out of their comfort zone, and gave the research team trust to share their stories and experiences in the program, hoping that in this way, they could raise awareness about the challenges and available support for people who walk alongside people with AOD and related challenges.

> "[participating in the interviews] gives us voice, cause carers don't know much voice" (PP1)

> "I really believe in this program… That's why I'm happy to participate in this interview…because it is so important…. if we can put this in a community if we can go to community…. we can prevent…high statistics of …using drugs… [and] having hope that we are not alone…we can find a healthier way to [manage challenges] …I really believe in this…pilot… I hope that these people [in the community] will have the same opportunity that I [had in this program] …I'm so pleased to be [part of it] … really good to have [the] circles of support, [I] really, really love the program." (PP10)

Also, they wanted to spread the word about the positive impacts of the program. Since they felt that peer support and work require more attention in the local community, it is still not well known and understood.

> "I see my [parent] every day and [they are] like, what's this group? What does [peer support] even mean…. And again, that it's OK to be a part of something like that." (PP9)

> "What peer support [is] needs good explanation, I think…" (PP1)

Being connected, accepted, and understood were among the most common experiences participants felt, which helped them to come out of their isolation and feel supported.

"I'm not alone, which is a comforting thing. And just knowing that… support [is] available." (PP9)

"that human connection… you could feel the need of… friendships have actually been formed…and you can't come into it expecting to make friends, but then when you feel it happening, you're like, yeah, it's just awesome " (PP2)

"I was not alone…other people also…. going through something similar…The peer connection and support was the most important…. I felt accepted, you know, they accepted me. Like who I am…" (PP11)

"You don't have to be alone in this journey…. And you don't have to feel isolated" (PP10)

Facilitators spoke openly about their challenges, role-modelled their journey and created connectedness. They also implemented activities that focused on self-gratitude. These all contributed to developing hope, optimism, and courage.

"Some of those people with the live experience are superstar. I think they are so brave. [I] admire everyone. They're very honest. They're very true to themselves. You can see in their body language that sometimes there are sensitive issues there. But they bravely faced it. And they would say, you know, look, this is how I experienced it, and this is how I overcame it." (PP10)

"focus on self-gratitude…keep that, cause it gives you a bridge to hope..." (PP1)

"[a facilitator] spoke openly about [their] experience through addiction, and I think that was really useful to have [them] in the room because…you're hearing from someone who [had this experience]… listening to their story and seeing [them] come through that" (PP9)

"the program that was delivered by peers… [they] were expressing their own living experience and related issues with mine and also, we sense personal stories, and we could understand better each other, and you feel safe when you are sharing… you see, you're not alone. Then you have connection, inspiring hope, and optimism..." (PP11)

Participants acknowledged their feelings and accepted their vulnerability.

"the acknowledgement of grief and recovery help me…reframe my thinking about what I'm feeling on certain days and help me name up emotions, powerful emotions and re-strategize….I tried to be the strong…and cope. Cope. Cope well. That's just wrong to think like that. We're all vulnerable, and you know [facilitators] modelled their thinking and really, really generously." (PP1)

The program allowed participants to dedicate time for self-reflection, creating avenues for a positive sense of self, self-acceptance, and overcoming stigma.

"I don't know whether we say things like this to protect ourselves, but it's like. I can't say I'm grateful for everything that's happened to me, but I appreciate that everything that's happened to me has made me who I am today, which is not a bad person. I mean, I'm broke, and I'm trying to re-establish myself at this age." (PP5)

"we did focus on the pictures, and what that means, that was kind of a really good reflection point because I think as a career, you just go, go, go, go care, care, care, care, you don't really stop … So that was a really good thing to stop it and think and reflect and

haven't implemented it yet, but you know something that I'm like, how can I implement this as a kind of a weekly practice or, you know, to look at pictures and pick something out and maybe journal about it, you know, with it in mind? (PP9)

Participants also learned how to separate the person from the behaviour, preparing them to be recovery-oriented advocates for their loved ones.

"for me… those visual pictures [were very useful]…pick out a picture about the person with the addiction and so that was really interesting for me because it was like it kind of… It took away the behaviour and sort of focused on the person and what they must be feeling regardless of the behaviour." (PP9)

"[I learned to] separate the symptoms or behaviours my [sibling] display[s] from who [they are] as a person" (PP11)

"I'll try to be the best carer that you can when to step in and really, really assist and when to pull off when they're recovering and recovery mode and when they really need you." (PP1)

The program helped participants navigate through the different stages of the journey successfully.
"I think I was just in a coping stage before…and just trying to breathe and get through and survive it, whereas [now] really sort of looking into it and having those sorts of realisations through the course that this is the deal like this is the lived experience deal" (PP8)

The knowledge and skills the program offered participants were much greater than what most had expected.

" I did [some studies], even though I've got a lot of life experience…. a lot of experience with different people. So, therefore, different conversations and learnings… However, none of it gave me all the foundation and the understandings that I got out of this [9]-week course" (PP5)

"I don't think I was fully prepared for the amount of content. I thought perhaps it might be people coming together. You know, discussing their life experiences and maybe some suggestions for supporting, but I didn't realise that we would be delving into quite as much detail as we did" (PP8)

"there was stuff that I'd learned. I was like, OK, because I've done a lot of reading… It kind of all [came] together… I do remember, you know, there were some moments I was like, oh, that's gold. Like. Yeah, I never thought of that… But from a carer perspective, it is so valuable in a sense that while it, you know, bringing people together, so they know that they're not alone… To having that resource in front of you and the various, you know, bits of information to refer back to…" (PP9)

They summarised the program's impact as follows:

"I think I've done a lot of spiritual growing…. I haven't felt overwhelmed. I think I've got new mental strategies…even when the ship gets tough… I've got renewed hope" (PP1)

"It empowered me. Help[ed] me not to be judgmental… That empathy, that genuine empathy… the healthy boundaries that we put to ourselves and to our loved ones, the rights and needs… it's so important" (PP10)

"I just feel a lot more connected with what's around for support... I've got a few more extra people of support in my life. Again, on top of what I already had" (PP2)

"[coming here, this group] it's a very important part of my life… Yeah, and that's what I'm looking for. And the learning experiences both on a professional and a personal, more so on a personal basis." (PP5)

The program provided opportunities to learn from each other. The participant below described how the conversation that happened in the group, and also the participation in the interview, helped them to reframe their thoughts.

"I haven't had such a good week…even today, I can feel, you know, after coming and engaging in the conversation, even talking to you has helped me reframe some of that important thinking that I need to be doing." (PP1)

"we have so many a good recommendation ideas from the team, sharing ideas and all that… [one I] really remember was screaming under the water… tell stories or listen and… change information. It's good for me because always you took something, you know, different and try." (PP11)

The learning was beneficial though sometimes emotional and sensitive, through the reflections and realisations. However, by the end of the program, they were equipped with tools to manage it.

"I think it's all beneficial, but at times I think I felt more sensitive to the situation that we're in, so yeah, I'm, and I think with I guess with that sensitivity of I know that I've got the tools that can support me too, you know, work through that. But I think definitely for me it probably. It probably just made me [sensitive] go into myself and reflect a lot more about the impacts of caring for [my child] than I had." (PP8)

Participants already implemented some of their learning in their daily life. They practice gratitude and self-care, set boundaries, self-reflect, share their experiences with their families, and apply communication strategies.

"So, I mentioned like the gratitude thing, I'm much more like. That's a daily practice now… So that's kind of embedded, I think, the self-care" (PP8)

"So on the way here in the car, I did some breathing while I drove….. [to] calm down a little bit, stop the thinking. [I] recognised that the thinking I was doing wasn't productive." (PP1)

"Setting boundaries…when [they are] drunk, [they are] not allowed to come to my home … safety is first… "(PP11)

"I sit with my [family], and I share with them what I've learned…, and I leave my folder on the table. Because it's a reference tool. It's a tool for life" (PP10)

"it's already happens for me… just take to remove the emotion from and just to take that breath, and even in just set that 2 seconds of taking that breath, I'm able to construct a sentence differently so that it's not doesn't sound like an accusation "(PP2)

Interpretation

While participants expressed how valuable it is to have fun and do things they enjoy, akin to previous studies(Marshall, 2013), they presented indicators of neglecting some of their fundamental needs. They reported adopting healthy habits and doing pleasurable activities less frequently than other indicators. The literature also shows that walking alongside persons with AOD and related issues is challenging; however, it may also offer rewards. For instance, giving purpose to their life, learning new skills, improving resilience, and feeling good about themselves (Sanders, 2020). Similarly, in the pre-program survey, more than 80% of the participants thought their support was valuable and helpful. While in the beginning, respondents scored high on the personal recovery scale, about 40% reported

that they did not have the tools to live the life they wanted, and 25% did not like themselves and did not know when to ask for help. Also, about 40% of the participants would not ask for help when needed and were not hopeful about possible changes in their own family context, such as fewer experiences of stress. Participants showed sound stress management skills and understanding of stressors; however, about 32% did not think they could handle it if it got worse. Regarding their social participation, our data showed that 75% of them had friends, though only about 50% reported friends who did not experience similar sources of stress. In addition, half of the respondents did not feel Ok with their family situation. However, participants showed improvement on these items by the end of the program; those were not statistically significant. We found a significant increase only in the total empowering and recovery scale and social recovery subscales.

Participants shared their positive experiences with the CoS peer-led program in the interviews, including authenticity, safety, confidentiality, and empathy. They were satisfied with the program, which completely met their needs. The program made them feel connected, accepted, and understood. They also developed hope, self-gratitude, courage, and optimism. They learnt about self-reflection, setting boundaries, separating the person from the issue, advocacy, communication, and system navigation. The program empowered them, and some also expressed the importance of participating in the evaluation interviews to raise awareness and spread the word in the community about the positive impacts of the program. Participants also shared how they had already implemented the learning in their daily life.

These findings highlight the need for psychosocial support activities targeting FF's recovery(Bradshaw et al., 2016), including modules about self-love and self-care. It also draws attention to improving help-seeking behaviours and exploring the reasons and barriers behind not asking for help, which may be influenced by stigma, shame and prioritising the person's needs(Corrigan et al., 2006; Marshall, 2013). Thus, implementing broader education activities in the community to neutralise conversations about various forms of addiction is vital.

5. Discussion

This project aimed to co-design a local support program for FFs of individuals with AOD issues to improve their mental wellbeing, including subsequent implementation and evaluation phases. When examining, the main stressors, challenges and perceived stress levels among Families and Friends, we found that while they reported sound stress management strategies and understanding of stressors, they still needed support to improve their stress management skills further to maintain their own mental wellbeing. They also required additional support in managing negative emotions and emotional distress, focusing on their own physical health and mental wellbeing, help-seeking, system navigation, tools for communication, advocacy, relationship skills, self-love, and self-care.

We built the baseline quantitative pre-program surveys and identified the impact of the program with the post-program surveys. Participants showed a significant decrease in their stress levels and an increase in total empowerment and social recovery. They also scored highest on personal recovery and least on clinical recovery scales. This demonstrates the value in support programs applying a non-clinical approach to recovery. Due to the small sample size, only limited analysis was used, and few statistically significant changes were found. This study reaffirms the significance of mixed-method approaches in pilot studies with small sample size. We found that administering the pre-program surveys breaks the flow in rapport building that emerges in the program's first session. Thus, implementing online surveys and including consultation with the peer workers about the evaluation prior to the program start may increase the willingness of participants to participate. By the end of the program, participants developed trust, were empowered, and wanted to share their experiences with the research team.

This pilot program provided capacity-building opportunities for the researchers and LE representatives at NTLEN, since consumer-led peer programs for FFs, and purposeful quantitative evidence in the NT, were scant. Also, the co-design process in the peer support program and survey development improved the degree of Public Participation in research and service provision. This project applied consumer-led participation in the CoS program development and co-design participation in the survey development, ultimately placing LE at the centre of the program development, implementation and evaluation.

The project team faced various challenges. The timeframe was problematic for initiating the project, as it took significant time to obtain full ethics approval for the research and evaluation and to socialise the program in the community. In responding to ethics committee feedback, we decreased the sample size and involved a cultural advisor. This impacted the timeframe, budget, and program delivery schedule. Thus, we would recommend longer funding periods to enhance community engagement processes, allow larger sample sizes, enable a broader reach, and ultimately have a more significant impact among FFs. However, time delays also brought opportunities. We involved Peer Work students in the program, who spent their placement hours supporting content and program development and the survey co-design. This was a capacity-building opportunity for them and increased the LE involvement in the project. It also enriched the collaboration between the research team and the NTLEN. In addition, these challenges helped the team develop a new approach. That involved introducing community education sessions within a broader community context. This approach was a tool to socialise the local community about the family peer support program, facilitate referrals to the program, raise awareness of challenges FFs face, provide education, and increase understanding of how FFs can get into the coping stage. The broader community sessions showcased successful individual and FFs recovery stories, including females and males. Presenting

diverse recovery journeys may be promising to neutralise conversation about AOD issues, decrease stigma and shame felt by these individuals and FFs and access people from different backgrounds. Still, there is much to develop an appropriate targeted approach to access males, youth, unemployed people, LGBTQI+ members, Aboriginal and Torres Strait Islander people, and people from CALD communities.

Ultimately, this pilot project described participants' experiences with the CoS program, built the quantitative and qualitative evidence base, and identified a high demand for peer support among FFs in the NT. This supports the idea of continuous delivery, future program iterations, and implementation in other regions of the NT.

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7. Appendices

Appendix A: - Pre- and post-program survey

Questionnaire – pre-program survey (T1) and post-program survey (T2)

Our research team at The Flinders University (Flinders) created this survey to understand the impact of the 'Circles of Support 'program on participants' wellbeing. This evidence-based program was developed by the NT Lived Experience Network (NTLEN) for the family and friends of people who have an alcohol or drug (AOD) problem. It provides both support and information for family and friends, including how to support the person with AOD issues, the management of overwhelming emotions and responses, and ways to support their own wellbeing and practice of self-care.

Please read the information sheet first and if you agree to participate, fill out and sign the consent form. The survey explores the sociodemographic background, wellbeing, perceived stress, and empowerment. It takes about 15-20 mins. Please fill it in when you start the program and when you complete it.

The questionnaire is anonymous and voluntary. You will not be identified at an individual level in the research reporting. To satisfy it, we will use codes only. Please create a code as follows:

1. Use the second letter in your first name and the second letter in your family name (e.g. John Smith – OM)
2. Use the month (two-digit) of your date of birth (e.g. 02/02/2022 – 02)
3. If you participate in the pre-program survey, use this: _T1
4. If you participate in the post-program survey, use this: _T2
5. Then write this code below (e.g. OM02_T1 or OM02_T2)

Survey code: _____

Sociodemographic background

1. **Gender:**
   [ ] Male
   [ ] Female
   [ ] Self-described (please specify):_____

2. **What is your age?**
   [ ] 18-24 yrs
   [ ] 25- 34 yrs
   [ ] 35-44 yrs
   [ ] 45-54 yrs
   [ ] 55-64 yrs
   [ ] 65+ yrs

3. **Country of birth**
   [ ] Australia
   [ ] Other (please specify):_____

4. **The main language is spoken at home:**
   [ ] English
   [ ] Other (please specify):_____

5. **Do you identify as Aboriginal or Torres Strait Islander?**
   [ ] No
   [ ] Aboriginal
   [ ] Torres Strait Islander
   [ ] Aboriginal and Torres Strait Islander

6. **What is your highest level of education?**
   [ ] Less than Year 10 or equivalent
   [ ] Year 10 or equivalent
   [ ] Year 12 or equivalent
   [ ] Vocational Qualification
   [ ] Bachelor Degree
   [ ] Postgraduate Degree
   [ ] Other (please specify):_____
   [ ] Prefer not to answer

7. **What best describes your current employment status?**
   [ ] Employed
   [ ] Self-Employed
   [ ] Domestic duties
   [ ] Student
   [ ] Unemployed
   [ ] Unable to Work
   [ ] Retired
   [ ] Other (please specify):_____
   [ ] Prefer not to answer

8. **What best describes your relationship/marital status?**
   [ ] Single
   [ ] Relationship
   [ ] Married / De facto
   [ ] Other (please specify): _____
   [ ] Prefer not to answer

9. **How many children do you have?** _____
   [ ] Prefer not to answer

10. **What is your relationship to the person/loved one you care for?**
    [ ] Partner
    [ ] Parent
    [ ] Child
    [ ] Siblings
    [ ] Other (please specify e.g. friend or carer): _____

Wellbeing

11. **In general, how would you rate your health and wellbeing?**

1	2	3	4	5
Poor	Fair	Moderate	Good	Excellent

Perceived stress

Caregivers are often so concerned with caring for the relative's needs that they lose sight of their own wellbeing. Please take just a moment to answer the following questions.

During the past week or so, I have …

	Yes	No
12. Had trouble keeping my mind on what I was doing….		
13. Felt that I couldn't leave my relative alone…………………		

14. Had difficulty making decisions.........................					
15. Felt completely overwhelmed...................					
16. Felt useful and needed					
17. Felt lonely........................					
18. Been upset that my relative has changed so much from his/her former self.............					
19. Felt a loss of privacy and/or personal time...................					
20. Been edgey or irritable........					
21. Had sleep disturbed because of caring for my relative......					
22. Had a crying spell(s)...........					
23. Felt strained between work and family responsibilities					
24. Had back pain..................					
25. Felt ill (headaches, stomach problems or common cold)......					
26. Been satisfied with the support my family has given me.............................					
27. Found my relative's living situation to be inconvenient or a barrier to care............					

28. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress:

1	2	3	4	5	6	7	8	9	10
not stressful									extremely stressful

Write the number here or circle the number on the scale:

29. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year:

1	2	3	4	5	6	7	8	9	10
very healthy									very ill

Write the number here or circle the number on the scale:

Empowerment

Below is a list of statements that describe how people sometimes feel about themselves and their lives. Please read each one carefully and circle the number to the right that best describes you at the moment. Circle only one number for each statement, and do not skip any items

DOING THINGS I VALUE

		UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE	Comments (optional)
30.	It is important for me to have fun	1	2	3	4	
31.	It is important for me to have healthy habits	1	2	3	4	
32.	I do things that are meaningful to me	1	2	3	4	
33.	I continue to have new interests	1	2	3	4	
34.	I do things that are valuable and helpful to others	1	2	3	4	
35.	I do things that give me a feeling of great pleasure	1	2	3	4	

LOOKING FORWARD

		UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE	Comments (optional)
36.	I can handle it if I get stressed again	1	2	3	4	
37.	I can help myself feel less stressed	1	2	3	4	
38.	I have the desire to succeed	1	2	3	4	
39.	I have goals in life that I want to reach	1	2	3	4	
40.	I believe that I can reach my current personal goals	1	2	3	4	
41.	I can handle what happens in my life	1	2	3	4	
42.	I like myself	1	2	3	4	
43.	I have a purpose in life	1	2	3	4	
44.	I have people in my life who like and value me	1	2	3	4	
45.	I have the tools to live the life I want to	1	2	3	4	
46.	I have an idea of what I want to do in the future	1	2	3	4	
47.	Good things will happen to/for me	1	2	3	4	
48.	I am the person most responsible for my own life	1	2	3	4	
49.	I am hopeful about my own future	1	2	3	4	
50.	I know when to ask for help	1	2	3	4	
51.	I ask for help, when I need it	1	2	3	4	

		UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE	Comments (optional)
52.	I know what helps me to feel good	1	2	3	4	
53.	I can learn from my mistakes	1	2	3	4	

MASTERING MY LEVELS OF STRESS

		UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE	Comments (optional)
54.	I can identify when I am stressed	1	2	3	4	
55.	I have my own plan to reduce my levels of stress	1	2	3	4	
56.	There are things that I can do to help reduce my levels of stress.	1	2	3	4	
57.	I know that there are services that can/could help me	1	2	3	4	
58.	Although my experiences of stress may get worse, I know I can handle it	1	2	3	4	
59.	My experiences of stress interfere less and less with my life	1	2	3	4	
60.	My experiences of distress seem to be a problem for shorter periods of time each time they occur	1	2	3	4	

CONNECTING AND BELONGING

		UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE	Comments (optional)
61.	I have people that I can count on	1	2	3	4	
62.	Even when I don't believe in myself, other people do	1	2	3	4	
63.	It is important to have a variety of friends	1	2	3	4	
64.	I have friends who have also experienced similar sources of stress	1	2	3	4	
65.	I have friends who haven't experienced similar sources of stress	1	2	3	4	
66.	I have friends that can depend on me	1	2	3	4	
67.	I feel OK about my family situation	1	2	3	4	

Finally, is there anything else that is important to you and your recovery that has not been covered?

_____
_____
_____
_____
_____

Thank you!
Research and evaluation team

Appendix B – Interview guide

Program participant interview guide

The individual interviews with program participants will evaluate the program impact on their wellbeing. The development of the interview guide will be discussed and further developed in the consultation workshop and/or individual interview. The interview guide will be built on previous questions applied in the PLEP projects.

Overarching goals:

- Understand the program impact on participants' wellbeing
- Identify strengths in the program, areas for improvement,
- Explore participants' journey as carers

Areas to include in the individual interview:

- Participants' background and mental health journey
- Overall experience with the program, program elements, activities and workshop materials
- Reason and motivation to enrol for the program
- Areas of experienced program impact
- Satisfaction with the program, strengths and challenges associated with the participation
- Possible areas for improvement, opportunities relating to the program
- Other areas identified through the literature review and consultation

Developed interview guide with questions

Participants' background and wellbeing:

- Please introduce yourself in a couple of sentences.
- Can you please explain a little about the journey of being a family/carer and supporting a person who has alcohol or drug issues?

You can share as little or as much as you want. You could explain to us, for example, about the level of care you provide (e.g. hrs/week), the duration of your family/carer role (e.g how long), the number of persons you support, the support you get (e.g. support group, services, family, friends), whether you are a current or former family/carer; reason for participation in the program

Characteristics of the family/carer role

- How would you describe the challenges you experience while you support a person who has alcohol or drug issues? *(Probe: impact of the family/carer role on employment, finance, quality of life, social life..etc)*

- What about the opportunities and rewards? What are they?

- How confident do you feel yourself in this role? Why?

- What would you tell me about your social life? Do you have friends? Do they experience similar sources of stress?

Perceived stress

- Supporting someone with such issues can be challenging. What do you do to support yourself?

- How do you recognise when you are stressed? What do you do to reduce the stress? *(probe: sleeping quality, dieting, risk behaviours, satisfaction with life)*

- How do you manage the levels of stress you experience?

- If you feel stressed, can you have a break? How?

- Have you ever sought help for yourself? Why?

Experiences with the Circles of Support program:

- What were your main reasons for participating in the Circles of Support program? Why?

- What were your expectations about the Circles of Support program? Did your expectation meet with the program?

- How satisfied you are with the program? And with the facilitation? Please elaborate.

- What do you think was most helpful in the Circles of Support program? Why?

- What were some of the other good things about the Circles of Support program?

- What knowledge and skills did you learn during the program? How will you use this knowledge and skills in your daily life?

- Could you give a specific example of how you used (or intend to use) one of the skills learned during the program in your life?

- How satisfied were you with the content in the program? Would you change anything in the program? Are there any areas for improvement with the Circles of Support? If so, what are they, and why?

- What do you think about the peer logbook, additional handouts and activities?

- Please share your reflection regarding to the program schedule? *(probe: frequency, days, date)*

- What were the key learnings that you took away from the program?

- Please share your experiences with the peer-to-peer approach used in this program? *(explain the approach it, if necessary)*

- How could you summarise the program's impact on your wellbeing in 3-5 words?

- Would you recommend this course to others?

Other:

- Do you have any other feedback you would like to share?

Appendix C – Ethics approval

menzies
school of health research

Postal: PO Box 41096, Casuarina NT 0811, Australia
Location: John Mathews Building (Bldg 58),
Royal Darwin Hospital Campus, Rocklands Drv, Casuarina NT 0810
Ph: (08) 8946 8600 Fax: (08) 8946 8464
Website: menzies.edu.au
ABN: 70 413 542 847
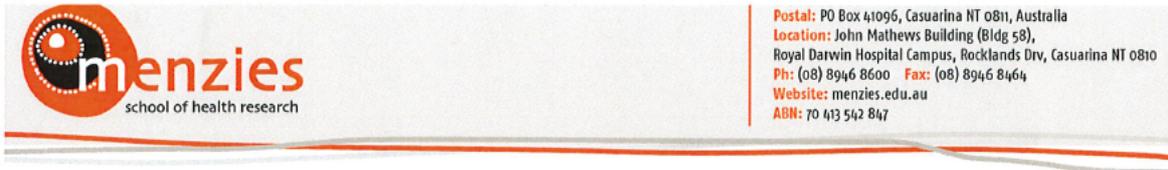
28 February 2022

Dr Noemi Tari-Keresztes
Menzies School of Health Research
noemi.tari-keresztes@menzies.edu.au

Via Email

Dear Dr Tari-Keresztes,

Ethics Administration Office
File Reference Number: HREC-2021-4164
Phone: (08) 8946 8687 or (08) 8946 8692
Email: ethics@menzies.edu.au

HREC Reference Number: 2021-4164
Project Title: *Supporting family members' and friends' individual recovery with a locally co-designed peer-led recovery program in Darwin*

Thank you for your letters dated 23/11/2021 and 04/02/2022 and taking the time to respond to the issues of concern identified by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC). This project was considered by members of the HREC and the Aboriginal Ethics Sub-Committee (AESC) and assessed against guidelines for human research including the NHMRC *National Statement on Ethical Conduct in Human Research 2007*.

I am pleased to advise that **full ethical approval** of this research project has been granted following assessment by representatives of both the AESC and the HREC. Please note that approval applies only to research conducted after the date of this letter and continued approval is dependent on annual reporting.

Approval Date: *28/02/2022*

Approval is granted for the above research project until the next report due date.

Annual progress report due: *28/02/2023*

Approved timeframe (subject to compliance and annual reporting): *28/02/2022 – 28/02/2023*

The nominated sites participating in this project that have been approved by this HREC are:

- **Darwin**
- **Palmerston**

Please note:
* Researchers must comply with site specific governance regulations, data custodian and other stakeholder requirements.
* Site-specific approval must be obtained from NT Health Research Governance Office before research may commence at NT Health sites, if applicable.

The documents listed below are approved:

Document	Version	Date
HREC application	3	04/02/2022
Study protocol		23/11/2021
Participant Information Sheet (Program participants – Individual Interview)		23/11/2021
Participant Information Sheet (Consultation workshop)		23/11/2021
Participant Information Sheet (Program participant survey)		23/11/2021
Participant Consent Form		04/02/2022
Questionnaire **pre-program survey (T1) and post-program survey (T2)**		04/02/2022
Workshop/ individual interview guide		23/11/2021
Program Interview guide		01/10/2021

menzies.edu.au
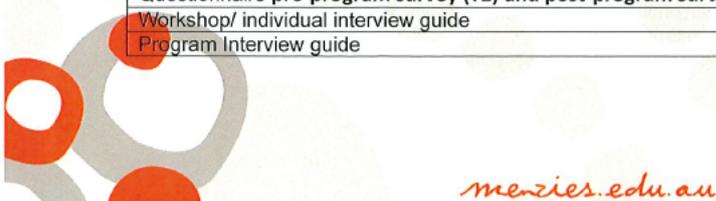
The documents listed below are noted:

Document	Version	Date
CV – Dr Noemi Tari-Keresztes		23/11/2021

APPROVAL IS SUBJECT TO the following conditions being met:

1. The Coordinating Principal Investigator will **immediately report anything that might warrant review** of ethical approval of the project.
2. The Coordinating Principal Investigator will notify the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC) of any event that requires a **modification or amendment to the protocol or other project documents** and submit any required amendments in accordance with the instructions provided by the HREC. These instructions can be found on the Menzies' website.
3. The Coordinating Principal Investigator will submit any necessary reports related to the **safety of research participants (e.g. protocol deviations, protocol violations)** in accordance with the HREC's policy and procedures. These guidelines can be found on the Menzies' website.
4. The Coordinating Principal Investigator will **report** to the HREC **annually** and notify the HREC when the project is completed at all sites using the specified forms. Forms and instructions may be found on the Menzies' website.
5. The Coordinating Principal Investigator will notify the HREC if the project is **discontinued at a participating site before the expected completion date** and provide the reason/s for discontinuance.
6. The Coordinating Principal Investigator will notify the HREC of any plan to **extend the duration of the project past the approval period listed above** and will submit any associated required documentation. The preferred time and method of requesting an extension of ethical approval is during the **annual progress report**. However, an extension may be requested at any time.
7. The Coordinating Principal Investigator will notify the HREC of his or her **inability to continue as Coordinating Principal Investigator**, including the name of and contact information for a replacement.
8. The safe and ethical conduct of this project is entirely the responsibility of the investigators and their institution(s).
9. Researchers should immediately report anything which might affect continuing ethical acceptance of the project, including:
    - Adverse effects of the project on participants and the steps taken to deal with these;
    - Other unforeseen events;
    - New information that may invalidate the ethical integrity of the study; and
    - Proposed changes in the project.
10. Approval for a further twelve months, within the original proposed timeframe, will be granted upon receipt of an annual progress report if the HREC is satisfied that the conduct of the project has been consistent with the approved protocol. Report templates are available on the Menzies ethics webpage.
11. Confidentiality of research participants should be maintained at all times as required by law.
12. The Patient Information Sheet and the Consent Form shall be printed on the relevant site letterhead with full contact details.
13. The Patient Information Sheet must provide a brief outline of the research activity including: risks and benefits, withdrawal options, contact details of the researchers and must also state that the Human Research Ethics Administrators can be contacted (telephone and email) for information concerning policies, rights of participants, concerns or complaints regarding the ethical conduct of the study.
14. You must forward a copy of this letter to all Investigators and to your institution (if applicable).

This letter constitutes ethical approval only.

This project, including amendments to the research protocol or conduct of the research which may affect the site acceptability of the project, cannot proceed at any site until separate research governance authorisation has been obtained from the CEO or Delegate of the institution under whose auspices the research will be conducted at that site, if not already obtained.

Any transfer of data is subject to institutional research governance arrangements for data ownership, data custodianship, and data transfer agreements.

Please forward this approval letter to the relevant research governance office.

menzies.edu.au

Should you wish to discuss the above research project further, please contact the Ethics Administrators via email: ethics@menzies.edu.au or telephone: (08) 8946 8687 or (08) 8946 8686.

Yours sincerely,

Dr. Mary Morris
Chair
Human Research Ethics Committee
of the Northern Territory Department of Health
and Menzies School of Health Research
http://www.menzies.edu.au/ethics

This HREC is registered and certified for multi-site review with the Australian National Health and Medical Research Council (NHMRC) and operates in accordance with the NHMRC *National Statement on Ethical Conduct in Human Research (2007)*. NHMRC Reg no. EC00153

Appendix D – Engagement activities of the project (Table 1)

Table 1. Engagement activities of the project

Dates of Engagement	Participants	Activity
28 June 2021	Project team	Successful grant notification from Research Administration (RA) team at Menzies
1 July – 31 July 2021	NTK	Literature review 1 (narrative review)
1 July – 31 July 2021	NTK and NA	Discussing the findings of the literature review and additional program elements
17 August 2021	Project team	Signed contract notification from the RA team at Menzies and project code allocation
17 September 2021	NTK and NA	A meeting to discuss the submission of the ethics application and relating questions.
20 – 30 September 2021	NTK (lead) Project team (feedback and support)	Preparation of the ethics application and development of the evaluation approach
1 October 2021	Project team	Submission of ethics application
October 2021- April 2022	NA	Engaging with some Peer Work students to work on the program development (consumer-led) as part of their work placement
02 November 2021	Project team	Conditional ethics approval received This included requests for (1) the engagement of a cultural advisor and professional interpreter, (2) the development of COVID-19 risk management strategies, (3) amendments to the Participant Information Sheet (PIS) and Consent Forms (CF), (4) re-addressing the six core values for Aboriginal and Torres Strait Islander people, (5) providing further details in design and methodology and (6) changes in the sample size.
15 November 2021	NTK (lead) Project team (feedback and support)	Mid-Project Report to ADF (Appendix G)
23 November 2021	NTK (lead) Project team (feedback and support)	Response to the Conditional approval Involvement of a cultural advisor (KM)
9 December 2021	NTK and NA	Meeting on project updates
21 December 2022	Project team	The second conditional approval received This included further requests of (1) providing further clarification of the involvement of the cultural advisor and the professional interpreter, (2) making further updates on the CF, (3) re-addressing the six core values again, and (3) sending a copy of the developed questionnaire.
4 February 2022	Project team	Response for second conditional ethics approval
28 February – 11 April 2022	Project team	The project was on hold due to a transfer process between Menzies and Flinders due to the employment transitions of key evaluation team members.
28 February 2022	Project team	Full ethics approval received
13 April 2022	NA NTK	Consultation workshop for the (1) development of the Family-to-Family peer

	LE representatives (n=7)	program/Circles of Support (consumer-led) and (2) evaluation approach and survey instrument (co-design)
14 April – 11 May 2022	NA Peer Work Students	Developing the facilitator' and participants' resources
20 April – 30 June 2022	NTK (lead) Project team (feedback and support)	Drafting the first part of the final report
25 April 2022	NA (lead) Project team (support)	Start of the Circles of support program advertisement Facebook Instagram LinkedIn NTLEN newsletter + Flyers (Appendix H)
4 May 2022	NA Peer Work students/ Peer Facilitators (SG, SE)	Info session about the Circles of Support program
6 May 2022	NA NTK	A meeting on project updates
May 2022	NA	Requesting support in program promotion from ADF (SU&SP)
7,9,14,20 June, 2022	NA Peer Work students/ Peer Facilitators (SG/SE)	2-hour Info sessions for the broader local community (AOD literacy) – raising awareness and facilitating referrals + Professional Development for staff (Appendix H)
11 May – September 2022	NA Peer Work students/ Peer Facilitators (SE, SG)	Continuous program delivery
11-May – 12 October 2022	NTK	Data collection
1 June – 14 October 2022	NTK Project team (feedback and support)	Data analysis
1 August – 21 October 2022	NTK (lead) Project team (feedback and support)	Finalising the report Feedback

Appendix E – Participant Information Sheet

PARTICIPANT INFORMATION SHEET
(Program participant survey)

Supporting family members' and friends' individual recovery with a locally co-designed peer-led recovery program in Darwin

This is yours to keep

What is the project about?
This project will aim to adapt and evaluate a locally developed Peer-Led Recovery and Wellbeing program (Program) for family members and friends of individuals with alcohol and drug issues. The project is being transitioned from Menzies School of Health Research (Menzies) to Flinders University, Remote and Rural Health (Flinders). Thus, the project involves a collaboration between Flinders and the Northern Territory Lived Experience Network (NTLEN).

Who will undertake this project?
Prof James Smith (Flinders and Menzies) will lead this study in collaboration and support from Co-Lead Ms Dr Noemi Tari-Keresztes (Flinders), Noelene Armstrong (NTLEN), Ms Lauren Keys (NTLEN), Dr Himanshu Gupta (Flinders).

What is the evaluation doing?
The evaluation will assess the appropriateness and effectiveness of the Program on Carers' and Consumer-Carers' individual recovery and mental health and wellbeing. It will include individual interviews and a survey with program participants, and a consultation workshop with sectoral stakeholders, including lived experience representatives and program/service providers.

What will happen during the evaluation (survey)?
This participant information sheet specifically relates to the survey component listed above. You have been identified as a program participant. We would therefore like to invite you to participate in this survey. It is anticipated these will last between 15-20 minutes.

If you agree to participate, we will ask questions about your sociodemographic background, stressors relating to the carer role, your mental health and personal recovery, and the main characteristic of the carer role.

The information you share will be used to build an evidence base about the effectiveness of the peer-led psycho-education program. Your information will be anonymous. This means that the information you share will not be used in reports, conferences, journals or on websites in such a way that you could be identified. Also, you are free to withdraw at any time during your participation in the survey study without any negative consequences

A final report and presentation will be publicly available upon project completion. You will not be identified at an individual level in the research reporting.

Benefits and Risks

If you choose to participate, you will be assisting in building an evidence base about a peer-led education program aimed at improving the lives of people with psychosocial support needs in Darwin. If you choose not to participate, it's OK.

If you feel concerned or distressed during or after the interview, the following helplines and services can be accessed free of charge (Northern Territory Mental Health Line: 1800 682 288, Beyond Blue: 1300 224 636, Lifeline: 131114, Mental Illness Fellowship of Australia NT: 1800 985 944)

Ethics Committee Clearance

This project has been approved by the Human Research Ethics Committee of the NT Department of Health and Menzies School of Health Research

Who can I contact if I have a question or want more information?

If you have any questions about this form, the project or about the use or exclusion of any particular information you provide, please contact Prof James Smith at Menzies on 0455 088 501 or via email at james.smith@menzies.edu.au

If you have any concerns or complaints regarding the ethical conduct of the study, you are invited to contact the Ethics Administration, Human Research Ethics Committee of the NT Department of Health and Menzies School of Health Research at (08) 8946 8600 or email ethics@menzies.edu.au

Appendix F – Consent Form

CONSENT FORM - PARTICIPANTS
(Individual interview, survey, consultation workshop)

Supporting family members' and friends' individual recovery with a locally co-designed peer-led recovery program in Darwin

This means you can say NO

I have talked to _____ at _____ about this project. I would like to be part of this project.

I understood...	Please circle		
... what is written on the Participant Information Sheet.	Yes	No	-
... what this project is about, including the purpose, procedures, benefits and risks associated with my participation.	Yes	No	-
... who I can contact if I have any questions regarding the project or ethical conduct.	Yes	No	-
... my information will not be used in reports, conferences, journals or on websites in such a way that I could be identified.	Yes	No	
... that I can choose not to answer questions.	Yes	No	

… that I am free to withdraw at any time during my participation in the study without any negative consequences	Yes	No	
… that in the event I pass away, my information will still be used for analysis purpose	Yes	No	
… that any information I share that requires mandatory reporting will be reported accordingly	Yes	No	
Optional:			
… that the information I provide may be used in future research projects relating to mental illness or social and emotional well-being*	Yes	No	
*The non-identifiable data and knowledge I share in this data collection may be used in future research projects that obtain ethical approval and focus on peer education and peer-recovery			
		Please circle	
Consent			
I am happy for my words/survey answers to be used in project outputs	Yes	No	-

such as reports, presentations, frameworks, education programs, conferences, journals, or websites.			
I am happy for the information I share in the interview as part of this project to be audio recorded.	Yes	No	Not Applicable for survey participants
Optional:			
I am happy to be contacted again in the future to be invited to participate in another relevant study (If yes, please provide your phone number and email below)	Yes	No	

Signed: _____

Full name: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

Email: _____

Phone number: _____

If you have any questions about this form, the project or about the use or exclusion of any particular information you provide, please contact Prof James Smith at Flinders on 0455 088 501 or via email at james.smith@flinders.edu.au

Appendix G – Mid-project report

ISS PROGRAM.

Mid Project Report Template – November 2021

Research Grant

The table below provides a template where you can capture the progress of your ISS Research Project.

Program Objectives	Guiding Questions	Progress to Date
Provide further/new evidence of the impact of your project	Provide a summary of how you are progressing with regard to the project objectives.	
Fast track the expansion of your existing project	How has the research project improved the reach and impact of your existing project?	
Strengthen the evidence of the translation to different populations or settings, of your existing project	Has the research project helped test existing programs or projects in new populations or new settings?	
Develop new innovative ideas as a result of the project work so far	Have innovative or new ideas been developed to meet the needs of Family and Friends of AOD users?	
Additional comments or challenges regarding the project.	Key lessons, what is going well and challenges such as COVID / timeframes. Please include a summary of any changes to methodology as a result of this project.	

1. **Provide a summary of how you are progressing with regard to the project objectives**
   - We received a successful outcome notification on 28 June 2021. The contract was executed, and a project code was allocated. We were notified about it on 17 August 2021 and started to work on the project after that. We involved former program participants from the Peer-Led Education (PLEP) pilot. They are studying Cert IV in Peer Work and will be involved in the program co-design and program facilitation to complete their placements. Menzies prepared the ethics application in support of NTLEN. The ethics application was submitted on 1 October 2021. On 2 November 2021, we received conditional approval. The ethics concerns were addressed, and the "reply to ethics" was sent on 23 November 2021. We are waiting for the outcome. When we have the outcome, in January 2022, we will organise a workshop to finalise the program co-design and start the delivery immediately after that. In addition, we conducted a literature search to identify potential additional program elements and strengths-based research tools. We will continue this process in January.

2. **How has the research project improved the reach and impact of your existing project?**
   - We can answer this question more appropriately after completing the research and program evaluation. However, given the fact the in the NT, peer support and peer work is a pioneering area and this recovery program was delivered only among individuals with mental health and AOD challenges, providing it among family members and carers of individuals with the previously mentioned challenges will improve the reach and impact of the program.

3. **Has the research project helped test existing programs or projects in new population or new settings?**
   - The answer is the same as above

4. **Have innovative or new ideas been developed to meet the needs of Family and Friends of AOD users?**
   - This is the aim of the workshop that we will organise in January 2022, including lived experience representatives, local stakeholders and Aboriginal and Torres Strait Islander representatives. The workshop will support the program co-design that the Peer Worker Trainees will implement after the workshop.

5. **Key lessons, what is going well, and challenges such as COVID/timeframes. Please include the summary of changes to methodology as a result of this project.**
   - We implemented some adjustments to how we progressed with the ethics application, and the PLEP program came to its end. For instance, we were engaged with an Aboriginal and Torres Strait Islander representative who was already part of the local peer recovery program development as a consultant. This person is now listed in the Investigator team. We also included some Peer Work Trainees, and this project will provide their workforce capacity with the opportunity to complete their placements by delivering this program to their peers. We have decreased the sample size to address the ethics concerns and complete the program within this tight timeframe.

Please find attached the following documents to support the present progress report:
   - Ethics application (submitted in October 2021)
   - Conditional Approval
   - Answer to ethics and updated application (submitted in November 2021)

adf.org.au

Appendix H – CoS Flyers

The NT Lived Experience Network presents

Circles of Support

A free support program for the family & friends of people who have an alcohol or drug problem

Circles of Support is an evidence-based peer education and support program developed by the NT Lived Experience Network.

Circles of Support has been created by local people for local people, specifically those who have a loved one with an alcohol or drug problem.

Circles of Support provides a safe and confidential space for family members or friends of someone with an alcohol or drug problem to access both support and information.
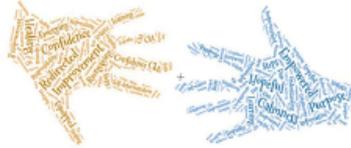
Source of image 'reaching hands': Tari-Keresztes, N., Smith, J. & Gupta, K., (2021): Follow-up Evaluation of the Peer-Led Education Pilot in Darwin. Darwin: Menzies School of Health Research

During 2022, a limited number of **Circles of Support** programs will be delivered in Darwin and Palmerston as part of a trial funded by the Alcohol and Drug Foundation.

As part of the trial, the NT Lived Experience Network will also provide a series of free **Community Education Sessions** about the hidden impact of alcohol and drug problems to individuals and families.

Circles of Support provides a supportive environment for family and friends to learn about:

❖ Mental health, alcohol and drug related misuse and co-occurring issues;
❖ Recovery and ways to support recovery;
❖ Identifying & responding to a crisis;
❖ Ways to support own wellbeing and practice self-care;
❖ Managing overwhelming emotions and responses;
❖ Setting boundaries on relationships;
❖ Effectively communicating your needs and rights;
❖ Responding to stigma and discrimination;
❖ Navigating the mental health and alcohol and other drug service system;

Circles of Support programs involve attending one 3-hour session each week, for 8 weeks. Programs are free to attend, with catering and resources provided.

To register or find out more about **Circles of Support:**

Call: Noelene on 0438 022 032
Email: contact@livedexperiencent.net
Web: www.bit.ly/ntlencos
Social media at livedexperiencent 📷 f in

NORTHERN TERRITORY LIVED EXPERIENCE NETWORK

adf | Alcohol and Drug Foundation

menzies school of health research

FLINDERS UNIVERSITY

The NT Lived Experience Network presents

Circles of Support

A free support program for the family & friends of people who have an alcohol or drug problem

Circles of Support is an evidence-based peer education and support program for people who have a loved one with an alcohol or drug problem. It has been created by (and for) local people with lived experience caring for a loved on with an alcohol or drug problem.

Circles of Support: Program 2
Palmerston, Thursday Evenings

Information Session:

Thursday 9 Jun 22   6:00 to 8:00 pm

Program Dates & Times:

Session 1	16 Jun 22	6:00 to 9:00 pm
Session 2	23 Jun 22	6:00 to 9:00 pm
Session 3	30 Jun 22	6:00 to 9:00 pm
Session 4	7 Jul 22	6:00 to 9:00 pm
Session 5	14 Jul 22	6:00 to 9:00 pm
Session 6	21 Jul 22	6:00 to 9:00 pm
Session 7	28 Jul 22	6:00 to 9:00 pm
Session 8	4 Aug 22	6:00 to 9:00 pm

Venue:

TeamHEALTH Palmerston
10/5 McCourt Road, Yarrawonga

Circles of Support: Program 3
Casuarina, Monday Evenings

Information Session:

Monday   27 Jun 22   5:30 to 7:30 pm

Program Dates & Times:

Session 1	4 Jul 22	5:30 to 8:30 pm
Session 2	11 Jul 22	5:30 to 8:30 pm
Session 3	18 Jul 22	5:30 to 8:30 pm
Session 4	25 Jul 22	5:30 to 8:30 pm
Session 5	1 Aug 22	5:30 to 8:30 pm
Session 6	8 Aug 22	5:30 to 8:30 pm
Session 7	15 Aug 22	5:30 to 8:30 pm
Session 8	22 Aug 22	5:30 to 8:30 pm

Venue:

Darwin Head to Health Centre
16 Scaturchio Street, Casuarina

To register for an Information Session, one of the **Circles of Support** programs, or to simply to find out more:

Call: Noelene on 0438 022 032
Email: contact@livedexperiencent.net
Web: www.bit.ly/ntlencos

Social Media *livedexperiencent*
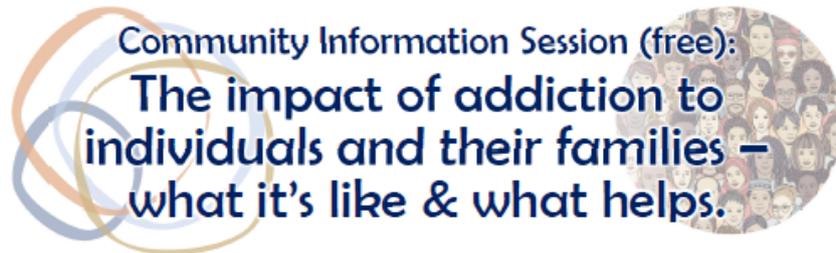
Community Information Session (free):
# The impact of addiction to individuals and their families – what it's like & what helps.

The **NT Lived Experience Network** is pleased to present a free, 2-hour community information session about the impact of addiction to individuals and their families, including: what it's like and what helps.

Community information sessions are open to the public and will benefit staff and volunteers, who support (or interact) with, individuals who have an alcohol or drug problem, and/or their families.

Session 1:
Tuesday 7 June 22, 2:00-4:00pm
Darwin Head to Health Centre
16 Scaturchio Street, Casuarina

Session 2:
Thursday 9 June 22, 2:00-4:00pm
Palmerston Recreation Centre
11 The Boulevard, Palmerston City

Session 3:
Tuesday 14 June 22, 2:00-4:00pm
Darwin Head to Health Centre
16 Scaturchio Street, Casuarina

Session 4:
Monday 20 June 22, 9:00-11:00am
Palmerston Recreation Centre
11 The Boulevard, Palmerston City

Each 2-hour community information session will include:

❖ Local people with lived experience sharing their stories of recovery;

❖ Understanding drug use and when use becomes problematic;

❖ Understanding the link between mental ill-health and alcohol and drug use;

❖ The behavioural stages of change people move through to recover from an alcohol or drug problem;

❖ The emotional/behavioural stages that families move through when a loved one experiences an addiction;

❖ Ways to support recovery;

❖ Why families need support and how to support families to cope.

Places are limited and registration is essential. To register for a community information session, or to find out more:

Call: Noelene on 0438 022 032
Email: contact@livedexperiencent.net
Web: www.bit.ly/ntlencis

Social Media *livedexperiencent*

Thanks to our generous facility sponsors:

TeamTALK is a free, confidential support line you can reach out to, wherever you are in the Territory. There's no shame asking for help – we're listening, and we can find you the right local support.

We're here for you, 7 days a week.
Weekdays 9 AM - 8 PM, and weekends 12 - 8 PM.

TeamTALK
📞 1800 832 600
📧 teamhealth.asn.au

Team HEALTH

TeamHEALTH have a variety of supports available for adults aged 16 and over who have a mental illness or are experiencing mental health concerns. TeamHEALTH also offer community access and capacity building support to people with or without an NDIS plan.

- Psychosocial Support Program
- Recovery Assistance Program
- TeamHEALTH Community Hub
- NDIS Supports
- Home Care Packages
- Child and Family Wellbeing
- TeamTALK Telephone Support

Darwin
HEAD TO HEALTH

A place to
Rest, Yarn and Heal

Caring, friendly and helpful mental health and wellbeing support in a calm, safe, and welcoming environment.

Open every day.
16 Scaturchio Street
Casuarina, Darwin
Call 08 89146600

neaminational.org.au/DarwinHeadtoHealth

People seeking support can arrive Monday to Friday 10 am - 10 pm and Weekends 12 pm Midday to 8 pm.

Darwin Head to Health is a free service, open every day with no referral required.

Response Employment and Training
RTO 90278
www.responsetraining.com.au

city of PALMERSTON
'A Place for People'
www.palmerston.nt.gov.au

Circles of Support
Expression of Interest Form

Name: _____

Phone: _____   Email: _____

1. Why are you interested in the Circles of Support program? *(Tick all that apply)*

☐ To meet other people with a loved one who experiences issues related to mental health, alcohol or drug use

☐ To understand recovery and ways to support recovery

☐ To manage overwhelming emotions and responses

☐ To learn how to respond to sigma and discrimination

☐ To learn how to set boundaries

☐ To understand how to navigate the mental health and alcohol and other drug service system

☐ To learn about mental health, alcohol and drug related misuse and co-occurring issues

☐ To learn ways to support your own wellbeing and practice self-care

☐ To learn how to identify and respond during a crisis

☐ To learn ways to effectively communicate your needs and rights

☐ To access support for myself

☐ Other: _____

_____

2. Which Information Session and/or Circles of Support program do you wish to attend? Write name and date below:

_____

If you wish to attend an Information Session and a Circles of Support program, write details for both.

3. Please confirm the following background information: *(Tick all that apply)*

☐ I am over 18 years of age

☐ I have a loved one who experiences an alcohol or other drug problem

☐ I have a loved one who experiences a mental health problem

☐ At this point in time, I can commit to attending most/all of the sessions I have indicated above

Signature: _____

Date: _____

Submit your expression of interest to contact@livedexperiencent.net

We will contact you to confirm receipt and your enrolment. We are also interested to talk to you about ways we can support you to participate and feel comfortable.