What helps and what hinders recovery: Narratives of service users and practitioners about Dual Diagnosis (co-existing mental health and substance misuse problems).

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Abstract:

What helps and what hinders recovery: Narratives of service users and practitioners about Dual Diagnosis (co-existing mental health and substance misuse problems).

Prevalence rates for mental health problems amongst drug and alcohol service users in the UK were 74.5% and 85.5% respectively (Weaver et al 2003). 44% of people with psychiatric problems also had a substance misuse problem (Weaver 2003).

Aims and objectives: This study aims to identify what service users with dual diagnosis and practitioners who work in this area perceive to be the factors that foster and inhibit their recovery (a meaningful quality of life). This is a narrative study using unstructured interviews to develop a framework for understanding the experiences of people who have a dual diagnosis and to guide those that help them.

Methodology: Ten service users and ten practitioners were interviewed using a narrative approach. These were then transcribed and analysed using Langdridge's (2012) Critical Narrative Analysis framework (CNA). Goffman's, Link and Phelan's and Sayce's theories on stigma and Frank's discussion of the role of narrative storytelling in illness were used as *hermeneutics of suspicion* to study meaning within the narratives.

Findings: The study explores how four key themes Stigma, Motivation, Recovery and Tension narratives provide an explanatory framework of recovery and identity for both service users and practitioners. It uncovers the interrelationships between the spoiled identities (double jeopardy) of service users and the influence this stigma has on practitioners. The study develops a perspective of how narrative storytelling can help articulate and reframe identities to aid recovery amongst people with a Dual Diagnosis.

Relevance: There have been very few studies that explore the lived experience of people with a Dual Diagnosis or the practitioners who work with them. Meta analyses of randomised controlled trials in Dual Diagnosis have found little conclusive evidence of interventions that are effective. The study suggests that in pursuing empiricist research standards, previous studies have missed the holism provided by seeing individual experience as an important factor in affecting the course and effect on people who experience Dual Diagnosis and those around them who try to help.

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Finally I'd like to dedicate this thesis to my Mother Rowena Manley-Weston who died because she never got the help she deserved.

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1. Introduction:

> *"Its first effects are sudden, violent, uncontrollable laughter; then come dangerous hallucinations- space expands- time slows down, almost stands still....fixed ideas come next conjuring up monstrous extravagances - followed by emotional disturbances - the total inability to direct thoughts, the loss of all power to resist physical emotions, leading finally to acts of shocking violence....ending often in incurable insanity."* (Glasnier 1936)

Psychoactive substances have been used throughout history, by nearly every human indigenous group, in religious and spiritual ceremonies, as self-medication and for recreation. Aldous Huxley (1958), commenting about psychoactive drugs said *"that humanity at large will ever be able to dispense with artificial paradise seems very unlikely".* Andrew Weil (1973) in his book *"The Natural Mind"* argued that the search for altered consciousness is a basic human appetite traceable throughout history and across cultures. Others (Davenport-Hines 2001, Huxley 1958, Jay 2005) have reflected upon the social context and history of drugs and concluded that our search for oblivion, altered consciousness or a 'high' say more about the nature of humankind and our range of emotions than prohibitionists would want us to attribute to substances of abuse.

The history of opiate use dates back to early man, with the first written reference found in a Sumerian text dated around 4,000 BC, predating the first brewing or distillation of alcohol (Davenport-Hines 2001). Cannabis has been found in a number of countries' Neolithic archaeological sites. A measure of cannabis's popularity and longevity as an intoxicant, are its variety of names in different languages (ancient and modern): *Hanaep* in old English, *hashisch* in Arabic, variations on the word *konope or konop* in eastern Europe, *kif, dagga* or *matakwane* in Africa, *liamba* or *maconha* in South America; *Ta-ma* in China; *bhang, ganja or charas* in India and *bust or sheera* in Egypt.

Cocaine is one of the earliest known stimulant drugs. In the thirteenth century the Incas of Peru celebrated the coca plant as sacred and there is evidence that the leaf has been chewed for its stimulant qualities dating back more than 2000 years (Davenport-Hines ibid). Other ancient intoxicants include khat (or *qat*), the

fly-agaric mushroom (amanita muscaria), alcohol and mescal or *peyote;* though their use tended to be more localised than opium or cannabis.

A thorough exploration of the physical and psychological effects of substance misuse cannot ignore the importance of drug and alcohol related law and its development in the UK. The effect of contemporary drug and alcohol policy and law has a direct influence over the social context and treatment for substance misuse, particularly in Britain where the criminal justice system and treatment systems for substance misuse have become intrinsically linked (Johnson 1997). "Dope Girls" a history of cocaine and opium use in Britain at the turn of the twentieth century (Kohn 1992), summarises the evolution of drugs laws in the UK. In the words of the author the book was written, *"about how drugs acquired their modern meaning in one particular place and time"* (Kohn 1992 p 12). Commentary on Kohn's writing has suggested the essence of this book is about *"how we ever came to invest this particular group of naturally occurring chemicals with such demonic properties"* (Skidelsky 2001). Increasingly society is attributing an additional 'modern meaning' to drugs which associates their consumption with the possibility of developing mental health problems (Devlin 2008). As recently as October 2014 Hall (2014 pp12), conducting a meta-analysis of the past 20 years of research into cannabis use concluded that

> *"Regular cannabis users double their risks of experiencing psychotic symptoms and disorders, especially if they have a personal or family history of psychotic disorders, and if they initiate cannabis use in their mid-teens."*

The idea that drugs are demonic and can harbour demonic properties resonates not only with some of the contemporary experiences described in literature but also with a historical perspective which often viewed the manifestation of mental illness as demonic possession (see the reference to Voltaire's experience described by Boon (2002) in section 2.7.3).

1.1. Prevalence of substance misuse and dual diagnosis:

In the United Kingdom (UK) about one in four adults have tried an illicit substance at some time in their life, which amounts to about ten million people between the ages of 16 and 69 (Robson 2002). The most recent data available from 2012/2013 (Health and Social Care Information Centre 2013) shows that prevalence for drug taking in England for adults aged 16-59 was 8.2%. However the proportion in the 16-24 age group was almost double that (16.3%). Cannabis was the most popular drug with 6.4% of adults aged 16-59 having taken it in the

year 2012-2013. The data shows that drug use amongst young people aged 11-15 has declined from 29% in 2001 to 17% in 2012. The most common drug used by young people was cannabis, 7.5% of young people reported taking the drug in the year 2012. Data on Alcohol consumption for England (Health and Social Care Information Centre 2014) shows that 55% of Men and 53% of women drank more than the government recommended daily amounts of alcohol, 31% and 24% respectively drank twice that amount. In 2012 43% of English school students said they had drunk alcohol at least once, a reduction from the data for 2003 when 61% of school students had drank alcohol. Admissions to hospital in England where drug related mental and behavioural disorder was the primary diagnosis rose by 5%. 61,142 admissions to hospital in England were associated with a primary or secondary diagnosis of drug related mental and behavioural disorder. Alcohol, as a primary problem, was responsible for 325,870 hospital admissions in 2012-2013.

Prevalence rates of problematic drug and alcohol use by people with mental health problems are considerably higher (commonly between two and five times greater) than the general population (Kendler et al 1997 & Regier et al 1990). In 2003 prevalence rates for mental health problems amongst drug and alcohol service users in the UK were 74.5% and 85.5% respectively (Weaver et al 2003). The same study found that 44% of people with psychiatric problems also had a substance misuse problem (Weaver 2003). A significant body of evidence (e.g. Drake & Wallach 2000, Gafoor and Rasool 1998, Lehman et al 1993) and UK policy (DH 1999, DH 2002 & DH 2006) covers dual diagnosis.

Researchers have explored prevalence (Fowler et al 1998, Weaver et al 2001); aetiology (Lehman et al 1993, Addington & Duchak 1997); and interventions (Kelly, McKellar and Moos 2003, Martino et al 2006) for dual diagnosis. Recently research has focussed on the effect of cannabis on mental health (Zammit et al 2002, Arsenault et al 2002 and Henquet et al 2005). Certain interventions, notably group interventions and residential programmes, appear to offer better outcomes for this group than others such as case management and counselling (Drake, O'Neal & Wallach 2008, Hunt et al 2013). Despite significant research spanning nearly thirty years, comprising more than 50 controlled studies, widely adopted approaches such as comprehensive outpatient treatments and self-help programmes remain relatively unstudied (Drake, O'Neal & Wallach 2008). These areas of research will be explored more fully in the literature review.

1.2. Defining dual diagnosis:

The term dual diagnosis commonly refers to the co-existence of substance misuse and mental ill health (Todd et al 2004). The roots of this terminology are explored in depth in chapter 2. A number of other terms have been used to indicate the coexistence of these specific problems including co-morbities, coexisting mental health and substance misuse problems, Dual Disorder and Chemically Addicted Mentally Ill (CAMI) and Mentally Ill Chemical Abuser (MICA), (illustrating how early US discussions focussed on the primacy of diagnosis). Some of these terms appear to be pejorative, others distasteful to people and their families who use services, and some are overly clinical or technical. Throughout this paper I will use dual diagnosis as my preferred term, not because it is more accurate but because it has become the commonly applied term in the UK and USA, and it is linguistically more efficient. Definitions of dual diagnosis are explored in greater detail in the next chapter.

1.3. Effects and impact of dual diagnosis:

The prevalence and aetiology of dual diagnosis in the UK are explored in detail in the literature review. For people who experience dual diagnosis there are numerous associated problems: They typically have poorer physical health (Drake et al 1998), significantly higher levels of disability and personality disorder (Mueser, Drake & Wallach 1998), they are at greater risk of assault and abuse (Link & Phelan 1997, Drake et al 2006) and pose risks to others (Johns 2001). As a result they have an overall lower quality of life (Strathdee et al 2002). Coupled with the fact that substance misuse in combination with mental health problems significantly affects the prognosis of mental illness (Regier et al 1990) there is good reason to believe that this group are disadvantaged and as a result have a significant impact on health, social care and criminal justice economies in the UK. The development of dual diagnosis services in the UK in the early 21st century coincided with funding reductions in the NHS and other health and social cares providers. UK policy advocates that integrated pathways in dual diagnosis are the preferred approach to the development of care, but this is set against a back-drop where services are under pressure, due to resource reductions, and have significant pressures on capacity as a result of increasing demand, rationalisation and service cuts. Schulte et al (2008) observe that despite policy initiatives in the UK joint working arrangements in dual diagnosis are unstructured.

1.4. Introduction to narrative methodology:

1.4.1. Qualitative methods:

Whilst there has been considerable growth in the use of qualitative methods in the UK the same cannot be said of the USA. As the literature review will establish a significant proportion of research into dual diagnosis originates from the USA most of which is quantitative. In reviewing the literature I establish that it is inconclusive about what works in aiding recovery for people with dual diagnosis and I suggest that this is partly due to the focus on quantitative methods. Whilst quantitative research establishes a useful generalised picture of dual diagnosis in the UK and USA, it does little to uncover the lived experience of people who have complex needs as a result of their problems. In the methodology chapter I develop the case that qualitative methods, and in particular narrative inquiry, can offer unique insights into experiences, complementing existing research both qualitative and quantitative.

1.4.2. Reflection on my interest in narrative and narrative methods:

When reading the narrative research literature I have been interested in the author's personal voice that provides a context to their focus in studying narratives. Riessman (1993) terms this *'locating myself'* and suggests that it is useful for an author and narrative researcher to reflect on their own context and the effect this has upon the creation of narrative. This context has been helpful for me in underlining the value not only of the story and how it is told but also the way the listener can influence narrative - something researchers and authors term *co-creation* (Frank 1995).

> *"Storytelling engages an audience in the experience of the narrator. Narratives invite us as listeners, readers and viewers to enter the perspective of the narrator.....it is generally acknowledged in the human sciences that the researcher does not find narratives but instead participates in their creation"* (Riessman 2008 p21)

In the methodology section I reflect at length on my personal perspectives. This is an important part of the framework of Critical Narrative Analysis (CNA) and reflection is part of the ongoing endeavour to show transparency and rigour in this study. Reflection is the first stage of CNA, which I will discuss further later.

I am a white man in my late forties and have been interested in working with people who have complex needs associated with drugs, alcohol and mental

health, for a variety of reasons for most of the past 23 years of my nursing career. From my professional interactions and the stories I have been told by service users and clinicians I have begun to sense that their stories are rich and sophisticated and reveal much of value in the retelling of their lived experiences. I have become increasingly interested in the potential for stories about dual diagnosis to reveal how people build recovery capital and begin to address their complex problems. I have a sense that these narratives might aid practitioners' understanding by articulating way marks and barriers on the road to people's recovery that can be used to inform therapeutic interventions. In essence if we begin to understand what helps and hinders recovery we can use more of the former and attempt to avoid the latter.

I first became aware of drugs in the late 1970s and early 1980s, through my love of rock music. Drugs and alcohol, it seems, have always been part of the contemporary music scene. The death of the Sex Pistols bassist, Sid Vicious from a Heroin overdose, thinly veiled references to psychedelics in the music of Pink Floyd, Hawkwind and Led Zeppelin and more overt references to drugs in the music of the Velvet Underground all opened my eyes. As a young person in the late seventies and early eighties my direct experience of drugs and alcohol was limited. Even when I attended my first university in Sheffield I had little contact with either drink or drugs, the nearest I got to a high was the adrenaline rush from rock climbing. It was through rock climbing that I first met people who took drugs. After graduating with a degree in Environmental Studies I worked in several jobs, all of them unsatisfactory for one reason or another until I eventually began my psychiatric nurse training in April 1989. Prior to this I had little or no experience of mental illness. During my nurse training I experienced a variety of mental health placements but only a brief two-day placement with drug and alcohol services. Dual diagnosis was not something that had entered my consciousness at that stage.

I have worked as a psychiatric nurse in a variety of roles, as a staff nurse on a ward for individuals with severe and enduring mental health problems; a Community Psychiatric Nurse in a mental health rehabilitation team; a Clinical Nurse Specialist with a Community Drug and Alcohol service; Dual Diagnosis Lead Practitioner and most recently as Consultant Nurse in Dual Diagnosis and Clinical Director of Specialist Services. In that time I have met many service users who have experienced concurrent mental health and substance misuse problems. I have always found working with them enjoyable, challenging and rewarding.

My role has included teaching and clinical leadership with a range of staff working with individuals with dual diagnosis. The experience of complex and concurrent mental health problems seems to accompany considerable chaos and often deteriorating outcomes for many. An observation, consistent throughout my career, is that not all people who experience these concurrent problems respond to treatment well (The next chapter demonstrates evidence for this). Practitioners involved in treating and supporting individuals with a dual diagnosis, find it extremely hard to work with them constructively on all aspects of their difficulties. For many of my colleagues the label dual diagnosis appears to imply a condition, which requires a response, based upon a concrete set of skills. I have found that the skill set needed to work with individuals is the opposite: ill defined, eclectic and broad based. Key characteristics possessed by practitioners, carers and service users which appear to be vital in any success include flexibility, optimism, assertiveness, confidence, openness and an ability to see past the stigma associated with mental health and drug and alcohol use. As a result I find myself particularly interested in the perspectives of both service user and practitioners, on what renders services for people with dual diagnosis helpful, accessible and acceptable.

In my clinical practice and embryonic research career I have been struck by people's desire to tell stories about themselves and the people around them. When conducting research interviews, where I had a specific goal in mind, and occasionally in clinical situations, when busy and pressed for time, my frustrations in being faced with 'lengthy' stories were often difficult to resolve. Some of my training that has led me down empirical, realist paths seems to urge me to want to "get to the point". Ultimately though, I've found people's stories interesting and revealing.

My interest in people's narratives are in the emphasis they place on the human experience of living with challenges, attempting to find reasons, answers and solutions to their problems and developing a sense of empowerment. Frank (2002 p5) observes, "*Stories give lives legibility; when shaped as narratives, lives come from somewhere and are going somewhere".* The importance of narrative to portray a life as '*going somewhere'*, must not be underestimated. Given that practitioners, carers and service users experience a lack of treatment optimism in dual diagnosis (discussed in chapter 2; embodied in research by Adams (2008) Coombes and Wratten (2007) & Deans & Soar (2005)) narratives of experience, struggle and recovery can engender hope and optimism in recovery.

I continue to be very interested in how other clinicians, particularly nurses, learn about people with whom they work. Brody (1987) notes that whilst the training of health care professionals typically focuses on objective or scientific evidence the most meaningful teaching moments often begin with the phrase "*I once had a client who…"*

1.4.3. The Context of narrative and narrative methodology in this thesis:

The role of narrative is to tell a story of what happened, the importance of the event(s) and the place the event has within a personal and community context. It has been suggested that a person may develop an internal narrative where they are both storyteller and audience, but Riessman (2008) states that for narrative to flourish there must be a community (audience) to hear and for audiences to listen; stories must weave together communities' identities, politics and histories.

Narrative researchers (Mishler 1986; Riessman 1993) argue that evidence in the form of personal descriptions, stories or narrative reveals knowledge about areas of unexplored or neglected human experience that other research approaches do not. I will establish in the literature review that the current evidence base relating to dual diagnosis is inadequate in its exploration of facilitators and barriers to recovery from a personal perspective. The existing research lacks the context to fully understand and appreciate the complexities experienced by a person with mental health and substance misuse problems. A narrative study of people's stories about their mental health problems, how drugs and alcohol are located as part of their lives, ensures that the participants' voice is heard by embracing the narrative of a drug user and someone with mental health problems within the context of their life and lived experience. By capturing the context of the interplay between substances, mental illness and their wider lived experience I aim to uncover a depth in the source data collected that will enable wider learning about dual diagnosis. The literature review establishes that there has been relatively little credence given to the wider context of an individual's lived experience. I intend to use a narrative approach to explore these lived experiences and to mine their value as stories of hope, optimism and lessons to be learned.

1.4.4. Critical Narrative Analysis (CNA):

The analytic framework I have chosen is CNA proposed by Langdridge (2007). It is described as a *"framework for reading text"* based on the work of Paul Ricoeur that marries phenomenological philosophy with hermeneutics. The methodology

is outlined in chapter 3. CNA was chosen for its suitability in uncovering contemporary meaning behind the narratives collected at interviews. CNA provides a practical six-stage framework, but the stages are not discrete because the aim is to synthesise a number of analytical tools into a method that *"enables critical analysis that sheds light on the phenomenon being investigated"* (Langdridge 2007 p133).

The six stages of CNA are explored in detail in the methodology chapter. Where I have applied each stage is indicated in bold in the text and highlighted on the thesis contents page to aid clarity. The stages are:

- Stage 1: A critique of the illusions of subjectivity (which I have already begun here in the introduction under section 1.3.2 and continues in the narrative theory and methodology chapter).
- Stage 2: Identifying narratives, narrative tone and rhetorical function (in the findings chapter).
- Stage 3: Identities and Identity work (also in the findings chapter).
- Stage 4: Thematic priorities and relationships (also in the findings chapter).
- Stage 5: Destabilising the narrative (the discussion chapter).
- Stage 6: Synthesis (in the discussion chapter and conclusions to the thesis).

(After Langdridge 2007)

1.5. Findings:

Each of the twenty narratives commences with a brief introduction to the participant to give the reader some context to the narrative. I analyse each narrative, collected during the interviews, applying stages 2, 3 and 4 of CNA. I describe narrative tone and function, explore what the narratives tell us about the identities of participants and develop themes from the narratives. In accordance with Langdridge's methods I frequently quote directly from the transcripts in order to ground the work in the voices of the participants and ensure that I privilege what they have said. Quotations from participants are *italicised* and the reference numbers in brackets after each quote refer back to the line numbers of transcripts. This is done to demonstrate rigour, enabling the reader to refer back to the original interview and to ensure there is transparency in providing the context in which the quote was made. I finish with a summary outlining the main themes uncovered in my analysis.

1.6. Discussion:

In this chapter I cover stages 5 & 6 of CNA, further reflections on the progress of the study and explore the strengths and limitations of my methodology. The chapter continues by applying social theory on stigma by Goffman, Link & Phelan and Sayce to destabilise the narratives and uncover some of what is behind what was said. I discuss why stigma is so pervasive and the effects that discrimination has on the participants. The chapter divides into theories of stigma introducing the relevant conceptualisations. Stigma and its effects are explored through the lenses of individual, self and structural stigma; and I explore the effect of labelling and discrimination on recovery in dual diagnosis. I discuss the way socio-economic factors influence stigma and the effects stigma has on the socio-economic status of people with a dual diagnosis. I also explore how labelling and biogenetic models of disease reinforce the stigma and discrimination of people with dual diagnosis.

I relate back to how politics, policy and the current climate of austerity in health services form an important context to social constructs of mental illness and substance misuse and how this has impacted people with a dual diagnosis.

1.7. Conclusions;

In the conclusions I summarise my findings and discuss the transferability and implications of the study for dual diagnosis practice. I aim to explain how I have answered my research questions and offer some suggestions for future research.

2. Literature Review

2.1. Context of the literature review

This literature review provides a context for dual diagnosis in this study. In her book '*Demons*' Berridge (2013) postulates that public health responses to the UK substance misuse problem are not solely driven by medical evidence, but when viewed through an historical lens are the culmination of changing attitudes, culture, wars, class and gender. This literature review will place this thesis in the context of the social constructs that have evolved historically in the UK and have come to define substance misuse, mental health and dual diagnosis.

I explore the historical background and development of the concept of dual diagnosis; the effect that the law, prohibition, public attitudes and policy have had upon the genesis of the concept; and the relationships between mental health and substance misuse that create complexity for both the service user and for practitioners who endeavour to help them. I will also examine the effect that diagnosis, labelling, attitudes and stigmatisation of mental health and substance misuse have upon our understanding of dual diagnosis. This chapter will highlight the differences between attitudes held by practitioners, service users and their carers.

There are many challenges in exploring dual diagnosis some semantic, some philosophical and others attitudinal. Understanding is influenced by existing knowledge and views about mental health and substance misuse as separate concepts. Often the nature of the problem is subjective, be it mental health or substance misuse and its effect on health and social functioning. An individual's gender, culture, ethnicity, spirituality, education, sexuality and moral perspective influence their experience and interpretation of substance misuse *and* mental health. These factors also influence how others make sense of these experiences (Velleman and Baker 2008).

This chapter will demonstrate that there is very little research exploring the experience of those professionals who seek to support recovery and even less studying service users' experiences of co-existing mental health and substance misuse problems.

2.2. Literature review: methods

This is not a systematic review with clear inclusion and exclusion criteria. Rather the review takes an evolutionary route iteratively uncovering literature, research

and policy from a wide range of sources to provide a backdrop to the study. The literature search began with electronic databases; British Nursing Index and archive (1985 to July 2008) Embase (1980 to week 26 2008), Ovid medline (1950 to June 2008), Psychinfo (1985 to July 2008), Google Scholar and Nottingham University Full Text. Initial search terms: dual diagnosis; psychosis and substance use, misuse, abuse; mental health and substance use, misuse, abuse; coexisting mental health and substance use, misuse, abuse; addiction and mental health problems, mental illness; were used to generate a series of relevant articles. A full breakdown of the review search terms and results is represented in Appendix 1 (p253). The bibliographies of articles generated further reading and search terms including the addition of: patient, client, service user views, perspectives, experiences, opinions; carer views, perspectives, experiences, opinions; staff attitudes, perspectives, experiences, opinions; in combination with the search terms above.

Articles which were included following the initial search helped to formulate a series of *a priori* topic headings for the literature review which was refined following reading of the literature. As each topic developed further searches helped to find articles and books for inclusion to broaden the discussion. Where there was a paucity of information in peer-reviewed journal articles, a more general search of the Internet was conducted using Google to find websites relevant to the aims of this study. References from Internet web pages were included from reliable sources determined by the nature of the hosting organisation, directly related to substance misuse and/or mental health. Internet sources, without supporting references validating the information they contained, were discounted from the literature review. Books were identified through a library search using the University of Nottingham Library Online Catalogue (UNLOC) and searches using Google Books.

The literature search and review was consequently reviewed and updated in December 2014 –January 2015 towards the end of my PhD study to ensure it was contemporaneous.

2.3. Drugs and alcohol in the UK.

Recently UK society has been going through a flux in its attitudes towards drugs and alcohol. As evidence of this Berridge (2013) emphasises the *'hotly publicised'* debate about the relative harms of alcohol and drugs between scientists (in particular the UK Advisory Council on the Misuse of Drugs; ACMD), senior UK police officers and social scientists. Taking cannabis has become widespread,

some might say common, amongst younger generations in the UK. Novel psycho-actives (inaccurately known as 'legal' highs) multiply in their availability, are frequently misrepresented in the media and pose variable often poorly understood risks to the imbiber. Efforts to reduce alcohol and tobacco use are firmly on the UK public health agencies agendas. In order to understand these changing attitudes it is useful to explore the history behind social constructs of substance misuse in the UK.

Prior to the 20th century control of the consumption, trafficking and sale of intoxicants was relatively unknown in the UK. The Alehouse Act (1828) and Beer-house Act (1830) liberalised control of the sale of beer and comprised some of the earliest legislation. It is ironic that the period of history during which humans began to develop synthetic drugs accompanied an increasingly prohibitionist attitude towards intoxicants of all kinds. Justus von Liebig developed chloral (one of the first reported synthetic drugs) from chlorine in the 1830s. Other physicians (most notably Liebrich 1839 to 1908) developed chloral hydrate as an anaesthetic, adopted by other physicians as an adjunct to detoxification from opium and morphine addiction. Inglis (1877) published a case study in the Edinburgh Medical Journal of a person who had been given chloral hydrate as a substitute for morphine, but developed a *"raging craving"* despite several years of apparent non-problematic use. Inglis later reported that his subject was admitted to the Royal Edinburgh Asylum suffering from fleeting delusions, irritability and had drifted into *"moral insanity"* (pp211-216). Inglis's description, at the time, bears significant similarities to the observations many contemporary diagnosticians make of amphetamine-induced psychoses (Brabbins and Poole 1996).

2.4. Drugs, alcohol and the law in the 20th century

The history of drug and alcohol treatment, and the populist theory that substance misuse is *'addiction'* and therefore disease is implicitly linked to the development of drug and alcohol law in the UK. Kohn (1992) contests that the popular opinion of drug misuse in the early part of the 20th century as debauched, shady and threatening to society led to the development of laws, which coalesced into the language and prejudices and created the modern 'war on drugs'.

Before the First World War there was little perception that drugs were a social menace in British society. Cocaine, '*Morphea*' (Morphine) and opium were widely and legally available. If anything alcohol was regarded as a greater problem than drugs. Alcohol possessed strong negative class and social connotations, with

particular fears that it would promote slovenliness and lack of productivity in the workforce. These eventually led to the first piece of legislation, under the Defence of the Realm Act (DORA 40B, Parliament of the UK 1914). DORA instigated new licensing hours in bars, clubs, hotels and restaurants (only recently reformed in the UK) to restrict alcohol consumption and ensure that the workforce were able to produce the munitions needed for the war effort. Sir Malcolm Delevigne, an Undersecretary of State in Government at the time, saw the opportunity of using DORA (ibid) to deal with the problem of intercontinental supply of drugs, and capitalised on this opportunity to avoid complexity in dealing with intoxicants (Berridge 2013).

The development of legislation had little immediate impact outside of the military and although many psychoactive drugs began to be seen as problematic (Edwards & Berridge 1981) many of them were still easily obtainable into the early twentieth century. The significance of DORA (Parliament of the UK 1914) was that Delevigne was the first person to take primary responsibility for implementing legislating and regulating the prescription of drugs. After World War I, Delevigne asserted that the control of drugs should be a police responsibility (Berridge 2013). The UK had earlier become committed to a more extensive system of domestic control over narcotic drugs when it signed the International Opium Convention in 1912 (League of Nations 1912). It was not until after the First World War that the Government was able to effect its obligations under the 1912 Convention by passing the Dangerous Drugs Act (Home Office (HO) 1920). The Dangerous Drug Act was vague about two critical issues, whether doctors/pharmacists could prescribe for themselves, and whether doctors could "*maintain*" addicts. In 1921 and 1924, the Home Office proposed regulations that ignored the rights of professionals and imposed many complex procedures (Berridge 2013). It also sought powers of search and seizure, higher fines, and longer sentences for convictions. The Home Office created regulations that would subject doctors to criminal sanctions and limit their prescribing practices, as was already happening in the USA.

Where Britain began to depart from the rest of the world was with the Rolleston Committee report commissioned and produced by the Department of Health in 1926 (Berridge 1980). The report emphasised that persistent drug use, in line with newly emerging medical and social theory, should be seen as a disease: *"as a manifestation of a morbid state, and not as a mere form of vicious indulgence*" (Berridge 1980 p129). The implication of this in the development of UK law,

policy, and treatment systems is significant. It was essentially the first time that the disease concept of addiction had been espoused. The Rolleston report led to significant revision of the 1920 Dangerous Drug Act in 1926 and further amendments in 1967 and 1968. Many of the provisions of the Rolleston Report remained in effect well into in the 1990s.

In the late 1950s, synthetic opiates, such as methadone were first manufactured. Doctors began to prescribe these for therapeutic purposes, but they were soon discovered to be addictive too. In 1958, the Home Office and the Department of Health and Social Security (DHSS) set up an Interdepartmental Committee; The 'Brain Committee' after its chair Sir Russell Brain. The Brain report concluded the incidence of addiction to controlled drugs in Great Britain was still very small and traffic in illicit supplies (with the exception of cannabis) was negligible. The report was heavily criticised at the time for failing to take into account the changes in the UK drug culture (Anderson & Berridge 2002). Taking heroin had actually increased in the late 1950s and early 1960s and patterns of drug use had changed significantly. The Brain Committee was reconvened in 1964 to produce a second report, which concluded that problematic use of heroin and cocaine had increased significantly in the UK with the main source of supply being pure sources of mis-prescribed drugs.

The Dangerous Drugs Act (1967) led to the implementation of the second Brain report findings. Under the Act clinicians were prohibited from prescribing, supplying or administering heroin or cocaine to addicts, except in the treatment of organic disease or injury, unless they were authorised to do so by the Home Secretary. This led to the development of special treatment clinics; it was only medics working in such clinics who were authorised to prescribe controlled substances. The emergence of substance misuse treatment as a speciality was defined. Further stigmatisation of drug use arose from the registering of addicts under the '*addicts index*'. Prescribers were required to report to the Home Office any person whom they considered to be addicted to any drug. The index remained in use until 1997.

In 1971 the Misuse of Drugs Act, repealed all previous legislation. The new law, which remains in operation today, created specific offences, such as unlawful possession of a controlled drug and unlawful possession of a controlled drug with intent to supply. The development of drug law in the UK has reinforced popular opinion that drug taking is criminal, debauched, shady and threatening. The consumption of and habituation to drug taking is often oversimplified as disease,

which mirrors to a certain degree, public opinion and understanding of mental illness in the 20th century. It is precisely these stereotypes that affect staff attitudes and may present barriers in the treatment of individuals with dual diagnosis (Maslin 2001). As will be explored further, social constructs tend to group 'deviances' together which offers one explanation as to why language and prejudice in mental illness and substance misuse have developed in parallel.

2.5. Drug use, social class, ethnicity and gender:

In the early part of the twentieth century it was common for women to hold morphine tea parties. An article in the British Medical Journal of 1902 describes the rising popularity of Ladies' Morphine Tea Parties, where the hostess would oblige her guests with an injection of something much stronger than caffeine. However, the reality of the time was reflected in the belief of privileged people that the poorer classes could not be trusted to use drugs responsibly. Kohn (1992) highlights this when exploring drug use by women in different strata of society and shows the social divide between genteel women using morphine and the working class dancers, performers and singers who used cocaine to facilitate their late and long working hours. At this time drug use and intoxication began to be associated with sinning and the "*self creation of private hells*" (Davenport-Hines 2001 pp36).

Whilst it was more acceptable for women of the privileged class to take drugs (particularly morphine) negative associations with drugs were commonplace. A paper produced by the British Gynaecological Society in 1895 (McNaughton-Jones cited by Davenport-Hines 2001) attributed drug habits to "*female silliness*". Dr Henry MacNaughton Jones was Professor of Midwifery and President of the Obstetrical and Gynaecological section of the Royal Society of Medicine and had become outspoken in the late 19th century on the subject of women's drug consumption and its association with neuroses. He once said about women using morphine that "*the habit becomes contagious, and there is even a morbid delight felt in the act of puncturing, not alone herself but others*" (p47 British Gynaecological Society 1895). This attitude towards women and the associations made between drug use and neurotic behaviour were wide spread in the male dominated medical world at the time. Whilst such attitudes may appear shocking by contemporary standards, the fundamental taboos associated with women and substance misuse and its links to mental illness still pervade in contemporary society. In historical and current popular opinion, these roles require control and

should preclude substance misuse (Van der Walde, Urgenson. Weltz. & Hanna. 2002, p148).

A number of widely published scandals involving cocaine in the early part of the 20th century affected the development of the drug market, leading to declining sales in the late 20th century (Robson 2002). One case was the trial of Reggie DeVaulle (cited by Kohn 1992) who was indicted for murdering Billie Carlton, a famous vaudeville actress of the time. Kohn (1992) explores how the popularised view of drug abuse along with other prejudices relating to race, sexuality and gender, heavily affected the outcome of this trial. The subsequent ruling of murder by the court and the social and media hysteria surrounding it significantly affected development of legislation and policy related to drugs.

Kohn (1992) describes how the First World War changed people's attitudes, xenophobia grew and different ethnic groups, particularly those that were easily identifiable as 'different', were scapegoated as corrupting influences. At the time Germans and '*Chinamen*' were attributed with introducing and dealing drugs, not of particular concern per se, more that these '*races*' were "*subverting the British troops"* (Kohn 1992 p56). In discussing the social constructs that affected the development of drug laws in the UK, Kohn (1992) highlights an important fact that illicit drug and alcohol use is more than a simple clinical issue that can be explained by disease. There are many more factors; social, environmental, cultural and spiritual that affects an individual's response to illicit drugs.

2.6. Biogenetic models of addiction:

As a result of the change in perceptions of drugs in the 19th century, addiction became more closely associated with "*sin and the self-creation of private hells*" (Davenport-Hines 2001). Society was going through significant change; new industries, commercialisation and the move from rural to urban living began in earnest. Opium and alcohol were the most widely available drugs (Dunachie 1996). Opium entered the century *"as a widely used medicine"* (Jay 2005 p51) and left the century without this having fundamentally changed. However, the way opium was perceived by 'modern' English society at the time changed significantly within that hundred-year period. Jay (2005 p51) summarises this transformation of attitude towards drugs (particularly opium) as a change *"from homespun folk remedy to oriental plague, from avatar of the sublime to agent of corruption and degeneration."*

Societal degeneration was widely associated with mental illness and drug and alcohol misuse in the past (Gilman & Chamberlin 1985). Pick's (1989) discussion of medical decline and degeneration showed that both were deeply intertwined with the political and scientific developments of the period. Degeneration, mental illness and moral decline became the central focus of numerous social and biological investigations (e.g. the work of Bénédict-Augustin Morel and Jean Baptiste Lamarck). Morel (1809-73), commonly seen as the first theorist of degeneration, expressed these ideas in a treatise entitled *Traité de dégénéresence* (Morel 1857 cited by Pick 1989). Morel was devoted to the study of '*cretinism*', an allegedly incurable, inherited mental and moral disorder. He viewed the '*cretin*' as a symbol of humanity's racial degeneration, which manifested itself in deteriorating physical, mental, and even cultural conditions. Morel's theories are a historical point of convergence, where substance misuse and mental illness were seen in the same light, part of societal degeneration. Abel (2004) in discussing Morel's contribution to psychiatry notes that

> "*What was being passed on was not a specific pathology but a susceptibility of the nervous system to disturbances originating from "overindulgence" of toxic substances such as alcohol*".

Psychiatry has a long association with attempts to develop new drugs, medications and cures. Shorter (1997) writing about "*the first drugs that worked"* in psychiatry observes that opium and its alkaloids were frequently prescribed for depression and mania in the 1970's and had been used for centuries in a more ad-hoc fashion. The psychopharmacological use of these drugs was only marginally successful but "*highly addictive*" (Shorter 1997). Shorter makes no comment on the possible effect of such prescribing practices on mental health, other than their addictive qualities and there is only moderate exploration across the literature of the historical and social parallels which mental health and substance use have followed.

One physician, renowned for his experimentation with drugs exploring their effects on the psyche was Sigmund Freud. In February 1884 Freud ordered his first gramme of cocaine after reading several papers on its application. An article in the Detroit Therapeutic Gazette claimed the drug was a "*harmless remedy for the blues*" (Thornton 1983). At the time Freud described himself as suffering from melancholy:

"I took cocaine again and a small dose lifted me to the heights in a wonderful fashion" (Streatfeild 2002).

In his career Freud published six papers on cocaine and was interested that it might be used as an adjunct in detoxification from opiates and alcohol. Freud was not the only medic to be interested in cocaine he was part of the groundswell of scientists interested in its application (Jay 2005). In his publications Freud often used subjective, positively biased language to describe the effects of cocaine. Many anecdotes were derived from his own experiences of taking the drug, which was heavily criticised as 'unprofessional' by Freud's medical colleagues. This was a time when medics were beginning to exert their ownership of drugs in the '*interest of the general public'* (Jay 2005). Growing aversion to suggestions that prescribed substances might produce unwanted but potentially enjoyable side effects meant medics might close ranks against any one from within their fraternity who made such 'unscientific' claims. Many of Freud's conclusions of the time accurately reflect our contemporary understanding of the uses of cocaine in society. Jay (2005) suggests that the physical effects of cocaine offer an analogy for its changing place in scientific research "*a surge of euphoric excitement, followed by a period of overstimulation and instability, followed in turn by a crash into a trough of depression*".

2.6.1. Alcoholism:

The term *alcoholism* was first coined by Marcus Huss (1807-1890) a Swedish physician who defined it as a chronic, relapsing disease. However, the presentation of a comprehensive disease model of alcoholism didn't occur until 1960 and is credited to E.M. Jellinek (Rasool 1998). Rasool (1998) offers the definition of a disease model of addiction as a behaviour which is a progressive, incurable disorder for which the cause is attributable to the genetic and biological make up of the individual. As a result, the medicalisation of drug and alcohol problems as a disease, entered popular consciousness and significantly affected the way in which people perceived drug and alcohol problems. Despite the fact that alcoholism and addiction are widely used terms by both professionals and wider society there is little agreement as to their precise meaning (Crome 1997). The disease model itself generates terms such as dependency, addict and addiction to label the experience of substance misuse and formulate disease concepts around drug and alcohol use.

The implication of the disease-based theory of alcohol and drugs is that substance misuse is always problematic. Heather and Robertson (1997 p22)

observe, *"There is more than one way of regarding alcoholism as a disease".* They note that Jellinek found 115 distinct ways in which alcoholism was described but suggest that there are three main commonly accepted types of "disease position" for alcoholism. These can be generalised to all substances of abuse and are exemplified by:

- Substance misuse as a pre-existing physical abnormality.
- Substance misuse as mental illness or psychopathology.
- Substance misuse as an acquired addiction or dependence.

(Adapted from Heather & Robertson 1997)

Berridge (2013 p195) argues that alcohol and drug use has been conceptualised as disease in order to "*justify treatment*". Jelinek's classification of alcoholism as disease has significantly influenced psychiatrists in the UK. His status as a senior researcher at Yale University and his Editorship of the Quarterly Journal of Studies on Alcohol had a significant effect. Disease concepts of addiction were further legitimated by the World Health Organisation (WHO) definition of addiction as a *"state of periodic or chronic intoxication produced by the repeated consumption of a drug and is a form of mental illness, not criminal behaviour"* (Room 1984 p81). Jellinek was chair of the WHO addiction group at the time.

Heather and Robertson (1997) have suggested that the language used in relation to people's substance misuse actually affects the course of treatment in itself. *Addiction* is a popular term because it is less challenging to understand than the amorphous continuum of abstinence, controlled consumption and severely problematic dependence. Over time society has confused the *fact* of physical addiction with other facets of substance misuse including social problems, crime and physical health problems. This is not to suggest that addiction doesn't exist but there are most certainly challenges to the simple social construct that all substances are addictive. Take for example the thousands of people admitted to hospital and prescribed opiates for their pain, who leave and neither experience cravings or are addicted, even after prolonged prescription. This study is based on a social constructivist perspective (i.e. the narratives of participants reflect the way in which they construct their experiences) therefore the wider cultural and social construction of dual diagnosis is important to understand as it forms an implicit part of the co-construction of participants narratives. Berridge (2013) has argued the psychiatric and medical constructs of substance misuse offer a

technical perspective and may not always be in line with wider societies views. The historical context of substances and substance misuse are important factors in societal constructs of the perception of drugs in society, which are stereotyped and stigmatised.

2.7. Historical perspectives of dual diagnosis:

2.7.1. Introduction:

Historic literature supports the impression that substances have often been used to relieve the distress of mental health problems (e.g. Homer's Odyssey, Coleridge's poems, De Quincey's writing and Burroughs Literature). More recently concepts of dual diagnosis have developed from and have largely been influenced by policy and service development in the USA and by the United Nations.

The difference between the literary presentation of drugs and mental health in music and literature, and clinical perspectives are stark. Literature and music have typically romanticised the search for altered consciousness and its links with drugs as a natural partnership, essentially an innate part of human experience. In his book, *The Road of Excess,* Boon (2002) argues that whilst literature and drugs are dynamically different domains of human action they have coevolved alongside each other and permeate each other. Alternately the clinical perspective has tried to separate, establish and quantify the causes of addiction and the negative interactions substances have upon mental health in an attempt to 'treat' it. This is an entirely different perspective to the more romantic literary view and the social constructivist perspective, where quantifying addiction has meant separating the excessive appetite for drugs and alcohol as distinguishable from the 'norm'. Clinical concepts are to an extent based upon an oversimplification about the complex interaction of chemical substances on the mind. The disparate way in which mental health and drug and alcohol treatment services have evolved in the UK, from commissioning to provision, may have significantly hampered services' ability to appreciate and realise the holistic continuum which links life experience, distress, consumption of drugs and alcohol and mental illness (Johnson 1997).

Clinical perspectives on the history of psychiatric treatment and the history of substance misuse treatment are most often separately documented in the UK (Shorter 1997). This reflects the largely separate evolution respective service models have in this country. Gournay et al (1997 pp94) have highlighted this as a

significant barrier to the development of dual diagnosis services. These separate evolutionary paths have resulted in diverging ethos, semantics and language that often reinforce the differences between service models. This can be demonstrated when exploring the meaning of "recovery". Anthony (1993 p11) defines recovery in mental health as:

> *"A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."*

Whilst recovery *can* have a similar meaning in substance misuse the ethos and nuances behind the use of the term have diametrically different roots. The recovery movement in mental health tends to be opposed to labelling and disease-based paradigms (Turner 2002). However, the term 'recovery' in substance misuse is commonly used in the twelve-step, disease based, approach to addiction (illustrated by the tautology *"I'm a recovering alcoholic").* The 'Big Book' (Alcoholics Anonymous 2007) states that *"the first step to recovery is that we learned that we had to fully concede to ourselves that we were alcoholics"* and further that *"We know that no alcoholic ever recovers control".* Recovery in this sense is a misnomer as it alludes to the impossibility of complete remission, concedes a disease-based paradigm, and implies an inability to assert control without abstinence.

Substance misuse treatment is a relatively recent twentieth century phenomenon; developing not only in response to an evolving concept of addiction as disease but also as a result of the increasing prohibition and criminalisation of drugs and drug use. In order to explore the nature of contemporary understanding of the relationship between drugs and mental health it has been necessary to use literary references, many of which take a philosophical stance and date back far beyond the origins of the clinical concept of dual diagnosis.

There are many examples throughout history that demonstrate that up until the late seventeenth century, people considered the 'abnormal' or 'mentally ill' to be suffering from something caused or brought on by a supernatural force. It was not an uncommon belief that external influences such as the devil or spirits were held responsible for strange, deviant, abnormal and uncontrollable behaviour in people and animals. This train of thought is termed '*Demonology'* and has its

roots in religious thinking (Davison & Neale 1982). Individual's concept of normality is inevitably affected by wider societies' impression of what is moral and amoral and acceptable or unacceptable. Diagnoses in mental health and substance misuse have however led to a contemporary bias in the way of looking at abnormality. Using the medical model as a basis brings its own set of terms such as illness or disease. However, it is more difficult to apply in mental health since groups with diverse experiences and poorly defined clinical criteria tend to be organised under one label (e.g. schizophrenia). Abnormal behaviour may often be just inconvenient or unusual for others who do not subscribe to societal mores, and it can be hard to define behavioural patterns as an illness. Since it is hard, if not impossible to measure mental states, and symptoms are not always consistent, it has therefore been suggested that mental 'illness' should not be described as a disease (Milton & Wahler, 1969).

2.7.2. Defining dual diagnosis.

The term dual diagnosis was probably first used in the context of substance misuse and mental health in a publication by Ridgeley et al in 1987. Drake & Wallach (2000) suggest that as agencies began to recognise and discuss service provision for the younger population of individuals with mental health problems and substance misuse *"Affected individuals were often discussed under the rubric of dual diagnosis but were also called mentally ill chemical abusers, substance-abusing mentally ill persons, and a host of other names that emphasized the concept of two co-occurring disorders."* (p1126)

Many articles (Lehman et al 1993, Drake et al 1989; Graham et al 2001) have noted the commonality of dual diagnosis as a term meaning co-existing mental health and substance misuse problems. However, the term is not without its critics and whilst it is widely used and appears to allude to a formal process of diagnosis it is not included in either of the most commonly used diagnostic manuals, ICD10 or DSM V. Some clinicians (Hryb, Kirkhart & Talbert 2007) suggest that a lack of standardised diagnostic criteria for dual diagnosis prevent adequate research that demonstrates appropriate treatments. Maslin (2003) has argued that the term dual diagnosis is misleading on several levels. Firstly it could refer to any two co-existing problems; in fact historically the term dual diagnosis was also applied to people with both mental health and learning difficulties. The second criticism that Maslin makes is that dual diagnosis rarely involves two problems. Individuals experience a raft of health and social difficulties, housing problems, financial difficulty, criminal justice problems,

physical health problems, and relationship difficulties that affect their lives on a multitude of levels. Hodge and Thomas (1998) criticise dual diagnosis by suggesting that the label demonstrates a fundamental lack of understanding of the problem and a tendency to "*medicalize them*" which they suggest may be inappropriate.

Velleman & Baker (2008) suggest that the term dual diagnosis is undesirable for several reasons:

- The term implies a medicalised definition.
- The focus is on diagnosis rather than the importance that the presence of complex need presents to the individual.
- Mental health and substance misuse problems are different and separate, at what point do they pass a threshold of severity enough to warrant a label of 'dual diagnosis'.
- The term implies a duality where many people who are identified with a dual diagnosis have multiple complex needs, some of which may not meet diagnostic criteria or are necessarily purely health related.

They have suggested that as a result of these undesirable associations it is preferable to use the term co-existing mental health and substance misuse or co-existing mental health and drug or alcohol problems. Despite their accuracy these are cumbersome, complex and wordy terms.

Clinicians working in mental health settings with little experience of substance misuse often go through a process of psychological reductionism, the process of reducing all social activity and behaviour to the psychological characteristics of the human actors involved. Clinicians may believe that they lack the skills to intervene in 'addiction' because it is a specialism requiring a high degree of 'inaccessible' knowledge. At this stage the term dual diagnosis runs the risk of becoming 'dustbin' terminology suggesting that the service user cannot be helped because they need specialist intervention. This leads to the '*ping-pong effect*' described by Ridgeley et al (1990), where people are pushed from substance misuse services to mental health services, due to the misconceived view that the services cannot help them because they *only* specialise in one problem or the other.

In one study (Rethink 2004) service users were asked by interviewers to what extent they agreed with the following definition in relation to their own personal experiences:

> "*Dual diagnosis is a term used to describe individuals who have complex needs and problems and in this study Dual diagnosis specifically refers to people who live with a psychotic illness (such as schizophrenia or bi-polar disorder) and use or have used in the past substances (for example alcohol or drugs) which have significantly affected their lives".* (Rethink 2004 p22)

The study found that most participants agreed that the definition was accurate and relevant. However, the majority of subjects also felt it important to emphasise the "*highly individualized and complex circumstances*" (Rethink 2004 p16) they experienced. It is interesting to note that in their definition the interviewers avoided using the term misuse and instead talked about substance *use.* It was felt to be less pejorative and more acceptable to their participants who were currently engaged in taking drugs or alcohol.

Another study conducted by Staiger et al (2008 p196) found that '*despite perceived shortcomings*' in the meaning of dual diagnosis there was a common, shared understanding of the term between staff working in a variety of substance misuse and mental health settings. The study also noted that when asked to consider alternatives to the term or ways in which the definition might be changed there was little consensus amongst staff.

The common use of dual diagnosis is shorthand adopted by clinicians, and to some extent service users, out of a need for brevity and convenience. Whilst the term is undoubtedly medicalised, stigmatising and implies a duality which over-simplifies the complex and chaotic experiences of the individual, it can't be denied that it is a neat linguistic package. Evidence shows the term *dual diagnosis* commands a consensus of understanding amongst clinicians and is beginning to become accepted by service users and carers (Maslin et al 2001). To understand the concept it is important to explore the history behind the development of dual diagnosis and substance misuse, the associations that they have with UK law, criminal justice, degeneration and demonisation. In doing so a greater understanding of the context of the term, and its clinical development as a phenomena which is both complex and challenging to service users, carers and providers can be constructed.

2.7.3. Origins of dual diagnosis

Drake and Wallach (2000 p1126, Citing Bacharac 1982, Caton 1981, Pepper, Ryglewicz, & Kirshner 1981) trace the origins of dual diagnosis in the USA back to "*A spate of articles in the early 1980s (which) identified, described, and labelled the "young adult chronic patient*"". In their article they surmise that research was beginning to describe young people's encounters with drug culture, as an attempt to cope with symptoms of their mental illness and as a result of the move from institutions into the community.

The phenomenon of mental health problems resulting from substance misuse (and vice versa) is much older than Drake & Wallach's (2000) summary suggests. Boon (2002) in his history of writers on drugs, describes an historic scene from 1778. A 73-year-old Voltaire, suffering from severe pain in his kidneys and bladder, received a visit from his friend the Duc-de-Richelieu who suggested his friend take an opium potion. Voltaire reacted badly to the Laudanum *"for two days he was wildly delirious"* and Boon (2002) notes that clerics of the time commented of Voltaire that he *"alternated between fits of derangement and sleep, in which it was claimed he saw the devil at his bedside come to claim him"*. Voltaire was dying at the time from cancer of the prostate, which may have affected his mental state; it is also possible that this is one of the earliest records of drug-induced psychosis.

The description of Voltaire's experience raises a number of questions. At what point does a drug experience cease being mind affecting or merely psychoactive and become psychosis inducing? At what point does a substance move from being merely used or taken and become misused or abused? The answer to these questions depend upon the observer's general attitude and understanding of psychoactive substances, their understanding and attitude to mental health, their cultural and sometimes ethnic perspective, the laws or rules (religious and governmental) to which they abide and their spiritual perspective. In some cases the extreme differences between use and abuse are easily identifiable, however it is at the point where use and abuse blur, *"that grey area"* (Zinberg 1984) where most cases of people who take substances and have mental health problems lie.

Aldous Huxley, an exponent of LSD (lysergic acid diethylamide), often wrote essays in which he explored the effects of drugs. Many of Huxley's articles explored ideas of consciousness and spirituality. In an article in the Saturday Evening Post in October 1958 Huxley explored narrative on people's experiences of psychoactive substances and referenced *"De Quincey, for example, first resorted*

to opium in order to relieve "excruciating rheumatic pains of the head." He swallowed his poppy and, an hour later, "What a resurrection from the lowest depths of the inner spirit! What an apocalypse!" And it was not merely that he felt no more pain. "This negative effect was swallowed up in the immensity of those positive effects which had opened up before me, in the abyss of divine enjoyment thus suddenly revealed.... Here was the secret of happiness about which the philosophers had disputed for so many ages, at once discovered." (Huxley 1958). It is notable from this description that De Quincey appreciated the analgesic qualities of the opium he took but found the mood altering qualities of the drug and its positive effects on his low mood equally satisfying. Later in the same essay Huxley likens the effects of psychoactive substances to the spiritual exercises undertaken by ascetics and mystics. Huxley attests that taking psychoactive stimulants mimics the effects of social isolation studied by experimental psychologists such as John Lilly and he uses the example of St Anthony who lived a life which *"provides very few external stimuli, soon undergoes a change in the quality of his consciousness and may transcend his normal self to the point of hearing voices or seeing visions, often extremely unpleasant."*

Zinberg (1984) has described an individual's drug experience being dependent upon three factors: the specific substance taken (*drug*), the environment in which the substance taking occurs (*setting*) and other factors (such as whether the person has eaten, their mood or mental state or their physical/mental health) specific to the individual (*set*). De Quincey (1822, cited by Jay 2005) also argued that opium, or any other substance, does not have the same effect on individuals, "regardless of their *will*". He argued that opium has a "*spectrum of effect*" which is always subject to the users' control to some degree. He develops this argument to suggest that the origins of his opium experience must have been previously lodged within his psyche and that the drug merely aided the realisation of his visions. This early observation is reinforced by more contemporary research on cannabis and psychosis (Arsenault 2004 & Henquet 2005), which has concluded that the drug tends to have a negative effect on the mental health of those individuals who have a predisposition to psychosis. So we are left with a less than definitive perspective of whether drugs induce or destabilise a person's control over the development of psychosis.

In the late 1980s articles began to appear in American journals, which were concerned with the prevalence, assessment and treatment of dual diagnosis. The Epidemiological Catchment Area (ECA) Study commissioned by the National

Institute of Mental Health in 1981 in America had produced previously unseen levels of data on the prevalence and incidence of mental illness in the US. The ECA had made the important finding that there were significantly high rates of substance misuse associated with mental illness (Robins & Reiger 1991) this became a catalyst for interest in dual diagnosis.

2.7.4. Drug-induced psychosis:

The biogenetic model of both mental health and substance misuse tends to label and compartmentalise *both* through diagnoses (labelling theory and its relevance to dual diagnosis is explored more thoroughly below in sec 2.7.5). This has been criticised as unscientific since diagnoses should be made based upon the inclusion and exclusion of strict criteria (Hryb et al 2007). To widely label people with a diagnosis that is broad based and without specific criteria poses risks as it suggests that there is an identifiable and common specific treatment to deal with the particular diagnosis. This is problematic for anyone trying to understand the concept of dual diagnosis since it restricts understanding of the fluidity of the relationship between drugs and mental health. The idea that there are distinct boundaries between 'normal' and problematic drinking, as suggested by the diagnostic classification of alcoholism, is challenging. In reality it is impossible to say where normal drinking ends and problem use begins. Where one individual may develop significant levels of physical health problems associated with consuming alcohol another may not. The picture becomes further clouded when an attempt is made to determine behaviour as disease, as in the case of habituation to alcohol or other substances.

Hahn (2007) states that the Diagnostic and Statistical Manual IV (2) includes a diagnosis of substance induced psychotic disorder, which it describes as the presence of prominent hallucinations or delusions and include the following criteria.

- Hallucinations and/or delusions develop during, or within one month of, intoxication or withdrawal from a substance or medication known to cause psychotic symptoms.
- Psychotic symptoms are not actually part of another psychotic disorder (such as schizophrenia, schizophreniform disorder, schizoaffective disorder) that is not substance induced. For instance, if the psychotic symptoms began prior to substance or medication use, then another psychotic disorder is likely.

- Psychotic symptoms do not only occur during delirium.

It's questionable how useful this diagnosis is for a variety of reasons. Implicit in the development of the criteria is that an individual is able to reliably narrate a chronologically accurate perspective of their drug use and their development of psychotic symptoms. The diagnostic criteria also assume that there is a logical lateral and discernable difference between symptoms experienced as psychosis and experiences associated with drug use. Psychosis does not develop along a smooth trajectory and there are a number of environmental, psychological and socio cultural factors that may affect the development of the problem.

Brabbins and Poole (1996) have highlighted that although drug induced psychosis is a commonly used diagnosis it lacks a universally accepted definition and the majority of clinicians they surveyed lacked *"a logical and coherent scheme for understanding drug induced psychosis"* (Brabbins and Poole 1996 p410) Not only does this undermine the fundamental ethos of a scientific disease based diagnostic approach but it has potentially serious consequences for the individual given the diagnosis. In a research article which critically examines the evidence for criteria associated with a substance induced psychosis, Mathias, Lubman & Hides (2008 p363) suggest that the new Diagnostic and Statistical Manual (V) should include *"An alternative, broader classification that better reflects the current evidence base, inferring association rather than causation"*

Robson (2002) states that an idea of the prevalence of drug-induced psychosis can be gathered from literature published on the prescription of LSD when it was used as a legal treatment in psychiatry. Prolonged psychosis seems to have occurred in one in ten individuals prescribed LSD and major complications were associated with 2% of psychiatric patients who were prescribed the drug. In studying the effects of Phencyclidine (PCP) and Ketamine, Sharp & Hendren (2007 p515) observe, *"The psychosis produced by these psycho-mimetic drugs is indistinguishable from schizophrenia and includes both positive and negative symptoms"*. One of the main challenges in defining the difference between drug-induced psychosis and psychosis which is brought on by or exacerbated by substance use is associated with the challenges of diagnosing psychosis in the first instance. Recent research on cannabis and psychosis (Zammit et al 2002, Arsenault et al 2004, Henquet et al 2005, and Moore et al 2007) hold a consensus that there is significant uncertainty about whether cannabis causes psychosis, but that it poses significant risks for those individuals who have a predisposition to psychosis. Wherein lies one of the most significant problems, in identifying a

predisposition to psychosis there is a lack of generalised symptamotology and whilst there is evidence of some genetic link this is poorly understood.

2.7.5. Labelling and dual diagnosis

Labelling theory suggests that the identity and behaviour of individuals are significantly influenced by the terms that people and societies use to describe them. Heather and Robertson (1997) have argued that the use of language in addiction is important because it not only acts to label individuals behaviour but the labels can in themselves affect the course of an intervention. A number of authors (Link et al 1989, Pasman 2011) have also recognised that the "*stigma of being labelled mentally ill actually causes one to be mentally ill as a result of effects described as self-fulfilling prophecy"* (Pasman 2011 p122).

This study has already recognised the lack of consensus on the operational definition of dual diagnosis. Todd et al (2004 p53) have determined that *"The term 'dual diagnosis' is more than just a label and the importance of this label is that it can and does determine service provision."* We might argue that the label dual diagnosis is simply a clinicians term used to identify individuals and to a greater or lesser extent sets one problem against the other in terms of primacy (Manley 1998). The problem with the label is that whilst it can be argued the growth of services to address the issue are to some degree a function of the label, the term dual diagnosis is undoubtedly stigmatising and can lead to some individuals being excluded from either mental health or substance misuse services and can impact on their recovery capital as a direct result (this is explored further in sec 2.8.1 on p43). Velleman and Baker (2008) argue that this creates a paradox because individuals with dual diagnosis who have highly complex needs tend to lose contact or are discharged from the services where there are the people who have the skills to help them, primarily due to the confusion caused by the label attached to them.

Underlying the label of dual diagnosis are issues of professional power and control. Many clinicians and practitioners tend to take a symptomatic view of individual's problems and with it an innate perspective that one set of problems may have causative associations with their other problems for example that psychotropic substance misuse causes mental health symptoms in particular hallucinations. This can lead to mental health practitioners dismissing the problem as 'drug induced' or substance misuse services seeing problem drug use as intractable due to an individual's mental health issues. In fact the issues are so

often intertwined within the individual that both practitioner perspectives are overly simplistic. In addition another problem with the label dual diagnosis is that it is based in a symptomatic perspective that pathologises problems rather than focussing on individual's strengths and so can be seen to be contrary to a recovery ethos.

2.7.6. Self-medication theory:

One theory associated with dual diagnosis (after Khantzian 1985) is that individuals take substances to self medicate, not only to help them deal with the symptoms of their mental health problems, but also to gain relief from side-effects associated with prescribed anti-psychotics and vicarious euphoria from stimulants or other street drugs. We might hypothesise then that psychiatry, in particular medical prescribing of psychiatric drugs, faces a challenge from individuals who experience mental health problems, who also take drugs or drink alcohol. Self-medication fundamentally undermines the concept of medics as 'custodians of drugs in the public interest' because it makes the role of prescriber redundant. Furthermore, it demonstrates a contradiction in belief between the assertion made by wider society and also many mental health practitioners, that substances of abuse are *always* detrimental to mental health and the experiences and beliefs of many service users who claim that they obtain positive effects from taking drugs and/or drinking alcohol (Test et al. 1989; Addington & Duchak 1997; Laudet et al 2004 and Cruce, Öjehagen and Nordström 2008).

2.7.7. Complications with primacy of diagnosis in dual diagnosis:

Johnson (1997 p205) observes *"Until the 1980s, research on the relationship between psychosis and substance misuse mainly focused on the difficulties of identifying which disorder is primary in people presenting with symptoms of both"*. Whether an individual has a primary drug/alcohol problem or a primary mental health diagnosis may be of little or no concern to them. Having established that the diagnosis of drug-induced psychosis is poorly applied and so can only be viewed as a label rather than a diagnosis, arguments of primacy of diagnosis (*i.e. is this person's presentation one of primary substance misuse or primary mental health?)* often get played out at a service level for financial and resource reasons.

Changes in commissioning, the separation of substance misuse and mental health budgets and funding shortages mean that clinicians are frequently in the difficult position of having to use diagnosis, and often primary diagnosis, to decide where

or indeed whether an individual is delivered a service. Dual diagnosis patients are more likely to be rejected by services as 'someone else's case', or to be passed between Mental Health and Addiction services repeatedly with what has been called *'the ping pong effect'* (Griffin et al 2004). In practice establishing primacy of diagnosis overlooks the individual's needs and can significantly affect the service user's experience and their opportunity to access services. There have been instances in the UK where services have criteria that prevent and most certainly complicate engagement of service users with complex needs. Gournay et al (1997 p 94) note that as a result "*It seems clear that, in order to target those with dual diagnosis, it is important that there is more integration of mental health and substance abuse services"*. This advice has become even more difficult to negotiate as a result of the Health and Social Care Act (DH 2012), which has broadened the divide between substance misuse and mental health services. Drug and Alcohol services are now commissioned by Local Authority Public Health departments and mental health services by NHS Clinical Commissioning Groups. In trying to deliver integrated care, services face the challenge of adopting a flexible approach which dispenses with the need to set service criteria around delivery, the very factors which have been a barrier to individuals accessing or engaging in care. The landscape of services is dominated by funding that use outcomes as performance targets. These are challenging to apply to individuals with multiple complex needs who rarely meet the target timescales commissioners apply to recovery or discharge from services. Services are in effect actively discouraged by commissioning mechanisms to offer holistic approaches to dual diagnosis because they are not funded.

2.8. UK Policy context relating to dual diagnosis:

Whilst some of the earliest research into dual diagnosis emerged in the UK between 1985-89, policy in this country was slow to develop in contrast to developments in the USA. Dual diagnosis featured prominently in the UK Government's mental health strategy, and the Mental Health National Service Framework (DH 1999). This wide-ranging policy observed that:

> *"Substance misuse is a growing concern; it may increase the risk that an individual poses and can make treatment of the coexisting mental illness more difficult."* (DH 1999 p46)

The National Service Framework (NSF) recognised the need for concern over issues of dual diagnosis in individuals due to "*their behavioural problems and*

reluctance to engage with services, which adds to the challenge" (DH 1999 p46). The document also observed areas of significant risk in dual diagnosis, including suicide. The NSF clearly states that the primary responsibility for the treatment of severe mental illness lies with mental health trusts and specialist services and these services needed to accurately assess for substance misuse when completing comprehensive mental health assessments.

In 2000 the All Party Parliamentary Drugs Misuse Group (APPDMG) produced a report entitled: *Drug Misuse and Mental Health: learning lessons on dual diagnosis.* This report explored the evidence for dual diagnosis in the UK and interviewed a number of key public figures exploring the deficits in service provision for this group. The report concluded that:

> *"It is apparent that the area of dual diagnosis is a difficult and complex one, particularly as it is an issue which straddles boundaries and professional organisations.... it is an area which has been neglected for too long, even though patients and/or offenders with drug/alcohol misuse and mental health problems are often some of the most vulnerable and socially excluded." (APPDMG 2000 p7)*

The report also recommended *"Service provision must be improved to stop people with dual diagnosis from falling through the gaps"* (p7) and that *"Work must begin to overcome the wide variation in philosophies between drugs and mental health services."* (p7)

In 2002 the publication of the Department of Health's Mental Health Policy Implementation Guidance; Dual Diagnosis Good Practice Guide (MHPIG 2002) ensured that evidence and good practice was published in one place. The MHPIG covered policy, assessment and treatment approaches; including screening, risk assessment and the main stages of treatment; and implementation of integrated packages of care. Whilst both evidence-based and comprehensive, the guidance was flawed; most of the evidence-base was drawn from U.S. research which had been shown to be in a different context to UK service provision (Graham et al 2001); it offered guidance on developing local definitions rather than a comprehensive discussion of the relative merits of established definitions. Probably its most fundamental flaw; was it status as *guidance* rather than policy. The status of the document and the subsequent lack of resources and funding

which followed it allowed provider services to choose whether to implement the good practice it contained, faced with some significant competing priorities it was clear that resource allocation and integrated practice were going to be low on many agendas.

The five-year report on the implementation of the National Service Framework for Mental Health (Appleby 2004) found that in 2002 only 8% of Local Implementation Teams (LITs) had produced a plan to help develop local mental health services to address dual diagnosis. This had risen to just 17% by the end of 2004. In 2006 the Care Services Improvement Partnership conducted a Themed Review (CSIP 2008) of the implementation of the MHPIG, they found that 40% of LITS did not have a dual diagnosis strategy as outlined in the guidance. The review also noted that 75% of LITS had highlighted the resource intensive nature of adequately treating individuals with dual diagnosis. They further reported that there was significant variation across England in the implementation of the MHPIG particularly associated with training and skills development:

> *"There is a mixed picture on training and the existing skills and capabilities of staff. Fewer than half the LITs had made an assessment of training needs. Variation between SHAs was extreme. 83% of LITs in the East Midlands reported that an assessment had been made compared to only 14% in the South West."* (CSIP 2008 p3).

In 2006 the DH produced *Dual diagnosis in mental health inpatient and day hospital settings* another set of '*good practice guidance*' aimed at promoting integrated practice in these settings. One of the challenges that staff on in patient units face is illicit substance taking. The MHPIG guidance (DH 2002 pp31) had been clear in stating *"If discharge is used as a sanction, this can result in the withdrawal of services from needy and vulnerable individuals. Often discharge is found to be an empty threat, as the statutory frameworks prevent the unplanned discharge of patients with complex needs."* The 2006 guidance had the formidable challenge of trying to offer some clear clinical guidance on how to deal most effectively with illicit drug use in inpatient situations; balancing issues of confidentiality, therapeutics and the law. The resulting guidance is as confused and conflicted, as staff often are, due to the irreconcilable conflicts posed by the

Misuse of Drugs Act (1971) and the need to give care and support to individuals with significant mental health problems in appropriate settings.

Models of care for Treatment of Adult Drug Misusers (DH/NTA 2006[a]) and Models of Care for Alcohol Misusers (MoCAM, DH/NTA 2006[b]) both make brief reference to issues associated with mental health and co-existing substance misuse problems but essentially reference the Department of Health guidelines mentioned above.

In March 2011, the National Institute for Health and Care Excellence (NICE) produced guidelines entitled *Psychosis with Co-existing Substance Misuse-assessment and management in Adults and Young People.* This best-practice advice contextualised dual diagnosis as a set of conditions, which are associated with *'significantly poorer outcomes than for individuals with a single disorder,'* (NICE 2011 p4). As with all other NICE guidelines the document was based on the best available evidence. They advocated integrated care that involves thorough assessment of substance misuse and mental health needs by both substance misuse and mental health services; they also highlight the need for good communication between services and collaboration in offering one and other specialist advice and support. The guidelines suggest that services should privilege engagement with this service user group. Most of the important elements of the NICE guidelines are related to increasing awareness of dual diagnosis, including:

- Asking about substance misuse at all routine assessments of people with suspected psychosis
- Involving patients and voluntary services more actively in discussions about diagnosis and management
- Encouraging testing for drugs in cases of suspected consumption but not without permission
- Applying a low threshold for referral to secondary care services.

(After Tyrer 2011)

It is difficult to assess what the impact of these guidelines has been on service developments in the UK as there have been no evidence-based assessments of their efficacy to date. Whilst the reinforcement of key principles is useful, in reality it suffers the same flaws outlined previously; a lack of resources to

support its implementation, relatively little research evidence identifying what interventions to use following assessment, and it is *guidance* with no power to ensure its advice is followed.

2.8.1. Recovery and recovery capital in substance misuse and dual diagnosis:

It is important to note that the concept of recovery has grown and developed separately in substance misuse and mental health services in the UK. In part this may be due to the separate development of services, but may also reflect other issues including the assumption of substance misuse providers that alignment with mental health services is a barrier to service user's engagement and is certainly not aided by the separate commissioning of these services put in place by the Health and Social Care Act (2008). Best et al (2010) have suggested three limiting reasons why there is little UK based evidence on recovery in substance misuse: much research is dated; it is based on alcohol or mental health rather than drug use; and most evidence originates from the US. Best et al (2012) observe that the recovery literature for substance misuse suggests three common elements to recovery: well-being, sobriety and citizenship. Other authors have suggested that one important factor in defining recovery is that it is a personal experience which is ongoing and defies definition (Davidson & White 2007). Davidson and White (2007) go on to suggest that recovery could be a useful organising principle for the integration of mental health and substance misuse services based in the fact that both systems share common elements of recovery. They observe that one such element to recovery is the need for people to develop *"transcendent recovery: a heightened level of personal and interpersonal functioning achieved as a result of having survived or transcended the limitations imposed by such severe and complex disorders"* (Davidson and White 2007 p113) which leaves them feeling stronger than before the onset of their dual diagnosis or "*better than well"*.

Recovery is based in more than the removal of symptoms, in each case, and necessitates a broader treatment approach beyond treating addiction and mental illness as a disease. Davidson and White (2007) argue that despite the wealth of evidence for integration in dual diagnosis dating back over 20 years there has been little progress in developing such systems in either the UK or US.

Laudet & White (2008) observe that a predictor of the likelihood of sustained recovery, lower stress and quality of life is that extent of *'recovery capital'* available to individuals. The concept of recovery capital was introduced by Cloud

and Granfield in 2001 and includes but is not limited to the personal and psychological resources of the individual, the social support available to them and basic foundations of quality of life such as housing, meaningful daily activities, citizenship or a sense of belonging (Best et al 2010). A critical aspect that affects an individual's access to recovery capital is the extent to which they are discriminated against. Increasingly recovery in substance misuse settings has become defined by the UK government's drug strategy (Home Office 2010), which places an emphasis on providing a 'recovery orientated' treatment system with an explicit focus on achieving substance-free outcomes. Thus success is defined as abstinence regardless of the quality of life or achievement of personal goals. The operational and commissioning systems set up to measure and competitively purchase substance misuse services may have unwittingly become a barrier to integration in the UK through shared recovery principles (explored further in the discussion chapter).

Cloud and Granfield (2008) have argued that whilst recovery capital is generally perceived to aid recovery an individual's resources may actually impede or inhibit recovery and can be described as negative recovery capital. They go on to describe groups who may be more likely to experience negative recovery capital including people who have been incarcerated in prison and those with mental health problems. Cloud and Granfield (2008 p1979) specifically state *"Substance dependent persons with very serious mental health disorders such as schizophrenia, bipolar disorders and other psychotic disorders can bring with them situations that can represent significant levels of negative recovery capital."* They go on to suggest that for these individuals engaging in substance misuse can be seen as a providing emotional comfort and escape from the disabling symptoms of mental ill health rendering the thought of cessation of substance misuse as highly unappealing. In earlier research Granfield and Cloud (2001) noted that social capital tends to adhere to certain social groups and in turn affects the propensity for those communities to experience natural recovery (the ability of individuals to recover from substance misuse without formal treatment). It could be argued that the mental health community is affected in such a way, seriously reducing the availability of recovery capital and therefore negatively influencing natural recovery.

2.9. Research relating to dual diagnosis:

2.9.1. Prevalence and demographics:

Prevalence studies of dual diagnosis have formed a cornerstone of the research over the past twenty years. In the late 1980s and early 1990s researchers noted that people with severe and enduring mental health problems were more likely to have substance misuse problems than the general population (Regier et al. 1990, Drake et al. 1989). However, the majority of early research was conducted in the USA and it was not until 1996 that Menezes et al (1996) produced the first British prevalence study. Studies concluded that the odds of having a substance misuse disorder were significantly higher amongst patients with psychotic illness than people in the general population (Kessler et al. 1994 & Regier et al. 1990). Rates of dual diagnosis demonstrated in the research are subject to a number of confounding factors, including the way dual diagnosis is initially defined, the instruments used to measure the disorders, the ability of clinicians to recognise the population which is investigated, the country in which the prevalence research is conducted and the setting of the research. Table 1 shows results from a literature search for studies that gave prevalence rates for dual diagnosis. Search terms used were Dual diagnosis and prevalence, co-morbidity and prevalence and population of dual diagnosis/co-morbidity. The same search conditions were applied that were used for the wider literature search.

Table 1. Studies reporting dual diagnosis prevalence amongst people in substance misuse or mental health services:

Author(s)	**Country/setting**	Population specific characteristics	**Prevalence Rates** (Current (C) Lifetime (LT))
Kiesler et al. (1991)	USA in patients.	-	55.5% (C)
Lehmann et al (1995)	USA in patients.	-	55.9% (C)
Cantwell et al (1999)	UK	First episode psychosis	37% (LT)
Menezes et al. (1996)	UK, South London psychiatric hospitals		32% (LT) 37% (C)

Kamaili et al. (2000)	Ireland, In patients		40% (LT) 20% (C)
Mueser et al. (2000)	USA, In patients		52% (LT)
Wright et al (2000)	UK, Inner London (SMI)	SMI	33% (C)
Duke et al. (2001)	UK, Outpatient clinic		16% (LT)
Graham et al. (2001)	UK, Community-based mental health		24% (C)
Isherwood and Brooke (2001)	UK, Forensic Psychiatric inpatients	Forensic	57% (C)
Weaver et al. (2001)	UK, London adult mental health services		24% (C)
Virgo et al (2001)	UK, Dorset. (SMI) In patients, day and outpatients from mental health (MH) and substance misuse services (SM).	SMI	20% (MH) (C) 12% (SM) (C)
Weaver et al. (2003)	UK, 2 London Boroughs, Nottingham and Sheffield, Community-based mental health (MH) and substance misuse services (SM).		44% (MH) (C) 74.5%(drugs) (C) 85.5% (alcohol) (C)
Ogloff et al. (2004)	Australia, Forensic Psychiatric in patients.	Forensic	74% (LT)
Bauer et al (2005)	USA, In patients with (BP) and substance misuse	Bi-Polar affective disorder	57.3% (C) 78.4% (LT)
Bartels et al. (2006) (Meta analysis)	UK & USA, meta analytical study of publications relating to prevalence in older	Elderly (65+)	7-38% (MH)

	people (65+) in Community-based and in patient mental health (MH) and substance misuse services (SM).		21-66% (SM)

In the United Kingdom, the National Treatment Outcome Research Study (NTORS) recruited 1075 adults; 90% who were opiate dependent (Marsden et al, 2000). Participants were recruited from eight in-patient detoxification units, 15 drug rehabilitation services, 16 methadone substitution clinics and 15 methadone reduction programmes**.** Higher levels of mental distress were observed in women compared to men; anxiety in 32.3% compared to 17.5%; depression in 29.7% compared to 14.9%; paranoia in 26.9% compared to 17.1% and psychosis in 33.3% compared to 19.6%. Poly-drug use is closely linked to psychiatric symptoms in the opiate dependent population. The study is limited by its reliance on self-report and the use of a single checklist instrument to assess psychiatric symptom severity.

2.9.2. Aetiology of dual diagnosis:

Researchers (Barnett et al 2007; Drake et al 1998; Fowler et al 1998; Laudet et al 2004; Lehman et al 1995; & Regier et al 1990) have studied the aetiology of co-existing substance misuse and mental health. The earliest study into the co-morbidity of schizophrenia and alcoholism was conducted by Alterman, et al (1984). They found that there was a high degree of prevalence and suggested further research was warranted. Cuffel (1996) observed that the risk of substance misuse amongst individuals with severe and enduring mental health problems is significantly higher than in the general population. Mueser, Drake and Wallach (1998) noted that there are a number of methodological problems with studies that utilise treatment populations to study aetiology of substance misuse. They state that *Berkson's fallacy* (1949) dictates, *"Estimates of co-morbidity are inflated when samples are obtained from treatment settings, as opposed to the general population, because either disorder increases the likelihood that individuals will receive treatment."* (Mueser, Drake and Wallach 1998 p718). They go on to suggest that the order of onset, or primacy, of substance misuse or mental health is generally irrelevant since both problems develop gradually and there are *"murky findings concerning the order of onset of different disorders"* (Mueser et al 1998 p718).

A number of theories have suggested possible reasons for higher prevalence of substance misuse in individuals with mental health problems: genetic, socio-economic and self-medication theories. There is evidence that demonstrate genetic factors affect the likely onset of psychoses (Gottesman, McGuffin & Farmer 1987 & Meltzer 1982). Parental substance misuse is also a factor in the later onset and severity of substance misuse in adolescents (Walden 2005). Hambrecht and Häfner (1996) and Vanyukov et al (2003) suggest that these factors combine with other socioeconomic factors to increase an individual's vulnerability to developing psychosis. Research has identified two genetic alleles (Valene-Valene), which are most likely to be present when an individual develops psychosis having taken cannabis (Caspi et al 2005). Other research discredits genetic models (Bidaut-Russell, Bradford, & Smith, 1994; Gershon et al, 1982 & Kendler, 1985).

Another theory, which suggests an aetiological explanation for co-existing mental health and substance misuse problems, is often described as cumulative risk theory. Essentially this suggests that there are a number of socio-economic factors which individuals with mental health problems, particularly psychoses, experience which leave them more vulnerable to falling into drug using circles and therefore into substance misuse. Green et al (2007 p403) have identified the

> *"Cumulative effects of poor cognitive, social, educational, and vocational functioning as well as poverty, victimization, and exposure to deviant and/or substance-using familial and social environments, all of which are known risk factors for substance abuse"*.

This has yet to be validated through research as a theory that adequately explains the underlying high rates of substance misuse in people who have a psychosis.

Khantzian, (1985) proposed a model of self-medication as an explanation for higher rates of substance misuse in individuals with mental health problems. He suggests that individuals use substances to help them cope with negative symptoms of their mental health. Or alternatively that people with mental health problems self-medicate using drugs and alcohol to ameliorate the extra-pyramidal side effects of medication prescribed to tackle their psychotic symptoms. Mueser et al (1998 p722) have suggested that there might be a number of research studies or methodologies which would support this theory including *"(a) self-report studies in which patients describe particular substances alleviating specific symptoms of mental illness, (b) epidemiologic studies showing that patients with particular diagnoses select specific substances, and (c) studies*

showing that specific substances are used in response to specific symptoms of mental illness." However, the studies which are available (Brunette et al 1997, Dixon et al 1990, Noordsy et al. 1991 and Addington and Duchak 1997 see table 2 below) do not support any of these relationships and as discussed in section 2.9.6 (p59) studies of service users experiences suggest people use substances to cope with experiences other than the negative mental health symptoms.

Another theory suggests that individuals with mental health problems use substances to alleviate dysphoria. Research (Birchwood et al 2000, McIntosh & Ritson 2001, & Brown & Inskip 2000) has identified that individuals who experience psychosis are more likely to experience unpleasant moods and they may be at greater risk of using psychoactive substances to alleviate dysphoric mood. Whilst this seems to offer a sensible rationale for substance misuse amongst people with mental illness, it is so general that it would offer a common sense explanation for nearly all substance misuse by people with or without mental health problems.

Table 2. Research studies exploring the self-medication hypothesis of dual diagnosis

Study Author	Study population	Study Method	Findings
Brunette et al (1997)	172 community-based individuals with DSM4 diagnosis of schizophrenia	Explored the hypothesis that the severity of substance abuse and severity of schizophrenic symptoms should be linked by either of two mechanisms: self-regulation of symptoms and drug-induced exacerbation of symptoms.	Relationships were weak or nonexistent, without any consistent pattern.
Dixon et al. (1990)	83 people who were inpatients with psychotic illnesses.	Literature review and subjective experience qualitative analysis.	The most popular drugs of choice were alcohol, cannabis and cocaine. Most frequent reported reasons for use were to increase happiness and decrease anxious feelings and depression.

Noordsy et al. (1991)	75 community-based individuals with DSM4 diagnosis of schizophrenia	Qualitative study of subjective experiences of alcohol use.	Over half of the sample reported that alcohol improved social anxiety, tension, apathy, and sleep difficulties. Approximately 15% of subjects reported that alcohol did not relieve any specific psychotic symptom, with similar proportions reporting that alcohol aggravated psychotic symptoms.
Addington & Duchak (1997)	41 individuals with a diagnosis according to DSM 4 of schizophrenia	Qualitative study where subjects were asked to describe their reasons for taking drugs.	Drugs were reportedly used to increase pleasure, to 'get high' and to reduce depression rather than to medicate symptoms of illness.

2.9.3. Treatment and Interventions in dual diagnosis:

Policy documents in the UK (DH 2002, DH 2006, NICE 2011) suggest that integrated care offers the best prognosis for individuals with severe mental health and substance misuse problems. Integrated care is defined as: an individual receiving treatment from a single team or individual for both their substance misuse and mental health problems. The evidence for integrated care is almost wholly taken from research conducted in the USA that has found that parallel treatment or sequential treatment tends to have less favourable outcomes (Drake et al 1998, McHugo et al. 2006 & Ridgely et al. 1987.). Integrated treatment concepts developed in the USA in the 1980s, predominantly in recognition that people who presented with a dual diagnosis did not tend to receive holistic treatment for their substance misuse and mental health problems. Individuals would instead be allocated to either a drug treatment or mental health system and be viewed and treated within the cultural context of the system they ended up in. Little planning or accurate clinical assessment appeared to affect this. This is similar to the UK and pervades today.

Drake et al (2007 p123) suggested that integrated treatment tends to offer two distinct advantages:

- Improving access by ensuring that mental health and substance abuse services are available in the same setting.

- Improving individualization and clinical relevance by combining and modifying the two types of interventions in a coherent fashion.

Studies have noted the treatment barriers to integrated care (Ridgeley et al. 1987) including organisational issues, the culture and language of the treatment system and professional boundaries, which prevent adaptation of working practices. Despite advocacy for integrated treatment systems, research has only demonstrated modest treatment benefits (Brunette et al 2004) and some UK researchers have suggested that there are significant system and cultural barriers to integrated care in the UK (Graham et al 2003). UK policy (DH 2006 & 2002) suggests that mental health services will be the most likely treatment setting for individuals with severe mental health problems and that clinicians in these settings should adopt a *"flexible and adaptive therapeutic response (which) is important for the integrated management of these dual conditions"* (DH 2002 p21).

Prior to the 1990s there was little or no research into psychosocial interventions that might be adapted to this service user group (Ridgeley et al. 1987). However, ten years later a number of post treatment studies have identified the benefits of tailored psychosocial interventions for this group. In 2008, Cleary et al produced a systematic review of psychosocial interventions for people with both severe mental illness and substance misuse. The review used the Cochrane Systematic trials register and included all randomised controlled trials (RCTs) comparing psychosocial interventions for substance misuse with standard care in people with serious mental illness. The Cochrane review (Cleary et al. 2008) included 25 RCTs covering interventions that included: integrated and non-integrated care; motivational interviewing plus cognitive behavioural therapy/interventions (CBT); motivational interviewing alone and CBT alone. Motivational interviewing and CBT combined offered no significantly beneficial outcomes for retention in treatment, relapse or reduction of substance misuse. Motivational interviewing did positively affect the number of people attending their first aftercare appointment and had some affect upon consumption of alcohol, but not other substances. CBT alone showed a significant reduction in the number of people who dropped out of treatment but offered no significant effect upon reduction in

cannabis use, overall reduction of substances used or positive effects on mental health. Overall the authors conclude that they found *"no compelling evidence to support any one psychosocial treatment over another to reduce substance use (or improve mental state) by people with serious mental illnesses"* (Cleary et al 2008 p2). A number of methodological difficulties were noted: high dropout rates from studies, poor fidelity to treatment models and paradigms, variety of outcome measures and considerable variation in treatment and research settings. Another Cochrane review conducted in 2013 by Hunt et al analysed 35 RCTs and also concluded that there was no compelling evidence to support any one psychosocial treatment over another.

Drake et al (2007) observed *"No interventions show consistent results on mental health outcomes, although legal interventions improve treatment attendance"* (p 127). Their overall results reflect those found in the Cochrane reviews though they note positive outcomes in long-term residential treatment. No research has been conducted into residential treatment in the UK, possibly because there is a paucity of residential care specifically aimed at this group and the cost of placement at those few residential rehabilitation programmes, which accept and provide specific treatments for individuals with co-existing problems, is prohibitively high for many.

2.9.4. Treatment outcomes in dual diagnosis:

A number of studies have shown that treatment outcomes: symptom levels, hospitalisation rates, housing stability, and functional status, are worse in general psychiatric settings among people with dual diagnosis than among people with mental health problems who do not take substances (Drake et al. 1989; Drake et al. 2007, Linszen et al. 1994; Osher et al. 1994; Chouljian et al. 1995; Swofford et al.1996).

There is a paucity of research that quantifies treatment outcomes for individuals who receive integrated dual diagnosis interventions, whether through specialist teams or from mental health or substance misuse services (section 2.9.3 p49 for a discussion of integrated care). Jerrell & Ridgeley (1999) examined the robustness of treatment delivery and its effects upon outcomes for this group over an 18-month period. The longitudinal study compared three treatment modalities: behavioural skills training, case management, and a 12-step recovery model among 132 people. The quality and robustness of treatment programmes appeared to affect treatment outcomes and related treatment costs. The study

concluded that the type of treatment delivered was less important than its robustness. We might assume by robustness the authors mean fidelity to the treatment model and assertiveness in delivery, but they lack a specific definition.

Drake et al (2006) reported six recovery related outcomes, identified by dual diagnosis service users with co-occurring schizophrenia and substance use disorders:

- Absence of clinically significant psychiatric symptoms.
- Having attained late substance misuse treatment stages (Osher and Kofoed 1989).
- Living independently with evidence of community integration.
- Working in competitive employment, contracted with the individual directly and which is not supported.
- Regular contact (at least weekly) with non-substance misusing friends.
- Expression of general satisfaction with one's life is an indicator of quality of life (> 5 on the 7-point QOLI global satisfaction rating (After Lehman 1988)).

This study evaluated ten-year outcomes for 130 individuals with a dual diagnosis and found they were positive for a significant proportion of the study group improving steadily between years 3 and 10 throughout their research. They note that there were some outcomes which whilst stable from 0-3 years improved after the third year, concluding that there is longitudinal improvement in positive outcomes over a number of years for individuals with a dual diagnosis. This reflects conclusions made in previous research (Drake et al. 1998 & Drake et al. 2000).

Drake et al (2006) recognise that the study group may not be representative, or their results generalisable due to the developed treatment systems for dual diagnosis in New Hampshire. They note that there are weak relationships between their outcomes other than quality of life and psychiatric symptoms. Citing Diener (2000) Drake et al (2006 p 471) note that using subjective measures of quality of life are controversial, as they *"tend to be stable over time as people readjust their own expectations"*. The authors observe that they do not attribute the improving outcomes to integrated dual diagnosis treatment. There was a general culture change of mental health services during their study period, which placed increasing importance on recovery and facilitated greater social

inclusion in all mental health service users including the study group. New Hampshire has seen comprehensive development of social inclusion and in particular competitive employment, which may offer an explanation for the increase in positive outcomes identified. Importantly their study recognised the potential for positive long-term outcomes for this group despite attitudes to the contrary from some clinicians.

Morse et al (2006) looked at costs and treatment outcomes for 149 homeless individuals with dual diagnosis, over 24 months. They studied three treatment paradigms: Integrated Assertive Community Treatment (IACT); Assertive Community Treatment only (ACT) and standard care (SC) (as a control) to see which offered the most superior outcomes and cost. They noted that their study produced *"some data which indicate that integrated treatment combined with assertive community treatment probably costs no more than standard care, yet provides better outcomes for dual disorder clients."* (p397). Whilst they observed no significant benefit and difference between IACT and ACT in terms of improvement in substance misuse and psychiatric symptoms; study participants reported greater satisfaction with the IACT and ACT treatment system. Agreeing with Drake et al (1998, 2000 and 2006) that a longitudinal perspective is vital when viewing treatment outcomes for this client group; Morse et al. (2006) suggest that 24 months is too short a period to sensitively detect positive treatment outcomes. Their conclusions appear to reflect other studies that highlight outcomes for this group should be measured over a period of 3 to 10 years.

2.9.5. Cannabis and mental health:

Research has begun to focus upon the effect of cannabis on mental health. This may be partly explained by the increasing acceptability of the drug and its increasing use by a diverse range of people including those who have mental health problems. *"Six major studies following users over a number of years have linked cannabis use to the development of psychotic symptoms"* (Revill & Bright 2005). Considerable interest in the effect of cannabis upon mental health resulted in three major longitudinal cohort studies providing the backbone of evidence: Zammit et al (2002), Arsenault et al (2004) and Henquet et al (2005). Johns (2001 p120) states that *'controversy remains about whether cannabis use can actually cause schizophrenia or other functional psychotic illness in the long term.'* Johns (2001) goes on to classify five ways in which cannabis may cause or affect psychosis:

- Acute use of large doses of the drug may induce a toxic or organic psychosis with symptoms of confusion and hallucination, which remit on abstinence.
- Cannabis use may lead to an acute functional psychosis, similar to an acute schizophreniform state and lacking the organic features of a toxic psychosis.
- Cannabis use may lead to a chronic psychosis, which persists after abstinence.
- Long-term cannabis use may lead to an organic psychosis that only partially remits after abstinence, leaving a residual deficit state, sometimes called an a-motivational syndrome, which is thought to be analogous to the chronic organic brain syndrome seen after prolonged misuse of alcohol.
- Cannabis use may be a risk factor for serious mental illness such as schizophrenia.

(Johns 2001 p118)

Subsequent studies have concluded the latter hypothesis is the most likely.

Henquet et al (2005) used data from The Early Developmental Stages of Psychopathology (EDSP) study (Lieb et al 2000). The data was from a baseline survey in 1995 (3021 participants) and a four-year follow up in 1999 (2548 participants) of a sample randomly drawn from the population registry of the city of Munich and 29 counties. The author's (Henquet et al 2005) hypothesis was that *"Individuals may start using cannabis because of a predisposition for psychosis rather than cannabis use causing expression of psychosis"*. This study is the first to conclusively test the self-medication hypothesis. The authors include details of their statistical power calculation confirming that the study size was adequate to prove their hypothesis.

Arsenault et al (2004) analysed data from the Dunedin Multidisciplinary Health and Development study (Silva and Stanton 1996). Data was obtained from a representative group of 759 living study members from a birth cohort taken in Dunedin in New Zealand between 1972 and 1973. Each of these individuals had a complete set of data relating to psychiatric outcomes, adolescent use of illicit substances and childhood psychotic symptoms. There were three study groups

based upon cannabis use at ages 15, 18 and a control group who reported never using cannabis (or only once or twice). Arsenault et al (2004) hypothesise that adolescent cannabis use is a consequence of pre-existing psychotic symptoms rather than a cause.

Zammit et al (2002) studied a cohort of 50,087 conscripted, Swedish men who were surveyed using non-anonymous structured interviews. The interviews included questions on family and social issues, adolescent behaviour and substance use including first drug use and frequency of use. Follow up data was gathered from the Swedish national hospital discharge register 1970 to 1996. The authors observed that the incomplete nature of this register is unlikely to affect their results, as coverage was no lower than 95% and as high as 100% between their study dates. This research draws its hypothesis from previous work completed by the same authors (Andreasson et al 1987) seeking to develop that work and dispel critical reviews. Their hypothesis was that cannabis might be an independent risk factor for schizophrenia. They sought to dispel previous uncertainties that the results of the 1987 study were confounded by several factors, including that the observed phenomenon may be attributable to drugs other than cannabis.

Zammit et al (2002) recognised a variety of factors, which may have biased their results including pre-morbid personality traits and effects (particularly on mental health) of other drugs consumed, such as amphetamine. A variety of statistical methodology was used to factor out confounding or potentially confounding variables. However, critics of this research have pointed out that these confounding factors and other factors which can also cause mental health issues cannot always be adequately accounted for and that they may lessen the power of the association between cannabis and mental health (BBC 2005).

Previous research on this topic (Thornicroft et al 1990 and Andreasson 1987) has concluded that the developments of longitudinal population-based cohort studies were needed to establish the nature of this phenomenon. Studies of this nature provide data of a temporal association between exposure and outcome (Greenhalgh 1997). This is more appropriate than a cross sectional study because of the aetiology of psychosis. The studies used similar methods to gather their data, structured or semi- structured interviews. All of these studies have reasonably large cohorts with Zammit et al (2002) being significantly larger. The

hypotheses of all the studies suggest an attempt to measure a common phenomenon and are based upon a clear awareness of previous research from literature reviews.

An important factor concerning the topic and methodology of these studies concerns axiological issues. It is important to understand that all of the authors in these studies have a medical background and as such may be affected by the bio-medical model (Bowling 2002) in particular the disease concepts of mental ill health. Whilst this may lead the authors into a bias towards disease-based theory on the affects of cannabis on psychosis all of the studies recognise that there may be other factors, including behaviours, which influence the development of cannabis problems and associations with mental ill health. Issues of causality in relation to cannabis use and psychosis are discussed at length by Arsenault et al (2004) and are relevant to all of the studies. Causality is at the basis of the association between consumption of cannabis and effects on mental health. In effect Arsenault et al (2004 p110) observe, *"When a putative cause is present the outcome rate is higher than when the putative cause is absent"*. All of the studies succeed in demonstrating this causal association to a greater or lesser extent and are clear in defining the causal associations.

Henquet et al (2005) stated that their study population was sufficiently randomised, although criticism of the study has suggested otherwise (Fox 2004). It is important to note that the ethical considerations of the Henquet et al. (2005), Arsenault et al. (2004) and Zammit et al. (2002) studies rendered randomised controlled trials (RCTs) unethical because they could not reasonably *"expose some adolescents to cannabis and others to a suitably equivalent placebo hazard"* (Caan 2004).

With the Swedish conscript study (Zammit et al 2002) the population was not randomised. However, the article gives a clear explanation for this, it is a conscript study, and all Swedish men in their cohort went through compulsory military training between the ages of 18 and 20. At conscription, 2-3% of the population are excluded due to pre existing mental health and learning disabilities. Whilst the authors suggest this is not a significant number of individuals the exclusion of this part of their population affects their results because they exclude a group who may offer important evidence in the causal link. They only measure drug-induced psychosis (which is part of their original

intent) but by excluding this group they omit the opportunity to measure the potential effects of cannabis on individuals with pre-existing psychoses. Henquet et al (2005) and Arsenault et al (2004) overcome the limitation of the Swedish study by examining psychotic symptoms at a much earlier age.

There are difficulties with the data obtained by Zammit et al (2002): the first was the self-report questionnaire was not anonymous and could have affected reporting of drug use by participants. Conversely Henquet et al (2005) obtained data using anonymised questionnaires. However, data was obtained at interview, which may have affected the willingness of participants to disclose information about illicit drug use to the researchers. They excluded 90 participants who elected not to disclose information. This is important if we assume that those individuals elected not to answer the questions because they were engaged in significant drug use and were concerned about reporting it.

The Arsenault et al study (2004) omits to report data on their control group and therefore there is no information available on whether the psychiatric effects noted in other groups were present. This is significant for the findings since evidence of psychosis in the control group would undermine the causal relationship of cannabis and psychosis that they observed. It seems an oversight that this information is omitted. In the reported data from the Arsenault study (2004) there are some wide confidence intervals (1.84 to 70.45 under schizophreniform disorder in Schizophrenia outcomes), which suggest that the study may be underpowered to explore the association between cannabis and psychosis in adolescents. The authors point out:

> *"In addition, onset of cannabis use by age 15 years was associated with an increased likelihood of meeting the diagnostic criteria for schizophreniform disorder at age 26 years, 10.3% of cannabis users aged 15 years in this cohort were diagnosed with schizophreniform disorder at age 26 years, as opposed to 3% of the controls"* (Arsenault et al 2004 p113).

The data they present supporting these findings appears too small to conclude this is a real effect.

The conclusions from these studies have factors in common. They all found the likelihood of developing a psychosis in later life is significantly increased if

cannabis is taken early on. They conclude that early cannabis use is associated with schizophrenia rather than other psychotic illness such as bipolar-affective disorders. The authors observe their findings are *"in keeping with accumulating evidence that cannabis has detrimental effects on mental health in some people"* (Zammit et al 2002 p1198). Arsenault et al (2002 p1213) state that "*early cannabis use (by age 15) confers greater risk for schizophrenia"* and that *"risk is specific to cannabis use as opposed to use of other drugs"*. Both of these studies state they adequately proved their hypothesis. Henquet et al (2005 p2) find that their data refutes their hypothesis that self-medication forms a *"base line predisposition for psychosis"*. However, they state that there is evidence in their data, which reinforces the findings of previous studies, including the other two studies discussed. Hall (2014) in conducting a meta analyses of the past twenty years of studies into cannabis and psychosis demonstrates that frequent cannabis use in adolescence doubles the risk of psychosis and cognitive impairment in adulthood, especially if there is familial predisposition to psychosis.

Each study concludes that their findings suggest cannabis consumption amongst groups vulnerable to schizophrenia should be discouraged. In reality though, identifying the individuals most at risk is difficult. Rapidly changing cultures mean people are becoming increasingly polarised in their views about cannabis. Some are tolerant to cannabis use and advocate liberalism and legalisation, others are increasingly intolerant advocating discouraging and criminalising cannabis use. The media, reinforcing social constructs that are reflected in policy, plays out these polarities.

Later research has tended to focus on the neurophysiological effects of cannabis on the brain (Skosnik et al 2006) and the genetic factors and risks associated to cannabis use (Caspi et al 2005). Skosnik et al (2006 p1798) claim that their results *"adds support for a cannabinoid link to schizophrenia spectrum disorders"* because people in their study that took cannabis *"exhibited altered neural synchronization"* (p1801). Skosnik et al (2006) suggest that their findings are consistent with other studies of this type. Whilst their study methodology used objective measures (EEG tests) to explore differences in neural synchronisation their selection criterion for study participants was based upon self-reported cannabis use suggesting that inaccuracies in estimated drug use, patterns of cannabis use, frequency, use of other substances and time of last use of cannabis

are possible. The authors also suggest that a possible explanation for their observation is the effect of cannabis on attention, which may be a confounding factor. Their study population of 17 lacks the necessary statistical power to be able to generalise their results. Whilst the studies provide some interesting insights they are far from conclusive about the effect of cannabis on the brain and the potential psychosis inducing effects.

In the majority of individuals, cannabis does not have lasting psychotic effects. However, Caspi et al (2005) have noted that certain genetic-allele groups may predispose individuals to the psychotogenic effects of cannabis. This study identified an enzyme (catechol *O*-methyltransferase (COMT)) which is important in the metabolic degradation of dopamine and which has been shown to have a weak effect on adult development of psychosis (Lewis et al. 2003). COMT appears to moderate the influence of adolescent cannabis use on the development of adult psychosis, with a five-fold increased risk of developing schizophreniform disorder in cannabis users with the high activity Val-allele (Caspi et al. 2005). Referencing this study and others mentioned in this section DiForti & Murray (2005 p186) conclude that:

> *"Cannabis is not a necessary cause of schizophrenia in that most individuals with the illness have not smoked it. Neither is cannabis a sufficient cause in that most cannabis users do not develop schizophrenia. However, the available evidence indicates that cannabis acts as a component cause and part of a constellation of causes including genetic predisposition."*

Research concurs that excessive cannabis use poses significant risk to individual's mental health. In some the effects are short lived and transient but with others it is significant and potentially chronic. Determining who might be most at risk is fraught with difficulty.

2.9.6. Mental health service users' experiences and attitudes:

The reality of drug and alcohol consumption is that the objective effects and subjective experience of imbibing a substance are dependent on a number of factors. Zinberg's (1984) *Drug* (the substance), *Setting* (the environment and environmental factors at the time of consumption) and the *Set* model (or the individual's other multitudinous personal circumstances), encapsulates this and underscores Gossop's (2000, p14) perspective that:

'....specific drugs have fixed and predictable effects which are the same from person to person is extremely widespread, but it remains a fallacy'

The point these authors make is that the drug is only one factor influencing the drug experience so therefore '*set*' factors such mood and mental health are significant in affecting drug experience. Viewed in the light of these complex factors affecting a drug taking experience an individual's *attitude* to intoxication or substance taking is also affected by a variety of factors including their mental health (Test et al. 1989; Dixon et al.1991). This consequently affects numerous choices they make including: their drug of choice, their attitude towards treatment and the extent to which they believe drinking or drug taking affects their mental well-being. Some studies differentiate between individuals who take substances to control negative symptoms and those who use drugs and alcohol as a means of social inclusion (Spencer, Castle and Michie 2002). Experiences of intoxication vary from person to person; in turn this affects an individual's understanding of controlled consumption and hence their ability to control substance use (including recreational or non-problematic use). Society's attitudes towards substances and intoxication have a concomitant effect on mental health and substance misuse treatment provider's attitudes and understanding of substance misuse and mental health issues, which may compound an attitudinal effect on the individuals who experience mental health problems and who take substances. Evidence has demonstrated that perceived negative attitudes by individuals have a negative effect on engagement and are a factor in poor recovery rates (Ahern, Stuber & Galea 2007).

A number of studies explore the attitudes of service users with a psychosis towards substance misuse (Test et al. 1989; Dixon et al.1991; Warner et al. 1994; Baigent et al. 1995; Addington & Duchak 1997; Fowler et al. 1998; Laudet et al 2004 and Cruce, Öjehagen and Nordström 2008). Some of the studies presented subjects with an *a-priori* list which they used to select their reasons for drug taking/drinking (Test et al. 1989; Dixon et al. 1991; Warner et al. 1994; Addington and Duchak 1997) other studies used semi-structured interviews with open-ended questions (Baigent et al. 1995; Fowler et al. 1998; Laudet et al. 2004 and Cruce, Öjehagen and Nordström 2008). Those studies that provided participants with a list might be criticised for bias. Options, likely reasons for substance misuse, based upon pre-supposed criteria and generated by the researchers were presented to participants, preventing the capture of free

narrative. Studies using a semi-structured interview methodology might be less biased as narrative was captured. However, pre-structured questions may also bias the participant's response by offering a degree of direction. Despite the significant methodological differences there was consensus in the results in these studies highlighting three main reasons for substance misuse in their participants:

- To enhance positive mood or get "*high/stoned"*.
- To cope with negative emotions (depression, stress).
- Using for social reasons or as access to a social group.

Laudet et al. (2004) used a semi-structured interview schedule to study the experiences of three hundred and ten individuals, all who attended a 12 step orientated 'Double Trouble' Recovery (DTR) group in New York city. The majority of their study participants had either a diagnosis of schizophrenia, major depression or bipolar affective disorder. Self reported substances used across their participant's lifetimes were: crack/cocaine (42%), alcohol (34%), heroin (11%), marijuana (10%), and other substances (3%). The aims of their study were:

- *To examine stated reasons for initiation of and relapse to substance use,*
- *To examine reasons and strategies used for quitting, and*
- *To explore the perceived association between substance use and mental illness among a large sample of persons with co-occurring SMI and SUD.*

(Laudet et al. 2004 p365)

Cruce, Öjehagen and Nordström (2008) also conducted semi-structured interviews but with a much smaller study population of eight individuals who had a Severe Mental Illness (SMI) and a concurrent Substance Use Disorder (SUD). Their objective was to try to *"gain a greater understanding of how individuals with a co-morbidity of SMI and SUD experience the roles alcohol and other drugs play in their health and in their life situation"* (Cruce, Öjehagen and Nordström ibid p229). Of the eight individuals they interviewed three had alcohol problems, one had a problem as a result of benzodiazepines and the remaining two participants were poly-drug misusers (amphetamine, heroin,

cannabis, cocaine and alcohol). Their findings showed that participants reflected the three main self-reported positive reasons for taking substances outlined above. They found that participants believed that the substances they took had led to their severe mental illness. This finding was reflected in previous research conducted by Laudet et al. (2004). All the participants in the Cruce, Öjehagen and Nordström (ibid) study either found it difficult to accept the identity of being 'mentally ill' or perceived that mental illness implied a low status, weak identity and was disempowering. The study found that the label of 'addict' was more desirable due to the relationship promoting effects of substances. Participants noted that alcohol and drugs tended to have a positive effect on their experiences of themselves. Drugs helped them feel well and provided motivation to do and achieve that was otherwise absent when they stopped taking drugs. Participants rationalised that drug and alcohol taking was a reasonable coping mechanism for the otherwise debilitating symptoms of their severe mental illness.

Some studies develop these themes and apply a cognitive motivational model for substance misuse to this population based upon Cox and Klinger's motivational model of alcohol use (1988 cited by Cooper 1994). Research conducted by Mueser et al. (1995) criticised the qualitative studies mentioned previously for their lack of validity in expressing the participant's ability to articulate their reasons for substance misuse. Mueser et al. (1995) instead propose that there is a strong link between expectancies and motives for substance misuse in individuals with a psychosis. Their study established the internal reliability of an adapted Drinking Motivations Measure (DMM) (after Copper 1994) which they called the Drug Use Motivations Measure (DUMM, Mueser et al. 1995) which they applied to 70 individuals who were diagnosed with schizophrenia or a schizoaffective disorder. The study concluded,

> *"… In schizophrenia and schizoaffective disorder, where there is a high rate of both alcohol and drug use disorders, strong substance-specific expectations may be present"* (Mueser et al. 1995 p377).

This seems to suggest that individuals who experience mental health problems could be using the substances for a specific purpose to ameliorate the effects of a given set of symptoms.

Spencer, Castle and Michie (2002) argued that as a result of Mueser et al. (1995) study there is strong evidence that a motivational model offers some explanation for substance misuse amongst individuals with a psychosis. They go on to

remonstrate that Meuser et al (2005) fail to associate the potential for substances of abuse to alleviate symptoms of both an individual's mental health problem and/or symptoms associated with negative side effects for prescribed anti psychotics (after Khantzian's (1985) theory of self-medication). Spencer, Castle and Michie (2002) argue that if the presence of cognitive motivations, including ideas associated with self-medication, are present in this study group then treatments such as relapse prevention and motivational interventions are indicated as valid. They suggest that motivators for substance misuse *"may be the mediator between symptoms and substance misuse—that is, the means by which symptoms exert their influence on substance misuse"* (Spencer, Castle and Michie 2002 p234). Their study goes on to explore the:

- Reasons for substance use among individuals with psychotic disorders to explore the use of substances to alleviate psychotic symptoms (positive and negative) and sequelae of the disorder, including medication side effects;

- Influence these motives for use have on the quantity, context, problems, and dependence associated with substance use; and

- Role of motives as mediating the relationship between mental health symptoms and problematic substance use.

(Spencer, Castle and Michie 2002 p235)

They found that there is a strong link between the amount of substances used *"to cope with unpleasant affect or to enhance positive affect"* (Spencer, Castle and Michie 2002 p243) and that increased use as a coping strategy was closely linked with eventual dependency upon the substance. They conclude that people with psychosis who take substances have a strongly positive perception of the effect of substances on their mental health problems.

> *"Psychotic disordered individuals who use alcohol or cannabis to cope with unpleasant affect have a higher readiness to change their use than those who use for social or conformity purposes, enhancement, or relief of positive symptoms and side effects."* (Spencer, Castle and Michie 2002 p244).

This suggests that motivational enhancement interventions are likely to offer significant treatment benefits to those individuals who use substances to cope as

opposed to those individuals who see substances as a device for social engagement.

In 2004 Rethink, completed the report "*Living with severe mental health and substance use problems".* Research interviewers experienced in managing mental health problems or experiences as mental health carers interviewed 28 individuals, 15 carers and 13 people with dual diagnosis. The report noted the heterogeneous nature of both the service users and carers and the impact that substance misuse had upon the general chaos present in the lives of the study participants.

Participants identified six areas where dual diagnosis impacted upon their lives:

- The diagnosis process helping and hindering recovery. In particular diagnosis as a key to accessing specialist services but also as a factor in stigmatisation.
- Problems arising from management of dual diagnosis.
- Difficulties arising from living with dual diagnosis. The positive well being enhancing effects of substances but negative effects on finance, impact on lifestyle and reduced quality of life.
- Health impacts of dual diagnosis. Low self-esteem, loss of motivation, stress, anxiety, pessimism and guilt.
- Social impacts of managing mental health and substance use. In particular negative effects on their relationships with family and others, inability to obtain employment and their involvement with crime to fund drug and alcohol addictions.
- Financial pressures. (Rethink 2004)

The report concludes that *"The lives of both users and carers were characterised by a series of losses: loss of an ordinary everyday life, loss of social networks, including loss of friends and family, loss or inability to obtain employment and loss of financial security."* (Rethink 2004 p61). This reinforces that dual diagnosis has far greater impact than simply those symptoms and experiences attributable to drugs and mental health. The Rethink study (2004) is the first study to consider a sociological explanation for dual diagnosis based in social deprivation, trauma, poverty and loss. Whilst the impact of mental health on an individual is profound and broad dual diagnosis may deepen individual's loss and render improvement and recovery even more difficult to achieve.

The significance in appreciating individual's experience of their substance misuse and its effects on their life and their mental health cannot be underestimated. Laudet et al. (2004) underline the reasons why many of these studies that explore individual's experiences are important *"The effectiveness of therapeutic interventions is likely to be enhanced if the field can gain a greater understanding of the causes of substance abuse"* (p366). Both Laudet (2004) and Rethink reinforce that narrative accounts of individual's experiences of dual diagnosis may aid a deeper understanding of the depth and breadth of their problems and experiences and offer service providers insight into what constitutes positive help and treatment.

There are a number of shortcomings with the studies mentioned above, the most critical being issues associated with diagnosis of substance misuse. It is common for substance misuse, in this heterogeneous group in the UK, to go undiagnosed, or to be present at levels that do not warrant a formal diagnosis of substance misuse (Graham et al. 2003). All of the studies establish clear inclusion criteria based upon DSMIV diagnostic criteria of psychosis, inclusion criteria for substance misuse problems are less defined. Some studies have used DSMIV diagnostic criteria for substance misuse (Addington & Duchak 1997; Cruce, Öjehagen and Nordström 2008), others self-reported lifetime use of substances (Test et al. 1989; Spencer, Castle and Michie 2002) some complete remission from substance misuse (Laudet et al. 2004) and others, practitioners subjective assessment of probable substance misuse (Fowler et al. 1998). Whilst use of DSMIV diagnostic criteria can be seen as empirical the other inclusion criteria are subjective assessments of substance misuse and therefore open to bias. As much of the research on staff attitudes demonstrates, problem substance misuse criteria are likely to be viewed and applied differently. Laudet et al. (2004) study population inclusion criteria may be biased; subjects attended an Alcoholics Anonymous based DTR group, which by definition requires the attendee to accept they have an addiction. A significant factor in determining an individual's experience of substance misuse is fundamentally affected by their pre-existing attitudes, experiences, insight and perceptions of their mental health and/or substance use. Mueser et al. (1995) comment on the validity of some of the qualitative studies is in essence questioning the studies' representation of this fact. This is important because such attitudes can affect the acceptability to the individual of the type of intervention they request or whether they believe they need help at all.

2.9.7. Service provider and carer attitudes:

There is a body of evidence (Adams 2008, Billings et al. 2003, Coombes and Wratten 2007, Deans & Soar 2005, Foster & Onyeukwu 2003, Maslin et al. 2001 and Ryrie & McGowan 1998,) that explores the attitudes of staff providing services to people with dual diagnosis. The observer's perspective and their attitudes; be it the attitudes of diagnosticians, service providers, carers or the attitudes of the wider public; are important as they often generate stereotypes or prejudice towards people who experience dual diagnosis. A number of authors (Adams 2008, Coombes and Wratten 2007 & Deans & Soar 2005) have noted that the negative perceptions of staff and service providers, especially the lack of optimism for improvement or recovery, affect the way in which services are provided. It is probable that this subsequently affects whether a service user successfully engages with services. Adams (2008 p106), in exploring the attitudes of staff offers the tentative hypothesises that:

> *"Lower optimism among mental health professionals who conduct assessments and 'gate keep' services contributes to system failures."*

Critically this reinforces the need for providers to demonstrate optimism and hope for recovery and underscores optimism as a factor that positively influences recovery. Narrative accounts of service providers' experiences may offer insight into the positive influence optimism has or the negative effect its absence might have on service users experiences and recovery.

Studies note the high prevalence of people with dual diagnosis on case loads estimated by staff (Coombes and Wratten 2007, Maslin et al 2001 and Ryrie & McGowan 1998). Adams (2008) states a number of researchers conclude health professionals have stereotypical attitudes towards people with substance misuse problems. There is a lack of concordance across the literature about the level to which mental health staff have positive and/or negative views towards this service user group. Deans & Soar (2005) identify significant levels of negativity towards dual diagnosis clients. They found low levels of training in substance misuse coupled with negative experiences in clinical settings and a subsequent lack of skill in working with this group contributed significantly to negative perceptions. Lack of training and its impact upon skills is noted to be a significant factor in influencing staff attitudes in some articles (Adams 2008, Coombes and Wratten 2007, Maslin et al. 2001 and Ryrie & McGowan 1998). Richmond and Foster (2003) have noted that mental health staff who undertook postgraduate training tended to have significantly better attitudes and much higher optimism

about the effect of treatment than their colleagues who had undertaken undergraduate training or had no training.

Aside from the impact which training has had upon attitude, Coombes and Wratten (2007) observe that staff generally find the term 'dual diagnosis' confusing and unhelpful in their practice. The study noted that even when nurses engaged with 'dually diagnosed' service users the support, desire to share work and understanding they received from colleagues was poor. They also found that staff felt that this type of work was time consuming, and the impact on their capacity poorly tolerated by colleagues. Staff involved in this study consistently commented on service user's lack of motivation to change and the powerlessness they perceived in treating substance misuse problems in this group.

Literature has determined that practitioners' perceptions of substance abuse are significant in affecting service delivery and outcomes. Clinicians can experience frustration, resentment and powerlessness when working with the dually diagnosed. Negative attitude seems to be a function of stereotype and stigma (Deans and Soar 2005), which is important context to this study and worthy of further exploration.

2.9.8. Stigma:

In the preface to his book 'Stigma' Erving Goffman (1963 p9) describes stigma as:

> "*The situation of the individual who is disqualified from full social acceptance"*

Goffman goes on to clarify that the 'modern day' literal use of stigma is akin to that of the ancient Greek original, where *"bodily signs were designed to expose something unusual and bad about the moral status of the signifier"*… *"But* (in modern parlance) *is applied more to the disgrace itself than to the bodily evidence of it"* (p11). He defines three types of social stigma:

1. Overt or external deformations such as scars and other physical manifestations.
2. Deviations in personal traits, including mental illness, drug addiction, alcoholism and criminality.
3. Traits or tribal stigmas of an ethnic group, nationality or a religion that is deemed to be a deviation from the prevailing norm.

Having established that the recognition and assessment of dual diagnosis is important in engaging service users and treating them it is also important to note that labelling can simultaneously create positive consequences through treatment but negative outcomes as a result of stigma (Rosenfield 1997). Research has demonstrated that adults stigmatise people with mental health and alcohol problems much more harshly than other health conditions (Corrigan et al 2005).

Stigma can significantly and negatively affect the lives of individuals with mental health problems (Link et al 1989). Some authors emphasise that the effect of stigma on people with mental heath problems are both limited and fleeting. Gove (1982) has suggested that the effect of stigma is minimal because mental health treatments are effective. Alternately Goffman (1963) has argued that the positive effects of psychiatric treatment are few due to the negative and dehumanising effects of stigma in institutions. Whilst treatment may have effective outcomes, stigma as a consequence of mental health problems is a significant barrier to education and employment (Link et al 1982 & 1989). Stigma negatively affects social interactions and social networks for individuals with mental health problems (Harris et al 1982; Link et al 1989).

Studies have noted that the extent of stigma and the degree to which it affects the stigmatised varies. Probably one of the most interesting differential stigmas is highlighted by Cruce, Öjehagen and Nordström (2008): service users perceive that the label 'addict' has fewer negative connotations than other labels like 'psychotic' or 'mentally ill'. This is a function of social constructs of substance misuse that increasingly portray some drug use, by celebrities and rock stars for instance, as glamorous and socially acceptable.

In drug cultures the type and manner of drug use leads to differential stigma. Drugs such as cocaine powder, snorted or taken orally by wealthy individuals or celebrities, carries a different stigma to injected heroin or crack cocaine amongst poor individuals or people who are marginalised in other ways (Jones et al 1984). There is a comparative difference in stigma between genders as a result of substance misuse. Lisansky-Gomberg (1988 p507) states that:

> *"While socially deviant behaviour is clearly unacceptable, regardless of sex, it is widely held point of view that social attitudes towards such behaviours (delinquency, alcohol and drug abuse, etc.) are more negative when manifest by women"*

Lisansky-Gomberg (1988) has noted that young females who drink alcohol heavily are a particularly disapproved combination. Alcohol use by younger women raises significantly more social concern and hostility than in similarly aged young men. This is of significance because her research has noted that younger alcoholic women tend to feel more stigmatised and subsequently disengage from relationships and avoid non-drinking friends. The result of social isolation carries its own risks of increasing psychological problems and poorer mental well-being. One contemporary social construct that underpins differential stigma of different aged female drinkers, results from the situations that younger women drink in and the resulting public displays of intoxication that are seen or perceived by society. Older female heavy drinkers tend to drink at home in socially isolated settings where as younger women are more liberal in their attitudes to heavy drinking and increasingly consume alcohol much more publically.

Stigma within families towards family members with mental health problems has been found to affect recovery outcomes for the individuals concerned. Markowitz, Angell and Steenberg (2011 pp160) observe that:

> *"Perhaps critical comments from relatives induce shame that is directly internalized by the ill family member, thus leading persons with mental illness to think and act in ways that inhibit recovery."*

Rejection by other people as a result of stigma, and the expectation of rejection due to stigma, can cause heightened levels of stress and lead those who are stigmatised into using coping strategies such as withdrawal and isolation, that negatively influence mental health and wellbeing (Ahern, Stuber & Galea 2007). The impact stigma has upon access to healthcare for drug users is significant. Cunningham et al (1993) have noted that perceived and actual stigma will prevent some drug users from accessing treatment; this is particularly evident in certain groups; mothers of children, pregnant women and minority communities. Research has also found that when drug users seek treatment or help they often experience stigma or discrimination from the healthcare agencies they attend and as a result experience poorer quality care and help (Miller et al 2001).

Researchers argue that stigmatisation of heavy drinking and drug use presents a rational approach to public health messages (Schomerus et al 2010). However, drinking alcohol in itself is not stigmatised by mainstream British society, in fact drinking in bars is seen as an institution and normal behaviour in the UK. Room

(2005) observes that drinking can be seen as a signal of power and status in western civilisations. Stigmatisation that results from misinformation and prejudice cannot be ignored. Negative stereotypes associated with alcoholism suggest individuals are weak-willed, that they only have themselves to blame and that they are powerless in the face of alcohol. Research has demonstrated that lifestyle changes and treatment adherence in alcoholism is superior when compared to other chronic conditions such as diabetes or hypotension (McLellan et al 2000). Self-stigma, as a result of reflected perceptions of stigma, by people with alcohol problems, increases the chance they will drink due to social pressure and is therefore a factor in lower recovery rates and continuation of problem drinking. (Schomerus et al 2006)

Very little research directly addresses the issue of stigma in dual diagnosis. Link et al (1997) demonstrated that stigma leads to rejection associated with both mental illness and drug abuse, which continues long after any improvement in mental health or abstinence from drink and drug taking. The consequences of stigma associated with dual diagnosis are wide spread; service users have reported that they have been denied medical treatment, denied access to accommodation, lost their job or believed they had been paid less, been avoided by others and teased or taunted for their psychiatric history (Link et al 1997). Whilst there is a paucity of evidence on stigma associated with dual diagnosis, there is clearly a significant body of evidence on the affects of stigma in mental illness and for drug and alcohol users. Importantly for this study Byrne (2001 p281) highlighted the relevance of personal narratives in exploring stigma and remarked, *"The first and last words on stigma belong to the people with mental disorders."* This adds credence to the research methodology I have chosen to use to explore the personal narratives of people with dual diagnosis and practitioners who try to help them.

2.10. Literature review conclusions:

Social constructs radically influence peoples' perceptions of mental illness, drugs and alcohol and by default, dual diagnosis. Beliefs about drugs and alcohol are influenced by social constructs of addiction and directly affect the people with a dual diagnosis, their carers and the people who help and treat them. Individual narratives can help explore the impact these social constructs have upon individuals and the extent to which they influence facilitators and barriers to recovery. The language of mental health and substance misuse underpins and reflects these social constructs and has a significant influence on prejudice and

discrimination, people and families' engagement and recovery outcomes for people with dual diagnosis. Research has established that the attitude of practitioners affects whether individuals are able to access help and support for their problems and whether appropriate treatment is delivered.

Research into dual diagnosis has been a relatively recent phenomenon in contrast to research in the field of mental health. Contemporary research has tended to focus on the prevalence and aetiology of dual diagnosis. Recent research topics associated with dual diagnosis have included the effect of therapeutic interventions, staff training, staff attitudes, treatment experiences of service users and the effect of cannabis on mental health. RCTs and those, which rely on rigid inclusion criteria, tend to be reductionist in nature because they factor out the chronic and chaotic nature of the experience of service users. RCTs also fail to uncover the attitudes of service users and practitioners that affect the fidelity of treatment and subsequently recovery outcomes. Research has tended towards psychological approaches rather than attending to individual's social situations. The narratives of service providers could be useful in uncovering some of the more esoteric factors that affect recovery and outcomes.

Skills that have a positive impact upon dual diagnosis have been explored extensively in both quantitative and qualitative research (Drake et al. 1998, Drake et al. 2006, Drake et al 2008, Martino et al. 2006, Ridgeley et al 1987, Cleary et al 2008). The lack of conclusive and comprehensive evidence detailing appropriate interventions and treatment outcomes suggests that research may be missing something significant. In their endeavour to produce generalisable results quantitative researchers adjust for variables that are individually significant and may shed light on factors that facilitate recovery in dual diagnosis. Some of the research relating to practitioners attitudes recognises this factor in affecting treatment optimism but stops at exploring the impact this has upon service users. Rich stories and narratives of individual's lives and experiences of dual diagnosis may have an illuminating effect in not only highlighting treatments that work but also in demonstrating how positive or negative attitudes influence outcomes and recovery.

This literature review has established there is limited evidence exploring the goals and personal experiences of people with dual diagnosis. Research

contrasting service user's goals and perceptions with those of practitioners is poorly represented too.

In exploring study methodologies I might use I have discounted other approaches because I am interested in an exploratory approach to peoples experiences, Narrative inquiry seemed to fit this aim admirably. Other methods such as qualitative description seem inappropriate because as Sandelowski (2000 p339) states it *"is the method of choice when straight descriptions of phenomena are desired"*. Grounded theory was discounted on the basis that the aim of this study was not to generate theory but to explore individual experience. I had used Template Analysis (King 1998) in my research conducted for my Masters degree, and apart from wishing to develop wider research skills the use of a priori themes and a related coding frame felt too restrictive of my exploratory aim. Narrative studies use the medium of stories to demonstrate breadth and depth and illuminate factors in an individual's experience. Using a narrative methodology for this study will enable exploration of the depth of some of the stories of both service users and providers. I hypothesise that this depth and breadth will unveil some of the more hidden factors that influence people's propensity for recovery, which other research fails to uncover. In the following methodology section I will explore and underscore why my own experiences influence my methods and why reflexivity is important to this studies context and rigour. This literature review is influenced by my frustrations that attitude and stigma appear to be factors that affect whether an individual who has dual diagnosis receives appropriate help or treatment. This is an important area of exploration in uncovering the facilitators and barriers to recovery in dual diagnosis.

2.11. Research questions:

What do service users with dual diagnosis and practitioners who help them tell us are facilitators and barriers in promoting recovery?

- What factors, skills, aptitudes and attitudes do service users and staff identify as helpful in enabling them to achieve their goals?

- What value do narratives of service users and staff have in elucidating the nature of recovery?

3. Narrative theory and methodology:

For clarity I commence this chapter by restating my study aims and research questions:

What do service users with dual diagnosis and practitioners who help them tell us are facilitators and barriers in promoting recovery?

- What factors, skills, aptitudes and attitudes do service users and staff identify as helpful in enabling them to achieve their goals?

- What value do narratives of service users and staff have in elucidating the nature of recovery?

3.1. Narrative structure:

> *"Like weight bearing walls, personal narratives depend on certain structures to hold them together. Stories told in conversation share common parameters, although they may be put together in contrasting ways and, as a result, point to different interpretations."*
>
> Riessman (1993 p18)

The philosopher, Aristotle observed that in their simplest form stories have a beginning, middle and end. More accurately Aristotle saw that narratives were created within a 'unity' of time, place and action. These Aristotelian unities were developed as rules for dramatic storytelling in plays. Later the 'unities' were adopted (and adapted) by medieval playwrights. Aristotle suggested significant detail relating to action insisting that there was a continuation of action throughout his tragedies. He offered very little detail on the meaning of the unity of time or place. The unity of time was only implied through his rigorous description of the flow of action. Aristotle understood that narratives were not direct copies of the world but that they mirrored it in an individual and interpretive manner. The study of narrative theory really began to shift and develop in the late 19th century as French, Russian and Eastern European Philosophers began to explore post modern, structuralist and formalist ideas.

Propp (1928) was one of the earliest to study narrative structure in the Morphology of the Folktale (1968). His study of fairytales extended traditional Russian formalist narratology and concluded, by breaking down and contrasting

a number of fairytales, that there were 31 different typical typologies. Propp also identified eight different characters typically present in fairytales. Contemporary academics (Levi-Strauss and Riessman 1993) have criticised Propp's methodology of analysis for extracting all verbal references, even though the Russian tradition of telling fairytales was predominantly verbal. In the latter part of the 20th Century the concept of narrative took another important 'turn' with the introduction and exploration of the effects of culture on narrative. Todorov (1969) observed all narratives begin with a state of equilibrium and are followed by a disruption that changes the equilibrium state. Finally the narrator reaches a stage of resolution in their story that brings about a new equilibrium state.

Based upon his observations of kinship systems, myths and rituals Levi-Strauss (1966) studied numerous myths perpetuated amongst a variety of tribal cultures; developed the structuralist views of Todorov and Propp, forwarding the idea that all human minds work in the same way. He concluded that people make sense of the world through seeing others, the world and events within it as a series of 'binary opposites' and that all narratives are organised around them. He suggested that people didn't make sense of words in isolation but that they were interpreted through a sense of relative opposites. For example, we understand good as a concept relative to what we perceive as evil or our appreciation of happiness is dependent upon experience of sadness. This was an important challenge to the previous modernist acceptance that there were fundamental differences between the "native" and "civilised" mind and led the study of narrative into new territories.

Other researchers have suggested a more complex definition of narrative structure. Those proposed by Labov (1999 and Labov and Waletzky 1967 & 1997) are commonly cited (Riessman 1993, Sandelowski 1991 & Holloway and Freshwater 2007). A fully formed narrative according to Labov (1999) has six key characteristics or elements:

- An *Abstract:* summary of what follows and acts as an introductory phrase.
- *Orientation*: time, place, characters or participants and setting
- The *Complicating Action*: the substance to the narrative sometimes referred to as the 'problem' of the narrative.
- An *Evaluation:* the meaning of the story, which sometimes functions to add clarity to the narrative.
- The *Resolution:* what finally happened

- And the *Coda*, used to signal the end of the narrative including detail of how the story relates to the present.

This structure allows the teller to relate their primary experience and to give meaning to the significance of events by relating narrative as a series of clauses. Riessman (1993) suggests that Labov's structure of narrative explains how narrators avoid potential conflict with their audience by warding off the "*so what?"* question. In the evaluation phase of their narrative, narrators inform their audience of the point of their story, outlining how they want it to be interpreted and so essentially are attempting to defend against the accusation that their story is pointless (Riessman 1993).

A narrator is constantly seeking to convince their audience of the authenticity or truth of their story. This state of negotiation between narrator and audience makes narration a social negotiation where the narrator seeks to convince their audience of the 'truth' and the audience looks to narrate and justify their reaction. This dynamism means this is not simply an exchange of responses, frequently the narrator may anticipate the reaction of their audience and re-evaluate and reconstruct their story in a manner they perceive may be acceptable to the listener(s). Gergen and Gergen (2001) have termed this pre-structuring of narrative "*anticipatory or implicit*", the narrator rehearses their story, possibly with an imaginary audience, in advance of the actual action of narrating their story to their '*real*' audience. In proposing the idea of an implicit narration Gergen and Gergen (2001) fail to discuss the extent to which this is introspective. Their use of the term "*implicit"* appears to challenge the notion that narrative re-evaluation is a preconceived and practiced or premeditated act, but *is* rather an unconscious process for the narrator.

Holloway and Freshwater (2007) suggest that narrative stories are continuous and have a common construction consisting of a plot, a cast of characters and a stated problem. They describe the plot as a recognisable series of events and that narratives are always about something such as illness, disability, recovery or everyday experiences (Holloway and Freshwater 2007).

3.2. Nested Narratives:

The personal stories that place and describe an individual's life are made up of a multitude of interlinked stories developed over time. Gergen and Gergen (2001) term these interlinked stories '*nested narratives*'. The idea of stories (what I term micro-narratives) within stories (macro-narratives) is an important one because

it helps explain how narratives change over time based on the constant flux and re-evaluation of interlinked stories by the narrator. If an audience's response to a micro-narrative alters the narrator's future interpretation and retelling of that narrative, this may have fundamental implications for wider macro-narratives within the individual's life-story. As stories are told and retold the narrator also revises them. Frank (2002 p5) summarises this by stating

> *"Narratability provides for legibility and out of both comes a sense of morality - practical if tacit answers to how we should live. This morality is not fixed but is constantly being revised in subsequent stories, including retelling that puts different emphases on old stories"*

Personal narrative can be seen as a dynamic re-evaluation, review or reconstruction not merely a basic accumulation of life experiences that are told and retold without change. When telling their story people are both narrator and audience, re-evaluating their narrative in the light of their audience's feedback as outlined in figure 1.0 below.

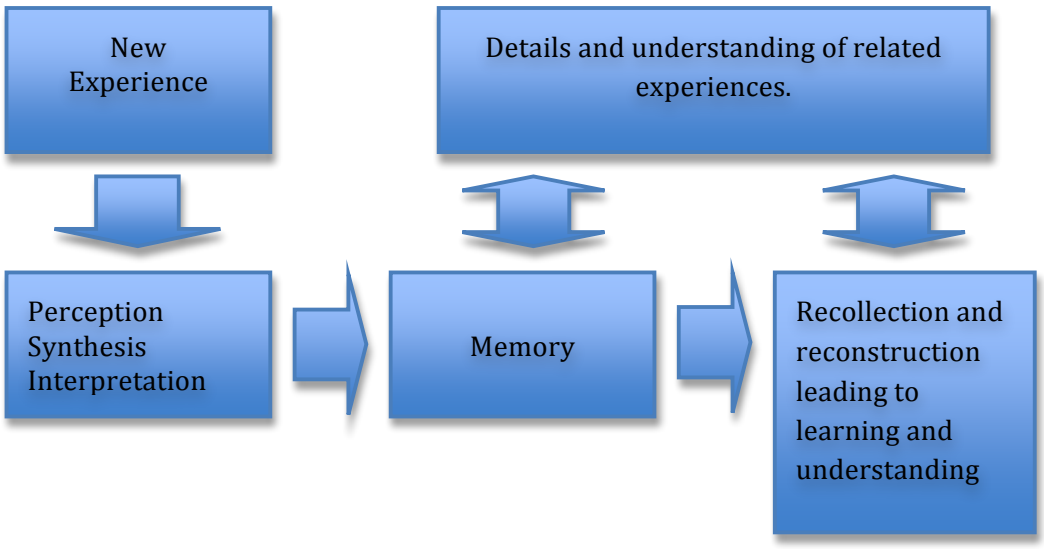
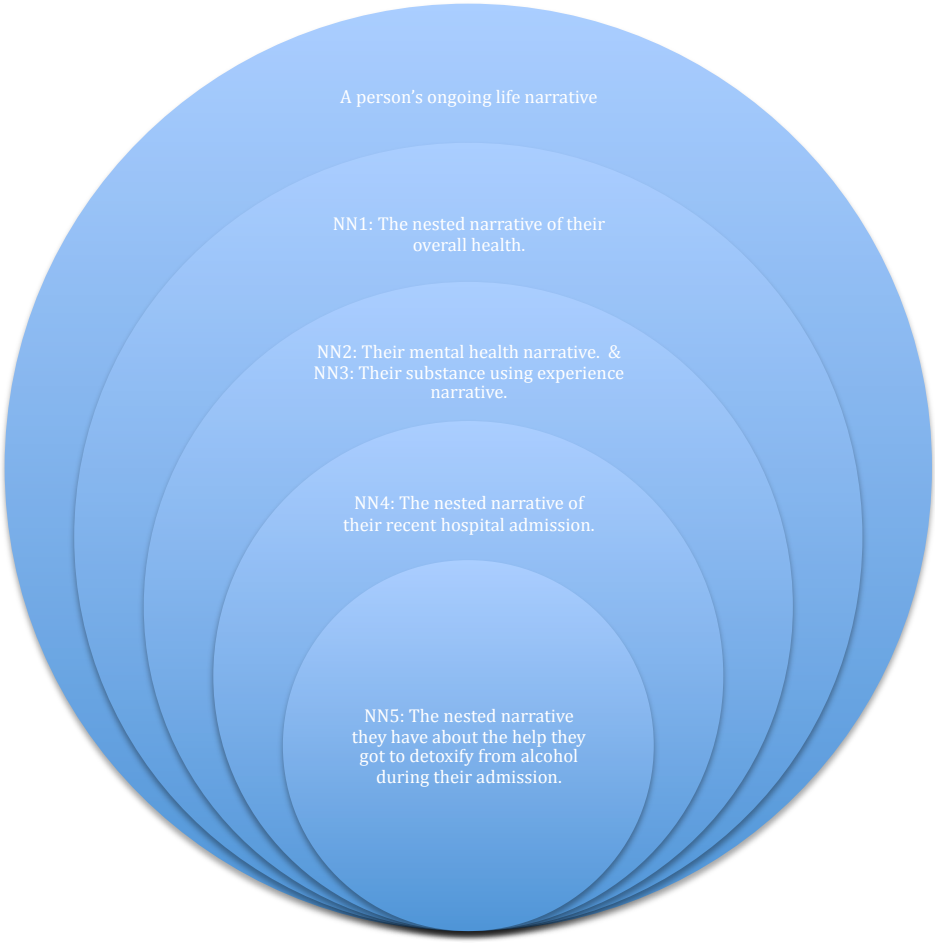


Figure 1.0 the dynamic process of narrative re-evaluation

An individual's overall life narrative comprises numerous smaller units of narrative that Gergen and Gergen (2001) term *Nested Narratives*. Nested narratives can be small stories within a larger narrative or much larger within an even larger narrative. There is in a sense no limit and often no distinct boundary to a nested narrative. The importance of nested narratives though is that they illustrate the multidimensional nature of an individual's narrative. Gergen and

Gergen (2001) have suggested a more specific definition of nested narratives talking of macro-narratives; events spanning long periods of time; and micro-narratives; spanning brief periods. Viewing narrative in this way potentially aids analysis, since micro-narratives could also be themes within a larger, macro-narrative, which enable thematic analysis of narrative. I have synthesised the concept of nested narratives (NN) in figure 2.0:

Figure 2.0 Nested Narratives



3.3. Philosophical Origins and the Narrative Turn:

Scholars of narrative theory (Mishler 1986; Riessman 1993, 2000 & 2008 and Sandelowski 1991) use the term '*narrative turn*' to describe the dynamic progression of narrative interest and theory in line with other significant changes in social scientific research, turns to qualitative research, reflexive practice and participant centred research, in the late twentieth and early twenty first centuries.

The study of narrative and its meaning in literature has existed for centuries. Narrative theory is based on the assumption that in their day-to-day lives people interpret reality in the form of stories (Murray & Sargeant 2012). Narratives can sometimes be referred to as stories that people tell themselves or others about issues important to them or their community. Probably the most complete definition, which captures the importance of temporality and culture to narrative, comes from Richardson (1990)

> *"Narrative displays the goals and intentions of human actors; it makes individuals, cultures, societies and historical epochs comprehensible as wholes, it humanizes time, and allows us to contemplate the effects of our actions and to alter the directions of our lives."* (Richardson 1990 p116).

The idea that narrative brings a human perspective in time but also as context for past and future actions is compelling and has a strong resonance with the concept of recovery in mental health. At its basis the thinking of Paul Ricoeur drove this idea.

Ricoeur (1984) was one of the earliest philosophers to suggest that our lives or actions have a narrative dimension. His interest in narrative grew from a phenomenological philosophical perspective, emphasising the importance of human experience. Ricoeur determined that narratives have an important role in our lives but significantly that our lives are not stories. He suggests that we locate ourselves as humans by placing ourselves as part of a story. He argued that in the first instance in order to be able to examine other people's lives the telling of stories is necessary. Ricoeur also suggested that our identities are formed by the stories that we tell and that different individuals interpret our identities in different ways.

Central to Ricoeur's narrative philosophy is its capacity to represent the human experience of time. He distinguishes between cosmological time; a linear progression of hours, days and weeks; and phenomenological time, as past, present and future. Ricoeur's perspective differed from other philosophers who saw phenomenological and cosmological time in opposition; Ricoeur saw them as complimentary, which he expressed as '*human time'*. Bruner (1991 p6) describes this human time as "*time whose significance is given by the meaning assigned to events within its compass"*. Narrative time can be reconstructed in many ways that belie the construct of 'factual' or actual time, for example when a person talks about a *'flash back'* or other temporal synecdoche they are producing narrative that steps outside of the factual temporal or cosmological time frame. Ricoeur argued that as self-aware sentient beings, we not only experience time as a linear

succession, but that we also see the succession of time in terms of what has been, what is, and what will be. Atkins (2005) summarises that

> *"Ricoeur argues that any philosophical model for understanding human existence must employ a composite temporal framework. The only suitable candidate here is the narrative model."*

Frid et al (2000 p697) suggested that Ricoeur's theory is important to narrative based research in nursing because

> *"Through narrating, reality and its problems may be reformulated by viewing reality as a dynamic process."*

Frid et al (2000 p697) observe that a person's narrative creates an approximation of something that occurred previously, but it is not simply a repetition but a "*reformulated description*". By interpreting narratives, they suggest our understanding will deepen and expand, and our changed understanding will go on to reinforce the pattern and continued interpretation of the subject of interest. This is an important concept that is a central tenet of recovery in mental health. Through viewing reality as a function of narrative we can begin to see that recovery is not a measurable fact, dependent upon external criteria or validation, but is a function of an individual's perception of their recovery, or recovery milestones, within their overall life-story.

A distinct definition of narrative as a concept is inherently difficult to arrive at (Riessman 1993 and Hinchman and Hinchman 2001). Hazel (2007 p1) offers a series of explanations for this and suggests that due to the interdisciplinary nature of narrative research *"Study in this area is fraught with semantic problems as different disciplines use the same sets of words but attach different meanings to them, or use different sets of words when talking about the same thing".* There is consensus amongst most authors on the subject that narrative is a creative (some suggest artistic) and imaginative act. Hurwitz, Greenhalgh and Skultans (2004 p1) state that *"narrative thinking and imagining embody temporal and causal frames of reference manifest in myths, cave art, fables, fiction and drama"* they suggest that narrative is synonymous with humanity itself which has offered marked evolutionary advantages to humans over many thousands of years.

3.4. The significance of narrative to health and nursing:

Nurses frequently experience stories told by service users, to give context and meaning to their 'illness'. Sometimes, the lengthy stories that people tell about their problems can be perceived as an inconvenience, a barrier to getting the job done because the emphasis is in understanding a clinical narrative rather than a

persons' life narrative. Listening to and reflecting on a story is time consuming, time in healthcare is an increasingly rare resource, so time spent as audience, listening, may be perceived as diverting time away from the task of 'healing'. However nursing is not purely a task-orientated profession intent on singular acts of concrete healing. People we help may be beyond a conclusion or ultimate recovery. In palliative care, mental health, oncology, and diabetes, for example, complete cure is not always a realistic option. Ultimately these people's recovery stories may be more meaningfully seen as remission, change or discovery (Frank 1991).

In these instances and even when a person's body can be healed a person's 'illness' is experienced as a hiatus in their lives that fundamentally changes their '*road map'* (Frank 1991). For the person to recover fully or enter remission, where full recovery is not possible, they must learn to adjust to their new life circumstances. Developing this '*new road map'* requires readjustment to the new context of their life that illness brings. Their new story 'embraces' their 'illness' experience and reframes and restructures their lives relative to it. In turn this re-contextualises their life as a result of the understanding they gain from telling their own story. Understanding is enhanced through the experience and the reaction of their audience. Riessman (1993 p3) has suggested that the narrative context of health is useful to those people who are experiencing chronic ill health or "*biographic disruption*" as it "*allows the reconstruction of a coherent self*".

Increasingly nursing interventions appreciate the value of personal narrative. During my own nursing career there have been shifts in the nurses role. Increasingly nurses facilitate exploration, with an individual, the impact mental health has upon their life. People's stories and the sharing of them have increasingly come to be seen as valuable *marker* on other peoples' *road to success* in coping with their problems. I emphasise the journey analogy here as it reflects Ricoeur's central tenet of 'human time'. The change of therapeutic approaches with individuals who experience psychosis and hear voices is a pertinent example of the catharsis and learning associated with narrative and storytelling. As a student nurse, I was taught that when faced with "delusional talk" distraction techniques were appropriate interventions. By contrast there has been a contemporary growth, in individuals narrating their experiences related to hearing voices, in *'hearing voices'* groups. This has led to a growth in recovery-orientated approaches that place the individual in greater control of their life, through their own narrative.

The terms narrative and stories are frequently used interchangeably both in clinical settings and in nursing research (Frid et al 2000). Nurses who ask, "*What is your story?"* are more likely to elicit specific knowledge about the person than "*How are you?*" (Hall & Powell 2011). However, nurses need to be aware of approaches to the people they treat, such open ended questions as "What is your story?" may be overtly challenging and frustratingly broad to some. It is important that nurses bare in mind that exploring an individual's narrative helps us place them in context and understand the meaning of their experience.

Narrative inquiry has growing value in nursing research as a means of exploration, interpretation and as a means of forming consensus between service users, families and practitioners (Holloway and Freshwater 2007). Narrative consensus is reached through the interpretation and reinterpretation of storyteller and audience.

Several authors (Holloway and Freshwater 2007, Richardson 1990, Sandelowski 1991) perceive narrative research as both art and science; Art because of the "*creative craft elements*" (Holloway and Freshwater 2007), science because the approach is both methodical and systematic. Central to the scientific nature of narrative research is the critical stance of the researcher towards their 'discoveries' and a rigour in demonstrating their systematic approach.

3.5. Narrative in Dual Diagnosis:

The literature review established that there are few studies of dual diagnosis that use narrative methodology to capture the stories of people's experience of substance misuse and mental health problems. Studies (Baigent et al. 1995; Fowler et al. 1998; Laudet et al. 2004 and Cruce, Öjehagen and Nordström 2008) that employed open-ended questions in semi-structured interviews, elicited some narrative. Each of these studies recognise that responses were generally 'directed' by questioning.

Giving voice to marginalised or minority groups is a strength of narrative research (Riessman 1993). Empowering individuals to speak and tell stories about their experiences may be a liberating experience and allow exploration of taboo subjects. Dual diagnosis stories are often hidden since the complex interaction of mental health and substance misuse is difficult to comprehend for some. The dual diagnosis experience may be stigmatised by audiences as '*bringing problems on yourself*' as a result of the perceived negative effects substances have upon mental health. Individuals are often marginalised or given

medicalised explanations that stunt or devalue their voice. Hall and Powell (2011 p7) argue that narrative allows exploration of the interaction of substances and mental health beyond traditional socio economic paradigms of drug and alcohol use.

> *"Narrative understandings of subgroups in relation to substance use will foster greater awareness amongst providers of the impact of co-occurring disorders as well as trauma in early life".* Hall and Powell (*2011*)

The value narrative has in engendering exploration of co-occurring disorders and giving a voice to people, who experience these issues, resonates strongly with this study. Hall and Powell (2011) explain that direct questioning about drug or alcohol use rarely elicits reliable answers due to the person's feelings of stigma associated with substance misuse and sometimes related to an unwillingness to stop drug use.

Practitioners who work with people experiencing dual diagnosis often maintain a relationship with a service user simply to fulfil the hope of change. My experience and the literature suggests that practitioners are reluctant to discuss drug and alcohol consumption because of concerns about illegality of drugs, their perceived lack of skill to talk about substances and concerns at their lack of skill and the specialist nature of substance misuse treatment. Hall & Powell (2011) have suggested that narrative based questions often lead to the client telling stories that *"indirectly reveal motivations and the problems the substance cause"* (p5).

Overcash (2004 p17) argues a use of narrative research that is relevant to this study *"Narrative research tends to correlate well with understanding the effects disease and/or illness may have on both the patient and the support persons".*

3.6. Phenomenology: Narrative inquiry as a qualitative research methodology.

Riessman (1993) is emphatic in stating that there is no single method of narrative inquiry. She explains that narrative inquiry "*has to do with how protagonists interpret things*" (Riessman 1993 p5). The value of personal narratives to the researcher is in the subjectivity of the statements that are rooted in time, place and personal experience. Narratives are soaked in personal perspective, which does not always bear objective assessment or categorisation. Riessman (1993) suggests that it is not possible to be neutral or objective in our assessment of narrative. This lack of objectivity does not render the narrative

valueless, because we value the subjective perspective. The Personal Narratives Group (1989 p261) sum this up:

> *"When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they are revealing truths. These truths don't reveal the past as it actually was… They give us instead the truths of our experiences."*

Truth used in this statement is far from traditionally described scientific proof. Some researchers suggest it is contestable whether subjective individual experiences can really be termed *truth*. However, scientific truth is not the only sort of truth there is in the world. Phenomenology is concerned with the objective study of issues that empiricists would normally term *subjective*. Observation is a unifying principle that spans all scientific methodologies. All theories are rendered plausible or implausible by their relation to the way things are and what is observable. However, science faces a challenge in achieving consensus about what is, and what is not, observable. For some scientists truth is dependent on human consciousness, so logical empiricist science grounds its concept of truth in what is observable by humans. Constructivist empiricists suggest that truth can be demonstrated through what Van Frassen (1976) terms '*descriptive excellence*' or what we might call the transparency of scientific methodology. Phenomenology would suggest that such perspectives on what is observable are ultimately reductionist.

Riessman (2008 p10) states that the concept of narrative "*continues to be elusive, contested and indeterminate*" however she goes on to state that narrative scholars generally agree that "*narrative is not simply a factual report of events, but instead one articulation told from a point of view that seeks to persuade others to see events in a similar way."* This fundamental function of narrative will be explored later. With narrative analysis contestability is often '*laid at the door*' of the subjectivity of the data (the stories), and the lack of reproducibility or generalisability of evidence. Studies that rely on realist or positivist methodologies, argue that truth can be demonstrated by factual accuracy gathered in a systematic, clearly demonstrable manner, that can be tested, reproduced and uses statistical calculations to demonstrate the significant results have validity. The same cannot be said of narrative methodologies. Bruner (1991 p4) suggests:

> "*Unlike the constructions generated by logical and scientific procedures that can be weeded out by falsification, narrative constructions can only achieve "verisimilitude." Narratives, then, are a version of reality whose acceptability is governed by convention and 'narrative necessity' rather than by empirical verification"*

Narrative truth is measured in terms of its proximity to truth or other truths. Returning to the Personal Narratives Group (1989) statement, truth in this context can therefore be seen as a personal interpretation of reality, one where experience is potentially more important because it reveals more than apparent fact; for example someone's painful suffering is important, and can be storied, even though medical tests can't locate a cause.

Truths in narrative are reliant on the plausibility and trustworthiness of the researchers' interpretation. Evidence of 'truth' in narrative analysis can be demonstrated by the extent to which the researcher makes explicit the link between their source data and the generation of theory. In order to determine the validity of the analysis the audience of the research must be able to appreciate and understand the specifics of the mode of inquiry. In narrative analysis the description of the research approach, methods of data collection and the path from source data to theory generation should be specified so that it is clearly understandable to the audience. One method that can be used to underscore the truth of a narrative is its relative correspondence to other narratives or other evidence. Historians commonly support oral or written truths by triangulating narrative with archive data, their correspondence is said to support plausibility.

In this study the facts of an individual's experience are potentially less valuable than what their story tells us about their experience of recovery and the support that they considered helpful. Individual's perception, narrated through stories, of what is helpful or unproductive in facilitating their recovery are valuable because of the impact that their meaning making has upon the course of their recovery.

Scientists face moral and ethical dilemmas when conducting research, but they cannot claim that science alone has the answers to issues of morality and values. Individual scientists may or may not have the insight into moral sentiments that govern human behaviour. What is certain is that science does not hold the answers to what is appropriate or acceptable in human morality.

3.6.1. Plausibility of the story:

The narrative approach does not assume or necessarily aim for objectivity but instead values the positionality and subjectivity of individual's stories. Narrative inquiry takes as its object of investigation the story itself (Riessman 2000). Frank (2000 and 2002) calls this subjectivity "*authenticity*".

Freshwater and Holloway (2007) argue the credibility or plausibility of a story is not enough to underpin validity in narrative. We know that when people tell their stories they are often influenced by a number of factors such as their memory of events, their perception of their audience, they may exaggerate for effect or embellish to the point of telling lies. Narrative researchers should take these factors into account and should recognise that even when lying, storytellers reveal aspects of their world because they lie for a reason (Holloway and Freshwater 2007).

A further threat to the plausibility of a story is whether the narrative is a construct of the interaction between the narrator and the researcher. In order to tackle this Polkinghorne (2007 p9) observes, *"For the reader to make an informed judgment about claims resting on the textual evidence, narrative researchers need to spell out their understandings of the nature of their collected evidence".*

3.6.2. Validity and Rigour in Narrative Research:

Validity in research concerns the believability of a statement or claim to knowledge (Bowling 2002). Polkinghorne (2007) suggests that narrative research falls into the reformist research community. He explores the nature of validity in narrative research and suggests that both conventional and reformist (post-modern) research communities:

> *"Use different kinds of data and employ different analytic processes. In both communities, researchers develop arguments to convince readers of the validity of their knowledge claims. Both need to respond to threats to validity inherent in their designs."* (Polkinghorne 2007 p1).

Other researchers (Sandelowski 1991) have suggested that validity is alien to narrative research and efforts to prove validity and reliability are misplaced, tending towards the positivist research values. One advantage of narrative is that its truth differs from that of conventional scientific truth because its emphasis is upon the "*life-like, intelligible and plausible story*" (Sandelowski 1991 p162). The subjective experience of the individual offers an authentic insight that is of value,

whether it is objectively reproducible or not. The subjectivity of an individual's narrative can have significant value in augmenting other research that tends towards the objective.

Holloway and Freshwater (2007) talk about validity using the terms trustworthiness and authenticity and suggest there are two perspectives to this in narrative research: validity of the original narrative from participants and the account of the researcher who creates narrative inquiry, which "*is also narration*" (Holloway and Freshwater 2007 p105). The depth of the narrative researcher's account of their methods is important because it provides context to the research and enables the audience to determine the rigour applied in developing and employing their methodology.

Polkinghorne (2007) argues that validity is not absolute but there are degrees of validity. The degree to which validity is attributed to research depends upon the strength and power of the argument used by the researcher (Polkinghorne 2007). Validity is therefore based in inter-subjective judgement in the research community or wider audience. The COnsolidated criteria for the Reporting of Qualitative research, or COREQ (Tong, Sainsbury & Craig 2007), is a checklist enabling qualitative researchers to outline the context of their research to their audience with the aim of demonstrating the quality of the study methods. The authors argue that other frameworks used in empirical research such as CONSORT for randomised controlled trials have improved the quality of reporting and therefore enable the audience to judge the rigour of the study methods. Whilst it is useful to provide a framework for qualitative research it risks comparing empirical research validity and rigour to that of quantitative research, resisted by narrative inquirers. In this instance the transparency of my research methodology is central to demonstrating the quality of the process and methods I have adopted and the use of COREQ (Appendix 2 p261) promotes transparent reporting, supporting the credibility and trustworthiness of the interpretation of participants narratives.

3.6.3. Trustworthiness of the interpretation:

The purpose of analysis and interpretation in narrative research is to deepen the audience's understanding of the stories' meaning. In narrative research the claims to validity of interpretation are not absolute. The audience is asked to make a judgement of the plausibility, trustworthiness and authenticity of the argument the researcher develops. The validity of narrative research is based upon the extent to which the researcher's argument is persuasive and to what

extent their argument demonstrates the likelihood of what they say is true (Bench-Capon 2003).

Researchers build trustworthiness when they are able to defend the appropriateness of their interpretation of narrative by offering an explanation of the context in which interpretations were made.

Narrative analysis is characterised by four key elements (Riessman 1993), it:

- Uses texts for analysis (sometimes photos or pictures) and is concerned with content.
- Is interested in the connection between the individual and their social context.
- Takes an interpretive approach of how events are restructured and interpreted after they have taken place.
- Is interested in how events are understood within context.

Narrative inquiry explores the rendition or representation by an individual of the real world. Riessman (1993) proposes that a personal rendition of experience, or narrative can be formatted into at least five stages in which representation takes place. The boundaries between the types of representation are not rigid but porous and are summarised below.

1. **Attending** to experience: The stage where the narrator filters the experience and it becomes a story about something. No narrative contains information about everything (sights, sounds and smells) present at the time. A story is filtered, i.e. the narrator attends to the experience along a given line, for an illustrative reason.

2. **Telling** about experience is the performance of the personal narrative, influenced by the audience and constrained by the language that represents the lived experience. There is a reality gap between the lived experience and the language that summarises and attempts to portray the experience through narrative.

3. **Transcribing**: (example transcripts of interviews in this study are appended as Appendix 5 and 6 on pages 269-302) The point where the narrative is textualised into a script by the investigator. Usually the narrative will be converted into text from an audio recording. The act of transcription can edit out a number of verbal and non-verbal elements,

pauses, emphases, facial expression and linguistic elements such as accent. Riessman (1993) describes this stage of representation as an "*interpretive practice*".

4. **Analysing**: where the researcher explicitly analyses a number of scripts. The area of interest or research question acts as a filter through which elements of the narrative are scrutinised. Decisions about form, ordering, style of presentation and amount of context included are made by the researcher and influenced by the eventual audience of the research.

5. **Reading**: The final element of rendition affected by the audience but also the process by which a final readable summary is reached.

These five stages have influenced the structure of this study, leading me to seek out an approach that enables systematic description of the stages of data collection, analysis and discussion of the findings. This was important at each stage as I wanted to be transparent about how the narratives are co-created and influenced by the researchers own subjectivity. My chosen methodology of Critical Narrative Analysis (outlined in section 3.10) provides a structured framework to do this and in particular encourages a reflexive approach that explores how I personally influence the narratives elucidating those influences described by Riessman (1993) in her five stages. In the **attending** stage I influenced the structure of the narrative as a result of my area of interest, the clearly stated aims of the study in the participant information sheets that they were sent in advance of their interviews, through the phrasing of my opening statement and during interviews through additional questioning. The **telling** of the narrative was inevitably influenced through my verbal and non-verbal feedback throughout interviews which participants may or may not have taken as feedback and adjusted their narrative accordingly as part of the co-creation process. Asking questions and reflecting on elements of the participant's stories during interviews influenced the direction the telling took by the narrator. The **transcription** of audio narratives was undertaken by a secretary supporting the research for purely pragmatic reasons. However it is important to recognise that her perspective and translation will inevitably have affected the transcribed data. In order to check accuracy and ensure authenticity I listened back to audio recordings whilst correcting transcriptions and I also used field notes to recall context. My decision on the use of CNA as the analytic framework for this study inevitably influenced the form and ordering of my **analysis**. In the case of this

study, my supervisors and anyone who reads and gives feedback on it influence the **reading** experience. A reader may have other interests that the study text does not capture and are essentially un-answerable due to the studies' area of emphasis. It is possible that the meaning of the representation is influenced by the context in which it is read and subsequent additional readings may provide the same reader with a different rendition.

3.7. Narrative Analysis Method:

All narrative inquiry is concerned with the content of the story. Analysis typically focuses on what is said, written or visually depicted. However, in thematic analysis content is the exclusive focus (Riessman 2008).

Mishler (1986) distinguishes thematic analysis as focussing on what is *told,* or individual's reportage of events*,* rather than the method or facets of the *telling*. In thematic analysis data is represented in the light of themes developed that are relevant to the research question to be answered. During the process of analysis it emerges that aspects of the narrative are linked by a theme. Researchers (Riessman 2008 and 1993, Mishler 1986 and Sandelowski 1991) suggest that reflexivity in the development of themes and discussion of the pragmatic attempts to thematically interpret the data adds plausibility.

Where several narratives are being analysed, analysis is performed by moving from one narrative to the next, checking the significant or dominant features, using elements of one narrative to confirm the previous account and identifying commonalities between the individual narratives. Narrative thematic analysis does not *"fracture"* the data as grounded theory coding does but interprets it as a whole (Riessman 2008).

3.8. Ethics:

Holloway and Freshwater (2007) argue that ethical problems are endemic in research but that interactional and relational research like narrative inquiry can intensify these concerns. Riessman (1993 p8) suggests that qualitative researchers are seeking to depict other people's experience but "*often act as if representation is not a problem*". Attempting to minimise the ethical impact of narrative research on participants requires the researcher to recognise that both the process of research and interpretation of data have potential ethical consequences. In this study it is important to reflect on the impact that discussing drug taking and drinking might have upon the participants but equally to reflect upon my interpretation of issues. The influence I bring to the narrative dynamic

as a clinician who works in statutory drug and alcohol services, as a senior NHS manager/leader, and as a son who has personal experience of someone with a significant alcohol problem is equally important; these are explored in stage one of my analysis.

Kuhse and Singer (1998 p4) suggest that ethics in narrative are about *"the value of life, what it is to be a person, the significance of being human"*. They suggest that ethics are more than just possession or mastery of an ethical code applied to narrative, but form a political standpoint, that is not static, but ebbs and flows. Researchers using narrative methodology should be vigilant to the varying ethical standpoints of their subjects and constantly reflect on this.

Parker (1990 p34) criticizes nurses and nursing academics attempt to develop a *"theory of nursing ethics"* without *"listening to what experiences with patients tell us"*. Parker observes how ethical principles serve to "*defend one's own biases*". Parker concludes that nursing researchers should embrace ethical uncertainty and accept that in doing so we are not failing to codify ethics but that we understand its limits. Elliott (2005) suggests that researchers enter into a moral and personal relationship with participants when collecting, analysing and disseminating data.

Discussion of ethical issues in interactive data collection has in the past concentrated on the power dynamic between the interviewer and interviewee. In narrative research it is suggested that telling stories can be empowering for participants. Adams (2008 p 179) observes that working with ethics involves realising that we do not know how others will respond to or interpret our work. Reflexive ethics in narrative research acknowledges that we can never definitively know *"who we harm or help with our communicative practices"*.

Researchers have argued that narrative theory has value in research because it takes an empathic stance: *"a narrative interview can be helpful to the patient by allowing a person to tell an often emotional, stressful account to someone who is an impartial listener"* (Overcash 2004 p17)

Frank (2000 p136) observes that there is an ethical standpoint in narrative that is of value *"to make ill people's stories more highly credited primarily among the ill themselves and then among those who care for them"*.

3.8.1. Ethical approval:

Before commencing research data collection this study was submitted for research ethics approval via the Integrated Research Application System (IRAS) to NHS/HSC Research and Development Offices and a Research Ethics Committee (REC). I attended the Trent Research Ethics Committee on 3rd February 2011 to present the ethics application and answer questions from the REC. Approval was received from the NRES East Midlands (Derby) REC in writing on 08/02/2011. Annual progress reports have been submitted in line with research ethics guidelines.

3.8.2. Reflective Ethics:

It is an important endeavour of qualitative research, and particularly narrative inquiry, to reflect on ethical issues and their effect on participants. This will become a feature of my study as it progresses. I hope that this wider thinking will ensure I fulfil my responsibility to do no harm as a result of this research.

The setting for this research, in UK healthcare settings, with its typical hierarchical and unequal power relations, is at odds with my desire to open up and democratize the research process. As a senior practitioner in Substance Misuse Services (SMS) and Clinical Director (CD) with responsibility for a diverse directorate including Child and Adolescent Mental Health Services (CAMHS), Learning Disability (LD), Psychological Therapies (PT) and SMS, I am perceived in different ways based on the role I am expected or seen to be fulfilling. Becoming a researcher and attempting to divest myself of perceptions of myself as Consultant Nurse, CD is probably impossible and certainly beyond my control. Throughout the ensuing pages I have endeavoured to reflect on power relationships that may influence this study. My default position is to try to minimise negative power barriers by being open, approachable, warm and honest. However, it is likely that I am not always all of these things. I am not in control of how others perceive me. I also recognise that it is impossible for me to be entirely objective in conducting this study, subjectivity is something that narrative researchers recognize and embrace rather than eschewing.

I have broadly categorized the potential ethical challenges I see in conducting this study into three main areas after Ramos (1989):

- Study design (methodology)
- Access to study participants and
- Risk to participants.

3.9. Study Design:

An area of methodological and ethical consideration is the relative balance between the risks of the study and the benefit it may produce. The qualitative methodology used is partly based in my determination to reduce the distance between researcher and participant. The literature review reveals that previous research in this area lacks a participative perspective between researcher and participant. I hypothesise that this affects the sophistication and richness of the data collected and therefore the conclusions of those studies.

It is common for qualitative studies to be viewed as relatively low-risk compared to more interventionist quantitative studies. However, qualitative studies require that participants engage in a process that can involve a lot of personal investment and revelation. For participants this may generate negative experiences, feelings of shame, loss or other emotional responses when divulging deeply personal and sensitive information (discussed further under risks to participants). There is a tension between the informal nature of story telling at interview and the more formal aspects of analysis and translation of the data. An important part of the ethical consideration of my methodology is in the analysis of data. It is an ethical endeavour of narrative analysis to privilege the voice of participants to ensure I avoid, as Langdridge (2007 p140) puts it:

> *"Subsuming the subjectivity of the participant beneath that of the analyst and the particular social theoretical hermeneutic being employed"*

3.9.1. Access to study participants:

As a clinician and senior manager working in the NHS, I had unique and privileged access to a potential study population. To illustrate the complexity of the power relationships present in this study I will discuss how the first two potential participants came to show an interest. Both were using services. One became interested in my study through his membership of the Nottingham Dual Diagnosis Service User Forum. I mentioned my doctorate study to him and he asked if I would send him further information, which I did. We agreed to discuss his involvement with his key-worker who felt it would be appropriate for him to become a participant and thought he would have a lot to say.

> *Is he interested in being involved in the study because he sees it as a way to please me or influence his care?*

I worked with his key-worker for a number of years. I managed and supervised her manager and facilitated peer group supervision with the Team in which she

worked. She was one of the 900 members of staff in the directorate that I am CD of.

Could she have agreed to her client's involvement in my study because of her perception of my seniority as both CD and Consultant Nurse?

Is she unwilling to challenge any perceived conflicts of interest because she has concerns about the influence this may have on our professional relationship?

The other participant I had no prior involvement with. She contacted me via my work email, which she obtained from the study poster, displayed in the Recovery Education College (REC), where she is a student. I responded to her email enclosing a study invitation letter, service user information sheet and consent form and offering to discuss any questions she had in relation to the study.

What influences helped her decide to make an approach to me, was it as simple as the poster?

Was she encouraged to participate by one of my PhD supervisors, who also work at the REC?

These power issues are beyond my immediate control but are worthy of exploration.

3.9.2. Power and Coercion:

An aim of qualitative research is to democratise the process of research and rebalance the traditional power relationships present in quantitative approaches. Narrative study attempts to describe phenomena from the point of view of the study participant and the methodology recognises the co-creative values of narrative. My role as researcher, clinician and manager were potentially in conflict with each other and the endeavour of this study. The influence my seniority brought; both as a Clinical Director and Consultant Nurse may have intentionally or unintentionally put me in the position of pressurising individuals to participate in the study. Further blurring of roles and boundaries occurred since I was also acting as researcher for this study. In an endeavour to separate out my roles I always interviewed participants dressed informally, rather than in the suit I would normally wear at work; I saw people away from my professional office settings, typically in places of their choice (the Nottingham Voluntary Action Centre, Trust Learning and Development Centre or the REC for example). I always used 'ring-fenced' research days, to ensure I was in an appropriate frame of mind and undisrupted by typical work pressures. I believe this was all I could

do to emphasise my researcher role to participants (and to an extent myself) rather than any other role I hold.

I cannot dictate how individual participants may perceive my role; staff may have felt compelled to participate because they felt that to refuse could have affected their employment, or may have influenced a preferential relationship with me. Service users may have feared that by refusing to participate their treatment or services they received from me, or services in the directorate I lead, may be adversely or positively affected. Informed consent (described below) is critical in ensuring I can positively influence these issues to the best of my ability.

3.9.3. Relational:

The fact that I have established relationships with some participants was of further importance as this may have lead individuals to participate out of a sense of duty to me. People involved in the study relate to me as a peer, colleague, care provider, their senior, a nurse or my other roles other than the role of researcher. This may have influenced their perception of my research and the stories they tell.

None of these factors necessarily occurred as a result of intentional use or abuse of this power by myself. Power relationships are two sided and it is not within my control to influence another individual's perception of the power dynamic within our relationship. What I am able to do is ensure that I am as open as possible about the nature of my study, the methods I used to gather data, offer choice about participation, and ensure lack of consequences if they choose not to participate.

3.9.4. Consent:

As part of research ethics approval I developed participant information sheets that, in accordance with usual practice, were circulated to potential recruits. It was important that all participants were able to understand the nature of the study ensuring they could give informed consent to participate. Gaining assurance that someone fully understands what participation means is subjective. It is entirely possible that as interviews progressed individuals revealed issues they had not intended. For some of the participants it is possible that their mental well being, including relative state of intoxication, or withdrawal may have influenced their decision to participate. Once engaged in the study participants may have decided that they no longer wanted to be involved but remained obliged to continue despite their concerns.

3.9.5. Payment:

I considered paying people to be involved, which posed a number of challenges. There is an ethical tension between inappropriate coercion as a result of payment and appropriate compensation for the inconvenience of being involved. For participants payment posed risks associated with the relationship between money and procuring drugs or alcohol. Payment could have provided the financial opportunity to buy substances, and may have through a triggering effect associated with habituation, induced cravings in individuals who were abstinent or controlling their substance use.

3.9.6. Risk to Participants:

Although it was impossible to predict the outcomes of interviews it is an important part of preparing to interview to try to capture all the possible risks and conflicts of participation:

3.9.7. Interview technique and reflective listening:

My training and experience means that I developed a particular style of interaction both in my therapeutic work and in my leadership style. Narrative interviewing demands a different set of skills that may be at odds with what participants ordinarily expected from me. The nature of my clinical work means that I am often involved in offering advice. Narrative methods are more dependent upon listening and reflecting, which may have been contrary to participants' expectations.

3.9.8. Ending interviews:

The topics people storied, involved disclosure of distressing or emotionally charged information. There was a risk in discussing these issues people could leave the interview with unresolved feelings, stimuli, anxieties and frustrations. In order to minimize the associated risks I developed two 'safeguards':

- I made it clear to participants that they could terminate interviews at any juncture.
- I offered to debrief participants following interviews.

3.9.9. Anonymisation:

Despite anonymising identifiable names and places in transcriptions, some stories were so unique they may be identifiable to the audience even though anonymised. This risks damage to the individual's reputation. In each narrative I anonymised all persons names along with identifiable buildings, services and other locations in an attempt to minimise the possibility of this. However, many

of the narratives are unique and it would be impossible to completely guard against a reader recognising a narrative and thereby its narrator. Essentially there is an irreconcilable tension between the need to ensure confidentiality through anonymisation and the desire to render authentic accurate narratives.

3.9.10. Misrepresentation:

Participants in this study may be an audience to it and may feel misrepresented by my retelling and analysis of the narratives. By offering participants the chance to see their completed transcripts I aimed to minimise this. My interpretation of their narrative may be misrepresentative but this is a hazard of co-creation.

3.9.11. Discussing illicit drug use and mental health problems:

Participants may have unintentionally revealed information they had not intended. The emotional effect in relating experiences may have caused distress, which could have induced cravings for substances. Inevitably studies of this nature resurrect thoughts that may have been long forgotten, leading participants into feeling shame for previous behaviours. For some, relating stories involved admissions of criminality. In line with my clinical practice and codes of professional conduct, I am confident that I am and was under no obligation to disclose criminal activity associated with the consumption of illicit drugs. I highlighted this fact in the participant information sheet to enhance informed consent and to reduce participants' anxieties.

3.9.12. Participant Selection:

Within the potential study population two specific study groups were indentified:

- Individuals who use or have used services
- Practitioners (mental health or substance misuse) who provide services.

Service user participants self-selected in response to promotional materials and through a process of snowballing where participants suggested to their peers that they might also like to participate. Service user participants were recruited from statutory mental health services, Nottinghamshire Healthcare Trust Recovery Education College (REC) and service user forums. Staff participants were recruited through email advertisement and self-selected.

In order to be a participant in this study service users were classified as people who:

- Have or had a dual diagnosis of mental illness and substance misuse.

- Are accessible (i.e. live in the county of Nottinghamshire, UK).
- Were (within the past 5 years) engaged in a service within Nottingham or Nottinghamshire County health, social care, or third sector mental health service.
- Could give informed consent.

Practitioners were defined as:

- Individuals employed or volunteering for an organisation within Nottingham City or Nottinghamshire County health, social care, or third sector mental health services in a clinical (or clinically related) capacity.
- Who delivered services to an individual service user (as defined above).
- Could give informed consent.

3.9.13. Sample Size:

With other research methods sample size is intrinsically important as a reflection of power and generalisability. In narrative research sample size is of less importance since each narrative stands on its own. Holloway and Freshwater (2007 p66) argue that the researcher should be explicit in the fact that narrative research is inductive in nature and proceeds from *"specific instances to general statements rather than the reverse".* Importantly they clarify sampling and sample size and suggest that:

> *".... In narrative research the sample size need not be large as it is based on information rich cases"* (Holloway & Freshwater 2007 p 66)

It is important to acknowledge the debate around sampling in qualitative research. There is much discussion in the literature and some confusion over sampling methods in qualitative research. Patton (1990) argues that qualitative research typically uses purposeful sampling to enhance understanding of the information rich case, which is particularly pertinent to narrative inquiry and this study. My sampling method was purposive in that advertisement for study participants was made in places where there were likely to be potential participants with relevant experiences to narrate.

The decision to have 20 participants in this study was based on discussions with my PhD supervisors, based on what was a reasonable size to capture a diverse group of participants, was convenient for the purpose of the study and that our

experience suggested was a suitably sized study group for this PhD. Sandelowski (1995 p179) supports this approach:

> *"Determining adequate sample size in qualitative research is ultimately a matter of judgment and experience in evaluating the quality of the information collected against the uses to which it will be put, the particular research method and purposeful sampling strategy employed, and the research product intended."*

To an extent the decision of sample size was constrained by three factors: the first was the aim of producing transferable knowledge into the clinical setting. My PhD was partly funded by my employers with the expectation that it would have an impact on clinical practice. Working in a healthcare environment that predominantly uses quantitative research as its evidence base has a cultural effect, which influenced this study since research is expected to be generalisable and is often more valued as a result of its objective, generalisable perspective. To a degree my decision to select 20 participants was influenced by the need to demonstrate a suitably sized study. It must be recognised though that this is in tension with the second influence, a purist narrative perspective, which argues each narrative stands on its own and sample size is inconsequential since the aim of narrative inquiry is privileging the subjective experience of each participant rather than developing generalisability. The third influence on my study sample size, that is important to recognise, were the expectations and restrictions set by the University for the length of a PhD study. I wanted to conduct a study that was manageable given these restrictions but I was also encouraged by my supervisors to use 20 participants in order to demonstrate a breadth and depth of approach appropriate to a PhD study.

3.9.14. Interview process and methods:

Individuals were invited to attend a one to one interview, in writing, via poster advertisement or electronic mail-shot. They were also sent a study information sheet (Appendix 3 p263). The invitation letter (Appendix 4 p266) specified that the interview would be audio taped. The venue for the interview was negotiated and arranged with them by research admin support.

Interviews were held in a place chosen or agreed to by the participant, which was private and informal enough to be conducive to the studies narrative methodology. At the start of interviews participants were given the opportunity to discuss the information sheet and asked to sign a form

consenting to participate. This outlined conditions affecting their withdrawal from the study, how data would be processed, how it would be stored and who could be party to the data.

Once they were ready to talk the tape recorder was started. Overcash (2004 p15) comments that:

> *"Attention must be given to the type of interview and the type of responses provided by the participant so a reasonable understanding of the data be attained. Narrative data are usually derived by asking open-ended questions, which can be a part of structured or semi-structured interview."*

Participants were then given a brief introduction to my study and asked to talk about their experience of using/providing services and the things that were either helpful or barriers to recovery journeys. My introduction was typically along the lines of:

> *"Thanks for coming today, my study explores what people think are facilitators and barriers to recovery in dual diagnosis. I'm interested in hearing your stories about dual diagnosis."*

This opening statement added a degree of structure and direction to participants' narrative. Whilst this statement varied only slightly each time (the two examples of transcriptions in appendices 5 & 6 offer testament to this), every interview commenced with a statement very similar to this as an explanation and frame for the narrative. This was the only type of framing I used, I did not use an interview schedule or offer any outline topics as a guide for participants. Riessman (2008 p23) argues that interviews in narrative studies should be reframed away from the traditional questioner and respondent power dynamic, into a process where there are "*two active participants who jointly construct narrative and meaning*". Ultimately my research question and my research interest framed the overall grand narrative of each story. In most if not all cases the free flowing nature of the interview meant that participants had the opportunity to develop their own emphasis. As interviews progressed participants became more relaxed and longer, rich stories emerged. I was surprised how quickly participants forgot that the interview was being recorded, which aided narrative development. I frequently asked questions and returned to areas that they had mentioned or alluded to earlier in the interview. This felt natural and aided frank participation.

Typically interviews lasted between 45 and 90 minutes. At the conclusion I offered participants the opportunity to see the transcript of their interview once it had been typed. Only two participants asked to see these and they did not provide any feedback.

3.9.15. Transcription:

(Example transcripts of interviews in this study are appended as Appendix 5 and 6 on pages 269-302) Once each interview concluded the audio copy was sent to a typist, who as an employee of Nottinghamshire Healthcare Trust was conversant in the need for confidentiality and had been specifically briefed on the confidential nature of the data in my study. She transcribed the audiotapes into an electronic document, that Riessman (2008 p29) describes as *"straddling the border between speech and writing".* Typically this captures the spoken discourse, including pauses, coughs, laughs and other verbal 'gestures'. This transcription method is common in phenomenological research and is contrasted with more detailed transcription in discourse and conversation analysis by Langdridge (2007 p73) who says:

> *"The focus is nearly always on producing a transcript that, in effect, provides the analyst with a verbatim account of the interview. This will include ums and ahs but not any finer level of detail"*

Langdridge (2007) questions the extent that the transcript should be corrected. He asks whether we should erase aspects such as 'urms' and if the transcript should change to improve clarity when the narrator uses colloquialisms, abbreviations or mispronounces something. To aid clarity, where this occurred, I retained the narrator's original quote in italics and clarified or explained in parentheses. I remained true to the principles of critical narrative analysis and stayed *"as close to the speech of the participant as possible"* (Langdridge 2007 p74).

Audio data was retained for use during the analysis stage, to ensure accuracy and to allow me to sense check any incongruities in the written transcript. In line with ethical approval the data will be stored on University and NHS password protected computers for up to 7 years. As each transcript was analysed, names and recognisable places were anonymised to aid confidentiality. The audio recordings were listened to in conjunction with the transcripts to ensure accuracy and to enable recollection of some of the non-verbal nuances to conversations. Each line of transcription was numbered in the final document to

enable referencing of quotations in the analysis chapter, ensuring accuracy and rigour in the recounting of participants stories.

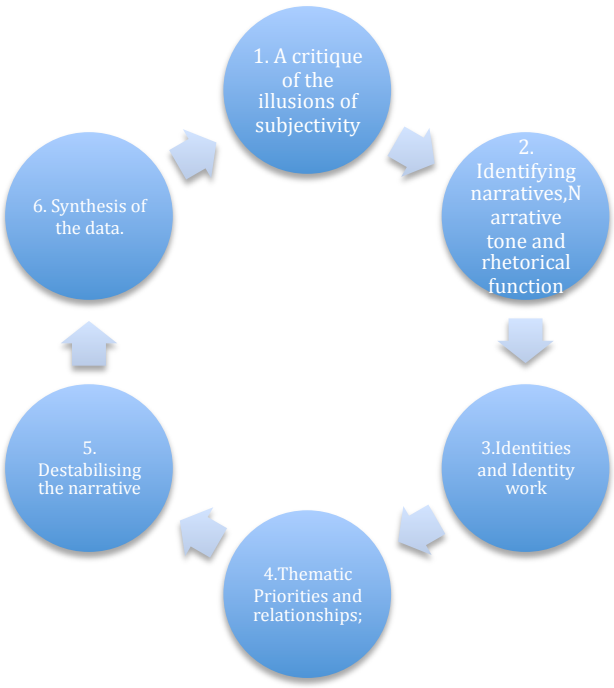
3.10. Critical Narrative Analysis (CNA)

The analytic framework chosen is CNA, proposed by Langdridge (2007). It is described as a *"framework for reading text"* based on the work of Paul Ricoeur that marries phenomenological philosophy with hermeneutics. Langdridge (p129) states that the form of CNA he describes is unusual in that its *"disparate components are philosophically grounded and practically combined into one analytical approach".* He argues that in combining approaches into one analytical framework CNA addresses many of the criticisms levelled at phenomenological methods while staying grounded in phenomenological tradition. The six-stages of CNA are outlined in Figure 3. The stages are not necessarily to be seen as discrete but as Langdridge (2007 p133) says:

> *"One of the aims of CNA is the synthesis of a variety of analytic tools to better enable the analyst to work critically with the data and to shed light on the phenomenon being investigated."*

3.10.1. Analysis of the data:

The analysis of data was completed using a framework suggested by Langdridge. Critical Narrative Analysis uses a framework consisting of 6 stages as shown in Figure 3: Stages of Critical narrative Analysis (Langdridge 2007).



Langdridge (p134) describes stage one as a *"moment of reflexive engagement, where the researcher thinks through their background and experience and the*

impact this might have on the questions being asked, the data that they have produced and that will form the basis of their analysis". As the reader will note much reflexivity has gone into the writing of this thesis and areas of relevance to this part of the analysis can be found in a number of other chapters, notably the Introduction, the chapter on Narrative Theory and the section on Reflective Ethics. Throughout my data collection I used reflection, both personally and in supervision to recognise the influence I had on the process and in order to develop my analytical technique. As this process developed reflexivity led to a refinement and to some extent, in my opinion, an improvement in my interview technique and subsequently the data collection process. This was notable on rereading the transcripts. This analysis section will focus on stages 2 to 4 for each of the narratives. Stages 5 & 6 of the framework form the discussion chapters of this thesis. The first stage of CNA follows as part of this chapter.

3.10.2. CNA Stage one:

As described by Langdridge (p134) the first stage comprises reflexive writing about my place and experience in influencing the captured narrative. This reflection on my own values and beliefs are important as it helps shine a light on the '*illusion of subjectivity'* (Langdridge 2007p140). CNA demands that I take this opportunity to lay bare my own bias to give context to the co-creation of the narratives captured, which I hope adds rigour to my method through transparency. Stage one of my analysis further involves applying a '*hermeneutic of suspicion'*, a term coined by Ricoeur (1970) and later developed by Gadamer (1975), which assumes that all description is interpretive and it is the researchers job to use suspicion as a form of inquiry to reveal the underlying or hidden truths in narrative. Langdridge (2007 p136) distinguishes between two types of hermeneutic of suspicion, '*depth hermeneutics'* which he describes as a process of "*dig(ging) beneath the surface to find the deeper meaning*"; and '*imaginative hermeneutics'* of suspicion which uses appropriate social theory as a counterpoint to create "*imaginative variation*" whilst preserving the narrative *voice* of the participants in research.

I have used reflexivity on an ongoing basis in attempt to critique my own perspective as co-creator and audience to the stories being told. My methodology and epistemological perspective demands that I explore my own beliefs about the nature of substance misuse and addiction and their influence on the epistemological perspective of recovery:

As a senior clinician working in substance misuse my tendency is towards a behavioural perspective of addiction. Typically I prefer to use behavioural interventions in my work because my experience and knowledge of the evidence base suggest behavioural approaches offer the best long-term outcomes for people. This is difficult when working in a system that encourages substitute prescribing since the idea of 'give a drug to replace a drug' tends to reinforce reliance on drugs rather than self-efficacy as a reliable coping strategy. Ultimately though I believe that providing a stable platform through prescribing allows an individual to deal with the immediate habituation they experience and provides space to work on issues that undermine their recovery journey.

Pragmatically and ethically it is important for me to be able to offer a range of treatments to my patients based on their choice. I often use the term addiction in therapeutic sessions, but I am philosophically averse to the term. I believe there is much loaded language applied to treatment and recovery that can ultimately affect outcomes in substance misuse. This can be in direct tension with the language that people know, understand and accept in relation to addiction. Typically I avoid the use of the term addiction because it is implicitly linked with the concept of disease; however, it is useful because it is in common use, succinct and it has a shared meaning. Contrast this with 'problematic drug and alcohol use' which whilst more acceptable from a behavioural perspective, is linguistically cumbersome in the extreme!

The idea of addiction in itself occurs in response to people's sense of loss of control over their drug and alcohol related appetites. It's important to point out at this stage I am not trying to suggest there is no such thing as addiction. Many people in this country and the world over have significant problems due to drugs and alcohol and many of them believe they have an addiction. These service users are frequently treated by people who also believe in the disease concept of addiction, who employ therapies orientated towards abstinence and who work within systems that view recovery from addiction as implicitly linked to abstinence. Evidence suggests that this system appears to serve many people well (Montgomery, Miller & Tonigan 1995). But my experience tells me that there are many casualties of this system, people who feel indoctrinated by an ethos that doesn't fit with their experience or worldview. One of the main challenges for practitioners and service users in these circumstances is being able to un-programme some of the beliefs that previous unsuccessful addiction treatments develop. There is a tension between behavioural concepts of substance misuse

and disease concepts of addiction that potentially undermines the success of behavioural interventions. As an example the Abstinence Violation Effect (AVE; Marlatt and Gordon 1985) suggests there is a difference between lapse and relapse that affects the behaviour of an individual and ultimately their outcomes in maintaining abstinence. AVE therapies work on paying attention to controllable and situational factors that can positively affect the degree of lapse or relapse and, through learning, ultimately lead to positive long-term recovery outcomes. However, If an individual's beliefs, formed through earlier treatment, remain firmly attached to disease concepts of addiction, based on an absolute perspective of abstinence, then there is a conflict, since abstinence is absolute, there can be no degree to lapse or relapse. I do not perceive that behaviourism holds the same problems.

As my data collection progressed I experienced a number of surprises. In reflecting on some of the interviews, I was struck by how passionate participants were about their journeys of recovery. In particular I noted how unfamiliar I was with the fact that many people held a particular ethos or set of beliefs about addiction to be dear, yet they were magnanimous in recognising that not everyone subscribed to the same beliefs. I mention this because in the past I have often found people can be dogmatic about their 'take' on addiction and its causes. To some extent I expected participants in this study to be much more dogged about their 'take on addiction', but the opposite was true.

As a professional 'expert' in dual diagnosis I regularly challenge my interpretation of the meaning and manifestation of such complex phenomena as mental health and substance misuse; through reading, supervision, peer discussion and reflection. Equally I am passionate and protective of the concept of dual diagnosis. This is a direct result of having what some might call a 'vested interest'. I have developed the local dual diagnosis service over the last 14 years and I chair a national group of 'experts' in dual diagnosis all of which can be said to influence my beliefs about what can be done and what works for people who have dual diagnosis. That said I am also a passionate advocate of user involvement, having been a seminal member (invited by the wider group) of an active dual diagnosis service user forum in Nottingham. I strongly believe that our service users and their carers voice should influence and shape the way we deliver care and therapies. My experience tells me that people who experience a multiplicity of complex problems often get a poor deal from services, that are rarely equipped to offer good quality holistic care to help individuals cope with

all their issues. The fact that I set up a dual diagnosis service makes me passionate about the service, the staff that run it and the service users, patients and families we work with.

As a practitioner working in this arena for more than twenty years, the concept of joined-up, integrated and holistic provision of services has never faced greater challenges. Financial imperatives in the NHS, the restructuring and fragmentation of mainstream health, public health and social care budgets and commissioning mechanisms in the UK make holistic care a greater challenge than it has ever been. It is difficult to remain professionally a-political whilst addiction and mental health are rarely treated with the esteem other health and social care issues receive. Parity of esteem is an emerging issue in the field of mental health and as a CD I am frequently faced with situations where I argue that mental health issues deserve as much attention and funding as physical health, social care or criminal justice.

Participants in my study commented on the political impact on services and care they received or delivered. The tension for me is manifest in holding a dual role as both clinician, who is passionate about the need for holistic dual diagnosis care, and CD (a leadership, strategist role) that enables me to see the 'real' operational challenges and priorities that are often at odds with my clinical passion. Some of my research participants know me in my professional capacity, both as Consultant Nurse and CD. I cannot underestimate the effect that this may have had in their decision to participate in my study but also in what they decided to say.

Underpinning many of my professional values are a number personal experiences and perspectives that influence my understanding of substance misuse. Within my own immediate family I have experiences of the catastrophic effects that drinking alcohol excessively can have upon someone's life; my mother drank excessively and died of alcohol related problems at the age of 60. My brother has extensively 'experimented' with drugs and has developed some significant health problems as a result. These perspectives allow me to empathise with many of the patients who I work with, but they also influence my perspective on what I believe helps. My mother didn't get any help for her profound drinking and when people, rarely, talked to her about it they always seemed to suggest she could 'just stop'. Just stopping, the thought of being abstinent, as opposed to controlling her drinking, became a barrier for her in dealing with her problem. Conversely I have friends and family who drink, and

use drugs in what I believe is a controlled and unproblematic way. I myself am fond of a glass of wine or a beer. In the past I smoked roll-up cigarettes, but stopped smoking ten years ago. I didn't have any professional help and neither was I prescribed any of the nicotine replacement therapies that are more commonly available now. I believe this reinforces a strong belief in the values of self-efficacy. Most people who have a substance misuse problem recover because they have both the right attitude (Ball Graff and Sheehan 1974) positive psychological well-being (De Leon & Jainchill 1986) and the recovery capital in place to do so.

Class has always played a significant role in how we as society view drinking and drug taking, but also in how substance misuse problems manifest themselves (Berridge 2013). The evidence suggests that there are significant links between social class, ethnicity and problematic consumption of drugs and alcohol as well as a number of physical health problems (Foster, Marshall & Peters 2006; Norstrom & Romelsjo 1998, Fone et al 2012). I am a middle-class white male who drinks alcohol, and I smoked in the past. When I drink I tend to drink what I regard as good quality wine, or 'craft' beer. You could say I'm interested in wine and beer or even that it's a hobby (I've been on the odd brewery tour for instance!). Clearly this is a very different perspective to a 'white lightning cider' street drinker who would be laughed at if they tried to suggest it was a hobby! I make light of an important factor, social class is not only a direct impact on whether, how much and how frequently we drink, it is a factor in how or whether we engage with treatment (Galea et al 2004).

I have often found in my clinical and research practice that my tendency to use behavioural conceptualisations of addiction is at odds with other's beliefs, particularly those that conceptualise addiction as disease. The fact that my interview participants were less precious about this has made me think differently as a result. In her book "Demons" Virginia Berridge (2013 p3) notes that British (and probably international) society is going through a state of *"flux in relation to attitudes and practices surrounding the use of mind altering substances".*

3.10.3. Writing up the Analysis:

Throughout the process of writing up each analysis I endeavoured, as Langdridge (2007) suggests, privileging the voice of the narrator. I used quotes from the original transcript to illustrate and underscore findings. Quotes are clearly referenced with line numbers from the transcripts. For the sake of confidentiality

each participants' name was changed. Names and also places mentioned in transcripts were anonymised. Each transcript was analysed separately and written up in the same format using Langdridge's CNA framework stages as headings, the only adaptation is that I added a brief introduction for each participant to add context.

3.11. Methodology section conclusions:

Coles (1989) relates a story of his supervision sessions with his two clinical supervisors to illustrate the value of avoiding "*prematurely brush(ing) aside the particulars to get to the general*". In his narrative he describes his respect for one supervisor, Dr Binger *"a brilliant theorist,"* and his frustration at his other supervisor, Dr. Ludwig who *"did more listening than talking".* As time passed, Coles *(1989)* describes realising that: *"I wasn't getting very far with the "phobic patient" but felt reassured by Binger, who would remind me that "phobics are hard to treat"..... One day sensing his student's disappointment and frustration Ludwig decided to do more talking than listening. He told Coles a detailed and suspenseful story about a female patient of his who had been paralyzed by stifling worries and fears."*

Coles recalls being *"quite taken up by listening, even forgetting for a long spell that this was a patient's 'clinical history' I was hearing . . . as I pictured her in my mind."* Ludwig's story stuck in Cole's mind for the next 30 years of his career: *"The people who come to us bring us their stories. They hope they tell them well enough so that we understand the truth of their lives."* (Coles 1989)

Cole's illustration of the value of narrative has resonance for this study. In seeking theory or generality to support treatment approaches taken from substance misuse and mental health in treating dual diagnosis, researchers have missed uncovering the specific and authentic, subjective experience in narratives of people who experience these problems. I believe that this offers a strong rationale for using a narrative theoretical approach.

In an interview with Arthur W Frank, Eldershaw, Mayan & Winkler (2007 p132) highlight Frank's thinking about power relations in storytelling. Frank discusses the sense that a power relationship is played out in society between individual's who have *"fully narratable"* life stories and those whose experience of disability renders their life story "*non-narratable".* Frank discusses how the narratability of an individual's story can be directly related to individual's political entitlement. The temporal disruption of people's lives, who experience disability or illness,

because their lives do not follow the pattern of expected developmental milestones, renders their stories non-narratable or limits their narratability. This is of particular relevance to individuals who experience dual diagnosis whose sense of *'double jeopardy'* is played out by the services they receive and in wider society.

Recovery is a powerful and empowering concept precisely because it allows individuals to re-story their lives in terms of their past and future goals. Increasingly UK central government policy on substance misuse is reinterpreting recovery to mean abstinence from drugs and alcohol as part of a pathway of self-improvement and reengagement with 'functional society'. Recovery as a concept that encompasses an individuals own life goals and empowered decisions about change in their life is potentially being hi-jacked by this reinterpretation. Frank (2002 p9) describes this as a "*knock to authenticity*" because "*culture is exerting enormous pressure on people to settle for identities that are trivial*". By discovering people's narratives about their recovery and the facilitators and barriers around their recovery I aim to render narratable things that have been 'non narratable'. These are poorly represented by existing research and policy. In this manner Holloway and Freshwater (2007 p57) state that:

> "*Narrative research can be an appropriate method to give a voice to marginalised groups within society"*

This study aims to uncover the stories people who experience problems with drug, alcohol and mental health tell about their recovery, the things that they see that helped, and those that they sense were unhelpful. I am also interested in the stories of those people who try to help them. This may help understand some of the actions of stereotyping widely reported in research literature associated with dual diagnosis. By contrasting the narrative between these groups it is my hope that a set of narrative experiences will emerge that offer insight into facilitators and barriers to recovery in dual diagnosis. Some social scientists (Riessman 1983, Mishler 1986 and Holloway and Freshwater 2007) term this power of narrative research "*transformative*".

4. Findings: CNA stages 2,3 & 4.

4.1. Introduction:

The following chapter takes each of the twenty narratives and analyses them using stages 2, 3 and 4 of CNA. In order to maintain structure and consistency and to ensure that one participant's narrative isn't privileged more than another each analysis has the same structure and each analytical section is approximately equal length:

- Stage 2. **Identifying narratives, narrative tone and rhetorical function**
    - **A brief introduction**
    - **Grand Narrative,** (approximately 150 words)
    - **Narratives, narrative tone and rhetorical function,** (approximately 500 words)
- Stage 3. **Identities and identity work** (approximately 500 words.)
- Stage 4. **Thematic priorities and relationships** (approximately 500 words.)

Service user narratives:

4.2. Critical Narrative Analysis "Anne"

Introduction: Anne regards herself as an ex-drinker who is on a recovery journey. She is an active member of the dual diagnosis service user forum and also cares for her daughter with drug problems.

4.2.1. Narratives, Narrative tone and rhetorical function:

Grand narrative: in Anne's interview is predominantly one of a struggle to maintain control and as Frank (1995) describes meeting her "*suffering head on*" (p115); this is a quest narrative; accepting her problems and seeking to use it to benefit herself and others. Struggle and loss feature throughout; struggling to control her drinking; cope with her agoraphobia and depression; to maintain a relationship with, and cope with her daughter's drug use; maintain hope and self-efficacy. This narrative is one of the misunderstood beleaguered mother, stigmatised drinker, and employee, juxtaposed with the reflective emerging peer champion, author and public speaker.

"Not everybody would have drunk heavily but they would have all struggled. They might of ended up on anti-depressants…. I mean at one point I was on beta-blockers, at the time my husband died. I'm not sure why, even now I'm not sure why." (3.56-3.60)

Narrative Tone and Rhetorical Function:

The overarching tragic tone to Anne's narrative has intertwining narrative elements of turmoil, stigma, passivity, guilt, and struggle.

"Slowly I started drinking more and more heavily and getting more and more depressed and anxious and stressed. And then I lost my driving licence and I became agoraphobic because I couldn't get into my own little bubble…. Then getting panic attacks when I was out and just generally had a really crap time". (1.26-1.31)

Whilst this tragic tone is pronounced in her early narrative Anne's tone gradually becomes more hopeful and positive as she moves into a quest narrative that has heroic elements of keeping busy, learning to cope with agoraphobia, balancing control over her drinking and taking control in authoring her life story. Frank (1995 p115) describes the quest narrative as important in affording the "*ill person a voice, as teller of her own story*". Anne's positive tone is always balanced with a tone of tentative caution in an endeavour to convey her sense of the fragility of her recovery.

"I'm really fortunate in that wherever I've been, people have recognised that I'm an intelligent person…mmm and I'm going mad sitting at home doing nothing. Sadly I don't feel well enough to work full time" (7.2-7.6)

"I've just passed my city and guilds in 'training the trainer', so I've got two options to either do peer training or peer support at the hospital for people who have been admitted with alcohol problems…both of which I'll need training for…I've left my options open at the moment, so I'm down as a volunteer." (8.9-8.16)

Anne's notes of caution are consummate with Frank's (1995) assertion that both restitution and chaos stories always remain in the background of quest narratives.

Anne uses repetitive and alliterative language throughout her narrative to illustrate the cyclical nature of her experience in endeavouring to control her drinking and her struggle with psychological difficulties.

"They cross referred me to Annesley St and I had three months of sort of going in, coming out, going in, coming out but eventually I did settle" (1.19-1.22)

"Most of the time I can overcome it, I've learned how to overcome it….Mmm I sort of get to the front door and think 'oh dear I really need to, yes'…..so I live in a little cul-de-sac, so I get to the end of the cul-de-sac and I breathe and then I walk along the road and then I breathe….a couple of lampposts, I just do it in stages. I don't rush." (9.4-9.12)

Anne uses sarcasm as a rhetorical device illustrating the struggle she has with her daughter and how stress in the relationship affects her drinking.

"My dearly beloved daughter moved back home and it all just went pear shaped. I ended up back at Annesley Street because I couldn't cope…. My key-worker came round to the house and did a mediation session because she really was driving me absolutely potty and I was drinking again, heavily" (1.34-1.41)

Argumentation is also present as a rhetorical function:

"someone came out and got me, took me back to my office and the first thing they said was you've been drinking, I said I haven't because they didn't believe me" (1.83-1.86)

4.2.2. Identities and identity work:

Anne portrays herself as struggling heroine, a victim who has been stigmatised but continues to battle through.

"It was a very responsible job, I was a unit administrator in a really busy department…We had three inspections in three months and I did them all perfectly, (I was) chuffed to bits…. And then I had my annual appraisal and all my head of department could concentrate on was my alcohol problem. No 'well done you've worked really hard'….I was absolutely mortified" (1.51-1.62)

" The final straw was having a panic attack…. Thinking I really don't want to be here but I knew I'd got an important meeting and I just collapsed half way across the car park, physically collapsed. Someone had to pick me up and help me. (1.78-1.81)

She also identifies herself as a "Beset Mother", frequently emphasising her daughter's lack of respect for her.

"I don't like being out in the dark. That's new since all this started. I mean my daughter just takes the piss, she thinks its funny but its not funny Charlie I can't control it" (9.22-9.26)

Anne's struggle with her daughter and the lack of respect she gets is contrasted in her story with the emerging identity of respected public speaker and storyteller.

> *"I know when I go to these meetings I'm respected, my opinion is respected. I did a presentation at the dual diagnosis conference…I spoke about my family history, mmm and how I turned to alcohol. I lost my confidence and I lost my self-esteem. Gradually I have built it back up." (13.3-13.10)*

Anne identifies with turmoil and struggling for control, but sees herself as an emerging controlled drinker.

> *"I've had a couple of weeks where I've been drinking heavily and a couple where I haven't. This week's been really good….. I've had four days on the trot where I've not had anything, which for me is really good" (4.3-4.9)*

As her narrative develops she begins to portray herself as a writer, speaker and tentative recovery peer. She identifies with her author persona as one of her main achievements and a positive coping strategy.

> *"If I'm honest, urm I know I'm coping a lot better, urm yes I know my triggers, I know my coping mechanisms one of which is writing" (5.5-5.7)*

Authoring her life story is clearly an important identity to Anne; it sums up her emergent recovery, her control over her life and improving relationship with her daughter.

> *"The homework was to put together a group of photographs that would signify who you were and the important things within your life. I actually sat down with my daughter and went through a good stage….. It ended up being twenty pages, we did an album…. and there is a photograph of me at 19 and one of my daughter at 17 and its like looking in a mirror, which I've got on the front page. Now I'm writing narrative around it, which I'm really, really enjoying" (13.26-13.37)*

4.2.3. Thematic priorities and relationships:

There are a number of interrelated key themes in Anne's story that indicate a developing quest narrative. Authoring her life story stands out and is related to her need for respect, her need for control and organisation in her life. There are developing themes of Anne as a volunteer peer support worker and public narrator of her experiences. Underpinning these themes is a strong belief in self-efficacy as a key element of her recovery.

"most of the time I can overcome it….I've learned how to overcome it" (9.4-9.5)

Early in her narrative Anne emphasises a cyclical/chaotic theme of her experience in attempting to take control of her drinking:

"So I had one key-worker, had a couple of appointments and thought, no I'm fine. Three months later we went through it all again! But then the third time I ended up with a key-worker that I saw continually and for some reason he and I clicked immediately" (3.20-3.25)

"physically, yes I have insomnia I'm used to that…have been for years. If I'm really, really stressed I don't eat properly but then I make up for it, so I know its swings and roundabouts, what goes around comes around." (14.43-14.47)

"I went through the gradual reduction programme, which (was) expected me to zero on the breathalyser, which I achieved three times, but then immediately went back to drinking" (18.2-18.5)

This in turn reinforces later emerging themes of control and being organised:

"I've always been a very strong and organised, independent person. So anytime I found I couldn't cope I thought…no this isn't me, I can cope with anything….which of course I didn't" (3.46-3.49)

Throughout Anne's narrative, themes of loss of dignity, lack of respect and being stigmatised are closely interrelated. Talking about her old job after her boss and other staff had begun to notice her drinking Anne says:

"I was timed on everything, which I found really demeaning" (1.7-1.71)

And in relation to her daughter:

"If I have too much to drink she will have a real go at me. She's now doing recreational drugs, urrr including ecstasy….and if I dare say anything to her…..I'm not entitled" (20.4-20.8)

"She comes home absolutely 'bladdered' crashing into things, banging, breaking things. I'm not allowed to say anything….I've tried to say to her look you don't like it if I go off the rails….I don't like it if you go off the rails. And she says "but its different I don't have your history"". (20.10-20.16)

As her narrative progresses this stigmatised theme gradually turns into one of developing respect, feeling believed and valued, underpinned by her emerging role as public speaker and narrator of her life story

> *"And Gary said 'you really ought to do your story' because of when my daughter was coming home and I was caring for her coming off the methadone, how her difficulties influenced my substance misuse. He said you really ought to do it because yours is a story of two halves, both with good endings" (18.36-18.41)*

Talking about presenting at a conference Anne says

> *"And afterwards, as I say feedback was brilliant and Gary now goes round saying, she can talk of the cuff, she's good…….Thanks Gary (laugh)" (13.65-13.68)*

4.3. Critical Narrative Analysis "Clive"

Introduction:

Clive has been actively using drugs for many years. He experiences paranoia, hears voices and was at the time an inpatient on the substance misuse unit, detoxifying from methadone, heroin and alcohol.

4.3.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

This is a narrative of multiple archetypes, the victim, the stigmatised sufferer and the reluctant hero.

> *"….everything's been fine, there's a long break between seeing him (*the psychiatrist*), where I suffer and have really bad times and there's nothing there to help me in those times, do you know what I mean?" (8.13-8.16)*

At first Clive found it difficult to talk, seeming confused about why he was being interviewed, he eventually relaxed and was able to tell a story. It transpired he had promised his key-worker, who he clearly held in high regard, that he was going to be interviewed

> *"…… but I did tell Peggy I'll do it, so I have" (46.13)*

This passive tone resonates throughout and is to some degree an allegory for his whole experience of drugs, alcohol and mental ill health.

Narrative Tone and Rhetorical Function:

There is a tragic tone to this narrative. Clive has struggled with a chaotic history of substance misuse and his mental health since his childhood. He often feels stigmatised and has used substances, particularly alcohol in an effort to cover up what he sees as his inadequacies. Clive tells a story of getting into drinking alcohol and taking drugs at an early age, as a tacit explanation for his behaviour:

> *"I think I used drink and drugs, urm to hold my mindset because I have always had a problem, I was always in trouble at school for not being able to sit still and all sorts of things. I couldn't concentrate on anything so I reckon my illness has been there all the time and the amphetamines triggered the voices." (44.3-44.10)*

He also used alcohol to help him cope with emerging negative mental health and develop his confidence.

> *" I'm not as shy as I was, I couldn't, I used to get really worried and scared and shy in front of people and alcohol used to help with that you see. Because alcohol used to change me to urm, well an idiot really but at the time it was confidence, alcohol gave me confidence." (30.22-30.26)*

The tone of Clive's narrative is passive but there are also challenging if not slightly aggressive undertones to some of what he says:

> *"I think it is important… you don't want to be treated like a child, coz I've not really been spoken down to myself because I don't give the staff any reason to speak down to me……. But if they did I'd find it a bit, I wouldn't like it." (7.3-7.10)*

There is a grateful tone to Clive's narrative

> *"Yeah, I've… I've heard lots of other people moaning about things in this sort of environment, but at the end of the day they…. they can only do so much." (6.6-6.8)*

Gradually his narrative adopts a more optimistic tone. Clive talks about getting off drugs and beginning to learn to cope with his mental health problems. He looks forward to going back to living with his partner and three children and going to college.

> *"And urr, so I have changed a lot do you know what I mean? I understand my mental health……. but I can't control it and I can't help it, do you know*

what I mean?....It's there and I want it to go away..... but it won't. But like I say the last few days I've not been too bad." (39.11-39.17)

Clive frequently repeats the phrase *"do you know what I mean?"* throughout his narrative. Romero-Trillo and Lenn (2011) have described this as a pragmatic linguistic marker or strategy to avoid cognitive maladjustment. Clive uses this rhetorical function, so frequently, that it appears to be both a marker of nervousness but also an unconscious attempt to gain agreement and reinforce the points he makes.

4.3.2. Identities and identity work:

Clive identifies as a victim both of the voices that he hears and of other people's negative attitudes towards him:

"..... the voices are their own independent voices, there were hundreds of them .....and yeah they were just talking to me constantly, shouting at me and berating me constantly they were, but like I say the Olanzapine has got rid of them..... But there's still the after effects of it all." (12.2-12.9)

Clive identifies himself as someone who has been stigmatised and suffers as a result of having to hide his mental health problems.

"Yeah people say this and that, he's got schizophrenia or he's got psychosis and they probably look on you different don't they.... Where as they shouldn't but they do. Stigma isn't it... with anything". (43.2-43.7)

There are heroic elements to Clive's narrative, talking about detoxifying from alcohol at the same time as coming off heroin, he says:

"I wasn't that bad that I had to have Librium and that because I'd slowed it down out there.....prior to coming off, but I have got an alcohol problem as well, quite bad as well." (4.4-4.8)

He has also been a hero in his attempts to cope with, and hide his emerging mental health problems, which becomes an explanation for his emerging substance misuse:

"And then it started getting really bad as I got older. Well that's why I used to use the drink to mask it you see." (44.37-44.38)

"Oh it was a nightmare but I kept it all to myself. People could see he's not right, do you know what I mean but I was very good at trying to look OK because I didn't want to get sectioned, that was another part of my paranoia." (40.33-40.38)

Clive reinforces an identity of two halves one as the hero locked in a tragic struggle with his own mental health and substance misuse the other as a responsible father, caring son and loyal partner:

> *"But I've never had it* (drink and drugs) *round my kids', do you know what I mean, I don't need to drink or take drugs if my children are there." (37.8-37.10)*

In talking about his improving relationship with his mother Clive says:

> *"I think its because I've calmed down you see…. I'm not such a pain in the arse that I used to be I suppose…… because it's nice to get on with your family isn't it and I do get on with my mum now very well." (24.1-25.3)*

Clive is keen to portray himself as an honest person, even if he is shy and finds it difficult to gather his thoughts. As the interview ended and I asked him if he had any other thoughts he responded:

> *"No but something will come to me later. I'm not very good at this sort of stuff…… I've tried to be as open as I can to you, do you know what I mean, hold nothing back and I don't really like talking about it." (46.6-46.11)*

4.3.3. Thematic priorities and relationships:

In the early stages of his narrative there is a theme on the attitude of staff in relation to the quality of his experience.

> *"…since I've been in here it's been fantastic, do you know what I mean. Urmm, I don't know what I can tell you really." (1.14-1.16)*

Clive impressed upon me that he was having a positive experience and that whilst he had heard other people "*moan*" on the ward he was not one of them. In reflecting on the interview I wonder if this early stage of interaction arose out of a belief that I was interviewing him about his current experience of inpatient treatment. Despite this potential misunderstanding Clive makes some important points on the theme of staff attitudes:

> *"They are very relaxed, they sort of treat you on a level, well they have me anyway, they've treated me like a mature adult, do you know what I mean? They've treated me very well." (3.4-3.7)*

Stigma is an important theme throughout his narrative. Stigma first arises as Clive tells a story about seeing a psychiatrist at school, but *'blagging him'* because he already implicitly understood the connotations of having to see a "*shrink*".

> *"….they did get me to see a psychiatrist but I just blagged him anyway, I knew what he was. I wasn't stupid…..They came to see me…… 'are you going to see a doctor today Clive'. I knew straight away he was a*

psychiatrist, not a doctor. 'What do you mean a doctor, is it a shrink'. Because I used to watch Prisoner Cell Block H so I called him 'the shrink'…… So when I went in I just acted like 'nowt was wrong, do you know what I mean." (44.19-44.30)

Clive demonstrates he is aware of the stigma that mental illness brings, he frequently refers to keeping quiet about it and the voices he hears (see *40.33-40.38* above). The theme of stigma is closely related to the theme of substance misuse as an explanation for helping him cope and mask his mental health problems. To Clive taking substances offered an alternative explanation for his behaviour to the more stigmatising mental illness rationale.

A frequent theme throughout is Clive's perspective on the positive and negative interactions between his mental health and his substance misuse. He is conflicted in this; he sees his use of alcohol and drugs both as something he did to cope with negative feelings and early mental health issues; but he also perceives the negative effects substances have on his mental health.

"…I'm not as shy as I was, I couldn't, I used to get really worried and scared and shy in front of people and alcohol used to help with that you see. Because alcohol used to change me to urm… well an idiot really but at the time it was confidence, alcohol gave me confidence." (30.22-30.26)

Clive has a sophisticated view of this interaction, he understands that different substances can affect his mental health much more negatively than others. In talking about hearing voices Clive clearly states:

"They came back at one point, but urm that was due to amphetamines." (12.31-12.32)

4.4. Critical Narrative Analysis "Dave".

Introduction:

Dave has used drug and alcohol services for a number of years. He is currently taking heroin as well as getting a methadone prescription. He also gets a service from a county community mental health team.

4.4.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

This narrative is one of continuing struggle, boredom and ambivalence. Dave struggles with his rate of progress in becoming abstinent from drugs; he struggles with his prescription medication, despite recognising it as a stabilising factor; he bemoans the support he gets from services and he struggles with the

isolation he feels. Ultimately he is as ambivalent about his recovery and the help he gets as he is about continuing to use heroin and other street drugs.

> *"I'm presently in recovery at the moment but I haven't, I'm not actually linked into the new service yet, which is up at the old KTD building, but I have been using for, this is my 18th year now, but urrr, so I haven't used for 18 months constantly, but as far as I am concerned, I haven't had no positive input from drug workers or doctors with my recovery because I was in shared care with the Castle practice and I've just been left basically to my own devices" (3.3-3.13)*

Narrative Tone and Rhetorical Function:

There is an overarching negative tone to this narrative, even when he is optimistic this is frequently conditional. Dave's tone is immediately critical.

> *"but apart from that, I've been left to my own devices, I thought when I went to this shared care service I was going to get, you know, a bit more help than I have got, but its been, here's a Methadone script for you, see you next month and that's how its been for the past 9 years." (4.21-4.25)*

Much of his early narrative is couched in a tone of complaint and blame, which he uses as a rhetorical device.

> *"it's more like, just like sticking a band aid over the problem, you know, go away we'll see you next week, instead of getting to the root of the problems and trying to sort it out from there, but to me, nobody's talked to me if I was having any mental health issues or you know, housing issues or anything like that, I was just shoved from hostel to hostel and left to do my own thing and that's not helpful to me." (6.7-6.12)*

Dave complains of boredom and is concerned that this poses a risk for him. The tone of boredom and concern pervades the whole narrative.

> *"….for me boredom is my biggest part of it. If I'm just sat, like I say, left to my own devices I will just go out and sod it, I'll go and score, because I know by scoring that will take a couple of hours up and then using the drugs and my day's done then." (8.19-8.23)*

His narrative uses an explanatory tone justifying his lapses into illicit drug use. There is a tone of inescapability to Dave's narrative in these instances.

> *"Like a couple of years ago, urm so as far as I've kept my side of it. I'm staying out of trouble and what have you, not putting myself through the Courts every fortnight and that I'm just being left to my own devices, you don't leave an addict to do that because they will, well they'll just use. I will I'll get so bored, so fed up, so depressed, I'll just go out and I'll use, I'll score, especially when you've got a bit of spare change in your pocket." (5.16-5.23)*

Conversely, there are at times, tones of hope and optimism but these are typically conditional on someone or something else. Dave externalises his responsibility, or when he asserts that he has taken responsibility, this is often conditional. There is a tone of resignation to his narrative that reflects his ambivalence.

> *"So hopefully with the new service and this work programme things will start picking up but you know I don't know." (9.28-9.30)*

Ultimately there is a tone of helplessness that pervades the whole of Dave's narrative.

> *"this Methadone its just like you're on a continuous wheel, you're going round and round and round and round and you're not getting anywhere and its just getting deeper and deeper and you just find it the longer you are going round the deeper it gets harder to climb out."*

4.4.2. Identities and identity work:

Dave is struggling with his identity. He refers to addicts in the third person throughout this narrative. There is a tension for him in recognising his addiction, many of his cautionary stories end with him lapsing and joining '*the addicts*' in procuring and taking drugs. Whilst he reluctantly identifies with other addicts to some extent, he sees himself as something other than them. His ambivalence puts him in a position of limbo where he identifies with his addict former self, sometimes relapsing, and as someone who is in transition, trying to make a go of recovery, wishing and hoping to become a non-addict.

> *"Going up into the town and bumping into addicts, if you've got 5 or 6 pound in your pocket, you just, you tend to find people who will go and find 5 or 6 quid and a couple of quid here, a couple of quid there and then you just gang together and you go and use and that's what I don't want to do. I don't want to use the drugs no more, I want to get off this Methadone as well. I'm starting my reduction programme, its just, to me it just seems to take too long but I do know when you're in recovery you have, like what we call a honeymoon period where you want everything now, you want everything yesterday" (8.378.47)*

This puts him in the role of loner, which he sees as risky but necessary.

> *"I'm just isolating myself and I know that's the worse thing that I can do. Is isolate myself but at the moment that's my way of coping because I find it easier to sit in my flat a mile and a half away from the City centre and I think oh I'm going to go and score, I know I've got to walk into the city centre first" (10.56-10.61)*

He portrays himself as a victim in his narrative, both of addiction, early on in his drug-taking career as a victim of his own naivety, and a victim of his families disdain for him.

> "*That's when my problem came, that's when the money went, that's when I started taking things out of the house, stealing off my Mrs. and things like that and about 3 months after that I had to tell my Mrs. that I had a habit and it was as quick as that, she kicked me out, you know drained the bank account. I didn't see my kids for about 4 months, went back and she didn't want to know me basically. She told me to go and so I did." (10.110-10.118)*

4.4.3. Thematic priorities and relationships:

The overarching theme is one of helplessness and being stuck, or in limbo. Dave talks at length about what it is like to be an 'addict', referring to addicts in the third person. A recurring theme throughout Dave's narrative was his methadone prescription. This can be seen as an analogy for his feelings of being in limbo. Dave recognises fleetingly the value of stability in his life which he partly ascribes to his prescription but there is a tension for him because with stability comes boredom (another significant theme). Dave associates taking drugs with getting high but sees methadone as an impotent tool because it neither satiates his desire to 'get high' or has moved him on into recovery quickly enough. He strongly believes methadone makes him stuck.

> *"I think when you're on Methadone you are just, I think you're just, you know, you're just treating the problem and not the cause. You know you're not getting down to the root of the thing." (20.45-20.48)*

> *"I think it's the Methadone that's stopping me. It's just made it too easy for me." (20.3-20.4)*

Closely nested within this theme are stories about what its like to be an addict and the risks that Dave faces on a daily basis, the most significant of which is boredom.

> *"I'm just going to lock the door and I'm going to be sat in those four walls again. Do I want to stay out and risk the chance of using and standing there talking to a load of other addicts up in town or do I go and lock myself away and isolate myself and just sit and stew on things, you know. I can go and sit and I start thinking about the wrong thing, that can set me off." (21.21-21.27)*

Dave revisits a theme on the psychological challenges of being an addict, boredom being one risk, but there are numerous others. In recounting a story about a recent meeting with a job seekers advisor Dave says:

"…….not going back into full time employment straight away probably wouldn't suit me …. even if I took a part time job we worked out that would be something like 40 or 50 pound a week better off than what I am today and I remember feeling frightened when he told me that" (26.22-26.27)

Stigma is a recurring theme that he recognises affects his confidence and his ability to move on.

"…… the whole recovery thing and its hard for an ex addict to get back into work, I'm not just saying, oh look at me I've had, its not that, it's when people know your past history,…….But if there's nobody out there to give you a second chance then you're just going to get kicked in the teeth every time you step forward" (10.4-10.15)

4.5. Critical Narrative Analysis "Dean".

Introduction:

Dean is a dual diagnosis service user who is taking heroin. He also gets a service from a county community mental health service.

4.5.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

Dean's story is one of the perils of relapse. He is anxious about relapsing into drug use and concerned about the interrelationship between his mental health and the drugs he used to take.

"I just don't want to go back and do a relapse because if I did it might trigger it off again." (46.8-46.9)

Dean is conscious that he has achieved a degree of stability and wants to continue to be stable.

"I don't know it's… it just happens. Shouting at my voices, telling my voices to stop it you know and swearing and what, as soon as I take the medication you know it seems alright." (74.1-74.4)

He is aware of the impact illicit drugs have on his mental health problems.

"When I first started you know with, when I was hearing voices and taking drugs and I was taking tablets, you know the tablets weren't working as good as what they were. So I just stopped taking drugs, you know amphetamines and what not" (6.3-6.7)

Narrative Tone and Rhetorical Function:

There is a distinctly passive and shy tone to Dean's early narrative. In my reflective writing about this interview, directly after I had seen Dean, I noted that the interaction had been difficult. Dean was not a willing storyteller and was shy

and anxious. At times he opened up and talked at much greater length, at others he was sparse with his narrative or he sat silently for long periods. As Dean's narrative developed his tone developed into one full of anxiety and suffering.

> *"My experiences, I used to you know, when I first, I thought I had a camera in my eye that's why you know, I was watching and I was watching them and it was horrible." (28.5-28.8)*

His anxiety makes him tentative about succeeding partly because he has tried and failed so many times in the past.

> *"it keeps playing on my mind a lot just lately…….I just don't want to go back to how I was" (46.11-48.1)*

He is regretful when thinking about previous relapses and what that might mean for his future.

> *"It just does, yeah I'm thinking shall I go and get some of that and have a good smoke on it or shall I inject it, no I can't do that and I feel very, I don't feel very good, I'd just regret it……. (DM: So have you had experiences where you've relapsed before?) Yeah, yeah…you know when I've really relapsed, used and took my drugs and whatever, I just regret you know taking them." (52.2-52.5)*

On occasions his tone was positive and hopeful about his current situation but even then Dean struggled to be optimistic about his future.

> *"Yeah I tend to love it now when I get tested for drugs and it all comes back negative, and it's just positive for Methadone, because you know, that's the substitute that I'm taking, and I'm on these antipsychotics for mental health and that……. I'm starting to hear my own voice and things like that." (5.3-5.8)*

> *"I think that I'm going to stay on it now for the rest of my life because if I come off it I don't think I'll ever be the same again." (12.2-12.4)*

He seems lonely and some of his narrative is couched in tones that reflect his sense of isolation.

> *"I used to go out on my own at night time, I used to ride out on my bike and just be on my own, hearing voices and what not." (28.10-28.12)*

> *"I've got my feelings back you know from not taking drugs, because when I did I used to be in a dark world all the time, just cut everything off" (50.2-50.4)*

Overall Dean is passive and ambivalent, he struggles to see what the future might hold. Whilst discussing what recovery means for him he responded in a flat monotone:

"I don't know yet. I'll see when it comes." (40.1)

4.5.2. Identities and identity work:

Dean identifies himself as a past-addict; he has been a heroin user and an injector of heroin amongst many other illicit drugs.

> *"You know I used to get my money together and go and score for some Heroin and then I used to be alright for the next morning but once all that's gone and you've got no money, you've got to do it all again (laugh)" (24.7-24.10)*

He recounts brief stories about the pattern of his daily life as an addict. Dean recognises that theft and shoplifting is part of that lifestyle but he seems reluctant to identify himself as a criminal.

> *"In the end I ended up going to prison for it, you know I was doing a five month jail sentence for just shop lifting and then I used to get probation and go to them and whatever, I used to be released out you know and then I used to get other charges on top of my shop lifting you know, I used to get remanded back into prison." (25.1-25.6)*

He also identifies his past self as "*mental*" someone with developing psychiatric problems.

> *"My mental health at that stage, it you know, I didn't have it then, I wasn't diagnosed until, what…… I started taking amphetamine and that's when I started getting mental……..I went to hospital and tell them, look I've got something wrong with me and I had to see a psychiatrist and tell them, they put me into Millbrook for a week and they started giving me these medications." (26.1-26.9)*

Dean would like to identify himself differently in the future, as an independent capable person who can travel but he always returns to his current reality.

> *"get me sen' a passport and fly away (laugh)…….Yep, I don't think, I wouldn't be able to go on my own I don't think, I need someone with me." (42.4-42.7)*

Dean now identifies himself as someone who doesn't use illicit drugs and even though he worries about relapsing he is certain that he is someone who needs to be abstinent. This is evident when he contrasts himself with his brothers and sister.

> *"I think I've learnt my lesson now with drugs. I've got a strong mind I suppose. You know my brothers and sisters still using and what, still taking them now……. You know I still see them injecting you know, but I don't……. no, I don't touch it no more." (69.6-69.12)*

He highlights his identity as something different to his siblings:

"I try and tell them now you know, I'll say what you doing, why don't you just stop taking it like I did, but they just can't, they can't do it…. They are more gone if you know what I mean, with the drugs than what I was."

4.5.3. Thematic priorities and relationships:

There are a number of themes in Dean's narrative, which relate to the overarching theme of stability and his concerns about relapse. Dean's view of his current stability is closely linked to a theme on medication, in particular methadone and his psychiatric medication. He sees this as important in preventing withdrawals, resolving the voices he hears that make him paranoid and the overall interaction between his mental health, anxiety, paranoia and his use of drugs.

"Psychiatric drugs, they help with my mental health. You know I can't hear voices now, and now I'm not taking drugs it's a lot better."(15.3-15.5)

Dean is so certain of the role that Methadone has in creating his current level of stability:

"…it helps a lot to me I think. You're not, you're not withdrawing from Heroin, you're not getting them rattle effects you know." (14.1-14.3)

"I think that I'm going to stay on it now for the rest of my life" (12.2-12.3)

Whilst he doesn't always acknowledge it, Dean's narrative demonstrates that he is aware of the complex interactions between his mental health and substance misuse. He frequently returns to the theme on the effects of illicit drugs and a drug-takers lifestyle on his mental health.

"When I first started you know with, when I was hearing voices and taking drugs and I was taking tablets, you know the tablets weren't working as good as what they were. So I just stopped taking drugs, you know amphetamines and what not… And now my tablets work a lot better. I still hear voices sometimes but you know it subsides a lot…. it's a lot better." (6.3-6.11)

Whilst Dean is aware that he is engaged on a recovery journey he struggles to articulate where he is heading next. He does however recognise the value of having personal targets, a theme that he alludes to on a number of occasions throughout his narrative.

"Yeah I tend to love it now when I get tested for drugs and it all comes negative" (5.3-5.4)

Dean worries about relapse, a theme that he talked about a lot. His inability to talk about progression and recovery milestones is partly couched in his

recognition of the value of his current stability, linked to his prescription of methadone. He is concerned that he still thinks about heroin and he uses this as a rationale underpinning the fragility of his current abstinence and his worries about the effect that a relapse into taking heroin or other drugs might have on his mental health.

> *"I keep, you know, I keep thinking about drugs and what even though I'm on medication….. I just don't want to go back and do a relapse, because if I did, it might trigger it off again." (46.4-46.9)*

Dean worries about the effect illicit drugs have on his physical health and this creates anxieties for him about dying. He says quite forcefully

> *"…this has got to stop or I'm going to end up dead." (57.8-57.9)*

4.6. Critical Narrative Analysis "Norman"

Introduction:

Norman describes himself as a recovering alcoholic. He is an active member of the Recovery College. He now provides teaching and mentoring to his peers.

4.6.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

Norman talks about his alcohol problem and its relevance to the transient mental health problems he has experienced. The overarching narrative here is of multiple archetypes, the sufferer, the victim, the survivor, and the hero. These resonate with temporality as Norman talks about them in three stages, the sufferer and victim in the *before,* the survivor in the *after* and the hero in the *present. This* temporality of narrative fits with Ricoeur's theory of Time and Narrative (1990). This has relevance to Norman's experience of treatment and recovery. He has used services that subscribe to a disease model, that champion the time an individual has been in recovery as a mark of achievement that reinforces abstinence as recovery, a fact Norman was keen to extol at an early stage of the interview:

> *"I've quit for 19 months and I'm, I'm just loving life again" (2.67-2.68)*

Narrative Tone and Rhetorical Function:

Norman portrays himself as a recovering alcoholic, on a recovery journey. Throughout, he asserts his belief that he could relapse disastrously at any point. He argues this as a counter point to controlled drinking.

> *" I can't have even one little sip of it because I'll go back" (8.13-8.14)*
>
> *"If I have six pints. It's the same in AA, one's too many and twenty four's not enough" (15.7-15.9)*
>
> *"If I touch a drink, I will die" (17.17)*

Norman attends Alcoholics Anonymous (AA) which focuses on a disease based ethos of alcoholism. His argumentation is entirely concordant with his experience of that system. Arguing against any possible counter narrative Norman is occasionally critical of services that offer controlled drinking options.

> *"I was first referred to KTD* (drug and alcohol services) *on 19th December 2009…… they're totally crap! That is my view. If you come back onto views of controlled drinking. I watched that documentary with Russell Brand and he don't believe in like methadone because it's just prolonging the illness……I'm not slagging controlled drinking off by any stretch of the imagination, it just wouldn't be for me" (21.7-21.14)*

Other narratives seem to contradict this staunchly held belief in abstinence:

> (talking about his daughter) *"She gets frightened now….. she's going to turn into an alcoholic. I said to her no, all your mum is drinking is two glasses of wine very Friday night ……. every Friday not every day" (16.16-16.19)*
>
> *"But there are people out there who can do a full time job Monday to Friday, go out on the Saturday night and get absolutely battered and then won't touch it again until Saturday or the next Friday" (8.14-8.18)*

Norman's tone is tragic especially when describing his '*alcoholic*' self. When he talks about his time as a sufferer he emphasises the tragedy and loneliness of his previous isolation and lack of connection to wider society.

> *"Because I used to be just stuck in the house, that was it. That was my life, getting up, getting drunk, the shaking, starting rattling" (5.35-5.37)*

Norman is melodramatic most noticeably when he is illustrating his risk of relapse. Occasionally he takes on a critical but apologetic tone, there is a sense that he feels uncomfortable criticising services because they don't fit with his

world-view, maybe because it is an adopted worldview that contradicts previously held beliefs.

The tone of Norman's narrative is transformational, optimistic and positive, he talked animatedly about his change from alcoholic to recovering alcoholic.

> "*It's just a transformation!" (10.12-10.13)*

> *"I went in to hospital, I was 8 stone 4, I came out I was 10 stone 1 and I'm still 10 now" (11.8-11.9).*

4.6.2. Identities and identity work:

Norman describes himself in the *before* as a sufferer, living a chaotic homeless life, being sectioned under the mental health act due to a psychotic episode and suffering with *alcoholism*.

> *"I was diagnosed with alcoholism, obviously, and psychosis, or psychotic or whatever, but I was told that I don't suffer from it anymore" (2.25-2.28)*

This identity is reinforced by his sense of disempowerment

> *"I can't even have one little sip of it because I'll go back" (8.13-8.14)*

Norman juxtaposes previous lack of insight with his current identity, an enlightened recovering alcoholic, to emphasise his recovery.

> *"Yeah, yeah I…. I lost everything. I lost my wife, I lost 7 years of my daughter growing up, I lost my job. I was homeless for six months, mental health issues, homelessness and I had loads of debts when I came in to the hospital" (2.81-2.85)*

> *"It's so nice to get to the flat and to actually open the door and switch a light on, to put the kettle on, you've got electric and you've got hot water so you can have a bath. I didn't use to do that when I was drinking, I was lucky to have two pot noodles a week and say a bath once a month" (11.3-11.8)*

His identity evolves from one of sufferer from alcoholism to a current sufferer from disability, which he links to stigma:

> *"well my stigma is the stick because the amount of times I've been escorted out of the posh shops like Next because they think I've got a rucksack, I've got a crutch. I'm going to be like stealing, shoplifting! Which would be crazy because I wouldn't be able to get far for a start" (9.4-9.8)*

> *"once people know that you're a recovering alcoholic they just tend to step back rather than thinking oh good on you" (9.13-9.15)*

"25 years of drinking you're just totally lost. I don't know…. it's…I suppose it's like coming out of a coma" (5.10-5.11)

His sense of hope and optimism is tinged with concern that he faces other challenges now as the sufferer of a disability, stigmatised for being a recovering alcoholic.

"I've accepted I've got mental health issues which will come back if I do start drinking again. But once people know you're a recovering alcoholic they just tend to take a step back rather than thinking…. good on you" (9.11-9.15)

"its easy to stop drinking, its maintaining the abstinence that's the killer." (5.16-5.17)

Norman portrays himself as a victim, tolerating criticism from others which reinforces his hero identity:

"I think the problem with my ex-wife is she don't like to see me succeed because I was a beeb when I was married to her" (13.13-13.14)

"…She'll slag me off about being oh you're costing the NHS money, I say yeah I was…I'm not anymore" (13.24-13.26)

He recognises his previous self as wallowing in suffering and highlights the risk in doing so, at the same time seeing his present identity as a survivor:

"I can stop feeling sorry for myself and get on with it, like I am doing, or I can just go back to that isolation in the flat and drink" (2.76-2.78).

Norman identifies his 'survivor/hero self', living with alcoholism, and remaining abstinent despite people around him drinking. His heroism is linked to a sense of himself as magnanimous**:**

"if we go to the pub and someone says oh why aren't you drinking, oh I'm on anti-biotics….I don't do that I just come out with it, yeah…. I'm a recovering alcoholic I have a problem with my drink. You haven't…. get on with it" (14.17-14.20)

4.6.3. Thematic priorities and relationships:

The main themes that emerge from Norman's narrative are: abstinence versus control, progression/achievement, stigma and support.

Abstinence is a significant theme to Norman as it underpins his whole recovery. However it's a personal theme, he frequently recognises that abstinence is essential for him but not necessarily others:

" I wouldn't just pick up one drink, it wouldn't just be one it would be until I'm in oblivion…whereas other people it wouldn't…it's all to do with my chemicals…I just can't drink" (15.9-15.12)

He seems conflicted in this belief, notably in his criticism of services and others who advocate control as an option for people who drink problematically. However, he justifies by emphasising complexity and diversity and talks about alcohol leading to a range of other problems.

"I lost my job… I was homeless for six months, mental health issues…. loads of debts" (2.82-2.84)

In recognising this diversity he seems to accept that not everyone is suited to a particular recovery ethos or approach. Norman talks about the importance of choice and recognises that being given the option of control or abstinence is important, as well as accessing a range of recovery groups with like-minded individuals.

"Well the biggest help was my after care at outpatients, because she gave me two suggestions……once I walked into Step Ahead…. you're singing from the same hymn sheet" (7.3-7.4)

Norman relates the theme of choice and abstinence to support. The pursuit of recovery through abstinence in AA is closely linked to peer-support through mentorship, and group work with a shared view of abstinence being vital to recovery. In AA recovery is closely linked to temporal progression, marking the period of abstinence. Norman also sees progression and achievement as the growing richness of his life and his increasing ability to cope and provide for others. This theme develops in relation to his daughter illustrated by Norman telling a story about her being able to ask him for new trainers now he is no longer ill.

Norman sees *'being busy'* as a key facet of his recovery. He reinforces this through juxtaposing his inactivity and '*sloth'*, when he was drinking, with his current success; being a mentor, teaching and training others and giving back to society, which he believes he only previously took from. Importantly stigma is a significant theme which arises in Norman's narrative as a potential barrier to activity and thereby continued recovery. He recognises a range of stigma that affects him in relation to his physical disability, his mental illness and his alcoholism. Whilst he often dismisses stigma as something he has to get used to he talks about it as a barrier to old friendships, to being accepted when he goes out shopping, and in being able to go to the pub to socialise without drinking

alcohol. Whilst he perceives stigma as a barrier he is also aware of the importance that respect from others brings him. Norman uses a number of his stories to illustrate how empowered he is now in contrast to when he was drinking.

4.7. Critical Narrative Analysis "Susan"

Introduction:

Susan uses multiple services, both mental health and substance misuse. She has been an active member of the dual diagnosis service user forum for a number of years.

4.7.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

Susan's story is a quest narrative outlined in Frank's (1995) writing: accepting her problems and seeking to use them to benefit herself and others. At first Susan's narrative resonates with distress, turmoil, challenge and suffering.

> *"I went straight down into a deep depression where I can't function, I don't function at all and they had to tell me when to wash and wash my hair, change my clothes and what have you and this, tell, you know, the doctors at the moment are talking about getting me off them and I'm scared stiff because I don't want to go back there again and I don't want to drink again" (2.55-2.62)*

This gradually begins to resolve itself throughout the interview into determination, taking responsibility and actively helping others:

> *"... Just two weeks ago I was a stem cell donor for my brother. So he's on the mend now, you know and these things I can do when I'm in recovery, coz the drink it doesn't bother me now." (15.15-15.18)*

Narrative Tone and Rhetorical Function:

In narrative Susan uses a tone of distress and struggle to emphasise the challenges she has managed and the incredible, almost insurmountable, turmoil she has faced. Later, she juxtaposes this with more triumphal tones of achievement and caring to emphasise how far she has come.

> *"When the kids had been taken off me I'd got nothing to live for and also my mum died when she was 27 and I didn't want to get older than her and so before that time I nearly starved myself to death on a couple of occasions and ended up at City Hospital tied to a.... Well the first night they tied me to the things" (2.79-2.85)*

Susan's tone is resentful and angry about her life and the way her family treated her.

> *I resented having to do everything and when I got, I got married at 17, had my first baby at 17, the next day I was 18, but I'd got postnatal depression (2.18-2.21)*

She uses stoicism to illustrate how jaded and tired she was of the distress and chaos in her life.

> *"I thought I was so at peace at that time, I thought well if this is dying I don't mind doing it." (2.87-2.89)*

On occasions there is a tone of incredulity to Susan's story; she is shocked by her behaviour and is beginning to contrast this with her new self. She is essentially saying look how bad I used to be and how far I have come.

> *"…Even when I was in labour with that baby I was in the pub playing dominoes and riding the pains along" (2.21-2.23)*

As her narrative develops Susan's tone changes, she begins to use empathic and caring tones for her fellow *sufferers*.

> *"I went to the forums. The alcohol forum and the drug forum and from then I went to dual diagnosis forum, but I do realise they're not personal for me. I'm there to help others and what have you." (11.10-11.13)*

Her tone is emphatic about how much she has changed and developed. She uses tone to emphasise her journey and to convince the audience of her growing honesty, expertise through experience and caring, giving self. Susan tells a story of meeting an old childhood friend, also an active drug user. She uses a caring-concerned tone to convey a sense of how much she wanted to help him, but her frustration also comes through as her AA group tell her to leave him alone because associating with other drug users is too risky at this stage.

> *"….they said well you best give him a wide berth and I hated having to do it because I saw him a few more times and he tried to talk to me and I had to snub him and I hated having to do that but I had to….Because I know my gateway into drinking again would be smoking or what have you" (16.14-16.20)*

4.7.2. Identities and identity work:

Throughout this narrative Susan identifies with her past and present self in very different ways. In the past she was reckless and chaotic, she was provider and housekeeper from an early age, a very young mother and eventually a psychiatric in-patient.

"I got married at 17, had my first baby at 17, the next day I was 18, but I'd got postnatal depression and even when I was in labour with that baby I was in the pub playing dominoes and riding the pains along" (2.21-2.23)

She also sees herself as naive

"… I didn't realise that alcoholism, alcohol made you depressed. But I also, when I was really in the throws of drink, I stopped taking the antidepressants because I didn't see the point in taking them if I'm drinking the amount I'm drinking." (2.44-2.48)

To an extent Susan identifies with herself as a psychiatric patient as someone who was oppressed as well as severely depressed. She relates a story about being restrained whilst in hospital suffering with post-natal depression and an eating disorder.

"When the kids had been taken off me I'd got nothing to live for and also my mum died when she was 27 and I didn't want to get older than her and so before that time I nearly starved myself to death on a couple of occasions and ended up at City Hospital tied to a…. Well the first night they tied me to the things, put my hands out there and a tube up my nose to feed me. I managed to pull my arms out and pull the thing out because I didn't want to…." (2.79-2.87)

Susan identifies with her bereaved self, referring to the loss of her mother, the losing her children to care and the loss of her husband through divorce.

"…. My husband had divorced me, my children had gone. I'd got nothing to live for." (2.133-2.134)

We get a sense throughout her narrative that she is also bereft of her childhood and her innocence.

"And it's always been put on me as a child to do the shopping and everything. I did everything that a woman, a mother would do except sleep with my dad" (6.17-6.19)

In the present, she is much more 'sober', both literally as an ex-alcoholic, but also more broadly in her general character. In a story about drinking illicitly under the stage when she was a psychiatric inpatient she says:

"….I mean that's how daft things were at that time. I did some ridiculous things that I wouldn't do now I'm sober. (2.70-2.72)

She also identifies herself in the present as a recovering alcoholic, very much in line with the ethos underpinned by her attendance at Alcoholics Anonymous. But in her stories of recovery Susan identifies herself as a supportive peer and mentor, a helpful volunteer

"I used to be with the Nottinghamshire Hospitals choir and then I volunteered to be a librarian and that turned out to be really tough work" (22.32-22.35)

4.7.3. Thematic priorities and relationships:

There are three significant themes in Susan's narrative: responsibility, independence and peer support. Within these overarching themes are a number of nested themes including the importance of being occupied, integration and holism around mental health, psychological issues and their relationship to alcoholism, and relapse risks.

Susan developed significant insight over many years and her stories point to a growing realisation of her own role and responsibility in owning her alcoholism and in dealing with the underlying psychological issues she has.

"I wanted to be on the day programme, which I did go on because then I'd got some responsibility…I don't like having responsibility taken away from me, because I've always been a responsible person." (6.10-6.15)

Her responsibility extends to recognition of the developing need to be honest and develop trusting relationships where she can be honest about the challenges she has faced and continues to face.

"I was my own barrier until I got into recovery from alcoholism and the drugs, you know, because I had to be honest on the day programme because of the drugs as well as the alcohol." (11.40-11.43)

Her developing honesty is linked to the need to have trusting relationships and this is where her theme of peer support begins to develop. Susan talks about her sponsor, in the AA group. She explains that having someone who can empathise as a result of personal experience has been invaluable to her. In response to my question about whether there was one person she valued for their help she said:

"My sponsor. I chose her because she's been through more or less the same things that I've been through. Because my first sponsor I had never had children. She hadn't got grandchildren and I thought well I've got nothing you know but my sponsor I've got now, she's had her children taken off her. She's had, her daughter lives with her mum and her children don't know that she is their grandma." (19.3-19.12)

Throughout her narrative Susan mentions her membership of AA many times. As she develops the theme of peer support she tells stories about AA and other groups she is a member of, but she also recognises some of the tensions for her in the AA model. When talking about the risk of relapse she talks about her old school friend (16.14-16.20 above) and how she has to "*snub*" (16.16) him. Within this theme is a developing theme on risk and relapse. Susan seems to find tension

in her new role, wanting to care, and the realisation that being around active drinkers and drug takers poses risks for her. She consults with her peer group and they advise her to keep her distance. Susan exhibits remorse at snubbing him, maybe because she realises how important peer support and empathy has been to her. She wants to support her friend but is conflicted with her own need to stay away from the risk he poses.

4.8. Critical Narrative Analysis "Terry"

Introduction:

Terry has experienced many services, the dual diagnosis service, mental health in-patient wards and drug and alcohol services. He is a regular attendee at the dual diagnosis service user forum.

4.8.1. Narratives, Narrative tone and rhetorical function:

The Grand narrative:

Terry's main narrative theme is one of multiple archetypes, the victim and sufferer, the contrite hero and the reflective philosopher.

> *"Now I wasn't using, so that is a massive chunk of my time that I've got spare but there wasn't any services available to me because I was on Subutex. I was still using DI I wasn't telling the staff I was on Subutex... mmm that created more problems in itself because I felt I was being disingenuous all the time, that there was always, even in one to one sessions I couldn't be honest or open because there was always that secret, elephant in the room, but the secret that I wasn't being fully honest disclosing about my medication because I would have got kicked out of the service……..That really, I wouldn't say tortured me, but it caused quite a lot of problems for me internally." (2.9-2.21)*

Narrative Tone and Rhetorical Function:

Throughout his narrative Terry uses a regretful, contrite tone. He is conscious he has not led a wholly honest life but wants to assert he has left that behind.

> *"I'm not exactly proud of the life that I've led mmm and I don't see it as a badge of honour being a drug addict or being in and out of prison all my life but it's my past." (2.32-2.35)*

> *"I have probably drained the system of god knows how many thousands of pounds" (10.29-10.31)*

At times his tone is critical of the care he has received. He discusses a period in residential rehab and asserts that his lack of success there was down to an ethos he didn't agree with.

"for me it felt like conditioning, it didn't feel like recovery. It felt like replacing the drugs for this religious, I don't know, not dogma but you have to go to so many meetings" (2.41-2.44)

His criticism of services is juxtaposed with a heroic tone that reinforces his emerging role as a champion

"It kind of goes back to what I was saying about DI, how counter productive, when I was going to DI, it was because there was no service for someone on prescription…….mmmmmmm there was chaotic prescribing group and there was abstinence but there was nothing in between… Mmmm and although I can't take credit for it, mmm I played a part in the bid that was put in for a service, into erm… for people that are on scripts." (12.7-12.16)

His tone is frequently philosophical and reflective

"I think being open and honest takes the power away from the addictive side of me, the self destructive side of me." (5.10-5.12)

His philosophising and reflection can be seen as a rhetorical device, he externalises his addiction (5.10-5.12 above) and he uses it to reinforce a sense of his endless journey through recovery.

"so with hindsight I think I could have done things a bit differently and this journey would be further on stage than I am now. As you know the length of time to recover, for me it's a lifetime the recovery and the life go hand in hand because there will come a point when I will, I won't even think about substances" (7.80-7.86)

Later in his narrative he begins to adopt a much more positive, optimistic and hopeful tone:

"I'm 40 now, if I'm lucky, touch wood, I've got another 40 years left. I've done a lot in 40 years, although they've been negative and quite destructive things, I've done a lot. So it just goes to show the next 40 years that I could do a lot, but I can do a lot of positive things….. And actually things that will make me feel better in myself and things that can help other people feel better in themselves. So that's important for me." (8.46-8.55)

4.8.2. Identities and identity work:

Terry blames his bad behaviour on drugs and his addiction, he sees himself as a victim and sufferer.

"…You end up sort of, unless you're a sociopath, you feel bad for the things that you did. I've done things that I'm not proud of, burgled peoples houses, mmm robbed out of peoples cars, robbed cars, robbed out of shops, mmm stolen from my family, stolen from partners, just being basically dishonest. Because that's a sense of who I am, but that was a driver to feed my drug addiction." (5.31-5.38)

Terry also sees himself as the victim of his parents broken relationship

> *"And there's my parents behaviour, my parents divorced, things like that. I find it very hard to talk about them sort of things. Mmm I find it very hard to verbalise what is going on and I'm no Einstein. I'm a reasonably intelligent bloke and quite articulate but I find it very hard to find the words to describe what is going on" (4.21-4.28)*

He identifies as someone who suffers from a dual diagnosis but who is different to other people who have mental health or substance misuse issues

> *"I wouldn't say I am an Aspergers, but I think there is something more than just depression because at times that you go beyond the depression I become very obsessive about things, I tend to catastrophise things, urm and I don't cope well with day to day life." (1.48-1.52)*

> *"So there's got to be some, something going on more so than addiction to be driving that, I think, and more so than a touch of depression" (1.90-1.92)*

Terry talks about his past seeing himself as a rogue who hasn't always behaved well. He sees this as something that is different and separate to his current self:

> *"I always struggled with the criminality side of it, urm. Prison, going to prison was a nightmare for me. I think if I'd been released after my first two weeks in prison, things would have worked out a lot different." (5.24-5.28)*

He still sees himself as an outsider someone who is a loner and isolated

> *"it gave me a feeling of, again being on the fringe of things, not being, not fitting in, not being the same as everybody else." (2.22-2.24)*

Terry relates stories throughout his narrative that identify him as a hero which he juxtaposes with his previous '*rogue*' self to illustrate his reform and recovery.

> *"When I was into drug use I didn't even have TV, never mind a TV licence. Now I've got a lovely flat which is really kitted out well. Mmm, I've got a dog that I, I'm a responsible dog owner, mmm that's another thing I mean rescuing a dog. I mean I wouldn't have cared about anybody or anything in my drug addiction, mmm but a few months ago I rescued a dog that was being mistreated, took him in and that's been really good for me in lots of ways." (5.48-5.56)*

4.8.3. Thematic priorities and relationships:

Terry's narrative has five main themes; Trust and honesty; Judgementalism and stigma; Empowerment, self-efficacy and responsibility; Personal sense of recovery and the role of medication and treatments in his stability and its relationship with abstinence.

Medication and treatment is constant throughout his narrative and Terry frequently reinforces its value in providing him with a stable platform to rebuild his life and continue his recovery journey.

> *"I think at the moment, the Subutex has given me the edge to stay abstinent and come back to be involved with society" (3.37-3.45)*

There are tensions in being stabilised on medication for Terry particularly in relation to the ethos of abstinence

> *"how counter productive, when I was going to DI, it was because there was no service for someone on prescription" (12.7-12.10)*

Terry links this to his sense of Judgementalism and stigma

> *"When it did come out that I was on script I was asked to leave DI. I wasn't happy about that because my recovery was as good as anybody else's" (12.16-12.19)*

> *"I think to judge me and say I can't use the service because I'm taking Subutex, urm and so and so can use it because they're taking Diazepam, urm that that was double standards"(12.24-12.27)*

These experiences are juxtaposed with another theme, trust and honesty. He talks about services and key-workers that have instilled trust in him and have enabled him to be honest and face up to some of the barriers he faces in his recovery.

> *"The prescribing and my key-worker sessions have been really good because I was able to be really honest with my key-worker" (2.27-2.29).*

> *"I can't pin point one specific thing and say this person, that and that. I think overall… yeah again, the lack of judgement, being open minded, being calm, understanding" (11.1-11.4)*

> *"I couldn't be honest or open because there was always that secret elephant in the room… I wasn't being fully honest disclosing about my medication" (2.15-2.18)*

Terry refers to personal responsibility, *"self-confidence and self-worth"* (7.7). This theme of self-efficacy and personal responsibility is something he returns to regularly. He juxtaposes his current ability to take responsibility with his previous drug using self and emphasises the sense of achievement this gives him.

> *"These achievements are bitter-sweet pills because of the situations I've created that put me in this position." (7.35-7.37)*

> *"the longer I'm clean and abstinent or not using illegal drugs, the better I feel in myself and I lose that disempowered feeling, I feel more empowered" (7.17-7.19)*

Terry is keen to reinforce the relationship between being empowered to take responsibility, his sense of self-worth and self-efficacy with a personal sense of recovery.

> *"Well in recovery there is no have tos and no have nots, its so personal for each person and mmm there is no set formula" (2.47-2.49)*

4.9. Critical Narrative Analysis "Elsie"

Introduction:

Elsie is a woman who has been using Complex Alcohol services for many years. She also has a diagnosis of depressions and has had some major physical health problems. Recently she has started attending the recovery education college where she heard about this study and volunteered to participate.

4.9.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

Elsie's grand narrative is of a growing sense of confidence in herself and in her motivation to change.

> *"I've never looked back, so I, I feel quite good that I, I mean that was six weeks ago now. I feel quite good that urm I didn't have to go in and have all the drugs and everything. I managed it, you know. Yes, I did have a few days of the shakes but I feel that it is something that I have done…But I still maintain that a lot of it, you've got to want to. I mean I've never smoked in my life so I don't know what it's like, but I think you've got to want to do it." (1.130-1.141)*

Throughout, Elsie refers to time and its relationship to her changing motivation and confidence, emphasising Ricoeur's (1990) theories of narrative time.

Narrative Tone and Rhetorical Function:

Elsie's narrative is full of positive and optimistic tone that she contrasts with stories of acute and unbearable depression. In retelling a story about a friend, who also had depression and an alcohol problem, Elsie says:

> *"She said to me at the time, believe you and me you will hit rock bottom and that, just sank into me and I thought, I feel so lousy, I can't do with feeling anymore rock bottom than I do and I listened to her because she'd been through it. So I did take notice of her and in a way I wish I hadn't because you know I'm six weeks on and I haven't hit rock bottom. In fact if anything I've hit rock high." (2.31-2.37)*

Her positivism is demonstrated by tones of optimism and confidence that she asserts throughout her narrative. Her growing confidence is conveyed by strong assertions, assertive but balanced argumentation and stories that are emphatic in their delivery of fact of her physical improvement.

> *"In fact I've been to a pub. I've been to a pub with my new boyfriend and he has had a pint and it doesn't bother me at all. I honestly do not think I will falter, simply because of I've come that far, my liver function was not good but within, within 3 weeks. I mean, one of the readings was 600 something and its down to 200 within 3 weeks, it was down to 200." (2.60- 2.66)*

Elsie's tone is occasionally proud. She is proud of her achievements, her desire and ability to work but also has pride in her family, her Polish culture and her status. She is keen to impress on her audience that she is not an average alcoholic; she is moralistic, not slothful.

> *"Well, that's when I say I've got to do something. I can't sit around doing nothing." (8.7-8.8)*

> *"I am looking for work, there isn't much around but also I think now, whereas at one time I would have thought whilst I was still drinking I would have thought ohh you know, take any job. Obviously not many people are going to want to employ an alcoholic. Urm but now I think I've got self-esteem and pride back. I think I want to do something that I want to do. You know, its not a case of anything will do because it won't." (10.17-10.24)*

Elsie's tone can be both moderately sarcastic and comic at times, she uses this as a rhetorical device. In describing her interaction with a doctor at the complex alcohol services who had assessed her she says:

> *"I said to him if you ask me anymore questions you'll know more about me than I do." (2.10-2.11)*

4.9.2. Identities and identity work:

In contrast to other narratives in this study Elsie never uses the term *alcoholic* or refer to herself or others as an *alcoholic*. Throughout, she uses stories to illustrate the diversity of individual's alcohol problems and talks about controlling her drinking and the desire to drink socially. She identifies herself not as an alcoholic but as a person who has had problems with depression, self-esteem, confidence, brain tumours and stress that have resulted in uncontrolled drinking. She uses two stories about Christmas to describe how she perceives this. Firstly she stories the bottles of red wine she has in her kitchen cupboard:

> *"I thought I'll shove them at the back of the cupboard and use them for Christmas presents and my daughter said to me it's not a good idea to have alcohol in the flat. I said well I've only got to nip across the road to*

Sainsbury's if I really wanted and I found a good use for it. I use it in cooking now." (2.50-2.55)

The second Christmas story is about controlling her drinking:

> *"The way I see it now, my next hurdle will probably be Christmas...Urm, but I've decided, well being Polish. Our Polish, our Christmas is Christmas Eve. I've decided Christmas Eve and Christmas day I will have a couple of drinks, two or three drinks that's it and then that's it. I'm not bothered about the New Year because to me it's just another day I've never bothered anyway (laugh)" (6.35-6.43)*

Elsie portrays herself as two different temporal personalities throughout her narrative. In the before/past she describes herself as passive and controlled by alcohol and in the present as a strong self-determined woman whose life is no longer dictated by the need to drink.

> *"I do have a craving for sweet things...but I don't think there is much I can do about that at the moment. I think that will happen, urm but now I just (pause). Now I just reward, it's little things like. I used to think if I had an appointment you know, a doctors appointment or a dentist appointment in the, late in the afternoon, I used to think when am I going to get my first drink……. It sort of, it comes, that's what I'm saying, it controlled me. Now it doesn't matter. You know, I can be perfectly presentable and I don't stink of alcohol." (5.5-5.18)*

She is alluding to herself as both victim and hero. This statement also identifies Elsie as a pragmatist *"a doing person"* (5.22), someone who gets on and does things as she later describes herself. Her assertion that she is a doer is another narrative device that she uses to contrast herself in the present with that of the passive, under the control of alcohol and depression, previous self.

4.9.3. Thematic priorities and relationships:

There are a number of interrelated themes in Elsie's narrative that converge in illustrating how prejudice and stigma have affected her journey. Elsie frequently talks about being "*nagged"* by her boyfriend and her daughter (1.32, 1.34, 3.31, 7.7, 11.6, 12.15) and there are early linked themes on non-judgementalism, being understood, being condescended and being patronised.

> *"I have to say, very, very helpful because they are obviously all professionals and they were non judgmental. They went through the options with me. They listened and I just felt that they were people who understood." (1.46-1.50)*

In talking about her son she says:

"Yes, but (laugh) there is also the other side of it. Some people are a little bit too condescending. You know, I mean my son laughs at me because, in fact I'm going over to see him after I've been here, but he, I query whether he was in actual fact alcohol dependent but he was certainly a very heavy drinker, urr and he gave up, he gave up smoking and he gave up drinking straight away. He went on the Antabuse… and you know when I asked him for some support, you know he just said to me oh just stop drinking, you know just like. Just stop drinking because that's what he did, but now you know he says ohh I never, you know sarcastically, he says I never thought you'd do it for this long. He said I never thought you'd last that long, but he says you've done it now, you've done it. But urm, people could be quite condescending" (13.2-13.18)

Elsie alludes to changes to her own perceptions and prejudices towards fellow problem drinkers, that under scores a sense that stigma and prejudice are detrimental. It underlines her sense that peers are helpful in understanding the challenges she faced.

"I think it would have been helped if I'd had access perhaps to some previous service users or even existing service users who were, who had become abstinent or CD controlled drinking or whatever, because I think once you have been through it yourself I think you are that little bit more sympathetic."(1.52-1.58)

Elsie uses a theme on relationships; in particular with her family and boyfriend, to reinforce the valuable support she gets, she sees this as a facilitator to good health and a stable lifestyle. This is contrasted with the theme on '*nagging'* that she returns to on several occasions, which she contrasts as being unhelpful.

"My family life was, family were fairly supportive but I had an awful lot of nagging, which is one thing that certainly didn't help. My boyfriend was nagging about my drinking, my family were nagging and that did not help." (1.31-1.35)

"Family relationships have much improved and everything. I'm allowed to babysit for my grandchildren now and this sort of thing so, you know….. That's good!" (19.24-19.29)

Elsie uses themes of self-efficacy, pride in herself and confidence to underscore a wider theme on the importance of motivation.

"…As I said at the beginning I think you've always go to do it for you, for yourself…….I think it was really for me." (19.35-19.38)

4.10. Critical Narrative Analysis "Simon".

Introduction:

Simon became interested in my study through the Recovery Education College. He had been using both mental health and Dual Diagnosis services for a number of years for his depression and heavy drinking. He now regards himself as being in recovery and is an active participant in teaching and telling his story.

4.10.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

This narrative has an overarching theme of loss, re-found health, well-being and self-determination. Simon describes the loss of family members, the loss of his dignity, loss of motivation and loss of his mental health.

> *"I had 5 members of my family die within 18 months, which I didn't really recover from one funeral to the next and basically I just drank myself into a coma, you know basically and I was very much under the influence and it lasted for 4 years... I had low mood and I can date back my depression years, until 19, I think. " (1.9-1.15)*

His narrative forms two halves one in the before as a depressed, chaotic drinker, suffering loss; the second, in the present, as a person in recovery, full of hope, optimism and self-efficacy.

Narrative Tone and Rhetorical Function:

In telling a story full of distress and struggle some narrators might be tempted to be melodramatic. Simon's predominant tone is stoic throughout.

> *"As long as the dogs are fed and I've got a bag of crisps and a sandwich and some fags and plenty of booze, I wasn't bothered about anything else, nothing at all." (1.27-1.30)*

Despite his stoicism, which may have resulted from the fact that he has related his story on many occasions, Simon's early story of his previous or 'before self' is laced with tones of tragedy, loss, struggle and shame.

> *"Looking back I had my first episode in 1985 but I didn't get diagnosed or anything until 2006 and that was when I was drinking lots of alcohol trying to block out the pain and that exacerbated my mental health, you know. It made everything feel black and dark and I did several overdoses but like I said to the psychiatrist and stuff, I don't think I meant to die. I just wanted to block out the pain because I was so fed up feeling like crap basically" (1.16-1.23)*

Simon uses tone to convey a strong sense of guilt.

"I was always sad and crying and thinking of things, like my mum's death or different funerals and it bugged me a bit that I couldn't remember, one, in fact any funeral as an entirety, I could remember bits of and they were all muddled up in my brain. And I really, I tried really hard to like differentiate between them and figure out what happened there, what happened there but I can't…." (1.63-1.69)

He is also fiercely critical, angry and vitriolic in his tone at times, especially when he talks about other people who lack self-efficacy.

"I'm sympathetic to some but the bottom line is I think to myself if you want to stop drinking you'd stop drinking, like what really cheeses me off is Gascoigne. Like with all these expensive rehabs they would have been given money to do it and then within a week he's on it again. Its just like a game to him and it really annoys me……. He's just a waste of space, he's just a weak waste of space type of a man. " (2.50-2.59)

As his narrative progresses into the present, Simon uses a tone of determination to reinforce to his audience a sense of renaissance and change.

"…. I'm determined that it doesn't bother me anymore. It was hard at first but I can go into pubs, I don't go clubbing, but I can go into pubs and restaurants and stuff and my friends who I'm with they can drink as much alcohol as they like, I'm not bothered." (1.291- 1.295)

4.10.2. Identities and identity work:

As Simon tells his story of recovery he gives a sense that he is going through a renaissance, rebirth and re-emergence.

"I'd got my head round it, become mentally stronger and I thought yeah I can do this now, I don't need a crutch all the time because the alcohol was the crutch, now I'm using my key-worker as a type of crutch. Well that's part of his job I think but I was going to say alright then I've gone through detox I'm never going to do that again, I was 100 percent sure of that, I would never do detox again and mmm I thought yeah I'm going to do it and so I did it and just one day I urm I just told me key-worker that's me and alcohol finished for good" (1.200-1.210)

He wants to impress on his audience how self-determined and self-efficacious he is. He identifies himself as the risen hero of his story and frequently contrasts this with his 'before self'.

"I'm a firm believer that you've got to want to stop yourself because I've said it in the past that I'd do it for my mum when she was alive and my dad, I'll do it because I've got a full time job and I want to keep it and this that and the other but I never did it for me. It was never my decision and under my terms." (2.38-2.43)

He uses stories to emphasise that he is someone who is still on a journey of active recovery, someone who has hope and optimism but can get caught up in the negative sense of his previous self. In storying a conversation he had with the Recovery Education College manager Simon says:

> *"…She said you've got to come to terms and let go of that life in your head……which I never thought of before. She said now your life is going in a different direction and it doesn't mean you can't be just as successful in this new life as you was on your first journey and I thought wicked. So I thought yeah I'll put that to bed about the teaching business and all the rest of it and what am I now, I'm a volunteer at college, which I love and I'm happy and that's when I realized I was proper happy" (8.65-8.75)*

Simon identifies himself as a man who has simple needs now, who is uncomplicated and content.

> *"But now I'm on benefits, I get through, I don't starve, but I'm not extravagant anyway, do you know what I mean, happy medium and I'm quite happy." (8.35-8.37)*

In the end he defines himself as a repentant, relieved man who is now able to resolve his shame and guilt:

> *"…That's a big relief off me, off my shoulders… I'm finally doing what I said to my dad that I would do, the house is good, I'm alright, dogs are alright, the car's alright… I'm doing everything now so that makes me feel better… Because I did feel a bit of a fraud saying it but I just dismissed it. I just said it because that's what he wanted to hear, I know he didn't have long left and so obviously I'm going to tell him aren't I." (8.92- 8.103)*

4.10.3. Thematic priorities and relationships:

One of the main themes in Simon's narrative is the importance he places on self-determination and self-efficacy. This can be contrasted and linked to, his sense of himself in the past, as someone who became a dependant drinker and is related to his dependency on and the eventual loss of his family (*as above 8.92-8.103*).

Related to this is a theme on how facilitative his dual diagnosis key worker was.

> *"…He was fantastic because on the first anniversary of my dad's death I said to him I'm going to have a drink, I'm not going to lie to you, I'm going to have a drink, I'm going to stop doing Disulfiram for 7-10 days whatever it takes before it gets out your system and then I'm just going to have a drink, just on that day, and he went "all right then" and he didn't say I couldn't he said he was there to manage my drinking not to prevent me from drinking and he said I was in the driving seat" (1.168-1.176)*

Simon uses his story to illustrate how important developing self-determination was to him and reinforces this theme by contrasting it with a story about other members of the team and some of his friends who were less facilitative and forced him into a position of having to lie.

> *"…It was like I've got to lie to people and I've got to plan around it and to be perfectly honest I couldn't be bothered. It was more trouble than it's worth, and I was thinking I'd drink on that day so I just said to my key-worker that I'd forget it, forget that plan. I'm not having a drink, I'm going to stay on the Disulfiram and carry on and he was pleased with me but he said I needed to come to that decision on my own." (1.180-1.188)*

Another theme he uses to underscore his self–efficacy, about his difficulty being with people when they drink excessively or are drunk, is touched on numerous times. Simon uses this to underscore his control and ability to cope around drinking, he tells us he can even go to pubs.

> *"It was hard at first but I can go into pubs, but I don't go clubbing, but I can go into pubs and restaurants and stuff and my friends who I'm with they can drink as much alcohol as they like, I'm not bothered. It doesn't bother me, it isn't like I'm sitting there thinking god I need a pint, it doesn't enter my head anymore, you know." (1.292-1.297)*

However, he knows his limits and uses themes on degrees of control to reinforce his self-efficacy. In extreme circumstances Simon feels that he has to resort to removing himself from drinking situations because of the risks. He illustrates this with a story about a trip friends are organising.

> *"……my friends are going on a train trip on 22 May to Liverpool. Well I know darn well its going to turn into a pub crawl…… so I'm not going to sit in the pub all day watching them all get drunk and then come all the way home on the train, it's like I just told them I'm not going…… I heard you planning on how many cans you're taking on the train on the way up there so I don't know what time they're going but it's like, I don't mind being in situations where there's alcohol but I'm not going to like torture myself you know" (3.57-3.70)*

Professional's narratives:

4.11. Critical Narrative Analysis "Benjamin".

Introduction:

Benjamin is a Consultant Psychiatrist in Adult Mental Health services. He has an academic background. As a Senior Specialist Registrar he was interested in dual diagnosis and drug and alcohol issues and worked on a busy drug and alcohol inpatient unit.

4.11.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

The grand narrative in this interview is one of liberal paternalism.

> *"We would generally say if you're going to use (drugs) then try and get off the unit, but I mean if they are clearly intoxicated then no we keep them in their room, look after them in their room, we wouldn't throw them out." (3.3-3.6)*

Benjamin demonstrates throughout his narrative that he is inquisitive and is interested in complex mental health and substance misuse issues. He regards himself as a 'scientist' as he frequently refers to the evidence base or lack there of, for elements of dual diagnosis treatment.

> *"Well I don't have a strong view as to whether inpatient care is the answer or not. Again it was one of the issues in the Russell Brand programme…he was a strong advocate for residential rehab, but my sense of the literature is that, actually no, there is quite a high relapse rate after a period in residential treatment." (2.73-2.80)*

Narrative Tone and Rhetorical Function:

The narrative tone throughout this interview is one of reflective inquiry. Given that Benjamin is a professional medic and a medical academic this tone is entirely consummate with his background.

> *"And so this notion that you have a free judgment or unimpaired judgment when you are choosing to take drugs, I mean the popular dialogue has just suggested that is the case. I mean you can't be a clinician for this many years and not see people in such desperate states that you very rapidly question…… do these people choose to have a life like that?" (7.22-7.28)*

Benjamin's tone is political at times

> *"I mean it sounds like you would agree with me that the kind of social, political context effectively removes a degree of social convention from this group of people and the absence of those social conventions reduces the likelihood of recovery" (2.94-2.99)*

Benjamin uses reflection and argumentation as rhetorical devices

> *"Another curious aspect for me is say the trust policy (on violence and drug misuse) of zero tolerance. Mmm There are a couple of times I've had outpatients who have been very psychotic, they've been thrown out of acute inpatient care because they had some cannabis with them and yet others who have gone around slapping other people, members of staff….. they actually get more care. Mmmmm …and so I always ask myself the question what is all that about?" (2.115-2.225)*

At times Benjamin's tone can also be almost psychoanalytic

> *"I think, I mean from a cognitive behavioural perspective you could argue when you see dichotomous thinking like that it's evidence that the system has got stressed some how." (3.129-3.131)*

Whilst his tone is professional Benjamin becomes more personally reflective later in the interview using his own smoking habit to illustrate some of the points he makes.

> *"And my dear mother, at the grand old age of 76, still says to me 'please stop smoking' and I think there's something particularly stupid about addiction.…it's not a rational process. Mmm….. maybe that's part of what makes it easier for me, not to want to take sort of a 'distinct choice' view about substance misuse" (7.38-7.44)*

Benjamin uses this example to demonstrate his connection with his patients and emphasizes this by adopting an empathic tone

> *"I kind of think that it is interesting, there is quite a mixed reaction to the fact that I'm a smoker. Certainly a large number of my clients are very happy that I'm a smoker. Urmm, and again as a Consultant, it is always a sign of humanity" (7.46-7.51)*

4.11.2. Identities and identity work:

Throughout the interview Benjamin identifies himself as medic and academic. He consistently identifies with the need to be scientific, to be evidence-based.

> *"I'd probably want to start by looking at the use of the word recovery, which strikes me as having a very chequered semiotic career and I kind of find it quite entertaining how different groups use the word differently. So, to be able to answer that question, I'd probably want to know what you want to talk about in the context of the use of the word recovery because it can mean so many different things." (2.5-2.12)*

Benjamin also identifies himself as different to his colleagues, more willing to be flexible to explore and try new things, he sees himself as maverick, non-conformist and a hero. This is illustrated in the interview during his story about prescribing Modafinil, an off-licence medication that has some emerging evidence as a substitute drug for stimulant misuse.

> *"We kept him on the Modafinil, which we suspect… maybe we shouldn't be doing if you take him off the depot. But actually we were able to work with him and we established him back on a depot…..Previously we would've probably lost contact with this chap urm, but the quality of our relationship is very different now. I've got a much better sense of working with him…..Now (pause) the way we're using the Modafinil with him does not*

follow, your procedures within substance misuse…..Ok, occasionally I will do a urine test, but it's certainly not a great deal, as would be expected……I mean we're working towards it but he's some way off the standards which you would normally want within substance misuse services…..may be that messiness is part of working with dual diagnosis" (3.74-3.94)

Benjamin identifies with the dichotomous perspectives of illness, social control and the tensions between mental health and substance misuse treatments.

"I could talk to those families, and again they aren't bad people, when they are saying please just lock them up don't let them out but its difficult, families are different…….they are desperate for someone to take responsibility for the drug use " (8.22-8.38)

At certain stages Benjamin seems frustrated or even impotent in the face of some of the more challenging dynamics

"I don't think as a service we have a clear narrative as to what we are supposed to do at that point and even say between adult mental health services and substance misuse service. I suspect we actually diverge on our thresholds for admitting someone" (8.40-8.44)

4.11.3. Thematic priorities and relationships:

This narrative includes themes on inpatient treatment for substance misuse, prescribing, staff skills and training. There are also overarching philosophical themes of liberalism versus paternalism, social and political perspectives of addiction and mental health, stigma, labelling and empathy.

Early in his narrative Benjamin is concerned about resources and the availability of help for his patients with substance misuse in contrast to the number of resources he has dedicated to treating mental illness.

"We have shed loads of inpatient units for severe mental illness and (pause) the question as to why there are so few inpatient resources for substance misuse isn't actually widely addressed" (2.68-2.71)

This theme is linked to social-political perspectives that influence the services people with a dual diagnosis receive and ultimately their recovery.

"The kind of social, political context affectively removes a degree of social convention from this group of people and the absence of those social conventions reduces the likelihood of recovery" (2.94-2.99)

Throughout Benjamin's narrative he uses themes of liberalism and paternalism closely associated with socio-political themes. To illustrate this Benjamin highlights the tensions that are around for services and clinicians in aiming to

maintain supportive therapeutic environments whilst heeding guidelines, policies and issues of legality:

> *"we would generally say if you're going to use (*drugs*) then try and get off the unit but I mean if they are clearly intoxicated, then no we keep them in their room, look after them in their room, we wouldn't throw them out. It's, it's…. Urm (pause) I don't know. We've had issues when people are leaving needles around the place for example and the nursing team struggle a bit with that" (3.3-3.10)*

Benjamin perceives tensions between delivering creative, flexible approaches to dual diagnosis treatment and the evidence in the form of clinical guidelines. He is concerned that other colleagues tend to adhere to guidelines and see him as reckless by being more creative and flexible. This tends to reinforce something of the hero/maverick in Benjamin that resonates with Frank's (1997) description of the "*modernist medical hero*" who "*believes in a cause that is nobler, loftier, more worthy than their own self preservation*" (p93)

> *"With various doctors who work with me they would sort of say 'no Benjamin that's something you do' (laugh)……. Because the clinical guidelines sort of definitely say, what I'm doing I shouldn't be doing. And I'll say look I've got 4 case studies of reasonable quality that show there is an effect and these are crack users, so come on give me a break." (6.7-6.15)*

At the heart of this theme of the flexible, creative, maverick hero is a nested narrative on the need for training and skills development. Underpinning this is Benjamin's sense that colleagues are conservative in their approach to dual diagnosis because of a lack of skill; fear, due to poor training and stigma associated with socio-political aspects that *"stress the system" (3.133)*

> *"I mean its true across all of the teams, this sense that they keep looking to me to provide answers to substance misuse and there are certain times I think you… no you should be able to use motivational interviewing, you should have sufficient knowledge to talk about this that and the other" (4.40-4.45)*

> *"I was just kind of struck particularly by the complete ignorance amongst staff on the residential units, I wasn't entirely happy with that but it did make me feel well actually how much training are they getting?" (4.60-4.63)*

Benjamin contrasts his own experience and creative approach to that of colleagues:

> *"I suspect the other consultants…. I know the other consultants, certainly don't do the stimulant prescribing that I do. They don't even do the alcohol*

related detoxing. It's not the end of the world… But even then, I am sometimes surprised that my colleagues don't use more treatments." (4.70-4.75)

4.12. Critical Narrative Analysis "Carly".

Introduction:

Carly, an Occupational Therapist working in the dual diagnosis service, worked in alcohol services for a large part of her career.

4.12.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

This interview is one of enabling empowerment through holism and integration. Carly emphasises the need for professionalism in engaging people, employing empathic understanding and developing trust.

"I tend to have a very low DNA rate, considering our client group and I think that's because I put in a lot of effort at first, so people start coming to see you and trusting you and working on some of the wider issues first, mmm and I think that really helps. But I guess, I guess I like to think because I'm an Occupational Therapist and that's what my training was, that I do tend to look at lifestyle and activities of daily living and looking at what's getting in the way of that." (4.15-4.23)

Narrative Tone and Rhetorical Function:

Early in the interview Carly was self-conscious and she used an apologetic tone. Whilst she had volunteered to be interviewed and had agreed to it being tape recorded she felt awkward; for which she apologised frequently.

"I'm trying to think, I can't think today (laugh) I'm being recorded." (3.44-3.45)

Carly's narrative begins in a critical tone, she is conscious that not all her colleagues are positive towards people with a dual diagnosis and she believes this has a negative impact on people's engagement in services. She returns to the attitudes of her colleagues throughout the interview and is consistently critical of the negative impact this has on service user's experience of services.

"sometimes the attitude of the mental health teams is that while they've been using lots of substances therefore its just drug induced and they get a very different treatment I think in hospital. They may only stay in for a short period of time but they might have quite negative view points about that person's care and they may not get mental health follow up or proper information about

psychosis which then can stop them from wanting to come back onto the ward or come into mental health services." (2.4-2.13)

This critical tone is counter balanced by an empathic and caring tone towards service users and their needs.

"I always think when you first see somebody the first appointment, although we have lots of information that we have to gather, it's about allowing somebody to come and talk about the things that are important to them" (7.3-7.7)

Throughout her narrative there is a tone of professional pride in the skills and approaches of an Occupational Therapist.

"I think it's about, not just doing things for somebody because that won't help, its about empowering somebody and again that's, for an OT training it's all about empowerment as part of, allowing somebody to be able to have the confidence to do things themselves." (8.8-8.12)

There is a tone of optimism in Carly's narrative. She believes that empowering people to tell their own stories of recovery can have a positive impact upon self-efficacy and hope for change.

"So I always think that it's worth having….. having and maintaining hope for somebody else, because often we work with people that don't have that hope or confidence and their own ability to change." (17.20-17.23)

"I think, I tend to try and try and maintain not a completely positive attitude but maintain some hope that somebody eventually will make some change and the way that I do that is that I've always had, anybody that works in this job will always have people that have made massive differences to their lives." (17.27-17.32)

4.12.2. Identities and identity work:

Carly is proud of her role as an Occupational Therapist and strongly identifies with the professionalism she brings in interacting with service users.

"Sometimes when people first come and see you, they need to know that not only are you going to listen to them but you know what you're on about and that you're qualified to help them." (19.14-19.17)

She is also a pragmatist who recognises that in order to develop a trusting relationship with her service users she must see their life in context rather than taking a purely sterile professional perspective.

"It's not like you have to sit there and say oh I've got this degree and blah blah blah. It's about how long have you've been working in and what kind of positive outcomes with some of the people you've been working with got." (19.1719.21)

She sees her identity as pragmatist as an important tool for engagement with her service users.

"I worked with young lads with psychosis, teaching them about cooking, realistic cooking, like cooking super noodles (laugh)…. And beans on toast. You know like things that they are actually going to do and going to their local shops with them to see what things they would buy on their budgets." (10.23-10.29)

She identifies herself as a hard and diligent worker, something of a hero at times.

"I think that's because I put in a lot of effort at first, so people start coming to see you and trusting you and working on some of the wider issues first, mmm and I think that really helps" (4.16-4.19)

Carly regards herself as a good listener, building trust with her service users. She clearly perceives that being dependable and someone who does what they say, is an important part of her identity to her service users.

"I always think that you can get more information if that person comes back again but if you get it wrong and get all the information they're not going to come back and I think from the kind of people that we have they may or may not have had very good experiences of services before so if they feel listened to, which I think is key. mmm and that someone and that you're going to do what you say you're going to do then they are the most important things for engagement." (7.11-7.20)

She identifies herself as a tenacious and motivated dual diagnosis clinician. She believes this is important in maintaining a good relationship with her service users and maintaining an optimistic belief in recovery.

"I think its important to workers because it keeps you motivated and for you to keep chipping away….. Mmm….. and it's important to other people to know that somebody has been in a similar place to them and they've made a difference. I think that's really important." (18.6-18.12)

4.12.3. Thematic priorities and relationships:

An overarching theme in this narrative is stigma.

> *"I think it's about stigma... I'd like to think we work in an organisation where there isn't lots of stigma but I'm afraid there still is (pause). I think there's still, there are still quite negative attitudes about some of the people we work with." (15.7-15.12)*

Stigma is linked to staff's negative attitudes. Carly criticises her colleague's attitudes from the outset (illustrated in lines 2.4- 2.13 above) and she clearly links negative attitudes to stigma and to poor engagement of service users in treatment. This is not limited to mental health teams but also substance misuse services, who she believes fail to see, or actively overlook, the mental health needs of their service users.

> *"Mmm…. the other side of it may be that somebody has been using lots of substances, come into substance misuse services and their mental health needs aren't picked up for a while, may be until their substance misuse is reducing." (2.19-2.23)*

She is clear that it is not always negative attitudes and stigma that effect staff's ability to work with the service user group but often lack of appropriate skills and training.

> *"I think sometimes…. mmm its not that people don't want to help, but it's that people don't necessarily have the skills or know what answers, what questions to ask. Or if they do ask questions then they don't know what to do with the answer" (3.6-3.10)*

She juxtaposes the effects of negative attitudes with those of people who have more positive attitudes

> *"I think people that have different attitudes tend to stay involved in somebody's care. The people that have positive attitudes would be working with that person, mmm regardless of how many times they'd been in hospital and trying to get to the bottom of why that is and what help they can offer, rather than somebody with quite negative attitudes, might be very quick at getting them off their caseload." (16.5-16.12)*

Themes emerge in this narrative that identify positive skills that enable better engagement of dual diagnosis service users including.

Active listening:

> "Active listening skills are actually really important and reflecting back what you've heard" (13.17-13.18)

Optimism:

> *"So when you're in a situation where you might feel frustrated that things aren't moving as fast as you want to, or somebody's not helping themselves, you can always try and reflect back on the fact that well actually I work with this person, never thought that they'd make any difference and they really, really did." (17.32-17.38)*

Maintaining a long-term perspective:

> *"A lot of the work I do, or that our team does is just kind of chipping away and trying to make small changes to enable people to get better. " (3.31-3.33)*

She strongly believes that holistic and integrated approaches to care benefit service users.

> *"I'm looking at somebody as a whole I'd like to think, so I'm not just looking at somebody in isolation thinking well this is to do with drug use or this is to do with mental health." (4.6-4.9)*

4.13. Critical Narrative Analysis "Christian".

Introduction:

Christian is Psychiatric Nurse in the dual diagnosis service; he worked for a number of years in a community mental health team before to joining the dual diagnosis service.

4.13.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

In this interview is about stigma, stereotypes and prejudices towards individuals who take drugs, and how the prejudices of mental health staff can significantly affect the experience and outcomes for dual diagnosis service users.

> *"I'll just talk about prejudices, people are influenced by the media horrifically, people are influenced by both tabloid media, news media and also films and see alcohol as an evil substance that will break up homes and marriages or that people become aggressive and angry when they are using alcohol. Likewise all Heroin addicts are going to be or Heroin dependent individuals are going to be thieves, robbers, muggers etc, which clearly isn't the case." (8.6-8.14)*

Christian talks about stigma and prejudice in the context of personal or third party experience

> *"…for the professional who has never drank say due to cultural or religious beliefs, for them to then say well you should just do this, I think there is immediately a question in the client's mind, "how do you know?" " (16.18-16.22)*

Narrative Tone and Rhetorical Function:

There is an optimistic tone throughout Christian's narrative underpinned by his ability to see the positive in many things

> *"So I work in a positive reframing manner I guess is one way of putting it, well assist people perhaps to see things in a more positive light," (4.26-4.28)*

Christian's narrative has an overtly critical tone, he believes that his colleagues are dismissive or at best naive about substance misuse amongst people with mental health problems.

> *"People talk about "well I thought cocaine you only snorted it, I didn't know you could inject it" and that's a very basic one and when it comes to crack cocaine they don't understand it's a different hit" (6.4-6.7)*

There is a tone of empathy and concern throughout for his service users.

> *"..People fall into drug use for a variety of reasons, mmm…. quite a few people because it helps them with their mental health issues in the first case before they become dependent, so and it's quite concerning when you meet professionals who have been around for quite a while who still haven't got that, who still don't make that connection between clients using substances to aid their recovery or to perceive that they are aiding their recovery, compared to clients who just use substances to get high." (7.8-7.17)*

Christian is confident and passionate when talking about dual diagnosis and uses an emphatic tone to reinforce his audiences understanding of his confidence.

> *"We come in with a very clear substance or alcohol use agenda, we talk about it explicitly and openly to encourage the individual to become more aware of the impact a drug or substance is having on their physical health, the impact it has on their mental health". (11.13-11.18)*

Christian uses a reflective, insightful tone to emphasise his ability to see his shortcomings, which reinforces a sense of openness and approachability.

> *"I personally can talk quite confidently about my own insecurity if that makes sense and therefore I think I give quite a transparent picture of myself. I hope that engenders other people to be more open with me." (13.3-13.7)*

During the interview Christian talks about his personal experiences of drinking using a confessional tone.

> *"I have a history of drinking, …..am I supposed to say this sort of thing? (laugh), in as much as (pause) once or twice in my life there have been hassles and stressors and I've drank too much, probably well undoubtedly, I can now reflect, mmm for too long when I was quite young, I didn't*

recognise any symptoms of withdrawal but I undoubtedly had them and it's talking about when that sort of experience is said to an individual and then I'm suddenly not this clean white sterile clinician, professional who has, who isn't in touch with the real world." (15.40-15.50)

Christian uses 'third person talk', quoting others, throughout his narrative, as a rhetorical device. He is demonstrating that he has direct experience of an individual and illustrates what they say rhetorically in the third person. It's a device to add credibility to what he is saying to reinforce what Aristotle described as extrinsic ethos (Fortenbaugh 1992) or credibility with his audience.

4.13.2. Identities and identity work:

Christian identifies himself as an empathic, optimist from the outset

"well things that foster recovery for the client in my belief is their belief that somebody believes in their recovery. Its not just their belief in their own ability to recover, it's their perception that people around them believe that they can also recover as well." (2.5-2.9)

He wants to impress upon his audience that he is genuine, open and transparent, a 'down to earth' practitioner that can engage with people who are often challenging to build a therapeutic relationship with.

"I think people can see that I'm being genuine and being open. If I say I'm going to do something I will do my utmost to do it, if I say I cannot do that but I think of somebody who can then I won't, I desperately try to not give any false hope because that's unrealistic and if things go wrong then "Christian said it would happen, Christian said that it would work and it didn't, he's a liar" and that's my credibility gone." (14.2-14.9)

He voices his service users concerns in the third person to reinforce his point about being credible and trustworthy and sees this as an important part of his professional identity. He uses his narrative to convince us that he is able to build trust in his service users, he sees himself as, and wants us to believe he is, a trustworthy, 'solid' practitioner. In the context of this interview this is an attempt to contrast and juxtapose the facets of a facilitative practitioner with those staff who lack skill, that Christian sees create barriers to recovery.

He identifies with the lure of drinking and recounts a story of his own life where he drank in excess of what is safe and responsible.

"I can now reflect, mmm for too long when I was quite young, I didn't recognise any symptoms of withdrawal but I undoubtedly had them" (15.44-15.46)

He uses this identity to break down therapeutic barriers, convince his service users that he is not the "*clean, white sterile clinician*" (15.48-15.49) that some may believe he is. Christian is not only convincing us of his ability as an empathic clinician but he reinforces that he is an expert by experience as well as a professional. This story contrasts the facilitative practitioner with the in-experienced, prejudiced and in his eyes inadequate practitioners who cannot engage well with people who experience dual diagnosis.

Whilst Christian stories his identity as an accessible and approachable down to earth 'guy' he also identifies himself as a skilled, specialist professional with expert scientific knowledge.

> *"you can read about dependence addiction you can read about withdrawal, you can read about the impact of substances on the body, people take alcohol for example and how it can have, how people become dependent, suffer withdrawal in the morning, need to drink. It's all very well documented, likewise when it comes to brain shrinkage, Korsakoff's or peripheral neuropathy" (16.3-16.10)*

4.13.3. Thematic priorities and relationships:

Nested within the grand narrative of this interview are a number of related themes that Christian believes influence the level of naivety and prejudice an individual may experience from professionals. Interpersonal themes of optimism, empathy and compassion are evident as Christian demonstrates his belief that a clinician's ability to engage with dual diagnosis service users is fundamentally based in their personal experiences, skills, training and personal development. In this narrative these themes are linked to personal prejudice and lack of personal experience acting as barriers to personal development in professionals that ultimately affect recovery for people with dual diagnosis.

Christian develops a theme on transparency, openness, trust and honesty that he sees as important in engaging individuals with a dual diagnosis.

> *"So when I say transparent, I don't know if I used that term, that word, in the right way but I, I'd like to think that people can see into me and see that I'm not trying to bull shit them too much." (14.14-14.17)*

In turn this theme is linked to one on the importance of personal experience and self-disclosure.

> *"I'm actually somebody who has a greater understanding than that clean white individual who says oh no I'm not going to drink at all, I've never done substances etc. and so I think self disclosure is important, it has to be moderated and it has to be used appropriately and I think it works. I think it helps build my relationships." (15.50-15.56)*

Christian asserts that direct personal experience is important because it breaks down prejudice; he also recognises that prejudice and stigma can be resolved through training and learning even if a practitioner has no direct personal experience of drinking or drug use.

> *"Education, education that's more education. Mmm as a dual diagnosis clinician we are now, we are more visible in clinical areas so we have, there is more of an opportunity for individual clinicians to come to us and to just ask a question and we give an answer that helps educate them, point them in the right direction or mmm allows a greater understanding of a dual diagnosis client I think. I think that helps an awful lot." (9.10-9.17)*

One theme he develops relates to goal setting and targets. He believes that attaining stability and eventually managing both mental health problems and substance misuse problems can only be achieved in stages.

> *"I think that people are more able to make appropriate goals as opposed to the far fetched I'm going to give up next week goal which can quite often be far too big for them at the time but any slight reduction can then, we can then put more achievable steps in place for them in order to achieve the goal" (2.17-2.23)*

Setting achievable goals or targets is linked to optimism for recovery in his narrative:

> *"I think it's very important to allow the client to know that these diaries and also urine tests and Alco meter tests etc. aren't there as punitive or aren't you doing badly but just a record of any positive change……allows that individual to again build their own, foster their own belief that they can change and that they are changing." (2.40-2.50)*

4.14. Critical Narrative Analysis "Colin"

Introduction:

Colin is a community psychiatric nurse working in an adult mental health service. He has more than twenty years experience in psychiatry and is also a research assistant with the Institute of Mental Health.

4.14.1. Narratives, Narrative tone and rhetorical function:

The Grand narrative:

This interview focuses on the capacity of community psychiatric nurses to do their work. This is linked to concerns that integrating dual diagnosis skills is not only compromised by lack of resources but skills and training too. The narrative explores the impact that austerity and financial pressures have upon the ability of nurses to deliver services. He is derisory and frustrated about *'box ticking'* and

believes it impacts his colleagues ability to deliver good quality, service user focussed services.

> *"So then to hope that they might offer more with their more limited resources would be, you know it would be like trying to pour two pints into a pint pot, you know." (27.23-27.25)*

> *"…. We're lucky if we've got any time to do anything with your clients, you know, we tick the boxes to make sure the budget is satisfied." (6.18-6.20)*

Narrative Tone and Rhetorical Function:

There are multiple tones within this interview ranging from frustration, contempt and annoyance towards the organisation in which he works through to empathy and concern for his service users. His empathic, caring tone is apparent when he talks enthusiastically about his service users needs.

> *"I mean some of the clients because of the paranoia, some of their problems takes them a long time to get to trust somebody so you know in order to get that trust, you've got to be there regularly." (11.5-11.9)*

> *"…Then you start to get a relationship going and they begin to trust you and do realise you're not just a person doing a job, you're a person that's you know committed and tied to help them." (11.16-11.19)*

Early on in the narrative, Colin's tone is concerned, annoyed and frustrated at what he sees as a national problem affecting the NHS, brought about by the health and social care bill and increasing competition from third sector organisations.

> *"So if someone can do EIP (Early Intervention in Psychosis) cheaper then we'll buy them won't we……it just, it looks like the whole idea of the commissioning process is a way of dismantling the NHS basically." (8.39-8.46)*

Colin's frustration is marked when he talks about the importance the organisation he works for places upon measuring interventions and outcomes.

> *"It's just dominated by, as I think Einstein said, if I may just quote Einstein, 'not everything that counts can be counted and not everything that is counted is worth counting', if you see what I mean, and we just spend our time counting the stuff which is completely and utterly irrelevant." (11.62-11.67)*

This overall tone of 'righteous anger' appears to be born out of recent experiences and is prompted by what Colin sees as the inability of psychiatric staff, mostly due to lack of resources and capacity, to develop skills to understand substance misuse and help people with dual diagnosis in a holistic and integrated way.

At times the tone of this narrative is mournful and pensive underpinned with sarcasm. Colin harks back to his earlier career where he clearly felt he had time to deliver interventions that aided recovery.

> *"So things that were really important like getting people out of their homes, meeting other people, engaging all that kind of stuff is just going and then they can just say oh yeah you can go to the recovery college can't you because that's going to solve everything." (13.33-13.38)*

Later in this narrative Colin becomes more reflective and critical in tone of some of his colleagues .

> *".....on a number of occasions I've known psychiatrists to say well I won't prescribe you anything until you've stopped taking Cannabis,.....and I think well it's bloody bonkers really isn't it, because the reason why they take Cannabis is because they are really quite unwell" (22.2-22.7)*

4.14.2. Identities and identity work:

Colin sees himself as a pragmatist. He values psychiatric nursing skills highly, but derides what he sees as the homogenisation of psychiatric practice. He identifies himself through this as an anti-hero. He is an experienced practitioner, increasingly becoming disillusioned with modern practice because some of his core skills and roles have been eroded by the need to systematise and measure everything.

> *"I mean there's this fantasy somehow that if you've got, you've got some sort of tools you can take along, oh yeah let's do some pro-dromal signs or we love 'signatures' and it all sounds very good but you'll find that for most clients they actually don't really want to know, but you know from the Trust point of view, oh, oh what is a relapse, do that as if that really makes any difference to care." (9.3-9.10)*

> *"You know what bloody schedule you want to implement on them you know is if you could, may be you could just plug them into a computer and say look well just follow these guidelines you know" (11.24-11.27)*

Colin identifies as someone who has liberal views about drug taking and takes a balanced perspective on the experiences of service users and colleagues. Talking about the service users he works with he says

> *"……there's not very many that don't smoke it as a rule and it's part of their attempt to deal with whatever they are trying to deal with you know……but it can be an issue with the doctor sometimes, and some nurses, particularly on the ward because the wards are in the situation where they are very stressed they've got lots of people coming in and they want to be able to identify the bad and the good and the bad are the smokers of dope and the drug users, and 'really we don't want them' " (22.29-22.39)*

Colin tells stories about what he sees as the inflexibility of services in meeting his service users needs. He juxtaposes these examples, and uses them as vehicles to illustrate his flexibility as a CPN who outreaches and assertively engages with his service users.

> *"....nothing happens for a while so you make a re-referral, so he gets crossed off because he's not got the motivation, because the problem is a lot of them haven't got the motivation so they are not, its not like simply about well I'm an addict, so I've really got to be wanting to do it, its like I'm an addict but also I've got all this other stuff going on which makes it difficult. So unless there's a bit more of an outreach kind of thing going on they tend to get lost quite quickly" (3.67-3.76)*

4.14.3. Thematic priorities and relationships:

There are several interrelated themes in this narrative. The overarching theme of capacity and resource paucity is linked to CPN's inability to deliver specialist substance misuse interventions and Colin voices incredulity at the idea that a CPN should become a "*jack of all trades*" (32.5).

> *"....it just feels that maybe you're testing out the idea of whether its possible for CPNs to be more empowered to do the work without having other people to do it……I think it's difficult to be a jack of all trades isn't it really because there are so many things that you've got to try and master anyway" (30.13-32.6)*

He relates these themes to the inflexibility and inaccessibility of services:

> *"....so you've got to go to dual diagnosis and dual diagnosis are saying well we don't really do that sort of stuff so it feels like sometimes a bit of a gap really to quite know where to, where to go." (1.28-1.32)*

Colin perceives engagement and flexibility in service delivery as key in creating barriers or facilitating recovery. He thinks that his service users lack of motivation is used as a barrier to engagement; if they can't attend a clinic then substance misuse services interpret this as lack of motivation and are unlikely to offer an alternative.

> *"There's something about the service structure, there's something about the kind of interpersonal issues between counsellor, practitioner and service user and there's a lot about motivation?"*

He doesn't have the specialist skills to support his service users because he isn't immersed in working with substance misuse in the same way his specialist colleagues are. There is a linked theme on knowledge and skills that emerge from Colin's narrative. He sees training as important and has received some himself

from the dual diagnosis service, but he thinks training is no substitute for knowledge that is gained through regular work-experience.

> *"I mean I see people from 'Chill Out' at work, they're really knowledgeable, they know what they're talking about. That's far more sensible than trying to get one person, trying to do it all. So if that's someone's suggestion I think it's a fantasy really." (6.34-6.39)*

> *"So I might go along to a bit of training, dual diagnosis training, oh yeah I know all about this stuff now but within a week or two I've already forgotten about what it was and unless I'm actively involved in working with somebody with it, you know its not necessarily going to affect my practice really. So that's why it's nice to have these other organisations that can you know take that bit away and say right we're going to work on that, (18.12-18.19)*

4.15. Critical Narrative Analysis "Cormoran".

Introduction:

Cormoran is a dual diagnosis clinician and a qualified psychiatric nurse. Prior to joining the service he worked in community and inpatient forensic psychiatric services.

4.15.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

This is a story of a nurse who struggles to provide an integrated service and is frustrated by the inflexibility of other services. Like his patients he's 'stuck in the middle' and he frequently empathises with the sense of neither being one thing or the other, in his patients case a person with a mental health problem or a drug problem, in his own case a psychiatric nurse or an addiction specialist.

> *"Well I mean there's been a number of times when I've had patients who are very, what I would consider very stable and I've referred them to psychology for example, step 4 and they've bounced back saying, look there's still this substance misuse work to be done and I've said, look you know this piece of work isn't going to be done until they've done the psychological stuff, it just isn't going to happen……. Mmm so I've had a number bounce back. As a result I very rarely refer now to psychological services"* (6.10-6.20)

Narrative Tone and Rhetorical Function:

This narrative has a tone of frustration underpinning it.

> *"They can't reach that level of stability in order to be able to access those services so we're kind of left with it, with a level of expertise which I consider to be not high enough to give the right service to those people." (1.46-1.50)*

There are tones of defiance and loss in this narrative

> *"When I first came into this role, its been four years, it seemed like we used to do a lot of training of other people, supervision of other people and unfortunately because of how some of the constraints that we have as a service, that's kind of slackened off a bit. We don't do so much of that and that's a shame really because that was really good, positive part of our role….." (10.2-10.33)*

He is an impassioned storyteller who is aware of the need for expertise, has pride in that expertise and in being able to share it with others to benefit patients.

> *"I guess from our perspective as a team……. it's a very specialist team isn't it. We are all mental health nurses apart from one, one member of staff who is an OT, but her knowledge is very good in terms of mental health, so kind of offering that knowledge to other practitioners is great and over the time that I've been doing my job people do pick up on things that we say" (12.6-12.12)*

Cormoran privileges a flexible approach to his work that benefits his patients as a result of responsiveness, he is sceptical of process and somewhat derogatory about 'red tape'.

> *"Our role was to sit between drug services and mental health services and offer assistance to both, without necessarily having to have long winded referrals. It was almost like a buffer. I can't understand why they need to get people referred ineffectively and you know, our figures and targets and things like that, that's absolutely very important because our service wouldn't exist without those things but I think we sometimes get away from the fact that sometimes just supporting our colleagues on a very ad-hoc basis is easier for us, easier for them and better for the patients." (15.6-15.16)*

The tone of this narrative is often pessimistic with an overarching sense of frustration coming across, but there are some very positive tones to the story too.

> *"I think there's been a massive shift now and realisation that the two are very closely linked. Consultant psychiatrists are a lot more open to the idea of assisting people with substance misuse and mental health" (17.63-17.67)*

Cormoran uses argumentation and recourses to the evidence base as rhetorical devices throughout.

> *"They like the medication to be at a certain dosage level before they'll see them. Now I can understand that in terms of having stability with people they're seeing, but I get the impression that the main concern is that when*

people aren't at that level there is a lot more harm to be done rather than good." (1.34-1.40)

4.15.2. Identities and identity work:

Throughout this narrative Cormoran tries to demonstrate that he is an expert, is proud of his nursing identity and his heritage as a healthcare professional.

> *"You know they may have a psychology degree or whatever but they're not nurses, they're not OTs". (9.84-9.85)*

Cormoran is also portraying himself as a hero and a man of the people who can get down to their level and do something meaningful but simple

> *"I mean an example was a DA worker was talking to me last week and said I've got this lady, this this and this. I said lets go and see her, lets go and see her at home and we went to see her at home, just a drop in visit, one off, not necessarily a new referral. It was just a straight-forward chat about half an hour and that was it." (9.59-9.64)*

Cormoran is someone who has to get a lot done with few resources and with limited time to do it.

> *"We all have very high case loads. You know time management is an issue." (10.35-10.36)*

This identity is associated with his role as negotiator and conduit. In response to a discussion about the need for responsiveness Cormoran says:

> *"It's very positive for the people we work with, you know, again back to that lady I went to see at home with one of the drug treatment workers, you know just by having a chat for half an hour she benefited from that. Yeah, whereas if we'd gone down the line of referral to mental health services, it would have been 2-3 weeks before we sorted all the paperwork." (13.7-13.13)*

> *"I see somebody and I say, they are quite clearly very psychotic, you know lets do a referral to mental health services and I will help with that so you put the right things in the referral." (13.26-13.30)*

4.15.3. Thematic priorities and relationships:

Cormoran's narrative contains multiple themes, which I have broadly condensed into three; skills and training, service criteria or what he calls 'red tape' and Service integration and responsiveness. There is a strong interrelationship between these themes and he uses case examples or patient stories to illustrate this and draw the flow of his narrative together.

The level of skill and training of his colleagues, in both mental health and substance misuse services, is an area that Cormoran returns to frequently. He links this with the other themes to illustrate how service criteria and poor skills can lead to a lack of integration. When discussing the challenges of getting patients help from psychological services he says:

> *"….it's a personal view from talking to people that the amount of knowledge that psychology staff have, psychotherapy staff have around substance misuse and the impact that has on mental health is quite limited" (4.12-4.16)*

In relation to the skills of colleagues in drug and alcohol services he says:

> *"One of the things that I was thinking is, that would be…. you know a good partnership with our drug treatment services or would be in our interests, to skill those people up a bit, so that we don't get loads of bouncing around referrals" (10.17-10.21)*

Adopting and translating these skills into an integrated approach is a barrier that Cormoran sees in providing services to people with dual diagnosis.

> *"Substance misuse is one thing and psychological trauma is another thing and marrying the two up doesn't fit with the models that they use. Does that make sense?……. the general opinion is that the two don't marry" (4.25-4.35)*

Cormoran frequently talks about service criteria and 'red tape' being a barrier to integration and delivery of services in an integrated manner. When discussing the difficulty of getting people into psychological therapies he recognises the challenges in offering therapies to people who might be intoxicated but juxtaposes this with his own experience.

> *"Yeah you don't want people turning up for your interviews intoxicated but then my argument is that very few people turn up for my assessments intoxicated" (3.12-3.14)*

Cormoran seems to believe that integration of services is based in a need to be flexible and responsive to people's needs without getting too enmeshed in concerns about whether people meet service criteria, or whether a formal referral has been sent

> *"I think its very positive for the people we work with, you know again back to that lady I went to see at home with one of the drug treatment workers, you know just by having a chat for half an hour she benefited from that. Yeah, whereas if we'd gone down the line of referral to mental health services, it would have been 2-3 weeks before we sorted all the paperwork." (13.7-13.13)*

4.16. Critical Narrative Analysis "Dominic".

Introduction:

Dominic is a Consultant Addiction Psychiatrist who has experience of working in both mental health and dual diagnosis services.

4.16.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

Dominic concentrates on the role of stigma, training and experience in facilitating an adequate service to people who have highly complex needs.

> *"it's also about the fear of treating the unknown because actually I don't think that they feel that they've got the skills to actually adequately deal with these individuals." (3.33-3.36)*

He highlights lack of skills and training in both mental health and substance misuse services. He uses a number of stories to illustrate, from his own experience, how lack of training results in an inappropriate level of skill in working with people who have dual diagnosis.

When recounting one story about two brothers, Dominic is surprised, even incredulous, about the lack of skills in even his most senior colleagues.

> *"he was responding to tactile hallucinations he thought he'd been interfered with by radio waves, completely psychotic, he was drinking a bit, he was seen by one of the psychiatrists, actually it was a professor of psychiatry, who gave him a diagnosis of alcoholic psychosis no, sorry alcoholic hallucinosis!" (3.63-3.68)*

Narrative Tone and Rhetorical Function:

A tone of frustration runs through much of Dominic's dialogue. Dominic is aware of the tensions that exist between mental health services and addiction services in treating people with dual diagnoses. In telling a story about a service user who was referred to him he is frustrated that his colleagues are not thorough in their assessment of all the factors affecting this man's mental health.

> *".....when you looked at him he was a heavy end drug taker, you could see it straight away and if they'd looked up his arms he'd got track marks and everything, lost loads of weight and again a lot of his problems were due to him withdrawing." (3.111-3.114)*

Dominic's sense of frustration is not only aimed at his colleagues in mental health services but he is critical of the wider system and frustrated with the increasing

bureaucracy that prevents him from responding to people's needs in a flexible and individualised manner.

> "*trying to put these people into the diagnostic boxes and then actually saying if you don't fit this box then I'm afraid you know you're not suitable for our service and that probably is one of the problems with you know speciality services really." (4.21-4.25)*

Dominic's expert-tone renders him conscious of the skills, experience and training needed to work effectively with people who have a dual diagnosis. He recounts stories of his training to emphasise what is needed to develop expertise and juxtaposes these with the level of skill of other professionals he has met.

> *"Yes, you probably are going to be better than the GPs because there is a big overlap with drugs and mental health, urm but again its still quite limited and you know, for me, as an addictions consultant, it's really difficult to get a grasp on it, you're talking about a good seven years, but even then you don't, I look back in terms of when I qualified as a Consultant and I kind of then, even then, didn't know a great deal." (5.51-5.58)*

Dominic uses argument as a rhetorical function throughout his narrative:

> *"I'd argue that the Dual Diagnosis patients are even more complicated, so it's a really complicated group of individuals and as I said even with addiction and psychiatry to give them a diagnosis and put them in there that's very difficult" (4.73-4.77)*

His tone is empathetic when he tries to understand why his patients find themselves in their current circumstances:

> *"from experience I think, some of the individuals, well they are taking the drugs to self-medicate so they're not taking the drugs for hedonistic reasons, because they like them, because they enjoy the effects of taking drugs, they take them to actually dampen down their symptoms." (9.31-9.36)*

4.16.2. Identities and identity work:

Dominic identifies himself as a skilled Consultant Psychiatrist and an expert in the field of addictions, he refers to himself as an "*Addictions Psychiatrist*" (3.14) In doing so he emphasises his specialist role. He articulates the need for a diversity of experience across both mental health and substance misuse service provision.

Dominic is an advocate and champion of his role, he regards himself as patient centred, and he advocates for specialised addictions and dual diagnosis services. He is tenacious in doing this and in telling a story of two brothers he saw he says:

> *"I think to get him into psychiatric services which we did, it took 5 years to get him through" (3.83-3.84)*

Dominic is essentially identifying with a role of hero. He is a trainer of trainee medics and emphasises through stories of his own development and his trainees, how important he feels it is to gain experience of working in the specialist field of addictions.

> *"I was talking the other night to a chap that was with us as an SHO, he's a Forensic Consultant now, but he still talks very highly about his experience in KTD." (8.36-8.39)*

Dominic identifies with his role in supporting the Dual Diagnosis team with expertise and leadership but he is keen to identify himself as an approachable team player and mentor

> *"going back to the first bit, that it is about having really good clinicians that have got a lot of experience of seeing these folk…….And the thing is if they talk to the members of the Dual Diagnosis team I actually ask them to give me psychiatric diagnosis and why, a lot of them would struggle but they all know what they are doing." (4.53-4.60)*

Dominic identifies himself as an approachable and likeable doctor who builds strong relationships with his patients allowing him to know and understand them better and improve treatment outcomes for them.

> *"As well really, you need to know the individual and again the thing is, I think, well the other issue about recovery is you do actually have to quite like your patients. And I think most of the time they have to like you as well, so generally, I mean I know I can think of patients where we've fallen out and disagreed and everything but we've kind of like worked through it and urr you know you continue through those rough times really" (9.219.28)*

Dominic talks about prescribing and identifies himself as having a key role with his patients as their prescriber, but he is also concerned to be identified as a well rounded clinician who uses a full array of interventions.

> *"So we're quite, we're quite limited really with I think pharmaceutical treatment really, but the answer probably isn't pharmaceutical treatment for a lot of them, its more psychosocial." (12.19-12.22)*

4.16.3. Thematic priorities and relationships:

There are numerous themes nested within this narrative, the most significant being; stigma; knowledge, skills, training and experience all of which are interrelated; and broadly linked to each is a theme on complexity.

From the outset, Dominic talks about stigma as a significant issue that he believes influences the quality of care both within mental health services and substance misuse services.

> *"....one thing that I think is difficult for patients with dual diagnosis is probably stigma really and I still think that there is actually a lot of stigma, I think within mental health services about patients with dual diagnosis and that's mainly the stigma because of the urm the drugs and the alcohol side of it all." (2.1-2.6)*

Dominic recognises that stigma can manifest in an unwillingness to treat and work with individuals in an holistic way but also as dismissiveness. In recounting the story of the two brothers he treated he observes that the opinion of psychiatric services was they just had an alcohol problem. He discusses his frustration that his colleagues felt the alcohol problem needed dealing with first, before they would even recognise his mental health issues.

> *"Anyway, they gave him that diagnosis and again the answer was just really "you need to stop drinking and that's the problem, you just need to be under alcohol services"...." (3.70-3.73)*

Dominic sees this patient group as highly complex with a significant level of need. The theme of complexity is one that he revisits regularly.

> *"Dual Diagnosis patients are even more complicated, so it's a really complicated group of individuals and as I said even with addiction and psychiatry to give them a diagnosis and put them in there that's very difficult" (4.74-4.77)*

This is closely linked to the predominant theme, a commentary and rationale on the need for knowledge, training higher level skills and experience to be able to adequately treat and work with the dually diagnosed service user.

> *"I still think that an awful lot needs to be done in terms of educating the workforce really and its not, its not just about education really it's, it's about somehow gaining the experience of working within Dual Diagnosis." (4.84-4.88)*

This theme is linked to the theme of stigma as Dominic sees the lack of education, experience and skills as the fundamental reason why people with dual diagnosis are labelled (diagnosed), stigmatised, and stereotyped by services.

"it makes me think, well actually general adult psychiatrists and forensic psychiatrists they haven't got experience, unless they've done that training, which a lot won't have done, they are going to be very limited. So with the Dual Diagnosis patients, there is a lot going on and they won't feel confident." (4.97-4.102)

"…….they give them a detox, then they start to play up on the ward and everything, they disappear, they come back drunk and everything and eventually they've had enough of them and they just discharge them and say "off you go"." (6.15-6.18)

4.17. Critical Narrative Analysis "Martin".

Introduction:

Martin is a clinician with many years experience working in the dual diagnosis service. Prior to this he was a nurse in a city adult mental health team.

4.17.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

This relates to staff attitudes and the negative impact this has on engagement and outcomes for service users with a dual diagnosis. Nested within this narrative is a discourse about the impact of training and personal experience on individual's attitudes towards substance misuse.

"You get a number of staff who are quite fixed that its just, sort of, substances and behaviour related and there's no real underlying mental illness because perhaps their behaviour is out of order on the ward a little bit and without explaining that to them and doing the full assessment sometimes things can be misinterpreted, perhaps if somebody is admitted who is of a manic presentation but also takes stimulants sometimes, that's overlooked from the mental health side of it and things like that and you know fine tune and that and staff attitudes is a big one I think, massive one and I think that is a barrier" (2.11-2.21)

Narrative Tone and Rhetorical Function:

Martin uses a critical tone towards a number of practitioners he works with in relation to their attitude to drugs and alcohol.

"At first he was seen by sort of other teams who didn't believe he was unwell, quite dismissive of him, crisis team didn't want to see him, they say… "just drugs and that, it's just, bad behaviour and when the drugs are gone there's no mental illness"." (5.13-5.17)

His criticism is firmly aimed at particular teams and he uses stories of his clinical experiences to illustrate and reinforce these criticisms. As his narrative develops he begins to introduce a more positive, reconciliatory tone into his narrative.

> *"it sounds like I'm apportioning blame to the crisis team for that, but its not, it's, I appreciate the sort of pressures they're under" (7.6-7.8)*

He gives examples where teams or individuals that he works with have changed their attitudes and uses a complimentary tone to recognise this growing change.

> *"but it seems to be getting a little bit better in areas that I cover, chipping away, chipping away and chipping away over periods, you know." (2.21-2.23)*

On a number of occasions throughout the interview Martin's tone is of frustration towards the negative attitudes he perceives in his colleagues.

> *"it's frustrating for us as well because sometimes it's almost dismissed," (7.15-7.16)*

> *"Sometimes they haven't perhaps got the time to do that, its easier to develop them sort of attitudes because it saves time, this person can be discharged." (17.47-17.49)*

Throughout this narrative Martin frequently uses the term *"sort of"*

> *"which may have been a contributing factors to the relapse, you know, sort of, looking at, sort of. If you look at somebody's, sort of, before, sort of, what happened before they became unwell, what were the key indicators for them becoming unwell, what was, sort of, declining in their functioning perhaps, (4.6-4.11)*

This rhetorical device resonates with Romero-Trillo and Lenn's (2011) description of a pragmatic linguistic marker and strategy to avoid cognitive maladjustment. On reflection it appears so frequently that it is probably a marker of Martin's nervousness. He seemed conscious of being recorded, and of our professional relationship, as I am a senior colleague.

> *"He says to his boss" (laugh) (29.39)*

His repetition of "*sort of*" is a linguistic device that allows him time to think. He uses other rhetorical devices such as echoing or repeating my questions to him, partly to sense check his understanding, but also to give himself time to structure his answer.

4.17.2. Identities and identity work:

Throughout this interview Martin rarely, if ever, refers directly to himself in the first person. He frequently uses third person narrative to illustrate his beliefs about himself and others. Martin's identity as a hard working, conscientious and

empathic nurse is important to him. He prides himself on working with other services to support and develop integrated packages of care and uses stories throughout his narrative to demonstrate this.

> *"He worked well, he was integrated and worked well with us, got links to the colleges, he was at the University before he became unwell, mmm slowly but surely that's getting back on track with him, he's now reducing his meds. It's just worked really well that whole package of care from the psychologist as well." (5.25-5.30)*

Martin is keen to reinforce his identity as a non-judgemental person, in contrast to some of his colleagues around him, who he feels are judgemental and very negative about their service users substance misuse.

> *"They judge too quickly when a genuine dual diagnosis comes along, without, sort of, checking it out, without a thorough in-depth assessment" (6.7-6.9)*

Conversely Martin identifies himself as being an open-minded individual

> *"I think its sort of having an open mind to the client really and not being so judgemental, being as open and understanding as you can regarding substances and the mental health and the way they interact" (15.9-15.12)*

The quote above also illustrates that Martin identifies himself as a specialist in dual diagnosis, not necessarily an expert, but certainly a nurse with higher level skills.

Martin sees himself as an educator who has the resources to change people's attitudes as a result.

> *"You can see with the people that have come along to, sort of, dual diagnosis training, the link-workers mmm…… you can see all those people are, you know, it makes our work far easier because of the sort of work that we've done and sort of dispelled a lot of myths, perhaps around people who use substances and why they perhaps use substances and things like that and the work is a lot easier and you can see that people have a better understanding and because of that, the training, the education, yeah." (17.2-17.10)*

Later in the interview Martin develops a theme about personal experience and he reveals his identity as a brother of someone with experience of substance misuse. He also goes on to explore his own experience of drinking alcohol and relates a story of a relationship break up where he began to recognise the personal impact of his mental wellbeing on his consumption of alcohol. He identifies himself as a reflective and insightful person who can empathise with his service users.

"I'm not particularly bothered if this goes on my record because I'm not mentioning any names but I split from a relationship recently so…….I suppose I drank a little bit too much and I was really conscious of it"(29.6-29.10)

4.17.3. Thematic priorities and relationships:

Martin's narrative has two main themes; negative (or stigmatising) attitudes, particularly staff attitudes, towards people with dual diagnosis; and the role that education and personal experience has to play in developing insight and empathy to tackle stigma.

"But sometimes I think people can be fobbed off a little bit too quickly really, and yeah, I have actually seen it in the past with a number of ours that you know, if we needed to put referrals in for weekends and things like this with crisis, I think they are a bit reluctant because they hear drugs and alcohol and just say no." (6.13-6.19)

Linked to this is a theme on service culture. Martin uses his experiences to illustrate that culture can reinforce stigma, which negatively influences the services approach to people with a dual diagnosis.

"It's learned isn't it. If you are a newly qualified nurse coming onto a ward with urm sort of old nurses who've been working there for many years, who take these people under their wing and say "forget about all that, this is the way that it works, this is the way that we get things done on this ward, this is the way we get things done in this team", you know, that won't work, believe me I've been trying it for years. It's a massive influence on somebody and sometimes it's hard to change that." (19.7-19.16)

"But you do still come across those ones and they make life quite difficult I think. They can be a big influence on people who are motivated, urm who want to come in, who want to work, sort of, you know, more openly and, sort of, client focused" (21.19-21.24)

Martin describes the benefits of education in developing practitioners and services understanding of dual diagnosis, the positive impact this can have in counteracting stigma and improving service delivery for people with dual diagnosis.

"I remember one guy who was particularly, I remember him from the wards when I was younger, being very black and white about substances urr, quite the macho guy on the ward, his urr. He attends all the link worker events now and is quite, sort of, he's said quite honestly himself that yeah, he's a little bit more open to it and a bit more understanding now and he enjoys the, you know, the training on dual diagnosis" (17.15-17.22)

He reflects on the impact that personal experience can have on individual's beliefs about drug and alcohol use. He relates this to the theme on education and knowledge.

> *"my brother smoked cannabis and I still think he does dabble for you know, but he smoked massive amounts for years and years, my younger brother, so that's a big influence on the way that I work because you always have in the back of your mind, hang on what would I want my family or my sibling to be treated like" (27.2-27.7)*

4.18. Critical Narrative Analysis "Ralph"

Introduction:

Ralph is a qualified psychiatric nurse who is the unit manager on a 12-bed community rehabilitation unit. He has extensive number of years of working in mental health.

4.18.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

The main theme is about tensions for staff on a residential unit working with people who have dual diagnosis. Tensions between being therapeutic and having to 'police' drug use; between staff who have different opinions about problematic drug and alcohol use; and tensions in ensuring individual's safety without accepting disruptive intoxicated behaviour.

> *"I mean we've had people who've been told "You have to stop taking drugs before you can go to Livesy Close". For example maybe during our assessment we find out that perhaps their behaviour is risky when they've taken substances, could be a problem on the unit. So you know the person is told you may have to stop. So then people may stop or they may just hide it better and again it's not the best way necessarily to have somebody start their placement, because they are going to be thinking well I'm already trying to be controlled by Livesy and I'm not even there yet." (8.3-8.14)*

Narrative Tone and Rhetorical Function:

Throughout the interview Ralph uses narrative tone to emphasise the imbalance and tensions he perceives. His tone is reflective, enquiring and empathic. This is illustrated by a story he relates about an individual going home to visit their family:

> *"We often get phone calls saying "So and so isn't very well, urm they've just visited me, I don't think they're very well, they've come home and they're not very well and I'm sure they've been smoking cannabis again because they always get like this from smoking cannabis"…… that may be right or it may be wrong, urm and you have to think well why are they smoking*

cannabis before he goes home, is it because it's so stressful and you know we often think, we often find that people get much more ill when they go home to visit family, so you think about it in the round if you like." (11.9-11.20)

Ralph's narrative tone demonstrates tensions he experiences between his role as a nurse and role as manager and later in the narrative the tension he experiences in empathising with service users as a result of his personal experiences of substance use. Ralph recognises the tensions for practitioners he works with and manages. His tone appears critical of certain staff:

"Sometimes even on a shift if you think about, lets say you have an incident form and lets, may be there's been an altercation between staff and clients because staff have tried to lay down some boundaries about drug use, if you look at the incident form and you look at the staff who were working on that shift you could think well may be if so and so was working, if there was a different staff mix this wouldn't have occurred." (12.23-12.30)

He empathically recognises the challenge for many staff and is reflective in tone when he says

"It's, you know, it's a daily job to think about that when you're interacting with clients and, you know, if you're a good professional you should always be aware of your own prejudices and everything that you're kind of saying and doing… But it's not easy, when you're busy and you're stressed." (12.35-12.44)

Ralph uses tone to demonstrate how conflicted and frustrated he can be in being stuck with theses tensions and anomalies.

"For some reason I found myself being quite angry that actually all his answers were right and he put a very good case forward about his behaviour. That he didn't supply other people with it, he only used it in his bedroom, it fitted in with his religious beliefs, urm.. "It's in the bible and it's a herb" and urm "its one of god's herbs". As a very cast iron argument if you like and I found myself getting really angry about it and I had to think about why, you know why that was and what actually was I trying to achieve by having this conversation with him. That's the kind of thing you get into sometimes." (12.99-12.109)

4.18.2. Identities and identity work:

Ralph was a good narrator; he used stories to underscore the points he made. His narrative identifies him as a libertarian and a pragmatist.

"So, you know keep smoking if you want but why don't you think about smoking something less strong." (16.31-16.33)

Throughout his narrative Ralph identifies himself as an empathic nurse and a supportive manager. At times this manifests as somewhat patriarchal.

"I've got a junior member of staff doing the right thing and letting me know that someone can smell cannabis on the unit, so you feel like well ok we need to go and do something about it...." (13.6-13.14)

Ralph identifies with being an even-handed manager and is philosophical throughout his narrative about his own behaviours and traits. He underscores his identity as someone who is not only philosophical but who often feels conflicted with his dual role.

"Am I trying to show the junior member of staff that I'm doing something about it, responding? Or am I actually talking to the person about their drug use?" (13.15-13.18)

Ralph frequently refers back to the conflicted identity of the nurses on the unit as disciplinarian policeman and evenhanded therapists. Ralph contests being seen as a disciplinarian but recognises his identity as the responsible leader. He frequently demonstrates his creative, intelligent ability to take on his responsibility without being too draconian. He is identifying himself as the hero. In further relating the story about challenging a service user who is smoking cannabis on the unit, Ralph tells us he eventually said to the service user:

.... "we don't disagree with you but you have to understand we have a duty and this is our job and our duty and what you're doing challenges that" so yeah, the conversation's a bit more about respect for each other's point of view I suppose" (14.28-14.32)

Later, Ralph identifies himself as someone who has experience of drug use outside his professional life.

"I mean I know people who've got real problems with drugs and alcohol. Urm and people who if you like use drugs and alcohol and it doesn't cause them a problem. So I suppose I've seen both different sides of it if you like." (22.9-22.13)

4.18.3. Thematic priorities and relationships:

Ralph's narrative is rich in interrelated themes and he covers a diverse range of issues both organisational and personal. Throughout he juxtaposes ideas and experiences that demonstrate the personal and professional tensions nurses experience in trying to work with someone who has a dual diagnosis. A recurring theme in his narrative relates to engagement, trust and empathy between staff and their service users.

"...We've also done work with their mental health and their medication, so we've got on board and got them on board and made some, took some therapeutic risks with their psychiatric medication, you know. So that's

made a huge difference in terms with engagement and trust if you like" (20.3-20.8)

Ralph explores the relationship between paucity of resources and capacity of nurses to undertake specialised interventions.

> *"Everybody's covering a shift, getting the diary done and if you're lucky getting to spend a bit of time with clients. So everybody, it feels like everybody is a bit more…is having to be a bit more generalised and you haven't got time to do those special bits of interest." (17.18-17.23)*

Linked to this theme is one related to environment or "setting" as Ralph puts it.

> *"….a lot of it is the setting, the environment and the setting can have a really big influence and make a real difference in terms of your ability to manage people if you like…. its not just about staff, its about the building you're in and where it fits, you know. What locality you're in…" (17.26-17.31)*

> *"…. It's very homely setting, it's a semi-realistic life setting, you know and within that you get challenges that you're going to get in every day life, urm about what to spend your money on, what to do with your time, urm who to associate with, you know peer influences." (18.10-18.14)*

He links the themes of setting and environment with pragmatism and staff attitudes. Ralph sees the approach that staff take, on a unit that is situated off hospital campus in a community, as important in helping service users to resolve some of the complexities they experience in day-to-day life.

> *"They've done very well in this setting, a lot better than they have in other settings and I think its because there's been an acceptance where they are at the moment with their drug use." (19.33-19.36)*

Later in his narrative he talks about the tension between divulging personal experiences of drug and alcohol use (Ralph talks about his friends and family) and the experiences of the service user that is being engaged.

> *"I think you are going to get yourself in a mess if you think because you've had a couple of joints at college you know what it's like to be a heroin addict." (22.55-22.58)*

He links this to themes on prejudice and stigma frequently referring to staff seeing things as "black and white"

> *"It's often a challenge for the staff team and it can be staff, individual staff who perhaps have a very black and white view of people who use drugs and have got a mental health problem" (2.5-2.8)*

".....some 'black and white' thinkers who, you know, have a very clear idea of what's right and wrong" (12.17-12.18)

4.19. Critical Narrative Analysis "Shirley"

Introduction:

Shirley has been working in the dual diagnosis service for more than ten years. Prior to this she was a community psychiatric nurse in an assertive outreach mental health service.

4.19.1. Narratives, Narrative tone and rhetorical function:

The Grand narrative:

This narrative features tensions, tension between services, tensions between professionals and tensions between partners and within families.

"I remember seeing a guy whose family was incredibly supportive and they really wanted him to address his drug and alcohol use that he's actually got... no, he doesn't want to, he doesn't want to see us, he doesn't want to engage in any work and so there is a big issue. It sort of strains within the relationship because I mean he spends a lot of time at his parents but he actually doesn't really want to make any changes to his drug and alcohol use but his family obviously see the destruction and the effect its having on him and, are struggling to cope, and want him to make these changes." (17.2- 17.13)

In relating a story about another service user Shirley discusses her differences with the mental health team.

"Mmm and the attitude of that consultant possibly is not urm... and urm.....there's reluctance to perhaps view it from a different angle from, you know, sort of, listening a bit more to myself" (14.11-14.15)

Narrative Tone and Rhetorical Function:

At times there is a tone of frustration to Shirley's narrative. As a dual diagnosis clinician she regularly works with people who have multiple complex needs and she is often frustrated that services are sometimes reluctant to work with people with drug and alcohol problems or are dismissive of their needs.

"I get frustrated because I don't think they listen to me, perhaps I've been seeing him a long time and urm that may be there should have been a bit more compromise with his care. And I think it's led to a huge barrier with that particular client because the consultant doesn't see that he has any psychosis..." (13.7-13.12)

She is also frustrated that operational changes in the NHS mean that she is no longer able to be as flexible as she used to be in meeting service users needs. She

uses a tone of disappointment that illustrates her concerns that her clinical imperative has been overshadowed by a bureaucratic drive.

> *"We used to be a lot more flexible back in the day" (7.9)*

Shirley uses a tone of professionalism and honesty throughout her narrative and her tone is passionate about this when she says:

> *"I suppose it's about an interest it's being interested, its being bothered, its about not just, just about a pay packet." (25.4-25.6)*

Throughout her stories, Shirley uses a liberal tone that demonstrates how much she privileges collaboration, above all with her service users, but also with other services and professionals.

> *I think it really helps sometimes if they know that they can, sort of, it's within their control as to whether they see us or not... (18.26-18.29)*

Shirley uses a tone that demonstrates an empathic commitment to her service users. Her narrative is often couched in a questioning tone, debating the value of one approach over another or the growing popularity of an ethos.

> *"I'm not always clear that recovery is good, recovery is such a popular word now, its been used everywhere and I'm not entirely sure it should be used. It's all over the place. Its become the big buzz word about, but sometimes what's more important is about stability and that goes back to when I worked more you know in assertive outreach and rehabs, mental health rehab services that people, you are working with lots of very chaotic people, the recovery might be more about that sort of not ending up in hospital all of the time" (20.11-20.20)*

Shirley's juxtaposes knowledgeable, philosophical tone and an uncertain tone, illustrating that she lacks confidence in her argument. To some extent she uses this questioning as a rhetorical device, at the end of her statements, to check concurrence with her audience and also as a pragmatic device to give her time to think.

> *"...being able to give information to a client promotes hopefully recovery, urm and the client wanting to receive that information isn't it?" (8.27-8.29)*

4.19.2. Identities and identity work:

Shirley portrays herself as a dependable, consistent nurse who cares about her service users and is responsive to their needs.

> *"I do believe that when you see somebody you turn up and you see them and you don't cancel appointments unless absolutely necessary, you're consistent with your contact." (23.22-23.26)*

"…you don't set people up with hopes and then not follow through, so you say what you're going to do and you turn up, and you're their when you should be, its about that consistency, when they've not perhaps had much of that in their life." (23.30-23.35)

"I've been his most consistent worker so with the services he's had lots of changes of workers and I support I have been the one…. and changes of consultants actually, and I've been the one constant" (23.10- 23.13)

The overarching theme around the variety of tensions she perceives in her role, demonstrates how closely she identifies with her service users. She identifies with the conundrums that dual diagnosis pose and often experiences them first-hand.

"…You can't make somebody engage it just doesn't work generally, because we've found that sometimes in forensic services when someone is told to see us in order to move along their discharge, now some of them will see us because they know that they've got to do that to tick the box to get the discharge and you may be able to offer a bit of information, it might be an opportune moment, but its not the best way to be……Engaging with somebody, is it really?" (18.4-18.11)

She identifies with her role as advocate for her service users and is keen to ensure that the treatment they receive is planned and developed appropriately

"It's about being really careful and I suppose we can sometimes act may be as a little bit of an advocate for the client possibly or at least challenge and ensure that that you know that when they are setting up the CTO that they think and they are mindful about what they are putting within it and whether its right to do that." (19.7-19.12)

She sees herself as an optimist who is positive about the potential for improving outcomes for her service users. She is identifying with the role of hero.

"I suppose it's important if you've got a worker that is going to obviously have a, that is positive isn't it. You've got a positive outlook and not overly cynical." (24.24-24.27)

4.19.3. Thematic priorities and relationships:

The main theme of this narrative is about the challenges and tensions in working with people who have a high level of complex need. Nested within this theme is a panoply of other themes relating to the challenges of being a dual diagnosis clinician and her perceptions of what it is like for her service users.

Shirley illustrates this complexity and its challenges by talking about the tensions between building a professional, therapeutic relationship with people and

developing a relationship that is over-reliant or not therapeutically challenging enough.

> *"there is a backlash to that because he's always, you know, you get reliant don't you and there's sometimes a concern that may be at some point he should have a change of worker" (23.1423.17)*

She recognises the tensions between professionalism and approachability

> *"I think there probably are times where clients might feel that we're a bit hard on prescribing and we are may be at times a bit rigid, but then that comes with safety and things that are expected of us." (26.23-26.25)*

There are tensions between bureaucracy and her ability to focus on the needs of the service user. She always privileges the developing relationship with the client but recognises that this often involves a resource intensive approach that has a tension with the operational and management imperatives in the modern NHS.

> *"I saw a client at Turtington Lodge, who I had seen years before, mmm he was a bit ambivalent really about seeing me. I didn't do an assessment, I chatted to him and to the worker as well. Mmm and we did agree to just leave it open for a few weeks, meet again and then decide from there what's possible." (6.20-6.26)*

> *"I do think there is sometimes a barrier about bureaucracy when we're trying to start to engage with somebody. There is often a lot of emphasis I find, when we're about, about assessment, about obtaining details from a client when we see them first of all and that's always at the back of my mind." (2.24-2.29)*

> *"I think there is an expectation that we complete the paperwork, and I don't think it's always appropriate."*

A theme of stigma develops in Shirley's narrative. She recognises that stigma of drugs and alcohol have gradually changed in some of the services she worked with:

> *"I think there is less stigma, there is less criticism these days around substance, you know I think there is more understanding around substance misuse and about harm reduction and about reducing the risk, rather than driving towards abstinence being the only answer" (22.3-22.8)*

This positive tone on the reduction in stigma is to an extent counteracted by narrative about the dismissiveness by other professionals. In particular she develops a theme about the importance of communication and recognises that some of her colleagues reluctance to communicate about their shared service user's care is fundamentally about stigma.

"…. and you also get a feeling if you're sending letters or emails or whatever, if you get a response it's brilliant isn't it? But if you don't you're not quite sure if they are digesting that information, they are really bothered about that information."(11.16-11.20).

4.20. Critical Narrative Analysis "Trisha"

Introduction:

Trisha is an experienced psychiatric nurse who has worked with the dual diagnosis team for a few years. Prior to that she worked in a county community mental health service.

4.20.1. Narratives, Narrative tone and rhetorical function:

The Grand narrative

This narrative is about change. Trisha talks about the importance of change to her service users and the challenges that trying to facilitate change present her. She also discusses the positive effect change can have upon her patients.

"I think some of the other things about changing is some of the positives, people have to get to a point where they decide themselves that they are ready to change, urm and I've got a few people whose physical health has got to the point where they've said enough is enough now, I've just got to give this up" (9.8-9.13)

Later, she describes how she facilitates change in her colleagues who provide mental health services; through training and the positive impact she believes this has upon those staff engaging with people who have dual diagnosis.

Narrative Tone and Rhetorical Function:

From the outset Trisha uses an embarrassed-awkward tone. This may be because she sees me as a senior, knowledgeable colleague, which manifested as a rather deferential dynamic throughout the interview. However, I know her to be somewhat self-effacing at times.

"Where do you want to start... (Laugh)" (1.16)

"(Laugh)… Urm, I don't know really. I guess I don't, I don't feel I have a very high drop out rate so I do tend to keep people in service, so I don't know whether that means that they like the way that I work with them" (5.1-5.4)

She uses this deferential tone as a rhetorical function at times to sense check and pose some of her statements as questions, seeking affirmation from me as her audience.

"…Shall we think about barriers then?" (1.18)

When she begins to discuss barriers to change that she perceives in her service users she uses a tone that I would describe as sympathetic frustration

> *"…There are a few people that I can think of that don't even recognise that their drug use is causing their mental health problems and often it takes something quite significant to get them into a place of them realising that, for example hospital admission under compulsory detention, moving away from the area etc." (3.33-3.38)*

Trisha works hard with her service users and recognises their role and responsibility in changing their lives but seems frustrated that many of the people she works with seem to go around in circles.

Trisha tells stories about how her colleague's attitudes and approaches can positively and negatively affect how service users with dual diagnosis engage with services. She uses a critical, pejorative tone in her narrative and impersonates a colleague's judgemental tone.

> *"I think there are some people, some workers that are quite kind of straight-laced and they'll say "they need to stop using the drugs and until they stop using the drugs nothing is going to change" ". (4.12-4.15)*

Trisha wants to demonstrate that she is a caring nurse who can understand the challenges her service users face. She uses an empathic-understanding tone to illustrate this in her narrative.

> *"I spend a bit of time kind of talking to some of my clients about, they will say "well I've got nothing, I've got nothing in my life, that's all I do, I can go and score drugs," so we kind of turn it around a little bit and suggest that actually the time and effort that they put into doing that they can adapt those skills into other areas of their life." (6.22-6.27)*

As the interview developed she becomes more assertive in her tone using an emphatic tone to underscore what she sees as important

> *"…People* **have to** *get to a point where they decide themselves that they are ready to change" (9.9-9.11)*

4.20.2. Identities and identity work:

Trisha identifies strongly with her nursing-dual diagnosis clinician role she is proud of what she does and is keen throughout her narrative to demonstrate her passion, drive and enthusiasm for her service users.

> *"…Well I've got lots of various different clients that are in various different stages of recovery, some that I've been working with for a long time and have been in the service for a long time." (1.9-1.12)*

Within this narrative is a nested narrative that identifies her as someone with expertise. She uses terminology associated with substance misuse therapies, in particular motivational interviewing.

> *"I guess for me it feels like there's a, a bit of a… a fine line between kind of rolling with the resistance and accepting their drug use a little bit and kind of giving that information and advice about using safely etc to also suggesting that actually you know this needs to change." (4.5-4.9)*

Linked to this is her identity as mentor and teacher, she talks about her colleagues lacking confidence and training and then stories how she develops knowledge and understanding.

> *"I think its about them not feeling confident enough or enough training or educated enough to be able to kind of deliver that intervention really and I spend a lot of time kind of explaining that it's not a magic wand scenario, you know it's just about sitting and sometimes talking to the client and understanding what's going on for them and how their drug use kind of fits into that" (16.19-16.16.25)*

> *"with all the students at the moment I'm really trying to get them to kind of start asking those questions and even when they're on the acute ward to start asking those questions about somebody's substance misuse" (16.32-16.36)*

She also identifies herself as a thoughtful and reflective professional

> *"I think what's really interesting is that the whole concept of dual diagnosis and whether people understand that and understand that actually the two kind of come hand in hand and trying to separate it is really, really difficult, but then why do we try and separate it, lets not just try and treat them together really…" (16.10-16.15)*

Trisha believes she is tenacious and committed, she uses repetition of words as a rhetorical device to emphasise the complexity of her service users needs and how difficult it is to deliver a service to them. In storying the challenges of being labelled with both mental health and substance misuse problems she says:

> *"…..trying to get them into main stream stuff can be really difficult or really time consuming and you need to take them to an interview and then you need to do this, you know it's really, really difficult." (20.17-20.20)*

Throughout her narrative she uses certain words and phrases to emphasise how 'down to earth' and consequently accessible she is. She talks about the *"guys"*

(1.22) and *"young lads"* (2.10) and uses these as rhetorical devices to show that she is connected and approachable.

4.20.3. Thematic priorities and relationships:

Multiple themes in this narrative relate to the concept of change. Within this overarching theme are themes of stigma both within the family and from other mental health staff; a theme on responsibility and empowerment to make changes, the role of personal targets in highlighting and encouraging change, an important theme on the impact knowledge and skills have on understanding, staff's prejudices and the willingness of staff to engage in treating dual diagnosis holistically.

Trisha develops two distinct themes on stigma one where she talks specifically about the negative impact of stigma, which develops further in her exploration of differential stigma between people's perceptions of drug users and drinkers juxtaposed with the stigmas experienced as a result of having mental health problems.

> *"there are lots of people within mental health services who might not look favourably on somebody disclosing substance misuse" (16.26-16.28)*

In developing the idea of differential stigma she uses two examples; firstly she tells a story about one of her patient's parents

> *"I think it's because the parent or the family members give them a lot more lee way because of their mental health problem and kind of excuse their behaviour really because of their mental health problem and allow that drug use to continue." (13.3-13.8)*

She is developing the link between parental beliefs and the relative stigmas associated with drug use and mental health. In essence the parents in the case she is describing overlook their son's substance misuse and even engage in personal risk taking behaviour in order to protect him because they perceive that his mental health problems expose him to risk and to some extent excuse his drug use.

> *"They* (the parents) *know that they're* (their offspring) *not going to get themselves into any crime or trouble when they go and score"* (for them) (12.22-12.24)

Secondly, she emphasises differential stigma by relating a story about a parent who she visited the day before our interview.

> *"Just yesterday, in fact we were, I was talking to a family member who is ok with her son accessing drug rehab, but doesn't want him to have a diagnosis of a mental health problem." (14.11-14.14)*

Trisha links staff's knowledge and skills of dual diagnosis to fear of the unknown and stigma. She sees equipping staff with the right skills and knowledge as one way to increase their confidence and tackle the stigma of drug taking. In a story about some students she was encouraging to ask service users about their drug use, Trisha theorises on the reasons why staff tend to avoid asking and clearly links knowledge and skills to stigma.

> *"Personally I think it is about not knowing what to do with the answer and feeling like they don't know how to deal with the problem personally, that's what I think it is and I think if, from some of the training that we've done recently there has already been a bit of a shift in people being more willing to sit and talk to somebody about their substance misuse because they've had that small amount of knowledge." (17.4-17.11)*

The theme on differential stigma is a complex one and worthy of more extensive exploration later in this text.

4.21. Critical Narrative Analysis "Ashley"

Introduction:

Ashley is both a current user of services and a peer support worker/staff member at the trust. She has worked closely with me on a number of projects and is a regular supporter of activity at the Recovery Education College. Ashley uses her experience of services in her work and is explicit about being a service user but prefers to define herself as a member of staff.

4.21.1. Narratives, Narrative tone and rhetorical function:

Grand narrative:

This narrative has an overarching theme of self-determination and choice. Ashley talks about what is needed to enable service users to build their own confidence and motivation to change. She stories the need for services and providers to be open to and accommodating of the service users wishes.

> *"Some people will obviously take that and try and blagg their way through it and try and get more things, medication wise, I'm talking about more than they need or more than is necessary but generally people know what they want and they know what they kind of need and if that can be accommodated where possible." (1.53-1.59)*

Narrative Tone and Rhetorical Function:

Ashley's tone challenges power roles throughout and she is positively critical of some people's attitudes she experienced throughout her journey.

> *"I had a relapse recently and a member of staff on my return to work told me that the last 5 years of my life accounted for nothing, I'd had a long fall, I needed to start at the bottom and work my way up again and just constant mmm comments like that that were just, they weren't helpful and for me it was that could have pushed me straight back to taking drugs again because it just made you feel really worthless" (7.7-7.14)*

Ashley is proud of her achievements and she uses a proud tone to emphasise her self-determination.

> *"I suppose it was good because it kind of gave me a bit of motivation to say well 'stuff you' really and get back into work and really try hard to get myself back on track." (7.48-7.51)*

However, in retelling this story of relapse she demonstrates that she feels conflicted and victimised because whilst she is developing in strength and self-determination she also recognises her anxiety and feelings of repression by questioning that self-determination.

> *"at the same time it was horrible because it was the team I was going back into and it was just very wrong" (7.51-7.53)*

Ashley uses a tone of isolation and darkness to convey the emptiness and loss she has felt when she was using drugs and on other occasions when she was abstinent. She talks about the challenges of dealing with a drug problem, the lack of purpose and what she describes as a *'black hole'* (13.5).

> *"…Just going back to the same street and the same house when you've, you know been abstinent for a while, its not going to be long before things creep back in again" (13.19-13.21)*

> *"When I first stopped taking drugs and I used to sit on the doorstep. If there was no one in I'd sit on the doorstep and wait for a mate to come round or for my partner to come home before I could actually go in the house because it was just, well I'd normally come home and take drugs or I'd normally do this and that's not there anymore so what do I do." (16.16-16.22)*

Ashley contrasts these dark tones with brighter positive tones to illustrate her sense of optimism that things are not only improving for her but that there is a growing positivity in society towards recovery for people with a dual diagnosis.

> *"So I think urm on the whole we're getting a lot better as a nation and as human beings understanding that you know people have problems and its*

fine. So that's a good thing but there just needs to be a lot more out there" (13.2913.32)

4.21.2. Identities and identity work:

Ashley identifies herself as someone who has been a victim. She is a victim of stereotyping and stigma that has been borne out in negative attitudes towards her. This is tangible when she stories her return to work after relapsing into drug taking (7.7-7.14 and 7.51-7.53 above).

Ashley sees herself as a strong willed and self-determined woman who has good support and knows how to use it when necessary.

> *"...It was useful to kind of sound out with other people and work out you know a plan around where that person might have been coming from, what they actually meant from it, was it best interests that just came out very wrong, mmm so yeah I used a lot of people around me and not many, I had probably about 4 or 5 people very close people that I could trust and I could confide in and that would give me supportive useful advice, so I could make the right decisions because all my instincts and my natural reaction would be to kick off and then take drugs." (9.9-9.19)*

Ashley identifies as a reflective person who can use her past and current experiences to support her peers and help them move on.

> *"I think insight has been quite huge for me and a lot of it was when I first relapsed talking to people who said write this down, write down how you're feeling……. For once I listened to people and I wrote down how I was feeling and tried to kind of analyse myself a little bit..." (10.3-10.11)*

Whilst Ashley is open about her lived experiences of drug use, she also identifies herself as a professional, which creates personal conflicts. Her ongoing stability is associated with being medicated and she is insistent that she can only move on and change when she is ready.

> *"I don't want to be looked as a service user I want to be the professional that I am and I want people to respect me and I want people to treat me like they treat all my other colleagues, but then there's that bit in the back of your head that reality check that says you are still in treatment, yes you are under a key-worker, yes you are on a Methadone script, yes you have to go to the chemist, you know and so it's a real double life." (29.5-29.13)*

Ashley places a great deal of importance in her recognition that she is someone who is on an incomplete journey someone who is becoming increasingly responsible.

> *"I trick myself a lot into thinking and I've, you know I've done it before, I relapse thinking I'm fine and before I relapsed I was convinced I was recovered, you*

know there are articles that I wrote where I said I have recovered, my recovery is over you know and urm and it's not, far from it" (29.13-29.18)

Ultimately Ashley wants to see herself as '*normal*' but recognises she has further to go.

"Yeah it's a reality check every now and again that I'm not quite normal (laugh) as normal can be" (28.7-28.8)

4.21.3. Thematic priorities and relationships:

Stigma, stereotype and prejudice occur throughout this narrative. These are strongly associated throughout, by Ashley, to attitudes of services and the staff in those services.

Ashley underscores this sense of difference through stereotyping by highlighting herself as *"not quite normal" (28.8).* She refers to a related theme on her medication as being something that gives her a platform on which to build her life and appear normal.

"Methadone gives me, it gives me the freedom to have a life and to be a normal person that gets up in the morning, comes to work, holds down a full time job, working with people I enjoy, helping people and then I go home and if you ask any of my neighbours they would have no idea of what was going on and if you ask people who didn't know me that's what I really like about it you know, anybody else I'm just Ashley, support worker or whatever." (28.10-28.18)

This reflection on her life and the impact drugs have had upon her strongly echoes Goffmans' (1963) theme of spoiled identities and underpins the overall theme of stigma in this narrative. In the quote above she contrasts her virtual social identity with her actual identity and whilst she recognises that she was once completely different confirms she has little recollection of what she used to be.

"I don't have any recollection of why I started taking drugs at such a young age. So 13 smoking cannabis and progressed rapidly from then, from 15 probably took drugs nearly at least 3 times a week so I don't really know what it's like to be normal" (29.5-29.9)

Ashley uses significant parts of her narrative to story how her relapse has affected her, both positively and negatively. She demonstrates that she sees this as a learning opportunity but also recognises that it has caused her and others around her to question how far recovered she actually is. She is annoyed and

even angry at the prejudice she faced from staff due to her relapse and appears to respond so strongly to this because it reinforces feelings she has about herself.

There are a number of other related themes within her narrative but one of the more prominent associated themes relates to her sense of the 'black hole'. Having nothing to do, nothing to replace the occupation that taking drugs provides, associating her home with drug taking and advising others to move away from where they live, or at the very least to redecorate.

> *"It was like, this isn't hard you've done this for years, you've done it for 3 years you've managed it and it didn't bother you but its that thought process and that kind of fear and the panic of what am I going to do, what am I going to do." (30.18-30.22)*

4.22. Reflection on the interviews and analysis:

As I began data collection in this study I am aware that my research interview technique was poorly developed. On reflection I realise that my technique was more based in clinical work as I had little, if any, practice as a research interviewer. At the outset I would say I was sceptical and concerned about the free flowing, apparently random nature of the unstructured interview techniques of narrative inquiry. At times it felt as if participants were too, they seemed surprised that I wasn't going to ask them more probing questions and frequently sought affirmation from me in what they were saying. I remember in the early stages a discussion with one of my supervisors; I was struggling to see how my study was going to answer the research questions I had identified. His response was:

> *"Continue with the data collection and trust that the methods will begin to reveal things to you*".

He was of course right! As the process of data collection developed I was more able to listen and allow stories to grow. I noticed that the participants got over their initial discomfort, shifting to telling longer stories and developing themes without prompting. I became more involved in the role of researcher, feeling my enthusiasm grow, not only for the subject but also the methodology. I was often surprised at the sophistication of the narratives and the things they were beginning to show me. I was able to reflect on what was being said with participants and although I didn't always agree with their perspective, I found what they said elucidating. It could be argued I was becoming open to their different 'truths'. By the time I had completed all twenty interviews and read and re-read some of the transcripts I felt that I had been on a significant journey of

development and understanding. Narrative inquiry had 'sold' itself to me. I began making tenuous notes about what I thought was being said and how it was of relevance to what I was interested in uncovering. I was beginning to see themes and patterns emerge and to understand how these narratives were highly relevant to my area of inquiry. Additionally these narratives complemented and deepened my understanding of previous research and policy related to dual diagnosis. As is often the case with PhD theses writing the discussion chapter has been both challenging and rewarding. My main anxiety has been how to privilege the voice of the study participants whilst destabilising their narratives and much work has been achieved on this through discussion with my supervisors and others around me who have shown interest in what I am doing.

4.23. Summary:

The diversity of themes across the narratives in this study is significant. Whilst there are some differences between the service user participants and practitioners it is also remarkable that there are numerous points of convergence. In summarising this section I have avoided trying to suggest any one theme is more important than another but it is clear that whilst there is diversity many seem to coalesce into the impact that stigma and discrimination can have in restricting recovery.

Stigma and its impact along with negative attitudes of staff, peers and families are a frequent, common theme across narratives in this study. In the next section I will explore the impact of stigma and prejudice that participants have storied. Langdridge (2007) suggests that the application of social theory is an important part of the synthesis of critical narrative analysis and I apply Goffmans' theory on stigma and spoiled identity to this along with more contemporary work by Link & Phelan and Sayce.

Service users frequently talk about the importance of choice, control, feeling valued and empowerment or self-direction in their narratives. Choice in being medicated or medication as a control was a theme developed by some. Some participants saw medication as a stabiliser and facilitator and others as a hindrance or '*shackle*'. They often contrasted these with the desire to feel 'normal' or be seen in a more positive light by their families, significant others, services that helped them or wider society. Medication was seen as a marker of stigma, because it identified them as an addict or because it held back or marked their lack of progress.

Practitioners' training and skills and its link to service culture were frequently raised in professional's narrative and some service users. Practitioners storied the challenges and tensions for them that came with their capacity to offer integrated care effectively. Capacity, bureaucracy and the tension between 'policing' illicit drug use or excessive drinking and being optimally therapeutic coupled with the broad demands and stresses of working empathically with people who have dual diagnosis was a common theme. These systemic tensions result from structural stigma that I will explore more thoroughly in the discussion chapter.

Being able to tell their story by talking, supporting others or writing it down was something many service users thought was helpful. The resonance of this with some of Frank's writing (1991, 1995 & 2000) is worth remark. Recovery narratives are testament to the impact of stigma both structural and individual. They also reveal something about how societal constructs reinforce beliefs that result in self-stigma, explored further in the next chapter. Recovery narratives show how the participants were able to re-identity themselves and leave behind stigmatising labels that they had become burdened by.

5. Discussion.

5.1. Introduction:

This chapter will develop a discussion of the findings from the previous chapter by applying Langdridge's (2007) framework using the final two stages of CNA, destabilising the narrative by applying a hermeneutic of suspicion and developing a critical synthesis. Paul Ricoeur (1970) distinguished between two types of hermeneutics: a hermeneutics of faith that aims to give meaning to a text and hermeneutics of suspicion that attempts to decode meanings that are hidden. Ricoeur appears to be concerned about the subjectivity of narrative wishing to balance the call for objectivity with seeking to remain open to what the narrator has to say. His development of a hermeneutic of suspicion is one way in which he argued the reader could apply art and science without allowing either prescience.

> *"Hermeneutics seems to me to be animated by this double motivation: willingness to suspect, willingness to listen; vow of rigor, vow of obedience."* (Ricoeur 1970)

Langdridge (2007) is clear that each of the stages in his framework is not discrete. In writing this section I am aware that some destabilising of narratives began in the previous chapter. My aim in this chapter is to make sense of what was said and to begin to synthesise this with the narrative texts. I aim to uncover the relevance of what the participants said, to my central research question: *What do participants perceive are barriers and facilitators to recovery in dual diagnosis?* In developing the themes in the previous chapter I have demonstrated that there are four broad narrative themes in my study: Motivation, Recovery, Stigma, and Tension Narratives with the overarching link being stigma and discrimination. Within these narrative themes are a multitude of nested narratives that I will elucidate using direct quotes from the study data. My aim in doing so will be to retain and privilege the voice of the participants in order to avoid allowing my own illusions of subjectivity to cloud the interpretation of their stories.

The predominant hermeneutics of suspicion I apply are Erving Goffman's seminal text on *Stigma: Notes on the Management of Spoiled Identity (1963)* progressing with Link & Phelan's (2001) work on *Conceptualizing Stigma* and more recent work on stigma and discrimination by Liz Sayce (in Press).

This chapter will also take a critical view of my methodology exploring the strengths and limitations of this study, its relevance and transferability and a discussion of what the results mean for practice.

5.2. Stigma & Discrimination:

> *"I think regarding, well regarding mental health drug and alcohol there should be more understanding because all three of them they get a massive stigma." (Norman 21.25-21.31)*

The central and pervasive theme in this study that links all the narrative themes is stigma. People with dual diagnosis experience stigma because of their substance use, as a result of their mental health problems, as a result of their lifestyles and due to a whole range of other elements in their lives which culminate in '*spoiled identities';* including physical health problems and disabilities adding to the stigma they experience. Link et al (1997 p177) identify the consequences of stigma for dually diagnosed individuals and demonstrate *"a strong connection between the experience of stigma and well-being of the stigmatized".* In their paper they cite numerous studies that identify the consequences of stigma for dually diagnosed people that negatively affect social networks, employment opportunities, self-esteem, mood, and general quality of life.

5.2.1. Stigma Theory:

Goffman (1963) defines stigma as the devaluation of an individual and the exclusion from full societal acceptance. Goffman outlined three groups and their relative positions to stigma:

1. The *stigmatized* are those who bear the stigma;
2. The '*normals'* those who do not bear the stigma; and
3. The *'wise'*, the *normals* who are accepted by the stigmatized as "wise" to their condition.

He also defined three distinct types of stigma; *'abominations of the body'* or the physical deformities; *"blemishes of individual character",* which includes addiction and finally *"tribal stigma"* of race, nation and religion. Norman's narrative describes how the first two categories manifest for him:

> *"I'm just loving life again at the minute, everything's, everything's I get more respect, I still get the stigma because of who I am, I was diagnosed with osteoporosis, I've already broke my right hip and my right elbow and due to the 25 years of constantly drinking my left leg is completely gone, I've got nerve and muscle damage, that's irreversible. So I am now living with the consequences of my drinking" (Norman 2.68-2.75)*

Goffman identified that the source of an individual's stigma can be visible or not. When it is visible then Goffman refers to the stigmatised as the *discredited*, when the source is not obvious then he describes them as *discreditable*. In most cases service users in this study recognised themselves as being stigmatised some recognised that this changed throughout their journey. Norman now perceives the stigma he experiences as a disabled man (he walked with crutches) more acutely than he experienced stigma about his drinking; possibly because he was discreditable as a drinker, sometimes he could *pass* on being identified as such, (more on *passing* below), but his obvious physical disability made him discredited. Being discreditable can lead to stigmatised individuals leading a 'double' life where in some walks they are stigmatised and in others they are only potentially so. The effects of being discreditable are tangible in a number of the narratives in this study. Individuals with dual diagnosis are potentially multiply discreditable, as their mental health and substance misuse problems are not always immediately apparent. The stories about stigma in this study frequently allude to the ambivalence individuals might feel through what Goffman describes as *"…oscillations of identification and association with fellow stigmatized"* (Goffman 1963 p 89). This ambivalence occurs because of the identity gap between their personal and social (or stereotyped) identities. People with a dual diagnosis might have multiple social identities dependent upon what is known (discredited) about them and what is potentially unknown (discreditable) and so they are likely to struggle under a greater stigma *potential* as well as in some cases being stigmatised for their multiple problems. Goffman (1963) described individuals whose stigmatising attributes are not immediately evident. The individual can encounter two distinct social contexts. In the first, she is discreditable—her stigma has yet to be revealed, but may be revealed either intentionally by her (so she will have some control over *how*) or by some external factor she cannot control. It might also be successfully concealed; Goffman called this *'passing'.*

> *"I don't see it as a badge of honour being a drug addict or being in and out of prison all my life but it's my past. Mmm and on that I wouldn't want to scream from the rooftops, I'm not ashamed to sort of be honest with people, so I found that I was honest with my key-workers, mmm that really did help me"(Terry 2.33-2.38)*

From Terry's narrative we can see the implied sense that there are certain people he can be open with, in this case his key-workers (*the wise*), but with others he '*passes*' on letting them see the parts of his identity, drug user and prisoner/criminal, that might spoil his identity in their eyes. One of the

significant things that Terry's narrative demonstrates is that for people with dual diagnosis '*passing'* can become a daily strategy they use to overcome stigmas that prevent them accessing services. Link and Phelan (1998 p180) develop this concept of passing into two distinct ways that individuals *pass*; through secrecy or by withdrawal. In the first people seek to conceal elements of their identity to avoid rejection, in the second withdrawal involves limiting engagement or interaction in order to avoid rejection.

Link and Phelan (2001 p363) note that Goffman's essay has catalysed further research leading to *"elaborations, conceptual refinements, and repeated demonstrations of the negative impact of stigma on the lives of the stigmatized".* Sayce (in Press) argues that stigma in itself is stigmatising because it locates the responsibility for stigma with the stigmatised rather than the discriminator: *"Stigma risks emphasising the 'marked' individual rather than the systemic processes that discriminate".* She offers a compelling argument for the use of the term discrimination rather than stigma based upon other stigmatised populations, such as LGBT groups and black people, who have successfully reframed stigma into discrimination and prejudice. Sayce (1998 and in Press) argues that in order to effectively combat the effects of stigma and discrimination it is important that the responsibility for discrimination is situated with those who discriminate rather than the stigmatised.

The strength of Link & Phelan's (2001 p365) conceptualization is that it develops Goffman's and other stigma theory by adding *"the component of discrimination".* Their conceptualization divides into four components:

1. **Distinguishing and labelling difference:** there is social selection of human differences when it comes to identifying differences that matter socially. Substantial oversimplification occurs when identifying groups. The central role of the social selection of difference is salient because they differ dramatically according to time and place.
2. **Associating human difference with negative attributes:** labelled differences become linked to stereotypes. This aspect of stigma involves both a label and a stereotype where the label links the individual to a set of undesirable characteristics that come to form the stereotype.
3. **Separating 'us' from 'them':** social labels connote a separation of 'us' from 'them'

4. **Status loss and discrimination.** When people are labelled and linked to a stereotype a rationale is constructed for devaluing, rejecting and excluding them. They are stigmatised when the fact that they are labelled, set apart and linked to undesirable characteristics leads them to experience status loss and discrimination. (Link and Phelan 2001)

They also argue that power is a necessary component in stigmatisation, which is frequently overlooked.

> *"When people think of mental illness, obesity, deafness, and having one leg instead of two, there is a tendency to focus on the attributes associated with these conditions rather than on power differences between people who have them and people who do not" (Link & Phelan 2001 p375)*

Link and Phelan (2001 p376) illustrate the importance of power by using an example of relative power in mental health services where patients might engage in all the four components of the concepts of stigma but because they lack *"the social, cultural, economic, and political power to imbue their cognitions about staff with serious discriminatory consequences"* the staff are not stigmatised.

The twenty narratives that comprise this study demonstrate that stigma and discrimination affect recovery, well-being and optimal living for the participants. Stigma is both perceived, acted out by individuals towards service users (micro-level), at a structural (Macro) level through institutional discrimination and as a result of national policy and commissioning practice. In addition self-stigma appears to be a factor for individuals that is supported by the relevant literature (Room 2005, Link and Phelan 2001, Luoma et al 2007).

5.2.2. Micro-level (individual) stigma:

> *"The two key-workers at KTD wasn't judgmental at all, really supportive, just gave me the space to be myself and be open and honest about my addiction." (Terry 3.22-3.25)*

In their narratives participants see some practitioners as '*normals*' and others as '*wise*'. Goffman's definition of the wise is important to practitioners in this study, who often saw themselves or other practitioners around them as wise, because it assigns a position of privilege to them as a result of their close working relationships with the stigmatised (Bates & Stickley 2013). Assumptions that in being 'wise' about people with mental health, practitioners have a superior level of insight, empathy and compassion for people with dual diagnosis is contestable

in the light of the narratives in this study. Understanding or being knowledgeable about one *or* the other is not sufficient. This is supported by evidence (Thornicroft 2006, Link et al 1998) that some people's encounters with mental health services are stigmatising and distressing. Participants' narratives attest that being wise about dual diagnosis demands a more sophisticated perspective than simply being able to understand mental health and substance misuse in isolation to each other:

> *"I'm looking at somebody as a whole I'd like to think, so I'm not just looking at somebody in isolation thinking well this is to do with drug use or this is to do with mental health. I tend to just work on whatever issues and symptoms and things that are happening at that time for that person." (Carly 4.6-4.11)*

Sayce (1998) supports this when she states that

> *"One of the greatest challenges facing anti- discrimination proponents is to build understandings of multiple discrimination that go beyond simplistic additive models like `double' or `treble' discrimination. These fail to account adequately for the way that, for instance, stereotypes of black men and of mentally ill people have fused into new forms of demonising imagery".*

The same could be said of dual diagnosis stigmas. When I was involved recently in scrutiny of dual diagnosis, as part of the statutory process Local Authorities are required to undertake, one member of the panel suggested that dual diagnosis was the reason behind the street drunks who were frequently noticeable on corners of certain parts of the city.

Practitioner participants occasionally alluded to but rarely explicitly recognised themselves as stigmatized by association. Coombs and Wratten (2007) described negative perceptions of those engaged in helping dual diagnosis service users by their colleagues. When CPNs, in their study, invested significant time and resources in supporting dual diagnosis service users Coombs and Wratten (2007) found their colleagues perceived this use of resources excessive and by default perceived the '*helping'* CPNs negatively. Benjamin, a practitioner participant in this study, talks about the importance of self-disclosure in his conversations with clients and alludes to the fact that he can empathise with them because he understands their stigma as a smoker.

> *"……there is quite a mixed reaction to the fact that I'm a smoker. Certainly a large number of my clients are very happy that I'm a smoker. Urmm, and again as a Consultant, it is always a sign of humanity I think, so there are a range of sympathys with that." (Benjamin 7.46-7.51)*

His act of self-disclosure, in this case about smoking, can be seen to be in tension with his professional identity (although even psychiatrists can be stereotyped as mad scientists by association (Thornicroft p96 2006)). Benjamin suggests, that revealing his identity as '*partially spoiled*', being a cigarette smoker, enables empathetic interaction. However, power is an important factor in this narrative since Benjamin is a senior clinician and whist he may be discriminated against for being a smoker the consequences for him are relatively minor in contrast to those his clients' experience as a result of their psychoses and illicit drug use. It is possible that staff can be discriminated against for the reasons suggested by Coombs and Wratten (2007), whether this is stigmatising is debateable, due to the absence of power and any serious consequences for practitioners. Where stigmatisation and discrimination may occur towards practitioners is in the typical hierarchical relationships that exist in healthcare services. Accepting Coombs and Wratten's example of discriminatory team cultures we might suggest that there can be structural stigmas manifest in these teams and staff may be stigmatised as a result because their colleagues and superiors potentially have the power to do so. Benjamin's perspective highlights the potential effect stigma can have in creating tensions between practitioner's personal and professional identities. As a practitioner if you have or had a substance misuse problem then you are *discreditable* and the consequences of becoming *discredited* may be dire such as loss of professional registration or employment. I would argue that self-disclosure as a basis for empathic interaction between practitioner and service user are based on permissible degrees of stigma in this instance. Revelation of spoiled identity for professionals has its limits, especially in relation to substance misuse. As a professional, revealing that you either had or have a substance misuse problem is taboo and is stigmatised in more professionally prejudicial ways than revealing having a mental health problem (Dunn 2005).

This study reveals that some of the practitioner participants have lived experience but they often conceal this behind their professionalism. For example Ralph talked about his tendency to drink and his awareness that it was becoming too much of a way to cope with work stresses, but he cautions against making assumptions.

> *"I think it would be foolish to assume that because you have a pint at the weekend you understand an alcoholic." (22.49-22.50)*

For practitioner participants there is a dilemma in using self-disclosure because whilst it may appear to aid empathy and identification with service users it also risks overstepping the professional 'divide'.

Ashley's narrative is one example where her professionalism was called into question as a result of this type of discrimination.

> *"I've had it myself when I had a relapse recently and a member of staff on my return to work told me that the last 5 years of my life accounted for nothing, I'd had a long fall, I needed to start at the bottom and work my way up again and just constant mmm comments like that that were just, they weren't helpful and for me it was that could have pushed me straight back to taking drugs again because it just made you feel really worthless and it didn't, you know it was a hard struggle and it was hard to get back to work and I was really proud of myself for relapse lasting just 3 or 4 months, in the past for me it probably would have gone on for years, so to get back to work and to get my life back on track really quickly for me relatively quickly, urm to then have somebody in a position of power and responsibility making snide comments like that and discussing it with other team members and you know with the team that you're supposed to go back to, urm was really detrimental to my recovery …." (Ashley 7.7-7.24)*

The fact that Ashley has progressed significantly in her recovery journey, as an employee peer support worker and had attained some stability in her life is denigrated because the stigma of dual diagnosis is pervasive and sustained. Stigma added to the stress she narrates as a result of the discrimination, even though she is a peer with lived experience she was labelled, separated and experienced status loss. In Goffman's terms Ashley carries the stigma of her substance misuse because she is *discredited*. Link et al (1996) identified in their study of people with a dual diagnosis that stigma is enduring and has enduring effects on well-being. Ashley's story illustrates the enduring effects of stigma, the role of power and how stigma and discrimination results from the four elements of Link & Phelan's (2001) conceptualization. She was treated differently by virtue of being seen as different, a *relapsed* person rather than a colleague with equal status. The discrimination by Ashley's senior colleague could be seen as an attempt by them to create distance from what they saw as unprofessional. This is of particular interest to this study because it could be argued that stigmas associated with substance misuse and dual diagnosis carry a different weight within the context of mental health settings to those associated with mental health problems. Practitioners may be *wise* to mental health issues and stigma but regard substance misuse as something 'other' because of personal values that reinforce prejudices and stereotypes towards people whom misuse drugs and

alcohol. Equally people who have mental health or psychological problems and who access the substance misuse treatment system are categorised differently and potentially discriminated against because there is an assumption that psychological problems affect motivation and therefore ability to engage (stigma associated with motivation is explored more thoroughly later in this chapter). Service users may be exempted from services or categorised as non-compliant as a result of the stigma attributed to their substance misuse or mental health problems; which will impact on their ability to recover.

The study also suggests that practitioners are selective about disclosure of their own previous substance misuse because of the *discreditable* effects, perceived or real stigma and its impact upon their professional identity. Whilst current substance misuse clearly poses risks to patients and is a professional conduct issue there is no reason, other than stigma, that practitioners should not share relevant life experience. A reluctance to do so is understandable, due to the potentially discrediting effects of stigma, but it hampers empathic interaction and useful opportunities to illustrate hope and optimism for recovery to service users. Societal taboos and stigma prevent honest adult interaction as a result of social constructs that deny the reality of a continuum of substance misuse amongst the general population.

Practitioners often label service users as being in *denial* about their substance misuse or mental health problem. Occasionally service users will also say that their peers are in denial. The term implies a pejorative sense that the individual concerned lacks the maturity or insight to accept their problems. Anne uses the term in relation to her daughters' drug problems:

> *"I mean her theory was that Heroin is not as addictive as alcohol, that was when she was in denial." (Anne 20.22-20.23)*

Denial appears to ignore the fact that the stigma of substance misuse is of concern to people with dual diagnosis for several reasons. It is evidently a barrier to accessing help and services. Service users may not perceive their substance misuse as significant when others do (aspects of this are explored in relation to psychological therapies in the section on structural stigma) or they may perceive the identity of being a drug user or drinker as preferable to other labels.

> *"some of them would rather be seen as a drug addict or a drinker rather than being perceived as somebody with mental health problems." (Dominic 2.14-2.16)*

Link et al (1997) studied men who used a dual diagnosis services and found that they endorsed secrecy and withdrawal ways of coping with stigmatisation. There was an even split in their study population about whether it was a good idea to keep their drug use a secret. This offers a deeper explanation for '*denial*' than simply a lack of insight. A majority of their study population were emphatic that it would not be a good idea to inform an employer of their drug use or their mental health problems. So the perspective of practitioners and service users can be seen to be at odds with each other when it comes to issues of insight and denial. From the service user perspective it is an adaptive coping strategy for stigmatisation; from the practitioner perspective it is a denial of a problem that leads to lack of treatment concordance (I will explore this further under motivation later in this chapter). This is of significance to people with a dual diagnosis because studies (Luoma et al 2007) have identified that higher levels of secrecy used as a coping strategy were significantly associated with poorer psychological flexibility, lower quality of life, higher levels of internalised shame and guilt, higher levels of rejection and higher levels of perceived stigma.

5.2.3. The stigma attributed to lack of motivation:

Several studies have identified that people with dual diagnosis have low motivation to change (Ziedonis & Trudeau 1997, Martino et al 2006). Motivation is widely accepted to be a significant factor in achieving change both in mental heath and substance misuse and is often a pre-requisite for engaging with both services, although the need to be motivated to attend is often a more explicit criterion for substance misuse services. This may offer one explanation as to why motivation becomes more of an 'issue' for people with dual diagnosis. They don't always self-select to engage in mental health treatment or services in the way that people with substance misuse problems choose to go for substance misuse treatment. Additionally non-motivated individuals are often quickly filtered out of substance misuse treatment settings by their lack of engagement or through other contractual infringements.

Whilst there has been a body of literature (Martino et al 2006; Drake et al 2004; Glassman 2013) that recognises the efficacy in using motivational interviewing (MI); the Cochrane review (Hunt et al 2013) recognises that MI has an effect in promoting engagement in services and improving outcomes for people with co-morbid alcohol problems for people with a dual diagnosis; there is little in the literature that explores the effect perceived degrees of motivation have on stigma. Simon one of the participants in this study offers a perspective that

suggests identity and motivation are a linked part of the journey of change and a factor in enabling recovery.

> *"I'm a firm believer that you've got to want to stop yourself because I've said it in the past that I'd do it for my mum when she was alive and my dad, I'll do it because I've got a full time job and I want to keep it and this that and the other but I never did it for me. It was never my decision and under my terms. It was all me fitting into the right box or other peoples' expectations and whatever, but I just. I don't think it was because I was rebelling against it, because I was an adult, I wasn't like a teenager rebelling against stuff. I just didn't want it." (Simon 2.38-2.47)*

The concept of wanting or needing to "*do it for yourself*" is a recurring theme across a number of the narratives in this study and appears to be an accepted pre-requisite for change amongst the majority of participants.

> *"…. With recovery I think it doesn't matter how much support you've got, it's down to yourself. Do you know what I mean, its up to the individual," (Clive 26.5-26.8)*

At its most basic it seems that motivation or the lack of it is a potentially stigmatising concept for people with a dual diagnosis based upon an inference that their lack of progress in recovery results from a lack of desire to do anything about their substance misuse which fundamentally undermines their mental well-being. Service user and practitioners' narratives in this study recognise that individuals can have different levels of motivation. Rather than there being absolutes, motivated or not, it would be better to view motivation as a continuum, recognising that an individual's place on that continuum also varies over time. The important factor in the stories in this study is the need for an understanding of the continuum of motivation; that different levels of support are needed to enable motivation to flourish and develop at different stages.

> *"I think that motivation, that motivation comes from desperation and you know desperately not wanting to be poorly and feel crap and desperately needing to feel aright and desperately wanting to block out those emotions that are coming flying back and you know, so yeah motivation comes from the desperation then and then it's a different type of motivation again to give up"* (Ashley 25.4-25.11)

Equally practitioners need to recognise that their perspective of motivation in an individual with dual diagnosis may have stigmatising and discriminatory effects. An example of this is where a practitioner knows that the person they are helping has a drug or alcohol problem in addition to their mental health problems, but they choose to ignore actively working with them on the substance misuse issues

because the practitioner perceives their patient as ambivalent and unmotivated to change. This can prevent any interaction occurring around substance misuse and opportunities to support motivation and explore change are neglected. The justification for this is often that the practitioner lacks the necessary skills. However, given motivational interactions are commonly used when supporting a person with mental health problems, engagement in discussing their substance misuse and '*keeping drug and alcohol use on the agenda'* (Graham 2003) shouldn't be a major barrier. Alternatively it is possible that *passing* may be an issue in reducing the motivation of the service user to discuss their problems with practitioners. Practitioner's awareness of this issue and the constructs of stigma associated with it would enable sensitivity to this and an empathic approach which is more likely to be helpful, rather than dismissing the lack of interaction as denial.

5.2.4. Self-Stigma:

Luoma et al (2007 p1332) defines self-stigma as "*negative thoughts and feelings that emerge from identification with a stigmatized group and their resulting behavioural impact*". Internalising stigma in this manner does two things potentially according to the literature (Corrigan & Watson 2002, Watson et al 2007); firstly is that it negatively affects self-esteem and self-efficacy; secondly it may mobilise a sense of anger and promote reaction. Anne's reaction to combating the self-stigma that underpinned her poor self-esteem and confidence was to narrate her life story:

> *"…. Because I know when I go to these meetings I'm respected, my opinion is respected. I'm sure it builds up my self-esteem and self-confidence. I did a presentation at the dual diagnosis conference, mmm in where are we, 2011 and I spoke about my family history, mm and how I did turn to alcohol and I said you know, and I lost my confidence and I lost my self esteem. Gradually I have built it back up." (Anne 13.3-13.10)*

Many of the service user narratives in this study are testament to the value of telling recovery stories as a way to reconstruct their identity and move away from the debilitating effects of self-stigma and discrimination by others. McIntosh & McKeganey (2000 pp1501) have argued that *"Sociological accounts of the process of recovery from dependent drug use have emphasised the importance of the individual constructing a non-addict identity for themselves"* in their article they describe the process of narrating recovery stories as one of the processes in which people might achieve a refreshed identity. The narratives in this study underscore this, for instance:

Frank's (1995 pp36) statement that *"storytelling is one mechanism through which the dyadic body both offers its own pain and receives the reassurance that others recognize what afflicts it"* is reflected in a number of narratives in this study in particular Norman's narrative on his attendance at AA meetings that demonstrates the camaraderie in relating ones '*pain*'. Watson et al (2007) suggest that individual's stereotypes of mental illness (and the same can be applied to substance misuse) are built up over years prior to the individual's own experience of mental health problems. When people then experience their own problems related to dual diagnosis *"these stereotypes then become relevant to the self"* (Watson et al 2007 p1312). So people begin to restrict their social networks anticipating rejection due to stigma. This social isolation can then lead to a sense of worthlessness, unemployment and reduced income. This reinforces Norman's perspective on the camaraderie he narrates associated with his AA group. Like-minded individuals gather in self-help groups and find solace in shared experiences, the ethos of the group is central to their membership and so is adopted as a framework for their own values and beliefs. The camaraderie of the group provides a relief from being discredited or discreditable because the membership is made up of Alcoholics with shared experiences. But, the second A, Anonymous is also important as members also recognise that for many of them passing, in the form of secrecy, is an essential part of their continued coping in a wider society that would otherwise stigmatise them. It is difficult to know whether the camaraderie of the group and its positive effects on self-stigma balances out the potential stigma that adopting a biogenetic explanation for their 'alcoholism' that AA membership demands of them. Watson et al (2007) suggest that self-stigma manifests in different ways from individual to individual based upon perceived legitimacy of the stigma and identification with the stigmatised group. These factors would appear to be important in individuals with a dual diagnosis identifying with a given group and the impact of self-stigma.

The value of Ann's and other participants (Simon, Susan) narration of their life stories is both cathartic but also helping. Their narratives illustrate to others how they are stigmatised and the ways in which they can change their identity and begin to divorce them from stigmatisation. Narrating a positive recovery also enables them to change their perceptions of themselves, their self-stigma and as Ann suggests improve self-confidence, self-esteem and self-efficacy.

Anne emphasises the temporality of her recovery journey in contrasting herself in the now with what Frank (1995) calls her monadic self that sees itself as

separate and alone. Anne's narrative of telling recovery stories, in a publically 'heroic' way at a large conference actively constructed an alternate identity of her as helper, teacher and public speaker not simply someone who has controlled their problematic drinking. Stereotypes of 'alcoholics' frame them as chaotic, out of control, self-centred, and incapable of coherence. By contrast the narratives of participants ('*recovering*' or controlled) in this study reframe that identity as helping, coherent, compassionate and caring people who have struggled to divest themselves of a habit that they developed to cope with social and mental distress. The act of narrating a recovery story is not just about constructing an alternate identity that distances them from their chaotic, self destructive drinker-selves; but for Ann and Norman it bears witness to their belief in the value of role models; or '*I've done it, so can you'*. Frank (1995 p18) supports this view when he says

> *"The teller offers herself as guide to the other's self-formation. The others receipt of that guidance not only recognises but values the teller"*

The concept of self-stigma would appear to be important to individual's identification with others. Narration of life stories that contain information about experience of stigmas confirms to others both the legitimacy and enables them to identify with the other stigmatised. Ultimately recovery narratives in this study are about hope, optimism and confidence. The recovery stories are a journey reframing the participant's identities from negative, stigmatised and impotent to positive, independent and valued in a variety of ways. The narratives in this study support that participants build recovery capital through sharing their stories with, learning from and becoming, mentors and peers. Becoming an expert by experience is an important part of this journey because it can be argued that recognition of the value of that experience catalyses the shift from monadic to dyadic self enabling the recovering person to change identity and move on. This seems particularly significant to people with dual diagnosis as their monadic state is socially constructed as self-centred: where they, their ailing mental health and their substance of choice, makes them a single minded '*addict*' who craves and values substances more than anything, even their mental wellbeing. The shift to dyadic changes this negative perception because in order to become connected to others they must divest themselves of the identity of self-centred addict whose mental wellbeing suffers as a result.

5.2.5. Macro-level (Structural) Stigma:

Evans-Lacko & Thornicroft (2010) have identified that people with dual diagnosis may encounter higher levels of structural discrimination in healthcare settings and are systematically excluded from research. In the literature review to this study I have described why I see *dual diagnosis* as a label of convenience, most often for professionals rather than service users, which affords a consensus of understanding. Structural stigma results from being labelled with a dual diagnosis, it is used as an epithet that sets people apart and treats them as a group to be excluded from services and help. Some authors have described dual diagnosis as a '*dustbin*' diagnosis for this reason (Brabbins & Poole 1996, Gournay et al 1997). It is possible that the dual diagnosis label has been beneficial because it has raised awareness of the need to offer services and in some cases has led to the funding of additional resources to support treatment and recovery for people with dual diagnosis. However, there is evidence to suggest that whilst treatment and services can have a beneficial effect on quality of life for service users, *"stigma has equally strong negative effects"* (Link et al 1997). To an extent the language and labels associated with dual diagnosis can be measured in levels of undesirability, dual diagnosis being the least stigmatising in my belief. I have noted that there are potentially worse labels; Mentally Ill Chemical Abuser (MICA) is one example that is used commonly in early literature on dual diagnosis, and surprisingly throughout the American literature on stigma in dual diagnosis (Link et al 1997 and Rosenfield 1997). It is important that we recognise that even though a label may become the *zeitgeist* and commonly used by many it is not without its stigmatising qualities as well.

5.2.6. Biogenetic labelling: the stigma of substance misuse and mental illness as disease.

Whilst adequate psychosocial explanations for both mental illness and substance misuse exist they are complex. Narratives in this study are testament to the fact that practitioners and service users subscribe to biogenetic explanations for substance misuse problems.

> *"Straight away I said I wanted the abstinence because I don't, I don't agree in controlled drinking, its just, its just not a way. To actually go to a service where they actually telling you, you can have a drink to me that's just prolonging the illness and disease" (Norman 2.42-2.47)*

Studies (Read et al 2006) have noted that even though services often promote biogenetic explanations for mental health problems people generally prefer psychosocial explanations. This is not necessarily the same for explanations of

substance misuse, and the media in particular promulgate a disease perspective of addiction that allude to *diseases of addiction* and *diseases of the will*. Sayce (in Press) has been critical of high profile media figures, such as Ruby Wax, promotion of disease concepts of mental health: *"she risks pulling people away from their (relatively benign) psycho-social explanations to biogenetic understandings which could entrench prejudice".* The same could be said of celebrities, such as Russell Brand, support for addiction as a disease.

> *"The mentality and behaviour of drug addicts and alcoholics is wholly irrational until you understand that they are completely powerless over their addiction and unless they have structured help they have no hope" (Russell Brand, The Guardian 09.03.14)*

One argument (Read et al 2006, Sayce in press) against biogenetic explanations is they tend to underscore and support people's view of unpredictability reinforcing the prejudice that people with mental illness are violent and dangerous.

Room (2005) suggests that the shift to biogenetic explanations for substance misuse occurred as a result of the American perception that greater levels of stigma were associated with crime. He tells us that the "*alcoholism movement dedicated itself to persuading society that changing the conceptualisation of drug and alcohol problems from a vice or crime to an illness would diminish stigma*" (p146). The fact that this is a misconception, is supported by evidence from a World Health Organisation study (WHO; Room et al 2001) looking at social disapproval showed that drug addiction ranked higher than criminal behaviours (in particular burglary) in 11 out of the 14 countries studied, including the UK. I have discussed the problems with the concept of 'addiction' and its biogenetic connotations. I have always found it interesting that Alcoholics Anonymous ethos is contradictory; subscribing to disease concepts of alcoholism, yet eschewing prescribed medications, and espousing psychosocial interventions, such as mutual aid and group work. As a mutual aid organisation this is surprising given that research has demonstrated that biogenetic causal beliefs are closely linked to stigma, discrimination and a desire for distance (Read et al 2006). For people with a dual diagnosis there appears to be a constant tension around their substance misuse treatment and the fact that they are often prescribed drugs to help with their mental health problems. Terry reinforces this perspective about his attendance at an abstinence based self-help group:

> *"I couldn't be honest or open because there was always that secret, elephant in the room, but the secret that I wasn't being fully honest disclosing about my medication because I would have got kicked out of the service" (Terry 2.15-2.19)*

Some researchers, particularly those in the domain of social control, (Blume 2003) would argue that the stigma associated with substance misuse is justified on the grounds of its links with criminality and violence. This is an example of what Room (2005) terms '*moralization*'. Stigma used to exert social control can be in the form of criminalisation or as a deterrent effect through application of social norms. The WHO study (Room et al 2001) exploring social disapproval clearly challenges this notion since the stigma of substance misuse ranks higher than crime. Blume (2003) recognises that stigma, as a form of social control, is not always successful. The nature of substance misuse as a clandestine, covert activity maintains the 'shady' nature of its image, and is a stereotype that is at the root of stigma and discrimination but is also a cause for intrigue and interest to others.

Subscribing to a biogenetic explanation of substance misuse allows other potentially stigmatising factors to arise, *denial* being one example of significance. The term denial appears important to practitioners because it is closely associated with issues of concordance and non-compliance.

> *"It's when you know they don't comply, they fall out of psychiatric services because they don't want to engage with them anyway, because they can't see being put on medication, which is giving them terrible side effects, helps." (Dominic 2.48-2.52)*

Biogenetic explanations for substance misuse would suggest that if an individual denies they have a problem then it is impossible for it to be treated. This takes on important dimensions when practitioners are engaged with a person who has a dual diagnosis especially if they assume that substance misuse undermines mental health. Frank (1995 p15) has suggested that this is important because *"ill persons delegate responsibility for their health to physicians so illness responsibility is reduced to patient compliance".*

Biogenetic explanations are also associated with the stigmatising concepts of motivation or lack thereof. Contemporary understanding of the nature of alcoholism and addiction revolve around loss of control, which means that they are often characterised as "*diseases of the will"* (Room 2005) which ultimately are stigmatising because they denigrate any sense of free will or motivation that

an individual may have and play into associations of moral turpitude that ultimately reinforce stigma.

Read et al (p 313 2006) have shown that even ardent supporters of 'brain disease' concepts accept that research has shown:

> *"Disease explanations for mental illness reduced blame but provoked harsher behaviour toward an individual with mental illness, that biological explanations may also imply that people with mental illness are fundamentally different or less human, that there is research evidence that biological arguments may actually strengthen dangerousness stereotypes and that in contrast to biological arguments, psycho- social explanations of mental illness have been found to effectively improve images of people with mental illness and reduce fear"*

Sayce (in Press) has suggested that seeing mental health challenges as a biological illness make people more, not less, likely to view people with mental health problems as incapable. She terms this "*oppressive benevolence*". In this study Clive's narrative reinforces this perspective, his eventual labelling as psychotic offered his family an explanation for his behaviour and in particular, his mother, for his reliance on drugs and alcohol.

> *"My mum is more supportive now…"*
>
> *"*What's changed do you think?" *(DM)*
>
> *"I don't know, may be the diagnosis, if my shrink says something's wrong,"*
>
> *(Clive 20.3-21.1)*

This oppressive benevolence may be an advantage to people with dual diagnosis. For instance, I have witnessed elderly parents of a fourty-something man, with mental health problems, go out and buy cannabis for him to protect him from the negative attention of drug dealers and the police. Clive's narrative alludes to an acceptance of the benefit that his family and mum's benevolence affords him as a result of the biogenetic explanation of his mental illness and the implication that this is at the root of his lack of judgement in taking too many drugs and drinking excessively. However, this sort of stigma will eventually hamper recovery because it limits opportunity to build recovery capital because it views and renders the individual incapable.

It is possible that biogenetic explanations are at the root of some individuals resort to substance misuse. If we accept the argument that mental illness is merely a biogenetic phenomenon then we must also accept that it requires a

medicated or medicalised solution. If service users believe this and find that the drugs they are prescribed don't work, or have undesirable side effects, then they may be more likely to seek out alternative 'medications' and experiment with substance misuse. When they then find the effects of drugs and alcohol are pleasant, have an ameliorating effect on some of their mental health symptoms and the act of procuring and taking drugs comes with a social group who are more tolerant of difference this often 'seals the deal'.

In the literature review I discussed Brabbins and Poole's (1996) assertion that the diagnosis of *drug induced psychosis* is without sufficient theoretical grounds to justify its accurate use. Despite this it is still in common use within mental health and substance misuse services. Studies have established that there are insufficient grounds to regard drugs as causing a psychosis (Brabbins & Poole 1996, Arsenault 2002). In the report into the murder of Jonathan Zito by Christopher Clunis (Ritchie et al 1994) the investigators criticised services for "*the uncritical attribution of his psychotic symptoms to drug use*". So why then is the use of drug-induced psychosis perpetuated? I would suggest it is because the label is discriminatory. People are not labelled *abuse-induced psychosis* or *parental death induced psychosis*. My illustration is flippant, but the point is whether the psychosis is drug or otherwise induced is not helpful to the individual, can offer a misleading focus to practitioners and is a pejorative label that leads to discrimination. It is discriminatory because it singles out the diagnosis as something other than a psychosis and devalues it because it suggests by association that the cause is something completely within the control of the person who suffers it. The label incites blame and can be used as a reason to treat people with a dual diagnosis as unmotivated and undeserving of services. In the case of Christopher Clunis the fact that he was a black man added to this (culture and ethnicity is discussed further later). The Ritchie report (1994) was clear that he was failed by services because the label he was accorded led to people seeing his problems as self-induced and denigrating the importance of his psychosis as a result. It is nonsensical to discriminate in this way, evidence suggests that prevalence of drug and alcohol use amongst people with mental health problems is so significant that it effects between one third and a half of the psychiatric population (Weaver et al 2003). Dual diagnosis is not different by merit of its rarity; it is common and a factor that should be taken into account in all helping interactions with people who have mental health issues. Equally psychological

problems amongst people with a substance misuse are so prevalent (Weaver et al 2003) that mental health should not be discounted in that population.

When these two *'diseases'* are combined into a *dual diagnosis* it is possible to see how there is not just a combined effect of stigma but a synergistic effect due to the added stigma moralisation adds. The separation of mental health and substance misuse pathways and service structures reinforce stigma. This effect can lead to greater marginalisation than mental illness or substance misuse alone. This is important because it increases the chance that people with dual diagnosis will experience a greater range of adverse consequences as a result, which will fundamentally affect their ability to recover and may be at the root of poor outcomes in the short, medium and longer term.

Motivation and service criteria: One of the major barriers in receiving services is the criterion set around an individual's motivation to engage. 'Indulging' in excessive drinking or drug taking conforms to the social construct of hedonism and can be labelled in services as an act of non-compliance or something that affects an individual's ability to engage in treatment. Room (2005 p143) argues that this results from an additional factor, which has been neglected in research, that "*alcohol and drug use problems are heavily moralized territories often resulting in stigma and marginalization"* this is of significance in adverse outcomes for this group. The perspective that sobriety is a natural pre-requisite for therapy is perpetuated by a number of services but in particular psychological therapy services. That prevalence levels of substance misuse amongst people with psychological problems is so significant (44% state Weaver et al 2003) it would suggest that some people choose to '*pass*' on informing psychological and IAPT practitioners of their substance misuse. This appears to be given little thought by these services. In my own practice I have come across circumstances where mental health services have said explicitly or by implication "*we don't work with drug addicts*" which labels and is discriminatory of individuals with a dual diagnosis. Cormoran's narrative illustrates this:

> *"….my biggest concern is the amount of people we get through our services who have historical trauma or abuse stories and mmm one of the biggest barriers to recovery for them is the access to psychological services or the lack of access to psychological services….The difficulty is that the criteria for access to those services is very similar when it comes to the level of substance misuse…….they like people to be abstinent from substances"* (Bob 1.09-1.30)

Some services or practitioners see motivation as absolute, you are either motivated to do something about your problems, or you are not. Benjamin describes this culture of absolutes:

> *"I mean it's true across all of the teams, this sense that they keep looking to me to provide answers to substance misuse and there are certain times I think, no, you should be able to use motivational interviewing"* (Benjamin, 4.40-4.44)

Benjamin sees motivation through the lens of the prescriber and suggests his colleagues regularly look to him to support a medicated solution rather than working with an individual in building their motivation to change. This may be because his colleagues ascribe to a biogenetic perspective of substance misuse (explored further later in this chapter) or because they lack the skills to use motivational techniques.

The narratives in this study support the view that there is a stigma attributed to dual diagnosis where ambivalence to change is seen by practitioners as non-compliance with treatment; by taking drugs or drinking excessively, individuals are perceived to be sabotaging their mental health. Perceived lack of motivation and its associated stigma leads to practitioners ignoring substance misuse, or in some cases withdrawal of services, because it is too difficult to manage.

> *"I think people that have different attitudes tend to stay involved in somebody's care. The people that have positive attitudes would be working with that person, regardless of how many times they'd been in hospital and trying to get to the bottom of why that is and what help they can offer, rather than somebody with quite negative attitudes, might be very quick at getting them off their caseload."* (Carly 16.5-16.12)

Inherent in the study narratives about motivation are power relationships between practitioners and service-users, often related to the perception of people with dual diagnosis being 'difficult' patients (Coombes & Wratten 2007, Kavannagh et al 2000). Dual diagnosis patients are perceived as 'difficult' because they challenge practitioners' notions of competence and control (Breeze & Repper 1998). Ultimately these notions are born from social constructs of what it is to be a patient.

In addition stigma has a significant influence over recovery and other outcomes for people with dual diagnosis. Whilst individual practitioners may endeavour to be holistic and non-discriminatory in their practice inevitably structural or institutional stigma and discrimination impacts on people with dual diagnosis despite this.

5.2.7. Socio-economic deprivation:

> *"With poverty and unemployment come all the other social consequences of being underclass – vagrancy, panhandling, substance abuse, and crime."*
> (Read et al 2006 p313)

Wilkinson & Pickett (2009) have demonstrated that there is a strong relationship between income inequality and the proportion of people in a countries' population who have mental illness. Poverty is associated with vulnerability for mental health problems. Sayce (in Press) has suggested that it creates a "*vicious spiral that restricts economic participation"* which impacts on families and children. Whilst the stories in this study have not covered the broader effects of socio-economic deprivation, employment was an important theme in some of the narratives (Anne, Susan, Simon and Norman). Participants' narratives cite the prejudice and discrimination they experienced that led to them feeling highly stigmatised and to the loss of, much valued, employment:

> *"I mean it was a very responsible job I was a unit administrator in a really busy department, urm we had 3 government inspections because we were licensed, we did research and we also had to be licensed for our treatments and we had 3 inspections in 3 months and I did them all perfectly, chuffed to bits urm really, really stressful, every hour I was working. And then I had my annual appraisal and all that my head of department could concentrate on was my alcohol problem, no well done you've worked really hard, it lasted 10 minutes and he said you've got to have help and that was it." (Anne 1.51-1.61)*

Thornicroft (2006 p50) underscores the effect that stigma in the work place towards mental health problems can have: *"the simple fact is that a diagnosis of mental illness is one of the most potent ways to remove a person from the workforce".* The loss of employment is inevitably linked in most cases with severe reduction in income, reliance on welfare and a downward spiral in socio-economic status. Sayce (in Press) suggests this adds to a sense that people with mental health problems lack competence and credibility, which may in turn lead to a loss of voice, power and social role.

When exploring the links between substance misuse and poverty Wilkinson & Pickett (2009) note that illicit drug use is more common in unequal societies. Room (2005) tells us that whilst people from all socio-economic backgrounds

may have heavy drug or alcohol problems, it is those people in the lower socio-economic classes that suffer significant physical and mental health problems and higher levels of mortality as a result. One example where poverty directly impacts outcomes associated with substance misuse is in the relationship between alcohol and nutrition where poorer nutrition interacts with alcohol in increasing the risk of liver disease.

Sayce (In press) notes that in 2014 people with mental health problems in the UK were the largest single group of Employment and Support Allowance (ESA) claimants. A recent research report by Bath University for the UK Department of Work and Pensions (Bauld et al 2010) notes that there are multiple barriers to people with substance misuse and mental health problems successfully claiming and sustaining benefits including: knowledge of the benefits system; obtaining advice; difficulties with benefit system processes and infrastructure; and challenging relationships with job centre staff. This often leads to people with dual diagnosis losing income. In addition recent years has seen people on benefits increasingly stigmatised in the UK as we pursue biting austerity measures. Sayce (In press) sums up the impact of this by saying, *"the image of the needy scrounger who doesn't deserve support may suit the purposes of a cash-strapped state, but refusal of support can lead to the very risks that services try so hard to avoid"*

Poverty has the effect in reducing the resources an individual may have to cope with the negative effects of substance misuse. With homeless men, for example, there is a high prevalence of dual diagnosis and their risks are much greater because they are more likely to inject drugs and to take them in unsafe circumstances (Morrison 2009). They have a higher risk of infection because of their lack of housing associated with lack of safe storage for clean injecting equipment that increases the likelihood of needle sharing and therefore the risk of blood borne viruses. The person with dual diagnosis then is not only likely to be trapped by lower social economic status but this will be reinforced as a result of both poor mental health and substance misuse and risks a panoply of negative outcomes that seriously affect their well being and likelihood of recovery.

5.2.8. Culture, Race and ethnicity:

Whilst none of the narratives in this study mention culture and ethnicity directly it is an important area to explore. Alvidrez & Havassy (2005) studied racial

distribution of 179 people with dual diagnosis in the US (there is a paucity of research into racial distribution of dual diagnosis in the UK) and found that there were significantly larger proportions of black men and that there were *"black-white"* differences in the types of substances used in their study population. They also noted that black people with a dual diagnosis tended to be over represented in substance misuse services without receiving mental health support. Importantly their hypothesis that diagnosis and drug use type would explain the differences was only partially supported. Their conclusions would suggest that there are other reasons for the unequal distribution of people from diverse racial and ethnic backgrounds in the dual diagnosis population and that black people are not receiving the services they need. Whilst it is unlikely that this research is generalisable to the UK for cultural reasons it raises important questions of equity of treatment for people with a dual diagnosis on the grounds of race and culture that will ultimately influence recovery. In a systematic review of ethnic variations in pathways for mental health services in the UK (Bui et al 2003 p114) noted that:

> *"There is some evidence for variations in pathways to specialist mental health care, with Black people traversing more complex pathways."*

This would suggest that we could expect to see significant representation from black people in dual diagnosis populations in the UK, however cultural factors and possible discrimination outlined below may counter balance this. Bui et al (2003) also noted that black people were overrepresented in UK inpatient mental health services and four times more likely than white people to be compulsorily detained. Asian people were less likely to use inpatient services (Bui et al 2003). Controversy has surrounded claims that cannabis use is a risk factor for psychosis in people from both White and African-Caribbean backgrounds (Ghodse 1986). Callan and Littlewood (1998) asked relatives of mental health patients about the cause of their problems; they found black families were more likely to blame cannabis use than white families. It is debateable whether this is a reflection of actual use and a causal relationship or simply indicative that the black families had a better understanding of the issues. Sharpley et al (2001) have identified that socio-cultural factors such as high unemployment, more single parent families, solitary living, lower educational achievement and poorer social support are purported to be factors affecting higher rates of psychosis amongst British African-Caribbean families.

Christopher Clunis' case is an illustration of the effect race can have in adding to the demonisation of an individual. Sayce (in Press) argues, the fact that he was black added to the perception that Clunis was dangerous and the media regularly reinforced this by referring their readers to the '*big, black and dangerous psychiatric patient Christopher Clunis*'. As highlighted in the section on biogenetic labelling Clunis' drug use was overlooked by services and the Ritchie report (1994) was critical of this. At the root of services overlooking his substance misuse could be stigma based upon the stereotype that black men use drugs regularly and that it is an innate part of their African-Caribbean heritage/culture. I have experienced this in my own practice where black men are seen by their practitioners as 'Rastafarian' and so an assumption is made, based upon a stereotype, that smoking cannabis is unchallengeable as part of their culture. Culture and race in this context is used as the justification for the practitioner neglecting to address or neglecting to offer people the choice to address their substance misuse. Clunis' case demonstrates the risk in discriminating in this manner. Similar stereotypes can be applied to people of Asian, Indian and Pakistani heritage where the assumption is made that for cultural and religious reasons they tend not to drink alcohol and condone or are more liberal about the use of cannabis, which is only true of a small subsection of the British Asian population.

There are a number of stereotypes applied to drug users and drinkers in the UK. The general public perceive substance misusers to be unpredictable, dangerous, deceitful and unreliable (Lloyd 2010) similarly some of these stigmas are attributed to mental health problems and also result from racial discrimination (Minior et al 2003). Problem drug users have frequently reported experiencing multiple-discrimination; being black is significant amongst these but the label of being a problem drug user far outweighs all other perceived stigmas (Lloyd 2010). In a study conducted in the USA, Minior et al (2003) noted that Black and Hispanic Americans experienced significant drug-related discrimination by the police, in particular, and families, friends and employers frequently.

Given that none of the narratives in this study raised stories associated with culture, race or ethnicity this might be a weakness of the methodology. In order to explore this further future studies would need to take an even more purposive sampling approach to specifically target contributions from those people who might have experiences to narrate about the effect of culture, race and ethnicity on recovery and dual diagnosis.

5.2.9. National Policy, politics and structural stigma:

Structural stigma can result from national policy and commissioning practice. Room (2005) has suggested that national policy decisions to be "tough on drugs" carry the potential to be stigmatising marginalising people who do not conform. Taylor (2008 p369) summarises the relationship between the media perspective, national policy and its stigmatising effects on drug users:

> *"Both media coverage and policy direction are disproportionately aimed at specific stereotypes of drug users and drug-using offenders, to the point whereby simplistic notions have developed at the expense of a much wider and more complex discussion to the detriment of a holistic drugs discourse."*

Beyond the immediate stereotypes of drug use and mental illness there are specific factors in national policy that influence dual diagnosis. One of the main narrative themes in national dual diagnosis policy has been its advocacy of integrated care. This assumes that the best prognosis for people with dual diagnosis is afforded by treatment for their mental health, drug and alcohol problems being delivered by a single team or practitioner. Colin talks about this in his narrative:

> *"I think it's difficult to be a jack of all trades isn't it really because there are so many things that you've got to try and master anyway. You know its always a great relief to be able to have a worker say like Debbie, looking after this guy, spend some time with him so we can liaise we can talk about what their perspective is, you know she has a particular sort of knowledge that you know I haven't got." (Colin 32.4-32.13) .*

Practitioners' narratives in this study raise concerns that they lack the specialist skills and the resources to develop integrated practice in dual diagnosis. Colin's tone was sarcastic when he responded to my statement that national policy advocates staff delivering integrated dual diagnosis care:

> *"Would they, wow! Amazing workers you've got there haven't you?" (Colin 6.14-6.15)*

Behind this narrative is a pragmatic sense that whilst the evidence may support integrated care, current levels of resources hamper the time practitioners have to acquire the skills and deliver the help and support that is necessary. In an attempt to meet all the bureaucratic demands of working in mental health services integrated treatment becomes policy idealism that is difficult to deliver in the current economic climate for pragmatic reasons.

Increasingly national policy requires mental health and substance misuse service staff record outcome metrics when delivering services to people. This has purportedly enabled the measurement of recovery in a more demonstrable manner. However, the metrics that are used often lead to discrimination against

individuals with the most complex problems. The main measurement of outcomes in substance misuse is the National Alcohol and Drug Treatment Monitoring System (NADTMS), which in recent years have moved from measuring engagement in services to measuring recovery. The recovery metric is measured in number of individuals who become abstinent from drug and alcohol use. As I have established in the literature review outcomes for individuals with a dual diagnosis tend to be long-term, up to ten years (Drake et al 2000, Drake et al 2006). The move to recovery related outcome measures means that services have been reluctant to work with individuals who have such long-term outcomes. Services can be penalised for engaging with people with complex needs; commissioners can impose reductions in performance related payments or if performance is negatively affected, it can prejudice their contract.

In recent years the division of substance misuse and mental heath commissioning as a result of the Health and Social Care Act (2012) has led to further schisms in commissioning services for people with a dual diagnosis. Competition and the tendering of substance misuse services is now common in the UK since funding was transferred to Local Authorities under the Act. In a recent article published in the British Journal of General Practice, Lawson (2013) is highly critical of the situation:

> *"It may have bypassed most GPs but substance misuse services in England have been privatised. They have been subjected, almost in their entirety, to the forces of the market. Organisations now spend significant amounts of time and resources on tendering and re-tendering for services throughout the country. This has, in many areas, reduced the capability of organisations to deliver basic health care as they sit outwith the NHS infrastructure."*

Evidently the resources associated with tendering create a drain on service delivery and ultimately affect the services people with substance misuse problems might receive. In some areas of the country the separation of Local Authorities' commissioning of substance misuse services from Clinical Commissioning Groups' (CCGs) purchasing of mental health services has negatively impacted integrated approaches and pathways for dual diagnosis. In some cases people with mental health problems are being excluded from substance misuse services due to unsophisticated contracting and ongoing debates between commissioners concerning who has budgetary responsibility to provide services for people with a dual diagnosis. People with dual diagnosis are being denied access by providers to substance misuse services, on contractual grounds endorsed by commissioners. This is highly discriminatory; it is most

probably in breach of the disability rights act and the human rights of people with mental health problems, a fact that appears to have escaped some commissioners.

Political perspectives underpin both mental health and substance misuse policy and reflect and inform societal constructs of mental health and substance misuse, influencing stigma and discrimination towards people with a dual diagnosis. The difficulties political sensitivities create can be illustrated by one aspect of drug treatment good practice that has yet to be implemented in the UK. In 2007 the National Institute for Health and Clinical Excellence (NICE 2007) recommended the use of contingency management (CM) in the treatment of people with substance misuse problems. CM involves incentives such as vouchers or privileges being offered to those on methadone maintenance treatment contingent on drug-negative tests. There is good evidence for the efficacy of this in treatment (Prendergast 2006) but it has yet to be implemented anywhere in the UK despite the NICE recommendation. The main reason is that paying drug users for 'clean' urine samples is both politically and socially sensitive. To illustrate just how sensitive this is; Paul Hayes, the Chief Executive of that National Treatment Agency for Substance Misuse walked out of an interview, with Mark Easton of the BBC Radio 4 Today programme, when he mentioned that contingency management had been included in NICE guidance which Mr Hayes wasn't aware of (Shapiro 2013). This culminated in a number of somewhat hysterical newspaper headlines stating headlines like, *"Controversial trial at NHS clinics to offer cash for drug addicts who stay clean"* (Cooper; The Independent 09/04/14).

5.2.10. Austerity and rationing of health and social care:

Participants in this study recognised that some practitioners have the skills to work with dual diagnosis but there is a tension between capacity to do this work and the increasing need to demonstrate outputs. The NHS is going through its most significant period of austerity and rising demand in its entire history (McDaid & Knapp 2010), which inevitably affects available resources. The term '*parity of esteem'* (Royal College of Psychiatrists (RCP) 2013) has emerged as a byword for treating mental health with the same attention as physical health in the past few years, however disparities between budgets across the NHS would suggest there is anything but. The RCP (2103 p23) have noted that whilst Mental Health problems are responsible for 22.8% of the "*disease burden*" in the UK only 11.1% of NHS budgets were spent on mental health in 2010/11. Furthermore

there is considerable inequality between funding given to other major health problems in contrast to mental health: *"A review of the 2004/05 research portfolios of the largest UK funders of health research showed that mental health research received 6.5% of total funding, compared with 25% for cancer, 15% for neurological diseases and 9% for cardiovascular conditions."* (RCP 2013).

Martin one of the practitioner participants in this study illustrates his perception of the impact austerity is having:

> *"There is a sense these days that increasingly we're trying to force people into a journey that is shorter and shorter" (Martin 33-33.2)*

Martin recognises there is a tension between a desire to spend time listening and helping and delivering outcomes. However, participants' frequently demonstrated frustration with the amount of bureaucracy and the time it took to '*box tick'* demanded of many healthcare professionals in the current climate. They were often explicit in seeing bureaucracy as a barrier to delivering care and help and that this was therefore a barrier to recovery.

Throughout his narrative Colin became increasingly animated and frustrated with the tension between having the resources to be a good CPN and the skills to be a *'jack of all trades'* as he put it. Previous research (Graham et al 2006, Maslin et al 2001, Deans and Soar 2005) has identified that CPNs feel unskilled in working with people who have a dual diagnosis. However, the tension here that Colin is narrating is a more contemporaneous issue, having time to provide quality care in mental health and the policy meta-narrative of integration:

> *"….we're lucky if we've got any time to do anything with your clients, you know, we tick the boxes to make sure the budget is satisfied. What we actually do nobody actually cares that much about because what happens is you've not got that much time for clients…." (Colin 6.18-6.23)*

5.3. Strengths and limitations of the study:

The voyage of discovery that I have described in the previous chapter may be a weakness of this study. As an act of co-creation the early stage interviews may have been hindered by my lack of skill and scepticism of narrative inquiry. However, the richness of the narratives that I have gathered suggests otherwise. Equally the nature of a doctorate study is one of discovery and development. My development as researcher has been two fold throughout my study; as narrative inquirer developing my interview skills and as writer of narrative in developing my voice. I have noticed the development of both over years of writing, reviewing, editing and rewriting this thesis. Rereading and analysing the texts

that the methodology demands enables a developing perception of the person behind the narratives but also of oneself in co-creating the narrative. I used reflection in an attempt to be open and demonstrate rigour in what I have done. Whilst early interviews may have been influenced by my developing skills they still reveal stories and themes of relevance. One option might have been to go back and extend or repeat interviews with those early participants. However, repeating interviews could have affected narrative development in other ways, by seeming to privilege a particular narrative or person, and so I chose not to revisit them.

Another limitation of this study is the method of recruitment of participants. Whilst some of my approach was purposive, in that I chose to send recruitment information to services and places where I was most likely to find an audience with an interest in or experience of dual diagnosis. Ultimately participants self-selected and it would be reasonable to assume they did so out of interest in the topic. The narratives that I have captured therefore cannot demonstrate the breadth of opinion nor are they illustrative of the views of people who I describe 'dual diagnosis sceptics'; practitioners who do not feel a responsibility to work in a holistic manner with both substance misuse and mental health issues; or service users who may not see their substance misuse as significant. Equally, as we will see later in this chapter, Goffman argues that an important concept in stigma is passing, Link and Phelan (2001) develop this as secrecy or withdrawal, the act on the part of the stigmatised to conceal or minimise elements of their identity. This may have been a factor for some people in not participating in this study, because to do so would be to disclose or threaten disclosure of elements of identity they wish to hide. In analysing the interviews my perspective is that most if not all participants had a sense of passion for, or ownership of dual diagnosis. This vested interest could be said to skew the findings if we were seeking generalisability. In my methods chapter I have discussed the concept of generalisability in narrative analysis and would argue that the data that I have captured stands on its own as the 'truths' of the individuals who participated rather than being generalisable. The findings are of value because they offer personal insights into individual's experiences and that they complement quantitative studies into dual diagnosis by enriching their apparent objectivity.

The nature of the topic may have been a considerable barrier to participation for some people who were concerned that in discussing dual diagnosis they would reveal something they see as clandestine; either because they do not want

services to know of their substance use (I have already discussed in my methodology section my perceived roles and the impact this might have on the study) or because of the taboo or illegality involved. This is always a risk in exploring topics that are socially unacceptable or are stigmatised. I found the participants to be remarkably candid, this may be because many of them have become used to revealing deeply personal information in certain circumstances, alternatively with a number of the narrators there seemed to be a strong sense of the value they placed in narrating their stories. This has been supported by previous research (Riessman 2008, Hall & Powell 2011, Link et al 1997).

The size of the study group could be perceived as both a strength and weakness in this study. The twenty participants generated a significant amount of narrative text and numerous stories that are reflective of the diversity of issues and experiences of people with dual diagnosis. They do not demonstrate all experiences of dual diagnosis but are illustrative of a wide variety of perspectives of people with diverse experiences and backgrounds. It is questionable whether a narrative analysis could ever hope to capture the complexity of issues that people with dual diagnosis experience but the aim here is not to generalise findings since narratives are personal and of value on their own. It could be argued that whilst the diversity and breadth is of value it has been a barrier to in depth analysis of individual stories. The amount of narrative is significant and the nature of an academic thesis, the parameters placed around word count for instance, means that, as analyst I have been conscious throughout of what can be included. There are areas of some participants' narratives that are worthy of much deeper exploration than is possible here: personal experiences of substance use by practitioner participants is one such area, another is the influence and experience of carers and significant others in influencing identity and the recovery of individuals with dual diagnosis.

The fact that narrative is co-created and constantly developing has been established earlier in this study. Training, reading research and other learning including electronic media ultimately could influence the perspectives of interviewees in this study. I knew many of the participants because they are members of groups that I attend, because I work with them, because they have been long standing service users in a service where I have worked for 23 years, or because they have attended supervision or training I facilitated. I point this out because my opinion or perspective could have not only influenced their decision to participate but also may have been present in the views or stories they

expressed through previous interaction in some manner. It is impossible to know how I may have influenced the co-creation of their narratives and even though I have endeavoured to use reflexivity to expose my influence on their stories I cannot contest that this is without flaw, merely an attempt to demonstrate rigour by being open about what I *can* know about my influence on the co-creation of these narratives. They are subject to my own interpretation and in turn to the interpretation you place on them as a reader/audience to this study.

5.3.1. Challenges to narrative theory:

For some the authenticity, rigour and validity of narrative theory is open to challenge. Connolly (2007 pp453) has suggested that

> *"Research involving this level of human interaction and human relationship is going to feel messy!"*

Reading Connolly (2007) the audience gets no sense that this is meant as a criticism but merely a perspective that separates the methodology from the seemingly highly organised and objective perspectives of many other research methods. It can be argued that the objectivity attributed to other methodologies is often temporal and subjective, science evolves and theories develop superseding other theories that pre-exist. Canagarajah (1996) states that narratives function in opposition to scholarly discourses and narratives provide marginalised groups with an opportunity to participate in knowledge construction. This is one of the main strengths of using the chosen methodology in this study since the study group is frequently marginalised and their experiences ignored. For instance Evans-Lacko and Thornicroft (2010) have highlighted how people with dual diagnosis are systemically excluded from research cohorts because the nature of their experiences may skew data and results. Other research methods have proved inconclusive in identifying what promotes recovery in dual diagnosis and maybe this is due to their lack of understanding of the importance of individual experience. The deliberate aim to seek out these marginalised voices runs the risk that this work is dismissed because it doesn't conform to more empirical research standards. Morgan et al (in Press) have summed this up by saying:

> *"The subjective nature of personal narratives is often seen as reason enough to invalidate them as scholarship. Despite the claim to objectivity, professional interactions with personal narratives take place within the inter-relational space influenced by our moral, ethical, social and political values and contexts."*

According to Trahar (2009) three key areas of narrative critique exist:

- That the storytelling process is therapeutic rather than analytic.
- That narrative inquirers present narratives as authentic when narrative is no more authentic than other representations.
- Narrative inquirers resist generalisability at the cost of developing global systems of meaning.

The potentially therapeutic nature of narrative inquiry is one aspect that has increasingly drawn me to it; it is humanistic, respectful and recovery orientated. The argument that the method maybe therapeutic rather than analytic is a function of our Cartesian-dualist perspective of research in western society that assumes that it is not possible to maintain analytic rigour if you are also being therapeutic. The challenge to that perspective is why can I not be analyst, analytic and therapeutic at the same time? In fact I would argue that my reflexivity demonstrated throughout this thesis not only adds to its rigour but also demonstrates an ability to be both analytic and empathic. I believe people's stories about things that have influenced their own identities provide valuable insight into how their identities are constructed and complement other research in developing a sophisticated, holistic picture of a complex set of issues. An important aspect of narrative is that it reveals the temporal context or 'human timeframe' of individual's experiences, which is relevant since other research has identified the longitudinal nature of recovery outcomes for this group.

The second 'criticism' that narrative inquiry has no claim to greater authenticity than other representations does not render narrative inquiry inauthentic. In constructing their narratives the participants in this study have structured and restructured their stories over time taking into account the 'feedback' they have received from previous audiences. Leggo (2004 p98) emphasises this

> *"Any story we tell will always be a fragment of the complex and wide-ranging experiences that each of us lives daily in our bodies and imaginations, the experiences we live daily in interconnections with family, colleagues, and community."*

In turn, I have retold these narratives and they have been open to further translation by you as the audience. Polkinghorne (2007 p476) suggests that in narrative inquiry we should work with the information or stories that we gather but that the methodology also demands that the audience looks for: *"the supporting evidence and argument given by the researcher"*

Some narrative analysts would argue that dividing or developing themes fractures the narratives and in turn creates something other than the storyteller

originally intended. The method I have used endeavours to overcome this through maintaining the voice of the participant throughout. What I see as common themes, participants may view otherwise. I endeavour to show rigour in my thinking by relating this to quotes from participants' narratives but also by providing references to the text lines so that the reader can refer back to the context in which the comment or narrative is made.

The criticism that resisting generalisability prevents development of globalised meaning is also representative of the dualism that besets research and understanding. That dualism, would have us believe that without generalisability then no collective understanding is possible. In questioning, *"Are real people fictions?"* Winterson (1997) sums up my sense that society is made up of individuals, so individual understandings are valid in gaining societal or global understanding. A lack of generalisability does not prevent me from using these narratives to generate an explanatory framework that offers guidance and understanding of what works to improve prospects of recovery for people with dual diagnosis.

5.3.2. The importance of the research 'setting':

In discussing this research it is important to explore how the nature and culture of the organisation where I work, and from which other participants received a service might influence the findings. NHCT is nationally renowned for developing and supporting a recovery culture (as defined by Anthony 1993 p11) and as a result many of the participants may have a different experience to their peers elsewhere in the UK. As I have highlighted many participants saw value in their ability to testify or bear witness about their recovery. Not all services have a culture that embrace or espouse a recovery approach. Having peers and colleagues that are used to supporting service user voices in articulating their identities, being involved in service evaluation and development influences outcomes for individuals. Whilst this has undoubtedly influenced my findings I would argue that this is a strength of this study because it highlights the type of culture or cultural elements that engender recovery related talk, which ultimately influences peoples identities and onward recovery.

5.4. Transferability and implications for practice:

Labelling people with a dual diagnosis is potentially hugely stigmatising for the individual involved. There is undoubtedly a negative effect created by the label dual diagnosis itself. Equally there is far more negative language used to create labels that indicate the co-existence of substance misuse and mental health.

Whilst it could be argued that the label has enabled the development of policy and service structures that directly benefit people with dual diagnosis it is also possible that the need to do so is a direct result of stigmatisation and discrimination. Ultimately if people with a dual diagnosis were not discriminated against then they would be offered integrated treatment as a matter of course. Structural stigma resulting from a paucity of resources is one reason that services become embroiled in arguments about primacy of need, which results in the exclusion of people with complex needs. This study supports previous conclusions drawn by Davidson and White (2007) that integrated systems of transcendent recovery are more likely to achieve ongoing recovery for this group.

The effect of stigma and discrimination is not just that service users experience a combined stigma associated with both mental health and substance misuse but that there is a synergistic affect that fundamentally disadvantages the individual in multiple ways. Practioners in both mental health and substance misuse services need to be aware of this and enact non-discriminatory practice. Most practitioners understand the undesirable effects of racism and other discrimination on mental health, it is a subject that is addressed through essential training in the NHS. Societal constructs and the socially controlling effects of stigma against drug users are present in the microcosm of both mental health and substance misuse service structures and comprise justification for discrimination and service withdrawal. Services need to work to actively raise and tackle the structural discrimination that is present in services to improve the effective engagement and recovery of people with a dual diagnosis.

Whilst motivation is a critical facet of change for people with a dual diagnosis it is critical that practitioners and services are aware that self-stigma and perceptions of stigma might engender *'passing.'* Coping strategies such as secrecy and withdrawal that could be mistaken for lack of motivation to change, denial or other stigmatised perceptions of ambivalence are commonly used by people with a dual diagnosis to cope with the stigmas they experience and perceive.

One of the ways in which stigmatised individuals might reframe their identity is through narrating their experiences of stigma. Narratives in this study are optimistic and hopeful because they story transcendent recovery. Participants felt that they benefited personally but gained esteem and worth from supporting others through offering hope and optimism. Frank (1995 pp32) underscores this and describes post-modern ideas of the stigmatised 'coming out', or taking an

active role in tackling their stigma by taking *"meta-control"* or narrating their stigma. This would seem to suggest that enabling the narration of experiences of dual diagnosis is more than just a cathartic experience but can actually enable the shared recognition of stigmas and barriers to recovery. *Re-identitying* through narration has the benefit of enabling people with dual diagnosis the opportunity to become more empowered in pursuing their recovery. The narratives in this study suggest that supporting 'story' groups that enable the telling and sharing of experiences of dual diagnosis could be of considerable value in helping people recover.

Some service users may find it difficult to engage in groups and the narration of their life stories may be distressing experiences that they seek to avoid; this should not prevent the sensitive use of personal narratives as a tenet of treatment. Individual practitioners can enable people to use their experiences to have open conversations about dual diagnosis, to challenge self-stigma and perceptions of stigma. Practitioners need to be open to this through active reflection of their own prejudices and how this might influence interaction with people with dual diagnosis. They also need to be aware of the limiting factors that prevent active discussion of mental health and substance misuse problems. Secrecy and withdrawal are commonly adopted coping strategies that stem from experiences of discrimination by people with a dual diagnosis. Service Users may perceive that there are negative consequences to divulging their problems, service withdrawal, compulsory treatment; criminal sanctions and marginalisation are a few examples. This study demonstrates that the experience of stigma is also significant for the people involved and was a negative experience that was to be avoided.

Similarly to other research, service user participants in this study have identified a number of positive skills that they attribute to helpful practitioners including flexibility, openness, holism, trust, consistency, optimism and hope. In particular being amongst peers who demonstrated optimism for recovery was seen as important. Whilst divulging personal experiences of substance misuse may support empathic interaction and is one way trust can be built between service user and practitioner there are innate risks and conflicts for practitioners in doing so.

Legislation and policy has created barriers to effective treatment and recovery in dual diagnosis in the UK. Current competitive commissioning has the potential to be a significant barrier to integrated services being commissioned for complex

individuals. The barriers that this create mean that people with a dual diagnosis are not only disadvantaged but that as their health and circumstances deteriorate they have a significant impact on the wider health, social care and criminal justice economies. Many people with both mental health and substance misuse problems frequently present to Acute Emergency Department (A&E) services and are labelled High Volume Service Users (HVSUs); this is a direct result of structural stigma. Commissioners need to develop an awareness of the issues for people with dual diagnosis and work closely with providers and other organisations is developing sophisticated and innovative responses to the needs of people with dual diagnosis including supporting integrated practice across service boundaries that enables transcendent recovery. Integrated commissioning practices across health, social care and criminal justice economies can ensure integrated services are delivered that address the multiple needs of people with a dual diagnosis. Recent developments in street triage of people with mental health problems, where the police and mental health services work together, are a precedent for innovative integrated commissioning responses.

6. Conclusions:

6.1. Introduction:

This study set out to explore the narratives of people who have experiences of dual diagnosis and to uncover some of the participants' perceptions of what aids or are barriers to recovery. The research literature on this topic is generally inconclusive and whilst a lot has been written separately on recovery in mental health and substance misuse, little has synthesised the two to reach conclusions about what the challenges are for people who experience both. This study shows that it is not enough to simply synthesise the separate issues of mental health and substance misuse. Whilst the experience of people with dual diagnosis bear similarities, and can be compared to, people who have separate substance misuse or mental health problems the narratives in this study demonstrate that the experience of co-existing problems and its complexity are far more profound. Stigma is the main theme identified as significantly affecting people with dual diagnosis. The health and social consequences of stigma associated with dual diagnosis are also significant. Stigma and discrimination fundamentally restricts people's access to services and support, even in supposedly enlightened or wise services that should be aware of the issues. Stigma impacts on their social economic status, significantly affects self-esteem and self-efficacy and ultimately restricts their access to social capital that promotes recovery.

The narratives in this study are testament to the complex journeys people often have to navigate by themselves, with little support over years, to recover. The culmination of recovery journeys narrated by the participants is one of toiling to rebuild and re-identity themselves in order to become acceptable, functional members of society. In doing so they are frequently conflicted, the coping strategies they often use to minimise the impact of stigma engender self-stigma, feelings of guilt and duplicitousness and also hamper their recovery.

6.2. Reflections on the study:

Ultimately my interpretation and analysis of these narratives is affected by my own experiences that lead me to select certain passages and elements of the narrative over others. An essential part of my methodology has been to privilege the voice of the narrator "*without losing a sense of the (often coherent) narrative*" (Langdridge 2007 p138). Throughout the process I have been aware of many factors that might affect this interaction and I have learned a great deal about

good qualitative interview techniques. I have spent a considerable amount of time thinking and reflecting, particularly about the nature of truth and verisimilitude. I accept that each narrative stands on its own; each one contains a version of truth. This recognition in itself is important because I can learn something of importance in what is being said even though it may lack logic, may be based on prejudices, misconceptions or even lies. Sometimes I have struggled with this highly qualitative perspective. My endeavour here has been one of exploration and discovery that I believe is only made richer by the variety and depth in the cross section of my participant's voices, which I hope I have preserved through the rigour of my methods.

Using imaginative hermeneutics of suspicion is a constant endeavour of 'light touch', when participants engage in the process they do so from a very personal perspective, some more aware than others of the underlying meaning of what they are saying. My own personal and professional perspectives add further richness, depth and challenge to this complex scenario. As I wrote this thesis I became increasingly enthused by what the participants had to say and what their narratives reveal about experiences of dual diagnosis. Whilst they are individuals I hope the audience to this thesis will also recognise the coherence and cohesiveness of what was said across many of the narratives. I strongly believe that their narratives add richness and depth to previous research. Whilst there have been few eureka moments distinguishing this study I have been surprised that it has revealed the considerable burden of stigma and discrimination on this group, the barriers that it creates for recovery and the societal burden that stigma creates by preventing people receiving adequate care.

I have described how I felt confused at first and anxious about the methodology. As my writing developed I have seen my skill and confidence grow and my enthusiasm has developed.

6.3. What do service users with dual diagnosis and practitioners who help them tell us are facilitators and barriers in promoting recovery?

There are many barriers to recovery in dual diagnosis but the narratives in this study indicate stigma underlies them all. The narratives demonstrate stigma is significant for individuals with a dual diagnosis because of power issues. For people with dual diagnosis stigma is pervasive and leads to discrimination not only influencing their socio-economic status but also because it affects their

mental and physical well being as a direct result of experiences in mental health and substance misuse services. Assessments of people's mental health and/or substance misuse needs are often overlooked, so people are not identified as needing help. Assessments often lead to arguments of primacy of diagnoses and due to structural stigmas exclusion from services. Often in some cases, stigma and discrimination affects whether people with a dual diagnosis get a service at all. *"Diagnostic overshadowing"* (Sayce in Press), a process where one problem is overlooked because its symptoms are attributed to a different issue, is a significant issue for people with a dual diagnosis. Pejorative diagnostic terms such as *drug-induced psychosis* and other terms such as *denial* overshadow the real issues of distress and hardship that people with a dual diagnosis experience. The way in which practitioners approach people with a dual diagnosis, affects their self-image, their optimism and hope of positive outcomes, their ability to access appropriate services and their overall ability to recover. The narratives in this study demonstrate that stigma manifests on both a personal level, one individual or group to another, and as structural stigma, akin to institutional racism, where accumulated institutional practice works to disadvantage people even in the absence of direct individual prejudice and discrimination.

Practitioners and services have concerns about illicit drug use and excessive drinking that create heightened anxieties about risk, poor concordance and legality which reinforces tensions that practitioners feel in attempting to be therapeutic and pragmatic. They have often looked to UK national or local policy to support their understanding and actions in addressing dual diagnosis. The lack of clarity and frequently conflicting direction of policy has reinforced their concerns rather than aiding appropriate resolutions. Many policy initiatives are based in and reinforce societal constructs of mental health and substance misuse, which are unhelpful and can reinforce stigmatisation and discrimination. Room (2005 p.151) perceptively points out that "*policies against stigma usually carefully exclude from their scope those who are at the time under the influence of alcohol or using drugs*". Research has also been fundamentally flawed in exposing dual diagnosis issues because it often excludes participants with those experiences. Narrative research has the advantage of uncovering the personal perspectives that shed light on this.

6.4. What factors, skills, aptitudes and attitudes do service users and staff identify as helpful in enabling them to achieve their goals?

Accurately assessing both mental health and substance misuse issues is critical. The interrelationships between mental well-being and drug and alcohol use are profound but often overlooked and are far more prevalent than many professionals would freely feel comfortable to admit. Practitioners need to be aware that passing, in the form of secrecy and withdrawal, mean that people with a dual diagnosis may appear unmotivated or untruthful, but their reluctance to divulge information maybe based in deep-seated coping strategies attempting to avoid the harmful, distressing affects of stigma and discrimination. Engagement by building trusting relationships through flexibility and empathic understanding is important to people with dual diagnosis. Training and skills development on issues associated with dual diagnosis are important for practitioners, but a lack of specific skills should not be seen as a reason not to engage with people who need help. Engagement is a much more fundamentally open approach that understands diversity of people's needs and is based in a skill-set essential to all practitioners alike whether they provide mental health, substance misuse or other services.

For practitioners being open about personal experiences of drug and alcohol use may be valuable to service users, however, professional risks in divulging personal experiences of substance misuse pose conflicts between their professional and personal identities. Conversely peer support workers or other people who are experts by experience seem to be one acceptable way that services might use experiences of dual diagnosis to break down barriers and engage people who have substance misuse and mental health problems. This is an area of interest raised by this study that is worthy of further research exploration.

The diversity of experiences of substance misuse and mental health inevitably influence the perspective of service users and practitioners alike. In order to develop better services for people with dual diagnosis practitioners not only need to accept its prevalence and impact but they need to challenge their beliefs about people with dual diagnosis. Training and skills development can achieve some of this but challenging and questioning culture through reflexivity is just as important.

Whilst research has supported the value of integrated approaches to dual diagnosis there is significant risk that stigma, discrimination, conflicting service priorities and lack of skill has significantly impacted on the development of pathways for people with dual diagnosis. This coupled with emerging societal constructs developing in a period of austerity across public services, mean that people with dual diagnosis are often vilified and denied services. In turn this causes concomitant impact on services as demand due to increasing distress, disability, criminality, deteriorating physical health and deteriorating social conditions as a result of dual diagnosis make the situation for the discriminated against more unbearable. Ironically this often has the effect that people seek solace by attempting to divorce themselves from the reality of their lives through increasing use of substances. Specialist resources, dedicated to dual diagnosis, run the risk that people are identified and segregated which increases stigma and can be retrogressive in achieving recovery. However, specialist resources are needed because engaging with people with dual diagnosis is time consuming. Support needs to be structured in such a way that is sensitive to the stigma and discrimination that may result. Specialist services can effectively support a system of integrated pathways that help people engage, get treatment and that encourages optimistic approaches to recovery. The assumption based in stigma that people with dual diagnosis are unmotivated, that they are in control of a problem they brought upon themselves, which they deny is a barrier to effective help, is in itself stigmatising and discriminatory. People with personal experience of recovery in dual diagnosis can help challenge beliefs and help practitioners and service users build understanding and optimism for recovery.

One area that this study has not addressed are the barriers for people who are sceptical about the impact of their substance use on their mental health; as they are unlikely to be represented as participants, for the reasons already discussed earlier in the methodology and discussion chapters. Further research using a purposive method to identify and engage participants representative of this group would be worthwhile. Using people with personal experience of dual diagnosis as researchers or research assistants may be one way to change or challenge some potential participants perceptions and improve participation. Another may be to illustrate the positive impact of narrative research demonstrating the empowering nature of the process.

6.5. What value do narratives of service users and staff have in elucidating the nature of recovery?

Participants in this study narrated the positive experiences of sharing their personal experiences through storytelling. The ability to narrate a changed identity and growing recovery was personally cathartic but also perceived to be helpful in encouraging others to engage in a recovery journey. The findings of this study suggest that narrative groups exploring personal narratives can help recovery in dual diagnosis not only through catharsis but also by aiding engagement of individuals who are less trusting or who have had negative experiences of services.

Narratives on dual diagnosis are powerful tools in challenging associated perceptions and stigma. Personal stories engender optimism and hope, illustrate challenges to be addressed and expose the stigma that creates barriers to recovery.

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8. Appendices

8.1. Appendix 1: Literature search.

Table of database search terms including number of articles returned.

Search code	A	B	C	D	E
Search term	Dual diagnosis	Outcome measures	Service user perspectives	Carer perspectives	Patient Views
AMED, British Nursing Index, British Nursing Index Archive, Embase, Ovid medline, Psychinfo	3588	124095	30	26	395
Search code	F	G	H	I	J
Search term	Substance Misuse and Mental Health	Treatment Concerns	Service user Involvement	Effective treatment	A & H
AMED, British Nursing Index, British Nursing Index Archive, Embase, Ovid medline, Psychinfo	1106	266	184	56191	1
Relevant Articles	-	-	-	-	0
Search code	K	L	M	N	
Search term	A & B	A & C	A & D	A & E	B & F
AMED, British Nursing Index, British Nursing Index Archive, Embase, Ovid medline, Psychinfo	77	0	0	0	95
Relevant Articles	14	-	-	-	14
Search code					
Search term	A & I	G & A	A,C & I	A, B & C	
AMED, British Nursing Index, British Nursing Index Archive, Embase, Ovid medline, Psychinfo	109	8	0	0	
Relevant Articles	14	2	-	-	

Additional search terms derived from the literature following the initial search:

Search term	Patients' experience	Client views	Service user views	A&O	A&P
AMED, British Nursing Index, British Nursing Index Archive, Embase, Ovid medline, Psychinfo	7287	56	26	9	0
Relevant Articles	-	-	-	2	-
Search code	O	P	Q	-	-
Search term	A&Q	Service user Perspectives	Client Perspectives	Patient Perspectives	A&R
AMED, British Nursing Index, British Nursing Index Archive, Embase, Ovid medline, Psychinfo	0	31	119	603	0
Relevant Articles	-	-	-	-	-
Search code	-	R	S	T	-
Search term	A&S	A&T	Staff attitudes	A&U	History of dual diagnosis
AMED, British Nursing Index, British Nursing Index Archive, Embase, Ovid medline, Psychinfo	0	0	3404	9	2
Relevant Articles	-	-	-	2	1
Search code	-	-	U	-	-

8.2. Appendix 2: COREQ form.

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

No. Item	Guide questions/description	Reported on Page
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Inter viewer/facilitator	Which author/s conducted the inter view?	p96
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	Title page
3. Occupation	What was their occupation at the time of the study?	p14
4. Gender	Was the researcher male or female?	p14
5. Experience and training	What experience or training did the researcher have?	pp14-16
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	p90
7. Participant knowledge of the interviewer	What did the participants know about the researcher? E.g. personal goals, reasons for doing the research	Information sheet
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? E.g. Bias, assumptions, reasons and interests in the research topic	pp13, 90-94, 100, 193, 230.
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study?	pp12-15
Participant selection		
10. Sampling	How were participants selected? E.g. purposive, convenience, consecutive, snowball	p94
11. Method of approach	How were participants approached? E.g. face-to-face, telephone, mail, email	pp95-96
12. Sample size	How many participants were in the study?	p95
13. Non-participation	How many people refused to participate or dropped out? Reasons?	N/A
Setting		

14. Setting of data collection	Where was the data collected? E.g. home, clinic, workplace	p96
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	p96
16. Description of sample	What are the important characteristics of the sample? E.g. demographic data, date	p94
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	N/A
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	N/A
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	p96 & 265
20. Field notes	Were field notes made during and/or after the inter view or focus group?	p96
21. Duration	What was the duration of the inter views or focus group?	p97
22. Data saturation	Was data saturation discussed?	p96
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	p97
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	1
25. Description of the coding tree	Did authors provide a description of the coding tree?	N/A
26. Derivation of themes	Were themes identified in advance or derived from the data?	Derived
27. Software	What software, if applicable, was used to manage the data?	N/A
28. Participant checking	Did participants provide feedback on the findings?	p97
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified?	Findings (p108) and Discussion (p192) chapters with line numbers
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes, transcripts available
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes pp108-190
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Yes pp194-198, 230.

8.3. Appendix 3: Study Information Sheet.

Service Users and clinician's perceptions of factors which foster or inhibit recovery in people with dual diagnosis.

Information about the research for Service Users.

(version SU v2 17/04/2012)

We would like to invite you to take part in our research study. Before you decide whether you want to take part we would like you to understand why the research is being done and what it would involve for you. Talk to others about the study if you wish.

What is dual diagnosis? Dual diagnosis is a term commonly applied to people who experience both mental health and substance misuse (drug and/or alcohol) problems.

What does recovery mean? There is no single definition of the concept of recovery for people with mental health problems, but the key idea is one of hope that it is possible for meaningful life to be restored, despite serious mental illness. Recovery is often referred to as a process, outlook, vision, or guiding principle.

What is the purpose of the study? We are aiming to gather information from service users (or patients) of mental health services who also experience, or who have had, drug and/or alcohol problems. We want to find out about their experiences of recovery and the factors that help promote recovery and/or hinder or inhibit recovery. We also want to gather this information from the people who provide them with mental health services (e.g. nurses, doctors, social workers, occupational therapists, and voluntary workers). There has been very little research about recovery for people who have both mental health and drug or alcohol problems.

We are particularly interested to find out what people believe are factors that can help promote recovery or things which hinder recovery so that we can promote good practice amongst mental health service providers by highlighting things that they can do to promote recovery and avoid employing approaches which hinder recovery amongst this service user group.

Why have I been invited? You are being invited to join the study because you have either seen one of our posters which you have responded to or we have been told by a mental health professional known to you that you have experience of dual diagnosis and have agreed to participate in this study.

Do I have to take part? It is up to you to decide to join the study. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw

at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part? You will be asked to sign a consent form, agreeing to be a participant in the study. You will then be invited to attend an individual interview. Interviews will last between 45 minutes and 1 hour. The costs you experience for travelling to the interview/group will be reimbursed after the interview.

At the interview you will be asked to discuss your experience of recovery and highlight issues, which you think have either helped or hindered you in achieving your goals or gaining hope of recovery. The interviewer will help you to discuss this by asking questions. They may also make notes of the interview proceedings. The interviews will be recorded and later typed up for analysis in the study. At the end of interview session the interviewer will discuss whether you need to meet again to continue the interview and you may be invited back. If you agree with the interviewer that you do not need to continue further, your involvement in the study will then end. The decision to extend your interview into more sessions will be agreed between you and the interviewer as necessary.

What are the possible disadvantages and risks of taking part? The study involves discussion of some potentially difficult or distressing life experiences. You may find it upsetting to go over these issues. You will be provided with the opportunity to discuss any problems you experience as a result of your involvement and gain further support, if necessary, after the group or interview.

What are the possible benefits of taking part? We cannot promise the study will help you. But we hope the information we get from this study will help improve the treatment of people with dual diagnosis.

Will my taking part in the study be kept confidential? Yes. We will follow ethical and legal practice and all information about you will be handled in confidence.

What will happen if I don't want to carry on with the study? If you decide to withdraw from the study it will not affect any treatment or support you are receiving from services. Information that we have already collected may still be used in the analysis of the study. If you decide to withdraw it may not be possible to erase data from group recordings.

What if there is a problem? If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions (contact David Manley on 0115 9563355 or david.manley@nottshc.nhs.uk). If you remain unhappy and wish to complain formally, you can do this through contacting Prof P Callaghan on 0115 9691300 or emailing Patrick.Callaghan@nottingham.ac.uk. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure or Patient Advice and Liaison Service. Details can be obtained from the Service Liaison department at Nottinghamshire Healthcare Trust on 0115 9691300.

Will my taking part in this study be kept confidential? *Yes.* All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password-protected database. Any information about you, which leaves the hospital, will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it. Recordings of interviews will be made with a digital voice recorder, which will be uploaded to a computer after each interview. Only the researcher and research admin staff will have access to information that can identify participants. Digital recordings will be stored under anonymised file names on a secure University of Nottingham computer system. The information will be treated with the same levels of confidentiality that is applied to any other NHS patient sensitive information. If you join the study, some parts of your medical records and the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Your personal data (address, telephone number) will be kept for up to three months after the end of the study so that we are able to contact you about the findings of the study – if you wish to receive them. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen to the results of the research study? The research is being conducted as part of a doctorate (PhD) research study in nursing and will eventually be published as a thesis as part of the PhD study. Subsequent to this the research may be published in journals. A brief report on the study will be made available to participants. You will be asked at interview or at the group whether you wish to receive a copy of the report.

Who is organising and funding the research? The research is being conducted through Nottingham University (who are also the sponsors of this PhD research study) and the study is part funded by Nottinghamshire Healthcare Trust.

Who has reviewed the study? All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by East Midlands-Derby Research Ethics Committee.

Further information and contact details:

General information about research or specific information about this research project including further advice as to whether to participate can be gained from David Manley, SMS 'The Woodlands' Highbury Hospital, Highbury Rd, Bulwell, Nottingham, NG6 9DR or by telephoning on 0115 9560850 or email david.manley@nottshc.nhs.uk.

If you are unhappy with the study then please contact: Prof. P Callaghan at The School of Nursing, A Floor, Queens Medical Centre, University of Nottingham, Nottingham, NG7 2HA or by telephoning on 0115 8230817 or emailing Patrick.Callaghan@nottingham.ac.uk.

8.4. Appendix 4: Invitation letter.

Invitation Letter v1.2 04.10.11

Study Title: ***Service Users' and clinician's perceptions of factors which foster or inhibit recovery in people with dual diagnosis.***

Dear _____ ,

My name is David Manley and I am a part time student studying for a Doctorate in Nursing at Nottingham University School of Nursing. I am being sponsored to complete this course of study by my employer, Nottinghamshire Healthcare Trust, where I work as a Nurse Consultant in dual diagnosis and the Clinical Director of the Trust Specialist Services Directorate. I am conducting this research as part of the requirements of my degree and I would like to invite you to participate. You may be receiving this letter because you have received promotional material about it and you have shown interest in being involved.

If you decide to participate, you will be invited to be interviewed by me about your experiences of recovery in relation to mental health and co-existing drug and/or alcohol problems (dual diagnosis).

The interview will take place at a mutually agreed time and place, and should last about 45 minutes. The session will be audio taped so that I can accurately reflect on what is discussed. You may feel uncomfortable answering some of the questions. You do not have to answer any questions that you do not wish to. The tapes will only be reviewed by members of the research team who will transcribe and analyse them. We will reimburse you for your travel expenses.

We hope the results of the study will help services become more recovery focussed in working with people who experience both mental health and drug and alcohol problems. Although you may not benefit directly from participating in this study, we hope that others will benefit from the learning generated.

Participation is confidential. Study information will be kept in secure computer files at Nottinghamshire Healthcare NHS Trust. The results of the study may be

published or presented at professional meetings, but your identity will not be revealed.

Taking part in the study is your decision. You do not have to be in this study if you do not want to. You may also stop being in the study at any time or decide not to answer any question you are not comfortable answering.

Further information detailing the study is available in the attached information sheet. I will be happy to answer any questions you have about the study. You may contact me at 0115 9555435 if you have study related questions or problems.

Thank you for your consideration. If you would like to participate, please sign the attached consent form and return it to Rachel Redford at SMS, The Woodlands, Highbury Hospital, Highbury Rd, Bulwell, Nottingham. NG6 9DR. When we receive your response we will contact you to discuss your involvement in the study.

With kind regards,

David Manley,
SMS, The Woodlands, Highbury Hospital, Highbury Rd, Bulwell, Nottingham. NG6 9DR.
Telephone: 0115 9560850
Email: david.manley@nottshc.nhs.uk

8.5. Appendix 5. Example service user transcript.

DM

Ok, Hi ER, thanks for coming today. I have explained to you a little about my study, but the discussion I wanted to have was (urm) what your experience of dual diagnosis has been and what you see as things that have helped with recovery or those things that might have been barriers to recovery or not helped.

ER

Now I assume you mean by dual diagnosis and I was sort of diagnosed with alcohol dependency and depression. The two sort of interlinked. Is that the sort of thing you

DM

Yes

ER

You mean

DM

Yes, yes

ER

Yes, (urm) …., I don't, I started, I started drinking. I've always liked to drink, laugh

DM

Yeah

ER

I've always liked to drink. The problem began about ten years ago when I lost my son, a 21 year old son. I then turned to it. (Urmm) wasn't so bad for a while then things got worse, (urm) I lost my job nearly 3 years ago and then I had all day more or less and then the depression set in and (urr) I was being treated for depression but of course, (urm) it was a bit difficult with antidepressants because (urm) some GPs are reluctant to give them if you are drinking and because alcohol is allegedly a depressant

DM

Aha

ER

And you know you have your antidepressants working against each other, against the depressant. So that didn't work very well and I don't know (urm), what actually happened but just all of a sudden (urmm) …, I just decided I need to do something about this. My family life was, family were fairly supportive but I had an awful lot of nagging, which is one thing that certainly didn't help. My boyfriend was nagging about my drinking, my family were nagging and that did not help. I have always said all along (urm) when I do it, I'll do it myself, I'll do it in my own time and I'll do it for me and nobody else. (Urm), however, to cut a long story short I was in a difficult relationship (urm), I was subject to some

domestic violence, which I came out of and ended up in supported accommodation and (urm), I was advised to go to Time Please!, I don't know whether you are aware of them?

DM

Yes

ER

Yes, I went to Time Please! and they referred me to Complex Alcohol services where I have been going since the 2nd of April. (Urm) they were, I have to say, very, very helpful because they are obviously all professionals and they were non judgmental. They went through the options with me. They listened and I just felt that they were people who understood. The one thing I did feel and in fact I'm going to mention this when I next go to Complex Alcohol services that was lacking. I think it would have helped, ok they were professionals, they weren't judgemental but I think it would have been helped if I'd had access perhaps to some previous service users or even existing service users who were, who had become abstinent or CD controlled drinking or whatever, because I think once you have been through it yourself I think you are that little bit more sympathetic.

DM

Yeah

ER

I feel now myself I think I will be very, I could be very useful (ur) to people in that situation (urm) so to cut a long story short I carried on, I had a very good key-worker, J and every week I would keep a log of how much I was drinking, reducing it gradually, (urm) so that we could sort of look at patterns, (urm) well the patterns we did notice was that in the morning I definitely had the shakes (ur), it was a vicious circle then. You know the only way to get rid of the shakes was to have a drink. Now this was what I was told, I mean I have since heard that there are drugs to deal with it so I don't know, that was what I was told at Complex Alcohol services. (Urm) it actually worked quite well, I did reduce quite a lot, you know my units went down from something which was absolutely horrendous, it was about 70 units a week. Went down to about 30 units a week, which is still too many but you know.

DM

Yes

ER

It was improvement, but what I found was that urm I would, although I was drinking less but what I did find was that if I was down I would turn to the bottle. Now again I have got everyone telling me it's a depressant but in the short term it does mask the symptoms.

DM

Yes

ER

(Urr) so I didn't, you know, I didn't find that terribly helpful. Although I knew, I mean I'm not daft, I knew exactly what I was

doing (cough). Anyway, that went on for a bit and I don't know what happened. But, all, one night I went home, I was in touch quite a lot with my key-worker, which was brilliant, by email (urr) I went home and I thought I've had enough of this. It is controlling me. I'm not in control anymore and it's gone, it had gone on for a while.

DM

Aha

ER

So I emailed my urr key-worker and said that you know I was, seriously thinking of detoxing and she emailed me back and said that it may be good idea, because I've also, I didn't mention I have sleeping problems. I wasn't having problems falling asleep. I think the alcohol would knock me out, (laugh). But I was having problems staying asleep. I was waking up and having very restless sleep, nasty nightmares. But as I say I just decided, urm you know to go the whole way and detox. Anyway she emailed me back, you know with the, you know how it's done and said that she would, you know have a word with the doctor to see if he approves, which it was. I was due to go in urm, I got a, a Monday, it was, I was due to go. Anyway as luck would have it or may be not luck, urmm about (pause) 4 or 5 days before I was due to go in I became really, really ill, urm, now I've had two brain tumours in the past and I panicked, so that was the problem. I was vomiting, I had got headaches, I was, I'd got no appetite. I really really felt ill and I just could not, the last thing I fancied on this planet was a drink.

DM

Yes

ER

I really couldn't and this went on for, I did go to the doctors. It went on for about (pause). On the first day I was due to go to Complex Alcohol services and I thought, I was sick twice in the morning, I thought if I'm sick once more I'm going to have to ring and say I can't make it. Anyway, I thought I really want to go and I went, took my sick bag with me (laugh). I was alright fortunately, urmm and it was the fourth day and she said well you know if you carry on now not drinking, you know you won't have to come for detox with all the drugs and everything you know. Perhaps you can do it yourself.

DM

Yeah

ER

And I did! And that was it really.

DM

Right

ER

And I've never looked back, so I, I mean that was six weeks ago

1.131 now. I feel quite good that urm I didn't have to go in and have all
1.132 the drugs and everything. I managed it, you know. Yes, I did
1.133 have a few days of the shakes but I feel that it is something that I
1.134 have done, at the end of the day and I still maintain, and I mean
1.135 obviously you have worked with previous alcohol dependent
1.136 people.
DM

1.138 Lots yes.
ER

1.139 But I still maintain that a lot of it, you've got to want to. I mean I've
1.140 never smoked in my life so I don't know what it's like, but I think
1.141 you've got to want to do it.
DM

1.142 Yes
ER

1.143 And I think the more patronising people are, the worse it is. It got
1.144 to the point where I thought to myself if you keep going on, you
1.145 know, you're just driving me to drink even more.
DM

1.146 Right
ER

1.147 That's what I found really unhelpful, whereas I felt that at Complex
1.149 Alcohol services I didn't get that. They were very very good.
DM

1.150 Ah hum
ER

1.151 Yeah
DM

2.1 Ok, that's a really interesting story, urm. I suppose I'd like to just
2.2 focus in on a couple of things. You talked about your key worker
2.3 being good. Just tell me a little bit about why and what aspects of
2.4 the key-worker helped?
ER

2.5 Well, the best, the first, she would always listen. Urm she was non
2.6 judgemental and she would offer alternatives. She never, When I
2.7 first went to Complex Alcohol services urm, I saw a doctor there,
2.9 you know, basically my life story, I'm thinking. I said to him if you
2.10 ask me anymore questions you'll know more about me than I do.
DM

2.12 (Laugh)
ER

2.13 (Cough). You know whether I was bullied at school and
2.14 everything. Urr but I was you know, he said you know, we've
2.15 discussed you know. How they go for detox, you know, but he

said I'm not sure that you're ready for it and this was again listening to somebody else. I was as I say, when I first went there I had just come out of the relationship. I was really, really depressed and the GP I was with at the time would not give me antidepressants so I was pretty much on my own. Urm but he said at Complex Alcohol services that was one of the options but a friend of mine who was also in the same boat she is, in fact she had just had her pancreas out, but she was in hospital, in and out of hospital with acute pancreatitis, pancreatisus, whatever it is and she had to stop drinking because they more or less told her that there was no point in treating her if she carried on drinking and she said to me at the time, because she obviously had to do it straight away. She said to me at the time, believe you and me you will hit rock bottom and that, just sank into me and I thought, I feel so lousy, I can't do with feeling anymore rock bottom than I do and I listened to her because she'd been through it. So I did take notice of her and in a way I wish I hadn't because you know I'm six weeks on and I haven't hit rock bottom. In fact if anything I've hit rock high.

DM

Yeah

ER

You know, I can more or less feel. I mean don't get me wrong I've still got my problems, but I can feel that my depression is going away and one thing, I don't know how much you know about the recovery college.

DM

A little yes.

ER

Little, yeah. But there are posters there and it said recovery is, you know, recovery is this, you know and one of them says recovery is when you sometimes feel happy and I thought, well yes! That is me now, but I certainly haven't hit rock bottom and I don't think I will because urm, because I thought I've got these bottles of wine, red wine. I thought ohh what shall I do with them. I thought I'll shove them at the back of the cupboard and use them for Christmas presents and my daughter said to me it's not a good idea to have alcohol in the flat. I said well I've only got to nip across the road to Sainsbury's if I really wanted and I found a good use for it. I use it in cooking now.

DM

(Laugh)

ER

And you know I can't stand the smell of it.

DM

Yes

ER

In fact I've been to a pub. I've been to a pub with my new

2.61 boyfriend and he has had a pint and it doesn't bother me at all. I
2.62 honestly do not think I will falter, simply because of I've come that
2.63 far, my liver function was not good but within, within 3 weeks. I
2.64 mean, one of the readings was 600 something and its down to 200
2.65 within 3 weeks, it was down to 200. It's still higher than it should
2.66 be.
DM

2.67 Yes
ER

2.69 But they said, they're not worried, they will re do it in about 3 or 4
2.70 months time.
DM

3.1 So how does seeing things like that, you know seeing progression
3.2 or improvement, has that helped?
ER

3.3 Oh yes, yes. This is it, which is why I think. I mean I don't know
3.4 how you do it here. I mean I only know how they do it at Complex
3.5 Alcohol services. Are you urmm, do you keep people over night
3.6 here?
DM

3.7 Th This is residential, the Woodlands.
ER

3.8 It is residential
DM

3.9 Yes
ER

3.10 You see Complex Alcohol services isn't.
DM

3.11 Yes
ER

3.12 Urmm (pause). But I feel, you know. I do feel very much. I know
3.13 you've got different, different sorts of clients, clients/patients what
3.14 ever you call them. But I know because I've been going on a
3.15 Wednesday morning to the abstinence group and one of the
3.16 workers there was saying, you know that they have some really
3.17 awkward patients and they also have patients who go in for detox
3.18 and they take orange juice in with them which has got vodka in it
3.19 (laugh)
DM

3.21 Yeah
ER

3.22 And I said well surely if they are in for detox they want to detox.
3.23 Well she said, the probation service people send them so they've
3.24 got, they're not necessarily volunteers.

DM

Right, so that's really interesting. So again it sounds like you're contrasting that with the thing you said before which is about the sense of personal motivation to change.

ER

Mmm

DM

There were lots of things and you talked about your boyfriend nagging you and that not being helpful?

ER

Mmm, yes, no that wasn't. Anybody nagging to be honest is not helpful. Urm if I look back how could people of done it. Now when I look, you know. When I sort have a bit of a clearer mind, a sober mind, when I think how could people have helped. I would say the thing to do it was perhaps a total distraction. You know an activity that is totally different. I mean people say when they give up smoking they turn to eating sweets. Now I've gone for, (laugh) I've gone to eating ice cream.

DM

Right

ER

I, you know, but I was told that when you stop drinking you quite often get sugar cravings because you're missing the sugar and the alcohol, but I would, I would think best way people can deal with it, be total, you know distractions. Something totally different.

DM

Yes

ER

I mean alcohol just doesn't feature in my life now.

DM

So what's that distraction been for you?

ER

Eating the ice cream (laugh) or swimming.

DM

So just

ER

Exercise!

DM

So do you use, it sounds like, what you're saying is you need to find that alcohol sort of acts as this reward and you, you need to find something else that replaces that, is that what you're saying with the ice cream?

ER

Not exactly, urmm (pause). No, urmm that I know. I do have a craving for sweet things.

DM

Right

ER

But I don't think there is much I can do about that at the moment. I think that will happen, urm but now I just (pause). Now I just reward, it's little things like. I used to think if I had an appointment you know, a doctors appointment or a dentist appointment in the, late in the afternoon, I used to think when am I going to get my first drink.

DM

Yes

ER

It sort of, it comes, that's what I'm saying, it controlled me. Now it doesn't matter. You know, I can be perfectly presentable and I don't stink of alcohol.

DM

Right

ER

You know, so, So no but I have, you know, but yes I am doing something different. I found, you know I have to be, I've always been a doing person. I have to do things, urr but yes.

DM

So keeping busy is important then is it?

ER

Yes I think it is.

DM

Right

ER

I mean I think (pause). You see, I, I don't know if I were to sit in the flat and do nothing, I don't think I would turn to the alcohol because to be honest with you I don't like the smell of it anymore.

DM

That

ER

I've just gone off it.

DM

Yeah, that comes across very strongly. That's interesting. I've heard that a lot from other people.

ER

6.12 Have you?
DM

6.13 Yes. I have actually heard it from people who continue drink.
6.14 They say I don't like the drink, I just can't give it up, which is
6.15 interesting.
ER

6.16 Mmm, no because its funny, because one of the questions I asked
6.17 when I went up, when I first went to, not sure if it was last August
6.18 or Complex Alcohol services, I think probably both. I did ask,
6.19 because obviously the aim was eventually to come off the drink.
6.20 Originally I wanted to (pause), I didn't actually want to be
6.21 abstinent, I wanted to drink within government guidelines.
DM

6.22 Yeah
ER

6.23 You know, you know be able to have a social drink. You know say
6.24 two units a day or something like that , and urmm and I did ask the
6.25 question if I did give up, would it be, would I be able to have a
6.26 drink. Because my daughter who, she's got, she's actually got a
6.27 PhD. She did it on Diabetes and she said she didn't think I would
6.28 be able to drink socially again and I asked the question and they
6.29 said to me everybody's different. Some people can, some people
6.30 can't.
DM

6.32 Mmm
ER

6.32 A lot of people choose not to, urr definitely they said the first three
6.33 months a no no. Urmm No, I don't, I don't know. I don't think I'm
6.34 far enough down the line to think can I or can't I. You know my
6.35 next, urm. The way I see it now, my next hurdle will probably be
6.36 Christmas.
DM

6.37 Yeah
ER

6.38 Urm, but I've decided, well being Polish. Our Polish, our
6.39 Christmas is Christmas Eve. I've decided Christmas Eve and
6.40 Christmas day I will have a couple of drinks, two or three drinks
6.41 that's it and then that's it. I'm not bothered about the New Year
6.42 because to me its just another day I've never bothered anyway
6.43 (laugh)
DM

7.1 So it sounds like you, you're planning which sounds very positive.
7.2
ER

7.3 DM Yes, but I am also planning that I am not going to.

7.4 ER Umm

7.5 7.6 7.7 7.8 7.9 DM You know I will be very very strict about that and I think I will be because I have battled for a while with it and a lot of the time, you know when people were nagging me. To be honest with you I didn't really want to give it up because ok, you know, they say it's a depressant, but it does mask the symptoms.

7.11 ER Yeah

7.12 7.13 DM I could you know, I could go, you know have half a bottle of wine and sleep in the afternoon and you know, I was in oblivion.

8.1 ER And what was good about that?

8.2 8.3 DM It was very temporary. So that wasn't good. What was good, I suppose it gave me temporary relieve.

8.4 ER So it was very

8.5 DM So you see, yeah

8.6 ER And the falling asleep it sounds like what you're saying.

8.7 8.8 DM Well, that's when I say I've got to do something. I can't sit around doing nothing.

8.8 ER Mmm

8.9 8.10 DM And obviously I'm not falling asleep now in the afternoons, so you know, I've got to do something positive.

8.12 ER Right

8.13 DM Like looking for work (laugh)

9.1 And is that something you are doing at the moment?

ER

9.2
9.3
DM Yes, aha. Yes, I'm looking at retraining as well. Well lots of things up in the air at the moment.

10.1
10.2
ER Can you tell me a little bit about the support that you're getting around that and how that helps?

10.3
DM The what?

10.4
10.5
ER The support, because you were talking about looking for a job, retraining?

10.6
10.7
10.8
10.9
10.10
DM Well I don't, I have applied for a couple of courses so I don't know. I mean I did, I was teaching urm. I don't in actual fact want to go back into teaching full time, teaching children. I am looking now at teaching English as a second language to adults on a part time basis. That is one of the courses I've applied to go on.

10.12
ER Oh right.

10.13
10.14
10.15
DM So you know, I'm looking at teaching adults and also life skills, teaching life skills to adults, you know I'm looking into that.

10.16
EW Aha

10.17
10.18
10.19
10.20
10.21
10.22
10.23
10.24
DM And yes, I mean I do look, I am looking for work, but there isn't much around but also I think now, whereas at one time I would have thought whilst I was still drinking I would have thought ohh you know, take any job. Obviously not many people are going to want to employ an alcoholic. Urm but now I think I've got self esteem and pride back. I think I want to do something that I want to do. You know, its not a case of anything will do because it won't.

10.30
ER Mmm

10.31
10.32
DM You know, and I'm sort of assertive and I think you know I'll hold out to that.

10.33
ER Right

10.40
10.41
And if it doesn't, you know, it will come along one day and if it doesn't you know.

DM

10.41 Yeah
ER

10.42 That's it.
DM

11.1 So getting your self esteem and your pride back and a feeling of
11.2 self.
ER

11.3 Mmm
DM

11.4 Sounds very important?
ER

11.5 It is. You see this is something that was never really pointed out
11.6 to me before. It was always nag, nag, nag, nag, nag. Even at
11.7 Complex Alcohol services they didn't really say, they did say it
11.8 would probably help with my sleep problems, help with my
11.9 depression. Urmm, say initially, initially it hasn't helped with my
11.10 sleeping problems. Urm, but I know that that's a temporary thing.
11.11 It will do. Urm, but they never, that side of it was never put over to
11.12 me. I don't think that the positive side was put over sufficiently.
DM

11.14 Right
ER

11.15 For me to, you know, take note.
DM

11.16 Mmm
ER

11.17 Yes they were full of you know different suggestions and
11.18 everything but I don't think even the key-worker, you know she did
11.19 say the oppression and the sleep, but never mentioned things like
11.20 self esteem and being able to do more. Because I can I've got
11.21 more energy.
DM

11.22 Right
ER

11.23 Basically. I don't just mean physically energy, I've got more
11.24 mental energy. I can concentrate for longer.
DM

11.25 Ok
ER

11.26 Yeah

DM

So that sense of well being, how does that help?

ER

Yes, yes I do, I feel much better. Say physically and mentally I just feel much better. And as, there are two sides to it as well which I suppose there are for most people, urmm. There's the negative side of it, I could kick myself for how long I've been doing it for and what it's done to my help. I mean ok fortunately you know my liver is still at the point that it can repair itself. It's not beyond repair. My kidneys and pancreas are fine. It could have been much worse, but I've been quite lucky. But I've looked at what it's done to family relationships, what its done to my health, what its done to other people, like you know that's negative side of it. On the other hand you know, I think you can't, you can't turn the clock back. You know as my daughter said to me you know and believe you and me she has nagged me in the past and she said well there's no point going over the past you've done it now.

DM

Right

ER

So you know, so.

DM

Is that helpful?

ER

Yes, but (laugh) there is also the other side of it. Some people are a little bit too condescending. You know, I mean my son laughs at me because, in fact I'm going over to see him after I've been here, but he, I query whether he was in actual fact alcohol dependent but he was certainly a very heavy drinker, urr and he gave up, he gave up smoking and he gave up drinking straight away. He went on the antabuse.

DM

Right

ER

Urmm and you know when I asked him for some support, you know he just said to me oh just stop drinking, you know just like. Just stop drinking because that's what he did, but now you know he says ohh I never, you know sarcastically, he says I never thought you'd do it for this long. He said I never thought you'd last that long, but he says you've done it now, you've done it. But urm, people could be quite condescending, you know oh.

DM

Yeah

ER

You must feel so proud of yourself, you know how have you done it and some you know. I think they are, I think they mean well. I

13.22 don't think, you know but.
DM

13.23 Yeah.
ER
13.24

There is a fine line.
DM

13.25 I think that comes across quite strongly. You talked a lot about
13.26 being patronised.
ER

13.27 Mmm
DM

13.28 And a lot about you know, you use the word patronising and
13.29 condescending.
ER

13.30 Aha
DM

13.31 A number of times throughout our conversation so far.
ER

13.32 Mmm
DM

14.1 Can you tell me a little bit more about why you think that? I
14.2 doesn't help or?
ER

14.3 Well I don't, I look at it and what terms of what I've done. Yes, ok.
14.4 I'll give myself a pat on the back. I have done well but on the
14.5 other hand I'm really just normal now (laugh)
DM

14.7 Yeah
ER

14.8 I've not achieved anything so fantastic, you know, may be yes. I
14.9 know a lot of people struggle and I suppose in a way. To cut a
14.10 long story short my illness has now been diagnosed, it is migraine
14.11 that I had, well that I've got. It's being treated now. Urr, but
14.12 (pause) I don't sort of see myself as, well I don't know what the
14.13 word is that I'm looking for (pause). I don't see myself as
14.14 something on a pedestal, do you know what I mean. I just think
14.15 I've done something I should have done a long time ago really.
14.16 Yes I'm pleased about it.
DM

14.18 Aha
ER

14.19 And as I say, I curse that I didn't do it sooner, but

DM

Can I just point out one other thing which you've said which is mmm, you mentioned on a number of occasions and you clearly are very knowledgeable about your physical health, particularly in relation to your drinking, urm so (pause) has that helped? How, how has that helped in sort of knowing what your liver function's like and that your pancreas is ok and finding out about your migraine, those things, how has that helped?

ER

Well you see in a way it was, well the migraine is very recent, although we don't know, I mean I may have had signs of it before, urm it was diagnosed recently but you see the knowledge that my pancreas was ok and my kidneys were ok and that my liver, although the liver function was not good, it was not beyond repair. At one point, urm it was a bit of, cosy in a way I thought to myself well I'm ok here, you know and I've not got any pain. I've not got any symptoms or anything like that. Looking at my friend with the pancreatitis, you know she was doubled over. So in a way that wasn't terribly helpful. I don't know how I would have reacted had somebody said to me right you know if you don't stop drinking now you will die.

DM

Yeah

ER

I probably would have stopped drinking then. I honestly don't, I don't know because I wasn't in that situation. But now I think to myself well I've been lucky, you know my liver function's not good. I have got a bit of scaring on it but it's not beyond the point of no repair. So I can, you know, I can do what I can do.

DM

Yeah

ER

And I feel you know, that that is another incentive really and its not just my liver its my more being and everything. Also I wasn't. I don't know whether this is, it probably is, I had whilst I was drinking, I had very, very little appetite, urm my GP said it was because I was getting all the calories from the alcohol, which is logical. I didn't fancy any food. Now its gone the other way, you know I'm really, I am eating above, I've got this thing now that I'm no longer putting this poison into my body, I'm not going to put any other poison into it either so I'm really well and truly into healthy eating.

DM

Yeah

ER

You know

DM

16.1 Is that a new thing?
ER

16.2 Pardon?
DM

16.3 Is that a new thing?
ER

16.4 I've never really been full on healthy eating to be honest with you.
16.5 I've always eaten fairly healthily, but I'm more, you know I won't
16.6 even have a Chinese takeaway now. I'm more. Don't get me
16.7 wrong I'll have what I enjoy.
DM

16.8 Yeah
ER

16.9 Within reason but I am quite careful now. Much more so than I
16.10 was. I make sure, whereas before I probably did have my five a
16.11 day, well I didn't whilst I was drinking. But I certainly do now. I
16.12 make sure I do.
DM

16.13 Right
ER

16.14 You know I am quite conscientious with that and that's probably
16.15 also urm helping me feel better.
DM

16.16 Yeah
ER

16.17 But if a body's got no fuel its got no, I mean I don't think alcohol is
16.18 very good fuel for us.
DM

16.19 Mmm. Ok. That's brilliant thank you.
ER

16.20 Laugh
DM

17.1 Is there anything else you want to tell me about that you think oh,
17.2 you haven't covered or you haven't discussed, because you've,
17.3 we've covered quite a lot of ground already?
ER

18.1 I don't know, urm. I'd be interested, you say you've got people
18.2 who are residential detoxing?
DM

18.3

Yeah

ER

19.1 On average how long have they been drinking for?
DM

19.2 Various usually. Mmm there are mmm. People that tend to get
19.3 residential placements tend to urr have much more complex
19.4 problems. So they might be drinking a lot, not have anywhere to
19.5 live, urm but they tend to be very much at their, a later stages and
19.6 urm, so they, they urr they tend to have a lot of complex problems
19.7 and I think because they can't urm help themselves, can't sort
19.8 things out in the community themselves, urm that they will end up
19.9 as an inpatient spell. So they, a lot of them I would say have been
19.10 drinking for a long time. Some many years, some you know many
19.11 months.
ER

19.12 Aha
DM

19.13 Mmm, so it's not how long they've been drinking its more how
19.14 (pause) urr complex their problems are.
ER

19.15 Aha
DM

19.16 But they only stay generally for a week or two no longer.
ER

19.17 Yeah, aha. Yeah, no I mean. I just feel lucky that I've got out of it
19.18 when I did. Because I, mean to, I was bad but I am sure there are
19.19 people a lot, lot worse than me. Not that I'm, you know, excuse
19.20 but I mean I am trying to be very positive because as I say on the
19.21 one hand the thing that really does, I am annoyed with myself for
19.22 having gone on for so long. Urm fortunately, (pause) it's been,
19.23 you know, managed to get round it, you know. Family
19.24 relationships have much improved and everything. I'm allowed to
19.25 babysit for my grandchildren now and this sort of thing so, you
19.26 know.
DM

19.28 Yeah
ER

19.29 That's good!
DM

19.30 And did you see that, had you seen that as an incentive in a way,
19.31 that because you are able to have more positive contact with your
19.32 family and grandkids
ER

19.33 Urrr

DM

19.34 That that helped?
ER

19.35 Yes and no because as I said at the beginning I think you've
19.36 always go to do it for you, for yourself.
DM

19.37 Right
ER

19.38 I think it was really for me. Yes it, yes I could see that you know.
DM

19.40 Yeah
ER

19.41 Urm, I suppose it was but you know at the end of the day I did it
19.42 for me and I did it at a time that was convenient and I was helped
19.43 along with my illness but I mean I was already booked in to going
19.44 for detox.
DM

19.45 Yeah
ER

19.46 So it was just coincidence how it happened.
DM

19.47 Ok, great. That's brilliant thank you very much.
EW

19.48 (laugh)

8.6. Appendix 6 Example Practitioner transcript

DM
1.1 Right, ok Martin. Thanks very much for coming today. What I'm
1.2 doing is urm asking people to tell me stories or tell me about their
1.3 experiences I suppose of urm what they see as facilitators or
1.4 barriers to recovery in dual diagnosis.
M
1.6 Ok do you want me to elaborate on that now?
DM
1.7 Mmmm
M
1.8 What we see as facilitators or barriers to urm. Ok I suppose
1.9 some barriers are sort of people's perception of what dual
1.10 diagnosis is and of clients with dual diagnosis. A big one of
1.11 those is I suppose staff attitudes, urm what staff think about dual
1.12 diagnosis, sort of you know going back to the whole thing about
1.13 staff on the ward sometimes thinking that patients its just a drug
1.14 induced psychosis and it passes or this is just substances and
1.15 then once those substances are out of peoples' systems that you
1.16 know its purely been behaviour related because of the
1.17 substances and you know…there's no underlying mental illness
1.18 there. So that's the big one I think, when I did the clinics, where I
1.19 do the clinics because I still see that sort of thing happening.
1.20 Urm.
1.21
DM
2 Why, do you think that is, you're saying essentially that most
2.1 people have slightly different attitude to yourself or other people.
M
2.3 Yeah I think that its not all staff, I think that there are a number of
2.4 good staff who have perhaps come out of placement with us
2.5 from some of the acute wards who that continues to happen who
2.6 you know, I think that's education on their part, how their
2.7 attitudes change then towards sort of people on the wards, you
2.8 know people present with query, sort of dual diagnosis issues,
2.9 you know they are a lot more understanding then. Mmm but
2.10 there is sort of, yeah you get a number of staff who are quite
2.11 fixed that its just sort of substances and behaviour related and
2.12 there's no real underlying mental illness because perhaps their
2.13 behaviour is out of order on the ward a little bit and without
2.14 explaining that to them and doing the full assessment sometimes
2.15 things can be misinterpreted, perhaps if somebody is admitted
2.16 who is of a manic presentation but also takes stimulants
2.17 sometimes, that's overlooked from the mental health side of it
2.18 and things like that and you know fine tune and that and staff
2.19 attitudes is a big one I think, massive one and I think that is a
2.20 barrier, but it seems to be getting a little bit better in areas that I
2.21 cover, chipping away, chipping away and chipping away over
2.22 periods, you know.
DM
3 Why do you think it gets better, what improves?
M
3.1 I think it's education isn't it, about teaching people about it and
3.2 what isn't, it isn't just behaviour related, it isn't just substances,
3.3 perhaps there are underlying issues, perhaps there are mental

health issues there, proper assessment. You know a real sort of, a real sort of good old assessment, not a short brief assessment really. A good assessment period. Yeah, things like that and probably loads of other things I can't remember at the moment (laugh) yeah. But I am, I mean I think facilitators is a good, facilitators to what sorry, good?

DM

To recovery.

M

To recovery. I think facilitators to recovery are sort of good involvement from a number of different areas really, not just sort of dual diagnosis, I think from sort of carers and family and their support, good recovery care package for a sort of the education/employment afterwards. Mmm social, you know support, mmm a good holistic sort of approach of after care.

DM

Mmm ha. When you say holistic what do you mean, can you elaborate for me?

M

When I say holistic I mean sort of multi-disciplinary approach to care but not just multi-disciplinary you know, sort of everything sort of fine tuned a little bit, the care afterwards, sort of what's looked at, deficits in their life which has needed addressing, which may have been a contributing factors to the relapse, you know, sort of looking at sort of. If you look at somebody's sort of before sort of what happened before they became unwell, what were the key indicators for them becoming unwell, what was sort of declining in their functioning perhaps, was it sort of something socially, was it because you know, what were the stressors, all them kind of things are looked at, but looked at by not just a dual diagnosis team, looked at via if they are with the Community Mental Health Team, if they're with sort of other non statutory agencies where that support can be offered and sort of a good care package afterwards, its massive for recovery I think. When that's in place properly rather than a little bit of input from the CPN now and then, going along and waving and saying hello and by myself as well and just doing that. I think if that's in place a good approach to case, care management's important, yeah.

DM

So do you have any specific examples that you can recall that that urm…you think were particularly illustrative of what you're talking about?

M

Yeah, I think while I'm explaining that I'm thinking of a particular guy, a young guy (cough) excuse me. Eighteen/nineteen urm first episode of psychosis was admitted to the ward, very disruptive, his behaviour is a little bit way, a little bit, very boisterous, very urm urm showing off quite a lot. Got underlying, over the period of time, quite clear mild psychotic symptoms. He was quite an unwell chap and EIP came on board, then appropriate worker came on board, a male worker which suited this guy, urm he was, he was really unwell, quite psychotic when it was drugs underneath. At first he was seen by sort of other teams who didn't believe he was unwell, quite dismissive of him, crisis team didn't want to see him, they say "*just drugs and that, its just, bad behaviour and when the drugs are gone there's no mental illness".* With a longer period of assessment with EIP and

the Dual Diagnosis team it was considered he was quite unwell, this guy was really quite bizarre and psychotic behaviours he was displaying quite guarded and when he opened up you know he was more trusting of us and worked with us well, so EIP came on board, where he urrm.. his worker, they set up sort of vocational activities with him, social activities with him, sport and stuff. He worked well, he was integrated and worked well with us, got links to the colleges, he was at the University before he became unwell, mmm slowly but surely that's getting back on track with him, he's now reducing his meds. It's just worked really well that whole package of care from the psychologist as well. Mmm his family are more understanding of his illness now, because I think at first they put it down to more of drug related behaviour and they can see now that it wasn't perhaps just that. Perhaps he was using drugs to cope with more what was going on for him, rather than drugs creating the problems and they are really on board, very supportive and things are looking ok for him. It's quite nice now and then to have a bit of a success story really like that.

DM

Mmm

M

It's going well for a young lad who is an intelligent chap and knows, you know he's working well, engaging really well. That for me is one of the better sort of, what's the word I'm looking for, an example of recovery and recovery working well, where everyone is working well together and really supporting him. Now he's involved in it, his family everything. No statutory agencies are great.

DM

So you mentioned the crisis team, so you're sort of saying well actually, you seem to be saying their response wasn't optimal.

M

No

DM

Can you tell me a little bit more about that?

M

It's something that we come across, urm quite a bit, in the sense that I appreciate their impression and things like that but I think.. is that because of the amount of work that they have that they see this, they see perhaps behaviour related to drugs and alcohol and at times when there isn't perhaps underlying mental health problems and the crisis team have to intervene but then they judge too quickly when a genuine dual diagnosis comes along, without sort of checking it out, without a thorough in-depth assessment because perhaps they haven't got time to do that.

DM

Mmm

M

They haven't got the resources to do that. But sometimes I think people can be fobbed off a little bit too quickly really, and yeah, I have actually seen it in the past with a number of ours that you know, if we needed to put referrals in for weekends and things like this with crisis, I think they are a bit reluctant because they hear drugs and alcohol and just say no. Rather than hearing the mental health side of it. Rather than this uses his drugs and alcohol to cope with what's going on for him, it's so that you

6.21 know, the drugs and alcohol are a small part of it, you know so
6.22 that again is the sort of education needs for the crisis team which
6.23 we, you know, continuously try to chip away at and things like
6.24 that, and its ongoing, you know.

DM

6.27 Mmm

M

6.28 That's been historic I think.

DM

7 So that sense of not only urm having a holistic team approach
7.1 but actually being able to see the picture of the person, the whole
7.2 picture of the person, so may be you seem to be contrasting the
7.3 sort of snap shot that the crisis team have with, with the wider
7.4 team that has this kind of lengthy experience of an individual.

M

7.6 Yeah, yeah you know, its hard because it sounds like I'm
7.7 apportioning blame to the crisis team for that, but its not, it's, I
7.8 appreciate the sort of pressures they're under and perhaps they
7.9 have to triage the paperwork they treat and then face somebody
7.10 on Trent Bridge, you know quite psychotic or there's somebody
7.11 who is, do they have to make that call at that particular time and
7.12 sort of you know. Its difficult to see without you know

DM

7.14 Yeah

M

7.15 But it's frustrating for us as well because sometimes it's
7.16 frustrating for us as well because sometimes we're almost
7.17 dismissed, it's not a very nice word but as they see it, this is just
7.18 drugs and alcohol and a bit of disruptive behaviour, we're time
7.19 wasters. This guy uses a bit of drugs and alcohol because his
7.20 mental health is so bad, this is just the way that he copes with it.
7.21 So I think you know getting that across to people will take more,
7.22 sort of, education, teaching them to get that understanding I
7.23 think.

DM

8 Ok, so in your example you also mentioned that the family began
8.1 to understand that may be drugs were being used by that
8.2 individual as a coping mechanism.

M

8.3 Yeah

DM

9 Tell me a little bit more about family support, because family
9.1 issues are something that come up quite frequently in the
9.2 interviews?

M

9.3 Well I think your normal response to the sort of person in sort of
9.4 England or whatever may be ahhh! They are using drugs and
9.5 alcohol and if it's a young lad, he's gone off the rails, its
9.6 behaviour, get him out of the bloody house, kick him up the arse,
9.7 sort himself out type of scenario and you know without that
9.8 education and, I think to bang on like a politician, education,
9.9 education, education but I think a big part of it is that and about
9.10 sort of, you know they used to do urr family work for
9.11 schizophrenia didn't they, a little bit about educating people
9.12 about the illness and I think a similar sort of thing is that what we
9.13 do is we educate the families about why they may be using the
9.14 drugs and because of dual diagnosis and telling them about that,

9.15 is that often people are coping with the symptoms that they've
9.16 got and that's the only thing that they find to cope with those
9.17 symptoms, so when the families get a better understanding of
9.18 that, obviously they are far more understanding towards their
9.19 siblings and, you know, are prepared to work with them and the
9.20 understanding is there, its developing understanding isn't it I
9.21 think.
DM
9.24 Mmmm
M
9.25 You know what the illness is and in depth some reasons why
9.26 they use the drugs that they do. So when that's done, I think
9.27 things are a lot smoother and families work with you a lot better
9.28 really.
DM
10 So you work frequently with families?
M
10.1 Urrr yeah. I would say I do yeah, yeah. Quite a few families,
10.2 yeah.
DM
11 Can you tell me a bit about an intervention that you've had with a
11.1 family that's been particularly productive?
M
11.2 Mmm I suppose, I suppose it's about one perhaps yesterday,
11.3 about family members all in a review. Mmm were quite unsure
11.4 about the medication that somebody was taking and explaining
11.5 why that medication is used and the way it's used. You know
11.6 and giving them a better understanding of it.
DM
11.8 Mmm
M
11.9 Is one way. Yeah. You know because although you know there
11.10 was a push a while ago for families and carers to understand
11.11 about different medications I think sometimes that slips and but
11.12 that just little bit of educating the family yesterday from a meeting
11.13 with the client's consent about what the medication is, why it's
11.14 used, Naltrexone. Urm gave them a better understanding really,
11.15 and you know
DM
11.17 Mmm
M
11.18 Because they thought it was some quite horrific drug, with
11.19 massive, massive side effects and you know, compared to a lot
11.20 of others, you know its not that bad.
DM
11.21 Mmm
M
11.22 So that was good and worked quite well but you know they were
11.23 quite anti-services, sort of thing, and a bit of understanding and a
11.24 bit, sort of, allaying their fears really and things like that works
11.25 well.
DM
12 Ok. So in your previous example you were talking about getting
12.1 people involved in football and
M
12.2 Yeah
DM

13 And a whole load of activities and things like that. Again a lot of
13.1 people have talked about that idea of social support or social
13.2 capital, I think sometimes its called, mmm how important is that?
M
13.4 I think its massive, I think that's a massive part of it. I think its
13.5 massive because its not isolating people within mental health
13.6 services its yeah, reengaging people with the community isn't it.
13.7 I think it's a big part of it, some part.
DM
13.9 Mmm
M
13.10 So it's normalising. It's not sort of taking people away from it and
13.11 sort of isolating them with the mental health services, it should be
13.12 done within the community and accepted and you know, yeah
13.13 and there's massive benefits from it which is, with the, with the
13.14 Notts County sort of football thing which you know a lot of clients
13.15 from, sort of, EIP go along which is proved to be really good.
13.16 Where they have an education programme on there as well and
13.17 they have the football, but they have, like, workshops for maths
13.18 and things like this and they themselves integrate back into
13.19 colleges and things like that. I think stuff like that and getting
13.20 back, like with the recovery college and the links to sort of you
13.21 know the Unis and things like that, it's massive.
DM
13.24 Mmmm
M
13.25 Yeah, because its normalising stuff, its back into sort of main
13.26 stream rather than being taken away and, sort of, isolated and
13.27 people just thinking that they're in mental health services.
13.28
DM
13.29 Mmm, mmm. So that sense of integration and normalisation is
13.30 really important?
M
13.31 Yeah, yeah.
DM
14 Why?
M
14.1 Because that's gives them a sense of purpose, wellbeing, back
14.2 into normal life. So people have a normal life as possible.
DM
14.4 Mmm ha
M
14.5 When they may have been away from that for so long, they meet
14.6 people, they engage, they socialise, like what we would view as
14.7 perhaps, again, normal.
DM
15 Ok, thinking about your work and all the people you meet both
15.1 practitioners I suppose you meet, you talked about the ideas
15.2 there is a sort of attitude and people's perceptions, you started
15.3 off talking about that, what do you kind of think of optimal or sub
15.4 optimal urm attitudes, what do you think influences that?
M
15.6 Do you mean what's the best kind of attitude to have, sort of,
15.7 yeah?
DM
15.8 Mmm

M
15.9 I think its sort of having an open mind to the client really and not
15.10 being so judgemental, being as open and understanding as you
15.11 can regarding substances and the mental health and the way
15.12 they interact and if you know practitioners are like that, you
15.13 know, you're on to a winner already aren't you, I think. With
15.14 treatment, if they're going to be a lot more open because barriers
15.15 do come up, you see it a lot in day-to-day things which some of
15.16 the care co-ordinators, they are pretty fixed really regarding their
15.17 views about substances, it's still there. A fair few people have
15.18 those ideas, still fixed about it. Urmm but then when you do
15.19 come across a care co-ordinator who is really quite open and
15.20 sort of understanding and has an interest and has an interest in
15.21 dual diagnosis as well is a big thing because there are a lot
15.22 more, sort of, open to ,sort of, what we may suggest and come
15.23 along with those suggestions themselves and it just works, its far
15.24 easier. Yeah.
DM
16 Because you talked a lot about education being important
M
16.2 Yeah
DM
17 If you educate people, people seek out education, that can often
17.1 help with changing their attitudes?
M
17.2 You can see with the people that have come along to, sort of,
17.3 dual diagnosis training, the link workers mmm you can see all
17.4 those people are, you know, it makes our work far easier
17.5 because of the sort of work that we've done and sort of dispelled
17.6 a lot of myths, perhaps around people who use substances and
17.7 why they perhaps use substances and things like that and the
17.8 work is a lot easier and you can see that people have a better
17.9 understanding and because of that, the training, the education,
17.10 yeah. You can definitely see it over sort of, over time and sort of,
17.11 you get a lot more people, there's a certain core group who will
17.12 attend all those sort of things that you were after, obviously must
17.13 have more of an interest in it and are willing to be a bit more
17.14 open. I remember one guy who was particularly, I remember him
17.15 from the wards when I was younger, being very black and white
17.16 about substances urr, quite the macho guy on the ward, his urr.
17.17 He attends all the link worker events now and is quite sort of,
17.18 he's said quite honestly himself that yeah, he's a little bit more
17.19 open to it and a bit more understanding now and he enjoys the,
17.20 you know, the training on dual diagnosis, bits to do with basic
17.21 awareness and all that kind of stuff.
DM
17.25 Mmm
M
17.26 So it does, I think it does sort of, it must change peoples'
17.27 perceptions I think.
DM
17.28 Mmm
M
17.29 I think that's a big part of it yeah.
DM
17.30 Mmm. Why do you think people come holding those ideas, do
17.31 you have a sense of where those perceptions or attitudes stem

17.32 from?
M
17.33 I think its from, say for instance if it's a nurse, I think its learned
17.34 behaviour, if they've learnt and followed the career path of,
17.35 they've worked on acute and then they've worked in somewhere
17.36 else and then, it used to be that you develop the attitude or
17.37 there'd be a lot of older nurses around there who were quite fixed
17.38 in their beliefs about substance users, *"bloody druggies,*
17.39 *whatever",* this is about behaviour that's all it is.
DM
17.41 Mmm
M
17.42 And it gets ingrained, I think people who get 'burnt-out', who are
17.43 working on really busy wards, sometimes it's an easier way of
17.44 dealing with people, rather than, sort of, taking on board a lot
17.45 more complex piece of work, more you know, urm more in depth
17.46 assessment things like that. Sometimes they haven't perhaps got
17.47 the time to do that, its easier to develop them sort of attitudes
17.48 because it saves time, this person can be discharged.
17.49 Somebody with a personality disorder, its just behaviour related
17.50 because of the drugs that they use, so yeah, its inherited. I think
17.51 and its learnt behaviour over time. And the system creates that I
17.52 think with some people.
DM
18 Mmm. What do you think that there are, other things that
18.1 influence practitioners attitudes that, so you, kind of, said
18.2 education, better training, the attitude of others around them, is
18.3 there anything, when you think about the people, again thinking
18.4 about the people that you work with who you think are really
18.5 good and actually have a very positive attitude and then thinking
18.6 about other people that are less positive?
M
18.8 Yeah I think that's a massive influence, somebody perhaps who,
18.9 say if you had somebody on a ward who, one nurse had a really
18.10 positive attitude and was working really well with that client and
18.11 you could see they were making gains with them, with their sort
18.12 of progress, that will influence other practitioners I think.
DM
18.14 Mmm
M
18.15 You know rather than, sort of, a negative approach which isn't
18.16 working, people are going to pick up on that. Hopefully that kind
18.17 of attitude, you know, more positive, sort of, engagement with
18.18 somebody is going to rub off on a lot of people isn't it
DM
18.20 Mmm
M
18.21 Because they're going to get results.
DM
18.22 Mmm
M
18.23 You know and I think that does happen at times yeah, you do
18.24 see that. You see that with, sort of, with the link-workers working
18.25 with people on the ward. urm I think their attitude rubs off and is
18.26 starting to rub off on a lot of different workers…… just the way,
18.27 the way, in which they engage with people, clients.
DM

19 Ok, I'm just scribbling myself a note down here because I think
19.1 what you've just said is really interesting, the idea of the
19.2 environment that people work in, the environment that their team
19.3 creates, the attitude of environment I suppose.
M
19.5 Yeah
DM
19.6 Mmm.
M
19.7 Yeah, I think it does, I think, you know. Its learned isn't it. If you
19.8 are a newly qualified nurse coming onto a ward with urm sort of
19.9 old nurses who've been working there for many years, who take
19.10 these people under their wing and say *"forget about all that, this*
19.11 *is the way that it works, this is the way that we get things done*
19.12 *on this ward, this is the way we get things done in this team*", you
19.13 know, that won't work, believe me I've been trying it for years.
19.14 It's a massive influence on somebody and sometimes it's hard to
19.15 change that. People are fearful to try and change that because
19.16 they are 'rocking the boat'.
DM
20 Mmm, because you sort of mentioned urm the older, more
20.1 experienced, longer in the tooth nurse.
M
20.2 They may not be more experienced but they are old, longer in
20.3 the tooth.
DM
20.4 Yeah
M
20.5 Yeah and you sort of see that.
DM
21 Isn't that us now then Martin (laugh)
M
21.1 Yeah but we're not un-experienced (laugh)
DM
21.2 (laugh)
M
21.3 Yeah I'm older, yeah (laugh)
DM
21.4 (laugh)
M
21.5 Just sitting here I've got to get my grey hair cut this week.
DM
21.7 But I think, you know, you sit there and you think, he's an older,
21.8 slightly stick in the mud nurses, but there are a few of them,
21.9 we're getting rid of various people now.
M
21.10 Yeah but there is, you know what I mean, there are the ones out
21.11 there who are really quite black and white. Not prepared to look
21.12 outside the box. Not…… They are quite rigid in the way they
21.13 work.
DM
21.14 Yeah
M
21.15 And they are, sort of, set in their ways to a use of a word but
21.16 there is a lot of, you know, older nurses like ourselves who aren't,
21.17 who are open minded as well.
DM

21.18 Yeah
M
21.19 But you do still come across those ones and they make life quite
21.20 difficult I think. They can be a big influence on people who are
21.21 motivated, urm who want to come in, who want to work, sort of,
21.22 you know, more openly and, sort of, client focused and things
21.23 like that. You know you, sort of, see that.
DM
21.25 Mmm
M
21.26 You know, I think.
DM
22 But it's interesting because just hearing you speak and thinking
22.1 back to one of the interviewees who is a ward manager who I
22.3 was talking to and he was talking about you know the idea of that
22.4 difficulty, that tension between being a therapist and having to be
22.5 kind of the unit policeman, so you know you catch somebody
22.6 using drugs and you have to do something to respond to that.
M
22.8 Yeah
DM
23 But you're also trying to maintain and even develop a therapeutic
23.1 relationship with that individual.
M
23.2 Yeah
DM
24 But it was interesting because he kind of, he said, he gave a
24.1 specific example of you know going home on a Friday evening
24.2 and perhaps having one too many beers and kind of reflecting on
24.3 that and thinking, I'm just kind of behaving in the same way and
M
24.5 Yeah
DM
24.6 And I found that very interesting.
M
24.7 Yeah, definitely. Yeah.
DM
25 And I guess, I suppose I'm quite interested in individual's
25.1 experiences, you know both in work and outside of work as well.
M
25.3 Yeah
DM
26 Because it seems almost that peoples' personal experiences
26.1 whether it's in the first person or whether it's the third person can
26.2 really significantly influence their attitude, both negatively and
26.3 positively. So for example if you'd got a brother who used drugs
26.4 like I have
CM
26.5 Yeah
DM
27 Then that clearly influences my thoughts and my attitudes.
27.1
M
27.2 Yeah massively, my brother smoked cannabis and I still think he
27.3 does dabble for you know, but he smoked massive amounts for
27.4 years and years, my younger brother, so that's a big influence on
27.5 the way that I work because you always have in the back of your

27.6 mind, hang on what would I want my family or my sibling to be
27.7 treated like this and I think it's always a grounder that is to sort of
27.8 remember those kind of things.
DM
28 Mmmm and so, just reflecting on that then, can you think about,
28.1 you say there are times when you are actually working with
28.2 individuals and you kind of reflect on your own family experience
M
28.4 Yeah
DM
29 What is it that, kind of, influences you most when you think about
29.1 those things?
M
29.2 Urm I suppose it's a developing an understanding of why they
29.3 might do that and I think you can develop an understanding as to
29.4 why people may, because you've had perhaps within your own
29.5 family or you've perhaps done it yourself a little bit in the sense
29.6 of, I'm not particularly bothered if this goes on my record
29.7 because I'm not mentioning any names but I split from a
29.8 relationship recently so when I first, all a bit of a shock, I suppose
29.9 I drank a little bit too much and I was really conscious of it, over a
29.10 period of the first month-month and a half, I recognised that my
29.11 alcohol was going up, so I was monitoring it, perhaps doing my
29.12 own little control check but it was easy to come home to a house
29.13 that was empty at night and have a bit of a beer and knock
29.14 yourself out of it, you know so it was going from one or two
29.15 glasses to perhaps 2 or 3 and things like this and knocking it all
29.16 up, whereas I wouldn't usually drink that much in the week.
29.17 I started to see it escalate a bit. So you understand why and why
29.18 people use it perhaps to cope or not to cope or to block things
29.19 out, knock themselves out and recognising that and developing
29.20 that kind of understanding as to why people do it, you know
29.21 is,…… It's important, isn't it?
DM
29.25 Mmm
M
29.26 If you do it yourself you can understand people a bit better as to
29.27 why they do it, why they need or they want to do it you know so
29.28 yeah, as with my brother and sort of seeing him do it and the
29.30 reasons why he was doing it to the extent that he was, yeah I
29.31 think it just gives you that better understanding doesn't it?
DM
29.33 Mmmm
M
29.34 A little bit more of understanding in a way that you practice it.
29.35
DM
29.36 Mmmm
M
29.37 But you're alright I'm not drinking too much (laugh)
DM
29.38 (laugh)
M
29.39 He says to his boss (laugh)
DM
29.40 (laugh)
DM

29.41 So I mean and I really value that personal experience.
M
29.42 Yeah
DM
30 I mean I suppose it's, you could actually say its just another type
30.1 of prejudice…….. just a positive prejudice in many ways?
M
30.3 Yeah
DM
31 What do you think about that?
M
31.1 I, explain to me what you mean by it?
DM
31.2 Well you know there is often a criticism isn't there about why we
31.3 treat people in a given way or perhaps a criticism, more of a
31.4 tension, about the way people would treat people in substance
31.5 misuse services, do we use a particular ethos, do we think about
31.6 should we be forcing abstinence or should we be, should we be
31.7 you know encouraging people to map out their own journey
31.8 which includes, perhaps taking abnormal behaviour or
31.9 perspective where abstinence isn't important its how you improve
31.10 your own well being and what your recovery journey is like, what
31.11 your milestones are that you're meeting.
M
31.13 Yeah I think its got to be individual hasn't it. That's the way it
31.14 should be that you know you're working with, going in their
31.15 disciplinary saying you can't do this, you can't do that, its never
31.16 worked, never will work urm working with how they want to do it,
31.17 but you know urm motivational interviewing is a massive part of
31.18 that I think to getting people to sort of to climb on board with what
31.19 they want, I know what I'm trying to say.
DM
31.21 That's alright.
M
31.22 Urm you know to, but it's very individual for each person, it's not
31.23 the same but getting to help them get to where they want to be,
31.24 that's what I'm trying to say is really important and may be very
31.25 different for a different person. If they want to be totally abstinent
31.26 but, you know, different approaches for different people. It's got
31.27 to be really flexible in that sense I think, yeah. I think I've
31.28 answered it.
DM
32 Yeah, in some form. No and I think its interesting isn't it that idea
32.1 of urm a journey.
M
32.2 Yeah
DM
32.3 And how people get on at different stages of the journey.
M
32.4 Yeah
DM
33 And the different lengths of those journeys because there is a
33.1 sense these days that increasingly we're trying to force people
33.2 into a journey that is shorter and shorter. The idea is you have
33.3 this ultimate goal which is, if its not abstinence it's to become a
33.4 useful member of a society, and at very least not a burden to
33.5 society.

M
33.6 I mean for time constraints like that people have to be put into
33.7 specific sort of time zones, packets whatever you want to call it.
33.8 Urm they've got to be done by this time, they've got to have this
33.9 done by this time, their recovery has got to be started on the and
33.10 completed by then, recovery is ongoing isn't it? It always will be
33.11 ongoing and sort of you know, people will access those stages at
33.12 different times, so, its got to be individual, its got to, it can't be so
33.13 standardised and categorised for everybody. It won't be because
33.14 things will, well life gets in the way sometimes doesn't it, things
33.15 happen and that may put people back and then they've got to
33.16 learn to cope or deal with that, so that will put that journey back a
33.17 little bit, that, you know, on their way to wherever they want to
33.18 be, you know, things happen, so yeah its got to be. You know, it
33.19 can't always work like that, we can try and no matter how we do
33.20 it, get into nice neat packages but I don't think that always works.
33.21 You can, to a certain extent you can try and get to a place
33.22 but……..
DM
34 Mmm and you talked about that idea of, you know, families
34.1 attitudes, workers attitudes, potentially being, if its good, if they
34.2 are optimal then they are facilitated to that journey.
M
34.4 Yeah
DM
35 Negative attitude perhaps being a barrier which is.
M
35.1 Yeah
DM
36 And we talked a little bit about that idea of social capital, that
36.1 idea of, you know, being able to go and get involved in stuff, do
36.2 football. You talked about the links with go to football and finding
36.3 the link with the college because they're doing a maths course
36.4 and you know, they're doing something they enjoy and you know
36.5 there's like a domino effect.
36.6
M
36.7 Yeah
DM
38 In many ways. Urmm have you got any particular thoughts about
38.1 why that is, why is it that, that helps people, what it is?
38.2
M
38.3 Other people being socially integrated more?
DM
38.4 Yeah
M
38.5 Not being so isolated. That's a massive part of it I think, meeting
38.6 other people, you know because their self esteem confidence is
38.7 so low after, sort of, being isolated or suffering an illness for so
38.8 long that meeting people who may have a similar sort of, similar
38.9 sort of things happen for them, you know, seeing that they are
38.10 coming through, enjoying themselves, again perhaps not being
38.11 able to for a while, its going to raise their confidence, their self-
38.12 esteem to perhaps they can get on, perhaps they can do these
38.13 things that they've wanted to.
DM

38.15 Yeah
M
38.16 You know, getting back out there and that support, that good
38.17 human nature from support in the community it works really well,
38.19 you know.
DM
38.20 Mmm
M
38.21 Yeah I think it's a big part of it you know.
DM
39 Ok, so is there anything in particular, anything else that you kind
39.1 of think either important, what are barriers or are things that
39.2 help?
M
39.3 Off the top of my head (laugh) there's probably hundreds Dave. I
39.4 was just, yeah, there's loads, but at the moment (pause) I
39.5 suppose financial constraints will affect people, you know.
39.6 Physical abilities, you know, the people's cognitive abilities, all,
39.7 you could look at it all couldn't you individually
39.8
DM
39.9 Mmm
M
39.10 Lots of things within sort of what makes up a person, you know,
39.11 could be seen as a barrier sometimes to accessing things, you
39.12 know. So removing them and working on those barriers is as
39.13 you know in which ever way you can, you know urmm I've got an
39.14 amputee on my caseload and things like that. He's never really
39.15 had the support or accessed the clinics to go and get his leg
39.16 checked out, stuff like that and getting rid of.
DM
39.18 Mmm
M
39.19 That's a barrier for him.
DM
39.20 Mmm
M
39.21 Getting the proper leg, more of the sports leg to get sorted to go
39.22 and do what he wants to do. Its massive, massive change to
39.23 something so simple like that. That's a barrier in a way isn't it?
39.24
DM
39.25 Mmm mmm
M
39.26 You know, it's a bit of a bizarre example but there's barriers in
39.27 everything isn't there and I suppose, you know the questions
39.28 massive I think, yeah. You know if the benefits aren't right, little
39.29 things like that and you know they're all barriers to helping you
39.30 sort of progress. Because if you haven't got the right money you
39.31 can't get to the bloody bus to go and attend the football, you
39.32 know all these kind of things, they are all massive parts of co-
39.33 ordinating care and co-ordinating.
DM
40 That's a really interesting example about the issue around the
40.1 amputee and I suppose I was just going to say, ask you a
40.2 question about whether is he, is he an amputee because of his
40.3 drug use?

M
40.4 No
DM
41 Is he an amputee because he was in the army or something like
41.1 that?
M
41.2 It was an injury, just an injury and apparently they didn't nit it
41.3 back together properly.
DM
41.4 Right
M
41.5 Yeah
DM
42 I mean, I suppose just thinking because I think one of the things
42.1 that's really interesting isn't it with sports and amputees, the
42.3 Paralympics within the last year has really, kind of, changed
42.4 peoples' attitudes
M
42.5 Massive yeah
DM
42.6 And that idea of the blade runner, you know all of these positive
42.7
M
42.8 Yeah
DM
43 Mmm names that are now being attributed and I suppose as well
43.1 I'm quite interested in the idea of you know, what the difference
43.2 might be if and I think also you see it related to veterans coming
43.3 back from Afghanistan who have lost limbs, they've got
43.4 replacement limbs and there's that sort of heroic element
43.5 attributed to that individually
M
43.7 Yeah
DM
44 Or that sense and I suppose that doesn't necessarily get
44.1 attributed to those people that need openings because of
44.2 injecting drug use for example.
M
44.3 Yeah yeah
DM
44.4 Which is interesting.
M
44.5 Because that's done out of their own choice and they've brought
44.6 that on themselves and you know and very negative
44.7 conversations about that rather than this guy fought for our
44.8 country and lost his legs because of this.
DM
44.9 Mmm
M
44.10 And look how quickly he's got himself back on his feet and now
44.11 he's off to the arctic with Prince Harry, but yeah
DM
44.12 (laugh)
M
44.13 You know, its so (clap) well done yeah and yeah well done to
44.14 them, you know fair play to them, but yeah the very negative
44.15 thing that somebody's had a real shitty up bringing, or shitty life

44.16 and you know for some reason or other they've tried to cope with
44.17 life from using substances, but now on their journey they've got
44.18 themselves better and they've dealt with it, unfortunately through
44.19 injecting they may have lost a limb or whatever they are really
44.20 positive about life and moving on, still will have the same positive
44.21 sort of you know has this come back from Afganistan would it,
44.22 you know. Although hopefully that could change and you know
44.23 that could be an example about this guy did this and went
44.24 through this journey, but the right people will help to support that
44.25 and foster that. It could be a positive story couldn't it.

DM

44.28 Mmm

M

44.29 Yeah

DM

44.30 Ok thanks ever so much, that's really useful.