

**Narratives of recovery in people with coexisting  
mental health and alcohol misuse difficulties**

**Andrew Stott**

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## CANDIDATE DECLARATION

<b>Title of degree programme</b>	Doctorate in Clinical Psychology
<b>Candidate name</b>	Andrew Stott
<b>Registration number</b>	14026522
<b>Initial date of registration</b>	22 <sup>nd</sup> September 2014

<b>Declaration and signature of candidate</b>	
<p>I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.</p> <p>I confirm that the decision to submit this thesis is my own.</p> <p>I confirm that except where explicitly stated, the work has not been submitted for another academic award.</p> <p>I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.</p> <p>Signed: _____ Date: _____</p>	

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## Preface

### Journal for submission

This thesis consists of three connected papers; a literature review, an empirical paper, and a reflective paper. The first two papers are written in a format to make them suitable for publication in the peer-reviewed journal *Advances in Dual Diagnosis*, which has the following aims and scope:

*Advances in Dual Diagnosis is an international applied research journal offering peer-reviewed, practical and thought-provoking content and a forum for topical debate on dual diagnosis (co-occurring substance abuse and mental health conditions) and complex needs.*

This journal accepts articles of 4000 to 7000 words. The papers are under 7000 words, however the journal includes references in the word count so some editing of the papers will be needed before submission.



## **Thesis abstract**

People with coexisting substance misuse and mental health difficulties are multiply disadvantaged, through trauma, stigma, and fragmented services. This thesis explores the experiences of recovery of this population in order to inform more effective service responses.

Paper One is a review of the literature on how people with coexisting substance misuse and mental health difficulties experience recovery. A thematic synthesis of the findings shows that people follow varied paths to recovery, with personal growth, social relationships, mental health and substance misuse services, peer support and material security all playing a role.

Paper Two is an empirical paper which explores the recovery narratives of people with coexisting mental health and alcohol misuse difficulties, and the role of mental health and substance misuse services in these narratives. A narrative analysis of ten interviews is undertaken and shared subplots are identified. The recovery journey is presented in terms of three broad phases, and the influence of cultural and community narratives are discussed. The practical and therapeutic value of input from services is explored, and clinical and research implications are highlighted.

The third paper is a reflective account of the researcher's journey in creating this thesis. The personal and professional origins of the thesis are explored, and the influence of the researcher's epistemological position is discussed. The practical challenges of carrying out the research are noted, along with the decisions which the researcher took in order to meet these challenges.

## **Paper One: Literature Review Paper**

**A traditional critical review of the literature on how people with coexisting mental health and substance misuse difficulties experience recovery**

Word count: 7515

## Abstract

**Purpose:** People with coexisting mental health and substance misuse difficulties face multiple disadvantages. The recovery model adopted by many services provides a person-centred approach which recognises the social context of these difficulties. The delivery of mental health and substance misuse services is however often fragmented, with people facing significant structural and implicit barriers to accessing services. Moreover some people recover independently of services. It is therefore important to understand people's own experiences of recovery.

**Methodology:** Electronic databases of peer-reviewed and grey literature were searched and eleven papers were selected for thematic synthesis.

**Findings:** Four broad areas were identified as important in people's experiences of recovery. Personal growth and new identities; varied experiences of social relationships; services and peer support; wider contextual factors. People's experiences of these areas varied widely.

**Originality/value:** This review provides an up-to-date synthesis of the varied ways in which people with coexisting mental health and substance misuse difficulties experience recovery across a range of countries and settings.

**Keywords:** Mental health; substance misuse; experience; recovery.

## Introduction

The aim of this review is to synthesise the research literature on how individuals with coexisting mental health and substance misuse difficulties experience recovery. The prevalence of coexisting disorders is discussed and current debates surrounding recovery are summarised. A search strategy and critical appraisal of the eleven papers selected is provided. A thematic synthesis of the findings is presented.

### Prevalence

A sizeable proportion of people who access mental health or substance misuse services have coexisting difficulties. A 2003 survey of UK Community Mental Health Teams (CMHTs) and specialist substance misuse services found that 44% of CMHT clients had a difficulty

with substance misuse, and 75% of clients at substance misuse services had a psychiatric disorder (Weaver et al., 2003). A 2009 systematic review on the prevalence of coexisting substance misuse and psychosis in the UK estimated rates of 20 – 37% in mental health settings and 6 – 15% in addiction settings, with particularly high occurrence in acute and forensic settings. There was considerable regional variation, with higher rates in deprived urban areas and amongst some minority ethnic groups (Carrà & Johnson, 2009). The prevalence of coexisting difficulties is therefore variable depending on geographic, socio-economic and service factors and needs to be assessed locally.

### **Difficulties faced by this population**

People with coexisting difficulties are vulnerable and marginalised, at greater risk of homelessness and offending and more likely to experience economic deprivation and social stigma (Dinos, Stevens, Serfaty, Weich, & King, 2004; Marcus, Brown, Stockton, & Pilling, 2015). This is a population which often lacks material and social power and may have internalised a negative social identity (Manley, 2015). These problems may be compounded by fragmented service provision (Schulte, Meier, Stirling, & Berry, 2008).

### **The recovery agenda**

The concept of recovery grew from service users' narratives of what it means for an individual with a mental health difficulty to build a meaningful life; it therefore provides an alternative to pathology orientated models of coexisting difficulties (Roberts, 2010). Though there is no universally accepted definition of recovery it is widely understood as an ongoing journey of growth and personal change towards living a more satisfying and meaningful life. It may include, but is not solely defined by, abstinence from substance use or remittance of symptoms of mental health difficulties. Recovery is centred on people's individual needs and may require an increase in material and social resources (Cloud & Granfield, 2008; Davidson & White, 2007). Recovery has been widely adopted as an underpinning philosophy in policy and practice across mental health and substance misuse services (Home Office 2010; Department of Health, 2014).

As recovery has become an established aim of services, there have been increasing attempts to operationalise the term more precisely. This has benefits in terms of measuring the effectiveness of services in order to improve commissioning (Department of Health, 2014). It has been argued, however, that the power of services to define recovery raises the danger

that its value in empowering people may be diminished. Vulnerable people who are unready to direct their own recovery could lose support (Pilgrim & McCranie, 2013).

Hence, people's experiences of recovery may diverge from how it is conceptualised by services. This may be particularly the case for people with coexisting disorders, who face additional barriers to gaining support, and follow a wide variety of pathways to individual recovery goals. Recovery may also take place outside of formal treatment and therefore be unknown to providers (Ness, Borg, & Davidson, 2014). Since recovery is concerned with people's varied journeys towards more satisfying lives, an understanding of people's recovery experiences is crucial for services which aim to promote recovery.

### **Rationale for this review**

Two recent reviews provide a context for this paper. A 2014 literature review investigated first person perspectives of barriers to and facilitators of recovery for people with coexisting mental health and substance misuse difficulties. It concluded that recovery is both an individual and a social process and that services need to take account of the stigma people face and the varied pathways they may follow (Ness et al., 2014). This paper aims to address some of the methodological limitations noted by the authors, by including a broader range of search terms in order to capture more papers, as well as including some more recent literature.

A 2015 systematic review was published by NICE as part of the evidence for a new guideline for this population (Marcus et al., 2015). The review looks in part at service user experiences of barriers to and facilitators of access to services. It provides evidence on the importance of housing and employment and on how the structure and fragmentation of services can create a barrier for people. The authors cite integrated care, positive relationships with professionals and a service user focussed approach as factors supporting access to services. The present paper is narrower in scope, but is more specifically focussed on the experience of recovery rather than the experience of services, including evidence of recovery outside services which Marcus et al. exclude.

Research question for this review: How do people with coexisting mental health and substance misuse difficulties experience recovery?

## Method

### Search Strategy

Figure 1 shows the search strategy and results. Truncations were used when appropriate; 'alcohol\*' was used to capture 'alcoholic', 'alcoholism.'; 'experience\*' was used to capture both 'experience' and 'experiences'; 'narrative\*' was used to capture both 'narrative' and 'narratives'; 'stor\*' was used in order to capture both 'story' and 'stories'. Google Scholar produced a very large number of results (about 31,200) and it was not possible to screen all of these. Beyond the first 50 results, none were found which related to the experiences of people with coexisting disorders, so it was considered reasonable to stop looking through further records beyond the 300<sup>th</sup> result. EBSCO Host – All Health included these databases: AMED, Medline, PsychInfo, SportDiscus, Ageline, CINAHL Plus, PsychArticles.

The inclusion and exclusion criteria were as follows:

#### Inclusion criteria

- Peer reviewed English language papers from any date.
- Literature which investigates the experiences of service users with coexisting alcohol or drug misuse and mental health difficulties.
- Literature which highlights people's experience of recovery (whether or not this is its primary aim).

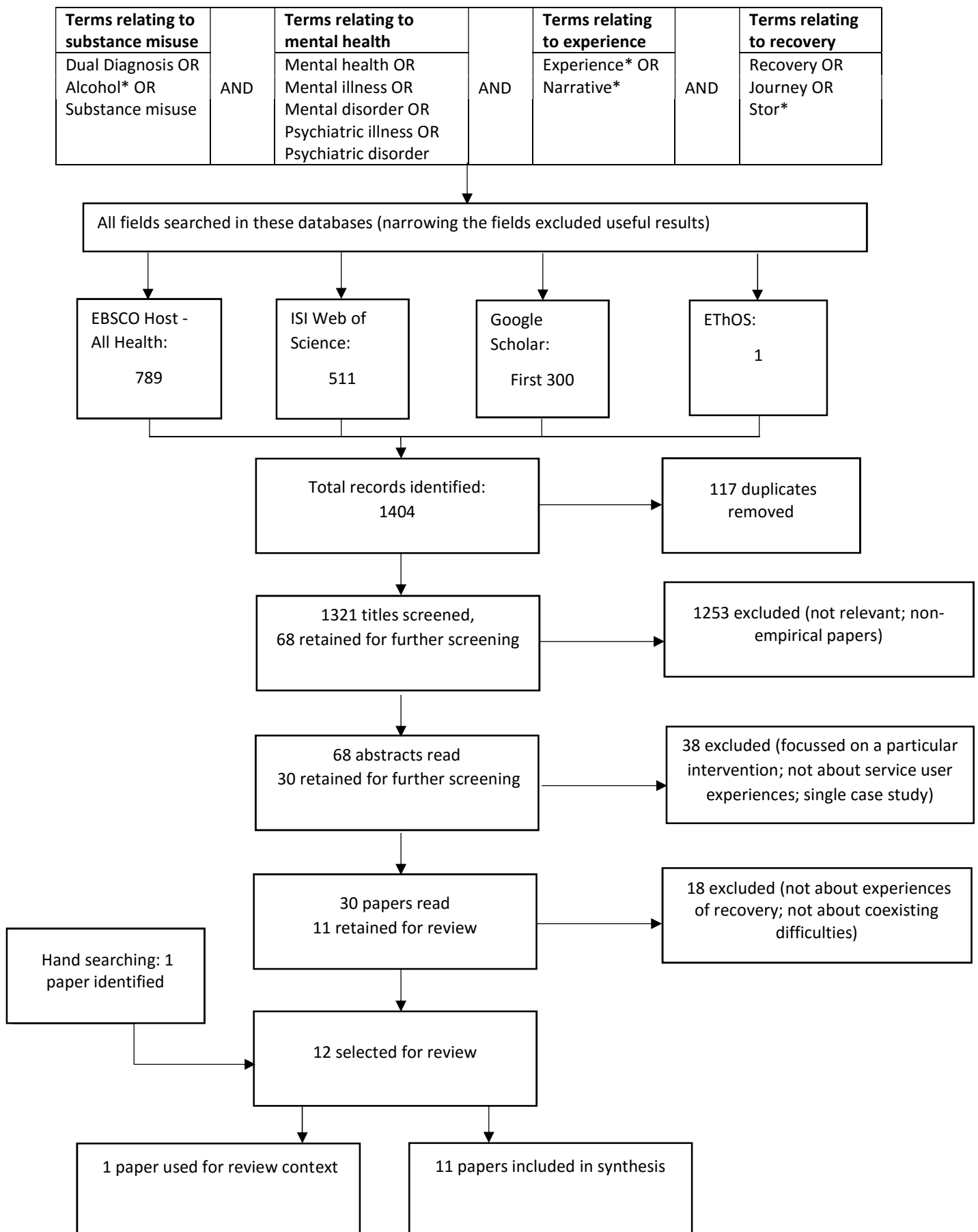
#### Exclusion criteria:

- Literature focussing on service users' experiences of a particular intervention or service.
- Literature which does not represent the experiences of service users.

Publication bias and grey literature: It is widely reported that unpublished studies differ systematically from published studies, with unpublished quantitative studies less likely to report statistically significant findings, and unpublished qualitative studies less likely to show clear or striking findings (Petticrew et al., 2008). In order to avoid, so far as possible, the results of this review being skewed by this publication bias, a search of grey literature was conducted using Google Scholar.

Critical appraisal: A critical appraisal tool was developed which combines Elliott et al.'s (1999) evolving guidelines for reviewing qualitative papers with the current qualitative checklist from the Critical Appraisal Skills Programme (CASP, 2013; Elliott, Fischer, & Rennie, 1999). The combined tool can be found in Appendix A.1. A four point rating scale was used to rate the quality of each paper against each criterion. Scores on this rating scale and individual quality appraisals for each paper can be found in Appendix A.2.

**Figure 1: Search Strategy and results**





## **Results**

Eleven papers were included in the review and their findings synthesised to explore individuals' experiences of recovery.

### **Study Characteristics**

Five studies took place in the USA, three in the UK, one in Norway, one in Sweden and one in Australia. Though the search strategy did not specify a methodology, all the studies used a qualitative methodology, with three using an inductive approach on the lines of grounded theory, two using a phenomenological approach, two using case study analysis and three using thematic analysis. Four took place in community settings, four in residential settings, two in forensic settings and one used data from internet forums (see Table 1).

Semi-structured individual interviews were the most common method of data collection and were used by most of the studies. Some used single interviews, however several conducted a series of two or more interviews over a period of up to two years. Several studies used focus groups or participant observation in addition to individual interviews.

A brief summary of each paper is provided in Table 1.

**Table 1 – Overview of studies**

Authors	Title	Year and Country	Sample	Aims	Method	Key findings
Lawrence-Jones	Dual diagnosis (drug/alcohol and mental health): Service user experiences.	2010, UK	6 adults living in the community. Age range 37 – 61 4M/2F All White British	Develop an understanding of the lived experience of dual diagnosis by exploring the narratives of service users, with particular focus on: <ul style="list-style-type: none"> <li>- Difficulties in accessing services</li> <li>- Experiences of seeking support for both issues</li> <li>- Experiences of stigma</li> </ul>	<p><i>Recruitment:</i> Convenience sample at a statutory substance misuse service.</p> <p><i>Data Collection:</i> Single, individual, topic-focused semi-structured interviews.</p> <p><i>Analysis:</i> Thematic analysis.</p>	<p>Themes:</p> <ul style="list-style-type: none"> <li>• Parallel substance misuse and mental health services hinder recovery;</li> <li>• Skills deficit of professionals not trained in dealing with both difficulties;</li> <li>• Importance of peer support;</li> <li>• Stigma</li> </ul>
Green, Yarborough, Polen, Janoff & Yarborough	Dual recovery among people with serious mental illnesses and substance problems: a qualitative analysis.	2015, USA	177 adults living in the community. Diagnoses of schizophrenia, bipolar disorder or affective psychosis. Age distribution matched to wider population. 52% female 94% white	Develop an understanding of the perspectives of individuals with serious mental illness regarding dual recovery experiences; understand how people cope with the varied trajectories and challenges of dual recovery.	<p><i>Recruitment:</i> Interview data used from an existing mixed-methods study of mental health recovery.</p> <p><i>Data Collection:</i> Four individual interviews over two years.</p> <p><i>Analysis:</i> Thematic analysis.</p>	<p>Themes:</p> <ul style="list-style-type: none"> <li>• Learning about the effects of substances</li> <li>• Wide variety of recovery pathways, with and without services and self-help groups</li> <li>• Abstinence enables mental health recovery</li> <li>• Self-development and growth in confidence</li> </ul>

Edward & Robins	Dual diagnosis, as described by those who experience the disorder: Using the Internet as a source of data	2012, Australia	108 statements relating to dual diagnosis, taken from 9 publicly accessible sites dedicated to peer support groups for dual diagnosis.	Explore the personal narratives of those who experience dual diagnosis through online forums. Add to the understanding of resilience and coping amongst this group in order to contribute to treatment considerations.	<p><i>Recruitment and data collection:</i> Use of internet search engines to find data, which is selected for inclusion using specific quality criteria.</p> <p><i>Analysis:</i> Inductive-explorative-qualitative design based on Grounded Theory.</p>	<p>Themes:</p> <ul style="list-style-type: none"> <li>• Persistence of difficulties; loss of control</li> <li>• Giving and receiving support</li> <li>• Anger at health professionals</li> <li>• Finding meaning and activity</li> <li>• Honesty with self and others</li> </ul>
Henwood, Padgett, Smith, & Tiderington	Substance Abuse Recovery after Experiencing Homelessness and Mental Illness: Case Studies of Change Over Time.	2012, USA	31 adults living in supported housing. Mean age 51. 26M/5F. 61% African American.	Explore the understanding of recovery from substance misuse amongst people with dual diagnosis who were formerly homeless. How does past substance abuse fit into people's present-day narratives? Do policies of harm reduction vs abstinence affect recovery?	<p><i>Recruitment:</i> Purposive sampling from two housing support agencies (one using a harm reduction model and one using an abstinence model).</p> <p><i>Data Collection:</i> Minimally structured in-depth interviews, mean length 90 minutes.</p> <p><i>Analysis:</i> Case study analysis by developing case summaries and data matrices.</p>	<p>Two overarching patterns in narratives of recovery:</p> <ul style="list-style-type: none"> <li>• For some recovery was gradual, for others it was linked with a particular memorable decision or event.</li> <li>• People's attributions of what helped them achieve recovery were different to what helped them maintain recovery.</li> </ul>
Hipolito, Carpenter-Song, & Whitley	Meanings of Recovery From the Perspective of People With Dual Diagnosis	2011, USA	Approximately 64 adults living in 8 recovery communities. Mean age 47. 75% female. 83% African-American.	Explore the perspectives on recovery of people living small housing communities for people with coexisting mental illness and substance use disorders.	<p><i>Recruitment:</i> Convenience sample in the residential community.</p> <p><i>Data Collection:</i> Focus groups at 4-monthly intervals.</p> <p><i>Analysis:</i> Inductive approach based on Grounded Theory.</p>	<p>Themes:</p> <ul style="list-style-type: none"> <li>• Acknowledgement of difficulties</li> <li>• Present orientation</li> <li>• Transformation and growth</li> </ul>

Padgett Henwood, Abrams & Drake	Social Relationships Among Persons Who Have Experienced Serious Mental Illness, Substance Abuse, and Homelessness: Implications for Recovery	2008, USA	41 adults entering residential programs. Age range 21 – 60. 71% male. 46% African American, 29% Hispanic, 17% White.	Explore the nature of social relationships among homeless individuals with serious mental illness and comorbid substance misuse, and how these relationships are related to progress in recovery over time.	<p><i>Recruitment:</i> Every newly enrolled service user with coexisting difficulties was invited to take part.</p> <p><i>Data Collection:</i> In-depth interviews at 0, 6 and 12 months.</p> <p><i>Analysis:</i> Multiple case-study analysis.</p>	<p>Themes:</p> <ul style="list-style-type: none"> <li>• Solitude and connectedness</li> <li>• Family ties as good and bad news</li> <li>• Other things come before finding a partner</li> <li>• In search of positive people</li> </ul>
Cruce Öjehagen & Nordström	Recovery-promoting Care as Experienced by Persons with Severe Mental Illness and Substance Misuse	2011, Sweden	8 adults living in the community. Age range 27 – 54. 6M/2F. Urban Swedish population – ethnic mix not given.	Explore recovery-promoting care. Increase the understanding of the process of recovery from the perspective of the people experiencing it.	<p><i>Recruitment:</i> Convenience sample from an outpatient treatment programme.</p> <p><i>Data Collection:</i> Two semi-structured in depth interviews.</p> <p><i>Analysis:</i> Phenomenological.</p>	<p>Themes:</p> <ul style="list-style-type: none"> <li>• ‘Entirety’ – staff taking a holistic approach</li> <li>• Participation in group activities</li> <li>• Stability of staff support</li> <li>• Symptom control using medication</li> <li>• Mindfulness</li> <li>• Dignity and autonomy through individual care</li> </ul>
Luciano, Bryan, Carpenter-Song, Woods, Armstrong & Drake	Long-term Sobriety Strategies for Men with Coexisting Disorders	2014, USA	12 adults in a residential clinic. Age range 23-42. All male. 91% white.	1) What is the subjective experience of maintaining sobriety for people with coexisting psychosis and substance use disorder? 2) What behavioral strategies supported continued lifestyle change from these participants’ points of view?	<p><i>Recruitment:</i> Convenience sample from private coexisting disorder residential clinic.</p> <p><i>Data Collection:</i> Single semi-structured individual interviews.</p> <p><i>Analysis:</i> Grounded theory.</p>	<p>Themes:</p> <ul style="list-style-type: none"> <li>• Building a supportive community</li> <li>• Meaningful activities</li> <li>• A healthy mindset</li> <li>• AA as a catalyst for change</li> </ul>

O'Sullivan, Boulter & Black	Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study.	2013, UK	5 adults in a Medium Secure Unit (MSU). Age range 26 – 42. All male 3 Afro-Caribbean, 1 mixed heritage, 1 white British.	Explore the experiences of individuals in MSUs with dual diagnosis who have been recalled, in order to inform treatment for this poorly understood population.	<i>Recruitment:</i> Convenience sample from MSU  <i>Data Collection:</i> Single semi-structured individual interviews.  <i>Analysis:</i> IPA.	Themes: <ul style="list-style-type: none"> <li>• Changing identities from pride in substance use to responsible adulthood</li> <li>• Need for intrinsic motivation to engage in treatment</li> <li>• Recovery through increased self-awareness and aspiration</li> <li>• Loss of substance using friends</li> </ul>
Elison Weston, Dugdale, Ward & Davies.	A Qualitative exploration of UK prisoners' experiences of substance misuse and mental health difficulties, and the breaking free health and justice interventions	2016, UK	32 adults in prisons in North-West England. Age range 23 – 56. 29M/3F. No data on ethnicity provided.	Explore prisoners' understanding of the links between their substance use, offending, and mental ill health. Explore the past and present personal experiences and circumstances that may be a barrier to recovery.	<i>Recruitment:</i> Convenience sample of prisoners who had completed the 'Breaking Free Health and Justice' intervention.  <i>Data Collection:</i> Single semi-structured individual interviews.  <i>Analysis:</i> Thematic analysis.	Themes: <ul style="list-style-type: none"> <li>• Difficult early experiences and the emergence of complex problems</li> <li>• Difficulties accessing support</li> <li>• Criminal justice system as a catalyst for positive change</li> <li>• Development of recovery capital</li> </ul>

Edland-Gryt & Skatvedt	Thresholds in a low-threshold setting: an empirical study of barriers in a centre for people with drug problems and mental health disorders.	2012, Norway	66 adults living in the community. Mean age 36. 69% male. No data on ethnicity provided.	Explore the characteristics of the explicit and hidden thresholds that service users need to cross in order to access support from services and start a process of recovery.	<p><i>Recruitment:</i> Convenience sample of service users at a low-threshold centre for people with drug use and mental health problems.</p> <p><i>Data Collection:</i> Participant observation, semi-structured interviews, focus groups, informal field talks.</p> <p><i>Analysis:</i> Grounded theory using multiple data sources.</p>	<p>Four thresholds found in people's stories:</p> <ul style="list-style-type: none"> <li>• Trust: respect and flexibility from staff builds trust</li> <li>• Registration: basic needs have to be met first</li> <li>• Competence: learning how to ask for help in this context</li> <li>• Efficiency: change may be small scale and gradual</li> </ul>
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## **Critical Appraisal**

### Explicit scientific context and purpose, appropriate design

All the papers had a clear statement of aims and were situated in a broad practice and research context. All the designs were appropriate, with some authors giving a strong scientific rationale for the use of a particular qualitative methodology (Henwood, Padgett, Smith, & Tiderington, 2012). One paper had a very clear aim of developing theory in response to changing clinical practice (Edland-Gryt & Skatvedt, 2013).

### Method of recruitment, situating the sample

Most studies provided a detailed and replicable description of their recruitment strategy, giving clear inclusion/exclusion criteria and basic demographic details about the sample. Two discussed the impact that the limitations of their recruitment strategy may have had on the study (Edward & Robins, 2012; Lawrence-Jones, 2010). Two gave particular attention to situating the sample in its social context and explicitly sought to recruit from a socially excluded population (Edland-Gryt & Skatvedt, 2013; Padgett, Henwood, Abrams, & Drake, 2008). Seven studies provided information about the ethnic mix of the sample, with four of these having a sample mainly composed of minority ethnic groups (Henwood et al., 2012; Hipolito, Carpenter-Song, & Whitley, 2011; O'Sullivan, Boulter, & Black, 2013; Padgett et al., 2008).

### Method of data collection

All studies gave a clear description of the method of data collection and nearly all gave this to a replicable level of detail. All studies included some information about the qualifications, level of training or background in the field of the people who collected the data. One study using a particularly large sample of 177 gave a detailed description of how interviewers were trained so that there was consistency in data collection (Green, Yarborough, Polen, Janoff, & Yarborough, 2015). Another discussed how multiple methods were used to generate rich data (Edland-Gryt & Skatvedt, 2013).

### Rigour of data analysis

Most of the papers gave a clear and replicable account of how the analysis was conducted, referring to a particular qualitative approach. Some paid particular attention to competing

and varied accounts (Edward & Robins, 2012; Henwood et al., 2012; Hipolito et al., 2011; Padgett et al., 2008). Two papers were less rigorous, with themes either derived from the interview questions (Lawrence-Jones, 2010), or poorly supported by the data (Cruce, Öjehagen, & Nordström, 2011).

#### Grounding in examples

Most of the papers grounded the presentation of findings well in examples, structuring quotes through themes and sub-themes while staying close to the data. Theory developed was clearly rooted in the data; in one case, quotes from participants were contextualised in the participant's broader story (Henwood et al., 2012). In three papers the results were less grounded, with direct quotes either absent (Cruce et al., 2011), illustrative of the authors' pre-existing ideas (Lawrence-Jones, 2010), or presented in terms of existing theory such that the voices of the participants were lost (O'Sullivan et al., 2013).

#### Clarity, coherence and resonance of presentation

The papers were all written to a reasonable degree of clarity and coherence, with some providing particularly clear and nuanced presentations of findings (Edland-Gryt & Skatvedt, 2013; Elison, Weston, Dugdale, Ward, & Davies, 2016; Hipolito et al., 2011; Padgett et al., 2008), in one case using a diagram to present an integration of the findings (Henwood et al., 2012). Weaknesses in coherence were due to the introduction of tenuous links in the discussion (Edward & Robins, 2012) or findings being presented without sufficient supporting evidence (Cruce et al., 2011). 'Resonance' refers to whether the presentation of findings seemed to the reader to bring the subjective experience of the participants to life. One paper failed to resonate with this researcher (Cruce et al., 2011), because the voices of the participants were absent from the findings.

#### Ethics

All the papers discussed ethics though in many cases this was limited to stating that ethical approval had been given by the relevant university and that informed consent was given by participants. One paper which had used ethnographic methods provided a detailed account of the ethical dilemmas present and how these were resolved (Edland-Gryt & Skatvedt, 2013). Three papers disclosed a small incentive payment to participants, in one case justifying this in terms of facilitating the retention in the study of clients who had dropped out of services (Padgett et al., 2008).



### Reflexivity

Most of the papers provided some very limited reflexivity, for instance through disclosure of the authors' professional backgrounds and any conflicts of interest. None, however, included detailed reflexivity in the sense of reflecting on the researchers' own theoretical and personal perspective on the subject matter. Since these are all qualitative papers, the researchers' own standpoints will have influenced the research at every stage, so this is a significant weakness of the literature.

### Credibility checks

Four papers provided no information about credibility checks (Edward & Robins, 2012; Elison et al., 2016; Hipolito et al., 2011; Lawrence-Jones, 2010). One paper used feedback from consumer advisory panels and detailed the involvement of researchers and clinicians from multiple backgrounds (Green et al., 2015); otherwise participant verification was not reported. Several of the multiply authored papers detailed a team process of considering themes and divergent cases, for instance discussing the training of staff who assisted with the data collection (Cruce et al., 2011; Henwood et al., 2012; Luciano et al., 2014; Padgett et al., 2008).

### Contribution to Knowledge

All the papers related their findings to existing research. Most included a clear discussion of how the findings might be used to inform future research and practice, though some included little or no discussion of practical implications.

### **Overall quality of the literature**

As a whole these papers demonstrated a clear context and purpose, used appropriate methodology and provided clear and replicable descriptions of their procedures for recruitment, data collection and analysis. Analyses were generally coherent, rigorous and well-grounded in examples.

Several studies were of particularly high quality in certain areas, and this is partly reflected in their scores on the ratings scale in Appendix A.2. The ratings scale has the benefit of systematising the assessment of the overall quality of the literature and the relative quality of different papers. However, it risks presenting a reductive assessment of quality in which the particular strengths of individual papers are subsumed into a set of mean scores. The

mean scores are therefore meaningful only in the context of this review as a whole, and it will also be useful to comment on the strengths of some papers individually. One study provided a particularly clear analysis of a large dataset (Green et al., 2015); three both built on existing theory and made very clear recommendations for research and practice (Edland-Gryt & Skatvedt, 2013; Henwood et al., 2012; O’Sullivan et al., 2013); two successfully situated the research in a wider social context (Edland-Gryt & Skatvedt, 2013; Padgett et al., 2008).

The clearest weakness of the literature was its lack of reflexivity, even though all the papers used qualitative methods for which reflexivity is considered essential. The influence of the researchers’ own experiences and beliefs about the topic is therefore unclear, and cannot be considered by their readers. This makes it difficult to assess the validity of the papers’ findings, since the active role of the researchers in generating these findings is not acknowledged.

### **Synthesis of findings**

This section aims to summarise and synthesise service users’ stories, drawing attention both to the commonalities and to the diversity and complexity of these experiences. The synthesis was generated using thematic synthesis (Thomas & Harden, 2008) and by following a guide to conducting a traditional critical literature review (Jesson, Matheson, & Lacey, 2011). This involved reading each paper several times and assigning its content initial, descriptive, codes. Initial codes from all the papers were then arranged into groups and second-order codes were created to capture the content of each group. Finally, broader themes were developed from the second-order codes. This involved an iterative process of moving between the initial codes, the second-order codes, and the papers themselves. Table 2 summarises the findings.

Four themes were generated in this way; personal growth and new identities; varied experiences of social relationships; experiences of services; and wider contextual factors. The overall paths people took to recovery varied widely both between and within studies. Several studies found that people followed varied trajectories and that progress could be gradual, fragile and prone to multiple setbacks. Incrementally achieved gains could be lost

**Table 2: Summary of findings**

Broad theme	Second-order code	Examples of descriptive codes
Personal growth and new identities	Expressing and revising stories of early experience	Acknowledging problems in early life. Finding meaning. Persistence of difficulties and set-backs. Pivotal moments.
	Personal and spiritual growth	Self-development and growth. Fear of losing recovery. Spiritual journey. Self-knowledge. Self-acceptance.
	Identifying with social norms	Taking personal responsibility. Becoming a legitimate member of society.
Varied experiences of social relationships	Relationships as vital support	Family member prompted key moment of change. Recovering for my relationship with my children. Family as both helpful and unhelpful.
	Avoiding previous social milieu	Other people as a negative influence – isolation in order to recover. Being by myself helps. Recovery takes priority over personal relationships
Experiences of services	Barriers to accessing services	Parallel services hinder recovery. Not feeling understood by professionals. Inconsistent messages from professionals. Stigma. Power differential.
	Positive experiences of professionals and services	Extended support from services was important. Being detained or imprisoned can start recovery. Being able to trust.
	Abstinence or continued use of substances	Abstinence a vital step in mental health recovery. Low-level use with no ill effects. Continued controlled use.
	Recovery without mental health or substance misuse services	Recovery without services. Recovery attributed to factors outside services. Other factors important to recovery as well as services.
	Peer support – help or hindrance	Importance of peer support. AA vital to recovery. Peer support links to unwanted past identity.
	Psychiatric medication	Important that psychiatric medication is not stigmatised as a form of substance misuse. Medication as helpful. Medication unhelpful.
Wider contextual factors	Achieving material security	Importance of material conditions. Keeping routines. Importance of housing. Material security brings personal security.
	Ethnicity and culture	Derived from the population data; many participants from ethnic minority groups in the countries in which the studies took place.

rapidly (Edland-Gryt & Skatvedt, 2013; Padgett et al., 2008). Two studies contrasted accounts of key moments of change with more gradual recovery, perhaps associated with increased age and maturity (Edward & Robins, 2012; Henwood et al., 2012).

## **Personal growth and new identities**

### Expressing and revising stories of early life experience

Recovery was widely discussed as an experience of personal growth and change. Many people explored and revised stories of early life experience (Elison et al., 2016). For some this involved both acknowledging problems in early life for which they had not been responsible, and taking responsibility for their own past choices (Hipolito et al., 2011). Some people saw their substance use as a way in which they had coped with complex difficulties, often stemming from childhood trauma (Elison et al., 2016), or as concealing an underlying mental health difficulty of which they had been unaware (Green et al., 2015).

### Personal and spiritual growth

Many people experienced recovery as a journey towards greater self-knowledge, resilience and meaning. Recovery was described as a spiritual journey in two studies which took place in the United States (Henwood et al., 2012; Hipolito et al., 2011). People found new meaning through routines such as work, and experienced increased self-knowledge and self-acceptance (Edward & Robins, 2012; Green et al., 2015). For some this required a new honesty with others in their lives including professionals (Edward & Robins, 2012).

### Identifying with social norms

Personal change was also experienced as a process of conformity to and identification with expected social norms and standards. Some people described personal change in moral terms, to do with taking personal responsibility (Hipolito et al., 2011), doing what was right (Luciano et al., 2014), or becoming a legitimate member of society (O'Sullivan et al., 2013). In contrast, in one study in a forensic setting the participants opposed conformity to social norms, viewing substance misuse as conveying status (Elison et al., 2016).

Many reflected on recovery as a process of developing greater understanding and acceptance of their difficulties. For some, embracing a label such as 'alcoholic' or 'bipolar' was experienced as a positive part of recovery as it allowed them to accept that they needed to work on their recovery (Green et al., 2015; Hipolito et al., 2011). Others however wanted to resist being labelled as having mental health problems, which they saw as stigmatising (Hipolito et al., 2011).

### **Varied experiences of social relationships**

Padgett et al. (2008) offer a detailed investigation of the complexity of social relationships in recovery. Some people had complex and volatile relationships with family members, who often had their own substance misuse or mental health difficulties. Others withdrew from social contact during recovery, as a strategy to avoid triggers to substance use or because previous experiences had made them suspicious of others. For many people, withdrawal from social and family interactions protected them from destructive relationships. Romantic relationships were secondary to recovery, which had to be the priority (Padgett et al., 2008).

For others, however, social support was central to recovery, with close family members sometimes prompting key moments of change. People were selective about who would be a positive influence. For some, the fear of loss of contact with family members, particularly children, was a motivator for maintaining abstinence (Henwood et al., 2012; Hipolito et al., 2011).

Three studies found that the loss of substance using friends was a social cost to recovery. All three drew their participants from homeless or imprisoned populations, who may have been more likely to lack alternative social networks (Henwood et al., 2012; O'Sullivan et al., 2013; Padgett et al., 2008).

### **Experiences of services**

#### **Barriers to accessing services**

Many people experienced barriers created by the division between specialist mental health and substance misuse services. Some felt they were not understood by professionals due to

lack of training in both areas, or that having mental health difficulties disqualified them from support for their substance misuse (Lawrence-Jones, 2010). Others felt that staff ignored the difficulty which was not their main specialty (Cruce et al., 2011). Edward & Robins (2012) conducted the only study that obtained people's views without recruiting via services. They highlight the anger that many felt towards professionals, who were seen as giving inconsistent messages about what would help (Edward & Robins, 2012).

In addition to these structural barriers, some people experienced implicit barriers as a result of disempowerment or stigma. Edland-Gryt & Skatvedt (2013) explored in some detail the experiences of implicit barriers to a service designed to be easy to access. For people who had previously experienced services as rejecting them, or intruding upon their lives, a lack of trust in the service and in professionals was a fundamental barrier to getting support. Further barriers were created if people did not know how to express their needs in a way which the service could understand, or struggled to make changes at the rate that the service expected (Edland-Gryt & Skatvedt, 2013). Power differentials were also important in O'Sullivan et al.'s (2013) study in a forensic setting, in which British offenders largely from Afro-Caribbean backgrounds experienced frustration and disempowerment (O'Sullivan et al., 2013).

#### Positive experiences of professionals and services

Many people discussed the actions and qualities of staff which helped them overcome these barriers. When staff treated people with respect and patience, reaching out in a way which removed some of the power differential created by their professional status, clients experienced increased trust in and respect for services (Edland-Gryt & Skatvedt, 2013). Trusting professionals enough to be honest with them was important (Edward & Robins, 2012), with staff empathy and stable support helping to restore dignity (Cruce et al., 2011). It was recommended that services recognise and respect small gains in areas such as housing, substance use, or engagement with services, in order to encourage expression of needs and build trust (Edland-Gryt & Skatvedt, 2013). Some people felt that professionals had been key to their recovery, whether through a close and sustained relationship (Cruce et al., 2011; Edward & Robins, 2012), or through firm yet compassionate intervention at a moment of change (Henwood et al., 2012).

The power of professionals and services was also experienced as a catalyst for recovery. Two studies which took place in forensic services found that detention could be experienced as a positive step-change, with psychiatric hospital offering respite from a chaotic life in the community and imprisonment giving better access to support (Elison et al., 2016; O'Sullivan et al., 2013). Residential recovery programmes were also experienced as a positive change in the environment which could create conditions more conducive to recovery (Luciano et al., 2014).

#### Abstinence or continued use of substances

Many people felt that abstinence from using drugs or alcohol had been a vital step in their recovery from both substance misuse and mental health difficulties (Cruce et al., 2011; Green et al., 2015; Padgett et al., 2008), though some reported continued low-level use of alcohol with no ill-effects (Green et al., 2015). Trajectories towards eventual abstinence, however, varied widely. For people who had been homeless, a requirement of abstinence before housing was provided was a barrier to recovery, whereas the provision of housing boosted motivation for achieving and maintaining recovery (Henwood et al., 2012).

#### Recovery without mental health or substance misuse services

There were accounts of recovery in which services were not involved at all; this was true for some people in the study which did not recruit through services (Edward & Robins, 2012). Another study, though it recruited through services, found that substance misuse recovery was not usually attributed to formal services but to a wide variety of other factors (Henwood et al., 2012). Others felt that there were too few services for them in the community (O'Sullivan et al., 2013), or had positive relationships with staff but felt a sense of loss when these came to an end (Padgett et al., 2008). Even the studies which were more focussed on people's experiences of services found that people cited many other factors in enabling their recovery (Cruce et al., 2011; Green et al., 2015; Henwood et al., 2012; Hipolito et al., 2011).

#### Peer support

For many, peer support was a central pillar of recovery; this was particularly true of studies carried out in the USA, in which Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were particularly important influences (Edward & Robins, 2012; Green et al., 2015; Henwood et al., 2012; Lawrence-Jones, 2010; Luciano et al., 2014). For some however peer

support could be an unwanted link to a negative past identity (Henwood et al., 2012); similarly, housing schemes aimed at helping people with coexisting difficulties were sometimes experienced as valuable, but could also be chaotic settings with many triggers for substance use (Edland-Gryt & Skatvedt, 2013).

### Psychiatric medication

For some people accessing specialist substance misuse services and peer support, it was important that these organisations acknowledged the validity of taking psychiatric medications and did not stigmatise this as substance misuse (Green et al., 2015). For some, use of psychiatric medication played a significant role in stabilising their symptoms (Cruce et al., 2011). Conversely many people in a study in a prison saw medication as a coerced and unhelpful intervention, viewing psychosocial support as the support they wanted but were unable to access (Elison et al., 2016).

## **Wider contextual factors**

### Achieving material security

A lack of material resources was a barrier to recovery, and improved economic conditions were often important in maintaining recovery. Several studies interviewed people who had been homeless, finding that stable housing was both a precondition of further steps towards recovery (Edland-Gryt & Skatvedt, 2013) and a motivating factor in maintaining recovery (Henwood et al., 2012). Similarly a lack of stable housing was a trigger for substance misuse amongst people released from prison (Elison et al., 2016).

Lack of resources also constrained people's opportunities to develop positive relationships (Padgett et al., 2008). Achieving material security was therefore both a practical matter and an aspect of developing a more positive and socially acceptable sense of self. Daily routines structured by work, education or involvement in peer support helped boost self-esteem and self-efficacy (Edward & Robins, 2012; Luciano et al., 2014).

### Ethnicity and culture

Three of the five studies set in the USA recruited a majority of participants from relatively disadvantaged African American and Hispanic communities; two of these studies recruited people who were or had been homeless (Henwood et al., 2012; Hipolito et al., 2011;



Padgett et al., 2008). They therefore explored the experiences of people who were multiply socially, economically and racially disadvantaged. Indeed one study took social disadvantage as its rationale for exploring social relationships and isolation amongst this group (Padgett et al., 2008). One of the UK based papers had a majority Afro-Caribbean sample though the significance of this was not explored (O’Sullivan et al., 2013).

## **Conclusions**

This review has appraised and synthesised the literature on the recovery experiences of people with coexisting mental health and substance misuse difficulties. The appraisal found that the quality of the literature varied, with some papers making particularly strong theory-practice links. There was however a lack of reflexivity across the literature as a whole, and this makes it difficult for the reader to assess the impact of the researchers’ own perspectives on their analysis.

Nonetheless, the synthesis of findings suggests several conclusions; it provides evidence that people follow varied pathways to recovery, and that integrated, person-centred services which recognise the importance of practical support are experienced as most helpful. It also shows the importance of recognising stigma, both as direct experience of disempowerment and as a negative internalised identity. Part of people’s individual journeys is to find a new way to locate and understand themselves in relation to socially constructed understandings of mental health and substance misuse.

The synthesis also highlights that some people recover without the support of services, and for those who do use services there are often many other factors which they experience as important in their recovery. It is notable that some of the most critical accounts of professionals and services came from the only paper not to recruit through services (Edward & Robins, 2012). The stories of people who recover outside of services may be important in ensuring that services are able to recognise the wide variety of paths to recovery and to adapt support accordingly.

This review included research from a variety of community, residential and forensic settings and this will have increased the variety of experiences in the synthesis. A factor which appeared to apply across settings is the experience of a power differential between service

users and professionals, and the value of individualised support in overcoming this barrier. The need to address practical and material issues of disempowerment was also seen across many settings. This may reflect the large proportion of studies which recruited people who were economically disadvantaged and from ethnic minority groups, whether or not the studies had explicitly targeted these groups.

Literature on recovery has often highlighted the importance of social support and this is found also here. It is striking however that several papers commented on the ways in which recovery could have a social cost; achieving recovery in the face of this cost required the development of personal resilience linked to improved material conditions and access to a new social identity.

In drawing these conclusions, however, the limitations of the literature should be acknowledged. In particular, the lack of reflexivity throughout the literature raises questions about the confidence it is possible to have in the validity of the conclusions. For instance, several studies identified that the division between substance misuse and mental health services was experienced as a barrier to recovery. The researchers themselves, however, may not have been perceived as neutral in relation to this division; perhaps they would be perceived as having a loyalty to the service through which the participants were recruited. The literature would be strengthened if researchers were to reflect on the nature and possible impact of their own position in relation to the participants. Though the methodologies used preclude an objective researcher perspective, greater reflexivity would allow both authors and readers to consider more clearly the standpoints and biases present in the research.

### **Limitations**

Though grey literature was searched, all eleven papers included in this review are published, peer-reviewed papers, with just one unpublished paper cited for background information (Manley, 2015). This suggests either that the method of searching the grey literature was ineffective, or that there was little grey literature of relevance to be found. In either case, this review will replicate any publication bias in the literature. A broader literature reviewing method making more use of web-based literature such as forums and videos

might have benefits in reaching more experiences of people who are not using services. Edward and Robins (2012) provide an example of the data which can be found in this way.

The literature reviewed was from various different countries and settings. This has allowed the review to focus on the experiences of people with coexisting mental health and alcohol misuse difficulties, but dilutes the implications for any particular setting. All the papers were published in English and in five OECD countries, so the conclusions cannot be generalised more widely.

The review was carried out by a doctoral student under supervision. The researcher sought support and advice throughout the process of carrying out the review; for instance the final stage in the selection of review papers was replicated by an experienced researcher. However, the researcher did not have comparable resources or experience to a research team carrying out a systematic review and this necessarily limits the rigour of this paper.

### **Clinical Implications**

The review found that people experience varied paths to recovery, drawing on a range of social and material resources as well as professional support. This corresponds with the central premise of the recovery approach, that recovery is an individual journey which may involve building resources across many areas of life, and that the role of specialist services is to support this journey (Cloud & Granfield, 2008). This is encouraging for the continued adoption of a recovery centred approach and for the potential for this approach to help integrate mental health and substance misuse services (Davidson & White, 2007). The negative impact of fragmented service provision on recovery has been reported previously (Schulte, Meier, Stirling, & Berry, 2008), and was found also by this review. A finding which may perhaps be more novel is the need to be aware of the power differentials which service users experience, even in low-threshold services (Edland-Gryt & Skatvedt, 2013) and to take steps to build trust, material security, and an understanding of how the service can be of help.

### **Research Implications**

The literature considers the experiences of people who use a range of substances, but does not link the differing experiences of recovery to the differing social perceptions of these

substances. It also focusses largely on mental health difficulties as defined by Axis I of DSM-V, i.e. schizophrenia and related disorders, excluding other mental health difficulties. Investigating the experiences of people with mental health difficulties more broadly who use particular substances could be useful for further understanding the varied pathways and barriers to recovery. Future research could also benefit from paying closer attention to its social context through greater use of reflexivity, and by considering the economic and cultural influences on people's experiences. Greater use of narrative methods could be helpful in understanding particular experiences of recovery, as deconstructing experiences into themes can make individual trajectories more difficult to discern.

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## Appendices

### **Appendix A.1: Quality assessment tool**

This quality assessment tool was developed from Elliott, Fischer, & Rennie, (1999) and from the qualitative CASP checklist (CASP, 2013).

1. Explicit scientific context and purpose, appropriate design
2. Method of recruitment, situating the sample
3. Method of data collection
4. Rigour of analysis
5. Grounding in examples
6. Clarity, coherence and resonance of presentation
7. Ethics
8. Reflexivity
9. Credibility checks
10. Contribution to knowledge

## Appendix A.2: Individual quality appraisals

A 4-point rating scale was used to rate the quality of each paper against each criterion:

1. Does not meet criterion at all
2. Partly meets the criterion but with significant omissions or shortcomings
3. Meets the criterion well but with some omissions or shortcomings
4. Meets the criterion very well with very few or no omissions or shortcomings

Based on this rating scale the papers achieved the following mean scores on the 9 criteria:

Paper	Mean rating score
(Lawrence-Jones, 2010)	2.1
(Green et al., 2015)	3.5
(Edward & Robins, 2012)	2.7
(Henwood et al., 2012)	3.3
(Hipolito et al., 2011)	3.0
(Padgett et al., 2008)	3.3
(Cruce et al., 2011)	2.6
(Luciano et al., 2014)	3.4
(O'Sullivan et al., 2013)	3.4
(Elison et al., 2016)	3.2
(Edland-Gryt & Skatvedt, 2013)	3.6

Paper	Criterion	Appraisal	Rating
Lawrence-Jones, 2010	Explicit scientific context and purpose, appropriate design	Situated in broad practice and research/policy context – but not in other qualitative literature. Clear statement of aims – semi-structured interviews are appropriate however the interview schedule appears potentially leading.	2
	Method of recruitment, situating the sample	Inclusion criteria unclear from the point of view of the level of severity of mental health difficulties; not specific about nature or severity of difficulties. Demographic information included. Notes that recruitment from services excludes those not accessing services.	3
	Data collection	Process of interviewing discussed however specifics not given so not replicable. Discusses own background in the field.	2
	Data analysis	Clear description of thematic analysis. Initial themes ‘derived from the interview schedule topics’; themes do not go beyond those introduced by the interview; little evidence that contradictory data is considered.	2
	Grounding in examples	Examples used however they are mainly used to illustrate the author's pre-existing ideas based on policy rather than to support new ideas	2
	Clarity, coherence and resonance of presentation	Resonant. Generally clear and coherent.	3
	Ethics	Notes university ethical approval	2
	Reflexivity	Notes own background in the field but lacks reflection on how this background influences his perspective.	2
	Credibility checks	None – single researcher with no participant verification.	1
	Contribution to knowledge	Confirms existing policy and research however does little to take it forward or discuss specifically how the findings may be used.	2
		Mean rating	2.1

Green, Yarborough, Polen, Janoff, & Yarborough, 2015	Explicit scientific context and purpose, appropriate design	Clear aims, well grounded in the recent literature.  Design allows for rigorous analysis of a large qualitative dataset.	4
	Method of recruitment, situating the sample	Detailed and replicable. Inclusion/exclusion criteria. Demographic information included. Description of social context.	4
	Data collection	Highly detailed description, replicable and gives details of qualifications of interviewers and how consistency in data collection was achieved for such a large study.	4
	Data analysis	Detailed and replicable. Rigorous, clearly described procedure for coding and credibility checking.  Includes data illustrating less usual views and experiences, acknowledges multiple pathways to recovery.	4
	Grounding in examples	Well-grounded in examples of the data - lots of quotes for each theme and point. However, the idea in the conclusion that the 'chronic disease' model is more effective does not appear to be strongly merited by the findings.	3
	Clarity, coherence and resonance of presentation	Clearly and professionally written – appears transparent about methods and findings.	3
	Ethics	Notes monitoring agencies, informed consent, right of participants.	3
	Reflexivity	Notes qualifications and potential conflicts of interest (grant from pharmacological company) but doesn't explore the meaning and importance of this further.	2
	Credibility checks	Feedback from consumer advisory panels and involvement of researchers and clinicians from different backgrounds in the design and analysis process.	4
	Contribution to knowledge	Clear recommendations for practice: importance of addiction services recognising the non-substance related difficulties experienced by people with MH difficulties.	4
		Mean rating	3.5

Edward & Robins, 2012	Explicit scientific context and purpose, appropriate design	Clear theoretical context especially in terms of prevalence. Clearly stated aim. Design follows from previous web-based research.	4
	Method of recruitment, situating the sample	Replicable search strategy for internet-based data. Description of sample and limitations of this sample (especially being unable to access most forums which require membership). Explicit strategy for inclusion/exclusion based on quality.	4
	Data collection	Replicable strategy for collection of internet data. Gives the positions of those carrying out the searches. Considers shortcomings of web-based research.	4
	Data analysis	Detailed and replicable. Limitations of the selection process considered however not own role in this. Contradictory themes included.	3
	Grounding in examples	Well-grounded – multiple examples for each finding.	4
	Clarity, coherence and resonance of presentation	Resonant. Some of the links made in the discussion are interesting but a little tenuous – they don't seem to follow directly from the findings but from the researchers' thoughts about the subject. Lack of integration of the findings with the discussion.	2
	Ethics	Claims that ethical approval is not needed this is not needed because this is all publicly available information.	2
	Reflexivity	None	1
	Credibility checks	None	1
	Contribution to knowledge	Does not make clear practice/research recommendations but does flag up the potential of further research using web forums.	2
		Mean rating	2.7
Henwood, Padgett, Smith & Tiderington, 2012	Explicit scientific context and purpose, appropriate	Clear aims related to the literature. Strong rationale for chosen case-study analysis methodology – include contextual factors that can be lost when using thematic approaches.	4

	design		
	Method of recruitment, situating the sample	Detailed and replicable description. Clear inclusion/exclusion criteria. Demographics included.	4
	Data collection	Clear and replicable, using trained interviewers with experience with this population.	4
	Data analysis	Particularly detailed description and discussion of method. Attention paid to the varied and frequently conflicting accounts. Own perspective not discussed.	3
	Grounding in examples	Very well-grounded in examples which illustrate the method of analysis used by contextualising quotes in wider stories.	4
	Clarity, coherence and resonance of presentation	Very clear presentation including diagram and integration of the findings into an overall structure of two trajectories towards recovery. Resonant.	4
	Ethics	University approval; informed consent; incentive payment of \$30 to participants.	2
	Reflexivity	None other than disclosure of no conflicts of interest.	1
	Credibility checks	Team meetings to discuss themes, use of memo-writing	3
	Contribution to knowledge	Very well linked with other research, clear recommendations for practice.	4
		Mean rating	3.3
Hipolito, Carpenter-Song & Whitley, 2011	Explicit scientific context and purpose, appropriate design	Clear aims, research situated in wider recovery context. Methodology appropriate.	4
	Method of recruitment, situating the sample	Clear inclusion/exclusion criteria and description of the social context of the study. Extent of mental health difficulties required for inclusion not clearly defined.  Demographics included.	3
	Data collection	Clear and replicable – description of the 'funnel' strategy used in running focus groups.	4

	Data analysis	Clear and replicable description. Variety of perspectives included in the findings. Own role/perspective not discussed.	3
	Grounding in examples	Well-grounded in the data, theory developed linked clearly with data.	4
	Clarity, coherence and resonance of presentation	Very clearly written – integration into three ‘dimensions’ of recovery with quotes supporting findings and illustrating diversity of experiences. Particularly resonant.	4
	Ethics	Ethics: University approval and informed consent specified. \$20 payment for time given.	2
	Reflexivity	None.	1
	Credibility checks	Unclear – two researchers carried out analysis so there may have been cross-checking and there would have been combining of ideas/themes.	2
	Contribution to knowledge	Provides clear answers to the questions that motivated the research. Related to theory and literature. No recommendations for practice.	3
		Mean rating	3.0
Padgett, Henwood, Abrams and Drake, 2008	Explicit scientific context and purpose, appropriate design	Clear aims and appropriate methodology, well-justified.	4
	Method of recruitment, situating the sample	Clear inclusion/exclusion criteria. Replicable.  Socially situated sample – the social context of the participants’ difficulties is part of the rationale for the study.  Demographics included.	4
	Data collection	Clear and replicable – strength in longer term (12 month) engagement with clients (0, 6 and 12 months) with little attrition.	4
	Data analysis	Clear and replicable, attention to emerging patterns and discrepant cases. Team reflections however no discussion of own role/perspective in analysis.	3

	Grounding in examples	Well-grounded in the data; giving structure through themes and sub-themes whilst saying close to the data.	4
	Clarity, coherence and resonance of presentation	Clearly written, strong integration of findings while preserving nuances in the data. Resonant – sense of getting a real picture of the data.	4
	Ethics and reflexivity	Incentive payments \$30 plus \$10/month for 12 months. Allows the study to keep track of clients who stop using services. University ethical approval.	3
	Reflexivity	None.	1
	Credibility checks	Developed themes and considered divergent cases as a team. Interviewers trained.	3
	Contribution to knowledge	Very clear on implications for practice. Links with theory. No recommendations for future research.	3
		Mean rating	3.3
Cruce et al, 2011.	Explicit scientific context and purpose, appropriate design	Clear aims, appropriate methodology, situated in wider theoretical context.	4
	Method of recruitment, situating the sample	Clear inclusion/exclusion criteria. Replicable. Socially situated sample. Demographics included.	4
	Data collection	Clear and replicable.	4
	Data analysis	Clear and replicable. Themes not well linked with data – e.g. the description of the theme ‘mindfulness’ gives no indication of whether the participants actually practiced/experienced mindfulness and found this helpful. Own perspective not discussed.	2
	Grounding in examples	Very few quotes – not well grounded in the data, loss of the direct words and stories of the clients.	2



	Clarity, coherence and resonance of presentation	Written clearly but the lack of direct quotes undermines confidence in the findings.	2
	Ethics	University approval, discussion of confidentiality, voluntary, no impact on treatment, informed consent.	2
	Reflexivity	None	1
	Credibility checks	Discussion between the authors until consensus reached.	3
	Contribution to knowledge	Links with research, however difficult to have confidence that these links were not imposed on the data due to lack of direct quotes from clients. Recommendations for practice follow from the findings however are quite vague.	2
		Mean rating	2.6
Luciano <i>et al</i> , 2011	Explicit scientific context and purpose, appropriate design	Clear aims, following directly from findings in the literature. Appropriate methodology.	4
	Method of recruitment, situating the sample	Demographics included. Convenience sample at a service rather than explicit inclusion/exclusion criteria.	3
	Data collection	Clear and replicable – full interview schedule.	4
	Data analysis	Clear and replicable. Own perspective mentioned in terms of professional backgrounds and experiences giving a 'lens' on the subject.	4
	Grounding in examples	Very much grounded in the data – findings mostly consisting of quotes to support each theme.	4
	Clarity, coherence and resonance of presentation	Clear, resonant, integration of quotes with themes.	4

	Ethics	University approval, discussion of anonymity.	3
	Reflexivity	Noting the backgrounds of the researchers and discussing 'active construction' of findings in line with constructivist grounded theory.	2
	Credibility checks	Team discussion – challenging researchers' interpretations of the data, checking that findings were not rooted in a particular observer's lens.	3
	Contribution to knowledge	Well linked with the wider literature, recommendations for future research. Some practice implications given.	3
		Mean rating	3.4
O'Sullivan, Boulter & Black, 2013	Explicit scientific context and purpose, appropriate design	Clear rationale from the literature, appropriate methodology.	4
	Method of recruitment, situating the sample	Detailed and replicable, demographics included, situation of the participants (in a Medium Secure Unit) discussed. Consideration of recruitment bias.	4
	Data collection	Clear and replicable.	4
	Data analysis	Clear and replicable – discussion of how IPA was used.  Discussion of own role as a researcher working in the Medium Secure Unit.	4
	Grounding in examples	Well-grounded – many quotes. Makes a great deal of links to theory in the results section, however appears to present the participants' experience through the lens of extant theory rather than giving voice to it in itself.	3
	Clarity, coherence and resonance of presentation	Coherent, densely written with theoretical links throughout. Resonates, however personal resonance perhaps limited by the specific challenges of the forensic client group.	3
	Ethics	Ethics committee approval, discussion of informed consent.	3
	Reflexivity	Notes the advantages and disadvantages of interviews by a researcher whom the participants did not previously know.	2

	Credibility checks	Investigator triangulation.	3
	Contribution to knowledge	Links with wider knowledge, especially theory e.g. Social Identity Theory. Clear recommendations for practice.	4
		Mean rating	3.4
Elison et al, 2016	Explicit scientific context and purpose, appropriate design	Clearly situated in the literature. Appropriate methodology.	4
	Method of recruitment, situating the sample	Detailed and replicable. Prison context explored.  Demographics and nature of difficulties noted.	4
	Data collection	Clear and replicable.	4
	Data analysis	Clear and replicable, detailed description. No discussion of own perspective/role.	3
	Grounding in examples	Well-grounded, many quotes to support each theme.	4
	Clarity, coherence and resonance of presentation	Clear and coherent, incorporates complexity and nuance within each theme.	4
	Ethics	Ethics: Basic discussion of informed consent. Declaration of conflict of interest due to employment by the Breaking Free Group.	3
	Reflexivity	None.	1
	Credibility checks	Not discussed (perhaps would be especially important given conflict of interest)	1
	Contribution to knowledge	Clear links with wider literature and recommendations for practice.	4
		Mean rating	3.2
Edland-Gryt &	Explicit scientific	Clear aim of developing theory around developments in the field. Terminology –	4

Skatvedt, 2013	context and purpose, appropriate design	'threshold theory'; 'low-threshold settings'; 'harm reduction' is explicitly queried and explored. Recovery defined as 'a process of multiple recovery that involves many levels of reparations'	
	Method of recruitment, situating the sample	Particular attention paid to situating the sample – service exists to serve people in a particular social context. Demographics noted.	4
	Data collection	Detailed and replicable, multiple methods used, focus on generating rich data.	4
	Data analysis	Clear and replicable, using and referencing Grounded Theory.	4
	Grounding in examples	Well-grounded in illustrative quotes. Longer text by the authors but this conveys the sense of the clients' experiences well. Sense that the quotes represent the large sample accurately.	4
	Clarity, coherence and resonance of presentation	Very clear and nuanced presentation. Strongly resonant.	4
	Ethics and reflexivity	Detailed discussion of the ethical dilemmas present when working with this group and how these were dealt with. Ethical approval obtained.	4
	Reflexivity	None	1
	Credibility checks	Several methods used and two researchers involved.	3
	Contribution to knowledge	Very clear links with the theoretical literature and many recommendations for practice.	4
		Mean rating	3.6

## **Paper Two: Empirical Paper**

**Narratives of recovery in people with coexisting mental health  
and alcohol misuse difficulties.**

Word count: 7306

## Abstract

**Purpose:** People with coexisting mental health and alcohol misuse difficulties face multiple disadvantages. The concept of recovery has become important for policy and practice in both mental health and alcohol misuse services. However, the recovery narratives of this population are under-represented in the literature.

**Methodology:** Ten interviews with people with coexisting mental health and alcohol misuse difficulties were conducted, audio-recorded, and transcribed. The transcriptions were analysed using narrative analysis.

**Findings:** Participants' narratives reflected varied paths to recovery. Most of the narratives shared a three-part structure, from a traumatic past, through an episode of change, to an ongoing recovery phase. Change and recovery were attributed to several factors including flexible and practical support from services, therapeutic relationships with key professionals, peer support, and a redefinition of self.

**Originality/value:** The narrative methodology enables the study to draw links between personal stories of recovery and wider social influences, allowing comment on the implications for services. Further, the experiences of people with coexisting mental health and alcohol misuse difficulties have rarely been studied apart from the dual diagnosis population in general, so this paper is able to investigate the specific challenges for this population.

**Keywords:** Mental health; alcohol misuse; narrative; recovery.

## Introduction

The aim of this study is to investigate the recovery narratives of people with coexisting mental health and alcohol misuse difficulties. This introduction discusses the service and policy context in the UK, then establishes the rationale for investigating the stories of people who misuse alcohol in particular.

### **Divisions in service provision**

People with coexisting mental health and substance misuse difficulties face multiple disadvantages. They are often at risk of homelessness, offending, and economic deprivation (Marcus et al., 2015); they face stigma and may have internalised a negative social identity (Manley, 2015). These difficulties are compounded by problems with accessing services. Substance misuse and mental health services in the UK have tended to operate separately. This requires people to negotiate two parallel service pathways, frequently encountering barriers to accessing either (Schulte, Meier, Stirling, & Berry, 2008). Differing service priorities and thresholds may leave people without adequate support (Roberts & Bell, 2013).

For people who do succeed in accessing a service, there are barriers to achieving a positive outcome. Many professionals feel unskilled when dealing with coexisting difficulties and may be overly pessimistic about the likelihood of positive outcomes (Adams, 2008; Weaver et al., 2003). Further, the evidence for the effectiveness of specific psychosocial interventions with this population is poor (Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2013). Research in the UK and internationally has concluded that the division between mental health and substance misuse services is problematic and has recommended that services become more holistic and integrated (Roberts & Maybery 2014, Carrà *et al* 2015). Existing UK policy reflects this, with NICE guidance recommending that existing specialist services should be adapted to serve this population effectively (NICE, 2016).

### **Experiences of recovery**

In this context, there is a role for qualitative research in highlighting the experiences of this population, so that the barriers to successfully accessing services can be better understood and addressed. Investigating people's experiences of recovery can be empowering because the recovery agenda emphasises strengths and meaning as defined by the person with the difficulty, and challenges narratives of diagnosis and deficit (Shepherd, Boardman & Slade, 2008). This gives people greater opportunity to define themselves, in relation to and perhaps in opposition to dominant cultural and medical narratives (Kirkpatrick, 2008). Recovery has been taken up by policy-makers in both mental health and substance misuse as a way to develop more accessible and client-centred services (Home Office 2010; Department of Health, 2014). As the language of recovery is increasingly adopted by

services, there is a renewed need to ensure that the recovery experiences of service users continue to be explored (Pilgrim & McCranie, 2013).

### **Coexisting mental health and alcohol misuse difficulties**

Existing research into the recovery experiences of people with coexisting mental health and drug or alcohol misuse difficulties has often defined this population in a way which excludes people with non-psychotic disorders who misuse alcohol. Studies based in the United States have used a diagnosable psychiatric disorder on Axis I of the DSM-V as an inclusion criterion (Green et al., 2015; Henwood et al., 2012; Padgett et al., 2008). British studies have also focussed largely on people with symptoms of psychosis (O'Sullivan et al., 2013), and recently published guidance in the UK applies to people with psychosis or mood disorders (NICE, 2016). The recovery experiences of people who misuse substances and have other mental health difficulties, such as personality difficulties or anxiety disorders, appear to be lacking in the literature.

In terms of substance use, UK studies of experiences of recovery reflect research internationally in often recruiting either people who misuse both alcohol and illicit drugs, but with a greater proportion of drug users, or just people who misuse illicit drugs (Elison et al., 2016; O'Sullivan et al., 2013). A 2003 prevalence survey recruited over three times as many participants from drug services as from alcohol services (Weaver et al., 2003). These discrepancies appear to reflect the settings of these studies, in inner-city communities (Weaver et al., 2003) or secure settings (O'Sullivan et al., 2013). Alcohol is, however, the most commonly misused substance in the UK, both for the general population (NICE, 2011) and amongst people with mental health difficulties (Carrà & Johnson, 2009). Alcohol has a complex set of associations in British society, contributing for example to the construction of gendered identities through consumption of 'girly' or 'masculine' drinks (Emslie, Hunt, & Lyons, 2015). An understanding of the complex meanings of alcohol for people with coexisting mental health difficulties may be important for understanding how services can support recovery. The lack of research around the recovery experiences of people who misuse alcohol and have mental health difficulties therefore presents an opportunity for enquiry.



## Research questions

Paper One reviewed the literature on experiences of recovery in people with coexisting mental health and substance misuse difficulties. Varied pathways to recovery were identified, with services acting as a catalyst for recovery in some cases, but fragmented services creating a barrier in others. The papers reviewed focussed largely on people with psychosis who used illicit drugs. This study will explore the recovery experiences of people with a range of mental health difficulties who misuse alcohol.

### Research Questions:

- What narratives do people with coexisting mental health and alcohol misuse difficulties create about their recovery?
- What role do mental health and substance misuse services play in the recovery narratives of people with coexisting mental health and alcohol misuse difficulties?

## Method

### Narrative research

When asked to give an account of who they are, people are predisposed to create meaningful stories out of their experience. Narrative research draws attention to how people achieve changes in personal identity by re-presenting their story to themselves and to others, drawing upon the wider stories, or narratives, that are available in their social and cultural context (Wood, 1991). The narrative approach in this study draws on Clandinin and Connelly's (2000) metaphor of a three-dimensional narrative inquiry space. The first dimension is the interaction between the personal and the social; how people tell their individual story by drawing on the social narratives that are available to them. Here this dimension is investigated by adapting Rappaport's (1995) model of *levels of influential context*, which highlights three levels of narrative. *Dominant cultural narratives* pervade social institutions and the mass media; cultural stereotypes around alcoholism, for instance, occur at this level. *Community narratives* are the stories shared by social groups or within organisations or families. In this study the participants' narratives of mental health and

substance misuse services are given particular attention, since one of the aims of the study is to identify the role of services in people's narratives of recovery. *Personal narratives* are stories of individual experience which will draw on available community and cultural narratives.

The second dimension is *continuity*; narratives take place over time, usually making causal links between past, present and future. The narrative will have a starting point, points of change or transition, and end-points in the past or present, or imagined endings in the future. The narrator faces a predicament or struggle and moves through points of transition to some kind of resolution (Ollerenshaw & Creswell, 2002). This gives the narrative its overall shape and is therefore central to its meaning.

The third dimension is *situation*; the place in which the narrative is produced, and the audience to whom it is told. This is addressed here through researcher reflexivity and discussion of the impact of the research setting.

### **Research setting**

The setting was a Local Authority funded, community-based substance misuse service providing integrated psychosocial and medical support for people misusing substances including alcohol. This included individual keyworking, group programmes, detoxification, and signposting to mutual aid and family support groups. Appointments were most often monthly, however could be weekly or even twice weekly if needed. The service allowed self-referral as well as referral from other agencies, and employed a Clinical Psychologist who offered specialised psychological therapies. The research setting was therefore a low-threshold substance misuse service which provided some specialised mental health support. At the time of the research the service 750 people were using the service, of which 160 had a primary substance use difficulty with alcohol.

### **Recruitment**

Recruitment was carried out by keyworkers on the basis of criteria discussed with them by the researcher at team meetings and individually. Seventeen of the 160 alcohol users were approached by their keyworkers and given a Participant Information Sheet (see Appendix B.1). Three service users declined to participate immediately. Fourteen agreed to being

contacted by the researcher, of which four did not attend appointments which the researcher then arranged with them. Ten took part in the research. Treatment was completely unaffected by service users' decisions about whether or not to participate in the study, and no inducements to take part were offered. Informed consent was obtained immediately before each interview; this included explanation of the right to withdraw from the study, and of the procedures for ensuring confidentiality and anonymity (see Appendix B.2 for a copy of the Consent Form).

#### Inclusion criteria:

Adults with coexisting mental health and alcohol misuse difficulties:

- At the time of the study, or in the previous two years, in service with both the substance misuse service and with specialist mental health services. Specialist mental health services included Community Mental Health Teams, Crisis/Home Treatment Teams and acute admission, and/or the Clinical Psychologist based at the substance misuse service.
- Primary substance difficulty with alcohol.

#### Exclusion criteria:

- Individuals who were at the time of the study in crisis relating to mental health, substance misuse or both, or if there was concern that the individual was so vulnerable that discussing their story with a new person could have led to increased risk to themselves or others;
- Individuals who were drinking alcohol daily at a level that would seriously impair their ability to consent to and participate in the research. However, stable daily drinking at a lower level did not in itself exclude a participant from the study.
- Individuals who were physically or mentally unwell to the extent that it would have been detrimental to their wellbeing to participate in the interview.
- Significant evidence of aggression towards staff that would have posed a risk to the principal investigator during an interview.
- Individuals unable to speak English

## Ethical approval

Ethical approval was obtained from an NHS Research Ethics Committee and from the person at the Local Authority with responsibility for Research and Development. See Appendices B.7 and B.8.

## Participants

Ten people took part in the study. Table 1 gives their pseudonyms and basic demographic information.

**Table 1: Participant pseudonyms and demographics.**

Pseudonym	Gender (M/F)	Ethnicity	Age Range	Mental health difficulty	Additional substances
Sheila	F	White British	30 – 39	Depression	Heroin (Current)
John	M	Black British	40 – 49	PTSD	Heroin (Past)
Gary	M	White British	60 – 69	PTSD	None
Trevor	M	White British	30 – 39	BPD	None
Sarah	F	White British	30 – 39	BPD	Various (Past)
Steve	M	White British	30 – 39	BPD	Heroin (Past)
Helen	F	White British	40 – 49	BPD	None
Laura	F	White British	50 – 59	PTSD	None
Bill	M	White British	50 – 59	Anxiety	Mephedrone (Past)
Mark	M	White British	40 – 49	Depression	Various (Past)

Notes: PTSD = Post-Traumatic Stress Disorder; BPD = Borderline Personality Disorder. Particular diagnoses were not required by the inclusion criteria, which focussed on use of services. The Mental Health column therefore gives the labels or diagnoses which the participants themselves referred to in the interviews. The same applies to the Additional Substances column.

## Procedure

All interviews were conducted by the researcher at the substance misuse service and were audio-recorded. The mean duration of the interviews was 43 minutes (range 20 – 61 minutes). Interviews were largely unstructured, with questions and prompts used as necessary to encourage participants to tell their story. Appendix B.3 gives an interview schedule.

## **Transcription and analysis**

All interviews were transcribed by the researcher within two weeks of being conducted. The researcher made marginal notes while transcribing to capture immediate impressions of the participants' stories, aiding analysis and reflexivity. Core stories were then created from each transcript, based on the approach developed by Emden (1998). Interviewer questions and utterances were removed, along with superfluous words and phrases. Words that detracted from the key idea of each sentence or group of sentences were then deleted.

'Subplots' were then identified within the remaining text, subplots being the key idea of a part of the story which produces meaning in the context of the story as a whole (Emden, 1998). Fragments of text were grouped together in subplots, with repetitious content deleted. The subplots themselves were reordered chronologically to create an overall core story of about a quarter of the length of the original transcripts. This followed the 'restorying' approach of Ollerenshaw and Creswell (2002), emphasising the continuity of the participant's story. An example of this process from raw transcript to core story can be found in Appendix B:4. Tables showing the subplots found in each transcript can be found in Appendix B:5.

The analysis then followed an iterative process of moving between the raw transcripts, the core stories, and analysis of the subplots within each core story. A summary of shared subplots across all the transcripts was developed, and ordered in terms of level of influential context, highlighting the links between individual narratives, community narratives including narratives about services, and dominant cultural narratives. Subplots were also arranged chronologically and shared phases in participants' recovery narratives were identified. These analyses of level of narrative and continuity of narrative were then synthesised into an overall presentation of shared subplots by level of influential context and continuity of narrative.

## Findings

A visual summary of the findings is provided in Figure 1, which presents shared subplots in terms of levels of influential context and continuity. Figure 1 also includes brief details of the situation in which the narratives were produced.

A more detailed account of the shared subplots follows, in three main sections following the three phases which were identified; origins of difficulties, episode of change, and ongoing journey of recovery.

### **Narratives about the origins of difficulties**

All the participants gave some account of the origins of their difficulties. Seven began their story by referring to traumatic experiences, with five of these specifically mentioning physical and/or sexual abuse in childhood. Several people contrasted their experiences with the idea of being 'normal'. For some participants their past self was defined by trauma, abuse, and powerlessness. Others described themselves as having been outside normal social structures or moral accountability. For two participants this was explicitly linked with a minority status; John, a black British man, said '*I was never accepted, I always wanted to be white.*' Helen, a gay woman, linked her alcohol misuse history to belonging to the '*very secret world*' of the gay scene in the late 1980s. Two of the male participants described and distanced themselves from a past self who had been involved in serious crimes; '*I did the shadiest things you could ever wish to think of. But that wasn't me*' (Mark). Emotional distress was mentioned before alcohol use in almost all the narratives. Several talked about how alcohol had been a comfort for them in coping with the symptoms of trauma.

Social disadvantage was implicit in participants' descriptions of the role trauma had played in their lives; in addition to specific episodes of trauma, participants tended to have grown up in an insecure or chaotic family environment, often lacking educational opportunities. Their lives as young adults tended to repeat these patterns, through involvement in crime, abusive relationships, or having children removed. Some participants talked about how problems with alcohol had started off as part of identifying with a social group or community. Steve gave this account of how he had substituted alcohol misuse for heroin addiction on release from prison:

**Figure 1: Summary of findings on the three dimensions of levels of influential context, continuity, and situation**

		Continuity				
Phase →		Origins of difficulties	Episode of change	Ongoing journey of recovery		
Chronology →		<i>Past</i>		<i>Present</i>	<i>Future</i>	
Levels of influential context	Dominant cultural narratives	Social normativity of alcohol use. Socio-economic disadvantage. Exclusion due to race or sexuality.	Personal growth through moments of redemption.	Mental health diagnosis providing medical validation of difficulties. Label of 'alcoholic' resisted in favour of mental health diagnoses, or embraced in mutual aid context.		
	Community and family narratives	Finding belonging or comfort in a social group through alcohol.  Lack of support from family or social institutions.	Joining a mutual aid group; support from a sponsor.  Family member confronted me.	Mutual aid: sharing experiences with others; valuing recovery above all else.  Family support; keeping going for my family.		
	Role of mental health and substance misuse services	Beneficial experiences ↗  ↘ Unhelpful experiences	Crisis leading to acute admission and/or diagnosis  Individual professional who understood  <i>Mental health difficulty not identified; problems attributed to alcohol</i>	Support from several services often including both substance misuse and CMHT  Practical help and respite  Therapeutic relationship with professional Flexible; trustworthy; therapeutic skills	Gives me a new perspective	I do not want to let them down  Challenge of therapeutic relationship ending
	Individual narratives	Trauma: Abuse in childhood, domestic abuse. I have never been normal. Not knowing my true self. Alcohol as comfort.	My own realisation I needed to change	Support from CMHT inadequate or absent; services are underfunded; punitive response to alcohol use.  Changing patterns in personal relationships, putting recovery first  Self-discovery; becoming honest; facing my emotions; focussing on myself		
Situation		Service	Substance misuse service with some mental health support; accepts self-referrals; participants referred by keyworkers.			
		Researcher	Previously an alcohol practitioner; research as part of a qualification; social-constructionist epistemological position.			

*When you're in jail everything's done for you. When you come back out you've got to live in a normal society. I was working and it was just party time and it was acceptable. So then it became a problem....*

By noting that alcohol was 'acceptable' Steve contextualises his development of a drinking problem within the dominant cultural narrative of alcohol use as a normal part of British society.

Other participants gave accounts of how alcohol offered belonging and support within their family or workplace. Gary reflected on his experience in the army in the 1970s, saying that drink was 'forced upon you...they didn't make you drink it but...it was just a natural thing.' Gary's was one of several stories in which the participant felt that they had spent a long time confused about their difficulties, without the help they needed to understand them.

### **Narratives about an episode of change**

Six participants described a particular episode which had led to change. In several cases this involved a conversation with a professional who saw and understood their mental health problem clearly. Helen describes how a nurse from the Crisis Team recognised that she fitted the diagnosis of Borderline Personality Disorder:

*She started talking to me, she'd ask me a question, and as soon as I started to answer she was finishing my sentences. And it was a breath of fresh air.*

For Helen, this was a moment of clarity, providing her with an explanation of her drinking behaviour as a way of coping with a mental health problem. Previously she had taken a series of overdoses resulting in acute admission, and her experience was that these were seen as simply alcohol-related. Similarly, Gary said 'no-one asked me why I drank', until a particular nurse recognised that he was suffering from PTSD.

Other participants attributed their episode of change to their own individual realisation. John gave this story about how he lost the taste for alcohol:

*It was a case of waking up one day, going into the shop, buying one can, really looking forward to it. Cracked it, had a swig [exhales]. Tasted wrong, tasted like it was off, that bad... I said d'you know what, I can't do this anymore. And the rest is history.*



John creates a narrative of personal responsibility and redemption. Though he notes that a *'push from my sponsor'* was an important part of his recovery, at the vital narrative moment of deciding to stop drinking, he is on his own. This creates a dividing line in John's narrative between his past, drinking self, and his present, sober self; reinforcing his decision not to drink.

Four participants did not give an account of a particular episode of change. Partly by virtue of this, these narratives tended to have less of a clear trajectory from a difficult past to a better future. Bill, for instance, said that there was a lot that he could not remember. Sheila, whose narrative is one of struggle and partial recovery, was nonetheless seeking a moment of change: *'maybe one time I'll come and something'll click.'* Trevor, in contrast, described a particular incident which had led him to say *'enough was enough'*, but this was within an overall narrative of ongoing struggle; *'battling every day to stay on the straight and narrow.'* Within Trevor's story of partial recovery, a particular incident of change plays less of a role.

### **Narratives about the ongoing journey of recovery**

#### Personal narratives

Several participants told stories of self-discovery; coming to know a truer version of themselves, in contrast with a past self who avoided or ignored the truth. Change was often narratively linked with reflexive talk about a realisation that one's sense of self needed revision or rediscovery:

*'I looked at myself, is that really me. That was the hardest point.'* Bill.

*'I've never understood me, I've never had a chance to experience me.'* John.

By describing themselves in this way, Bill and John open up a distinction between themselves as they have been and themselves as they are, creating a context for a story of personal growth and change.

For two participants, prioritising self-discovery meant a change in their approach to personal relationships. Helen presents her recovery as an opportunity to connect with her true self:

*I think my whole life has been... relying on other people and relying on relationships to keep me happy. Rather than ever look at myself and realise that I need to do that for myself...So, this is a time for me.*

Helen had lost her relationship, her home and her job and was living in a shared property. By emphasising her journey of self-discovery she is able to present this change as an important and temporary transition to a better future.

Mark had previously been in relationships with women who misused alcohol, and was in a new relationship with a woman who was also in recovery. However, he described recovery as his priority; *'if one of us was to mess up, we've both agreed that we'd just walk away'*.

### The role of mental health and substance misuse services

#### Unhelpful experiences

Nine participants talked about negative experiences of services, with four participants focussing on the local Community Mental Health Team as not meeting their expectations for support. Sarah described the CMHT as a *'waste of time'* and as *'doing nothing for me'*; similarly Sheila said that the CMHT *'don't really do anything'*. Trevor's experience was of a declining service:

*The psychiatric nurse I had [seventeen years ago], she was brilliant, but there's nothing like that now. I can't even keep my own care co-ordinator to talk to, cos they said the services are so overstretched.*

Sarah, Sheila and Trevor all wanted the CMHT to provide more practical and ongoing support. This was contrasted with the Crisis/Home Treatment Team (CRHT), who will *'come out and talk to you'* (Sheila), and particularly with the substance misuse service in which the interviews took place.

Other participants experienced mental health professionals as taking a punitive approach towards them because of their alcohol use. John said of a meeting with a psychiatrist *'I've had softer interviews with the police'*; Steve said *'I think as an alcoholic and a mental health patient, you get dragged into stereotype. A lot of people will say, well, while you're drinking we can't help you.'*

### Beneficial experiences

Every participant reported some benefit to engaging with mental health or substance misuse services. Sarah, for instance, had described being unable to cope with basic tasks following the death of her violent and controlling husband. She emphasises the practical respite provided by acute admission more than any medical or psychological support which was available:

*Being in [psychiatric hospital], that did give me time to reflect on what I was doing. I just found it so relaxing you hadn't got to worry about bills...*

Similarly, step-by-step practical support was central to the value of the substance misuse team for Sarah:

*[Substance misuse service] have been a big support to me, in getting me out [of the house]. It's right, this week's task is to learn to use the electric meter, next week's task, learn the gas meter. They put me in touch with [local housing and support service], [which] I found absolutely brilliant.*

For other participants, services provided a perspective which helped them revise their understanding of their difficulties. Sheila said:

*I think coming in talking about things does make it real. You feel like you didn't realise how long you've been doing it for and, it's just mad. It's that bit of a push, it does help you reduce a bit, because it's like I'm letting them down.*

Sheila was one of the participants who tended to move from describing one set of experiences to another without building an overall picture. Telling her story to her keyworker appears to give her some clarity. Similarly, Bill says of services '*They can see you changing, when you don't*'; both Bill and Sheila are prepared to trust that sometimes their keyworker has a clearer view of their recovery than they do themselves. Sheila's fear of '*letting them down*' is echoed by Gary, who says that he is '*not that type of person*' who would '*throw it back in their face*' by drinking. Maintaining his recovery has become a way of repaying the trust and concern of others.

Seven participants described a therapeutic relationship with a particular professional as a key part of their recovery. In most cases this was their keyworker at the substance misuse service. Laura's story of her past was one of powerlessness and not being able to trust others, particularly men. Now, however, she can use the image of her keyworker to soothe her distress:

*I trusted [keyworker], I couldn't trust any other males in my life, because of all the abuse...him understanding it all and giving me little coping mechanisms... No matter how bad I get, I just picture myself, I see [keyworker], telling me. So he's helping me, keep me grounded.*

Laura describes how she has internalised her keyworker and his messages of support; by contrasting him with the men who abused her, she tells herself a new story about the role of men in her life. It is also important to her that he has the knowledge and skills to understand her specific mental health difficulties. Other participants reported benefits from specific therapeutic interventions, such as Eye-Movement Desensitisation Response (EMDR; Gary) and Dialectical Behaviour Therapy (DBT; Helen).

Three participants discussed the future ending of their therapeutic relationship. All three created a narrative which acknowledged the distress that this ending would cause while maintaining that they would carry forward their keyworker's support in some way. Sarah found this way of constructing an account of the relationship ending:

*I'm sure [keyworker] is getting ready to drop the bombshell, say well you've got to move on. But I can't say that I haven't had my good innings, here. They've done a hell of a lot for me.*

Sarah's language makes it clear that the 'bombshell' of the ending will be difficult for her, but by describing her time as a 'good innings' she is able to claim it as a beneficial experience.

### Community and family narratives

Two participants told stories which were largely characterised by loss and struggle, but with elements of recovery present, including stopping or reducing drinking, and establishing more stable mental health. The recovery elements of both these stories drew heavily on

the idea of having to keep recovery going for significant others, especially close family. Bill, for instance, speaks of a sense of self that is primarily one of loss, especially of his masculine identity as someone able to do manual work. When talking about why he keeps going with recovery, Bill says:

*I've already lost everything and just got myself on the straight and narrow again. I wouldn't put my family through that again.*

Similarly, Trevor said that *'My eldest son actually accesses the mental health services as well... so I've had to keep myself going for him... You know, I've had to do it.'* Trevor's difficulties become part of how he can be a supportive father, reinforcing his commitment to recovery and distancing himself from his past self.

### Peer support

Four participants referred to peer support as part of their story of recovery, describing how the narratives of these communities had helped them change. John reflects on how shared experience helps him identify with others in peer support groups:

*It's sitting there with somebody else who's been in the same situation... You tell them your stories and then they'll tell you... theirs. And the events might have been one chalk, one cheese. But the feelings in the middle are all the same.*

John creates a story in which the essential part of his experience is shared by others, allowing him to identify with the values of the peer support group. Similarly Mark talks about how he has come to embrace the Alcoholics Anonymous (AA) approach to abstinence from alcohol, saying *'My sobriety now is the most important thing in my life.'* Belonging to the AA community helps Mark identify with abstinence as a community value rather than merely an individual decision.

### Dominant cultural narratives; changing identity in relation to labels and diagnoses

Participants differed in how they related to the labels and diagnoses that can follow from mental health difficulties and alcohol misuse. Helen embraced her diagnosis of Borderline Personality Disorder (BPD), but objects to being labelled an 'alcoholic':

*I went for a diagnosis. A lot of people are scared to get a diagnosis, but for me, to get a diagnosis meant that I could now start looking after my mental health and put the trust in mental health services... I'm not willing to have a label as an alcoholic.... I think I'm someone that has relied heavily on alcohol to deal with emotional upset.*

Helen conveys a very active sense of her role in her story. She takes control of the narrative around her diagnosis, using it as an opportunity to validate her identity as someone who is not 'an alcoholic' but has used alcohol because of a mental health problem. She distances herself from stereotypes around mental health and alcohol misuse, refusing to be defined by cultural perceptions of those labels. For Helen, having a mental health diagnosis (BPD) allowed her access to services and gave her a label she considered more desirable than 'alcoholic'.

Mark did not report a diagnosis of a particular mental health difficulty though he had had a number of acute admissions. He draws on narratives of what it means to have mental health issues in different ways within his story:

*I wouldn't say I was like real mental health issues because I've seen people in [psychiatric hospital] with real mental health issues I weren't hearing voices in my head...*

*I did have the Crisis Team come out and I didn't think they were very helpful. Cos they seemed to have this perspective, if you're not hearing voices in your head, you're not mental. I don't agree with that cos I was doing mental things, taking tablets and stuff like that. But that's not serious enough for them...*

Mark takes two positions in relation to mental health, contrasting his mental health issues with the 'real' difficulties of people with psychosis, but later objecting when he finds the Crisis Team's narrative about mental health excludes his distress. Mark's story may reflect a wider difficulty for both service users and professionals. May (2001) argues that when confronted with alcohol misuse, clinicians have to attempt to divide the 'susceptible', who

need treatment, from the 'culpable', who need to take responsibility for their actions (May, 2001, p. 385); here Mark's own narratives fall between these contradictory understandings.

## **Discussion**

This study had two aims; firstly, to investigate the narratives which people with coexisting mental health and alcohol misuse difficulties create about their recovery. Secondly, to investigate the role of mental health and substance misuse services in these narratives. This discussion explores the extent to which these aims have been achieved. The nature of the narratives themselves are discussed, followed by the role of services.

### **Recovery narratives: varying degrees of transformation and empowerment**

Participants followed varied pathways to recovery in terms of the relative importance of services, personal growth, family, mutual aid, and economic security. This is consistent with the findings from Paper One. Within this diversity, there was a common pattern in the shape of participants' narratives, from a traumatic past, through a phase of change, to an ongoing recovery phase. Many described gaining a sense of themselves as normal that they had never previously had. These could be described as narratives of transformation, distinguishing them from restitution narratives in which the narrator's difficulties are constructed as an interruption to a normal existence (Frank, 1995). Narratives of greater transformation tended to have a clearer structure, with a more defined episode of change.

Participants also described a journey of empowerment in relation to dominant cultural narratives. Rappaport (1995) describes narratives as unequally distributed resources; disempowered people tend to have fewer narratives available to them, and to internalise stigmatising cultural narratives about themselves. Many participants understood themselves as defective or morally failing. Alcohol provided comfort and social belonging, but alcohol misuse added to their stigmatised social position. For some this made it more difficult to obtain support for their mental health difficulty. Dominant cultural narratives thus worked against recovery, and recovery narratives required a change in how the participant related to these dominant narratives. This change took a range of forms. For instance, Helen opposed the label of 'alcoholic', while John embraced it but negated its stigma through membership of a recovery community. Medical narratives of mental health

were generally embraced. For some participants, a specific mental health diagnosis was cited as an important positive step in recovery, and allowed them to position their drinking as a symptom of mental difficulty rather than a moral failure (May, 2001). Others did not reflect explicitly on their relationship with these narratives, but drew comfort and understanding from internalising their keyworker's supportive perspective on their difficulties.

### **The role of mental health and substance misuse services**

Services played a key role in the change and ongoing recovery phases of many participants' narratives; this included acute hospitals, Crisis/Home Treatment Teams, CMHTs and substance misuse services. Participants valued individual, flexible and practical support; this is in line with the findings in Paper One. Where participants had less helpful experiences of services this related to barriers to access or a lack of flexible and ongoing support; most of these experiences were of CMHTs. Pilgrim and McCranie (2013) argue that mental health services have adopted a vision of recovery in which their role is to offer relatively brief, targeted support to treat specific difficulties. These findings suggest that this may create additional barriers for people with coexisting mental health and alcohol misuse difficulties, echoing previous research with people with psychosis and substance misuse (Edland-Gryt & Skatvedt, 2013)

In contrast, participants were particularly positive about the support available at the substance misuse service. This may reflect the recruitment through this service. The seventeen potential participants were selected by keyworkers, who would be inclined to select participants with whom they had a positive relationship. Participants then self-selected whether to take part in the research, with those more motivated and available more likely to have taken part. These are therefore the narratives of a self-selecting minority of service users, possibly fulfilling a sense of generosity or obligation to the service or their keyworker by taking part. With these caveats in place, it appeared that the flexible and consistent support offered by the substance misuse service was of benefit to service users. The substance misuse service allowed self-referral which may have made it more accessible to people with coexisting difficulties. Many participants gave particular importance to their therapeutic relationship with their keyworker, whom they were able to internalise as a source of support. This echoes both research on the use of a professional as



a positive attachment figure in substance misuse recovery (Waters, Holttum, Perrin, Campus, & Wells, 2014) and the narrative therapy view that through providing an alternative narrative, the therapist can facilitate identity change (Matos, Santos, Gonçalves, & Martins, 2009). It was also important for the keyworker to use specialist knowledge, particularly relating to the effects of trauma, to provide effective therapeutic interventions.

### **Reflexivity: the situation of these narratives**

Narratives are always told in a particular place, to an audience, for a purpose (Clandinin & Connelly, 2000). For the participants, there were several possible purposes in telling their story. This could include taking an opportunity to give feedback about services, or positioning themselves as an expert by virtue of their experiences. These and other purposes will have influenced the narratives produced.

Similarly the researcher had purposes in hearing the story, such as proving himself as a competent researcher. The researcher had previously worked as an alcohol practitioner in a substance misuse service. This experience is valuable in motivating the research, but will also have shaped the researcher's analysis of these narratives, since narratives fitting the researcher's previous experience may have appeared more salient. For instance, as an alcohol practitioner the researcher had difficulty obtaining adequate mental health support for some service users. This may have led to an emphasis on the difficulties participants had in accessing mental health services or the benefits of the substance misuse service. The practical advantages the researcher had as a former practitioner in this area must be weighed against the possibility of overlooking interpretations which did not fit with previous experience.

The researcher's social-constructionist epistemological position meant he was predisposed to understand participants' stories in terms of wider cultural narratives. This is congruent with the purposes of the research; however, it could exclude other interpretations. For instance, most participants had experienced significant pharmacological interventions, whether through chemical detoxification or psychiatric medication. Medical input here is discussed in terms of the power of dominant medical narratives, which may miss the importance of medical interventions to the participants' recovery.

### **Strengths and limitations**

A strength of this study is its originality in exploring the recovery narratives of a population which is overlooked by much previous research. This is especially significant given the size of this population, the stigma and disadvantage associated with these difficulties, and the fragmented nature of service provision. By recruiting from an agency which allowed self-referral, and on the basis of service use rather than diagnostic criteria, the study was able to reach people with a range of mental health difficulties alongside alcohol misuse. Finally, by using narrative methodology, the study has produced findings which link individual experiences such as childhood trauma with wider social and cultural forces and the role of services in recovery.

The study also has significant limitations. It excluded people who recover outside of services, replicating a shortcoming of much research in this area. By analysing only transcripts of recorded interviews, the study neglected the possible benefits of using wider narrative materials such as diaries, photographs or film (Andrews, Squire, & Tamboukou, 2013). Participant verification of narratives was not used, limiting the extent to which the study can claim to be empowering of its participants. The recruitment method relied on keyworkers' understanding of the aims of the research and on their perceptions of their clients. Service users experienced as more 'chaotic', for instance, may not have been approached, or may have declined to take part. This recruitment bias is doubtless reflected in the results. Further, some participants appeared to be less comfortable with the relatively unstructured interviews which were required by the narrative methodology. Those who were more used to talking about their difficulties, or perhaps who were better educated, may have been more likely to create fluent narratives. The study is also acknowledged to be the product of a particular context, so the generalisability of its findings is necessarily limited.

### **Conclusions**

Participants' narratives explored recovery as a process of gaining a sense of normality or moral acceptance that they had previously lacked, by changing their identity in relation to community and cultural narratives. The degree of this change varied, with the most clearly

structured narratives being those of greatest transformation. Substance misuse and mental health services played a significant practical and therapeutic role, along with other factors such as support from family members and mutual aid.

### **Clinical implications**

The prominent role of mental health and substance misuse professionals in participants' accounts of recovery could give professionals grounds for optimism that they can have a positive impact on this group, challenging pessimism about outcomes (Adams, 2008). The value participants placed on professionals having specialised therapeutic skills underlines the need for training in supporting this complex population. In particular, the role of childhood trauma in the origins phase of so many participants' narratives suggests that skills in supporting people who have experienced trauma are essential for professionals working with this group.

At a service delivery level, the value placed on practical and material support alongside psychosocial interventions highlights the importance of multi-agency working, both between mental health and substance misuse services and with third sector agencies such as housing associations. The provision of specialist mental health support within a substance misuse service was important in several stories. This suggests that the recommendation that existing services should adapt to meet the needs of people with coexisting severe mental illness and substance misuse difficulties (NICE, 2016) should also apply to people with non-psychotic difficulties who misuse alcohol. This could entail either substance misuse services providing elements of mental health support, as in the setting used for this study, or elements of substance misuse support being provided within mental health services.

### **Future research**

One possibility for future research would be to involve participants more in the design and execution of the research, with the aim that the research creates a product which would be of direct value to participants and other service users. For instance, a book of core stories or poems illustrating experiences of recovery, which could become a resource for service users and staff. This would be congruent with the aims of narrative research in ensuring that the recovery narratives of service users continue to be heard.

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## Appendices

### Appendix B.1: Participant Information Sheet

## Invitation to take part in a research study

### Participant Information Sheet

Title of Study: Narratives of recovery in people with co-existing mental health and alcohol misuse problems.

What is the purpose of this research?

Thank you for considering participating in this research. The aim of the research is to find out about the stories of people who have both mental health difficulties and alcohol difficulties. The research will also look at what recovery means to people and how they have found support from services.

Why are you doing this research?

Difficulties with alcohol and mental health are very common but the stories of people who have both difficulties have not often been researched. This could be useful to people who are working to provide better services for people with these difficulties.

What would taking part involve?

I am going to be conducting interviews with around ten participants. If you decide to take part, you will have one interview which will last for up to an hour. In the interview I will be interested in your story, what recovery means to you, and how you have found the different services that have supported you. I will ask you some questions; however, the main aim of the interview will be to give you a chance to tell your story in your own words.

Where and when would the interview take place?

The interview would take place in a private room at [REDACTED]. If you decide to take part then we can agree a time that is convenient for us both.

What information will you collect and what will you do with it?



I will record the interviews and the recording will be typed up and the transcript will be analysed along with the other interviews. This analysis will be written up and published in an academic journal. The recordings and transcripts will be kept securely for five years and then destroyed (this is in accordance with Data Protection legislation).

#### Will my information be anonymous?

Yes. I may use quotes from your interview in the write-up with your consent; however, your name and any other information that could identify you (e.g. your age and where you live) will be removed or changed.

#### Is the interview confidential?

Yes, the recording and transcript will be kept securely and not shared with anyone else. The only exception to this would be if you were to say something in the interview which indicated that you or anyone else could be at risk of significant harm. In that case I would have a responsibility to share that information to make sure that you and other people are safe.

#### What are the possible benefits of taking part?

The study is not designed to provide any particular benefits to people taking part, though you may find it rewarding to tell your story. You may also be pleased to know that by taking part you are contributing to research which will help services to understand the stories of people with these sorts of difficulties.

#### What are the possible disadvantages and risks of taking part?

The interviews will not particularly focus on difficult or traumatic experiences, however it may be that you find telling your story is emotionally difficult or draining. Please consider carefully whether taking part is right for you. For example, if you think that talking about your story for an hour might trigger a relapse, then it would be best not to take part in this research on this occasion.

#### What will happen if I don't want to carry on with the study?

You can choose to withdraw from the study at any time up to four weeks after the interview. If you decide to withdraw and let me know within four weeks, I will destroy

the recording and not use it when writing up the research. In all cases your information will remain anonymous.

Who is organising this study?

The study is being organised by Andrew Stott as part of a Doctorate in Clinical Psychology at the University of Staffordshire, and has been reviewed by an NHS Research Ethics Committee. Andrew will be carrying out the interviews and writing up the results.

What if there is a problem?

If you have a concern about any aspect of this study, please contact Andrew Stott on [REDACTED] or e-mail [REDACTED]. If you do not want to talk to Andrew about the problem, please contact Andrew's supervisor, Dr Helena Priest, at [REDACTED] or by telephone at Staffordshire University on [REDACTED].

You can also contact the Patient Advice and Liaison Service (PALS), which provides information and on-the-spot help to service users. PALS can be contacted on 01785 783026 between 9am and 5pm Monday to Friday, or by e-mailing [sssft.customerservices@nhs.net](mailto:sssft.customerservices@nhs.net).

If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. You can do this by telephoning 0800 318850 or 01785 783026 between 9am and 5pm, or by sending a letter to: Chief Executive, Freepost WV2103, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, St George's Hospital, Corporation Street, Stafford, ST16 3SR. You can also find an online form you can use to make a complaint, along with more information about the complaints procedure, at <http://www.sssft.nhs.uk/service-users-carers/service-relations>.

\*\*\*\*\*

Thank you again for considering taking part in this study. If you have any further questions please ask Andrew (or let your keyworker know that you would like him to get in touch).

E-mail: [REDACTED]

Research mobile: [REDACTED].

## Appendix B.2 Consent Form

Version: 1

Date: 15.04.16

Participant Identification Number for this study:

### CONSENT FORM

Title of Project: Narratives of recovery in people with co-existing mental health and alcohol misuse difficulties.

Name of Researcher: Andrew Stott

Please initial box

1. I confirm that I have read the information sheet dated 15.04.16 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the study without giving any reason, without my access to services or legal rights being affected.
3. I understand that relevant sections of my data collected during the study may be looked at by individuals from the Universities of Staffordshire and Keele, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.
4. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers.
5. I understand that my interview will be audio-recorded.
6. I understand that anonymised quotes from my interview may be used in publications by the researcher.
7. I agree to take part in the above study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## **Appendix B.3: Interview schedule**

### **Introduction to the interview**

I am interested in hearing your story of having both a mental health and an alcohol problem. I would like to hear about what has happened, what has influenced you and what recovery means to you. I am also interested in what part alcohol services and mental health services have played in your story.

### **Topic Prompts**

How did your story begin?

How did you first get involved with alcohol or mental health services?

What has it been like using these services?

Who and what has influenced you in your recovery and how?

### **General Prompts**

Could you say a bit more about that please?

What happened after that?

Is there anything else that seems important?

## Appendix B.4: Step-by-step example of the analysis process

### Stage 1: Raw interview transcript (extract of interview with Helen)

Interviewer: OK (.) so I wonder if you could just start by telling me, kind of your story (.) from your point of view (.) when it comes to alcohol, and mental health (.) (H: OK) where did it start from (.) what happened from there and (.) how have you got to where you are now (.) that story.

Helen: Umm, OK (.) so (.) I mean I'd always been a drinker, I started drinking when I was probably about fifteen (I: Mm hm) (.) did the whole club scene, whatever (.) um, got into various bits of trouble (.) through alcohol, binge-drinking (.) um (.) I always went to the pub with kind of (.) work colleagues (.) I worked kind of – worked for the Council but always in a Police building so we worked long shifts, and if you knew you had a couple of days off (.) umm (.) then we'd all go to the pub and clubs and stuff like that (.) (I: Mm hm) then (.) I got diagnosed with epilepsy (.) um, probably around ten years ago (I: Mm hm) and decided – I remember one of the questions that the neurologist asked me she said have you ever taken drugs or abused alcohol and I said well I've never taken drugs (.) um, and I said alcohol no (.) complete kind of like, bit of denial (.) knowing full well that I'd kind of binge drink (.) (I: Mm hm) you know since the age of fifteen or whatever (.) um (.) so, I actually gave up drinking for, about eight years (.) though I'd probably have like, in the summer, one can of Caffreys (.) um (.) and maybe a glass of Pimm's and maybe a sip of buck's fizz Christmas morning (.) um (.) and I guess up until that kind of eight years, always, with alcohol, I'd always end up getting into a fight, or (.) a serious argument or spend a night in a police cell (.) (I: Mm hm) I've got no, you know, convictions or anything I was very lucky (.) um (.) and then two (.) two and a bit years ago um (.) I had a long term relationship (.) finish (.) um (.) and I think I'd always maintained my mental health (.) um, you know I knew that I'd suffered from depression in the past (.) but I kind of, if I knew that I was stressed I would probably go off sick from work and stuff like that so I'd managed it without kind of alcohol (.) and then two years ago I had a long-term relationship came to an end and um (...) yeah, I mean I look- (...) I part owned a house, I was self employed as a therapeutic foster parent (.) um, so (.) yeah, so hence I was self-employed, I lost my job (.) lost the roof over my head because my ex (.) made it very difficult for me (.) and (.) I started drinking again (.) I started the first night drinking half a Guinness, the second night, pint of Guinness, pint and a half, the fourth night two pints and then I realised that Guinness is like a meal, so I needed to switch my drink (.) um (.) and that was two and a half years ago (.) um, I guess (...) I didn't drink when life was kind of OK, and I was in a relationship and felt kind of secure (.) and any kind of mental health issues that came up, I was managing (.) take me out of the security of a relationship (.) and take away my job, I was left with me (.) so (.) I slowly started drinking more and more, it was every night (.) I was meeting friends after work, their work (.) um (.) and that was in about the (.) July 2014 (.) by the (.) April 2015, I realised that my mental health wasn't good, I was (.) I wasn't sleeping (.) I was crying a lot (.) quite (.) just, emotionally (.) and quite um, what's the word (.) I was very distressed (.) um (...) and I went to the Doctor's (.) and I said look you know I haven't been sleeping and I mean I haven't been sleeping, you need to give me something (.) um, they (.) I begged them for sleeping tablets I didn't know anything about them never knew anyone that had taken them, but I just thought I need to sleep, so they gave me (.) sleeping tablets, I had to do two nights on, one, one day off and another two nights, so I went to the Doctor and I said look can you give me more and they were like

no (.) so I said OK fair enough (.) they put me on antidepressants (.) and that was in May 2015 (.) but because I'd left it from the (...) kind of June July when that relationship broke down (.) and I'd left it kind of six months before I went to the Doctor's (.) my mental health was really deteriorating and (.) in hindsight I know that I should've gone (.) before, but I was kind of the person that I'll be alright tomorrow, I'm having a crap day today, every day was like that I'll be better tomorrow (.) um (...) so what happened was, I got the antidepressants, and my drinking was still creeping up (.) and it got to a stage where, last summer (.) so, summer of 2015, I'd entered into a new relationship within two weeks of my old one (.) and that (.) was up and down (.) I was out of work (.) I'd never been out of work since I was about (.) eighteen, I think I was out of work when I was eighteen for a year, I've always worked, see myself as a professional, I've got a degree (.) and my drinking, probably from last summer (.) I started drinking wine (.) never particularly drunk wine in my life (.) discovered prosecco (.) I had a payout from my divorce (.) it was only fifteen grand (.) that went on alcohol (.) I started drinking (.) three bottles of wine a day (.) my (.) what I would call drink o'clock, it seemed to be OK if I wasn't drinking in the afternoon (.) but if I started about six o'clock in the evening to me, that was acceptable (.) but then that got earlier and earlier (.) to kind of three o'clock in the afternoon (...) um (.) and all the time, my mental health is deteriorating, I'm on antidepressants (.) and obviously if I'm drinking they're not working (I: Mm) (.) my life is falling apart (.) um, my relationship my new relationship is falling apart (.) um (...) I (.) and I did have a history of this as well (.) taking overdoses (.) um (.) within a period of fifteen months (.) I ended up taking (.) eleven overdoses (.) and it was only when (.) I came up to [place] this (.) first of February this year, and I continued to drink for a month, and I took (.) I was taking overdoses during February (.) during March when I was up here (.) and it got to one point where the Crisis Team came to see me (.) um, in hospital and when I got (.) released from, um (.) hospital (.) I just turned round and I said something's not right (.) no-one (.) takes this many overdoses (.) something's seriously not right this is not just to do with my drinking, there's something else going on (.) so, someone from the Crisis Team had been (.) um (.) just on a placement in a residential (.) for people with (.) er (.) Borderline Personality Disorder (.) um, and I didn't know at the time but they sent this nurse round to see me, I didn't know her background, she started talking to me, asking me questions (.) and, she'd ask me a question and as soon as I (.) started to answer (.) she was finishing my sentences (.) and it was a breath of fresh air (.) and I said to her how, how come you're finishing my sentences (.) I says whoa, this is like really freaky (.) then she said that she'd you know, been working in a residential blah blah blah and I said (.) OK, and I said right (.) I know something's not right, you know something's not right (.) can you refer me on to Community Mental Health Team (.) because (.) I need to see a Psychiatrist (.)

## Stage 2: Deletion of superfluous words, phrases and interviewer questions

Interviewer: ~~OK (.) so I wonder if you could just start by telling me, kind of your story (.) from your point of view (.) when it comes to alcohol, and mental health (.) (H: OK) where did it start from (.) what happened from there and (.) how have you got to where you are now (.) that story.~~

Helen: ~~Umm, OK (.) so (.) I mean I'd always been a drinker, I started drinking when I was probably about fifteen (H: Mm hm) (.) did the whole club scene, whatever (.) um, got into various bits of trouble (.) through alcohol, binge-drinking (.) um (.) I always went to the pub with kind of (.) work colleagues (.) I worked kind of — worked for the Council but always in a Police building so we worked long shifts, and if you knew you had a couple of days off (.) umm (.) then we'd all go to the pub and clubs and stuff like that (.) (H: Mm hm) then (.) I actually gave up drinking for, about eight years (.) though I'd probably have like, in the summer, one can of Caffreys (.) um (.) and maybe a glass of Pimm's and maybe a sip of buck's fizz Christmas morning (.) um (.) and I guess up until that kind of eight years, always, with alcohol, I'd always end up getting into a fight, or (.) a serious argument or spend a night in a police cell (.) (H: Mm hm) I've got no, you know, convictions or anything I was very lucky (.) um (.) and then two (.) two and a bit years ago um (.) I had a long term relationship (.) finish (.) um (.) and I think I'd always maintained my mental health (.) um, you know I knew that I'd suffered from depression in the past (.) but I kind of, if I knew that I was stressed I would probably go off sick from work and stuff like that so I'd managed it without kind of alcohol (.) and then two years ago I had a long-term relationship came to an end and um (...)~~  
~~yeah, I mean I look— (...)~~ I part owned a house, I was self employed as a therapeutic foster parent (.) um, so (.) yeah, so, hence I was self-employed, I lost my job (.) lost the roof over my head because my ex (.) made it very difficult for me (.) and (.) I started drinking again (.) I started the first night drinking half a Guinness, the second night, pint of Guinness, pint and a half, the fourth night two pints and then I realised that Guinness is like a meal, so I needed to switch my drink (.) um (.) and that was two and a half years ago (.) um, I guess (...) I didn't drink when life was kind of OK, and I was in a relationship and felt kind of secure (.) and any kind of mental health issues that came up, I was managing (.) take me out of the security of a relationship (.) and take away my job, I was left with me (.) so (.) I slowly started drinking more and more, it was every night (.) I was meeting friends after work, their work (.) um (.) and that was in about the (.) July 2014 (.) by the (.) April 2015, I realised that my mental health wasn't good, I was (.) I wasn't sleeping (.) I was crying a lot (.) quite (.) just, emotionally (.) and quite um, what's the word (.) I was very distressed (.) um (...) and I went to the Doctor's (.) and I said look you know I haven't been sleeping and I mean I haven't been sleeping, you need to give me something (.) um, they (.) I begged them for sleeping tablets I didn't know anything about them never knew anyone that had taken them, but I just thought I need to sleep, so they gave me (.) sleeping tablets, I had to do two nights on, one, one day off and another two nights, so I went to the Doctor and I said look can you give me more and they were like no (.) so I said OK fair enough (.) they put me on antidepressants (.) and that was in May 2015 (.) but because I'd left it from the (...) kind of June July when that relationship broke down (.) and I'd left it kind of six months before I went to the Doctor's (.) my mental health was really deteriorating and (.) in hindsight I know that I should've gone (.) before, but I was kind of the person that I'll be alright tomorrow, I'm having a crap day today, every day was like that I'll be better tomorrow (.) (H: Mm) (.) so what happened was, I got the antidepressants, and my drinking was still creeping up (.) and

it got to a stage where, last summer ~~(.) so, summer of 2015,~~ I'd entered into a new relationship within two weeks of my old one (.) and that (.) was up and down (.) I was out of work (.) I'd never been out of work since I was about (.) eighteen, ~~I think I was out of work when I was eighteen for a year,~~ I've always worked, see myself as a professional, I've got a degree (.) and my drinking, probably from last summer (.) I started drinking wine (.) never particularly drunk wine in my life (.) discovered prosecco (.) I had a payout from my divorce (.) it was only fifteen grand (.) that went on alcohol (.) I started drinking (.) three bottles of wine a day (.) ~~my (.)~~ what I would call drink o'clock, it seemed to be OK if I wasn't drinking in the afternoon (.) but if I started about six o'clock in the evening to me, that was acceptable (.) but then that got earlier and earlier (.) to kind of three o'clock in the afternoon (...) ~~um (.)~~ and all the time, my mental health is deteriorating, I'm on antidepressants (.) and obviously if I'm drinking they're not working (~~I: Mm~~) (.) my life is falling apart (.) ~~um, my relationship~~ my new relationship is falling apart (.) ~~um (...)~~ I (.) and I did have a history of ~~this as well (.)~~ taking overdoses (.) ~~um (.)~~ within a period of fifteen months (.) I ended up taking (.) eleven overdoses (.) and it was only when (.) I came up to [place] this (.) ~~first of February this year,~~ and I continued to drink for a month, and I took (.) ~~I was taking~~ overdoses during February (.) during March ~~when I was up here~~ (.) and it got to one point where the Crisis Team came to see me (.) ~~um,~~ in hospital and when I got (.) released ~~from, um (.) hospital (.)~~ I just turned round and I said something's not right (.) no-one (.) takes this many overdoses (.) something's seriously not right this is not just to do with my drinking, there's something else going on (.) so, someone from the Crisis Team ~~had been (.) um (.) just~~ on a placement in a residential (.) for people with (.) ~~er (.)~~ Borderline Personality Disorder (.) ~~um,~~ and ~~I didn't know at the time but~~ they sent this nurse round to see me, I didn't know her background, she started talking to me, ~~asking me questions (.) and,~~ she'd ask me a question and as soon as I (.) started to answer (.) she was finishing my sentences (.) ~~and~~ it was a breath of fresh air (.) and I said to her how, how come you're finishing my sentences (.) I says whoa, this is like really freaky (.) then she said that she'd ~~you know,~~ been working in a residential blah blah blah and I said (.) OK, ~~and I said~~ right (.) I know something's not right, you know something's not right (.) can you refer me on to Community Mental Health Team (.) because (.) I need to see a Psychiatrist (.)



### Stage 3: Deletion of words that detract from the key idea of each sentence or group of sentences

Helen: ~~I'd always been a drinker,~~ I started drinking when I was probably about fifteen (.) did the whole club scene, got into various bits of trouble through alcohol, binge-drinking (.) I always went to the pub with work colleagues (.) I worked ~~for the Council but always~~ in a Police building so we worked long shifts, and if you knew you had a couple of days off (~~-~~) then we'd all go to the pub and clubs (.) I actually gave up drinking for, about eight years (.) ~~though I'd probably have, in the summer, one can of Caffreys (-) and maybe a glass of Pimm's and maybe a sip of buck's fizz Christmas morning (-)~~ up until that eight years, always, with alcohol, I'd end up getting into a fight, or a serious argument or spend a night in a police cell (.) I've got no convictions or anything I was very lucky (.) and then two and a bit years ago I had a long term relationship finish (.) ~~I think~~ I'd always maintained my mental health (.) ~~I knew that~~ I'd suffered from depression in the past (.) ~~I knew that I was stressed I would probably go off sick from work and stuff like that so~~ I'd managed it without ~~kind of~~ alcohol (.) ~~and~~ then two years ago I had a long-term relationship came to an end ~~and~~ (...) I part owned a house, I was self-employed as a therapeutic foster parent (.) hence I ~~was self-employed,~~ I lost my job (.) lost the roof over my head because my ex (~~-~~) made it very difficult for me (.) and I started drinking again (.) ~~I started the first night drinking half a Guinness, the second night, pint of Guinness, pint and a half, the fourth night two pints and then I realised that Guinness is like a meal, so I needed to switch my drink (-) and that was two and a half years ago (-)~~ I didn't drink when life was OK, and I was in a relationship and felt secure (.) and any kind of mental health issues that came up, I was managing (.) take me out of the security of a relationship (.) and take away my job, I was left with me (.) so I slowly started drinking more and more, it was every night (.) ~~I was meeting friends after work, their work (-) that was in about July 2014 (-) by April 2015,~~ I realised my mental health wasn't good (.) I wasn't sleeping (.) I was crying a lot (.) ~~just, emotionally (-)~~ I was very distressed (...) and I went to the Doctor's (.) ~~I said look I haven't been sleeping, you need to give me something (-) I begged them for sleeping tablets, I just thought I need to sleep,~~ so they gave me (.) sleeping tablets, ~~I had to do two nights on, one, one day off and another two nights, so I went to the Doctor and I said look can you give me more and they were like no (-) so I said OK fair enough (-)~~ they put me on antidepressants (.) ~~that was in May 2015 (-)~~ but because I'd left it ~~from the (...)~~ kind of June July when that relationship broke down (.) ~~I'd left it kind of~~ six months before I went to the Doctor's (.) my mental health was really deteriorating (.) in hindsight ~~I know that~~ I should've gone (.) before, but I was kind of the person that I'll be alright tomorrow, ~~I'm having a crap day today, every day was like that I'll be better tomorrow (-) so I got the antidepressants, and~~ my drinking was still creeping up (~~-~~) and it got to a stage where, ~~last summer,~~ I'd entered into a new relationship within two weeks of my old one (.) and that (~~-~~) was up and down (.) I was out of work (.) ~~I'd never been out of work since I was about (-) eighteen,~~ I've always worked, see myself as a professional, I've got a degree (.) and my drinking, ~~probably from last summer (-) I started drinking wine (-) never particularly drunk wine in my life (-) discovered prosecco (-)~~ I had a payout from my divorce (.) it was only fifteen grand (.) that went on alcohol (.) I started drinking (~~-~~) three bottles of wine a day (.) ~~what I would call drink o'clock,~~ it seemed to be OK if I wasn't drinking in the afternoon (.) but if I started about six o'clock in the evening to me, that was acceptable (.) but then that got earlier and earlier (.) ~~to kind of three o'clock in the afternoon (-)~~ and all

the time, my mental health is deteriorating, I'm on antidepressants (.) and obviously if I'm drinking they're not working (.) my life is falling apart (.) my new relationship is falling apart (.) ~~I and I did have a history of taking overdoses (.)~~ within a period of fifteen months I ended up taking eleven overdoses (.) ~~and it was only when (.) I came up to [place] this year, I continued to drink for a month, and I took overdoses during February (.) during March (.)~~ ~~and~~ it got to one point where the Crisis Team came to see me in hospital and when I got (.) released I ~~just turned round and I~~ said something's not right (.) no-one takes this many overdoses (.) ~~something's seriously not right~~ this is not just to do with my drinking, there's something else going on (.) ~~so,~~ someone from the Crisis Team been on a placement in a residential (.) for people with (.) Borderline Personality Disorder (.) and they sent this nurse round to see me, ~~I didn't know her background,~~ she started talking to me she'd ask me a question and as soon as I started to answer (.) she was finishing my sentences (.) it was a breath of fresh air (.) ~~and I said to her how, how come you're finishing my sentences (.)~~ I says whoa, this is like really freaky (.) then she said that she'd been working in a residential blah blah blah and I said (.) OK, right (.) I know something's not right, you know something's not right (.) can you refer me on to Community Mental Health Team (.) because I need to see a Psychiatrist (.)

Stage 4: Identification of subplots and moving fragments of subplots together; further deletions of material that is repetitious or detracts from the key idea of each sentence or set of sentences.



Borderline Personality Disorder (.)they sent this nurse round to see me,  
○

she started talking to me she'd ask me a question and as soon as I started

to answer (.) she was finishing my sentences (.) it was a breath of fresh

air (.) then she said that she'd been working in a residential blah blah

blah and I said (.) OK, right (.) I know something's not right, you know

something's not right (.) can you refer me on to Community Mental

Health Team

**Andrew Stott**  
Deleted: and

**Andrew Stott**  
Deleted: (.) I says whoa, this is like really freaky

**Andrew Stott**  
Deleted: (.) because I need to see a Psychiatrist (.)

Stage 5: Identification of the use of different levels of narrative: personal, community, cultural

*Subplot: Alcohol providing belonging and release*

I started drinking when I was probably about fifteen (.) did the whole club scene (.) I always went to the pub with work colleagues (.) we worked long shifts, and if you had a couple of days off then we'd all go to the pub and clubs (.) ...Always, with alcohol, I'd end up getting into a fight, or a serious argument or spend a night in a police cell (.)

**Andrew Stott**  
Community narratives of alcohol use

*Subplot: Loss of relationship and of economic security*

I actually gave up drinking for about eight years (.) I'd always maintained my mental health (.) I'd suffered from depression in the past (.) I'd managed it without alcohol (.) I didn't drink when life was OK, and I was in a relationship and felt secure (.) Two years ago I had a long-term relationship came to an end (...) I part owned a house, I was self-employed (.) I lost my job (.) lost the roof over my head (.) take me out of the security of a relationship (.) and take away my job, I was left with me (.) I started drinking more and more (.) it got to a stage where I started drinking three bottles of wine a day (.)

**Andrew Stott**  
Personal narrative – relational security

**Andrew Stott**  
Personal narrative – loss of economic security;  
cultural narrative – loss of social status

**Andrew Stott**  
Personal narrative – not knowing my true self

*Subplot: Seeking help*

I realised my mental health wasn't good (.) I wasn't sleeping (.) I was crying a lot (...) I went to the Doctor's (.) they put me on antidepressants (.) but because I'd left it six months before I went my mental health was really deteriorating (.) I should've gone before, but I was kind of the person that I'll be alright tomorrow (.) and all the time, my mental health is deteriorating

**Andrew Stott**  
Personal narrative – I sort things out myself

*Subplot: Meeting a professional who understood my mental health difficulty*

Within a period of fifteen months I ended up taking eleven overdoses (.) it got to one point where the Crisis Team came to see me in hospital and when I got (.) released I said something's not right (.) this is not just to do with my drinking, there's something else going on (.) someone from the Crisis Team been on a placement in a residential (.) for people with (.) Borderline Personality Disorder (.) she started talking to me, asking me questions, and as soon as I started to answer she was finishing my sentences (.) and it was a breath of fresh air (.) then she said that she'd been working in a residential blah blah blah and I said (.) OK, right (.) I know something's not right, you know something's not right (.) can you refer me on to Community Mental Health Team (.)

**Andrew Stott**  
Cultural narrative – diagnosable mental health difficulty provides an acceptable explanation for overdoses and drinking

**Andrew Stott**  
Personal narrative – being understood by a professional is a key moment of change

## Appendix B.5: Summary of subplots for each transcript

### Helen

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	Alcohol providing belonging and release	Communities; gay scene of the 1990s, work	<i>...a lot of the gay bars then were in basements and stuff like that (.) So for me, going to a gay pub, club or whatever, was in secret. We still had things like Section 28 in place (.) In terms of publicly expressing feelings or relationships it was always done behind closed doors and in clubs and pubs.</i>
	Loss of relationship	Personal; alcohol as substitute for lost attachment figure	<i>I didn't drink when life was OK, and I was in a relationship and felt secure (.) Two years ago I had a long-term relationship came to an end (...) take me out of the security of a relationship (.) ... I was left with me</i>
	Loss of social status/economic security	Cultural; expectations of material and occupational success	<i>I'm in a shared house, with other women, I mean I've got a room (.) at my age, to share a house (.) you know, it's tough (.) especially when, you know, you've owned a house with partners or whatever</i>
Episode of change	Seeking help	Personal; used to sorting it out myself	<i>I went to the Doctor's (.) they put me on antidepressants (.) but because I'd left it six months before I went my mental health was really deteriorating (.) I should've gone before, but I was kind of the person that I'll be alright tomorrow</i>
	Meeting a professional who understood my mental health difficulty	Cultural; mental health difficulty explains drinking/overdoses. Personal; being understood is key moment	<i>Someone from the Crisis Team been on a placement in a residential (.) for people with (.) Borderline Personality Disorder (.) she started talking to me, asking me questions, and as soon as I started to answer she was finishing my sentences</i>
Ongoing journey	Support from Keyworker at Substance Misuse service	Personal; relationship with key professional	<i>If things became too much, it could be eleven o'clock in the morning, and if I wanted a drink I'd ring here and say I need to speak to [keyworker]. And she'd either get straight back to me, or she'd be there on the phone and she'd say what's the matter</i>
	Specific mental health intervention – DBT – was very useful.	Organisational; provision of specialist therapy	<i>I'm on a DBT course, and they got me on that really quickly.... I don't have a bad word to say in terms of the NHS and the mental health. I think because I met them halfway they opened the doors to me, and it was fantastic. I've put my faith in the DBT course and it's absolutely amazing.</i>
	Peer support; practical routine	Community; peer support provides structure	<i>I wouldn't be where I am now without... going to [peer support]. I got up and I got out of the house five days a week</i>
	Self-development and change	Personal; connecting with	<i>I think my whole life has been... relying on other people and relying on</i>

		my true self	<i>relationships to keep me happy. Rather than ever look at myself and realise that I need to do that for myself...So, this is a time for me. I've spent time on my mental health, my therapy and my DBT course are a priority.</i>
	Defining myself in relation to mental health diagnosis	Cultural; identifying with mental health diagnosis as an explanation for my difficulties, but countering cultural views of people with mental health difficulties	<i>I think because I was so self-aware, educated... I don't feel that at first I was listened to. Maybe I didn't fit the stereotypical person with a mental health issue... I went for a diagnosis. A lot of people are scared to get a diagnosis, but for me it was really important, because my outlook on life generally is positive. I'd just had a bad two years. So for me, to get a diagnosis meant that I could now start looking after my mental health and put the trust in mental health services</i>
	Defining myself in relation to narratives around alcohol	Cultural; positioning herself against the social identity of an alcoholic  Cultural; availability of alcohol is a challenge  Cultural; alcohol is part of being an adult	<i>I'm not willing to have a label (.) as an alcoholic. I think that I am somebody that cannot just have one drink. I think I'm someone that has relied heavily on alcohol to deal with emotional upset... I'll be in the supermarket and I'll just breeze past and see the price of Prosecco, ohh yeah that's a really good bargain. And that's all the time. So part of me would like to think, some point in the future, as an adult, I can just have a drink socially.</i>

Sheila

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	Early experience of emotional and physical abuse	Personal; trauma	<i>I've grown up with a lot of violence, a lot of nastiness, my step-dad was horrible to me, he used to call me names he used to hit me and ground me, so that weren't the best</i>
	Drinking as escape and belonging as a teenager	Community; belonging through alcohol	<i>After school we used to go drinking that twenty-twenty and the special cider (.) it was nice and I had a friend that used to drink super, 7.5, and I had one of them and I was like really merry ...it made me feel good, more outgoing because I've always been a quite in myself person</i>
	Not seeing it was a problem	Personal; not seeing myself	<i>You look back and you think, God, every day for the past year or so I've been having a can and you sweat and shake... It just gets on that path where you know you don't realise yourself, that it's like it is, and you think</i>

			<i>you're invisible you don't know that other people can see like what a mess you are.</i>
	Being isolated and not normal	Personal; absence of support, identifying as not normal	<i>I've never been like normal, there's always been something (...) in my life (.) I think it's the isolation where (...) I've not got a good network of family, or friends (.) So you just feel isolated.</i>
Episode of change	Practical support from hospital/Crisis Team is what helps me	Organisational; acute admission is route into services	<i>I tried to commit suicide, and I was in hospital. The man in the hospital, he was from [CMHT] (.) and he referred me to go and see them...The Crisis Team are good, because they come out, you ring them and they come out and talk to you and see what's best for you to do. [CMHT], I don't think they're very good really... I just feel like they don't get things done</i>
Ongoing journey	Psychologist helps me understand	Personal; relationship with professional Organisational; provision of specialist support	<i>I find (Psychologist) quite interesting, because you can make sense of, the way that I feel, like it's normal, like it's not just me... maybe one time I'll come and something'll click</i>
	Talking makes what I'm doing real	Personal; developing self-awareness	<i>I think coming in talking about things does make it real. You feel like you didn't realise how long you've been doing it for and, it's just mad. It's that bit of a push, it does help you reduce a bit, because it's like I'm letting them down.</i>
	My dog is really important to me	Personal; dog is a more reliable relationship	<i>He's my best friend in the world, he's not like peop- cos I've found a lot of people in my life, like I've said have let me know, but I love my dogs because they don't judge me, they don't slag me off behind my back, they don't ask nothing, there's no ulterior motive, just feed me, love me, take me for a walk</i>

John

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	Not belonging with my family	Personal; lack of secure base Organisational; care system	<i>I got put into a children's home at an early age, I've been dropped down the stairs by my first mother... My natural mum didn't want me, and I didn't want my adopted family</i>
	Being black meant I wasn't accepted	Cultural; racial difference	<i>I was always too black for the white lads and too white for the black... I was never accepted, I always wanted to be white</i>
	From being bullied to being a bully	Personal; victim and perpetrator of violence	<i>I used to get chased on a daily basis, beat up on a daily basis, till I was about seven (...) and then I learned to fight (.) which was (.) handy (.) so I ended up (.) from being bullied to being a bully</i>
		Personal; escaping	<i>I've never really been accountable for my actions (.) Yeah I've been in and</i>



		accountability	<i>out of jail, but as growing up (.) I've never really been accountable for (.) what I've done (.) I've always got out of it</i>
	Substance use covers mental health difficulties	Personal; substance use as solution	<i>My best friend, was my voice inside my head...it kicked in when I was about, five or six (.) lasted through till I was probably eighteen nineteen, then the drinking and the drugs took over and I think cos I think that dulled down the voice</i>
Episode of change	Particular event – hating the taste	Personal; moment of redemption	<i>It was a case of waking up one day, going into the shop, buying one can, really looking forward to it. Cracked it, had a swig [exhales]. Tasted wrong, tasted like it was off, that bad, that I couldn't physically finish ... and I said d'you know what, I can't do this anymore. And the rest is history.</i>
Ongoing journey	Getting to know myself and my emotions	Personal; self-discovery	<i>I've never understood me, I've never had a chance to experience me. I put the drink down, and I quickly realised the reason why I picked up drink in the first place, because I can't handle life... with [my] anger, there's no in-between.... all these emotions are the in-between</i>
	Finding belonging through peer support	Community; shared experiences in peer support	<i>It's sitting there with somebody else who's been in the same situation... You tell them your stories and then they'll tell you... theirs. And the events might have been one chalk, one cheese. But the feelings in the middle are all the same.</i>

### Gary

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	Trauma in the army	Personal; trauma	<i>I done some things that you shouldn't ask a young man to do... I had a bottle of whisky that night.</i>
	PTSD not recognised	Organisational; individual blamed by the organisation	<i>They never, not once did they ask me, why I drunk like that (.) they only saw it as, you're drinking too much, we'll have to stop you, they never, not once did they ask me the reason, why I drunk (.) and then, up in front of the Colonel, services no longer required</i>
	Alcohol as reward in the army	Community; expectation of drinking	<i>When you're in the army (.) when you're in the football team or the boxing team, you win something, you get rewarded wi' a case of beer (.) drink was forced upon you (.) no point – they dinnae make you drink it but, if you won something, you were rewarded wi' drink</i>
Episode of change	Years later my PTSD was recognised	Personal; recognition of mental health difficulty is key moment	<i>I ended up in [psychiatric hospital] (.) for drink ...it was the third time I was there (.) a male nurse there, ...he told me, he said I know what's wrong with you, it's post-traumatic stress</i>

	Specialist ex-military trauma service was a turning point	Community; shared identity Organisational; legitimisation of trauma experience	<i>It was such a weight off my shoulder seeing other people like me (.) cos I thought I was alone (.) and I saw all these other blokes (.) telling their stories and I was going (.) that's me (.) and that was such a relief</i>
	My wife got fed up of my drinking	Personal; crisis in relationship leads to change	<i>[Wife] get that fed up w'it one day, she tried to suffocate me (.) I thought I was dead (.) an she came down she said (.) I was drunk, I was drunk (.) she'd had enough (.) that's what sort of set the ball rolling</i>
Ongoing journey	EMDR made a massive difference to me	Personal; relationship with keyworkers  Organisational; specialist mental health support	<i>I went to see [psychologist]... and she was a godsend... we done [EMDR], it's brilliant. It was hard, don't get me wrong, it was hard. But we got through it, we done it. The results were tremendous, tremendous. I don't use it as a method of escape now, I talk to [my wife], or I can hone up [psychologist], or I can phone up [keyworker]. If I'd been on my own, I'd be dead now.</i>
	Importance of therapeutic relationship	Personal; ending of therapeutic relationship is a big step	<i>It's gotta come to an end with [psychologist], I know it has (.) but as I says to [psychologist] I said you're like diazepam, I cannae stop you right away.</i>
	I wouldn't let people down	Personal; integrity	<i>Let's say, right, I'll go and get drunk. Then I say, well that's me letting...down...people that have bent over backwards, to do their utmost for me, and I just throw it back in their face. Well I'm not that type of person.</i>
	I've got hope for the future	Personal; investment in my own life	<i>I can see the future but (.) I've never been so happy now than I've been in a long long time and drink's not going to ruin it. I don't use it as a crutch any more. I use my two legs now, the crutch is out the window</i>

### Trevor

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	My past came to the surface when my son was born	Personal; effects of trauma	<i>It all started, seventeen years ago, when my first son was born. I had a mental and emotional breakdown due to my past. I'd been emotionally and physically abused ... Which I'd kept to myself till the age of twenty-two. And then when my son was born it – it all came out</i>
Episode of change	I sought help because I was punishing my dog	Personal; I wasn't being the person I recognise.	<i>Seventeen years ago, it all come about because I used to punish my dog. That's where I first went to my doctor's. Enough was enough. My dog didn't deserve it bless her.</i>
	Dealing with my mental health has been a struggle	Personal; being born again  Cultural; stigma of	<i>It was a new way of life, talking about it. I was suffering from flashbacks, nightmares. It was like being born again... It's left me with depression, BPD. It was like everybody was looking at me and everybody knew. ...It</i>

		childhood abuse	<i>still affects me today, I've had countless tablets to try and stabilize me.</i>
Ongoing journey	I carried on drinking for a while because there aren't enough services.	Organisational; services should do more	<i>I stopped self-harming, but, I'd binge-drink for two or three years. Cos the services were so limited, at weekends when I'd got more time on my hands, I binge drank. I was drinking half to a bottle of vodka a day. Just to suppress. Cos I couldn't have services to access</i>
	Substance misuse keyworker is flexible, but the CMHT has let me down.	Organisational; the government don't put enough money in	<i>They've been brilliant here, [keyworker]'s come out to my house on a few occasions. But the other side has been terrible. I really do wish the government'd put more in.... I think they're overstretched to breaking point to be honest.</i>
	It's a struggle, but my family are there for me.	Personal; family keep me going	<i>My story overall has been very hard. Luckily I've got a very strong wife, and her family from her side have been brilliant. They could have just said (.) dump him he's a waste of space. But they've been there for me</i>

Sarah

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	I started drinking when my abusive husband died	Personal; victim of domestic abuse	<i>My husband was an alcoholic, you didn't know from one minute to the next what mood he was in.... What started it all off was [my husband] dying. I didn't realise how reliant I was on him. He did everything, he demanded that he would do it.</i>
Episode of change	I sought help from my GP	Personal; sought help when I hit rock bottom Organisational; GP as first port of call	<i>Basically I broke down in front of a doctor saying I shouldn't be here, I'd tried to commit suicide and blah blah blah. He made a few phone calls, to see what he could do to help me</i>
	Psychiatric admission was a respite from my problems	Organisational; practical respite more significant than medical or psychological intervention.	<i>Being in [psychiatric hospital], that did give me time to reflect on what I was doing. I just found it so relaxing you hadn't got to worry about bills, you hadn't got to turn around and say well where's my next meal coming from</i>
Ongoing journey	The CMHT were no use to me	Organisational; CMHT seen as less useful because less flexible	<i>All in all, I actually waited three months, from my release, meeting anyone from the CMHT... They never followed through with anything, as far as I was concerned</i>
	Practical support from substance misuse service helped me	Organisational; flexibility and practical support	<i>[Substance misuse service] have been a big support to me, in getting me out [of the house]. It's right, this week's task is to learn to use the electric</i>

			<i>meter, next week's task, learn the gas meter. Making a challenge each week. They put me in touch with [local housing and support service], [which] I found absolutely brilliant.</i>
	I'm anticipating the ending with my keyworker	Personal; end of secure relationship	<i>I'm sure [keyworker] is getting ready to drop the bombshell, say well you've got to move on. But I can't say that I haven't had my good innings, here. They've done a hell of a lot for me, and to be truth, I agree with [keyworker] there's not much more they really can do for me. For me personally, just carry on, but I know it can't happen, that's not fair on other people.</i>

Steve

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	Didn't feel able to seek help for mental health difficulties as a child	Personal; trauma Organisational/cultural; change in perception of mental health difficulties.	<i>I had a mental problem from a very young age, but when you're thirteen fourteen you don't want a psychiatrist. You'd feel stupid. So you didn't talk to them then. So it weren't, I don't know, it weren't accessible. Nowadays it's more accepted, it's more accessible.</i>
	Alcohol is considered normal, so I didn't realise it was a problem.	Cultural; alcohol as normal Organisational; institutionalisation in prison	<i>When you're in jail everything's done for you. When you come back out you've got to live in a normal society. I was working and it was just party time and it was acceptable. So then it became a problem....I wanted to fit in. When I was a heroin addict you're ostracised, but when you're an alcoholic it's so acceptable to have a drink.</i>
	Not wanting to accept that I had a problem; not seeing it.	Personal; not seeing how I really was. Cultural; craving cultural norm of family life	<i>When you've got a family there you don't want to accept you've got a mental health problem It deteriorated and deteriorated over the years between me and my ex-partner. There was a lot of shouting a lot of arguments. But when I was in that madness, you don't realise you're in that madness.</i>
Ongoing journey	I drink because of my mental health difficulties, services don't understand.	Organisational; alcohol misuse as a barrier to accessing services.	<i>I think as an alcoholic and a mental health patient, you get dragged into stereotype. A lot of people will say, well, while you're drinking we can't help you. But then the reason you're drinking is because you're deteriorating. Beer gives you confidence, and that blocks out the anxiety.</i>
	Wanting to be normal	Personal; my identity is still as someone outside of the normal.	<i>It was always easier for me just to push it all under the carpet. But until I let go, until my head lets go, I'll never be normal. And that's all I've ever craved, to be normal.</i>

Laura

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	Early experience of sexual abuse, continued domestic abuse in adulthood	Personal; trauma Cultural; violence against children and women	<i>I was left for dead, me and my daughter were. I didn't know what was all happening at the time. Obviously with my mental health side or anything. I just kept on coping with every bad situation I had.</i>
	Alcohol as a way to cope with symptoms of trauma	Personal; coping	<i>The only way I could deal with it, was drinking. All my life, that's what I done. Something would happen and I'd drink for a while</i>
	Dissociating to protect myself from the chaos of my experience	Personal; effects of trauma	<i>I kept on jumping, they call it. Going back to when I was little. And then all them Lauras started coming out.</i>
Episode of change	A particular conversation helped me stop drinking	Personal; realisation.	<i>Thursday night I went to a recovery group, and the man said to me, what medication are you on. And I said I'm still on my chemo tablets. And when I said that I realised, I'm killing myself with the drink, or I'm killing myself cos of my cancer. So, I stopped drinking that Thursday night, and I haven't touched a drink since.</i>
Ongoing journey	Trust in the women's group meant I could discuss my trauma.	Community; women's group provides safe space.	<i>I started my women's group. And then all this sexual stuff was coming out, and I was able to trust them and they trusted me cos I opened up as well. And it's the first time I felt safe and I can talk.... To get all the way through what I had done, and still be here, it's a miracle, I think</i>
	I trusted my keyworker and he gave me tools to cope with my symptoms.	Personal; keyworker as secure base. Organisational; understanding of mental health in the substance misuse team.	<i>I trusted [keyworker], I couldn't trust any other males in my life, because of all the abuse...him understanding it all and giving me little coping mechanisms... No matter how bad I get, I just picture myself, I see [keyworker], telling me. So he's helping me, keep me grounded.</i>
	The mental health team were no help.	Organisational; exclusion from CMHT	<i>They sent me to this lady in the mental health team but I would start talking, and I would start regressing. And she turned around and said she couldn't deal with it. ...they weren't doing what I thought they would do to help me</i>
	Better relationships with my children	Personal; self-development	<i>For my kids to turn round and say mum, you're actually dressing like an adult Mum, you're talking like an adult. Whereas before, you were talking like a child... you were dressing like a child. I couldn't believe I'd been a child state for forty-five years of my life.</i>
	I've learned to believe in myself.	Personal: self-development	<i>It's actually me believing in myself, that I'm a human being. Because I used to think that I was a dead person walking. But I'm not, I'm a real person,</i>

			<i>and I count. And what I really want in life now.</i>
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Bill

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	Drinking as part of male, manual working identity	Community; manual work Cultural; masculinity and alcohol	<i>When I went into the building trade, I was too young to drink. When we finished on a Friday I'd go out with them, so I was drinking early....So I just got in the habit, drinking every day, didn't think nothing of it. Cos I was a strong lad, just carrying on building.</i>
Episode of change	Behaving in ways I do not recognise as myself	Personal; lost my true self	<i>I looked at myself, is that really me. That was the hardest point</i>
Ongoing journey	Professionals see what is really happening and can help	Organisational; valuable support from both CMHT and substance misuse team.	<i>[Mental Health Team] were really good. I'd probably be locked up if it wasn't for them....[Substance Misuse Service], it's good. They tell you how you are and what you was like, and you see you're in a mess... They can see you changing, when you don't'</i>
	Loss of the man I used to be	Personal and cultural; masculinity.	<i>If I don't isolate myself I'll be back on it again. I'm not that guy I used to be, I can't build no more</i>
	I keep my recovery going for my family	Cultural; identifying with the value of family.	<i>I've already lost everything and just got myself on the straight and narrow again. I wouldn't put my family through me again.</i>

Mark

Phase	Subplot	Level of narrative	Examples
Origin of difficulties	Drinking giving the confidence to belong	Community; belonging with friends	<i>It started off with school friends, quite normal really, to start with. I found problems with dealing with people and that, but if I'd got a drink in me I was alright, I could speak to anyone</i>
	My drinking self did things that	Personal; not the real me	<i>I had an affair, and I had a relationship breakup and um I couldn't handle</i>

	were not really me		<i>what I'd done, it wasn't in my character... I was waking up in the night, just to get back to sleep I was having a swig of beer I did the shadiest things you could ever wish to think of. But that wasn't me</i>
Episode of change	Personal connection with police officer led to my realisation that I needed to change.	Personal; being understood, finding real self  Community; dis-identifying with criminal group	<i>Two police officers sat with me all day. One had arrested me a few times. My old so-called world, you didn't speak to copper and that like. But we actually spoke that day, and she said I've known you a lot of years, and I've arrested you a lot of times, and you've always had the gift of the gab, and you've always got away with a lot of stuff. But the things you've been arrested for over the last 18 months, They're just not you. You've lost the plot. And she explained that she had a brother that was an alcoholic, she went out of her way. My mum came and sat with us and it was quite an emotional day. It finally dawned on me the next morning, I can't do this no more.</i>
Ongoing journey	I had a mental health problem, but also not a <i>real</i> mental health problem.	Cultural/organisational; relating to a divided understanding of his behaviour.	<i>I wouldn't say I was like real mental health issues because I've seen people in [psychiatric hospital] with real mental health issues I weren't hearing voices in my head... I did have the Crisis Team come out and I didn't think they were very helpful. Cos they seemed to have this perspective, if you're not hearing voices in your head, you're not mental. I don't agree with that cos I was doing mental things, taking tablets and stuff like that. But that's not serious enough for them... Did I have a mental health problem. Yyes... Did I try to play on it. Definitely.... I was never truly honest, and I think you've got to be completely honest.</i>
	Sobriety through AA is my priority	Community; identifying with values of AA	<i>My sobriety now is the most important thing in my life. That comes before anything. When I was told that I thought, that's a bit... steep, but it's right. Because if I haven't got my sobriety, I haven't got anything. It feels good to have a programme in my life. Something I thought I'd never have.</i>
	Prioritising myself over being in a relationship	Personal; self before relationships	<i>If one of us was to mess up, we've both agreed that we'd just walk away</i>
	My substance misuse keyworker helped me	Personal; trusting relationship with keyworker.	<i>I've got to hold my hand up, if it wasn't for [keyworker], she's done wonders with me and she's brilliant at her job. We're talking about discharge now, and it's a big step, but it's a good step as well. I'm going to miss her because she's helped me through. She's very sensitive, she's very direct, and I owe a lot to her.</i>

## Appendix B.6: Independent Peer Review Approval



Date: 02/03/2016

**To whom it may concern**

### **Application for Independent Peer Review Approval**

**Researcher:** Andrew STOTT

**Study Title:** Narratives of people with mental health and alcohol misuse

I can confirm that Staffordshire University supports this research project proposal being put forward by the above research project applicant, and that the University is willing to act as sponsor of the project if it received LREC approval.

Our support for this project takes account of the outcome of an independent peer review of its scientific merit undertaking within the University.

I can also confirm that the University has generic indemnity/insurance arrangements in place as stated on the attachment to this letter, that arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed, that arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts and that the duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

A handwritten signature in blue ink, appearing to read 'N. Chockalingam'.

Professor Nachi Chockalingam  
Chair,  
University Academic Ethics Sub-Committee



## Appendix B.7: NHS Research Ethics Committee Approval



### Health Research Authority

North East - Newcastle & North Tyneside 1 Research Ethics Committee

Jarrow Business Centre  
Room 001  
Viking Industrial Park  
Rolling Mill Road  
Jarrow  
NE32 3DT

Telephone: 0207 104 8085

29 March 2016

Mr Andrew Stott  
Trainee Clinical Psychologist  
1b Meyrick Road  
Stafford  
ST17 4DG

Dear Mr Stott

**Study title:** Narratives of recovery in people with co-existing mental

**health and alcohol misuse difficulties.**

**REC reference:** 16/NE/0099

**IRAS project ID:** 198822

The Proportionate Review Sub-committee of the North East - Newcastle & North Tyneside 1 Research Ethics Committee reviewed the above application in correspondence.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Miss Kathryn Murray, nrescommittee.northeast-newcastleandnorthtyneside1@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

#### **Ethical opinion**

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### **Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

A Research Ethics Committee established by the Health Research Authority

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).*

*Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of management permissions from host organisations.*

#### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion").

## **Summary of discussion at the meeting**

### **Recruitment arrangements and access to health information, and fair participant selection**

The Sub-Committee requested clarification around who would be responsible for determining a participant to be 'too vulnerable' to take part in the project. It was further queried whether this would be part of the screening process or be during the interview.

*You responded to explain that determining whether the participant was too vulnerable to take part in the research was primarily part of the screening process. You explained that this would be carried out by keyworkers at the service who would assess whether the client met any of the exclusion criteria relating to vulnerability. You added that these included current crisis relating to mental health or substance misuse, or concern that discussing their story with a new person could lead to increased risk to self or others. You provided an example if a client was currently discussing highly sensitive details of past trauma with the Clinical Psychologist who worked at the service, this would not be a good time to invite them to take part in this research. You explained that the client's keyworker, having worked clinically with the client, would be best placed to make this judgement, you confirmed that you would discuss this with the team before any potential participants were approached about the research, so that they were clear to avoid approaching clients for whom the interview may not be suitable. You further added that the Participant Information Sheet asked the participant to consider carefully whether taking part was right for them.*

*You added that further to this, during the process of gaining informed consent you would discuss what the interview involved to ensure that the client understood this and whether they had any queries or concerns. This included ensuring that they were clear that this was an interview for research and not for therapy. You further explained that you would not proceed with the interview if he was concerned that the client may find it too distressing. You added that whilst you would be in researcher rather than a clinical role during the interview, you would also stay alert to any signs that the participant was becoming overly distressed by the interview and terminate the interview if this was necessary.*

Members received the response and no further issues were raised in this area.

### **Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity**

The Sub-Committee requested confirmation around whether the data was being stored on a home computer and what security measures were in place if this was the case.

*You confirmed that personally identifiable data would be stored on a password-protected NHS laptop and/or on an encrypted, password-protected NHS memory stick. You explained that this equipment was owned by your employer, South Staffordshire and Shropshire NHS Foundation Trust.*

*You further explained that anonymised data (anonymised transcripts of the interviews) would be kept on his home computer, and the report which would be produced based on the analysis (including some anonymised quotes) would also be kept on his home computer and subsequently published. You further added that your home computer was password-protected and you would also password-protect the individual documents. You confirmed that all the passwords used*

would follow guidelines for creating secure passwords (i.e. use of symbols, numbers, lower and uppercase letters etc).

Members noted from the application that support from the clinical team would be available if distress was caused and identified and if the participant wanted this. Confirmation was requested that this support had been agreed with the clinical team.

*You confirmed that this support had been agreed with the clinical team who were supportive of the project.*

The Sub-Committee received the responses and no further issues were raised.

### Approved documents

The documents reviewed and approved were:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		01 August 2015
Interview schedules or topic guides for participants		
Interview schedules or topic guides for participants	1	16 March 2016
IRAS Checklist XML [Checklist_10032016]		10 March 2016
IRAS Checklist XML [Checklist_16032016]		16 March 2016
IRAS Checklist XML [Checklist_18032016]		18 March 2016
Letter from sponsor		02 March 2016
Letter from sponsor		02 March 2016
Other [Educational Review]	1	20 July 2015
Other [Formative Research Proposal]	1	24 June 2015
Other [Peer Review Document]	1	13 January 2016
Participant consent form	1	16 March 2016
Participant information sheet (PIS)	1	16 March 2016
REC Application Form [REC_Form_18032016]		18 March 2016
Research protocol or project proposal	1	16 March 2016
Summary CV for Chief Investigator (CI)		16 March 2016
Summary CV for student		16 March 2016
Summary CV for supervisor (student research)		16 March 2016

### Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research

Ethics Committees in the UK.

### After ethical review

#### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

### HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

**16/NE/0099**

**Please quote this number on all correspondence**

Yours sincerely



pp.  
**Dr Mike Bone**  
**Vice Chair**

Email: [nrescommittee.northeast-newcastleandnorthtyneside1@nhs.net](mailto:nrescommittee.northeast-newcastleandnorthtyneside1@nhs.net)

*Enclosures: List of names and professions of members who took part in the review "After ethical review – guidance for researchers" [SL-AR2]*

*Copy to: Elizabeth Boath, Staffordshire University*

## **Appendix B.8: Research and Development Approval from the Local Authority**

Hi Andrew ,

In regard to your request to undertake a the research project in [REDACTED]:

I am the Service Delivery Manager for Community Casework in [REDACTED] Council: my post covers Mental Health, Drug and Alcohol Recovery, ALD, PD and Older People in Adult Social Services. . I believe this project will assist in providing relevant and accurate information that will in turn assist in the consideration of and progress of service improvement in Telford. I have read the amendments and am in agreement with them. I am writing to confirm my continued approval for Andrew's research

**Andrew Bailey**  
**Service Delivery Manager**  
**Community Casework**

[REDACTED]

Tel: 01952 381221

[andrew.bailey@\[REDACTED\].gov.uk](mailto:andrew.bailey@[REDACTED].gov.uk)

[www.\[REDACTED\].gov.uk](http://www.[REDACTED].gov.uk)

## **Paper Three: Reflective Paper**

**The story of my research into recovery narratives**

Word count: 4825

## **Introduction**

Paper One was a traditional critical literature review investigating how people with coexisting mental health and substance misuse difficulties experience recovery. Paper Two was a narrative analysis of the transcripts of ten interviews with people with coexisting mental health and substance misuse difficulties. It explored how they constructed their recovery narratives and the role of mental health and substance misuse services in these narratives.

This paper is a reflective account of the process of undertaking the research presented in papers One and Two. In this paper I comment on the personal and professional experiences that led me to undertake research in this area, the practical, methodological and ethical challenges of carrying out the research, and how this has informed my development as a researcher.

### **Beginning: where I started**

My own personal interest in stories dates at least as far back as my (unpublished) 1986 work *Have you ever seen an elephant whose ears were too big?* An elephant has a problem; his ears are oversized, at least in relation to dominant human cultural narratives of how elephants should look. In a twist of fate, however, his large ears give him a special gift. He is able to fly. His story is one of transformation, from comic defectiveness to joy. Such stories of transformation have always appealed to me. Another story which influenced me began with the premise that unequal access to resources shapes oppressive individual and cultural narratives, and proposed that the solution to this oppression would be the transformative overthrow of the existing economic order (Marx, 1848). I have long been interested in personal and social change, and in stories which challenge or deepen my understanding of what a problem looks like and what a solution might be.

### **Epistemological Position**

It has therefore been natural for me as a Trainee Clinical Psychologist to take an interest in models which link the personal and the social. Community Psychology, for instance, which



views individual distress as a natural response to difficult life situations created by underlying social and material inequality (Smail, 2005). This challenges the conceptualisation of mental health difficulties as individual pathology. A social constructionist epistemology fits well with this perspective, as it sees knowledge as being socially constructed, with the aim of the social constructionist researcher being to uncover the social power relations underlying apparently common-sense concepts such as mental illness or alcoholism (Berger & Luckmann, 1966). Narrative research appealed to me because it draws attention to how personal stories use the available social narratives. The narrative researcher can explore individual experience whilst accounting for how it is shaped by the distribution of material and narrative resources (Rappaport, 1995).

#### Experiences of fragmented support for people with coexisting difficulties

My previous work as an Alcohol Practitioner for a community substance misuse service greatly influenced me in the development of this research. It was apparent that people who misused alcohol frequently had mental health difficulties, varying from anxiety or depression as a result of their alcohol use, to a wide range of complex difficulties from which alcohol provided some escape. As an Alcohol Practitioner, I wanted to be able to do more to help people with complex difficulties, but there were several barriers to this. My role as an Alcohol Practitioner was clear; to support the person to recover from alcohol misuse, and to signpost them to other services for support with other difficulties. This was in line with the organisation's commissioning, and was the work I was supervised to do; further intervention would therefore have been unethical. I also lacked the more specialised therapeutic training needed to offer support for complex difficulties.

I therefore needed to signpost or refer people who appeared to have mental health difficulties to specialised mental health services. Here, however there were several barriers for my clients. People with less complex difficulties could be referred to an IAPT (Improving Access to Psychological Therapies) service locally, which offered CBT for anxiety and depression. People who met the criteria for this service reported that it was beneficial, but many people did not meet its criteria, which excluded anyone with more complex mental health problems, and anyone who was considered at risk of suicide. Anyone with a history or current pattern of taking overdoses when intoxicated would be automatically excluded.

Exclusion from IAPT did not, however, guarantee eligibility for secondary mental health services. For instance, one man I worked with had experienced a great deal of trauma. Part of his motivation to stop drinking was the belief that he would then be able to get support to deal with the effects of the trauma. However, an appointment with a CMHT was a long time coming, and when it did come it was an assessment appointment and a medication review; there was no offer of any therapeutic input. This did not appear to be the result of any neglect of responsibility on the part of any of the professionals involved; it was simply that the structure of services excluded this man from getting specialised support. The CMHT's threshold for treatment seemed to be very high, in contrast with the substance misuse service which accepted self-referrals. This first-hand experience of the impact of fragmented services provoked my interest in the recovery journeys of people with coexisting mental health and substance misuse difficulties.

I also became interested in the benefits and challenges of the recovery model. The culture of the organisation had undergone a dramatic shift over the previous five years; a 'therapeutic model' in which practitioners worked with clients for long periods was replaced by a 'recovery model' which emphasised SMART targets and strictly time-limited pieces of work. This change seemed to me to have had many benefits; the service treated far more clients, and had strategies for signposting clients who were not making changes to other options including groups and mutual aid. However, it meant that some of the longer-term support which had previously been provided to clients with complex difficulties was no longer possible. Pilgrim and McCranie (2013) argue that a similar pattern exists in mental health services; recovery is taken to mean that the role of services in people's lives should be limited and targeted, and this of course reflects the very real financial pressures which services face.

#### My specific interest in alcohol misuse

My interest in researching the experiences of people with alcohol misuse difficulties rather than substance misuse more generally was, naturally, partly related to my own first-hand experience with this group. There were aspects of my experience, however, which provided the beginnings of a rationale which went beyond a sense of personal loyalty. The substance misuse service I worked for covered an urban setting which included some very deprived

and some relatively wealthy areas. It was noticeable that while there were many more clients who used illicit drugs from the most deprived areas, alcohol misuse had a much more widespread impact. This reflected trends in British society generally (Office for National Statistics, 2015). Paper One showed that much of the qualitative research into coexisting mental health and substance misuse difficulties has focussed on people who use illicit drugs and on more deprived communities. I became interested in carrying out research which would include people from a wider range of social backgrounds.

Another distinction between alcohol misuse and substance misuse more generally was found in the attitudes held by staff. Alcohol using clients tended to be experienced as needy and vulnerable, whereas drug using clients were perceived as having a tough exterior masking underlying distress. This was of course unscientific stereotyping; but it was interesting to discover in carrying out the literature review that much previous research had focussed on people with psychosis; people who misused alcohol and had a wide range of mental health difficulties were largely absent from the literature.

### **Middle: carrying out the research**

This research started with a proposal which I wrote in June 2015. I obtained the support of the Independent Peer Review panel at Staffordshire University in March 2016, and ethical approval from an NHS Research Ethics Committee in April 2016. I completed my recruitment by October 2016 and began to write up the research. This was a lengthy process compared with my previous research experience. My understanding of the questions that I was investigating developed greatly over this time and I was confronted with many decisions about how the research would develop, especially in relation to the empirical paper. This middle section details and reflects upon some of these decisions.

#### **The Literature Review**

I had proposed to conduct a literature review on the recovery narratives of people with coexisting mental health and alcohol misuse difficulties. My initial scoping of the literature, however, showed that there was very little research that focussed on this group specifically. Some papers did investigate recovery narratives, and ideas from these papers provided

useful background. For instance Howard (2006) argued that ‘disidentification’ with a label such as ‘alcoholic’ formed part of people’s recovery narrative, and Dunlop and Tracy (2013) found that narratives of redemption formed part of recovery for many people with alcohol difficulties. There was narrative research on people with either mental health or alcohol misuse difficulties (Cunningham, 2005), but not on the combination of both alcohol misuse and mental health difficulties. I therefore widened my search both in terms of population, to include people with substance misuse difficulties in general, and in terms of methodology, to include a broader range of methods by looking for ‘experiences’ of recovery rather than only ‘narratives’ of recovery. This gave me the final search terms detailed in Paper One.

## **The Empirical Paper**

### Recruitment

#### Sample size

Ten participants were recruited, exactly meeting the recruitment goal. This provided a large quantity of rich data (around 70,000 words of transcript). There was, if anything, a surplus of data. A challenge for my write-up was to provide an in-depth analysis of this quantity of data, which would draw attention to shared stories while still communicating the diversity of the accounts. In retrospect a slightly smaller sample of 8 participants might have been optimal.

#### Challenges with recruitment

I had chosen a service in which I had previously worked as a Trainee Clinical Psychologist (one day a week for five months). This meant that I already had working relationships with some of the staff. The manager was very supportive of my research, and my Clinical Supervisor was a Clinical Psychologist who had worked at the service for several years. This was all immensely helpful when it came to recruitment. Nonetheless, recruitment was, at first, very gradual; I attended a team meeting in April 2016 but it was not until July 2016 that I completed the first interview. This largely reflected my lack of presence at the service during these months. Occasional e-mails were insufficient to remind a busy team to recruit. I had a great deal more success once I was able to spend a day a week at the service, making myself available to discuss possible participants with keyworkers.

Several participants agreed appointments with me but did not attend them. I clarified with participants who did not attend a first appointment whether they were interested in taking part in the research; I was concerned that a service user might have politely agreed to take part, but was then showing their reluctance through non-attendance. Several service users assured me they were certainly interested in taking part. Though I eventually met my goal for recruitment, these challenges gave me an experience of the reality of conducting research in a clinical setting, especially with a population whose lives are frequently chaotic.

#### Minor amendments to the inclusion and exclusion criteria

The original recruitment criteria required that participants were at the time of the study, or in the previous year, in service with both the substance misuse service and with the Community Mental Health Team (CMHT). In July 2016 I made the decision to make three minor amendments to this aspect of the inclusion criteria. This was partly because recruitment had been very slow up to that point. It was also because following conversations with the manager and keyworkers at the substance misuse service, it had become clear to me that the initial inclusion criteria would exclude some people with rich stories to tell. Adapting the criteria would better meet the core aims of the study.

These amendments were, firstly, to include people who had not been open to the CMHT, but had had secondary mental health team involvement i.e. with a Crisis Team or through psychiatric acute admission. Secondly, to extend the time period in which participants had to have been open to both services from 12 months to 24 months. This allowed me to interview participants who had had significant involvement with secondary mental health services which had ended more than 12 months ago. Thirdly, to include participants who had a substantial mental health difficulty which was treated by the Clinical Psychologist at the substance misuse service, but who had not been involved with secondary mental health services within the last 24 months. This decision was taken because of two individuals who had significant psychiatric histories and had been seen recently by the Clinical Psychologist at the substance misuse service. One of these individuals decided to take part in the research.

I would argue that the amended inclusion criteria better reflected the aims of the research. Exclusion from mental health services has often been a problem for this population (Schulte et al., 2008). The initial inclusion criteria replicated this exclusion. The amended criteria still

excluded those who had recovered outside of services, in common with most research in this area. However, by including people who had had contact with a wider range of mental health services, the amended criteria gave more opportunity for the stories of people who had been excluded from some mental health services to be heard.

Six of the ten participants who took part in the study met the original inclusion criteria, so the amended criteria had enabled a further four participants to be recruited. Two had been in contact with mental health services within the past two years but not within the past year. One had been treated recently by the Clinical Psychologist at the substance misuse service but not by mental health services. One had been seen by the Crisis Team and had had acute admissions but had not been open to the CMHT.

#### *Ethical dilemmas in recruitment*

People with coexisting mental health and alcohol misuse difficulties are a disempowered group. Many participants had experienced social control through prison, detention under the Mental Health Act, being taken into care as children, or having children taken into care as adults. Several participants at first completely passed up the opportunity to read through the consent form, and would have simply signed whatever I placed in front of them had I not gone through it with them. This raised the ethical concern that people would take part in the study without giving true informed consent. In particular, participants were recruited via their keyworkers, with whom they had a positive relationship. Given their apparent compliance during the discussion of consent I wondered whether any of the participants felt they needed to take part in order to please or repay their keyworker. I was however ultimately satisfied from my discussion with each of the participants that they could give informed consent. Recruitment via keyworkers also safeguarded the welfare of the participants as it meant that the person recruiting had direct knowledge of the individual and whether taking part in the research would be appropriate for them. In several cases participants were service users whom keyworkers felt would benefit from a further opportunity to reflect on their story.

### Conducting the interviews

I was not completely new to research interviewing; however I was much less used to this type of conversation than I am to clinical work. Conducting an interview for narrative research meant eliciting stories through a largely unstructured interview (Wengraf, 2001). Though I had prepared before conducting the interviews, there was undoubtedly an element of learning this skill through the interviews themselves. My challenge was to allow the participant to tell their story, supporting this with prompts or follow-up questions as required. Several participants disclosed distressing material, and though none went into vivid detail, I was aware of the potential for participants to become distressed. There was the potential that because the style of interview provided relatively little structure, participants would find themselves filling the space with accounts of distressing experience which they had not intended to share. This was a particular concern for participants who produced quite disjointed narratives. I therefore needed to strike a balance between an unstructured approach and intervening to provide structure when this would be helpful or containing for the participant. With two participants, I asked questions or reflected what they were saying reasonably regularly for this reason. For several others, I said very little for the whole of the interview, as they were comfortable and capable of structuring their own story. This highlights a challenge of narrative interviewing. Participants who are less verbally adept, more distressed, or both, may be less able to construct a coherent narrative, especially in what may be experienced as a somewhat pressurised situation of a one-to-one meeting with a new person. This underlines the importance of accounting for the situation in which the narrative was produced (Clandinin & Connelly, 2000).

The ethical questions around conducting a fairly unstructured interview with vulnerable people came to the fore during my interview with 'Steve'. Twenty minutes in, Steve started experiencing feelings related to telling his story, and asked to stop. I immediately stopped the recording. I debriefed with Steve and made it very clear that he could withdraw from the study and I would delete the recording straight away. Steve said that he was happy for me to keep and use the recording but just did not want to carry on talking about things as it was making him agitated and he did not want this. Steve's agitation calmed down as soon as we stopped the interview. We spoke further, I thanked Steve for his time and assured him that what he had said had been useful to me. I checked with Steve whether he wanted

to speak to his keyworker, who was available in the building. Steve thanked me and declined this offer; he was fine, but did not want to carry on with the interview. I spoke to Steve's keyworker after this interview, who contacted Steve and confirmed that he was safe and well.

On reflection I wondered whether the interview had been too unstructured. I had been leaving Steve to speak, encouraging him with nods and non-verbal sounds but was not providing a great deal of structure for the interview. I could have been more flexible with my interviewing style, perhaps by making it into more of a conversation which might not have been so challenging for Steve. Alternatively, it seems likely that Steve's reaction in the interview was simply a reflection of his current stage in his life and that this was not a good time for him to reflect on his journey. A learning point for me could be to emphasise more to keyworkers not to recruit participants who might experience distress when telling their story. I would also reflect that the kind of situation that arose with Steve cannot always be prevented when conducting research with a vulnerable population, highlighting the importance of planning how to support a distressed participant if this does occur. In this case I was satisfied that my debrief with Steve and with his keyworker were sufficient to ensure that Steve did not experience undue distress.

### Transcribing the interviews

In using transcriptions of interviews for my analysis, I was excluding other sources of narratives, such as photographs, video footage or diaries. This is a common shortcoming in narrative inquiry, and risks losing sight of the contribution of the situation of the narrative to its production (Andrews et al., 2013). In an effort to address this I made brief notes on each interview immediately after the interview, giving my immediate impressions. I transcribed the interviews within two weeks of conducting them, while the experience was still fresh, including marginal notes while I was still listening to the recording itself. In this way I aimed to ensure that some of the rich experience of how the narrative had been produced at the time was preserved in the analysis.



## Conducting the analysis

### Attempting to establish rigour

The challenge of establishing rigour in qualitative research is especially pertinent to narrative research, as the lack of an established protocol puts a strong onus on the researcher to justify the methodological decisions taken. This need not mean that the research lacks rigour. As Sandelowski (1993) argues, clear, replicable procedures can be helpful in establishing rigour, but making a fetish of procedures can undermine the 'playfulness, soulfulness and imagination' that produce the best qualitative work (Sandelowski, 1993, p. 8).

I attempted to make my research rigorous by adapting approaches which had been used elsewhere, such as the metaphor of a three-dimensional space of narrative inquiry (Clandinin & Connelly, 2000), and the idea of levels of influential context (Rappaport, 1995). I also provided appendices with a detailed example of the method of analysis, and a great deal of further information about the sub-plots identified in each participant's narrative, with supporting quotes. This aimed to show that the findings section is representative of the material in the transcripts more broadly. I also aimed to balance the presentation of shared stories with the inclusion of quotes showing the diversity of participants' narratives.

I did not use participant verification, though this would have been a way to increase the validity of the findings. This was partly due to time constraints. It was also, however, because it seemed highly likely that using participant verification in this study would have encountered significant pitfalls. At a practical level, it would have been challenging to obtain a second meeting with all the participants. A more fundamental difficulty would be that given the compliance I noted during the process of obtaining informed consent, it would seem likely that participants would have agreed with my understanding of their narratives. Further, as Emden (1998) argues, if participants had disagreed with my understanding, it could have been difficult to know what sense to make of this. My analysis was of narratives produced at a particular place and time. On another day, participants would of course produce their story differently, but this is the nature of narrative and would not mean that the original narrative was invalid. Finally, there might be a difference in perspective due to the differing aims of participant and researcher during the interview

itself; the difference between presenting oneself and aiming to understand someone else's self-presentation.

### Narrative features

As an illustration of the methodological decisions which I made, I will discuss the question of whether to include narrative features in the analysis. 'Narrative features' refers to the particular choice of language which people use to present their narrative. This would include rhetorical devices such as repetition or contrast (Andrews et al., 2013). An example from the narratives in Paper Two would be the vivid detail several people gave in their account of a particular moment of change, thus emphasising its importance.

The marginal notes I made during transcription included my reactions to the participants' use of language to create their stories. In many cases participants' use of language was an important aspect of the impact of their story on me as their audience. Some participants were skilled storytellers who would use metaphors or catchphrases to emphasise their points. I believed that an investigation of the narrative features used in the transcripts could have been a useful aspect of the analysis, but decided that it was beyond the scope of the paper. Including narrative features would have risked attempting to mix the experience-centred approach to narrative research which I was using (Squire, 2008) with a more structural approach such as that of Labov (1997). I decided that it was more important to keep the analysis clear, manageable, and focussed on the research questions than to attempt to include a further area of analysis.

### Presenting the findings

I considered several forms of presentation for the findings. A strength of narrative analysis is that the sense of the whole of a participants' story is retained in the analysis, rather than lost through the division of the data into themes. Some researchers have kept this holism in their presentation of the findings, giving a brief overview of each individual's story and then presenting relatively lengthy quotes from the transcripts (Manley, 2015; Waters et al., 2014). McLeod & Balamoutsou's (2001) elegant solution was to present their quotations in stanza form.

Many narrative studies, however, present relatively brief quotes from participants in order to illustrate themes or shared stories. Clandinin and Connelly (2000) argue that writing up narrative research involves a tension between formalism and reductionism. That is, between the aims of capturing the richly textured narratives of the participants' lives and of relating these narratives to wider social forms and structures. In my research, this tension arose as I decided whether to present the findings as a series of ten mini-biographies and stories, or to present quotes from different participants to support claims about common aspects of different narratives. My decision was partly dictated by the need to stay within a relatively brief word count; to present all ten narratives individually was simply infeasible. The challenge then was to include some sense of participants' individual narratives within a presentation of findings which was necessarily based around relatively brief quotes from core stories. I did this by giving some context for the more substantial quotes that were used, attempting to convey the role which they played in the participants' narrative overall. On reflection, the presentation of the findings in terms of level of narrative and continuity reflected the research questions by highlighting the overall form of the narratives and locating the role of services within this.

### **The end of this research: developing myself as a researcher-practitioner**

The final section of this paper provides reflections on how the process of conducting the research has supported my development as a researcher-practitioner.

#### The researcher role

Conducting this research required me to step out of my accustomed role of clinician into the less familiar role of researcher. This posed me a variety of challenges. Practically, I found the gradual and painstaking process of developing a research project was a dramatic change of pace from day-to-day clinical work. I set out a timetable for the project in a Gantt chart early in the research process and was able to follow this through. However, I was very aware that there were factors beyond my control which could delay my progress. The processes of obtaining ethical approval and recruiting participants were both of uncertain duration, and I had to tolerate the uncertainty that this created. I also had to adapt my

approach to interacting with service users, since my aim in the interviews was to develop understanding rather than to intervene.

### Reflections on my epistemological position

I adopted a social constructionist epistemology in this research, reflecting a social constructionist ontology of personal identity as constructed out of available social and community narratives. This was appropriate to the methodology and research questions. However, some of the content of the interviews led me to reflect on what this epistemological position may ignore. As an example, one of the participants, 'Trevor', talked about the importance of the medication disulfiram to his recovery. Whilst taking disulfiram he was unable to drink alcohol as it would cause a potentially dangerous reaction. He said that this had been very important for him in maintaining his abstinence, and expressed his apprehension about discontinuing this medication in the future. Trevor's story reflected my own experience as an Alcohol Practitioner, that for some people a pharmacological intervention is an important part of their recovery. Medical narratives are mentioned in the results, in terms of how people embraced or opposed such narratives. However, the biological effect of medication, or indeed of alcohol itself, is not included. It is therefore arguable that due to the social constructionist epistemological position, the biological aspect of recovery is ignored in this research. I see this as a limitation of the research, and a reason why research from a variety of methodological perspectives is of value in developing an integrated understanding of recovery.

### **Conclusion**

This research project has been a professional and personal challenge. It has given me an opportunity to further my professional interest in the experiences of this marginalised population. The acknowledgement of the impact of my personal perspectives throughout the development of this research has enabled me to reflect on how I have produced a meaningful but necessarily incomplete account of my participants' stories of recovery.

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