Canterbury Christ Church University

MAX O. WARD BSc. Hons.

EXPLORING 'DUAL DIAGNOSIS' TREATMENT MOTIVATION

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Acknowledgments

Section A: Literature Review of 'Dual Diagnosis' Treatment Motivation

This paper reviews the clinical and risk implications of dual diagnosis along with the treatment context. The value of gathering firsthand accounts of services users to inform the planning and delivery of healthcare is touched on. The second part of the paper centres on theories of motivation and how they might be applied to help explain low rates of dual diagnosis treatment uptake and engagement. Finally, gaps in the literature are highlighted with recommendations for further research.

Section B: Service User and Clinician Perspectives on 'Dual Diagnosis' Treatment Motivation: A narrative analysis

This study used a narrative approach to explore service user' and clinician' understandings of treatment motivation and engagement in relation to people with dual diagnosis. The outcomes suggest that the factors underpinning treatment motivation and engagement among this population are similar to those thought to be associated with addictions and mental health conditions generally although their relative influence and interaction effect might be different. It is suggested that negative perceptions of services, difficulties with trust, and therapeutic relationship are particularly important issues among dual diagnosis populations. The implications of the study are discussed as well as recommendations for future research.

Section C: Critical Appraisal

This paper provides a general overview of narrative research, including strengths and limitations as they relate to this study. With reference to the literature, clinical and theoretical implications are elaborated along with recommendations for future research. The author's critical self-reflections regarding the process of initiating, carrying out and completing the study are highlighted. Following this, there is a section on the ethical considerations of the study. Finally, the measures taken to ensure the quality of the study and maximise internal consistency are presented.

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SECTION A

Literature Review of 'Dual Diagnosis' Treatment Motivation

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Abstract

This paper begins with a review of dual diagnosis, co-existing mental health and substance use disorder, and its clinical, social and risk implications. The treatment context in relation to dual diagnosis is discussed with reference to the evidence base and best practice guidelines. The value of gathering firsthand accounts of services users to inform the planning and delivery of healthcare is touched on. The second part of the paper centres on theories of motivation and how they might be applied to help explain low rates of dual diagnosis treatment uptake and engagement. Finally, gaps in the literature are highlighted with recommendations for further research into dual diagnosis treatment motivation and its relationship with treatment engagement.

Introduction

Dual diagnosis, co-existing mental health and substance use disorder, is arguably the single most challenging issue facing adult mental health services. In recent years, various agencies and interested parties have sought to improve treatment provision for this population. A particular problem traditionally is that mental health and substance misuse services have operated separately and that neither, in isolation, is suitable for people with a dual diagnosis (Department of Health, 2002). To address this, services across the UK are developing integrated treatment programmes, pooling mental health and substance misuse expertise and resources. Although inconclusive, early outcome data for people completing these programmes is encouraging. Perhaps the biggest concern is poor treatment uptake and engagement, particularly for those who have most needs (e.g. Bellack, 2007).

In research and clinically, theories and measures of motivation developed in the addictions field have been applied to dual diagnosis to explain the low rates of treatment initiation and engagement (e.g. Nidecker, Bennett, Gjobalaj-Marovic, Rachbeisel & Bellack, 2009). Increasingly, the wisdom of this and the concept of motivation for health behaviour change more generally have been questioned in the literature. Although inconclusive, there is evidence to suggest that the mechanisms and processes of treatment motivation and engagement among people with dual diagnosis are different than the mechanisms and processes of treatment motivation and engagement among substance misuse service users generally and that they need to be conceptualised separately (Bellack, 2007). To test this, further research is needed to explore how motivation relates specifically to dual diagnosis treatment seeking or uptake and engagement. In the current paper, to provide context, dual diagnosis definitions, prevalence, aetiology, implications, services and treatments are discussed. Recent attempts in the literature to clarify motivation theory are considered as are

local and national initiatives to increase the accessibility of mental health and substance misuse services.

Search Method

A systematic search of PsychINFO, Pubmed, SAGE publications, Web of Knowledge and the Chochrane library was carried out using the following combinations of search terms: [dual diagnosis or drug abuse or addiction] and [treatment or motivation or engagement or readiness to change]. In total, 25 articles were identified. Two papers were discarded because they were not written in the English language. Reference lists of the 23 remaining articles were searched by hand.

Conceptualising Dual Diagnosis

In theory, dual diagnosis can encompass multiple interactions of mental disorder, personality disorder and learning disability co-existing with various types and levels of single or poly substance misuse or dependence syndrome (DoH, 2002). However, in practice, teasing apart the relative impact of these problems and their interaction effects represents a considerable challenge. Also, the term diagnosis is not without problems as it runs the risk of pathologising complex life issues (Bentall, 2005). In the current review, dual diagnosis will be referred to as dual disorder (DD) unless describing a specific service or treatment programme.

Typically, DD refers to individuals with psychiatric disorder who also misuse illicit substances, alcohol or non-prescribed medication, often in combination, irrespective of whether or not they meet the criteria for a dependence syndrome. According to DSM-IV, people with DD can be subdivided into two separate but overlapping categories; those with

"both a major substance disorder and a major psychiatric illness" (Williams, 2002, p. 3) and those who use substances in a manner that "affects the course and treatment of their mental illness" (Williams, 2002, p. 3). A distinction is made between DD and substance-induced mental disorder; the latter referring to the occurrence of psychotic symptoms during or for a limited time following drug intoxication or withdrawal states.

How substance misuse and dependence are defined is also important. Broadly speaking, substance misuse refers to problematic drug use including but not restricted to dependency or addiction. According to The Royal College of Psychiatrists (1987), substance misuse is "any taking of a drug which harms or threatens to harm the physical or mental health or social well-being of an individual, or other individuals, or of society at large, or which is illegal" (p. 17). As defined by DSM-IV (American Psychiatric Association, 2000), drug dependence is "a cluster of cognitive, behavioural and physiological symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences" (p. 192).

Prevalence of Dual Disorder.

Weaver et al. (2003) carried out research into the prevalence of DD in the UK. According to this study, 74.5% of referrals to community substance misuse services had one of the following disorders: psychosis (7.9%), personality disorder (37%), severe depression (26%) or severe anxiety (19%). One in three met DSM-IV criteria for more than one co-occurring mental health disorder. In community mental health services, 39.9% of referrals had misused substances during the previous twelve months. Half met DSM-IV criteria for dependence syndrome and a third were poly-drug users. Experts in the field believe these figures are now considerably higher, particularly in socially deprived urban areas (DoH, 2002).

High levels of DD are also found in UK prisons and psychiatric inpatient settings. According to The Office of National Statistics, 40% of men on remand are dependent on substances; 79% of whom also have at least one co-occurring mental health disorder (DoH, 2002). For people detained in psychiatric hospital, the prevalence of substance misuse and dependence ranges between 15% and 60%, rising to 80% in high secure settings (Menezes et al., 1996). Of 209 inpatients at a South East London regional secure unit, 37% met ICD-10 criteria for DD. Poly-substance misuse was reported by 39% of the patient group (Isherwood & Brooke, 2001).

Aetiology of Dual Disorder

The 'multiple risk factor model' (Smith & Hucker, 1994) attributes substance misuse among people with DD to a number of often related factors, in addition to those characteristic of the general population. According to the 'self medication hypothesis' (Khantzian, 1985), people with mental health disorder use substances to counteract symptoms and side-effects from medication, albeit temporarily. Other risk factors include boredom, inactivity and impoverished life circumstances due to disadvantaged social, educational and vocational opportunities as well as cognitive deficits and poor interpersonal skills. As a marginalised group, involvement in the drug subculture can provide a sense of social connectedness. For some, being identified as a 'drug user' is more acceptable and less stigmatising than a psychiatric label (Mueser, Bellack & Blanchard, 1992).

Implications of Dual Disorder

According to the 'supersensitivity model' (Mueser, Drake & Wallach, 1998), people with mental health disorder are particularly susceptible to the adverse effects of psychoactive

substances, impacting not only the individual but also their family, their social network and the wider community. Within this population, substance use, even in moderation, is associated with: 1) earlier onset and exacerbation of mental health problems ; 2) lower levels of motivation to change; 3) comparatively poor engagement or non-compliance with treatment (Mueser, Drake, Turner & McGovern, 2006); 4) increased risk of relapse in mental state; 5) more frequent and longer hospital admissions (Drake, Mueser, Clark & Wallach, 1996); 6) increased incidence of violence and suicide (Oyefeso, Ghodse, Clancy & Corkey, 1999); 7) increased risk of blood borne disease; 8) increased risk of cardiovascular and respiratory disease and other medical conditions (Batki et al., 2009; Meade & Weiss, 2007); 9) increased criminality and rates of imprisonment; 10) poorer social outcomes including breakdown in family relationships and homelessness (DoH, 2002). Compared with mental health service users generally, people with DD are more likely to be the victims of violence and sexual abuse (Lehman, Myers, Dixon & Johnson, 1994).

Dual Disorder Services and Treatment Context

As mentioned, there is poor collaboration between NHS mental health and substance misuse services, voluntary and private sector organisations working in this field, and the criminal justice system. As a result, people with DD are often bounced backwards and forwards between services, receiving inadequate if any input. As mentioned, when treatment is provided, it tends to be sequential across services or in parallel, neither of which have proven particularly effective (DoH, 2002). Compared with non-DD mental health service users, people with DD report higher levels of dissatisfaction with treatment and "perceived unmet need" (p. 283) which may dissuade them from returning to services in the future (Urbanoski, Cairney, Bassani & Rush, 2008). Other problems with services in this area

include insufficient resources and capacity and gaps in professional training specific to DD (DoH, 2002).

Based primarily on research from the US, experts in the field now recognise the need for integrated approaches that treat co-existing mental health and substance use disorders simultaneously within a single service. The DoH (2002) Dual Diagnosis Good Practice Guide recommends mainstream mental health services take the lead in case-managing people with DD, involving specialist drug and alcohol teams where indicated. Parallel care, although not ideal, can be used as a make-way for integrated programmes. At the very least, which agencies are involved and in what capacity should be made explicit within a single overarching rather than separate policy.

The Combined Psychosis and Substance Misuse (COMPASS) Programme (Graham et al., 2003) is perhaps the most comprehensive integrated DD service in the UK. A shared protocol was put in place to coordinate treatment across existing mainstream and specialist mental health and substance misuse services. The aim is to address both disorders and their interaction effects as a whole, with "mainstream mental health clinicians" (Graham et al., 2003, p. 184) taking the lead. Consultation and training is provided in DD assessment, motivational enhancement, cognitive therapy and relapse prevention. The Stages of Change (SoC) or transtheoretical model (TTM) espoused by Prochaska and DiClimente (1982) is used to match service users with the appropriate combination of treatments based on their 'readiness to change'. The accessibility of the programme is maximised through assertive outreach, involving interagency working and families. Once in treatment, a longitudinal perspective is taken where setbacks are seen as part of the recovery process (Bellack, 2007).

Whilst the outcomes of the COMPASS programme and other similar initiatives are promising, low treatment uptake, attrition and non-adherence remain common issues. More often than not, people with DD are either ambivalent about modifying their substance misuse or refuse altogether (Bellack, 2007). The National Institute of Drug Abuse (NIDA) invited 1,777 people with co-occurring mental health and substance misuse disorders to engage in DD treatment not dissimilar to the COMPASS programme. Approximately half failed to attend the initial briefing and a further half dropped out during assessment. In total, 73% of the original sample did not take up treatment (Crits-Christoph, Siqueland, Blaine, Frank, Luborsky & Onken, 1999). Similar outcomes were reported by Bellack, Bennett, Gearon, Brown and Yang (2006). In this study, 46% of people with DD who consented to treatment failed to complete the initial assessment.

Dual Disorder Treatment Uptake and Engagement: Barriers and Predictors

Research has been carried out into factors that deter people with DD from accessing and engaging in treatment. According to Rassool (1998), possible barriers to DD treatment include: 1) stigma, 2) mistrust of healthcare professionals and fear of incrimination, 3) perceived unsuitability of treatments, 4) chaotic personal circumstances including debt, 5) psychiatric symptoms, particularly anxiety and depression, and 6) cognitive deficits. According to Williams (2002), it is not uncommon for healthcare professionals to hold negative attitudes towards people who misuse substances, perceiving them as 'difficult to manage' which can be stigmatising (Weaver et al., 2003). Other service characteristics that are thought to impact attendance, therapeutic alliance and engagement in substance misuse and mental health services, even when motivation to change is high, include unwieldy referral processes and lengthy waiting lists (Cooper, Fairhurst, Hill, Ollerton & Roscoe, 2006).

Until recently, minimal research had been carried out into the characteristics of people with DD that predict treatment uptake and engagement. Brown, Bennett, Li and Bellack (2011), found that men, people diagnosed with schizophrenia and people with an ongoing cocaine problem were significantly less likely to enter treatment. Recent arrest, comparatively high levels of drug dependency and perceived negative family relationships were inversely related to treatment engagement. In this study, motivation to change in accordance with the TTM was not shown to be related to either DD treatment initiation or engagement. However, by their own admission, Brown et al. (2011) acknowledged that the measures they used, albeit based on previous research, did not fully account for the complexities of individual people's lives and the nature of services as social operations involving human relationships. Inspired by the service user movement, Beresford (2006) argued that if clinicians and academics "do seek to undertake research and interpret service users knowledge and experience, then they must seek to get closer to it, in all its diversity" (p. 168) through qualitative explorations of first hand experiences.

Involving Service Users in Service Planning

Over the last ten years, numerous local level and national agencies and documents have addressed the issue of uptake and engagement in mental health and substance misuse services. In the UK, seven national mental health organisations including service user groups came together to form the Future Vision Coalition (DoH, 2005) based on the recovery model, which is endorsed by National Institute for Mental Health in England (NIMHE, 2005). Amongst other things, this initiative emphasises the importance of involving service users in their care, encouraging them to take the lead in 1) identifying their treatment needs, 2) planning their care and 3) identifying their treatment goals. The concept of recovery in this

context is something service users define for themselves based on their own experiences and aspirations (e.g. Shepherd, Boardman & Slade, 2008).

In 2001, the National Treatment Agency for Substance Misuse (NTA) came into existence with the remit to increase the accessibility of evidence based treatments for people who misuse substances. In 2005, NTA guidelines for 'retaining clients in drug treatment' were published, outlining six broad recommendations. Like the above strategies, they highlight the benefits of having clients input into all aspects of service development, provision and management. The Audit Commission report, Drug Misuse 2004, stated "that to harness the potential to change behaviour, service providers must appreciate a user's own view of the future and allow informed choice and opportunity" (NTA, 2005, p. 18). To a degree, these developments are a reaction to traditional ways of working which attempt to fit service users to treatments rather than the other way round. In order to match people to the most appropriate treatment, it is increasingly recognized that it is important to understand their motivations for being there as they experience it (Drieschner, Lammers & van der Staak, 2004), further building the argument for qualitative as well as quantitative research in this area

Theories of Motivation

Few scholars and clinicians would disagree that motivation plays an important role in "why and how individuals change health behaviours" (DiClemente, Nidecker & Bellack, 2008, p. 26), affecting the uptake and utility of substance use treatments. The first widely accepted definition of treatment motivation is credited to Raskin (1961), who viewed it as a 'traitlike' phenomenon. Experts in the substance use field such as Miller (1983) and Prochaska and DiClemente (1982) argued that this created a culture of blaming service users

for not engaging and progressing in treatment. According to Miller (1983) and the TTM, motivation for treatment is more accurately understood as part of a single dimensional change pathway which is responsive to multiple internal factors such as perceived need, sense of responsibility and commitment. It was suggested that these phenomena are fluid rather than fixed and that they are influenced by external variables, particularly interpersonal relationships.

Understanding treatment motivation and motivation to change as interpersonal as well as intrapersonal heralded an important shift theoretically and clinically. In particular, it led to the development of motivational enhancement approaches, previously considered of no value (Bellack et al., 2006). Typically, these approaches incorporate motivational interviewing; a style of counselling partly derived from experimental psychology but far from mirroring it, applying concepts like attribution, cognitive dissonance and self-efficacy. According to this approach or theory, motivation is an interpersonal dynamic that therapists and service users work on collaboratively (Miller & Rollnick, 2002).

The TTM provides an integrative framework for understanding, measuring and enhancing motivation for behaviour change. It is arguably the most predominant theory of motivation in not only addictions where it was developed, but preventive healthcare more generally (Prochaska, Redding & Evens, 2002). According to the literature supporting this model, the process of intentional behaviour change falls into five designations subdivided into two phases: 'pre-action' followed by 'action-oriented'. The pre-action phase comprises the precontemplation (no intention to change), contemplation (thinking about change), and preparation (preparing to change) stages of change. The action-oriented phase comprises the

action (taking steps to change) and maintenance (actively maintaining change) stages of

change (DiClemente & Prochaska, 1998).

The TTM also addresses how people motivate, action and maintain behaviour change. Pre-

action tasks include "consciousness raising, self re-evaluation, environmental re-evaluation,

and emotional arousal" (DiClemente et al., 2008, p. 26). Action-oriented tasks include "self-

liberation, stimulus control, counter conditioning, contingency management, and helping

relationships" (DiClemente et al., 2008, p. 26). Assessing which change processes or tasks to

target and selecting the appropriate intervention or combination of interventions is critical.

Failure to do this can lead to poor treatment outcomes (Giovazolias & Davis, 2005; Miller &

Rollnick, 2002).

According to the TTM as applied to substance misuse disorder, non- or semi-directive

interventions, usually motivational interviewing, are the treatment of choice for people in

precontemplation, contemplation and preparation stages of change. Action oriented or

directive approaches including traditional skills teaching, CBT and relapse prevention are

recommended for people in the action or maintenance stage of change. Typically, individuals

are assumed to move through the model or particular stages in the model multiple times

before reaching maintenance (Miller & Rollnick, 2002). Since its inception, several studies

have supported the use of TTM within addictions, demonstrating consistent and reliable

relationships between the processes and stages of change outlined (e.g. DiClemente &

Prochaska, 1998).

Dual Disorder and Motivation

To date, there has been relatively minimal research regarding motivation to change and treatment seeking motivation among people with DD. DiClemente et al. (2008) reviewed the literature in this area, most of which is based on the TTM. Their focus was on the conceptualisation and assessment of "readiness to modify substance use and readiness to initiate behaviours helpful for managing mental" (p. 25) disorder. As things stand, due to mixed findings, it cannot be assumed that the TTM, the conceptualisation of motivation underpinning it, and associated measures of 'readiness to change' are directly transferable to DD groups. The same can be said about motivational enhancement theory and approaches such as motivational interviewing. Haddock et al. (2003) found that motivational interviewing improves treatment outcomes for people with DD, especially when combined with CBT. However, a meta-analysis "of the efficacy of motivational interviewing in a dual diagnosis population" (p. 5417) by Osborn (2007) was inconclusive both in terms of treatment adherence and also substance use outcomes.

Several studies have demonstrated a positive correlation between motivation to change, as defined by the TTM model, and attendance and engagement in treatment among non-dually disordered service users (Carpenter, Miele & Hasin, 2002). Using 'readiness to change' measures based on the TTM, similar findings have been demonstrated with DD groups (e.g. Nidecker et al., 2009) but not consistently. Within the DD population, Pantalon and Swanson (2003) found lower, not higher, levels of motivation to change were predictive of treatment attendance. Similar outcomes have been reported by Zeidonis and Trudeau (1997) and Bellack et al. (2006). In their study of people with DD, Zeidonis and Trudeau (1997) found an inverse relationship between treatment seeking and motivation to change. According to Bellack et al. (2006), neither treatment attendance nor treatment adherence are associated

with readiness to change within this group. They argued that "these data cannot be discounted by questioning the ability of people with serious mental illness to provide reliable responses" (Bellack et al., 2006, p. 4) to the TTM measures that were used as has been suggested elsewhere in the literature (Strong, Kinnaman, Bellack, Brown & Yang, 2007).

According to Heather (2005), the extent to which motivation plays a part in health behaviour change among people with DD and the mechanisms underpinning it are different to that characteristic of non-dually disordered service users. Finnell (2003) suggests that DD and non-DD service users differ in how they move from pre-action to action-oriented phases of the TTM. In contrast with non-DD substance misuse service users, people with DD employ 'action' or behavioural mechanisms for change when their motivation is low and 'pre-action' or experiential mechanisms for change when their motivation is high, which has implications for treatment matching. Best practice guidelines for treating substance misuse disorder recommend taking a non-directive approach when motivation to change is low. This gives way to more directive interventions as intrinsic motivation for behaviour change increases (DoH, 2002). For people with DD, the opposite combination of treatments might be more appropriate (DiClemente et al., 2008). A possible explanation for this is that cognitive deficits associated with severe forms of mental disorder interfere with the processes thought to be important for motivating behaviour change such as decision making, goal setting, problem solving, concentration and perseverance.

According to the Centre for Substance Abuse Treatment (2005), the greater the severity of mental disorder the less likely the individual is to view their substance misuse as problematic. It is suggested that reduced capacity for self-appraisal along with so called negative symptoms of mental disorder such as avolition mitigate motivation to change, treatment

uptake and treatment engagement. Also, it is not uncommon for people with DD to be motivated to address their substance misuse or their mental health disorder but not both (Heesch, Velasquez & Sternberg, 2005). This has led people to speculate that each disorder has its own separate underlying motivational and behavioural change processes (DiClemente et al., 2008).

Consistent with Osborn's (2007) meta-analysis mentioned earlier, motivational enhancement theory and approaches to increase uptake and engagement in treatments may not benefit people with DD in the same way they benefit substance misuse and other service user populations for whom they have been evaluated (Finnell, 2003). Within the addictions field, the goal of motivational enhancement approaches in the early stages is to build intrinsic motivation for change, considered pivotal in overcoming substance misuse in the long term. For people with DD, interventions that target external determinants of motivation such as contingency management might have greater utility. Contingency management is recommended by the National Institute for Health and Clinical Excellence (NICE, 2007) for people who are dependent on opiates or stimulants, reinforcing positive behaviours and treatment adherence with incentives such as vouchers. Messina, Farabee and Rawson (2003) argued that rewards based rather than 'punitive' approaches might be particularly useful for people with co-occurring personality difficulties. A problem with all of these interventions, however, is that they only benefit people who are already engaged in services, failing to address the problem of treatment uptake.

Criticisms of the Transtheoretical Model

Despite capturing the interests of researchers since the 1950s, motivation and its relationship with treatment uptake and engagement remain conceptually ambiguous (West,

2006; Sutton, 2001). Sutton (2001) ascribes this lack of clarity to the dominance of the TTM which he, along with other luminaries in the field, believes is fundamentally flawed. According to Sutton (2001), defining motivation as the likelihood an individual will seek out and engage in a particular course of action is circular, leading clinicians and researchers to think of motivation to change and treatment motivation as synonymous.

Typically, human motivation is conceptualised in terms of the internal mechanisms driving a particular behaviour. According to Bellack et al. (2006), the TTM fails to adequately delineate these phenomena. Because of this, treatment motivation is often defined incorrectly by the forces affecting it such as a desire or wish to change. That is, people who want to change are by implication motivated to change which, as mentioned, is often not the case. Even when treatment motivation is linked to a resulting behaviour there is conceptual ambiguity. Sometimes the behaviour is defined as the act of entering treatment, whilst at other times it is defined as the act of engaging in the treatment process. Another criticism of the TTM and allied theories such as motivational interviewing is that they over emphasise the significance of 'problem recognition' at the expense of other "factors such as perceived external pressure, outcome expectancies, or the perceived suitability of treatment" (Drieschner et al., 2004, p. 1123).

A further criticism of the TTM is the notion that people move sequentially through five stages of change from precontemplation to maintenance. Sutton (2001) and West (2006) argue that these stages are not mutually distinct which makes it difficult to assess movement from one to another or to gauge fluctuations in motivation through time. Research indicates that the five stages of the TTM would be better conceptualised as two separate components: "cognitive determinants of treatment motivation" (Drieschner et al., 2004, p. 1123) and 2)

"behaviour that depends on the level of treatment motivation" (Drieschner et al., 2004, p. 1123).

Recent Developments in Motivational Theory

Attempts have been made in the last few years to address the ambiguities regarding treatment motivation highlighted above. Based on research into smoking cessation, PRIME Theory of Motivation (West, 2006) posits that human behaviour is driven by: plans, responses, impulses or inhibitions, motives and evaluations. Drieschner et al's. (2004) 'integral conceptualisation of treatment motivation' suggests: 1) external motivators are mediated by internal mechanisms; 2) 'motivation to engage in treatment' is based on 'internal determinants' of which there are six; 3) 'motivation to engage in treatment' is predictive of 'treatment engagement'; 4) 'treatment engagement' is predictive of 'treatment outcome'. As yet, to the author's knowledge, neither model has been evaluated within the DD population or addictions generally, with the exception of tobacco dependency, to see if it is a more useful alternative to the TTM.

Drieschner et al. (2004) argued that the exact nature of treatment motivation and related concepts differs depending not only on the client group under consideration but also the treatment approach being used. It is suggested models and measures of treatment motivation are adapted to account for these differences. The TTM seems to have had success in being applied to understand treatment motivation with a number of addictions and, more recently, mental health disorders (Jerkovic, 2007). However, in some quarters, the theory underpinning the TTM has been questioned. One problem is that it relates to 'readiness to change' which is not necessarily the same as motivation to enter and engage in treatment. To date, it appears that no models of motivation have been modified specifically for DD and then evaluated to

assess their utility for these service users in relation to difficulties with treatment uptake and engagement and how they might be overcome.

Summary

Dual disorder represents a considerable challenge for adult mental health and substance misuse services. As many as three in four people referred to adult mental health and substance misuse services suffer from DD, the implications of which include poorer mental, physical and social outcomes. To meet this challenge, health authorities up and down the UK are commissioning integrative DD treatment programmes based in mental health services. Once in treatment, the prognosis for people with DD is encouraging (Carey, Leontieva, Maisto & Batki, 2006). However, low rate of treatment uptake and dropout from treatment remains a concern (Mueser, Noordsey, Drake & Fox, 2003).

To address these issues, it is important to understand what motivates people with DD to enter and then engage in treatment. A criticism of the literature in this area is that, due to an over reliance on the TTM, motivation to change and treatment motivation are often seen as one and the same thing. As mentioned, among people with DD, attendance at treatment has not been shown consistently to correlate with 'readiness to change' (e.g. Bellack et al., 2006). By the same token, perhaps surprisingly, non-engagement in DD treatment is seen even in people with apparently high levels of motivation to change. This highlights that there is a difference between motivation to change, and treatment motivation, and it is suggested here that it is helpful to retain a distinction between these two motivations, although they are often closely related.

Also, it is suggested that motivation for treatment and change among people with DD is qualitatively different from motivation for treatment and change among singly disordered substance misuse service users (e.g. Bellack et al., 2006). The implications of this are that motivation measures and interventions developed in the addictions field, based predominantly on the TTM, might not be applicable to DD groups, clinically or for the purposes of research. Within the DD field, some service users seek treatment to address their mental health but not their substance misuse. Others may not accept their mental health diagnosis but want to stop substance misuse (Heesch et al., 2005). It is thought that both disorders and their interaction effects impact whether or not an individual takes up and engages in treatment. Understanding the motivational features and levels of each area of difficulty would seem important in order to provide the appropriate treatments (DiClemente et al., 2008).

Despite increasing interest in recent years, our understanding of how motivation relates specifically to people with DD remains limited. In part, this is due to the lack of clarity surrounding motivational theory generally. In particular, further research is needed to conceptually distinguish between treatment seeking motivation and motivation for change and how these interact among people with DD relative to other treatment contexts. This would inform the development of suitable measures for assessing DD treatment motivation and engagement. It might also lead to the adaptation and integration of more accessible and effective interventions for people with DD, enabling not only clinicians but also service mangers and providers to help people with DD address their multi-complex and overlapping problems (DiClemente et al., 2008).

The Need for Qualitative Research

Due to the lack of evidence base and clarity in the area, it is argued that qualitative studies involving in-depth interviews with service users and clinicians are needed to explore DD treatment motivation, the forces underlying it, and its relationship with treatment engagement. Drieschner et al. (2004) suggest that client self-report is "the most appropriate mode of assessment for the internal and subjective concepts" (p. 1131) of treatment motivation while clinicians might offer important insights into the observable aspects of treatment engagement (Schmidt & Woolaway-Bickel, 2000). Gauging the views of both clinicians and service users on these issues would be within the spirit of the Future Vision Coalition (DoH, 2005), NIMHE (2005) and NTA (2005) initiatives that seek to improve the accessibility and effectiveness of services for people with mental health and substance use disorder.

Numerous qualitative research studies have been carried out in the addiction field, contributing significantly to the literature in that area. One approach that has been particularly illustrative of how people change or recover from substance use problems is narrative analysis (e.g Hanninen & Koski-Jannes, 1999). To the author's knowledge, narrative analysis has not yet been used with DD service users. It is envisaged stories elicited from service users and clinicians, illustrating the points at which treatment motivation seems to change or engagement increases or decreases for specific individuals, could have implications for developing interventions to increase firstly the accessibility of DD services and treatments, and secondly retention rates of clients already engaged with services. Such a study could explore what appear to be the determinants of DD treatment motivation and its relationship with DD treatment engagement and how their interactions are experienced as unfolding over time in response to both individual and service related contingencies.

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Max O. Ward BSc. Hons.

Independent Research Project

SECTION B

Journal Paper

Service User and Clinician Perspectives on 'Dual Diagnosis' Treatment Motivation: A narrative analysis

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For Submission to the Journal: Addictions

Running Head: Dual Diagnosis Treatment Motivation

Abstract

Rationale. There is an emerging evidence base to support the use of integrated approaches that treat co-existing mental health and substance use disorder simultaneously. However, low rates of treatment uptake and engagement remain a concern. To address this, it would seem important to understand dual diagnosis treatment motivation and engagement, an area that has received little attention from the research community. Aims. The aim of this study was to explore service user' and clinician' understandings of how treatment motivation and its relationship with treatment engagement relate specifically to people with dual diagnosis. Methodology. Transcripts from semi-structured interviews with four service users and four clinicians were analysed using narrative methodology. Findings. The current study suggests that the factors underpinning treatment motivation and engagement among people viewed as having dual diagnosis are similar to those thought to be associated with addictions and mental health disorders generally although their relative influence and interaction effect might be different. It is suggested that negative perceptions of services, difficulties with trust, and therapeutic relationship are particularly important issues among dual diagnosis populations. Discussion. Clinical and theoretical implications of the study are discussed in relation to the literature as well as recommendations for future research.

Introduction

Dual Diagnosis

Dual diagnosis is arguably the single most challenging issue facing adult mental health services (Department of Health, 2002). In theory, it can encompass multiple permutations of mental and personality disorder co-existing with various types and levels of single or poly substance use. In practice, teasing apart the relative impact of these problems and their interaction effects can prove difficult. Also, the term diagnosis is not without problems as it runs the risk of pathologising complex life issues (Bentall, 2005). In this study, the term dual disorder (DD) will be used.

Prevalence and Implications of Dual Disorder

The life time prevalence of substance misuse among people with major mental disorder is between 15% and 60% (Menezes et al., 1996). Within this population, substance use, even in moderation, can have major detrimental effects (DoH, 2002) including poor compliance with treatment (Mueser, Drake, Turner & McGovern, 2006), increased risk of medical conditions, and poorer social outcomes and interpersonal difficulties (Batki et al. 2009; Meade & Weiss, 2007).

Treatment for Dual Disorder

Traditionally, there has been poor collaboration between adult mental health and addiction services. As a result, people with DD are often bounced backwards and forwards between services. At best, treatment is provided sequentially across services or in parallel, neither of which have proven particularly effective (DoH, 2002). Other reported problems include insufficient resources and capacity, gaps in professional training specific to DD and high levels of staff burnout (DiClemente, Nidecker & Bellack, 2008).

To address these problems, experts in the field now support integrated treatment approaches within a single service that address a range of biopsychosocial factors simultaneously, not just mental health and substance misuse issues (Jeffrey, Ley, Bennum & McLaren, 2000). Typically, Prochaska and DiClemente's (1982) transtheoretical model (TTM) is used to match service users to the appropriate combination of treatment approaches based on their 'readiness to change'. In the UK, the COMPASS Programme (Graham et al., 2003) is perhaps the most comprehensive initiative of this kind. Whilst the outcomes of this and other similar programmes is promising, low treatment uptake, attrition and non-adherence remain common issues (Bellack, 2007; Mueser, Noordsy, Drake & Fox, 2003). Given the emerging evidence base for DD services, more needs to be done to increase treatment motivation within this population (Bellack, 2007).

Theories of Motivation

Over the past 20 years, the TTM has been the predominant theory of motivation, particularly in the addictions field. Based on this model, Miller and Rollnick (2002) defined motivation as the likelihood a person will adopt and follow a particular pathway for change. According to this definition, treatment motivation is thought to comprise part of a single dimensional change pathway. In research and clinically, this has led people to think of motivation to change and treatment motivation as synonymous which has been criticised as circular (Sutton, 2001).

Also, attendance at DD treatment does not correlate with 'readiness to change' (e.g. Bellack, 2007). Perhaps surprisingly, non-engagement in DD treatment is seen even in people with apparently high levels of motivation to change. Others enter into DD treatment but are

not motivated to change their substance misuse (Heesch, Velasquez & von Sternberg, 2005). This highlights that there is a difference between the more generic concept of motivation to change and treatment motivation. Although closely related, it is suggested here that it is helpful to retain a distinction between these two motivations.

Typically, human motivation is conceptualised in terms of the internal mechanisms driving a particular behaviour. According to Bellack (2007), the TTM fails to adequately delineate these phenomena. Because of this, treatment motivation is often defined by the forces affecting it such as a desire for change. Even when treatment motivation is linked to a resulting behaviour there is conceptual ambiguity (Drieschner, Lammers & van der Staak, 2004). Sometimes it is defined as the act of entering treatment whilst at other times it is defined in terms of treatment engagement. A further criticism of TTM is the notion that people move sequentially through five stages of change. Sutton (2001) argued that these stages are not mutually distinct which makes it difficult to assess movement from one to another or to gauge fluctuations in motivation through time and in different contexts.

Drieschner et al.'s (2004) 'integral conceptualisation of treatment motivation' addresses the lack of conceptual clarity highlighted. It suggests treatment motivation and engagement are based on 'internal determinants' of which there are six: 'level of suffering', 'outcome expectancy', 'problem recognition', 'perceived suitability of the treatment', 'perceived cost of the treatment' and 'perceived external pressure'. According to Drieschner et al. (2004), the exact nature of treatment motivation and related concepts differs depending on the population under consideration. It is suggested models and measures of treatment motivation are adapted to account for these differences. The TTM was an attempt to understand the mechanisms and processes of behaviour change relating to addictions. Subsequently, it has been applied to

other clinical fields including DD (e.g. DiClemente et al., 2008). To date, no models of

motivation have been evaluated and adapted specifically to explain DD treatment uptake and

engagement. To explore these issues, it would seem important to gather a small number of in-

depth accounts from DD service users and people who work in the field.

Summary and Study Rationale

Dual disorder represents a considerable challenge for mental health services. To meet this

challenge, health authorities are commissioning integrative DD treatment programmes. Once

in treatment, outcomes for people with DD are encouraging (Carey, Leontieva, Dimmock,

Maisto & Batki, 2007). However, levels of treatment uptake are low (Bellack, 2007; Mueser

et al., 2003). To address this, it is important to understand what motivates people with DD to

enter treatment. In this regard, it cannot be assumed that treatment motivation and motivation

to engage in treatment, although related, are one and the same thing.

To date, minimal research has been carried out into the factors and processes underlying

treatment motivation and its relationship with treatment engagement among people with DD.

Studies of DD motivation more generally have relied on the TTM and associated measures

which have been criticised in the literature as conceptually ambiguous. To the author's

knowledge, no research has been carried out into the meanings service users and clinicians

make of DD treatment motivation and engagement. It is envisaged the information provided

by participants will have implications for developing interventions to increase 1) the

accessibility and uptake of DD services and treatments, and 2) retention rates of people

already engaged in DD services and treatments.

Aim of Study

The aim of the study was to gain insights into the 'stories' service users and clinicians tell about DD treatment motivation. This gathering of narratives or 'stories' (Riessman, 2008) would provide a starting point for examining the complexities of motivation and treatment entry and engagement in the context of DD.

Specific Research Questions

The current study was guided by the following questions:

1. What determinants of motivation to enter DD treatment feature in the stories of service users and clinicians?

2. What stories do DD service users and clinicians tell about how motivation for treatment fluctuates over time?

3. What connections do people make in their stories between DD treatment motivation and DD treatment engagement?

Method

Participants

Through 'purposive' sampling (Marshall, 1996), the study recruited eight participants from Community Adult Mental Health Teams (CMHTs) and Community Drug and Alcohol Teams (CDATs): four service users with DD and four clinicians with experience working with DD and DD treatments. Narrative analysis, the current methodology, is a case rather than category-centred or population based form of inquiry (Riessman, 2008). As such, sample size and configuration tends to be based on theoretical or opportunistic grounds (Squire, 2008). Within healthcare, it has been used with as few as one or two participants (Bell, 1988;

Lee & Bonnie, 2006; Lee, 2001). On this basis, the current sample size of eight was

considered sufficient to provide usable data to address the research questions.

As a case-centred approach, narrative analysis is not concerned with generic concepts.

However, it can be used to make inferences about the wider population and social processes,

illuminating variations across people and contexts (Riessman, 2008). With this is mind,

interviews were carried out with both DD service users and DD clinicians. This was based on

the idea that treatment motivation is an interpersonal construct, influenced by not only the

service user but also the treatment context (Miller & Rollnick, 2002). Another reason for

interviewing both service users and clinicians relates to the current emphasis on involving

different stake holders in the evaluation and development of mental health treatments (e.g.

NIMHE, 2005). Guided by the research questions, the following inclusion and exclusion

criteria were applied:

Service user inclusion criteria:

a) DD acknowledged as present by both service user and clinicians with or without a
   formal diagnosis.

b) Receiving treatment for mental health and substance use within the NHS Trust

c) Authorization by the responsible NHS Team

d) Sufficient command of English to engage in the data collection process

e) Capacity to consent

Clinician inclusion criteria:

a) Any CMHT or CDAT clinician with experience working with DD.

Exclusion criteria:

a) Service users were excluded from the study if they were assessed by their care team

or the researcher as representing a risk to themselves or others.

Clinicians involved in the study included three females and one male. With regards to

ethnicity, two were Black African and two were White British. All had at least 10 years

experience working with DD clients. Table 1 provides information about their work setting

and job title.

Table 1: Clinicians

Pseudonym	Work setting	Job title
Susan	CMHT	DD service link worker
Jane	CMHT	Social worker
Isabel	CMHT (Assertive outreach)	Team leader
Sid	CDAT	Team leader

Three service users involved in the study were male and one was female with an age range

of 35 to 57 years. One was Black Caribbean and three were White British. Table 2 provides

information about their mental disorder, substance use and current treatment.

Table 2: Service users

Pseudonym	Mental disorder	Main substance use	Current treatment
Tracey	Borderline PD/Depression	Opiates/Cocaine/Alcohol	CDAT
Anne	Depression/Panic attacks	Alcohol/Non-prescribed meds	CDAT
John	Borderline PD/ Anxiety/Depression	Opiates/Cocaine/Alcohol	CDAT
Bill	Anxiety/Panic attacks/Depression	Opiates/Stimulants	CDAT

Ethics

   The study was approved by an Independent Research Review at Canterbury Christ Church University, National Research Ethics Service (see Appendix A) and NHS Foundation Trust Research and Development (see Appendix B). Prior to interviews, participants were required to read and sign a consent form (see Appendix C).

Design

   Due to the lack of research in this area, a qualitative design was thought to be appropriate to gain a richness of data that would not be accessible using variable-based quantitative methods. From a social constructivist perspective, narrative analysis of stories was used to highlight personal sense-making and to preserve the way people do this in their recounting of the complexity of interactions between motivation and their experiences of different elements of DD treatment and services, taking into account reciprocal relationships

and wider social influences. According to Bruner (1990), people make sense of and describe the consequential interrelationships between events and ideas through narratives or stories.

Narrative analysis was chosen as opposed to other qualitative methodologies such as Interpretive Phenomenological Analysis, Grounded Theory and purely discursive approaches for three reasons. First, through focussing on whole stories, narrative analysis does not reduce individuals' experiences down into smaller parts or categories that become separated from their context. According to proponents of this approach, identifying and preserving stories as a form of analysis illustrates more naturalistically the meaning of events for participants (e.g. Riessman, 2008). Second, it seemed important to investigate not only the content of participant's stories but also how and why they were told in relation to the interview context and wider theoretical and social discourses. Third, while useful for developing population based models or generic concepts, category-centred methods, such as Grounded Theory, lose the sequence of events or actions embedded in personal histories, a defining characteristic of narrative (e.g. Riessman, 2008). This emphasis on sequential or temporal features seemed important to capture how participants' experiences of DD treatment motivation and engagement, and the interrelationship between the two, shifted and transformed through time.

Interview Schedules

Interview schedules (see Appendix D and E) were constructed, inviting participants to tell stories about particular times and experiences in their life concerning the research questions. They were piloted on colleagues to rehearse technique and to iron out problems with format. Further modifications were made based on feedback from the study lead supervisor.

Procedure

Clinicians were recruited through CMHT and CDAT meetings. Care coordinators were asked to distribute the 'participant information sheet' (see Appendix F) to service users who met the inclusion criteria. It was also possible to volunteer for the study by responding to leaflets (see Appendix G) posted in clinic waiting rooms. Interviews were at the clinic where participants worked or received treatment.

Data Analysis and Quality Issues

Although there are different interpretations of narrative methodology, generally they share the view that narrative is about sequences of events or causal relationships unfolding in time (Riessman, 2008). The current study "privileged respondents' views, responses, voice, experience and meaning-making" (Murray, 2003, p. 50) in relation to the topic under investigation, taking into account the researcher's role in co-constructing narratives and the influence of broader theoretical and social discourses.

The analysis was carried out in five stages beginning with the transcription of audio-recordings (see Appendix H). Transcripts captured not only the content of what participants said but also non-lexical features such as pauses and repetitions which, according to the literature, indicate "why a story is worth telling" (Bell, 1988, p. 109). Non-verbal communications were excluded. Initial thoughts about participants' stories based on preliminary readings of whole transcripts were recorded (see Appendix I).

In stage two, core narratives relating to the topic of investigation were defined and extracted from transcripts based on structural features using Labov's (1982) method (see Appendix J). Clauses within core narratives were grouped into the following categories based

on their function: 1) summary of the narrative (abstract); 2) contextual factors such as time and place (orientation); 3) salient points, themes, characters and plots (complicating event); 4) the narrator's view or interpretation (evaluation); 5) endings (resolution); 6) how the narrator was reoriented in the present (coda). Applying this method, stories were defined as "a brief, bounded segment of interview text, rather than an extended biographical account" (Riessman, 2008, p. 61). In stage three, core narratives thought to be most relevant to the research questions were selected (see Appendix K) and interpreted in relation to these questions (see Appendix L). In particular, the focus was on 'complicating events' and 'evaluations'.

Riessman (1993) argues that reducing transcripts down to "core narratives, although useful initially, excludes important features that are essential to a fuller interpretation" (p. 38). In stage four of the analysis, like Bell (1999), the current study expanded on Labov's (1982) method to include "reciprocal actions" (Riessman, 1993, p. 41) of participants and researcher. For this purpose, the researcher's questions, prompts and utterances were considered. Close attention was paid to how participants positioned the researcher in relation to their stories, taking into account issues such as gender and professional status (see Appendix M). In stage five of the analysis, thematic links (Polkinghorne, 1995) were made between participants' core narratives previously grouped under the research questions in stage three of the analysis (see Appendix N).

Steps taken to maximise the rigour and quality of the analysis were based on Elliot's (2006) 'common sense' approach and Mishler's (1990) notion of 'trustworthiness'. With regards to independent validation, the research lead supervisor provided feedback on each stage of the analysis for one service user and one clinician. Following interviews, for

respondent validation, participants were given a written summary of their stories (see

Appendix O) and invited to feedback whether or not they reflected what they wanted to

convey (see Appendix P).

Results

There are two parts to the results section. First, excerpts from stories are reported to

illustrate the themes identified in stage five of the analysis, providing "explanatory answers to

the research questions" (Polkinghorne, 1995, p. 15). Second, one service user (Anne) and one

clinician (Susan) are reported to illustrate how language was used in the telling of stories and

the role of the researcher in co-constructing narratives.

What Determinants of Motivation to Enter DD Treatment Featured in the Stories of Service Users and Clinicians?

This question seemed to be addressed by stories relating to the following themes: 1) life

events, both positive and negative, that had personal significance, 2) a wish for things to

change and 3) negative perceptions of services.

Stories about significant life events.

Participants told 16 stories associated with this theme. The events referred to included

pregnancy, new 'loving' relationship, family ultimatum, medical problems, near death

experience, bereavement and *"hitting rock bottom"*.

'The Power of Love', a story by Susan (clinician), highlighted how a new 'loving'

relationship can elicit treatment motivation: *"They [service users] finally find someone that*

paid them attention and loved them like they had never been loved before." In his story, 'Do

It For Me [Girlfriend] and Do It For The Girls', John (service user) recalled an ultimatum

from his then girlfriend that gave him the impetus he needed to initiate treatment:

"I come home one night stinking of it [heroin] and she [ex-partner] went "you're back on

that shit again aren't you?" And I went "yeah", she went straight to bed and I fell asleep

on the settee, [...] then she came downstairs, she's got a hold-all packed, she went

"where do you want dropping off?" and I went "well what do you mean" and she went

"go", she went "I've had it" she went "sixteen years I've put up with it. I can't put up

with it no more".

According to clinicians' stories, some people are unmotivated to access services and

treatment until they *"hit rock bottom"* or until matters are taken out of their hands. This was

illustrated in the following excerpt from Sid's (clinician) story 'Most Are in a Desperate

Situation When They Access Services':

*"I think they more or less lurch around until they go into v*arious states of depression and

either pitch up in treatment that, um, looking for help, or, um, it's picked up somewhere

along the line either through the Criminal Justice System or, or the mental health services.

[...] Most people, by the time they've reached somebody like me are in a desperate

situation".

Stories about a wish for change.

The stories linked to this theme, 10 in total, were about people being motivated to access

treatment and address their problems due to pride, unfulfilled ambitions, family relationships

or a desire for a happier and less chaotic life.

Susan's (clinician) story, 'The Power of Pride', described a woman who was resistant to addressing her drinking problem despite serious medical concerns. In the end it was the prospect of going into care and losing her home, which she was *"proud of"*, that seemed to be the tipping point that elicited treatment motivation. In a separate but overlapping story, 'To Realise a Dream', Susan described a service user who came to a point in his life where he wanted to fulfil hopes and ambitions he had prior to his mental health and substance use disorders:

*"I had a guy [service user] who had been smoking cannabis since nine years old and felt look "I am not getting any younger, I am in my mid for*ties, I need to do something with my *life, I want to write a book, this [cannabis] affects me". Their own future dreams and ambitions."*

'I Wanted Help Because My Children Need Me', a story by Tracey (service user), highlighted how sense of responsibility and preferred identity as a mother helped her turn a corner. She said:

"I am important for my children, you know. I changed the way I was thinking, you know. Before I didn't matter, but now I suddenly became important; yes I do matter, I matter for my ch*ildren so I need to be alright for them to be alright."*

Stories about negative perceptions of services.

The majority of the stories in this theme, 38 in total, were about perceived failings within services. Stigma associated with mental health and addictions clinics and its affect on treatment motivation was also highlighted.

Anne (service user) repeatedly asked for help from services without success. When they did eventually take up her case, she felt ignored, silenced or disbelieved. As a result, she had difficulty trusting services. Tracey's story, 'I Only Got to See a Psychiatrist When I Was Really Ill', criticised services for not intervening until she was in crisis. Like Anne and Tracey, John *"knew something was wrong"*. He said he *"begged for help"* from *"doctors"* but they *"did not listen"*, telling him his preoccupation with being *"ill"* was actually making him *"worse"*. In several connected stories, he said he was neglected and victimised by services and professionals. The following excerpt is from 'I Had to Fight to Be Believed':

"he [psychiatrist] said "er, you haven't had a fit this week", I went "I have", I said "I've had at least four a day". And he went "well there isn't anything in the book [clinical record]" [...] and he went [to the nurses] "well, why isn't it put down there [in the clinical record]" "Well John never told us". And, like, they [nurses] were blatantly lying, calling me a liar."

Isabel (clinician), in her account, argued that *"mentally ill"* labels can be a *"sort of* bugbear *[for people and] something they can do without"*. According to Sid, the physical appearance of CDATs can be a problem, stigmatising those who access them. The following is an excerpt from his story 'Physical Environment of Clinics': *"bulletproof glass, you* know, *air locks etc etc, er, a particularly fetching burnt front door, um, that we've got at the*

moment.[…] If you're seen walking through here [Addictions Service] you might as well be wearing a sign."

What Stories do DD Service Users and Clinicians Tell About How Motivation for Treatment Fluctuates Over Time?

The stories thought to provide answers to this research question were subdivided into two themes. The first theme highlighted conflicting variables that had a destabilising effect on treatment motivation. The second theme was about how treatment motivation can ebb and flow in response to services.

Stories about opposite pulls.

Nine stories were thought to relate to this theme. According to these stories, levels of treatment motivation can be pulled in different directions by family pressures, chaotic life circumstances, pressures of parenthood, 'drug identity' and social networks, 'cravings' and unstable mental health conditions.

The following excerpt from Isabel's story, 'Disagreements Within Families', describes a service user with conflicted feelings about treatment due to differences of opinion between his parents:

"when one member of the parents […] hold[s] one view and then another member holds another view, then the client is in the middle, and often times we find that dad will be saying something, everything quite negative [...] whereas maybe mum will be the one, you know, be positive and working with you [services]."

Tracey's story, 'I Would Dwindle In and Out of Services', referred to her desire to regain custody of her children which was motivational one minute and destabilising the next. As such, for several years, she oscillated between her 'drug life' and services, *"never really taking it in"*. Anne also had an ambivalent relationship with substances. On the one hand, she *"never liked"* 'drugs' and recognised the consequences. On the other hand, she relied on them as a means of coping. Also, they were important to her sense of identity and relationships as following excerpt from 'I Still Miss it Sometimes' illustrates:

"I needed to be liked at one point as well so I would go around buying drink and drugs then, you know, everybody would come to me, and I, that was like my own buzz as well as *taking the drugs, you know".*

John was in two minds about accessing his current CDAT. He felt the service had *"looked down [their] nose"* at him on a previous occasion. At the same time, he was under pressure from his partner to address his difficulties. This dilemma is illustrated in the following excerpt from 'The People Here [Specialist Addictions] Sat and Listened to Me':

"and I stood outside for a week, just stood outside looking up [...] at this building [CDAT] thinking do I go in there and get looked down my nose at and get abused or do I *stay here, do I stay on the gear?".*

Stories about the ebb and flow of treatment motivation in response to services.

The stories in this theme, 10 in total, emphasised the importance of having accessible treatments that are appropriate to the needs and expectations of service users. In her story, 'The Right Treatment at the Right Time', Susan described a service user who *"went back to*

square one" due to the inability of services to provide the treatment he believed he needed within an acceptable timeframe:

"Often when we get people [service users] that started off very motivated and wanting to do it [treatment], the kind of service sometimes puts them off. [...] They want to go to [a] 'detox' unit, but actually there is a seven month waiting list."

It is typical for people to see whichever team member is available for a period when they first enter services. According to stories from Sid and Tracey, this can be unhelpful. In 'Service Users Want Consistency in Their Relationships with Professionals', Sid argued: *"you need to be consistent, and that's another thing that in my experience clients want. You* need to be around, so they [service users] *don't like being passed from pillar to post"*.

What Connections do People Make in Their Stories Between DD Treatment Motivation and DD Treatment Engagement?

Stories that seemed to address this question were about 1) individual factors that inhibit engagement, 2) negative perceptions of services, 3) the role of services in promoting engagement and 4) how progress in treatment reinforces engagement.

Stories about individual factors that inhibit engagement.

Participants told 11 stories that were thought to fall into this theme, highlighting issues such as mental capacity, unrealistic expectations, difficulties with trust, reliance on 'drugs' and 'drug identity'. Susan and Jane told stories about service users who have difficulties engaging in treatments due to impaired 'mental capacity'. In 'Mental Capacity to Engage', Jane (clinician) said: *"To be honest his [se*rvice user] mental illness impacts a lot on his capacity

to cope with any traditional drug treatment [...]. He can't sit and hold a conversation for

longer than about 15 minutes".

According to stories from Jane and Isabel, some service users are motivated to address

their mental health problems but not their substance use, suggesting a lack of awareness of

the interaction effects of the dual disorders and wider social difficulties. According to Susan's

account, it can be difficult for people to give up something they enjoy or have come to rely

on as an *"emotional crutch".* Over time this reliance on 'drugs' can become an integral part

of the person's identity and social networks. As Isabel put it *"what else is there".*

Stories about negative perceptions of services.

The majority of stories in this theme, 10 in total, were about past unhelpful experiences of

services and their impact on subsequent relationships with clinicians and engagement in

treatment. John's story, 'It's all in Your Mind; You're a Hypochondriac', is about a

consultation he had with a psychiatrist. He did not feel listened to and understood and

disagreed with the treatment he was given:

"I said "I don't want to take these tablets no more", I said "they're making me feel worse

instead of *making me feel better and he [psychiatrist] said "I told you, it's all in your*

mind, you're a hypochondriac". So that was it, I thought I've had it with mental health".

Participants told stories about services that were not just unhelpful but *"abusive".* John's

story, 'They Physically Beat Me', was particularly powerful. As an inpatient, he was

"punched in the head, punched in the ribs, stamped on, [...] hit with a liquid cosh

[medication]" and then left in seclusion overnight on a cold floor with no blankets. In

'Professionals Can Be Uncaring Even Cruel', Sid spoke about negative attitudes and approaches of colleagues. He recounted a woman who arrived late to pick up her methadone prescription:

*"She [service user] was trying to get through the door. Her arm was through the door. She'd tried to force her way in, and he [nurse] was leaning on her arm. And he was actually hurting her and saying "you know you're late. You were all told four o'clock". It was two minutes past four. Now I'd be sceptical about ev*er going to that person [nurse] again."*

Stories about the role of services in promoting engagement.

There were 61 stories related to this theme. According to these stories, it is important service users feel listened to and understood, safe, accepted and not judged and that they are treated as individuals. In this regard, 'therapeutic relationship' and issues around trust featured extensively. Once 'therapeutic relationship' is established, according to participants' stories, other issues come into play such as setting out clear and realistic expectations of treatment, empowering services users, involving service users and their families in care planning, and specific interventions to increase problem awareness and coping skills.

Due to issues around trust, it takes time for service users to feel safe in their relationships with clinicians. This is illustrated in the following excerpt from Anne's story 'All You Can do is Trust':

" It's hard, you need some help and support, but you don't know who to trust. You don't always want to come here [current treatment] because you have to face a lot of pain. And

is it really going to help in the long run? [...] The only thing you can do is you should *trust in this team, is go along with it, because if you don't,* like I said, you are going to go *loopy or you're going to commit suicide. So I've got no choice but to, to go for that help now"*

In her story, 'Banging On', Jane spoke about allowing service users to address their 'problems' when they are ready and on their terms. As an inpatient, John responded well to professionals who were willing to adapt Ward routines and treatments to take account of patients' needs and who listened and validated his concerns. This kind of approach and being consulted about his treatment made John *"feel, yeah, special"*. The following excerpt is from his story 'They Involved Me in My Treatment Which Made Me Feel Special':

"I don't sleep", [...] and I said [to a nurse] "but I've never got any help", so he went "right [...] we're going to change your medication, John, you've got to agree to this", which I'd never been asked to agree to. I've just been told I've got to take it".

In 'I Bonded With My Psychologist Because He Did Not Judge Me', Tracey described the factors underpinning her positive relationship with her psychologist. Unlike previous unhelpful encounters with professionals, he took the time to get to know her as a person rather than making assumptions based on diagnostic labels and previous reports. Like Tracey, John values professionals who *"know what they are talking about"*. This is illustrated in his story 'My Psychologist Understood My Problems':

"and he [psychologist] like drew a diagram on the board of how your mood goes and how one leads to the other, and I went *away and I looked at the board and I thought "that's*

me" so he does know what he is talking about. Soon as I see that drawing and I knew that what he was saying that was me to a 'T'. Then I just sat back and I opened up."

Stories about how progress in treatment reinforces engagement.

There were 11 stories in this theme, suggesting that progress in treatment reinforces motivation to engage and vice versa. In her story, 'I'm More Engaged in Treatment Because I'm No Longer Attracted to the Danger of Drugs and Because My Self-Esteem Has Increased', Tracey said that the coping skills, sense of achievement and pride she gained through treatment was more important to her than the thrill of drugs: *"After being a bit clean, maybe after being a month clean, I felt proud of myself, you know, I am worth it, I can do it, my self esteem is rising, why do I want that life?"*

In his story, 'It's Nice That People Are Comfortable Around Me', John said that people perceive him differently since he has been in treatment, reinforcing his motivation to engage: *"And it's nice to feel that people are comfortable around you, not laughing and joking with you because they feel they've got to, you know, it's because they want to, and it's nice"*

Use of Language in the Telling of Stories and the Role of the Researcher in Co-constructing Narratives.

Use of language in the telling of stories (service user).

Like the other service users interviewed, Anne tended to tell stories in the first person. Recapitulations and evaluations of events were re-enacted and emphasised using 'direct speech', 'repetitions' and 'extended pauses'. According to Riessman (2008), using language this way draws the listener in, recreating not only what happened but also the emotional

content. In addition to conveying key messages, linguistic features give stories credibility or believability.

All the service users showed a tendency to take 'disempowered' or 'victimised' positions in their stories, except when they were speaking about their current treatment. At times, Anne became tearful, punctuating her speech with extended pauses. This was emotionally compelling, making it hard for the listener to not empathise with her difficult life experiences and relationship with services. Towards the end of her account, although still portraying herself as a victim, Anne grew in confidence, adopting a more assertive position in relation to the researcher and wider audiences. This was perhaps most evident in her story 'Messed Up'. In this story, she asked a series of questions of services and society, demanding to know why they treated her the way they did:

"No one can really give me answers. All I know is that society has messed up. […]. Why I lost my children? Why I was put back to abusive, evil person [mother]? […] Why nobody come and checked properly? Why nobody heard my, my screams or crying for help? *Why?"*

Use of language in the telling of stories (clinician).

In contrast to service users, clinicians told more 'us' and 'they' stories. According to Robichaux and Clark (2006), this is not untypical of professional carers' accounts of service users' experiences. In Susan's case, 'us' stories positioned her within her team and 'they' stories were about service users, other services and to a lesser extent carers.

Reflecting their wealth of experience, clinicians told a comparatively high proportion of 'habitual' (Riessman, 2008) or 'overarching master' (Cain, 1991) narratives; generalisations based on repeated exposure to the same or similar events. According to Riessman (2008), habitual or 'us' and 'they' narratives make less of an impression than single case examples referring to specific people and events. The single case examples given by Susan tended to be brief and embedded within stories to illustrate particular points. She used them to highlight important shifts or 'turning points' (Frank, 1995) in service users' treatment motivation and engagement.

To further increase the 'dramatic effect' of her single case examples, Susan told them in the service user's voice. Re-enacting rather than simply reflecting on events brought the researcher closer to what service users were thinking and feeling at the time. This use of language is illustrated in Susan's story, To Realise a Dream, about a service user who decided: *"I am not getting any younger, I am in my mid-forties, I need to do something with my life, I want to write a book, this [cannabis] affects me"*.

With their specialist experience, the clinicians were accustomed to being consulted in this area, understood what to expect from the interview, and seemed empowered in their relationship with the researcher. As such, they asserted themselves throughout, speaking quickly and confidently. In Susan's account, there were minimal non-lexical utterances extended pauses, or inconsistencies indicative of 'narrative tension', that is, "unresolved conflict or confusion regarding particular areas of experience" (Ayres, 2000, p. 362). However, she did use repetitions to alert the listener to what she was about to say or to emphasise important messages. The early part of her account about the nature of DD and her

work in this area was not in story form. It was interpreted as an 'aside' where she "stepped out of the action to engage directly with the audience" (Riessman, 2008, p. 112).

The role of the researcher in co-constructing narratives (service user).

In her stories, Anne described a context in which she was prevented from being a 'good mother', partly due to unhelpful interventions by services. Where necessary, she redirected the researcher's questions to stay on this topic. Despite difficulties with trust, it seemed Anne wanted to have a 'voice', positioning the researcher as a witness to her strong feelings towards services. Occasional references to 'society' suggested that she was also performing to wider audiences.

With the exception of her current treatment, Anne cast herself in the role of 'victim' and her mother, services, and wider society as the 'abuser'. It can be argued that attributing responsibility externally protected her 'preferred identity' (Goffman, 1969) as a 'good mother', offsetting feelings of guilt and shame. Also, it mitigated the risk of being judged harshly by the researcher. It is suggested here that dominant societal discourses around motherhood and associated pressures on women to fulfil certain expectations were embedded in Anne's stories and how they were told.

On the whole, Anne's account can be described as a 'tragedy' although there were glimmers of hope. In her closing stories about her current treatment, she portrayed herself and her care team as 'heroic' characters, overcoming insurmountable odds. The extent to which interviewing Anne at the clinic where her current treatment is based impacted these stories is unclear. It is possible she inhibited her 'true' feelings in order to protect the positive relationship she has with her care team.

The role of the researcher in co-constructing narratives (clinician).

Side stepping my opening questions, Susan made evaluative statements about the complex nature of people with DD, providing a context to the stories she went on to tell and giving an indication as to how she wanted to be perceived by the researcher. As mentioned earlier, this part of her text was not in story form. Like the other clinicians interviewed, it seemed she was willing to be open about her shortcomings and the shortcomings of her team, provided they were judged fairly, taking into account the difficulties inherent in the work.

Throughout their accounts, clinicians punctuated stories with 'you know', implying shared knowledge. This positioned the researcher as a fellow 'expert' or what Bell (1999) refers to as an 'insider' and perhaps explains why their stories were not detailed and fully formed structurally as they might have been with a layperson. To some extent, all the clinicians used technical terms such as 'harm minimisation' without defining what they mean.

Towards the end of her account, Susan told "hypothetical narratives" (Riessman, 2008, p. 2) about what she believed DD services could do differently to enhance treatment motivation and engagement. This can be seen as an indirect self-endorsement of her role and expertise in the area; something that would have been "difficult to say in other ways" (Riessman, 2008, p. 112). At this point, she might have wondered about wider audiences and whether the study would have implications for her role within a DD pilot scheme. Although she omitted to mention it, she knew senior professionals within the Trust would have access to the results.

Discussion

Findings in Relation to the Literature

Story themes that provided explanatory answers to the research questions are summarised and discussed in relation to the literature on DD treatment models and models of treatment motivation, particularly Drieschner et al's (2004) 'integral conceptualisation of treatment motivation'.

The sources or determinants of treatment motivation highlighted in the current study related to 1) significant life events and 2) a wish for change. Events such as pregnancy and a new 'loving' relationship can be understood in terms of Drieschner et al's (2004) concepts of 'outcome expectancy' while family 'ultimatums' relate to 'perceived external pressure'. Stories about people accessing treatment due to medical problems, a near death experience, bereavement or when they 'hit rock bottom' were typically about 'problem recognition' and 'level of suffering'. These events and their impact on treatment motivation can be thought of as 'turning points' which, according to Frank (1995), are integral in how people construct their experience of recovery. Stories about service users seeking treatment to fulfil a life ambition or because of personal pride stemmed from 'a wish for change' rather than specific 'turning points'. With regards to Drieschner et al's (2004) model, they can be explained in terms of 'outcome expectancy' and 'problem recognition'.

Stories about the relationship between negative perceptions of services and treatment motivation were generally based on past unhelpful experiences of healthcare or what Brown (1998) refers to as 'possibility turned to disappointment', that is, people being disbelieved, misunderstood, uncared for, stigmatised, neglected or victimised. This focus on the impact of services on treatment motivation is somewhat inconsistent with the predominant models of

motivation which tend to focus on the individual and personal responsibility for change

(Kearney & O'Sullivan, 2003; Heckhausen, 1991). The TTM (Prochaska & DiClemente,

1982), particularly in the early stages of change, is primarily concerned with issues such as

'problem recognition' and 'self re-evaluation' while. Drieschner et al. (2004) argued that

treatment motivation is based on 'critical self-appraisal' of external forces rather than

external forces themselves. According to Davis (2010), a social inclusion champion, the

recovery process for some service users is at least partially based on "the realisation that

external not personal factors were largely responsible for their plight" (p. 32)

Stories about fluctuations in DD treatment motivation can be understood in terms of Miller

and Rollnick's (2002) conceptualisation of ambivalence. The current study suggests that

ambivalence arises when motivation for treatment is contingent on a range of competing

variables simultaneously or 'opposite pulls'. This was illustrated in Isabel's story,

'Disagreements Within Families', about a service user who was caught between his mother

who supported treatment and his father who disapproved. Also, several stories described

people who were aware of their problems and motivated to address them but unsure about

treatment due to the 'perceived costs' or its 'perceived suitability' (Drieschner et al., 2004)

based largely on past negative experiences of services. Within a motivational interviewing

framework, impasses of this nature would be understood and targeted using 'decision balance

matrices' (Miller & Rollnick, 2002).

The current study highlighted a range of individual factors that were thought to inhibit

treatment engagement such as cognitive impairment, unrealistic expectations of services and

issues around trust. Also, stories suggested that entering treatment and giving up 'drugs' can

be distressing and seem unrealistic, especially when they are integral to the person's sense of

identity, relationships and ability to cope. It is argued here that failure to take account of

complex psychosocial issues like this can lead to differences of opinion within services and

between services and service users regarding the nature of problems and what constitutes

appropriate treatment. According to the literature, applying approaches such as motivational

interviewing (Miller & Rollnick, 2002) and harm minimisation (Marlatt, 2002) that start

treatment by focussing on service users' concerns as defined by them might minimise the

likelihood of such misunderstandings. With people that have DD, unlike addiction only

services, there is the added complication of fluctuating mental health conditions.

The main focus of participants' stories regarding the impact of services on treatment

engagement was on 'therapeutic relationship'. According to Drieschner et al. (2004),

'therapeutic relationship' is not in itself a determinant of treatment motivation. However, it

does target variables that are. In the current study, it was suggested that 'therapeutic

relationship' underpinned by client-centred principles (Rogers, 1959) such as empathic

listening, acceptance and genuineness is important to offset the 'perceived costs' of treatment

and low 'outcome expectancy' based on previous negative experiences of services. This

association between 'therapeutic relationship' and treatment engagement is consistent with

the broader literature on addictions (e.g. Meier, Barrowclough & Donmall, 2005). Although

inconclusive, Meier et al. (2005) argued "that a good therapeutic relationship may have

particular importance in retaining drug using clients with psychiatric co-morbidity" (p. 12).

Limitations

If viewed from the positivist tradition, the outcomes of the current study do not infer cause

and effect nor are they generalizable to other DD service users and clinicians. It is possible

that the people who chose not to participate in the study were qualitatively different to those

that did. Also, the analysis was concerned with participants' reconstructions of experiences which are unique to them and by definition not replicable. However, the outcomes and how they are represented in story form can be used to help other clinicians and service users gain a more in-depth insight into their own roles and experiences (Polkinghorne, 1995).

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The extent to which clinicians based their stories on preconceived ideas of treatment motivation from training and consulting with colleagues rather than direct experienced-based thoughts and feelings is hard to determine. Perhaps their stories were somewhat staged to give the impression they were familiar with the literature and best practice guidelines. Similarly, service users may have simply "parroted programme rhetoric" (Kearney & O'Sullivan, 2003, p. 150) they had picked up through treatment. They may have censored what they said to avoid compromising current or future relationships with services. By the same token, due to previous unhelpful encounters with services, they may have been overly critical. As part of the analysis, an attempt was made to understand how the researcher and wider social discourses may have affected participants' stories.

Transferability

In essence, narrative analysis constitutes the researcher's interpretation of the participants' interpretation of their experiences conveyed through stories which could have been biased by a range of factors. As such, the researcher was reflexively aware of the personal and professional issues he brought to the interviews with participants that might have encouraged or impeded what was said. Applying Elliot's (2006) 'common sense' approach and Mishler's (1990) notion of 'trustworthiness', steps were taken maximise the internal consistency of the study to enable readers to make judgments about the transferability of findings to other contexts.

Clinical Implications

The outcomes of the current study could have implications regarding the rates of people with DD seeking, accessing and engaging in treatment. A greater awareness and emphasis on motivation and the factors underpinning it can inform the configuration of integrated services and models of care planning to take account of a range of individual, contextual and relational factors in addition to diagnoses and severity of symptoms. Also, it might help address the lack of confidence, frustration and burnout that are all too familiar to clinicians working in this area (DiClemente et al., 2008). Equipping clinicians with the tools to assess and treat both mental health and substance use disorders might successfully challenge the culture that still exists within some services of 'referring on'.

Models of motivation developed in the addictions field and applied to adult mental health such as the TTM and MI are primarily concerned with 'problem recognition'. Among people with DD, at least in the first instance, it might be better to focus on negative perceptions and low expectations of treatment due to previous unhelpful encounters with services. It is acknowledged that 'therapeutic relationship' based on mutual trust, collaborative working and Rogerian (1959) client-centred principles has a pivotal role to play in most strands of healthcare. However, it is suggested here that it might be especially important for people with DD to help them overcome negative perceptions of services and to account for the chronic nature of the problems that often beset this client group, not least issues around trust and relating to others (Meier et al., 2005).

Theoretical Implications

Interventions such as CBT and MI have been adapted and incorporated into DD treatment programmes with encouraging results. Perhaps surprisingly given the low rates of treatment

uptake and engagement, little research has been carried out into the motivational processes that characterise this group. Although inconclusive, the outcomes of the current study offer some original contributions to the debate in the literature regarding the conceptualisation of motivation and associated models and treatments and how they can be evaluated and adapted specifically for people with DD. Based on the current study, the dimensions of motivation among people with DD are likely to be similar to addictions and other mental health related conditions. However, their relative influence and interaction effect might be different with particular emphasis on the link between outcome expectancy and the perceived match between the treatment and the service user's needs. Theoretically, this last point might help explain why problem awareness and motivation to change within this client group does not always translate into treatment uptake and engagement.

Further Research and Conclusions

This study offers insights into the factors that promote and inhibit DD treatment motivation and engagement. Most notably, there were several stories about people with DD wanting to address their difficulties but not wanting treatment due to previous negative experiences of services. On this basis, it could be argued that motivation to enter into and engage in DD treatment is a different form of motivation to the more generic concept of 'readiness to change'. This supports the notion that models of motivation developed in the addictions field and associated emphasis on 'problem recognition' and personal responsibility for change fail to adequately account for the needs of DD groups. However, in order to draw firm conclusions, further research is required.

Additional issues that might be of interest to the research community include: 1) similarities and differences in motivation across client groups; 2) interaction effects of

determinants of motivation and how their relative influence shifts over time and in different

contexts; 3) how the interaction effects of dual and multiple disorders impact on treatment

motivation and engagement; 4) 'therapeutic relationship' and its link with DD treatment

engagement. Based on the current study, this final point would seem important to help people

overcome negative perceptions of professionals and treatment and associated difficulties with

trust based on having felt let down by services in the past.

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Max O. Ward BSc. Hons.

Independent Research Project

SECTION C

Critical Appraisal

Service User and Clinician Perspectives on 'Dual Diagnosis' Treatment Motivation: A

narrative analysis

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Running Head: Dual Diagnosis Treatment Motivation

Abstract

This paper provides a general overview of narrative research, including strengths and limitations as they relate to this study. With reference to the literature, clinical and theoretical implications are discussed along with recommendations for future research. The author's critical self-reflections regarding the process of initiating, carrying out and completing the study are highlighted. Following this, there is a section on the ethical considerations of the study. Finally, the measures taken to ensure the quality of the study and maximise internal consistency are presented.

Critique of Study

This was an exploratory study of a sample of eight service users' and clinicians' understandings of dual disorder (DD) treatment motivation, the factors underpinning it, and its relationship with treatment engagement. Part of the focus was on fluctuations in motivation over time and the meanings people ascribe to this. A qualitative design, from a social constructivist perspective, was thought to be appropriate for this study to gain a richness of data that would not be accessible using variable-based quantitative research. Narrative analysis in particular was chosen to highlight personal sense-making and to preserve the way people do this in their recounting of events, taking into account reciprocal relationships and meaning making processes and wider social and ideological influences. It seemed important to capture the way participants made sense of the complexity of interactions between motivation and their experiences of different elements of DD treatment and services, an area which has as yet been largely overlooked by the research community.

Narrative Research

Narrative analysis.

Narrative analysis has roots in a range of scholarly and clinical domains as well as political movements such as feminism (Riessman, 2003). During the early and mid 20th century, a handful of psychologists argued that narrative analysis provided a deeper understanding of human experience and action than the predominant behavioural approaches of the time which were based on positivist ideology. According to the narrative approach, individuals make sense of their experiences and the world around them by setting them in story form. Recordings of narrative accounts within the stories people tell about their experiences are therefore the subject of analysis (Riessman, 2008).

The way narrative is defined determines the methods used to construct and analyse data (Mishler, 1995). Within the social sciences, there is no single definition of narrative and therefore no single definition of narrative analysis (Riessman, 1993). Some scholars view narratives as distinct units, "referring to brief, topically specific stories" (Riessman, 2003, p. 1) which can be analysed in isolation of the social context in which they are embedded. Others argue that this definition is overly individualistic and that narratives need to be understood taking into account not only the 'teller' but also the 'listener' and surrounding social norms and discourses.

Along these lines, Hinchman and Hinchman (1997) suggested that narratives "should be defined provisionally as discourses with a clear and sequential order that connect events in a meaningful way for a definite audience and thus offer insights about the world and/or people's experience of it" (p. xvi). Shaped by the socio-cultural landscape, narratives represent the stories people use in everyday life to construct, interpret and communicate personal experiences and sense of identity. In essence, storytelling is the means by which we understand "the 'self' and our sense of others in the social world around us" (Bruner, 1986, p. 69). Through analysis, these stories offer representations of personal experiences which, according to Riessman (2003, p. 15), are "fluid and contextual not fixed and universal". Although there are different methods of narrative analysis, generally they share the view that narrative is about sequences of events unfolding temporally or causally in time (Riessman, 2008).

Why narrative analysis?

As mentioned, according to the narrative approach, people describe and make sense of their world through stories. In medical education, Greenhalgh and Hurwitz (1999) interpret

case examples as in effect stories that have a certain power to convey important

understandings. Through focussing on whole stories, narrative analysis does not fragment

individuals' experiences into the smallest bits and pieces, separated from the context in which

they are embedded. This underlying assumption of narrative analysis sets it apart from not

only variable based research but also other qualitative methodologies such as grounded

theory, interpretive phenomenological analysis (IPA) and purely discursive approaches

(Mishler, 1995). Although open to debate, it is argued that preserving stories in their original

form, as they are told and intended, represents more naturalistically the meaning people

ascribe to their personal experiences, allowing research participants more control over the

process of generating data and determining outcomes, than is generally the case with other

methodologies (Murray, 2003). Giving participants control over what was appropriate and

important to talk about was considered important in the current study due to the sensitive

nature of the topic under investigation and to validate their experiences as defined by them.

Also, it reflects the increasing popularity of research that seeks to get as close as possible to

"first-hand experience and understanding" (Beresford, 2006, p. 169).

Forms of narrative analysis.

Riessman (2003) outlines three methods which have been found to be particularly useful

for analysing orally presented narratives of personal experiences: thematic analysis, structural

analysis and interactional analysis. Thematic analysis focuses on the content of narrative

accounts. The linguistic properties of how stories are told do not feature in the investigation.

In structural analysis, the emphasis is on not only what is said but how it is said. With

interactional analysis, what is communicated and how is important; however, the focus is on

context, particularly "the dialogic processes between teller and listener" (Riessman, 2003, p.

4). From this perspective, personal narratives are viewed as co-constructed between the teller and listener within the "broader social and cultural context" (Murray, 2003 p. 99).

Riessman (2003) argues that there is overlap between the different methods described and that they can be used in combination. Applying the structural and interactional approaches, Bell's 1988 and 1999 studies explored identity transformation in two women who developed cancer as a result of their birth mothers being prescribed medication to reduce the risk of miscarriage. Core narratives and the links between them were identified and analysed thematically and linguistically using Labov's (1982) method to represent the experiences of these women before and after finding out they had cancer. The focus was on the narrative structures the women used to construct, link sequentially, and recapitulate topically relevant events within the interpersonal context of the research interview. This allowed for an in-depth exploration of how the relationship between these women and their doctors changed from one based primarily on medical discourses to one based more on the "women's health" (Bell, 1999, p. 347) movement.

Amongst other things, Bell's 1988 and 1999 studies illustrated the unfolding, multi complex, unique and contextual nature in which individuals make sense of health and health treatments. Similar to Bell (1999), the current study was interested in how understandings and relationships with services and treatment unfold over time in response to identity shifts and shifts in perspective based on wider social discourses. In this regard, structural analysis was used to outline the content of stories relevant to the research questions and how they were told linguistically. Additional analysis was used to understand how stories might have been influenced by the researcher and wider healthcare, social and political discourses. Themes were extracted from the structural analysis of interview transcripts to provide

"explanatory answers to the research questions" (Polkinghorne, 1995, p. 15) based on the authors "readings" (Bell, 1999, p. 353) of stories.

Narrative interviews.

Typically, research interviews have tended to discourage 'story telling' (Murray, 2003), whereas in narrative research it is encouraged. According to Murray (2003), there are two kinds of narrative interview; 'life history' and 'episodic'. The current study used the 'episodic' approach which is more targeted. The emphasis was on the research questions guided by pre-existing theory, particularly Drieschner, Lammers and van der Staak (2004) 'integral conceptualisation of treatment motivation'. To start, participants were asked a 'complex' question, outlining the issues under investigation and prompting them where to begin telling stories. Thereafter, to minimise researcher effects, the questions and prompts outlined in the interview schedules, or variations on them, were used selectively in response to the stories unfolding or to refocus participants if they became sidetracked. The interview schedules were piloted in advance and amended based on feedback from the Independent Research Review at Canterbury Christ Church University and through consulting with a Salomons Advisory Group of Experts by Experience (SAGE) member.

Study Limitations

Narrative analysis has been carried out with as few as two participants (Bell, 1999; Lee & Bonnie, 2006). On this basis, the current sample size of eight was considered sufficient to provide usable data. However, it is possible the clinicians who chose not to volunteer for the study did so due to factors that would have led them to tell different but no less relevant stories which has implications in terms of generalizability. The same can be said of people with DD who were not involved with services at the time and therefore unaware of the study.

Also, it is hard to determine the extent to which participants' stories were biased by

"programme rhetoric" (Kearney & O' Sullivan, 2003) or the thought of compromising their

work or the care they receive. For example, Tracey (service user) alone told eight separate

but overlapping stories extolling the benefits of the psychological work she was engaged in.

Through exploring dialogical processes, potential biases of this nature were not seen simply

as a threat to the internal consistency of the study; rather an opportunity to gain insights into

why participants told the stories they did (Bell, 1999).

The stories and excerpts from stories selected and how they were understood as part of the

analysis might have been substantively different had somebody else undertaken the study.

Important "contexts shaping the researcher as interviewer and analyst" (Bell, 1999, p. 351)

included prior knowledge of DD literature, clinical experience in the field and an inclination

to advocate for approaches that empower service users. The latter potential bias may have led

the researcher to make what Ayres (2000) refers to as moral rather than literary judgements.

In this study, there were a number of stories from both service users and clinicians about

unhelpful, sometimes punitive interventions by services. It is possible that these distressing

accounts resonated with the researcher's own sense of frustration and disillusionment with

DD services and treatments. The extent to which the researcher positioned himself alongside

service users and in opposition to services needed to be understood and managed so as to

inform rather than compromise how interviews were conducted, and the selection and

interpretation of data. In this regard, regular meetings with the lead research supervisor for

the purposes of independent validation were seen as essential, not only to maintain the

integrity of the study but also as a learning experience within the context of the author's

training.

Using Labov's (1982) structural method to identify and define narratives was challenging. Often participants dipped in and out of stories, making it difficult to determine where they began and ended. At other points, interesting and potentially valuable information was not in story form as defined by Labov's criteria. Despite not conforming strictly to Labov's system, partially formed, 'habitual' and 'hypothetical' narratives were considered in the analysis (Riessman, 2008). Habitual and hypothetical narratives were difficult to interpret using Labov's model because they did not centre round specific past events or experiences. Habitual narratives were about generalised experiences of the same or similar events whereas hypothetical narratives were precisely that (Riessman, 2008). Taking a flexible approach to the application of Labov's model was considered necessary in order to do justice to the breadth and depth of information provided by participants.

Study Implications

Clinical

Models of motivation developed in the addictions field and applied clinically to DD and other aspects of adult mental health such as the TTM and MI are primarily concerned with 'problem recognition'. 'Problem recognition' as a determinant of treatment motivation was reflected in clinicians' stories, for example, 'Set in Their Ways' from Susan's account. In contrast, service user' stories suggested they were aware of their problems and wanted help but had doubts about the benefits of treatment due to past negative experiences. This raises two issues. First, service users and services might have different definitions of problems and what constitutes appropriate treatment. Second, at least in the first instance, it might be better to focus on negative perceptions and low expectations of treatment rather than 'problem recognition'. Of course, this is difficult to do when people are not in contact with services and reluctant to attend clinics.

With regards to treatment motivation and engagement, participants in this study seemed to be in agreement about the importance of 'therapeutic relationship' and the service and clinician' qualities required to achieve it such as empathic listening, not jumping to conclusions about areas of difficulty, a caring respectful approach, seeing people as individuals and collaborative working. However, according to clinicians' stories, the relationship between these phenomena, 'therapeutic relationship' and treatment uptake and engagement is not straightforward. As a result, there can be conflicted opinions among clinicians regarding the most appropriate configuration of services and interventions.

According to Jane and Isabel (clinicians), some teams support *"intensive"* and *"persistent"* approaches, for example visiting people at home. The counter argument was that this is *"interfering [...] sort of never leaving them alone"* or that it encourages dependency and a lack of personal responsibility. They suggested that service users can be critical of approaches that are *"compassionate and understanding"* if ultimately they lack objectivity and credibility and are ineffective. This suggestion that there is a lack of consensus within and across services about the best methods of working with people with DD is consistent with a Delphi study carried out by Jeffery, Ley, Bennun and McLaren (2000). In the author's view, it illustrates the need for training to help teams develop a shared understanding of DD issues and appropriate treatments based on best practice guidelines (Department of Health, 2002).

Based on the current study, according to services users, it was the absence or perceived inappropriateness of input rather than its intensity that was unhelpful. Making it easier for people with DD to access or return to treatment on their terms might make services feel more

patient-centred and supportive, challenging some of the negative preconceptions that were highlighted. To account for and manage fluctuations in motivation, it might be helpful to develop drop-in treatments, employing brief motivational interviewing strategies which are recommended by the National Institute for Health and Clinical Excellence (NICE, 2007) for substance use, and more flexible approaches to closing cases due to missed sessions. In other areas of mental health, workshops in neutral settings such as leisure centres or libraries have been introduced in an effort to increase rates of treatment uptake among people that might otherwise not engage due to, for example, stigma (Brown, 1998). Davis (2010), based on interviews with mental health service users, highlights the importance of "working conjointly with people often vilified by society" (p. 32) in order to enable them to help themselves and combat their social exclusion and stigma. With this in mind, and based on the current study, it would seem important to establish shared understandings of service users' areas of difficulty and needs at the outset, before jointly deciding on a treatment plan. Also, it should not be assumed that people are unaware of their problems and lack motivation to change just because they choose not to access and engage in services.

According to the literature, DD populations are more likely to have experienced abuse earlier in life than mental health and addictions service users generally (Lehman, Myers, Dixon & Johnson, 1994). Taking this into account, the number of stories in the current study regarding relational difficulties and trust is not surprising. To address this, workers with the skills and style of approach necessary to build positive relationships with DD service users would be of enormous value. In this regard, clinical psychologists with specialist knowledge in the area could have a role in training services in approaches such as MI, client-centred counselling and attachment based therapies (e.g. Reading, 2002) that pay particular attention

to the importance of therapeutic relationship. In line with the service user movement, service users themselves could be trained up to contribute to these initiatives.

Theoretical

As yet, the evidence base regarding DD treatment motivation and engagement is sparse and based almost exclusively on the TTM and associated measures, developed in addictions to explain stages and processes of change. This assumes that 'addictions motivation' is the same as 'DD motivation' and that 'motivation to change' is the same as 'treatment motivation' which, according to this and other studies, is not necessarily the case. This, among other conceptual ambiguities, calls into question the application of the TTM to people that have DD "despite its intuitive appeal to practitioners" (West, 2006, p. 1). Although inconclusive, the findings of the current study may contribute to the development of new models of treatment motivation and engagement and associated measures and treatments that relate specifically to DD populations.

Based on the current study, as mentioned, the factors underpinning treatment motivation among people with DD are likely to be similar to addictions and other mental health related disorder. However, their relative influence and interaction effect might be different. There were numerous stories from participants in this study about service users feeling let down or even abused by services, leading to negative perceptions of professionals and treatment in terms of compatibility and outcome expectancy. Theoretically, this last point might help explain the suggestion from this and other studies that problem awareness and motivation to change among people with DD does not always translate into treatment uptake and engagement.

In terms of the link between DD motivation to change and DD treatment entry and engagement, the current study would recommend models of DD treatment motivation and engagement pay particular attention to issues of trust. Difficulties with trust were highlighted repeatedly in stories across the whole sample. In this regard, consideration should be given to not only the person's past experience of services but also histories of sexual and physical abuse which are relatively common among addictions, leading to insecure patterns of relating and attachment (e.g. Duncan, Saunders, Kilpatrick, Hanson & Resnick, 1996). To help people understand and work through these difficulties, therapeutic relationship based on client-centred (Rogers, 1959) principles and understandings of attachment theory might be of particular relevance to this group.

Future Research

Although inconclusive, outcomes of DD treatment programmes are encouraging. Arguably, as mentioned, the main problem is low rates of treatment uptake. To address this, it would seem important to understand the factors and processes underpinning treatment motivation and how they relate specifically to people with DD using models such as Drieschner et al's (2004) 'integral conceptualisation of treatment motivation' as a framework to see if it offers a viable alternative to the TTM. The current study highlighted a number of issues that might provide important insights into these issues. However, further research is needed before firm conclusions can be drawn.

Particular issues that might be of interest to the research community include: 1) similarities and differences between the generic concept of readiness to change and treatment motivation and engagement; 2) similarities and differences in motivation between people with DD and other client groups; 3) the interaction effects of determinants of DD motivation

and how their relative influence shifts over time and in different contexts; 4) how the interaction effects of dual and multiple disorders impact on treatment motivation and engagement; 5) 'therapeutic relationship' and its link with DD treatment engagement taking into account issues such as fluctuating mental capacity and volitional control.

As suggested by the current study, service users and clinicians might have different understandings of DD treatment motivation and engagement and the factors underpinning them. For example, individual variables such as mental capacity and lack of problem awareness featured in the stories by clinicians. In contrast, service users focussed more on the negative impact of services. As such, endorsed by the National Institute for Mental Health in England (NIMHE, 2005) and the recovery model (e.g. Shepherd, Boardman & Slade, 2008), it would seem important to gauge the views of both. Where possible, service user groups could be approached to contribute to the process of designing and carrying out research. In terms of methodology, qualitative or mixed qualitative and quantitative approaches are recommended.

Researcher Reflexivity

Research Idea

The author first became interested in DD in the mid 1990's whilst working as a rehabilitation worker at a forensic psychiatric hospital. Two things were apparent at this time. Firstly, psychiatry was having difficulties adapting to the increased prevalence of drug use in this population. Secondly, there was a predominant discourse that drug use among people with mental disorder was an inconvenience because it interfered with traditional treatments and that it should be managed with sanctions and increased levels of security which seemed somewhat punitive. In response to this, the psychology department set up a substance misuse

service which the author went on to coordinate. In this capacity, part of the author's role was

to develop psychological interventions for this group and to consult with staff around

substance use and DD issues.

At this time, reflecting the literature, most of what the author knew about DD and DD

treatments stemmed from the addictions field. In the author's view, further research was

needed specifically into DD. The current study, focusing on motivation to enter and then

engage in treatment among people with DD, was influenced by two debates that emerged

from the literature a few years later. One argument was that the TTM, which had come to

dominate understandings of motivational processes, lacked clarity. Another argument

suggested that motivational processes relating to DD treatment are different than motivational

processes relating to addictions treatment and that they need to be understood and

conceptualised independently. A particular frustration for the author was hearing people who

had DD described as insightless and unmotivated because they did not attend and engage in

treatment. This encouraged a culture of blame and stigmatisation and seemed like an overly

simplistic view on what are complex issues, both in terms of individual factors and social

context.

Carrying Out the Study

The initial stages of putting this study together ran smoothly. The lead and second

supervisor seemed pleased to be involved in the project and the Salomons review board gave

positive feedback as did NHS ethics. The author started to encounter difficulties going

through R&D. This was partly due to changes in personnel within the department and partly

due to a misunderstanding regarding a contract that had previously been set up between the

Trust and Salomons to support the process. It was frustrating not being able to start recruiting

participants before the Christmas break 2009 as planned. The author understood that delays

of this nature are a common experience when carrying out research of this nature. However,

even at this early stage, he was mindful of the July deadline for completing the project.

After approval from R&D, the author began recruiting participants. This process was beset

by one delay after another. Directors and managers of services had expressed interest in the

research itself which was encouraging. However, at a team level, there seemed to be

numerous barriers. As part of the recruitment strategy, the author contacted team leaders,

attended team meetings, e-mailed staff the external supervisor thought would be supportive,

and met with dual diagnosis link workers that had been assigned to community adult mental

health teams across the borough as part of an 18 month dual diagnosis pilot project.

The plan originally was to interview clinicians or managers of services, service users, and

carers of service users. In the first instance, the focus was on clinicians and managers.

However, this proved more difficult than anticipated. Also, despite enthusiastic feedback

about the study proposal, care coordinators seemed hesitant to introduce the author to service

users and carers of service users. The reasons for this were never made explicit although the

author could guess at some of them. The manager of one of the services had recently been

appointed and was busy settling into the post and therefore not available to provide much

assistance. All the services were in the process of completing a borough wide audit

commissioned by the Trust which had been given high priority. The dual diagnosis pilot

scheme within the borough was drawing to an end which meant that the link workers who

had promised help were busy securing their futures. Also, there seemed to be a saturation of

other research studies ongoing within the borough, competing for staff time and resources.

Completing the Study

By the end of April 2010, it was becoming increasingly less likely that the study would be written up in time for the July deadline and that a rethink of the original study proposal was required. The author had several conversations with the research supervisors about changing the focus of the study in order to reach this deadline. Various modifications were considered as long as they did not deviate too much from the original focus. As a result, the author went back to NHS ethics and R&D with amendments to widen the pool of possible participants. With support from the study external supervisor, this proved successful and the author quickly managed to collect the data needed to complete the analysis and write up the project. Throughout this process, the support provided by the internal and external supervisors was greatly appreciated, giving the author the courage to request a deferment which was granted. In retrospect, this seems like the right decision to maintain as much as possible the integrity of the study as it was originally envisaged. Also, it afforded the author more time and more opportunities to gain invaluable experience developing and carrying out research within the NHS, particularly the importance of building relationships with services and professionals that can support the process.

Ethical Considerations

The study was approved by an Independent Research Review at Canterbury Christ Church University in April 2009, National Research Ethics Service (NRES) in October 2009, and NHS Foundation Trust Research and Development (R&D) in December 2009. Amendments to the original proposal, including the option of recruiting participants from across the Trust as opposed to a specific borough, were approved by NRES and R&D in May 2010.

Based on the inclusion criteria, people indentified as suitable for the study were given a 'participant information sheet'. Those interested were invited to meet the researcher to discuss the study in more detail including the format and expected duration of individual interviews, what would be required of them, issues of confidentiality and the use of data, and any other queries they may have had. If they still wanted to be involved, participants had the option of being interviewed straight away, provided 24 hours had elapsed since they first read the 'participant information sheet', or at a later time if they wanted to think about it further. Prior to interviews, participants were required to read and sign a 'consent form'.

According to the literature, most respondents welcome the open nature of narrative interviews, willingly sharing their stories. Others find the approach anxiety provoking (Greenall & Marselle, 2007). In the current study, part of the researcher's role was to put participants at ease, adopting an empathic and supportive approach. This was important in the current study due to the distressing nature of some of the stories told by service users. Anne in particular became upset speaking about her children being taken into care and how she felt let down by services in this regard. Where necessary, Anne and the other participants were reminded that they could take a break from the interview or withdraw their consent to participate at any time if they wished. Although not required, they were told that the researcher was available to speak with them after interviews about how they found it and any discomfort they may have felt. Alternatively, service users could speak with their care coordinators if they wished. In the 'participant information sheet', a phone number was provided where the researcher could be contacted if there were any questions or concerns prior to or following meetings.

Quality Assurance Checks

As mentioned earlier, the study outcomes are not generalizable to the wider population of service users with DD and professional carers working with DD. However, steps were taken to maximise the internal validity of the study to enable other researchers and clinicians to make reasonable judgments about the transferability of findings to other contexts. Based on Elliot's (2006) 'common sense' approach and Mishler's (1990) notion of 'trustworthiness', these steps included: 1) providing descriptions of participants and the research setting; 2) providing a description of the methodology used; 3) providing excerpts from texts; 4) making explicit how narratives were extracted and interpreted; 5) respondent validation; 6) independent validation.

The purpose of respondent validation or correspondence (Riessman, 1993) is to ensure analysis of data fairly and accurately reflects what participants intended to convey. In this regard, participants in the current study were given a written summary of their stories and a feedback form to return to the author in a pre-paid envelope. The form invited participants to 1) comment on how representative they felt the summary was of their interview and 2) bring to the author's attention any important information they neglected to mention at their interview. Unfortunately, only Tracey (service user) returned the form, saying that the analysis of her stories *"was accurate"*. In retrospect, follow-up telephone calls might have been helpful.

In addition to Elliot's (2006) and Mishler's (1990) respective 'common sense' and 'trustworthiness' approaches, to further ensure transparency and to maximise the 'persuasiveness' (Riessman, 1993) of the study to the wider research community and other interested parties, the interpretive evaluation of the researcher was taken into account at each

stage of the analysis (Mishler, 1995). This critique involved asking questions such as: 1) what

information was included and omitted and why; 2) did the analysis remain true to the

narrator's words; 3) how and to what extent have the researcher's interpretations of the data

imposed on participants' stories? For independent validation, the analysis for one service user

and one clinician was reviewed by the lead research supervisor. The lead research supervisor

also read and commented on each section of the study write up for submission to the

Salomons clinical training programme.

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Max O. Ward BSc. Hons

Independent Research Project

SECTION D

Appendices of Supporting Material

Running Head: Dual Diagnosis Treatment Motivation

Appendix A

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Appendix A

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Appendix B

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Running Head: Dual Diagnosis Treatment Motivation

Appendix C

CONSENT FORM

Title of the research study
What motivates people to enter and engage in 'dual diagnosis' treatment: an analysis of service users', carers' and clinicians' and managers' opinions?

Name of researcher
Max Ward (trainee clinical psychologist)

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation in this study is voluntary and that I am free to withdraw at any time without giving any reasons and that this would not affect the health care I receive (currently or in the future), my legal rights, or my rights as an employee. ☐

3. I understand that the information I provide during this study will be kept confidential and secure in a locked filing cabinet or on a password protected computer. The only time confidentiality would be breached is if the researcher felt that you or somebody else was at risk of being harmed. This would include child welfare issues or crimes against the person, past and present. ☐

4. I understand that I will be interviewed as part of the study which will be audio-taped. ☐

5. I understand that the audio-tapes of my individual interview will be transcribed by either the main researcher or a professional transcriber. If used, the professional transcriber will be required to sign a confidentiality form. ☐

6. I understand that the audiotape from my individual interview and from the group meeting will be erased once the study is completed but that anonymised computer copies will be kept in a locked file for ten years before being destroyed. ☐

7. I understand that the main researcher will write a report about this study and a journal article and that these papers could include information taken from the anonymised copies of my individual interview and the group meeting, for example quotations. ☐

8. I understand that I am able to request a paper copy of my individual interview as well as a written summary of the findings from this study. ☐

Please sign below if you have ticked all of the above boxes and agree to take part in the study.

_____   _____   _____
Name of participant   Date   Signature

Appendix D

Interview Guide
Co-existing Mental Disorder and Substance Use Treatment Motivation: service user perspective

Briefing
Thank you for agreeing to participate in this interview. Before we start, I would like to go over some of the information contained in the leaflet I gave you when we first met. First, you are free to stop the interview and withdraw your consent to participate in the study at any time. Second, you do not have to answer any questions you don't want to. Third, I will tape record the interview. Without this recording, it would be very difficult for me to remember all of what you talk about. Forth, everything you tell me will be kept confidential unless I thought you or somebody else was in danger of being harmed. Fifth, you will get the opportunity to comment on the results of this interview before they are written up into a paper. Is what I have said ok? Do you have any questions?

Introduction
As you are aware from our previous conversations, this study is about what motivates people to enter into dual diagnosis treatment and to engage in it. During the interview, I will ask you to tell me in your own words and based on your own experiences what you think about dual diagnosis and dual diagnosis treatment. To get you started, I will ask you a question. After that, I might prompt you from time to time to tell me more about the things you mention. As much as possible, I will try not to interrupt. This is because I am interested in hearing your life stories and what you think is important. Please feel free to speak openly and honestly and for as long as you think is necessary. I have set aside an hour and a half for this interview. It is ok if we finish early. If we need longer, we can arrange to meet again later today or at some other point in the next two weeks. Please let me know if you would like to take a break during the interview. At the end of the interview, you will get the opportunity to talk about how you found it and any discomfort you may have felt.

Interview: opening question
Can you tell me what it has been like for you living with both a mental health and a substance misuse disorder? I am particularly interested in the period from when you first experienced these problems to when you decided to start treatment with the X DD Team. Later on I would like to hear how you have found the treatment you receive from the X DD Team. I would like you to start at the beginning – from when you first began to have problems or difficulties. How old were you? .... What was happening at the time? .... ok, carry on .... then ....?

The objective of the interview is to get an overall picture of the participant's experiences of dual diagnosis. Within that, the emphasis is on eliciting stories about the nature and relationships between 1) determinants of motivation to engage in treatment i.e. a wish for life to be different, 2) motivation to engage in treatment itself i.e. what people do by way of entering treatment such as attending an initial appointment and 3) treatment engagement i.e. following or participating in a care plan. Special attention should be paid to how and for what reasons motivation to engage in treatment waxes and wanes over time. The following list of questions and prompts or variations on these questions and prompts will be used selectively to encourage the participant to further elaborate their stories or to refocus them on the issues under investigation should they become sidetracked. They will be used in response to the stories told by the participant rather than in a pre-planned way.

Stage 1 questions: stories before X DD treatment

What made you realise you had problems?

What did you do next?

And then...? What happened?

How did people close to you react?

When you first realised you had problems, what did you know about services or sources of help or support? How did you get to know about these services? What did you think when you first heard about that? Did you think you might be able to access help there?

Can you tell me about the treatments you received before the X DD Team?

Stage 2 questions: stories about entering X DD treatment

How did you come to start treatment with the X DD Team?

What was happening in your life at this time?

What were your reasons for starting treatment with the X DD Team?

Can you tell me about your motivation to start treatment?

Describe for me a situation where your motivation was higher than usual.

Describe a situation where your motivation was lower than usual.

What stopped you from seeking treatment earlier?

What needed to change before you decided to enter treatment? What brought about this change?

What would have happened if things had stayed the same?

What did people close to you think?

What were you hoping to get out of treatment?

Stage 3 prompts/questions: stories about receiving X DD treatment

What is your first memory of contact with the X DD Team? .... What happened after that?

How does the X DD Team compare with the treatment you had previously?

Does the treatment you receive meet your expectations?

Are there times when you feel like stopping treatment? If so, could you give me an example of a time when you felt like that – what was happening at that time?

In what ways has the treatment you receive from the X DD Team been helpful?

Based on your needs, what would make the treatment better?

In what ways are you satisfied with the treatment?

In what ways are you satisfied with the treatment?

In what ways are you dissatisfied with the treatment if at all?

Prompts

Can you tell me more about that?
And what happened next?
What were things like before you...?
What were you thinking when...?
What were you feeling inside when...?
It sounds like when X happened you...?
What was more important to you when...?
In what way was X important...?
What was your motivation like when...?
What was that like?
What did you mean when you said...?
What helped when...?
What did not help when...?
Is there anything else you would like to say about that?

Running Head: Dual Diagnosis Treatment Motivation

Appendix E

Interview Guide
Co-existing Mental Disorder and Substance Use Treatment Motivation: NHS clinician or manager perspective

Briefing
Thank you for agreeing to participate in this interview. Before we start, I would like to go over some of the information contained in the leaflet I gave you when we first met. As we discussed then, you are free to stop the interview and withdraw your consent to participate in the study at any time. Also, you do not have to answer any questions you don't want to. Here I have a Dictaphone. I will use it to tape record the interview. Without this recording, it would be very difficult for me to remember all of what you talk about. Everything you do talk about will be kept confidential unless I thought you or somebody else was in danger of being harmed. Finally, you will get the opportunity to comment on the results of this interview before the study is written up into a paper. Is what I have said ok? Do you have any questions?

Introduction
As you are aware from our previous conversations, this study is about what motivates people to enter into dual diagnosis treatment and to stay in it. During the interview, I will ask you to tell me in your own words and based on your own experiences what you think about dual diagnosis and dual diagnosis treatment. To get you started, I will ask a question. After that, I might prompt you from time to time to tell me more about the things you mention, but as far as possible, I will try not to interrupt. This is because I am interested in hearing your life stories and what you think is important. Please feel free to speak openly and honestly and for as long as you think is necessary. I have set aside an hour and a half for this interview. It is ok if we finish early. If we need longer, we can arrange to meet again later today or at some other point in the next two weeks. Please let me know if you would like to take a break during the interview. At the end of the interview, you will get the opportunity to talk about how you found it and any discomfort you may have felt.

Interview: opening question
Can you tell me about your experience working with people with both a mental health and a substance use disorder? I am particularly interested in what you think life is like for this client group during the period between first experiencing these difficulties and entering treatment with the X DD Team? I would also like your views on how the people you work with find the treatment they receive from the X DD Team. Please could you start with the first bit of the question – tell me about people's lives before entering treatment with X DD team – what is your impression of this? ..... Go ahead.

The objective of the interview is to get an overall picture of the participants' experiences of dual diagnosis. Within that, the emphasis is on eliciting stories about the nature and relationships between 1) determinants of motivation to engage in treatment i.e. a wish for life to be different, 2) motivation to engage in treatment itself i.e. what people do by way of entering treatment such as attending an initial appointment and 3) treatment engagement i.e. following or participating in a care plan. Special attention should be paid to how and for what reasons motivation to engage in treatment waxes and wanes over time. The following list of questions and prompts or variations on these questions and prompts will be used selectively to encourage the participant to further elaborate their stories or to refocus them on the issues under investigation should they become sidetracked. They will be used in response to the stories told by the participant rather than in a pre-planned way.

Stage 1 questions: stories before X DD treatment

What is your impression of what makes the people you work with realise they have mental health and drug use problems? Does it tend to happen at the same time or…?

What do they do when they realised they have problems with their mental health or drug use – or both?

What is your impression of how people think about health and substance misuse services before entering treatment?

What treatments have the people you work with received before entering the X DD Team if any?

In what ways do people seem to have found previous treatments useful?

In what ways do people seem to have found previous treatments unhelpful?

Stage 2 questions: stories about entering X DD treatment

How do the people you work with come to start treatment with the X DD Team?

What is your impression of what life is like for clients in the weeks and months before they enter your service?

What stopped the people you work with seeking treatment earlier?

What would have happened if things had stayed the same? If they hadn't entered your service.

What is it that needs to change before the people you work with decide to enter treatment?

Can you tell me what motivated the people you work with to start treatment?

What do the people close to the people you work with think about...?

What do the people you work with hope to gain from treatment?

Stage 3 prompts/questions: stories about receiving X DD treatment

What causes people to engage in the X DD Team treatment programmes?

Are there times when the people you work with talk about stopping treatment? If so, could you tell me about them?

What causes your clients to have difficulties engaging in the treatment you provide?

What causes motivation to engage to fluctuate during treatment?

What causes people to enter treatment but not engage?

What causes people who are motivated to change drop out of treatment?

Does the treatment you provide meet the expectations of your clients?

In what ways has the treatment you provide been helpful?

In what ways are the people you work with dissatisfied with their treatment?

Prompts
Can you tell me more about that?
And what happened next?
What were things like before you...?
What were you thinking when...?
What were you feeling inside when...?
It sounds like when X happened you...?
What was more important to you when...?
In what way was X important...?
What was your motivation like when...?
What was that like?
What did you mean when you said...?
What helped when...?
What did not help when...?
Is there anything else you would like to say about that?

Running Head: Dual Diagnosis Treatment Motivation

Appendix F

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**Study on why people go into and stick with treatment for 'dual diagnosis' -
Invitation to take part**

This information is about a research study you may be interested in.

What is the study about?
The study is about what motivates people with dual diagnosis to start treatment and to stay in treatment. It is about service users' and NHS clinicians' and managers' views.

Who is doing the study and why?
My name is Max Ward and I am a trainee clinical psychologist. I am doing this study as part of my training and I am inviting you to take part. Before you decide it is important for you to understand why the research is being done and what you will be asked to do. Please take the time to read the following information carefully and discuss it with others if you wish. I have included my contact details at the bottom of the page if there is anything about the study that is not clear or if you would like more information.

What is the purpose of the study?
In the study I am interested in the reasons people start and then the reasons they stay in dual diagnosis treatment. I would like to hear the views of: 1) people who receive or have been offered treatment for their dual diagnosis, 2) NHS clinicians and managers working with dual diagnosis.

What will I be asked to do if I take part?
The first thing you will be asked to do is meet with me at your local specialist addictions or adult mental health clinic to discuss in person the information contained in this sheet. If you still want to be involved in the study, I will ask you to read and sign a consent form. After you have signed the consent form, I will interview you. You may want to do the interview straight away. If not, we can arrange to do it another time that is convenient for you. The interview itself will last up to an hour and a half and will take place at your local specialist addictions or adult mental health clinic. If we need longer, we can meet again the same day or at some other point within a two week period. In the interview, I will ask you to tell me in your own words and based on your own experiences what you think about dual diagnosis and dual diagnosis treatment. I am interested in the stories you have to tell about these issues. But you do not have to talk about things you don't want to.

After I have completed all of the interviews, you and everybody else who participates in the study will be given a summary of what you told me and a feedback form. This will be an opportunity for you to comment on the results of the individual interviews and to discuss anything you think was missed.

Expenses and payments
Your travel expenses getting to and from individual and group meetings to participate in this study will be reimbursed.

Are there any disadvantages of taking part?

It is unlikely you will be harmed in any way by taking part in this study. However, talking about periods in your life that were difficult and upsetting can cause some distress. For this reason, there will be time at the end of the interview for you to talk with me about how you found it and any discomfort you may have felt. If you are a service user, it can be arranged for you to speak with your mental health or specialist addictions care coordinator, although this might not happen straight away if they are otherwise engaged or absent from work.

What do I do if there is a problem?
There are three things you can do if you are unhappy about something to do with the study such as how you are treated whilst taking part. You can speak with me (24-hour answering service tel: XXX) to see if I can help. You can leave a message for me and I will pick it up and get back to you. Alternatively, you can contact either Dr Sue Holttum or Dr Tim Meynen (see details below) who are supervising the project. If you want to take the matter further, you can make a complaint through the NHS Complaints Procedure by going to the Department of Health website www.dh.gov.uk.

Will my taking part in this study be kept confidential?
All of the information you give me during the study will be kept confidential. The audiotape of your individual interview and the group meeting will be typed up by me or a professional transcriber, removing your name and certain other information such as your home town or other people or places you might mention. All audiotapes will be erased once the study is completed. Audiotapes and anonymous written accounts of audiotapes will be stored on my own personal computer at home and erased once the study is completed. They will be password protected which means nobody except me can access them. Paper copies of anonymous written accounts of audiotapes will be kept in a locked filing cabinet at my home and shredded once the study is completed. Following the study, anonymised typed copies of audiotapes will be password protected and stored on a CD which will be locked away on file at the university where I am doing my training for 10 years before being destroyed.

There is a possibility I will ask my lead supervisor (Dr. Sue Holttum) to help me analyse what you tell me in the interview. If this happens, she will only get to see written copies of audiotapes with all identifiable information removed. Once the study is completed, I will write it up into a paper. This paper will be seen by two examiners from the clinical psychology training course I am doing. Some of what you tell me will be included in this paper along with information from other participants in the study. But nobody will know this information came from you.

Though it is unlikely to be necessary, the only time I would break confidentiality is if I thought you or somebody else was in danger of being harmed as a result of something you told me. This would include child welfare issues and crimes against the person, past or present. In circumstances like this, I am duty bound to pass on the information to the appropriate people. But if possible I would discuss it with you first.

What will happen to the results of the study?
As I have mentioned, I will write up the results of the study into a paper. This paper will be examined by two examiners – one from my university and one from another university. Following this, an article will be submitted to a journal for publication. This article will be read by other health care professionals. It is an opportunity for them to learn from what you and other participants in the study tell me. It is also possible that the outcomes of this study

will be presented at professional meetings and conferences. In these reports there will be anonymous quotes from participants.

The overall outcomes of the study will be given to you in writing once completed.

Who is funding the research?
The study is funded by Canterbury Christ Church University.

Who has reviewed the study?
Before going ahead, this study was reviewed and approved by an NHS Ethics Committee and the X Research and Development Programme.

Contact details

Main researcher: Max Ward (Trainee Clinical Psychologist)
                     Salomons Clinical Training Programme
                     Salomons Estate
                     Broomhill Road
                     Tunbridge Wells
                     TN3 0TG
                     (24 hour tel: XXX)

Lead supervisor: Dr. Sue Holttum (Research and Teaching Psychologist)
                     Salomons Clinical Training Programme
                     Salomons Estate
                     Broomhill Road
                     Tunbridge Wells
                     TN3 0TG

Second supervisor: Dr. Tim Meynen (Consultant Clinical Psychologist)
                     [Address deleted to protect anonymity]

THANK YOU for taking the time to read this information sheet. I look forward to meeting you should you decide to take part in the study.

Appendix G

Study of why people go into and stick with treatment for 'Dual Diagnosis'

Are you currently receiving treatment at X for 'Dual Diagnosis'?

If you have answered <u>YES</u> to this question, would you like to tell your story about what 'Dual Diagnosis' means to you and about your experience of 'Dual Diagnosis' treatment?

Please ask at reception for further information if you are interested in taking part in this study or contact Max Ward (Trainee Clinical Psychologist) on XXXX.

Appendix H

"Example of research transcript has been removed from the electronic copy after examination"

Appendix I, J, K, L, M & N

"Examples of narrative analysis using transcripts have been removed from the electronic copy after examination"

Running Head: Dual Diagnosis Treatment Motivation

Appendix O

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Running Head: Dual Diagnosis Treatment Motivation

Appendix P

What motivates people to enter and engage in 'dual diagnosis' treatment: an analysis of service users', clinicians' and managers' experiences
PARTICIPANTS' FEEDBACK ON THE SUMMARY OF THEIR RESEARCH INTERVIEW

Please complete this form and return it to me in the pre-paid envelope provided. I would welcome any comments you might have on how well you think my summary of your research interview represents what you wanted to say?

1) **Please use the space below to mention things you agree or disagree with about my summary of your research interview.**

2) **Is there information you think might be useful for this research study that you did not mention in your interview? If so, please write it in the space below.**

3) Do you have any general comments about my summary of your research interview? If so, please write them in the space below.

Thank you for taking the time to complete this form.

Kind regards,

Max Ward
Clinical Psychology Trainee
Salomons Centre for Applied and Social Psychology Development

Running Head: Dual Diagnosis Treatment Motivation

Appendix Q

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Appendix Q

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Running Head: Dual Diagnosis Treatment Motivation

Appendix R

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Appendix S

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Running Head: Dual Diagnosis Treatment Motivation

Appendix T

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