STREET DRUGS, ALCOHOL AND MENTAL HEALTH – WHAT HELPS?

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This thesis records my attempts to collect information, analyse it and construct something sensible and coherent relating to dual diagnosis. To help me to do this I worked with Michael Linnell from Lifeline Publications, a drug information agency. His artistic skills and interpretative ability of the key themes were instrumental in presenting the important findings in an illustrated storybook fashion.

This thesis and the health information materials (four published booklets) have condensed the experiences of the 41 people who participated, to who I am most grateful. Many participants contributed on more than one occasion making the total number of accounts higher. I hope I have done justice to their valuable and very personal contributions.

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I'd like to dedicate the research to my father, MJSH, who was always quietly in the background.

AWARDS

This study generated information materials that were published in March 2007. They were submitted as examples of positive practice and innovation in three award schemes. The final was made in all three. The resulting recognition that the information materials received has been personally and professionally satisfying. The judging panels comprised esteemed and knowledgeable peers and the hosting organisations were reputable and respected. Subsequently I believe my original inspiration to conduct the research has been validated. The awards have helped the dissemination of service user information materials into mainstream mental health and substance misuse services. The dissemination has impacted upon services and practitioners by raising awareness of the need to actively engage with people experiencing a dual diagnosis and challenge the associated prejudice towards them that so often prevails.

The awards achieved were as follows;

1. North West NHS Innovation Awards (Training or Educational Materials - Winner) September 2007

2. Nursing Times Chief Nursing Officer's Award (Finalist 2007) November 2007

3. National NHS Technology Awards (Publications and Media - Runner-up 2007) December 2007

GLOSSARY OF TERMS AND ABBREVIATIONS

Abduction - To draw out themes from the data
Abstract - A theoretical idea less formed than a concept
Alcohol - A legal psychoactive substance
BBV - Blood Borne Virus
Carer - Relative, friend or other concerned and involved in the care of a service user
Category - A classification of an absolute, proven or feasible concept
Change - The process of moving from one stage of thought and behaviour to another for example from contemplating drug abstinence to achieving abstinence
Charlie - Cocaine
Client - Service user of mental health or mental health service
Concept - An idea or general notion pertaining to an incident or collection of incidents
CPN - Community Psychiatric Nurse
Deduction - To remove elements in the testing of ideas / logic
DH - Department of Health
Drug - Illicit substance, medicinal drugs taken when not prescribed, alcohol and solvents
Dual Diagnosis - The simultaneous presence of both a substance misuse and a mental health problem
Dual Diagnosis Service User- A person with a dual diagnosis who uses mental health / substance misuse services
Harm Reduction - A philosophy based on amelioration of harm not extinction of harm leading to overall health and social improvement for the individual, the community and society
Help - denotes the researches substantial grounded theory
'Help' - denotes the researches major category
Induction - To install ideas that match (the data)
LSD - Lysergic acid diethylamide, an psychoactive substance
IV - Intravenous
Motivation - the intentions, desires, goals and needs that determine behaviour
Psychoactive Substance - a substance that exerts an extreme psychological effect
Psychotropic Substance - a substance licensed and prescribed to exert a therapeutic psychological effect
SCMH - Sainsbury Centre for Mental Health
Service User - Client of mental health and / or substance misuse services
Speedball - a mixture of cocaine and heroin taken simultaneously, usually intravenously
Substance - A psychoactive substance, or compound, usually street drugs but including alcohol and prescribed medicines when taken in non prescribed manner
Substance Use - Use, misuse, abuse or dependency of a chemical compound or substance
WHO - World Health Organisation

ABSTRACT

The use of street drugs and / or alcohol combined with mental health problems is referred to as dual diagnosis within mental health and substance misuse services. The aim of this research study was two-fold. Firstly, to discover what people considered helpful in terms of support or intervention that could then be developed into information materials. And secondly, to develop an explanatory theory that added to the subjects' wider understanding.

A grounded theory methodology was employed to elicit the personal experiences of participants which in turn would ensure that the production of information materials and the development of theory remain rooted in the data.

Twenty-six unstructured conversational interviews and 9 focus groups were conducted. Two carers, 6 practitioners and 18 service users were interviewed. The focus group participants were all service users, just under half of whom participated in interviews also, the remainder were new to the study; all took place in mental health and substance misuse treatment settings. In total 41 people, 34 of whom were service users, participated. Including repeat participants, 51 separate voices or contributions were made.

Data incidents and happenings (n = 977) were analysed using open, axial and selective coding procedures overlaid by constant comparison. Twelve categories sharing properties and dimensions relating to helpful advice, intervention or behaviour emerged. The theme of helpfulness was a key concept and emerged as the major category subsequently entitled *Help*.

The theory related to help developed. It challenged dual diagnosis convention by identifying people with a dual diagnosis as positively seeking, for themselves or others, recovery or alleviation of substance or mental health related problems. They did this from within a harm reduction or damage limitation paradigm. The examples of help related incidents (from which the help theory emerged) were collated and formed the content of dual diagnosis information materials.

CHAPTER 1. INTRODUCTION

Background to the Research

In recent decades the number of people with combined substance use and mental health problems has grown (Weaver *et al* 2001). Mental health and substance misuse services were originally established to treat people with a mental illness or substance use problem, not both. Subsequently they have found a significant challenge in meeting the needs of people with both conditions (Department of Health 2002). The resounding impact upon both services, and the people who require those services, has been one of conflict and confusion manifest in major difficulties of engagement (Drake *et al* 2006).

Mental health and substance misuse services adopted the term 'dual diagnosis' in the late 1980s. The term technically refers to any pairing of diagnosable health conditions, for example diabetes and hypertension. Prior to the seminal dual diagnosis, substance misuse and mental health studies in the UK and USA (Smith & Hucker 1993; Regier *et al* 1990) the term had, among most non-physical health practitioners, denoted the presence of learning disability and mental illness. In this thesis the term means the co-existence of substance misuse and mental health problems.

Within psychiatry in the mid 1990s, dual diagnosis emerged strongly as the main broad term to indicate co-existing substance misuse and mental health problems. Associated with the term and the client group was a growing sense of despair and frustration among practitioners. They felt under-prepared to work with people with a second condition because it presented issues outside their speciality (Rorstad & Chesinski 1996). The consequences of feeling unprepared for this client group were manifested in resistance to engage with them. A debate about how, where and who should provide interventions for people with a dual diagnosis grew (Johnson 1997).

The debate encompassed attitudes, values, skills and knowledge. Arguments based upon weak aetiological theory created additional barriers for service users (Mueser *et al* 1998). For instance people were, and remain denied a service on the spurious

grounds that the primary problem was the other (or second) condition. This has resulted in people being shunted from one service to the other. The following quote illustrates this trend very clearly.

> *I was pushed around like a tennis ball. The alcohol people said I had a mental illness and the mental illness group said I had an alcohol problem. Neither of them did very much for me.* (Rorstad & Chesinski 1996, Page 9)

Similarly in 1995, Building Bridges (DH 1995) asserted that the Care programme Approach (CPA) should be 'the cornerstone' of mental health care for people with a severe mental illness, whereby multi-disciplinary and multi-agency working was expected to improve on the introduction of an organisational structure. The structure placed responsibility upon services and professionals to work cohesively and also place service users and carers at the centre of the process of care. It provided a framework to manage difficulties of complexity such as those faced by dual diagnosis service users and their carers. At this time however NHS Trusts in England were far from service user centric and despite formalised care procedures, joint working external to mainstream psychiatry, such as with substance misuse services, was infrequent (Schneider *et al* 1999).

As treatment orientated research was conducted and encouraging findings disseminated, policy in the UK and abroad recommended that substance misuse and mental health services work jointly to provide or coordinate care appropriately (DH 2002). The refocused CPA guidance (DH 2008) also specifically cited 'dual diagnosis' as an inclusion criteria in order to reinforce this message and improve engagement with the client group as a whole. The CPA (DH 1991) had originally been intended to enhance multi agency working at all levels of mental health need by firstly, identifying the agency and practitioner responsible for coordinating the care designed to meet an individuals needs and secondly, by communicating an agreed plan of care to all the practitioners and agencies involved in that individuals care. The Service user was identified as central to this process. The 2002 dual diagnosis guidance emphasised the obligation placed upon mental health services to assertively engage with what were, and remain, regarded as one of the most challenging and arguably most dangerous service user groups, those people with a dual diagnosis.

Those less severely affected were left to conventional treatment but within a joint working arrangement, in such circumstances one of the two agencies was expected to coordinate or take a lead responsibility for the client. For example it was proposed that a person with opiate dependence and moderate depression would have their care led by a drug service. A person who smoked cannabis but suffered from schizophrenia would conceivably have care delivered by mental health alone and under the CPA framework. And so it went. Policy and research, hand in hand, slowly developed systems that attempted to avoid repeating the major problem of poor engagement between services and those people who experienced a dual diagnosis.

By 2000 dual diagnosis was recognised as a distinct and highly important challenge (DH 1999) with particular concern for the safety of service users and the public in relation to poor engagement. Upon engagement however a distinct gap was evident. The gap was considerably less to do with effective treatment options since evidence was emerging (Barrowclough *et al* 2001) and more to do with the skills of the workforce in the delivery of effective approaches. My research study therefore was concerned broadly with improving the standard of care available to the dual diagnosis population since their low level of engagement and high level of need demonstrated legitimate health and social care concerns. The research process would reveal the prominent areas, in line with prior research and literature, such as gaps in services, deficits in mental health and substance misuse practitioner competencies and a paucity of service user orientated health behaviour change information.

Justification for the Research

Efforts to address deficiencies in practitioner skills with regard to dual diagnosis have been sporadic and *ad hoc* (Everitt *et al* 2001) and their effectiveness limited. Hughes (2006) published a comprehensive framework of dual diagnosis competencies which has become the benchmark for UK services in equipping practitioners to work with dual diagnosis service users. The landscape at the inception of my study therefore appeared to be promising. Policy, research and training initiatives were developing at a similar pace in a linked manner.

My concern at this time was two fold. Firstly, there was very little accessible and stimulating information about dual diagnosis for people who experienced the phenomenon or their carers. There were reams of text for practitioners, however much of that was repetitive since the field is relatively young in research terms. I was aware of this gap and believed it feasible to conduct research with the aim of discovering what information would be useful and then compiling it in some form of leaflet.

Secondly, I had a nagging doubt that despite policy and training drivers, the dual diagnosis client group would remain stigmatised, or marginalised, and viewed negatively by a significant number of people. They would remain a challenge that certain practitioners might feel justified in avoiding. My hunch was originally based on local research (Research and Service Development Centre 1999) where staff argued for the development of specialist services for the dual diagnosis client group rather than meeting their needs within existing services. Furthermore, it was later corroborated when the UK Department of Health (DH 2004a) concluded that earlier recommendations (DH 2002) had gone unheeded.

Therefore on the grounds that information about dual diagnosis was limited and that the client group remained poorly understood and often avoided I proposed to conduct research that would (i) produce useful information for service users and (ii) add to the understanding of what dual diagnosis means. The latter would be addressed by my research report, for it is aimed at primarily fellow researchers, policy makers and practitioners. The information product that was developed was mainly aimed at service users themselves. Any enhanced knowledge and skills for carers and practitioners stemming from their exposure to the service user information would be a secondary benefit.

Research aims and objectives

This research study was service user orientated. The choice of a grounded theory methodology arose from its key principle of obtaining insights and understandings about the subject matter direct from the persons affected and retaining their essence from start to conclusion. The aim of the research was to discover and then reflect

accurately, and recognisably, on the prominent concerns dual diagnosis service user participants raised.

In understanding the processes my objectives were to 1) develop information materials tailored for service users (and if possible for carers) and 2) explain or give added understanding to the dual diagnosis phenomenon which would benefit practitioners, carers and service users alike.

As the examples of various dual diagnosis combinations given earlier suggest, the term globally fits many in conveying the presence of two conditions but is less useful on an individual basis for treatment planning. The 'who should treat who?' debate, alluded to above, culminated in people being moved from one service to another (MIND 2004). This was an important motivating factor for the study in my role as researcher as well as for my work as a practitioner. It suggested that despite the recognition of the homogenising impact a broad term like dual diagnosis has, practitioners or services continued to make unhelpful assumptions. They could confer upon dual diagnosis service users at almost any time the attributes of poor motivation and the judgement that problems (mental health) were self inflicted (by drug taking). To an extent it is true. Substance use is largely a volitional behaviour but evidence that an understanding, empathic and collaborative approach to counter this had appeared some time ago (Carey 1996).

With this practitioner and service tendency to make less than positive assumptions about the dual diagnosis client group in mind, my intention was to discover some nugget or key issue that would positively influence attitudes within services. I believed that taking a grounded theory approach would enable me to pursue this aim ethically and in a structured manner. It offered a process that discouraged prior assumptions and understanding from dominating analysis and outcomes.

Meeting the expectations of my role was an important personal aim too. It was conceivable that the research study would provide a structured opportunity to further my professional practice. My job as a consultant nurse placed an emphasis upon expert skills and knowledge acquisition in both my specialist field of dual diagnosis and as a researcher. I was expected to perform clinically as an expert, lead opinion,

develop practice, develop services and contribute to strategy at commissioning and operational levels. I expected the research study findings would help me to learn and develop expertise that would then contribute to the fulfilment of the various responsibilities demanded of me.

Methodology

A grounded theory approach which used focus group and interview data was employed. Field notes and observations were integrated into the analysis. Analysis was a process of constant comparison in order to discover categories and then define them in a valid manner.

As data were collected themes emerged which then formed early concepts such as the use of drugs to self-medicate or the involvement in drug use for social reasons. Twelve key categories appeared. The major category 'Help' was defined by incidents possessing help related properties. Selective sampling of new data confirmed this category as cross-cutting of most others. After collecting and categorising almost 1000 incidents, just under half related directly to helpful or unhelpful happenings or events.

Grounded theory requires that data is collected and analysed with as little external influence related to the subject matter as possible (Glaser 1978; Glaser 1992). Prior knowledge that could lead to inaccurate conclusions is guarded against by comparing incident with incident as they emerge from the data (Charmaz 1983). By applying these rules the data retains its integrity and subsequently any theory that develops should do the same.

Face to face, individual, unstructured interviews using introductory information explaining the nature of the research were conducted. Focus groups complemented the data collection and analysis and contributed greatly to the development of information materials since the consensual processes regarding key themes emerged naturally in group discussions.

Interviews and focus groups were audio recorded. As the tapes were transcribed and analysed key themes were noted using memos in the text and a colour coding system.

Organisation of the Thesis

This thesis contains seven chapters. In Chapter 2 I have reviewed the literature concerning dual diagnosis. The review took place following data collection and analysis to retain grounded theory consistency and encourage the raw data to refine and develop alone. The review is located here in order to contextualise the study adequately and provide the reader with the necessary background to follow the thesis.

Chapter 3 describes my choice of methodology and methods against the backdrop of other approaches. Quantitative and qualitative methods are examined with grounded theory being described in greater detail in order to justify its selection and demonstrate its relevance to the subject area and the research objectives. I also outline my role as a practitioner-researcher and describe the context and the relevance to practice the study holds for me. An account of how the data was collected and analysed is provided. The chapter closes with a detailed discussion about the methodology and its implementation.

Chapter 4 presents the findings in two parts. Part 1 describes the 12 key categories, two of which relate to help issues which subsequently forms the major category of 'Help' presented in Part 2. 'Help' when referred to in the context of a category appears in single quotation marks. From this a substantive theory, entitled *Help,* integrating help related issues, emerged. Help, in the direct context of my theory appears in title case and italics *(Help)*. The major category of 'Help' and associated issues is described. Its properties and dimensions are defined in such a way that the theme's origins as raw data are clearly distinguishable yet the relationship with policy and practice is revealed. Throughout, clear connections between the categories and incidents are made by using cross-cutting and comparative techniques. This chapter uses extensive quotes from participants and progresses to both the *Help* theory and the production of health information materials in the form of illustrated booklets.

All participant quotes are italicised however when quotes appear in a single word or sentence, rather than a passage, double quotation marks are added.

Having established the categories and the emergent *Help* theory, Chapter 5 moves on to discuss their relevance to practice. Part 1 relates to Part 1 of the findings (the 12 key categories) and Part 2 demonstrates the junction at which the study findings meet the literature. This adds further validity to the study's theory of *Help*. Furthermore it begins to challenge the basic tenet upon which dual diagnosis service users are at times excluded, that is an absence or diminution of therapeutic optimism. Motivational issues and self-help are discussed. They form the practical essence of *Help* theory and enable the thesis and reader to progress to the following chapter.

Chapter 6 describes the output of service user information materials and is the final piece of the jigsaw. A grounded theory methodology relies upon the patience and perseverance of the researcher. Grounded theory employs an analytical approach of induction that gradually produces results. Clarity of categories and their relationship to one another emerges slowly only after comparing data incident with data incident over and over. Chapter 6 unifies the data collection and analysis by describing the precise nature and format of the user information in four booklets directly based upon the research findings. This chapter promotes the style, manner and model on which the information rests by reviewing relevant health education literature. It gives excerpts from the four booklets and demonstrates their orientation around the *Help* theory. It delivers a coherent description of these important study outputs.

My concluding chapter, Chapter 7, summarises the thesis. It encourages the reader to revisit the findings and integrate the optimism of *Help* theory into their practice. My final study conclusions are presented and I articulate my unique contribution to knowledge in the field of dual diagnosis. The conclusion poses a number of questions such as how could the study have been done differently, where does the study lead and what does it represent?

The answers to the questions and limitations of the study are discussed whilst particular points of significance that might influence future research are highlighted.

In order to assist the reader navigate the substantial data and findings, a fold-out research map is located inside the back cover of the thesis.

Research Findings and Outputs

The findings from the research enabled the research objectives of producing information materials and developing a grounded theory to be met. The constant comparison and coding of categories and their significance encouraged the emergence of a theory defined by the concept of help. The incidents, categorised and analysed in great depth, were represented in a series of four user information booklets. The gap in client orientated information was evident within my own practice and more widely too. The pessimism found in services and among a significant number of practitioners was countered by my research findings. I identified that people with mental health problems who simultaneously used substances may well be particularly challenging but equally they were motivated to recover and help others do so too.

The key findings from this research begin to redress the balance both in the development of theory and the production of information.

The data revealed 12 categories;

1. Relationship with Illness
2. Levels of Knowledge of Drugs / Alcohol
3. Relationship with Substance(s)
4. Explanations for my Condition / Situation from other People
5. Policy, Service or Practice Development Issues
6. Significant Childhood and Adult Incidents
7. Impact on Behaviour and Life
8. My Explanation for my Condition / Situation
9. Feelings / Beliefs / Symptoms
10. Role of Substance(s)
11. Things that have not Helped
12. Things that Helped / Might have Helped

Categories 11 and 12 were prominent in the number of occasions they were counted (incidents or happenings) but also in the depth of their quality. They developed into a picture that was multidimensional. *Help* was described in type (mental illness, drug use, goals), nature (practical / psychological), level (individual, community, service) and source (peers, carers, services and professionals). These dimensions were examined closely and contrasted to the issue of motivation which then aids practitioner and client to conceptualise help in practical terms. For example the practical help needs of a person using drugs or alcohol depends on their view of their needs. A person who wants to inject heroin and crack cocaine (but is ill from abscesses / vascular damage) and who has no intention of stopping at that moment in time would benefit from (and usually accept) clean injecting equipment and antibiotics more than coerced abstinence.

The properties of the 'Help' category are listed and those of prominence are discussed further to illuminate the vastly differing factors upon which help hinges. The conclusions drawn from this major category were that help was wanted by service users but not always available in the form it was being offered by services; helping ability was available and on offer from service users to their peers or self (self-help / peer support); and help could be catalogued into advice or guidance (health information materials).

Chapter Summary

This chapter has introduced the background and justification for my research. It has explained the aims and objectives and provided an outline of my methodology and why a grounded theory approach was chosen. The organisation and structure of the thesis is presented and a description of the findings and output begun.

CHAPTER 2. LITERATURE REVIEW

Introduction

A grounded theory methodology suggests that the main literature review takes place at the end or near completion of a study in order to retain data integrity in relation to its source; the participants (Glaser & Strauss 1967). I was able to follow this suggestion in that the full literature review was completed after data analysis. As a result several bodies of literature related to this research study materialised.

Firstly there is the wider general literature from the field of dual diagnosis which I discuss here in order to establish the background to the study. The definition of dual diagnosis, its prevalence and problems or common consequences appear. The prevailing views on effective practice and service delivery are then discussed. Literature pertaining to my research findings is presented in the latter part of Chapter 4, as it is integral to the explanation and discussion of *Help* theory, and Chapter 5.

Further literature related to drug and health education which helped me navigate through potential information producing approaches is identified in Chapter 6. This chapter ('Outputs') also identifies the links between the contents of the user information booklets and the research findings. It also incorporates literature pertaining to the specific diagnostic and substance groups which form the backdrop for the role characterisation and personal stories within the booklets.

This chapter therefore provides a review of the wider general dual diagnosis literature. All remaining literature is presented later in the thesis.

Search Method

A key-word and key-phrase search of electronic databases CINAHL, EMBASE, MEDLine, Cochrane and PsychLIT was undertaken. Internet search engines and government websites provided up-to-date policy and legislative information. The local hospital library, my personal archives and reference material provided further supplementary information. Where it was possible I obtained further information by

following up relevant reference lists and pursuing authors and opinion leaders in the field of dual diagnosis.

Background

Dual diagnosis or co-existing mental illness and substance misuse has been a concern for mental health and substance misuse services throughout the developed world for approximately two decades (Drake & Meuser 2000). Numerous studies have demonstrated that a range of problems ordinarily associated with mental illness or substance misuse alone are amplified when the two conditions occur simultaneously (Table 1, Page 13).

Among the many adverse effects experienced by dual diagnosis service users ten general areas emerge as prominent (Table 1, overleaf). Furthermore the degree of severity appears greater in people with substance misuse and mental health problems than those singularly diagnosed. Subsequently dual diagnosis represents both social and clinical challenges for individuals who experience the condition and for services that provide their care.

A study by Drake *et al* (2006) examined 10 year recovery outcomes which emphasised the need for a multidimensional concept of recovery for dually diagnosed individuals. Six key recovery elements were identified; (i) symptom control, (ii) active attainment of substance misuse remission, (iii) living independently, (iv) daily activity or employment, (v) regular social contacts (of a non drug use nature) and (vi) overall increased life satisfaction. This study is a recent and widely valued addition to the field by renowned authorities. It examined the long term course of co-morbidity within specialist dual diagnosis services in New Hampshire, USA. It used a definition of recovery emphasised by service users as being an internal process of life appraisal beyond conventional illness terms but included the pursuit of independent living. It added that life satisfaction within the community was crucial.

The concept of recovery was influenced by the defining factor of 'participating' fully in a community (New Freedom Commission on Mental Health 2003). This lent a subjective component to the findings that could invite criticism about the accuracy or

credibility of arguably less quantifiable domains. The authors however combined aspects of recovery with aetiological measures using psychiatric ratings, substance use ratings, independence of living, competitive employment and social networks as outcomes. The net result demonstrated that people steadily improved over time in both substance misuse and mental health domains. What wasn't clear was the extent to which their specialist dual diagnosis services influenced this progress since both disorders ordinarily have an inherent tendency to improve over time.

Table 1. Ten Adverse Consequences in Dual Diagnosis

1. Poor treatment response (Drake & Meuser 2000)
2. Greater relapse risk (Swofford *et al* 1996)
3. Increased hospitalisation (Haywood *et al* 1995)
4. Increased blood borne virus incidence (Campbell *et al* 2006; Cournos *et al* 1991)
5. Higher suicide rates (DH 1999; DH 2001a; Pages *et al* 1997)
6. Higher rates of violence (DH 1999; DH 2001a; Mulvey 1994)
7. Increased likelihood of victimisation (Goodman *et al* 2001)
8. Increased imprisonment (Martell *et al* 1995; Scott *et al* 1998)
9. Increased likelihood and duration of homelessness (Kushel *et al* 2005; Williams 2002)
10. Family difficulties (Clark 2001; Schofield *et al* 2001)

The poor treatment response highlighted by Drake and Meuser (2000) bears similarities with other hard to engage groups such as personality disorder (Bateman & Fonagy 2001), or other primary care based treatment populations, for example those with obesity, problematic alcohol use or chronic heart disease (Simons-Morton *et al* 2000). There appears to be difficulties in service delivery related to their flexibility to meet the demands of chaotic, disorganised or inactive lifestyles (SCMH 1998; Rosenheck *et al* 2003). In addition, service users encounter negative attitudes from services and practitioners when they are viewed as actively disengaging or passively failing to engage (Staiger *et al* 2008). These issues are highly notable and demanding of greater research with an apparent focus on service delivery and practitioner competence. Table 1, above announces to the reader that dual diagnosis clients are

likely to experience extreme consequences from the duality of their condition, however an argument can be made for simultaneous workstreams exploring the service issues, practitioner competence *and* service user competence. Dual diagnosis service users appear to spend much of their time receiving mandated service involvement (Home Office 2004; Pereira *et al* 2005). As a result the focus on service user views and the provision of information to service users in my study took precedence. As illustrated by Meuser *et al* (1995b), Haywood *et al* (1995) and more recently Drake and Wallach (2000) institutionalisation of varying durations is a common factor for virtually all dual diagnosis clients. The commencement of the provision of information and educational intervention, whilst they are 'held captive', is opportunistic in this context and relevant to the unfolding discussion within this thesis relating the client groups basic survival and their individual community tenure. Hunt (2009) followed 99 patients for 4 years, plotting their relapses and admissions; he concluded that non engagement in treatment, including medication, initially resulted in shorter duration admissions however longitudinally their aggregated duration of stay was greater than singularly diagnosed clients. This suggests that despite greater service exposure (in this case through admissions) dual diagnosis clients had the propensity for escalating deterioration.

The likelihood of being imprisoned or victimised is increased among the drug using and mental illness populations in their own right (Goodman *et al* 2001). Combine the two conditions and the risk is significantly amplified. Consequently the dispersal of dually diagnosed individuals across a range of services from criminal justice, housing, mental health and substance misuse is understandable and logical. Yet it is compounded by the difficulties implicit in inter agency communication and coordination of care (DH 1999). The CPA introduced, over 15 years ago has undergone three transformations in form however it has remained fundamentally the same. Both symbolically and practically it personalises service user experiences and their care plans by placing them in a central position whereby their involvement is actively sought. The demand by secondary mental health services to deliver or coordinate such care is marked in the dual diagnosis population (DH 2002; DH 2003a) regardless of setting. Prisons for example, have seen reforms enable community mental health teams to become active within prison walls, the entire population, imprisoned or not, became incorporated into mental health care delivery

through the National Service Framework for Mental Health (DH 1999). Appleby's report (DH 2003a) correlated the self harm and suicide risk prison population with substance misuse, mental illness and homelessness factors. Conceivably assigning the term dual diagnosis to a client could be regarded as 'red alert', a 'red flag' for an increased risk of homelessness, exploitation, poor treatment response and engagement and ultimately harm to self or others. If this argument is accepted, then current treatment systems are failing to capitalise on the frequent and regular presentations of those people with a dual diagnosis. The background to my research and the field of study itself indicates a justifiable focus upon information provision to dual diagnosis service users. Equally the case has been introduced for structural and practice issues to change also.

For at least 15 years, dual diagnosis has been a broad term for people with mental health and substance use problems that conveys to practitioners, carers and services in general that the issues are complex and multifaceted. As a result the initial need for high quality research examining aetiology, epidemiology and treatment was emphasised. This resulted in several seminal publications (Barrowclough *et al* 2001; Kavanagh *et al* 1998; Regier *et al* 1990; Smith & Hucker 1993) from which arose greater research and policy interest (Haddock *et al* 2003; DH 2002; DH 2004a). The impact of this work was successful in emphasising the magnitude of the problem and advancing potential solutions. Regier *et al's* paper (1990) identified the high prevalence of dual diagnosis in the USA and similarly Smith and Hucker's review (1993), related to the UK, did the same. Consequently research and concern grew in the UK and internationally.

Notwithstanding this, the published results of credible treatment focussed papers were limited. In Barrowclough *et al's* 2001 study an integrated approach of cognitive behavioural therapy, family intervention and motivational interviewing was used to treat people with co-morbid schizophrenia and substance use disorder. Positive symptoms and days using substances were reduced in the treatment group however of the three treatment modalities within the integrated treatment none appeared stronger than the other. An extension of the same study by Haddock *et al* (2003) failed to demonstrate further drug reductions.

Despite early dual diagnosis research focusing on severe mental illness and substance misuse (Drake *et al* 1996), research has broadened more recently to include common mental health problems such as anxiety, depression, obsessive compulsive disorder (Frisher *et al* 2004) and to an extent personality disorder (Seivewright & Daly 1997; Verheul 2001).

The specific problem areas listed above were found to be frequently associated with poor levels of engagement between practitioners and service users (DH 1999; DH 2001a; Sainsbury Centre for Mental Health 1998). Furthermore service entry criteria were traditionally for one type of condition, substance misuse or mental illness (Holland 1998; Menezes *et al* 1996), a second condition was conceived by services as an exclusion criterion in many cases (Gournay *et al* 1997). To compound this problem further practitioner competencies were usually orientated towards one specialism or the other, not both conditions (Gibbins 1998; Gournay & Sandford 1996). Disengagement was a joint issue for which the individual service user and the range of service providers were responsible.

In the UK mental health and substance misuse services are now provided within the context of policy guidance from the Department of Health (DH 2002; DH 2006a) and as a result are expected to actively provide coordinated or integrated care that addresses both conditions. No longer could services pass service users around the health and social care system with such ease on the grounds of them being unresponsive to treatment or ineligible for a particular service due to the presence of a second condition or illness (Rorstad & Chesinski 1996).

In addition training programmes have proliferated at local and national level (Derricott & Mckeown 1996; Everitt *et al* 2001; Graham & Maslin 1998; Hughes *et al* 2008). Hughes (2006) has developed a competency framework for working with the dually diagnosed based upon the 10 Essential Shared Capabilities (DH 2004b). Concern exists internationally also (WHO 2004) with governments elsewhere developing similar guidance and policy (Drake & Wallach 2000). Overall competency based staff preparation for both substance misuse and mental illness appears a priority.

The combination of specific dual diagnosis training for practitioners alongside service development initiatives, in line with government policy, should potentially lead to improved care. However gaps are likely to continue. Effective information for service users and carers, successful self-help and natural recovery programmes, and practitioner competency based training remain unproven areas of need. The UK recently had 88 ongoing dual diagnosis research studies recorded (NHS 2005) reflecting the promise expressed elsewhere (Sacks 2000) and suggesting that effective treatment will emerge. They also represent a high level of interest and commitment around the topic which is consistent with national policy and the recent operational service development (DH 2006b; NHS Litigation Authority 2006).

Definition

Several terms appear interchangeable in relation to the co-existence of substance misuse and mental illness. In the UK the phenomenon is commonly referred to as 'dual diagnosis' or 'co morbidity'. In the USA 'mentally ill chemical abuser' (MICA) is frequently applied. The terms require qualification since, outside the field of substance misuse or mental health dual diagnosis or co-morbidity can refer to any combination of health conditions such as diabetes and hypertension or mental illness and learning disability.

Furthermore the relationship between the two conditions, whilst difficult to establish, can be important for therapeutic work and for service development reasons. Four defining mechanisms are considered important in this respect (Mueser *et al* 1995a).

1. The primacy of a mental health problem precipitating or leading to substance misuse.
2. Substance misuse worsening or altering the course of mental health problems.
3. Acute intoxication, intoxication or dependency leading to psychological symptoms.
4. Substance misuse and / or withdrawal leading to mental illness or symptoms.

The Department of Health (2002) cites the importance of making accurate aetiological assessments for treatment purposes and recommends services avoid exclusion criteria based upon disorder primacy assumptions.

'Substance use disorder' and 'mental and behavioural disorders due to psychoactive substance use' are the preferred diagnostic headings applied by the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (APA 2000) and the International Classification of Diseases 10th Edition (WHO 1994) respectively. Both diagnostic classification manuals contain vast numbers of specific substance misuse or mental health conditions. An individual experiencing mental health and substance misuse problems could be assigned any one of many combinations.

The term dual diagnosis merely indicates co-existing mental health and substance misuse problems, to add accuracy requires further explanation. Considering the multitude of combinations of mental and substance related conditions the term appears homogenising and thus has the potential to lead people to conceptualise dual diagnosis in broad, non-specific terms. This could be misleading for treatment purposes. Subsequently dual diagnosis is a conceptual term that raises awareness of the phenomenon but inadequately guides treatment formulations.

A consensus definition has been sought (DH 2002; Osher & Kofoed 1989) however the trend (and policy) appears to be for *any* second condition to be regarded as the norm rather than the exception (DH 2002). In this sense the term dual diagnosis becomes de-emphasised as a diagnostic label for exclusion from services on eligibility criteria grounds but encourages services to anticipate a complexity of multiple needs. Needs which policy states services should coordinate care for, be it through singular integrated care delivery by one service or joint care in a co-working arrangement.

The Department of Health definition matrix below (Figure 1) has encouraged services to understand that dual diagnosis, whilst complicated, can be simplified for treatment and service provision purposes. The four quadrants convey the level of need related to a specific condition within an individual's dual diagnosis. Improved coordination of care and joint working between services is expected since the framework encourages agencies to identify the lead service based on which condition appears most severe.

Figure 1. Scope of Substance Use and Mental Health Problems in People with Dual Diagnosis (DH 2002, Page 10)

	Severity of problematic *Substance misuse* **High**	
e.g. a dependent drinker who experiences increasing anxiety		e.g. an individual with schizophrenia who misuses cannabis on a daily basis to compensate for social isolation
Severity of *mental illness* **Low**		**High**
e.g. a recreational misuser of dance drugs who has begun to struggle with low mood and after week-end use		e.g. an individual with bi-polar disorder whose occasional binge drinking and experimental misuse of other substances de-stabilises their mental health
	Low	

To conclude this section it is important to note that dual diagnosis is a term that can be misleading if applied outside the field of substance misuse or mental health. Dual diagnosis within the specialist substance or mental health fields also needs greater explanation and understanding for treatment purposes and for designating lead agencies. Overall the term is a broad heading that is inadequate in capturing specific care needs but successful in conveying the presence of additional complexities. Further, the relationship mechanisms concerning definition are potentially obstructive if they are perceived in concrete delineated terms.

The following section regarding prevalence of dual diagnosis elaborates on how diagnostic and classification issues prevail in both treatment and service planning terms.

Prevalence

According to UK government statistics 26% of the adult population in Great Britain drink at or above hazardous levels (ONS 2002). This means they consume above the

recommended safe drinking levels. Within the same report, of 16 to 74 year olds, 11% had used illicit drugs within the previous year whilst lifetime prevalence was 27%.

Mental health morbidity ranges from 5 per 1,000 for psychotic disorders to 14% of men and 19% of women experiencing neurotic conditions or common mental health problems in the last year (Home Office 2008). No significant gender variation was discovered in the psychotic population.

Set against the backdrop of these general population prevalence rates for mental health, and drug and alcohol use as a single morbidity, the four defining mechanisms cited previously (DH 2002; Mueser *et al* 1995a) may account for substantial increased prevalence for a second disorder.

In a major study (Weaver *et al* 2001) covering three inner city areas, 560 users of mental health, drug and alcohol services were surveyed. Among the alcohol and drug services, co-morbidity one-year prevalence was found to be 85% and 74% in the respective populations. Within mental health services the prevalence was 44%. Anxiety and depression were commonest among substance misuse service users whilst alcohol and cannabis were the most widely reported forms of problematic use among the mental health group. Specific group prevalence suggests potential patterns exist that may be of use for treatment and care purposes. For instance psychosis was estimated at 7.9% within the drug misuse services population. However, rates of anxiety and depression and personality disorder within drug misuse services were 68% and 37%. Prevalence of this magnitude for affective conditions places an emphasis upon substance misuse services to be competent in managing common mental health problems.

Strathdee *et al* (2005) examined rates and patterns of dual diagnosis across specialist mental health and primary care settings. Mental health services revealed 48% co-morbidity prevalence whilst substance misuse services 93%. Concurring with Weaver *et al* (2001) the majority of the substance misuse sample had common mental health problems or personality disorder. Furthermore, this group would fail to meet most community mental health teams eligibility criteria of severe and enduring mental illness leaving either primary care or substance misuse services to meet their needs.

This aspect of dual diagnosis care and treatment, where service lead designation was based on service user profiles, appeared prominent and problematic throughout the policy and service development literature (DH 2002). It raised the issue of which service should lead or coordinate care and resulted in the Department of Health repeating key policy recommendations concerning joint working between mental health and substance misuse services (DH 2006a).

The following section discusses the problems, and consequences, of dual diagnosis found within the wider research literature.

Practice & Service Issues

Practice

Studies examining specific treatments for specific populations have been conducted to guide services and practitioners in their choice and allocation of treatment modalities. A major study (Project MATCH 1997) for example attempted to match individual treatments to specific substance disorders with no conclusive findings that could translate into practice. However, numerous studies (see Table 2, Page 24) have been successful in demonstrating effective combinations of substance misuse and mental health interventions in different sub groups of dually diagnosed individuals.

Table 2, Page 24, summarises relevant research that has demonstrated the feasibility of conventional mental health treatment regardless of substance misuse being present. Limitations were often evident. For instance the inconsistent descriptions of study outcomes made 'like for like' comparison difficult and the attrition rates were reportedly high. Whilst this latter point was not highlighted as a major research problem it could be construed as a characteristic of the client group worthy of further mention and research in itself as disengagement is a frequently reported issue of working with people who are dually diagnosed (DH 2002; SCMH 1998).

In reviewing evidence based practice in dual diagnosis I have included both demonstrably effective interventions and those that are regarded by opinion leaders as promising. Few of the reviewed studies with the exception of the ten year longitudinal outcome study (Drake *et al* 2006) and Barrowclough *et al*'s (2001) study are able to

show sustained positive changes in substance use or mental health. However, the relevant elements of studies pertaining to the generating of practitioner and service user optimism, which in turn improves engagement (Mueser *et al* 1995b) are discussed.

Brown *et al* (1997), for instance delivered 8 sessions of Cognitive Behavioural Therapy (CBT) in alcohol dependence. Not only did depressive symptoms diminish but alcohol reductions appeared to have been mediated through improved mental health. This suggests alcohol treatment among people with depression requires an integral mental health intervention (CBT for depression in this case).

Further pharmacological therapy appears worthwhile, as either a singular treatment or in conjunction with others. Among alcohol dependant and depressive participants Salloum *et al* (1998) identified naltrexone, an anti-opioid craving compound, as reducing the frequency and strength of urges to drink alcohol which resulted in reduced consumption. No changes in depressive symptoms were significant, despite this, the sense that combinations of 'promising' treatments prevails. Petrakis *et al* (1998) found antidepressant therapy (fluoxetine) to be ineffective among opioid using participants in a randomised controlled trial held over 12 weeks. This all reinforces the assertion by the Project MATCH (1997) researchers that individual responses to specific treatment modalities vary so extensively that predicting positive responses, or tailoring treatments may not be feasible. A heuristic approach based upon the comprehensive range of treatments, combined or singular, appears more realistic.

Research conducted by Barrowclough *et al* (2001) and by Haddock *et al* (2003) has relevance here by illustrating improvements through psychosocial measures. The Barrowclough *et al* study (2001) devised an integrated treatment programme of cognitive behavioural intervention, family intervention and motivational interviewing and compared it to conventional mental health treatment. Each aspect of the integrated treatment contained stress management, the teaching of communication and problem solving skills and information about illness, medication, stress and substance use. Integrated treatment demonstrated improvements in positive symptoms and reductions in drinking or drug using days. Mental health relapse rates reduced also. Interestingly those from the integrated treatment group who did relapse experienced

the same severity and duration of relapse as the non-treatment group. Generally the study conveys optimism that mental health intervention is not rendered ineffective by the presence of substance use. The study fails to isolate the power of each treatment domain however Haddock *et al* (2003) extended the study and were able to distinguish motivational interviewing and cognitive behavioural intervention as a probable significant pairing.

In a smaller sample of people with schizophrenia Drake *et al* (1993) followed up 18 participants over 4 years who were in receipt of assertive case management. Participants received behaviourally orientated substance use counselling, medication management and housing support. Whilst there was no comparison group substantial reductions in substance use occurred, with 11 sustaining abstinence for periods up to 6 months.

Combined cognitive behavioural and pharmacological therapy could be effective given the impact of antidepressants, mood stabilisers and anxiolytics even when trialled as individual treatments within dual diagnosis groups. Nunes *et al* (1993) found almost half of a sample with primary major depression when given imipramine improved. Eighteen of these also reduced their alcohol consumption. The study was limited by size (60 participants) and lacked follow up but an opportunity to deliver additional intervention on improvement appeared to occur.

Overall dual diagnosis treatment would appear to have a promising foundation according to the studies cited above (Table 2). The studies show effective mental health intervention despite the presence of substance misuse. They show reductions rather that discontinuation (abstinence) of substance use strongly suggestive of the need for services to adopt harm reduction approaches (DH 2002; Hulse & Tait 2002).

Table 2. Summary of Effectiveness in Dual Diagnosis Treatments

Mental Health	Substance	Intervention	Reference
Depression	Alcohol	CBT	Brown *et al* 1997
	Alcohol	12-Step and Relapse Prevention	Irvin *et al* 1999
	Opiates	Anti-depressants	Nunes *et al* 1998
	Polydrug	Psychosocial Intervention	Charney *et al* 2001
	Alcohol & opiates	Naltrexone	Salloum *et al* 1998
Anxiety	Alcohol	Buspirone	Tollefson *et al* 1992
Anxiety & PTSD	Polydrug	Exposure-based CBT	Foa & Meadows 1997
Schizophrenia	Polydrug	CBT, Family Intervention and Motivational Interviewing	Barrowclough *et al* 2001; Haddock *et al* 2003
	Cannabis, cocaine and alcohol	Relapse Prevention and Social Skills Training	Shaner *et al* 2003
	Polydrug	Intensive Case Management	Drake *et al* 1993
	Alcohol	Naltrexone	Petrakis *et al* 2004
Bi-polar Affective Disorder	Polydrug	Medication Management and CBT	Schmitz *et al* 2002
	Polydrug	Group Therapy	Weiss *et al* 2000
	Polydrug	Anti-convulsants and mood stabilisers	Salloum *et al* 2005
	Cocaine and alcohol	Mood stabilisers	Longoria *et al* 2004
Severe Mental Illness (SMI) (diagnosis unspecified)	Polydrug	Intensive Case Management, Activity Scheduling, Patient and Family Psycho-substance Use Education, Group Therapy and Self-help	Lehman *et al* 1993; Drake *et al* 2000
	Polydrug	Self Management	Jerrell & Ridgely 1995
	Polydrug	Self-Management and Recovery Training	Brooks & Penn 2003
	Cannabis	Contingency Management (financial incentives)	Sigmon *et al* 2000
	Polydrug	Substance Misuse Information Packs and Motivational Interviewing	Hulse & Tait 2002
	Polydrug	Patient and Family Education	Herman *et al* 2000
	Polydrug	Inpatient Care, Medication and Substance Education and Relapse Prevention	Moggi *et al* 1999
SMI With homelessness	Polydrug	Housing Support, Integrated Substance Use and Mental Health Care	Drake *et al* 1997

Services

Service considerations are broad and varied. For example primary care, secondary mental health care, substance misuse, criminal justice, education, children's and young person's services; wherever the client presents it appears a response is necessary that would begin to address both conditions simultaneously. Whether that means the service will (i) complete treatment independently, (ii) work in conjunction with other services or (iii) refer elsewhere is unclear. The lack of clarity concerning which service should address which need has caused resounding problems for many service users over the last decade or so (MIND 2004; Smith & Hucker 1993).

Department of Health guidance (DH 2002) and the National Treatment Agency for Substance Misuse (2002) have examined the three prevailing themes related to service delivery in detail and ascribed models accordingly. Firstly, the issue of services either perceiving themselves, or actually being, ill equipped to treat a second condition discourages them from addressing both substance misuse and mental health problems simultaneously (Rosenheck *et al* 2003). In this circumstance a sequential form of treatment occurs whereby service users get passed from one service to another. This form of care is often referred to as serialised and can be problematic because the two conditions are usually interactive in nature and not independent (Mueser *et al* 1998). Thus treatment for one condition alone is likely to be ineffective.

The second model of joint working relies upon service users engaging with both substance misuse and mental health services in a collaborative manner. The delivery of both substance misuse and mental health interventions is conducted by two or more agencies simultaneously (Johnson 1997). Liaison between services enables care to be coordinated, however the approach can be problematic since it expects engagement by service users to be with two distinct services. This can translate into different locations, organisational, treatment and care philosophies and, most problematic, poor communication. Where this approach has been successful substance misuse and mental health staff have shared knowledge and skills during the process (Graham & Maslin 1998; Ridgely *et al* 1998). Furthermore they have established stronger communication links, training programmes and joint working or referral protocols

(Maslin *et al* 2001). UK policy expects the parallel or joint working model to lead to increased integrated practice in the future.

The third model is that of integrated treatment. Here one service, agency or team delivers both intervention types to the service user. Studies from the US have led this trend (Drake *et al* 2006; Granholm *et al* 2003) indicating that practitioners who possess the necessary repertoire of skills for both conditions achieve greater levels of engagement and success. This also ameliorates some of the risks inherent in the client group that are compounded by poor engagement and multiple agency input (DH 2006a; SCMH 1998).

These 3 models of service delivery are simplistic in their representation of the themes the literature identifies. They are concerned with structures that will improve care delivery by defining dual diagnosis and its sub groups more precisely, allocating an effective treatment and then identifying which service or services should provide it.

Three key questions regarding care and treatment appear to emerge from the literature.
1. Which is the most appropriate treatment? (substitute prescribing of opiates, mental health inpatient care, outpatient cognitive behaviour therapy or housing support for example)
2. Where is the most appropriate service setting (primary care, drug service day treatment or psychiatric rehabilitation for example)
3. What is the most efficient model of service delivery (sequential, parallel or integrated)

Table 3 below (Research and Service Development Centre 1999) attempts to address these questions by allocating a lead service depending on condition severity. Where both conditions are equally serious one multi-skilled service takes responsibility and adopts an integrated approach. Regardless the CPA is cited as necessary in the effective provision and coordination of care for all those people experiencing serious mental health illness with or without substance misuse.

Table 3. Lead Agency by Severity of Substance Misuse or Mental Health Need

Mental Health (MH)	Substance Misuse (SM)	Care
Specific / limited mental health need	Occasional / recreational substance use	MH only
Specific / limited mental health need	Frequent / dependent substance misuse	SM (lead) & MH
Moderate degree of mental health need	Occasional / recreational substance use	MH (lead) & SM
Moderate degree of mental health need	Frequent / dependent substance misuse	SM (lead) & MH
Severe mental health problems	Occasional / recreational substance use	MH only
Severe mental health problems	Frequent / dependent substance misuse	MH (lead) & SM or Integrated Care

Key: Integrated Care = Assertive Outreach Service / Intensive Case Management.

MH = Mental Health Service. SM = Substance Misuse Service.

To summarise this section it appears that service and treatment issues are both orientated around diagnosis. Treatment effectiveness research demonstrates pharmacological and psychological types are promising. This is encouraging because services could become less likely to exclude service users on the grounds that they will be unresponsive to an intervention due to the presence of a second condition. The organisation of services and their inclusion criteria, primarily diagnosis driven, are increasingly likely to consider collaborative or parallel (joint) working arrangements. This follows policy development and illustrates the formulas for decision making related to joint working and the subsequent allocation of a lead agency.

Overall services and treatments appear to be adjusting positively, through the various study findings and through policy development, to the increasing prevalence of dual diagnosis within both substance misuse and mental health services.

Chapter Summary

Dual diagnosis or co-existing mental illness and substance misuse is common throughout mental health service and substance use service settings. The prevalence is significant enough for UK Department of Health policy to recommend that services consider dual diagnosis to be the norm rather than the exception. Further to this, since the prevalence is high in both service settings, the definition of dual diagnosis must be broad and inclusive of all forms of mental illness and substance use. Research initially

focussed upon severe mental illness and substance misuse but has expanded to include less severe, but arguably equally distressing and costly illnesses, such as anxiety and depression.

The definition of dual diagnosis, referring to the simultaneous presence of both substance misuse and mental health problems, extends to a multifaceted model that considers the specifics of both presenting conditions as Figure 1 (Page 19) illustrates.

This review summarises the effective interventions and concludes that there is sufficient evidence to orientate aspects of intervention around harm reduction and information provision. Cognitive behavioural intervention, motivational interviewing and pharmacological therapy appear as credible models of treatment to follow. The review demonstrates that abstinence was achieved less frequently whereas significant reductions in use and consumption were observed (see Table 2, Page 24). This is strongly suggestive that the client group in general adopted harm reduction strategies rather than making wholesale change.

The issue of service provision and which service provides what intervention revealed itself as problematic but potentially solvable. Historically services had been focussed upon their core or specialist functions to the exclusion of individuals who presented with a second condition, particularly if the second condition (drug use or mental illness) was perceived to compromise treatment. Government policy has recommended services work jointly, share skills through such joint working practices and provide training to increase overall capability. Policy and research suggest also that joint working requires a lead agency to coordinate care as a way of preserving continuity; subsequently engagement issues have become very important in influencing the fundamentals of care.

Having presented the background literature, the next chapter describes the methodology I employed and how it related to meeting the specific aims of the study.

CHAPTER 3. METHODOLOGY

Introduction

The purpose of this chapter is to describe the research methodology used for the study and justify its selection. The chapter therefore contains discussions relating to research types and their applicability to the subject of enquiry and how grounded theory was finally chosen and executed.

This chapter is set out in six sections. Firstly, 'choice of methodological approach' which compares qualitative and quantitative research approaches and concludes with a description of grounded theory and its inherent qualities relating to social and human inquiry. Secondly, 'the research context' considers the practitioner-researcher role, the study context, its relevance to practice and the extent to which reflexivity was applicable. The third section, 'research quality' discusses various quality factors. I compare the key grounded theory tenets of fit, relevance, modifiability and workability to those of validity, reliability and generalisability; concepts found in conventional research approaches. Section four; in 'data collection, analysis and theory development' I outline the data collection and analysis in both procedural and theory generation terms. In addition an objective of the study, to develop educational information for services users, is examined. The fifth section presents what I did, and how, with regard to recruitment and data management. The sixth section is a discussion related to the methodology I employed and appraises the execution of my grounded theory approach.

Choice of Methodological Approach

Before discussing grounded theory in detail and how it matched the field under enquiry better than other methodologies, I will present the interplay between the two conventional research paradigms, qualitative and quantitative. I will then justify my choice of grounded theory as a theory that addresses both data collection and analysis procedures to offer (i) a plausible explanation related to the subject under enquiry (ii) an indication of its importance in everyday social or health situations and (iii) a catalogue of useful or helpful information related to dual diagnosis.

Qualitative or Quantitative

Carr (1994) describes quantity as a measure or a numerical collection of meaning that, when contrasted with other similar sets of data from similar sample groups, becomes increasingly powerful. Quantitative research is concerned predominantly with the collection and analysis of data that can be presented numerically through validated processes, for example, confirmatory data analysis (CDA) (Van de Geer 1993). Accumulation therefore adds to the overall significance of data. In order to do this pre-specified questions are necessary and data collection techniques are subsequently orientated around the discovery of specific information. On the other hand qualitative analysis of data examines inherent properties and dimensions that may be less measurable than quantitative data (Miles & Huberman 1994) but of sufficient resonance to promote an understanding of the experience of the research participant.

Among the range of qualitative approaches grounded theory methodology is designed to reveal a wide range of findings from which a substantive theory can emerge. Exploratory data analysis (EDA) (Turkey 1977; Velleman & Hoaglan 1981) is an example of data being presented in diagrammatical or illustrative form (Robson 2003). This I viewed as potentially helpful in organising both data analysis and findings. Equally the presentation of findings may provide greater clarity for the reader. It was anticipated that both descriptive, and to a limited extent, measurable findings would be presented since the study examines both the properties and dimensions of dual diagnosis. A qualitative study, presented in this manner may hold appeal to readers of both qualitative and quantitative dispositions.

Polarised views based upon the general assertions above (Sandelowski 1995) have inclined researchers to adopt a methodological philosophy consistent with their personal worldview (Robson 2003), either a perspective emphasising importance through proof and probability or an explanatory model that promotes feasibility and understanding.

Gephart (1998) pragmatically suggests that neither research methodology can be certain of capturing the essence of the situation or field under study. The notion therefore exists that a primary and supplementary approach, for example qualitative

and quantitative combined (Breitmayer *et al* 1993), could fulfil the ambitions of a researcher wishing to explain or describe both a situation and indicate associated probabilities in relation to frequency and size, for example.

The mixing of methods alluded to above has been described as a unique blend by some (Swanson-Kauffman 1986) and a 'sloppy' even though 'do-able' approach by others (Morse 1991). Whilst limited evidence is available as to the appropriateness of mixed methods of research (Maggs-Rapport 2000), Glaser and Strauss (1967) introduced an analytic process enabling dense text to undergo structured and interpretive analysis.

Glaser and Stauss claimed that, as a result, grounded theory research could be generalisable to other people and other settings despite the goal of generalisability being de-emphasised. In quantitative research generalising findings to larger populations or samples is a chief goal (Oppenheim 1992) and subsequently time and energy is spent obtaining a sizable, measurable, describable sample, at random, in order to accurately match such a sample (and its related findings) to a 'real life' group or situation. Therefore quantitative research has established the standard for generalisability of findings (Brighton *et al* 2003) to matched samples. In practical application however it may be deficient when the accuracy of matching diminishes. For example when operationally applied to a broader sample which lacks the specific inclusion and exclusion criteria on the grounds of its aetiological or demographic profile (Bowling 2000).

Qualitative studies, selecting small purposeful samples, have also been considered non-representative of wider populations and subsequently generalisability deemed weak. Morse (1991) claimed that since generalisability was not a primary goal of qualitative research its findings hold little widespread significance. However, a positivist investigation aspiring to statistical significance in its research answer may be of little or no value when applied to a social construct such as 'care' (of those who are ill, disabled or disadvantaged for instance), a construct arguably that lacks a precise measurable description yet conveys an essentially understandable meaning to the world. Therefore the variability of personal experiences and responses to stimuli or change is such that a quantitative examination may be insufficient to discover the

complexities and differences among a given sample and, furthermore, may over simplify findings.

Strauss and Corbin (1998) proposed a structured methodology that organises data by participant experienced incidents, where numerous incidents may relate to one category or concept and several categories or concepts may exist for several participants. The accumulation of hundreds of incidents from a relatively small sample (20 participants for example) not only achieves a numerical strength but can also reveal wider and deeper information of an undetermined nature. To claim generalisability then, according to Strauss and Corbin, is part accumulation, to the point of saturation (where no new information or concepts are emerging) and essentially, part representativeness throughout the sample of the phenomenon under enquiry.

Glaser (1978), in the absence of Strauss, later focuses upon the importance of a purposeful sample. A sample that contains characteristics of the phenomenon under study has the potential to reveal the comprehensive, in-depth and broad data set necessary to explain the phenomenon, thus suggesting that theoretical explanations would not be forthcoming in a study methodology that had pre-specified questions or hypotheses. After all, the depth and breadth of information is largely unknown at the outset.

The debate centred on the advantages and disadvantages of quantitative and qualitative methodologies is partially academic in this study since I have concluded, like many others (Bond 1992; Koch 1996; Morse 1991) that a research methodology should be chosen to suit the area of enquiry. Given that research findings gain significance through their accumulation no study alone can provide a comprehensive answer. Given also, that my area of study and work lacked conclusive literature findings to generate satisfactory hypotheses, it appeared appropriate to select a methodology that would enable a theory to be developed that related to a vast, but as yet, unspecified range of variables (Glaser 1978).

I would conclude then that dual diagnosis is under-researched (DH 2002, Schulte & Holland 2006) and for this reason hypothetical questions would be based more on

speculation than prior research. In other words it is implausible to test a theory where none exist. The sphere of dual diagnosis in practice terms however, is familiar to many service users, practitioners and carers. Grounded theory by its empirical observations and structured analysis (Glaser & Stauss 1967; Strauss & Corbin 1998) provides a basis on which to investigate uncharted waters in a familiar situation in order to offer an explanation that has potential to include all variables, known, suspected and unknown.

Grounded Theory

Grounded theory is classified as a qualitative research approach whereby the collected data is the main source of theory generation (Punch 1998; Taylor & Bogdan 1998). Influences from other sources such as literature pertaining to the subject are unavoidable however the prefix 'grounded' applies because concepts within the data form the theory. Critically the theory therefore stems from the data directly; it is grounded in the data.

Barney Glaser and Anselm Strauss (1967) throughout their book *'The Discovery of Grounded Theory'* guide researchers to develop theory through a constant process of data collection and analysis right to the point of publication. Strauss later emphasised procedure and the use of analytical tools or techniques over intuitive processes (Strauss & Corbin 1998), though constant comparative analysis remained a central feature. Therefore despite grounded theory methodology being emergent in nature, initially absent of hypotheses or structured in data collection and analysis, a general framework in which to proceed would be necessary. Combining practical stages with analytical techniques and then illustrating them within a research framework can provide a necessary sense of direction (Figure 2, overleaf). In the absence of a prescriptive methodology, which is considered to be counterproductive in grounded theory (Charmaz 2000), a research framework is a critical source of guidance.

Figure 2, informed by Robson (2003), and developed early in the research process outlines my research method and formed a satisfactory guide for managing time and data. Details of the framework's implementation and findings are reported in later chapters (Findings & Discussion).

Figure 2. Research Plan Overview

Participant Observation, Field Notes & Journals	Interviews	Focus Groups	Prior Literature

Data Generation

Concept Formation
Code and Categorise Incidents
Identify Major Categories

Concept Development
Theoretical Sampling
Selective Sampling of the Data
Saturation of Data
Selective Review of the Literature

L I T E R A T U R E

**Explanation of Phenomenon /
Substantive 'Grounded Theory'**

Grounded theory methodology cites the development of theory as the main goal with the process of induction in category identification and later, development of concepts and hypotheses, as crucial. Additionally, providing the research follows a combined intuitive and structural process, not necessarily procedural, then field (or practice) based ideas can flourish, generating theoretical propositions.

The appeal in grounded theory methodology is that a field based issue of little understanding, but of great concern, an issue of limited prior research, can be examined in depth and explained from a particular perspective (Robson 2003). Some might describe it as a thematic method but that would detract from a research process

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that, from Glaser's perspective (1992), through theoretical sampling, categorising and condensing of incidents and drawing inferences, can form a valid theory. This process distils the significant common or shared experiences which appear to explain a phenomenon in depth. Its application in social or healthcare situations, in terms of what may be helpful or unhelpful, effective or ineffective, appears highly appropriate.

Although grounded theory was originally developed by Glaser and Strauss (1967) and initially emphasised the intuitive process they later parted company with Strauss deviating from the original concept to a structured and procedurally based grounded theory method (Strauss & Corbin 1990). Table 4 (overleaf) illustrates the different schools of thought that have emerged; I however, have found such differences to be complementary and not mutually exclusive.

For instance Glaser (Points 1 & 2 of Table 4) stipulates that two core questions initiate the process, one identifying the chief concern, the second, asking what category does that chief concern most likely represent. The process that follows for Glaser is one of organic theory development, pragmatically comparing incident with incident that relates to the chief concern. Hence the reference to grounded theory as constant comparison.

Corbin and Strauss (1990) initiate the process with a research statement identifying the phenomenon followed closely by a set of procedures that will identify key concepts and their interactions.

The final stages differ significantly in that Glaser's approach concludes with a theory for others to test. Strauss and Corbin on the other hand, with an emphasis on operationalising the findings (Parker & Roffey 1997; Robson 2003), undertake systematic validation. This could hold greater appeal to the practitioner-researcher whose research aspirations, by virtue of their dual role, are likely to be practice orientated.

Table 4. A Comparison of Grounded Theory Methodology Orientations: Strauss and Corbin (1990) versus Glaser (1992)

Strauss and Corbin (1990)	Glaser (1992)
1. The research question is a statement that identifies the phenomenon to be studied.	1. Two core questions: What is the chief concern/problem of people in the area under study? What category does the concern indicate?
2. Researchers need help with the interpretation process: procedures and techniques need to be spelled out. Subcategories are linked to categories that denote a set of relationships (i.e. causal conditions, action/interaction strategies, and consequences).	2. The problem emerges and should not be forced by the methodology. Categories and their properties 'emerge' through constant comparison of incident to incident and source to source.
3. Easier to operationalise.	3. Can be difficult to operationalise.
4. Generates an inductively derived theory about a phenomenon comprised of interrelated concepts.	4...Generates concepts and their relationships to explain and/or interpret variations in behaviour in the substantive area under study.
5. Undertakes continual verification and testing to determine likely validity of concepts and relationships between them.	5. Produces a theoretical formulation or set of conceptual hypotheses. Testing is left to other researchers interested in such work.

(Parker & Roffey 1997, Page 221).

The rationale for my choice of a mixed grounded theory methodology is outlined below.

1. There is limited research relating to service user experiences of dual diagnosis

2. Service user experiences vary, subsequently a quantitative approach to enquiry could be homogenising and over simplify the phenomenon

3. Service user experiences may share commonalities and as such could begin to explain, by theory development, what helps and what does not help (in their dual diagnosis)

4. Combining both purist (Glaser) and progressive (Strauss & Corbin) research schools can promote an inclusive research philosophy. The combination has the potential to create an organised systematic procedure that can retain an emphasis upon constant comparison

The Research Context

The research took place across health and social care services however the majority occurred in my direct work setting within mental health inpatient wards and community venues. This section discusses the dual role of practitioner-researcher, its advantages and disadvantages and how theoretically such a role can be relevant to both research and practice.

The Role of a Practitioner-researcher

As a practitioner (consultant nurse) conducting research within my specialist sphere (dual diagnosis) and operational location of specialist mental health services, it was important to communicate to colleagues about the practicalities of recruitment and data collection. Since many pre-existing relationships were, and remain, based upon my role as a practitioner any research activity I conducted had to be clearly defined. The role of practitioner-researcher posed a potential threat to both the ethical parameters of the study and the integrity of grounded theory methodology. The former related to information that could be viewed as data gained through my day-to-day practice and potentially without consent. The latter referring to the influence my role as a practitioner might exert during analysis. (See Consent section on Page 50 for further discussion).

This dual role, whilst cited as enriching social and health care research (Lindblom & Cohen 1979; Marris 2003; Robson 2003) has inherent challenges. Firstly, there can be role confusion for the researcher, colleagues and service users, and secondly the generating of unrealistic expectations that the research will yield significant changes. In this respect Weiss (1986) cautions the practitioner-researcher against naïve optimism in relation to their study's impact.

> *Researchers need to be aware that the work that they do, no matter how applied in intent and how practical in orientation, is not likely to have major influence on the policy decision at which it is purportedly directed.* (Weiss 1986, Page 232)

Subsequently, the dual role of practitioner-researcher posed important questions about the feasibility of conducting grounded theory research and also about retaining realistic aspirations for its results.

The context in which this study was conducted was broad and encompassed numerous services from Primary Care Trusts (PCTs), the Local Authority (LA), NHS Health Trusts, independent and voluntary sector providers in health and social care to criminal justice and housing agencies. Furthermore, from a specialist provider perspective it included mental health and substance misuse. The field therefore was potentially vast. The phenomenon of dual diagnosis was cited in research and policy (DH 2002) to permeate this wide range of services listed therefore findings had to be *understandable* to non-specialists and be sufficiently *general* in a range of situations within the area under study to be of practical use (Glaser & Strauss 1967). The practitioner-researcher working across services therefore holds the potential to address any generalisability of findings due to their practical experience.

Given such considerations research supervision and reflection were essential mechanisms practiced throughout for two key reasons. First, the grounded theory method benefits from a broad sample. This way representation of the phenomenon through differing settings is achieved. As a result numerous service settings were involved which generated a multitude of complex communication issues. Second, my practice role created opportunities for data collection in the form of field notes. This needed to be balanced to avoid practice and research roles merging unconsciously. Thus avoidance of operational action back in practice based upon emerging findings was discussed in research supervision in order to prevent its application being premature.

Importantly, in grounded theory the variety of views, tested for the similarities in conceptual terms by axial coding, is considered to give greater strength to the final explanatory theory. Should I have limited the study to a defined group in one designated area (for example males in psychiatric intensive care) counter propositions would have been fewer in number subsequently limiting the exposure to criticism from within the data set itself.

On the one hand the context appeared overwhelmingly broad and on the other hand an opportunity was apparent to develop theory relating to, and tested from, multiple perspectives. This latter point is arguably the most significant for practitioner-researcher studies since it links the research directly to the job purpose, which at

senior level can carry organisational authority to develop evidence based practice and services.

The core concern was that my role as practitioner-researcher enabled my research to be relevant to the field under study. Hammersley (1992) discusses the merits and pitfalls of a dual role giving a critical argument for the practitioner-researcher in terms of their inherent relevancy and insight yet warning of the parochialism an 'insider' position could generate.

Relevance to Practice

In this section I identify the relevance of the practitioner-researcher role, the benefits and drawbacks such a role generates and how these were managed within this study. Substance misuse and mental illness is both a conceptual and practical problem (DH 2002) for health and social care services. Therefore a research study examining the experiences of existing dual diagnosis service users and carers was an opportunity to discover helpful contemporaneous information.

The role of Consultant Nurse in Dual Diagnosis demanded that evidence based practice was promoted in those services outlined above. This demand gave me the authority to conduct the research study and obtain accompanying support, funding and study leave. This illustrated an understanding from my host organisation's senior management and executive of the relevance to practice and service development the research would have.

A drawback to my position however was that research fidelity could have been jeopardised in the event that the organisational or practice objectives relating to dual diagnosis overrode the research process. For example information materials being published prior to checking processes, or themes being integrated into organisational or therapeutic strategies, before research completion.

Zeisel (1984) identifies problem-orientated studies as being inherently complicit in this, a practitioner being able to conduct their 'insider' research to solve an operational problem seems open to researcher bias. An important task therefore was

to address this throughout the research journey, steadying myself through constructive critical supervision and reflection.

Robson (2003) writes of the unparalleled expertise of a specialist practitioner-researcher, with insider opportunities and practice insights. But equally, problems of an 'insider' nature, such as confusing communication in dual roles, being drawn into operational emergencies and experiencing demands on study leave time can take their toll. To maintain my balance and motivation I adopted a strategy of 'remaining conscious' of both roles and referred to the advantages-disadvantages matrix (Table 5, Page 41) constructed at the study outset and echoing the advice of Robson (2003).

Winter (1989) makes a challenging statement that is useful in promoting a disciplined approach to research that rivals the practice expertise inferred by the practitioner-researcher role. In essence it implies that any research expertise deficits, once addressed, could conceivably lead to an increase in overall practice performance.

> *Experienced practitioners approach their work with a vast and complex array of concepts, theoretical models, provisional explanations, typical scenarios, anticipation of likely outcomes, etc.…*
> *A research process must demonstrably offer something over and above this pre-existing level of understanding.* (Winter 1989, Page 34)

Table 5. Pros and Cons of the Practitioner-researcher Role. Adapted from 'Practitioner-researcher compared with outside researchers' (Robson 2003)

Disadvantages	Advantages
1. Time. *Ensuring that time requirements are predicted accurately and where compromised research time is logged and renegotiated.*	1. Insider opportunities. *Make use of pre-existing knowledge of systems and key people whilst avoiding over exposure to aspects of the study phenomenon that would lead to premature theory development.*
2. Lack of research expertise. *Utilisation of University research modules, library facilities, Trusts R & D unit and University academic supervisors.*	2. Practitioner opportunities. <u>*In final stages only*</u> *consider how local practice knowledge will enhance dissemination of research findings.*
3. Lack of research confidence. *As above but also address through PhD student support network.*	
4. Insider problems. *Remain aware of 'prophet in own land' phenomenon and practice emotional intelligence when faced with demands by host Trust and operational demands that block research.*	

*Italics denote self-instruction / solutions.

The research context and the practitioner role can generate important questions such as how do I balance the role without compromising the separate functions? Or how do I utilise the duality of this role to improve practice and research alike? The necessary process of reflection through supervision lends itself to a reflexive research approach that in itself has potential for added rigour in terms of the plausibility of the study findings. The position promoted by Koch and Harrington (1998) suggests a study adheres to a reflexive approach in order to maintain the direction of both practitioner and researcher roles whilst adding rigour to the research finding by a contextual and role awareness. This is achieved by self-appraisal, self criticism and knowledge of the moral, social and political atmosphere in which the study is being conducted.

Application of Reflexivity

Reflexivity as an approach is described below; its precise influence on the methodology in analysis and theory development terms however is revealed in later chapters of the Findings and Discussion.

Koch and Harrington (1998) suggest that reflexivity is used to convey to readers what is going on during the research process and why. Reflexivity does not simply promote reflection by the researcher but demands an explanation of what bearing that reflection has in the context of the study itself. For instance the rationale for research decisions that led in particular directions. One example was the decision to ask focus group participants, who appeared knowledgeable but inhibited among their peers, to return for individual interviews, where information may be more forthcoming.

Decision-making memos and field notes were kept. Therefore the question 'what is going on?' (Glaser & Strauss 1967) can be constantly considered. Gadamer (1976) extends the question from a data *collected* perspective to a data *collectors* perspective i.e. what does the data say and how does the researcher interpret it? Are these two questions however legitimate in health and social care enquiry given the current high status of quantitative research in health in particular? (Glasziou *et al* 2004). If they are, how do they become conceptualised when there exists an expectation that research should demonstrate unquestionable quantifiable rigour?

As the rigour of research and its application often relies upon valid evidence researchers inevitably seek to demonstrate this both in method and findings. Method being the foundation upon which the findings rest, the research process and what was discovered should be neither flawed nor false. Avis (1995) promotes rigour in the latter sense, stating research should be judged on its usefulness thus de-emphasising, not disregarding method as the construct responsible for demonstrating rigour. Reflexivity enabled research decisions to be consistent with the chosen methodology and not unduly influenced by a modern health doctrine that embraces more readily quantitative principles (NHS Executive 1997).

In adapting this concept within my study and considering the previous discussion above there is consistency between Glaser's assertions (Glaser 1992) regarding 'fit' and 'relevance' to that of rigour and utility. I became aware that despite strategies such as standing back from the data and observing it neutrally (Parse *et al* 1985) as much as is possible, my personal bias was present. My prior knowledge was therefore likely to intrude on data collection and analysis. *Bracketing,* a deliberate process of suspending judgements about the study was practiced. Whilst conventionally a phenomenological strategy, Husserl (1990) introduced bracketing to ensure the subjective experiences of participants were not prejudiced.

Adhering to an objective methodology need not be the only way to instil rigour (Nolan & Behi 1995) and indeed through seeking rigour in this fashion I could have excluded the sociological contextual awareness necessary to build theory (Bhavnani 1993). By keeping a record of research thinking and subsequent decision making during analysis, usually in the form of memo writing on transcripts, I was able to adhere to the study plan whilst also responding to the context based themes. The memos were often written as hypotheses which encouraged a broader analysis of a theme to test its relevance and significance. By disputing themes in this manner theory grows but only when the data connections remain intact. This synthesis of data gives rise to structured theory from the initial abstract or partially formed theme.

This type of reflexivity has been labelled as the 'politics of location' (Koch & Harrington 1998). It is neither subjective (reflexivity based purely upon an empathic understanding of the data or participant) (Marcus 1994) or objective (reflexivity whereby the researcher maintains a conscious distance from the data). It is by an awareness of location within the data (what is being said) that the researcher can understand his or her interpretation of it. In other words how the researchers' identity, experience, knowledge and values engage with those expressed in the data. In addition constant questions of the data and research process are posed which give rise to greater interpretive potential. Willig (2001) describes this as epistemological reflexivity. My self directed questions were thus;

How could I have investigated this differently?
How has the research topic limited my method?

How has the method limited my findings?

I concluded, during the initial research stages that I would maintain Glaser and Strauss' principle of shedding prior knowledge and insight to the extent that data collection and analysis led me rather than the opposite. By adopting a reflexive approach it was then feasible to integrate my own awareness of the phenomenon under study and distinguish prior knowledge and experience from the data itself as described by Freshwater and Rolfe (2001). In other words I was conscious of the data's effect on me as a researcher and my effect as a practitioner-researcher on the data.

Research Quality

Despite prior discussion regarding the merits and suitability of grounded theory as a methodology for this study, important quality concepts should be considered to demonstrate the study's methodological quality and integrity. Yin (1994) and Kvale (1996) cite construct validity, internal validity, external validity and reliability as necessary quality proving measures in empirical research. However they can not be claimed as present or necessary in grounded theory research. The equivalents such as workability, understandability and modifiability are discussed here. These focus upon the actual strategies employed for data collection and analysis in a flexible research study such as mine and emphasise research quality in terms of credibility (of both method and findings).

Whilst data collection and analysis sections of this thesis contain greater detail of their application, this section concerns itself with the fundamental tenets of grounded theory quality. I remained mindful throughout that unequivocal tests in grounded theory are not feasible or necessary. However my pursuit of quality and rigour concerned itself with conventional grounded theory goals of fit, relevance, workability and modifiability. I therefore found it necessary to consider traditional quality tests in conceptual terms, since they are usually achievable only in quantitative research (Mays & Pope 2000), and adapt the principles in the following common sense manner for the purposes of this study.

Construct Validity

Examining the phenomenon of dual diagnosis differs little from the study of other complex issues and to an extent this makes construct validity difficult to achieve. It is concerned with establishing the correct operational measures for the concepts under study (Yin 1994). However from a grounded theory perspective the concepts are not as yet discovered therefore I undertook to strengthen methodology by obtaining data from as broad a range of sources as was practicable. By using triangulation (Denzin 1989) through multiple sources (interview, focus groups and field notes) I believe I constructed a study design that would enable relevant data to be collected and refined.

Workability

Internal validity is concerned with cause and effect, for example does A lead to B when C is present? In principle this appears appropriate in the development of an explanatory theory. Yin (1994, Page 35) refers to *"pattern matching"* and *"explanation-building"* as techniques that could demonstrate internal validity. They are self-explanatory prompts in reality and pursuing them within my study proved effective since they form both test and analysis simultaneously, a feature of grounded theory discussed above.

Pursuing external validity according to Ovretveit (1998) will establish the research findings generalisability to other situations, it is still necessary to clarify how, as a quality aspect of the study, I interpreted the principle. If workability (Glaser 1992) is defined as the theory, explaining how a problem or a set of problems, associated with the phenomenon can be solved, then the result of its application speaks for itself. How the theory grabs or captures the readers' attention adds to the external worth of the theory. Such credibility is demonstrated when the theory appears relevant to the subject matter and offers a plausible explanation applicable to practice - workability.

The tests of workability and relevance, therefore, were interpreted as quality tests equivalent to conventional external validity.

Understandability and Modifiability

A grounded theory does not set out to achieve reliability (Glaser & Strauss 1967) but does seek to demonstrate to readers the fit and modifiability of the theory. Reliability as a test of reproducibility of results should the same approach be applied to the same field of study, at a different time and by a different researcher, is understandably inappropriate for flexible designs, such as used in this study. However conceptually it makes sense because what it conveyed was a principle that the study must embrace and convey logic. Glaser and Strauss (1967) are unambiguous in their assertion that explanatory theory should do just that, logically explain, or produce a justifiable position. Therefore, applying the test of 'fit', or how closely concepts fit with the incidents they represent, and describing how the incidents within the data compared to concepts (by constant comparison), the principle of reliability can be established.

Modifiability, the ability for the theory to be altered in light of new information relating to the same phenomenon, is a goal of grounded theory. Consequently, if a theory matches the phenomenon (relevance), the concepts and incidents relate understandably (fit), it explains what is happening (workability) and is open to change as things change around it (modifiability), it will demonstrate the necessary quality and rigour for readers to accept and put into practice.

A modifiable workable theory therefore exerts research quality. The prime goal of grounded theory is to discover participants' main concerns and how they attempt to resolve them. When these are accurately described and accompanied by an understandable theoretical explanation modifiability and workability are likely to be achieved.

Data Collection, Analysis and Theory Development

I have suggested that grounded theory addresses qualitative principles in collection and analysis terms. For example the sample size, governed by the principle of saturation, demonstrates data adequacy. The purposeful inclusion of a specific sample that possesses key characteristics of the phenomenon under study aims to provide relevant data, a point conveyed by Morse and Johnson (1991).

In the following section I describe, in chronological order where possible, the approach established for the study, outlining the procedure adopted, the reasons why and how they relate to not only Glaser and Strauss' original methodology (1967) but also the more structured and systematic methodology developed later by Strauss in partnership with Corbin (1998). In reality stages and steps in the process overlapped and were not strictly linear.

Since grounded theory data collection, analysis and theory development take place almost simultaneously, except for the initial data collection wave, this section will consider all three aspects of the study's methodology. It concludes with a description of the quality issues related to the information materials emerging from the study. These are described in detail within Findings and Discussion chapters.

Data Collection

Participants (service users, practitioners and carers) were recruited using a purposive sampling technique. These were drawn from inpatient mental health wards, community mental health teams, non-residential substance misuse services, and other areas such as housing agencies and self-help groups.

In the recruitment of service user participants their care coordinators, primary nurses or key workers had been initially asked if they had service users on their caseloads suitable for the research study who were also able to give informed consent to participate. Where this was the case service users were then approached, the study was explained using the Participant Information Sheet (PIS; Appendix 1, Page 266) and their consent obtained. A small number of service users approached me independently after seeing a recruitment poster; in these instances I checked their suitability through key workers before seeking participation and consent. Carers and practitioners who participated underwent the explanation and consent process only.

Service user participants were engaged in focus groups and / or individual interviews depending upon their preference. These were audio-taped and transcribed for analysis using a colour coding system distinguishing incidents and themes. Early hypotheses emerged, which when combined with theoretical sampling of further data, facilitated

the development of theory. Carer and practitioner participants did not participate in focus group interviews.

All participants were approached again several months later to give their perspective on the general themes that had emerged; this process of 'member checking' (Sandelowski 1995) added credibility to the theory development but overall increased the accuracy of the categories and what they meant. This was not an attempt at verification in conventional terms however it was an important aspect of the study because any output such as that of information materials would require resonance for service users and carers. Figure 2, presented previously on page 34 shows the framework used for data collection and analysis.

Sampling

The size of sample in qualitative research is important if the researcher is to demonstrate any claim of theory saturation or redundancy of information (Sandelowski 1995). Glaser (1992) and Strauss and Corbin (1998), in their sampling of incidents (but not participants) also convey this point. In addition they spend a great deal of their time proposing to readers that the changing of sampling techniques, as the sample incidents change in nature, is equally crucial.

In recognition of this, the study sample required defining, in participant terms, for inclusion and exclusion in relation to the phenomenon. This purposive sampling strategy needed careful consideration since the study aims related to the issues around dual diagnosis, a clinically driven phenomenon. In other words the person related characteristics such as age, address, race or religion may be important but were deemed secondary to their behaviour and lifestyle. The behaviour (substance misuse) and lifestyle (mental health care recipient) in combination formed the basis for the inclusion criteria.

Despite logistical and organisational restrictions a sample was proposed that would include people who;
  (i) Had a dual diagnosis of mental illness and substance misuse *or*
  (ii) Had experience of supporting people with a dual diagnosis as carers or professionals *and*

(iii)   Were geographically accessible (lived or worked within Manchester, UK)

(iv)   Were served by or worked within local health or social care services

(v)   Could provide informed consent

Sampling by the above profile provided the participant sample. Sampling by themes (theoretical sampling) derived from the data then followed (Glaser & Strauss 1967; Sandelowski 1995). This illustrates the two dimensional nature of sampling in grounded theory, firstly the importance of selecting broadly appropriate participants (source) and secondly, selecting the significant themes (data) they convey that are likely to explain the area under study. Theoretical sampling itself takes a variety of forms, which are discussed later in the chapter, but as the term implies the samples obtained and analysed are defined by the concepts or theories emerging from the data and not necessarily the person.

To clarify the sampling process an understanding that two key stages were employed is required. Firstly, the selection criteria of participants that represent the area of study and secondly, the movement from participant-based data collection to incident-based data analysis. The incident (or unit) count in relation to saturation is more important than the total number of participants (Sandelowski 1995; Strauss & Corbin 1998). It is from the depth and detail of recurrent themes that theory emerges. As a result the quality, not number of incidents, guides the data collection process. Data redundancy (Morse 1995; Strauss & Corbin 1998), where new data ceases to reveal new themes, therefore determined the duration and number of participants included.

My concern was not to demonstrate the completeness or confirmation of a hypothesis but to provide explanatory theory related to dual diagnosis. The sampling objective therefore was to obtain data in sufficient amounts (incidents) and of sufficient quality (credible) from people experiencing dual diagnosis (or their carers / practitioners) to generate a substantive theory and produce information materials.

I concluded that a predetermined sample size of participant and incident was difficult to predict at the outset. No numerical standard for sample size has been established in grounded theory (Goulding 2002) because research quality is ultimately a case of judging the information collected against the uses to which it will be put

(Sandelowski 1995). Saturation therefore determines the participants and final incident count. From a quality point of view I was mindful of Glaser and Strauss' (1967) assertion that the balance between mathematically derived conclusions and human experience could be achieved through the research process of constant comparison, providing saturation was reached.

Consent

The concept of informed consent is central to both therapy and research (Fryer 1995) however procedurally it differs in each context. The mental health setting for the study and the vulnerable nature of the client group from which participants were recruited dictated that a rigorous procedure for obtaining consent and maintaining its currency, through what was an extensive period of data collection, was followed. Prior to managing research consent issues it was necessary to examine the matter at both an ethical and a practice level.

Examples of good practice in health settings for assessing capacity in order to give treatment and / or research consent are well documented (DH 2002; DH 2001b; Gunn 1994). As a result the task of devising a capacity test prior to requesting consent was necessary. Again literature pertaining to capacity in mental health is extensive with opinion leaders making similar recommendations (DH 1999; Grisso & Appelbaum 1998; Johnston & Liddle 2007).

Further, Gillon (1991) cites from the Medical Ethics Dictionary that consent is;

> *A voluntary, uncoersed decision made by a sufficiently competent or autonomous person on the basis of information and deliberation to accept rather than reject some proposed course of action.* (Gillon 1991, Page 113)

The context within which this study was conducted raises questions about numerous elements of the statement. Firstly, 'voluntary' and 'uncoerced', whilst evident during the process of obtaining consent for the study, may questionably have been absent in relation to treatment, for example in the case of those service users detained under the Mental Health Act (Department of Health and Welsh Office 1999). Equally, those inpatients of voluntary status on mental health wards, or those service users within

Assertive Outreach Team caseloads (Thornicroft & Tansella 2004) arguably receive their care and support under 'sufferance'. For example on the insistence of a relative, through a court of protection, a guardianship order, a condition of bail or as part of a tenancy compliance programme. Add to this the cognitive deficits associated with mental illness (Pantelis *et al* 1997) or as an adverse effect of psychotropic medication (Lindstrom 1994) and the concept of consent begins to unfold into an uncertain and complicated issue requiring frequent and regular attention.

It was necessary for me as a practitioner-researcher to consider carefully with the primary nurses of inpatient participants and the care coordinators of other service users, regardless of legal status under the Mental Health Act, whether autonomy and the ability to deliberate and reflect was present. Potentially those people who were acutely disturbed might have been excluded through consent issues or simply deemed too unwell to participate by their primary nurse or care coordinator. Incorporating acutely ill participants as well as participants in remission would provide greater breadth in the data. I was keen therefore to emphasise that participation was voluntary and dropping out at any point was a participant's right. By constantly checking participants' motivation to remain in the study people in general were reassured. Subsequently recruitment was not limited to those people who were well or in recovery.

Each potential participant, and their primary nurse or care coordinator in the case of service user participants, was given a Participant Information Sheet (Appendix 1, Page 266), explaining the study in full. This was reinforced by providing verbal information outlining the research objectives, the methods to be used, their anonymity and confidentiality, and assurances that consent could be withdrawn at any time. Although audio-taping of interviews and focus groups was employed in the data collection phase, consent to do so was sought and recourse to note taking employed on the occasions that audio-taping was objected to or judged counter-productive or impractical.

To aid consent, a capacity test was devised (Appendix 2, Page 270) that applied to all potential participants whose ability to provide informed consent was suspected of being compromised by illness or context.

Obtaining consent for any study should not be regarded as a single task but as an ongoing process (Ogloff & Otto 1991). Due to the client groups vulnerability to exploitation, intentional or not (Weaver *et al* 2003), their propensity to change (Drake *et al* 2001) and the overlapping role I performed as practitioner-researcher a 'constant consent' process was employed. In practical terms this meant checking consent verbally with each participant at every new episode of contribution. For example on their attendance for a second interview or further focus group.

Consent proved to be a continuous process throughout data collection and theory development. It was complicated by issues associated with mental illness, the context of mental health care provision and by my dual role as practitioner-researcher. The former requiring additional ethical consideration given that information recorded as field notes whilst in practice may conceivably have been obtained within 'therapy' rather than 'research'. Consequently this issue was subject to close scrutiny within supervision as to the research legitimacy of certain data. Themes from interviews and focus groups were clearly research derived however I considered field note information from therapy settings as supplemental to the formulation of theory and categories. Whilst using this rule and clarifying through the research design and supervision what constituted research data, the danger of excluding meaningful information was addressed. Freud (Strachey 1961) based his theories on therapeutic data and Glaser and Strauss (1967) remarked that 'all was data'; whilst cautious, these were reassuring assertions that encouraged the consideration of my field notes or inferences from clinical practice in analysis and theory development.

In generating meaningful representative theory, depth and diversity of data is essential. I concluded that whilst the collection and analysis of data from multiple sources required enormous effort to remain within the confines of consent it was ethically essential and ultimately worthwhile.

Confidentiality and Anonymity

The study objectives stated that information materials (Appendix 3, Page 271) in some form, probably service user and carer education orientated, would be produced in light of the findings, therefore it was necessary to assure all participants that their

identity would be protected. Should they believe their contributions to be identifiable within the information it was agreed that amendments would be made.

The Local Research Ethics Committee application contained clear confidentiality measures. These included adherence to Caldicott NHS data protection legislation (DH 2003b) and Nursing and Midwifery Council (NMC 2002) guidance and policies. These describe the necessary procedures for recording and sharing service user related information. They demand research data be anonymised and restrictions applied regarding access on the basis of what is necessary or appropriate. For instance data demonstrating an increase in the risk of suicide would be divulged to appropriate agencies.

Further measures ensuring practical safety of information were used. Data was stored confidentially using lockable filing cabinets in a designated research office. All tapes and transcripts were stored in the locked filing cabinets with access restricted to researcher and transcriber only. Destruction of raw data at the completion of the study was guaranteed be it audio or paper. The anonymised data however were retained, to be destroyed within 2 years of completion by which time analysis will have been adequately summarised for reference purposes.

Analysis

Analysis of grounded theory data requires a systematic approach in order to identify themes and discover their similarities and differences in pursuit of an explanation of the phenomenon. Coding, memo writing, developing hypotheses and using constant comparison of participants and their incidents are tools used in the study for analysis purposes. Below they are described and their application discussed.

Coding and memoing

Extensive texts and guidance notes were adhered to which included a variety of analytical tools and frameworks, the fundamental elements of which are presented within this section.

Firstly, *open coding* was used for all audio-taped transcripts, this procedure requires themes to be listed as categories or concepts. Categories were tagged by colour and

labelled with basic participant details such as service user, carer or practitioner source (summarised in Table 9, Page 90). Field notes with observations and remarks were considered important during analysis however the categories emerged solely from the transcripted data. Twelve separate categories were coded and *memos* explaining their significance typed onto the transcripts in bold type (example in Appendix 4, Page 349). Each category then revealed several subcategories as analysis proceeded. I used self-directed memos which served as reminders of the conclusions I drew during open coding and they also provided a running commentary that culminated in theory development. The informal manner in which memos are written encourages researchers to think-out-loud in an attempt to include into the data as much as possible, a free flowing exchange between the data and researcher. Subsequently memo writing was a manifestation of percolating theories identifiable within the data itself.

Selective coding and axial coding took place following the initial open coding or early theme recognition. Whilst Strauss and Corbin (1998) describe an almost simultaneous coding procedure of all three types I found that axial coding, the process of relating concepts and categories with other related concepts and categories (or subcategories) across their central point (the axis), to be a largely separate exercise. It was through axial coding that I discovered clear links between categories that went on to form the major categories worthy of theory development. Selective coding became progressively emphasised as multiple categories (12 in total with 977 separate incidents) reached saturation.

The absence of great effort or force to link categories is encouraged by Glaser (1978) who asserts that inductive reasoning, where conclusions can be of greater generality than the premise, will encourage category similarities to emerge. I interpreted this to mean that shared properties or dimensions of categories would indicate the presence of any underlying similarity, such as the context, the person or some other factor. Subsequently the underlying factor may be revealed as the significant element in the development of emerging theory. In short, by avoiding preconceived ideas, shedding prior established opinion and views, the data should naturally code as a reflection of itself rather than a distortion of external influences.

Having reached a point through axial coding where significant categories were evident, my concern shifted to selective coding of data. With these categories in the forefront of my mind it enabled an efficient and focused examination of the data since my objective now was to identify subcategories and begin their linkages. The analysis moves from one of induction, the data generating themes that generalise, to one of deduction whereby explanatory theory is sought.

Using hypotheses

Whilst a hypothesis at the study outset would have been limiting and contradict the essence of grounded theory research, as a tool later in analysis, hypothesising became crucial. Collecting data in the manner the study dictated was a moderately passive process as little structure or leading was required, in fact, as I discovered, unstructured interviews can encourage participants to reveal their experiences in greater personal detail than when structured (Corbin & Morse 2003).

Table 6. Combining Coding, Theory Generation and Hypotheses: An Example of a Subcategory under the Category 'Impact on Behaviour and Life'

Elements of Theory	Type of Theory	
	Substantive	**Formal**
Subcategory	Exclusion from mainstream society	Social and cultural value of mentally ill and/or drug users
Properties of Category	Limited life opportunities, fearfulness of unpredictable person by society	Calculation of the value of the mentally ill or drug user on the basis of perceived threat or difference
Hypotheses	The greater risk, fear or difference in a person the more likely that person is to be sidelined or excluded	Exclusion requires stigmatising characteristics (i.e. mental illness, threatening or odd behaviour, drug use)

Given the data collection of this passive nature, codes and memos are the main routes to elicit meaning, subsequently suggestions as to their importance emerge. It is through these suggestions that questions and hypotheses form. Glaser (1978), and

reiterated by others (Chiovitti & Piran 2003), suggest proof is not sought to confirm a theory but the accumulation of interrelated hypotheses is; the net of hypotheses provides yet another tool from which to view data. Multiple hypotheses proved to incorporate axial coding principles (looking for cross over of categories) but in sufficient detail to select out possible explanations (early theories) that informed the selective sampling of theory from both new and existing data.

The example 'Impact on Behaviour and Life' cited above used a simple matrix (Glaser 1978) to compare concepts by their properties, produce hypotheses and describe, in this example in basic terms only, theories of explanation. By subjecting categories to the process a strong constant comparison method of analysis relating directly to the data, not prior information, took place. Formal theory development (Glaser 1978) is usually the result of continuous grounded theory research. Table 6 outlines a formal theory for example purposes only, whereas the substantive element is justified through the study findings. Anticipating potential formal theory therefore enabled deeper analysis but remained absent as an objective of my research. Substantive theory on the other hand, described in the following chapters, appeared feasible in isolation. It can form the original source of, or contribute to other research, in the development of, 'formal' theory.

Comparison Groups

Approximately half way through the open coding of data, axial and selective coding commenced. Questions were asked of the data in hypothetical terms but the existing data remained intact to ensure its integrity. The use of comparison groups enables analysis of themes from varying perspectives yet similar sources.

The initial focus group selection was based on the fact that the pre-requisite criteria were met (a person with mental health and substance use problems) which bore relevance for the phenomenon under study. Comparison groups were constituted by returning and new participants with an emphasis placed on comparing themes.

It is important in grounded theory to avoid identifying the precise sources of data for the study at the outset (Pandit 1996) since this would limit the choice of relevant comparison groups for theory development. As a result the concepts were analysed

and formatted in story form (Appendix 3, Page 271) and further focus groups were conducted whose participants met study inclusion criteria but for whom the storyline (including the concepts and categories) would be understandable and relevant. At this point views were collected directly in relation to the main categories and themes in order to verify their accuracy and be included in the theory development stage (see Figure 3, 'A Tentative Core Category', Page 59).

Theory Development

This section addresses the process of theory development by describing how coded themes require deconstructing to discover their properties and dimensions. It then describes how coding for overlap (axial) and comparison (selective) encouraged greater depth of information and a wider spread of included information. Furthermore it distinguishes empirical theory, that of a practical nature, from formal theory, that which provides an explanation. The section ends with a reference to the production of information materials for service users and carers. Crucially the information output, described in detail in Chapter 6, constitutes the theory in empirical, or substantive, terms.

Core Themes and the Development of Theory

To facilitate the development of a theory of generalisable proportions grounded theory studies employ comparative analysis. The area in question is researched as a whole rather than focusing on a specific aspect, for example a single group, team or unit. Therefore, grounded theory because of this breadth of data collection and analysis, whilst productive in generating theory, can become extremely complex and appear cumbersome.

This can be due; firstly, to the fact that data analysis does not conclude with a description, moreover it progresses into an explanation with potentially predictive qualities. Secondly, eliciting a broad range of data and analysing for relevance through open, axial and selective coding is a substantial analytical process. And, thirdly, *fit* and *relevance* procedures that fail to reinforce or relate to the final theory can cast doubt on its applicability to the subject under study, subsequently defying the essence of a grounded theory – that it is grounded in, and recognisable as, a reflection

of the participants' contribution. A definition that typifies grounded theory is offered by Kerlinger (1973).

> *A theory is a set of interrelated constructs (concepts), definitions and proportions that present a systematic view of phenomena by specifying relation among variables, with the purpose of explaining and predicting the phenomena.* (Kerlinger 1973, Page 9)

Glaser and Strauss (1967) make a persuasive argument that systematic analysis of empirical data will be more revealing than deduction and speculation. The key, they suggest, is the use of a comparative method of analysis and constant comparison of theoretically sensitive samples.

Constant comparison consists of discovering basic conceptual elements in the data and comparing for similarities, and dissimilarities, of the events or situations (incidents) discovered. It elicits concepts and carefully analyses them using a series of coding techniques, open, axial and selective, enabling substantive theory to develop and propositions or hypotheses to emerge which then form a framework for theoretical comparison.

When categories or concepts are linked, through axial coding, the most significant concepts stand out. Deciding on which of these concepts constitutes the core and major categories requires further analysis. The open coding therefore serves to identify preliminary themes. Axial coding encourages themes to be analysed for overlap and connection (i.e. is there a commonality or axis on which the themes meet or pass). Selective coding, once convinced of the validity of the major category, promotes theoretical sampling to discover the depth and breadth of the category. On fathoming this, theory becomes more prominent.

An example chosen to illustrate a tentative category or variable and how it links to a theory follows. This process is applicable to all salient themes.

Figure 3. A Tentative Core Category

```
┌─────────────────────────────────────────────────────────────────────┐
│                                                                       │
│         Concept – 'using drugs to feel good'                          │
│                          │                                            │
│                          ▼                                            │
│  Cross-cut with other incidents / categories – 'avoiding drugs to     │
│                 avoid mental health relapse'                          │
│                          │                                            │
│                          ▼                                            │
│      Frequent regular occurrence of concept within several categories │
│                 denotes tentative core variable                       │
│                    /                         \                         │
│  The words of the participants  and researcher conceptualisation      │
│                       of the words                                    │
│           │                                      │                    │
│           ▼                                      ▼                    │
│  "It like chills me out                   "Self-medicating" of        │
│  and takes the edge off"                  anxiety/stress/tension       │
│                                           (Self-Medication            │
│                                           Hypothesis)                 │
│                                                                       │
│      Ready for selective coding and extensive theoretical sampling    │
│                                                                       │
└─────────────────────────────────────────────────────────────────────┘
```

What happened?

Where does this happen?

Why does this happen?

When does this happen?

How often has it happened?

Is it a negative or positive experience or both or neither?

Strauss and Corbin (1998) elaborate further and call this organisational scheme for analysis 'the paradigm'. What happened, for what reason and what reaction resulted contain important information related to the incident or category? Using a paradigm helps with structured analysis. It begins to explain the *conditions* in which the incident occurred, the *actions* or *interaction*s of individuals or groups involved and the *consequences* that result.

Understanding of the structure or conditions in which the incident above occurred (self-medicating, for example) constructs or adds to the explanation. The explanation develops into a theory with why, how, who and when, thus adding the predictive power that potentially translates to practice based validity.

Although grounded theory has a range of established methods and tools (see Figures 4 & 5, Pages 71 & 72) that are systematic in their application, they are not codified to the same high level of specificity as those used in quantitative methods. Remaining open to differences in views and experiences of participants would be difficult if a mechanical codified analysis technique were employed. It is important when applying either Glaser's philosophy or that of Strauss and Corbin that the researcher is sensitive to theoretical development, samples concepts accordingly, and analyses them within both the overall context and that of the individual participant him or herself. This complex process is simplified by Strauss who advises in an on line interview.

> *There are three basic elements that should be included in all grounded theory studies,*
>
> *(i) Theoretical sensitive coding, that is generating theoretically strong concepts from data to explain the phenomenon researched,*
>
> *(ii) Theoretical sampling, that is deciding whom to interview or what to observe next according to the state of theory generation, and that implies to start data analysis with the first interview and write down memos and hypothesis early and*
>
> *(iii) the need to compare between phenomena and contexts to make the theory strong.*
>
> (Legewie & Schervier-Legewie 2004, on line interview)

Rather than strict constant comparison it is possible to complete data collection and analyse it later, however, that fails to heed the advice of Strauss and Corbin (1998), and despite their later differing views, Glaser's (1992). Each promotes simultaneous collection and analysis with selective sampling. In most research a sample is identified in advance of data collection whereas grounded theory requires a purposeful sample at the outset that is reflective of the phenomenon with successive samples being influenced by the prominent emerging concepts.

Comparing each data incident is a constant process enabling, through accumulation of similar incidents, a weighty construct to emerge. Further sampling based on the emergent theory is then subjected to selective theoretical sampling. The principle underpinning theoretical sampling is to obtain greater illumination of the theory by matching concepts from older data and new, revisited or fresh, whilst also rescrutinising their dimensions and properties.

Deciding where to collect from was crucial and posed a minor dilemma. Glaser and Strauss (1967) suggest that all information should be considered data including field notes, informal information sources, newspapers, television, conversations and meetings. For both ethical and research quality reasons it is important to cite precisely the data sources, and since my role as practitioner-researcher has potential for overlap it was important to distinguish research interviews and focus groups from clinical activity that may ultimately become research field notes. High volume data collection was therefore confined, in the main, to interviews and focus groups, whilst field observation which was less dense complemented the analysis and theory development rather than underpinning it. In these circumstances the validity of consent was examined, as previously stated, within my research supervision, ensuring only data from service users who had consented to participate could be used, that it remained incidental and was not the prime focus within therapy. Data from clinical activity was informative but did not constitute the themes, rather it reinforced or refined themes emergent from the focus group or interview derived data.

Remaining reflexive was important in this respect particularly if new ideas or thoughts emerged from therapeutic work rather than research data collection processes. Here the significance of new ideas generated in therapy needed examination; were they new ideas or variations on existing ideas, were the ideas too much a deviation from the route my research analysis was taking or perhaps the new ideas were legitimate developments of an idea that had percolated for sometime only to be distilled within another context that contained critical cues? These questions were constant in my development of ideas and concepts, the defining line was that of originality and genesis, only by re-examining transcripts and early coding was I able to differentiate. Even in the absence of transcript information that reflected an idea I did not necessarily abandon it, I was more inclined to reflect on it in supervision and

re-compare several times. My aim was to avoid firstly the unethical inclusion of non research originating data and secondly promote research integrity by avoiding external bias. Ahern (1999) asserts the importance of utilising sources of support such as research supervisors and peers as crucial in the process of reflection and reflexivity. The subsequent exchanges enable research to be scrutinised from wider or alternative perspectives. Although this may be considered by some to introduce bias, on the other hand it encourages deeper analysis and, in my case, was invaluable in delineating my grounded theory ideas from externally generated or reassembled substantive concepts.

Therapy is a dynamic process and combined roles of practice and research in the same therapy field will inevitably lead to overlap. My initial concern that the two aspects would converge and be indistinguishable was unfounded in practice. Moreover the therapy side of my role, from which the inspiration to conduct the research came, provided ongoing inspiration and interesting information often conducive with my results or ongoing analysis. Discovering consistencies in research and practice, if Glaser and Strauss (1967) are to be understood correctly is validational providing that the researcher is aware of the sources of information; I would add that their chronicity is equally important. These measures were strengthened through re-reading transcripts containing the original memos that had identified particular categories or concepts in question.

In conclusion, grounded theory development requires key themes to be identified, then, through systematic analysis, conceptual elements are linked and compared in order to demonstrate their fundamental similarities. These similarities characterise new and old data which are then selected for further coding and theoretical sampling.

Substantive and Formal Theory Generation

A concept should be understandable and analysis should reveal its firm character. The characteristics of one concept may exist in other concepts, whilst the concepts in their entirety may be considerably dissimilar. For example, the categories 'Role of Substances' and the 'Level of Knowledge about Drugs' are two distinct categories which share certain properties, one such property being the sustained use of a psychosis exacerbating substance, like cannabis, to relieve distress from auditory

hallucinations. Glaser (1978) suggests the value of identifying comparable characteristics enables substantive theory to support the development of formal theory. This assertion was encouraging for me since it promoted theory of an empirically substantive nature (what was helpful and unhelpful) which then posed further questions. The development of a formal theory explaining dual diagnosis would be the result of cumulative research rather than a single study such as mine.

The link between substantive and formal theory in dual diagnosis would be satisfying for readers. This study provides substantive theory of immediate and practical relevance whilst also contributing to wider formal theory development beyond. The purpose was to provide useful information to service users, carers and practitioners. The substantive theory was therefore expected to provide an underpinning principle or set of principles on which any information would be based. The substantive theory *Help* is discussed later in Chapters 4 and 5.

Product Development

Aiming for an outcome of a physical nature from a grounded theory study, such as information materials for service user/carer education, raised challenging questions. Firstly it presupposes that an explanation and accompanying detailed information will emerge. Secondly, additional researcher pressure may occur in order to tailor the explanatory theory in a product format. Thirdly, a process of theory development might be governed by product grounds not for explanatory theory purposes. Glaser (1978) concerns himself less with the verification of theory process from participants and more with explanatory power to the phenomenon as a whole, providing incidents and concepts link adequately. This principle encourages adherence to methodology which in turn decreases the risk of the compromise alluded to above. In addition thorough research supervision, maintaining an awareness of potential practitioner-researcher role conflict and adherence to my research plan enabled the research process to run its scheduled course.

A final problem I encountered and adjusted for was the simplicity that educational or information material required in order to be 'user friendly'. How a complex phenomenon with multiple incidents can condense into a booklet of some form was conceptually challenging. However, in practice the refinement of theory through

theoretical sampling tested and retested the major concepts, and what they meant in reality to a person taking substances and experiencing mental illness. As a result, checking the accuracy of themes by returning to the same and similar focus groups and presenting the themes in story form with the product (booklet based information materials) in mind served as a user-friendly vehicle on which to locate concepts. This process was planned; however it was unexpected that the corresponding concepts of theory development and information materials would integrate so well.

Over two years, four booklets were developed. A central illustrated character for each booklet was devised who possessed an amalgamation of key issues from within the data. The characters were orientated around common diagnoses and substance types to resemble the participants' clinical presentations. The illustrated characterised storylines were the vehicle for conveying (i) the essence of help, as defined by the studies *Help* theory and (ii) the practical and helpful actions, advice and issues contained within the data.

The information materials are presented and discussed in Chapter 6; Outputs.

Method

This section of the chapter sets out the procedures I followed in collecting and analysing data. It describes coding and how coding operated in tandem with the theoretical sampling and constant comparison of both participant groups *and* data. The coding strategies I employed are illustrated by example and description. The major categories are identified and how they guided theory development is explained.

> *In keeping with the foundations in pragmatism…grounded theorists aim to develop fresh theoretical interpretations of the data rather than explicitly aim for any final or complete interpretation of it.* (Charmaz 1983, Page 111)

Despite the organised structure grounded theory provides, the research process and that of theory development is relaxed and unforced. The fundamental rules of grounded theory deter the researcher from making early interpretations that might lead to inaccuracy. This allows the data to accumulate in greater density and volume and eventually reveal the authentic credible themes.

Ethical Approval

Local Research Ethics Committee (LREC) approval was granted in September 2004. Approximately six months prior to this the research study was registered with Manchester Mental Health & Social Care Trust (MMHSCT) Research Committee and ethical approval to proceed obtained from the University of Salford.

In July 2005 I obtained further permission from the LREC to have an illustrator present at focus group interviews. This was granted as per the Committee Chairperson's decision and required that a) the illustrator holds a contract with the service provider from whom participants receive treatment (an MMHSCT honorary contract was arranged) and b) no other methodological changes to the study took place.

Annual research reports were submitted, conditions relating to data collection and its storage adhered to, and submission of a final research report, once the study was completed, agreed.

Recruitment of Participants

To recruit service user participants the study was advertised at a local mental health inpatient unit, a substance misuse day treatment centre and across a range of community mental health services (Appendix 5, Page 356). This took place in October 2004. Carers and practitioners were recruited from local voluntary sector mental health services, the substance misuse day treatment centre and local housing and resettlement services.

Recruitment comprised of circulating research flyers and making requests to conduct research recruitment seminars at team meetings. Following team meetings or from enquiries resulting from the recruitment flyers, letters of invitation were sent to potential participants who had expressed an interest (Appendix 6, Page 357).

Participant Information Sheets (Appendix 1, Page 266) were provided to all potential participants and their carer or key worker where applicable. Written consent was obtained however in the case of service users their capacity to give consent was

checked. This was supplemented, as stated previously, by an explicit constant consent process to ensure participants did not feel coerced into remaining in the study.

Interview and focus group dates, times and venues were organised and conveyed to participants in writing. In the case of inpatient ward based focus groups several service users expressed a desire to participate on the day the focus groups were conducted. These participants received the same information, and followed the same process for participation, as people who had agreed well in advance. Service user participants received a £10 payment for each occasion they contributed. Travel expenses were also met.

Collection of Data

Participants were interviewed and also invited to join focus groups. Interviews commenced in December 2004 and continued until September 2005. Twenty-six interviews were held, 18 with service users, 2 with carers and 6 with practitioners. Of the 18 service users who took part in individual interviews 12 also participated in the focus groups. A further 16 service user participants contributed to the focus groups but did not choose to attend individual interviews. The focus groups were held between February 2005 and September 2005. Participants involved in the focus groups attended on several occasions (for details see Table 7, Page 68).

Individual interviews and focus groups were audio taped and transcribed on to a Microsoft Word document. One individual interview participant did not want to be taped but agreed to written notes being taken.

Field observations were recorded and noted in memo form during collection and coding phases. In the later focus groups, comments about the form and structure of the information materials were noted and used to produce mock-up booklets for the later refinement and final draft stages.

In total data consisted of field notes, transcribed audio tapes (individual interviews and focus groups) and observations of interaction and behaviour. The latter being a necessary component of the booklets in order to convey the thematic content in a realistic fashion. By this stage the format for information materials had been devised

(illustrated short stories in booklets). Transcripts contained the bulk of the data from which the themes emerged. Field notes and later literature searches, both general relating to the field of study and specific to the information materials, supplemented the analysis and thus theory development.

Interviews

Individual interviews were unstructured and conducted by me alone. Participants were asked to say anything they felt was interesting or important about their experiences relating to mental health problems and drug use. Where necessary, for instance, if a participant was unable to talk freely or spontaneously, prompts of a general nature were given. For example reminding them about dual diagnosis and asking how, if at all, they had been affected by it. On establishing a rapport the conversation was mainly led by the participant. Both participant and I were aware of the subject matter and purpose of the interview therefore deviation was rare. When deviation to another apparently unrelated topic occurred participants were asked why. Usually a good reason was given and the logical connection described, often revealing the breadth and depth that drug use and mental illness had generated within their lives. A typical example might be family breakdown or disharmony. The interview format was therefore justifiably unstructured with the meandering stories providing greater contextual and historical information about experience. The themes therefore were anticipated to be participant led and subsequently informed by the participants' sense of salience, not mine.

Focus Groups

Similarly the focus groups were unstructured, however confidentiality and other ground rules concerning conduct, politeness and respect for fellow participants were highlighted. All but one of the focus groups included the information materials illustrator who also participated in discussions in order to obtain a clearer idea of the context and activities he was expected to depict. Nine groups were held with participant numbers between 2 and 7 for each. They therefore appeared small enough not to exert additional social inhibitions and as they were also conducted in ward areas (and one on the day treatment unit) participants seemed familiar with each other which may partly explain why discussion was usually free flowing. The groups were audio taped. Written notes were made after the groups had closed, these were usually

brief and in memo form to describe ideas or themes that appeared important and would be considered during transcript analysis.

The groups formed and discussion topics evolved as themes were identified. Subsequent focus groups became more structured as a result. For instance the themes relating to what participants found helpful (e.g. harm reduction orientated advice) were described, then written down and presented in illustrated stories for focused comment and discussion. The lifestyles, drugs used, and the helpful or unhelpful experiences began to take form. Focus groups therefore became a source for constant comparison of data themes as well as adding to the overall credibility of findings and output of information materials (Booklets; Appendix 3, Page 271).

Table 7 below provides an overview of data collection sources. Analysis commenced one month after the data collection commenced. The following section describes the data analysis procedures and elaborates on the overlap between aspects of recruitment, collection and analysis.

Table 7. Participation Rate

Participants	
Service Users	34
Carers	2
Practitioners (one was also a service user)	6
Total Participants	41
Individual Interviews	
Service Users	18
Carers	2
Practitioners	6
Total Individual Interviews	26
Focus Groups	
Focus Group Participants (who also participated in individual interviews)	12
Focus Group Participants (did not participate in individual interviews)	16
Total Focus Group Participants	28
Total Groups	9

Analysis of Data

Transcripts were analysed manually. Open coding revealed 12 main categories which were then analysed using axial and selective coding techniques. The main objective was to use a structured form of analysis to the mass of data, this involved the

application of several analytical strategies (see Figures 2-6). Open coding was the first distinct step. Further coding (axial and selective) was an integral, and simultaneously conducted element to analysis that enabled constant comparison of ideas, themes and explanations to take place.

Open Coding

The initial categories emerged from open coding. This process identified events and occurrences within the data that appeared distinct, recurrent and inter related to other happenings or incidents. Open coding was the initial stage of analysis which revealed salient themes. The themes where conceptual and practical in nature and were labelled as categories (see Table 9, Page 90). Below, Passage 1 illustrates how the presence of themes was recorded using colour coding (Table 9). The second passage provides an example of line by line microanalysis generated ideas which were then recorded as memos. Square brackets ([]) denote the category title. Emboldened text denotes microanalysis and memos. Names of all participants have been changed to maintain anonymity.

Passage 1: Open Coding

Mark   *So what happened then after you locked yourself in?*

Noel   *Erm, I shut myself up from most of my friends. One guy used to come round… a lot of em called, but I was more like (telling me mam) I wasn't in and that, cos I didn't know if I could trust* [Impact on behaviour / Life]. *I was coming up with mad scenarios in my head and if I spoke to my friends from school them, they'd think, they would think you're fucking mad YOU'RE MAD!* [Explanations for my Condition from other People] *and like it wasn't madness to me, it was real to me and I started to like lose trust in all my friends even though they were telling the truth saying you're fucking mad* [My explanation for my condition]. *But they weren't telling me to stop the drugs, they were all young. They weren't (inaudible) know it was the drugs even they just thought I was off my head,*

and they were coming in here when I was 15, I think I was 16,
but I was a bit wiser and I was painting on doors. [Things that
have not helped].

Passage 2: Line by Line Microanalysis and Memo

Mark   *Can you tell me a little bit about your overall use of*
                drink or drugs and what you found good about that?

Karen   *It stopped the voices.*

Mark   *Okay. What was it you found useful then in terms of*
                stopping the voices?

Karen   *It give me something else to think about, so...*

Microanalysis - *It give me 'It'* – an entity, *gave* – provided something, *me* – personal to Karen. These three words suggest a relationship perhaps between the drug and Karen. *It*, the drug, appeared to have imparted something to Karen to be grateful for.

Memo – is this another theme or category? That a RELATIONSHIP WITH A DRUG develops and the drug starts to be seen as an entity of its own. If this is so, upon abstinence, an individual may lose the effects of the drug *and* the relationship. Is this significant? Is there a relationship between participant and drug? If so then what implications for loss, separation, substitution or replacement exist?

Early analysis was therefore a crucial platform that generated categories upon which to base axial and selective coding.

Axial Coding

Axial coding enabled the accumulation of related incidents to be compared. The comparisons and differences of incidents within the same category subsequently revealed the extent of the depth and breadth of a category. Axial coding was the

process that explored linkages and cross-cutting properties. An example of the greater depth axial coding provided is exemplified in Figure 4 below.

Figure 4. Axial Coding: Identifying a Property

Concept – Using drugs to feel good
Category – 'Role of Substance'

↓

Cross-cut or relate dimensions of individual incidents

↓

2 levels of analysis happen here

The words of the participant   My conceptualisation of the words

↓   ↓

"It like chills me out and takes the edge off"   *"Self-medicating"*
(Self-medicating is a subcategory of the category 'Role of Substance')

↓

Where does this happen?
Where else does this happen?
Why does this happen?
When does this happen?

↓

(The answers started to reveal other incidents in further categories for example 'Levels of Knowledge of Drugs / Alcohol')

↓

Apply 'Properties and Dimensions Matrix' (Dey 1993) to Concept (see Figure 5)

Figure 5. Axial Coding: Properties and Dimensions Cross-Cutting Matrix
"Diagrammatic displays are not just a way of decorating conclusions; they also provide a way of reaching them". (Dey 1993, Page 192)
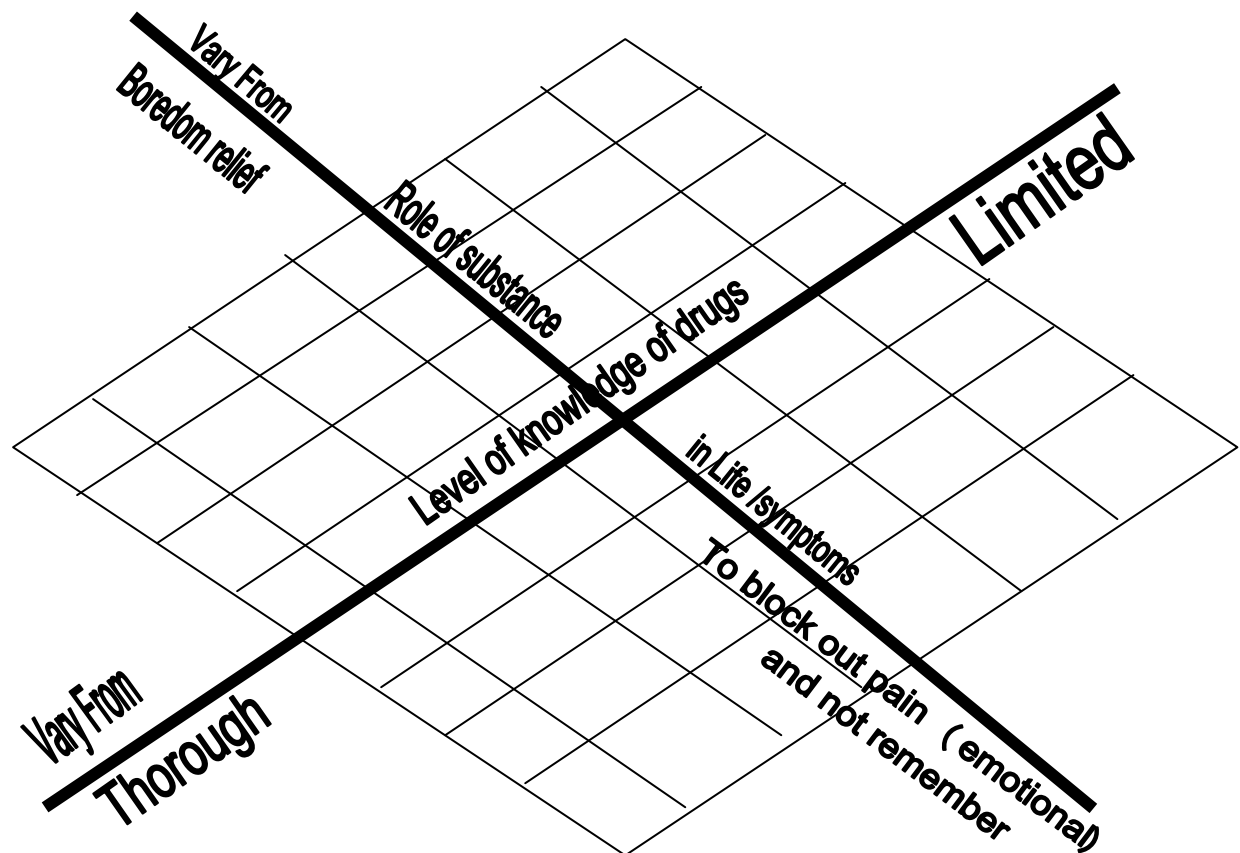
A cross over between categories occurred enabling the important connections between categories to emerge. In Figure 5 participants required knowledge about the effects of their drug in order for the role to be performed. Examining the dimension (size and extent) of *knowledge* revealed potential risks (opiate overdose and respiratory depression) and successes (*role*). For example experiencing the blocking out of emotional pain by using heroin reinforced the *role* of the drug whilst lack of knowledge about potential overdose increased mortality risk.

This example illustrated the variable levels of drug knowledge (limited to thorough) and drug role (boredom to emotional pain relief). It superimposed the category 'Impact on Behaviour and Life' upon the category 'Role of Substance' continuum.

Axial coding was therefore a strategy that used the shared properties of different categories to reveal their connections. Through the identification of shared properties the categories, whilst discreet in a conceptual sense, were exposed and reconstructed as interdependent.

This process was repeatedly applied. Categories were deconstructed into properties and where possible, dimensionally. Deconstructing concepts is a pivotal procedure in grounded theory in order to avoid prior ideas and understanding to dominate concept development. For the practitioner-researcher it is impossible to totally bracket off previous experience as research 'incidents' cluster into categories, but the process of deconstruction can help to differentiate the incidental related concepts from previous conceptual understanding developed elsewhere, consciously and subconsciously as a practitioner. Bringing my knowing into the study had substantial value as I discuss in the following pages, however it can be disadvantageous; it was necessary to identify what *was known* in order to identify *new knowns*. Chenail and Maione (1997) reiterate the advice of Glaser and Straus (1967) in that ahistorical positioning of the practitioner-researcher is improbable and as such deconstruction of all elements salient in a concept followed by their reconstruction will enable integrity to remain intact. Dervin (1992) couches this in deferent terms which add to the quality of grounded theory research by adding a second dimension, not only does the deconstruction and reconstruction assist the researcher to differentiate their ideas from data generated concepts but it also stimulates the analytical climate by challenging popular or accepted opinion. This Dervin calls 'sense-making remade'. The challenge of such opinion or position lays at the heart of many a research project; the words of John Stuart Mill (1859, Page 105) come to mind referring to the error inherent in *"the deep slumber of a decided opinion"* for which much inspiration through this labour intensive analytical procedure was taken.

The reconstruction weaved the categories back together but only after insights, relationships and contradictions had emerged. The context from which they emerged and any cause, effect or intervening properties added to breadth and depth. The deconstruction-reconstruction of categories was therefore a process that encouraged understanding of the subject matter. With such understanding a theory underpinned by the major and core categories developed.

Selective Coding

Axial coding revealed a core category of drug use in mental illness. This was a consistent and overarching activity present in, or directly related to, all categories. The categories related to help or helpfulness were dominant. Major and core categories are discussed in depth later in the Findings and the Discussion chapters, however their identification enabled selective coding to take place. Selective coding consisted of picking up threads that appeared connected to the major categories and subjecting them to further analysis including axial coding. I then searched for incidents that distinctly related to the major category with the aim of moving from conceptual understanding to a practical explanation; a substantive theory.

The analytical procedure of coding incorporates constant comparison of themes. The coding and theoretical sampling took place jointly. Sampling relied upon my sensitivity to incidents or constellations of incidents that would reveal issues relevant to the main categories. Sampling was therefore guided by emerging theory. As the categories grew in depth and breadth but not number I knew I was reaching a point near to data saturation.

The central categories presented and discussed later, contained key issues that encouraged hypothesis led analysis. I was guided by Strauss and Corbin's (1998, Page 147) criteria for choosing the major categories (helpful and unhelpful incidents) which in summary consisted of the following;

- It / they must be central and relate to all other main categories.
- Must appear frequently
- Must be logical and consistent in property and dimension.
- The label or name given must be sufficiently abstract to be used elsewhere
- Must possess a concept that has grown in depth and is explanatory
- Must be able to explain variation

Thirty-five transcripts in total were made, after the analysis of 26, saturation had occurred. The remaining 9 were listened to and memos written where appropriate in order to (i) discover any new themes, (ii) confirm saturation had occurred and (iii)

identify relevant information relating to the existing themes. Five service user interviews, one practitioner interview and 3 focus groups transcripts were analysed in this 'scan and focus' manner (Strauss & Corbin 1998). Whilst new information was not apparent the process ensured that all data had been subjected to inclusion and analysis.

Methodology Discussion

Grounded theory was an appropriate methodology for two reasons. Firstly it promotes conceptual development from raw data and secondly encourages theory to emerge (Glaser & Strauss 1967). Both aspects were consistent with my practice experience whereby the limited evidence base available in dual diagnosis led me to rely upon professional intuition and creativity. An example of this is the application of substance misuse treatment protocols within mental health settings and *vice versa*. The principles of grounded theory support intuitive data collection and analysis but discourage initial hypothesising.

The 'Research Plan Overview' (Figure 2, Page 34), provides a coherent and uncluttered research framework. This was useful because grounded theory is a complex methodology that unearths vast amounts of descriptive data. I therefore found Strauss and Corbin's (1990) structured approach to be essential because it allowed me to organise data and categorise emergent issues whilst maintaining their descriptive qualities. The descriptive qualities were then examined in more detail, identifying properties and dimensions, overlap and similarities. The advice from Glaser (1992) was integrated too, he emphasised the importance of allowing conceptual meanings to emerge rather than forcing them out. This tempered my research analysis by encouraging me to be patient; by drawing conclusions prematurely I would have compromised both the integrity of the data and grounded theory principles. I was therefore constantly comparing concepts, and despite the absence of a major 'breakthrough' was reassured that significant findings would surface.

Choosing grounded theory enabled me to conduct research in the setting that I worked. The emphasis placed by my organisation upon my role as a consultant nurse

to conduct and disseminate specialist role related research put me firmly in the position of practitioner-researcher. There exist two counter views that I considered important here and found useful in delineating these two elements of my post. Zeisel (1984) warned that practitioner-researcher was open to bias because of the problem solving nature a practitioner might hold. Robson (2003) however highlighted the practitioner-researchers' location within practice as providing insights and opportunities external researchers lack. In terms of my research the compelling desire to generate meaningful results or solve existing practice problems was not prominent and this enabled me to exploit my insider knowledge without compromising methodology.

Utilising the guide ('Pros & Cons of the Practitioner-researcher Role', Table 5, Page 41) constructed specifically to manage insider research issues enabled me to address specific problems. I anticipated that performance within the operational aspect of my role would be more visible than the impact of my research role. To counter what I perceived here to be organisational pressure, I participated in local research and development endeavours, such as policy development, committees and a research interest group. As a result implicit reinforcement of my research role was generated; this relieved operational pressures and helped me preserve dedicated research time. My research role was therefore elevated to an activity equal in importance to operational work. The processes involved in negotiating protected research time remained challenging and the quality of relationships within the organisation varied but I remained conscious of the necessity to retain sight of my research goals. A study by Van Heugten (2004) introduces the concept of countertransference within the researcher, whereby the relationship with participants and / or organisation can become confused to the researcher. I found grounded theory from the inside required critical self-analysis much of which occurred through the research structures I had in place such as supervision. Coghlan and Casey (2001) provide pragmatic advice which was constructive and enabling for me; they described the multilayered and political nature of health organisations and its impact on insider-researchers. This heightened my awareness of the processes involved in research and any potential change as a result. It stimulated a stronger sense of my position within the organisation and enhanced my commitment to the research study and methodology. In short, the maelstrom of operational practice and service delivery was countered by i) adhering

to my research aims and methodology and ii) maintaining and protecting the research function of my role.

Grounded theory, was suited to the accumulation of vast amounts of data that required time and patience to deconstruct and build theory from. The detailed micro-analysis to discover initial meanings and the powerful personalised statements that were coded for categorisation contained a depth of human experience that I was confident would bear fruit. Subsequently, the methodology, whilst providing a framework for large amounts of data to be collected also provided the structure to organise it. The process of data collection and analysis became virtually parallel in order to accommodate constant comparison. The duration of data collection and analysis was not foreseeable at the beginning since saturation of categories is an unpredictable state. Any anxiety about insufficient or matching data incidents was proved unnecessary as saturation was approached.

Some authors have utilised grounded theory case studies (Yin 1994) and suggested prior development of hypotheses to be essential. Glaser and Strauss (1967) suggest the opposite and encourage preconceptions to be kept to a minimum by avoiding literature and policy. Dey (1993, Page 66) says that prior information is *"accumulated knowledge"* implying that it is valid and not compromising to collect relevant information before data handling. I recognised that my background knowledge in the specialist field of dual diagnosis was in fact largely responsible for me being in the position to undertake this research. It was not possible or desirable to seek to prevent my knowledge playing a role in the research process, however, I became equally aware that research interviews were revealing either new ideas or presenting known ideas in a new way. As a result I was open to new concepts and my existing knowledge merely complemented the merging of prior and new information. I found this consistent with the premise that grounded theory is an inductive approach utilising social processes and phenomena to inform emergent theories. Failing to acknowledge background information about dual diagnosis, sociology and mental health would render me less informed about the psychosocial processes of helping, inclusion, and motivation for instance. My decision to conduct a general literature review initially, followed by a comprehensive review during summative analysis therefore proved the right thing to have done.

There are dangers inherent in grounded theory research that relate to demonstrating rigour and validity. These concepts are highlighted in Chapter 3, Methodology, but there is value in raising them again. The fidelity of the study requires that theory is recognisable as originating from the data; however the testing of this rule is performed mainly by the researcher who is open to interpretative bias. My critical concern was subsequently that theory was truly grounded in the data and not a result of subjective deviations. Thomas and James (2006) articulate similar concerns and although they attribute poor theory development to the grounded theory procedures I found the opposite. The procedures of coding and constant comparison leading to concept formation are examples of strategies that enabled me to both organise data and make interconnections within the data itself. I viewed the adherence to analytical procedures as adding to the validity of theory not diminishing it.

The theory of *Help* is substantial in that it converts the experiential sense my research participants described into information with practical utility. Grounded theory methodology enabled this development because the organisation of data and analysis procedures it advocates was rigorously followed. The danger identified by Hammersley and Atkinson (1983) of over emphasising symbolism was addressed successfully through constant comparison. The critical concern, and identified by numerous researchers (Lonkila 1995; Robrecht 1995), was this link between data and theory. Was it tenuous or sound? By finding the cross-cutting themes that repeatedly demonstrated their conceptual connections I was able to develop key concepts and theory. The constituents of my theory were therefore recognisable in the initial categories and *Help* theory as discussed in Chapter 5.

Chapter Summary

This chapter has provided the rationale for a grounded theory approach to eliciting and analysing views on dual diagnosis that would reflect participant experience. The research context has importantly illustrated the need to be mindful of conflicting advantages and disadvantages of practitioner-researcher roles. I have however described mechanisms to safeguard and capitalise on the context without being compromised in either role.

The selection of a grounded theory, with flexibility and an emphasis on a method that would draw out the qualitative experiences of participants was justified. The outputs of both theory and information materials were outlined and detailed presentation of methodology presented, including the use of reflexivity as a research enhancing strategy.

A discussion relating to research quality highlighted the grounded theory tenets I employed to maintain research rigour and meet the demands for representativeness and generalisablity of the findings. A systematic data collection and analysis process that included focus groups and individual interviews was developed and discussed. Furthermore, detailed analysis techniques of coding, memoing, theoretical sampling of themes and participants, demonstrated the practical application of a constant comparison form of enquiry.

The final sections described and discussed implementation of the method. At open coding the concepts initially related intuitively. It was later in the analysis process that constant comparative strategies revealed substantial themes. The reflexive response helped me digest and synthesise the data gradually.

Categories were deconstructed and their properties (characteristics) and dimensions (duration of occurrence, breadth and overlap with other themes) examined in order to discover cross-cutting themes. The cross-cutting effect uncovered inter-relationships between categories and subcategories that led to multiple hypotheses. These hypotheses were then used to explain or dispute particular points. A broader or general hypothesis was not sought since it would have been unable to accommodate the multitude of emerging concepts.

Figure 2 (Page 34), the 'Research Plan Overview' illustrates that data collection and analysis were continuous parallel processes. Concepts formed at the coding stages were then developed further when subjected to theoretical sampling. Core (the context and activity related to drug use in mental illness) and major ('Help' in dual diagnosis) categories were stripped of their detail to form an uncluttered substantive theory about helpfulness in the context of dual diagnosis. In other words analysis led to a theory

that focussed on an important and partial explanation for what was happening in the lives of people with a dual diagnosis.

I have discussed the methodology employed and cited key qualities that a grounded theory approach provided. A combination of both the fundamental approach and the later modified and structurally confined approach was examined and justified. My role as an insider, or practitioner-researcher, was elaborated upon to generate a sense of the atmosphere and climate in which this study was conducted. I argued in support of the advantages this dual role offered. Despite the unstructured processes of data collection I concluded that the wide range of information was managed and refined, through to theory development, by rigorous adherence to constant comparison techniques. Grounded theory therefore proved to be highly compatible with the research purpose of producing information materials and developing theory based on service user experience.

Theory generation and product development were linked as two final stages of data analysis in order to complete the research study and meet the study objectives. The findings from which they emerged are presented in the following chapter.

CHAPTER 4. FINDINGS

Introduction

This chapter is in two parts. Part 1 presents the results from open, axial and early selective coding to form 12 categories and summarises their significance. The data from the first analysis phase then informed selective coding and theoretical sampling in a second phase described in Part 2. The progression from 12 key categories to the detailed understanding of the findings and how a theory based on the concept of 'Help' emerged is then presented.

The properties of 'Help' constitute much of the information contained within the information materials therefore a brief introduction to the service user information booklets is provided. The anonymised stories of four participants, named David, Martha, Jason and Geoff (aka God) that began to emerge at this stage briefly appear. The characters within the stories were developed beyond the individuals themselves to incorporate the relevant experiences of *all* participants. They act as a focal point upon which the categories cross, overlap or converge. The stories were completed following further analysis of the major categories related to *Help* but are introduced here to illustrate how the translation process of data findings to an information product commenced.

Transcript quotations of participants are in italics, indented and anonymised by the use of pseudonyms. All undesignated quotations are from service user participants. All carer or practitioner participant quotations are labelled as such. Additional contextual information concerning the quotation source is provided where necessary, for instance when taken from a focus group. Focus group participants whose identity at transcription was unclear are labelled 'anonymous'. Where applied, the term drug use / drug taking includes the misuse of alcohol.

Part 1: 12 Categories

Table 8, below indicates the participant demographic and health data collected during the research study and is valuable in contextualising the findings in a number of ways.

Table 8. Demographic and Health Data of Service User Participants.

Item	Number
Age	
21-30	12
31-45	9
46+	9
Sex	
Female	4
Male	26
Ethnicity	
White British / Irish	17
Black British	9
Black Caribbean / African	2
Asian / Middle Eastern	2
Main Substance	
Cannabis	10
Opiates	3
Alcohol	12
Stimulants	5
Level of Substance Use	
Abstinent	9
Occasional	2
Abuse	17
Dependent	2
Main Mental Health Diagnosis	
Schizophrenia or Schizo-affective Disorder	18
Bi-polar Disorder	2
Depression / Anxiety	10
Duration of Substance Use	
< 2 Years	2
>5 Years	28
Duration of Mental Health Problem	
< 2 Years	3
> 5 Years	27
Suicidality	
Past	19
Current	3
None	8
Criminal Justice Contact	
Past or Present	16
None	14
Homelessness	
Past	7
Current	5
None	18

The information does not readily prove generalisability however themes and categories are given added resonance in light of the discussion that accompanies this data. The demographic and health related data was collated from the profile each participant presented through transcripts and observation, and information from the recruitment referral forms completed either by participant or their key worker. Subsequently of the 34 service user participants 30 data sets were complete; this amounts to adequate information for discussion purposes however does not constitute generalisability in the strict quantitative meaning of the term.

The information concerning ethnicity is notable and warrants further consideration. The UK is a multicultural society with 7.9 % (4.6 million) of the population being of Black or Minority Ethnic (BME) origins (OPCS 2001). In England it is 9%, half of whom live in established metropolitan areas of London, Manchester, West Midlands and West Yorkshire (Balarajan & Raleigh 1992). The cultural breadth of BME populations is reflected in a heterogeneous variety of values, attitudes, beliefs and behaviours not always consistent with Western medicine (Rassool 1995). My study reflects such cultural diversity but in addition demonstrates the over representation of BME prevalence in mainstream mental health. This begs numerous questions of an explanatory nature as well as questions leading to specific solutions. Certainly the latter sphere indicates the need for culturally sensitive services staffed by culturally competent workers. Mental health services, like substance misuse services are struggling with both these aspects of diversity. Access to mental health services is lower across the BME population yet representation higher in specific groups, mainly Mixed / Black British, and Black African or Caribbean (DH 2005). To add to these issues in mental health settings the Advisory Committee on the Misuse of Drugs (ACMD 1998) reported that ethnic groups are marginalised by the injecting, rather than smoking, focus taken by drug services. UK drugs policy (DH 2006a) is emphatic on this point demanding local Drug Action Teams follow race legislation and employ approaches to maximise engagement with their residing BME populations.

The absence of focus upon drug smoking coupled with the opiate related crime reduction agenda (DH 1998) conspire to exclude the majority of BME drug users whose preference is for non injectable substances, usually cannabis or cocaine / cocaine derivatives. This issue is gaining wider momentum and in deed the chief

concerns emerging from the DH 2005 report on the death of David Bennett are explicit in this respect. The individuals whom the report is referring to match almost half of the participants' in my study. The report expects mental health services to reduce BME compulsory detentions and violent incidents whilst addressing similar prison disparities and workforce cultural competence. In the absence of culturally sensitive drug services only half the equation looks set to be addressed, aspects of my study deliver information useful for non injecting service users and is culturally contextualised to reflect the ethnicity concerns cited above. However it is limited for a variety of reasons which are discussed later in the thesis.

The poverty of literature on this combined issue of dual diagnosis and ethnicity has been reported by Wright *et al* (2000) in a government commissioned literature review. It remains though for extrapolation from substance misuse or mental health research to provide partial answers. The World Health Organisation (1994) found no psychiatric epidemiological differences across all ethnic groups therefore the anomaly of Black over representation in psychiatry for instance goes unanswered from a health point of view. Social explanations may be of value here such as the idea that symptom expression is more overt in Black African or Caribbean populations. Another explanation may be that BME groups due to their likelihood of experiencing lower socio-economic status (NTA 2003) are more susceptible to drug use, which then becomes an exacerbating or triggering factor in psychosis (Rassool 2006).

The association between stereotyped cannabis drug users (Rastafarians for example) and high prevalence of mental health detention in Black populations led to the commonly used, yet technically inaccurate, 'diagnosis' (label) of 'cannabis psychosis' (Harrison *et al* 1997). Sangster *et al* (2002) prove that cannabis is more prevalent in the Black African or Caribbean originating populations than others however this does not justify the labelling of an ethnic group in this way. Newcombe (2004) analysed all national mental health hospital admission data 1995 to 2003 and irrefutably concluded that misdiagnosis of cannabis induced psychosis was common, he suggested that acute cannabis intoxication (a shorter duration psychosis with spontaneous recovery within hours or days) would be a more accurate diagnosis and one less likely to escalate mental health statistics relating to race and detention. Capturing these issues through my research was appropriate. It required sensitivity and the illustration of

both forms of psychotic presentation. The debate and discussion adds rigour to the claim that my research is highly resonant to BME dual diagnosis populations. The issues are captured in growing research agendas and the policy guidance identified in this section. The workforce competence for all is evident from the culturally sensitive case worker to the admitting doctor or responsible clinician. The 10 Essential Shared Capabilities (DH 2004b) incorporate clinical and value based measures of competence and relate to this section, however they are discussed in greater detail later in the thesis because of their relevance to the presentation and discussion of the value and attitude based categories.

I have emphasised that demographic information emerging from my study is not statistically generalisable. On the other hand it does illustrate the significant presence of cultural diversity in the dual diagnosis population indicating that mental health and substance misuse staff need not be expert in all ethno-cultural groups but should possess an understanding, acceptance and flexibility that enables them to see the client as an individual whilst employing cultural sensitivity. My study findings demonstrate this need emphatically.

Psychosocial vulnerability of children and young people includes exposure to, and sustained use of drugs (Measham *et al* 1998). From my data it can not be argued that the duality of substance misuse and mental illness occurs later in life merely because the higher participant age range accounted for over half of the participants. It is interesting and of relevance that my study sample, comprising largely of inpatients, had been using substances and experiencing mental health problems for 5 years or more. This indicated the longitudinal nature of dual diagnosis. A larger sample using quantitative formulas for statistical analysis would probably reveal other pertinent factors beyond the scope of this study. One issue that I would anticipate emerging strongly and is supported by my transcript data is that substance misuse tended to start at an early age and preceded overt psychiatric symptomatology. I would not claim however that mental health changes were absent earlier, merely less prominent than the act of drug taking. In the transcript below Noel describes the chronology of his dual diagnosis.

Noel   *…then when I left primary school, the first night I left primary school I started on (gas) air freshener which I was on for five years. When I started high school erm, we were like (smack and weed), but gas was different*

Mark   *yea, what was it about gas that attracted you it, I'll try that?*

Noel   *Cos it made me feel different*

Mark   *How did you know it would make you feel different? Did somebody like tell you?*

Noel   *I was with a friend that give it me and said you'll trip but I didn't. But I didn't understand that at the time and I took some and I did trip….then I started high school met some other friends from high school from out of area and started taking whiz and pills, LSD*

Mark   *How old?*

Noel   *LSD, 11*

Mark   *….so is there any like, contact with psychiatric services or anything at that time?*

Noel   *No, not until I was erm, the first year of high school, I seen an educational erm, she was a psychologist, in first year…… when I was about 14/15 I started going to Sedgebourne, which was a school where he worked for behavioural problem children*

Mark   *Why do you think were into drugs?*

Noel   *Cos my friends were, just wanted to be part of the crew*

Mark   *Yeah. When did you first have contact with the psychiatric services?*

Noel   *When I was 15. Got brought into the A&E by police for painting on doors, on a 136....because I was painting all over doors, painting them and what, 27 colours whatever it was*

Mark   *Did, were you aware of anything being different, were you aware of....*

Noel   *Yeah, voices since I was 14*

As with Noel's, most transcript quotes come from male participants. Since the majority of focus groups took place in psychiatric intensive care units it is unsurprising that the gender ratio is marked in favour of males. As a result no firm dual diagnosis gender conclusions can be formed however it is notable that substance misuse is increasing among women (Macrory 2006). They are more likely to experience social isolation, poverty, sexual abuse or domestic violence (ACMD 2003), all factors that escalate substance misuse risk. In addition as most parental or carer roles are carried out by women the future landscape for dual diagnosis populations will inevitably expand. The significant future care considerations in relation to gender equal those of diversity and cultural sensitivity; these have immediate research as well as practice implications.

The final area of significance presented here and illustrated through the demographic information relates to homelessness, a key concern cited within the literature search (see Table 1). Current statistics revealed, that compared to other countries in Europe, the UK has one of the highest levels of homelessness with more than four people per 1,000 estimated to be homeless. The Alcohol, Drug Abuse and Mental Health Administration (1983) defined homelessness as follows: 'Anyone who lacks adequate shelter, resources and community ties'. However, homelessness comprises a variety of conditions ranging from actual 'rooflessness' to 'concealed households' (Fitzpatrick *et al* 2000). In my study homelessness was not specifically defined or asked about however it emerged through participant stories, its significance to each participant influencing its mention. Of the 30 full data sets seven had been homeless

in the past whilst 5 were currently so. Given that this information was emergent it is reasonable to suggest homelessness experiences were under estimated.

Consistent with gender and age figures previous research has shown that the majority of homeless populations are male, middle-aged and often poorly educated (Kemp 1997; Scott 1993). Furthermore, approximately one third of homeless people may suffer from mental illness and higher proportions were reported to misuse alcohol or other drugs (Drake *et al* 1991). Thus, the risk of dual diagnosis appears to be significantly higher among homeless people than in the general population. The stories from my research reflected this risk and the accompanying needs.

Supporting this, previous prevalence studies demonstrated rates ranging from 15% to 70% in the US (Ball *et al* 2005; Gonzales & Rosenheck 2002; O'Toole *et al* 2004; Reardon *et al* 2003;) compared to 47% to 57% in the UK (Gill *et al* 2003; Silverman 2006). Additionally, homeless people often have multiple physical problems, legal difficulties and suffer from social exclusion (Croft-White & Parry-Crooke 2004). Thus, homeless people can be described as a highly vulnerable group and therefore depicting their plight, and any harm reduction approaches that help, was essential.

The nature of homelessness makes these people a very difficult to reach population as they have often not only fallen through the net of housing but also health care and other support systems. Thus, the majority of homeless people may not receive treatment (Koegel *et al* 1999). For instance, Stark *et al* (1989) emphasised that nearly two thirds did not know where to get help. On a service level, negative attitudes towards homeless people, abstinence requirements and overall low levels of awareness regarding this population may build further barriers to the treatment of homeless dual diagnosis service users (Drake 1996; Drake *et al* 1991; Lauber *et al* 2006; McQuistion *et al* 2003; Osher & Lamberti *et al* 2001).

Delivering their care and support is a challenging task since homeless dual diagnosis clients tend to drop out of services easily (Stefancic *et al* 2004) and when in services such clients are associated with poor therapeutic engagement (Leal *et al* 1999). Reaching and retaining contact with the homeless dual diagnosis client group is a well

documented area of concern, my research participant profile has consistency here and in this sense the resonance produced for readers constitutes a form of generalisability.

The demographic and health data presented in Table 8 overall reflects the profile of dual diagnosis needs also cited in Table 1. These comparable data support my assertion that this research report and its information output (harm reduction booklets) are highly relevant to the dual diagnosis population currently associated with UK mainstream mental health care. The contextual scene having been established I now present the thematic findings, accompanied by their elaboration where necessary.

Table 9, Page 90, displays the 12 categories following open coding. Saturation had been reached and all 12 categories related directly to the core category (or study context) of 'Drug Taking' in mental health. This category seems obvious since the study is about drug taking and mental illness, however mental illness as an entity did not emerge to the same degree. Participants cited drugs (including alcohol) as their main activity and concern. Drug taking was perceived to influence their life in specific domains, as well as their general lifestyle more profoundly than mental illness did. Notwithstanding this, mental illness symptoms were an integral aspect of drug taking. The cross-cutting trends of mental illness and drug taking lifestyle weave in and out of all 12 categories to greater and lesser extents. It is through these connections that prominent themes appeared and core and major categories identified.

The core category 'Drug Taking' seemed to be the activity around which most concern was expressed, most issues arise from and the majority of activity related to. It was therefore categorised as the core category because it appeared to be the most significant aspect of participant's lives. It transcends all categories and subcategories. What arose from open coding was the sense of distress related to drug taking. Distress was linked (and is linked in the wider health field) to obtaining help and relief. The sources of help cited by participants ranged widely such as the use of a drug to relieve anxiety, talking to peers to feel less isolated, finding an explanation for the presence of distress, dealing with stress from childhood traumas, or blaming and projecting distress on to external incidents or society (see Table 9 for all 12 categories and their incident count).

Table 9. Categories by Number of Incidents

Cat No.	Categories	Total Incid-ents	Carer Int N =2 (of 2)	Pred Alc. User Int N =7 (of 9)	Pred Drug User Int N = 6 (of 9)	Pract-itioner Int N = 5 (of 6)	Pred Alc Focus Group N = 1 (of 1)	Pred Drug Focus Group N = 5 (of 8)
1	Relationship with Illness	24	3	9	3	7	0	2
2	Levels of Knowledge of Drugs / Alcohol	24	0	5	6	7	0	6
3	Relationship with Substance(s)	28	2	11	4	4	0	7
4	Explanations for my Condition/ Situation from other People	33	0	6	12	8	0	5
5	Policy, Service or Practice Development Issues	46	4	19	8	12	3	0
6	Significant Childhood and Adult Incidents	46	0	22	15	0	4	3
7	Impact on Behaviour and Life	68	5	28	10	5	6	14
8	My Explanation for my Condition / Situation	70	1	21	25	5	5	13
9	Feelings / Beliefs / Symptoms	95	5	22	25	6	9	28
10	Role of Substance(s)	113	0	28	34	8	11	32
11	Things that have not Helped	151	15	27	21	51	9	28
12	Things that Helped/ Might have Helped	247	12	83	57	55	21	19
	Total	**977**	**47**	**281**	**220**	**204**	**68**	**157**

Key: Pred = Predominantly

Int = Individual Interview

Alc = Alcohol

N = Number of transcripts analysed prior to saturation

(of) = Total number of transcripts

Two main categories emerged, 'Things that Helped/ Might have Helped' and 'Things that have not Helped'. Due to the unrelenting distress participants were under, much

of which arose from their dual diagnosis and its consequences, it is understandable that issues around relief from distress were prominent. The focus upon such relief through the concept of helping or not helping was conveyed in the sentiments of most participants, throughout most categories. This was evident when analysis progressed to axial coding and theoretical sampling as described below under each heading.

To understand the relevance of 'Help' conceptually, each category was analysed again for links with other categories. Also by labelling the two major categories above as one conceptual category I was able to select samples from the remaining categories that reflected help related issues. This was done in tandem with axial coding. Two simultaneous processes took place. One, the comparison of all categories with each other to discover similarities and differences across the range of categories and two, the theoretical sampling from all categories of the concept of help itself.

1. Relationship with Illness

Participants did not dispute that they experienced mental distress. They tended to recognise the distress as something that needed remedying. There was variability among participants as to the role drug use played in their mental distress. Did drugs improve their distress or worsen it?

Two positions appeared. Firstly, those participants that were taking drugs at the time of their participation in the study. They tended to deny completely, or accept minimally that drugs might be worsening their distress, or simply be so distressed that they would consume drugs in the 'hope' that some level of alleviation might result. This was despite them being aware of the unlikelihood of such an occurrence.

> *….with me I'll take any drug apart from crack and heroin yeah even if I was offered PCP I'd try that just to feel different I think, I think that's why, I don't know, even if I was ill now* (tape inaudible) *and I walked down the street and I met a friend who said do you want half a spliff and I know it's going to make me a hundred times worse I think it's just that I live in hope that it won't, that it will help it out.* (Inpatient mental health ward focus group participant, Noel)

The second position was held by those participants who had concluded, on balance and often after many years of drug use, that drug use definitely made their distress worse.

> *People say to me cannabis never harmed anyone, but it's not like that. It's damaging, especially to 'sensitive minds'. I started smoking it when I was 18 and it took me until my 42nd birthday for me to realise that cannabis makes you psychotic, it makes you scared and puts you on edge. It does your brain no good.* (Dylan)

Participants' relationships with drugs demonstrated an understanding or acceptance that the drugs were an external entity. They were easy to conceptualise and their place in their lives was understandable. However, mental distress or illness was less clearly defined or understood. The overlap between the two 'Relationship' categories (with illness / substances) was not marked. There was little evidence that participants held a relationship with their mental distress in the same way they did for their drugs. This was understandable since to have a relationship with something emanating from within is probably illogical or at least unusual. What was emphasised was the relationship between drug taking and mental distress. There was a cause and effect (mental distress →drug use →mental distress →drug use) pattern revealed that ran in parallel to the development of insight over time.

Table 10, Page 95, illustrates the accumulated experience of drug taking. The pattern starts at position one (Noel) and ends at position two (Dylan) as identified above. The middle ground is characterised by the gradual emergence of insight into the effect drug use has on mental distress. It appeared that in early-stage drug use the short lived positive effects (e.g. feeling high) outweighed the middle and longer-term effects (e.g. comedown, financial and relationship problems). Subsequently early-stage drug use was seen as justifiable in the absence of longer-term negative consequences. The middle and longer-term consequences were simply less evident because elapsed time was shorter. Middle and longer-term consequences accumulated to tip the balance in late-stage drug use. Insightful statements demonstrated this such as Bill's below where insight was dependent on the accumulated experience of the negative consequences.

Depression, feeling low and and that's when a lot of drinkers, a lot of alcoholics they do the same, they get to that point in life and they'll say ah! Enough is enough, to hell with it! (Community / Day Treatment Unit service user participant, Bill)

An anomaly appeared that initially was unexplainable. Mental distress was a significant factor in commencing and sustaining drug use at the early stages of many of the participants' drug use. But what happened to the mental distress when drug use, as a way of coping (position one), was abandoned (position two) as illustrated below in Table 10 Was the mental distress treated or managed in another way? Was the mental distress less marked? Had the participant found a new way of coping with mental distress? Had the mental distress become less marked by comparison with the accumulation of problems consequential to drug use?

It is therefore unlikely that a relationship here, between drug use and mental illness, can be found in a single explanatory factor. The relationship is one of constant movement, or probably one of constant growth. The concepts within this section and those shown in Figure 6 ('Deficit Management Model', Page 130) reveal a set of complex dynamics which are based on drug effect over time and the development of insight into the effects through accumulated experience. These are highlighted in Table 11 ('Mental, Physical and Social Signs of Distress', Page 118).

The strongest dynamic appears to be that of time. This was expressed by participants through their accumulated experiences, good and bad, of drugs, and there experience of the same effects (feeling less mentally distressed versus middle and longer-term problems as shown in Table 10 below, 'Accumulated Experience and Drug Taking').

The duration of drug intervention, regardless of its intensity, is positively associated with recovery (French *et al* 1993). Although retention in treatment is also associated with positive outcomes, the duration of exposure to drug intervention and information appears critical. Aligned with hopeful beliefs about treatment, recovery becomes more likely (Liese & Beck 1997). An additional factor, reliant upon the service-user's insight of their condition is of relevance here. When substance misuse is long-term, it becomes regarded as chronic and 'career' based (NCDP 1998), when substance users view their problems as long-term the process of recovery in turn

becomes a conceptual reality for the individual. This usually occurs after numerous 'failed' attempts at treatment or rehabilitation (Leshner 1998). An alternative explanation for the importance of the time continuum in effective drug intervention might be mere chance or probability. Eventually the individual is exposed to, or hits upon, an intervention that 'suits' him/her, but was not predictable (Project MATCH 1997). Notwithstanding either explanation for the impact of accumulated experiences, treatment or illness episodes, my findings demonstrate that eventually hopefulness and optimism become established concepts preceding and accompanying change. Harm reduction approaches to treatment and possessing therapeutic optimism are therefore fully justified concepts, expanded upon later in the thesis.

The decisions about reducing or stopping drug use were largely based on the participants' personal experience rather than someone else's experience. Some took longer to draw definite conclusions from their experiences than others. The fact emerged and remained indisputable; most decisions were based on personal learning.

It was important to retain this theme of personal experience and learning since it linked numerous categories effectively. It showed the importance of time and how learning and decision-making needed an adequate passage of time to have elapsed. The National Treatment Agencies 'Routes to Recovery' (DH 2009) uses a modularised treatment manual within which instructions about care planning being process orientated and in constant development are overtly expressed. Such assertions meet with those of DiClemente and Prochaska (1985) stages of change and of my own findings presented here. Recovery is a combined affair whereby present circumstances and opportunities are contextualised in and influenced by past experiences. If this is the case there is a strong suggestion that reducing or stopping drug use is inevitable albeit gradual. In treatment terms participants were suggesting damage limitation or harm reduction approaches, consistent with government policy and good practice as discussed in Chapter 2.

The outcome (stopping or cutting down), implied considerable experience and was expressed coherently. The in-between, the collection of experiences that led to such a decision, was less coherently expressed.

Table 10. Accumulated Experience and Drug Taking

Drug taking	Short term effects	Middle and longer term consequences	Insight / understanding position
Early Stage *Feel bad (mental distress)*	Feel better	None immediate	Position One
Early to Middle Stage *Feel bad*	Feel better	Unremitting depression. Lengthening duration of psychotic symptoms. Family relationship deterioration	Position One
Middle to Later Stage *Feel bad*	Less marked feeling of well-being	Depression. Persistent psychotic symptoms. Poor response to treatment. Isolation, financial hardship. Neglect and deteriorating physical health	Less convinced of Position One
Later Stage *Feel bad*	Less marked feeling of well-being undermined by accumulation of negative effects	Above consequences, plus greater in duration and intensity	Position Two

Below, Bill cited social and health reasons for abstaining from drugs. Simon recalled how a drug helped him cope initially with anxiety. These are representative statements about drug taking that convey an abruptness in the decision making process of participants. This reinforces the notion that an accumulation of negative experiences led to stopping drug use but the decision to stop was promptly followed by the deed.

> *Realising that er I can't drink successfully, I can't, I'm just a nuisance and I will get ill mentally and physically.* (Bill)

> *Anxiety made me drink but it didn't make me drink to excess, anxiety – it's illogical, heart pounding, thinking you'll die, you need a drink to take away that overwhelming feeling.* (Simon)

The relationship possessed three main elements; illness, distress and drug use. Distress was a strong mediating factor to greater (Bill) and lesser (Simon) extents.

This section has illustrated how maturation of the relationship led to insight and potential change. It has also alluded to how this process could be facilitated.

2. Levels of Knowledge of Drugs / Alcohol

This category was broad, it pertained to health and reducing the level of harm yet knowledge was predominantly poor. There are some reasons why knowledge of drugs is limited, take for instance South Asian community participants who spoke of poor access to services and subsequently poor knowledge of services and treatment. British models or indeed European and North American models relating to health and social well-being are not readily compatible with Asian cultural beliefs and models in which mental illness is frequently unrecognised; social care is confined largely to the family and drug use is taboo.

Comparing other categories within this group also reveals situations and circumstances that could be problematic in the uptake of help. The significance of cultural beliefs in explaining or understanding the feelings and symptoms related to mental illness or drug use was quite marked. Analysing such obstacles further across the range of categories illustrated the importance of knowledge as a gateway to either recovery, or in its absence, deterioration. Ultimately South Asian participants usually found help at times of major deterioration when bizarre behaviour or physical decline necessitated external help.

Knowledge about specific drugs is another example where deficits existed. Participants cited stimulants as a way to address their depressive feelings without considering the impact of rebound hypersomnolence or 'comedown' they create. When 'comedown' was addressed and managed it was through the use of cannabis, alcohol or benzodiazepines. Limited understanding of the depressant qualities of alcohol or cannabis was seen, and equally the addictive side of benzodiazepines was often underestimated or ignored.

The growth of knowledge frequently led to a desire to cut down drug use. The response from practitioners at these points depended on their knowledge levels. Service user participant views were expressed that showed a tendency among practitioners to know very little about a drug that was perceived as useful (drug use

being detrimental in every way was the prevailing perception user participants felt practitioners held). This was also demonstrated in practitioner attitudes whereby practitioners held the view that service users should be aiming for abstinence in order to benefit from their intervention. This conflict of user and practitioner philosophy permeated categories relating to the concept of help and to that of policy and practice.

> *I think it's the same syndrome as smokers, drug use, who do you go to, go to the GP?, when my doctor discovered I took amphetamine I was taken off his list.* (Sid)

Participants were not always experts on their drug(s) of choice. They knew how to obtain (score) drugs, knew street prices, availability and usually how to administer them - not always safely however. They knew the immediate effects from their subjective experiences but they knew less about the medium and long-term effects. An example of this was in the use of cannabis as a relaxant without consideration of the accumulative effect of cannabis as a cause of anxiety in long-term use. Another trend was that of alcohol use to lift mood. The short term euphoric effects were attributed to alcohol consumption but the later depressive effects were not. This met with the general trend among participants to value and understand the drug in a short time frame (the 'trip' or 'buzz') whereas the practitioner and carer participants were more inclined to view drug use over a longer time frame, focussing on the deleterious effects. These are further grounds for, and explanations of, interpersonal conflict or difference which cross cuts the 'Help' categories and the category of 'Impact on Life and Behaviour'.

In conclusion to this section there was a vast amount of knowledge to be held in relation to drug use. There were barriers which were cultural, personal or philosophical in terms of health beliefs, however ethnicity appeared to amplify significance. There was an understanding of the immediate benefits derived from drug use among participants which was not shared so obviously by carer or practitioner participants. The specific effect of a particular drug was usually conveyed in experiential ways but the objective scientific facts on health and well-being were mentioned less by the user participant.

A quote from one participant, a regular and frequent stimulant user, captured the two positions neatly showing that they may not be incompatible and illustrating that knowledge growth was important to user participants.

> *I'd like to know the safety of ecstasy you know, like make sure you've enough fluid in your body, like know not to overdo it when you're out.* (Daisy)

3. Relationship with Substance(s)

Service user participants described their relationship with drugs as a comfort or as a medication however the non-chemical interaction between drug and participant offered a picture that implied personal attachment. The attachment differed from the functional or physical role such as boosting energy or relieving anxieties.

The relationship with a substance was represented in three ways (3 subcategories).
(i) Endings; that are similar to relationship endings where talking about the drug as if it were a person or entity was characteristic.

> *I was addicted, I tried to stay away but always went back, I couldn't stop myself...the consequences were not commensurate with the love affair.* (Mathew)

(ii) Control; where personal autonomy was jeopardised by the need for alcohol or drugs. A parallel between commitments in personal relationships, such as self sacrificing behaviour was evident in the expression of resentment towards the controlling effect drug dependency exerted.

> *I found it hard to keep control but I've got used to it now and have control of it.* (Mathew)

The hostility and resentment flavour found in *control* was invariably compared to the positive *companionship* drugs provided. The *"good and bad"* of drug use was a theme that could have appeared as ambivalence or being *"in two minds"*. I rejected labelling an ambivalence category however because the term possesses powerful practice connotations relating to motivational interviewing and other forms of talking therapy (Miller & Rollnick 2002). Identifying the two polar positions (companionship

and control) in one category would have a limiting effect on their analysis because the evidence base for practice (motivational interviewing) would have exerted too great an influence on theory development. Subsequently, I retained the original three subcategories and concluded that the characteristic linking them was that the substance(s) took on interpersonal qualities in the eyes of the user participant. The relevance of which was its location within the major category 'Help'.

(iii) Companionship or friendship with a substance is not inconceivable. Advertising slogans such as *"You're never alone with a strand"* (Strand Cigarettes 1959 TV commercial) relied upon the concept. To see it emerge in the data so prominently and reflect the potential meeting of interpersonal needs was surprising. Nevertheless the significance in deficit management or symptom management models was clear (see Figure 6). It was meeting a need at some point for the service user participant and the nature of the need in this instance was interpersonal.

> *You can be happy with friends – if you've got a drink then you're never alone because your friend is the drink. Drink is reliable, it won't let you down, it will always be there for you.* (Anonymous in Alcohol Focus Group)

4. Explanations for my Condition / Situation from other People

Since the various participant perspectives are relevant in this category I have identified the specific sources and frequency. Thirty three comments or incidents were noted, 6 from predominantly alcohol users, 12 from predominantly drug users, practitioners commented too but not extensively. The predominantly drug user focus groups made the remainder of the comments.

Two opinion groups appeared, one from carer and practitioner participants, the other, from user participants. The context was two-fold. One, how it fitted within mental health and two, what were the consequences of drug use that led to changes in drug use or lifestyle.

Alcohol dependency was seen frequently as a disease requiring medically orientated treatment. This was accompanied by a sense of external attribution towards the cause

of alcohol dependency without an erosion of the strongly expressed need to take personal responsibility for it.

Personal explanations were significant and again appeared in medical terms such as self-medication for worrying thoughts. Some explanations had a moral emphasis coupled with self neglect and general deterioration in well-being.

> *You're a worrier, you took the drugs and your brain hasn't been strong enough to cope.* (Simon quoting his father as the father to a recovering alcoholic)

> *You're losing weight, but you're just bad, you don't even shave.* (Anonymous Focus Group Participant paraphrasing his mother as the mother to a drug user)

Explanations from other participants varied over time, indicating different presentations, to different admitting doctors in changeable circumstances. Nevertheless it was confusing for participants who rarely conveyed their reason for admission to hospital or their illness diagnosis.

> *They* (doctors and nurses) *are beginning to think there is a relationship between drugs and mental illness because I keep coming in* (to hospital*) and drying out so they are trying to say it's all drug induced but then why do I still have symptoms when I'm dry and clean?* (and when not in hospital). (Daisy)

Explanations appeared to fit on a time line for many participants and it was not until the participant had progressed along the time line and reached a point of insight that their explanation could match the explanation of their carer or practitioner. This dimension to explanations shows a convergence for participants in several categories. 'Sharing' an understanding of the participant's explanation was cited as helpful, it also incorporated greater understanding of drug effects on symptoms and allowed the role of the substance in the participant's life to be examined properly.

> *I couldn't see what was wrong with me then but I knew it had something to do with the weed.* (Connor)

The knowledge of drug use and its consequences built over time. What may have been previously rejected as an explanation was later more acceptable. Knowledge of drug use and explanations for drug use by others converged in this sense leading to changed views and potentially changed behaviour. There did not emerge a substantive concept relating to other people's explanations however what did arise was the notion that participants would benefit most when they and their carer / practitioner shared similar views or explanations.

It appeared that other people's explanations were significant to some participants because they wanted their carer or practitioner to help them. In this instance the shared view of substance use was present. A factor among participants holding this view was that their readiness and motivation to cut down drug use was high. Among the group whose motivation was less high, low or non-existent the opinions of others were not usually expressed.

5. Policy, Service or Practice Development Issues

This section is divided into the two distinct areas of information and services. Information relates to material designed for service users and carers about their condition, treatment and about the services that provide the treatment. Treatment in the context of this section is used as a 'catch-all' term for any provision or intervention from hospital admission, through medication to social and network support. The analysis of service issues revealed views related to service configuration that held policy and procedure implications. Properties such as collaboration and communication that aided joint working and encouraged integrated practice were revealed as highly important. Integration in this sense was defined by services integrating their efforts at the point of client care. In other words joint or parallel working.

Information

> *The CAT* (Community Alcohol Team) *proved and validated my concerns about alcohol therefore I was convinced of the need to change after receiving the information from them – the concrete, tangible truth about the use of alcohol... I had panics, sweats, I was experiencing dependency. Services saved my life – give you hope, a sense of identity - a problem shared is a problem halved.* (Mathew)

In the quotation above Mathew displays a level of insight and readiness to change that coincided with the community alcohol team's intervention. The information they provided was timely. He states he was convinced of the need to change after receiving the *"concrete"* and *"tangible"* information. This suggests he was open to evidence that alcohol was damaging; the information may also have reinforced the significance of his physical symptoms (panic and sweats). Information in this example was effective and reinforced the validity of my goal to construct education or information materials.

Becoming aware of sources of help was significant too. Asking for help when impeded by social inhibitions or shame was overcome by services advertising such as on flyers and in leaflet form. I asked;

> *Were there any major difficulties to getting help?*
>
> *Embarrassment of owning up and the stigma was stopping me for a while until I saw poster.* (Substance Misuse Day Treatment Centre Focus Group)

Information for Mathew that helped him was factual and appealed to him because it was consistent with his experiences and circumstances. Obtaining the information for some was necessarily preceded with direction or advice about services in the form of a prompt from a carer or a practitioner. A conclusion drawn from this was that information had to be widespread. It had to appear in a range of settings (advertising a service or providing brief advice). As the analysis progressed and theory development grew the issue of access to information, its form and appeal were noted.

Strands of information across a range of circumstances and experiences and possessing a variety of characteristics have been revealed in the previous categories. Margaret emphasised that cultural diversity within the general population required diversity within service provision and professional practice. This aspect of information relates less to specific conditions, such as Mathew and alcohol dependency, and more to the concept of collaboration and inclusion. Having identified social isolation as a barrier to engagement the diversity of certain groups emerged as a further potential barrier.

A low level of awareness within South Asian communities of mental health and substance misuse issues was one such factor. It was reinforced by taboo and stigma. Reaching those communities may be a challenge as Margaret suggested however given the diversity within the participant sample it seemed conceivable that the represented views within the data would possess a cultural significance and appeal.

> *Yes. But it would mean finding out from the faith leaders what, how they can support the clients but equally how they can support you to deliver the service to the client, to your clients. They need to know where you are coming from and what support you can give, so it's collaboratively working together.* (Margaret Practitioner Participant)

Diversity was a characteristic of the study sample. Their behaviour and adherence to British social convention was apparent in their appearance and values.

> *You know younger, younger generation as well as older generation are more fashion consciousness and you know, labelled clothes and labelled shoes and all that, and children get marginalised at school if they aren't equal to everybody else.* (Margaret Practitioner Participant)

This point of convention within diversity was salient when considering the production of information or educational material. There was an emerging cultural theme derived from general observation of participants and the analysis of transcripts from the specialist diversity practitioner (Margaret). Sample population diversity existed but in terms of the studies' information materials it became apparent that specifically tailored content need not be necessary. An information product and theory that possessed resonating features for a diverse range of people was feasible. This theme within the subcategory of information linked with other categories closely. For example the experiences of drug use on symptoms, the issues of blood borne viruses, opiate overdose, and feeling socially included spanned the majority of participants regardless of their background or culture.

The issue of information and its cultural sensitivity was solved by matching the participants' pattern of experiences. That is drug effects generally do not discriminate and therefore the essence of the data should be construed as relevant to all groups. Consequences such as isolation cross cut all and endeavouring to find *things that helped* was the major concern – the major category.

Yes, yes its (health problems) *not particular to dual diagnosis its right across the field and right across the field is taboos, you know the South Asian communities have lots of taboos like all other cultures in the world, you know they have their own belief systems about issues, you know, especially health issues.*

But children are growing up, going to universities, or going where the jobs are. So they are actually in the same boat as everybody else, yeah, yeah, they maybe more sort of westernised as you may call them even though that needs to be defined (laugh*) erm, that break up is making them feel more isolated, there isn't the family and community.* (Margaret Practitioner Participant)

In this section the subcategory 'Information' has been presented as three dimensional. Firstly, the importance of it being accurate and timely was shown; secondly, an emphasis was placed on awareness and availability of services, and thirdly cross cultural issues in this context were considered. The latter aspect suggested that information could reach a diverse audience, without being culturally tailored, by virtue of the common themes (of dual diagnosis) being shared by all.

Services

The analysis of data pertaining to the later category 'Things that Helped / Might have Helped' showed a substantial number of themes related to the treatment approaches provided by services, see Table 16, 'Properties of Help', Page 148. The themes were explored and their nature revealed in order to interpret how participants' experiences could inform the development of information materials. The properties of 'Help' therefore provided individual treatment issues of value rather than matter concerning the organisation of services.

In this section however treatments are more global in nature. The framework for practice rather than the nuts and bolts of intervention is described. For instance daily support groups may provide an *extended family* (Mathew) however they are peer intervention based and subsequently signal the power of peer intervention programmes in a range of recovery settings (Allott 2004; Rowe *et al* 2007). Peer intervention therefore constituted a valid theme that services could potentially facilitate.

Having group sessions was really healthy and then, these people you say look down upon, invite you to these groups where's there's other people themselves and they all discuss their experiences and then theories and some practical advice. That's what the group sessions are all about isn't it? So you're not on your own. (Sid)

Collaborative working and efforts to integrate practice and services appeared important to practitioner participants.

….this is talking about a systemic approach to dual diagnosis, of the idea that you … you may develop integrated services but probably what is going to develop is the capacity for both services to enhance their ability to deal with these patients. (Ranjeev Practitioner Participant)

Here what became clear was that practitioners appeared to hold an over-arching view of what was required from services in terms of the way they were organised, whilst service user participants' were more likely to view service issues on a personal level.

If we can't access health services or drugs services or any of the services that are needed to provide a support network for people then it's going to have a knock on effect elsewhere.

I think because mental health care services are so big we don't actually know who to go to all the time. It would be really helpful to us if we had just one focal point that we could refer to. (Vanessa Practitioner Participant)

The framework for effective treatment was therefore viewed as collaborative and communicative; two qualities that emerged on an individual basis and surfaced frequently throughout the analysis. Here collaboration and communication were portrayed on a service provision level with clear implications for services in their efforts to joint work.

The CPA, whilst not referenced or labelled as such by most participants, is a valid framework for organising and implementing care which encompasses the criticisms emergent in my research. For instance Vanessa cites the size of mainstream psychiatry as being problematic. The imposing positional power psychiatry emits in care provision matches its volume and often goes unaddressed. An example of such a powerful position revealed itself in the research by Scheider *et al* (1999) where

assessment of need within the CPA did not include substance misuse workers, housing workers or practitioners from criminal justice. These failures invariably undermine the consistent policy message of joint working and may indicate the power imbalance between mainstream mental health and previously non psychiatric areas of need such as those associated with social care or substance misuse. Indeed the diagnostic criteria for severe mental illness, medically orientated and adopted for the implementation of the original CPA, could conceivably exclude volitional based disorders or issues such as substance misuse or homelessness.

A harm reduction or damage limitation understanding appeared as a frequently occurring manner or model of work. Participants described examples whereby services worked with them whilst they continued to use substances. Goals therefore were focused on limiting the damage drug use created. Complementing this position however were those who promoted abstinence opportunities for service users.

> *There's been potentially an over emphasis on harm reduction at the loss of patients potentially being abstinent from substances as well. So I think what we need to think about if we are going to develop services is a range of potential places that patients could go, so for instance you may take a harm minimisation approach in general psychiatry in the main but there should also be facilities where you can look at patients from an abstinence perspective as well so that you aren't just a one trick pony.* (Ranjeev Practitioner Participant)

What became apparent during analysis was that a substantial range of responses (treatment approaches and models) would be required to accommodate the variety of views on what constituted an effective approach. Furthermore different approaches were clearly defined as useful by the stage of change a person was in (DiClemente & Prochaska 1985). The conclusion in this respect is two fold. Services adopted principles, or held a philosophy, that informed practice; harm reduction, abstinence, peer intervention or social networks for example, but regardless of the service type inter service collaboration was a prerequisite. Such collaboration integrated care and enhanced efforts to include people with a dual diagnosis. In addition, by services working together, the process of exposure to new forms of practice encouraged their own capability to develop in both philosophical and practice domains.

Whilst the issues this section presents were conveyed with passion, the incident count was modest with only a minority of participants overall having contributed. It is remarkable that this section contains comments mainly from practitioner participants. This may indicate that policy, service and practice development issues are less easily conceptualised by service user participants than for example concrete examples of their individual experiences. Alternatively, the unstructured manner in which data was collected may have been responsible for eliciting personal experiences rather than wider views on service issues.

In summary this section demonstrates that participants made constructive comments about the need for information and education related to dual diagnosis. Participants elaborated on this by suggesting the sources and types of information that should be available. Furthermore the need for services to work together and incorporate both substance misuse and mental health interventions into their repertoire of skills was reinforced.

6. Significant Childhood and Adult Incidents

Getting started (on drink or drugs) was usually at an early age (teens). It was cited as a response to stress (for example entering foster care or social services residential homes or grief through parental loss) or as the norm within most peer groups. The two reasons were also mixed. Self-management of reactive stress to significant childhood or adolescent incidents seemed to be a starting point. Future late adolescent and adult stress appeared to trigger what was conveyed as an inevitable repetition of such drinking or drug use. The repeated use of drugs in response to stress revealed a pattern.

The statement below captures this pattern.

> *There is quite a few different circumstances like me youth, my upbringing and then I started drinking with my mates at the age of 13 or 14. Things progressed. I did try and sort things out then, I joined the army, but I lost my mate in the army and I was no longer required for the army. Just since 1980, just got worse…..the way I was put in care and everything – abused...* (Ron)

The description of the pattern in adulthood continued. Married, loss of a young child, deteriorating marriage leading to heavy alcohol use and a more marked decline in circumstances and quality of life.

Connor was different; signs of a significant psychosis were present at an early age. His mother, a heavy drinker who died young, was thought to have suffered a severe mental illness herself. The genetic and environmental influence upon Connor could be speculated upon but his perception of the world and subsequent stress from bizarre sensations and perceptions led to drinking alcohol at an early age. He said;

> *….and my childhood, yeah. I was always having weird dreams over my childhood. Like dreaming about the devil and god.*
>
> *The world was coming to an end and I started throwing money away and I could see red balls coming out of the sky*
>
> *Like stop breathing and going down in that hole or getting burnt or…when I went to town shopping I couldn't walk into a shop because I thought the shop was closing in on me and everyone was getting smaller and shrinking.*
>
> *It got to a stage that it, that I was drinking that heavy, it got to a stage that I was paranoid that I needed that drink. A few drinks to stop the paranoia, but it got to a stage where I got paranoid no matter what.*
> (Connor)

The significance of an incident or series of incidents was dependent upon individual thresholds. Below, Simon started drinking due to social anxiety at school and maintained drinking through to middle age. Homelessness, alcohol dependency and loss of contact with his family resulted from the initial feeling of being self-conscious. It was evident from further interviews that the severity of an isolated incident bore less importance than the ability to cope with adversity or stress. Subsequently this category revealed less in its dimensions and properties and more by its implications about an individual's resilience. The category accounted for getting started on drink or drugs, it accounted for a coping strategy (taking drugs) in response to stress but did not identify a level of stress or severity of incident commensurate with the core category ('Drug Taking') itself.

> *The reason I started drinking was to alleviate some of the stress I was feeling in my late teens and that helped.. and then drinking got out of control over the years and when I stopped drinking all the anxiety started to come back so that was the main thing really...every time I tried to give up drinking it was the anxiety which if you like sent me back drinking. It wasn't the fact that I felt I needed the drink once the detox had been finished but it was the anxiety.....it was mainly situations where I felt really self-conscious. It was... generally, it was to the point of getting on a bus would cause me anxiety and I'd have a panic attack on the bus and I'd have to get off the bus wait til I'd calmed down and get on another bus and the same thing would happen and have to take 4 or 5 buses to make one journey.*

> *Something I found really difficult was going to get a haircut at the barbers, once I sat down in that chair and knew I couldn't move for the next 20 minutes I'd start panicking and have to leave.. you know get out the chair..* (Simon)

Being alone was cited as important. In the category 'Relationship with Substance(s)' the role played by drugs was powerfully conveyed. Drugs were seen as reliable and consistent factors in participants' lives.

> *Well the drink started off first ....erm I was a loner, a quiet loner and er to get on with people better and have more friends I was drinking. I just chatted more, before I was too quiet but once...* (Dean)

Drugs alleviated social anxieties. The manner in which this experience overlapped with other categories illustrated the complexity of the pattern identified above. It raised questions that relate to the course of drug use as presented in more detail later (Figure 6, Page 130). Where, when did it start and what kept it going? Key questions that cross cut with help orientated categories.

Stress from circumstances or mental illness was seen to trigger drug taking. The drug taking conclusively represented coping with the stress. Another theme in this category however is related to social behaviour. The expectation from peers to take drugs was highlighted in several focus groups as a starting point. Taking drugs was a *"no questions asked"* activity, a right of passage deemed inevitable and not necessarily with risk.

Below, Noel at age 5 started smoking cannabis, he was drinking at primary school age and sniffing solvents, later progressing to stimulants and psychedelics at high school. In interview and focus groups he spoke confidently, other participants nodded and voiced agreement. They had similar stories about themselves or people they knew in relation to starting substance use young.

The passage below shows how significant childhood incidents (the act of, or catalyst to, taking drugs at an early age) can progress unchecked and unchallenged due to peer group norms. It conveys when mental illness started, when it became recognised as mental illness and when an understanding of the role drug taking played in sustaining marked mental illness symptoms. It forms a key element in the depiction of dual diagnosis in the user information materials (David- Booklet One).

> *I was with a friend that give it me and said you'll trip but I didn't, but I didn't understand that at the time and I took some and I did trip, but (inaudible) chasing a chicken round the room with my friends I got other friends on it, I mean, I got other friends on it cos when I was taking it my other friends that I hung round started taking it….*

> *…not until, not until I got took in A&E by the police and this doctor, do you hear voices?, and I thought I was the only one that ever heard them!, you know, I didn't even know what was going on there, I didn't have a clue that I was ill or anything it was just like…(normal)*

> *First time I was on the roof, Kentucky Fried chicken near erm, on the road and were leaning over the roof, it's the upstairs part, me and mate, Eddie, we were leaning over and knocking on the window, (inaudible) wagging it, and my friends behind us stood up, backing roof and erm, I heard 'why not just kill him' and I thought, or that's what this meant, push him off the roof, so I 'what the fuck, who the fuck said that?' cos it freaked me out, dint it and said 'who said what I said who told me to push him off the roof?' They went 'no one', that's when people starting noticing I was bit mad. Started calling me psycho and schizo and stuff like that. That's when I started to hammer drugs hard core, you know proper hard core.*

> *I didn't go round telling me friends I heard voices, they just called me schizo, psycho because I was doing weird things, because I was doing things different to them, we were wagging school, I never actually told anyone I was hearing voices, it was more like, I'd saying mad shit, daft shit that the voices were saying to me and I was doing mad things, I wouldn't do before the voices. You know, it was like, like that. But they never, I never told people from Newton Heath or me friends from high school that I was hearing voices, I only told Carmel, Toni and …*

First time I noticed that the drugs were giving me a big problem was when erm, I did go to the HDU (High Dependency Unit) *because I was off them completely, I was completely free, from drugs for two and a half years near enough, and the first night out, still, you know in them two and half years, I clocked a big change in myself, because I wasn't on drugs, cos it was a locked ward, high dependency unit – like this one, but a lot, bit more securer, and if I would have took drugs in there, I wouldn't have got out.* (Noel)

This category originally revealed incidents that appeared to have potential significance in explaining the occurrence of dual diagnosis. The presence of high levels of stress emanating from physical or sexual abuse for example seemed logical and understandable. Numerous participants cited it as such. Equally, the absence of an incident did not indicate a lower propensity for drug taking. It is possible that non-disclosure of incidents took place; however there was resounding support in focus groups for the notion that drug taking and alcohol use was an inevitable aspect of life, regardless of an individual's background.

This section closes with questions about the role drugs play in alleviating distress (trauma related or not). The question alludes to the complexity of dual diagnosis and suggests that multiple explanations are likely to emerge as opposed to one overarching theory. Nearly all participants had a beginning to their stories of drug use and or mental distress. No causal conclusions emerged however the importance of a beginning seemed significant. For some it was highlighted by an incident and for others no significant event was recalled. The prospect of change probably requires the conceptualisation of relativity; the beginning point of a participants account provides an opportunity to reflect on changes and differences, compare present with past, and eventually consider the future.

7. Impact on Behaviour and Life

Drug taking in mental illness and the categories identified in this chapter reveal a strong theme of connectiveness. This category links with the others to form a vortex of drug taking incidents, health and social consequences and further drug taking. The subjective sense of well-being on taking a drug appears powerfully demonstrated throughout this chapter. Initial substance use has subsequently reinforced further use

by firstly giving symptomatic relief (to a degree) and secondly worsening symptoms. Thus the need for relief increased.

This section identifies the deleterious impact of drug taking and mental illness on service user and carer participants' lives. It focuses upon the actions and behaviours directly linked to drug taking and mental illness. The consequences of which were seen by participants to largely accumulate over a long period of time, eventually mitigating further drug use.

Subcategories were distinct. There were psychological, social and physical consequences (impacts). The consequences were not confined to the participants themselves; the social and close relationship dimensions were clearly conveyed, and usually with considerable insight. For example an incident of drug-induced violence was described as having several victims from the participant (in this case as perpetrator), the immediate victim, the victim's family, the participant's family, and accompanying friends (professionals through vicarious trauma).

> *….yeah I took it* (crack cocaine) *at a mate's house and I don't remember doing anything I just remember schized out and he tried calming me down and I went back to my house and got a bat went back round to his house battered him, battered his dad, broke his dad's hand, his dad was trying to defend his face and broke both his hands and I smacked his girlfriend a few times with the bat.* (Anonymous Inpatient Ward Focus Group)

The timeframe was not confined to the immediate incident or event either. There was a high level of insight expressed related to the accumulation of drug use and associated negative consequences. Differing types of impact upon the participants existed however. For some there was a sense of hopelessness.

> *..don't ask me why because I don't know why* (inaudible) *drugs leaving me paranoid even (*inaudible*) what I think is I'll just put my scaff barrier at my door, my broom handle up against the handle of the door and make mad stares around the room fucking just sitting there smoking but knowing that it's making me more paranoid, but not thinking about it just going* (mimics smoking) *popping the bong and hoping to get a sleep, hoping the weed will knock me out but it never does. You never can get a sleep proper on weed can you?* (Anonymous Inpatient Ward Focus Group)

For others there was a sense that something could be done to halt or reverse the consequences; a sense of hopefulness.

> *I was inhibited before a drink. Drink enhanced capacity regarding my intellect and work. I have now realised that I deceived myself, it was a delusion.* (Mathew)

The previous quotes revealed that the impact of drug taking had the potential to motivate or de-motivate participants in their efforts to address drug taking. However, the degree, duration and frequency of impact varied across the participants. For most an accumulation of negative consequences over a long period of time helped develop insight, a prelude to cutting down or stopping.

> *....yeah, it's getting more and more of a worry... I want to stop that's why I'm going into hospital. I stop use... stop spending... so much money on it and spend it on the flat, its making Donna's life hell at the moment I think.* (Sid)

The insight however did not necessarily lead to change or improvement.

> *...then I stopped for a while and I came in hospital and I got myself together again and then it sort of like ......hospital sort of like err, a jail, really. I can't seem to get into any clinics, I don't know how to get into any clinics, at least if I was in jail…*(inaudible) *. They get annoyed with me 'cos they say you're using stimulants this next and that next and you're gonna' go off on one and I say, yeah but, err, I like my enjoyment and I find it difficult and I struggle coming away from it.* (Daisy)

The concept of insight appears important in this category since it relates it to the category 'Things that Helped / Might have Helped'. This key category of the twelve is cross cut by most of the other categories. The impact of drug taking on behaviour and life is revealing here in several ways. Most prominent, however is the overriding effect on the role drugs performed by the negative consequences (or impact) of drug taking itself. The drug role diminishing and the ensuing damaging effects of drug use becoming prominent. This contributes to the complexity of dual diagnosis somewhat. A person taking drugs to relieve anxiety only to find the anxiety worsening (initially as an unseen consequence of drug exacerbated paranoia for example) is caught in a Catch-22 situation. The balance is between short term anxiety relief (the role or

function of drug taking) and longer term impact such as social isolation (possibly paranoia driven), job loss and financial hardship, for example. As the latter accumulates the former effects diminish. This for some participants is conceivably the process of change deriving from accumulated negative experiences.

Prominent core consequences emerged and formed two salient themes; (i) actions that led to relationship breakdown and (ii) actions that led to exclusion from mainstream society. Exclusion here incorporated detention in mental health or criminal justice settings, living without a permanent home or simply deliberate social withdrawal.

Relationship Breakdown

At that time yes, well my first marriage I had a child and I was drinking then too, losing control, that's what it is losing control of your life. I think drink and with the ex-partner there's nothing but trouble 'cos she was a drinker as well and it was nothing but a chaotic life.

Its always been chaotic you know I mean things would go smooth for a while then ...all hell breaks loose type of thing. (Alan)

He was very, very sick when I met him. I probably chose not to see it, and got involved before it was... before I could get out – you know, I was in there and I was in over my head..... I thought I knew about alcohol and its abuse, I knew nothing. And you know, now I realise how co-dependent I was (Jane Carer Participant).

Yeah, it does, it helps take worries away and stuff. Like sometimes I don't get to meet people because a lot of people don't want to meet me cos they can tell I've got mental health problems. (Daisy)

It was a love affair with alcohol, alcohol was the only medium of help. Started properly in 1984 – oblivion, respite, carefree, selfish, oblivious to health, financial costs as well as friends and family. (Mathew)

Exclusion

This was like, when the guys said do you know what it feels to burn down a £300,000 house. A few of them were talking about feeling really powerful because God or whatever is telling them what to do and they've got to do stuff so there was this kind of business that you know. (Don Practitioner Participant)

The world was coming to an end and I started throwing money away and I could see red balls coming out of the sky. It was like the world was closing in on me. You get the hot sunny days and you get your

dull days and its like, I was like shrinking... and they put me on a section of six months, and I was paranoid about getting on public transport and buses. (Connor)

Yeah, he (psychiatrist) *put me on three sections, Section 3, Section 5 and Section 17, and he said I'm putting you on these sections, and I said what for and he said blah, blah, blah, you know what I mean, all these sections, you know what I mean.* (Floyd)

But I was mainly like, stay in, I would stay in and sleep and mostly sleep throughout the day and not doing much with myself, you know what I mean. (Floyd)

Some were worse, I mean I had a flat in Oldham for a while and I was mixing with people who were on coke, methadone, heroin, sharing a flat with a girl on methadone who kept relapsing and going back on drugs, I was drinking .. and there was mad crazy things happening all around but I didn't care as long as I had my drink I couldn't really care what was going on. (Simon)

A Combination of Both

That's how my life goes, nice and quiet and then bang I do something but I smoke weed and drink and just end up on passing out in the flat on my own. When I've got to go outside, that's why I'm here the police brought me on Thursday because I'd been drinking, I'd had charlie (cocaine) *and I don't remember what happened but I remember I'd been at my ex-girlfriends house and I wanted her step dad to come out and fight me and then I don't know, her family turned up and the police got called and then the police put me in the back, you know there's a cage in the van as soon as they put me in I ran into the cage and started head butting it and they had to come and restrain me and when they brought me to the hospital they slapped me against the wall and I started head butting the wall.* (Anonymous Inpatient Ward Focus Group)

The impact of drug taking had broad dimensions and properties. Some were directly attributed to drug taking. Participants that made such attributions were usually cutting down or abstaining from drugs. Some areas of impact attracted lower levels of importance. Participants that expressed less concern or a lower connection between drug taking and negative consequences of drug taking were more likely to still be involved in regular drug use.

The timeframe was important. The longer a participant had experienced negative consequences the more susceptible they were to cutting down or stopping. However,

it was evident that variables existed in this area. Some participants had a singularly negative experience to a particular drug (for example nausea and vomiting after heroin; paranoia after cannabis) and did not take that drug again but continued to use other drugs. Other participants adapted their lifestyles so they could continue their drug taking. An example was the practice of self-isolation, to reduce external stimuli, when taking crack cocaine and/or cannabis in order to avoid an escalation of paranoid ideas.

It is conceivable that a general rule applies to this category. That drug taking has to amass negative experiences before it is recognised as a major problem. How this then brought about a reduction or cessation of drug taking was not wholly answered, however, the two help-related categories presented in detail later formed important links to this and other categories which address the matter. The development of a theory related to help principles and practice had surfaced at this point.

This category is not necessarily more important than other categories, but it did reveal practical issues related to drug taking and mental illness. This practical element was important in developing the information materials because it related drug use actions and mental health consequences. Participants preferred and understood more fully the practical format of the research themes which were illustrated clearly in story form in the booklets (information materials presented in Chapter 6).

8. My Explanation for my Condition / Situation

Two important concepts existed under this heading. Firstly, the belief that external factors played an important role in a participant's condition or secondly, that internal or personal factors were dominant in the development of their condition. External factors varied in source; parents, family distress, trauma, 'the devil', imprisonment, drug dealer, availability of drugs, social anxiety, peers, loneliness, life and work related stress. Internal or personal factors stemmed from beliefs about ones self such as a condition being self inflicted through weakness, gullibility, changed perspective on life or environment, and the development of a mental illness or emotional distress.

Psychosis participants described an influence on their condition that they perceived to be external yet could arguably be described as internal. For instance visual or auditory perceptual disturbances combined with delusional beliefs. Those non psychosis

participants who described their condition as being caused by more concrete external factors such as sexual abuse, like their psychosis counterparts, explained their condition by attributing it to others ('blame'). Those participants who regarded themselves, rather than external factors, as being causal in their condition also expressed themselves using blame language. The concept of blame or attributing their condition to a single source or experience appeared important. This concept appeared in other categories too, such as 'Significant Childhood and Adult Incidents' but of particular relevance was its appearance in the help-related categories. Here participants processed the concept of help by explaining the causal factors. From the causal factors grew a remedy that might work, and equally remedies that failed. In order to examine more deeply this concept of blame (relational to attribution theory) the specific function or role of a substance was raised. Within the category 'Role of Substance(s)' (Category 10) a mass of material appeared that cross cut the explanations and also thrust the concept of cause (blame or attribution) into one of remedy. This is understandable when considering the function of attributional thinking. Attribution theory is based on the assumption that an individual will interpret their environment and circumstances in a manner that maintains or promotes a positive sense of self (Weiner 1980). Factors influential upon the degree of attribution, and ability to change or be motivated to change, are the individuals' circumstantial stability (external) and their personal stability (internal / psychological). If they attribute their problems to external factors then change is conceivable if accompanied by lifestyle changes. Should they attribute their difficulties or distress to internal factors substantial psychological support or intervention is required. Either attribution bent appears surmountable.

The prospect of applying such theory to my study participant group requires care. Within the general population widespread biases and judgmental errors exist when accounting for problems and successes but overlaid upon those individuals with mental health problems these matters may be amplified considerably. Debiasing techniques within the mental illness population are applicable and considered effective (Hayes & Hesketh 2005) however the presence of substance misuse and the accompanying lifestyle and difficulties in sustained engagement add further problems. The relevance therefore of study participants' focus on their distress and formulating a practical remedy partially sidestepped the issue of attribution. In this context

attribution was conveyed by participants in blame language which in turn appeared both motivational and straightforward. The resultant focus upon practical solutions was empowering through its conceptual simplicity.

Both externally and internally attributed explanations for service user participants' condition shared a key component - distress. Table 11 presents the distress in 3 types; mental, physical and social.

Table 11. Mental, Physical & Social Signs of Distress

Mental	Physical	Social
Paranoia, worry, anxiety, low self-esteem, confidence and motivation, sedating effects of medication, low mood, suicidal feelings, poor concentration, insomnia.	Low energy levels, feeling docile, drug withdrawal symptoms ('cold turkey'), back pain, muscular pain, itching (formication), insomnia, poor appetite.	Social anxiety, perceived social incompetence, fear of peers, strangers or general public, loneliness, inactive, unemployed, excluded, isolatory.

In the quote below Daisy explains that the drug component of her dual diagnosis is beneficial in improving social and recreational aspects of her life. The explanation also reveals how she sidesteps stigma by entering a social group accepting or encouraging of drug use behaviours.

Mark   *…even if it was drug induced, if, I don't mean whether you disagree with them* (the doctors), *but if you thought it was drug induced, would it make any difference?*

Daisy   *Yeah, but, yeah because my illness is serious, I have a nervous breakdown quite often.*

Mark   *Yeah. So as far as you're concerned and from what you are telling me anyway, that your drug use is quite controlled, that it is, you know, all the stigma and boredom and stuff like that of having the illness that is* (drug use) *actually a positive thing in your life.*

Daisy   *Yeah it keeps solid 'cos I get out I get to meet people and that, and I get to see everybody and that's what* (inaudible) *I'm only stuck in the flat and I've got nobody to talk to and I'm bored. I've got no neighbours and then I'll only see doctors and nurses coming up and I don't get much people round in my community that will talk to me cos they think her she ill, and I get out and I meet students that come to Manchester every year and that's how I meet people. It is good for me.*

The explanations provided by participants for their condition (drug or mental health or both) appeared to pivot on the concepts of cause and distress, which later progressed to a concept of remedy. However it also appeared that drug use was a culturally and age related activity that preceded distress for some. When drug use was cited as a 'right of passage' participants were more likely to see distress as a progressive entity that was not necessarily caused by drugs but simply existed. On experiencing distress drugs were found to provide relief suggesting that distress had become a central point to *drug taking* as a consequence rather than a cause.

Mark   *So they* (practitioners) *should be helping what you need help with and not judge or condemn?*

Simon   *Yeah, you have to treat it as a form of illness, and there's always a reason why people go on drugs, its usually circumstantial. Things are going bad in their life, they've had a nasty experience they can't get over, they can't seem to face ordinary day-to-day life like other people, you don't just go hey, lets take drugs.*

Participants who used drugs to relieve mental, physical or social distress were likewise less inclined to see drug use as a causal or exacerbating factor of any distress. Subsequently whilst 'Drug Taking' formed the core category that cut across all other categories it did not get identified by service user participants as the core concern.

"*Getting started*" (on drugs) due to culture or environmental influences (peers, gangs, friends, family and other inpatients) was a term used by a focus group participant that attracted strong agreement from others. The emphasis upon this social reason for drug taking (without the emotional charge conveyed by participants when using blame language) appeared acceptable and understandable to focus group participants. The phrase "*if you can't beat them join them*" was used by one. This appeared to represent a sense of fatalism or disempowerment to prevent the inevitable lapse.

> *Even though I had four pints, I didn't even want to have a drink at first, it was just the upset and the kids, we was having a meal, they were crying, I were crying. I used to call him baby (Ron's lost child), but he is older than them, you know, he's not older than my eldest lad, he's 21. Well it was, but like I said to my one to one counsellor, I've got over his death. Christmas, I didn't have a problem, I had a great time, but this was the part I was dreading more, where normally I either get locked up, have a fight…..(Ron)*

Sociological and psychological explanatory models for fatalism exist (Vogt 1993) that disempower individuals in two ways. First, societal positions characterised by limited wealth, health and power can promote an acceptance of negative incidents, (gun crime or drug use for example). Second, by psychologically accepting negative incidents or circumstances a sense of resignation can be achieved. Thus prominent properties emerged that based drug taking and mental illness into a potentially socially explainable domain as well as the mental and physical domains cited above.

Finally, participants conveyed a belief in external remedies for their distress or social circumstances that matched a medical understanding that distress (or dis-ease) can be treated. Furthermore, it has been suggested that since mortal health risks have declined in recent centuries society in general now possesses a psychological explanation for distress regardless of its appropriateness (Foucault 1970). It appeared understandable that participants conveyed an external attribution theory to both remedy and cause. This section closes with Connor describing his internal attributes (worries), what they led to, (drug use) and how they changed to external attributions (paranoia). Both worry and paranoia are prominent and reflect wider participant consensus that psychological or emotional distress are integral explanatory factors.

> *I am a worrier, worry too much about the word and... when I took this LSD, I just went on one. It got to a stage that it, that I was drinking that heavy, it got to a stage that I was paranoid, that I needed that drink. A few drinks to stop the paranoia, but...* (Connor)

9. Feelings / Beliefs / Symptoms

This category became evident immediately. Participants talked about depressed mood, feelings of anxiety and paranoid thoughts in a manner that linked them directly to the act of drug taking. In many cases, drug use was adapted, rather than ceased, to accommodate symptoms as depicted by the quotation below.

> *It's happened to me that, I was taken into a club and I felt paranoid. Felt like people were watching me and were coming in close to me and coming out (out of it) you know what I mean. They were coming nearer and going out and they were looking at me. I just, I just had to get outa the club. That's why I have to smoke at home or something like that.* (Anonymous Inpatient Focus Group)

Only when feelings and symptoms were discussed in the broader context of life and relationships did they emerge as a cross-cutting category. They were cited as reasons for drug taking (for example alleviating anxiety) yet they were cited as a consequence of drug taking too (increased paranoid thoughts for instance). This section elaborates on the duality of mental health and drug taking from a symptomatic perspective. Depression, relieved momentarily by alcohol, cannabis or ecstasy returning sometime later with greater severity represented a reasonable illustration of the double bind situation participants described. The data was so dense it is presented in table form (Table 12, Page 123) rather than quotations to display the prominent symptoms-relief seeking relationship that emerged. Distinguishing favoured substances for specific symptoms is revealed as is the symptom severity following drug use.

This category encouraged a greater understanding of drug use as a coping strategy. Here I do not describe the psychological mechanisms involved in participants coping, but present the broad range of symptoms and feelings that either pre-exist or occur following psychoactive substance use. Information relating to substances and their effects is presented also which relates directly to the categories about 'Knowledge' (Category 2) and 'Role' (Category 10) of substances.

The feelings generated by certain drugs such as ketamine induced derealisation (the sense that the environment is unreal) were deliberately sought. Alcohol to facilitate the expression of anger or general emotional catharsis was another example. Psychedelic drugs like LSD or ketamine to generate visual distortions and hallucinations met with group approval.

The most popular of drug and symptom relationships to emerge were;
- Stimulants to energise
- Cannabis to relax
- Depressants (alcohol and heroin mainly) to raise mood or induce a state of euphoria otherwise difficult to obtain (*"oblivion"* Mathew)

This relationship between 'Feelings/Beliefs/Symptoms' and drug connects to the 'Knowledge' category (2). Stimulants used to provide energy and motivation in the

short term depletes energy in the medium to long term. Cannabis whilst exerting a relaxant effect initially wears off. Cannabis accumulation subsequently builds up chemicals that lead to greater anxiety. Alcohol and heroin both depress the central nervous system in turn depressing mood. The euphoric effect craved for being due to a short term biochemical reaction akin to nerves relaxing.

Hypothetically then if drug taking occurred in order to manage symptoms, then educating drug users about the time line effects of drugs could potentially create a change in their usage. This was a useful hypothesis for further analysis. The longer-term effects were known; through experience most participants acknowledged this to be the case. Their subjective experience of short term but 'effective' symptom relief outweighed the longer-term deleterious effects. This was true for earlier stage drug taking.

Furthermore symptoms were muddled in their recollection. For instance what came first? low mood, paranoia or anxiety? Cases were made for paranoia leading to anxiety. On taking cannabis to relax chemical changes (increased dopamine and reduced antipsychotic medication effectiveness) led to greater paranoia in turn producing more anxiety. An established cycle of symptom and drug use was therefore the only firm conclusion drawn.

As the cycle became a permanent fixture, a way of life around drug use and mental illness was evident. The role of a drug and the relationship the participant held with their symptoms was inextricably linked. What is more, is that clusters of symptoms and feelings did not necessarily lead to a diagnosis or treatment in early stages and therefore participants appeared to have had little alternative other than to 'self-medicate' to cope (see Figure 6, 'Course of Drug Use: Deficit Management Model', Page 130).

Overleaf, Table 12 ('Dual Diagnosis Symptom Categories') sets out the symptom types as conveyed by participants. This illustrates potential clinical relevance for treatment purposes and emphasises the symptom-drug relationship. The latter being relevant for building insight that might lead to change. Categories 'Things that have not Helped' and 'Things that Helped / Might have Helped' (11 and 12) possess

similar properties that suggest further explanations related to dual diagnosis resolution.

Overall this symptom related category reinforced the importance of distress in the process of drug taking and mental illness. It emphasised that individuals differ greatly in their subjective experiences yet generalities emerged. Subsequently the presence of feelings and beliefs resembling or representing symptoms can be both causal and consequential to drug taking especially after the pattern of drug taking-symptom management has become established.

Table 12. Dual Diagnosis Symptom Categories

'Feelings / Beliefs / Symptoms'	Prior to drug taking	During and immediately following drug use / intoxication	Later following drug taking	Most reported/ likely drug
Paranoid ideas and feelings	Mild	Absent - mild	Severe	Stimulants / cannabis
Paranoid beliefs (delusions)	Moderate	Absent - mild	Severe	Stimulants / cannabis
Instructive voices - Command hallucinations	Mild	Absent - mild	Moderate - severe	Heroin / stimulants / speedball / cannabis
Other auditory (and visual) hallucinations	Mild	Absent - mild	Moderate - severe	Heroin / stimulants / speedball / cannabis
Derealisation (environment does feel real)	Severe	Absent	Moderate - severe	Cannabis / alcohol / benzodiazepines
Depersonalisation (person does not feel real or part of environment)	Severe	Absent	Moderate - severe	Cannabis / alcohol / benzodiazepines
Psychotic symptoms induced by drugs (psychotomimetic)	Absent	Moderate - severe	Severe	Cannabis / crack / heroin / amphetamine / cocaine / LSD / magic mushrooms / ketamine
Post hallucinogen perception disorder (flashbacks)	Severe (but infrequent)	Severe (but infrequent)	Severe	Cannabis / crack / heroin / amphetamine / cocaine / LSD / magic mushrooms / ketamine
Self isolation and	Severe	Mild	Severe	Alcohol / cannabis /

avoidance				stimulants / benzodiazepines
Depressed mood	Severe	Mild - absent	Severe	Alcohol / cannabis / stimulants / benzodiazepines / ecstasy
Emotional lability (erratic emotions)	Severe	Severe	Severe	Alcohol / cannabis / stimulants
Irritable mood	Severe	Mild - absent	Severe	Alcohol / cannabis / stimulants
Suicidal and feelings of hopelessness	Severe	Moderate	Severe	Alcohol / cannabis / stimulants
Self harm / non-fatal overdose	Severe	Severe	Severe	Alcohol / cannabis / stimulants
Passive death wish/disregard for own well-being	Severe	Severe	Severe	Alcohol / cannabis / stimulants
Loss of energy and motivation	Severe	Mild - absent	Severe	Stimulants / cannabis / alcohol
Self neglect (safety and activities of daily living)	Mild - moderate	Not mentioned	Mild - moderate	Stimulants / cannabis / alcohol / heroin / benzodiazepines
Anhedonia	Severe	Mild - absent	Severe	Stimulants / cannabis / alcohol / heroin / ecstasy
Agitation	Moderate - severe	Mild	Severe	Alcohol / cannabis / benzodiazepines
Anger	Moderate - severe	Mild - absent	Severe	Alcohol / cannabis / stimulants/ benzodiazepines
Violence and aggression	Moderate - severe	Mild - absent	Moderate - severe	Alcohol / cannabis / stimulants/ benzodiazepines
Tension (motor) anxiety	Moderate - severe	Absent	Moderate - severe	Alcohol / cannabis / benzodiazepines
Fright / fear (Autonomic) anxiety	Moderate - severe	Absent	Moderate - severe	Alcohol / cannabis / benzodiazepines / heroin
Panic attacks	Severe	Absent	Severe	Alcohol / cannabis / benzodiazepines
Insomnia and nightmares	Moderate	Moderate	Moderate	Alcohol / cannabis / hypnotics
Impaired concentration	Moderate	Moderate - severe	Severe	Alcohol / cannabis / stimulants/
Loss of appetite and weight	Moderate - severe	Mild - absent	Moderate - severe	Cannabis
Stigmatisation	Moderate -	Mild -	Moderate -	Alcohol / cannabis

	severe	absent	severe	
Vulnerable to exploitation (physical)	Moderate	Severe	Moderate	Heroin / alcohol
Vulnerable to exploitation (financial)	Severe	Severe	Severe	All drugs
Poor nutrition	Moderate	Moderate	Moderate	Alcohol / heroin / heroin + cocaine
Liver disease / Hepatitis / HIV	Moderate - severe	Moderate - severe	Moderate - severe	Alcohol / heroin / speedball

Key: Mild, moderate or severe indicates quality of symptom most frequently reported.

10. Role of Substance(s)

The last four decades have seen important medical advances in pharmacology. Barbiturates *offered* a cure for insomnia, benzodiazepines *promised* relief from anxiety, methadone a *substitute* for heroin and perhaps less contentious antidepressants a *treatment* for low mood or suicidality (Gournay *et al* 1997). These examples of medical intervention echo the dominant rationale given by service user participants for the role of substances in their lives, which was "*to feel better*". Equally the rationale for drug taking or the role that the drug performed was consistently conveyed in medical terms or within a medical framework. It followed then that deconstructing distress as a concept into its component parts demonstrated the role drugs performed for participants in symptom management. For example insomnia aided by alcohol or cannabis, lethargy relieved by cocaine. This could mirror the process of constructing individual symptoms of distress into clusters to form medical diagnoses by doctors and psychologists. It appeared then that the participants' fundamental treatment beliefs varied little from those of medical health beliefs in that distress represented a disorder that could potentially be remedied by drug taking / medical prescription. The remedies were the variant whilst the rationale was the same.

This section presents its findings in Table 13 ('Role and Properties of Substance Use', Page 127) and incorporates sample quotations accordingly. It concludes with a theoretical model (Figure 6, Page 130) explaining the possible course of substance use

and how substance use compensates for difficulties in coping. It examines the role of drugs largely from a lay-medico perspective however the concept development concerning distress and remedies (found also within the two help-related categories) floundered at times when social influences such as *"to fit in"* or *"peer pressure"* were raised. Similarities between relationship orientated categories and those categories of 'Help' were evident. Importantly this demonstrated through cross-cutting concepts that it did not appear possible to separate concepts entirely. They were connected in a co-dependent manner that explained their existence and was relevant in predicting their future impact.

To develop this theme further and clarify the connections I selected matching properties of three categories; (i) Role of Substance(s) (ii) Relationship with Substance(s), and (iii) Things that Helped/ Might have Helped. The connection ran in linear fashion; (i) an alcoholic drink relieved loneliness, (ii) alcohol became a reliable source of comfort (*"a friend... it was a love affair"*) and (iii) as a replacement for company it proved to be helpful.

By identifying the properties that connect one category with another an understanding of the chronicity emerged. Drug use in alleviating social and personal woes ('Role' category) created other problems such as dependency, financial hardship or relationship breakdown ('Impact' category) that subsequently generated a second reason for drug use. This cycle revealed the psychological, physiological and social elements to the core category of 'Drug Taking'. It also discovered the sites (the precise function of the drug) at which the major 'Help' category could be located.

Nineteen separate roles for substance use were described which started to expand on the cycle and provided greater understanding of the phenomenon of dual diagnosis. Table 13 overleaf lists the roles and cites the key properties most prominent in each.

In its entirety the role substances played for participants was wide and varied. It appeared to be chosen for specific reasons such as to help relieve anxiety, to generate enough energy and motivation to socialise, or to generate confidence or improve mood. Regardless of the specific reason for using, the properties in each subcategory revealed evidence that supported a form of self-medication against the negative

aspects of life. The nature of the negative aspect appeared to be an influence on, or a reason for, drug use and the role it played. It transpired through axial coding, that properties inter related or cross cut on this theme.

To understand this point further it was necessary to find facets of drug taking behaviour that were located across a number of the subcategories. Boost energy, counteract sedating effects of medication, increase alertness to threats, enhance pleasure, and aid socialising were subcategories that all shared the *stimulating* effect of drug use. Yet to simply group these together as a subcategory of stimulatory effects for example would have detracted from any emerging explanation for drug use. It would also carry the implied quality that stimulatory effects were sought for pleasure or to enhance a sense of well-being. It would have created a pattern of thinking in the analysis that would not be open to exceptions. An exception here being increased alertness to threats for example. Whilst stimulatory in nature this related to survival or safety for the participant and differed considerably from other subcategories. The need to be alert (*) to danger, in a case that was symptomatic of paranoid ideation, transferred the drug use from a theme of self-medication to one of self-preservation. In both cases a direct link between mental health symptoms and drug use was evident however the view of the participant needing to be alert for danger did not fit into a self-medicating model, despite being a response to a symptom. Danger was an external factor (perceived or real), whereas stimulation to feel motivated or boost energy was an internal factor, the latter being attributable to an illness or internal absence in need of relief (through a 'form' of medication, the self-medication hypothesis).

Table 13. The Role and Properties of Substance Use

| Role	Properties (explanations given, substance used, behaviours before and after)
Aid Sleep	Cannabis and alcohol used
Boost Energy	Improved concentration and motivation to achieve tasks such as reading, shopping or going out. Energy accompanied by sense of achievement and satisfaction leading to sense of well-being, happiness and contentment.
*Increase Alertness of Threats	Alcohol and crack cocaine. Promoting courage and allaying fear. Generating anger and hostility deliberately to feel unassailable.
Aid	Ecstasy, alcohol and cannabis boosting energy for socialising.

Socialisation	Drug use a passport to gangs and peer groups.
Combat Boredom	Drug use as an activity in itself provided a pastime (*"something to do"*) and company (*"someone to do it with"*) Absence of alternative activities and poor employment opportunities for drug users / mental illness sufferers.
An Escape	An escape or respite from distressing mental illness symptoms and the accompanying poor quality of life. ..from painful memories related to past traumas such as sexual abuse. ..from reality and a depressing or hopeless life. To do crazy, otherwise ill advised, things not participated in when sober (*"fun"*). ..from problems or a change in the perception of problems.
A Punishment	Anaesthetised from feelings of guilt. For bad things done.
Relieve Anxiety	Cannabis, alcohol, cocaine and heroin commonly used as anxiolytic. *"Takes the edge off". "Removes worries".*
Combat Loneliness	Alcohol, ecstasy and amphetamine popular. Alcohol improved confidence and heightened level of self-esteem. Ecstasy used as an antidepressant relived depressing feelings of isolation. *"On drink girls found me attractive"* *"Everyone was my friend". "Alcohol was a reliable friend, it never judged me". "Amphetamine is comforting".*
Lift Mood	Ecstasy as an antidepressant. Alcohol controlled mood and induced periods of euphoria. Cocaine and heroin taken together (speedball) moderated mood and weakened unwanted side effects of both drugs whilst improving the desired effect of both drugs. Amphetamine raised mood and increased confidence to handle delusions of paranoia. Other bizarre or distressing thoughts became less significant and intrusive. *"Just something that instantly feels good".*
Counteract Sedating Effects of Medication	Crack cocaine and amphetamine. Both promoting feelings of energy and motivation, the lack of being attributed to sedating effects of antipsychotic medication.
Experience Enjoyment	The absence of pleasure as a facet of mental illness counteracted by drug use. *"Just something that instantly feels good".* *"Fun", "Feel things".*
Boost Confidence	Alcohol creating sense of courage. *"Frightened of nothing"* - when previously socially anxious or phobic. Generating anger and providing *"Dutch courage"* to cope with social anxieties and fear inducing psychotic symptoms (paranoid delusions, insulting or threatening auditory hallucinations).
Block Symptoms of Psychosis	Dampens auditory hallucinations (voices). Reduced intrusiveness and preoccupation with voices.
Combat	Changes the perception of the significance of content of auditory

Paranoid Fear	hallucinations (e.g. *"we are gonna get you"*).
Enhance Pleasure	Cannabis and ecstasy. Music, food, dance, sex improved. Partying common.
Combat Withdrawal Symptoms	Craving relieved. Withdrawal symptoms (delirium tremens, sweats, diarrhoea for example) relieved.
Physical Role	Relieve withdrawal symptoms. Remain slim. To become slim. To relieve formication (itchy skin that feels like bugs under the skin). Analgesia (e.g. back pain).
Calming and Slowing Life Down	Heroin used.

Elaboration of this theme or arguably another angle altogether took the line that drug use was a replacement for the absence of something, for example physical energy. The model that emerged I labelled 'Deficit Management'. Locating this theme throughout the nineteen subcategories (see Table 13) revealed a dimension for each that resembled a course upon which drug use (and the person taking drugs) embarked.

Figure 6 displays this course of drug use. It demonstrates that deficits become bigger rather than smaller and that the accumulation of drug use (impact of drug use) problems increase disproportionately yet they are in parallel with drug use itself. A simplistic example is the participant who used amphetamine to increase physical energy and activity. Short term energy increase occurred as desired. Their longer-term energy deficit increased because of the energy depleting effect amphetamine causes ('comedown' and serotonin depletion). The original reason for drug use (lack of energy) became more marked and subsequently drug use escalated in response.

Figure 6. Course of Drug Use: Deficit Management Model
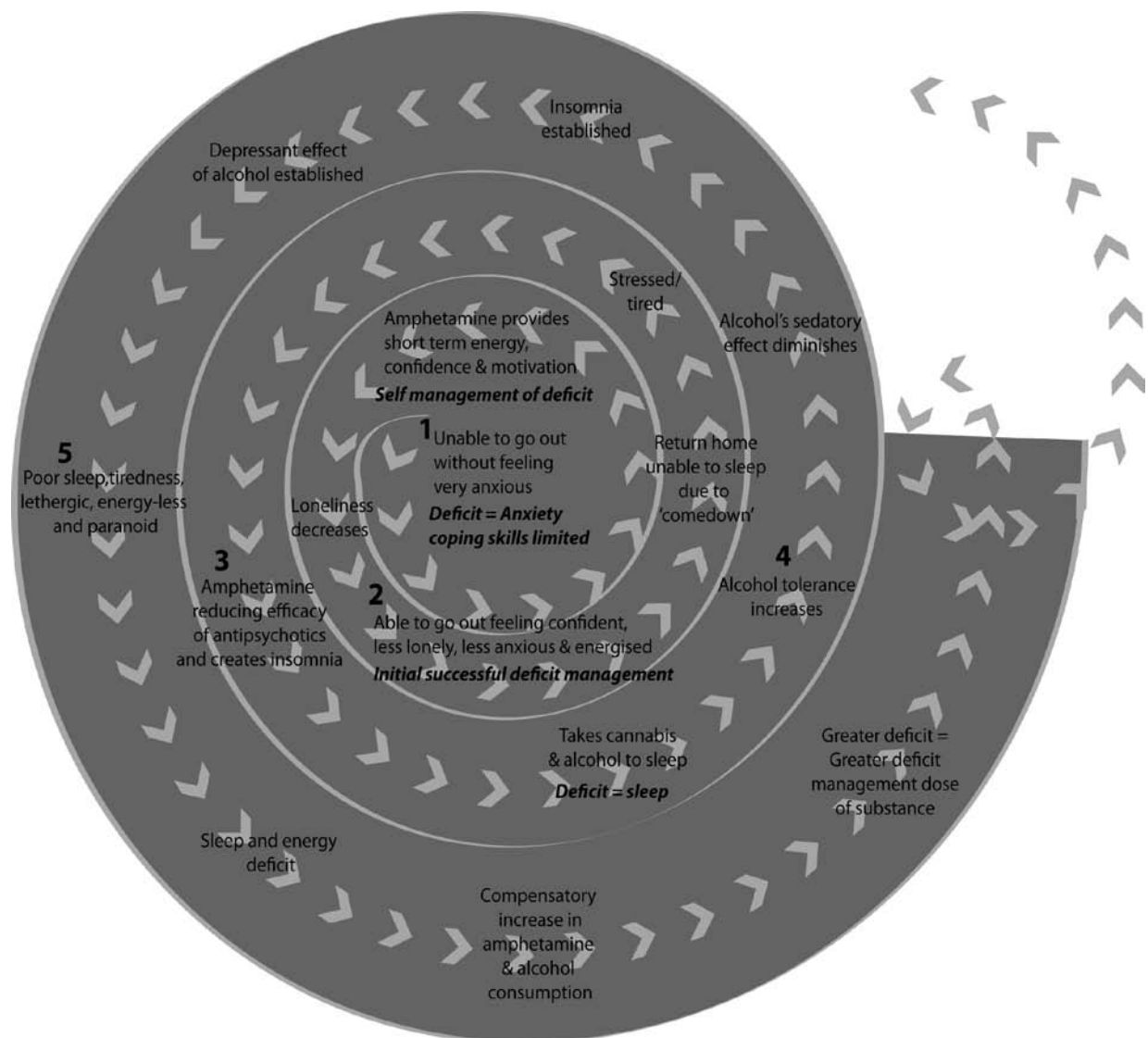
In conclusion, the role drugs performed was varied. Specific roles revealed specific rationales. Little emphasis was openly expressed on the pharmacological category of the drug such as hallucinogenic, depressant or stimulant. The emphasis, in conveying the role of the drug, was placed upon the individual experience of the drug in relation to a participant's problem(s). The strongest theme emerging appeared to be that of self-medication (Khantzian 1997). Another label for self-medicating could be deficit management or coping with life, with illness or with a lack of well-being.

The significance to the development of theory here is two-fold, the purpose and the manner of drug taking. One, for example, the nature and the role of drugs interlink

with achieving a sense of well-being. This is important because it links drug taking with the absence of well-being. It also confirmed the validity of 'Drug Taking' (in mental illness) as the core category. And two, whereby the *nature* of drug taking appeared functional in outcome ("*it made me more relaxed and sociable*"), the manner of drug taking integrated additional motivating and reinforcing factors. These were considered secondary factors but effectively sustained drug taking as depicted in the cycle of drug taking shown in Figure 6, 'Course of Drug Use: Deficit Management Model'.

11. Things that have not Helped

The category 'Things that Helped / Might have Helped' (Category 12), summarised next and discussed in detail in Chapter 5 is linked closely to this category. In this section unhelpful experiences are listed and analysed. They mirror in places those experiences found helpful, however, the data were less dense or detailed. This in itself was interesting. Participants appeared to discuss more readily their views that related to recovery or feeling 'better' than negative experiences associated with decline.

Whether this represented a deliberate avoidance of negative experiences linked to pain or failure or a purposeful attempt to be helpful through the course of the research is arguable. There may have been other reasons but the comparatively limited data in this section and wealth of data in its polar opposite category suggests an ability on the part of participants as a whole to look optimistically at their future rather than negatively on their past.

Notwithstanding that possibility the unhelpful experiences appeared realistic and insightful. Comments such as the one below convey an almost fatalistic view in contrast to the optimism alluded to earlier. In the case of this quote optimism and fatalism are not mutually exclusive. Noel could be expressing his sense of powerlessness whilst retaining a sense of hope.

> *Even if I was ill now and I walked down the street and I met a friend who said do you want half a spliff and I know it's going to make me a hundred times worse, I think it's just that, I live in hope that it won't, that it will help it out.* (Noel Inpatient Ward Focus Group)

As with all the data a sense of my subjective and the objective interpretation needed recognising, and in order to understand the full meaning conveyed by participants it was crucial that I was aware of the context from which an incident arose. The 'politics of location', as Koch & Harrington (1998) described, enabled me to wrestle with incidents by integrating my intuition and knowledge with the participant and their context. By employing a reflexive approach I was less likely to make reactive interpretations, indeed, reflexivity promoted a wholly conscious and deliberate interpretive process. Recognising the theme duality within Noels' comment above exemplifies the usefulness of the process.

The emphasis on positive experiences may have been due to the psychological need related to hope (Abramson *et al* 1989). It may have been tempered by the actual experiences of an unhelpful nature. These two positions were useful in that they demonstrated the breadth of the dual diagnosis experience; the positions appeared not to be mutually exclusive but simply a factual representation that participants had undergone positive and negative experiences. They had been up and down, stable and unstable. They had perhaps travelled through the cycle of change from using drugs, to contemplating reduction or abstinence to achieving it, several times.

This range of knowledge and experience appears highly significant from a validation or credibility point of view. Participants mutually appreciated their peers' views when they discussed the pros and cons of certain aspects of care, or of a drug, or of a treatment programme. The sense that recovery, for example, of a heavy or dependent amphetamine user when describing pre-recovery experiences, conveyed two things. Firstly it demonstrated a kinship with other participants and secondly, their present state of recovery showed optimism to be a valid concept, thus imparting hope and inspiration.

Themes of a similar nature were found in several subcategories. For instance a coercive approach adopted by staff to encourage medication compliance was cited as a negative unhelpful attitude.

Cross-cutting views associated with systems (service and social in nature) were discovered. A prominent one was that of systemic exclusion from services on the

grounds of race or culture. Exclusion on these grounds was not elicited in great numbers despite approximately half the participants being from black or minority ethnic backgrounds. The example conveyed by a practitioner participant described the cultural orientation of services that reflected society. It cited language barriers, greater stigma of mental illness and substance misuse than White British counterparts. In addition cultural explanations of delusional beliefs or bizarre psychotic behaviour (*'black spirits / voodoo'*) and a strong tendency to avoid disclosure or discovery of either substance misuse or mental illness in their community (South Asian) compounded problems.

In the following three quotations Margaret, a practitioner participant, provided an example of how disclosure of mental health or substance misuse problems to the wider South Asian community could jeopardise important cultural and social norms.

> *So women may not come out and disclose anything until they can't cope anymore and also there is a stigma attached of shame and humiliation, and that's a huge stigma that applies in many communities but much, much more compounded in the South Asian community because of arranged marriage prospects, things like that. If there is violence and aggression and if there is mental health, if there is drug and alcohol abuse then people don't want to marry their children into these families.*

Furthermore stigma appeared to dominate the perception of carers who would ordinarily be considered informed about the health system and necessary treatments.

> *…yeah, and if they're, if somebody in err, for say example, a GP's family, a wife is mentally ill, he not going to tell anybody, he is going to try a treatment. He is not going to disclose before he reaches a crisis.*

Treatment however when obtained would not automatically be culturally acceptable;

> *she was dropped back off* (by a Community Psychiatric Nurse CPN)*, in the evening, the mother would perform driving the black spirits away – driving the evil eye of the CPN away so she would burn some chillies and perform this ritual with the girl and she was already paranoid schizophrenic so she got more and more paranoid.*

The subcategories are summarised in Table 14 below. The dominant themes were related to systems of service delivery, treatment (usually it was medication related), attitudes (of practitioners and peers) and social issues. Accommodation and social networks were two examples in this latter subcategory.

Table 14. Themes of Unhelpfulness

Subcategory	Example	Theme of unhelpfulness	Outcome
Systems	1. Appointment system versus chaotic / disorganised lifestyle of participant	Service too rigid / *inflexible*. Service user unmotivated and / or disorganised	Low, poor or non engagement
	2. Services orientated to treat single disorder	Second disorder or condition *neglect*ed	Incomplete treatment or support
	3. Differences in cultural, professional and ideological philosophies across services	Poor *communication* Poor understanding Unnecessary erection of social barriers	Poor collaboration
	4. Lack of Information	Lack of *awareness* of services among service users and professionals	Non / inappropriate referral (includes self) or failure to joint work
	5. Diagnostic criterion / threshold levels into services set too high	Poor or untimely (late) *access* to services	Service user condition declines
	6. Health and Social Care agencies too complex for service users to navigate	System *Complexity* ("*a minefield*")	Service user becomes "*lost*" Poor/non engagement
	7. Emphasis on abstinence / harm reduction	Differences in treatment *philosophies*	Inappropriate referral/ care plan and level of motivation mismatch
Treatment / medication	1. Unwanted medication side effects (weight gain, loss of energy, sense of dependency)	Poor compliance to medication	Mental health deterioration / sustained mental health symptoms
	2. Ineffective medication	Poor compliance	As above. In addition a loss of faith in the potential usefulness of

			medication
Substances	1. Heroin and / or intravenous administration disliked and stigmatised among majority of participants	Drug and drug user hierarchy of perceived harmfulness and subsequent stigma (*"dirty drug"*)	None or late disclosure of stigmatised drugs / administration routes. Delay in seeking treatment.
	2. Cannabis induced paranoia or paranoid delusions	Insight into unwanted effects of drug delayed	Relapse and treatment delay
	3. Development of addiction or dependency syndrome	Escalation of needs	Increase in severity of both conditions
Coercion / Persuasion	Persuasive arguments presented by practitioners	Inappropriate counselling strategy	Poor collaboration between service user and practitioner
User involvement	Communication and language barriers	Provider / practitioner dominance	Poor engagement on service development and individual care planning level
Social	1. Drug peers and social network	Social reinforcement of drug use and peer pressure to sustain	Established drug using lifestyle
	2. Cultural, racial and language barriers	Poor understanding of drug use issues	Different and inconstant explanations, guidance and intervention
	3. Isolation and stigmatisation	Exclusion from mainstream society	Downward social drift. Economic and health decline
Attitudes	1. Hostility or passivity from practitioners towards service user or carer	Active disengagement by practitioners	Dissatisfaction with practitioner. Absence or disruption of therapeutic alliance. Treatment deficits
	2. Beneficence from practitioners towards service users	Undermining self efficacy and personal responsibility	Reliance upon services and loss of self determination

This section lists the subcategories and analyses them in respect of the category 'Things that Helped / Might have Helped'. It elaborates on the issues drawn upon to inform the user and carer information materials (booklets). This appeared crucial since insight into the problems faced and experienced by participants would enable

the information materials to convey understanding and empathy to the reader as a form of engagement. They also appeared of practical use, aiding exploration of new strategies of recovery or entirely avoid situations and circumstances depicted that may have previously seemed inevitable.

During analysis certain quotations appeared salient. They represented an entire passage and its meaning within the text of an interview or focus group in a remarkable way. The representation was then depicted as a theme or storyline within one of the booklets. The booklet stories were read by participants who then gave critical verification to the themes. This illustrates how the findings at initial analysis progressed to build theory and content for the information materials as discussed in Chapters 5 and 6.

> *…..depot, I have that every two weeks and that keeps me quite happy, but it keeps me tired, I get tired on it, I'm waiting for them to change it.*
> (Daisy)

The quote above signifies a concern about medication side effects whilst conveying an acceptance of the fact that medication in this instance is beneficial. The balance between adverse effects and benefits was summed up in this single sentence; the quality and utility that can emerge from a short passage being evident.

> *It* (antipsychotic medication) *made me tired at first. Then, that was, they put, I think I was on like 200, 100 in the morning and 100 in the evening at first. Something like that, and didn't do much for me voices. Medication never gets rid of 'em completely anyway, never, never have, never will. The clozaril still doesn't get rid of it completely.*
> (Noel)

Above Noel imparts the same attitude. Medication has pros and cons however the advantages eventually led to Noel and Daisy concluding the side effects were off-set sufficiently enough for them to adhere to their treatment regime. This suggests that side effects alone may not be the sole concern in relation to adherence or compliance to treatment. An attitude that is less coercive and more collaborative is cited in Category 12 where conveying care through collaboration appeared to prevent polarised views between user and practitioner forming.

> *It's great* (current medication)*, getting better and better on that score, but I worry about putting weight on with the injections.* (Sid)

The concerns raised about medication that were clearly important and were not totally obstructive, proved surmountable as the quotations suggest. They are important inclusions within this section because they emphasise the ambiguities faced by practitioners, carers and service users. They also allude to the process of recovery. It is doubtful that the conclusions reached by the participants above were immediate. Their experiences during periods of non-compliance would probably have helped develop their views. Equally their views could change over time, concern that medications were too frequently relied upon featured also as a valid perspective.

Another prominent theme among service user participants was the view that intravenous and / or heroin use was unacceptable.

> *Well it* (heroin) *makes you trip dun it. Like in that train spotter* (the movie Train Spotting)*. Where they're all taking it. And the guy swimming* (inaudible) *to go and get his drug. Then comes back up and the baby dies because they took heroin. Cos heroin's bad. You're digging yourself with it. It's just bad.* (Anonymous Inpatient Ward Focus Group)

The practice of injecting or using heroin was one aspect of drug use that appeared to attract stigma and disapproval from focus group participants. It demonstrated a theme that differences between drug users were hierarchical and often based on perceptions of harmfulness. Overall however it represented, for the purposes of producing information materials, that the drug using population were far from the homogenised group depicted through popular media. In this sense the differences between drug users were exemplified within the booklets as individuals. The story lines challenging stereotyped views by virtue of personalising the individual characters within.

The unhelpfulness of homogenising the drug using population therefore emerged only after deconstructing an attitude within a focus group itself. From this unhelpful theme came an intervention of a helpful nature; depiction of drug users as individuals with a history - individuals bound together *only* by the core behaviour of drug use.

Personal attitudes and social values weave and connect in virtually all areas of society. Which informs which is important but arguably indistinguishable. For instance does legislation influence society to be less racist, age discriminatory and unfair to minority social groups, or is diversity related legislation a reflection of prevailing social attitudes that necessitates legislation in order to have a comprehensive social impact? A parallel to this occurred frequently within the data where commonly held negative or prejudicial values emerged. For instance participants suggested that service deficits were a symptom of social values, that where stigma was strong (say employment opportunities for people with mental illness), services were weak (under resourced).

> *It's a shame there's not more for other people who are left to fend for themselves, who are being judged and ostracised by society, cos they've got a stigma and they do drugs.* (Sid)

The hostility cited in Table 14 above, that participants had experienced or heard about among peers, was a mixture of professional indifference or antagonism.

> *I don't know what they think because they never informed me. That's the impression I got. I've experienced both sides of the coin. People who do judge and people who don't and offer a helping hand.* (Sid)

> *The things that didn't help were two-fold that were blaming or judgemental or that were passive.* (Jane Carer Participant)

Pejorative attitudes were not confined to professionals but also to drug using peers.

> *But I always made an excuse. I said what did you think after that? and they said yeah so I said well there you go again, but not for all of them that's a cop out, that's me defending my drinking again. Cos alcoholics, they are,* (long pause) *they're crafty, they're sly and* (pause) *they're crafty. An alcoholic is just like a drug addict.* (Bill)

Finally the beneficence displayed by services and practitioners that had potential to undermine therapeutic progress and engagement was often accepted as sympathetic and well meaning by participants. Staff insisting that a service user becomes drug free and medication compliant, potentially counterproductive, was often understood to be *'part of their job'* and accepted. In focus group settings participants empathised with

the role staff had to perform and acknowledged the difficulty faced by nursing staff in relation to medication or enforcing a substance free environment. One aspect participants valued was the manner in which an attitudinally influenced or value-based policy was implemented emphasising that a collaborative approach was valued.

Below I enquire about a participant's response to a hospital policy discouraging of drug use (and preventing it on NHS premises).

> *What would you do? Would you stop taking the medication, or would you stop taking the weed?*
>
> *Well I had too much of a trip, yeah went to there* (tape inaudible) *and she's* (nurse) *helping me with the alcohol and the drug use and I said I'd stop taking the drugs, so I said I'd stop taking the drugs and the booze... yeah.* (Anonymous Inpatient Focus Group Participant)

In concluding this section it is indisputable that services or system related issues were important. This does not necessarily indicate that the system examples were the most severe; it is quite conceivable that the themes of race, culture or attitude on an inter-personal level were specifically more deleterious but harder to recall, describe or express. The services or system themes were prominent also under the fifth category 'Policy, Service or Practice Development Issues'. Subsequently, this section having examined the *unhelpful* themes and isolated their structural, behavioural and attitudinal manifestation successfully sheds light on the next category presented whilst also providing breadth to the major category of 'Help'.

12. Things that Helped / Might have Helped

This section and Category 11 formed the major category of 'Help' and therefore its analysis merited further exploration and discussion. An overview below is provided which promotes the core issues upon which ideas related to help are based. The overview is necessary to maintain a broad contextual picture of the data and analysis as a whole however the associated theory is presented in detail in Part 2 of this chapter.

Ten properties of 'Help' emerged, within each property were numerous thematic examples totalling 166. These elaborated on each property but remained linked. For

example the property of 'Safer Drug Use' was conceptually one of reducing the harm that drug use can cause the individual, the community and society as a whole. Needle exchange clinics helped reduce the harm from blood borne viruses on individual and community levels. Understanding that sharing injecting equipment, taking high dosages and frequency of certain street drugs could be detrimental led to moderation of use ('Education and Information').

The notion that help was a variable entity depending on the source (peer, friend, family, service, practitioner), the nature (practical or psychological), the type (drug or mental health related) and the level of motivation, was emphasised by the majority of participants. 'Help' was the term used to locate all actions and influences associated with recovery. As noted, recovery was often long term in nature and usually, but not necessarily, dependent upon conscious efforts by the individual concerned.

Critical connections across this category appeared that related to change and the need or desire to change by the participant. 'Care and Support' and 'Networks and Individuals' were two aspects that provided an insight into the prerequisite approach of any source of help. Here participants had been concerned that help should be understanding and empathic in manner.

Table 15. Properties of Help and Their Frequency

Subcategories / Properties	Number of themes
1. Communication with Others	4
2. Medication.	6
3. Support: Networks and Individuals.	30
4. Education and Information	17
5. Safer Drug Use	10
6. Care and Support	25
7. Treatment	29
8. Goals	5
9. Attitude	28
10. Activity	8
11. Self-view (subsumed into 'Attitude')	4

This could be demonstrated by offering appropriately timed intervention such as housing assistance when homeless. The caring attitude had to be equalled by competence. The knowledge and information on interactions between medication and street drugs being another area cited, symptom management and relapse prevention being examples of others.

This category generated my grounded theory and also proved crucial to the development of the four information booklets. Participants were eager to share their experiences for others to benefit from and subsequently the helpful strategies delivered or adopted by participants reveal themselves in live fashion within the booklets (information materials as outlined in Chapter 1 and presented in Chapter 6).

> *I seen three people sitting there in the snow in the bus shelter with their bottles out and that in there and I thought that could have been me in the past…I walked a bit further there wasn't many people to ask, anyway it would have been a waste of time asking them 'cos I might have ended up sitting down with them and eventually I bumped into er…someone. I saw an off-license that was opened ……and er was ready for something to eat and I go in and asked him directions for town again and er when I got back into town and I was ok.* (Dean)

Above a participant gives the briefest extract from his life. The struggle to remain drug free and the implicit satisfaction derived from each apparent small success. The collection of properties and themes related to 'Help' are vast, this is but one example, yet they condensed to form a conceptual understanding of what participants regarded necessary for change or recovery.

'Help' and all 166 property examples were reconstructed as actions or circumstances that led to, or facilitated, change. Change was aided by motivation, which manifested in a combination of positive or therapeutically optimistic attitudes (among helpers and participants) and an equal amount of competence.

This section has identified 'Help' as the leading concept within the data. Ten key properties were listed and their inclusion in the information materials noted. The detailed analysis of data and theoretical sampling to follow enables the reader to

determine precisely how 'Help' manifests (useful intervention / advice) and why it features as the concept from which my *Help* theory was built.

Summary of Categories

The findings presented here have been wide ranging but despite the breadth of data and the substantial number of categories clear patterns are evident. The linkages between categories through the deconstruction of incidents contained within followed by their comparisons with similar and dissimilar themes illustrated a significant model upon which to base theory.

The concept of help or helpfulness featured highly in the number of incidents counted. The incident count was necessarily matched by the relevance of help, in terms of values, attitudes and motivation and practical advice (do's and don'ts or harm reduction guidance). In order to establish the credibility of help as a concept for selective coding and theoretical sampling, as will be re-presented in Part 2, a rationale for its prominence was sought. Part 1 of this chapter has provided this by discussing in detail how distress motivates people to seek remedies or relief. The model (Figure 6, 'Course of Drug Use: Deficit Management', Page 130) emphasises the magnitude of the dual diagnosis phenomenon on the grounds of cyclical reinforcement of self defeating actions.

The 12 categories and 977 incidents do not depict the phenomenon of dual diagnosis sufficiently to explain why and how it occurs. They do however provide powerful insights into the experiences of people who use substances and experience mental illness. In this sense the categories that emerged help to fulfil the study objectives. Firstly the tendency for participants to continue using substances despite receiving information, advice and treatment to the contrary supports the research and policy guidance based on harm reduction strategies. Secondly, several categories focussed upon relationships and explanations (for example categories 1, 3, 4, 8 and 10) that placed service user participants in a centrally located position for receiving care. The central position of service user participants subsequently orientated the remaining categories. It therefore followed that the information materials would contain guidance on the issues discovered salient within the study, an example being to increase the knowledge of drugs and alcohol among service users. It also demanded

that theory should reflect the issues concerning helpfulness since it emerged as the major category.

Thirdly, the role substances performed (see Table 13, Page 127) whilst not comprehensive, was wide and varied. This category identified a range of specific functions of drugs and successfully conveyed the importance of tailoring care to the individual rather than assuming a substance's widely reported or global effects. The 'Role of Substance(s)' category, as a consequence, contained a combination of practical drug related information and the principle of individualised care.

Timeliness and how accumulated negative experiences induce motivation was discussed. These accounted for a variety of views and concluded with a sense of optimism because those participants well into recovery had previously shared the profile of those participants currently struggling. The following section elaborates on this point by detailing the analysis of help-related categories and how 'Help' emerged and developed. The content, or substance, of 'Help' presented within this chapter constitutes the guidance and advice contained within the information materials.

Part 1 of this chapter has presented the key findings in 12 categories. It has cited the context or core category, that of drug use in mental illness and set the scene for the reader to follow the development of theory and information booklets based directly upon these findings in Part 2.

Part 2: Major Category of Help

Part 2 builds upon the previous analysis by examining in greater depth the key categories related to helpfulness and unhelpfulness. The findings are presented here to demonstrate why 'Help' was such a prominent issue and how it was conceived by participants. The chapter therefore justifies the identification of 'Help' as the major category and describes in practical terms how it translated into (i) a source of useful information and (ii) a theory leading to a greater understanding of dual diagnosis. The development of theory took place through analytic and reflective processes.

The help-related categories included a wide range of responses largely because help is an expansive concept influenced by individual subjectivity and wider social norms. To order the data it was necessary to consider its dimensions; type, nature, level and source, and in parallel to the dimensions, examine the specific functions or properties it possesses.

Part 2 therefore presents the help-related data incidents in a structured manner. They are categorised into 10 groups and consider the characteristics and properties that emerged and how they began to translate into helpful strategies, be they formal or informal. I then present and discuss helpful strategies within a motivational framework of behaviour change in an effort to explain how the concept of 'Help' materialised and why motivation and help combine. This constitutes the basic psychosocial processes present when individuals are contemplating their own or other peoples need for change.

The prime purpose of this part is to discuss the concept and practice of help as defined by the data. It also discusses the major category in sufficient detail to set the scene for the 'Outputs' chapter which presents the four booklet series of service user information materials.

Throughout collection and analysis, themes that appeared salient and possessing potential explanatory power were sought. The lengthy process of theory development means that this section is only one of the closing stages of the research. In this stage conclusive discussion does not materialise. What does take place however is in-depth exposure to the data in relation to the outputs of a grounded theory and information materials. Chapter 5 discusses the research implications in relation to the literature.

Dimensions

Help for dual diagnosis participants took on numerous forms. Types of help varied from mental illness management, to safer drug use, to cutting down or stopping. For some the nature of help was emphasised more, reflecting on strategies or incidents that could be deliberately planned, or were accidentally discovered, that helped in a psychological or emotional way. The nature of help was largely dependent upon what the participant believed to be a legitimate cause for concern. This again varied. Those

participants who were continuing to use drugs tended to cite types of help that would alleviate drug consumption related problems. An example here was the discovery and then strategic use of alcohol or benzodiazepines to reduce the distress of post stimulant depression ('comedown').

Other participants concerned themselves more with psychological distress related to mental health. This aspect relates strongly to the category 'Role of Substance(s)' whereby help was conceptualised as anything that could relieve general (or specific) sources of mental distress. Subsequently drug use itself was often regarded as helpful, demonstrating the potential breadth of *Help* theory. In those participants who were trying to cut down or stop their drug use, it was regarded as unhelpful. There was concurrent concern expressed in relation to psychological distress generated by drug use. Depressed mood, anxiety, cravings, infections, overdose or poor quality drugs were causes of drug related problems where help was regarded as necessary. In this respect help was about maintaining drug use with the least amount of harm or distress arising from it.

The quantifiable or measurable aspects of 'Help', its dimensions, fell into one of four subcategories.

- Type of Help
    - Mental illness related (e.g. drug use as relief from symptoms)
    - Drug related (e.g. whilst using drugs / harm reduction)
    - Goal related (e.g. for cutting down use, coming off and staying off)
- Nature of Help
    - Practical
    - Psychological
- Levels of Help
    - Individual
    - Community / service
- Sources of Help
    - Peers
   - Carers
    - Services / professionals

Making sense of the subcategories occurred when it was stated that *"it all depends on if you want to stop your drug use or not"* (Simon). If you do not want to *"stop"* then the help was orientated around the status quo, becoming intoxicated and avoiding withdrawal. Help was either drug related or related to ameliorating the indirect effects of drug use such as relationship breakdown, financial hardship or physical health decline.

If people wanted to stop or had stopped drug use then help was related to reconstructing lives and sustaining drug reduction or cessation (relapse prevention). The model 'Stages of Change' (DiClemente & Prochaska 1985) below is a framework that appears to add clarity and an explanation of participant's differing conceptualisation of help. The dimensions and properties of 'Help' and their potential to influence practice and understanding emerged. In the context of theory development, the major category of 'Help' is defined in terms of its source and nature, and its extent (level) and orientation (mental health, drug or goal related). These aspects demonstrate conceptually and practically how a model of motivation and readiness to change is relevant. This model by DiClemente and Prochaska (1985) broadens conventional understanding of motivation to encompass those people who might attempt, yet fail to make immediate substance use changes. This group were represented throughout the research; subsequently there is an observable alignment of 'Help' incidents with such a motivation based framework.

DiClemente and Prochaska developed the Stages of Change Model (Figure 7, overleaf) for treatment of nicotine addiction in the 1980s. It has since been applied to numerous aspects of health behaviour change from weight loss to gambling (Rollnick *et al* 1992; Rollnick *et al* 1999). It is a model that cites 5 distinct stages reflective of an individual's attitude and behaviour towards drug use or change. Drug use and the failure to abstain in the past had traditionally been viewed as black or white. An individual was regarded as insightful when they were abstaining from drugs. They were judged to be in 'denial' or held no conscious insight when they were using drugs. This promoted a model of understanding based entirely on the drug related actions of the individual and failed to integrate preparation be it psychological or behavioural (preparation, contemplation and late precontemplation stages).

The model expands motivation into a concept depicting stages of readiness or eagerness to change that is both behaviourally and psychologically defined. Motivation may fluctuate from time to time in differing situations or under certain circumstances. These changeable states of motivation appear to explain why participants as a whole were so varied and at times inconsistent in their assertions of what was helpful.

Figure 7. Stages of Change: Model of Motivation. (DiClemente & Prochaska 1985)
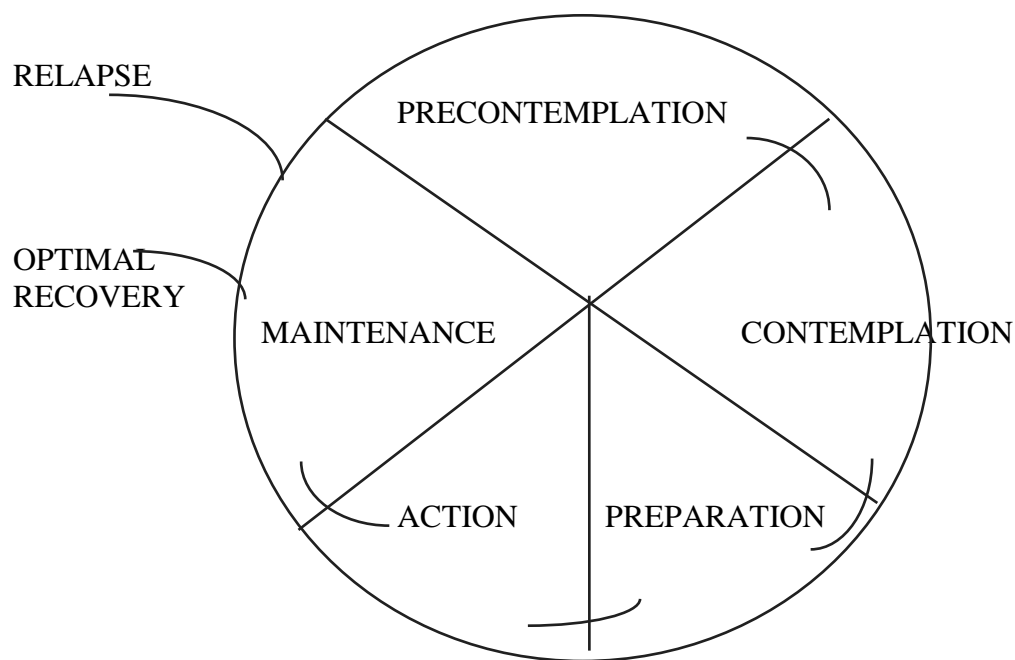
Helpfulness therefore varied in dimensions and properties. Discovering a major linking element within this category was potentially significant in that it could form the foundation to the information materials. As the following properties emerged it was clear that participants, regardless of their level of motivation, wanted help of some form. They held an understanding that external sources of help were available and consequently their life and recovery was communal not singular. As a result the foundation to the study's emerging grounded theory, and implicit within the service user information booklets, is the understanding that drug use and recovery both rely upon social interaction. In order to expand on this theme the practical aspects, the properties, related to help are presented and discussed.

Properties

Eleven subcategories from 'Things that Helped / Might have Helped' emerged. They were labelled using the most prominent conceptual theme, for example goals, communication, attitude or medication. They remained inextricably linked however identifying those links of relevance required their analysis in isolation. The frequency and strength of conviction conveyed by participants on the issue of helpfulness elevated this category and the category 'Things that did not Help' to the research study's major category of 'Help'.

In this section 11 subcategories are described. They are presented separately and unranked, as they emerged at analysis, with commentary on salient linkages to the major category.

Table 16. Properties of Help

Subcategories / Properties	
1. Communication with Others	7. Treatment
2. Medication.	8. Goals
3. Support: Networks and Individuals.	9. Attitude
4. Education and Information	10. Activity
5. Safer Drug Use	11. Self-view
6. Care and Support	(subsumed into 'Attitude')

1. Communication with Others

Being able to communicate effectively with people in a position to help appeared valuable. The cathartic element was emphasised as was the confidence in professionals to listen and not pass judgement.

Professionals imparting sound and objective information upon which participants had made changes were cited regularly. The groups in which stories were shared, tips passed on and worries given a sympathetic hearing, were seen as useful but crucially these needed to be peer conducted groups rather than professionally delivered.

> *Well I think that the staff – they do a good job, because they are there and they will listen to you if you've got a problem, and that's why – even if I go to the groups, I do talk in the groups, but if there is*

> *something that I need to talk about, I don't talk in a group, that's why I've my one-to-one. I prefer it to be private that. They'll listen.* (Ron)

Ron conveys his faith in confidentiality here. He also distinguished between group and individual sources of help. The distinction suggests that help is multifaceted which was consistent throughout data collection and analysis.

> *I think being there really, being there if you need someone to talk to I mean I have Carol, here for one-to-ones and just have a chat with her and that's good, that's useful. If you talk to people who know. You see if I went to see a relative or a friend I couldn't have the sort of conversation I have here because they wouldn't understand so it's that above all, the communication.* (Simon)

Simon captures a point echoed by others. Professional or peer intervention enables intervention to remain focussed upon the person receiving care. Carer needs are substantial and they appeared indisputably linked to the service user for whom they cared. This being the case those aspects of help a carer wishes to deliver but is unable to do so due to the closeness of their relationship could become lost. It is conceivable that carers need to know that care is being delivered, or is under serious consideration. This was considered a relief for carer participants in this study. Conveying the point within the information booklets was likely to be of great value. Illustrating the drug related distress (for all, including professionals to see) would be an acknowledgement of need that previously carers may have considered neglected or unnoticed. This point suggests that carers may be partially relieved of the pressure to deliver care but also experience relief through the empathic content of the materials.

2. Medication

Medication was an issue for all participants. Antidepressants and antipsychotic medication were referred to more frequently than other medications such as mood stabilisers or those taken to relieve side effects from antipsychotics. The views on medication (prescribed psychotropic drugs); its effectiveness and frequency of use (or compliance to treatment regime) were often as varied as those views expressed in relation to illicit or psychoactive drug use.

Where a participant preferred cannabis to alleviate intrusive auditory hallucinations another would suggest alcohol. When heroin was cited as helpful in blanking out painful memories another would say crack cocaine was more so. Subjectively then individuals found a variety of drugs useful in meeting a common need; relief. Attitudes towards medication demonstrated similar variances. Context, circumstances, level and type of illness were among a number of explanations for the range in views. However, three chief factors emerged.

One. Did they want the medication?
Two. Were any conditions attached to taking it?
Three. What interaction would it have with their drug or alcohol use?

> *Its not too bad now, I'm on injections now and that seems to have calmed it all down, but I have trouble with the voices from the outside when people are out here, they are making my life hell. Tormenting me.* (Sid)

What features here is a strong sense of desperation. The distress generated by psychotic symptoms (*voices*) fluctuates yet a discernable positive effect from medication is conveyed. Medication in this instance has been helpful but fails to alleviate illness-orientated distress completely; subsequently drug use has potential to continue. This suggested that medication and drug use had become a combined coping method for mental distress. Arguably Sid is using medication as an adjunct to his drug use. The helpfulness of both is limited and the two combined not fully effective, in fact it is likely to be counterproductive. The constant search for fully effective combinations or new drugs / medications therefore continued, illustrating the longitudinal nature of dual diagnosis.

> *I think erm, the erm….. I think the problems like gone away now, my nightmares have gone away but some nightmares are still there, but there just odd dreams that I have really, not as bad – I'm taking the clozapine but I think at the time when I* (first) *took the clozapine I thought well erm, the nightmares have gone, I thought that was the end of the nightmare and I took the trip* (drug use) *with a best friend of mine and I went to, I started infant school with him, and we took it as two grown men, yeah, and my brain wasn't strong enough and he got the better of me and he got into my head…* (Connor)

A repeated experience of partial effectiveness of medication is demonstrated in the quotation above. Medication effectiveness was viewed as limited. Medication viewed as helpful consisted of a clearly demonstrable subjective benefit, such as reducing the intrusivity of delusional beliefs, the volume of offensive auditory hallucinations or preoccupation with bizarre thoughts.

> *I just say drinking is fine in moderation if you know you can stop. Personally I wouldn't have done anything different in my early years than I did because I wasn't out of control and my life was alright through drink, just having a couple in the evening but in terms of looking at drink to solve your anxiety or stress I'd say no, I'd say not, I'd look for other ways, because no matter, even on things like medication, and OK I understand people need certain drugs for medical conditions but I don't necessarily think that's the case for anxiety I think you are just delaying it and making it far worse when you do stop and it does hit you.* (Simon)

Although the quote above refers to a 'milder' form of mental illness (anxiety), this had no bearing on the prevailing attitude that medication was limited in its power. Participants who sought to use medication in combination with alcohol or other psychoactive substances often found the pattern was erratic depending upon its availability and their underlying level of health or distress.

Psychosis was a long-term condition for three quarters of people who participated. They had marked sustained symptoms and as a result medication, usually antipsychotics were prescribed and encouraged throughout service contact. The limited effectiveness of medication as experienced by participants was counterbalanced by a constant flow of encouragement from their practitioners and doctors. A strong element of forced or coerced compliance was detected; conversely participants frequently conveyed a faith in their practitioner's judgement about the helpfulness of medication that conflicted with negative subjective experiences. This remained unexplained but intimated two factors; (i) the persuasive ability of practitioners and (ii) the desperation of service users to obtain relief.

A paradoxical conclusion was reached that medication was of limited helpfulness yet not disregarded; moreover it was considered a source of help not fully realised. It may

also have been the vehicle for conveying and receiving empathy, a prerequisite for care, as presented in the following sections.

3. Support: Networks and Individuals

This section looks at the positive aspects of networks and any individuals connected to users. A network became defined as individuals or groups with whom that participant was in touch. Groups could be formal such as a local authority service, a community mental health team or probation service. Informal groups were familial, friend, peer, work, study or community orientated for example.

Elements of networks, be them individual components or group, usually possessed negative and positive traits. Some participants found negative and positive aspects occurring simultaneously from the same source. Take for example the scenario of support from a CPN whose role included encouragement to take medication and monitor for signs of relapse. Whilst the CPN's intervention relating to this was considered intrusive at times by many, their overall role was also seen as legitimate because of other valued support elements such as assisting with benefits and housing or providing reassurance and counselling.

The question of support networks and the role they played in helping therefore was complex and often two sided. Consideration was given to the source and nature of support during analysis, however this section includes all network type support, even that which could be deemed as largely unhelpful. There appeared two reasons for this inclusion. Firstly, if participants considered it helpful any exclusion from this category on the grounds that it was inappropriate would create a false picture. The full extent to which helpful things linked to unhelpful things illustrates lifestyle, social and cultural dimensions that are inextricably connected. My role as a researcher was to present categories as they emerged and avoid making significant judgements that could potentially disrupt the outcome. Subsequently if it was deemed helpful by a participant but detrimental by me it remained included. Secondly the methodology of grounded theory requires that raw and refined data retain their core characteristics and resemblances. Refining the themes and categories into theory is where resemblances became less obvious. At this juncture an inclusive principle was applied where all data were considered.

Two conceptual sets of data are presented here in relation to support. One relates to the source, the other to the nature. Overlap occurs where for instance the nature determines the source and *vice versa*. An example was that of peer recovery from alcohol dependency. This was delivered in a formally structured group within a day treatment service however the nature (collaborative, empathic, peer advice and intervention) underpinned the intervention as a whole and subsequently informed the group's formation and sustained its ongoing presence. The sources of support were various and wide ranging.

Table 17, lists the sources of support and their purpose. The key point emerging here was that support contained innate properties of positive social interaction. The intervention or advice delivered being equalled or surpassed by the positive effect group orientated recovery processes generated.

Notwithstanding this, the context and circumstances participants operated within were often chaotic and appeared incompatible with stability or routines that would benefit their well being. The disruptive nature of mental illness and its impact upon confidence and security, self esteem and economic or social status is well documented (Goldberg & Morrison 1963; Link *et al* 2001) as are the consequences of erratic or persistent drug or alcohol use. According to established theory (Becker 1967; Zinberg 1984) the effects of substance use differ depending on the individual personality ('set') and the situational factors in which substance use takes place ('setting'). The constraints and measures individual users place upon themselves and peers is effective in reducing harm from all forms of drug use (London Dance Safety Campaign 1997). Drug users, once conscious of the negative or detrimental effects of their drug of choice can modify usage. They monitor drug dose and food intake, are mindful of drug combinations and interactions and look out for friends and peers, reminiscent of the strategies adopted by my research participants. Much of this is expressed within the booklets and demonstrates that amidst the chaos of mental illness and drug use, participants tended to, or were receptive to health messages. In the absence of suicidality or death wish mindsets (Minois 1999) the dual diagnosis client group of my research sample resembled mainstream drug users with regards to safety. Of possibly greater significance are the health related behaviour change issues of smoking, alcohol consumption, diet and nutrition, and sedentary lifestyles. These

aspects arguably hold greater risks for the dual diagnosis client group and the general population yet evoke less unequivocal responses concerning attitude. Subsequently, it is likely the challenging and chaotic profile presented in dual diagnosis populations, whilst well evidenced, as cited in previous chapters, possesses a social dynamic that escalates concern and colours inappropriate attitudes.

To expand further it is worth considering the ordinarily effective social sanctions and modifying structures relating to behaviour and conduct. Actions within a given context and social group of unacceptable levels can be construed as damaging (Festinger 1950; Tesser 1988), this then has implications to the order of a group and patterns of interaction and behaviour. Social rituals and norms were wholly apparent among the study participants. The concerns, by some, that injecting drugs (e.g. heroin) was a dirty and despicable habit implied unacceptability, the presence of such values indicates the parameters of the drug using groups. Inviting as it is to regard the drug using population as chaotic and disorganised it would appear their ritualistic behaviours and codes of conduct exist in order to form and retain group coherency, even survival in some instances (Farrell & Marsden 2005; Harding & Zinberg 1977).

It could appear that the service user, with the shackles of mental illness and the perceived chaotic lifestyle persistent drug use suggests, is incapable of managing their life, let alone recover from their challenging conditions or situations. Here it is noteworthy that participants valued, received and delivered intervention or help across their groups. They found the value of peer support high and as such their social role within peer groups was subject to control and constraint. I posit that substance use is often a more orderly activity than it would appear and that substance using groups exercise substantial social order despite the public perception to the contrary.

The helpfulness of support appeared to define the sources from which it came however the fundamental 'nature' of support appeared more significant to service user participants overall. It was emphasised in the abstract and conceptually. The connection between a helpful nature and the alleviation of mental distress or role that drugs played was strong.

Table 17. Sources of Support

Title / label	Purpose and formation
Service user support group	Informal peer support taking place in ward day rooms or smoke rooms. Not facilitated formally but approved of and encouraged by practitioners.
Befriending service	Formal befriending service established by voluntary sector services to encourage friendship skills development. Befriending was also commonly referred to as a natural consequence of sharing meals, space and concerns with fellow inpatients or peers in treatment type settings.
Representation and Advocacy Service	Formal NHS service designed to advocate for and represent service users.
Recovery Group	Formed to encourage sharing of recovery successes. Ideas and suggestions from peers were identified as crucial in the recovery process lending weight to the conceptual interpretation that drug taking and recovery are fundamentally group activities. Isolation only compounding problems.
Community Mental Health Service	Formal multi-faceted support provided by NHS and voluntary sector services to monitor, intervene and aid in the recovery of mental illness.
Friends	Loose and tight friendships formed for several purposes. Group efficiency and safety in procurement and use of drugs. Friendships for support and pleasure in recovery and day-to-day life.
Family	Roles and quality varied enormously. Sustaining or rejoining families as part of recovery was helpful and motivational for many. Remaining distant or severed from families was helpful and necessary for others.
Carers Group	Formed to help carers of dual diagnosis service users. The function was viewed by carer participants as critical. Such support was helpful when it contained similar elements in nature to those regarded as helpful by service users. See Nature of Support below.

The cross-cutting strands of positive interpersonal exchanges and personal feelings was evident. This encouraged storylines in the information booklets to emphasise the plight of user participants (generating empathy and identification) with the inclusion of more concrete advice and support appearing later (the useful information and advice).

This sequence in the booklets of empathy (engagement) then advice (harm reduction) also mirrors evidence based mental health and substance misuse service provision; the practice of engagement followed by intervention. Table 18, 'Nature of Support', identifies the core and peripheral elements considered helpful by participants.

Table 18. Nature of Support

Title / label	Function
Empathic	Conveyed understanding and reduced the sense of isolation through a lack of understanding. Could be delivered from various sources such as professionals or peers and in various formats such as information literature, DVD / video.
Practical Relapse Prevention	Offered tips and guidance related to keeping well, staying off drugs, sustaining drug consumption reduction or health advice about blood borne viruses, thrombosis and overdose, for example. Activity scheduling and replacement activity.
Peer orientated	Shared experiences of success and failure in keeping well and staying off or reducing consumption carried validity. It confirmed to participants that their problems were not insurmountable. Participants knew untruths would be spotted by peers too. Providing peer support was equally helpful but apparent at later stages of motivation and recovery.
Humour and fun	Sharing tales and strategies evoked sadness and elation. The exchange of stories and experiences contained amusing insightful observations from most participants. Couching painful experiences in amusing anecdotes appeared popular, added kudos to the story teller and facilitated group recognition and reflection. The role of humour and action of laughter appeared therapeutic. It appeared naturally and spontaneously within this research setting.
Friendship and kinship	Related to peer orientated support with the added dimension of extending beyond group setting into day-to-day life.
Comforting	Knowing someone else cared and understood was comforting. During cravings, relapse fears or relapse itself the value of unconditional support was a powerful reminder that users were not returning, through their relapse, to an isolated state. Isolation contributed to a sustained relapse therefore comfort through supportive contact was a protective factor.
Collaborative	As a principle within one-to-one work or as a method of working together between agencies or peers, collaboration was seen as essential. It emphasised the support network and its presence was incompatible with isolation.
Reliable	The content of support had to be accurate and valid for users to consider it helpful. Reliability was also seen in terms of flexibility and longitudinal availability. This applied to friends, peers or professionals.

Below Simon conveys elements of the nature and source of support described above. In addition the passage possesses an insight and acceptance of the limitations present, such as the extent to which the family could help. This is consistent with choice and decision making. Service user participants, regardless of their level of motivation or stage of readiness to change, made decisions based upon more than one option.

Erm.. well in terms of my rehab hostel, I think it is the education, and certainly from the programme here. That has helped enormously. To be with people in the same sort of situation as well, I didn't really get much help from my parents or family because they didn't really understand, you know they helped me where they could if you know what I mean but it got to the situation that the family.. well it was tough love if you know what I mean they couldn't deal with it anymore so I didn't see my family for about three years. (Simon)

Below Ron cites several efforts to become abstinent which eventually paid off. This demonstrates the longitudinal timeframe involved and the timeliness of a particular approach such as activity scheduling. Integrating several helpful commodities simultaneously reveals that a menu of helpful strategies is necessary, whilst the timing of them needs to be prudent (see Table 20, 'Motivation and Intervention Cross-Walk', Page 173).

Later, the importance of peers and friends emerged. The usefulness of insight into potential triggers of relapse whilst experiencing drug misuse cues is also crucial. Despite the dangerous cues or triggers to drink again, this quote places friendship, kinship and reliability above avoidance of the drug (in this case alcohol). It provides a revealing conclusion concerning isolation that weaves into the storylines of all four booklets.

Well the place where I've gone into, my new hostel, after coming out of the detox was a better thing, because I didn't think the ten day detox worked for me. I relapsed four times last year and ended going in doing a ten day detox, I've got a key worker, I come here and I also go to Turning Point. I go to the gym club. I started a computer class, which I'd never touched in my life, laptop, first time yesterday...

...the rehab hostel – see I only go home at weekend, and I still go to my friend's pub and I don't drink and my friends that I thought were my friends, because I don't drink now, they've wandered off. The friends that are my friends have stuck by me, because they've understood that I had a problem, and they have been good with me. I don't tell them to stop drinking, and if it comes to where, if I am in the pub and I'm having a soft drink and I feel – I start getting panicky and paranoid when I see people getting drunk, I leave the pub, I go. (Ron)

Below Ranjeev reflected upon the impact that a collaborative approach among services and practitioners dealing with the conditions of substance misuse and mental

illness can achieve. Ultimately Ranjeev, a practitioner participant, makes a career choice based upon this aspect of helpfulness in dual diagnosis.

> *..I was a part of the group that would review the programmes that they developed... individual workers would get together and work on a particular project which may even be just working on a patient and seeing how those systems, their separate services, actually improved the care and outcomes for those patients, it really inspired me about well actually ultimately I think this is probably an area that I definitely want to get involved with.* (Ranjeev Practitioner Participant)

With further reference to collaboration, and linking with peer orientated help, the quote below captures both elements in tandem.

> *If you mix them together, then that would be great because you get all the best ideas from all the recoverers. They* (fellow patients) *can have all the great ideas that they want but its putting them into practice, so that you've got to have the other people* (practitioners) *to give and say well, you can do that, but you've got to do it this way.* (Jake)

A value is placed on the help received from other people who had experienced a dual diagnosis because of the very specific and accurate empathy they can provide. Furthermore the dual diagnosis experience placed people who had recovered in a position to potentially help others. The 'Source' and 'Nature' subcategories powerfully convey the duality of 'Help' in this context. The 'Source of Help', experientially based, appeared to strengthen engagement in the helping process whilst the 'Nature of Help' provided a potential vehicle for conveying accurate empathy and comfort. (See Karen's quote below)

> *I'd like to get to know more people that have been in my situation* (partial recovery) *and say, they have started counselling or something like. They* (professionals) *haven't been through what I've been through .. .. it will give me the satisfaction, helping people that have been in the same situation as me.* (Karen)

4. Education and Information

In this section the participants desire for quite concrete factual information was apparent. The major category of 'Help' was broad. It elicited various views from several basic positions. Someone using substances constantly with no or little

intention of reducing intake wanted help in relation to safer usage of drugs, they wanted supplementary information related to housing and benefits and they also wanted help around distancing themselves from or avoiding the mental health or criminal justice system.

Other participants in a state ready to cut down their substance use wanted help focused upon their cravings, alleviating their mental distress (often the driving force or sustaining factor for their substance use) or help with replacing drug taking activities (obtaining money / drugs / overdosing). The meaning of help for them was specific to helping them in their goals around reducing substance use and establishing lifestyle changes. These consisted of developing new or re-establishing old social networks, reforming family relationships, embarking upon educational or vocational activities. A substantial and often dramatic lifestyle change was evident for this group.

A third position emerged among those participants who had successfully stopped using drugs. Their help was concentrated upon maintaining their changes and managing the risks that would threaten their new found abstinence. This group were also interested in the health promotion and preventative aspects of drug misuse. A sense that if they had been aware of (i) the risks of drug use and (ii) where help was available from, they would have been able to avoid drug use or curtail it far sooner. Given the high level of motivation required at this later stage (action / maintenance as depicted in Figure 7, Page 147) this position appears to emerge after considerable self reflection. It promoted strongly a need for information provision to dual diagnosis service users. In addition, from a psychological perspective it also revealed that recovered service users remained in an external attribution state. This model of self view and its relevance within dual diagnosis emerged within the categories 'Role of Substance(s)' and 'Feelings / Belief / Symptoms'. It appeared to demonstrate that substance misuse among the mental illness population was not viewed as wholly the service users responsibility. Overlay this perspective with views expressed in the category 'My Explanation for my Condition' and a theme of powerless and lack of self-efficacy is evident.

This section concerns itself less with theory and speculation of what might help and why, but more with what did in fact help and what the reasons for success were as

described by participants. It presents distinct elements of helpful information and education from the point of view of one of the three positions of service user (in relation their stage of change) described above. The utility of this is conveyed within the information materials (see Chapter 6) where the central characters within the booklets travel through stages of readiness to change with useful or helpful events or happenings being located at the appropriate point.

Precontemplative users, or those service users not considering change as beneficial cited the following as helpful;-

- Information about medication and how it interacts with their drug use
- Information about their drugs of choice including coping with 'comedowns', safer usage and the law in relation to drug possession
- Information about their mental health
- Information about the mental health and housing systems
- Assistance with benefits and housing

The request for information and their experience of those aspects listed as helpful revealed a concern that drug use and drug lifestyle contained a number of difficulties. From a treatment perspective and in relation to writing the booklets, these were construed as opportunities for service users reading the booklets to reflect on situations that resembled their own, read further and discover useful strategies for moving on. In other words demonstrate a route to recovery.

Below Connor was talking about the help received from daily peer support groups he attended. The level of credibility and empathy peers provided coupled with valid and accurate substance misuse information made a powerful combination for changing drug use and lifestyle.

The conversations within daily support groups contained two prominent themes. One was the power of peers' experiences (empathy and credibility) and two, the process and value of sharing factual relevant information.

Connor	*I wanted people to support me, do you know, say well this is bad for you – don't take this anymore but just carry on with the general day-to-day* (inaudible)…….
Mark	*based on your experiences and current success what would you say to other drug users*
Connor	*I'd say well erm, steer clear from drugs like that. It did me a lot of harm and I wouldn't advise you to take it.*
Mark	*Do you think they'd listen? Would you have listened to someone saying that to you?*
Connor	*Well not at that time. I mean, no one put a gun to my head to take the drug. There was only me and my friend.*
Mark	*Why did you take it then?*
Connor	*I don't know. It was like the devil looking over me and saying well here, take it, its not going to do you any harm.*
Mark	*Right, right,*
Connor	*Go on take it, chew it.*
Mark	*Yeah*
Connor	*It was like the devil forcing me to take it – that's what I think.*
Mark	*And do you think that's what happened then, do you still think that that's what happened, the devil made you do it.*
Connor	*That I'm going to be tempted again, its like with the drink.*
Mark	*What's going to help you stop using now?*
Connor	*Just keeping my brain occupied and using these daily support groups* (peer)
Mark	*Yes*
Connor	*Start going to the education resettlement centre, doing computers and keeping, basically, just keeping my brain occupied, keeping busy all the time – every day!*
Mark	*So you don't use any substances anymore*
Connor	*No. I'm even trying to cut down on the cigarettes as well*

Those service user participants thinking of reducing or sampling (see contemplation, preparation and action in Figure 7) a reduced drug use / abstinence lifestyle conveyed a middle ground. They wanted the information and assistance cited above in the same way as precontemplative participants did, however they declared a strong sense of faith in more formal, firmly established, drug reduction techniques. Among these were;

- Devising a personal relapse prevention or contingency plan based on their relapse signature or early warning signs for both mental illness and drug use. This gave an illustration of the movement in their thinking, that reduction was possible and that mental health and drug use were directly linked.

- Information about specific hospitals, wards, detoxification and rehabilitation units

- Information about models of addiction, mental illness and scientific information relating to the psychoactive and psychotropic properties of drugs and medication respectively

- Avoiding drug relapse through the management of dependency, craving and urges

- Managing previously distressing psychological symptoms with alternative therapies and treatment

- Additional support such as Alcoholics Anonymous and Al-anon (for their 'carers') as well as statutory services

- Individually tailored help including a sponsor or key worker, someone that they could confide in, gain confidence from and examine developments

- Support through group or individual means from other ex-users (peer intervention)

- Replacement activities such as leisure, work or study

The final group were those who had successfully had periods of abstinence (see action, maintenance and optimal recovery, Figure 7, Page 147). They refined and emphasised aspects from the lists above. They described specific educational programmes that provided clear scientifically based information about health (blood borne viruses, liver failure, blood pressure, heart failure, over dose and nutrition for

example). Clearer signposting to services would have been appreciated and subsequently this was also couched in critical terms as to how services might improve.

A more in-depth knowledge about their circumstances, past, and avoidance of relapse for the future created a new space where relapse to drug use was not an option. This was openly reinforced through group discussions with peers. To the extent that formal peer groups for support had been established within some centres, they were valued by their participants and emphatically promoted as helpful, or, for the majority in this stage, essential.

In this section the stages of motivation have been linked to relevant types and sources of help. They cross cut the entire 'Help' category and relate directly to the content of the information booklets arising from the study. The transcript excerpt below is an example of how motivated participants shared information and experiences in order to help others. Their motivation to do this was powerful. Coupled with the content of their stories tangible benefits appeared feasible. Help and optimism are commodities that are difficult to quantify yet readily felt emotionally, translating data into information materials was inspired by the motivational thrust borne from helpfulness and emanating from participants – further justification for the prominence of *Help* as a theory. This section is pivotal in the research since the provision of educational information was a core study objective.

It is significant that relapse prevention in drug use matches in many critical ways that of mental illness. Birchwood *et al* (2000) and Linszen *et al* (1998) incorporate the biological factors of mental illness relapse with the psychosocial. In the same way that exposure to stress of drug use cues will increase the risk of drug lapses or relapse, stress of a biological, psychological or social nature will increase mental illness symptomatology. By employing the principle of individualised care planning as formulated by the service user and presented within *Help* theory it is likely the specific early warning signs of relapse for an individual can be identified and their tailored plan instituted. If the participant transcripts have been interpreted correctly and their desire for factual information is to be met then evidence in the area of relapse prevention is highly appropriate. What resonates strongly is the desire on the

part of the participant to receive such concrete or proven help or guidance. This much maligned client group, in expressing their demand for help, is delivering a subliminal message, previously unheard, or below many practitioners radar, that they possess motivation to change. The application of individual care with the available evidence base is as applicable to the dual diagnosis client group as any other; this property of 'Help' exemplifies the point.

Below a participant reflected on his experiences with considerable clarity. He was asked what would be helpful. He implied desperation to manage psychotic symptoms; he had partial success but was left with an addiction to amphetamine. He regarded his experience as importantly informing the process for treatment of others in his situation. He placed an emphasis on reconciliation to mental health treatment. This only occurred to him however after a considerable period of self treatment resulting in amphetamine dependency.

Sid   *I'm looking forward to be able to talk about it in detail, what I've not been able to do before*

Mark   *What kind of bits, detail is it that you think you'd talk to them about?*

Sid   *The reasons why I went on it* (taking amphetamine to reduce paranoia and auditory hallucinations), *why I'm addicted* (could find no better alternative) *and how best to come to terms with treatment* (eventual mental health treatment) *and what people could expect* (if they started self treatment of psychosis with amphetamine).

Whilst the content of education and information was identified precisely the urgency and timing was not so evident. This section regarding education and information concludes with a cautionary yet optimistic quotation. Ron conveys a positive faith in the help that was available but also alludes to the fact that general awareness of help is lacking and that there does exist urgency for individuals to obtain the help promptly.

> *The only thing that I would say, if it went to somebody else, not me personally, is that there is help out there, and it's getting it and eventually I got help. I think people should be aware that there is help there to get and don't leave it too late.* (Ron)

Education and information therefore is a highly ranked theme. Underpinning the success of delivering education and information however is the ability for it to reach the individuals who need it, generate receptiveness and subsequently enable change.

5. Safer Drug Use

The concept of safer drug use has been established as a principle within substance misuse service delivery and practice for over two decades (Strang 1993). The premise is one of damage limitation, a concept that participants in this study identified pragmatically in two forms. Firstly, value for money, for instance in the purchasing of drugs. This meant being confident about the quality of a substance and the reliability of the dealer as well as obtaining a competitive price for the substance itself. And secondly, issues of safety be they related to accidental overdose, interactions with medication, contracting of blood borne viruses or destabilising effects on mental health.

> *My advice would be like… err…. It'd be like, it'd be like, the sort of advice I would give them is like, if your're gonna buy a weed (bag or sack) you're gonna buy that yeah, then you buy, you buy how much you want on the first, on the first, first, the first time, the day that you're going to buy it, you buy at least something what's gonna last you, until you get paid the next time, you know what I mean, something like a quarter ounce.* (Floyd)

The quote above conveys a practical and cautious approach to obtaining drugs that could be seen in any aspect of buying or shopping. Participants were keenly aware of their need for certain drugs and to find themselves being sold short in terms of quality or running short due to overuse usually created problems. Exercising judgement and discretion in drug use did not usually generalise to other aspects of life such as bill paying or activities of daily living. This anomaly was also illustrative of a level of cognitive and intellectual ability to participate in social exchanges not readily expected of many people with a severe mental illness. It also appeared to be connected to other subcategories of 'Help' in that social exchanges and interpersonal skills were necessary for participating in education and information programmes or using support networks. Subsequently, 'Safer Drug Use' was not a subcategory that necessarily fixated upon dangerousness but extended to the pragmatic realities of

most peoples lives such as living within a budget and operating within a socially constrained group.

> *Yeah, I feel that they* (drug supplier) *give me good advice, I do, cos they, cos we know, coming from the hood you know what I mean, that, that err, but erm, certain, if you go to certain people and buy, buy weed, they are going to sell you some rubbish you know what I mean.....so you got, got, got to be certain in what you're buying...* (Floyd)

> *Erm... just pick the right people, go to the right people that's selling it and stick to the right people that are your friends...and just judge them by your friends to see whether they are your friends or not and not just somebody who's using you through your drugs or for your money. Just see if they're friends....... if you don't know em, they'll go and put baking soda or stuff like that in it.* (Winston)

The prevailing media and public view that danger exists from drug dealers or suppliers was counterbalanced here by Floyd identifying his supplier as being trustworthy and knowledgeable. Arguably advantageous for any successful salesperson regardless of product, Winston corroborated this view.

Finally on this aspect of procurement and safer use participants readily endorsed the idea that a reliable supplier was the key to safety. Overdose from opiates (and stimulants) was more likely to occur if the supplier was poorly informed or had failed to build a trusting bond. A supplier offering consistently 'good' quality drugs posed fewer risks of opiate overdose for instance because participants could calculate dosages accurately.

Directly related to overdose and mortality were strategies passed on from user to user. Cardio Pulmonary Resuscitation (CPR), taught by drug teams to opiate users, was practiced or known of among the majority of the intravenous (IV) drug users in the study. It would normally be applied if a peer went into respiratory depression or arrest. This was coupled with knowledge of the recovery position and that the calling of emergency services would not lead to legal repercussions. Allied to these survival strategies was ensuring IV drug use equipment was not shared and knowing that lone use was more dangerous because no one would be present to carry out CPR or dial 999. It is worth noting that the expressed negative view within focus groups of heroin

and intravenous drug use described previously reveals the variation in drug use and attitudes similar to the general public. The potential for dangerous consequences however led to its prominence here and within the information materials.

A catch all advice message emerged; that heroin, when smoked, carried a very low risk of overdose compared to intravenous administration. Furthermore blood borne viruses (BBV) were less likely to be contracted. One participant pointed out the danger of contracting a BBV through sharing of straws when snorting cocaine or amphetamine. Participants present in that group acknowledged the information and said they would no longer share straws.

There emerged conclusive evidence that despite the documented high risk behaviours commonly associated with the dual diagnosis client group (Shaw *et al* 2006) they were in fact either acutely aware of, or very receptive to, information concerning their vulnerability. This resulted in participant's readily promoting and sharing harm reduction information. Their receptiveness was influential in terms of the information output of the study. It has been noted within this chapter that the majority of participants were current drug users regardless of aspirations to become drug free for many. Subsequently the information and advice relating to safer drug use would need to be of a harm reduction nature. An initial abstinence emphasised message appeared incompatible with engagement and subsequent receipt of advice.

Individual safer drug use strategies emerged also. A frequently mentioned view was that *"when you find a drug you like stick to it"* and don't experiment too much. On exploration however the majority of participants had long histories of polydrug use and had administered drugs through a variety of routes in a wide range of locations. Despite this fact the dominant view was that individuals learnt how to stay reasonably safe quite quickly. Notwithstanding the safer drug use themes cited previously relating to finances and physical danger there were numerous other representative examples of individually tailored strategies to safer use (Table 19, **'**Tailored Drug Use Strategies')

Table 19. Tailored Drug Use Strategies (Inpatient Ward Focus Group)

Strategy	Evidence
Avoiding specific drugs at particular times	*Yeah sometimes having a weed makes me paranoia even worse. Sometimes I just try and stay off it and just try and drink*
Safer feeling environment	*I'd go to my room and barricade myself in*
Oblivion / enhancing confidence	*When I'm paranoid I just drink vodka straight because that either knocks me out or gets me to cope with anything and I'm not scared of the paranoia and just think bring it on. I don't give a shit*
Being alone	*The best thing to do is to have a drink and chill on my own*
Recognising mental health relapse indicators	*Like on Thursday I don't remember leaving my flat like the last thing I want to do is buy charlie and then I went shopping and bought vodka and the next thing I remember is being on my girlfriend's street and being held down by the police and being put in the van...the frustration... I knew I was getting ill again*
Insight into psychoactive effect (prescribed or illicit)	Reference to prescribed antidepressants *That made me high as kite* (inaudible*) I was running around the building and that*
Insight into symptom, medication and drug relationship	*The problem with me is I stopped taking my medication for the past six weeks so I've been getting more and more paranoid so I've been drinking to stop the paranoia*

In concluding this section three components to this subcategory are noted;

1) Issues related to physical risks of overdose and blood borne disease. Nothing was stated in relation to poor injecting technique and associated problems of thrombosis, infected wounds, cellulitis or collapsed veins despite this being a prominent feature within the research literature regarding IV drug use in general (Ebright & Pieper 2002).

2) The procurement aspects were conveyed strongly. These related to trustworthiness and credibility of suppliers in order to obtain good quality drugs at reasonable prices.

3) The concept of individually tailored strategies to enhance safer drug use in both mental health and substance domains.

6. Care and Support

This section discusses how care and support appeared in both practice and principle. It illuminates the fundamental aspects of interaction between practitioner and service user by demonstrating how care was experienced and then translated into a helpful

entity. It reflects the importance of well timed intervention using a motivation-intervention model (Table 20, Page 173).

'Care and Support' as a subcategory shared concepts related to the subcategory 'Attitude', this was attitudes of carers, practitioners and society. Among these the prime concern was possession of a non-judgemental approach. The manner in which care was conveyed held a high level of importance; care was descriptive of the intervention and the motivation to intervene. The motivation to intervene was conveyed in a number of ways, an example of which was providing adequate time, access and privacy to talk in confidence; signs of respect. In other words successful care was at least two dimensional. It was incomplete without the deliverer conveying that they cared, equally the absence of competent care and care coordination type skills indicated an unsatisfactory intervention.

The overlap with 'Treatment' (a further subcategory) was also emphasised. Treatment delivery, medication or cognitive behavioural intervention for example, required supplemental strategies for success. Prescription of medication for instance required an explanation from a trusted practitioner (who cared), talking therapy such as cognitive behavioural intervention would require an empathic attitude to be conveyed; a recognisable caring approach being the central element.

Empathy has an established role across the range of psychological therapies. Carl Rogers described empathy in his thesis (Rogers 1975) as being the ability to listen and reflect accurately in order to demonstrate concern and connectiveness to clients. Whilst the value of empathy in therapy is proven at least as successful as psychotropic medication in determining improvements in mental health (Torrey 1995) and effective within substance misuse work (Miller & Rollnick 2002) it is a more recent development for mainstream psychiatry to consider the therapeutic effect of empathy in severe mental illnesses such as schizophrenia (Singer 2001). The nature of empathy is profoundly interpersonal and requires the empathiser to 'taste' the recipients' experience. In the context of substance misuse, sexual abuse, severe mental illness, post traumatic stress and many other conditions the vicariously absorbed psychological stress involved in the empathising process is marked. This may partially explain why participants described empathy as important but far too

infrequent. Yet it is indisputable that effective therapeutic intervention rests on authentic empathic relationships (Jordan 2000). If one examines the earliest work around the function of empathy in therapeutic exchanges, Laing's (1965) for instance, the need to engage and accept the person as a whole is critical. Viewing the dual diagnosis service user against the potential backdrop of homelessness, criminality, harmful behaviour, relapse, unpredictability and so forth, holistic acceptance can appear unfeasible for many. Add the ingredient of inconsistent motivation levels the therapeutic challenges the client group presents can feel overwhelming. *Help* theory is instrumental in representing the dual diagnosis client in an optimistic light; it brings to prominence previous hidden motivational factors, in turn encouraging engagement. Empathic engagement and its impact as an antidote to loneliness and isolation can not be underestimated hence its salience in my findings.

Support within the context of this section was described as requiring the prerequisite caring attitude of others but also identified practical interventions. An example was assistance attending an appointment (benefits, doctors) or help obtaining accommodation. Furthermore demonstrating the magnitude of support in itself was significant. Joint working arrangements between agencies and teams were indicators of a high level of effort and complexity, conveying to participants that as individuals they *"counted"*.

> *I was ostracised….but working with the team* (assertive outreach team) *its, its, they've opened doors for me, they don't judge me, they don't judge me at all, which is why I'm getting help, why you're here today and Nairobi House* (detoxification and rehabilitation unit)*, these are all very positive things that... you're not on your own, and you're not being judged or condemned. You're being understood and you're being helped* (practically).

> *Once they get that into their minds I think they respond to that. It's a shame there's not more for other people who are left to fend for themselves, who are being judged and ostracised by society, just 'cos they've got a stigma and they do drugs.*

> *Well the support, they come and take me to appointments, they come once a week, just had my injection today, they pop in to see how I am, they helped me to get on a course, so that way, in that respect they're great but once I had err, a CPN, support worker and they came round one day and* (inaudible) *you've got to come clean that you're on*

amphetamines, says (CPN) *if you are, they can help me. They said if you don't say anything, you won't, you can't, so I admitted that I was. And they just took all the care away.*

I think it's the same syndrome as smokers, who go to, who go to a GP with a bad chest. And say that they smoke, and they say 'well cut down on the smoking and we'll see, we'll treat it then'. I think it's, I think its, the wrong thing to do. I mean, that person is probably inside, probably crying for help, and would respond to help, given the opportunity. (Sid)

This subcategory ('Care and Support') therefore identified two perspectives or two key elements; the *essence* and the *pragmatics* of care. Whilst distinct elements, they are paired here because they were found to be largely interdependent. Figure 8 shows the cyclical action of the two elements.

As illustrated below the subcategory 'Attitudes' connects to 'Care and Support'. The "*right*" attitude identified by participants assumes a value base of being non-judgmental (Stage 1 of Figure 8). This essential property diagrammatically precedes those properties identified as care or support related. They occur simultaneously in practice however.

Figure 8. Care as a Prerequisite Property for Helpful Interventions

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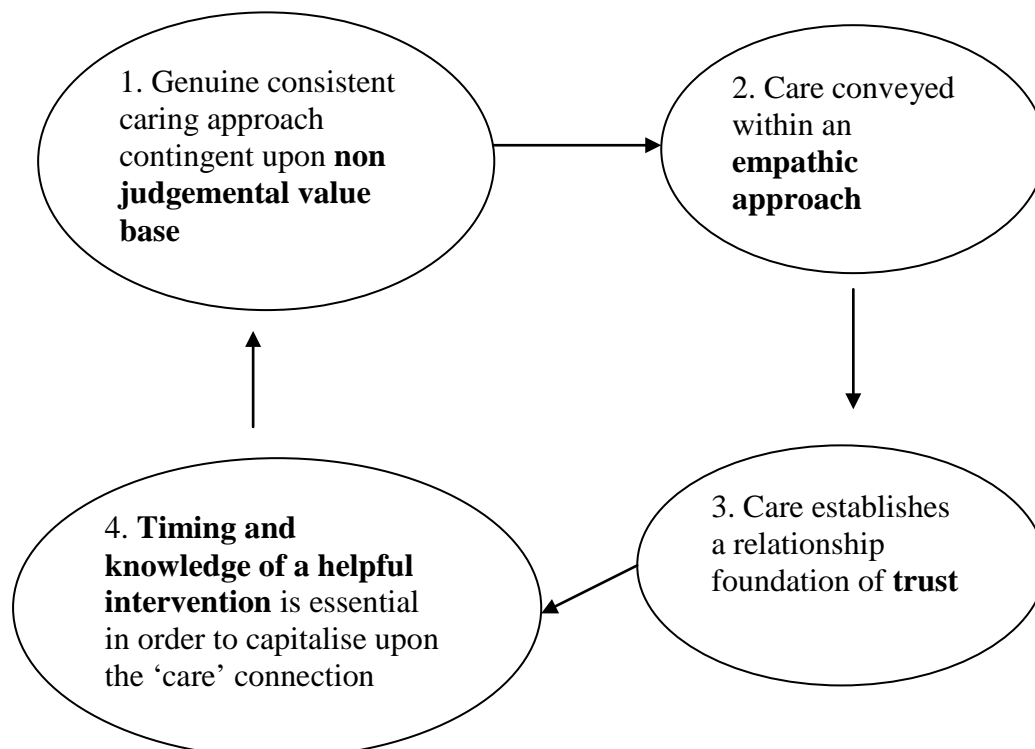
Interventions that proved helpful (Stage 4) reinforced the prior established ground (care / trust, Stages 2 and 3) upon which their success was dependent. This diagram and narrative illustrates two key elements – *regard* for the person (care) and *ability* to help (support). Care features as a central aspect of subcategory 'Attitude', whilst support is an associated concept of subcategories 'Medication', 'Safer Drug Use' and 'Treatment'.

The timing component of Stage 4 was linked to the motivational stage of the participant. Here the matching of an intervention to the motivational level had more than one effect. The delivery of an appropriately timed intervention not only improved the chances of a more helpful outcome, it also demonstrated to participants that the practitioner was aware of their needs in relation to their specific preferences.

The participants' preferences proved to be ordinarily based upon their motivational stage. Overleaf, Table 20, **'**Motivation and Intervention Cross-Walk', adapted from previous research (Holland 2002) provides examples of appropriately matched interventions in relation to levels of motivation.

The relevance of motivation lies in the development of theory where the key determinant of helpfulness from this subcategory appeared to be care and the demonstrating of such care. The mechanism of conveying care appeared empathic in nature, therefore to build trust and deliver appropriate interventions insight into the motivational state of service users had to be acknowledged.

Whilst the concepts of care and of support have been elaborated upon the examples from which they emerged are important sources of contextual evidence and are listed below in Table 21, 'Essence and Pragmatics of Care and Support'. They demonstrate how participant experiences and expectations resemble the research and policy background, particularly the key elements of recovery as described by Drake *et al* (2006).

Table 20. Motivation and Intervention Cross-Walk (Holland 2002)

Stage of Motivation	Intervention
Precontemplation The absence of any thoughts or behaviour concerning substance use reduction.	**Engagement** Despite absence of motivation the potential to develop a working relationship based on trust is present. At this stage clients have multitudinal problems around issues such as housing, welfare and health. Opportunities emerge immediately whereby a worker can assist with alleviating such problems leading to a therapeutic alliance. Preparatory work essential for later stages. Successful engagement is the development of trust and acceptance of 'help' however small.
Contemplation The presence of thoughts (not usually behaviour) and ideas concerning reduction/cessation of substance use, and/or recognition that life problems might be derived from substance use.	**Persuasion** A variety of strategies encouraging a client to understand the consequences of substance use are employed. Neither coercion or confrontation is appropriate - they merely compound the substance use or undermine the efforts to empathise. The emphasis is upon generating motivation for recovery from within an individual. Persuasion is most effective once engaged; however interventions have considerable overlap which suggests that stages of motivation are not entirely discrete.
Behaviour Change The presence of changed behaviour consistent with (i) reducing the adverse effects of substance use and/or (ii) reducing or abstaining from substance use.	**Active Treatment** The strategies employed to support reduction of substance use range from pharmacological adjuncts (e.g. Methadone, Buprenorphine) and detoxification to psycho-substance education (individual/group) and assertive substance refusal training. Clients at this stage are becoming proactive in their efforts but require constant support and encouragement.
Change Behaviour Maintenance A stage of consolidation, where reduction or abstinence from substance use is established.	**Relapse Prevention** Active treatment strategies are equally applicable here. Identifying triggers or predisposing factors of substance use are essential. Client and worker collaboration in devising contingency plans in the event of substance use relapse or 'near misses' may involve other workers, friends and family. Maintaining strategies of social approval and material/practical benefits reinforces progress. Continued input over a period of years not months will be required for a stable lasting recovery.

Table 21. Essence and Pragmatics of Care and Support

Essence (displaying of care)	Pragmatics
Accurate prioritisation of needs	Finding accommodation Knowledge of the range of accommodation types/ quality Benefits advice and intervention
Advocacy	Obtaining help from other agencies *"Opened doors"*
Persistence and flexibility	Attending appointments (in otherwise chaotic or de-motivated circumstances) *"They just pop in"*
Recognising social relationships	Outings with people
Conveying regard and respect	Helpful staff
Reliability	Consistency of services/flexibility
Collaboration	Joint working *"Joined up – not pillar to post"* Care coordination / case management / Care Programme Approach (helpful to non-mental health agencies to be fully involved) Confidentiality and communication *"Good communication across services"* Relapse signatures / prevention / longitudinal support Assertive out/in-reach / practical offerings (home, benefits, company, crisis bed) Detoxification after-care
Valuing progress and working long term	Employment (keeping job – employer support)
Motivating	Encouraging attitude from staff - *"a safe place"* (to talk)* Phone calls every day *Feedback

"italics" denotes partial quotes. * denotes full quotation below.

Feedback - *I've got a key worker, I come here and I also go to Creamfield. I go to the city gym. I started a computer class, which I'd never touched in my life, laptop, first time yesterday……and yeah, I'm getting supported here (day treatment centre), I've got one-to-one counselling, psychiatric help as well for my depression, anxiety, and I have seizures as well.*

A safe place to talk - *well I think that the staff, they do a good job, because they are there and they will listen to you if you've got a problem, and that's why – even if I go to the groups, I do talk in the groups, but if there is something that I need to talk about, I don't talk*

in a group, that's why I've my one-to-one. I prefer it to be private
that. They'll listen.

Joined up not pillar to post - *I've got to see another psychiatrist here*
next Tuesday, which I've been told they are going to try and
correspond with each through the hospital (psychiatric outpatients) *as*
well as here and try and work a network of helping me more, which I
find helpful, it will be a bit more better. (Ron)

This section has revealed the two dimensional character of 'Care and Support'. Its essence (caring) and its pragmatic application (intervention) that constitute helpfulness have been examined. Implicit in Ron's comment is the need for effective joint working and coordination of care as espoused by the CPA. The following subcategory of 'Treatment' develops care and support concepts further by focussing directly on what I have named the *pragmatics of care*; the practical intervention rather than the interpersonal foundation of trust and respect.
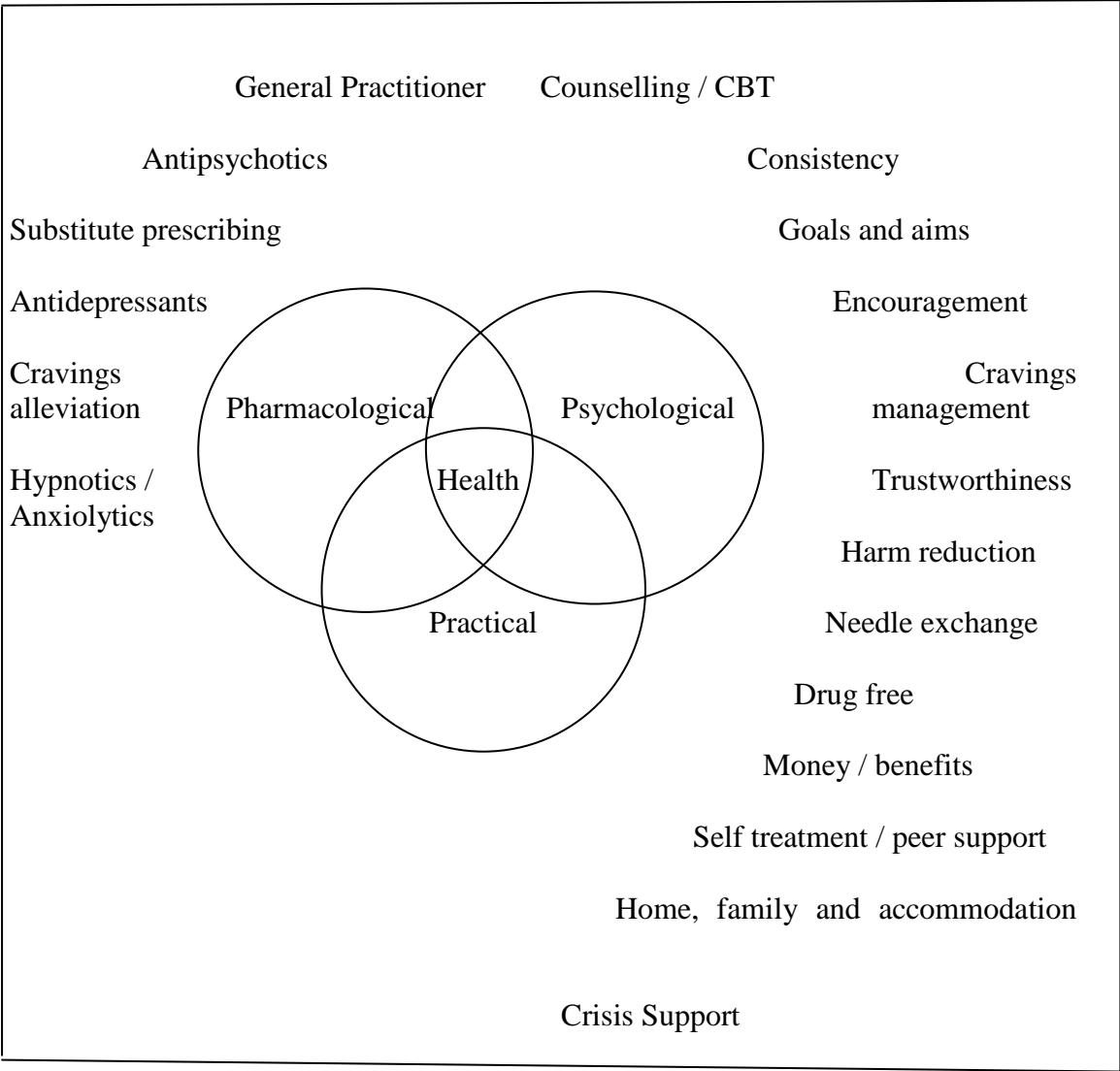
7. Treatment

This section is broad and encompassing since treatment means anything from a prescription of medication to case management. It meant practical direct intervention based acts to the principles and philosophy underpinning those acts. Most participants viewed treatment in the 'doing' sense. They were less likely to define the style or manner of treatment but more inclined to state what had been functionally helpful.

Analysis of the 'Treatment' subcategory enabled a clear idea to emerge as to what intervention was helpful. This meant deconstructing the major category 'Help' and separating actions of helpfulness from helpful attitudes. Comparing helpful and unhelpful actions, citing them and then superimposing them on an attitudinal or value-based foundation served to reconstruct the properties and dimensions of 'Help' in an explanatory format.

The analysis listed the treatments that were found helpful by participants, here it contrasts them with unhelpful examples and links them for contextual purposes with

other categories and themes. The key theme of treatment then emerges at the core as Figure 9 below illustrates.

Figure 9. Treatment and its Core

The core of this treatment focused subcategory appeared to relate to health because virtually all the helpful incidents reported were in pursuit of better health. Even the role of substances (see 'Role of Substance(s)' in Part 1) cited the alleviation of unhelpful feelings, symptoms or circumstances. Whilst circumstances and history (for example someone attempting to numb the pain of, or forget, trauma) were not reported to have responded to drug use in any practical way, persistent emotional, psychological or mental health states did. A connection between drug use and helpful intervention therefore emerged, a goal of identical properties, the goal of feeling

better. In other words from which ever angle 'Drug Taking' (the studies core category) was examined, the goal was to remedy illness or alleviate distress.

To support this emergence further similarity with other categories was noted. The 'Level of Knowledge' (Category 2) was seen as important where participants wanted to use drugs more safely (a subcategory of Category 7). The 'Role of Substances' (Category 10) and Category 5 ('Policy, Service or Practice Development Issues') contained clear responses associated with improving health also.

Treatment therefore was a concept not defined solely by who (doctor, nurse, carer for example) or what (psychological, social or pharmacological intervention). However its properties were revealed as almost exclusively health orientated as the passages below reveal. Health was then an emergent concept, the reconstruction of the treatment data are depicted in Figure 9, 'Treatment and its Core'. The practical orientation of this subcategory being significant for advice, information and theory development.

> **Drug Free** - *First time I noticed that the drugs were giving me a big problem was when erm, I did go to the HDU* (High Dependency Unit) *because I was off them completely, I was completely free, from drugs for two and a half years near enough, and the first night out, still, you know in them two and half years, I clocked a big change in myself, because I wasn't on drugs, cos it was a locked ward, high dependency unit – like this one, but a lot, bit more securer.* (Noel)

> **Harm Reduction (Safer Use)** - *The safety of ecstasy you know like make sure you've got enough fluid in your body when you're out and not to do too much* (take drugs excessively) *when you're out.* (Daisy)

> **Family and Health** - *I think if I did go back* (on drugs)*, I would lose my family and my health would deteriorate….they help me get my benefits sorted and stuff like that.* (Karen)

> **Peer Support** - *I'd like to get to know more people that have been in my situation and say, they have started counselling or something like* (Karen).

> **Harm Reduction** - On the subject of choosing a drug after several 'bad trips'. *That's through choice, do you know what I mean, cos, its like, its like, there's times when I've been feeling for it and I've just thought to myself there's nothing going right for me at the moment so I'm just going to go and buy, buy one, one, one, one substance of what I want to take, you know what I mean so, I've gone into a few peoples'*

places and asked them, you know, have you got this and have you got that. (Floyd)

Antipsychotics - *Risperidone injections err, it helps with the internal voices, yeah....its great, getting better and better on that score, but I worry about putting weight on with the injections.* (Sid)

I was more like... me friends used to say to me 'don't take the medication, don't take the medication', they used to think that the medication was making me worse, cos I was sleeping so they thought they was making me worse. Sometimes – I don't take them tablets, don't take them tablets – so I wouldn't for a bit. Then back in, I ended up back in (readmitted to hospital). (Noel)

Pharmacological - *I think its easier letting people do things for themselves or trying to do things for themselves, rather than, what do you call it? Prescribing a pill all the time.* (Jake)

Psychological - *The staff, encouragement, talk to me and all that, advise not to do this, don't carry loads of money er do your meetings, talk how you feel cos I never used to talk to them even though I'm craving I would just be sat in the meeting like that and just go and do one... You've got to admit it, own up and tell the truth when you have had a slip.* (Bill)

Services saved my life – gives you hope, a sense of identity, a problem shared is a problem halved. I derived satisfaction from the sharing at the unit (day treatment unit)*, other patients helped me and so did one-to-one sessions... and group work* (Mathew concluded with) *I sustain hope by believing that there is life without drink.*(Mathew)

This section has identified quite distinct forms of treatment. It has collated them, deconstructed them and finally formed the properties into a more defining model of treatment which simplifies the complexities of 'Help'. The model (Figure 9, Page 176) does not list the comprehensive range of treatments within the field of dual diagnosis - given that it stems from research participants and not the wider research literature that would be an unlikely outcome. The model and this section illustrates that complexity can be simplified. That the individual elements once grouped and categorised can provide clarity rather than confusion.

8. Goals

'Goals' emerged as a subcategory of 'Treatment' initially because the conversations participants had with professionals were related to reducing the amount of their drug use. The focus on reduction however was frequently taken by practitioner not service users as discussed previously. 'Reducing drug use as a goal' was therefore regarded as a legitimate label in the study yet was not always shared by participants and practitioners. This section examines goals of drug reduction in the context of dual diagnosis. It returns to the motivational model, Stages of Change (DiClemente & Prochaska 1985) as a model upon which to understand goals and associated conflict. Furthermore goals and rewarding consequences are noted since the absence of drug use in many participants required a replacement commensurate with the gains they experienced whilst using substances, for example possessing an alternative coping strategy.

Below Karen indicates that her goal of abstinence would be reinforced by re-establishing contact with her family. In addition the threat of the reward being removed was regarded as helping her sustain abstinence. Jake's statement however possesses pride and determination which inevitably helps sustain abstinence rather than material or actual reward.

> Mark - *And do you ever find yourself craving or having urges to use again?*
>
> Karen - *About twice a week something like that, haven't had any for a while now*
>
> Mark - *How did you manage to dismiss them?*
>
> Karen - *I go to France once a year to visit my mum and dad and I wouldn't be able to do that* (if drug relapse occurred).
>
> *...anyway, they came back and they said we've got you booked in for a detox on Thursday morning. So at ten past five on 25th April, that was my last drink – 1989.* (Jake)

In response to a question related to drug induced mental health decline, below Daisy gave a double barrelled explanation of achieving the *benefits* of ecstasy use whilst avoiding the dangers. Her goal was one of harm reduction not abstinence. This she

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elaborates upon when she describes the significant gains from drug use. In addition the difference between her view of drugs and those of the health practitioners demonstrates that harm reduction goals (Daisy's) were not considered compatible with mental illness treatment goals (practitioners). An area upon which conflict and disengagement was apparent. This position was commonly expressed among service user participants.

> *Err, I've had that before. I had that when I took the three E's* (Ecstasy)*, I got really depressed and couldn't remember my name and I couldn't remember what I was getting up to and I got really depressed and I couldn't see and I stopped sleeping and speaking and I woke up, and I was sort of like, I was awake but I was like over awake. I was getting depressed, that's why I won't take more than a certain amount now.*
>
> *I go through six months of partying and then I stop, or three months of partying and then I stop. I don't continue using all the way through the year because I don't feel benefit of the E's sometimes. Sometimes I take E and I go out and it's like I've not had one because I'm so used to it.*
>
> *They're* (practitioners) *beginning to think there is a relationship* (between mental illness and ecstasy use) *because I keep coming in and drying out and they want to change my diagnosis to say its drug induced.* (Daisy)

A point of contention. Daisy would not agree with the diagnosis of drug induced psychosis, partly because she did not want to attribute her mental health problems to the drug (ecstasy) which she cherished.

> *Yeah it keeps solid cos I get to meet people and that, and I get to see everybody and that's what* (inaudible) *I'm only stuck in the flat and I've got nobody to talk to and I'm bored, I've got no neighbours and then I'll only see doctors and nurses coming up and I don't get much people round in my community that will talk to me cos they think her 'she ill', and I get out and I meet students that come to Manchester every year! That's how I meet people. It is good for me!* (Daisy)

Choice and autonomy appeared as a recognisable theme in relation to goal setting. Participants were assertive about their drug use, practitioners were generally perceived by participants to be too assertive about treatment and abstinence goals. The choice to use drugs and the freedom to do so was partially curtailed as a result of

inpatient admission for many participants. The consequence was either secretive drug use or staff collusion (*"turning a blind eye"* if drug use took place off the hospital premises and was not overtly detrimental) or head on confrontation. The latter often resulting in conflict, absconsion, discharge or some form of sanction.

It emerged that goals could only be set by service users. They could be facilitated or influenced by practitioners and carers but ultimately the choice and participant autonomy dictated the outcome.

> *I certainly say that to advise them* (service users), *to be pushy but not to extremes in forcing people to do things they don't want to do. If I get forced into doing something I don't want to do I would tend to get more anxious and agitated about it.* (Simon)

The benefits of reducing or abstaining had to be immediate in most cases such as saving money otherwise spent on drugs to buy new clothes or household items, some cited holidays as a longer term reward. The immediacy of rewards was emphasised. The time frame for goals, be they abstinence or reduction based, was frequently short term.

> *You know just go to centres and you know like Turning Point and go er.. do things in craft you know arts and things like that but that doesn't bring any income in you know what I mean Mark and it just causes more stress on a person when you know like me I'm struggling every week trying to get through every week and it makes it difficult and it makes you anxious and makes you know, your head spin and so myself I still have a smoke at night* (cannabis) *, I still have a smoke at night and then once in a while I have a couple of drinks.* (Alan)

In summary, goals were not referred to in the concrete terms of an objective to cut back at specific rates, or to stop using and do something else as a replacement. Goals were implicit in lifestyle changes or aired whilst contemplating lifestyle changes. Aspirational statements such as the one below by Sid captured the essence of goal orientated comments. They frequently contained implicit criticism of drug use without fully condemning it, they had to contain hope or optimism and finally there had to be conceptualisation of the reward(s). A good example to end this section is the following quotation from Sid whose reward was the return to his normal life.

...err, lots of things, these people (delusional belief) *need to go and leave us in peace and I can concentrate on getting rid of amphetamines which I will do. I'm confident in that, but the guidance has got to be right....you know, so I can have, at least live, a normal life like everybody else.* (Sid)

9. Attitude (and Self-view)

This section examines attitude by collating attitudinal comments in map form (Figure 10, Page 184, 'Attitudinal Ingredients of Motivation') and categorising the themes representative of particular actions or behaviour.

Given the potential power of attitude on changing behaviour, be it of practitioners or carers towards service users or their loved one, or that of a person towards their drug use and lifestyle, this section includes an interpretation of attitude on behaviour (a storyline) which appears in the information booklets (study output of information materials).

No! because it's (drink and drug use) *like having a stone in your shoe. What you do is, you take your shoe off, get the stone out of the shoe and put your shoe back on. Ok, then in your mind it still feels like the stone, as though the stone's still there, but it isn't. You just carry on with your life.* (Jake)

'Attitude' was a label assigned to any comment that revealed the thoughts behind action. Such action (or behaviours) were active or passive. They ranged from insightful comments about how the stigma of mental illness impacted upon self disclosure to friends and aquantances to the understanding that drug use was harmful but not necessarily in need of changing. Attitude therefore appeared as a state of mind that may or may not have influenced behaviour. It emerged as a prevalent theme within this major category of 'Help'. It cross cuts most other categories due to the fact that most intervention, action, lack of action, beliefs and ideas possess a form of attitude in their rationale for existence. It is suggested therefore in this section that 'Attitude' is a fundamental cross-cutting category in relation to helpfulness.
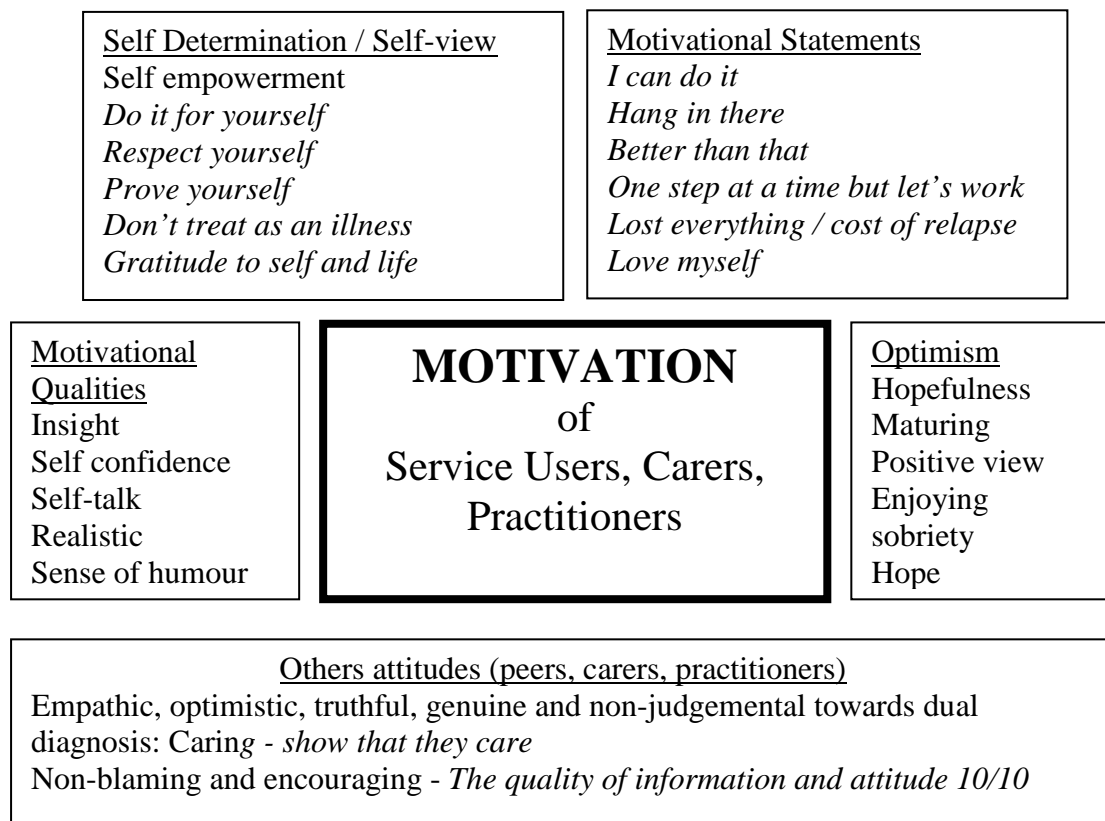
The figure 'Attitudinal Ingredients of Motivation' (Figure 10 below) links attitudes of service users, carers and practitioners to a central theme of motivation. Motivation

was expressed largely as the will, desire and ability to change something. In this context it was conveyed in terms of making life more bearable either by obtaining greater quantities of drugs and better quality drugs or by reducing the detrimental effects of drugs by abstinence or reduced usage.

The active ingredients of motivation appeared as strategies (action), circumstances (conducive to change), determination (attitude), previous experience (learning) and support to sustain change (networks). For instance an experience of past (even partial) success of reducing drug use resulted, for many, in a self-talk strategy through difficult periods of craving (e.g. "*you've lasted 6 months drug free, you can do the same or better this time*"). The past success also developed a sense of self-efficacy and confidence to surpass previous attempts.

The attitudinal figure below presents the various aspects of attitude separately but within a framework to convey their power as a comprehensive set of factors not merely isolated elements of interpersonal communication. The direct interaction between the elements was unlikely to be the same for each participant which merely emphasises the individual nature of need. The following table provides accompanying evidence, both data constructs possess direct participant quotes (in italics) to emphasise their relevance. The quotes are precise and have the quality of well used 'sound bites' suggesting the participants were familiar with issues of this nature and had spent considerable time in reflection upon them. In particular the aspects of optimism merit further elaboration since they strengthen an alternative perspective on the dual diagnosis client group for whom pessimism among carers and practitioners was often experienced. Further participant transcript material appears below that promotes a developing sense, rather than a diminution, of optimism and hope over time.

Figure 10. Attitudinal Ingredients of Motivation

<u>Self Determination / Self-view</u>
Self empowerment
Do it for yourself
Respect yourself
Prove yourself
Don't treat as an illness
Gratitude to self and life

<u>Motivational Statements</u>
I can do it
Hang in there
Better than that
One step at a time but let's work
Lost everything / cost of relapse
Love myself

<u>Motivational Qualities</u>
Insight
Self confidence
Self-talk
Realistic
Sense of humour

MOTIVATION
of
Service Users, Carers,
Practitioners

<u>Optimism</u>
Hopefulness
Maturing
Positive view
Enjoying sobriety
Hope

<u>Others attitudes (peers, carers, practitioners)</u>
Empathic, optimistic, truthful, genuine and non-judgemental towards dual diagnosis: Carin*g - show that they care*
Non-blaming and encouraging - *The quality of information and attitude 10/10*

Hopefulness - *And you give them some hope that things can change for the positive. Now sometimes there isn't any hope and sometimes you really do feel that people are beyond hope but even in those situations sometimes you'd be surprised at miraculous outcomes.* (Ranjeev Practitioner Participant)

I sustain hope by believing that there is life without drink. (Mathew)

Maturing - *Yeah, yeah, cos I've always been like, like a kid even though I'm forty five. But I have missed loads of years you know what I mean like kids homes and drinking and I regret it all now but when you're young you're like a, a young lion trying to take over the pack or whatever.* (Bill)

Positive View (of the World) - *A couple of years back, I was up in Scotland and was err, by the side of the Forth Bridge. And I heard this couple going on, going on, you know they had seen the Golden Gate Bridge and somebody was going on about the pyramids and I turned round and said you know, you're fascinated by that but have you ever seen the structure of a butterflies wing. So they said no. So I said you know, have a look at that and then come back and then tell me what is a sight worth seeing.* (Bill)

Sustaining Hope - *I've explained it to them, how I feel because we have this thing that we talk about, they call it the honeymoon period, I'm still in that honeymoon period, 16 years later.* (Jake)

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The attitudinal figure merely places motivation to change drug use centrally and identifies the peripheral elements that are helpful in building or sustaining its presence. Below is an excerpt from a service user participant (Mathew) that captures the essence and the action (change behaviour) of recovery. It succeeds in its raw state to convey the convergence of necessary thoughts and actions.

Note - Mathew did not want to be audio taped therefore this transcript was written as closely to verbatim as possible during the interview.

> Mathew - *Sobriety has given me my life back.*
>
> Mark - *You appear to have changed because you wanted to, can you tell me more about how others have helped you change also?*
>
> Mathew - *Services 10/10, their approach is good! And a high quality such as found in daily support groups - must not be complacent*
> *Course programme - admit always be an alcoholic*
> *Sharing - 1 drink away*
> *Supporting and sharing successes*
> *Hopefulness is seen through examples of success among others*
> *It requires bravery – to reveal a weakness (alcoholism)*
> *Before I was withdrawn and scared, now support is great.*
>
> When asked about personal rules shared with peers and carers -
>
> Mathew - *I must remain aware that I must stay dry.*
> *Drink is not good at resolving problems*
> *Consolidation not complacency*
> *Cooperative and grateful*
> *Extended family* (other service users) *where there is no stigma – all like a family for support.*

Further attitudinal elements are listed in Table 22. These were useful in articulating *Help* theory and providing concrete examples of helpfulness that would translate into the information materials. Whilst the information materials are presented fully in Chapter 6 their inclusion here is appropriate since they provide a clear example of the transformation from research data to service user information.

Table 22. Attitude: Participant Quotes

Motivational Statements (service user participants)
Motivated
Insightful into problems (not necessarily drugs)
Self-esteem (Karen- *"better than that"* – *"hang in there"*)
Confidence and self belief (Karen- *"I can do it"*)
Knowing the treatment for dependency is only first step.
One step at a time but let's work (Bill- *"six week"*)
Realistic and achievable

Optimism about Change
Hopeful (Ranjeev- *"miraculous"*) (Mathew- *"sustain hope"*)
Sense of humour (sharing)
Maturing and growing up, see self as grown up (Bill-*"forty five"*)
Seeing the positive in life (Jake-"butterflies")
Enjoy sobriety

Self Determining / View
"Do it for self" (Ron)
Empowered
Face the constant struggle v no longer exists for me (Alan *"honeymoon"*)
Prove yourself
Avoid reminiscing/going back
Don't treat as an illness
Gratitude to self and life
Cost of relapse
Respect (and love) self – Mathew *"love myself"*
Truth or lying to self
Normal Versus abnormal

Supportive and Understanding Attitudes of Others (peers, carers, practitioners)
Empathy (Karen- *"empathy"*) Empathic
Optimism (Ranjeev- *"optimistic"*) among practitioners.
Truthful
Staff knowing needs are genuine (not labelling service users as malingerers)
Caring (staff must convey)
You are not to blame (Carer Jane- *"blame"*)
Mathew- "services 10/10"
I have a drink problem – (Bill- *"encouragement"*)

Victim / Loss
Lost *"everything"* (Simon)
Gratitude and humbleness (inpatient participants say they must convey to staff)
Disease attribution

The characters Martha and Geoff who appear in Booklets 2 and 4 respectively (information materials) convey that attitudinal and subsequent behaviour change is

feasible within the study service user group in general. Geoff by virtue of his desire (his *"wants"* changed over the course of 9 months). Martha, on the other hand was forced to moderate her behaviour related to self disclosure. Preserving close relationships required an element of deceit, omission of information or self sacrifice. The attitude in this sense however belonged to others (in this case a member of the public, a boyfriend), and was influenced by mental illness related stigma yet the circumstances still demanded behaviour change from Martha.

This section has illustrated how complex the net of attitudes towards dual diagnosis has been experienced by the service user participants. It has demonstrated the value of extracting attitudinal and value-based issues in the overall analysis and presented a strong case for 'Attitude' as a fundamental property of the major category 'Help'.

10. Activity

This section examines activities and pastimes that helped participants either remain free from substances or use smaller or less harmful amounts. Strikingly the majority of views expressed relating to this were elicited at one-to-one interviews rather than focus groups. The majority of focus groups took place in inpatient mental health wards and the participants there were approximately in equal numbers, still using drugs, taking less drugs, or abstaining. When they met in focus group settings they preferred to share stories around their drug use rather than tales about being drug free.

However at individual interviews the same individuals abandoned much of their 'bravado' and earnestly talked with more willingness about their recovery or past attempts at recovery and change. Difficulties and failed attempts were disclosed more readily at one-to-one interviews.

This section therefore draws on the open and frank suggestions made by participants within confidential settings where they felt safe to expose their often hidden desire or efforts to change drug use or lifestyle. The discussion that emerges focuses upon the pragmatics of what were suggested as being helpful. However the sense that recovery among drug users within their peer group was a *wrench* was quite obvious. If comparison is made with other categories, such as the category 'Role of Substance(s)' where one benefit of drug use is the social contact or inclusion it generates, (*"fitting in"*), it becomes understandable that participants were reluctant to sacrifice their position among their drug set. This was often despite that set of people being recognised as detrimental to health and wellbeing.

This dimension concerning social contact is highly relevant since service user participants and their carers spoke of the need to change their friends and acquaintances, to mix in new circles and to make a clean break when changing drug use. It is conceivable that breaking away from the social group with whom the participants used drugs was as challenging as the physiological and psychological withdrawal abstinence generates. This theme emerged late in the analysis and did not therefore feature as a salient theme to note in ongoing interviews. Each booklet storyline however includes this important aspect.

It was emphasised by Karen. She made the point that re-establishing social contact with family for instance carried a high level of importance, sufficient enough it would seem to replace the social contact experienced with drug using peers. I concluded from this that inclusion in non-drug using groups where positive social rewards materialised was powerful in (i) replacing the drug peer group and (ii) preventing drug use relapse.

"....wanting to be more in the crowd" (drug using peers) illustrated the importance of inclusion by a group. "*I think if I did go back, I would lose my family and my health*

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would deteriorate" suggests an incompatibility of her drug using peer group with her family, it illustrates that choice exists for Karen, and that the final decision to remain with her family may have been improved health; *"I had to change my friends, circle….I stopped going to the places where they'd* (drug using peers) *be"*

Finally in relation to social dimensions of drug use and the category 'Things that Helped / Might have Helped' it appeared that the reinforcing properties found in social relationships and networks resembled the relationship properties reported by participants who viewed their substance as a reliable source of comfort (see Category 3, 'Relationship with Substance(s)'). Evidently the need to relate to something, substance or a person was significant. This emphasises the importance of contact, it promotes a wider position on the understanding of drug use and recovery from drug use. It demonstrates that recovering from drug use is not limited to the physical and psychological but is a highly social action. This complex backdrop to drug use as a whole formed the inspiration for the information booklets to be in pictorial and story format rather than conventional information sheets. The information output from the research would subsequently benefit from contextual social depiction.

The remainder of this section cites practical activities, the *what* rather than the *why* as discussed above. The help orientated themes described suggested that the fundamental reasons for the activities associated with recovery are in essence about positive contact. The activity itself, providing it is not continued drug use to the same harmful degree, is less significant than the context within which it occurred. Ron illustrates this point when highlighting his post detoxification follow-up support.

> *Well the place where I've gone into,* (a staffed dry house)*, after coming out of the detox was a better thing, because I didn't think the ten day detox* (alone, no follow up) *worked for me. I relapsed four times last year. Here I've got a key worker, I come here and I also go to a day centre. I go to the Y club. I started a computer class, which I'd never touched in my life, laptop, first time yesterday… Yeah, I've got a schedule for the week, certain things and everything that keep me going and occupied.* (Ron)

Others cited activity scheduling, alluding to a common sense notion that being distracted from drug use thoughts (cravings and memories), and occupied to prevent their occurrence, was an essential day-to-day strategy.

> *…started going to MERC,* (an education and resettlement centre) *going on computers and keeping, basically, just keeping my brain occupied, keeping busy all the time – every day.* (Connor)

Ensuring that a routine or regime was in place appeared crucial for most of the participants who spoke of their existing recovery, or of their past attempts. Below Dean mentioned slipping regularly back into drug use and how he was currently rectifying it.

> *When you slip!. This time I have ………I have a time sheet* (programme of activity) *every fortnight, every week for the week.* (Dean)

The activities cited were normal in the sense that they reflected everyday work, education and leisure;

- Gym
- A film or a book (distraction and re-establishing concentration ability)
- Seeing friends
- Necessary shopping (with money saved that previously went on drugs)
- Shopping for treats (reward)
- Housework
- Relaxation
- Keeping occupied
- Making a schedule for the week
- Managing everyday pressures of life
- Employment
- Day trips
- Holidays (future orientated reward)

If Table 13 ('Role and Properties of Substance Use', Page 127) and Figure 6 ('Course of Drug Use', Page 130) in the 'Role of Substance(s)' category are examined there

emerges fundamental similarities between what can be achieved by pursuing rewarding activities and what existed as precipitating and sustaining factors in drug use. Examples were combating loneliness and boredom and obtaining a sense of acceptance and satisfaction. All four elements were described as achievable through educational and leisure (replacement) type activities.

On education Dean said;

> *I tried, I'm at work at the moment on Mondays and trying to improve me reading and spelling and I might go back to do maths but there's always er ……. a calculator that's the easy way out* (said humorously)
>
> *I was mad at meself when I went to maths, when I was doing maths because I thought I'd be able to do all this long multiplication and subtracting in me head I thought it was normal, that everyone else could do it and …. but he* (tutor) *said no it's impossible … just to …… explain to me how it was done on paper and I could work out on a calculator as well Yeah, yeah so I might go back to doing some of that again whether it'll do me any good or not, help me in the future I don't know but …basic skills reading, yeah…* (Dean)

Activities therefore illustrated their importance in terms of distraction, occupation, social contact and were not necessarily outcome driven. The process in itself being therapeutic. The innate personal satisfaction through achievement and its impact on self-esteem emerged also. The desire to help others is appropriately included in this activity section. Helping acts fill time (occupied), they require undivided attention and commitment (distraction), are fulfilling and satisfying (self-esteem and confidence) and promote social contact.

> *Even now, I volunteer for ADS, the alcohol and drugs services in Bolton.* (Jake)
>
> *I'd like to get to know more people that have been in my situation and say, start counselling or something like.* (Karen)

The experience of drug use and recovery for some led to work, usually volunteer work but paid and trained posts were referred to among peers elsewhere. Participants on the whole had assertive views on recovery.

> *My advice would be to counsel them, and take the two issues as separately. Treat the one, and cure the other. Certainly you can't cure mental illness, but it'll help control the other.* (Sid)

These views appeared to manifest in everyday life in the sense that activities were often conducted with other people also recovering from drug use but at different stages of recovery or levels of success. It was noted that the desire to help others was strong and whilst helping others the deliverer of that aid was filling his or her time constructively.

In conclusion to this section Sid makes two highly relevant comments. Firstly he describes how recovery from drug use through activities requires a parallel improvement in mental health. Secondly he states that the factors involved in the initiation of drug use also require resolution or improvement.

> *I have to concentrate on a film or a book, and to do the house work, cos I get very lethargic when I'm not using..... depression... I don't bother doing anything again.* (Sid)

Mental illness here was compromising his ability to keep active and subsequently his mental illness became a factor in drug relapse prevention. It was crucial to avoid over sedation for instance which may have impeded levels of energy to participate in day-to-day activities.

> *Yeah, have to treat it* (drug use) *as a form of illness, and there's always a reason why, people go on drugs, it's usually circumstantial. Things are going bad in their life, they've had a nasty experience they can't get over, they can't seem to face ordinary day-to-day life like other people . . . ... you don't just go hey, lets take drugs for a buzz, and then you know, a normally balanced person wouldn't do that.* (Sid)

Summary of Properties

The properties integral to 'Help' have been identified and presented here in the context of the research setting (mental health and substance misuse). The properties collectively present help as a social construct that informs social interaction. The properties individually exemplify the simplicity of 'Help' in practical terms from

communicating with empathy to providing harm reduction advice to activity scheduling. Help has been highlighted as an entity to deliver to others as a carer, practitioner or service user. It has also emerged that help is both practical and attitudinal. A case was made that the delivery style appeared as important as the action. The following section draws firmer conclusions from the inferences above and presents *Help* as a substantive theoretical explanation.

Help Theory

> *"No one is useless in this world who lightens the burden of it to anyone else"*
> (Dickens 1865, Page 77)

The everyday concept of helpfulness could be defined as providing useful assistance in combination with friendliness as demonstrated by a kindly and helpful disposition. Whilst this definition of mine is open to criticism in that it lacks clinical rigour or specificity it does evoke satisfactorily the essence of positive interpersonal communication. A quality sought in therapeutic intervention.

Whilst the concept and practice of help has appeared frequently the *Help* theory is explored further in this section to demonstrate how it influenced the study output and how it may influence practice in the future. The manner in which the concept of help is viewed and then the theory of *Help* applied within the field of dual diagnosis is presented and explored.

Seeking help is not an activity readily associated with dual diagnosis service users. Their tendency towards lower levels of engagement with professional services is well established (SCMH 1998). Conversely, participants in this research study possessed a desire to pass on their experiences to others in order to be helpful. Translating their experiences for others to learn from may have revealed barriers within themselves to receive help (Rickwood *et al* 2004) but it also illustrated a high level of positive emotionality, empathy, and self-efficacy (Bandura & Loc 2003; Eisenberg 2000), significant components of an effective therapist as well as recipient. Furthermore White and Gerstein (1987) suggest those people high in self-monitoring are attuned to the expectations of others, subsequently being helpful if they believe helpfulness will

be socially rewarded. Helpfulness in this sense displays potential for socially satisfying interactions and suggests an influence on generating an optimistic outcome.

Why then was help-related data so rich when research and anecdote were suggesting dual diagnosis service users were less likely to be reflective, insightful, cognitively able and arguably unhelpful? (Martino 2003). Perhaps the participant similarities within the focus groups generated the trend or perhaps theories such as 'Arousal and Cost-Reward' (Dovidio & Penner 2004), whereby distress of others arouses discomfort and the need to extinguish it, or 'Empathy-Altruism' (Cialdini *et al* 1997), where empathy develops self-sacrificing behaviour, offer an adequate explanation. This study does not aim to address the question of why 'Help' emerged as the major category, it examines the components of 'Help' within the analysis and discussion and it isolates helpful actions for the purposes of the information materials. The role of helpfulness as a trait or state of being appears to elaborate upon the concept and potentially open the theory out to other domains. *Help* theory, if shown to be beneficial in self-help / peer intervention for instance, becomes a compelling model upon which to engineer a collaborative care plan.

In this study all data collection took place in help orientated settings. Participants were largely receiving help in one form or another, wanted or not. Opinion amongst participants tended to convey personal confidence in their ability and knowledge relating to drug use and their experience of mental ill health. There was a frank and open recognition that the ability and knowledge held was not necessarily sufficient to bring about satisfactory change in life, circumstances and health. Nevertheless what emerged was a desire to talk about attempts they had made to gain relief or discover remedies. The interactions within focus groups were evidence of such a desire. Themes and ideas were reinforced or challenged, opinions listened to and opinions given. The overwhelming passivity or disengagement associated with the dual diagnosis client group was absent. This prompted a string of questions.

- What were participants interested in?
- Why were they so interested in it?
- Where would this interest lead?
- When would things change or happen or improve?

The basic answers, in order, were;

- Drugs
- The positive psychological effects drugs generated
- More drug using behaviours or alternative methods of improving mental health
- When they wanted / needed it to (motivation)

In detailed terms the answers or the issues to which the questions relate lay in both the earlier analysis and ensuing discussions. Fundamentally however the specific issues were merely a vehicle for the driving ambition among participants to pass on their experiences. Be those participants in recovery offering aid and advice (peer intervention) or participants lacking motivation to stop or reduce drug use, offering drug use guidance. Almost as if the overarching desire was to inform others of what one considered important information.

This eagerness to convey a view, occasionally zealous in delivery, is what I termed *helpfulness.* It contained elements of the 'vocational helper' (for example altruism, personal reward and moral inclusion; Batson *et al* 2003), elements of the 'expert helper' (active concept integration, self-initiated ideas, collaboration and clinical astuteness; Allen 2003; Benner 1982) and knowledge of their 'world' (Daley 1999). Helpfulness also met with peer approval thus generating personal satisfaction.

Aside from the psychodynamic reinforcement of helping roles the practical utility of peer intervention is well documented. For instance in peer HIV prevention programmes (Weeks *et al* 2009) and reducing accidental deaths through overdose (Scottish DH 2008) peer health advocates and peer health educationalists were key roles assigned to existing substance users, with considerable success. It is likely that participants from my study expressed the same sense of credibility and reliability to their peers as other studies have suggested. Weeks *et al* (2009) describe the exchanges between drug users and their health advocate peers as triggering a feedback and diffusion cycle that firstly assists people to adopt safer health behaviours but secondly role models and encourages mimicked behaviours. Modification of risk practices

rather than avoidance of risk activities is seemingly a consistent theme in the peer health field and one emergent in my study.

The practice of peer intervention calls into question the beliefs and ideas participants' held about their own health, and as presented previously, the preference for help or advice to be delivered or offered by them to peers frequently dominated over the prospect of being helped. Health beliefs and learning theory may be relevant in this matter since self efficacy is vastly improved when helping others (Rosenstock *et al* 1988). To construe self-efficacy as a key element in the helping process, as defined by social learning theorists (Rotter 1954; Bandura 1977), is far from irrational, in fact it is perfectly logical that the ability to aid someone who is suffering will result in greater degree of self confidence in the self management of the issue in hand. The secondary gain from the process of helping, be it peer or professionally aligned, is the effect on self worth. Subsequently peer intervention in this context can be regarded as incentivising for the service user (self efficacy and self worth) and for the practitioner (positive impact on peer interventionalist and their receiving peer). For the dual diagnosis client group the potential gains borne from peer intervention are unlikely to be realised if the negative perception of them prevails. Helpfulness as a positive attribute of the client group grew throughout the analysis and theory development phases.

Consequently in noting the themes of dual diagnosis an underpinning, linking theme emerged of helpfulness. The study theory was predicated on the belief that participants would want to contribute their experiences of mental illness and drug use in order to help others. Whilst this was not a rationale openly discussed it would be hard to dispute. An argument against might be that participants attended focus groups and interviews to relieve the boredom of inpatient inactivity, to receive the £10 payment or perhaps they succumbed to institutional pressures and felt coerced into participating. An argument in support however might recognise their substantial or proactive participation was wholly inconsistent with the prior argument against and occurred because of their desire to be helpful. Therefore two aspects of the study are salient for theory development; (i) the matter of motivation to participate in the study and (ii) the help-related themes that emerged from the study data.

Substantive theory led to the delivery of practical examples of help within the booklets. 'Help' provided a solid position to consider how theory emerged and why. The clinical and social implications of drug use in the presence of mental illness, as illustrated within the previous background discussions and literature searches, promotes a strong sense of challenge or difficulty for practitioners and services. Yet the research data here revealed a dominant theme of a solution focused nature whereby improved health was important and desired. It was couched in terms such as *"feeling better", "boosting my mood", "forgetting about myself"* or *"numbing the pain"*. According to the wider research literature poor engagement between services and those who are dually diagnosed is commonplace and often attributed to the client groups characteristics (DH 2002). This notion is strongly challenged by the *Help* theory since it expands the psychological and contextual understanding of motivation from the mere behavioural. *Help* was revealed as a process whereby engagement and therapy could occur.

It appeared of great value to isolate this issue and determine its presence within the booklets. Therefore the theme of 'Help' is presented in content (for example promoting harm reduction advice), the substantive practical findings, and in principle. By principle I mean that the stories represent the values of optimism and helpfulness. They depict people living lives as drug users with a mental illness rather than present a service or research stereotype where help is likely to be rejected. Optimism and self-efficacy are cited in motivational literature as predictive of positive outcomes (Miller & Rollnick 2002); consistent with this the *Help* theory promotes an air of confidence. To emphasise this further the process of helping and the influencing factors practitioners and services are subject to, often in an outcome oriented pursuit, should be examined.

The nurse or practitioner working with their ill or vulnerable client or patient is expected to, and usually motivated to, provide care and eventually reach a remedy of sorts. The process of treatment is the opportunity to convey care. However the concept of helping may well be a reciprocal process, an exchange between practitioner (doing) and client (receiving). The receipt of care and help met with indifference or resistance would probably undermine a therapeutic relationship (Hanson 2000). The passivity or resistance to treatment in the context of dual

diagnosis was reportedly damaging to the care process however, such damage may have been avoidable. Participants in my study stated frequently that their professionally proscribed care was not necessarily what they felt was needed. If we assume the practitioner is following evidence based practice then their determination to implement a specific treatment is validated in, for instance, the medical research. A 'validated' approach then, rejected by the client, can leave the practitioner with no place to go, no satisfactory way to impart the proposed help. Such reliance upon a single approach and its potential damage to relationships in mental health work, whereby multiple factors converge, can lead to disengagement. This interplay between the motivated helper (practitioner or carer) and service user appears fraught with tensions, the key tension perhaps resting with the practitioner (or carer) who may be desperate to intervene with advice or help that will work, but which the service user in unprepared for.

The introduction of evidence based practice, heralded as a new dawn in health care (Hislop 1962) has arguably generated a reliance on technical activity and objective evidence to the detriment of 'clinical knowing' (Benner and Tanner 1987). This has been described by sociologists Jamous and Peloille (1970) whereby technical reform has been accompanied by a 'new truth' about health and treatment; in turn the 'non-compliant' patient (a term associated with my study participants) has risen to prominence. Some authors have cited the objective value-neutral ideology of evidence based practice (Porter 2004) as the reason for its rise to prominence. The participants in my study may have been on occasion the casualties of an unexpected paradoxical effect such faith in objectivity appears to create. Their rejection of conventional treatment, albeit evidential, places them in an invidious position of conflict. They may describe 'logical' reasons (their evidence) for continuing to use substances and stated on the whole their desire to recover from mental health and substance misuse problems, yet their immediate engagement in treatment they find unpalatable. How this position is reconciled is integral to the application of the *Help* theory, which encourages practitioners to understand and value the 'process' of care and not diminish its significance through the parochialised pursuit of an evidence based outcome; thus *Help* broadens the parameters of firstly 'doing' and 'receiving' health care and secondly conceptualising intervention as a process, not simply a route, to a destination.

A similar picture, or analogy, that highlights the conflict this interface of rational technicality and indeterminacy of caring is the debate relating to conventional and alternative forms of medicine (Hirschkorn 2006). Conventional medicine, rooted in research, seeks to deliver a reliable treatment whereby the form and content within context can consistently generate the same result. In order to map context and prescribe a form and content of treatment capable of generating reliable results, technical expertise is a core feature, either at prescription, implementation or supervision stages. The exclusivity such expertise generates is a further potential contributory factor of client-practitioner polarisation. The professional or exclusive position (Jamous and Peloille 1970) versus patient or service user 'everyday' or 'lay' knowledge is beginning to be addressed (Faulkner & Thomas 2001). The participants within my study, subject to greater levels of stigma than most, appeared to overcome this inter-relationship canyon by helping each other (peer support). An additional strategy was to respond positively to practitioners that perceived them less as non-compliant, more as partially engaging, as yet to be fully engaged. They engaged less or not at all with practitioners who failed to display a degree of positive regard. A plausible conclusion to draw here is that the quest and demand for evidential practice, worthy and just as it is, has potential to undermine the process of care since it can define the practitioners therapeutic position so precisely they feel justified in holding such a position despite the necessity to adapt and improvise. A strategy to manage this area of contention is discussed by Pitre (2007) who coins the phrase 'reciprocal interdependence'. Reciprocal interdependence is a way of 'knowing and doing' that is reflexive; it incorporates differing perspectives by inviting a comprehensive systematic analysis of an issue, thereby producing a fuller, contextualised approach to the client. The participant position within my study would appear responsive to such a care philosophy because they emphasise, as most user literature does, the individualistic experience above that of the cohort experience. Symptomatically, a treatment may be indicated however, holistically other factors mitigate towards careful tailoring of the treatment. Pre-requisitely the expression of care and its careful conveyance are the fundamentals to effective treatment, they characterise the *Help* theory I formulated through my research and echo loudly the key elements of therapeutic approaches elsewhere (Rogers 1967; Rollnick *et al* 1999).

In the dual diagnosis context where the social economics of help, ('you scratch my back I'll scratch yours') is defined by borrowing and repaying for drug use, it was particularly salient that participants emphasised the concept and goals of help. Behavioural transactions for survival and social harmony have long been recognised (Foa & Kozak 1986) however the tendency to perceive people with mental health problems and / drug problems in a negative light or outside such norms (Wahl 1999) is common. Help and helpfulness therefore rose to prominence within the research study because of (a) the utility of help and its prerequisite helpfulness for recovery and (b) its salience where a backdrop of pessimism ordinarily prevails. Both practical help (as per study findings expressed within the booklets) and the *Help* theory underpin what emerged as a therapeutically useful combination of action and its rationale, goals as the specific form of values (Locke 1997).

The theory of *Help* therefore generalises to practitioner ideologies in the vocational sense. It also holds resonance for helpers establishing a conceptual platform on which to digest the content of the booklets and encourage their delivery. *Help* theory then is not what the practitioner or carer needs to *do* but *why*.

Chapter Summary

This chapter has detailed the findings from initial analysis and identification of the 12 categories in Part 1. It has presented the development of theory through the constant comparison of the major categories related to help to a motivation based theoretical model. The analysis of the 12 categories has illustrated linkages between practical action and theoretical concepts which begins to explain aspects of the dual diagnosis phenomenon, a core aim of the research. The findings also fulfil the objective to discover information relevant to service user information materials.

The final section of the chapter focussed upon the major help-related categories. 'Things that Helped / Might have Helped' is understandably a category broad in presentation. Views varied enormously, equally they overlapped frequently. Why so many strands related to help emerged reflects life in general and all its complexities and pitfalls. Even in the absence of major problems such as drug dependency life is a complicated affair, a social affair where a dynamic co-dependency on organisations,

groups and individuals is the norm. Therefore it is unsurprising to discover that solutions (or helpful things) to drug use are merely an added complication not the complication itself. As a result the ensuing analysis and discussion here aimed to simplify this and construct a theory that drew the associated properties together.

In concluding this chapter then it is important to consider the cross-cutting themes. These appear to relate to change. Strategies, actions or circumstance that brought about positive results related to drug problems were perceived as helpful. In this sense *change* is a defining characteristic of the 'Help' category as a whole. Subsequently motivation, a quality necessary for most deliberately sought change, was an aspect emergent throughout the 10 property headings of 'Help' (see Page 148). In the collective this appears as a basic psychosocial process, discussed in the next chapter, where a willingness or motivation to assist or help oneself or others prevails.

Motivation and the 'Cycle of Change Model' (Page 147) was cited because it gave greater understanding and depicted change as a staged process rather than a two dimensional concept of misuse and abstinence. For instance the cycle had been travelled several times by most participants. They had attempted to stop or cut down their drug use and often not succeeded. They had moved from contemplating change to putting change into action, some had consolidated change whilst others found themselves unable to do so. But what made one person succeed where another failed?

To an extent this question has been answered. Which aspect of the participant's life s/he has the motivation to change needs to be clearly identified and shared by the service and service user. Forced or untimely intervention (for example admission to a heroin detoxification bed when the participant only wanted clean needles) of an unshared nature failed. Timely empathic interventions were more popular. In addition this suggested that timeframes were important. Over time participants learnt. They gained knowledge and motivation through personal experience (losing friends, family, financial security, employment and health), they gained knowledge and information about detrimental effects of drugs and furthermore they gained an awareness of services available.

The services, which include peer orientated intervention, required the presence of motivation within their staff. This appeared to be conveyed through a caring attitude.

Competence to match a caring attitude was also demanded. Therefore the effectiveness of any service, practitioner, carer, friend or peer necessitated the conveyance of motivation through these simple means. Thus help was reconstructed as an action or circumstance that led to or facilitated change. Change was aided by motivation which in turn was identified in the qualities of attitude and competence.

This chapter has continued the process of analysis through coding and constant comparison. It has also identified a wide range of specific practice and value-based issues which formed the central focus of the research in developing theory and information materials. Service users, carers and practitioners can consider these issues in relation to self-help, professional practice and further research. The following chapter discusses the implementation of my methodology and the 12 categories in relation to building a help-based theory.

CHAPTER 5. DISCUSSION

Introduction

Discussion of the findings is split into two parts: Part 1 focuses upon the initial 12 categories, Part 2 focuses upon the major help-related categories (11 & 12) and identifies a) the basic psychosocial process, b) the motivational issues and c) matters of self-help that emerged and became fundamental aspects of my study's *Help* theory.

Part 1: The 12 Categories

It has been clearly demonstrated that substance use and mental illness carries social stigma (Link *et al* 1997). Furthermore within the specialities of substance misuse and mental illness there are prejudices (Summerfield 2001); substance misuse is often regarded as volitional and mental illness as innate, the former can attract criticism and the latter evoke sympathy. The cluster of categories related to explanations and relationships (1, 3, 4 & 8) reveals the subjective nature of interpretation. Explanations and beliefs about substances on the one hand were conveyed by participants as very individualised yet on the other there was a shared understanding of the dual diagnosis experience in the whole. This resembles strongly the concepts within many treatment philosophies, the recovery model being an example (Allott 2004), whereby the basic condition is collectively understood and shared but the distressing effect is specific to the sufferer. Numerous studies consistent with this notion emphasise the personal experience of illness against a homogenising backdrop of illness categorisation and service mode (Drake & Meuser 2000; Miller & Mount 2001; Schoener *et al* 2006). The cluster of subjective interpretations of dual diagnosis discovered within my study merely reflects the issue that the classification of health conditions does not necessarily reflect the subjective experience. For each person that experiences the condition, or is involved in some way, it can be a one-off, or isolated, unique and individual entity (Angermeyer & Matschinger 1996).

The work promoted by Wolfensberger (1983) in relation to normalisation in the context of learning disabilities is strongly resonant here. It exemplifies the so called 'devalued' members of society (through their learning disability in the context of his work) and attempts to redress their segregation from mainstream society that resulted

through a devaluing process. In a similar way drug users are devalued and excluded. They seek to be treated well and respected however; their wishes are countered by passive *and* active social actions resulting from negative attitudes. How a person is treated by others will in turn influence considerably how they will subsequently act. Social valorisation, or normalisation, promotes a positive 'social image' in order for 'social competence' to improve. Participants in my study reflected on their ability to recover, or help others to recover, yet the barriers emanating from prejudice appeared at times too great.

Recognising subjective experiences of service users, without prejudice, is likely to engender a positive attitude among staff, carers and probably the public. Staff attitudes are critical in influencing the outcomes among substance users according to Watson *et al* (2007), without a positive attitude substance use fails to be addressed. Clutterbuck *et al* (2008) suggests that regular exposure to dual diagnosis rather than leading to greater stress or disengagement, has a paradoxical effect and improves staff confidence. The attitudinal based categories (1, 3, 11 and 12) and knowledge category (2) contain the attributes indicative of effective helping. It is conceivable that Clutterbuck *et al's* (2008) findings reflect those views and experiences of this study's participants whose consistent exposure to substance using peers diminished neither their attitude nor optimism.

The 10 ESCs (DH 2004b) were developed jointly by the Sainsbury Centre for Mental Health and the National Institute for Mental Health, England (NIMHE) to promote the application of fundamental capabilities and principles across the professions delivering mental health care. The basic training of all mental health staff should incorporate the values and practice set out in the 10 ESC framework (Baguley *et al* 2007). Central to the framework is the emphasis of value based practice, which is particularly pertinent within the current climate of change and to the challenges related to dual diagnosis. Value-based practice demands that the individual remains central to their care and central to decisions about their care. The 10 ESCs enables learners and practitioners to expand their conceptual understanding of the individual and their recovery process. Issues of stigma, inequality, risk taking, hope, an individual's uniqueness and strengths are all emphasised in order to understand the service user as an individual within a long-term, multidimensional context rather than

simply a patient within a mental health service. This important element of care resounds with the findings of my study because participants demanded that an understanding of their life and circumstances combined with expressed empathy and a willingness to help was present. The 10 ESC illustrates that practice cannot be satisfactorily delivered without these essential ethical and interpersonal considerations related to equity, diversity, and person-centred care. The validity of the attitudinal based categories within my research is strengthened further still when considering the significance of language and communication and its contextual sensitivity. Fulford's principles of 'Value Based Medicine' (Fulford 2004) assert the importance of communication and language within context. The sensitivity of service-users to the clumsy use of terminology by practitioners, or terms that lack accurate empathy lead to therapeutic disengagement. The participants in my study were understandably aware of the absence of caring attitudes since they are a stigmatised and stereotyped client group and thus constant exposure to inconsistent and frequently negative attitudes was common place. Subsequently, invisible or absent values and critical or unspoken views on dual diagnosis inevitably led to poor decision-making. The judging of the individual from various perspectives is advantageous but only if those perspectives are accurate or fair. In my study participants demanded optimism and to be seen as individuals worthy of care, the process of care was thus crucial. It is arguable that a good outcome is diminished beyond repair if the process in reaching that outcome was in fact damaging. Such a process demands ethical and reasoned competence as cited above.

The cluster of categories related to personal explanations and understandings (1, 3, 4 & 8) appear to be relevant, and in contrast, to the wider dual diagnosis literature relating to policy development (Category 5). Literature (Clutterbuck *et al* 2008) and policy (DH 2002) suggests that individual staff hold a variety of views on substance misuse and mental illness that can then lead to service engagement problems. In this sense the reason for poor engagement may be individual to the service user yet the outcome pertains to all concerned including services and public. The Department of Health (2002) recommend services work together and share skills however this document does not emphasise the importance of holding positive values and attitudes towards substance users. The findings from my research, like others (Barrowclough *et al* 2001) suggest that the dual diagnosis population are highly receptive to

intervention; however a general view to the contrary has been shown to be the more prevalent (Böllinger 2002).

The way in which this research relates to the gaps in services and engagement requires the acceptance that individual practitioners hold a power and ability to influence the quality of care. The concept of care is acknowledged widely (RCN 2003) and the understanding of professional conduct and service delivery is indisputably established throughout the world (Frenk *et al* 1997) yet the core aspects of service delivery fail to bridge the gap from abstract concept to objective reality.

Health workers are trained and prepared to act in positions of power, the inherent vulnerability through illness perhaps accounting for the genesis of such a dynamic. However the service user requiring autonomy, self efficacy and empowerment, integral elements of their recovery, may find their position undermined. This practitioner position of power, particularly within a large system of mental health care delivery can be imposing and reduce them to a state of anomie (Warne & McAndrew 2005). How this power imbalance is addressed is complex and only partially revealed through my research which encourages a way of being with service users that accepts and values their knowledge and insights. The *Help* theory refers to motivation and engagement qualities within the service user that were previously interpreted as negative or even non existent. By conceptualising the service user as central to, but essentially capable in, the care process, the power imbalance can be rectified.

The issue of drug 'knowledge' (Category 2) and the 'role' substances play in a person's life (Category 10) is an area for discussion highlighting the link between attitude and service delivery that has a bearing here. My research discovered that knowledge deficits were significant among participants and practitioners. Some of the deficits related to dangerous drug use, some were cultural in nature and others were related to treatments. If knowledge growth is integral to skills acquisition (Mann 2002) then the likelihood is that care will improve as the two combine however room for value judgements of a damaging nature remain. The 'striking-off' of a participant from a GP list for illicit substance use was a crude example but illustrates that knowledge and skills without a positive value base can be detrimental. Subsequently the categories that include knowledge are useful but limited when considered in

isolation. Subjective interpretations of mental health and drug use behaviours (by professionals and public) are influenced by other social mechanisms such as stigma, therefore emphasising the importance of related categories to promote greater understanding and potentially reduce parochial and value laden judgements.

Prevalence and definition issues whilst directly linked to one another for commissioning, provision and service development purposes were emphasised only moderately within the research. The practitioner and carer participants contributed the majority of data in this category. It appears that service user participants were less concerned about expressing definition and prevalence matters in technical or organisational terms; however as consumers, rather than providers, they expressed their concerns in an experiential manner. For example an ex-service user who had become a practitioner said this;

> *People not wanting to engage with psychiatry – sometimes when I first meet some of these, they'd rather be sleeping on the streets than have anything to do with services .… they end up getting dragged away on a 136* (Mental Health Act defined 'Place of Safety') *and ending up in hospital, being medicated and that's what they don't like.* (Vanessa Practitioner Participant)

Elaboration on this issue indicated that the service users, typified by this example were frequently passed from one service to another because it was difficult to differentiate their diagnoses. Additionally service users of this nature were viewed as challenging or difficult to engage. The research literature regularly discusses definition and prevalence in an attempt to quantify and articulate policy in line with treatment effectiveness (DH 2002). Participants within my research expressed concerns about the same fundamental issues ('Care' or 'Support' issues in Properties 3 and 6 of Category 12 for example) but from a recipients perspective, concentrated more on interpersonal experiences than the underlying organisational issues.

It is worthwhile examining policy further with this point in mind since the aim of government policy (DH 1995; DH 2002; DH 2004a; DH 2008) has been to enhance service delivery through structural and procedural changes yet the diversity of views, perspectives and opinions inherent in the lived experience of dual diagnosis has appeared less relevant. For instance policy struck at relapse rates (Swofford *et al*

1996), homelessness (Kushel *et al* 2005) and improving service user engagement (Drake & Meuser 2000) by using the chief strategies of staff training and joint working. Joint working however has not been conclusively proven as successful or cost effective (Johnson 2000) whilst strategies to educate the workforce have encountered problems in sustaining positive practice (Miller *et al* 2006; Schoener *et al* 2006). Such an approach has been understandably complicated by differing care philosophies in substance misuse and mental health where mental health services have struggled to embrace harm reduction for instance. Equally substance misuse services have developed a workforce that is less than fully orientated around mental health despite the high prevalence in both settings.

Service coordination and multi-agency working were concerns raised by practitioner participants. Several strands exist but prominent among them was the extent to which the CPA was used. Little reference was made to it by name however the implication was clear, services remained medically dominant in their application of mental health practice. This may have served to diminish policy implementation in relation to the inclusion of dual diagnosis service users. The salient mechanisms leading to exclusion for example were staff holding negative attitudes towards drug users or miscalculating their motivational levels to change, which in turn created a perception of lower engagement potential.

The dual diagnosis client group in keeping with the severely mentally ill has been a casualty of poor public perception where an association with violence or risk dominates unfairly (Bennett 1996). The CPA and associated guidance, that centralises service users in the delivery of care and calls for effective multi-agency working, does not appear to have the full commitment of services. It remains a concern, highlighted here, that attitudes towards substance misuse supersede the policy specifically developed to avoid subjective or incompetent practice. The short comings of a singularly bureaucratically based system within human services are examined by Burns and Priebe (1999) in their critic of UK mental health care which supports the notion that health care, particularly that of less clearly defined illness such as mental of behavioural disorders is subject to personal judgements. This being said the essential practitioner competency frameworks (DH 2004b; Hughes 2006) have been developed to work in conjunction with policy to close gaps and encourage more

inclusive, less judgemental, practice. Whilst it could be considered wild and naïve to claim *Help* theory is all encompassing theory that addresses these two aspects, it is reasonable to assert that the description of *Help* theory articulates the major findings of my study in a manner that encourages service user centeredness and promotes service user empowerment; key components of effective care coordination and case management (Simpson *et al* 2003).

The vast prevalence of dual diagnosis and the symptomatic impact of substance use mean that the dual diagnosis population presents frequently and with proportionately higher levels of need. Paradoxically they are prone to disengage, or be disengaged with, by services when engagement strategies are not prioritised. Upon what grounds would this latter point be based? Perhaps poorer knowledge levels about conditions and drugs leads to inaccurate diagnosis and treatment or perhaps the engagement efforts by services are present yet service users feel they are not understood (Cialdini *et al* 1997; Drake *et al* 2006). The connection or the need for a connection, between service users and practitioners became critical throughout my research. Ultimately the 12 categories contained a multitude of factors that converged to form what I have labelled *Help* theory. *Help* therefore represents the common ground, philosophically and practically, upon which service users and practitioners / services can meet. The following section elaborates on this concept further and discusses the relevant sources of evidence in its support.

Part 2: The Major Category: Help

Help theory was presented and discussed in the Findings chapter. Here I explain the two key elements of the *Help* theory (motivation and self-help) that sit alongside its basic psychosocial process. Combined, they lead to both the implementation and understanding of helpfulness; the rationale for help as an action and *Help* as a theory. Categories 11 and 12 provide the majority of material but it is important to recognise that incidents from all categories are interactional.

a) Basic Psychosocial Process

Below is the list of initial categories described in Chapter 4 and set out in the Research Map. Central to their connection is the concept of help. The categories are wide ranging and multifaceted with subcategories and concepts based upon

participants varied lifestyles, choice of drugs, mental health condition, values, and social circumstances for example. However, when the categories are condensed into the major help-related conceptual headings a basic process is evident.

1. Relationship with Illness
2. Levels of Knowledge of Drugs / Alcohol
3. Relationship with Substance(s)
4. Explanations for my Condition / Situation from other People
5. Policy, Service or Practice Development Issues
6. Significant Childhood and Adult Incidents
7. Impact on Behaviour and Life
8. My Explanation for my Condition / Situation
9. Feelings / Beliefs / Symptoms
10. Role of Substance(s)
11. Things that have not Helped
12. Things that Helped / Might have Helped

This process produced a notional idea that **there existed a desire among study participants to be useful or helpful to themselves or towards others**. This reverberated throughout the later stages of analysis. In essence *Help* emerged as an entity possessing psychological and practical mechanisms of assistance. These were represented in specific examples of advice giving, information sharing, encouragement, or practical intervention.

Being helpful and accepting help requires motivation of some level. The desire to help or be helped was expressed largely whilst participants were still engaged in drug use. Therefore it was necessary to consider the part harm reduction played in this process. Harm reduction or harm minimisation is a model of practice that enables a person to limit the damage a particular activity they engage in may be causing (Carey 1996; Strang 1993). It may underpin a service approach such as the provision of new and sterile equipment to intravenous drug users to avoid contracting blood borne viruses. The approach is a common sense way of addressing the realities of continued drug use when set against the challenges of attaining abstinence. Motivational issues within this context include how a person would explain to themselves, or others, what is

taking place in their lives regarding health, drugs and lifestyle. It includes what they have found helpful or unhelpful too. If motivation however is based purely on behavioural markers then the opportunity to recognise potential for change is missed (Miller & Rollnick 2002), particularly in severe mental illness (Bellack & DiClemente 1999). The basic psychosocial process of wanting to help encourages a firmer and deeper examination of the possibilities. The desire or motivation to help subsequently becomes the driving force behind the delivery. In this sense the research I conducted supports the view that the dual diagnosis client group *are* receptive to intervention regardless of the stage of readiness their behaviour may suggest (Drake *et al* 2006).

The process that led to the identification of 'Help' as the major category, and fundamental to the development of the information materials, requires an understanding of motivational and self-help issues. My personal motivation to effect positive change, through my research, does not interplay with the research process itself, but does represent a purpose or goal. In this sense my motivation to help people and the *Help* theory run parallel. The motivation and ability to help oneself is a natural forerunner, self-help, is thus an integral factor within the *Help* theory. Self-help is also a personal quality that extends from motivation and translates into the practical domain of behaviour change. In addition self-help includes the reciprocal help gained from group interaction. The information materials developed from my research are the behavioural and practical embodiment of *Help* theory that can lead to change. Wilk *et al* (1997) found exposure to substance misuse information material assists learning and decision making. It was evident within my research that information about treatment was helpful in the same way, and therefore the effects and role drugs performed, and potential of services to help, were incorporated into the final health information materials. Self-help in the context of my research is broad and incorporates an individual's discovery of what works and from where it can be obtained.

The basic psychosocial process, the need or desire to help, constitutes the mechanism that triggers help actions. It is presented in this chapter to signify the role and position it plays in progressing substantive practical theory from the abstract. How the psychosocial process occurs is illuminated through the following discussion.

b) Motivational Issues

Motivational interviewing is a specific approach with an evidence base largely within the substance misuse field (Miller & Rollnick 2002). It relies on the understanding that a person may be in one of five stages of readiness to change (DiClemente & Prochaska 1985). They may have no inclination to change their behaviour (precontemplative), be thinking about changing (contemplative), be sampling change (preparation), be implementing change (action) or sustaining change (maintenance). A sixth stage is sometimes identified where relapse prevention is permanent (optimal recovery).

Motivational interviewing encourages service users to talk about the positive and negative aspects of their substance misuse in a partially directive and partially person centred manner (Rollnick *et al* 1999). The process of discussing the positive and negative sides to their substance misuse enables a person to understand more fully the consequences of their substance misuse whilst also enabling the practitioner to hear why (the positives) it takes place. The dual exposure encourages collaboration between service user and practitioner, the former voicing both aspects of substance misuse whilst the latter understanding why (alleviating distress for example) and potentially helping with the discovery of alternative coping means.

A number of research studies have elaborated upon the premise that motivational interviewing can be effective among dual diagnosis service users (Drake & Mueser 2000; Minkoff 2001; Ziedonis *et al* 2005). Despite varied methodologies the accumulation of consensual findings are important. The principles of motivational interviewing (avoid argument, develop discrepancies, roll with resistance, expression of empathy and building confidence and self-efficacy) enable greater engagement, retention and attendance. The latter item, that of self-efficacy is linked strongly to self-esteem and self confidence, it is the translation of self-esteem and confidence to action that facilitates changes in substance use. The majority of dual diagnosis service users exhibit low self-esteem (Drake *et al* 1999). In a study by Oestrich *et al* (2007) of 23 dually diagnosed individuals eight brief cognitive behavioural intervention sessions were delivered. Sustained improvements were recorded particularly in the domain of self-esteem. Whilst substance use changes were not reported, those results

that were indicate that successful substance use behaviour change pivots on motivational considerations. Of further note is the association between the principles of motivational interviewing particularly avoiding arguments, developing discrepancies and expressing empathy, with cognitive behaviour based intervention.

Cognitive behaviour therapy is the therapeutic process of inter relating how an individual feels, thinks and behaves. Sometimes referred to as the cognitive triad this framework for a connecting process is helpful in identifying the precise nature of problems, their causes and sustaining features and potential solutions (RCP 2007). Solutions or interventions can be varied but usually involve some modification of an individuals actions and thoughts hence the term cognitive behavioural intervention. The evidence base for such intervention in mental illness and substance misuse is demonstrating promising but not irrefutable results of effectiveness (Bellack & Brown 2001). Its applicability within the motivation building context is the constructive manner in which past and present behaviours, feelings and thoughts are brought to bear on future actions. Since participants within my study displayed tendencies towards helpfulness such a framework and process is potentially invaluable. Their motivation to help or be helped once established through motivational approaches would need further direction, which is what CBT potentially provides.

Considering the tendency towards disengagement by both practitioners and service users, noted previously, a model that encourages engagement would appear important. Group motivational interviewing of 101 inpatients proved effective in boosting post discharge contact in a study by Santa-Ana *et al* (2007). Participants included in the motivational treatment group also drank less alcohol. The model of motivational interviewing offers practitioners a framework that locates the responsibility for change with service users, within a context absent of practitioner blame or judgement. It also emphasises the expression of empathy as an engagement and eliciting strategy. The principle of empathy resonated with my research findings whereby participants identified empathic approaches as helpful and supportive (Property 9, of 'Help' - 'Attitude and Self-view', Page 182). Furthermore under Property 6, 'Care and Support' (Page 168) empathy appeared a necessary element of demonstrating care.

Motivational considerations also include the educational component of a therapeutic exchange. Empathic approaches aid engagement but once engaged what next? James *et al* (2004) delivered motivationally based education sessions for six consecutive weeks to 58 dual diagnosis service users. The educational content was tailored to the stage of the participants' readiness to change (see Figure 7, 'Stages of Change Model of Motivation', Page 147). Results revealed reductions in alcohol and drug consumption and greater neuroleptic compliance.

Despite the promise generated by studies such as those cited above, Cleary *et al* (2008), in a systematic review of psychosocial interventions for the dually diagnosed were more circumspect. They examined 25 random controlled trials (participant n = 2,478; non-severe mental illness, personality disorder and organic illness were excluded). All trials delivered psychosocial intervention with cognitive behavioural and motivational forms the most prevalent. The variety in intervention form, duration and frequency made comparisons difficult. In the review no statistically significant findings of effectiveness were discovered however of prominence was the relatively improved level of engagement among participants from the motivational interviewing based trials. Five studies (participant n = 338) employing motivational interviewing were included. Whilst small in number it is compelling evidence that motivational issues are integral to success with this client group.

The link between motivation to help and motivation to be helped is strong within the *Help* theory. The two share similarities in that they both include insight or understanding about substance use and the possession of a positive outlook. In a study evaluating a specialist dual diagnosis training programme skills and knowledge acquisition were found to be enhanced, however attitudinal changes were not significantly improved (Hughes *et al* 2008). Attitude and values in the substance misuse field have been widely discussed yet under researched. Cartwright's 1980 study (Cartwright 1980) remains an important one that highlighted attitudes. Hughes *et al* (2008) adapted the Cartwright scale in their study and concluded that motivation to work with alcohol and drug users remained low among practitioners suggesting that dual diagnosis training of health professionals should emphasise value-based practice. The importance of attitude and motivation among front line staff to conduct dual diagnosis work revealed itself further in a study by Schoener *et al* (2006) where low

pre-training motivation to work with the client group predicted a poor outcome in attitude changes. Overall motivation appears to be a difficult attribute to assess, and learn or foster, but above all, maintain (Miller *et al* 2006) yet the concept of 'Help' was palpable throughout my study. It is possible that constant exposure to motivating factors such as seeing ones peers suffer, rather than desensitising participants, galvanised them into becoming helpers. The decline in motivational skills in practitioners over time and a boost in motivation upon additional training (Hettema *et al* 2005) suggests a form of motivation cue exposure similar to that identified within my research.

Ambivalence, manifesting in behavioural inconsistencies and a perceived resistance among service users to change their substance misuse can also lead to disengagement, in addition it can inadvertently convey a lack of motivation (Carey *et al* 2002). Practitioners who fail to identify such inconsistencies as indicators of a desire to change, albeit in the presence of perceived inability to change, miss an opportunity to engage and treat the service user. The absence of empathy and understanding of such ambivalence is incompatible with practitioner (or, in the case of my research, anyone who is helping) optimism. Both this study and established literature highlight the significance of practitioners conveying confidence and optimism about recovery to service users (Kofoed *et al* 1986). Subsequently motivation is not a clear cut state, it is more of a stage-wise concept that enables degrees of motivation to be acknowledged and utilised therapeutically. Ambivalence alludes to a degree of motivation to change; it does not indicate a lack of motivation. As Miller and Rollnick (2002) suggest, holding two apparently conflicting positions (the stated desire to stop drugs and the continued use of drugs) is crucial in the recovery process. The *Help* theory broadens the conventional understanding of motivation. It has potential to positively influence the perception of contradictory behaviours and statements made by service users in order that they remain or become engaged.

Motivation emerged in my research as a state not exclusively referring to substance use. Motivation to recover or motivation to alleviate distress was a prominent finding. It may result in established and ineffective patterns of substance misuse, yet it successfully illustrates that motivation to change (something) exists. This research found that motivation to *"feel better"*, or alleviate distressing thoughts and feelings,

may have led to substance use, indeed this study found motivation sustaining substance use for some. Therefore motivation was attached less to the singular act of substance use but applicable to managing distress and other domains also. The substance use in this context may have been a 'red herring' at times serving to discourage practitioners from exploring wider issues or problems that could eventually distil into substance use changes.

Participants were keen to help or offer advice to their peers about effective use of substances, most of which was harm reduction, not abstinence, orientated. The key issue in their view was to alleviate distress, a view described by Khantzian (1997) where he suggests that substance use is ordinarily a form of self-medication for unpleasant psychiatric symptoms. This study recognised that motivation to change is a key factor in recovery; where it differed from the literature was in definition. Participants held a broader view of the actions possessive of motivation including, for example, safer injecting techniques or smoking weaker forms of cannabis. Whereas the practitioner view, as conveyed through research and policy, suggests any lack of motivation is behaviourally indicated (DH 2002) by further or continued substance use.

Motivational issues emerged from this study as crucial because they represent the desire and ability to recover. Motivation appeared applicable to a range of behaviours not simply substance use. This broader definition of motivation and its position in numerous aspects of an individual's life challenges the conventional concept of motivation, or at least the conventional parameters. This research therefore recognises an expansion of motivation by presenting the intention to help others or gain help, in domains associated with, but not directly substance use, as legitimate. It discovered that motivation exists in unorthodox yet therapeutically useful forms and expressions which are likely to influence engagement. To elaborate on this matter further consideration should be given to the motivation orientated findings which, whilst not immediately explicit, rise to prominence through analysis and discussion.

In order to demonstrate their value it is worthwhile expanding their theoretical application or relevance by comparison with other motivation based models. Moody and Pesut (2006) studied motivational factors relevant to human caring by examining

a cohort of professional nurses. They demonstrated a correlation between 'good' quality patient care outcomes and de-motivating factors such as low staffing, poor job satisfaction and decreased patient satisfaction. The latter state bears relevance to this discussion since engagement and the ensuing care rests upon a degree of satisfaction in the care process for both parties (practitioner and service user). Care, particularly that of a long-term nature, as seen in dual diagnosis, is unlikely to proceed if dissatisfaction prevails. Achieving satisfaction in this context is a reciprocal process whereby the 'care giver' or 'helper' initiates engagement. In order to initiate the caring process certain integral personal and professional values and traits are proposed as necessary (Lock and Latham 2004). Essentially these are a humanistic concern and a belief in the success of a given intervention. The desire (drive component of motivation) to help is stimulated by an individual's emotional feelings (i.e. concern for an individual who is in distress) (Carver *et al* 2000) which in turn triggers cognitive functioning (problem solving) (Panksepp 1998). The success of cognitive functioning appears to generate satisfaction, and in a feedback loop, reinforces the appropriateness of original emotional concerns (Lucas & Diener 2003).

Equally, as described by Gray (1990), the absence or diminution of positive outcomes increases withdrawal behaviour and motivational inhibition. The key conditional factors for sustained motivation to work with peers or patients therefore would seem to be distress related stimulus, anticipated success of an action and outcome satisfaction. All three of which are emotionally bound constructs, however, the intervention and outcome tend to be defined practically or materially rather than emotionally and may be vulnerable to miscalculation. To expand further, within context, the dual diagnosis service user is likely to generate greater care challenges than most. As discussed previously, he or she will experience numerous psychosocial factors conducive with increasingly poor mental, physical and social wellbeing. The likelihood of visible 'success' is reduced when compared to most other mental health populations. How can motivation be sustained then if we accept that positive outcomes are an essential stage in the feedback loop maintaining motivation yet this client group is less likely to exhibit or experience positive outcomes?

The personal disposition of an individual may be relevant here, be it that of practitioner, carer or user. Lucus and Deiner (2003) proposed that negative effect

(NA) and positive affect (PA) traits were critical. The PA individual embodied happiness, joy, excitement and energy with a long-term disposition in all domains. NA encompassed dispositions of sadness, anxiety, fear and anger. Further individual characteristics pertaining to motivation appear important. Conscientiousness (based on an individual's values) and emotional stability (low neuroticism, or low tendency toward worry and anxiety) appear to increase resilience to challenges (Barrick *et al* 2001). In addition an individual's cognitive style is significant. Kirton *et al* (1995) suggested cognitive style characterised decision-making and creativity along a continuum from 'innovation' to 'adaptation'. Those individuals who preferred to adapt their practice faired worse in ambiguous circumstances whereas the 'innovators' creative leaning enabled them to problem-solve more readily. Given the multitude of 'challenging' factors facing the effective implementation of care in dual diagnosis it is unsurprising that engagement issues exist. Addressing the engagement issues is partially achieved by understanding the fundamental motivational factors between practitioner or carer and service user. These have been discussed within this section. I have presented an argument that motivation to recover and/or help others to recover was present in the majority of my study participants. I have added to this concept motivational theories pertaining to personality. I will now conclude by linking the two in order to understand the significance of *Help* theory within the context of dual diagnosis.

Ryan and Deci (2000) theorised that human motivation to act originates from the core psychological needs for interpersonal relatedness and social competence. Thomas (2000) emphasised the notion of personal autonomy and empowerment; the ability to exercise control over life choices. These factors combine to produce a motivational atmosphere; an atmosphere whereby the individual (practitioner, carer or service user) believes him/herself to be effective in their group and able, or so authorised to, pursue a chosen course of action. Such a course of action is the goal or practice or action element of motivation. The personal beliefs (autonomous, socially competent) are the pre-requisite value based skills for engagement, or initiation of the course of action. The personality of the individual, (e.g. tendency towards PA) the sustaining factor.

The negative affect individual, holding a propensity towards neuroticism or worry may not necessarily be a constant. Their state may be influenced by other external

factors and subsequently be amenable to change for the better, thus instilling or returning them to a motivated helper. Isabel Menzies Lyth in her classic nursing paper (Menzies Lyth 1988) highlighted the considerable risk to psychological well-being generated by exposure to intense or unmanageable anxiety, as seen in health care contexts. The nature of healthcare among nurses, in her study, but applicable across care-givers, is relevant in that the service user needs do not necessarily predict the care context. This resembles my study results. Menzies Lyth discovered, in considerable numbers, that the presence of illness within a family was so alien and stressful that transfer to hospital more often reflected the family's inability to adapt to care needs rather than the technical or professional care needs of the patient. It would seem that the containing or managing of stress and anxiety is pivotal to the successful implementation of the care process. As a consequence of accumulative anxiety in the care context burn-out or vicarious trauma (DH 2006c; Zimering *et al* 2003) may exceed motivational factors and break the motivation feedback loop, a potential consequence being lower levels of therapeutic engagement. The withdrawal from the care context (motivational inhibition) is considered by Menzies Lyth to be psychologically defensive. She describes the process of detachment in terms of a 'denial of feelings' necessary to avoid personal attachment and disturbing identifications with patients. This strategy is implicit within professional practice and may have been responsible for the participants within my study being emphatic about the worth of conveying care.

I suggest that the value in conveying care is paramount; that the process itself is therapeutic (Mitchell 1995) whilst professional detachment is counter-therapeutic. This stance is illustrative of the *Help* theory's relevance to practice in that it diminishes the negative attributes towards dual diagnosis service users by emphasising their inherent qualities such as the motivation to recover. Such articulated recovery orientated motivation, albeit within a longitudinal timeframe, is incompatible with a sustained belief that the patient outcome will be negative. It is clinically intuitive and a well established doctrine (Bandura 1997; Locke *et al* 1986) that confidence of success increases its materialisation. *Help* theory is founded on motivation; and attempts to generate therapeutic optimism thus encouraging a positive engaging approach and limiting the likelihood of psychologically defensive withdrawal.

The theoretical underpinning of motivation suggests the psychological and social mechanisms behind low levels of engagement and compliance are equally applicable to other difficult to engage groups such as personality disorder, problem drinkers, heart diseases and obesity (Bateman & Fonagy; 2001 SCMH 1998; Simons-Morton *et al* 2000). The importance therefore of practitioner or carer understanding of the concept of help alongside its practical implementation is crucial. Help and motivation to provide / receive help possess key social and personal ingredients as discussed above. It is significant that my study has identified these as salient among the range of issues considered important by participants.

c) Self-help

The concepts of self-help, peer intervention and mutual aid are similar in that they seek to develop an individual's ability to cope through experiential means. They do not rely upon professional involvement even though programmes may have had professional input at some point. Nor do they constitute a substitute for other forms of help, including that of professionals. They seek to derive help from the experiential process of illness or distress, offering a range of benefits professionals may not be able to provide, such as close emotional support, identity, 'know how', a sense of belonging and hope and the expression of empathy (Schiff & Bargal 2000). Self-help is defined in my research to include any form of help external to that provided by professionals. This includes peer orientated activity and groups comprised of peers. To illuminate:

> *Self-help or self-improvement refers to self-guided improvement, economically, intellectually, or emotionally - most frequently with a substantial psychological or spiritual basis.* (VandenBos 2007)

Self-help can complement professional help, professional help can complement self-help or, as is sometimes the case, self-help is highly preferable to that of professionals. A study by Jorm *et al* (1997) explored attitudes towards medication, psychosocial interventions and non-professionally associated health pursuits in relation to mental disorders. General Practitioners (n = 872), Psychiatrists (n = 1128), Clinical Psychologists (n = 454) and 2,031 18-74 year old lay people participated. Lay participants, through a household survey, held negative attitudes towards anxiolytic and antidepressant medication and electro-convulsive therapy whereas, counselling

services, peer support, physical activity and self-help engendered a more optimistic view. The only aspect professional and public agreed upon was that prognosis improved on professional involvement. Jorm *et al*'s (1997) study suggests the integration of intervention types and sources is beneficial.

The dual diagnosis research literature in the area of self-help is limited however illuminating studies do exist that support the theoretical stance my research takes. Powell *et al* (2001) formulated experimental self-help groups combined with a self-help sponsor or 'buddy' for people with affective disorders. The intervention was not described in detail however the basic tenet of sharing experiences with peers was. The sample was non-drug using and reportedly relatively well educated so comparison with my study may be weak, although I did not formally assess this characteristic. On the other hand, my research discovered that affective symptomatology was a major source of distress and a reinforcing factor for sustained substance use (see Figure 6, 'Course of Drug Use: Deficit Management Model', Page 130).

Pollack *et al* (2001) combined the professional and group components of self-help, cited above, in a study comparing professionally facilitated interactional groups with self-managed self-help groups. Participants (n = 121) had bipolar illness and were non-substance using. The study examined post intervention outcomes of coping ability and symptom and behaviour recognition at pre, immediately post and 3-month post discharge from hospital. The self-managed group emphasised participants' concerns and experiences whereas the professionally facilitated group emphasised 'patient-therapist' discussion. The significant finding relating to my research was the greater level of sustained satisfaction reported by the self-managed group. This equates to service user satisfaction with peer orientated self-help and suggests service user led self-help is likely to be more effective, at least in engagement terms. My research findings illustrate that significant capacity for self-help, even among service users that appear unmotivated, clearly exists.

Self-help can be individual (Bower *et al* 2001) or group orientated (Powell *et al* 2001). Being affiliated to a self-help programme has demonstrated effectiveness in drug dependency settings also (Fiorentine & Hillhouse 2000). The recovery research evidence in mental health has found positive benefits in process and outcome (Allott

2004) and presents the experience of self-help as genuinely therapeutic. However, people with more severe forms of mental illness have shown lower levels of engagement with self-help groups (Noordsy *et al* 1993). Substance use groups appear to lack acceptance of mental illness and according to Vogel *et al* (1998), demonstrate lower levels of empathy.

The 12-step recovery movement developed by Alcoholics Anonymous (AA 1952) has influenced numerous similar programmes emphasising self-help. The premise that a group of individuals who share a common illness or behaviour that is destructive or problematic can offer one another support is the basis upon which self-help is built.

Individual self-help remains experiential with equal emphasis upon learning as sharing. Daley and Douaihy (2006) found dual diagnosis educational materials for service users and their carers were popular. The effectiveness of developing a sense of self responsibility for coping (Magura *et al* 2003), based upon motivational interviewing principles of self-efficacy, concurs with findings in my research. Participants expressed encouragement, understanding and companionship to their peers based on their own and their peers' recovery experience. The quote by service user participant Jake conveys these qualities.

> *…plus it helps the patients as well when they come, you know, just come off the detox and they are coming down here for the first time. You know, you can see it in their eyes. They are like scared mice and you sit down and talk with them and let them see how easy…… you know, all we're doing is passing on the confidence and the the security that we feel within ourselves, you know and let them see and oh, we want some of that.* (Jake)

Self-help is growing in popularity and availability as the evidence base develops (Finch *et al* 2000). It appears to overcome obstacles of a geographical or relationship nature whilst promoting independence and autonomy which are two prime conditions for recovery (Miller & Rollnick 2002). The concept of self-help is important in the *Help* theory here because in the absence or failure of services to accommodate dual diagnosis needs, the service users have a resource in themselves. Has the resource of self-help emerged due to engagement problems borne from necessity though? Probably not, my research conclusions suggest the origins of self-help are more likely

instinctive and reflect the general humanity upon which health care is based. Furthermore self-help can be viewed as a manifestation of the motivation to recover. It is represented by the cyclical or linked nature of help emergent from my research in that it demonstrates the desire to recover *and* much of the means.

Chapter Summary

This chapter has discussed clusters of categories that reflected the research literature themes of poor engagement and gaps in service provision. The 12 categories set the scene for the ensuing *Help* related discussion. It was initially concerned with how my research findings interconnected and formed the major categories of 'Help'. In elaborating upon this the wide array of perceptions and positions taken by participants was raised. Examples of poor practice due to attitudinal, knowledge and skill deficits were provided to elucidate the inherent problems of stigma and prejudice. Conversely unhelpfulness was reframed and help qualities presented. The *Help* theory had its fundamental characteristics of motivation and self-help examined. The process by which practitioners and service users embrace help was identified as the 'basic psychosocial process' - the initial drive to help. The notion that sustained substance use in mental illness is incompatible with effective intervention (or help) was dispelled by expanding the basic understanding of motivation. *Help*, as a result could be justified as a legitimate activity despite the recipient not necessarily displaying conventional signs of treatment participation.

In the next chapter I present the outputs from my study; these are four information and education booklets. The context and literature that supports drug and health education is described whilst significant literature pertaining to the content of each booklet is also included.

CHAPTER 6. OUTPUTS

Introduction

This chapter describes information materials in the form of a series of four booklets that constitute practical outputs from the research. The booklets exceeded my expectations of a beneficial information product. The content of the booklets could not have been accurately predicted, nor could the appealing and creative manner in which it was presented.

This chapter will examine the development and utilisation of health information materials in general terms. Each individual booklet will be presented using characterisation, story-telling and illustrations to depict the specific substance and mental health issues my research revealed. It will unify the key findings and demonstrate the connectiveness between the information materials, the data as a whole and the *Help* theory. The connectiveness therefore supports my claim that the booklets are research based and appropriate for practice. In other words the translation of research findings to a service user information resource acts as a bridge for the theory-practice gap. As a practitioner-researcher this was highly valued.

Each booklet illustrates a main character upon which their life experiences, substance use and mental health orientate. The important prior research associated with each booklet, and the substances and mental health problems it depicts, are cited to ensure that the study's harm reduction advice met evidential standards on accuracy and credibility. Relevant background literature used for the booklets pertaining to health behaviour change and its significance in relation to helping is also presented.

The booklets are the result of both research and artistic endeavour. The illustrator who has experience in the field of drug education participated in the majority of the focus groups acting at times as a 'critical friend'. He translated the context and the participants' accounts into illustrations, and suggested storyline ideas and text upon which to integrate the data categories.

The theory (*Help*) that emerged was unexpected. My original hope for a fuller explanation of the dimensions and properties of dual diagnosis as a phenomenon was, on reflection, naïve. What did emerge was a theory that later informed the production of the information materials. A theory explaining or promoting (i) that people with a dual diagnosis want help, (ii) that they also frequently possess the knowledge, ability and motivation to help (either themselves or others) and (iii) a sense of feasible therapeutic optimism with a client group that is often regarded pessimistically. The booklets appear to capture these ingredients successfully.

This chapter therefore presents background information concerning mental illness, substance use and health behaviour change and identifies the connections between the contents of the booklets and the research data itself.

Information for Education and Behaviour Change

This section presents relevant literature concerning the effective use of information to improve health or encourage behaviour change in substance using populations, and discusses the influence this literature exerted upon the study output of the booklets.

Drug education is popularly conceived as an activity conducted within schools and to a lesser extent in health care settings. The media also play a role in delivering drug (and health) education through soap operas, news items and documentaries. The effectiveness of education through these latter sources remains arguably unproven despite their popularity. The impact of preventative education is also difficult to prove; nevertheless it is accepted as a justified approach receiving much investment and attention (WHO 1995, Pages 1 & 2).

The World Health Organisation (WHO) has described a model of Information, Education and Communication (IEC) in the following terms:

> *IEC is a broad term comprising a range of approaches, activities and outputs. Although the most visible component of IEC is frequently the materials produced and used, such as posters hanging on clinic walls, materials are only one component. Effective IEC makes use of a full range of approaches and activities.*

The impact of information and education upon people with drug problems has proven to be effective within a therapeutic model of motivational based intervention (Rollnick *et al* 1999). This model is among those referred to by the WHO that accompany and improve the effectiveness of information provision. Outside therapeutic exchanges, but within harm reduction, information, education and communication (IEC) has also shown effectiveness. IEC programmes in relation to HIV infection prevention were described by the World Health Organisation as essential components of the response to HIV among injecting drug users. Cost effectiveness research of such programmes has difficulty identifying the specific successful components. However the WHO (1995) emphasise the importance of visually engaging health promotion materials.

Despite widespread use of drug education materials alone, most of which is a mixture of illustrations and text (TalktoFrank 2008) there is relatively little research proving irrefutable effectiveness. Information materials in conjunction with wider programmes that include service provision (needle exchange services for example) are effective, though distinguishing the value of each component part has not taken place on a wide scale (Coyle *et al* 1999). The WHO in its attempt to promote IEC refers to an effective model of information and education combined with outreach (WHO 1995). Here the concern is that people need engagement and information provision simultaneously. Given that the mental health client group who use drugs are difficult to engage it seemed reasonable to adhere as closely as possible to the principles the WHO suggest in the development of the information materials. The Department of Health 'Safer Services' report (DH 1999) was among the earliest mental health research that revealed the correlation between drug use, violence and suicide. An underlying problem the 'Safer Services' report identified was poor engagement between services and service users. Therefore it appeared conceivable that dual diagnosis service users would respond more favourably to engagement attempts if they were supplemented by good quality drug information.

When considering the materials used in IEC approaches it is noticeable that visually appealing design, logo or art work prevails (Linnell 1993; TalktoFrank 2008). Drawing on marketing principles drug information and education has differed little from commercial selling. A product must have appeal to the consumer to gain their

attention but a discerning consumer is sure to compare and contrast a variety of products. A drug user with mental health problems is less likely to search for a product of this nature in a marketing sense; nonetheless, he or she will be similarly discerning when a product is placed before them. Therefore it was important to identify a product format that would firstly attract the attention of the reader but also hold it.

Having satisfied myself that an appealing format would be necessary to engage service users in discussion or reflection about drug use, a further examination of work conducted in the field would influence specifically what that appealing format might be.

A largely Anglo-centric selection of drug information materials are available (Henderson 1994; Henderson 2002; Linnell 1993). The information has not been demonstrated as clinically effective in outcome terms however it had gained high levels of cultural acceptability and credibility. In addition the target populations reported approval and positive impacts upon their attitude and behaviour (Henderson 2000).

As analysis and prior discussion of the major category 'Help' has demonstrated the manner in which help is delivered to people is crucial. The provision of information in an appealing and engaging format, once achieved, may work best when combined with a model of delivery, for example a programme of motivational interviewing and / or cognitive behaviour therapy. For many however, a process of natural recovery (Toneato *et al* 1999) is believed to be sufficient to bring about healthy behaviour change where exposure to information generates personal reflection and enhances intrinsic motivation. Reduced drug use or cessation in these circumstances then starts and finishes without professional input, apart from perhaps the original collation and provision of information. The booklets were therefore produced to meet the needs of both kinds of audience. People who might not readily engage in therapeutic conversations but might benefit from exposure to information and those who, on exposure, could then participate in motivational exchanges.

The rationale therefore for producing service user information draws on evidence from the drug and health field. This evidence has two levels of effectiveness. Firstly, and demonstrating greater efficacy, it supports the use of information materials within an IEC model where the information is accompanied by outreach, engagement or therapeutic approaches. Secondly, it draws more strongly on marketing principles and what one could refer to as 'received wisdom'. Here, information is provided in an appealing format on paper, DVD, video or internet for example. The presentation and content are emphasised however less focus is given to the model in which it is consumed. The absence of direct therapeutic approaches necessitates an emphasis on the product itself. The product being powerful enough to retain the attention of the reader. The format used for the booklets within this study was therefore informed by both models, both levels of evidence or influence. The booklets had to have stand alone qualities that possessed potential for bringing about healthier or safer drug use in the absence of therapy. The booklets needed to be user-friendly, easily read and understood, and understandable for carers and practitioners, thus encouraging their use in supportive or therapeutic modalities. Hence the booklets were primarily aimed at people with a mental illness who were using drugs. However they were also designed to meet therapeutic and carer needs should the information be integrated into whatever exchanges took place between practitioners, carers and service users, informally or within agreed care plans and therapy.

Not dissimilar to storytelling is bibliotherapy (Crawford et al 2004), a guided use of reading, with a therapeutic aim to help service users gain knowledge and insight. The booklets present scenarios reflective of life experiences without being prescriptive. This is consistent with the previously discussed model of behaviour change (DiClemente & Prochaska 1985) whereby 'psychological reactance', a form of resistance to a demanding authoritative assertion, is to be avoided. The booklet format therefore provides an opportunity for people to develop insight through either facilitative or lone processes.

Finally the content of the booklets, reflecting directly the themes from data analysis, was harm reduction in nature. This section has noted the importance of harm reduction information and education within the field of drug education. It takes into consideration the concept of psychological and practical readiness for changing drug

use and therefore does not create a barrier that an abstinence based approach might generate. Subsequently the booklets were harm reduction in content, engaging in format and adaptable in delivery.

User and Carer Information Materials: Unifying Categories and Themes to Produce Help Orientated Information

The process by which categories and themes came to be represented in storylines was a combination of tried and tested formats in the drug education field for conveying harm reduction health information (Lenton & Single 1998), and its natural synthesis with the data. By this I refer to the manner in which participants almost uniformly conveyed their views; by anecdote and personal account. Subsequently the storylines were reflective of the data in both content and delivery. The illustrative power then amplified certain categories further. It did this by attaching an issue or theme to a character which then became human and personal. By converting conceptual social figures (the mad or paranoid dangerous drug user) into everyday people with fears, weaknesses and strengths, prejudice and dehumanisation through stigma could be challenged. Thus the social process of stigmatisation was potentially reversed for some readers. Carers and practitioners fall into this category whereby pessimistic attitudes can be, unfairly for all concerned, a self-fulfilling prophecy. The booklets were formulated in an alternative style due to the limited impact conventional drug and health education materials appeared to exert in changing perceptions and attitudes (Hawthorne *et al* 1995).

All four booklets start with a short introduction providing the reader with a lay explanation of mental illness and drug use. The manner in which both conditions interact is emphasised. This interaction between drug use and mental illness is a principle incorporated into all four stories. Despite this common principle, the themes varied enormously depending on a range of factors such as the drugs used, the circumstances, motivation, health, supports, past and so on. The variables that impacted upon dual diagnosis were plentiful and converged or collided unpredictably. Therefore the information materials had to (a) recognise the differing manifestations of dual diagnosis related issues (breadth) and (b) remain focussed enough to

demonstrate relevance (specifics). This was achieved by using substance types and patterns and mental health categories (diagnoses) as a story framework (plot and cast) for each booklet, and then adding the relevant drug themes from the research data.

The result was a four-booklet series that would be focussed enough to portray specific conditions or substances, yet broad enough to avoid appearing prescriptive. One limit to the booklets, as a result of this endeavour, may be that they are a compromise and fail to encompass other issues that materialised in less depth, such as age, gender or race. They reflect the data but the data only reflects the participants. In the following examples of booklet content, I present quotations spoken by booklet characters in double quotation marks whilst booklet advisory text is in single quotation marks. Passages from study participants remain in italics without quotation marks, when they appear as a single word or sentence double quotation marks are used.

Each booklet carries crucial information relating to diagnoses, substances, medication, and prognosis. Relevant advice taken from the participants appears throughout. In order to deliver information about the help-related issues that emerged from the study, realistic case scenarios were developed. Consistent with grounded theory these intentionally reflected the participants' experiences, characters and profiles. The case scenarios, one per booklet, were simplistic depictions of complex issues. Their simplicity had to be explicit to guide and encourage readership. Consequently each booklet whilst conveying the practical essence of *Help* was in fact labelled, for easier reference, in diagnostic and substance type terms. They are as follows:

- Mental illness and Cannabis: the story of David - the man with the transparent head. (Booklet 1)
- Mental illness and Ecstasy: the story of 'Raving Mad' Martha (Booklet 2)
- Mental illness, Alcohol and other drugs: the story of Jason – the psychonaut (Booklet 3)
- Mental illness, Heroin and Crack: the story of A man called God – in heaven and hell (Booklet 4)

Relevant literature relating to each group was collated and examined to ensure the technical accuracy of the advice and guidance each booklet contained. It was essential that the key issues arising from the emerging findings were then related to existing research evidence that appeared significant. The key literature is summarised below following the description section of each booklet. The process of translating data into storylines ran parallel with constant comparison of themes. The deconstruction of a category relied upon understanding the meaning behind an incident. Reconstructing the incidents provided the opportunity to locate the significant incidents within case scenarios which then appear in the story of each booklet. The synergy between researcher and artist enabled the formal research process and the creative health education thrust to complement one another. Prior to presenting each booklet the next section identifies the precise relationship between data incidents and booklet depiction.

The Data

In Chapters 4 and 5 the categories emergent from the study were listed, analysed and discussed. The list appears again in this section but formatted to relate to the information materials (see Appendix 3, Page 271).

The 'crosswalk', or relationship, shown overleaf in Table 23, between the data categories and the booklets is crucial. The major category of 'Help' permeated every other theme and informed the nature of the final product; materials that contained helpful information for people who used drugs and experienced mental illness. The data were represented in two ways. The first was to incorporate the major category ('Help') to form the foundation principle. The storylines were all framed within the concept of help and helpfulness.

Secondly, deconstructing this concept then produced the specific examples of help such as practical advice. The process of deconstruction also revealed the circumstances and people involved in certain situations. This provided the context, or setting, for the storylines as well as ideas for characterisation.

The category 'Impact on Behaviour and Life' provides an example of this. The character 'Martha' who appears in the second booklet 'Mental illness and Ecstasy –

the story of Raving Mad Martha' elaborates on the issue of mental illness stigma and the role her drug use played in alleviating symptoms and consequences of mental illness and exacerbating them.

Table 23. Category - Booklet Crosswalk

Category number	Categories and Sub-categories	Information materials reference
1	Relationship with Illness	Bk 1 – Pages 6-17 Bk 2 – Pages 8,12-17 Bk 3 – Pages 6-13,16 & 17 Bk 4 – Pages 7,10-13,16 & 17
2	Levels of Knowledge of Drugs / Alcohol	Bk 1 – Pages 4,5,9,18 & 19 Bk 2 – Pages 4,5,7,11,15,17 & 18 Bk 3 – Pages 4,5,9,11,13,15,17,18 & 19 Bk 4 – Pages 4,5,7,9,11,13 & 19
3	Relationship with Substance(s)	Bk 1 – Pages 6,7,10 & 11 Bk 2 – Pages 7,9,10 & 11 Bk 3 – Pages 7 & 10 Bk 4 – Pages 6,7, 9,10 & 16
4	Explanations for my Condition / Situation from other People	Bk 1 – Pages 2,15,16 & 17 Bk 2 – Pages 2,16 & 17 Bk 3 – Pages 2,9,16 & 17 Bk 4 – Pages 2,14,15,16 & 17
5	Policy, Service or Practice Development Issues	Bk 1 – Pages 16 & 19 Bk 2 – Pages 15,16,18 & 19 Bk 3 – Pages 11,13,16-19 Bk 4 – Pages 6-9,14,17-19
6	Significant Childhood and Adult Incidents	Bk 1 – Pages 2,6,8,10,12 & 14 Bk 2 – Pages 2,6,8 & 9 Bk 3 – Pages 2,8 & 9 Bk 4 – Pages 2,6,7,9,12,14 & 19
7	Impact on Behaviour and Life	Bk 1 – Pages 6,7,14-17 Bk 2 – Pages 8-13 Bk 3 – Pages 11-13 & 17 Bk 4 – Pages 6-9,12,14-16 & 18
8	My Explanation for my Condition / Situation	Bk 1 – Pages 6,8,10,12 & 14 Bk 2 – Pages 6,7,8,10,12,14 & 16 Bk 3 – Pages 6,8,10 & 12 Bk 4 – Pages 6,8,10,12,14 & 16
9	Feelings / Beliefs / Symptoms	Bk 1 – Pages 6-15 Bk 2 – Pages 11-15 & 17 Bk 3 – Pages 7-15 Bk 4 – Pages 11-13 & 19
10	Role of Substance(s)	Bk 1 – Pages 2,6,7,10,12,13 & 18 Bk 2 – Pages 2,7,9-14 & 16 Bk 3 – Pages 2,7,9-13 & 17 Bk 4 – Pages 2,7,9,10,11,12 & 13

11	Things that have not Helped	Bk 1 – Pages 13,16 &17 Bk 2 – Pages 6,7,14,15-17 Bk 3 – Pages 7,16-17 Bk 4 – Pages 6,7,13-15
12	Things that Helped / Might have Helped: (Peer support / intervention or Education /information or Relapse prevention or Alternatives)	Bk 1 – Pages 9,11,15,17 & 19 Bk 2 – Pages 9,11,13,17,18 & 19 Bk 3 – Pages 13,16,17,18 & 19 Bk 4 – Pages 8,9,13,15-19 Every page relates to *Help* as it is the major category (see lower shaded section of each page), this box contains prominent practical forms.

The classic Catch-22 was apparent. Martha's mental health had required treatment prior to her drug use, drugs, mainly ecstasy generated a feeling of euphoria and inclusion but also worsened symptoms.

> *"I was like a butterfly opening its wings for the very first time......I never knew it was possible to feel this beautiful....I guess that's why they call it ecstasy".* (Booklet 2 character Martha)

Negative responses from boyfriends had taught her to avoid revealing her mental health status.

> *"You meet a guy, you're getting on great – but there's just that one little thing you haven't told him.....you spend half your life in hospital, because you've a mental illness!"* (Booklet 2 character Martha)

Martha's mental health impacted upon her life negatively. She discovered drugs and experienced feelings of euphoria and happiness ordinarily absent in her life. She also experienced more frequent and lasting relapses of her mental health. The need for more ecstasy-induced happiness grew as her mental health deteriorated, one condition influencing the other exponentially. Her drug lifestyle brought her greater social contact, some of which would become negative should she reveal her mental health problem.

Martha adapted her life style to cope with mental illness. The mental illness remained despite her coping strategy (drug use). The modification of her personal

circumstances within intimate relationships took place to preserve her self-esteem and avoid unnecessary rejection, but in doing so it maintained her drug orientated activity. This is an example that translates data incidents (see Daisy below) into an appealing story line. The text being developed with artistic licence, rarely being verbatim, retains its essence.

> *I had a mental break down, I was studying at college…started using drugs erm, shortly after that cos I didn't have much to do and I'd go out. I couldn't really take up a job because I was in and out of hospital. It was good, I felt like I wanted to dance, it was you know…in a way it takes me away from my illness…..it helps take worries away and stuff. Like sometimes I don't get to meet people because a lot of people don't want to meet me cos they can tell I've got mental health problems.* (Daisy)

A category depicted strongly in Booklet 1, (Mental illness and Cannabis – the story of David – the man with the transparent head) was 'Feelings / Belief / Symptoms'. This exemplifies the translation process from data to story. Here paranoid feelings, auditory hallucinations and delusional beliefs, described in interviews and focus groups, appear in both text and illustration. The illustrations do not deviate from the data themes but simply convey it visually. The character David walks through a shopping precinct believing that television sets refer to him directly and that people are watching him. The text then reinforces the illustration and incorporates prominent participant experiences.

> *"They were watching me at the precinct. Whispering and watching. I had to make sure they didn't follow me home".* (Booklet 1 character David)

> *'The effects of some drugs can be very similar to some of the effects of mental illness. Paranoia can be a symptom of mental illness. David's paranoia is very disturbing and doesn't wear off with the cannabis. If you start to feel paranoid go somewhere quiet, where you feel comfortable and safe'.* (Booklet 1 text)

The symptom related category contained 95 incidents at saturation, approximately 10% of the total incident count. Symptoms expressed in distress terms, also appeared in the category 'Role of Substance(s)' 113 times. 'Things that Helped / Might have Helped' was saturated with distress-relief related incidents. Therefore the

convergence of incidents related to mental distress and symptoms was vast. Help-related actions were prominent throughout, subsequently the construction of a character (David) experiencing such marked symptoms, receiving advice and eventually finding treatment was a reconstruction that was both succinct and accurate.

A further example for this section builds on the category concerning significant happenings or incidents. Here the presence of a recurring delusional belief of one participant, which had reappeared on each psychosis-type relapse he experienced, was recognised in principle by other participants. In other words participants understood that recurrent preoccupying thoughts plagued them and proved to be significant at the time of each mental health relapse.

> *"I had been chosen as the special one. They told me to use my incredible powers to drive the demons from the Lord's house".*
> (Booklet 4 character God / Geoff)

The quote comes from Booklet 4, 'Mental illness, heroin and crack – the story of A man called God – in heaven and hell'. The illustration of a troubled angry looking man with a devil on his back, set in a grave yard, a burning church in the background is a surreal, powerful and disturbing picture. Yet it depicts the overriding sensation for the participant when admitted for mental health treatment; that he was powerful and his powers emanated from religion whilst surrounded by distress and destruction.

The passage above, and illustration within the booklet, demonstrates the bizarre and distressing incident. The appearance within the booklet represents a delusional world participants would live in at times. The depiction leads naturally to explanatory text about illness and treatment, (psychoactive drugs and psychotropic medication).

The examples above represent specific categories and explain the manner in which one category links with another. The complexity of dual diagnosis is therefore evident yet the depiction simplifies it.

In general terms the 'Help' category, from which 11 subcategories emerged (Table 16, Page 148), contained key properties such as communication, medication, treatment, care, support, and attitude that demanded inclusion into the body of each

booklet. They were therefore incorporated into the booklets as themes with each page (text and illustration) bearing their influence.

To conclude this section it is important to note that help (and helpfulness) is an intrinsic property of the majority of incidents reported. In addition each incident collated and categorised can be traced back to the basic psychosocial process of obtaining or delivering some form of distress relief, be it from drugs, emotions, relationships or circumstances. Finally the importance of maintaining the integrity of the data on translation into the information materials has been described. This procedure is examined further in the following sections whereby the information materials are subject to greater explanation and understanding.

The Information Materials (4 Booklets)

In this section examples from the materials in each booklet are described to show how the translation from raw data, to appealing or useful information, occurred. It is necessary to display parts of the final information product to demonstrate the innate power of illustrative representation. The narrative or text accompanying many of the excerpts are also presented in order to demonstrate the formulation of stories and their linkage to the data. Full booklets are in Appendix 3.

As data was collected I sought information that might be satisfactorily integrated into the booklets that coincided with emerging themes and the overall background and profile of each character. Whilst elucidating the themes and categories in the storylines, the characters, their settings, circumstances, substances and diagnoses were developed. For the characters in each booklet, be it someone experiencing schizophrenia and injecting crack cocaine, or using cannabis to alleviate psychotic symptoms, it was imperative that the foundation upon which the stories were based be plausible. The storyline and character within each booklet is introduced to contextualise the information discussed within the preceding sections and chapters. The cast of characters had to possess a sense of realism and to this end I reviewed relevant research literature. The significant aspects from these articles are discussed following each booklet summary.

Booklet 1. Mental illness and Cannabis: the story of David the man with the transparent head

This character emerged as the representative image for prominent incidents within mental health inpatient focus groups. Proportionately higher numbers of people from African-Caribbean descent appear in inpatient mental health settings (Pereira *et al* 2005) and the study participants were similarly over-represented. Within the study the use of cannabis among the Black British and Black Mixed Race participants was either higher or more readily revealed. The ethnicity of the central character, David, reflected the source from which significant cannabis-related data arose.

Symptomatic relief and symptom exacerbation were consequences of cannabis use (Table 13, 'Role and Properties of Substance Use', Page 127 and Table 12, 'Dual Diagnosis Symptom Categories', Page 123) and were depicted within this booklet. In addition they are highlighted within research literature (Semple *et al* 2005).

The storyline then is one of cannabis use taking place in isolation as David becomes aware of *"bad things happening"* to him. This represents the early signs of psychosis and his automatic response, to smoke more cannabis. He then declares he *"couldn't think straight"*. Both terms reflecting his disquiet about perceptual and thought disturbance.
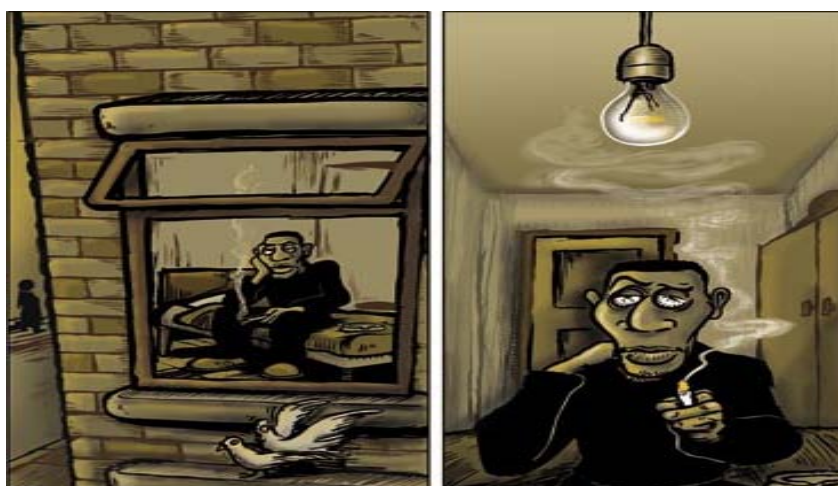
Warning signs and triggers are discussed on the opposite page to the illustrations. The text capitalises on the empathic and engaging picture to inform the reader what could

be taking place. The early signs of possible psychosis are described and the topic of cannabis introduced. Cannabis is raised as a potential source of damage, however care was taken in drafting the narrative to avoid authoritative statements that might generate psychological reactance, the forming of an opposing mind set to that being ordered or instructed (Brehm & Brehm 1981). Empathic care, consistent with therapeutic principles (de Vignemont & Singer 2006) had been cited as engaging and necessary for the process of help to commence.

The next eight pages of the booklet are comprised of symptom illustration and explanatory texts. Paranoid ideation, thought disorder and perceptual disturbances are emphasised in order to firstly engage the reader through their recognition of identifiable symptoms and secondly to 'tag on' treatment messages. The treatment (self and professional and/or carer) is entitled *'things you can do'*. This deliberately places an emphasis upon the readers' choice. It also promotes the 'do's and don'ts' emergent from the research.

Symptom representation and text containing explanations and suggestions lead the reader into the treatment section of the booklet, a feature of all four booklets. This is a

natural progression of the plot preparing the reader on each page through the *'Things you can do'* message box to a two-page section relating to aspects of help others can do, professionals and carers in this case.

The final pages, in response to the low level of drug knowledge (Category 2), elaborate on the cannabis information provided earlier, with additional information about types, strengths and effects. The booklet concludes with a *'managing cannabis use'* check list. It states clearly that no use is safer than some use, whilst also suggesting moderation is safer than heavy use. Given that greater numbers of participants were managing illness and distress through cannabis smoking than abstinence (albeit ineffectively), harm reduction advice was considered more appropriate.

Significant Literature

The literature associating cannabis use and psychosis is considerable (Hall *et al* 2004). There is no proof that cannabis causes psychosis (Arsenault *et al* 2004, Newcombe 2004) however cannabis use has been shown to trigger psychosis in vulnerable individuals (Hickman *et al* 2007), for instance among people with a family history of schizophrenia. It is accepted throughout the research, and to an extent through received wisdom, that cannabis will exacerbate psychotic illnesses, however, more recently it has emerged that psychosis appears to increase the likelihood of cannabis use (Ferdinand *et al* 2005). The bi-directional effect of cannabis and psychosis is therefore relevant. In this booklet the central character 'David' is advised about these aetiological factors, he is not told his cannabis use has caused him to become ill but he is informed that cannabis causes paranoia, and other psychotic features, to become more marked. There is also acknowledgement of the relaxing, euphoric and creative effects cannabis exerts (Johns 2001). This conveys an understanding to the reader that psychosis is a distressing condition and that cannabis, taken to help cope, is understandable, despite its overall ineffectiveness.

In order to tell this aspect of the story and engage with the reader in an honest, credible and evidential way, the use of good quality research findings was essential. Research external to the study was therefore reinforcing but not generating of the emerging issues.

The prevalence of cannabis use by people within mental health settings is high, particularly those in psychiatric intensive care units, a setting in which many of the participants had past or current experience (Isaac *et al* 2005; Schulte & Holland 2008). It comes third highest after alcohol and cigarettes (Holland 1999; Van Os *et al* 2002). The over-representation in mental health wards of people from Black African Caribbean backgrounds in mental health wards is well-researched (Miles *et al* 2003; Pereira *et al* 2005). The response from psychiatry to encourage or expect abstinence is quite overt (Hawkins & Aram 2004) not just for medical reasons but also in relation to professional and legal obligations (Home Office 1971). The character 'David' possesses these real life properties and therefore is a reflection of the dual diagnosis issues others like him face.

Within this story are the key considerations for recovery. The brief yet significant review of cannabis / psychosis literature enabled the booklet to convey its currency and reflect to the reader a plausible storyline.

Booklet 2. Mental illness and Ecstasy – the story of 'Raving Mad' Martha

Martha represents the broad issues of depression, psychosis and isolation. She finds a way of living that addresses her isolation, provides her with enjoyment, but on the negative side, worsens her mental state with episodes of acute psychotic breakdowns. Despite these taking place more frequently, and for longer durations, her drug lifestyle remains cherished.

As the story closes she makes an important comment in response to the offer of medication;

> Doctor – "*Those pills* (ecstasy) *have made you ill – these pills* (medication) *will make you better*".
>
> Martha – "*Yeah, but my pills made me glad to be alive*".

Ecstasy was revealed as a frequently, yet irregularly, used drug among participants. Its use was rarely sustained for long periods. In the case of Martha numerous issues about safer use and its impact upon mood, psychosis and vulnerability are raised. The

storyline does not represent a majority among participants but effectively informs readers of precautions necessary to alleviate risks associated with its use.

The younger participants appeared more interested in discussing music orientated social settings. Social networks that extended to dance and party activity had increased exposure to ecstasy. The likelihood of ecstasy use to ameliorate depressed feelings, both illness and ecstasy related (e.g. the 'comedown'), therefore increased. Martha's story starts with the revelation that ecstasy enables her to feel a sense of belonging. An experience frequently absent or lacking in people with a serious mental illness (Grove 1999).

A lifestyle is depicted conveying Martha's growing commitment to the dance scene and ecstasy. Weekends take on great meaning whereby preparation gradually becomes obsession. Problems associated with sustained ecstasy use are identified and as with all four booklets the do's and don'ts apparent from the data and evident in drug literature (London Dance Safety Campaign 1997; ONS 2006) appear on alternate pages.

The plot takes on an added edginess on page 14 where Martha's *'sky falls in'*. The accumulation of ecstasy causes a relapse of her mental health which results in admission to a mental health unit.

The illustration and text at the close convey Martha's ambivalence. From one perspective she is insightful of the damaging effect ecstasy has on her mental state (culminating in relapse) yet from another she seeks the release and sense of belonging ecstasy provides.
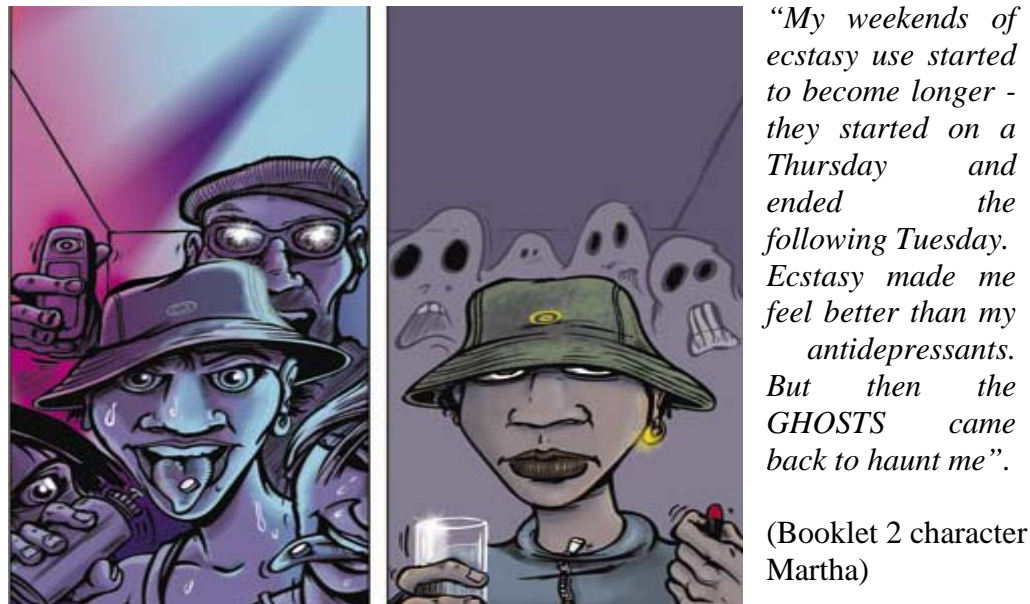

"My weekends of ecstasy use started to become longer - they started on a Thursday and ended the following Tuesday. Ecstasy made me feel better than my antidepressants. But then the GHOSTS came back to haunt me".

(Booklet 2 character Martha)

Figure 6, Page 130, 'Course of Drug Use: Deficit Management Model', is applicable to Martha. It suggests ecstasy enables her to replace the social and emotional deficit created by her mental illness. Whilst doing so it creates deficits elsewhere, until finally she relapses fully. Given her view, and the prevailing view of participants, that drug use has short term justifiable benefits, a cycle of relapse is almost inevitable. Within this context the final two pages are dedicated to safer (deliberately not termed 'safe') use, dealing with medical emergency and legality.

Harm reduction orientated information here spans the individual (Martha), and the wider community drawing attention to risks such as those associated with driving or child care (Advisory Council on the Misuse of Drugs 2003).

A cycle of relapsing, however, was not construed as failure by participants, more a way of life where drug-related social networks remained important despite the negative health implications. Nor was the cycle seen as finite. The themes related to *Help* within an orthodox treatment and care paradigm appear initially opposed to the

experiences of participants in this cyclical lifestyle of relapse and remission. Yet focus group participants who offered advice about reducing or abstaining from drug use were listened to, and their contributions respected by peers. This suggested that limiting the damage suffered through drug use was a valuable approach that could maintain health for a future time, when the cycle was finally broken. A realistic sense of optimism conceivably exists in statements that demonstrate insight and concern about personal well-being. Below Daisy, a key source of information and inspiration for Martha, conveys such optimism through her insight into drug effects and her mental health, and through her motivation to ameliorate risk.

In response to a question about ecstasy and its impact on mental health relapse she said;

> *I've had that before. I had that when I took the three E's, I got really depressed and couldn't remember my name and I couldn't remember what I was getting up to and I got really depressed and I couldn't see and stopped sleeping and speaking and I woke up, and I was sort of like, I was awake but I was like over awake. And I was getting depressed, that's why I won't take more than a certain amount* (of ecstasy tablets) *now.* (Daisy)

In response to a question about ecstasy and its impact upon health generally -

> *I'd like to know the safety of ecstasy you know, the safety of ecstasy like make sure you've got enough fluid in your body when you're out and not to drink too much when you're out. That...* (Daisy)

Significant Literature

Early literature reported unsustained psychosis following prolonged ecstasy use (Cassidy & Ballard 1994). Psychotic episodes following short term or single use ecstasy became well-documented over the following decade (Kampen & Katz 2001). There is now growing evidence pertaining to longer lasting effects in cognitive (Parrott 2000) and affective domains (Morgan 2000).

Case studies described by Keenan *et al* (1993) resembled data from my study and added weight to the notion that Martha faced a paradox due to (i) vulnerability to

psychotic episodes because of a probable underlying disposition and (ii) a compelling desire to use drugs due to her isolation and dysphoric symptoms associated with her mental illness. Locked into this cycle the 'Martha' issues appeared highly relevant, not simply in relation to psychosis sufferers, but to a larger population of people with less severe forms of mental illness (Soar *et al* 2001), a number of whom could potentially develop more frequent and intrusive episodes of psychosis (Cole & Sumnall 2003).

A concern commonly reported are ecstasy related deaths due to hyperthermia (Steele *et al* 1994) and the corresponding prevention and treatment (Drug Info Clearing House 2005; TalktoFrank 2008). At no point did participants views and knowledge conflict in this respect, what differed was their degree of concern. They appeared to regard the probability of serotonin crisis, characterised by anxiety, locomotor over activity and hyperthermia, as negligible. On the other hand managing the psychological and mental health consequences generated significant levels of concern. Whilst this booklet provided general harm reduction advice for current use it emphasised the longer term impact of ecstasy on mental health.

Booklet 3. Mental illness, Alcohol and other drugs – the story of Jason – the psychonaut

This booklet captures a range of drugs that did not readily fit into the storylines of the others. Jason is a polydrug user whose mental illness is less definable than the other booklet characters despite diagnoses of schizophrenia and depression being cited. The mental health symptoms are at times indistinguishable from signs of heavy drug or alcohol use. He is operating primarily within a drug using peer group who reinforce his drug use and accept his mental illness.

The introduction to Jason conveys the desperation and confusion generated by constant bingeing on different substances. Jason embarks on cocaine, amphetamine, ecstasy and alcohol benders (sustained bouts of drug use followed by periods of abstinence). The pattern is erratic and the consequences dire. The story goes on to describe symptoms of heavy stimulant use such as formication (dehydration, stereotypy behaviour accompanied by compulsive scratching of the skin). Integrated

into the effects of stimulant use are mental health symptoms. *'Things you can do'* on alternate pages make suggestions about how to avoid or alleviate the effects and symptoms listed.

"I was getting very confused . . . at least I think it was me"

"Me Mam says I'm going off me head again - but she always says that when she's been on the piss"

(Booklet 3 character Jason)

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"When I found me front door, I tore me kecks off so I could have a good scratch"

"Me nerves were starting and I was feeling dead sad. It's better being drunk than feeling like that, init?"

"I drank and drank until I couldn't remember if there was anything I was trying to forget . . .I drank all I could and then I drank some more. I drank until I passed out and pissed me pants" (Booklet 3 character Jason)

Information about stimulants and alcohol are supplemented with material relating to psychedelic or hallucinogenic drugs. In Booklet 2 (Martha), ecstasy is the central drug, however the pattern of consumption in ecstasy users is generally less sustained than for cannabis, alcohol or heroin users. In Booklet 3 (Jason), ketamine, LCD and magic mushrooms, drugs used in a similar pattern to ecstasy, are introduced. Whilst Jason is not identified as using them, these drugs are fitting to the lifestyle and their presence at this point is appropriate.

The story meanders through a wide range of drugs with Jason receiving mental health care. He, like Martha, reflect the study participants' behaviour in that he accepts care but does not feel able, or possess the motivation, to abstain from drugs or alcohol. Consistent with the harm reduction message the booklet concludes with two pages of drug-medication interactions information. This final section emphasises the importance of drug interactions, a clear theme within the data (Property 2, of 'Help', Page 149) and reflects the risk issues raised in policy and wider literature.

Significant Literature

Jason is a character who likes drinking alcohol and using amphetamine, both substances interact. Stimulants create thirst and dehydration (Liechti & Vollenweider 2000) and alcohol gives the user the initial impression of quenching thirst. Stimulants also enable the person to drink longer and if they derive pleasure or relief from alcohol then that is perceived as a substantial payoff despite the risks of respiratory arrest and other sequalae such as alcohol poisoning or heart attack (Tarrier & Sommerfield 2003). The literature reflects Jason's experiences of the physiological effects of stimulants such as formication, manifest in the sensation of insects crawling or burrowing under the skin (Koo 2003). Furthermore, research demonstrates that the

psychological impact regarding depression (Gossop *et al* 1995), confusion (Chelune & Parker 1981) and psychosis (Margolesea *et al* 2004) are profound and far reaching in psychosocial terms (Drake & Mueser 2000). Jason represents a depressed person with psychotic features whose aim is to alleviate his 'normal' underlying state of misery and isolation.

The development of anxiety related conditions due to excessive consumption of alcohol and / or drugs is reported widely (Bridget *et al* 2004). This booklet elaborates on this straightforward concept linking his anxiety to stimulant 'comedown'. Paranoid and perceptual disturbances are perceived as real threats. Subsequently a feedback loop between drug effect (e.g. paranoia and anxiety) and relief of mental distress is revealed. The booklet creates an atmosphere of insight and encourages reflection on substance use discrepancies (i.e. why do I feel worse?). Research-based advice provided in the booklets matches the advice provided by some study participants such as avoidance of sudden alcohol cessation resulting in alcohol withdrawal syndrome (Kosten & O'Connor 2003) or checking the interactions between prescribed medication and alcohol and / or illicit drugs (Bazire 2003; Kavanagh *et al* 2002). The issue of attributing the presentation and behaviour to drug or illness is conveyed (Shaner *et al* 1998) to encourage practitioners to consider both sides of a person's dual diagnosis presentation. The risks associated with inaccurate differential diagnosis can have serious disengagement consequences (DH 1999).

The detrimental impact of hallucinogenic drugs such as LSD, magic mushrooms or ketamine is raised (Philips & Johnson 2003). Advice to avoid lone use or seriously consider abstinence is given. The storyline conveys the problematic issues revealed in the data via Jason's lifestyle. Subsequently the process of matching the storyline to the literature, explored both here and within the main literature review, results in a credible and realistic information product.

Booklet 4. Mental illness, Heroin and Crack – the story of A man called God – in heaven and hell

Although this is the fourth and final booklet of the series it is not the least significant. Like the ecstasy booklet it focuses on substances cited less frequently in my data. The number of people to whom it will be applicable is therefore difficult to predict. Such a prediction may be an important aspect of further evaluation or research in the field. What was significant about this booklet, and where it differs greatly from the others in terms of target audience, is the service user profile.

Here the character is a homeless man. No background to his present circumstances is provided, the data did not reveal significant background incidents that could be readily portrayed in the booklet, however his plight of isolation, poor health and continued risky intravenous drug use is demonstrated. The themes related to severe and immediate health risks (blood borne viruses, injection site infections, emboli, opiate overdose) are conveyed clearly. The key difference between this booklet and the other three is that this character is harder to reach by services, carers and others in helping positions due to the additional obstacles of homelessness. Those participants who had been homeless in the past had been in contact intermittently with services, be they criminal justice, accommodation, health or social care. Voluntary sector agencies practising flexible, assertive and creative forms of engagement frequently made contact. Subsequently the prospect of delivering information to this group of people whilst challenging, appears feasible.

The information had to contain the realities of street life. It had to reveal both pictorially, and in text, an understanding (an empathy) for the circumstances, chosen at times, in which homeless people live. The booklet contains the most frequently reported substances and routes of administration among the group, and attaches information about safer drug use. It reflects the isolation and living conditions that reinforce the desire on the part of the character to escape. This then leads to information concerning mental health conditions, why a crack cocaine and heroin remedy fails to be effective in the long term for depressed feelings and how more severe forms of mental illness can then be both triggered and dampened by certain forms of drug use.

The lead story page shows the street homeless man. He is alone and asking for money in a grim looking street. Use of a contemporary and familiar grandiose type illustration 'The Ancient of Days' by William Blake, adds to the paradoxical sense of street homelessness and speedball use (crack cocaine and heroin); a heaven and hell, a relief or escape followed by the painful reality of homelessness.


"I lived in the ancient of days but I was cast out into the wilderness"

"They spit at me and piss on me while I sleep. But beneath this shell, I still feel, I'm still a human being and I know the Lord is with me"
(Booklet 4 character God / Geoff)

The story shows the character 'God' in a derelict setting using drugs intravenously. At this point advice concerning safer injecting is provided. Injecting with a peer is depicted next at which point heroin, cocaine and depression are raised as issues, and information about schizophrenia follows. The sense that the character 'God' is self-medicating with heroin is emphasised. This reflects the general point that emerged in the study data and is also cited in wider research that mental health service users frequently use drugs to ameliorate mental health symptoms (Khantzian 1997).

The story progresses to arrest, compulsory detention on an inpatient mental health ward and ensuing treatment. Further advice appears concerning what was considered important and helpful such as rights, information about treatments (withdrawal and mental health including medication) and making lifestyle and drug use changes.
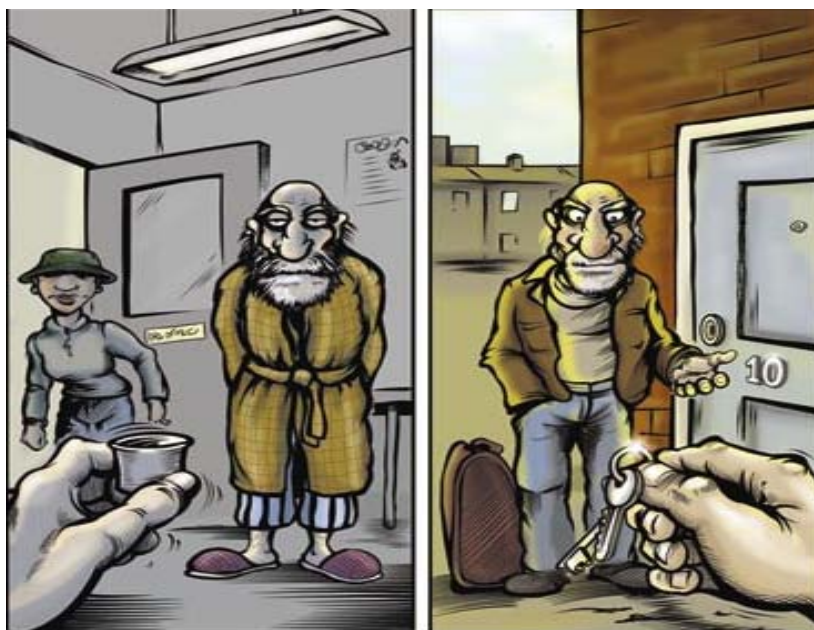
An optimistic flavour is conveyed that was reflective of the aspirations and achievements of participants. It concludes a harrowing story in a therapeutically hopeful manner. The final page is dedicated to the risk of opiate overdose, a prevailing problem throughout the opiate-using population.

Significant Literature

Homelessness is highly prevalent in both substance using and mental illness populations (Leal *et al* 1999). Substance use and suffering from mental health problems individually appear to amplify the risk of developing a dual diagnosis. Being homeless with one condition will almost certainly lead to the second condition (Goering *et al* 2002). Further to this is the frequent contact with criminal justice organisations (McGuire & Rosenheck 2004) often culminating in a mixed history of inpatient mental health admissions and custodial prison sentences (Wright *et al* 2002). This picture emerged in the data and matched closely the key issues in the wider published research.

The homelessness population tend to favour the use of alcohol and opiates (Crawley & Daly 2004). Accidental deaths through opiate use, particularly following a custodial sentence when physiological tolerance levels drop, are not uncommon (Strang *et al* 2003). This issue was raised and understandably the booklet emphasised

the use of recovery techniques and emergency services to address it since similar loss of tolerance can occur following mental health admission.

The increased likelihood of contracting blood borne viruses (Amundsen 2006) was also addressed. The circumstances in which participants had injected and the evidence from my field observations warranted the promotion of safer injecting behaviours (Craine *et al* 2004). The inclusion of crack cocaine with heroin in an injecting bolus is called a 'speedball' (Leri *et al* 2003). Speedballing appeared popular and when mentioned in focus groups it was the only time heroin use did not attract major criticism. Dependent and intravenous heroin use was decried yet heroin and stimulant concoctions were regarded as acceptable.

Psychiatric hospital admission is a traumatic process for most service users (Fennell 1998) and within this booklet God / Geoff's arrest is depicted as such. The experience of detention offers a treatment opportunity and, as a result, intervention, particularly medication, is raised. The biochemical complexities of drugs, mental illness and medication are explained in basic terms in response to the level of interest and curiosity expressed by participants. The longer treatment is delayed the worse the prognosis (McGlashan 1999), and so the booklet leads the reader through treatment and service possibilities as described by participants and recommended in policy (DH 2002).

The difficulties of engaging with people who are homeless and have mental health problems is described widely (Lauber *et al* 2006; Leal *et al* 1999). The isolation, depression and outright mental and physical health deterioration through street living is compounded by services inflexibility when delivering intervention to people who have no fixed abode (Holland & Shulte 2007). Yet the data projected a strong sense of willing service users who wanted to receive help and recover. The difficulties related to dual diagnosis homelessness work are clearly significant yet they contrast with the receptive attitude of participants themselves. Drake and Mueser (2000) assert that therapeutic optimism is a necessity for effective intervention here. Consequently the concept of optimism and a positive outcome was elaborated upon in the final pages of Booklet 4.

Chapter Summary

Help within the study resounded throughout the categories as they emerged during analysis. Since the category of 'Help' was established it logically became the foundation upon which to base information materials.

Information materials have demonstrated effectiveness in drug and health domains to varying degrees. The model of IEC alone, or accompanied by engagement strategies, guided the format and delivery process of the booklets. The evidence relating to IEC harm reduction approaches matched the data itself, in terms of participants promoting safer forms of drug use, as well as the potential appropriateness of abstinence. The booklets therefore met an emerging need for information production. They needed to be appealing to a client group that was ordinarily regarded as passive or disengaging, be flexible for therapeutic lone or facilitated use, and convey helpfulness and helpful advice. The latter successfully integrating the essential ingredients for recovery and well-being, those of hope and optimism.

CHAPTER 7. CONCLUSION

Introduction

In this concluding chapter I will summarise the study as a whole and emphasise the findings of most significance. I will then outline the *Help* theory and discuss how it is currently perceived to be impacting upon practice and the potential it has for influencing policy and service development. The information needs of service users, carers and to an extent practitioners appears to be well met through the publication of the health information booklets presented in Chapter 6. I will use this chapter to reiterate the link between *Help* theory (an explanation promoting positive approaches towards the dual diagnosis client group) and the health information materials (advice and guidance developed from my research data).

I view my study as a contribution to the growing dual diagnosis literature which is leading, gradually, to a fuller understanding among service users, carers and practitioners. I have elaborated upon the most adverse consequences of dual diagnosis such as homelessness, poor engagement and hospitalisation to justify the intense dual diagnosis practice focus my study took. I will discuss here the limitations to the study as I perceive them and make recommendations for future related research and development.

Methodology

> *As consumers we are experts about our experience – particularly of*
> *health issues and health services – and therefore our perspectives have*
> *a key part to play in the process of research and development.*

Consumers in NHS Research Support Unit (Royle *et al* 2001)

My aspiration to elicit, analyse and then publicise my findings in a manner that retained and conveyed the essence of living with a dual diagnosis was uppermost in my mind when selecting a methodology. Grounded theory, as a flexible design, allowed a model of data collection that has encouraged spontaneous experiential information to emerge. It has therefore been less influenced by my views and has

substantially promoted service user perspectives. Chapter 3 detailed the significant effort grounded theory goes to in pursuit of credibility, placing the judgement of credibility in the research process with those who use or read the research findings. The grounded theory method constantly tests and ensures that emerging concepts and categories represent the incidents they describe. By adhering to the principles Glaser and Strauss call 'understandability' (or 'fit') and 'workability' I am confident that my research is consistent and recognisable as grounded in the experiences of the participants.

My chosen method was not designed to be generalisable, however, it is important that readers are able to make a judgement about the theory that was generated so anonymised demographic data about the interviewees has been included. This threw up interesting issues relevant to the dual diagnosis client group, for example in relation to ethnicity, gender, and homelessness.

The practitioner aspect of my dual role influenced the research strategy too. Given the service and practice development expectations of this role, a study that had potential to produce findings of practical utility was very appealing. The need for promoting a better understanding of dual diagnosis is a further goal which I have achieved. The benefits of discovering health information to publish in leaflet or self-help format seemed feasible at the outset of my research. The paucity of good quality dual diagnosis related information materials for service users at that time has now been partially addressed.

Collaboration with Lifeline Publications was important in producing materials that were in an accessible format (with appealing and engaging qualities). The study itself enabled both research quality to be achieved and ethical standards to be maintained.

The Use of *Help* Theory: Impact on Policy and Utility in Practice

The study revealed 12 categories. Rigorous attention to deconstructing, comparing and reconstructing of the incidents led to their accurate categorisation. The themes, or categories, appeared consistent with research theory related to motivation, self-help,

harm reduction and engagement. Consequently these aspects became prominent in the process of *Help* as it emerged as the major category and the research theory.

A sense of the salience of 'Help' emerged during the focus groups and one could argue that the research setting (health care based) was simply being reflected. However, the conceptualisation of help among participants, whilst often resembling health care concepts such as chemical assistance / pharmacology, was more practical in nature. It was also more varied. Dimensionally, 'Help', from the perspective of the service user participants, could be knowing more about a drug in order to achieve a greater 'hit' or discovering a cocktail of substances and medication to help alleviate stimulant induced depression and lethargy ('comedown'). Help was described and discussed in many ways but it was the overriding drive to be helpful, or obtain help, that was resounding and meaningful.

The experiences participants found useful or helpful were incorporated into the information materials after considerable effort to ensure they matched categories and did not conflict with harm reduction guidance or safe practice. The *Help* theory however, remains more difficult to describe and convey. As Chapter 4 demonstrates, the process of analysis was constant and involved identifying the dimensions and properties of 'Help' as well as the subcategories such as support networks, education and information, safer drug use or attitudes. This labelling of incidents into categories and their deeper analysis quantified and described the extensive web of help apparent. It was manifest in many overlapping ways. It became a significant challenge to condense this category and understand its relevance to the study and dual diagnosis as a whole.

'Help' was revealed as the major category. This in itself justifies the original reason for pursuing the goal of producing health information materials. It reinforced the sense that information, if it was seen as relevant and appealing, would more likely be digested. Thus the two objectives of the study acted in unison. The *Help* theory provided strong evidence that the client group was motivated. The health information materials were a resource for which such motivation could be applied.

To emphasise this point Chapters 4 and 5 present and discuss how certain subcategories can inform both attitude and practice. Figure 8 ('Care as a Prerequisite Property for Helpful Interventions', Page 171) places empathy and the conveyance of understanding as the foundation to the delivery of practical interventions. In order for the practitioner to engage and deliver any intervention they require some faith or optimism that the intervention will work. Furthermore, should they enter the exchange with a service user without the prerequisite caring attitude their intervention may well be doomed to failure. From this I believe the *Help* theory supports and promotes the need to view the service user positively but also identifies how this could be done; initially by the expression of empathy.

Empathy and value based practice were described and correlated. It was evident that the characteristics of a skilled and willing helper where qualities shared by service users, carers and practitioners. The essential human qualities required for therapy and help, including personality traits of negative and positive affect, and cognitive styles, were described and placed in the context of the challenges inherent within the dual diagnosis client group.

One such challenge being the equivocal motivation and engagement level perceived of the service user by the practitioner. The notion that dual diagnosis service users are difficult to engage is countered by my assertion that their motivation is laced with contradictory behaviours emanating from maladaptive coping through substance misuse. That their motivation needs an extra effort for detection and that *Help* theory represents the rationale for the extra effort. Equally the competences, both value based and performance measurable, as reflected in the 10 ESCs, ricochet throughout analysis and discussion. Quotations from transcripts are presented regularly as evidence that my research portrays the dual diagnosis client group as worthy of attention. Such attention is essential if the broad spectrum of health and social care, in moral and fiscal terms, is to be met.

The following quotation from a service user participant captures the paradoxical nature of dual diagnosis. Here he is taking a drug to feel psychologically healthier and / or gain relief from stress. The drug taking achieves this temporarily and so becomes reinforcing. The longer term deleterious effect of the drug feeds into the need for

short term relief. This cycle from the perspective of an observer (carer or practitioner) can be perceived as volitional and self-destructive. Such a view is likely to then undermine efforts to empathise and engage.

> *That's through choice, do you know what I mean, cos, its like, its like, there's times when I've been feeling for it and I've just thought to myself there's nothing going right for me at the moment so I'm just going to go and buy, buy one, one, one, one substance of what I want to take, you know what I mean so, I've gone into a few peoples' places and asked them, you know, have you got this and have you got that.* (Floyd)

The *Help* theory and health information materials have potential to impact on policy and practice. *Help* theory included both helpful and unhelpful practice matters, almost a 2:1 ratio whereas policy issues were raised less. This may reflect the immediate concern participants had with their life rather than wider systems and potential organisational solutions. Having argued that *Help* theory possesses the evidence as to why carers and practitioners should be prepared to work optimistically with the dual diagnosis client group I anticipate that it has potential to influence policy development also. For instance the need for culturally sensitive services and culturally competent practitioners is highlighted when considering the demographic and health data of participants. The dual diagnosis client group demographic I sampled was described. It bore relevance to the multi-agency policy issues that the CPA attempts to address. The insularity of mainstream mental health, and its effect on service user status and power was presented, in this context the CPA, as a framework that unites services for the user and places the service user in a potentially more powerful role was cited as crucial.

The information materials have been recognised widely and on publication, in 2007, reached the final of three reputable award schemes winning the regional NHS Innovations Award, being runner-up in the National NHS Technologies Award and being one of five finalists in the Chief Nursing Officer's Award.

Such recognition and over 60,000 copies sold inevitably leads to a raised profile for the issues of dual diagnosis. In this sense an impact on policy and wider practice, whilst not quantified, seems possible. Electronic-learning materials and e-self-help

programmes, based on the health information booklets, are currently undergoing development as a means of greater dissemination.

The main implications of the study are related to dissemination of good practice. Good practice, harm reduction in nature and possessing optimism, is central to the information materials. The *Help* theory accompanies the booklets subliminally, but if other researchers developed the concept of help in this context further it may enlighten a wider audience. *Help* theory promotes service planning and the responsibility for engagement as shared between provider and recipient; between practitioner and service user. Whilst my own contribution is modest, a strengthened argument that elaborated upon the *Help* theory in this respect could be of major significance.

The thesis describes how my research can aid practitioners. At a basic level it raises the profile of dual diagnosis and provides support for the delivery of effective advice and approaches. The advice is consistent with concerns within the wider research literature and thus has resonance. The booklets contain information that practitioners can learn from and, as they practice, can convert their learning into capability.

This research then, has a direct audience of three types; service users, carers and professionals comprising of practitioners, managers, academics and policy makers. For service users the study output of the health information booklets provide opportunities for self-help. For carers the booklets explain what is going on and again provide relevant advice and guidance. For providers, policy makers and academics the same practice (and policy) issues apply but there is also scope for them to impact on values. The examples of life with a dual diagnosis, delivered in a sympathetic and personalised manner, have the potential to challenge stigma and reduce stereotyping, thus improving value-based practice.

I am under no illusion about how rare it is for a single research study to have a tangible impact on policy; however I intend to take the opportunities that arise to exert influence where appropriate. The research has an indirect audience of service planners, policy makers, commissioners and educationalists in that it adds a new dimension to the literature and evidence base. The research promotes harm reduction

in a mental health context and enables self-help. Neither are new concepts, but they are relatively novel in mainstream mental health services where the majority of the people with the most severe conditions continue to receive professionally prescribed support. The findings echo the policy demands from central government in relation to joint working and workforce competence. The research possesses the potential to influence joint working by i) enhancing therapeutic engagement of the client group and ii) highlighting the problems associated with a sequential care pathway.

Helping people is fundamental to health and social care. My role as a consultant nurse includes clinical practice and the development of services. The *Help* theory is evidence that the dual diagnosis client group with whom I'm employed to work *is* receptive to interventions. The health information booklets, whilst I use them in my clinical work, also demonstrate more widely the 'how to' and 'what to' from which *Help* theory emerged. This constitutes an important contribution to the dual diagnosis knowledge base.

Limitations of the Study

As with any study a number of limitations came to light and these are presented below. Grounded theory, a flexible qualitative design, does not immediately demonstrate the level or kind of validity in its findings that are often required in a quantitatively orientated health service. As a result the methodology I used could conceivably be disadvantageous in influencing service planning. Further, the term dual diagnosis, as discussed previously, has its limitations. It is a broad non-specific term, used freely to describe a client group, but is of little worth when tailoring individual care or treatment. Whilst the term itself is avoided within the information booklets the general publicity that my research has attracted may have paradoxically strengthened its power and popularity. This creates the danger of contributing to the homogenising effect through the use of a label. However, it remains difficult to know how to conduct research without using terms that are common in practice.

Another limitation relates to the study sample. Whilst saturation was achieved after two thirds of the transcripts had been analysed other revealing incidents that emerged could have possessed categorical strength had I sampled from other settings (for

example rehabilitation, criminal justice or black and ethnic minority services). Specific gender or race issues cited in the research literature were only partially addressed and discussed because they did not form distinct categories. The majority of research, by definition, is constrained to specific issues; boundaries within my research however were self-selecting due to grounded theory methodology. Therefore despite critical social and health issues appearing, their prominence in *Help* theory and the health information booklets was determined by the participant data itself. I believe then that a specific aspect of the study that I did not explore further was the apparent over representation of Black and South Asian men in the psychiatric intensive care unit in which almost half the individual interviews and focus groups were held. However, this is a reflection of the population treated there within our local services.

Furthermore the majority of participants were male, a factor that reflects mainstream psychiatry. Gender issues in relation to dual diagnosis were uncovered, and alluded to in Booklet 2 however an increased focus on these issues within the research may have provided a greater contribution to improving practice.

My role as a practitioner, employed by the NHS Trust hosting my research, was a situation of potential conflict. Despite being an 'insider' researcher, one who has detailed knowledge of, and a position within the organisation, no notable adverse effects occurred. Conversely, I believe my practice position enhanced communication for recruitment and data collection procedures whilst also adding relevant insights and opportunities from the field.

As dictated by my methodology the findings had to 'fit' the data *and* the source. I did not collect demographic data therefore the only translation of this issue was through the illustrated characters within the booklets. I believe this issue was highly notable and identifies an area for further exploration. Since I pursued 'modifiability' as a measure of research quality I anticipate that the ethnicity and diversity issues revealed could be further explored in a similarly designed study that samples the same population.

Recommendations for Further Research

Future research specific to this study could include an investigation of the *Help* theory in relation to changing attitudes and/or practice. Allied to this the effectiveness of the health information booklets (as an educative intervention to reduce substance consumption) could be pursued.

Further research and development related to this study could be associated with an educational or self-help package based upon the *Help* theory as rationale, and the information materials as content. Potential avenues to explore could include alternative formats such as braille, audio, video or computerised programmes or even an alternative medium such as a board game.

The individual booklets might hold value for certain types of service. Booklet number 1 for instance focuses upon a young man, David, who experiences psychotic symptoms and uses cannabis. Using this booklet within early intervention in psychosis services could be beneficial. Martha, Booklet 2, could provide the basis for harm reduction intervention among ecstasy users. The substance-medication interactions matrix in Booklet 3 (Jason) has greater potential also, particularly in relation to medication compliance.

Ethnicity and gender issues emerged which were not fully examined and could form a distinct area of future research. The prominence of minority groups within the booklets reflected the participant composition as a whole. Valuable and intuitively resounding insights from one participant in particular suggests that issues of diversity are amplified in the dual diagnosis population. Issues of social exclusion, on the grounds of diversity, further compounding any pre-existing stigma from mental illness and substance misuse.

I could envisage the *Help* theory being used within policy debate as well as research. Its potential to enhance the conceptualisation of the client group is powerful. The emphasis participants placed upon their experience of practice rather than views held about policy could be a future area of study with potential to provide insights into service user experience and expectations.

The *Help* theory dispels myth, anecdote and research evidence that dual diagnosis service users generally do not want help. The theory is justified and credible because it is reflected in the majority of the actions or incidents the participants described. As a result of detailed constant comparison the *Help* theory can provide distinct elements for the focus of future study. An example could arise from an aspect of 'Sources of Support' (Table 17, Page 155) which cites eight separate sources of help from service user support groups, or befriending services, to recovery groups and community mental health teams.

Under the heading 'Safer Drug Use' (Subcategory 5 of 'Help', Page 165) in conjunction with 'Tailored Drug Use Strategies' (Table 19, Page 168) the development of insight into the effects of drug use could be examined. Under 'Essence and Pragmatics of Care and Support' (Table 21, Page 174) research could examine the behaviours consistent with a positive value base. A wider variety of specific intervention based studies could proceed, and whilst related to my findings, could also be consistent with the wider literature. My research could therefore inform specific research studies, or provide a theoretical platform to underpin others.

Chapter Summary

I embarked upon this research study with a determination to gain a greater understanding of dual diagnosis. Since drugs, alcohol and mental illness generate a variety of opinions and positions from public and professionals alike I also hoped that a positive outcome would result that would improve perceptions of the client group in general.

To my satisfaction the objectives cited on page 4 have been reached. 1) Service users (and their carers) now have access to good quality and appealing information and 2) an emphasis on engagement and the evidence for optimism are firmly established within my *Help* theory, thus providing a greater understanding of the phenomenon of dual diagnosis.

The scope of the study was limited to people within mental health and substance misuse service settings who had experienced, or had cared for, someone with a dual

diagnosis. It was not envisaged that specific client groups or substances would be identified or targeted, but it emerged that within the confines of this study, psychosis was a common factor. Cannabis, alcohol, amphetamine, crack cocaine, heroin and ecstasy were the most remarked upon substances however the intention to distinguish particular substances and diagnostic groups at the outset was not articulated. Their emergence was determined by the participants and the data.

The dual diagnosis evidence base is growing. This research, utilising a grounded theory, makes a valuable contribution by way of its emphasis on the experiential. The qualitative nature of the enquiry is a welcome addition and complements the existing progression towards discovering what works, and what does not, for people who experience both substance misuse and mental illness. My research provides an explanatory theory contributing to the understanding of dual diagnosis. My research also provides information, in booklet form, that is immediately accessible to service users, carers and practitioners. Both aspects contribute to the field of dual diagnosis and represent the potential influence that a research study can exert upon both practice development and the growth of knowledge.

LIST OF APPENDICES

1. Participant Information Sheet & Consent Form
2. Competence and Capacity Test
3. Information Materials (4-booklet series of harm reduction booklets for users and carers)
4. Memoing Transcript Exemplar
5. Recruitment Poster
6. Invitation to Participate Letter
7. Award Certificates

Manchester Mental Health **NHS**
and Social Care Trust

MANCHESTER CITY COUNCIL

Version 3 October 2004

Participant Information & Consent form

1. Study title

Dual Diagnosis: consumer's views on policy and practice.

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. What is the purpose of the study?

Mental health problems and the use of drugs and or alcohol are closely linked for many people, quite often creating major difficulties for service users / clients, carers and service providers. The reasons why mental health, drugs and or alcohol are linked are often different for different people.

This research aims to find out why drugs, alcohol and mental illness are so closely linked and what, if anything, needs to be done to help.

The study will take three years to complete. If you take part in the study you will be involved once or twice over the next year.

4. Why have you been chosen?

If you are a service user

You and approximately 100 others are being asked to take part in this study because you may have had experience of mental health problems and drug or alcohol misuse. You may have a view or opinion on what helped you or what could have helped you. The research study aims to find out what could help people who experience mental health problems and drug or alcohol misuse so your experience could be useful for others. Participation in the study may not benefit you directly, but may well benefit others in the future.

If you are a carer

You and approximately 20 others are being asked to take part in this study because you may have had experience of caring for someone with mental health problems and drug or alcohol misuse. You may have a view or opinion on what helped them and you and also what could have helped. The research study aims to find out what could help people who experience mental health problems and drug or alcohol misuse so your experience could be useful for others.

If you are a practitioner

You and about 100 others are being asked to take part in this study because you may have had experience of working with clients who have mental health problems and drugs/alcohol misuse. You may have a view or opinion on what helped them and you and also what could have helped. The research study aims to find out what could help people who experience mental health problems and drug or alcohol misuse so your experience could be useful for other clients, carers and practitioners.

If you are involved in the planning, provision or evaluation of mental health, drug or alcohol services (non practice staff).

You and approximately 20 others are being asked to take part in this study because your role involves people with mental health problems, drug and/or alcohol misuse. You may have an opinion or understanding of what helps and what could help in the future.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you are a service user or carer a decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

6. What will happen to me if I take part?

If you agree to take part in the study you will also be asked to join a small focus group which will take place at a local venue such as a health centre, church hall, local hospital or convenient offices. This will last for approximately one hour.

You may also be asked a short series of questions in an interview. You can bring a friend, family member or member of staff if you wish and you will also receive payment for travel expenses. The interview will be 15 – 45 minutes long.

You can take part in the focus group or interview or you can take part in both.

A short questionnaire may be sent to you afterwards to fill-in in your own time.

7.Are there any changes to my treatment

Because this study does not involve a change in treatment or care and only seeks your views and opinions, if you are a service user nothing should change for you. If you or the researcher thinks anything important about your care should be shared with your mental health/drug/alcohol worker NHS rules of confidentiality will still apply.

8. What if something goes wrong?

It is unlikely taking part in this study will cause you any harm or distress, however, if you think taking part in the study has caused you harm in anyway then the NHS complaints procedure will help you. Any member of staff or the researcher will provide you with advice and a copy of the complaints policy upon request.

If you experience any distress or disquiet as a result of your participation in the study additional support will be arranged in negotiation with your care coordinator or therapist.

If you experience any harm as a result of taking part in the study there are no special compensation arrangements but normal NHS indemnity arrangements do exist. These can be obtained by using the Manchester Mental Health NHS and Social Care Trust complaints procedure. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it.

9. Will my taking part in this study be kept confidential

If you are a service user and you consent to take part in the research your records may be looked at for general information. Your name, however, will not be disclosed outside the hospital/GP surgery/clinic.

All information which is collected from you during the course of the research will be kept strictly confidential. Any information about you which leaves the hospital /surgery /clinic will have your name and address removed so that you cannot be recognised from it. Information gathered will not have names or any other source of identification attached. Tape recordings, if used, will be stored securely and destroyed immediately after transcription to paper. Transcriptions will be anonymised.

During the focus groups you may reveal sensitive information about yourself which you do not want to be widely known. There is a requirement for confidentiality by all members of the group.

10. What will happen to the results of the research study?

The results of the study will be written up and available to service users, carers, practitioners and others involved in providing services on request.

Specific results such as a survivors guide for users, carer and practitioner handbooks may be published locally or nationally.

No one participating in the study will be identified in any report or publication.

11. Who is organising and funding the research?

The study is being organised by the Manchester Mental Health and Social Care Trust. It is being funded by the Manchester Drug and Alcohol Action Team and supervised through the University of Salford.

12. Contact for further information

Mark Holland, Nurse Consultant, Manchester Mental Health and Social Care Trust, Chorlton House, 70 Manchester Road, Chorlton cum Hardy, Manchester, M21 9UN.
0161 882 1103.

Thank you for taking the time to read this information sheet and considering participating in this study. This information sheet is yours to keep and a signed copy of the consent form will be given to you should you agree to take part in the study.

Locality Number:
Participant Identification Number for this trial:

CONSENT FORM

Research study title:

Dual Diagnosis: consumer's views on policy and practice.

Researcher: Mark Holland

1. I confirm that I have read and understand the information sheet (dated………) (version ....) for the above study and have had the opportunity to ask questions.

2. I understand that any information collected (interview / focus group notes or tape recordings) will stored securely and disposed of properly and that all information will be treated confidentially.

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

4. I agree to take part in the above study.

_____   _____   _____
Name of Patient   Date   Signature

_____   _____   _____
Name of Person taking consent   Date   Signature
(if different from researcher)

_____   _____   _____
Researcher   Date   Signature

1 for participant; 1 for researcher (original); 1 to be kept with client notes (circle which)

Competence and Capacity to provide Consent in Mental Health Service Users

Adapted from Grisso & Appelbaum 1998 and Gunn 1994.

The questions below are for the care coordinator, primary nurse, consultant psychiatrist or GP ('advocate') to answer. The questions act as a guide not an absolute rule, however any decision to proceed against the guide must be fully justified.

This capacity check for mental health clients complements the Nursing & Midwifery Council advice which states "nurses should always work from the assumption that clients have the competence to consent to treatment or other aspects of care"

1. Does the client perceive himself or herself to be under duress, coercion or control to take part in their current treatment or care?   Yes-No
2. Is the client's decision-making ability compromised by illness, distress, intoxication or some other cause?   Yes-No
3. If invited, will they believe / feel they must take part in the study?
                                    Yes-No
4. Does the client have any intellectual or cognitive deficits, or any other problem that compromise his or her ability to provide research consent?
                                    Yes-No

'Yes' to questions 2, 3 or 4 means automatic exclusion.
'Yes' to question 1 and 'No' to questions 2, 3 & 4 indicates supplementary question 5

5. Will the client perceive an invitation to take part in this research study as compulsory?   Yes-No

If 'No' to question 5 proceed with invitation to take part in research study. If 'Yes' exclude.

Out of Your Head: Guides for people who use drugs and have experienced mental illness.

1. David has a diagnosis of schizophrenia, he has been in and out of hospital several times and he is still only in his 20's, he learns about the effects, both good and bad, of cannabis on his mental health. His story is told in a sympathetic and moving way.

2. Martha knows the dark side and bright side to ecstasy (and other drugs) and this comes through in a story that shows how a person might have to adapt their lives to the distress and stigma of mental illness. There are tips on safer use, relapse prevention and dealing with emergencies and more.

3. Jason will use anything as long as it makes him feel 'normal'. Thing is it doesn't make him feel normal; it just makes him feel less 'abnormal'. He hears things, sees things, gets weird and bizarre ideas and simply keeps using drink and drugs to get through it all. This booklet includes a drug interactions matrix.

4. Geoff (aka 'God') is usually living on the street, he has been for years. On occasions he has a roof over his head and that is often a hospital roof after being sectioned. His life is like heaven and hell, speedballing or drinking and being in hospital. But he wants what others want, it just seems to be a case of staying alive until those things come about.

Back Page (all booklets)

These guides are based upon the experiences of people in psychiatric treatment. The stories were told as part of a Ph.D. sponsored by the Manchester Mental Health & Social Care Trust and The University of Salford.

North West NHS Innovation Awards 2007 - First prize
NHS National Technology Awards 2007 - Runner up
Nursing Times, Chief Nursing Officer's Award 2007 - Finalist

The Out of Your Head guides for people who use drugs and have experienced mental illness

[ ] lifeline | publication guidelines

[>] aims
To provide up to date information and advice on drugs and mental illness.

[>] audience
people who use drugs and have experienced mental illness and the staff who work with them.

[v] content
Some swearing and graphic images of drug use.
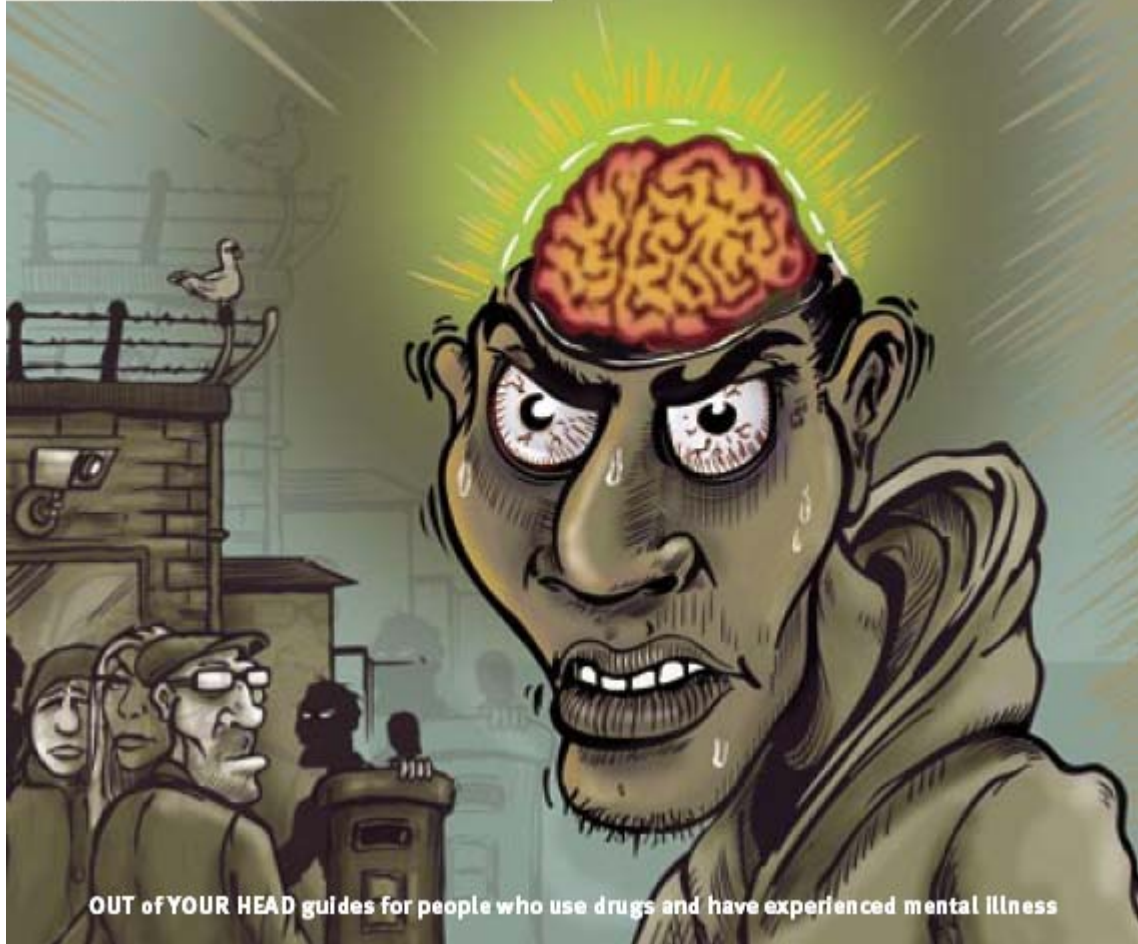
[£] funding
self financed

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lifeline publications

Mental illness and Cannabis -the story of
no. 1 **David** - the man with the transparent head

OUT of YOUR HEAD guides for people who use drugs and have experienced mental illness

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Mental illness is a reaction to life

The journey between our birth and death is the story of our life. On this journey we will meet with desperation, delight, love and loneliness. Sometimes our minds respond to the events and the experiences in our lives in ways that can become extremely disturbing for us and those around us. Doctors call this reaction to life 'mental illness'.

Drugs have an effect on mental illness

We use drink and drugs to give us pleasure, to stop us feeling pain or because we have nothing better to do. If drugs are part of our life they will have an effect on our mental illness. What this effect will be depends on the person, the drug and how the drug is used.

These stories are based on talking to people in psychiatric treatment.

This story is about David and the role that cannabis plays in his life and his illness.

David   Martha   Jason   God

Brain chemistry

Your brain is the most complex object in the known universe - it contains 100 billion special cells called neurons. Neurons communicate with each other by releasing a sort of 'chemical e-mail'.

There are more than 80 types of these chemicals - called neurotransmitters. Most illegal drugs cause the release of a neurotransmitter called dopamine.

This release of dopamine is why drugs feel pleasurable. But too much dopamine in your brain could cause problems. Drugs used to treat schizophrenia type illnesses seem to work by reducing dopamine.

The balance of neurotransmitters in your brain affects your mood and thoughts and seems to have an important role in mental illness.

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Cannabis chemistry

Most drugs affect between one and three neurotransmitters, but cannabis affects more than half a dozen, including:

Serotonin (also boosted by ecstasy);
Dopamine (also raised by cocaine);
Endorphins (also triggered by heroin).

That is why cannabis has such a wide range of effects on the mind: trippy, pain killing, relaxing etc.

Cannabis smoke contains over 2,000 chemicals. The ones that interest us are called cannabinoids and about a dozen of these have an effect on the brain.

THC (short for tetrahydrocannabinol) is the main one that gives you the really spacey high. CBN (cannabinol) and CBD (cannabidiol) have more relaxing and dopey effects.

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Warning signs and triggers

Some people become seriously mentally ill and others don't - nobody is sure why this is. David becomes mentally ill - although he doesn't know it yet.

The first signs of mental illness often start weeks or months before anybody notices and can include things like feeling anxious and tense, becoming withdrawn and isolated, not going out, neglecting your appearance, having trouble sleeping etc. If you are a regular cannabis user you might find yourself using more often. This is not surprising because cannabis is enjoyable, helps us relax, sleep and makes loneliness and even daytime telly a bit more bearable.

There is no clear evidence that cannabis causes mental illness (which would not otherwise have occurred). However, it is thought that cannabis can kick start or 'trigger' an episode of mental illness in people like David. If you are smoking all the time it can be difficult to tell if smoking weed is helping or making things worse - it may even be doing both at the same time.

Things you can do:

o **Learn to recognise your early signs of mental illness relapse.**
o **Learn skills which can help reduce your chances of becoming ill again.**
Ask the person who gave you this leaflet about warning signs and relapse prevention.

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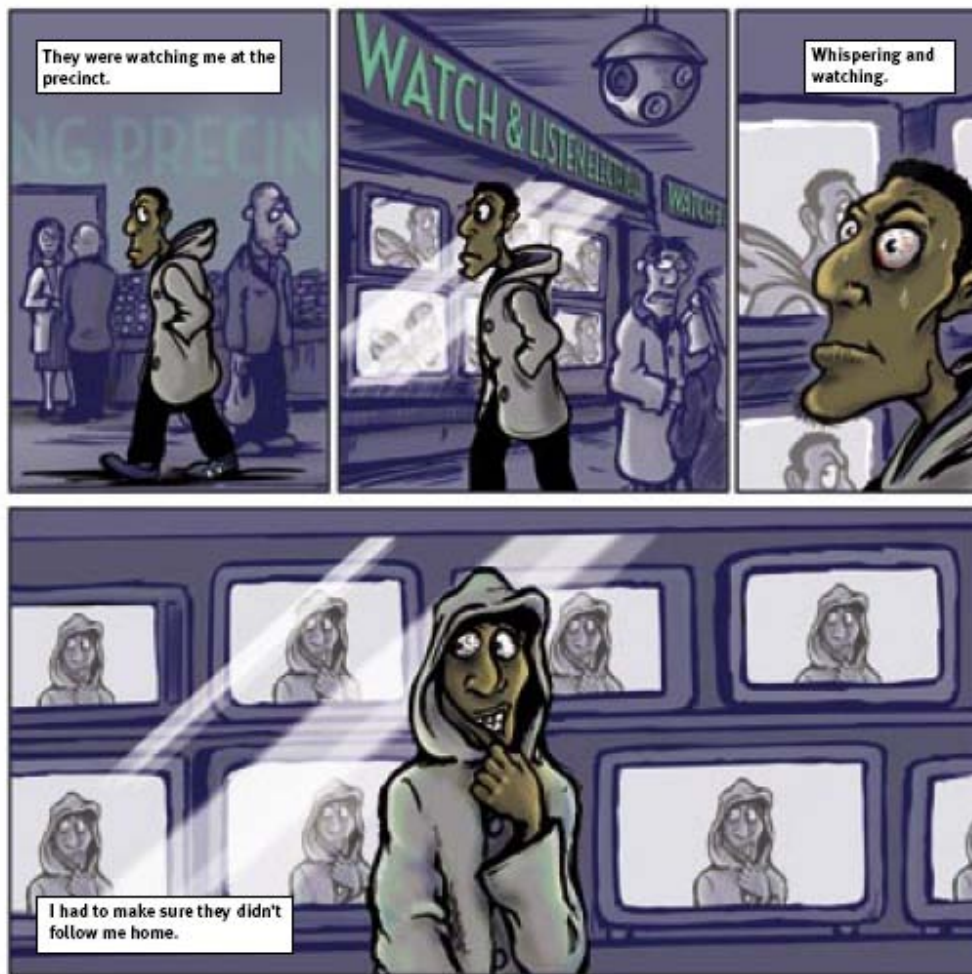
Paranoia

Every cannabis smoker is familiar with that uneasy, suspicious feeling that you are being watched, talked about, followed, spied on or plotted against when none of these things are actually happening. Paranoia is the unjustified belief or fear that somebody is secretly out to get you, often for no obvious reason.

The main drugs that which can lead to paranoia are stimulants (like cocaine and amphetamine) and cannabis. Paranoia is most likely when you smoke cannabis in unfamiliar places or with strangers - particularly when you're stoned (and they're not). If paranoia has been caused by cannabis, it will wear off (in an hour or two) when the cannabis does.

The effects of some drugs can be very similar to some of the effects of mental illness. Paranoia can be a symptom of mental illness. David's paranoia is very disturbing for him and doesn't wear off with the cannabis. Smoking cannabis might be making David's paranoia worse.

If you start to feel paranoid go somewhere quiet, where you feel comfortable and safe.

Things you can do:

O   Avoid getting stoned in strange or unfamiliar places.
O   If you have to go to strange places try arriving straight.
O   If you start to feel paranoid go somewhere where you feel safe.

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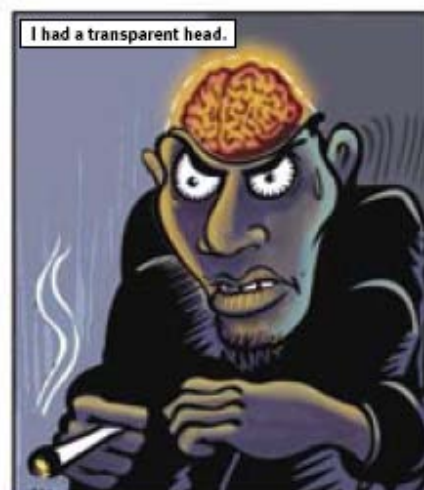
Secret messages and thought control

Has your iPod been talking to you lately? Is your head see-through? Are your thoughts being controlled by someone else? Are you having ideas that are not understood or believed by most people?

The trouble with all the brilliant ideas you have when you're stoned is that (a) you can't remember them when the cannabis wears off and (b) they often turn out to be crap ideas in the first place. What is happening to David is not caused by cannabis, but cannabis might be having an effect.

If you smoke all the time it's difficult to tell if cannabis is helping or not. There is no harm in stopping for a while to see if things seem better or worse. Regular users will actually feel properly stoned again if they have a break.

Most people can stop using without any problems. But if you're one of those people who think it might be difficult, ask the person who gave you this leaflet for some advice.

Things you can do:

O   Check out reality every now and again.
O   Think about having a break from cannabis.

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Hearing voices

Hearing voices is common among people diagnosed with schizophrenia type illnesses. There are almost as many explanations for the voices as there are voices. Voices are different for everybody who has them; they can range from the relatively friendly to extremely disturbing and terrifying.

Some people use cannabis when they hear voices. Some say the voices become quieter or less disturbing or even get stoned, and therefore appear less threatening. Some say cannabis makes things worse or that the voices come back even louder the next day.

It is important to be honest with yourself. It is not always easy to judge what is helping and what is not. Equally, if cannabis is helping it is important to ask yourself how it is helping.

For instance, are you using cannabis (maybe along with other drugs like alcohol) to get completely out of it and numb yourself to what's going on; or is it the relaxing and calming effects of cannabis that helps?

Things you can do:

O   **It is worth remembering that you can get a variety of different effects from cannabis. Learn to get what you want from it.**
See page 18 for tips

O   **Ask about other ways of relaxing or dealing with stress or voices.**
Ask the person who gave you this leaflet.

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Aliens under the floorboards

David believes that alien electricians have bugged his wiring. David's beliefs might be disturbing for other people, but it is his strange behaviour that is noticed and will result in him being taken to hospital.

Strange behaviour is often a sign that an illness is getting worse. By the time David starts dismantling his bedroom looking for alien devices, it's probably too late for him to do anything about his illness.

When you come into contact with doctors and nursing staff, they will almost certainly advise you not to use any drugs other than the ones they prescribe to you. What you tell the staff about your drug use will be treated in confidence. A lot of staff are sympathetic towards drug users, but it is illegal to allow someone to use drugs on your premises. So even if they wanted to, staff cannot allow anyone to use drugs in a hospital or psychiatric unit.

You will probably be searched before you are admitted to hospital. You can still be evicted, discharged or arrested by the police if you are caught with cannabis or other illegal drugs on you.

Things you can do:

o   Be honest with staff about your past drug use.
o   Remember that cannabis is still illegal.

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Diagnosis, treatment and medication

Doctors would probably call what David's been experiencing 'psychotic symptoms' or a 'psychosis'. Some doctors might say that David's psychosis has been brought on by using cannabis - they might even say it's cannabis psychosis.

Some people will become ill once and never become ill again, while others will experience many episodes of illness over their lives. If psychosis keeps recurring or it is very severe it could lead to a diagnosis of schizophrenia or schizophrenia type illnesses.

David's illness will require him to spend weeks or months in hospital. He will be given very powerful drugs called antipsychotics. Antipsychotic drugs will stop or reduce the symptoms of David's psychosis and help him cope with the stress of life. Antipsychotics can have unpleasant side effects (like gaining weight) - but these can be controlled.

David will take longer to get better and will need more medication if he carries on using cannabis or other drugs during his treatment. However, even if you are using cannabis during your treatment it is still better to carry on taking your antipsychotic medicine.

Things you can do:

o   Remember, even if you are using cannabis during your treatment you should carry on taking your antipsychotic medicine.

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Different types of cannabis

There are three main types of cannabis: herbal cannabis (grass), stronger forms of herbal cannabis (skunk) and resin (hashish). It is thought that because it has a very high THC* content smoking skunk is more likely to bring on paranoia and the kind of symptoms described in this leaflet. Smoking cannabis resin - which has more CBN and CBD - has a more relaxing and dopey effect and may be less likely to cause problems. Some people smoke a mixture, while some just smoke resin or save skunk smoking for weekends or special occasions.

Standard Moroccan resin (soap/slate) is cheap, but cut with all sorts of crap, so is rough on the lungs. Pollem (or Pollen) and black are more expensive, but are better quality types of resin.

* See page 5

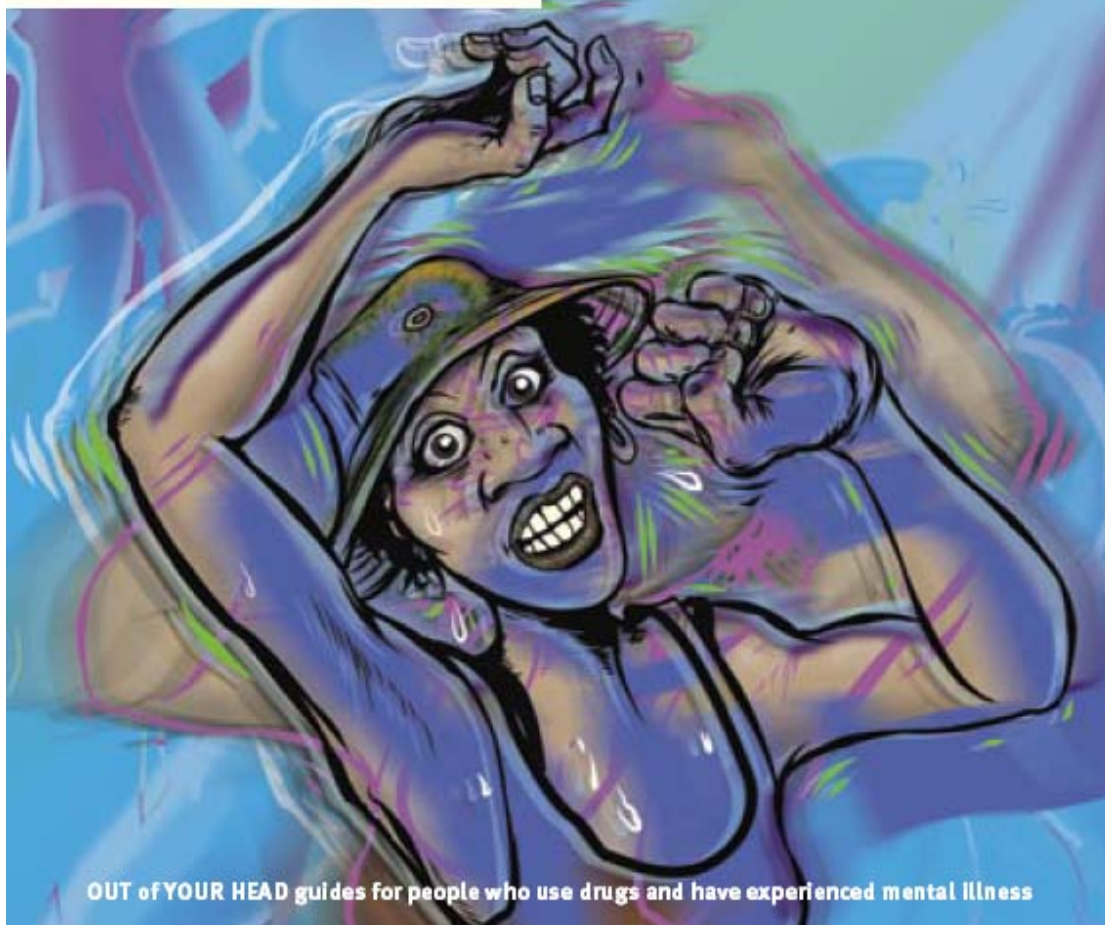Herbal cannabis   Skunk   Resin

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Managing cannabis use

As a general rule the more cannabis you use the more likely it is that it will have a negative effect on your mental illness. If you can't stop using try and cut down on how much cannabis you smoke and how often you get stoned. Take control - try and get as much pleasure and positive effects from cannabis as you can, and to reduce as many of the negative bits as you can.

o   Try using only in the evenings or at weekends etc.

o   Buy a set amount (in weight) every week/month and either make that last or if your stash runs out, go without until it's time to buy more again.

o   Have a rest from smoking regularly - you'll actually feel stoned again if you give it a break.

o   Don't use daily - if you do try and keep at least two or three hours between smokes.

o   Rather than smoking skunk only, try smoking resin instead, at least some of the time.

o   Don't use fast delivery methods - like bongs etc.

o   Avoid eating cannabis (it takes longer to have an effect but it can be very strong or unpredictable when it starts).

o   It's best not to mix cannabis with other drugs.

o   Avoid stressful or anxiety-causing situations when you are stoned (e.g. illicit use in toilets.)

o   Cannabis can make you forgetful - remember to take your medication.

o   Remember that cannabis is still illegal to posses or supply to others.

Mental illness and Ecstasy - the story of
no. 2 'Raving Mad' Martha

OUT of YOUR HEAD guides for people who use drugs and have experienced mental illness

Mental illness is a reaction to life

The journey between our birth and death is the story of our life. On this journey we will meet with desperation, delight, love and loneliness. Sometimes our minds respond to the events and the experiences in our lives in ways that can become extremely disturbing for us and those around us. Doctors call this reaction to life 'mental illness'.

Drugs have an effect on mental illness

We use drink and drugs to give us pleasure, to stop us feeling pain or because we have nothing better to do. If drugs are part of our life they will have an effect on our mental illness. What this effect will be depends on the person, the drug and how the drug is used.

These stories are based on talking to people in psychiatric treatment.

This story is about Martha and the role that ecstasy plays in her life and her illness.

Out of your head guides for people who use drugs and have experienced mental illness

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David   **Martha**   Jason   God

Brain chemistry

The brain works by using a sort of 'chemical e-mail' to communicate between its billions of cells. These chemicals are called neurotransmitters and play an important role in mental illness.

Ecstasy has both speedy and trippy effects. It raises the levels of three main neurotransmitters: serotonin; dopamine and noradrenaline.

Serotonin - (also known as 5HT) which controls mood and memory etc. and is responsible for ecstasy's 'trippy' effects

Dopamine - which is the brain's main reward or pleasure chemical.

Noradrenaline - which governs the brain's energy levels including alertness, movement and anxiety, and is mainly responsible for ecstasy's 'speedy' effects.

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Methylenedioxymethamphetamine (MDMA for short) is the chemical name for ecstasy, but pills commonly contain a number of similar drugs that resemble MDMA.

We know that serotonin damage causes mood disorders (eg. depression) and memory problems, while dopamine damage causes movement disorders (eg. parkinsonism) and thought disorders (e.g psychosis/paranoia). But the brain's connecting fibres may recover from this damage (unlike brain cells).

Young heavy ecstasy users are at risk of developing slower thought processes and disturbances of mood and personality.

Claims about ecstasy causing long lasting brain damage are not proven - but neither are they unproven. Some experts believe that ecstasy-related brain damage may show up 20-30 years after a period of 'caning' the pills.
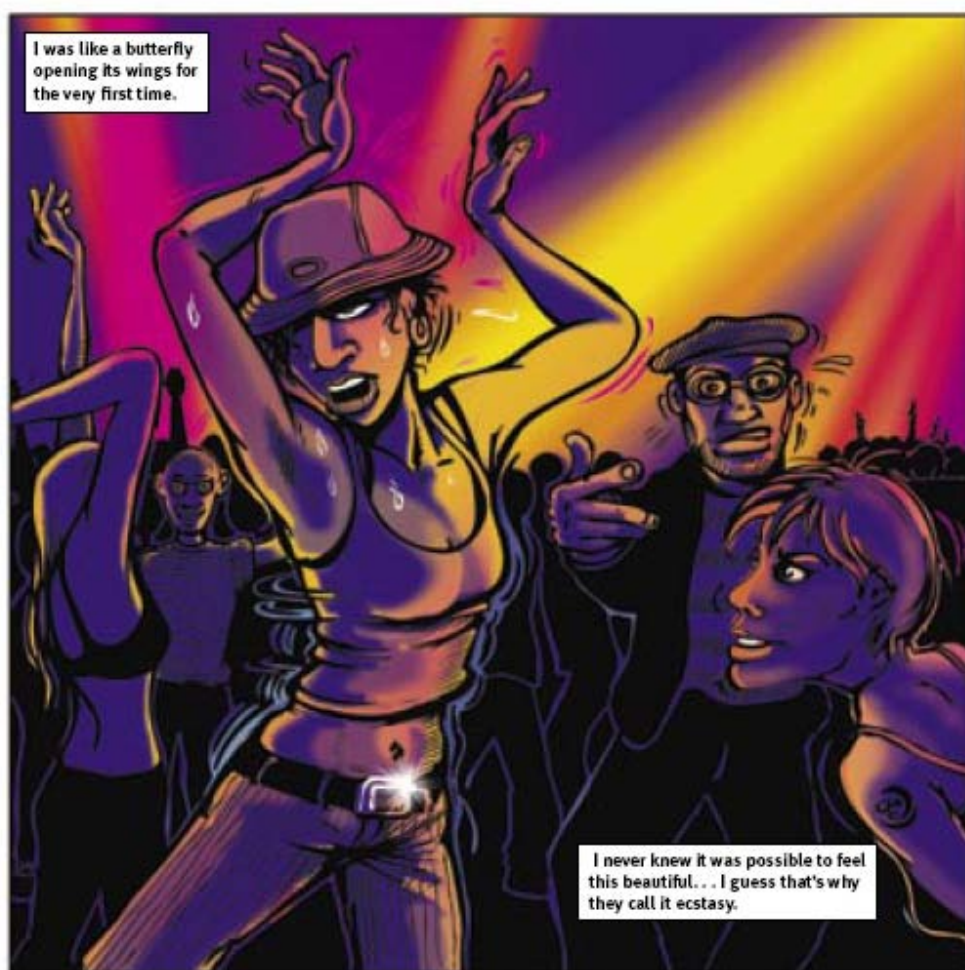
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Martha on a mission

Every ecstasy user remembers their first pill - that feeling of intense delight; the trippy rush of the ecstasy 'buzz' as serotonin suddenly floods the brain. Martha was feeling isolated and desperately alone when she came out of psychiatric hospital until she fell in with a group of hard core clubbers. When the pills start working her mental illness is no longer important - everybody's equal when they're off their head! Martha feels like she belongs.

But there are of course risks involved in using drugs. Stimulant drugs raise your heart rate and blood pressure so should be avoided by those with relevant health problems or older people (you are more at risk from heart attacks/strokes as you get older).

Taking too much can lead to overdosing (toxic poisoning). Double or treble doses of ecstasy can produce far more intense effects, but even higher doses mainly raise pulse-rate and temperature to uncomfortable levels, along with nausea (feeling or being sick), blurred vision, panting, muscular tension and headache.

Like speed, ecstasy produces 'stereotypy' - a preference for repetitive actions like dancing. Stimulant drugs like ecstasy, speed and coke raise your body temperature. Dancing for long periods in steaming hot clubs makes you even hotter which has led to people collapsing and in a number of cases has led to deaths.

Things you can do:

O **Take regular breaks from dancing and sip water at regular intervals**
(about a pint an hour is recommended, don't over do it as drinking too much is dangerous)

O **If somebody collapses, call security (door staff/bouncers).**
Learn the Recovery Position (page 19)

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Looking after no 1

Ecstasy very rarely leads to hallucinations or bad 'trips' like LSD or ketamine can - instead, it intensifies your mood, opens up your feelings, and makes you more friendly and empathetic (more understanding of others' feelings). In rare cases, people may become anxious or emotionally disturbed - but this is usually to do with the 'releasing' of their feelings (ecstasy was used in therapy before it was banned in the USA). Some users say that it boosts feelings of love and/or sexual desire, though it's not really an aphrodisiac and can make it hard for men to get an erection (known as 'shrink dick').

It is sad (but true) that there are some men who look to exploit women coming out of clubs when they are still on drugs or have been drinking. If you go off with somebody, let a friend know where you are going or at least send them a text. Trust your instincts: don't do anything you don't want to or let anybody take advantage of your drugged up state or mental illness.

There is a stigma associated with mental illness, which can make it difficult starting relationships because you fear the way people will react to you if you tell them about your illness. It is a good idea to talk this through with someone you trust, rather than let your feelings pour out when you are all 'luv'd up'.

Things you can do:

o **Use condoms and practice safer sex**
   to avoid unwanted pregnancy and sexually transmitted infection.

o **if you go off with strangers somewhere - let friends know where you are going**

o **Trust your instincts - if it feels dodgy, it probably is!**

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Waiting for the weekend

The effects of an ecstasy pill can last up to 6 hours or longer if you are 'stacking' (taking them at regular intervals). Stimulant drugs like ecstasy stop you feeling hungry, which can last all of the next day as you physically recover from dancing and lack of sleep, so regular users tend to lose weight. Although many people welcome losing a bit of weight this can become a problem and has been known to trigger off eating disorders like anorexia and bulimia.

Some people discover the ecstasy and dance music scene and fall in love with it. This is known as the 'honeymoon period' when nothing in their life seems as important as a weekend of dancing on ecstasy. Involvement in ecstasy use and dance culture can become excessive for some people, leading to neglect of work, a strain on relationships with family and friends and poor health and financial problems. The total cost of one night's clubbing can exceed £100.

If you are starting to become involved in a weekend dance scene, get plenty of sleep and eat properly during the week (eat at least 3 hours before you take any pills). It is simply not possibly to 'Ave'it Large' with a full on clubbing and pills life style all the time without burning out or triggering another episode of your illness - A once a month treat is plenty.

Things you can do:

O **Look after yourself during the week**
   Get plenty to eat and get plenty of sleep.

0 **Try to avoid burning out**
   A once a month treat is plenty.

What goes up must come down

Ecstasy is unique in having a come-down two or three days after it was used (instead of the same or next day), depending on how long it takes the brain to recover. It is known as the 'mid-week ecstasy blues', because most users take pills at clubs/parties at weekends - resulting in comedowns kicking in around Tuesday or Wednesday. The ecstasy blues involve similar symptoms to speed comedowns - sadness, tiredness, headache, hunger, and irritability - but can often involve emotional over-sensitivity (bursting into tears, startling, feeling panicky, afraid of going out etc.).

The ecstasy blues are the norm rather than the exception. About 90% of users in surveys report getting them - typically every time that ecstasy is used. Some people use cannabis or alcohol to try and take the edge off the ecstasy comedown - but this can lead to you becoming reliant on drugs to control your mood, which means you become dependent on drugs.

The E comedown is rarely serious, and is usually over within a day, so if you can, 'take it neat', do so. Try to monitor the (good or bad) effects the ecstasy blues are having on your mental health. If the bad bits are outweighing the good bits, if you feel alone and paranoid, if you feel suicidal, it's time to think about changing.

Things you can do:

O   **Be aware of the mid-week blues**
     Keep a record to monitor the effect it is having on your mental health

o   **Try to take the comedown neat**
     Everybody comes down eventually

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Martha gets mashed

Taking too much ecstasy in one go is dangerous (see page 7) and will just lead to more unwanted side effects. Using too often creates a different set of problems. The heaviest users tend to take ecstasy two or three days per week (i.e. all weekend) - daily or near-daily use is very rare. Though about half of ecstasy users report some signs of dependence - such as tolerance to the effects, craving and inability to stop using - most do not regard themselves as 'hooked', and there is no physical withdrawal syndrome as there would be for drugs like alcohol or heroin.

Ecstasy use can bring about what doctors call 'neurotic disorders' (anxiety, phobias, panic attacks) and 'mood disorders' (depression, mania). Nearly all such episodes are short-term and treatable by doctors.

Although such cases are rare, and usually involve heavy poly-drug use (using more than one drug), they are more likely to occur in people with a history of mental illness. It might be that people who have experienced mental illness are more vulnerable to the unwanted side effects of ecstasy.

Persistent anxiety disorders may be treated with a short course of benzodiazepines e.g. Valium (diazepam); while continuing depression is typically treated with anti-depressants e.g. Prozac (fluoxetine). Ecstasy use has also been linked to cases of 'elevated impulsivity' and chocolate craving, although the medical profession has yet to find a cure for the 'mad for it chocoholic'.

Things you can do:

o   Learn to recognise your early signs of mental illness relapse.
o   If you are frequently taking e's to lift a depressing feeling you could be suffering from a depression and need counselling or medication. Talk to someone such as your G.P or nurse for advice.

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Ecstasy Psychosis

Doctors are still a long way from understanding why some people develop serious mental illness and others don't. Martha had been admitted to psychiatric hospital on a number of occasions before she had ever used drugs. Her doctors have given her a different diagnosis every time she has been treated. They now think her psychosis is drug related, but it is difficult to be precise as the symptoms of general psychosis and drug related psychosis are almost identical.

Ecstasy psychosis is very rare among drug users, and nearly all cases recover (if they stop using) within a month or two - sometimes it may require a few weeks of in-patient treatment with antipsychotic medications. Common symptoms of a psychosis are paranoia (e.g.

the police are watching me, aliens abducted me), auditory hallucinations (hearing voices and noises that aren't there), 'ideas of reference' (wrongfully thinking that things are linked to you, e.g. the TV news reader is giving you a secret message) and thought disorders where you think your thoughts are tampered with, don't belong to you or have been read aloud. Like other drug psychoses, ecstasy psychosis tends to occur in people with a personal or family history of mental illness. Users who have experienced mental illness are more likely to develop ecstasy psychosis.

Martha will get better and get out of hospital, but she may well go back to using drugs. Even if she does it is still better for her to carry on taking her antipsychotic medicine, even though she is using ecstasy.

Things you can do:

o   **Stop using street drugs (at least while you are being treated)**
o   **Keep taking the antipsychotic medication even if you go back to using ecstasy.**
      And be honest with the doctors and nurses about the role drugs play in your illness.

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Safer Ecstasy use

The title above says safer ecstasy use - not **safe** ecstasy use. The only sure way to avoid any harm from ecstasy is not to take it. Although it is illegal for everyone, people who have heart or respiratory conditions, epilepsy, glaucoma, genito-urinary infections, asthma and diabetes - especially those with a mental illness - are advised not to use ecstasy. BUT for people determined to try it, or already using it, the following advice can help reduce the risks and problems identified above.

o   Find out from friends how strong a new E is before taking it - or else take a half-tab dose first

o   One standard tab of E per session is enough, but if using more, try to stick below 2 or 3 tabs. Avoid taking repeat doses during a session - but if you do 'stack', keep to half-tablet boosters

o   Use ecstasy no more than once a month - but if using more often, avoid using two days on run

o   Avoid over-heating. Drink up to a pint of water or non alcoholic drink per hour while on E, especially if dancing - although some people have over-heated on ecstasy without dancing

o   Avoid mixing other drugs with E especially alcohol, opiates, & prescription drugs (e.g. beta-blockers).
But keep taking your antipsychotic medication.

o   Store E safely where children cannot reach it, and in a dark, dry, cool, air-tight container

o   While on E, never drive, use machinery, or do risky sports - or have children in your care

o   Make sure that you eat well and catch up on sleep

(18)

Getting caught

Ecstasy is a class A drug with the same penalties as heroin and cocaine. Never carry more than two or three pills on you at a time or you risk being accused of dealing. In a club it is far more likely that you will be caught by the bouncers/security staff. Most clubs will confiscate small amounts of drugs and will call the police only if they think you are dealing. Either way it's a bad idea to take in more than you need or to take drugs in for other people.
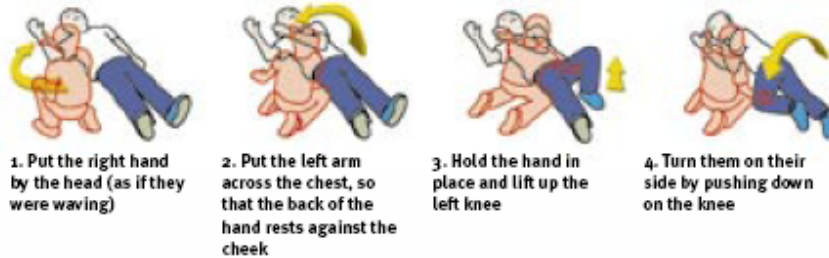
Dealing with emergencies

Learn how to deal with ecstasy-related emergencies in your friends:
*if they get too hot, help them cool down (rest somewhere cool, sip water, etc.)
*if they panic or have a 'bad trip', try to calm and reassure them
*if they collapse and are unconscious, put them in the recovery position;
*if they stop breathing, administer artificial resuscitation (if you know how) and get help

In any medical emergency, whatever else you do, call an ambulance or get them to hospital (if in a nightclub, contact security). If you or a friend does end up in hospital, always tell the staff or paramedics precisely what drugs were taken (the police are not automatically contacted).

The Recovery position

1. Put the right hand by the head (as if they were waving)

2. Put the left arm across the chest, so that the back of the hand rests against the cheek

3. Hold the hand in place and lift up the left knee

4. Turn them on their side by pushing down on the knee

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Mental illness, alcohol and other drugs - the story of
no. 3 Jason- the psychonaut

OUT of YOUR HEAD guides for people who use drugs and have experienced mental illness

Mental illness is a reaction to life

The journey between our birth and death is the story of our life. On this journey we will meet with desperation, delight, love and loneliness. Sometimes our minds respond to the events and the experiences in our lives in ways that can become extremely disturbing for us and those around us. Doctors call this reaction to life 'mental illness'.

Drugs have an effect on mental illness

We use drink and drugs to give us pleasure, to stop us feeling pain or because we have nothing better to do. If drugs are part of our life they will have an effect on our mental illness. What this effect will be depends on the person, the drug and how the drug is used.

These stories are based on talking to people in psychiatric treatment.

This story is about Jason and the role that alcohol and a range of other drugs plays in his life and his illness.

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David   Martha   **Jason**   God

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Brain chemistry

Your brain is the most complex object in the known universe - it contains 100 billion special cells called neurons. Neurons communicate with each other by releasing a sort of 'chemical e-mail'.

There are more than 80 types of these chemicals - called neurotransmitters and they have an important (though not yet fully understood) role in mental illness.

Alcohol, along with most illegal drugs, causes the release of a neurotransmitter called dopamine, which feels pleasurable. We know that drugs used to treat psychosis and schizophrenia type illnesses work by reducing the amount of dopamine in your brain.

Alcohol also affects your body's production of GABA and glutamate. GABA relaxes and sedates you making you feel euphoric at first before glutamate, a stimulant, kicks in to compensate.

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Alcohol & other drugs

If you are a heavy drinker, stopping suddenly will stop GABA immediately but glutamate will lag behind. This extra glutamate can cause DTs, fits and lasting nerve damage. Glutamate is involved in the way we interpret reality and is also affected by the drug ketamine.

Stimulant drugs boost noradrenaline. Ecstasy boosts both noradrenaline and serotonin (sometimes called 5HT) which is also boosted by LSD. Use of stimulants drugs like speed, cocaine or ecstasy can damage your ability to produce serotonin. A type of depression that is long lasting and difficult to treat can result.

Long term use of alcohol damages brain cells which can lead to problems with concentration, memory, judgement and controlling your emotions.

Using a variety of drugs at the same time is (at best) going to have unpredictable results on such a sensitive and complex object as your brain.
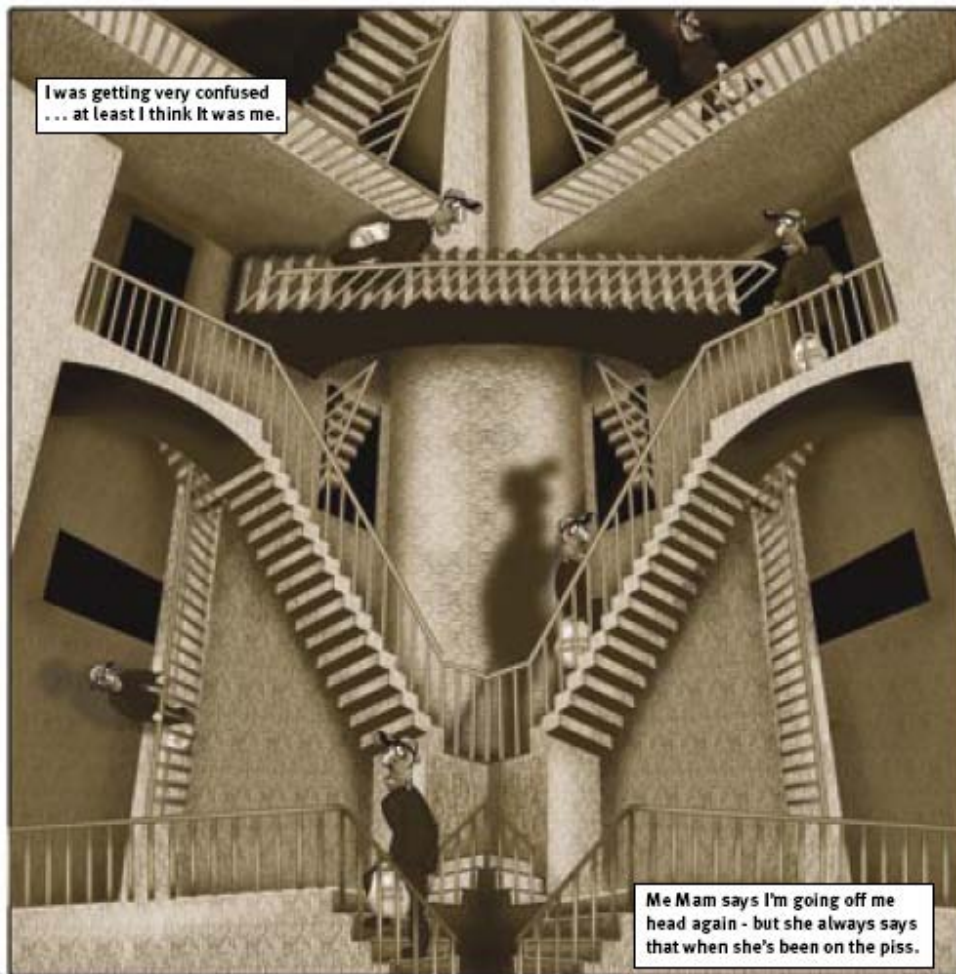
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Dazed and confused

Jason is very confused - he can't find his front door.

Schizophrenia type illness (sometimes called 'psychosis') often starts with confused and muddled thinking and speech. However, Jason has not slept for three days as he's been out with his mates, drinking and using amphetamine sulphate (speed).

As soon as his money arrives Jason and his mates go on a 'benefits bender'. Everybody Jason knows drinks heavily and uses drugs, but only Jason has a serious mental illness. He's not sure why this is and neither are the experts.

Some drugs can trigger a latent (hidden) mental illness, while some drugs may even cause mental illness. Nearly all drugs can make an existing illness worse. People use drugs during periods of mental illness because they say it helps them or is better than experiencing the symptoms of their illness 'neat'. Added to this, some of the effects from drugs can be almost identical to the symptoms of mental illness - which is one of the reasons they are often confused.

Like his friends, Jason is all muddled up by lack of sleep, the effects of the speed and alcohol and the thought of the deep depression when he eventually comes down and sobers up. Unlike his friends, Jason has been treated for depression and for schizophrenia, and is therefore more vulnerable to the unwanted effects of drink and drugs.

Going on a three day bender may be risky for people like Jason who have experienced mental illness. However, most of us have taken risks with drink or drugs at times, because that's just the way some of us are made. To Jason, his benders are the highlight of his life.

Things you can do:

o **Be aware of the risks.**
If you have a history of mental illness or history of mental illness in your family, you may be more vulnerable to the negative effects of drink and drugs.

o **Learn to recognise the early symptoms of your illness.**
The longer you leave an illness untreated the worse it gets and the harder it is to remedy. If you are worried, get help or advice from a health worker.

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When I found me front door, I tore me kecks off so I could have a good scratch.

It were them bastard creepy crawlies under me skin again.

It's thirsty work is scratching bugs -I need more drink!

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Stimulant drugs and those pesky little bugs

Confused scrambled thoughts, paranoia, delusions, strange beliefs and hallucinations are common symptoms of schizophrenia type illnesses (often called 'psychoses'). The main symptoms are the same no matter if they are triggered by life events or drugs. When drugs alone are the cause, the symptoms go away quickly.

Stimulant drugs (like amphetamine, cocaine and ecstasy) can not only trigger these symptoms in people with a hidden or existing illness, but they are among a small number of drugs that are thought to cause the illness in anyone who uses them heavily (often called 'a drug induced psychosis').

However, here, Jason's bizarre behaviour is a result of his mind reacting to the effects of amphetamine on his body. One of the stranger effects of heavy stimulant drug use is known as 'speed bugs' (formication or parasitosis). Stimulant drug use causes a rise in body temperature, dehydration, increased blood flow to the skin and sweating. When the sweat evaporates, it removes the protective oil that coats your skin. The combination of these things creates a sensation on the nerve endings, which feels like bugs under the skin.

Stimulant drugs also result in repetitive behaviour (called stereotypy) - such as dancing to electronic beats on ecstasy or crawling around obsessively looking for bits of crack (known as 'white eye'). The sensation of bugs under the skin leads to compulsive picking, scratching and even attempts to dig them out with sharp objects. They can become tactile hallucinations, where the physical feeling leads to a belief (delusion) that something is under the skin or in the body. This false belief feels real and frightening.

The reason Jason drinks so much when speeding also has a simple explanation. He likes drinking. Speed dehydrates him making him thirsty and speed keeps him awake, so he's able to booze for far longer.

Things you can do:

o **Be aware of the risks of using stimulant drugs**
Stimulant drugs can cause mental illness, can lead to relapse of an existing illness and makes your illness harder to treat. The more you use the greater the risk you run.

o **If you are 'speeding' try drinking something other than alcohol.**
Coffee and cola also cause dehydration because they contain caffeine - so try plain water, fruit juices or milky drinks instead.

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Drowning your sorrows

Alcohol affects your sense of right and wrong as much as it affects your ability to put one foot in front of the other without falling over. This makes accidents, violence and all sorts of trouble much more likely to happen when you've been drinking.

There are risks involved in using alcohol for anybody, but some of those risks are higher for people who have mental health problems. Drinking leads to more relapses, depression and suicidal feelings. Drinking increases paranoid thoughts leading to suspicious fear and sometimes violence. Drinkers are more likely to need psychiatric treatment in hospital, more likely to be taken there against their will and will take longer to recover from their illness.

Like Jason, most of us have tried to drown our sorrows in booze. Alcohol can dampen down your worries and fears or it can magnify and distort them until your head swirls around and you can't remember what it was you were worried about . . . until you sober up and find your troubles are still there.

Alcohol can lead to depression, just as suffering from depression can lead to alcoholism (or problem drinking as it is now called). Drowning your sorrows will only put off your problems making it less likely you will deal with them later.

If you are experiencing depression, anxiety, phobias or post traumatic stress disorder, your chances of becoming a problem drinker doubles. If you have bipolar disorder it is five times more likely. About a third of people with schizophrenia become problem drinkers.

Jason has found he needs more and more alcohol to cope with his anxiety and shyness. His heavy drinking is starting to become a habit.

Things you can do:

o **Be aware of the risks of using alcohol.**
   Heavy drinking can lead to depression and relapse. If you have experienced mental illness, you run an increased risk of becoming dependant on drink.

o **If your drinking is becoming a problem, ask for help and advice.**
   Ask the person who gave you this leaflet about the help available for drinking problems.

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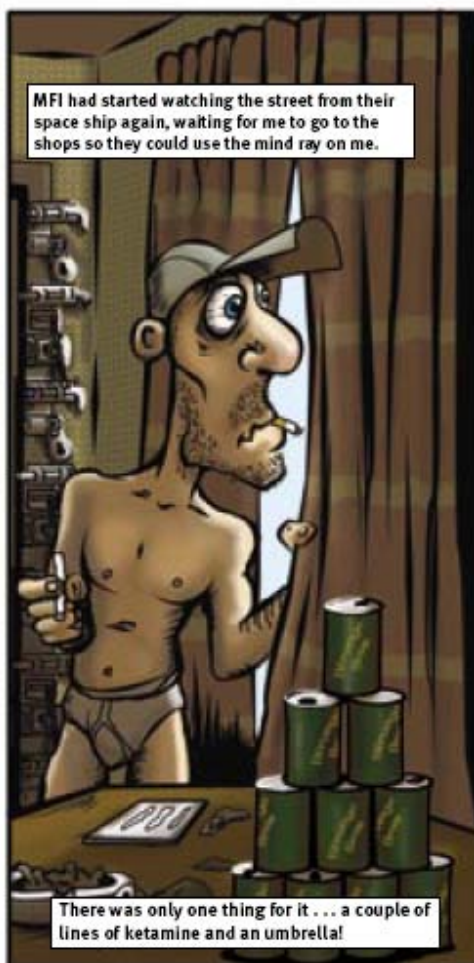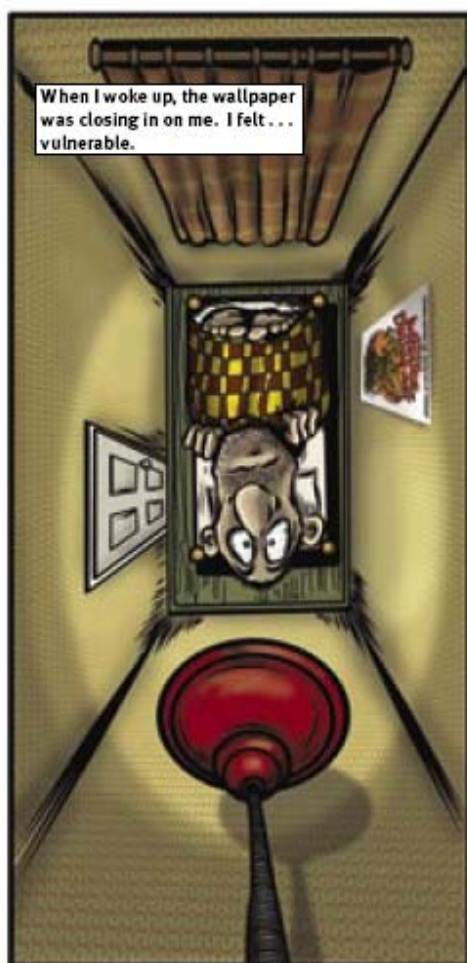
Hangovers, withdrawals and comedowns

The speed wore off and the drink knocked him out, so Jason has finally got some sleep. If you start to rely on alcohol to help you sleep it can interfere with your deep sleep (REM sleep), which means you'll become tired and irritable. In people vulnerable to depression or hallucinations (like hearing voices) this can lead to relapse. Alcohol is also a 'diuretic' so it disturbs your sleep because you keep waking up to pee.

When you wake up after drinking and speeding there is often a confusing and disorienting period before the headaches, sweating and shakes of the hangover from the alcohol kicks in.

Jason is still confused but, what with the hangover and the comedown, he's starting to feel anxious and paranoid again. Paranoia is common in drug users, as quite apart from the effects of the drugs there is the very reasonable fear that they might get caught. On the other hand, believing spaceships are trying to probe your mind is a fairly sure sign Jason is becoming ill again.

The 'high' of stimulant use is followed by feelings of depression and tiredness on the comedown which can last for days. Stimulant drugs can trigger manic episodes in people with bipolar disorder, whilst the comedown can result in very severe depression in people with bipolar disorder, schizophrenia or depression alone. Regular use of stimulants can also cause a form of depression that can last for a long time and is very difficult to treat.

The comedown with stimulant drugs can be harsh, so it is tempting to use other drugs like alcohol, cannabis or benzos to help ease the crash. Jason has chosen to use ketamine - which is not perhaps the wisest of choices . . .

Things you can do:

o **There is no cure for a hangover but-**
Drinking a glass of water before you go to sleep will help as it stops you feeling so dehydrated.

o **If you think you are dependant on alcohol - stopping suddenly can be dangerous.**
Ask the person who gave you this leaflet about where to get help or advice.

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Hallucinations and psychedelic drugs

In the past, drugs that cause hallucinations were called 'psychotomimetics' because they mimic a psychosis. They are now usually called 'hallucinogenic' or 'psychedelic' drugs.

The effects of a 'psychedelic' depends on the drugs type and strength, the mood, personality and previous experience of the user and where you are and who you are with when you take it. Experienced users often learn to control their 'trips' and avoid 'bad trips'. If you use psychedelics it is a good idea to have a friend there to calm and reassure you if things become frightening.

Hallucinations can involve distortions in all the senses, sight, sound, touch, taste and smell. Hallucinations caused purely by drugs in people without a mental illness are usually recognised as not being real and are therefore not as frightening. On the other hand, hallucinations caused by mental illness are more often 'true'

hallucinations - in that you believe what you are experiencing is totally real. Added to this a hallucination occurring unexpectedly can be far more frightening than one you expect because you've taken a drug. LSD or mushroom trips for people without a serious mental illness last for up to 8-12 hours - whereas hallucinations that are a result of an mental illness can last for days, even weeks, months or years.

In lower doses ketamine feels like being extremely drunk. At higher doses ketamine is a very powerful hallucinogenic drug. The effects last for less than an hour if snorted, but can go on for much longer if taken as a pill. Like stimulant drugs, regular use of ketamine can also cause all of the symptoms of a psychosis and is one of the drugs that it is thought to actually cause mental illness that would not have otherwise occurred.

Things you can do:

o   Psychedelic drugs are likely to lead to relapse or worsen your illness.
o   If you do use psychedelic drugs, find out all you can about the drug before you use it and don't use alone.

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Drugs, medication & the crafty spliff

Jason was admitted to hospital because the symptoms of his schizophrenia got worse (called a relapse). A likely reason for this is that Jason had stopped taking his antipsychotic medication. Most drugs, even cigarettes, can stop antipsychotic medication from working properly. But even if you are drinking and using drugs, it is still far less likely you will relapse if you keep taking your medication.

Jason's illness may have come back on its own, but his drinking and drug use may have also played a big role. Drink and drugs may have caused his illness to worsen or it may have been that he was using drink and drugs to cope with the symptoms of his illness. It might have been a bit of both - who knows? Discussing it will help you find out.

Drinking and taking drugs with his friends is the part of Jason's life that he values and enjoys more than anything else. Becoming ill is the part of his life he hates more than anything else. The two parts of his life clash badly with each other. Finding other things to do with his time and getting a group of friends who are not users is easier said than done.

Jason, David, Martha and God have all been known to have a crafty spliff when they are in hospital. They smoke because they enjoy it and because they are bored. Some of the doctors and nurses are sympathetic and understand why they do this, but they will still try and stop them.

They try and stop them not only because using drugs could make their illness last longer and be harder to treat, but because they have no choice. It is illegal for staff to allow you to use drugs or drink in hospital, psychiatric units, hostels or anywhere else they work and they could face being sacked if they allow this to happen.

Things you can do:

o **Keep taking the medication.**
Many people dislike the side effects of medication, but these can be controlled

o **Ask your mental health worker about help with making changes in your life.**

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Street drugs and your medication

Reported adverse reactions that can take place.

	Antipsychotics	Antidepressants	Anxiolytics & Hypnotics	Mood Stabilisers
Cannabis	Added drowsiness. Antipsychotic less effective (higher doses may be needed).	Increased heart rate (palpitations) with tricyclics. Possible delirium. Serotonin anti-depressant recommended.	Added drowsiness. Paradoxical agitation. Nervous edginess.	Added drowsiness. Possible rise in blood lithium levels (toxic).
Alcohol	Added drowsiness & lethargy. Increased heart beat/hypotension (low blood pressure). Respiratory depression.	Added drowsiness, seizures and hypotension with Tricyclics. Serotonin antidepressants recommended.	Added drowsiness. Hypotension (low blood pressure), fainting. Respiratory arrest. DANGEROUS.	Rise in blood Lithium levels. Dehydration/over hydration. Disrupt blood Lithium levels. DANGEROUS.
Stimulants. Cocaine/ Amphetamine/ Ecstasy etc.	Anti-psychotic less effective. Stimulant less effective (may lead to a higher dose of both). Flupentixol may reduce craving.	Disturbed heart rhythm (Arrhythmias). Serotonin antidepressants may cause stimulation/ agitation.	Added drowsiness. Over sedation. Anxiolytic/hypnotic less effective.	Heart problems (Arrhythmias). Dehydration leading to toxicity. Diminished 'high'. Could lead to poor meds compliance.
Heroin/ Methadone & other opiates	Increased sedation. Hypotension (low blood pressure). Respiratory depression (lower, stopped breathing).	Added drowsiness. Respiratory depression (laboured or stopped breathing). May increase blood opiate levels. Citalopram safest.	Added drowsiness. Risk of respiratory depression. Blood opiate may rise -danger of O/D.	Carbamazepine less effective and reduced blood opiate levels. O/D risk if sudden cessation of Carbamazepine. Sodium valproate possible alternative.
Caffeine & Nicotine	Antipsychotic less effective. Higher doses of antipsychotic may be needed -so more side effects in smokers possible.	Fluvoxamine - blood levels increased. Duloxetine -blood levels decreased. Antidepressant side-effects may worsen.	Blood propranolol reduction.	None /little known/ reported.

O/D = Overdose

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Anticholinergics	Examples of drugs used to treat psychiatric illness		
Possible anticholinergenic psychosis.	**Antipsychotics** Drugs used to treat psychosis and schizophrenia type illness. **Antipsychotics (Typicals)** Chlorpromazine Trifluoperazine Haloperidol Sulpiride Flupentixol Zuclopenthixol Pipotiazine Fluphenazine **Antipsychotics (Atypicals)** Risperidone *Olanzapine *Quetiapine Clozapine Zotepine Amisulpride Aripiprazole *also used for bipolar disorder or as sedative/hypnotic in low doses.	**Antidepressants** Drugs used to treat depression. **Serotonin/Newer Antidepressants** Citalopram Fluvoxamine Fluoxetine Paroxetine Venlafaxine Sertraline Reboxetine Duloxetine Mirtazapine **Tricyclic Antidepressants** Amitriptyline Clomipramine Dosulepin Lofepramine Trazodone Mianserin Imipramine Nortriptyline Trimipramine	**Anxiolytics & Hypnotics** Drugs used to treat anxiety and sleep problems. **Anxiolytics & Hypnotics** Diazepam Lorazepam Temazepam Buspirone Chloral Hydrate Zopiclone Zolpidem Propranolol (Beta-blocker) **Anticholinergics** Drugs used to treat anti-psychotic side-effects. **Anticholinergics** Procyclidine Orphenadrine Benzatropine Trihexyphenidyl **Mood Stabilisers** Drugs used to treat bipolar disorder, depression and other mood disorders. **Mood Stabilisers** Lithium *Carbamazepine *Sodium Valproate Semisodium Valporate Amotrigine *Also used in epilepsy.
None/little known/ reported.			
Agitation. **Over stimulation.**			
None/little known reported.			
Agitation. **Over stimulation possible.**			

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Mental illness, Heroin and Crack -the story of
no. 4 A man called God- in heaven and hell

OUT of YOUR HEAD guides for people who use drugs and have experienced mental illness

Mental illness is a reaction to life

The journey between our birth and death is the story of our life. On this journey we will meet with desperation, delight, love and loneliness. Sometimes our minds respond to the events and the experiences in our lives in ways that can become extremely disturbing for us and those around us. Doctors call this reaction to life 'mental illness'.

Drugs have an effect on mental illness

We use drink and drugs to give us pleasure, to stop us feeling pain or because we have nothing better to do. If drugs are part of our life they will have an effect on our mental illness. What this effect will be depends on the person, the drug and how the drug is used.

These stories are based on talking to people in psychiatric treatment.

This story is about a man they call 'God' and the role that heroin and crack plays in his life and his illness.

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David   Martha   Jason   **God**

Brain chemistry

The brain works by releasing a sort of 'chemical e-mail' to communicate between its billions of cells. These chemicals are called neurotransmitters and play an important role in mental illness.

Heroin is a pain killer (it reduces both pyhsical and emotional pain). It does this by boosting the level of neurotransmitters called endorphins - the body's natural pain killers.

Endorphines are released naturally when you excercise, they act on pain and probably also modulate mood. The release of endorphins can make you feel euphoric.

The stimulant effect of cocaine (crack is just smokable cocaine) is caused by the release of a neurotransmitter called noradrenaline. Like most other illegal drugs heroin and cocaine both cause the release of a neurotransmitter called dopamine.

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Heroin and Crack/Cocaine

Dopamine is the brain's main reward or pleasure chemical. The release of dopamine is one reason why drugs feel pleasurable.

Heroin almost doubles the level of dopamine in your brain, while smoking or injecting crack increase it to four times normal levels. Injecting both drugs at the same time (known as a 'speedball') increases the levels of dopamine to ten times normal levels.

Repeating this intense feeling of pleasure is what drives speedballers to continue using, until avoiding the comedown, habit and addiction take over as the main reasons for use.

Although we don't know everything about the relationship of dopamine to mental illness, we do know drugs used to treat schizophrenia type illnesses seem to work by reducing the levels of dopamine in the brain.
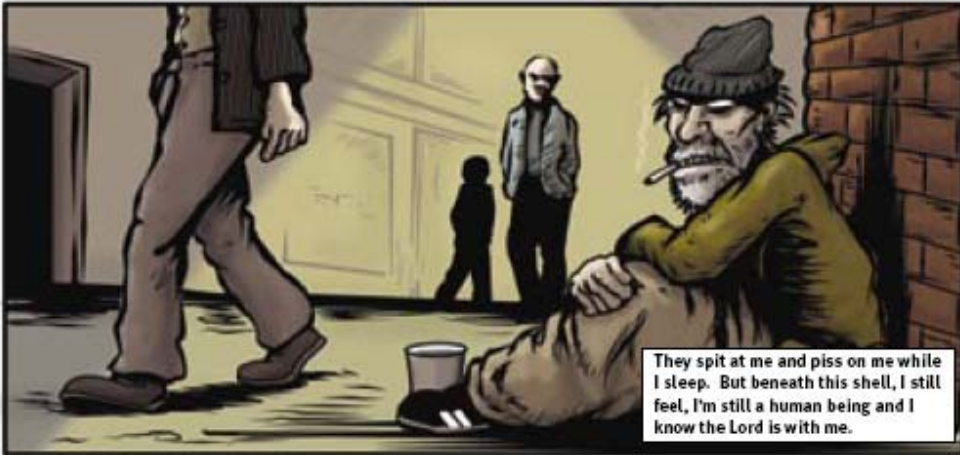
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Heaven and hell

On the streets they call him 'God' - maybe because he is old and has a white beard, maybe because he talks to the angels. He had a home and a family once upon a time, but drifted into homelessness and heroin use after coming out of prison.

On some days he doesn't beg, steal or borrow enough to stop him 'rattling' (going into withdrawal), on others he earns enough to 'treat' himself to a little piece of brown and white heaven: a 'speedball' injection of heroin and crack cocaine.

Heroin is a pain killer, it wraps him in a cloak of comfort, which the cold and the painful reality of his life can't penetrate. Using crack and heroin together allows each drug to reduce the unpleasant side-effects of the other - heroin takes the stimulant 'edginess' off crack, and crack takes the sedative 'fuzzy blanket' off heroin. Heroin also helps him deal with the sudden 'comedown' from crack. But the main reason why God injects speedballs is for the intense surge of pleasure injecting the two drugs gives him.

Injecting speedballs involves the most risky combination of drugs around at the moment. Compared with other injectors, speedballers are more likely to be: homeless; have a string of prison sentences behind them; at greater risk of overdose and involved in riskier injection practices. About a third are thought to have existing mental health problems.

The heroin and crack make God's existence at the edge of our society tolerable, but the drugs and the lifestyle which go with it, keep him trapped there.

Things you can do:

o **If you're in a hole - stop digging!**
   Never give up hope - other people have been there, survived and got back on their feet.
o **Use the services that are available** - needle exchanges, homeless services and mental health outreach workers are all there to help you.
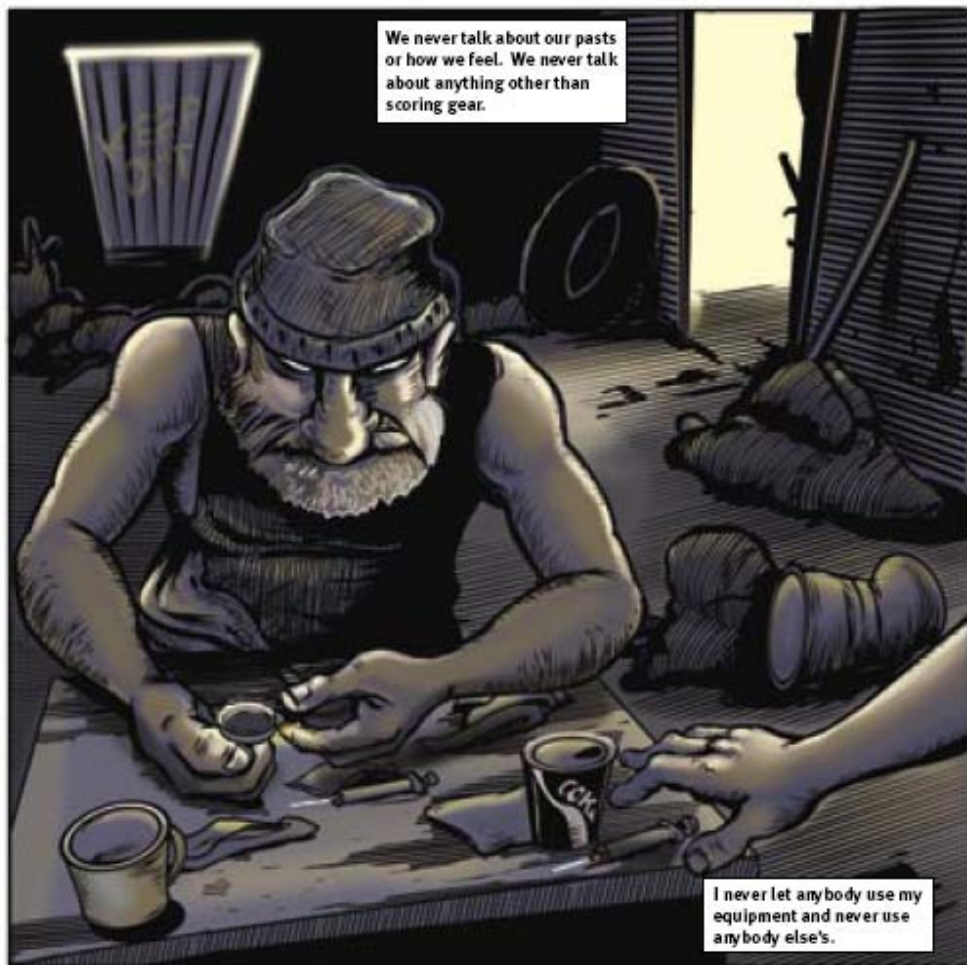
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Homelessness and Injecting

The average speedball habit costs up to four times as much as a heroin only habit. That's four times as much begging, crime and/or sex work, and four times the chances of arrest and imprisonment. This partly explains why many speedballers remain homeless, which means that many have few options other than to inject in unhygienic and insecure locations such as derelict houses and 'shooting galleries'. If you use a shooting gallery make sure you don't mix up your injection equipment with anybody else's.

Speedballers (and crack/cocaine injectors) inject more times a day than do heroin only injectors and are at increased risk of catching HIV, Hepatitis C and other blood borne viruses - which (worryingly) are on the increase. Don't share anything: needles, syringes, cookers/spoons, water, filters, citric ... ANYTHING! Work out how many times a day you are injecting and make sure you get enough equipment from your needle exchange to last between visits.

Speedballers and crack injectors are more likely to have damaged veins, abscesses, deep vein thrombosis, gangrene, ulcers, cellulitis, blood poisoning etc. These can be caused by using too much citric acid powder; not washing your hands; reusing your own used syringes; poor injection technique; 'dirty' drugs; multiple attempts to inject into the same site and repeatedly 'flushing' (drawing back of blood into syringe).

While heroin reduces the brain's experience of pain, crack has a local anaesthetic (numbing) effect at the injection site, and so speedballers are less likely than heroin injectors to feel and respond to pain from damaged veins, sores, abscesses, etc.

Things you can do:

o **Never share or reuse anything used for injecting**
o **Get any problems checked out as they won't get better on their own.**
If you notice any swelling, discoloured skin, pus or bad smell or your skin feels hot and/or tender around the injection site - get it checked out straight away. Ask your doctor or local needle exchange.

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Heroin, cocaine and depression

Depression is far more than feeling 'a bit shit today' - it feels more like a never ending sense of despair, an emptiness, where life has lost all meaning and purpose.

Depression does not arise from heroin use alone. Some people are depressed before they start using, others find they become depressed by the life that heroin has led them into. The effects of heroin are intense pleasure (at least to start with) and an extreme sense of well-being that feels like you're wrapped in cotton wool. It is understandable why these effects are attractive to people who are depressed. Opiates like heroin and methadone block your physical, mental and emotional responses, therefore masking the symptoms of depression.

Heroin and the heroin lifestyle can also lead to mood swings which 'mimic' bipolar disorders (manic depression). However, heroin is generally not that popular with people who have bipolar disorder as it reduces the high that untreated bipolar sufferers like. For those people in treatment it also makes the illness harder to overcome and stops mood stabilising drugs (like lithium) from working properly and increases the risk of suicide.

If you are depressed it seems to make sense to take a drug that makes you feel intensely happy and confident like crack/cocaine. But when the crack/cocaine wears off, the depression will come back and can be more severe. This is why using heroin and cocaine are such a popular mix, as the heroin takes the edge off the crack comedown.

As well as depression on the comedown, long term cocaine use 'burns out' certain parts of the brain (serotonin receptors), which can lead to a persistently low mood or depressed state, which does not respond well to treatment with medication.

Things you can do:

O   **Be honest with your mental health worker about what drugs you are using.**
Early intervention for mental health problems gets much better results. Without the right diagnosis you might not get treatment early enough to prevent long-term mental illness developing.

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Heroin, cocaine and schizophrenia

The main symptoms of schizophrenia are hallucinations (especially hearing voices that other people do not hear), delusions (having unusual, strange and often distressing ideas and beliefs), paranoia and disrupted thinking (thoughts and words seem bizarre or upsetting).

Stimulant drugs like speed, ecstasy, cocaine and crack can also cause all of these symptoms. Doctors call this drug-induced psychosis. The symptoms usually fade if you stop using, although it sometimes needs a few weeks of treatment (often in a psychiatric ward) to bring it under control. Once a person has had one drug-induced psychosis, they are more likely to have further episodes, in some cases, even if they do not use stimulants again.

Stimulant drugs can actually trigger schizophrenia in people predisposed to the illness. Using stimulants usually makes existing schizophrenia worse and prevents medication from working properly.

Heroin on the other hand often has the opposite effect. Drugs like heroin were once prescribed by doctors to try to control the symptoms of schizophrenia. This worked, but the treatment wore off very quickly and the patients unsurprisingly became addicted to the drugs.

Schizophrenia is not uncommon in heroin users. Heroin is sometimes used as a kind of 'self-medication' as some people find it reduces the distress caused by hallucinations and dampens down other symptoms of schizophrenia. This can make heroin users less likely to get help and use prescribed medicines (antipsychotics). These are much better than heroin in controlling schizophrenia, but take longer to work and have side-effects. Although the side-effects can be controlled or minimised to a tolerable level, it still means that because it is either not spotted or users prefer to 'self medicate', schizophrenia in heroin users often goes untreated.

Things you can do:

o   Be aware that if left untreated schizophrenia is much harder to manage.
o   If you are experiencing schizophrenia-like symptoms, seek help as soon as possible.
The earlier treatment starts the easier it is to deal with.

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Arrest and compulsory detention

Under mental health laws, the police have the right to detain you if you are in a public place, and they think you have a mental disorder and are in need of immediate care and control. They will take you to 'a place of safety' (usually a hospital).

If you are arrested and the police think you have committed crimes to pay for your drug habit, you can be drug tested and assessed for treatment (refusing a test is an offence). The courts can then make an order for you to undergo treatment with the threat of jail if you don't comply with the treatment.

Although you haven't got much of a choice about going through this process (called the Drug Intervention Programme or DIP), there is no reason why the treatment shouldn't be as good as any other treatment on offer. If you are arrested you have the same rights as anybody else

(right to silence, the right to see a solicitor for free etc.).

If the police think (or you tell them) that you have a mental health problem, you should not be questioned without an 'appropriate adult' (usually a social worker) present. This makes sure you are treated fairly. You should also be seen by a mental health worker. It is usually a good idea to tell the police about your mental illness. A doctor will decide if you are fit to be detained in custody or need to be admitted to hospital. If you go to a hospital you may or may not be charged with an offence at a later date.

If you need to be detained in hospital for assessment and/or treatment of a mental illness you have a right of appeal. This will be explained to you when you arrive. There is also a patient advocate service available in hospital to act on your behalf- ask your doctor or primary nurse about this service.

Things you can do:

o **If you start suffering from withdrawals in the cells - ask to see a doctor.**
They might prescribe something to help (but don't expect much).

o **If you go through the DIP, get a treatment plan from an experienced health worker**
A treatment plan is a written statement of the type of treatment you agree to undergo.

o **Tell the police about your mental illness.**

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Medication and withdrawal

In the past, people who had both a serious mental illness and drug problems tended to get a very poor deal. Drug treatment services and psychiatric services pushed them from pillar to post with each side claiming the other should be responsible for the person's care. Things are slowly improving with some areas being far better than others, but at least there is a recognition that this is a problem, and attempts are being made to sort it out.

You will be offered medication to treat your mental illness, but it's vital that you tell medical staff about your alcohol and/or drug use. You will be advised to stop using street drugs while you are in treatment, both because they are likely to make your illness worse, and because they may stop the medications prescribed to control your illness from working properly. Some medications can be dangerous if taken with street drugs*.
*see booklet No 3

A regular user of heroin and crack/cocaine who suddenly stops taking drugs will experience a double withdrawal syndrome (rattle or jangle) – a heroin-related 'cold turkey' combined with a crack comedown. Many users are also on methadone, tranquillisers or other drugs – so stopping use of all drugs at the same time without medical help would produce the 'mother of all rattles'.

Reducing heroin use or withdrawal needs special care if you are taking medication. A number of medications reduce the body's resistance to seizures (fits), especially the older antipsychotics (Typicals) *see booklet No 3. Some anxiety drugs and antidepressants can cause agitation, panic attacks and lower your blood pressure. Withdrawal can also mimic the symptoms of mental illness, so it is a good idea to obtain specialist help from a drug worker and/or doctor or mental health worker to help you through this safely.

Things you can do:

o   To get the best treatment, make sure your doctor or mental health/drugs worker knows what drugs you are taking.

o   Withdrawals from street drugs when on medication can be tricky
    Withdrawal can mimic the symptoms of mental illness, so it is best to get specialist help.

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Making changes

Heavy end use of drugs like heroin and cocaine effectively 'reprogrammes' the brain so that the need for drugs comes first. Basic needs like food, shelter and things that we once got pleasure from, like making love or watching the sun set, get neglected. But we still have choices - we don't lose the ability to think, reflect and make changes of our own free will. This is what makes us human. Every year, thousands of people do precisely this; they take a step back, look at their lives and say 'this isn't working – I need to change it'.

When people identify a problem with their drug use and want to make changes, they rapidly begin to notice the obstacles to making change happen. Some of these obstacles are inside ourselves. A good counsellor or joining a self-help group like AA or NA can help you to get over the unproductive thought patterns that act as obstacles to change. However, there can also be more concrete obstacles, like not having adequate housing, having no drug free friends, or having too much time with nothing to do.

Both mental health services and drug services can help you overcome all these obstacles.

Staying alive

If you are not yet at a point in your life when you can or want to make changes - take care to stay alive until you are. Overdoses and blood borne diseases are what kill injecting drug users.

*Don't share any injection equipment: always get clean equipment from your needle exchange.

*Go easy after a break: if you have come out of hospital, prison or have been drug free you will have lost your tolerance to heroin and other drugs. The amount that once got you sorted could now kill you. Use a smaller amount or smoke it rather than inject it.

*Taste the hit: inject a little of the drug and 'taste' the effect before you inject the rest.

*Don't inject alone: inject with friends who can help if things go wrong.

*Make a pact: talk with friends about what you will do if somebody overdoses

*Look after people who have overdosed: treat them the way you would want them to treat you.

Death from overdose is preventable - doctors and paramedics can administer an antidote to a heroin overdose called naloxone. They also have life-saving treatments for cocaine/crack-related overdoses, so never hesitate to call an ambulance when a friend or associate overdoses on either or both drugs.

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Dealing with an overdose

Overdoses on heroin often involve 'respiratory arrest' (breathing stopped), while overdoses on crack/cocaine are more likely to lead to heart attacks or fits. You may need to do different things to help someone who has overdosed (while waiting for the ambulance).
What you should do depends on their appearance and behaviour.

If they are overheating: cool them down by removing outer clothing, and fanning them. Don't give them anything to eat or drink. Call an ambulance.

If they are having a 'fit'- prevent them from hurting themselves, but make sure the head is tipped back so there airway is clear. Do not try to put your fingers in their mouth or try to force it open. Call an ambulance.

If they have severe chest pains, sit them up and call an ambulance. Stay with them and take their pulse (with the three middle fingers at wrist) to check their heart hasn't stopped.

If you think their heart has stopped use life saving procedure, if you know it.

If they are unconscious and can't be woken (by giving them a poke in the chest and calling their name) or their face or lips turn blue or they have trouble breathing, call an ambulance.

If their breathing has stopped, call an ambulance and use life saving procedure if you know how to do it.

The Recovery position

Always put a collapsed, unconscious person in the recovery position. This is designed to stop them choking on their vomit (a common cause of death). In most areas the police are no longer automatically called to overdoses. Always tell the paramedics (if you know) what they have taken.

1. Put the right hand by the head (as if they were waving)

2. Put the left arm across the chest, so that the back of the hand rests against the cheek

3. Hold the hand in place and lift up the left knee

4. Turn them on their side by pushing down on the knee

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Memoing Transcript Exemplar

Partial Transcript Interview with "Karen" and initial labelling and colour coding of categories

Microanalysis in Comic Sans

Memos in Bold

CAPITALS ARE CONCEPTS
(Such concepts may become categories)

'Levels of knowledge of drugs / alcohol' - RED
'Explanations for my condition'/ situation from other People – LIME
'My explanation for my condition / Situation' – ORANGE
'Role of substances (drink and drugs)' – BLUE
'Relationship with substance' – **BOLD**
- **As medication**
  - **As a Comfort**

'Relationship with Illness' – UNDERLINED
- Fearful
- Respectful
- Bodily experiences

'Things that helped / might have helped' – PINK
- Peer support / intervention
- Education /information
- Relapse prevention
- Alternatives

'Significant Childhood and ADULT happenings / beliefs / feelings' – PLUM
'Feelings / belief like symptoms' – TEAL
'Impact on behaviour/ Life' – LAVENDER
Things that Haven't Helped – BROWN
Policy, service or practice development issues – Bright Green

Mark	Clearly there were some things to do with drink or drugs and mental health that have appealed to you or have been of interest for you. Can you tell me a little bit about your overall use of drink or drugs and what you found good about that?

Karen	It stopped the voices.

It [It refers to drugs as an entity. Or 'it' refers to actual drug taking, i.e. the act. It maybe singular as in a specific drug perhaps for a specific symptom, the voices) stopped [stopped them dead? For how long? Implies this as a good thing and the voices are a bad thing] the voices [voices could be voiced thoughts in or outside her head. Or auditory hallucinations. Or belonging to someone. Thin walls the voices may be real sounds.

Memo -   The context (mental health / client) leads me to assume that the voices are a distressing symptom of mental illness, that they are treated effectively by Karen by drug use. One illness (drug misuse) treating another illness (voices, schizophrenia) yet justified in this statement. Does Karen's statement say drugs are ok in certain circumstances?. It cannot tell me how effective drugs were but it does convey a *phenomena* that could be *labelled* 'COPING WITH ILLNESS THROUGH DRUGS/ '.

The microanalysis is word-by-word analysis. The memo is more line-by-line. A crude hypothesis,

one of many that could emerge, could be that self-medication for voices is a cause or

SUSTAINING FACTOR in co-morbid substance misuse and schizophrenia.

The hypothesis above is an expression of a group of concepts (yet to emerge fully in this study)and will form one category. When microanalysis and memos are completed on a group of interviews I will open code per interview, then open code the group of interviews culminating in categorisation. Once categorised I will axial code this group of interviews and integrate into future interview analysis (I.e. scan transcripts) and into future interview.

Mark	OK. What was it you found useful in terms of stopping the voices?

Karen	It give me something else to think about, so…

It gave me [It – an entity, gave – provided something, me – personal to me. These three words suggest a relationship perhaps between the drug and Karen. It, the drug, in fact imparted something to Karen that she may be grateful for.

Memo – is this another theme or idea? That a <u>RELATIONSHIP WITH A DRUG</u> develops and the drug starts to be seen as an entity of its own. If this is so on

abstinence someone may lose the effects of the drug and the relationship. Is this significant SHOULD THIS FEATURE IN 2ND WAVE OF INTERVIEWS AS PART OF CONCEPT DEVELOPMENT?

Mark   What did you find yourself using to help you think about something other than the voices?

Karen   Rock, crack cocaine and heroine

Memo – helps her think of something else, GRATITUDE TOWARDS THE DRUG.
Which drugs do what? DISTRACTION = Crack and Heroin / speedballing

Mark   Did you use those together?

Karen   Yeah

Mark   or separately? Together?

Karen   Yeah

Mark   Over a long period of time?

Karen   Yeah, about two or three years.

Memo – long term relationship

Mark   and do you use at all now?

Karen   No.

Mark   so that's very good. So you've managed to really clean up in terms of using coke and heroine and you were using them together so…

Karen   Yeah

Mark   It sounds quite powerful. Were you spending a lot of money each day (or weekend)?

Karen   Yeah

Mark   OK, and did it draw you into a group of people that were involved in crime at all, or

Karen   Yeah, it did.

Mark   It did, OK. Can you tell me a little bit about those people that you were with?

Karen	Yeah they were just using me for what they could get out of me

Mark	Were they? Why was that? Why were you used? Were you easily used, more easily used than others?

Karen	Yeah, I think I'm very gullible, so…

Gullible [This and line above suggestive of victim status. The drug not cited yet as bad but aspects of the drugs scene (fellow users) are]

Memo – VULNERABILITY, powerlessness? Does she still feel this powerlessness, did she need to feel stronger and powerful to stop or did the power and strength that I am assuming exists develop after stopping?

Mark	Did they think you are or do you think you are?

Karen	I think I am

Negative self view

Mark. do?	You think you are. What kind of things did they end up making you

Karen	Begging for money

DEMEANING ACTIVITIES

Mark	Right, so you were able to collect extra money to help them and to help yourself?

Karen	Yeah

Mark	Right. How much crack cocaine were you using then?

Karen	It varied

Mark	Did it, and you had been using several rocks a day and several bags of heroine, was it that kind of extensive habit?

Karen	Yeah

Memo – how important is quantity here and with others, check out in 2nd Wave of interviews.

Mark	Were you injecting anything?

Karen	I was injecting heroine

Memo – route, analyse frequency re routes on software.

Mark	Right. And smoking the crack, right. Karen, tell us a little bit about your mental health then. You mentioned your voices before.
Karen	Yeah, they tell me that I'm no good and try and get me to commit suicide and stuff like that. I haven't heard them sort of voices for a while now.

..they tell me…[another reference to an entity with relationship properties and dimensions, is Karen referring to another entity that has greater power than she?

Mark	Haven't you
Karen	No.
Mark	And have things got better since you've stopped using crack cocaine?
Karen	In my health and my life style.

Health [what is a dual diagnosis clients concept of health, it properties, characteristics etc?. Here 'health' and 'lifestyle' may denote something major or is it a learnt phrase from professionals and media?]

Mark	Which parts of your health have got better?
Karen	I suffer from abscesses

[Concrete conceptualisation of poor health – an abscess]

memo – HEALTH AND LIFESTYLE CONCEPTUALISATION – is the concrete / short term understanding of health an obstacle to change in a similar manner that poor deferred gratification compromises long term considerations in relation to an enjoyable yet risky activity. CONCEPTUALSIATION OF LIFESTYLE AND HEALTH could be considered within a category of short-termism (poor conception of future or hopelessness / powerlessness)

Mark	Where you were injecting you mean?
Karen	And I've picked up an infection in the veins

[infection – concrete path]

Mark	So you've not had any infections and you've not had any abscesses?
Karen	No
Mark	So that's ok. What about the smoking crack, because you were smoking that and not injecting it were you?

Karen	Yeah

Mark	Has your health improved at all because you've stopped smoking crack do you think as well?

Karen	Yeah

Mark	You think it has. In what way has that improved?

Karen	My cough and

Cough [concrete again] my [relationship with something]

Mark	So you're not coughing as much?

Karen	No

Mark	Do you feel better in general

Memo – I should have noticed this concrete expression of health and pursued it, 2nd wave of interviews should have this concept about short term and longer term health gains.

Karen	Yeah

Mark	OK. What about your mental health? Has that improved, because you said that it was damping your voices down, so how has your mental health improved since you stopped?

Karen	I've stopped getting so depressed

Mark	So your moods better

Karen	Yeah

Mark	So why do you think that is?

Karen	Don't know, because it's a depressant isn't it

Mark	Yes, I think the crack seems to be, deplete your feel good chemicals, serotonin, does that and heroine, indeed yes it is a ……depressant isn't it. Were you connected to services at any point using methadone or anything like that?

Karen	I was using methadone on top of my drug use and I was going to the needle exchange.

Mark	Were you. Did you find those useful?

Karen	Yeah

Mark	Yes, what was your feeling or your experience with the drug service?
Karen	I got a lot of good input.
Mark	Did you?
Karen	Yeah
Mark	Was that, individuals were helpful for you as well as your methadone?
Karen	Yeah
Mark	What about the needle exchange, how did you find that, was that helpful?
Karen	Yeah it was, to get a box of hundred you had to give them loads back, so it stopped me from throwing them out in the open and stuff like that.
Mark	So it was kind of good for you, it was good for your immediate environment in terms of what you do with the needles.
Karen	Yeah

Memo - Services help by needle and methadone provision
………
……..

Manchester City Council · **Manchester Mental Health and Social Care Trust** · **NHS**

Drugs, Alcohol and Mental Health

Are you a service user who has experience of both mental health problems and drug or alcohol problems?

Are you a practitioner or carer who has helped people with mental health and drug / alcohol problems?

Are you non-practice staff (lecturer, manager, trainer, administrator etc) who has experience or knowledge in this field?

If you can answer 'YES' to one of these questions would you like to take part and contribute to a
research study to discover what helps?

The research study is called "Dual Diagnosis: consumer's views on policy and practice" and it aims to discover, from **service users**, **carers** and **providers**, what has been useful and what could be useful for service users, carers and providers in relation to the combined effects of drugs/alcohol and mental ill health in the future.

The study is being carried out by Mark Holland, Dual Diagnosis Nurse Consultant, in conjunction with Manchester Drug and Alcohol Action Team, Manchester Mental Health & Social Care Trust and the University of Salford.

You can take part in a focus group, an interview or both. Taking part is purely voluntary and confidential. In addition any travel expenses will be reimbursed.

For further information about taking part or learning more about the study please ring Mark on 0161 882 1103 / 07977 986 178, or email mark.holland@mhsc.manchester.nhs.uk or write Chorlton House, 70 Manchester Rd, Chorlton cum Hardy, Manchester M21 9UN. Or complete a referral form. Thank you.

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Manchester Mental Health **NHS**
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Manchester
M21 9UN

Telephone: 0161 882 1103
Fax: 0161 882 1001

Dear

I am writing to you concerning a research study I am undertaking with local mental health, drug and alcohol services called 'Dual Diagnosis: consumer's views on policy and practice.'

There is a lot of concern around the matter of mental health and drugs or alcohol misuse, many professionals now call this combination of mental health and drugs or alcohol problems a 'dual diagnosis'.

Many service users and carers have experienced difficulties with drug, alcohol and mental health services as well as the effects the two the conditions have on them and their families or communities.

I am researching this issue of substance use and mental health problems and with help from service users, carers and workers hope to find out what helps now and what could help in the future.

I would like to invite you as service user, carer or worker to take part in this study. If you have heard of the study already through my seminars or posters and agreed to participate further I apologise for duplicating the invitation. If you have not and are interested in taking part please read the enclosed information sheet. You can return the slip enclosed to the address above or telephone me on 882 1103 to arrange an appointment. Alternatively, if you are a service user you can ask your care coordinator or primary nurse to pass it on to me.

Thank you for your interest and time and I look forward to meeting you soon, if you are a service user or carer and have any concerns about the research study please contact me or your key worker, care coordinator or advocate.

Yours sincerely

Mark Holland
Consultant Nurse Dual Diagnosis
Manchester Mental Health and Social Care Trust

-----------------------------Reply slip--=-

Please return to:

        Mark Holland
        Chorlton House
        70 Manchester Road
        Chorlton
        Manchester
        M21 9UN

Dear Mark

I am interested in taking part in the study and you can contact me on the address / number below to arrange a focus group and / or an interview.

Name _____

Address_____

_____

_____

_____

Telephone_____

Name and telephone number of carer/advocate/ care coordinator/ key worker if applicable_____

_____

_____

_____

_____

Award Certificates

1. North West NHS Innovation Awards (Training or Educational Materials - Winner)
   September 2007

2. Nursing Times Chief Nursing Officer's Award (Finalist 2007)
   November 2007

3. National NHS Technology Awards (Publications and Media - Runner-up 2007)
   December 2007

North West NHS Innovation Awards

2007

COMPETITION

Maximise Efficiency

Training or Educational Materials

Joint 1st Prize

Out-of-Your-Head:
Guides for People Who Use Drugs and
Have Experienced Mental Illness.

Mark Holland

Manchester Mental Health
and Social Care Trust

Awarded by:

TrusTECH®

The North West NHS Innovation Hub

NURSING TIMES

NT AWARDS 2007

Finalist

This is to certify that

Mark Holland

of Manchester Mental Health & Social Care Trust

was a **finalist** in the category
Chief Nursing Officer's Award

Rachel Downey

Rachel Downey
Editor, Nursing Times

Category sponsored by

TA
TERRITORIAL ARMY
BE THE BEST

NHS

National Technology Awards
RUNNER-UP
2007

Publications and Media

Awarded to

Mark Holland

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Fold-out Research Map

Diagrammatic Illustration of 12 Categories and Subcategories (Part 1. P81-142)

Categories   **Subcategories**

  1. Relationship with Illness…………………………………………....Accumulated Experiences and Drug Taking. Table 10. P95.

  2. Levels of Knowledge of Drugs / Alcohol ….…………………………Poor Knowledge, Harm Reduction, Desire to Learn.

  3. Relationship with Substance(s)…….…………………………………....Endings, Control, Companionship…..Alone.

  4. Explanations for my Condition / Situation from other People…….....…Self Medication, Drug Induced Psychosis, Change-timeframe,

                  Shared Understanding.

  5. Policy, Service or Practice Development Issues…….……………….....Information, Services…….Collaboration, Communication.

  6. Significant Childhood and Adult Incidents……………………..……..Getting Started, Reaction to/Management of Stress….Alone.

  7. Impact on Behaviour and Life……………………………...……………Psychological, Social, Physical….Relationship Breakdown,

                  Exclusion and Combination of Both. P111-115.

  8. My Explanation for my Condition / Situation………..…………….....Internal and External Attributions….. Mental, Physical and

                  Social Signs of Distress. Table 11. P118.

  9. Feelings / Beliefs / Symptoms……………….………………………….Symptom Remedy Relationship. P120….Dual Diagnosis

                  Symptom Categories. Table 12. P123…..Distress/Relief

10. Role of Substance(s)………………………………………………………The Role and Properties of Substance Use. Table 13. P127.

                  Course of Drug Use: Deficit Management. Fig 6. P130.

11. Things that haven't Helped……………………………………………..Themes of Unhelpfulness. Table 14. P134.

12. Things that Helped / Might have Helped...…………..…….…………..Properties of Help and Their Frequency. Table 15. P140.

Diagrammatic Illustration of *Help* Related Categories, Subcategories and Concepts (Part 2. P143-194)

Category 11. Things that have not Helped: Subcategories (Themes of Unhelpfulness. Table 14. P134).

Systems, Treatment / Medication, Substances, Coercion / Persuasion, User Involvement, Social Attitudes

Category 12. Things that Helped / Might have Helped: Subcategories (Properties of *Help* and Their Frequency. Table 15. P140).

Dimensions of 'Help'. P144.	**Properties of 'Help'.** P148.	**Elements of 'Help' Properties.**

Type of Help
   Mental Illness
   Drug
   Goal
	1. Communication with Others	Cathartic in nature. Peer, group and individual in source.

	2. Medication	Provides a variable level of helpfulness.
	3. Support: Networks and Individuals	Sources of Support. Table 17. P155. Nature of Support. Table 18. P156.

Nature of Help
   Practical
   Psychological
	4. Education and Information	Trustworthy source. Information about medication, drugs, mental health, housing and benefits.

Level of Help Individual	5. Safer Drug Use	Tailored Drug Use Strategies. Table 19. P168.
Community Service	6. Care and Support	Care as a Prerequisite for Help. Fig 8.P171. Essence & Pragmatics of Care. Table 21. P174
Source of Help Peers	7. Treatment	Drug Free, Harm Reduction (Safer Use), Family & Health, Peer Support, Antipsychotics, Pharmacological, Psychological.
Carers	8. Goals	Essentially hopeful in nature.
Services Professionals	9. Attitude (Includes 'Self View')	Attitudinal Ingredients of Motivation. Fig 10. P184. Hopefulness, Maturing, Positive View (of the world), Sustaining Hope.
	10. Activity	Social contact and distraction. P188.

MOTIVATIONAL STAGES Page 147

Diagrammatic Illustration of the Key Concepts Underpinning *Help* Theory and Key Constituents Forming *Help* Theory. (P 210-224).

Service User Participants displayed prominent characteristics of a helper. The *Help* theory that emerged is powerful because it possesses explanatory concepts about why and how help occurs. These are shown below.

- **Arousal and Cost-Reward** }
  [Discomfort of others prompting help provision] }

  }   **Basic Psychosocial Process.** P210. }
- **Empathy-Altruism** } [The desire to be helpful to themselves or peers] }
  [Empathy triggering altruistic acts of help] } } *H*

  }   **Motivational Issues.** P213. } *E*
- **Drug Expertise** } [The desire and ability to recover or help] } *L*
  [A knowledge base to draw upon] } } *P*

  }   **Self-help.** P221. }
- **Helpfulness** } [Using the 'Know-How' borne from experience] }
  [Desire, combined with ability, to help] }

  }
- **Inclusion** }
  [Moral / instinctively helpful social act] }

Key: Fig = Figure. P = Page.

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