

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

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| Journal:         | <i>Advances in Dual Diagnosis</i>             |
| Manuscript ID    | ADD-08-2017-0012.R2                           |
| Manuscript Type: | Research Paper                                |
| Keywords:        | alcohol, mental disorder, narrative, recovery |
|                  |   |

## Abstract

**Purpose:** Existing literature has examined what recovery means to people with co-occurring difficulties, but does little to examine experiences of recovery as a process. This paper uses a narrative approach to explore the process of recovery as an individual journey in a social context. It focusses on people who use alcohol in order to explore the impact of alcohol's specific cultural meanings on the recovery journey.

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

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

**Findings:** Most participants' narratives shared a three-part structure, from a traumatic past, through an episode of change, to an ongoing recovery phase. Change and recovery were attributed to several factors including flexible and practical support from services, therapeutic relationships with key professionals, and peer support. Some participants redefined themselves and their alcohol use in relation to ideas of what it is to be 'normal.'

**Limitations:** The research excluded people who recover outside of services, replicating a shortcoming of much research in this area.

**Practical implications:** The value placed on professionals having specialised therapeutic skills in working with trauma highlights the need for training in this area. The role for practical and material support underlines the importance of multi-agency working.

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

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6 population in general, so this paper is able to investigate the specific challenges for this  
7 population.  
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## 10 11 12 13 **Introduction**

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15 People with coexisting mental health and substance misuse difficulties face multiple  
16 disadvantages. They are often at risk of homelessness, offending, and economic deprivation  
17 (Marcus, Brown, Stockton, & Pilling, 2015); they face stigma and may have internalised a  
18 negative social identity (Manley, 2015). These difficulties are compounded by problems  
19 with accessing services. Substance misuse and mental health services in the UK have  
20 tended to operate separately. This requires people to negotiate two parallel service  
21 pathways, frequently encountering barriers to accessing either (Schulte, Meier, Stirling, &  
22 Berry, 2008).  
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25 For people who do succeed in accessing a service, there are barriers to achieving a positive  
26 outcome. Many professionals feel unskilled when dealing with coexisting difficulties and  
27 may be overly pessimistic about the likelihood of positive outcomes (Adams, 2008; Weaver  
28 et al., 2003). Further, the evidence for the effectiveness of specific psychosocial  
29 interventions with this population is poor (Hunt et al., 2013). Research in the UK and  
30 internationally has concluded that the division between mental health and substance  
31 misuse services is problematic and has recommended that services become more holistic  
32 and integrated (Carrà *et al* 2015). Existing UK policy reflects this, with NICE guidance  
33 recommending that existing specialist services should be adapted to serve this population  
34 effectively (NICE, 2016).  
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38 The concept of recovery appears to offer a principle for developing more integrated and  
39 person-centred services (Davidson & White, 2007). Recovery has been defined as an  
40 ongoing process of growth and personal change in which the person builds 'a meaningful  
41 and satisfying life, as defined by themselves, whether or not there are ongoing or recurring  
42 symptoms or problems' (Shepherd, Boardman, & Slade, 2008, p. 2). This understanding of  
43 recovery as a personal process is widely used in policy documents in both mental health and  
44 substance misuse services (Home Office, 2010; Department of Health, 2014), but shifting  
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6 the orientation of services away from a focus on the clinical remission of symptoms remains  
7 a challenge. Slade et al. (2014) argue that the concept of recovery is 'abused' in a number  
8 of ways, becoming a justification for service cuts or another framework for fitting people  
9 into service-defined ideas of 'normal'. Neale et al., (2015) explored how service users  
10 experienced recovery differently from care providers. For service users, recovery was  
11 experienced as 'often more about 'coping' than 'cure''; about managing rather than  
12 eliminating difficult experiences.  
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16 Since personal recovery is an ongoing process rather than a specific outcome, research into  
17 service users' experience of this process is essential. Leamy et al's (2011) systematic review  
18 of first person perspectives on mental health recovery identified stages in recovery which,  
19 they suggest, map onto the five-stage transtheoretical model of change (Prochaska &  
20 DiClemente, 1986). The authors suggest that more research is needed on how social power  
21 impacts on recovery. The idea that recovery is not just an individual journey but also a  
22 social process of 'restoring a meaningful sense of belonging to one's community' (Davidson  
23 & White, 2007) may be particularly relevant to people with co-existing difficulties, who face  
24 additional barriers and stigma.  
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28 This paper takes a social constructionist approach to the understanding of experiences of  
29 recovery, aiming to explore how people construct an account of their personal recovery  
30 journey using available narratives. Previous studies of first-person accounts of recovery  
31 from co-existing difficulties have found that recovery is experienced as a personal journey  
32 towards a new identity. This may involve expressing and revising stories of early experience  
33 (Elison, Weston, Dugdale, Ward, & Davies, 2016); unravelling painful life events (Brekke,  
34 Lien, Davidson, & Biong, 2017a), and taking responsibility for past choices (Hipolito,  
35 Carpenter-Song, & Whitley, 2011). Some studies found that people experience a new sense  
36 of meaning which may have a spiritual dimension (Whitley, 2012). The importance of  
37 material security through secure housing and, for some, employment, is also noted (Brekke  
38 et al., 2017a; Marcus et al, 2015).  
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42 Two recent reviews provide a thorough account of the current literature overall. Ness, Borg  
43 and Davidson's (2014) review of facilitators and barriers in dual recovery emphasises the  
44 diversity of recovery experiences. The authors recommend that services take into account  
45 the individual pathways that people may follow to recovery, and the stigma that they often  
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7 face. De Ruyscher et al's (2017) systematic review of first person perspectives on dual  
8 diagnosis identifies four overarching themes. These are; the importance of family and peer  
9 support and community participation; the need for holistic treatment with a long-lasting  
10 therapeutic relationship; the importance of personal beliefs, goals and spiritual values; and  
11 the value of meaningful activities. They note, however, that ~~the~~ while the existing literature  
12 explores the meaning of recovery for people with co-occurring difficulties, it does little to  
13 examine recovery as a process. It is this omission that this paper will attempt to address,  
14 through a qualitative exploration of recovery in co-occurring difficulties which charts not  
15 just what people mean by their recovery, but how they recovered, and how services  
16 facilitated or hindered their recovery.  
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22 This paper also aims to address a gap in the current literature with a substance-specific  
23 focus on alcohol misuse. The social nature of recovery means that the culturally specific  
24 meanings of substances may impact on people's recovery journeys. Alcohol, as a widely  
25 available and legal substance with a long tradition of consumption in the UK, has a range of  
26 distinctive cultural meanings to do with the formation and maintenance of individual and  
27 group identities (Emslie, Hunt, & Lyons, 2015). People may make specific identity shifts in  
28 recovery from alcohol and mental health difficulties compared with those who use other  
29 substances. Though the experiences of people with co-existing mental health and alcohol  
30 difficulties are present in the existing literature, a survey of the papers reviewed by Ness,  
31 Borg and Davidson (2014) and De Ruyscher et al. (2017) shows that in many cases the  
32 particular substances used by the participants are not specified, and even when they are,  
33 there is no exploration of what impact this has on their recovery. This paper aims to  
34 address this in the case of alcohol, by recruiting specifically people who misused alcohol and  
35 exploring the role of alcohol in their recovery narratives.  
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## 47 Method

### 48 Narrative research

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50 Narrative research draws attention to how people achieve changes in personal identity by  
51 re-presenting their story to themselves and to others, drawing upon the wider stories, or  
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6 narratives, that are available in their social and cultural context (Wood, 1991). The narrative  
7 approach in this study draws on Clandinin and Connelly's (2000) metaphor of a three-  
8 dimensional narrative inquiry space. The first dimension is the interaction between the  
9 personal and the social; how people tell their individual story by drawing on the social  
10 narratives that are available to them. Here this dimension is investigated by adapting  
11 Rappaport's (1995) model of *levels of influential context*, which highlights three levels of  
12 narrative. *Dominant cultural narratives* pervade social institutions and the mass media;  
13 cultural stereotypes around alcoholism, for instance, occur at this level. *Community*  
14 *narratives* are the stories shared by social groups or within organisations or families. In this  
15 study the participants' narratives of mental health and substance misuse services are given  
16 particular attention, since one of the aims of the study is to identify the role of services in  
17 people's narratives of recovery. *Personal narratives* are stories of individual experience  
18 which will draw on available community and cultural narratives.  
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26 The second dimension is *continuity*; narratives take place over time, usually making causal  
27 links between past, present and future. The narrative will have a starting point, points of  
28 change or transition, and end-points in the past or present, or imagined endings in the  
29 future. The narrator faces a predicament or struggle and moves through points of  
30 transition to some kind of resolution (Ollerenshaw & Creswell, 2002). This gives the  
31 narrative its overall shape and is therefore central to its meaning.  
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35 The third dimension is *situation*; the place in which the narrative is produced, and the  
36 audience to whom it is told. This is addressed here through researcher reflexivity and  
37 discussion of the impact of the research setting.  
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#### 41 **Research setting**

42 The service was a Local Authority funded, community-based substance misuse service  
43 providing integrated psychosocial and medical support for people misusing substances  
44 including alcohol. The service allowed self-referral as well as referral from other agencies,  
45 and employed a Clinical Psychologist who offered specialised psychological therapies. The  
46 area served was a large town in England and the rural area surrounding it, a total population  
47 of around 175,000. The area had relatively high levels of income deprivation compared with  
48 England as a whole, and a predominantly (over 90%) White British population.  
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**Recruitment**

A convenience sample of ten participants was recruited. The inclusion and exclusion criteria for the study were explained by the researcher to keyworkers at the service, both verbally and in writing. Initial assessment of whether an individual met the inclusion criteria was carried out by keyworkers. The researcher was available for queries from keyworkers about whether a particular individual might meet the inclusion criteria. Seventeen service users were approached by their keyworkers and given a Participant Information Sheet. Treatment was completely unaffected by service users' decisions about whether or not to participate in the study, and no inducements to take part were offered. Ten agreed to being contacted by the researcher, and all ten took part in the research. Informed consent was obtained immediately before each interview; this included explanation of the right to withdraw from the study, and of the procedures for ensuring confidentiality and anonymity.

Inclusion criteria:

• Adults with coexisting mental health and alcohol misuse difficulties who, at the time of the study, or in the previous two years, were in service with both the substance misuse service and with specialist mental health services. Specialist mental health services included Community Mental Health Teams, Crisis/Home Treatment Teams and acute admission, and/or the Clinical Psychologist based at the substance misuse service. Alcohol had to be the primary substance misuse difficulty identified by the substance misuse service at assessment.

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

• Primary substance difficulty with alcohol, as determined at assessment.

Exclusion criteria:

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Individuals who were at the time of the study in crisis relating to mental health, substance misuse or both, or if there was concern that the individual was so vulnerable that discussing their story with a new person could have led to increased risk to themselves or others; **also**, Individuals who were physically or mentally unwell to the extent that it would have been detrimental to their wellbeing to participate in the interview.

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- ~~Individuals who were physically or mentally unwell to the extent that it would have been detrimental to their wellbeing to participate in the interview.~~

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### Ethical approval

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

### Participants

Ten people took part in the study. Their mental health diagnoses and current substance use was established through self-report. Table 1 gives their pseudonyms and basic demographic information.

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

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

Notes: PTSD = Post-Traumatic Stress Disorder; BPD = Borderline Personality Disorder. Particular diagnoses were not required by the inclusion criteria, which focussed on use of services. The Mental Health column



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6 therefore gives the labels or diagnoses which the participants themselves referred to in the interviews. The  
7 same applies to the Additional Substances column.  
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### 11 **Procedure**

12 Unstructured interviews were used in order to allow participants to structure their story of  
13 recovery around the events and causal links that were important to them. The researcher's  
14 understanding of recovery as an ongoing process was included in the introduction to the  
15 interview, with the researcher telling participants: 'I am interested to hear about the story  
16 of your recovery. How your story started, what happened, what influenced you and where  
17 you are now. I am also interested in what part mental health services and alcohol services  
18 have played in your story.' Further questions and prompts were used if necessary; often to  
19 ask a participant to expand on a part of their story, or to fill in a gap in the story. All  
20 interviews were conducted by the researcher at the substance misuse service and were  
21 audio-recorded. The mean duration of the interviews was 43 minutes (range 20 – 61  
22 minutes).  
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### 32 **Transcription and analysis**

33 All interviews were transcribed by the researcher within two weeks of being conducted.  
34 The researcher made marginal notes while transcribing to capture immediate impressions of  
35 the participants' stories. Core stories were then created from each transcript, based on the  
36 approach developed by Emden (1998). Interviewer questions were removed, along with  
37 superfluous words and phrases. Words that detracted from the key idea of each sentence  
38 or group of sentences were then deleted.  
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43 'Subplots' were then identified within the remaining text, subplots being the key idea of a  
44 part of the story which produces meaning in the context of the story as a whole (Emden,  
45 1998). Fragments of text were grouped together in subplots, with repetitious content  
46 deleted. The subplots themselves were reordered chronologically to create an overall core  
47 story of about a quarter of the length of the original transcripts. This followed the  
48 'restorying' approach of Ollerenshaw and Creswell (2002), emphasising the continuity of the  
49 participant's story.  
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7 The analysis then followed an iterative process of moving between the raw transcripts, the  
8 core stories, and analysis of the subplots within each core story. A summary of shared  
9 subplots across all the transcripts was developed, and ordered in terms of level of influential  
10 context, highlighting the links between individual narratives, community narratives including  
11 narratives about services, and dominant cultural narratives. Subplots were also arranged  
12 chronologically and shared phases in participants' recovery narratives were identified.  
13 These analyses of level of narrative and continuity of narrative were then synthesised into  
14 an overall presentation of shared subplots by level of influential context and continuity of  
15 narrative.  
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### 23 Findings

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25 A visual summary of the findings is provided in Figure 1, which presents shared subplots in  
26 terms of levels of influential context and continuity. Figure 1 also includes brief details of  
27 the situation in which the narratives were produced.  
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30 A more detailed account of the shared subplots follows, in three main sections following the  
31 three phases which were identified; origins of difficulties, episode of change, and ongoing  
32 journey of recovery.  
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Figure 1: Summary of findings on the three dimensions of levels of influential context, continuity, and situation

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

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| Situation | Service    | Substance misuse service with some mental health support; accepts self-referrals; participants referred by keyworkers.    |
|           | Researcher | Previously an alcohol practitioner; research as part of a qualification; social-constructionist epistemological position. |

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

Participants' narratives about how their difficulties began took early difficulties as a starting point, often describing a sense of themselves as having never been 'normal'. Seven began their story by referring to traumatic experiences, with five of these specifically mentioning physical and/or sexual abuse in childhood. In addition to specific episodes of trauma, many participants also described growing up in an insecure or chaotic family environment, and becoming involved in crime or abusive relationships as young adults. For some participants a sense of not being normal came from experiencing themselves as outside normal social structures or moral accountability. For two participants this was explicitly linked with a minority status; John, a black British man, said '*I was never accepted, I always wanted to be white.*' Helen, a gay woman, linked her alcohol misuse history to belonging to the '*very secret world*' of the gay scene in the late 1980s.

Alcohol entered the narratives as a response to these difficulties, usually in adolescence or early adulthood. Some described alcohol in terms of coping with the symptoms of trauma. For others, alcohol use began as a way of earning a sense of normality through identifying with a social group or community. Gary reflected on his experience in the army, saying that drink was '*forced upon you...they didn't make you drink it but...it was just a natural thing.*' Gary's was one of several stories in which the participant felt that they had spent a long time confused about their difficulties, without the help they needed to understand them.

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

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

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

For Helen, this was a moment of clarity, providing her with an explanation of her drinking behaviour as a way of coping with a mental health problem. Previously she had taken a series of overdoses resulting in acute admission, and her experience was that these were

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seen as simply alcohol-related. Similarly, Gary said *'no-one asked me why I drank'*, until a particular nurse recognised that he was suffering from PTSD.

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

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

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

Four participants did not give an account of a particular episode of change and produced narratives of ongoing struggle which did not have a clear trajectory from a difficult past to a better future. These tended to be the participants who were still drinking at significant levels; Bill, for instance, said that there was a lot that he could not remember. Sheila was seeking a moment which would help her stop drinking: *'maybe one time... ~~I'll come and~~ something'll click.'* Trevor, in contrast, had stopped drinking completely, describing a particular incident which had led him to say *'enough was enough'*, but this was within an overall narrative of ongoing struggle; *'battling every day to stay on the straight and narrow.'*

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

### Personal narratives

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

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

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

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6 By describing themselves in this way, Bill and John open up a distinction between  
7 themselves as they have been and themselves as they are, creating a context for a story of  
8 personal growth and change.  
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11 For two participants, prioritising self-discovery meant a change in their approach to  
12 personal relationships. Helen presents her recovery as an opportunity to connect with her  
13 true self:  
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16 *I think my whole life has been... relying on other people and relying on*  
17 *relationships to keep me happy. Rather than ever look at myself and realise*  
18 *that I need to do that for myself...So, this is a time for me.*  
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21 Helen had lost her relationship, her home and her job and was living in a shared property.  
22 By emphasising her journey of self-discovery she is able to present this change as an  
23 important and temporary transition to a better future.  
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26 Mark had previously been in relationships with women who misused alcohol, and was in a  
27 new relationship with a woman who was also in recovery. However, he described recovery  
28 as his priority; *'if one of us was to mess up, we've both agreed that we'd just walk away'*.  
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### 30 31 32 The role of mental health and substance misuse services 33

#### 34 35 Barriers to recovery 36

37 Nine participants talked about negative experiences of services, with four participants  
38 focussing on the local Community Mental Health Team as not meeting their expectations for  
39 support. Trevor's experience was of a declining service:  
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42 *The psychiatric nurse I had [seventeen years ago], she was brilliant, but*  
43 *there's nothing like that now. I can't even keep my own care co-ordinator to*  
44 *talk to, cos they said the services are so overstretched.*  
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47 Sarah, Sheila and Trevor all wanted the Community Mental Health Team (CMHT) to provide  
48 more practical and ongoing support. This was contrasted with the Crisis/Home Treatment  
49 Team (CRHT), who will *'come out and talk to you'* (Sheila), and particularly with the  
50 substance misuse service in which the interviews took place.  
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6 Other participants experienced mental health professionals as taking a punitive approach  
7 towards them because of their alcohol use. John said of a meeting with a psychiatrist 'I've  
8 had softer interviews with the police'; Steve said 'I think as an alcoholic and a mental health  
9 patient, you get dragged into stereotype. A lot of people will say, well, while you're drinking  
10 we can't help you.'

### 16 Facilitators of recovery

17 Every participant reported some benefit to engaging with mental health or substance  
18 misuse services. Sarah, for instance, had described being unable to cope with basic tasks  
19 following the death of her violent and controlling husband. She emphasises the practical  
20 respite provided by acute admission more than any medical or psychological support which  
21 was available:  
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25 *Being in [psychiatric hospital], that did give me time to reflect on what I was*  
26 *doing. I just found it so relaxing you hadn't got to worry about bills...*

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28  
29 Similarly, step-by-step practical support was central to the value of the substance misuse  
30 team for Sarah:

31  
32 *[Substance misuse service] have been a big support to me.... It's right, this*  
33 *week's task is to learn to use the electric meter, next week's task, learn the*  
34 *gas meter. They put me in touch with [local housing and support service].*

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

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

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47 Similarly, Bill said of services 'They can see you changing, when you don't', and Gary said he  
48 wouldn't 'throw it back in their face' by drinking. Maintaining his recovery has become a  
49 way of repaying the trust and concern of others.  
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Seven participants described a therapeutic relationship with a particular professional as a key part of their recovery. In most cases this was their keyworker at the substance misuse service. Laura's story of her past was one of powerlessness and not being able to trust others, particularly men. Now, however, she can use the image of her keyworker to soothe her distress:

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

It was important to Laura that her keyworker has the knowledge and skills to help her with her trauma symptoms. Other participants reported benefits from specific therapeutic interventions, such as Eye-Movement Desensitisation Response (EMDR; Gary) and Dialectical Behaviour Therapy (DBT; Helen).

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

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

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

#### Community and family narratives

Two participants told stories which were largely characterised by loss and struggle, but with elements of recovery present, including stopping or reducing drinking, and establishing more stable mental health. The recovery elements of both these stories drew heavily on the idea of having to keep recovery going for significant others, especially close family. Bill, for instance, speaks of a sense of self that is primarily one of loss, especially of his masculine



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6 identity as someone able to do manual work. When talking about why he keeps going with  
7 recovery, Bill says:

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

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14 Similarly, Trevor said that *'My eldest son actually accesses the mental health services as*  
15 *well... so I've had to keep myself going for him... You know, I've had to do it.'* Trevor's  
16 difficulties become part of how he can be a supportive father, reinforcing his commitment  
17 to recovery and distancing himself from his past self.  
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#### 20 21 22 Peer support

23 Four participants referred to peer support as part of their story of recovery, describing how  
24 the narratives of these communities had helped them change. John reflects on how shared  
25 experience helps him identify with others in peer support groups:  
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29 *It's sitting there with somebody else who's been in the same situation... You*  
30 *tell them your stories and then they'll tell you... theirs. And the events might*  
31 *have been one chalk, one cheese. But the feelings in the middle are all the*  
32 *same.*  
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35 John creates a story in which the essential part of his experience is shared by others,  
36 allowing him to identify with the values of the peer support group. Similarly Mark talks  
37 about how he has come to embrace the Alcoholics Anonymous (AA) approach to abstinence  
38 from alcohol, saying *'My sobriety now is the most important thing in my life.'* Belonging to  
39 the AA community helps Mark identify with abstinence as a community value rather than  
40 merely an individual decision.  
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#### 46 Dominant cultural narratives; changing identity in relation to labels and diagnoses

47 Participants differed in how they related to the labels and diagnoses that can follow from  
48 mental health difficulties and alcohol misuse. Helen embraced her diagnosis of Borderline  
49 Personality Disorder (BPD), but objects to being labelled an *'alcoholic'*:  
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*I went for a diagnosis. A lot of people are scared to get a diagnosis, but for me, to get a diagnosis meant that I could now start looking after my mental health and put the trust in mental health services... I'm not willing to have a label as an alcoholic.... I think I'm someone that has relied heavily on alcohol to deal with emotional upset.*

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Helen takes control of the narrative around her diagnosis. She distances herself from stereotypes around mental health and alcohol misuse, refusing to be defined by cultural perceptions of those labels. For Helen, having a mental health diagnosis (BPD) allowed her access to services and gave her a label she considered more desirable than 'alcoholic'.

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

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

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

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Mark takes two positions in relation to mental health, contrasting his mental health issues with the 'real' difficulties of people with psychosis, but later objecting when he finds the Crisis Team's narrative about mental health excludes his distress.

## 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 **Discussion**

The findings were consistent with existing literature in showing that participants followed varied pathways to recovery, with services, personal growth, family, mutual aid, and economic security all playing a role. There was a common pattern in the recovery narratives, from a traumatic past, through a phase of change, to an ongoing recovery phase. Central to this was gaining a sense of themselves as 'normal' that they had never previously had, through what could be called a narrative of transformation. Narratives of greater transformation tended to have a clearer structure, with a more defined episode of change.

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7 This linear account of the process of recovery contrasts with the cyclical structure of the  
8 transtheoretical model of change (Prochaska & DiClemente, 1986) which has been proposed  
9 as a model for mental health recovery (Leamy et al., 2011).  
10

11 The key episode of change which featured in many participants' narratives is, of course, a  
12 common narrative feature (Ollershaw & Creswell, 2002), and as such may reflect a  
13 methodology which elicited stories. It is nonetheless significant in showing that participants  
14 experienced recovery as involving a shift in personal identity. The idea of the 'normal'  
15 seems especially important to understanding how this shift was achieved. Early trauma and  
16 social exclusion meant participants' stories started outside of 'normal'. Alcohol use  
17 appeared to offer participants the chance of normality through social acceptance and  
18 respite from trauma symptoms, but the development of problematic alcohol use simply  
19 exacerbated the experience of exclusion. Recovery, then, involved a redefinition of past  
20 alcohol use. Some participants used a mental health diagnosis to position their drinking as a  
21 symptom of mental difficulty rather than moral failure. For others, membership of a  
22 recovery community provided a shared validation of their experience. The reduction or  
23 elimination of alcohol use formed only part of the story; it was also necessary for people to  
24 create a new account of themselves in which their difficulties with alcohol could be  
25 acceptable. This echoes previous findings about the significance of stigma as a barrier to  
26 recovery (Ness, Borg and Davidson, 2014), and shows some possibilities of how stigma can  
27 be overcome.  
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37 Services played a key role in the change and ongoing recovery phases of many participants'  
38 narratives; this included acute hospitals, Crisis/Home Treatment Teams, CMHTs and  
39 substance misuse services. Participants valued individualised, flexible and practical support.  
40 Where participants had less helpful experiences of services this related to barriers to access  
41 or a lack of flexible and ongoing support in mental health services, echoing previous findings  
42 on implicit and explicit barriers to support for this group (Edland-Gryt & Skatvedt, 2013).  
43 These findings are also consistent with existing literature in showing that ongoing,  
44 supportive and trusting relationships with a key professional was central to many  
45 participants' recovery (Brekke et al., 2017b), and previous research on the use of a  
46 professional as a positive attachment figure in substance misuse recovery (Waters, Holttum,  
47 Perrin, Campus, & Wells, 2014). An additional finding is the importance of specialist  
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6 therapies, which were mentioned by several participants as a central step in their recovery.  
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8 This suggests that despite the weakness of evidence for the effectiveness of psychosocial  
9 interventions for people with dual diagnosis (Hunt et al., 2013), therapeutic input may be  
10 helpful on an individual basis as part of a wider process of recovery.  
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#### 14 **Reflexivity: the situation of these narratives**

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16 Narratives are always told in a particular place, to an audience, for a purpose (Clandinin &  
17 Connelly, 2000). For the participants, there were several possible purposes in telling their  
18 story. This could include fulfilling a sense of generosity or obligation to the service or their  
19 keyworker; taking an opportunity to give feedback about services; positioning themselves as  
20 an expert by virtue of their experiences. These and other purposes will have influenced the  
21 narratives produced. Similarly the researcher had purposes in hearing the story, such as  
22 proving himself as a competent researcher. The researcher's previous experience as an  
23 alcohol practitioner in a substance misuse service will also have shaped the analysis.  
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#### 28 **Strengths and limitations**

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30 A strength of this study is its originality in exploring the recovery narratives of a population  
31 which is overlooked by much previous research. This is especially significant given the size  
32 of this population, the stigma and disadvantage associated with these difficulties, and the  
33 fragmented nature of service provision. By using narrative methodology, the study has  
34 produced findings which link individual experiences such as childhood trauma with wider  
35 social and cultural forces and the role of services in recovery.  
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40 The recruitment strategy was an area of both strengths and weaknesses. By recruiting from  
41 an agency which allowed self-referral, and on the basis of service use rather than diagnostic  
42 criteria, the study was able to reach people with a range of mental health difficulties  
43 alongside alcohol misuse. The inclusion criteria introduce an ethical tension into the  
44 recruitment strategy by including the consideration of whether the individual was too  
45 'vulnerable' to take part in an interview about their life story. As vulnerability is hard to  
46 define, this meant the researcher was attempting to balance the risk of exploitation of a  
47 vulnerable individual against the risk of perpetuating the exclusion of the voices of people  
48 deemed most vulnerable from the literature (Smith, 2008). As the researcher had clinical  
49 experience in the field and pre-existing working relationships with the keyworkers who  
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6 recruited the participants, he was in a good position to achieve this balance, but weaknesses  
7 in the recruitment strategy remain. For instance, the study excluded people who recover  
8 outside of services, replicating a shortcoming of much research in this area.  
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11 Other limitations relate to the analysis. By analysing only transcripts of recorded interviews,  
12 the study neglected the possible benefits of using wider narrative materials such as diaries,  
13 photographs or film (Andrews, Squire, & Tamboukou, 2013). Participant verification of  
14 narratives was not used, limiting the extent to which the study can claim to be empowering  
15 of its participants. The study is also acknowledged to be the product of a particular context,  
16 so the generalisability of its findings is necessarily limited.  
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### 23 **Conclusions**

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25 This paper explored the process of recovery of people with co-occurring difficulties, with a  
26 particular focus on how the social meaning of alcohol misuse impacted on this process.  
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#### 28 **Clinical implications**

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30 The prominent role of mental health and substance misuse professionals in participants'  
31 accounts of recovery could give professionals grounds for optimism that they can have a  
32 positive impact on this group, challenging pessimism about outcomes (Adams, 2008). The  
33 value participants placed on professionals having specialised therapeutic skills underlines  
34 the need for training in supporting with this complex population. In particular, the role of  
35 childhood trauma in the origins phase of so many participants' narratives suggests that skills  
36 in supporting people who have experienced trauma are essential for professionals working  
37 with this group. The social aspect of recovery as the achievement of belonging and being  
38 'normal' implies that practitioners need to recognise the role of societal, cultural and  
39 community factors as facilitators and barriers to recovery. At a service delivery level, the  
40 value placed on practical and material support highlights the importance of multi-agency  
41 working to meet material as well as therapeutic needs. The provision of specialist mental  
42 health support within a substance misuse service was important in several stories,  
43 underlining the often repeated recommendation that mental health and substance misuse  
44 services become more integrated.  
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### Future research

Future research could explore the impact of other specific substances on recovery. Another possibility for future research would be to involve participants more in the design and execution of the research, with the aim that the research creates a product which would be of direct value to participants and other service users. For instance, a book of core stories or poems illustrating experiences of recovery, which could become a resource for service users and staff.

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