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

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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. The purpose of this paper is to use a narrative approach to explore the process of recovery as an individual journey in a social context. It focuses on people who use alcohol in order to explore the impact of alcohol's specific cultural meanings on the recovery journey.

Design/methodology/approach – 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".

Research limitations/implications – 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 population in general, so this paper is able to investigate the specific challenges for this population.

Keywords Alcohol, Mental disorder, Recovery, Narrative

Paper type Research paper

Introduction

People with coexisting mental health and substance misuse difficulties face multiple disadvantages. They are often at risk of homelessness, offending, and economic deprivation (Marcus *et al.*, 2015); they face stigma and may have internalised a negative social identity (Manley, 2015). These difficulties are compounded by problems with accessing services. Substance misuse and mental health services in the UK have tended to operate separately. This requires people to negotiate two parallel service pathways, frequently encountering barriers to accessing either (Schulte *et al.*, 2008).

For people who do succeed in accessing a service, there are barriers to achieving a positive outcome. Many professionals feel unskilled when dealing with coexisting difficulties and may be overly pessimistic about the likelihood of positive outcomes (Adams, 2008; Weaver *et al.*, 2003). Further, the evidence for the effectiveness of specific psychosocial interventions with this

population is poor (Hunt *et al.*, 2013). Research in the UK and internationally has concluded that the division between mental health and substance misuse services is problematic and has recommended that services become more holistic and integrated (Carrà *et al.*, 2015). Existing UK policy reflects this, with NICE guidance recommending that existing specialist services should be adapted to serve this population effectively (National Institute for Clinical Excellence, 2016).

The concept of recovery appears to offer a principle for developing more integrated and person-centred services (Davidson and White, 2007). Recovery has been defined as an ongoing process of growth and personal change in which the person builds "a meaningful and satisfying life, as defined by themselves, whether or not there are ongoing or recurring symptoms or problems" (Shepherd *et al.*, 2008, p. 2). This understanding of recovery as a personal process is widely used in policy documents in both mental health and substance misuse services (Home Office, 2010; Department of Health, 2014), but shifting the orientation of services away from a focus on the clinical remission of symptoms remains a challenge. Slade *et al.* (2014) argue that the concept of recovery is "abused" in a number of ways, becoming a justification for service cuts or another framework for fitting people into service-defined ideas of "normal". Neale *et al.* (2015) explored how service users experienced recovery differently from care providers. For service users, recovery was experienced as "often more about 'coping' than 'cure'"; about managing rather than eliminating difficult experiences.

Since personal recovery is an ongoing process rather than a specific outcome, research into service users' experience of this process is essential. Leamy *et al.*'s (2011) systematic review of first-person perspectives on mental health recovery identified stages in recovery which, they suggest, map onto the five-stage transtheoretical model of change (Prochaska and DiClemente, 1986). The authors suggest that more research is needed on how social power impacts on recovery. The idea that recovery is not just an individual journey but also a social process of "restoring a meaningful sense of belonging to one's community" (Davidson and White, 2007) may be particularly relevant to people with coexisting difficulties, who face additional barriers and stigma.

This paper takes a social constructionist approach to the understanding of experiences of recovery, aiming to explore how people construct an account of their personal recovery journey using available narratives. Previous studies of first-person accounts of recovery from coexisting difficulties have found that recovery is experienced as a personal journey towards a new identity. This may involve expressing and revising stories of early experience (Elison *et al.*, 2016), unravelling painful life events (Brekke, Lien, Davidson and Biong, 2017), and taking responsibility for past choices (Hipolito *et al.*, 2011). Some studies found that people experience a new sense of meaning which may have a spiritual dimension (Whitley, 2012). The importance of material security through secure housing and, for some, employment, is also noted (Brekke, Lien, Davidson and Biong, 2017; Marcus *et al.*, 2015).

Two recent reviews provide a thorough account of the current literature overall. Ness *et al.*'s (2014) review of facilitators and barriers in dual recovery emphasises the diversity of recovery experiences. The authors recommend that services take into account the individual pathways that people may follow to recovery, and the stigma that they often face. De Ruysscher *et al.*'s (2017) systematic review of first-person perspectives on dual diagnosis identifies four overarching themes. These are: the importance of family and peer support and community participation; the need for holistic treatment with a long-lasting therapeutic relationship; the importance of personal beliefs, goals and spiritual values; and the value of meaningful activities. They note, however, that while the existing literature explores the meaning of recovery for people with co-occurring difficulties, it does little to examine recovery as a process. It is this omission that this paper will attempt to address, through a qualitative exploration of recovery in co-occurring difficulties which charts not just what people mean by their recovery, but how they recovered, and how services facilitated or hindered their recovery.

This paper also aims to address a gap in the current literature with a substance-specific focus on alcohol misuse. The social nature of recovery means that the culturally specific meanings of substances may impact on people's recovery journeys. Alcohol, as a widely available and legal

substance with a long tradition of consumption in the UK, has a range of distinctive cultural meanings to do with the formation and maintenance of individual and group identities (Emslie *et al.*, 2015). People with mental health difficulties who misuse alcohol may make specific identity shifts in recovery compared with those who misuse other substances. Though the experiences of people with coexisting mental health and alcohol difficulties are present in the existing literature, a survey of the papers reviewed by Ness *et al.* (2014) and De Ruysscher *et al.* (2017) shows that in many cases the substances used by the participants are not specified. Even when the substance or substances used are identified, there is no exploration of what impact this has on the recovery process. This paper aims to address this in the case of alcohol, by recruiting specifically people who misused alcohol and exploring the role of alcohol in their recovery narratives.

Method

Narrative research

Narrative research draws attention to how people achieve changes in personal identity by re-presenting their story to themselves and to others, drawing upon the wider stories, or narratives, that are available in their social and cultural context (Wood, 1991). The narrative approach in this study draws on Clandinin and Connelly's (2000) metaphor of a three-dimensional narrative inquiry space. The first dimension is the interaction between the personal and the social; how people tell their individual story by drawing on the social narratives that are available to them. Here this dimension is investigated by adapting Rappaport's (1995) model of levels of influential context, which highlights three levels of narrative. Dominant cultural narratives pervade social institutions and the mass media; cultural stereotypes around alcoholism, for instance, occur at this level. Community narratives are the stories shared by social groups or within organisations or families. In this study, the participants' narratives of mental health and substance misuse services are given particular attention, since one of the aims of the study is to identify the role of services in people's narratives of recovery. Personal narratives are stories of individual experience which will draw on available community and cultural narratives.

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

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

Research setting

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

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. In total, 17 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 (CMHTs), Crisis/Home Treatment Teams (CRHTs) 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.

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

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 I shows their pseudonyms and basic demographic information.

Procedure

Unstructured interviews were used in order to allow participants to structure their story of recovery around the events and causal links that were important to them. The researcher's understanding of recovery as an ongoing process was included in the introduction to the interview, with the researcher telling participants: "I am interested to hear about the story of your recovery. How your story started, what happened, what influenced you and where you are now. I am also interested in what part mental health services and alcohol services have played in your

Table I 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 focused on use of services. The mental health column therefore gives the labels or diagnoses which the participants themselves referred to in the interviews. The same applies to the additional substances column

story". Further questions and prompts were used if necessary; often to ask a participant to expand on a part of their story, or to fill in a gap in the story. All interviews were conducted by the researcher at the substance misuse service and were audio-recorded. The mean duration of the interviews was 43 minutes (range 20-61 minutes).

Transcription and analysis

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

"Subplots" were then identified within the remaining text, subplots being the key idea of a part of the story which produces meaning in the context of the story as a whole (Emden, 1998). Fragments of text were grouped together in subplots, with repetitious content deleted. The subplots themselves were reordered chronologically to create an overall core story of about a quarter of the length of the original transcripts. This followed the "restorying" approach of Ollerenshaw and Creswell (2002), emphasising the continuity of the participant's story.

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

Findings

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

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

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

Narratives about the origins of difficulties

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 (BPD):

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

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

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

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

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

Four participants did not give an account of a particular episode of change 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 […] 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).

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

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

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

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

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

The role of mental health and substance misuse services. Barriers to recovery. Nine participants talked about negative experiences of services, with four participants focussing on the local CMHT as not meeting their expectations for support. Trevor's experience was of a declining service:

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

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

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

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

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

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

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

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

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

Similarly, Bill said of services "They can see you changing, when you don't", and Gary said he wouldn't "throw it back in their face" by drinking. Maintaining his recovery had become a way of repaying the trust and concern of others.

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

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

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 (Gary) and Dialectical Behaviour Therapy (Helen).

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

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

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

Community and family narratives. Two participants told stories which were largely characterised by loss and struggle, but with elements of recovery present, including stopping or reducing drinking, and establishing more stable mental health. The recovery elements of both these stories drew heavily on the idea of having to keep recovery going for significant others, especially close family. Bill, for instance, speaks of a sense of self that is primarily one of loss, especially of his masculine identity as someone able to do manual work. When talking about why he keeps going with recovery, Bill says:

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

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

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

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

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

Dominant cultural narratives: changing identity in relation to labels and diagnoses. Participants differed in how they related to the labels and diagnoses that can follow from mental health difficulties and alcohol misuse. Helen embraced her diagnosis of BPD, but objects to being labelled an "alcoholic":

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

Helen 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".

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

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

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

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

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

The key episode of change which featured in many participants' narratives is, of course, a common narrative feature (Ollerenshaw and Creswell, 2002), and as such may reflect a methodology which elicited stories. It is nonetheless significant in showing that participants experienced recovery as involving a shift in personal identity. The idea of the "normal" seems especially important to understanding how this shift was achieved. Early trauma and social exclusion meant participants' stories started outside of "normal". Alcohol use appeared to offer participants the chance of normality through social acceptance and respite from trauma symptoms, but the development of problematic alcohol use simply exacerbated the experience of exclusion. Recovery, then, involved a redefinition of past alcohol use. Some participants used a mental health diagnosis to position their drinking as a symptom of mental difficulty rather than

moral failure. For others, membership of a recovery community provided a shared validation of their experience. The reduction or elimination of alcohol use formed only part of the story; it was also necessary for people to create a new account of themselves in which their difficulties with alcohol could be acceptable. This echoes previous findings about the significance of stigma as a barrier to recovery (Ness *et al.*, 2014), and shows some possibilities of how stigma can be overcome.

Services played a key role in the change and ongoing recovery phases of many participants' narratives; this included acute hospitals, CRHTs, CMHTs and substance misuse services. Participants valued individualised, flexible and practical support. Where participants had less helpful experiences of services this related to barriers to access or a lack of flexible and ongoing support in mental health services, echoing previous findings on implicit and explicit barriers to support for this group (Edland-Gryt and Skatvedt, 2013). These findings are also consistent with existing literature in showing that ongoing, supportive and trusting relationships with a key professional was central to many participants' recovery (Brekke, Lien and Biong, 2017), and previous research on the use of a professional as a positive attachment figure in substance misuse recovery (Waters *et al.*, 2014). An additional finding is the importance of specialist therapies, which were mentioned by several participants as a central step in their recovery. This suggests that despite the weakness of evidence for the effectiveness of psychosocial interventions for people with dual diagnosis (Hunt *et al.*, 2013), therapeutic input may be helpful on an individual basis as part of a wider process of recovery.

Reflexivity: the situation of these narratives

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

Strengths and limitations

A strength of this study is its originality in exploring the recovery narratives of a population which is overlooked by much previous research. This is especially significant given the size of this population, the stigma and disadvantage associated with these difficulties, and the fragmented nature of service provision. By using narrative methodology, the study has produced findings which link individual experiences such as childhood trauma with wider social and cultural forces and the role of services in recovery.

The recruitment strategy was an area of both strengths and weaknesses. By recruiting from an agency which allowed self-referral, and on the basis of service use rather than diagnostic criteria, the study was able to reach people with a range of mental health difficulties alongside alcohol misuse. The inclusion criteria introduce an ethical tension into the recruitment strategy by including the consideration of whether the individual was too "vulnerable" to take part in an interview about their life story. As vulnerability is hard to define, this meant the researcher was attempting to balance the risk of exploitation of a vulnerable individual against the risk of perpetuating the exclusion of the voices of people deemed most vulnerable from the literature (Smith, 2008). As the researcher had clinical experience in the field and pre-existing working relationships with the keyworkers who recruited the participants, he was in a good position to achieve this balance, but weaknesses in the recruitment strategy remain. For instance, the study excluded people who recover outside of services, replicating a shortcoming of much research in this area.

Other limitations relate to the analysis. By analysing only transcripts of recorded interviews, the study neglected the possible benefits of using wider narrative materials such as diaries, photographs or film (Andrews *et al.*, 2013). Participant verification of narratives was not used,

limiting the extent to which the study can claim to be empowering of its participants. The study is also acknowledged to be the product of a particular context, so the generalisability of its findings is necessarily limited.

Conclusions

This paper explored the process of recovery of people with co-occurring difficulties, with a particular focus on how the social meaning of alcohol misuse impacted on this process.

Clinical implications

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

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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