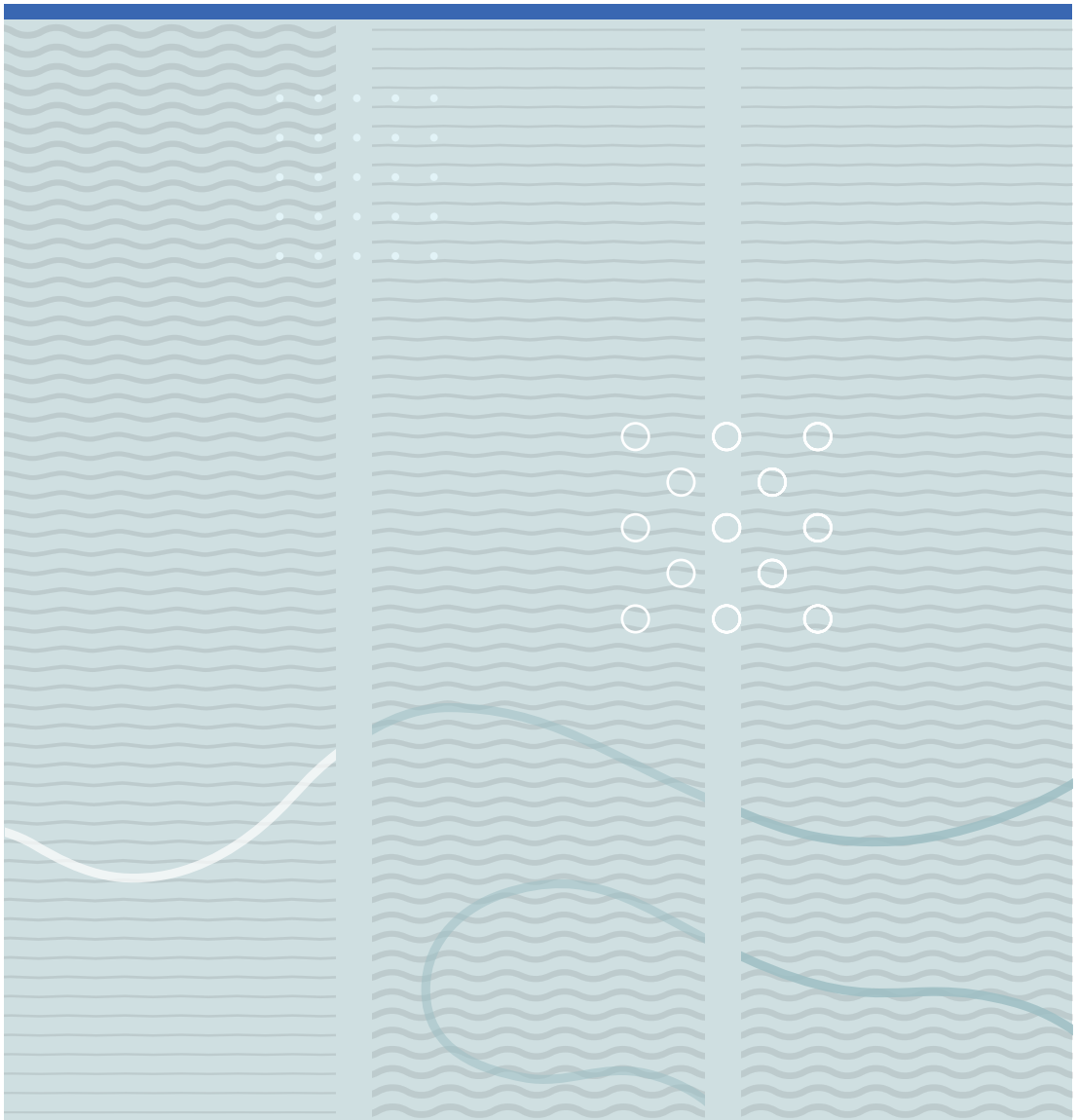


Eva Brekke

Recovery in co-occurring mental health and substance use disorders: A qualitative study of first-person and staff experiences





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**Recovery in co-occurring mental health
and substance use disorders:
A qualitative study of first-person and
staff experiences**

A PhD dissertation in
Person-Centred Healthcare

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Faculty of Health and Social Sciences
University of South-Eastern Norway
Drammen, 2019

Doctoral dissertations at the University of South-Eastern Norway no. 40

ISSN: 2535-5244(print)

ISSN: 2535-5252 (online)

ISBN: 978-82-7860-384-0 (print)

ISBN: 978-82-7860-385-7 (online)



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Print: University of South-Eastern Norway

*Did you want to see me broken?
Bowed head and lowered eyes?
Shoulders falling down like teardrops,
Weakened by my soulful cries?*

*Does my haughtiness offend you?
Don't you take it awful hard
'Cause I laugh like I've got gold mines
Diggin' in my own backyard.*

*Leaving behind nights of terror and fear
I rise
Into a daybreak that's wondrously clear
I rise*

From: Maya Angelou, And Still I rise, 1978

Acknowledgements

The work presented in this thesis was conducted between November 2015 and April 2019, and is the result of the generous contributions and support from many people and institutions.

Firstly, I would like to thank the people who participated in the two studies. Their willingness to share their lived experiences was crucial to the entire project.

I would also like to thank my main supervisor, Professor Stian Biong, for his empowering attitude, timely advice, genuine engagement, intellectual challenges, and personal kindness throughout the process.

I also wish to thank my other supervisor, Professor Lars Lien, for his pragmatic optimism, skilled advice, and persistent confidence in my ability to accomplish the different parts of the project.

I am very grateful to the members of the advisory group: Morten Brodahl, Tore Vold Klausen, Thomas Kulbrandstad, Kårhild Husom Løken, Kari Nysveen, Jon Arnfinn Stensønes, and Sunniva Skar Tangen. Their experience, goodwill, wisdom, and boldness in challenging my ideas have enabled a learning process within the project. I miss our meetings and remember them with gratitude. Thanks to the Sagatun user-led centre in Hamar for splendid lunch and accommodation at the meetings, and for their help in the recruitment process.

I am thankful for being part of the Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders. My thanks go to the leader of services, Professor Lars Lien, and to the head of research, Professor Anne Landheim, for building an innovative and supportive research environment. Thanks to my fellow PhD candidates and other colleagues.

Thanks to the University of Southeast Norway for accepting me as a PhD student. Thanks to Program director of the PhD program in person-centred healthcare, Professor

Kirsti Skovdahl and Administrative coordinator Elin Nordbø for support and help. Thanks to Professor Hilde Eide and Professor Brendan McCormack for their introduction to person-centred healthcare at USN, and to the other PhD candidates for support and inspiration. Thanks to the library services for all their help.

Thanks to The Inland Hospital Trust for financing the project. A special thanks to Kari Lillehaug of the Research Department for administrative and practical support, and to the library services for their support.

Thanks to Professor Larry Davidson and Kari Nysveen for valuable contributions as co-authors on the first and third articles, and to Professors Ottar Ness and Alain Topor for their inspiring feedback during the interim evaluation.

Thanks to the local authority area for generous facilitation in conducting the project. A special thanks to the leader of services, team leaders and team members.

Thanks to my leaders and colleagues in the Flexible Assertive Community Treatment team at Gjøvik District Psychiatric Centre for their support and encouragement in the last phase of the project.

Thanks to my friends and family for their support and love.

Last, but not least, thanks to my husband Leonardo for always supporting me, and to our children Sara and Ingrid for reminding me of what really matters in life.

Abstract

People with co-occurring mental health and substance use disorders (COD) face challenges related to living conditions, community participation, and a lack of tailored and integrated health and social services. Recovery and person-centred approaches allow for an understanding of COD that is grounded in each individual person and his or her context, where lived experience is seen as a valued source of knowledge. There is a need for knowledge of how recovery and professional help are experienced by people with COD in different contexts. While recovery-oriented practice is recommended through national guidelines, there is little knowledge of how such practice works at the service delivery level. Knowledge is also needed on how practitioners experience recovery-oriented practice to support people with COD.

This thesis has sought to contribute to the scientific knowledge on recovery and recovery-oriented practice in COD, with a particular focus on community services, by describing and exploring the lived experiences of people with COD and practitioners who work to support recovery in this group. An overarching purpose of the project was to make these lived experiences visible to decision makers in the field. The first aim was to explore and describe experiences of recovery among people with COD. The second aim was to explore and describe behaviour and attributes of professional helpers that support recovery, as experienced by people with COD. The third aim was to explore and describe practitioners' experiences with dilemmas in recovery-oriented practice to support people with COD.

This project is influenced by phenomenological and collaborative methodology and consists of two qualitative studies. Study 1 consisted of eight individual, in-depth, interviews with people with COD, which were analysed with systematic text condensation. Study 2 consisted of three focus group interviews with practitioners in a municipal mental health and addictions team that was committed to developing recovery-oriented practice. The interviews in Study 2 were analysed using thematic analysis. Both studies were conducted in the same local authority area in Norway. An

advisory group with people from the community with lived experience of COD, experience as family members, and professional experience has been involved in the project throughout.

Results from this project support findings from other qualitative studies which indicate that control over symptoms may be a pathway to, but not the essence of, recovery. Systematic investigation of first-person experiences in this project has painted a broader picture of recovery in COD, which includes community participation, living conditions, and existential phenomena. Community participation, particularly feeling useful, may be a central facilitator in recovery. Adverse living conditions and loneliness may be important barriers to recovery in COD. There were individual differences in how participants related to substance use, but control over substance use seemed necessary in the process of coming to love oneself and emerging as a person.

Professional helpers may play a central role in the recovery process once a trusting relationship has been established. Professional helpers' ability to understand and act on people's everyday struggles, and to address substance use in a competent and straightforward way, appear as specific valued attributes in professional helpers by people with COD.

Practitioners described dilemmas in recovery-oriented practice to support people with co-occurring disorders; these involved how to relate to substance use in a recovery-oriented way, how to give enough help and still facilitate empowerment, and how to relate to people's own life goals with neither moralism nor indifference. People with COD were described as expecting too little from services and tolerating unacceptable living conditions, which elicited directiveness from practitioners.

This thesis concludes that a better life is possible for people with COD. While perceptions of a good life are similar to, and equally diverse as, perceptions in the general population, the degree of adverse living conditions and the amount of barriers in solving them seem particular to this group of citizens. In order for professional helpers to support recovery for people with COD, a trusting relationship is fundamental.

Practitioners may experience dilemmas in recovery-oriented practice to support people with COD. Different traditions of understanding substance use may lead to different understandings of what it means to address substance use in a recovery-oriented way.

Results from this thesis suggest that services to people with COD need to be flexible, integrated and allow for continuity. Professional helpers and services should be able to address living conditions and loneliness, and increase opportunities for genuine community participation for people with COD. Services should be able to address substance use in competent and individualised ways.

Keywords: recovery, co-occurring disorders, lived experiences, qualitative methods, collaborative research

List of papers

Article 1

Brekke, E., Lien, L., Davidson, L. & Biong, S. (2017). First-person experiences of recovery in co-occurring mental health and substance use conditions. *Advances in Dual Diagnosis*, 10 (1), 13-24.

Article 2

Brekke, E., Lien, L. & Biong, S. (2018). Experiences of professional helping relations by persons with co-occurring mental health and substance use disorders. *International Journal of Mental Health and Addiction*, 16 (1), 53-65.

Article 3

Brekke, E., Lien, L., Nysveen, K. & Biong, S. (2018). Dilemmas in recovery-oriented practice to support people with co-occurring mental health and substance use disorders: a qualitative study of staff experiences in Norway. *International Journal of Mental Health Systems*, 12 (1), 30.

Definitions and abbreviations

Recovery: A personal and social process of positive life change, which may or may not include symptom reduction

Co-occurring disorders / Co-occurring conditions (COD): Co-occurring mental health and substance use problems with a strong impact on everyday life

Maintenance treatment: Substitution treatment of opioid dependency with buprenorphine or methadone

AA: Alcoholics Anonymous

NA: Narcotics Anonymous

ACT: Assertive Community Treatment

FIT: Feedback Informed Treatment

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1 Introduction

This thesis consists of two qualitative studies which sought to describe and explore (a) first-person experiences of recovery, and of professional help that supports recovery, in co-occurring mental health and substance use disorders (COD), and (b) practitioners' experiences with recovery-oriented practice to support people with COD. Both studies were conducted in an average-sized local authority area in Norway.

Many people live with both mental health and substance use problems, and such problems show a high degree of co-occurrence (European Monitoring Centre for Drugs and Drug Addiction, 2013; Grant et al., 2004; Landheim, Bakken, & Vaglum, 2002; Mueser et al., 2000; Westermeyer, 2006). However, the research literature tends to treat mental health and substance use problems separately, and this also applies to health and social services (Landheim et al., 2002).

Norwegian primary health care is run by local authorities, whereas hospital trusts are responsible for secondary and tertiary care. Specialised services are divided into physical health services, mental health services, and specialised substance use services. The 422 local authorities in Norway have a large degree of freedom in deciding how to organise mental health and substance use services, although official guidelines exist (Helsedirektoratet, 2014). In Norway, specialist and primary services have shared responsibility for treatment of people with serious and persistent mental health and substance use problems (Helsedirektoratet, 2014) and the Coordination Reform aims for a shift towards a greater degree of community health service provision (Helse- og omsorgsdepartementet, 2009). However, Norwegian local authorities report challenges in providing helpful services to people with COD, and governmental evaluations have concluded repeatedly that local services to citizens with COD are unsatisfactory. While integrated and coordinated services over time are recommended for people with COD (Helsedirektoratet, 2012; Mueser & Gingerich, 2013), implementation of such services has been difficult (Brunette et al., 2008), and fragmentation of services is recognised as a major challenge to recovery for this group of citizens (Helse- og

omsorgsdepartementet, 2011; Landheim, Hoxmark, Aakerholt, & Aasbrenn, 2017; van der Steel, 2015).

'Recovery' has been suggested as an organising principle for the integration of mental health and addiction services (Davidson & White, 2007), and recovery-oriented practice is recommended in Norwegian practice guidelines for COD (Helsedirektoratet, 2012, 2014). While different definitions and understandings of 'recovery' exist, the recovery movement has aimed to promote citizenship and civil rights, to make services beneficial from the perspective of service users, and to allow for an understanding of recovery as more than symptom reduction (Davidson, Rakfeldt, & Strauss, 2010). Several recent publications have addressed recovery-oriented practice, mostly based on international literature (Borg, Karlsson, & Stenhammer, 2013). However, recovery has been understood differently within mental health and substance use services (Roberts & Bell, 2013), and there is no clear consensus on how recovery orientation should be operationalised in Norwegian local health and social services to support people with COD.

There has been a recent growth in service user involvement in research into mental health and substance use, and increasing awareness of the benefits of multi-stakeholder perspectives (Neale et al., 2016; Rose, Thornicroft, & Slade, 2006). Collaborative approaches to knowledge development are prevalent in recovery research, along with an acknowledgment of first-person experiences as a valid source of knowledge. First-person accounts have challenged the belief that people with certain diagnoses are too ill to be involved in decision making, and have brought attention to how mental health problems occur in everyday life (Borg & Karlsson, 2016). While first-person accounts are increasingly informing the understanding of recovery in mental health and substance use respectively, there is less knowledge about how recovery is experienced by people who live with COD, and existing literature tends to treat recovery in mental health and substance use separately. There is a need for research that explores lived experiences of recovery in COD in different contexts (De Ruyscher,

Vandavelde, Vanderplasschen, De Maeyer, & Vanheule, 2017; Roberts & Bell, 2013; Slade et al., 2014; Thylstrup, Johansen, & Søndersby, 2009).

Although recovery may occur regardless of formal treatment (Klingemann & Sobell, 2007), many people with COD form relationships with professional helpers. While psychotherapy research has described common factors that affect the impact of therapy (Wampold & Imel, 2015), which have been suggested to apply to community mental health services as well (Kidd, Davidson, & McKenzie, 2017), there is little systematised knowledge of how these relationships are experienced by the service users. There is a need for research that addresses professional helping relations from the perspective of service users, including people with COD (Norcross & Wampold, 2011).

Studies from community mental health settings suggest that frontline professional helpers have less positive views of recovery orientation than leaders (Leamy et al., 2016), and exploring and describing challenges, paradoxes and dilemmas faced by practitioners, as well as solutions to these, may be a key to the successful implementation of recovery principles (Le Boutillier et al., 2011), and may highlight problematic issues associated with the implementation of such principles. We need knowledge about professional helpers' experience of recovery-oriented practice to support people with COD.

2 Aims and research questions

This thesis seeks to contribute to the scientific knowledge on recovery and recovery-oriented practice in COD, with a particular focus on community services, by describing and exploring the lived experiences of people with COD and practitioners who work to support recovery in this group. An overarching purpose of the project is to make these lived experiences visible to decision makers in the field.

These aims led to the following research questions:

- 1: How do people with co-occurring disorders experience recovery?
- 2: How do people with co-occurring disorders experience relationships with professional helpers, and what behaviour and attributes of professional helpers support recovery?
- 3: How do practitioners in community mental health and addiction services experience dilemmas in recovery-oriented practice to support people with co-occurring disorders?

3 Theoretical background

In the following section, a conceptual and theoretical background of the thesis will be presented. The main theoretical foundations are recovery and person-centred theory. Following a general introduction to COD, these perspectives will be described in relation to the aims of the thesis and how they relate to each other. Finally, implications for definitions and research approach in the current project will be described.

3.1 Co-occurring disorders

‘Co-occurring disorders’, ‘dual disorders’ or ‘dual diagnosis’ are used to describe the state of living with mental health and substance use problems at the same time (World Health Organisation, 2010). With the acknowledgement that co-occurrence often involves more than two conditions, the term ‘co-occurring disorders’ is increasingly used to replace ‘dual disorder’ or ‘dual diagnosis’, although all terms are still applied synonymously. ‘Co-occurring conditions’ is sometimes also used interchangeably, particularly in British literature.

While the term ‘disorder’ points towards a more biomedical understanding which may be at odds with a recovery approach (Veseth, 2013), the term ‘co-occurring disorders’ has been used in this thesis because it is the most commonly applied term in the literature. In line with recovery and person-centred theory, COD is defined as “co-occurring mental health and substance use problems with a strong impact on everyday life”. This is in line with the definition that underpins the Norwegian National Guideline for Treatment of COD (Helsedirektoratet, 2012), where the level of functioning in everyday life receives greater attention than any particular diagnosis.

Prevalence studies that focus on diagnosis have shown a strong association of substance use problems with mental health problems (Alonso et al., 2004; European Monitoring Centre for Drugs and Drug Addiction, 2013; Grant et al., 2004; Landheim et al., 2002; Regier et al., 1990). Living with mental health problems increases the risk of

substance use problems, and vice versa (Dom & Moggi, 2015; Evjen, Kielland, & Øiern, 2018; Mueser & Gingerich, 2013). There is a higher prevalence of mental health problems among persons with substance use problems than in the general population, particularly among people with addiction (Grant et al., 2004; Kessler et al., 1997; Kringlen, Torgersen, & Cramer, 2001; Landheim, Bakken, & Vaglum, 2006). There is also a higher prevalence of substance use problems among persons with mental health problems, particularly among persons with psychotic illness or bipolar disorder (Regier et al., 1990). There is a higher rate of substance use problems among people who are in treatment for mental health problems (Helseth, Lykke-Enger, Johnsen, & Waal, 2009; Ringen et al., 2008), and among persons with first time psychosis (Larsen et al., 2006), than in the general population.

While there is a high degree of co-occurrence of mental health and substance use problems, this does not necessarily mean that these problems affect everyday life to a large extent. There are no clear figures for the prevalence of COD in the Norwegian population, and this depends on how COD is defined (Landheim et al., 2017). In a Norwegian national screening based on reports from practitioners in primary health and social services, all adult service users were rated on eight areas: housing, work/activity, economy, physical health, mental health, substance use, social functioning, and social network (Lie & Nesvåg, 2017). Based on this screening, it is estimated that around 6000 people in Norway are living with severe mental health and substance use problems and are in contact with municipal services (Lie & Nesvåg, 2017). The average prevalence was 17 persons with COD per 10000 inhabitants, with a slightly higher prevalence in smaller towns and rural areas, but with considerable variation. The figures from this screening are inexact, but give an approximate indication of how many people with COD local services are in contact with.

Living with COD is associated with adverse living conditions and poor physical health (Lie & Nesvåg, 2017). One in four homeless persons in Norway has COD, and people with COD are more likely to stay homeless for more than six months than others (Kommunal- og moderniseringsdepartementet, 2014). People with COD are also more likely to live in

temporary housing and to receive short-term social benefits rather than long-term benefits or regular income, and one in four persons with COD who received municipal services did not receive coordinated services (Lie & Nesvåg, 2017). Living with COD has been associated with lower levels of hope, resilience and well-being than living with substance use problems alone (Ujhelyi, Carson, & Holland, 2016). Mental health problems and substance use problems are more common among prison inmates than in the general population (Bukten et al., 2016), and findings from a Norwegian prison study suggest that greater accumulation of childhood stressors and socio-economic problems is associated with increased drug use and mental health problems (Friestad & Kjelsberg, 2009). Living with mental health and substance use problems is associated with lower life expectancy (Laursen et al., 2013; Wahlbeck, Westman, Nordentoft, Gissler, & Laursen, 2011), one reason for this being that physical health conditions such as cardiovascular disease or cancer go untreated (Hartz et al., 2014; Lawrence, Hancock, & Kisely, 2013). Separate mental health and substance use services have resulted in a lack of comprehensive, integrated treatment for COD, and people with COD have sometimes been excluded from mental health services (Brunette et al., 2008). Fragmented services may be perceived as irrelevant by people with COD, leading to a lack of trust in the system (Landheim et al., 2017). Further, people with COD may face negative attitudes by health professionals (Avery et al., 2013) and the general population (Bye, Herrebrøden, Hjetland, Røyset, & Westby, 2014).

While these figures may lead to pessimism regarding the opportunities for recovery in COD, recent development of integrated services for people with COD may allow for a more hopeful view (Mueser, Noordsy, Drake, & Fox, 2003; van Veldhuizen, 2007; Whitley, Gingerich, Lutz W, & Mueser, 2009). First-person accounts of recovery in COD also paint a more hopeful picture of the opportunities for a better life (Landheim, Wiig, Brendbekken, Brodahl, & Biong, 2016).

3.2 Recovery

The recovery movement began as a civil rights movement among people with mental health problems in the 1960s. It was a political protest against suboptimal services as well as stigma and suppression in society (Davidson et al., 2010). Ideologically, the recovery movement is closely related to human rights, as exemplified in the United Nations Convention on the Rights of People with Disabilities (United Nations, 2006), which was ratified in Norway in 2013. This convention states that people with mental or physical disabilities have equal rights to safety, participation, and access to services as other citizens. Adherence to this convention and to human rights in general is described as one of six underlying principles of the World Health Organisation's Mental Health Action Plan for 2013-2020 (World Health Organisation, 2013). Recovery is also related to health promotion, where 'health' is defined as "...a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities" (World Health Organisation, 1998, p.1).

3.2.1 Recovery in mental health

Eventually, 'recovery' has gained a foothold as an approach to understanding mental health which acknowledges that recovery is more than symptom reduction, that recovery takes place in everyday life, and that the person's own perspective is crucial. This approach to mental health is often contrasted with a traditional medical-psychiatric approach, and with the understanding of recovery as "returning to normal", i.e. symptom reduction that can be observed and rated by an expert. A distinction has been made between recovery *from* mental illness, indicating cure, versus recovery *in* mental illness, indicating enhanced quality of life regardless of cure (Davidson & Roe, 2007). The former understanding is often referred to as 'clinical recovery', where recovery is defined as an *outcome* in the sense of symptom relief, while the latter understanding sees recovery as a *process* (Borg & Karlsson, 2016).

When recovery research was initiated in North America in the 1970s and 1980s, recovery was primarily understood as a personal process, or journey (Borg et al., 2013; Deegan, 1996). A commonly cited definition of personal recovery is that of psychologist William A. Anthony: *“Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”* (Anthony, 1993, p. 15). Based on a systematic review and narrative analysis of the literature on personal recovery in mental health, Leamy and colleagues presented five central processes in personal recovery: connectedness, hope, identity, meaning, and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). This approach to recovery is akin to positive psychology, as it focuses on growth, resources and well-being in addition to the treatment of symptoms (Resnick & Rosenheck, 2006; Slade, 2010).

Some argue that in the integration of recovery into mental health services, too much emphasis is placed on recovery as a personal process, at the expense of recovery as a social process (Price-Robertson, Obradovic, & Morgan, 2017; Rose, 2014; Topor, Borg, Di Girolamo, & Davidson, 2011). Critics have warned that individualisation of services leads to ignoring structural factors such as poverty and discrimination, making recovery-oriented services most helpful to those who are well-situated (Rose, 2014). In order to avoid this, civil rights and citizenship still need to be at the core of the recovery movement (Davidson, 2006; Mezzina et al., 2006). One might differentiate between recovery as something that happens to and within an individual, and recovery as a social process that involves the larger community, where the person is an active participant (Topor et al., 2011). Seeing recovery as a social process involves recognising everyday life as the main setting for change (Borg & Davidson, 2008; Slade, 2012), while also acknowledging factors such as money and housing as crucial elements in recovery (Tew et al., 2012; Topor et al., 2011; Topor, Ljungqvist, & Strandberg, 2016), along with relations to other people (Price-Robertson et al., 2017; Topor et al., 2006). The definition of recovery as *“a process of restoring a meaningful sense of belonging to*

one's community and a positive sense of identity apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition" (Davidson et al., 2007, p. 25) recognises the community as a central part of recovery.

3.2.2 Recovery in substance use

Recovery has been understood differently within the fields of mental health and substance use. Although there is no clear consensus as to the definition of recovery in substance use (Corrigan, Schomerus, & Smelson, 2017; Laudet, 2007, 2008), there is increasing agreement that multi-stakeholder definitions are valuable, which is also reflected in research (Lancaster, 2017; Neale et al., 2016). The Betty Ford Institute Consensus Panel (The Betty Ford Institute Consensus Panel, 2007, p. 222) defined recovery as *"a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship"*. The UK Drug Policy Commission has defined recovery as *"voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society"* (UK Drug Policy Commission, 2008, p. 6). Both of these definitions involve the same three components: wellbeing and quality of life, community engagement and citizenship, and sobriety (Best & Laudet, 2010). The issue of sobriety in understandings of recovery in substance use has caused debate between different approaches (McKeganey, 2014), and has been contrasted to the focus of recovery *in* mental illness, where symptom reduction is not seen as a prerequisite for recovery (Roberts & Bell, 2013). Some have pointed out that a focus on abstinence as a measure of recovery may lead practitioners to overlook psychosocial recovery processes for people with COD, and to lose the understanding of recovery as a process (Thylstrup et al., 2009). The need to acknowledge individual differences in substance use recovery has been stressed in studies of first-person experiences (Neale et al., 2015). Changes in social identity have been suggested as important in recovery in substance use (Best et al., 2016). The United Nations recently published international guidelines on human rights and drug policy, where human

rights, dignity, and participation for people with substance use problems is demanded, regardless of sobriety (United Nations, 2019).

Different ideological approaches have been dominant and affected the substance use field. The control-political ideology, that aims for “zero tolerance” and criminalisation, and the illness-oriented ideology, that predicts submission to treatment with the goal of total abstinence, are two examples of such ideologies (Asmussen & Dahl, 2002). Further, a distinction is often drawn between treatment interventions aimed at total abstinence from substance use and interventions aimed at harm reduction, with or without substance use.

Abstinence-based approaches are rooted in the Alcoholics Anonymous (AA) movement, which arose in the United States in the 1930s among people who defined themselves as ‘alcoholics’. The first 100 members of AA wrote a book describing 12 steps to recovery, which has later been revised several times and translated into many languages (Alcoholics Anonymous World Services, 2010). Central aspects of these 12 steps are total abstinence from alcohol, acknowledgement of one’s own inadequacy, and spiritual transformation. The AA movement is prominent in many countries in the form of user-led communities as well as professional treatment programmes (Best et al., 2016). Norwegian treatment guidelines recommend the 12-step treatment as one of several approaches to substance use problems (Helsedirektoratet, 2017). The AA communities have been mentioned as a main source of inspiration for the recovery movement in mental health, because of their tradition of organising mutual aid independently of services (Davidson & White, 2007).

Harm reduction approaches are not opposed to a focus on abstinence, but recognise that it is not a realistic goal for everyone, at least not in a short-term perspective (MacMaster, 2004; Marlatt, 1996). These approaches are underpinned by pragmatic and humanistic values, and include a focus on reducing harm, making cost-benefit evaluations, and setting hierarchies of goals. A central aspect is that people do not need to abstain from substance use in order to access health and social services. Harm reduction has been most prevalent in services for people who inject or otherwise use

illegal substances, but not exclusively. These approaches date back to the 1960s, with needle exchange programmes and prescriptions of methadone, and their popularity increased in the 1980s and 1990s along with public health interventions aimed at reducing HIV infections (Asmussen & Dahl, 2002; MacMaster, 2004). In Norway, services within the harm reduction approach include for instance low-threshold services such as needle exchange and screening for Hepatitis C, special areas for the safe injection of substances where substance use is not criminalised, as well as maintenance treatment with methadone or buprenorphine for people with opioid addiction.

3.3 Person-centred theory

The person-centred approach is both an approach to clinical practice in health care, particularly nursing, medicine and psychology, and an approach to research in these and adjacent fields.

The World Health Organisation recently launched a strategy to make health services more people-centred, defining such services as *“an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care (...) is organized around the health needs and expectations of people rather than diseases”* (World Health Organisation, 2015, p. 10). McCormack and McCance (McCormack & McCance, 2011, 2016) have presented a framework for person-centred practice which includes a holistic approach, working with the patient’s beliefs and values, engagement, shared decision-making, and sympathetic presence. This framework includes the care environment, the professional helper’s personhood, and, in the latest version of the framework, structural issues of the macro context.

The person-centred approach is often associated with Carl Rogers’ humanistic psychology and person-centred therapy (Rogers, 1967). Rogers builds on existential thinkers, highlighting the value of authenticity and the risk of reification, alienation and

“only existing in the eyes of others” if people do not get to be true to their authentic self (Rogers, 1967). The philosophical roots of person-centredness go beyond Rogers’ writings, and include ideas of the person and personhood (Dewing, Eide, & McCormack, 2017). A central premise in the person-centred approach is that all human beings have intrinsic moral value as persons, which aligns with Kant’s imperative of never treating people merely as a means to an end, but also at the same time as an end (Dewing et al., 2017). ‘Personhood’ as a moral status is not the same as ‘sense of self’ and ‘sense of self-worth’. The latter are psychological and existential phenomena that depend on the way we behave towards and regard each other. Personhood, on the other hand, implies that people have absolute, intrinsic and objective worth, regardless of how others happen to treat them (McCormack & McCance, 2011).

The person-centred approach has also been influenced by emancipatory and other critical theory (Proctor, Cooper, Sanders, & Malcolm, 2006). In emancipatory theory (Freire, 2011), structural factors that constrain authenticity are highlighted, and action to enable liberation from such forces is stressed, for the oppressed as well as the oppressors. In this line of thinking, regarding people as persons also means regarding them as subjects and fellow citizens, allowing for genuine communication and collaboration (Mezzina et al., 2006).

Person-centred research is supported by values such as respect for personhood, individual right to self-determination and mutual respect and understanding. Informed flexibility, sympathetic presence, negotiation, mutuality and transparency have been suggested as conditions for person-centred research (McCormack, van Dulmen, Eide, Skovdahl, & Eide, 2017). Connectivity has been suggested as a main principle in person-centred research, meaning that research is done with others, not about them. Related principles are attentiveness and dialogue, empowerment and participation, and critical reflexivity (Jacobs, van Lieshout, Borg, & Ness, 2017). A person-centred approach to research may entail qualitative as well as quantitative methodologies.

3.4 Recovery, person-centred theory and co-occurring disorders

Although recovery theory and person-centred theory have different roots, they have common implications for the understanding of mental health (Borg & Karlsson, 2016; Hummelvoll, Karlsson, & Borg, 2015), and, I argue, of COD. An important common point is that people are seen primarily as persons, not diagnoses. Placing the person at the centre implies valuing the expertise of the person and his/her network. Both a person-centred approach and a recovery approach imply that personal, social and spiritual aspects of mental health and substance use problems must be acknowledged by services meeting people as persons in their local community. Further, it has been argued that evidence from a broader range of research methods should be recognised, including research that addresses the lived experiences of service users, family members and practitioners (Borg & Karlsson, 2016).

In a biomedical approach, substance use is a common exclusion criterion from studies of mental health issues, leading to limited knowledge of treatment for persons with COD (Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2014). The same is true of research on recovery in mental illness, where persons with substance use problems are generally excluded from research (Leamy et al., 2011). Person-centred research approaches, regardless of methodology, may be particularly appropriate in investigating COD because it is an inherently complex phenomenon. In a person-centred approach, living with substance use and mental health problems is understood as potentially different from simply adding the two phenomena together.

Andvig and Biong applied recovery theory and person-centred theory in a descriptive and exploratory study of recovery-oriented conversations between professionals and service users in a community mental health centre (Andvig & Biong, 2014). They discuss recovery-oriented conversations in light of the person-centred framework (McCormack & McCance, 2011), and show that the person-centred approach and the recovery approach may have shared implications for practice. These included focusing on

patients' beliefs and values, appreciating the individual person, showing interest in patients' daily life, and acknowledging identity and spirituality. Further, shared decision making, engagement, and sympathetic presence were common implications of the two approaches.

Davidson and colleagues describe a person-centred and participatory approach to research into recovery in severe mental illness (Davidson, Bellamy, Flanagan, Guy, & O'Connell, 2017). They conclude that a collaborative, multi-stakeholder approach adds to clinical research by generating clinically relevant findings, highlighting outcomes that are relevant to the people directly affected by them, and by increasing the recovery opportunities for those participating in the research.

3.5 Implications for the thesis

The theoretical level of ambition in this project is to apply theory as a background and inspiration (Malterud, 2016). 'Recovery' is defined as "a personal and social process of positive life change, which may or may not include symptom reduction". The recovery and person-centred approaches are understood as complementary to other approaches, such as the biomedical approach, and not as opposites. As mentioned above, COD is defined in this thesis as "co-occurring mental health and substance use problems with a strong impact on everyday life".

A multi-stakeholder, collaborative approach to research has been sought, and lived experience has been considered a valid focus for research. Participants have explicitly been conceived of as subjects, not objects, and local understandings have been explored. In line with recovery theory, the focus of the project is on recovery and growth instead of symptoms and limitations. While emancipatory theory underpins the project at an axiological level, the aims of the thesis are descriptive and exploratory, and the project does not have emancipatory intent beyond the overarching aim of making the lived experiences of the participants known to decision makers in the field.

4 Status of knowledge

This chapter will present the status of knowledge in relation to the aims of the thesis. In order to present literature on COD in more detail, literature on recovery in either mental health or substance use problems has not been included.

Literature searches were conducted in advance of each of the sub-studies of the thesis: in April 2016, November 2016 and October 2017. Additional searches for each sub-study were performed in September 2018. Searches were carried out in MEDLINE, EMBASE, PsychINFO and CINAHL, with support from the library services. Since COD is understood as more than the sum of mental health and substance use disorders, the population was defined as 'dual diagnosis', or combinations of mental health and substance use disorder. For the first study, this was combined with 'recovery' as a keyword, and the search was limited to qualitative research. For the second study, the population was combined with client satisfaction. For the third sub-study, the population was combined with recovery-oriented practice or recovery orientation and staff perspective. In the initial searches, literature since 2000 was included. In the additional search, literature since 2016 was included. In addition to these searches, the indexes of the journals *Advances in Dual Diagnosis* and *Journal of Dual Diagnosis* were reviewed for relevant literature in September 2018. References of the selected literature were also searched.

4.1 First-person experiences of recovery in co-occurring disorders

Literature accessed through the first search and the additional search in 2018 that was considered relevant to the study aims is presented below.

4.1.1 International studies

De Ruyscher and colleagues (De Ruyscher et al., 2017) published a systematic review in 2017 aiming to summarise and synthesise existing qualitative research on the meaning of recovery from the perspective of persons with co-occurring disorders. The review was based on a literature search and revealed sixteen studies matching the aim. Feeling support from family and peers, community participation, personal beliefs such as hope, identity and spirituality, and meaningful activity appeared in the studies as central elements in recovery, while a holistic and individualised treatment approach was revealed as facilitating recovery. This review concluded that most of the reviewed literature had described facilitators and barriers to recovery, and that there was a need for research that aims to describe and explore the experience of recovery as a phenomenon.

Ness and colleagues (Ness, Borg, & Davidson, 2014) published a small-scale literature review of first-person perspectives on facilitators and barriers to recovery in co-occurring disorders in 2014. The review led to the inclusion of seven studies. A thematic analysis of the results from these studies resulted in five overarching themes. Facilitators to recovery included a meaningful everyday life, focus on strengths and future orientation, and re-establishing social life and supportive relationships. Barriers to recovery included a lack of tailored help, complex systems and uncoordinated services.

In a large qualitative interview study from the USA with 177 participants with severe mental illness and substance use problems, Green and colleagues described participants' substance-related recovery experiences (Green, Yarborough, Polen, Janoff, & Yarborough, 2015). They described individual recovery processes, including natural recovery, peer support and self-help groups, spiritual experiences, and therapeutic relationships. Overcoming substance use problems was described as a facilitator in mental health recovery in this study.

A North American focus group study of the meaning of recovery from the perspective of people with COD reported acknowledgement of one's illness and past, a present orientation, and transformation and growth as overarching themes (Hipolito, Carpenter-Song, & Whitley, 2011). Spirituality cross-cut all other elements of recovery in this study, and restoring a valued sense of self was described as an essential part of recovery. Similarly, an ethnographic fieldwork study among African Americans with COD aiming to assess barriers and facilitators in recovery (Whitley, 2012) described spirituality as a strong facilitator of recovery from the perspective of the participants.

In a photo-elicitation interview study with formerly homeless people with COD in New York City (B. T. Smith, Padgett, Choy-Brown, & Henwood, 2015), community participation and safe housing appeared as prerequisites for recovery, associated with hope and determination for a better future, while social relationships were revealed as potentially both supportive and stressful. Moving beyond past negative identities was also an element in recovery.

A British interview study with people who attended different specialised mental health services, among them COD treatment (Turton et al., 2011), concluded that key themes from the recovery literature, such as connectivity, hope, identity, meaning in life, and empowerment (Leamy et al., 2011) are as important to people with COD as to others with mental health problems. The study also discussed the emphasis on basic human values that are otherwise often taken for granted, such as kindness, being treated as a fellow human being, and being listened to. Participants reported that getting rid of symptoms and leading normal lives were important in the recovery process, and this included the recognition of specialised treatment.

In a British study exploring the lived experiences of people with COD in a forensic setting (O'Sullivan, Boulter, & Black, 2013), a lack of choice and a lack of hope in treatment were described as disempowering, while a lack of meaningful activities appeared as a barrier to recovery. Both personal and social facilitators in recovery were described, such as readiness for change, authorship over one's own behaviour, and new social roles.

A recent Swedish study (Skogens, von Greiff, & Topor, 2018) explored the experience of initiating and maintaining a recovery process for 40 individuals with co-occurring severe mental illness and substance use problems. Although there was individual variation in the process of recovery, a general tendency seemed to be a need for help in establishing or re-establishing a satisfactory social situation, as well as establishing or re-establishing meaning in life. Several participants described how living conditions had been barriers in recovery, and that solving problems related to living conditions had been an important factor in initiating a recovery process.

A recent British study explored narratives of recovery in co-occurring mental health and alcohol problems (Stott & Priest, 2018). The narratives were organised around the origins of difficulties, episodes of change, and the ongoing journey of recovery. While participants followed individual pathways to recovery, a common pattern included early trauma and social exclusion as origins of alcohol and mental health problems, with the process of recovery involving some sort of change in personal identity, with normality as a central concept.

In a questionnaire study aiming to address recovery challenges experienced by people with COD in New York City (Laudet, Magura, Vogel, & Knight, 2000a), participants reported emotional and socioeconomic problems as barriers to recovery, and dealing with substance use was a challenge to more people than dealing with mental health problems.

4.1.2 Norwegian studies

In a recent book on recovery in COD, 14 people with COD wrote their own recovery stories (Landheim et al., 2016). In an overarching analysis of these stories, Biong suggests that becoming a part of a community is a common theme, and that this involves continuous efforts from the person involved, and environments that support these efforts (Biong, 2016). The stories were discussed in two focus groups, one with members of service user organisations, and one with members of relevant professional

unions (Brendbekken, 2016). In both groups, recovery was understood on the basis of the 14 recovery stories to be quality of life, while supportive social environments, material security, work and positive activity were seen as facilitators in recovery. Both groups discussed the importance of collaborative and coordinated services that allow for service users' ownership of their recovery processes. The service user focus group highlighted that the community is the main setting for recovery, and noticed that recovery in the 14 stories was about reclaiming control from health and social services. The focus group of professionals, on the other hand, placed greater emphasis on health and social services as positive contributors to recovery.

In a qualitative interview study aiming to explore the recovery experiences of clients with a Norwegian team providing integrated services for people with COD (Kvam, 2016), the author concluded that recovery needs to be understood as subjective as well as social processes, with identity as a cross-cutting phenomenon. The metaphor of an "anchor in normality" was applied to illustrate central aspects of self-concept and material conditions in recovery. Relatedly, in an interview study exploring the experiences with community participation of young adults with COD (Semb, Borg, & Ness, 2016), participants reported experiences of being unable to relate to mainstream society, as well as balancing between mainstream and outsider life.

In an interview study exploring the experiences of meaningful activity in the recovery process among men with COD (Nordaunet & Sælør, 2018), participants described achieving a positive identity through feeling worthwhile, and feeling within societal norms by participating in activities outside one's home. Participants in this study reported that several factors hindered their participation in meaningful activities, including social phobia or other mental health problems, loneliness and a lack of trusting relationships, or stigma related to a criminal record or substance use.

In a qualitative interview study of the experiences of recovery of people with COD in Norway (Furseth, 2015), participants described gaining knowledge about treatment and social norms, mastering new skills, and having a network of people who do not use substances, as facilitators in recovery. In another interview study, Sælør and colleagues

(Sælør, Ness, & Semb, 2015) explored how people with COD experience hope as a crucial element in recovery.

4.2 Experiences of professional helping relations by people with co-occurring disorders

Literature on experiences of professional helping relations by people with COD is presented in the following section.

4.2.1 International studies

System barriers, such as a poor therapeutic environment, poor integration of services, a lack of flexibility, delayed response during a crisis, breakdowns in the referral process, and lack of knowledge about services were mentioned as major obstacles to recovery in two studies of first-person experiences with COD treatment (Brooks, Malfait, Brooke, Gallagher, & Penn, 2007; Staiger et al., 2011). Educating staff and the general community about COD, looking beyond symptoms, and building relationships were suggested improvements for services (Staiger et al., 2011).

An interview study with formerly homeless people with COD living in New York City explored factors associated with engagement and retention in services from the service user perspective (Padgett, Henwood, Abrams, & Davis, 2008). Acts of kindness from providers, access to housing, and pleasant surroundings appeared as facilitators in engagement in services, while rigid rules and restrictions and a lack of individual therapy were barriers to staying in contact with services.

A Swedish study explored experiences of recovery-promoting care of eight persons with COD (Cruce, Öjehagen, & Nordström, 2012). The participants valued appreciation of all aspects of their life situation, help to participate in meaningful activities, continuity and

stability, qualified treatment and symptom control, hope promotion, and dignity and autonomy.

In the above-mentioned British study exploring narratives of recovery in COD (Stott & Priest, 2018), services appeared as both facilitators and barriers in the recovery process. Services that promote recovery were described as flexible, well-timed, addressing both mental health and substance use problems, providing practical help, and involving trusting and flexible therapeutic relationships with providers with therapeutic and other skills, who understood the client's situation. Negative experiences with services included punitive responses to substance use, inadequate support from mental health services, and a lack of acknowledgement of mental health problems.

A British interview study explored the narratives of a small group of patients with substance use problems and different mental health problems who had experienced psychological therapy as helpful in the recovery process (Waters, Holttum, & Perrin, 2014). Results indicated that the psychologists providing closeness and proximity, a safe haven and a secure base for the clients enabled a therapeutic relationship where the clients could develop new internal working models.

In a focus group study investigating experiences with 12-step therapy of people with COD, participants appreciated that therapists fostered hope and gave the impression of being genuinely concerned (Hagler et al., 2015).

In three independent focus group studies investigating the subjective perceptions of participants in 12-step mutual aid groups for COD, participants reported that AA/NA groups had a judgmental atmosphere regarding medication that was negative to their recovery process, and that they appreciated adapted self-help groups for COD because medications for mental health problems were accepted (Hagler et al., 2015; Matusow et al., 2013; Roush, Monica, Carpenter-Song, & Drake, 2015). In a quantitative, prospective questionnaire study of support, mutual aid and recovery in COD, an association was found between mutual aid groups and recovery, but only for COD mutual aid groups and not for single-focus mutual aid groups (e.g. AA/NA groups)

(Laudet, Magura, Vogel, & Knight, 2000b). Participating in 12-step mutual aid groups was associated with a reduction in substance use as well as self-reported improvement in mental health and substance use problems at six months' follow-up compared to those who had not joined any 12-step group (Rosenblum et al., 2014).

4.2.2 Norwegian studies

Biong and Soggiu (Biong & Soggiu, 2015) explored the experiences of 13 persons with COD of contact with a Norwegian municipal COD team. They appreciated professional helpers being interested in their resources, collaborating in making treatment goals, offering flexible help, and not rejecting them.

An ethnographic fieldwork study from a low-threshold centre for people with severe substance use problems and severe mental illness in Oslo (Edland-Gryt & Skatvedt, 2013) examined the thresholds that these clients experience in accessing services by means of participant observation, individual interviews and focus group interviews. The study concluded that the threshold of trust was essential, and that establishing trust seems particularly important to people with COD. Participants in this study described feeling excluded, rejected and misunderstood by mainstream health care services, and some expressed a lack of trust in these services.

In an interview study with persons with COD aiming to explore their experiences of commencing and remaining in Assertive Community Treatment (ACT) (H. Pettersen, Ruud, Ravndal, Havnes, & Landheim, 2014), establishing trust and receiving benefits appeared as facilitators in commencing treatment, while feeling exclusive, seeing the treatment as a safety net, and feeling responsible for one's own treatment were facilitators for remaining in treatment.

4.3 Recovery-oriented practice to support people with co-occurring disorders

The literature search for the third sub-study, together with the additional search, yielded few previous studies matching the study aims. Literature on staff experiences with harm reduction versus abstinence-based services in COD is included in the following section because it is considered to be related to recovery-oriented practice.

4.3.1 International studies

In an observation study of treatment team members' responses to classroom-based training in recovery-oriented practices in a service directed at people with COD and/or severe mental illness in the US (Felton, Barr, Clark, & Tsemberis, 2006), several dilemmas were expressed by the practitioners who underwent the training. Some practitioners doubted whether recovery principles would be suitable for people with substance use problems, or patients who did not agree with their psychiatric diagnosis. Dilemmas included reconciling system-centred goals with patients' goals, collaborating with patients, and applying recovery principles in crisis situations.

A recent Danish interview study explored practitioner experiences of challenges in working with patients with COD within traditional specialised mental health services (Pinderup, 2018). Rigid systems that address one issue at a time, insufficient collaboration across services, and insufficient duration of treatment appeared as the main challenges in this study, leading the author to conclude that more flexible treatment that extends beyond the traditional treatment context is necessary.

Henwood and colleagues interviewed providers working in homeless services for people with COD (Henwood, Padgett, & Tiderington, 2014), aiming to explore how they apply abstinence-based versus harm reduction approaches in promoting recovery. Some of the providers worked in traditional, abstinence-based services, while others worked in Housing First services with a harm reduction approach. While practitioners working in

traditional services were less open to alternative practices, practitioners using the harm reduction approach described ambiguity in their practice. Harm reduction appeared as a welcome alternative, which was combined with accommodating abstinence, and was compatible with consumer-driven, recovery-oriented practice. The authors concluded that services for people with COD should include various tools for practitioners in order to avoid drop-out or premature referral to inpatient substance use treatment, and that narrow solutions would disrupt the ability to provide flexible, client-centred services.

4.3.2 Norwegian studies

A recent study used focus group interviews to explore practitioner experiences with providing a harm reduction approach in a Norwegian Housing First project for people with COD (Andvig, Sælør, & Ogundipe, 2018). Providers stressed the importance of collaboration with clients, including forming a relationship, and basing interventions on service users' perceptions of their own needs. Further, a flexible, individualised approach and collaboration with the local community were described as important elements of the practices in this study. Liberty to make joint decisions with clients on actions needed was a factor that enabled providers to help their clients.

In a qualitative interview study aiming to explore how practitioners working in municipal services for people with COD experience their own hope-inspiring practices (Sælør, Ness, Borg, & Biong, 2015), participants described hope as fundamental on both a relational and a practical level. Rigid and narrow systems were described as barriers to hope-inspiring practices in this study.

In a focus group study of the experiences of the concept of 'recovery' among practitioners in Norwegian municipal mental health and substance use services (Midtgarden, 2018), an understanding of recovery as an individual process prevailed, and system factors seemed to affect the participants' understanding of recovery in that flexible systems and colleagues with lived experience made it easier to work in accordance with recovery principles.

4.4 Summary

Previous studies of first-person experiences of recovery in COD suggest that accessing new social identities and material conditions that enable a sense of belonging in mainstream society may be central. Meaning, hope, spirituality and quality of life are consistently reported across studies. Some studies report that sobriety and relief of symptoms of mental health problems are facilitators to recovery. Relations with family and peers appear as supportive, but also potentially negative. A review of the literature concluded that there is a need for research that addresses the experiential aspects of recovery in COD (De Ruyscher et al., 2017).

Much of the previous literature on professional help that supports recovery has focused on system elements that act as barriers or facilitators in recovery. Fragmented, rigid systems and poor therapeutic environments that make services difficult to access and difficult to trust appeared as major barriers. Flexible, well-timed, and integrated services facilitated recovery. The few studies that addressed professional helpers reported that the ability to build trusting and genuine relationships, to collaborate and provide flexible help directed at all aspects of life, and being skilled and qualified, were valued by service users with COD. Punitive or judgemental attitudes towards substance use were described as negative experiences with professional helpers in some studies.

Previous studies of staff experiences with dilemmas in recovery-oriented practice to support people with COD describe potential dilemmas regarding substance use, situations of disagreement, and crisis situations. Studies of the experiences of staff from general services to support people with COD describe that rigid, narrow and fragmented systems pose challenges to practitioners.

5 Theory of science, methodology and methods

In this chapter, the theory of science, methodology and methods of the project will be described.

5.1 Qualitative research

Research from various approaches serves complementary purposes in knowledge development and in answering different research questions (Kagan, 2009). This project has a descriptive and exploratory aim with the overarching purpose of informing decision makers of the experiences of people living with COD, and those who work to support their recovery. The study of human experience implies a qualitative research approach. Qualitative research involves the systematic collection, organisation and understanding of textual (or other) material derived mainly from interviews or observation, aiming to describe, explore and understand the meaning of social phenomena as they are experienced by people in their natural context (Kvale & Brinkmann, 2009; Malterud, 2001). Qualitative approaches hold the potential of discovering new issues for further research, providing awareness of preconceptions and prejudice, critically addressing existing structural phenomena, allowing the voices of otherwise marginalised people to be heard, and accessing as well as communicating experiential/emotional and aesthetic aspects of social reality (Binder et al., 2016).

Much qualitative research shares the underlying theoretical foundations of social constructionism (Creswell, 2013; Malterud, 2012b), recognising that knowledge is contingent, situated, emergent, and subject to alternative interpretations. Underpinning this project is an ontological subjective stance, recognising the other as an experiencing subject. Subjective experiences are considered to exist to the extent that they are accessible through language, even if they are inexact (Giorgi, 2009). This points towards realist ontology, although it is acknowledged that the dependence on language in communicating subjective experience involves various possible

interpretations. In the light of person-centred theory (Rogers, 1955), reducing people into objects is considered to imply a reification of the experiencing subject, disturbing the study of subjective experiences by changing its nature. Acknowledgement of the intrinsic humanness (Giorgi, 2009) or personhood (Rogers, 1955) of the participants has been sought to underpin the research process throughout. However, the abstract concept of the 'person' is of less interest in the current project than the real people who have participated in it. Similarly, loyalty to the underlying purpose has prevailed over adherence to any specific methodological position, implying a pragmatic standpoint (Kvale & Brinkmann, 2009).

Hence, a flexible, rather than dogmatic, approach to methodology has been adopted (Carter & Little, 2007). The project draws on phenomenological methodology (Creswell, 2013) as well as literature on collaborative research (Moltu, Stefansen, Svisdahl, & Veseth, 2013) and user involvement in research (Trivedi & Wykes, 2002). It is phenomenologically inspired mainly at the methodological level, with different degrees of interpretation throughout the process (Finlay, 2009), as described in the following sections.

Before turning to a description of the procedure, I will seek to draw a line between phenomenological and collaborative methodology and the particular methods used in this project.

5.2 Phenomenological influences

Several issues should be considered by researchers who draw upon a phenomenological approach (Finlay, 2009). One issue concerns how tightly or loosely we should define what counts as 'phenomenology'. While it is beyond the scope of this thesis to provide a general answer to this question, the current project has drawn upon phenomenology primarily by searching for rich descriptions of lived experience, and by adopting an open attitude towards these descriptions, avoiding judgements about their realness and without imposing external frameworks.

A second issue is whether research should always aim to produce a general (normative) description of a phenomenon, or whether idiographic analysis (i.e. analysis that aims to describe the lived experience of one person) is also a legitimate aim. While Giorgi (Giorgi, 2009) aims for a clarification of the essence of the phenomenon being studied, independent of context and individual, Malterud (Malterud, 2012b, p. 796) aims to “*present examples from people’s life worlds, not to cover the full range of potential available phenomena*”. Underpinning the current project is the objective of describing and exploring the lived experiences of people with COD and people who work to support recovery in this group. Within a person-centred approach (McCormack et al., 2017), both context and individuals are considered important. However, the analysis is cross-case and categorical, aiming for descriptions of essential elements of the phenomena rather than narratives (Maxwell & Chmiel, 2013b).

Thirdly, researchers need to clarify to what extent interpretation should be involved in their descriptions, related to the division between descriptive phenomenology and interpretive/hermeneutic phenomenology. Systematic text condensation, which is used as an analytic method in Study 1 of this project, is explicitly defined as a descriptive approach, where experiences are presented as expressed by participants, rather than an approach that explores underlying meanings (Malterud, 2012b). However, Malterud also states that knowledge is developed from experiences by *interpreting and summarising* the organised empirical data (ibid.). In the current project, both descriptive and hermeneutical elements have been involved in the analysis. I agree with Finlay that there is no clear boundary between description and interpretation, and acknowledge that it is necessary to adopt some sort of perspective on the descriptions throughout the analysis. Despite this, the participants’ accounts have formed the basis of my analysis, and I have been ready to change my perspective according to the descriptions. This coincides with ‘empathic interpretation’ (Willig, 2013), where one seeks to elaborate on the meaning that lies in the material, rather than revealing hidden truths. Applying Kvale’s metaphor of the researcher as a miner or as a traveller (Kvale & Brinkmann, 2009), my position during this project has been closer to the latter.

Further, the researcher needs to decide whether researcher subjectivity should be set aside or brought to the foreground. While different phenomenological approaches generally agree upon the inevitable implication of researcher subjectivity in research and the importance of a 'phenomenological attitude' where one is open to seeing the world in a new way, there are different views on how to proceed in order to achieve this. Some argue for a selective bracketing of one's preconceptions throughout the research process, while others argue that researcher subjectivity should rather be brought to the foreground (Finlay, 2009). In bracketing, or phenomenological reduction (Giorgi, 2009), researchers aim to set aside their previous understandings, past knowledge, and assumptions about the phenomenon, as well as claims regarding the truth or falsity of the descriptions, in order to focus on the phenomenon as it is described. In the current project, I made an effort to bracket my preconceptions throughout the analysis, following the principle of neither adding nor subtracting from what is presented (Giorgi, 2009), although a complete bracketing is considered impossible (Malterud, 2012b), and the value of reflexivity is acknowledged (Finlay, 2002). I have sought a balance between closeness to the experiential world of the participants and constant consideration of my own influence as a researcher (Binder et al., 2016). Accordingly, reflexive remarks, including critical reflections on my own pre-understanding, are presented in the discussion section of this thesis, and throughout the methods section.

Another question to be considered is whether phenomenology should be more science or art. Qualitative research has been defined as being systematic, reflexive and transparent enough to be subject to critical scrutiny, with the ambition of transferability beyond the context under study (Malterud, 2001). This definition also underpins the current project. Some have stressed the kinship between art and science, cautioning that the application of strict rules for rigour in qualitative research may in fact be destructive (Sandelowski, 1993), and emphasising that interpretation is an art that cannot be formalised (Denzin, 2013). While I acknowledge the valuable contributions of such approaches, the current project is positioned within an understanding of phenomenology as a scientific venture.

Finally, phenomenology can be understood as a modernist or postmodernist project, or both. This naturally depends on how one defines these concepts (Finlay, 2009). As described in the initial section of this chapter, the current project is underpinned by the epistemological stance that knowledge is temporary and situated, and a result of dynamic interpretation of several possible versions of reality (Malterud, 2012b). At the same time, subjective experience is considered to exist to the extent that it can be shared through language, and the study of subjective experience is considered a valid focus of research, although several possible interpretations are available. In this way, the current project may be both modernist and postmodernist, or neither, according to the definitions applied (Finlay, 2009).

5.3 Collaborative influences

Service user involvement in research has increased, and is now mandatory in the largest research funding organisations in Norway. Collaborative research may be performed at different levels, and may involve user-led research (Rose, 2017), representation of lived experience among researchers (Lofthus, Weimand, Ruud, Rose, & Heiervang, 2018) researchers involving people with lived experience as co-researchers during data collection and analysis (Mjøsund et al., 2017; Veseth, Binder, Borg, & Davidson, 2012; Ynnesdal Haugen, Envy, Borg, Ekeland, & Anderssen, 2016), and involving people with particular contextual knowledge as advisors in the research process (Sælør, Ness, & Semb, 2015). Three main levels of involvement in research have been suggested: user involvement, where input from stakeholders is added into projects that are already planned, collaborative research, where stakeholders and researchers partner up in planning and undertaking research, and user-controlled research, where service users control the research (Beresford, 2013). This project finds itself between user involvement and collaborative research. According to Arnstein's ladder of participation model, where different forms of participation are rated from low to high (Arnstein, 1969), the level of participation in this project could be placed at the middle of the ladder, somewhere between consultation and partnership. This implies a risk of

tokenism, meaning that the people who participate serve as a symbol, but without genuine influence (Arnstein, 1969; Beresford, 2013). The theoretical grounds for collaborative influences in this project are rooted in recovery and person-centred approaches, and involve democratic and empowerment concerns of increasing the influence of the involved persons (Beresford, 2013), as well as the presumption that involving local stakeholders in the research process will provide pragmatic and validation advantages. In order to allow the reader to assess these issues, the actual contributions of the advisory group to the project are described in the procedure section.

5.4 Procedure

This project consisted of two studies. Study 1 sought to answer research questions 1 and 2, while Study 2 sought to answer research question 3 (page 4). In the following, the methods used in the two studies will be presented in detail, followed by ethical considerations. A discussion of the methods is presented in the discussion section.

5.4.1 Setting

The setting of this project was a Norwegian local authority area, containing agricultural areas, forested areas, and two small towns, both with fewer than 6500 inhabitants. The local authority is average sized in a Norwegian context with 20000 inhabitants. Health and social indicators are at, or slightly below, the average for Norway. The setting was considered appropriate because of its average characteristics, geographic convenience, and the fact that the local leader of mental health and social services had expressed a positive attitude towards service user involvement and alternatives to a biomedical approach to mental health problems. I contacted the leader, presented the project and asked if the mental health and addictions team, which is a small part of the total services, would be willing to collaborate in the project. In a subsequent meeting with

the leader of services and the leader of the mental health and addictions team, I presented the project in more detail, and we agreed on terms of collaboration. This agreement was then formalised by the appropriate local level of authority, the Inland Hospital Trust, and the University of Southeast Norway. The agreement stated that the mental health and addictions team was committed to developing recovery-oriented practice, and that they had full autonomy in how to define and develop such practice. It also stated that the services would facilitate recruitment and the conducting of interviews in the project, and that I would present results from the project at meetings in the community in agreement with the leaders. I have presented results from the two studies on several occasions.

5.4.2 The advisory group

A group of six people from the local community advised me throughout the process. Aiming to include different groups affected by the study (Ness, Borg, Semb, & Karlsson, 2014), I decided to invite two people with lived experience of COD, one family member of a person with COD, the leader of the mental health and addictions team, the leader of the local peer support centre, and one experienced practitioner. The group has had an advisory function throughout the process, including advice on planning the study, developing the interview guide, deciding the recruitment strategy and understanding the results in the local context.

The group met four times a year for three years, 12 times in all. The meetings lasted three hours, and were arranged in the local peer support house or in my office. The meetings were organised as reflective sessions, which has been associated with the development of trust and commitment in service user involvement in research (Barber, Beresford, Boote, Cooper, & Faulkner, 2011). The themes were mainly prepared by me, but participants were also invited to suggest themes for reflection. In the first year, meetings were audiotaped and transcribed, but it was then considered sufficient to

take notes during meetings. I wrote summaries from each meeting, which were e-mailed to participants.

In order to address ethical issues such as autonomy, confidentiality and integrity (Øye, Sørensen, Dahl, & Glasdam, 2019), the following rules were adopted for the advisory group: (a) all members are selected due to their unique expertise and connection to the local context, (b) all members and all opinions are equally valuable, (c) the researcher leads the group and is responsible for preparation, raising issues, and writing summaries of the meetings, (d) the researcher is responsible for and authorised to make decisions (together with supervisors). Input from the group will be considered, and have an impact, in the decision-making process, (e) diverse opinions, disagreement, and critical input regarding the research are explicitly valued in the group, (f) all group members should be able to understand what is discussed at any point, (g) group members sign a contract of confidentiality, and (h) members are paid according to standard remuneration (unless they participate as part of their job).

I wrote the rules and presented them to the group at the first meeting, except for rule (f), which was added later, based on input from participants. This rule implies that all members are responsible for using everyday language, avoiding difficult words or abbreviations. Members are also responsible for telling the others if they do not understand. I had a particular responsibility to supervise the group process in order to ensure that the discussion was accessible to all group members at any time.

I consciously adopted a reflexive attitude in collaboration with the advisory group, meaning an awareness of my own background and understandings of recovery in COD (described in more detail in the reflexivity section of the discussion), but I was also open to the understandings of the other group members and ready to let my own understandings be challenged (Veseth, Binder, Borg, & Davidson, 2017).

Advice from the group has directly influenced decisions on the research project at several points, regarding the recruitment process, inclusion criteria, development of research questions, and interview guide. These influences are described in the

corresponding sections on procedure. At other points, decisions were made contrary to group advice. One example was the study design, where the project does not match the range of ideas and suggestions from the group. To be precise, a more concrete, quantitative measurement of the effect of the recovery orientation of the services was called for, but not included. It was also suggested that the Norwegian Labour and Welfare Administration (NAV) be included in the study, which was not done. Underpinning these choices were considerations of feasibility within the framework of the project.

Another piece of advice that was not followed was to publish the results in Norwegian in order to make them accessible to local stakeholders. In this decision, my loyalty to academic standards, namely those of the PhD degree, became clear. This touches upon broader ethical issues regarding power and access to knowledge, and illustrates a conflict between user involvement in research and loyalty to academic standards. It has been decided to seek the publication of a summary of the thesis in Norwegian in order to ensure genuine access to the knowledge by participants and other stakeholders.

In addition to giving specific advice, the group was involved in validation of the analysis. This was done after the initial part of the analysis; the group was thus not presented with transcripts, but with preliminary categories and supporting quotes. This process was both a validation, in that group members recognised the categories and found them meaningful, and a way of gaining a richer understanding of the results, which provided directions for the discussion in the papers.

Based on the theory of group dynamics (Forsyth, 1999), a clear definition of power was sought in the group in order to avoid unclear or informal power structures. It has been suggested that fixed roles might lead to less genuine communication in advisory groups (Klevan, 2017). The fact that we spent regular time together, and that the meetings included informal conversations over a meal, is thought to have enabled mutual trust and genuine communication among group members. Also, in accordance with a person-centred approach (Rogers, 1967), a conscious effort was made to adopt and communicate an accepting attitude towards each group member, with explicit

emphasis that all group members and all opinions were equally valuable (rule (b) presented above).

The advisory group meetings started at the time of the planning of the research, which allowed for a more genuine involvement than if the group had been involved after important decisions had been made (McLaughlin, 2010). This also meant that I was new to the role of researcher. It may be easier for a more experienced researcher to manoeuvre an advisory group at all stages of the research process. In order to balance this, one of the group members, an experienced practitioner and participatory researcher, acted as an ally in the first meetings in monitoring the group process and providing feedback on my role as a group leader after the meetings.

5.4.3 Study 1

The aim of this study was to explore and describe how people with co-occurring disorders experience recovery, including their relationships with professional helpers.

5.4.3.1 *Recruitment and participants*

We wanted to recruit participants who had lived experience of recovery in co-occurring disorders, but were otherwise diverse in age, gender, duration of contact with services, and mental health and substance use problems. In making decisions on recruitment, the advisory group contributed previous knowledge from different perspectives, as well as familiarity with the local context, which added to my own previous knowledge. Following discussions in the advisory group, an explicit aim in recruitment was to allow people to decide for themselves whether they were fit and willing to participate, and avoid the gatekeeper effect (Øye, Sørensen, & Glasdam, 2015) where staff, consciously or not, exclude some potential participants that would have wanted to be part of the study. The following inclusion criteria were decided upon: (a) having experienced mental health and substance use problems that seriously affected everyday life, either

now or in the past, based on self-report, and (b) being in contact with municipal health and social services. The advisory group clearly indicated that inclusion should *not* be based on diagnosis, as this would imply an attitude that people are unable to assess their own situation. Further, the group was concerned that some potential participants would be left out, as mental health problems are often underdiagnosed among people with substance use problems. On this basis, participants' self-report was taken on face value.

Flyers with brief information about the study were handed out by team members to all service users they were in contact with over a period of two weeks. Flyers were also handed out by people with lived experience at the local peer support house, and at a low-threshold meeting place that provides harm reduction health services to people with substance use problems in the neighbouring town. Participants could contact me directly by SMS, telephone or e-mail, or could agree that staff would forward their phone number.

Twelve people made contact as a result of recruitment, and additional information was given by telephone before time and place for the interview were arranged. Three interviews were cancelled by the participants on the same day due to their condition at the time. One of them made a new appointment, while the other two decided not to participate any further. One participant made initial contact from prison, and an appointment was made upon release. However, this person did not come to the appointment and I was not able to get in touch. One person forwarded his phone number through staff, but the number was no longer working when I called. The number of participants was thus reduced to eight.

Participants were four women and four men between the ages of 25 and 75. They variously reported using or having used alcohol, amphetamines, benzodiazepines, opioids and cannabis. Most participants reported having used several substances. Four persons reported not using substances at the moment, one was in opioid maintenance treatment, and three persons were using substances at the time of the interview. The participants variously reported experiencing or having experienced affective disorder,

anxiety, post-traumatic disorder, psychotic illness, and hyperactivity disorder. Six participants received disability benefits and two received social welfare benefits. Two participants were students and one was a job-seeker, while five reported not being employed at the time. Five participants lived in rented flats (three of which were public housing), two persons owned their own home, and one person had no fixed abode at the time of the interview. Four participants were single and four were in a relationship. Duration of contact with services ranged from one year to more than ten years. Six participants had been in contact with other services before getting in touch with this particular mental health and addictions team.

5.4.3.2 Data collection

Qualitative research interviews are different from other forms of conversations, and may be perceived of as a craft that requires specialised skills, knowledge and judgement (Kvale & Brinkmann, 2009). Eight semi-structured, in-depth individual interviews (Kvale & Brinkmann, 2009) were conducted over the course of two months. The interviews aimed to explore and describe the meaning of recovery, and how professional helpers may contribute to recovery, based on the participants' subjective experiences from everyday life (Kvale & Brinkmann, 2009). Interviews were arranged in treatment settings, in the participant's home, in a meeting room in the town hall, or in a meeting room in my office building, according to the participants' preference. I brought a beverage to each interview, and pastries if the interview took place in people's homes. Before the interview started, I gave information about the study and participants signed a consent form. In line with a person-centred approach, a deliberate accepting attitude was adopted in the interviews, informed by Rogers' guiding questions for entering helping relationships (Rogers, 1967) (see appendix I). This involved a conscious attempt at emotional receptivity, aiming to deepen participants' experiential descriptions (Binder et al., 2016). Interviews are not therapy (Kvale & Brinkmann, 2009), and the guiding questions do not imply therapeutic intent. They are believed to enable a situation where the participant feels free and safe to communicate his or her

experiences, and where the researcher refrains from judgement or premature interpretation. An interview guide consisting of open-ended questions was developed in collaboration with the advisory group (see appendix II). Input from the advisory group led to an interview guide that consisted of two questions: “What does it mean to get better?” and “What can make people get better?”. Participants were asked to describe their own specific personal experiences of recovery, and of professional helpers supporting recovery. Follow-up questions were asked, such as: “What was that like for you?” and “How did that feel?”. Interviews lasted from 45 to 80 minutes.

At the end of each interview, a short debriefing session was conducted, where participants were invited to reflect on the interview situation, ask questions or give feedback to the researcher. Participants were offered to contact the researcher if they needed to get in touch with a professional as a result of the interview, but no one did this. Most participants stated that the interview had been a positive experience. Two participants reported that the interview had brought up unpleasant memories that had made them tired or upset, but they were still pleased to have participated. One participant was concerned that someone might have listened in on the interview, and also called after the interview to make sure that this was not the case (this was a reasonable concern, which was refuted by asking the people on the same floor if they had overheard anything). Many participants doubted if their contribution could be of any help, since they felt unable to express themselves very well. This was not my impression, which was that all participants shared their experiences in a genuine and eloquent way, yielding rich and nuanced descriptions. All participants said that they appreciated the opportunity to be of help to others in similar situations, and all were willing to be contacted again if needed.

5.4.3.3 Analysis

Since there has been little previous research on this topic, particularly in a Norwegian context, the aim of this study was descriptive and exploratory. The material consisted of

rich and nuanced descriptions of experiences of recovery and professional helping relations. Data analysis was guided by systematic text condensation (Malterud, 2012b), inspired by a phenomenological approach (Giorgi, 2009).

An inductive, cross-sectional analysis was considered appropriate. 'Inductive' is used here in the sense that the analysis was primarily data-driven, or bottom-up, i.e. not theory-driven, or top-down. The goal of the analysis was to yield descriptions, while efforts to explain these descriptions and suggest hypotheses have been made in the discussion parts of the papers and the thesis.

Interviews were audiotaped and transcribed verbatim by me, resulting in approximately 100 pages of transcripts. Interviews were transcribed consecutively, but a full analysis was only carried out after all interviews had been conducted. A decision log was used throughout the analysis in order to provide transparency in the analytical process (Malterud, 2012b).

Underlying the study lies the notion that persons cannot be reduced to objects (Giorgi, 2009). Instead, the text is the research object and the researcher is the subject. In the analysis, the researcher approaches the text with the research question in mind. In this study, the same material was approached twice, following the same procedure both times, in order to answer the two research questions, as described below.

Initially, all transcripts were read as a whole in order to gain an overall impression, resulting in preliminary themes. Secondly, the transcripts were systematically reviewed line by line, identifying, classifying, and sorting meaning units into code groups. The codes were adjusted and defined during the process. Thirdly, meaning units within each code group were sorted into subgroups. Meaning units within each subgroup were reduced to an artificial quotation, maintaining, as far as possible, the original terminology used by the participants. An authentic illustrative quotation was identified for each subgroup. Finally, analytic texts were developed, synthesising the contents of the artificial quotations and developing descriptions. The analytic texts were validated by returning to the full transcripts and asking whether our synthesis still reflected the

original context. At steps three, four and five, the advisory group was consulted, providing an understanding of the material from the local context. The N-Vivo 10 software was used in the analysis. Interviews, transcription and analysis were performed in Norwegian, and the analytic text was proof-read and corrected by a professional translator, while the quotes used in the articles were translated from the original Norwegian anonymised quotes into English by the same translator.

5.4.4 Study 2

The aim of Study 2 was to explore and describe how practitioners in community mental health and addiction services experience dilemmas in recovery-oriented practice to support people with COD. This aim did not involve an investigation of processes within the services, and there is thus no detailed description of the particular service context. In the following, I will present information about the services that is considered necessary to contextualise Study 2.

5.4.4.1 *Setting*

In the local authority area where this project was conducted, the mental health and addictions team had recently been incorporated in the mental health services, together with other teams that provide low-threshold services to the citizens. The team provided services to adults in the local authority area who lived with substance use problems or COD. The team was committed to developing recovery-oriented practice. Peer support workers were recruited to different system levels in the services, and interventions were explicitly based on what was important for the person seeking help rather than their psychiatric diagnosis. Feedback-informed treatment (FIT) (Miller, Hubble, Chow, & Seidel, 2015) was being implemented in the services during the process of data collection, which is a tool for collecting continuous feedback from service users concerning their opinion on services as well as their current life situation. Practitioners

were expected to use FIT in their contact with service users, and received weekly supervision based on the FIT input. Within this, they had a large degree of freedom in deciding how to structure their work.

5.4.4.2 Recruitment and participants

Practitioners in the local mental health and addiction team were invited to participate, based on their specific experiences with recovery-oriented practice to support people with COD, which were considered relevant in answering the study aim (Malterud, Siersma, & Guassora, 2016). The invitation was communicated by the leader of the services, and all team members agreed to participate. Participants were community support workers (2), mental health workers (2), peer support workers (2), psychiatric nurses (2), a social worker and a psychologist. Four participants were present at all the focus group interviews, three were present at two of them, and three were present at only one interview. Those who were not present at all interviews had either not started working in the team, or had left the team, at the time of the interview(s) in question.

5.4.4.3 Data collection

Three focus group interviews were conducted over two years. Focus groups are particularly suitable when the aim is to explore and describe experiences or attitudes in an environment where several people collaborate (Malterud, 2012a). The interviews were spaced out in order to explore experiences with recovery-oriented practice to support people with COD at different points during a process of recovery orientation.

The first interview lasted 90 minutes, while the second and third lasted 60 minutes. Interviews were conducted at the time and place of the weekly team meeting, in order to facilitate participation. Six to eight team members were present at each interview. Informed consent was obtained at the beginning of each interview, since there were some new participants each time.

All interviews were led by me and a moderator, an experienced practitioner who is also a member of the advisory group. I asked the questions as well as follow-up questions, while the moderator played the role of observing the interaction in the group, inviting less active participants to contribute, and asking follow-up questions that I had missed. She also kept track of time during interviews. We met before and after each focus group interview in order to plan the interview and consolidate our impressions, and both of us made field notes from the focus group interviews, including how we experienced the atmosphere and non-verbal communication during the interviews. An accepting attitude was explicitly sought in the interview situation (Rogers, 1967).

In the first interview, participants were asked to describe their current practice to support people with COD (see appendix III). In the second and third interviews, participants were asked to describe their experiences with recovery-oriented practice with this group of citizens (see appendix IV). Participants were asked to provide specific descriptions of their practice, and I asked for examples throughout the interviews. Different opinions were explicitly welcomed, and I stressed that I was interested in how they actually worked rather than how they would ideally like to work.

5.4.4.4 Analysis

Interviews were tape recorded and transcribed verbatim by me. Before the second and third interviews, the moderator and I read through the transcripts from the previous interviews in order to prepare and plan the interview situation. A full analysis was only performed after all three interviews had been transcribed. While the interaction in focus group interviews is considered to hold the potential of yielding nuanced and contradictory material, the focus of analysis in this study was the content of the focus group conversation rather than the interaction itself (Barbour, 2013). Thematic analysis was used (Braun & Clarke, 2006), based on the transcripts of the audiotaped recordings. Field notes made by the moderator and myself were used to help us understand the

meaning of the transcripts. I kept a decision trail of all decisions made during the analysis process, and this was reviewed at the end of analysis.

One choice to be made in qualitative analysis is whether to give a rich description of the whole data set, or a more detailed account of one particular aspect (Braun & Clarke, 2006). Tensions and dilemmas have been argued to constitute fruitful resources for analysis of focus group material (Barbour, 2013). In this study, an explicit aim of the analysis was to provide a detailed and nuanced account of *dilemmas* in the participants' descriptions. Within this aim, the analysis was inductive in the sense that the participants' descriptions were the point of departure. The choice of focusing on dilemmas was made after reading through the transcripts from the first two interviews, before conducting the third interview. The decision was made in collaboration with the advisory group, based on the assessment that a focus on dilemmas was a way of exploring contradictions, disagreements and tensions in the material without framing them as conflict, and avoiding any normative judgements of opinions as "right" or "wrong". An attempt was made to bracket my pre-understanding during analysis, although a complete bracketing is acknowledged to be impossible (Malterud, 2001). Themes were identified on a semantic level, based on the surface meaning of participants' descriptions. However, the analysis still involved elements of interpretation, as described below.

Firstly, transcripts were read several times while taking notes, in order to become familiar with the data. Secondly, the data set was read through systematically, giving equal attention to each data item, and content was coded by tagging and naming selections of text with the N-Vivo software. Using thematic analysis, I coded items for as many different patterns as possible, also keeping those that stood out from the dominating story. When all data had been coded and collated, codes were sorted into potential themes. All collated extracts for each potential theme were then read through, and themes were adjusted based on the criteria of internal homogeneity and external heterogeneity (Braun & Clarke, 2006). At this point, there were eight themes. Following this, the entire data set was read through, considering the validity of the

candidate themes in relation to the interviews, while coding additional data that had been missed during the first coding process. During this process, two of the eight themes were merged into one (responsibilisation and empowerment were merged into empowerment). One of the themes, related to the change process in the team, was left out of further analysis. This choice was made based on a consideration that this theme did not answer the study aim and contained issues that were difficult to address properly without obtaining data from additional sources. The six remaining themes were organised into three dilemmas, with each theme constituting one of the opposing elements of each dilemma: Empowering versus helping, Challenging versus listening, and Harm reduction versus total abstinence.

At this point, the three dilemmas were presented at a meeting with the advisory group, together with a description of the analysis process. The group found the three dilemmas to be recognisable and relevant, and a group discussion of the dilemmas elicited a deeper understanding as well as issues to be addressed in the discussion part of the paper. Some of the group members expressed disagreement at leaving the team process out of further analysis. This was one of the decisions that I made despite explicit disagreement within the advisory group.

After the meeting with the advisory group, a detailed analysis was performed for each of the three dilemmas, where data extracts were organised into coherent accounts with accompanying narratives, and the essence of each theme was identified. This created an analytic narrative with the names of the dilemmas that appear in the published paper. This narrative was then synthesised into the results section of the third paper included in this thesis. Braun and Clarke (Braun & Clarke, 2006) suggest a deductive final stage of analysis when writing the results part of a paper. However, I chose to keep the results section closely based on the analytic text, with less room for interpretation, in line with the approach to analysis described in the above section on phenomenological influences.

5.4.5 Ethical considerations

Ethical approval was sought from the Regional Ethics Committee (REK). They concluded that the project was not covered by the Health Research Act (Helseforskningsloven), and did not submit the project for evaluation (Case No. 2014/2190). The study was approved by the Norwegian Centre for Research Data (NSD) (Case No. 42244) and the data protection officer of the hospital trust (Case No. 2015/9863). The research was conducted in accordance with the Helsinki Declaration of 1975, as revised in 2000, and with the ethical standards of the Norwegian National Committee for Research Ethics in the Social Sciences and the Humanities. Further, I consider research ethics to be a continuous process which surpasses mere conformity with ethical principles (Øye et al., 2015).

Kvale and Brinkmann (Kvale & Brinkmann, 2009) describe ethical questions to be considered in interview studies, including considerations of benefit, informed consent, confidentiality, potential harmful consequences, and the researcher's role. In the following, the project will be discussed in light of these considerations. In addition, power issues in the project will be considered.

5.4.5.1 *Benefit*

Phenomenological research holds the capacity of enhancing readers' understanding of a phenomenon, possibly leading to changes in empathy and engagement towards people who have experienced that phenomenon (Natvik & Moltu, 2016). One purpose of this project was to make the participants' experiences visible to decision makers in the field. Participants reported being happy to be able to contribute by sharing their experiences, and several participants expressed that the interview situation in itself had been a positive experience.

5.4.5.2 Informed consent

Informed consent was a requirement for participation. Persons with mental health or substance use problems are considered 'vulnerable groups' in research ethics guidelines. However, exclusion of entire groups from research is discriminating, and may lead to services being under-informed by the experiences of people from 'vulnerable groups' because they are left out of research (L. J. Smith, 2008). Although knowledge at the group level was considered in the current project, individual considerations were also made, such as taking time to ensure genuine informed consent for each participant. All participants were considered fully capable of giving consent. Another issue related to informed consent concerned team members' possibility to decline participation in the focus group interviews, as they were recruited by their leader. All focus group interviews started with information about the research project followed by the signing of consent forms. The leader was not present at the interviews and would not have been informed if someone had chosen not to participate.

5.4.5.3 Confidentiality

All information was anonymised in order to ensure the confidentiality of participants. Descriptions that may have led to identifying individual participants has been omitted or modified in order to avoid identification while retaining the meaning content. A member of the advisory group who has particular knowledge of the target group was consulted in order to check whether individual participants were identifiable based on the published information.

The name of the local authority involved has not been published, but it has been mentioned at conferences by practitioners and leaders working for the authority. The identity of the team members will therefore be known to a certain degree. Particular attention was paid to anonymise the results to prevent individual team members from being linked to any particular meaning content.

5.4.5.4 Harmful consequences

To avoid harmful consequences is a core ethical issue for any researcher, and I have spent much time asking myself whether the research might cause any harm to the participants. The issue of confidentiality seemed important in this regard, as discussed above. Further, some participants shared painful experiences and deeply felt regrets, such as experiences of violence or sexual abuse, or having caused harm to their children. As a psychologist, I am trained in talking about emotionally upsetting issues, but the interviews were not therapeutic conversations. As such, talking about upsetting themes may have caused distress in the participants, and this was also explicitly reported by two participants. Distressing issues were not explicitly addressed by me, and the participants were able to decide whether to bring these up or not; I considered all of them to be capable of this. Furthermore, talking about painful issues is not necessarily harmful, but may also be beneficial. I consider that the possible harmful consequences of bringing painful experiences to the surface were reduced by approaching the interviews with Rogers' guiding questions in mind (see appendix I) and allowing for a debriefing at the end of the interview.

5.4.5.5 Power issues and the researcher's role

Power relations may constitute ethical and methodological dilemmas in qualitative research (Karnieli-Miller, Strier, & Pessach, 2009). One such issue in Study 1 concerned the fact that I had considerable power in the knowledge production, while the basis of the knowledge was lived experience.

Several participants said they were happy to be listened to, but the listening only involved their answers to a few questions decided by me (based on advice from the advisory group). The methods used do not guarantee that the analysis will focus on what is most important for the participants, and once recorded and transcribed, the material is owned by me. Even though the interpretation was based on participants' descriptions (Willig, 2013), interpretation still involves holding the power to influence

what is presented as someone else's experience. Further, the methods do not ensure that services will change on the basis of the participants' accounts, and even if they did, there would be a risk of using first-person experiences to make changes in services based on the researcher's agenda.

Epistemic injustice, a wrong done to somebody based on their capacity as a knower (Fricker, 2009), seems relevant in the first study. Not only are people with mental health and substance use problems regarded as 'vulnerable', but prejudice may lead to their accounts being seen as less trustworthy. In Study 1, some participants described experiences of not being taken seriously. Interestingly, other participants stated that people actively using substances should not be included in the study because they would not be trustworthy. I have actively assumed that participants are trustworthy with regard to describing their own lived experiences, and this was communicated to participants. The agenda of not adding to what is being expressed, consistent with a phenomenological methodology, reduces the researcher's influence in the analysis, but does not entirely eliminate it.

Research into service user participation in research has identified power issues as an area that needs to be addressed (Moltu, Stefansen, Svisdahl, & Veseth, 2012), and the need for academic environments to support co-researchers in claiming power has been highlighted. In the current project, I explicitly stated that I had decision-making power, but that input from the advisory group was listened to and considered to a large degree. However, some decisions were made contrary to group advice, e.g. during the analysis in Study 2.

6 Summary of papers

The thesis consists of three qualitative research papers that answer research questions 1-3, respectively. Results from Study 1 are presented in Papers 1 and 2, while results from Study 2 are presented in Paper 3. In the following, results from the three papers are presented sequentially, followed by a summary synthesis of the results from the three papers.

6.1 Paper 1

Brekke, E., Lien, L., Davidson, L. & Biong, S. (2017). First-person experiences of recovery in co-occurring mental health and substance use conditions. Advances in Dual Diagnosis, 10 (1), 13-24.

The aim of this paper was to explore and describe experiences of recovery among people with COD. Transcripts from eight in-depth, semi-structured interviews were analysed using systematic text condensation within a phenomenological approach. Four dimensions of experiences of recovery are presented based on our analysis of participants' descriptions: (1) feeling useful and accepted, (2) coming to love oneself, (3) mastering life, and (4) emerging as a person. Results are discussed in relation to other studies of first-person experiences of recovery in mental health, substance use, and co-occurring disorders, and in light of well-being and living conditions. The study indicates that a better life is possible for people living with COD. Descriptions of a good life are similar to those in the general population, and equally diverse. Adverse living conditions and untreated addiction appeared as barriers to recovery, while genuine community participation, particularly meaning something to others, was revealed as a facilitator.

6.2 Paper 2

Brekke, E., Lien, L. & Biong, S. (2018). Experiences of professional helping relations by persons with co-occurring mental health and substance use disorders. International Journal of Mental Health and Addiction, 16 (1), 53-65.

The aim of this paper was to explore and describe behaviour and attributes of professional helpers who support recovery, as experienced by people with COD. Building on the same material as Paper 1, transcripts from eight individual interviews were analysed using systematic text condensation within a phenomenological approach. Four categories of recovery-supporting behaviour and attributes of professional helpers are presented in the paper, and the ability to build trust cuts across all categories: (1) hopefulness and loving concern, (2) commitment, (3) direct honesty and expectations, and (4) action and courage. The findings are discussed in light of psychotherapy research and other research on helping relations. The study adds to existing literature by providing descriptions of how trust can be established and maintained in helping relations with people who have COD. The importance of being able to recognise the life circumstances of clients and take action in order to solve practical problems and reduce loneliness calls for integrated services to support this group.

6.3 Paper 3

Brekke, E., Lien, L., Nysveen, K. & Biong, S. (2018). Dilemmas in recovery-oriented practice to support people with co-occurring mental health and substance use disorders: a qualitative study of staff experiences in Norway. International Journal of Mental Health Systems, 12 (1), 30.

The aim of this paper was to explore and describe staff experiences with dilemmas in recovery-oriented services to support people with COD. Three focus group interviews with practitioners in a municipal mental health and addiction team were conducted

over the course of two years. Transcripts were analysed using thematic analysis. Based on the analysis of participants' descriptions, three dilemmas are presented in the article: (1) balancing mastery and helplessness, (2) balancing directiveness and a non-judgemental attitude, and (3) balancing total abstinence and the acceptance of substance use. Practitioners within the same team held different opinions on what recovery-oriented practice meant. Results are discussed in light of first-person experiences of professional help, while particular aspects of recovery-oriented practice in substance use as related to other mental health problems are discussed. The paper provides insight into practitioners' experiences of dilemmas in recovery-oriented practice as well as possible solutions to these, which may inform the implementation of such practice.

6.4 Summary of the results

All three papers deal with recovery in COD, building on an understanding of recovery as a personal and social process that exceeds symptom reduction. While Papers 1 and 2 explore first-person experiences of recovery, Paper 3 explores practitioners' experiences with recovery-oriented practice.

People with COD in a Norwegian context describe recovery as a process that consists of community participation, improved living conditions, and existential phenomena. There were individual differences in how participants related to substance use, but control over substance use seemed necessary in the process of coming to love oneself and emerging as a person.

In order for professional helpers to support recovery for people with COD, a trusting relationship is fundamental. Professional helpers may build trust by understanding and addressing everyday challenges, and making positive change in people's everyday life. A relationship of hopefulness and loving concern may help to build trust, and this concurs with common factors in psychotherapy research. Being honest and direct and addressing substance use in a straightforward way makes professional helpers easier to

trust. Continuity and commitment over time builds trust, and this may be related to how services are organised.

Practitioners described dilemmas in recovery-oriented practice to support people with co-occurring disorders, concerning how to relate to substance use in a recovery-oriented way, how to give enough help and still facilitate empowerment, and how to relate to the people's own life goals with neither moralism nor indifference. People with COD were described as expecting too little from services and tolerating unacceptable living conditions, which elicited directiveness from practitioners.

7 Discussion

In this chapter, I will discuss the main findings of the thesis in light of theory and existing knowledge, followed by a discussion of the methodological choices and their implications for the results, and reflexive comments.

7.1 Discussion of the results

7.1.1 First-person experiences of recovery

Results from this project support findings from other qualitative studies which indicate that control over symptoms may be a pathway to, but not the essence of, recovery. Systematic investigation of first-person experiences in this project has painted a broader picture of recovery in COD, which includes community participation, living conditions, and existential phenomena.

7.1.1.1 Community participation

Being accepted and being able to contribute in the community appeared as crucial aspects of recovery in this project. Other studies of first-person experiences with recovery in COD have also described community participation as a central aspect of recovery (De Ruyscher et al., 2017; B. T. Smith et al., 2015). This resonates with the concept of ‘citizenship’ (Perkins & Repper, 2014), which is described as an aim in the WHO mental health action plan (World Health Organisation, 2013). It also reflects the concept of ‘connectedness’ in Leamy and colleagues’ framework of personal recovery in mental health (Leamy et al., 2011).

A public health report from the Norwegian government (Helse- og omsorgsdepartementet, 2015) calls for supportive communities as a major strategy in combating mental health problems, including the prevention of loneliness and

discrimination. Glover (Glover, 2005) has suggested the term ‘recovery-nurturing environments’. In relation to natural recovery from substance use, ‘self-change friendly societies’ and ‘recovery capital’ have been described as crucial (Cloud & Granfield, 2008; Klingemann & Sobell, 2007).

Participants in this study who had experienced recovery in COD stated that they had much to offer to their community. Being able to contribute and help others was described as crucial turning points and central motivators. This resonates with other studies of first-person experiences of recovery in COD, where moving beyond past negative identities (B. T. Smith et al., 2015), accessing new social roles (O’Sullivan et al., 2013), and achieving positive identity by feeling worthwhile (Nordaunet & Sælør, 2018) have been described as important in the recovery process. Access to new social roles has been suggested as a central feature of environments that enable recovery (Klingemann & Sobell, 2007). Social identities that transcend substance use have been suggested as crucial in substance use recovery (Best et al., 2016), particularly social identities that involve helping others through community engagement (Best, 2016). The importance of meaning something to others is not specific to people with COD. ‘Generativity’, commitment beyond one’s own immediate needs, has been suggested as a major predictor of experiencing life as meaningful (Schnell, 2011). Gaining a sense of meaning through giving to others has been suggested as one of several elements of positive life events that, independently of treatment, enable recovery in severe mental illness (Davidson, Shahar, Lawless, Sells, & Tondora, 2006). This aspect of meaning – making a difference to others – may also be a key to utilising employment as a mechanism in recovery in COD. While employment is considered a recovery factor in COD, less meaningful employment has been found to potentially hinder recovery in this group (Hansen & Bjerger, 2017).

In addition to meaning something to others, results from the current project indicate that being acknowledged by others in everyday life situations may be an important part of recovery. Similarly, settings that allow for a sense of community and trust have been related to increased hopefulness in people with substance use problems (Jason,

Stevens, & Light, 2016). ‘Micro-affirmations’ have been suggested as crucial elements in environments that support recovery, indicating small, but frequent, signs of acknowledgment, in contrast to ‘micro-aggressions’ (Topor, Boe, & Larsen, 2018). The initial recovery movement involved protest against ‘micro-aggressions’ towards mental health patients; these are subtle negative communications in everyday life that may be experienced by members of socially marginalised groups, making them feel less human (Gonzales, Davidoff, Nadal, & Yanos, 2015). One participant in the current project described an experience of people explicitly leaving the table at the local café when she sat down, which can be seen as an example of a micro-aggression. Micro-affirmations, on the other hand, are small actions that make people feel more like a person. Skatvedt (Skatvedt, 2011) described how acknowledgment in a spontaneous, everyday interaction with another person provided her with a sense of self-worth and belonging in a situation where she felt alien and lonely. She called this phenomenon “the beauty of the ordinary”. Quoting Goffman, Skatvedt concludes: “...it is this spark, not the more obvious kinds of love, that lights up the world” (Skatvedt, 2011, p. 56). This resonates with what Larry Davidson has called “the little things” in life, seemingly trivial experiences of being met with common courtesy by other people on an everyday basis, which are suggested to be of crucial importance in recovery in severe mental illness (Davidson & Johnson, 2013).

7.1.1.2 Living conditions

Adverse living conditions were experienced as barriers to recovery by participants in the current project, particularly related to an insecure housing situation and economic problems that were perceived of as unsolvable. This is in line with other studies that have described the importance of establishing a satisfactory social situation (Skogens et al., 2018), safe housing (B. T. Smith et al., 2015), and material security (Brendbekken, 2016) in recovery in COD. Person-centred and recovery theory have been criticised for being too individualistic, ignoring the systemic and structural issues that the individual has no control over, which impact people’s genuine opportunities for positive change

(Jacobs et al., 2017; Proctor et al., 2006). Some have warned against applying the recovery approach as a new way of telling people to “straighten up” (Rose, 2014). Results from the current study support such criticism and point towards recognising structural factors in order to support recovery in COD.

Participants in this project described living conditions that are rare in a Norwegian context, in terms of both poverty and housing. Poverty has been suggested as both a risk factor and a complicating mechanism in mental health and substance use problems, and living with COD is associated with a particular risk of poverty (Dahl, Bergsli, & van der Wel, 2014; Ljungqvist, Topor, Forssell, Svensson, & Davidson, 2015; Read, 2010). A recent 10-year follow-up study from Sweden concluded that living with severe mental illness led to poverty, and the authors warned against confusing the effects of poverty with psychiatric symptoms, thereby pathologising the effects of poverty (Topor, Stefansson, Denhov, Bulow, & Andersson, 2019). Some participants in this project described how people seemed to expect too little from them and perceived them as vulnerable, which hindered recovery. Similarly, charitable kindness was perceived as very different from genuine acceptance in the community, and potentially negative. These phenomena have not been described in previous studies of recovery in COD. It is possible that they are related to an attribution of situational factors to the individual.

Results from this project indicate that people with COD may have an underdog position in Norwegian society. Participants described experiences of not being taken seriously by others, such as debt collectors or public officials, because of visible signs of substance use problems. Other studies have described how stigma (Nordaunet & Sælør, 2018), social exclusion (Stott & Priest, 2018) or a lack of access to “mainstream society” (Semb et al., 2016) may be barriers to recovery in COD. Further, the emphasis on phenomena that are otherwise often taken for granted, such as being treated like a human being and being listened to, has been discussed as an expression of former exclusion in other studies (Turton et al., 2011). Similarly, participants with COD in this project described being surprised and embarrassed by acts of kindness from other people, as if they did not expect or deserve them. Some participants expressed understanding of people

being negative towards hiring them, because they had substance use problems. These statements may be understood as expressions of self-stigma, where prejudice towards a group is internalised by the members of that group (Corrigan, Watson, & Barr, 2006).

7.1.1.3 Existential recovery

Spirituality was described as part of recovery in this study, supporting findings from other studies on recovery in COD and substance use (Green et al., 2015; Hipolito et al., 2011; Sørensen, Lien, Landheim, & Danbolt, 2015; Whitley, 2012). Spirituality was described in a broad sense, ranging from specific religious practice to experiences of nature. Spirituality has been associated with experiencing life as meaningful, by being part of something greater than oneself (Schnell, 2011), which was also explicitly described by some of the participants in this study. However, spirituality was not mentioned by practitioners, nor did participants with lived experience relate spiritual experiences to contact with professional helpers.

The categories of 'coming to love oneself' and 'emerging as a person' resonate with the concept of authenticity in person-centred theory (Rogers, 1967), and with seeing recovery as a personal journey (Deegan, 1996). Some participants described that gaining control over substance use enabled them to come to love themselves and emerge as a person. Others described that unravelling past experiences and addressing mental health problems made it easier to deal with substance use. The importance of control over substance use has also been described in previous studies (Green et al., 2015; Turton et al., 2011), while other studies have stressed the importance of understanding substance use in light of mental health problems and traumatic experiences (Stott & Priest, 2018). These findings support holistic and individualised approaches to COD, with flexible, client-centred services that include a variety of tools for addressing substance use and mental health problems (Henwood et al., 2014).

7.1.2 Professional helpers that support recovery

Trust cross-cut all other aspects of relationships with professional helpers in this project. This is in line with other studies that have described a lack of trust as a barrier between people with COD and health and social services (Edland-Gryt & Skatvedt, 2013). This project adds to the existing literature by providing examples of how trust may be established between people with COD and professional helpers.

7.1.2.1 *Everyday problems*

Previous studies have described that people with COD preferred to ask friends for help in health issues, because they had found that health personnel would not understand their life situation (Ness, Borg, & Davidson, 2014), while professional helpers who appreciate all aspects of one's life situation (Cruce et al., 2012) and provide practical help (Biong & Soggiu, 2015; Stott & Priest, 2018) have been described as facilitating recovery. This concurs with the category of 'building trust through action and courage' in this project. These findings indicate that professional helpers should pay more attention to, and see it as their job to address, the living conditions and everyday life situation of people with COD (Slade, 2012).

Helping people escape loneliness was also part of 'action and courage' in this project. Other studies have shown that services should pay more attention to helping people avoid loneliness. Lauveng and colleagues (Lauveng, Tveiten, Ekeland, & Ruud, 2016) found that participants experienced extreme loneliness after inpatient treatment of psychosis in a Norwegian sample, and that this was associated with decreased hope and opportunities for recovery. Similarly, a 10-year prospective study of people in substance use treatment found that people were "treated into loneliness", indicating that even if substance use problems were successfully treated, people lived isolated lives and experienced loneliness (Lauritzen, Ravndal, & Larsson, 2012). In a Norwegian interview study with men with substance use problems and suicidal behaviour (Biong, Karlsson, & Svensson, 2008), participants described the experience of being socially dead to the

extent that physical death would no longer make a difference. A lack of social relations has been suggested as a mortality risk factor (Holt-Lunstad, Smith, & Layton, 2010). This supports services that allow for addressing loneliness and working towards reducing it (Pettersen et al., 2019).

7.1.2.2 Loving concern

Participants in this project stated that professional helpers who expressed hopefulness and loving concern were easier to trust, which agrees with previous studies showing that acts of kindness (Padgett et al., 2008), hope promotion (Cruce et al., 2012; Hagler et al., 2015), providing a safe haven (Waters et al., 2014), genuine concern (Hagler et al., 2015), and a lack of rejection (Biong & Soggiu, 2015) may be attributes of professional helpers valued by people with COD. These phenomena resonate with common factors of the therapeutic relationship that are described in psychotherapy research, such as working alliance, empathy, and positive regard (Wampold & Imel, 2015). Within person-centred care, the concept of 'sympathetic presence' seems akin to the phenomenon of loving concern (McCormack & McCance, 2016).

7.1.2.3 Commitment

In many studies that have addressed first-person experiences of barriers to recovery in COD, fragmentation and rigidity of services have appeared as central barriers to recovery (Brooks et al., 2007; Ness, Borg, & Davidson, 2014; Staiger et al., 2011; Stott & Priest, 2018). On the other hand, flexibility, integration, and continuity have been seen as facilitators (Hagler et al., 2015; Matusow et al., 2013; Stott & Priest, 2018), representing commitment on the part of service providers. Commitment made it easier for participants in this study to trust professional helpers, which may in part be related to how services are organised.

7.1.3 Dilemmas in recovery-oriented practice

Research from mental health services indicates that practitioners may experience competing priorities between demands from the system and recovery principles (Le Boutillier et al., 2015). This has also been described in a study of recovery-oriented practice in COD (Felton et al., 2006), and in a study of empowerment-oriented practice in substance use treatment (Frank & Bjerger, 2011). Qualitative studies that have addressed practitioner experiences with supporting recovery in COD have described that rigid systems, lack of collaboration, and insufficient duration of treatment may be challenges to practitioners (Pinderup, 2018), and that rigid systems may be barriers to hope-inspiring practices (Sælør, Ness, Borg, et al., 2015). Freedom to base interventions on each client's needs (Andvig et al., 2018), flexible systems and colleagues with lived experience (Midtgarden, 2018) have been described as facilitating recovery-oriented practice. In this project, competing priorities with system demands were not described as problematic, which may be explained by the fact that practitioners had considerable freedom to base interventions on individual needs. Dilemmas related to system factors in this project concerned prioritising between clients, particularly when some clients were not engaged or compliant.

The dilemma of balancing responsibility and practical help in this project resembles 'the balance between care and responsibility' (Hummelvoll, 2012), which refers to finding out the circumstances under which people can manage alone, and making interventions tailored to individual needs. Relatedly, in the substance use literature, 'recovery capital' defines the sum of resources, both internal and external, that an individual can draw upon in the recovery process, which should be considered along with the severity of problems in order to decide the level of support to provide (Best & Laudet, 2010). Interestingly, this division was also described by participants with lived experience in this project, but not as a paradox or dilemma. So long as people's ability to take care of themselves is acknowledged, helping people was not described as negative. After all, as one participant put it, practitioners are professional *helpers*, and helping people is their job. Other studies have suggested that while mental health problems are perceived as

both existential and practical by people who experience them, working with the existential components seems to have more status among mental health practitioners than addressing the practical components (Klevan, 2017).

A related dilemma that appeared in this project was that of balancing directiveness and a non-judgemental attitude. This has also been described in other studies (Felton et al., 2006). This dilemma touches upon shared decision making in mental health and substance use treatment. It has been suggested that a barrier to taking recovery seriously is that professional helpers believe that service users, when given the opportunity to choose, will not make the right decisions (Drake, Deegan, & Rapp, 2010).

The dilemma of balancing total abstinence and the acceptance of substance use seems to mirror the difference between harm reduction and abstinence-oriented approaches (McKeganey, 2012). Results from the current project may enable nuancing of the sometimes polarised debate between harm reduction and abstinence-based approaches by exploring dilemmas and paradoxes within both approaches. In other studies, practitioners have described how harm reduction, when combined with accommodating abstinence, is compatible with recovery-oriented practice in COD (Henwood et al., 2014). The 12-step, abstinence-oriented treatment programmes have been accused of worsening self-stigma among people with addiction because of the emphasis on hitting rock bottom and recognising one's powerlessness in the face of addiction (Corrigan et al., 2017). Further, the focus on abstinence as the solution to everyone may be argued to be at odds with an individualised approach. Others have suggested that AA approaches support recovery by enabling social identity transitions (Best et al., 2016). First-person perspectives, including from this project, suggest that a solution to the dilemma of abstinence versus acceptance of substance use may be to acknowledge individual differences in how substance use is best understood in the recovery process (Padgett et al., 2008; Stott & Priest, 2018).

7.2 Methodological considerations

There are different quality criteria in qualitative research. Lincoln and Guba (Lincoln & Guba, 1985) suggested using the concepts of trustworthiness, credibility, confirmability and dependability in order to evaluate qualitative research, while others have applied concepts from quantitative research, such as validity, reliability and generalisability (Kvale & Brinkmann, 2009; Maxwell, 1992). Malterud (Malterud, 2001) proposes the terms relevance, validity and reflexivity as overall standards for qualitative research. In the following section, the validity and relevance of the results are considered in light of the methods, followed by remarks on reflexivity. While the section is structured around Malterud's terms, literature by other writers is also applied, as referenced throughout.

7.2.1 Validity

Validity in qualitative research concerns the credibility of its results and conclusions. Validity is not obtained by specific techniques, but concerns the entire research process and should be considered in relation to the aims and context of the research (Kvale & Brinkmann, 2009; Maxwell, 1992).

One may ask how the lived experiences of eight persons with co-occurring disorders, and one mental health and addiction team, may be relevant beyond the local context. Certainly, the methods used in the two studies of this thesis do not allow for a statistical generalisation of the results, and readers are warned against assuming that the described experiences are directly relevant to other people with COD or to professional helpers in other contexts. Rather than statistical generalisability, generalisability of qualitative research often concerns analytical generalisability (generalisation to theory) or transferability of particular results or understandings to other contexts (Maxwell & Chmiel, 2013a). In the current project, describing and exploring people's lived experiences of a phenomenon is considered to hold the potential of yielding a deeper understanding of the phenomenon which may be transferred to other contexts and other people.

Sampling in qualitative research involves making decisions on situations, sites or persons that offer a specific, information-rich perspective, rather than searching for a random sample. Sampling requires prior knowledge in order to make judgements regarding how the sample represents the phenomenon being studied, and to understand the potential diversity within the phenomenon. A purposeful sampling strategy means that one has considered how typical participants are of the phenomenon being studied, what connects the participants, and what divides them (Rapley, 2013), while searching to recruit persons who have experience relevant to the purpose of the inquiry, so-called 'information-rich cases' (Malterud et al., 2016).

In order to situate the sample and allow for considerations about transferability, detailed information about the participants as well as the study context was provided. As mentioned under ethical considerations, this was done within the limits of confidentiality of the participants. The participants in Study 1 differed in age, gender and living conditions while experiencing co-occurring disorders. However, due to the way recruitment took place, I may not have reached out to the people who had the greatest problems, or who did not trust the services. This is important to consider in relation to the transferability of the results. A more active and prolonged recruitment strategy could have made it easier for some people to participate in the study. In Study 2, the participants differed in professional background and the length of time they had worked in the services. However, only one setting was studied, and conducting the same procedure in another context, even if it involved a similar team in a similar process, might have yielded different results. Furthermore, Study 2 was conducted at a time when recovery orientation was still quite unfamiliar to many professionals in Norway, which may have influenced the findings, particularly the different opinions on what recovery-oriented practice is.

The fact that the project was conducted in one context may affect the transferability of the results, particularly in Study 2. One advantage of doing research in one context is that it is possible to describe the context in order to allow for considerations about transferability.

Data were collected through individual interviews in Study 1 and focus group interviews in Study 2. The accounts that emerged from the interviews are considered to be valid accounts of participants' experiences as they were expressed in that particular context, but do not necessarily allow for inferences about the full range of experiences or perspectives of the participants regarding the phenomena under study. This relates to internal generalisability, or the representativeness of the data and conclusions for the individuals being studied (Maxwell, 1992). Meeting with each participant several times or conducting the interviews together with a person with lived experience of COD might have increased the internal generalisability of Study 1. Conducting individual interviews in addition to focus group interviews might have allowed for a more thorough investigation of each participant's experiences in Study 2.

An analysis of the focus group interviews in Study 2 which focused on interaction in addition to content meaning, such as discourse analysis, might have yielded more knowledge about disagreement among the participants regarding recovery-oriented practice (Barbour, 2013).

Different approaches to data analysis and different data collection methods may affect the assembling and synthesising of knowledge from the different studies, possibly affecting the internal validity of the project as a whole (Maxwell, 1992). The two methods of analysing data used in this project have both similarities and differences. They both involve categorising strategies based on similarity rather than contiguity (Maxwell & Chmiel, 2013b). Although thematic analysis may be said to involve connecting strategies, the connections are made between categories, and not based on the original variation in the material (Maxwell & Chmiel, 2013b). One difference between the two methods of analysis is the sequence of the different steps involved. In systematic text condensation, the identification of themes precedes coding, while the procedure in thematic analysis involves coding the entire material before identifying themes. These differences are not considered to affect the internal validity of the current project.

The analytic methods used are quite detailed, and while they provide transparency, they may lead to a reduction of the participants' experiences. Recontextualisation in the analysis process, seeing the results in light of the original context, may partly counteract this tendency. However, recontextualisation within categorising strategies for data analysis has its limitations, as it involves a limited, categorical context (Maxwell & Chmiel, 2013b).

While authors disagree on the usefulness of different methods for credibility checks, there seems to be consensus regarding the benefits of describing how the credibility of one's results has been investigated (Elliott, Fischer, & Rennie, 1999). The advisory group was intended to be an arena for communicative validity in this project, where knowledge claims were tested in conversations with people familiar with the issue and context (Kvale & Brinkmann, 2009). While group members had different perspectives, and different opinions were explicitly welcomed in group meetings, the group did not represent everyone who was affected by the project, and it is possible that others would have had different views on the knowledge claims.

Pragmatic validity concerns whether the knowledge works in practice (Kvale & Brinkmann, 2009), which in this case might mean that the knowledge had been useful in improving the services, or in enhancing the community participation of people with COD. The methodological choices that were made in this project have not allowed for investigating such changes in a systematic way. An action-oriented, participatory approach would have enabled an investigation of pragmatic validity, and this could be an aim for future research.

7.2.2 Relevance

A challenge in recovery research is that results may seem commonplace and even naïve. However, this may also be a strength. As Borg and Davidson put it (Borg & Davidson, 2008, p. 131): *“Our major challenge as researchers and practitioners lies in making explicit, capturing and recognizing the simplicity as well as the complexity of daily life”*.

Research into mental health and substance use may, while striving for complexity, specificity and compliance with advanced academic standards, actually miss the obvious, ordinary things which have great importance in people's lives. Collaborative methods may increase the quality and relevance of research and highlight potential tensions between different stakeholders' perspectives (Mjøsund et al., 2017; Moltu et al., 2012, 2013). The advisory group in this project has served as a constant reminder of "keeping it simple", in the sense of staying close to everyday life and not complicating issues for the mere sake of academic elegance.

7.2.3 Reflexive comments

Reflexivity in qualitative research allows for an examination of the grounds for the knowledge claims, and an exploration of the limitations and strengths of the knowledge. Reflexivity concerns the researcher's latent and unarticulated preconceptions related to academic disciplines and training, as well as the social and power issues related to the social contexts of research (May & Perry, 2013). Reflexivity as a researcher involves transparency regarding one's theoretical, methodological and personal orientations relevant to the research, relevant personal experiences or training, and initial as well as emerging beliefs about the phenomenon under study (Elliott et al., 1999). Reflexivity is understood differently in different research traditions (Finlay, 2002). Collaboration with people who have lived experience of mental health and substance use problems has been argued to increase reflexivity in qualitative research (Veseth et al., 2017).

7.2.3.1 Pre-understanding

Pre-understanding is necessary for any understanding to take place, but may also involve a bias that affects knowledge production in untoward ways (Binder et al., 2016). For this reason, I present a short description of elements in my background that I consider relevant to the project. I took a degree in psychology at the University of Oslo,

within a traditional, psychological understanding of mental health, which implies a bio-psycho-social understanding, with less emphasis on the social aspect. During my specialisations in addiction psychology and community psychology, this understanding was broadened to include social aspects to a greater degree. At the onset of my research, I identified theoretically with phenomenological psychology and community psychology. I was not greatly aware of recovery theory or person-centred theory, but found both of them interesting. Throughout my work with the thesis, I have become even more aware of the social aspects of recovery, in addition to the psychological aspects, and I believe that these are often under-communicated and under-addressed. I consider that recovery and person-centred approaches complement bio-medical approaches to mental health and substance use.

My background as a psychologist in substance use treatment meant that I already knew many people with substance use problems and co-occurring mental health problems. I also knew the health and social services quite well. This may have been an advantage, in that it may have enhanced my understanding of the participants' experiences, and a disadvantage, in that I may have jumped to conclusions or failed to explore issues which I took for granted. In order to address this issue, I adopted a consciously naïve attitude during the interviews and analysis, using my previous knowledge as a horizon in understanding while at the same time challenging it and being conscious about not adding to participants' descriptions. A particular challenge was experienced in interviews with staff and the subsequent analysis, where I constantly had to remind myself not to inhabit the role of a supervisor, or to place emphasis on the often implicit clinical knowledge from my working life. Further, my interest in substance use may have led to excessive focus on this at the expense of mental health issues.

8 Conclusions and implications

People with COD in this project described recovery as a process that consists of community participation, improved living conditions, and existential phenomena such as spirituality, coming to love oneself, and emerging as a person. Community participation, particularly feeling useful, may be a central facilitator in recovery, and adverse living conditions and loneliness may be important barriers to recovery in COD. There were individual differences in how participants related to substance use, but control over substance use was described as necessary in the process of coming to love oneself and emerging as a person.

Findings from this project suggest that professional helpers may play a central role in the recovery process of people with COD once a trusting relationship has been established. Professional helpers may build trust by understanding and addressing daily life struggles, and contributing to positive changes in people's everyday life. A relationship of hopefulness and loving concern may help building trust, and this seems to concur with common factors in psychotherapy research. Being honest and direct, and addressing substance use in a straightforward way may make professional helpers easier to trust. Continuity and commitment over time may build trust, and this seems to be related to how services are organised.

Practitioners in this project described dilemmas in recovery-oriented practice to support people with COD. These dilemmas concerned balancing empowerment and autonomy with practical support and directiveness, and balancing a focus on total abstinence with acceptance of substance use. Further, practitioners within the same team described different understandings of what it meant to address substance use in a recovery-oriented way. These differences seem to be related to different traditions of understanding substance use.

Results from this project suggest that services to people with COD need to be flexible, integrated and allow for continuity. Professional helpers and services should be able to address living conditions and loneliness, and increase opportunities for genuine

community participation for people with COD. Services should be able to address substance use in competent and individualised ways.

There is a need for research on how the knowledge from recovery research may be translated into practice to support people with COD, both at the system level and at the service delivery level. There is a need for research into recovery in COD beyond clinical settings, addressing relations to family and friends, community participation and citizenship.

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Article 1

Brekke, E., Lien, L., Davidson, L. & Biong, S. (2017). First-person experiences of recovery in co-occurring mental health and substance use conditions. *Advances in Dual Diagnosis*, 10 (1), 13-24. <https://doi.org/10.1108/ADD-07-2016-0015>

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Eva Brekke, Lars Lien, Larry Davidson, Stian Biong,

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Eva Brekke, Lars Lien, Larry Davidson, Stian Biong, (2017) "First-person experiences of recovery in co-occurring mental health and substance use conditions", *Advances in Dual Diagnosis*, Vol. 10 Issue: 1, pp.13-24, <https://doi.org/10.1108/ADD-07-2016-0015>

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First-person experiences of recovery in co-occurring mental health and substance use conditions

Eva Brekke, Lars Lien, Larry Davidson and Stian Biong

Abstract

Purpose – *The purpose of this paper is to explore and describe experiences of recovery among people with co-occurring mental health and substance use conditions (co-occurring conditions) in a rural community in Norway.*

Design/methodology/approach – *In-depth individual interviews with eight persons with co-occurring conditions were conducted, audiotaped, transcribed and analysed using a phenomenological approach. This study is part of a research project investigating recovery orientation of services in a Norwegian district.*

Findings – *The analysis yielded four dimensions of recovery: feeling useful and accepted; coming to love oneself; mastering life; and emerging as a person. Insecure and inadequate housing and limited solutions to financial problems were described as major obstacles to recovery.*

Research limitations/implications – *Further research into the facilitation of recovery as defined by persons with concurrent disorders is needed, particularly regarding the facilitation of community participation.*

Practical implications – *This study supports an increased focus on societal and community factors in promoting recovery for persons with co-occurring conditions, as well as service designs that allow for an integration of social services and health care, and for collaboration among services.*

Social implications – *The results suggest that the community can aid recovery by accepting persons with co-occurring conditions as fellow citizens and welcoming their contributions.*

Originality/value – *The paper provides an enhanced understanding of how persons with co-occurring conditions may experience recovery.*

Keywords *Recovery, Dual diagnosis, First-person perspectives, Concurrent disorders*

Paper type *Research paper*

Eva Brekke is a Doctoral Research Fellow at the Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust, Brumunddal, Norway and Faculty of Health Sciences, University College of Southeast Norway, Drammen, Norway. Lars Lien is the Head of Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust, Brumunddal, Norway and a Professor at the Innlandet University College, Elverum, Norway. Professor Larry Davidson is a Director of the Program for Recovery and Community Health, Faculty of Psychiatry, Yale University School of Medicine, New Haven, Connecticut, USA. Professor Stian Biong is based at the Faculty of Health Sciences, University College of Southeast Norway, Drammen, Norway.

Introduction

Substance use and mental health disorders show a high degree of co-occurrence (Mueser *et al.*, 2000; Landheim *et al.*, 2006). There is growing support for tailored and integrated treatment for co-occurring substance use and mental health conditions (co-occurring conditions) (Drake *et al.*, 2004), but challenges to implementation remain. Recovery and recovery-oriented care have been suggested as organising principles for the integration of mental health and addiction services (Davidson and White, 2007).

Originating among persons with lived experience, an understanding of recovery as personal and social processes that go beyond symptom reduction has gained a foothold in clinical and research environments within the fields of mental health (Anthony, 1993; Mezzina *et al.*, 2006; Slade, Adams and O'Hagan, 2012) and substance use (Laudet, 2007; Neale *et al.*, 2014). Recovery has been defined as “a process of restoring a meaningful sense of belonging to one’s community and a positive sense of identity apart from one’s condition while rebuilding a life despite or within the limitations imposed by that condition” (Davidson *et al.*, 2007). Akin to such approaches as person-centred theory (McCormack and McCance, 2006), positive psychology (Slade, 2010) and emancipatory theory (Freire, 1970), this perspective adds to the traditional

Received 19 July 2016
Revised 29 August 2016
Accepted 16 September 2016

Conflict of interest: on behalf of all authors, the corresponding author states that there is no conflict of interest.

psychiatric understanding of recovery as clinical outcome. Systematising service user experiences through research validates a broader definition of recovery (Veseth *et al.*, 2012), challenges dominant discourses (Neale *et al.*, 2015), and allows for a deeper understanding of recovery processes among persons with co-occurring conditions (Hipolito *et al.*, 2011).

Underpinning this study is an understanding of recovery as a personal and social process. Viewing recovery as a personal process involves seeing the person as the central actor and decision maker and paying attention to and respecting each person's unique experiences. Seeing recovery as a social process involves recognising everyday life as the central arena for recovery (Borg and Davidson, 2008), while acknowledging contextual factors (Topor *et al.*, 2011) and underlying social-psychological dynamics (Best *et al.*, 2016). Much of the recovery literature focusses on mental health and substance use problems separately, which is reflected in parallel visions of recovery in mental health services and drug and alcohol services (Roberts and Bell, 2013). A recent review of the limited literature on first-person experiences of recovery in concurrent disorders (Ness *et al.*, 2014) found that a meaningful everyday life, a focus on strengths and future orientation, and re-establishing a social life and supportive relationships were experienced as facilitators of recovery. A lack of tailored help, complex systems and uncoordinated services were experienced as barriers to recovery. A report of first-person experiences with recovery orientation of mental health and addiction services in a Norwegian city (Biong and Soggiu, 2015) indicates that recovery is related to collaboration with health care professionals about goals that are important to the person, mainly concerning living conditions and everyday life. Living with co-occurring conditions may be both similar to and different from living with mental health problems or substance use problems. There is a need for accounts of first-person experiences of recovery in co-occurring conditions from varied contexts (Ness *et al.*, 2014; Slade, Leamy, Bacon, Janosik, Le Boutillier, Williams and Bird, 2012).

The aim of this paper is to explore and describe recovery as experienced by persons who live with co-occurring substance use and mental health conditions in a Norwegian local community.

Methods

Context

This study is part of a research project that investigates recovery orientation of services in a local authority area in Eastern Norway. Norwegian health care is organised into primary, secondary, and tertiary care. Primary care is run by local authorities, whereas hospital trusts are responsible for secondary and tertiary care. The results presented in this study will inform developments in the practices of local mental health and addiction services. The community consists of agricultural areas, forested areas, and two community centres (< 6,500 inhabitants).

Similar to the account in Sælør *et al.* (2015), a group of six persons from the community has advised the authors throughout the process. They are two persons with lived experience of co-occurring conditions, one family member of a person with co-occurring conditions, and three health care professionals. The group has participated in developing the interview guide, inclusion criteria and recruitment strategy. They have been consulted in the data analysis as an arena for validation and for understanding the results in relation to the local context.

Recruitment

A sampling strategy that aimed for diversity in age, gender, duration of contact with services, substance use and mental health problems was applied. Flyers were handed out by the staff members of the local mental health and addictions team to all service users they met with for a period of two weeks. Flyers were also distributed at a peer support house, in the local narcotics anonymous group and at a low-threshold meeting place that provides harm-reduction health services for persons with substance use problems in the nearest town. Participants were able to refer themselves by contacting the first author by e-mail or SMS, or by agreeing that staff members forward their telephone number to study personnel.

Participants

The participants were four women and four men ranging from their early 20s to their 70s. All were in contact with the community health and social services at the time of the interview. They acknowledged that substance use and mental health problems seriously affected their everyday life, now or in the past. They reported having used or using the following substances (number of participants reporting this as their main substance in parenthesis): alcohol (3), amphetamines (2), benzodiazepines (2), opioids (1) and cannabis. Most participants reported having used several substances. Four persons reported not using substances at the moment, one was in maintenance treatment, and three persons were currently using substances at the time of the interview. The participants reported experiencing or having experienced affective disorder, anxiety, post-traumatic disorder, psychotic illness, and hyperactivity disorder. This information is based on the participants' understanding of their mental health condition and not on an objective diagnosis. Five participants received disability benefits, one received social welfare, one was a student, and one was a job-seeker. Five participants lived in rented flats, two persons owned their own home, and one person had no fixed abode at the time of the interview. Four participants were single and four were in a relationship.

Data collection

Eight semi-structured, in-depth individual interviews (Kvale and Brinkmann, 2009) were carried out by the first author. Concrete and detailed descriptions of subjective experiences with recovery were sought. An interview guide consisting of open-ended questions about what recovery means and what might lead to recovery was developed in collaboration with the advisory group. Participants were asked to describe their own personal experiences of recovery. Follow-up questions were asked, such as: "What was that like for you?", and "How did that feel?" Interviews lasted from 45 to 80 minutes.

Analysis

Interviews were audiotaped and transcribed verbatim by the first author. Data analysis was guided by systematic text condensation (Malterud, 2012) within a phenomenological approach (Giorgi, 2009). Selective bracketing of the researcher's pre-understanding was sought in the analysis process. Initially, all transcripts were read as a whole in order to gain an overall impression, resulting in preliminary themes. Second, the transcripts were systematically reviewed line by line, identifying, classifying, and sorting meaning units into code groups. Third, meaning units within each code group were sorted into subgroups. At this point, the advisory group was consulted, leading to an enhanced understanding of the material. At the fourth step, all meaning units within each subgroup were reduced into an artificial quotation (a condensate) maintaining, as far as possible, the original terminology used by the participants, and an authentic illustrative quotation was identified for each subgroup. Finally, analytic texts were developed, synthesising the contents of the condensates and developing descriptions. The analytic texts were validated by returning to the full transcripts and asking whether our synthesis still reflected the original context. The results section consists of analytic texts with supporting quotes from the participants in italics. The N-VIVO-10 software was used in the analysis process.

Ethical considerations

The study was approved by the Norwegian Social Science Data Service (Case No. 42244). Informed consent was a requirement for participation. Debriefing was integrated in the interview situation. Participants were offered the opportunity to get in touch with the first author after the interview. Details that could identify participants were removed before the material was shown to the advisory group. The members of the advisory group signed a declaration of confidentiality.

Results

Participants described personal and social recovery as: feeling useful and accepted; coming to love oneself; mastering life; and emerging as a person. Gaining control over substance use,

coping with mental health problems, and unravelling painful life events were described as pathways to recovery. Insecure and inadequate housing and a lack of solutions to financial problems were described as major obstacles to recovery.

Feeling useful and accepted

Recovery was described as feeling useful and accepted. Experiences of contributing in the community and meaning something to others were associated with feeling valuable, light at heart, joyful, having a sense of goodness towards oneself and others, not having to deal with one's own difficulties, and feeling that one is not the only person with problems. Several participants suggested that they had something to offer, but felt that the community did not need, or want, their contribution. Some participants expressed an understanding of employers' reluctance towards hiring them, because of their unstable life situation and the fact that they had substance use and mental health problems. Participating in facilitated activities was appreciated, but described as different from contributing in a genuine way:

I hope that one day the council will get to the point where I'll be allowed to join in and be of help somewhere. Because I mean we're not useless just because we have disabilities.

You feel light at heart. Feel much more like doing other things as well. Almost no stomach problems. You feel a kind of goodness, in a way. Yes, you do. Satisfaction. So that [...] that was a good, pleasant time.

The course I'm going to, well, it's for teaching you about coping in everyday life. So the goal is to get up in the morning and start coping. That's all very well, but it's a bit pointless, because I'd like to contribute and make some money. So it's kind of pleasant enough, but I want something more (out of life).

Experiences of being accepted in the community were described as valuable, whereas being met with a lack of acceptance was described as hurtful. One woman had left a café in tears when others had visibly made a point of leaving the table when she sat down there. Several participants said that it was difficult to feel accepted when one used substances. Others reported that people in the community were nice to them. One person noted the important difference between being tolerated in the community as a substance user, and being accepted in the community on the same terms as everyone else. He had found charitable kindness to be convenient when he was using substances, but later wondered whether it had kept him from moving on. Experiences of social participation on society's premises were described as motivating milestones in feeling useful and accepted. Acceptance was described as unexpected and undeserved by some participants:

Now I've started going to the café. I think that's helped me a lot. You get the thoughts out of your head because you're talking to other people. And it's so nice there. [...] So when I leave on Friday, they say: "You're coming back on Monday, aren't you?" I think that's nice. [...] It makes a big difference. Yes, it really does. Apart from them, I haven't got anyone, you know.

[...] and then it's really embarrassing that they like us so much, you know. People really trust us here, in the supermarket and so on. If I haven't got enough money, they still let me have the groceries. And now at Christmas time I went to the supermarket, and they gave me flowers for Christmas too. It's quite incredible that they're so nice to me there.

Coming to love oneself

Recovery was described as a feeling of self-respect and coming to love oneself, related to persisting through hard times. This feeling was the result of one's own insights and struggle:

I've come to love myself, that's what I really value most of all. The fact that I've been in this pain for all these years and got through it and learned to value myself. So that I've got back my self-respect. It hasn't been put there, nobody's given it to me, I've fought for it myself.

Spiritual experiences such as religious faith, experiences of nature, and spiritual growth were highlighted by several participants. Being part of something larger than oneself was described as offering a feeling of dignity. Faith was described as feeling hope and consolation.

Several participants described a special tranquillity related to spiritual experiences, particularly concerning feelings of gratitude. One participant described having a sixth sense he thought of as a gift and an important part of life, but it was kept hidden from health care professionals for fear that it would be perceived as a symptom of severe mental illness:

I've got another perspective, and that's the spiritual perspective in life. Not the way it's always been. It's always been empty, you know. Understanding that maybe I'm part of a bigger context, and that being human is a much bigger thing than what I've thought [...] [...] It's about getting in touch with this big thing on the inside, you know [...] [...] getting a spiritual dimension in life too. Or else it all becomes so meaningless.

Mastering life

Recovery was described as mastering life. The value of actually practising and gaining experiences of mastering everyday life was highlighted by several participants. Having support from others was described as important, and peer support was mentioned as particularly helpful. One person described how he had learned to master life by exposing himself repeatedly to everyday life situations, like going to the supermarket. Having a close friend to talk to during that period had been crucial to analysing situations and his own reactions to them. The experience of mastering one's life was associated with confidence, joy, pride, and motivation to face future challenges:

Well, kind of, how can I put it, the more you learn to cope, the better you feel about yourself, in a way. [...] Learning how to master things, achieve things, trust yourself. Because your confidence can be really low. So [...] Well, you know, less confidence and maybe more alcohol. And more alcohol, maybe less confidence. So those things are really connected.

Like getting my driving licence, for example. And knowing what a brake pad is on a car. So I kind of had so little knowledge and insight in all those things. Like that, you see. For example, when I got my licence, it was a great sense of mastery. It's been important always having those goals that make me more like other people. [...] Because all the time I was taking drugs, and before too, I felt like I had so little in common with other people. When people were talking about something, I didn't have any experience about the subject.

Being able to pay one's debts was described as crucial in a recovery process, related to atonement, putting the past behind, and then moving forward. Financial difficulties were described as a barrier to mastering life, linked to feelings of hopelessness and despair, especially when solutions seemed unavailable. Difficulties with concentration and attention after a period of substance use were described as complicating the process of gaining an overview of one's finances:

What's bothering me most right now is the money problem. [...] The thing is, my head isn't really working yet. So when I sit down with a huge pile of bills, and I have to sort them out, I just switch off pretty soon, because it's too much. So it's hopeless. When I think I've done all of them, another seven sort of appear. It actually bothers me quite a lot.

I can walk tall a bit more now. That feels good. [...] Like before, I was never late for things, I paid my bills, did what I was supposed to [...] It feels really good to start getting back to that – and that others can see it.

A good place to live was described as a house in an ordinary neighbourhood. Being able to keep one's home cosy and clean was described as a sign of mastering life, related to feeling decent and normal. Inadequate housing was described as an obstacle to mastering life. Some participants reported feeling unsafe and constantly on the alert in their home. They described experiences of having people entering the house with a weapon at night, having a hammer thrown through the window, and having the flower pots they had just put in front of their house broken on purpose. Some did not dare to leave their home for more than a few hours. One person was constantly afraid that family heirlooms with sentimental value would be destroyed or stolen. Others stored valuables with friends or family. Visits from children or grandchildren were described as impossible by some participants due to the state of their home. Several participants had experienced neighbours offering drugs at their door shortly after they had been discharged from inpatient addiction treatment, which had made it difficult to maintain abstinence. Others had noticed that neighbours hid drugs on their property, which made them

nervous that the police would think they were involved. Some of the participants wanted to move, but did not think it was possible:

I hope [...] that I can live safely again. So I can start living again, not just stay at home, feeling terrified. If I hear footsteps in the street outside, I'll wake up. If I hear crunching on the gravel by my post box, I'm wide awake. And you're not supposed to live like that.

Emerging as a person

Recovery was described as emerging as a person. Acting in line with attributes that one values, improving cognitive abilities and health, or rediscovering skills, were described as part of emerging as a person. Participants described this phenomenon as involving experiences of appreciating oneself, relaxing one's shoulders, daring to come forward, and having peace with one's conscience. Several participants used the expression "becoming myself again", describing how skills, attributes and abilities had been lost in the course of alcohol or drug use and mental health problems, and then regained, to the pleasant surprise of themselves and others. Understanding mental health problems in terms of a psychiatric diagnosis was described as part of emerging as a person by some participants. Others described that having a psychiatric diagnosis felt irrelevant or that it felt like being put in a pigeonhole:

Recovery is [...] your health improves, you feel better inside, you feel good about yourself, especially. And you see things are going better with people around you, especially the closest ones. And that builds up your confidence, you can manage to join in things, you're not afraid you've got to get drunk before you can do something. Your self-esteem is better. [...] And then there's sort of a bit more point to your life. You can go on trips that you'd never have gone on otherwise, go to concerts sober [...] a lot of things. And it makes you feel better about yourself.

I wonder how they could give me that diagnosis. But you know I was just so dysfunctional at the time. So introvert, and kind of emotionally closed up. And on top of that I was terribly paranoid about everything. [...] It's not true anymore, so it doesn't bother me now. I really don't mind.

Gaining a distance from alcohol and drug use was described as a pathway to emerging as a person by several participants. Some described abstinence as a foundation for work, education, artistic creation, family life, and improvement of mental health. An explicit distinction was made between substance use problems and addiction. Living with addiction was described as all-consuming and associated with low self-esteem. Several participants said that they had needed someone else to make them aware of the seriousness of their situation, while at the same time emphasizing that they themselves were responsible for their actions and their life. A strong sense of regret was described, particularly related to not being able to care for one's children. Addiction treatment, such as adequate detoxification, peer support, increased knowledge and awareness of addiction, and maintenance treatment were all described as useful in emerging as a person. Some participants suggested that gaining a distance from drug or alcohol use made them feel like a different person from the one they were before. Some described that mental health problems were easier to live with without substances. Others described using alcohol or drugs in order to manage symptoms of mental health problems in daily life:

You feel really lonely and alone, like an alien. A bit strange, you know. You take drugs, and [...] [...] I thought there was something wrong with me, and everybody else thought so too.

My whole life was just shame and guilt and I just got drunk and [...] I wasn't very conscious then of why it was all happening, you know. I just blamed everybody else.

Distancing yourself from alcohol makes you feel more confident about yourself. You relax more. You kind of dare to come forward, and you gradually become yourself again. You feel it's easier to get things done, you don't push them away. And then you need to make your grey cells start working again.

For some participants, painful experiences in childhood had limited the possibilities of a good life. One woman described how her schooldays had been ruined by domestic violence and bullying, so that she eventually could not handle going up to the blackboard or doing exams. Some described how unravelling painful life experiences in psychotherapy had enabled them to emerge

as a person. Several participants reported wanting to talk to a therapist about past experiences, but their referral to therapy in the public health care system had been rejected:

(My anxiety) holds me back a bit, but I've become good at dealing with it. Now I go to the supermarket and I do what I have to and I can get things done. So a lot has changed completely. But it's a matter of finding out about the main reason and dealing with it [...] What happened to me when I was at school affected me really deeply. Because I've put up a wall between me and other people.

Valuing lived experience was mentioned as important in emerging as a person. One participant reported that he valued the insights he had acquired by “walking the road of life”, even though they came from difficult experiences. Several participants had experienced a special kind of support from peers, relating this to the insight these persons had acquired through their own lived experiences:

Once you've kind of fallen flat on your face and then got back on your feet again, I think you're really, really careful not to slide back again. Because [...] once bitten, twice shy, you know. [...] That's why I think it's important that people who've been down that road are there when people fall down. Because we know how bloody awful it is, we know what you think, we know how people think.

Discussion

In spite of living with substantial current or past mental health and substance use problems, participants had experienced positive changes in their lives. This is in line with follow-up studies of persons with co-occurring conditions that indicate a hopeful long-term perspective when recovery is viewed as defined by clients (Drake *et al.*, 2006). Control over substance use and over symptoms of mental illness was described as pathways to recovery, but not its essence. This concurs with previous accounts of recovery in co-occurring conditions (Davidson *et al.*, 2008), mental health (Topor *et al.*, 2011; Borg and Davidson, 2008) and substance use problems (Laudet, 2007; Neale *et al.*, 2015). Experiences of coming to love oneself and emerging as a person are consistent with recovery as a personal process, whereas feeling useful and accepted and mastering life resonate with recovery as a social process.

A main finding in this study is the importance of contributing to and being accepted by the community on equal terms; this has also been pointed out by others (Bellamy *et al.*, 2012; Perkins and Repper, 2014). We suggest that facilitating genuine community participation might be a missing piece in the promotion of recovery for persons with co-occurring conditions. Services acting as a link into the community may facilitate genuine participation. Also, informing a more nuanced and hopeful public opinion of people with co-occurring conditions may lead to communities being more open to accepting their contribution. Best *et al.* (2016) and Best (2016) discuss how accessing new social identities and a pro-social community role may act as mechanisms in recovery from substance use. Carpenter-Song *et al.* (2012) describe how recovery oriented, supported independent housing for people with co-occurring conditions, “recovery communities”, contribute to recovery from the perspective of residents. Residents highlight the social environment of neighbours, which provides a sense of belonging, recovery support and a way out of loneliness.

Experiences of recovery in this study resemble components of well-being and flourishing within positive psychology (Diener *et al.*, 2009; Keyes, 2002). This supports the assumption that health and well-being are the same – and just as diverse – for persons who live with concurrent disorders as for everybody else (Slade, 2010). What seems to differ in this study is the importance of improving aspects of an adverse life situation, such as unsolvable financial problems, unsafe living conditions, or a lack of access to working life.

Participants described adverse living conditions that are rare in contemporary Norwegian society. Living with co-occurring conditions is associated with having poorer life circumstances than the general population in Norway (Dyb and Johannessen, 2013; Langeland *et al.*, 2016). Within social psychology, the fundamental attribution error (Ross, 1977) indicates the tendency of attributing

others' behaviour to stable personality traits rather than to situational forces. Maybe health care professionals attribute the adverse living conditions of persons with co-occurring conditions to stable traits such as weakness, ignoring situational factors. The tendency of health care systems to provide separate, unchallenging activities for persons with co-occurring conditions may be an example of this.

Being excessively perceived as weak and helpless seems to be a potential barrier to recovery for persons with co-occurring conditions. In a study that explored experiences of identity and belonging among people with severe mental health problems in rural communities in Norway (Ekeland and Bergem, 2006), participants who accepted their role as a "mental health patient" found it easier to establish an identity and be part of a community than those who did not accept this role. While the former were integrated as part of a marginalised group, the latter felt marginalised as individuals. This resonates with accounts in the current study of the difference between being accepted as a substance user, and being accepted as an equal citizen. Having visible substance use problems seemed to elicit rejection, but also charity and kindness, which was highly appreciated by some participants. Others wondered if this had defined their identity as a substance user in the past. We suggest that kindness in itself is not the problem, so long as it is combined with recognition of resources and contributions.

Results from this study challenge the belief that co-occurring conditions need to be associated with having a difficult, hopeless life. This does not mean that co-occurring conditions are easy to live with, but rather that it is possible to live well. In a study of first-person experiences of hope in relation to dual recovery (Sælør *et al.*, 2015), participants reported that being met with positive expectations from others influenced how they perceived their future. A Swedish study found that persons with mental illness who received a moderate amount of money each month in addition to treatment showed a significant improvement in symptoms, social networks and sense of self, as compared to a "treatment only" control group (Ljungquist *et al.*, 2015). "Recovery-nurturing environments" (Glover, 2005) have been suggested as a description of how contextual factors facilitate recovery. Results from the present study suggest that recovery-nurturing environments should provide opportunities to solve adverse life circumstances, while at the same time recognising the person's potential.

Recovery was described as an experience of emerging as a person. Unravelling traumatic events, discovering skills and positive attributes in oneself, and learning from experience all seemed to contribute to this process. Our findings resonate with former accounts of recovery in co-occurring conditions as a process of acknowledgement, present orientation and transformation and growth (Hipolito *et al.*, 2011), and of understanding, accepting and redefining self (Davidson *et al.*, 2008). The concept of "possible selves" (Markus and Nurius, 1986) indicates how individuals' ideas of what they might become, what they would like to become, and what they are afraid of becoming, function as incentives for behaviour.

In the present study, recovery seemed to differ depending on whether or not the person had a positive identity to return to. The difference between "emerging as a genuine person" and "becoming my old self again" seems to illustrate an important nuance in dual recovery. The latter seems to point to regaining lost virtues, in spite of life experience, whereas the former means coming forward as a person in a new way, building on life experience.

Spiritual experiences provided meaning, consolation, dignity, and connectedness for participants in this study. This is in line with a study that explored recovery among African-American women with co-occurring conditions (Hipolito *et al.*, 2011), where spirituality was found to cross-cut all other dimensions of recovery. In the present study, spiritual experiences were kept secret for fear of negative judgement from others, and participants expressed a wish to talk more freely about these experiences without being judged. These findings suggest that health care professionals should be non-judgemental of spiritual experiences.

Abstinence from substance use was experienced as crucial in recovery by some persons. In recent studies, abstinence from substance use has been associated with increased quality of life (Vederhus *et al.*, 2016) and flourishing (McGaffin *et al.*, 2015). Others described how they used substances as a way of managing everyday life, which is in line with a study of self-reported

reasons for substance use in persons with severe mental illness (Pettersen *et al.*, 2013). The results suggest that substance use should be addressed and that individualised treatment should be available.

Limitations and strengths

The influence from recovery theory is demonstrated in valuing first-person experiences and exploring recovery beyond symptom reduction. Asking about experiences of recovery will have generated other descriptions than inquiring about experiences of suffering. Descriptions have been developed bottom-up from lived experience.

Strength of this study is the diversity among participants regarding age, gender, and life situation. We argue that a low-threshold recruitment strategy leads to a rich collection of descriptions, including voices that would otherwise not be heard. There is also an underlying emancipatory agenda of allowing people to speak their mind about issues of importance to them – particularly so since results from this study will inform developments in local practices.

Diagnostic interviews were not conducted, and the description of participants relied on self-report in reply to general questions about mental health, substance use, and life situation. This may be a limitation to the transferability of the results since the symptom load was not accessed. We believe that the descriptions by the participants are detailed enough to make judgements of relevance to other contexts, an important point being that all participants found that co-occurring conditions affected their everyday life to a large extent, either now or in the past.

The first author's background as a psychologist may have led to an influence of normative, psychological knowledge on the analysis. Selective bracketing of pre-understandings and explicit avoidance of diagnostic and theoretical terms was sought during analysis, although a complete bracketing is viewed as impossible. The advisory group offered an arena for validation and reflexivity, by challenging professional terminology. Involving the advisory group in all steps of analysis and during interviews might have offered further possibilities to address this potential limitation (Ynnesdal Haugen *et al.*, 2016).

Conclusion

This study provides an enhanced understanding of how people with co-occurring conditions may experience recovery. The findings support an increased focus on societal and community factors by health care practitioners, as well as service designs that allow for an integration of social services and health care, and a larger extent of collaboration and communication among services. Opportunities for genuine community participation and sustainable solutions to adverse life circumstances are needed, along with individualised substance use treatment, access to therapy, and recognition of existential-spiritual dimensions of life. The findings support an understanding of recovery as consisting of both personal and social processes. Further research into the facilitation of recovery for persons with co-occurring conditions is called for, particularly regarding the facilitation of genuine community participation.

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Corresponding author

Eva Brekke can be contacted at: eva.brekke@sykehuset-innlandet.no

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Article 2

Brekke, E., Lien, L. & Biong, S. (2018). Experiences of professional helping relations by persons with co-occurring mental health and substance use disorders. *International Journal of Mental Health and Addiction*, 16 (1), 53-65.

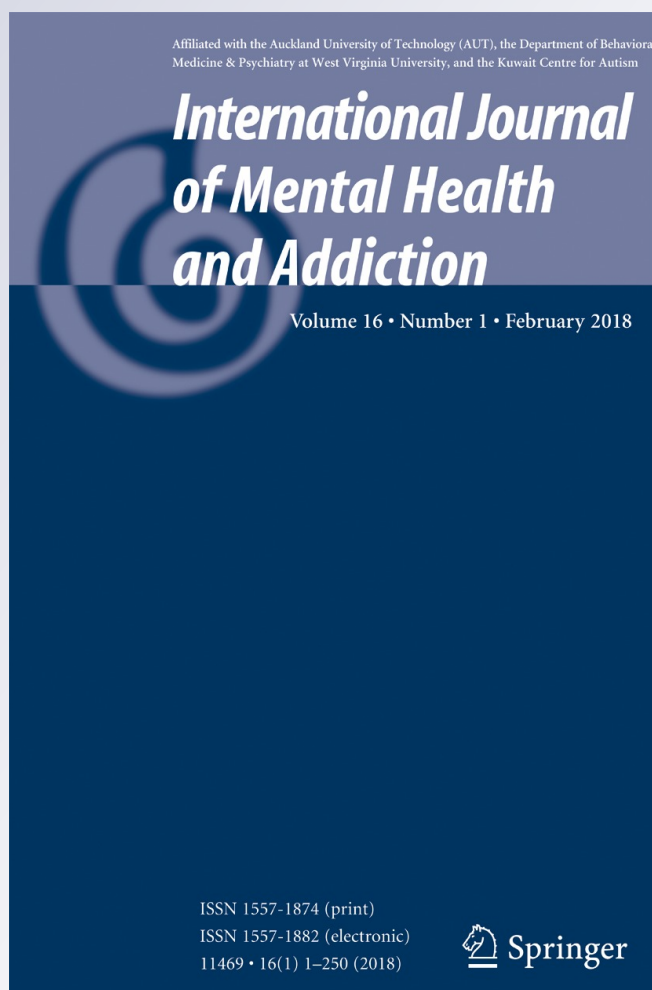
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International Journal of Mental Health and Addiction

ISSN 1557-1874
Volume 16
Number 1

Int J Ment Health Addiction (2018)
16:53-65
DOI 10.1007/s11469-017-9780-9



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Experiences of Professional Helping Relations by Persons with Co-occurring Mental Health and Substance Use Disorders

E. Brekke^{1,2,3}  · L. Lien^{1,4} · S. Biong²

Published online: 21 June 2017

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Abstract Recovery in co-occurring mental health and substance use disorders often involves relationships with professional helpers, yet little is known about how these are experienced by service users. The aim of this study was to explore and describe behaviour and attributes of professional helpers that support recovery, as experienced by persons with co-occurring disorders. Within a collaborative approach, in-depth individual interviews with eight persons with lived experience of co-occurring disorders were analysed using systematic text condensation. The analysis yielded four categories of recovery-supporting behaviour and attributes of professional helpers and the ability to build trust cuts across all of them: Building trust through (a) hopefulness and loving concern, (b) commitment, (c) direct honesty and expectation and (d) action and courage. Services should allow for flexibility and continuity, and training should recognise the importance of establishing trust in order to reach out to this group.

Keywords Co-occurring disorders · Drug abuse · Mental disorders · First-person perspectives · Therapeutic alliance · Helpful relationships

Recovery in co-occurring mental health and substance use disorders (co-occurring disorders) often involves relationships with professional helpers, yet little is known about how these relationships are experienced by service users.

People with co-occurring disorders are considered hard to reach and retain in treatment (Padgett et al. 2008). While the prevalence of co-occurrence is well established (Landheim

✉ E. Brekke
eva.brekke@sykehuset-innlandet.no

¹ Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust, Ottestad, Norway

² Faculty of Health Sciences, University College of Southeast Norway, Drammen, Norway

³ NROP, Postal box 104, 2318 Brumunddal, Norway

⁴ Faculty of Public Health, Hedmark University of applied sciences, Elverum, Norway

et al. 2006; Regier et al. 1990) and recommendations for treatment exist (Mueser and Gingerich 2013), services may still not match the needs of individuals with co-occurring disorders. This group is exposed to homelessness, poverty and unemployment, which may exacerbate symptoms and prevent recovery (Laudet et al. 2000; Margolese et al. 2004; Tsai et al. 2010). Persons with substance use problems face negative stereotypes, putting them at risk for discrimination (Bye et al. 2014). Many experience loneliness and a lack of belonging in mainstream society. These may be difficulties so unfamiliar to professional helpers that they fail to recognise them, let alone their impact on people's lives. People with co-occurring disorders may prefer to ask peers for advice on health issues rather than professional helpers, because they believe professionals would not understand their life situation (Ness et al. 2014). This suggests that exploring service users' experiences may be particularly relevant in order to improve services for this group.

Even if co-occurring disorders are associated with several life difficulties, there is hope for recovery in the long term (Drake et al. 2006). Originating among persons with lived experience, an understanding of recovery as a personal and social process that exceeds symptom reduction has gained foothold within the fields of mental health and substance use, adding to the traditional psychiatric understanding of recovery as 'returning to normal'—symptom reduction that can be observed and rated by an expert (Anthony 1993; Deegan 1996; Laudet et al. 2009; Slade et al. 2012). Different definitions of recovery exist related to mental health and substance use. This lack of consensus may hinder clinical practice and research (Laudet 2007), but it may also acknowledge the fact that recovery means different things to different people. One distinction has been made between recovery *from* mental illness, indicating cure, versus recovery *in* mental illness, indicating enhanced quality of life regardless of cure (Davidson and Roe 2007). Further, one might differentiate between recovery as something that happens to and within an individual, and recovery as a social process that involves the larger community, and where the person is an active participant (Topor et al. 2011). Even if there is no clear consensus of the definition of recovery, there is an increasing agreement that multi-stakeholder definitions are valuable, which is also reflected in research (Neale et al. 2016).

Underpinning this study is an understanding of recovery as a personal and social process, which involves both recovery from and recovery in co-occurring disorders. Seeing recovery as a social process involves recognising everyday life as the central arena for change (Borg and Davidson 2008) while acknowledging structural factors and underlying social-psychological dynamics (Best et al. 2016). Recovery is understood as 'a process of restoring a meaningful sense of belonging to one's community and a positive sense of identity apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition' (Davidson et al. 2007). In a previous study based on the material in this paper, participants described recovery as feeling useful and accepted, coming to love oneself, mastering life and emerging as a person (Brekke et al. 2017).

Previous studies that have examined the experiences of persons with co-occurring disorders with professional help report that service users appreciate that professionals are resource-focused, collaborating, flexible and accepting (Biong and Soggiu 2015), carry hope, promote mutual honesty and continuity of contact, are qualified to address both substance use and mental health conditions (Cruce et al. 2012) and show unexpected acts of kindness, in contrast to routinized encounters that may be experienced as dehumanising (Padgett et al. 2008).

Therapeutic alliance, which may be defined broadly as the collaborative and affective bond between therapist and patient, is established as a predictor of outcome in psychotherapy

(Martin et al. 2000; Norcross and Wampold 2011). Relational factors also seem to be significant in other helping relations, such as community health interventions (Kidd et al. 2017; Ljungberg et al. 2015). Relational factors are insufficiently understood, operationalized and emphasised in research on mental health and substance use treatment (Davidson and Chan 2014; Miller and Moyers 2015). There is a need for research that explores therapist behaviour and qualities that enhance positive change, from the patients' perspective (Norcross and Wampold 2011). Research on how professional helpers contribute to recovery has typically investigated mental health and substance use separately (Borg and Kristiansen 2004; Ljungberg et al. 2015). Further exploration of the perspective of persons with co-occurring disorders on how professional helpers may support recovery is needed (Cruce et al. 2012).

The aim of this study is to explore and describe behaviour and attributes of professional helpers that support recovery, as experienced by persons with co-occurring disorders.

Materials and Methods

Context

This study is part of a research project that investigates the recovery orientation of community mental health and addiction services in a local authority area in Eastern Norway. The community consists of agricultural areas, forested areas and two community centres (<6500 inhabitants). Drawing on literature on collaborative research (Moltu et al. 2013), an advisory group of six persons from the community has assisted the authors throughout the research process. They are two persons with lived experience of co-occurring disorders, one family member of a person with co-occurring disorders, and three professional helpers. The group has participated in developing the interview guide, the inclusion criteria and the recruitment strategy. They have been consulted in the data analysis for validation and for understanding the results in relation to the local context.

Recruitment

A sampling strategy that aimed for diversity in age, gender, duration of contact with services, substance use and mental health problems was applied. Flyers were handed out by the staff of the local mental health and addictions team, at a peer support house, in the local narcotics anonymous group and at a low-threshold meeting place that provides harm-reduction health services for persons with substance use problems in the nearest town. Participants were able to join by e-mail or SMS, or by agreeing that staff members forward their telephone number to study personnel.

Participants

The participants were four women and four men (see Table 1). All were in contact with the community health and social services at the time of the interview. Duration of contact with services ranged from 1 year to more than 10 years. They acknowledged that substance use and mental health problems seriously affected their everyday life, currently or in the past. They reported having used or using alcohol, amphetamines, benzodiazepines, opioids and/or cannabis. Most participants reported having used several substances. Four persons reported not

using substances at the moment, one was in maintenance treatment and three persons were currently using substances at the time of the interview. The participants reported experiencing or having experienced affective disorder, anxiety, post-traumatic disorder, psychotic illness and/or hyperactivity disorder.

Data Collection

Eight semi-structured, in-depth individual interviews (Kvale and Brinkmann 2009) were carried out by the first author. An interview guide consisting of open-ended questions about what recovery means and what may lead to recovery was developed in collaboration with the advisory group. Concrete and detailed descriptions of behaviour and attributes of professional helpers that support recovery were sought. Participants were asked to describe their own personal experiences of encounters with professional helpers. Follow-up questions were asked, such as: ‘What was that like for you?’ and ‘How did that feel?’ Interviews lasted from 45 to 80 min.

Analysis

Interviews were audiotaped and transcribed verbatim by the first author. Data analysis was guided by systematic text condensation (STC) (Malterud 2012) within a phenomenological approach (Giorgi 2009). STC is a descriptive and explorative method that aims at thematic analysis of meaning and content across cases. It offers prescriptive details for analysis which enable a process of intersubjectivity, reflexivity and feasibility, while maintaining transparency. Specific to STC is the procedure of incorporating text from all meaning units into an artificial quotation (step 4 below), safeguarding a systematic review of all meaning units in the material. Selective bracketing of the researcher’s pre-understanding was sought in the analysis process. Initially, all transcripts were read as a whole in order to gain an overall impression, resulting in preliminary themes. Secondly, the transcripts were systematically reviewed line by line, identifying, classifying and sorting meaning units into code groups. Thirdly, meaning units within each code group were sorted into subgroups. At the fourth step, all meaning units within each subgroup were reduced into an artificial quotation maintaining, as far as possible, the original terminology used by the participants. An authentic illustrative quotation was identified for each subgroup. Finally, analytic texts were developed, synthesising the contents of the artificial quotations and developing descriptions. The analytic texts were validated by returning to the full transcripts and asking whether our synthesis still reflected the original context. At steps 3–5, the advisory group was consulted, providing an understanding of the material from

Table 1 Participants

Participant	Gender	Age	Maintenance	Occupation	Housing	Civil status
1	Man	75	Disability pension	None	Own house	Single
2	Woman	55	Disability pension	None	Rented	Cohab
3	Man	40	Disability pension	Student	Rented	Cohab
4	Woman	26	Social welfare	Job seeker	Rented	Single
5	Woman	54	Disability pension	None	Rented	Cohab
6	Man	54	Social welfare	Student	No fixed abode	Single
7	Man	52	Disability pension	None	Own house	Married
8	Woman	62	Disability pension	None	Rented	Single

within the local context. The ‘**Results**’ section consists of analytic texts with supporting original quotes from the participants. Interviews were conducted, transcribed, and analysed in Norwegian. Analytic texts and supporting quotes were translated into English by the first author. The translated text was sent to a professional translator along with the original quotes in Norwegian. The names used in the quotes are fictional. The NVivo 10 software was used in the analysis.

Ethical Considerations

The study was approved by the Norwegian Centre for Research Data (case no. 42244). Informed consent was a requirement for participation. Debriefing was integrated into the interview situation. Participants were offered the opportunity to get in touch with the first author after the interview. Details that could identify participants were removed before the material was shown to the advisory group. The members of the advisory group signed a declaration of confidentiality.

Results

The analysis yielded four categories of recovery-supporting behaviour and attributes of professional helpers and the ability to build trust cuts across all of them: Building trust through (a) hopefulness and loving concern, (b) commitment, (c) direct honesty and expectation, and (d) action and courage.

Building Trust through Hopefulness and Loving Concern

Participants appreciated professionals expressing faith in their possibilities for a better life. Experiencing that professionals believed in them was associated with reclaiming hope and starting to believe that positive change was possible.

Carl was at my house yesterday, and he told me that he believes in me. He said he’s got no doubt that I’ll make it. And it’s like, then I don’t doubt that, either.

Loving concern was described as a certain demeanour or presence which communicated respect, acceptance, concern and a fundamental goodness. A lack of disdainful attitudes, distance, moralism and arrogance further described this phenomenon. To listen carefully, to be interested in the other and to respect the other’s opinions, were mentioned as expressions of loving concern. Experiencing loving concern was related to feeling secure and trusting that the other wants the best for you. Several participants described their relationship to a professional as a ‘good match’, which could not be obtained with everyone. A sense of humour, warmth and a comfortable and non-authoritarian manner were mentioned as attributes that allowed for a good match.

You can talk to him about everything. (...) He knows more or less everything about me. And I trust that he wants the best for me.

Loving concern was experienced when professionals seemed sure of themselves, were conscious of their own role and did not bring their personal needs into the relationship. Several participants mentioned that professionals who seemed to be in harmony with themselves had treated them in a way that allowed them to regain a sense of dignity. Some described it as helpful when professionals with lived experience shared their experiences.

It's how they receive you. You don't feel like a patient (...) Well, we're not equal, because they're well, and I'm ill. But we're equal all the same. Yes. It's like, as they're so self-confident, they actually make me feel well, too. You see.

A lack of hopefulness and loving concern was experienced when professionals acted negligently, too familiarly, not doing their job properly, or using the relationship to fulfil their own needs. One participant had found that a professional had seemed to hold her back when she was actually getting better, and wondered if it was done in order to keep helping her.

Like, their ego gets in the way of helping, they kind of become a person who needs to be seen by me. (...) Like, they're unprofessional, they start mixing things. And then they start telling me things. And they don't pay attention. (...) I think there are lots [of professionals] who try to be kind of a buddy and a friend and ... it's kind of unprofessional.

Building Trust through Commitment

A continuous, long-term relationship with a professional was described as supporting recovery. Knowing each other well led to mutual trust and honesty, possibly preventing relapse into substance use. All participants appreciated that professionals spent time with them and some wished that professionals had more time.

When I meet Anna, she knows me so well. Some simple words from her, and just seeing her, and I can relax. (...) And she's been worrying about me when she hasn't seen me for a while. 'Oh, there you are! Oh, I was so afraid that something might have happened to you'. Because she's known me for so long.

Professionals insisting on making contact and not accepting cancellations was described as supporting recovery by some participants. This enabled participants to trust that the professional was interested in helping them and would not let them down. Some wished that professionals had been more insistent in the past.

It's really important that they actually pester you a little bit. And that they think a bit about how to say things. Not: 'Should I come and pick you up?', if you have an appointment, but: 'I'll pick you up at twelve'.

The participants valued professionals that handled ups and downs and stood by them through relapses and times of mental distress. One woman described how a professional had not given up when change had seemed unlikely. The day she was ready to make changes, they were able to plan treatment with good timing. One person explained that a professional had been the only person he had seen for long periods of time and doubted that he would have managed without her. Illustrating a lack of commitment, another participant described how professionals seemed to distance themselves when his mental distress got worse, wishing they would instead approach him more during those periods.

I love Eric. But I'd like him to take me more seriously when I tell him that I'm struggling. Because when he realises that I'm struggling, he walks away. So you get punished twice, in a way. And when I'm doing well, he gets very happy. And it's almost enough to push me into the ditch, you know. Because then he should come even closer instead of disappearing. Because he shies away, and thinks something is wrong. But I don't know how to tell him this.

Keeping in touch with a local council employee during inpatient addiction treatment was appreciated. Close follow-up from a professional who knows you and whom you trust was helpful upon discharge from inpatient treatment. Making long-term plans for housing, work and finances was highlighted in this connection.

It's when you get out (from treatment). The first year. That's the toughest. And then it's so important that this and that's in place. It's important to have support staff out there then, who understand you and who know who you are. (...) But to get there, there has to be cooperation while you're in treatment, and build trust in each other and be honest with each other. That's by far the most important thing. Because then I dare to call Sara and tell her how things are. But if I didn't trust her, I would never have called. That's the difference between hitting the floor and managing to recover.

Building Trust through Direct Honesty and Expectations

The participants described it as helpful that professionals spoke their mind frankly and expressed concern about the participants' current and future health situation, combined with advice for change, especially when the situation was serious. This had enabled participants to understand the severity of their situation and the need for change, even if it had felt painful at the time. Also, direct honesty made it easier to trust professionals without wondering if they had a hidden agenda.

I trust Hans. (...) He's honest through and through. He doesn't hide anything. And that doesn't bother me, it's just fine. It's a lot better to have someone who calls a spade a spade, and no more fuss about it.

The participants appreciated if professionals were not easily manipulated and were skilled in addressing substance use. Several participants described a sense of empowerment when professionals made them understand, in a respectful way, that they were responsible for their own life. Some had experienced pity and 'pampering' from professionals as unhelpful.

Many staff are used to treating suffering people in a certain way. They think they're so-called 'nice', you know. (...) You can almost smell it when you enter a room with people like that. Whether I was drunk or sober, I would always realise who I was dealing with, who I could manipulate and play on their emotions, you know. You get to be a real expert at that.

It was appreciated by the participants when professionals followed up closely and expected efforts from them. Some had experienced routine checks, such as urine samples, as helpful. Some had found professionals to be afraid of being direct, which was not appreciated. One person had found that professionals expected too little from her after she was diagnosed with a severe mental illness, making it difficult for her to recover. Some had felt that professionals with lived experience were more honest and direct than others.

When I'm all hyper and distressed, people often think I'm on drugs. (...) But if one of the staff checks on me and does regular urine samples ... (...) It has to do with pride, too, to be allowed to show them. Because even if I was clean, I just cried all the time and everyone thought that I was high. But it's better to get a hold on yourself and be able to show them: 'I'm clean, you're wrong', kind of.

Several participants said that professionals should intervene to help children whose parents have mental health and substance use problems. Some participants felt that professional helpers should have intervened sooner to help their own children.

So I wonder: how's it possible for the support services to watch a mother raving about in the streets, blind drunk, and then the child still lives with that mother. How the heck is it possible? This went on for several years in my case. (...) And I had contact with them, they even came to my house. And they didn't do anything until the child started school.

Building Trust through Action and Courage

Some mentioned that their mental health condition made it difficult to take part in valued activities, such as hiking, sports or socialising. The participants appreciated professionals urging them to be more active and accompanying them to activities, at least initially. Having a partner in their everyday activities had enabled participants to learn new skills, gain confidence and escape loneliness. Some participants wished that professionals would focus more on action in addition to talking.

You need to accompany people to the activities they can use as they want. Not just say: 'Go there and do that'. I've experienced this myself. You know that it's there, but you can't manage to do it.

Acknowledging different aspects of their life situation, working hard to find out how to help, taking risks and having the courage to do more than just what is expected were all qualities appreciated in the staff. Professionals who were easy to get in touch with, and who said yes when asked for help, made it possible to ask for help without fear of being rejected. Helping out with practical, everyday issues and acting as a link to health and social services was appreciated. One participant had borrowed a trailer from a professional when he was moving, and found this to be a demonstration of trust which made him feel appreciated, hopeful and confident. Another participant described how professionals worked overtime in order to get her into acute treatment when she experienced a crisis. She now saw this as a crucial turning point in her recovery, expressing gratitude towards the professionals involved.

Liv has helped me with practical things, or other things. You know, made my life quite a lot easier. (...) I could just call, and she'd drive me to the supermarket, or to the doctor, or ... yes. So she's someone I trust.

Noticing actual changes in everyday life, such as improved health or solutions to financial difficulties, was described as very motivating. Some stated that they needed more help with sorting out financial problems, as they lacked skills in doing this. One woman said that the debt collectors would not listen to her when she asked for a payment plan on her debts. She thought that if a professional called in her place, they would trust him more and be willing to discuss solutions. Some of the participants also had close family members with mental health and substance use conditions, and would have liked more support from professionals in dealing with the burden of being a carer.

You have to do the job yourself, of course, but you need just that little bit of help. Not that much, really. So that you can kind of see: 'Wow, it works!', you know.

Discussion

The present study adds to existing literature by providing descriptions of how trust can be established and maintained in helping relations with persons who live with co-occurring disorders. Hopefulness and loving concern, commitment, direct honesty and expectation and action and courage appeared as ways of establishing trust. Results from the present study support the argument that trust is a basic prerequisite for a therapeutic alliance through which other interventions may be delivered (Davidson and Chan 2014; Topor and Denhov 2015).

Hopefulness and loving concern resonate with elements of common factors in psychotherapy research which explain the effectiveness of therapeutic interventions beyond the specific effect of particular interventions. A comprehensive account of common factors is beyond the scope of this paper, but they particularly resonate with therapist qualities that facilitate a working alliance (Wampold and Imel 2015), such as empathy (Elliott et al. 2011) and positive regard (Farber and Doolin 2011). The theme ‘loving concern’ also resembles ‘acts of kindness’ (Padgett et al. 2008), ‘human warmth’ (Laugharne et al. 2012) and ‘shared humanness’ (Ljungberg et al. 2015) which appear from first-person accounts of helpful relationships within co-occurring disorders and severe mental illness. These seem to go beyond a mere professional relationship. However, unprofessional behaviour such as role confusion, loss of focus, or sloppiness, was described by participants as unhelpful. Trust has been described as a characteristic of hope inspiring relations in substance use counselling (Koehn and Cutcliffe 2012; Sælør et al. 2015), as well as an ecological aspect of settings that promote hope (Jason et al. 2016). In the present study, there seemed to be a reciprocal relationship between trust and hope, where the ability to communicate hope also enables trust.

A lack of trust in the system has been described by others, but was less explicit in the present study. A ‘threshold of trust’, which has to be trespassed in order to access services, has been described in low-threshold services for persons with co-occurring disorders (Edland-Gryt and Skatvedt 2013). It is probable that the design and recruitment strategy of the current study fails to access persons who currently do not trust the system. Most participants were middle-aged, and many had been in contact with different services for many years. Also, the focus on what leads to recovery may have resulted in less attention on negative experiences. Still, the fact that trust was highlighted by participants may suggest that they had experienced a lack of trust in the system in the past.

Professionals who were able to recognise the life circumstances of the participants and take action in order to solve practical problems and reduce loneliness were described as supporting to recovery in this study. This was different from disempowering people by doing things for them that they could very well do themselves. On the contrary, showing expectations and stressing responsibility were described as promoting recovery. Further, the lack of a patronising attitude was underlined as fundamental by many participants. The concept of *responsibility attribution* in helping relations may shed light on these nuances (Brickman et al. 1982). This theory suggests that models for help that attribute responsibility for solving the problem to the individual, without blaming him or her for the origin of the problem, are able to help eliminate deprivation, and still consider individuals as responsible and competent in helping themselves once the deprivation is gone. The phenomenon of building trust through action and courage described in this study may be understood as a manifestation of such a model of support.

Direct honesty and expectations from professional helpers should not be interpreted as confrontation, hostility or devaluation. A confrontational style has consistently been found to be ineffective in addiction therapy (Norcross and Wampold 2011). Direct honesty and

expectations were perceived as helpful when they occurred within an atmosphere of hopefulness and loving concern, and the participants trusted that the professional helper wanted their best. This may indicate that direct honesty is easier to accept once a trusting relationship is established, but participants also described positive experiences of direct honesty in their first encounters with a professional helper. Direct honesty was particularly related to the professional helpers' competence in understanding and addressing substance use. Similarly, in a study of preferred therapist characteristics by women who had been treated for anorexia nervosa, participants appreciated therapists' ability to address anorexia in a straightforward and competent way (Gulliksen et al. 2012). Direct honesty may possibly be of particular importance within the cultural context of the present study: a rural area where the ability to use common, everyday language and appear unpretentious and down-to-earth will generally be perceived as trustworthy. This seems related to 'establishing credibility by being genuine and honest', which was described in a Canadian study of how counsellors inspire hope in persons with substance use problems (Koehn and Cutcliffe 2012).

The way services are organised influences professional helpers' ability to engage in behaviour that builds trust. Systems that provide services for persons with co-occurring conditions need to recognise the importance of building trust or they risk making themselves inaccessible to the people they are meant to help. Service designs that allow for continuity, flexibility and engagement in everyday life may encourage the building of trust, but further research is needed.

Limitations and Strengths

The methods do not allow for an immediate generalisation of the results, but rather an enhanced understanding of the phenomenon which may be transferred to other contexts. All participants lived in the same local area, and contact with professional helpers may be experienced differently in other contexts. The data contains experiences with professional helpers from different professions and different contexts, although the main focus is on the local addiction team. Participants seemed to value the same attributes in professional helpers across professions and levels within the health care system. However, a study which explicitly asked for valued attributes of professional helpers in other contexts, such as psychotherapy, would possibly elicit other descriptions.

The analytic approach in this study has a limited capacity for exploring processes over time (Malterud 2012). Qualitative studies with a narrative approach could shed light on how trust develops throughout the process of establishing a therapeutic relationship.

Diagnostic interviews were not conducted, and the description of participants relied on self-report in reply to general questions about mental health, substance use and life situation. This may be a limitation to the transferability of the results, since the symptom load was not accessed. Also, the problems described by the participants are varied, and one might question whether it is right to treat their experiences as representing the same phenomena. We believe that the participants' descriptions are detailed enough to make judgements of relevance to other contexts, an important point being that all participants found that co-occurring conditions strongly affected their everyday life, either now or in the past.

Conclusion

The study provides an enhanced understanding of how individuals with co-occurring disorder may experience relationships with professional helpers. Results suggest that building trust is

fundamental in order to support recovery for this group. Professional helpers may establish trust through hopefulness and loving concern, commitment, direct honesty and expectations and action and courage. The ability to take action to solve practical problems while recognising people's competence and responsibility for helping themselves appears as central. Services should be organised so that they allow for flexibility and continuity, and training should recognise the importance of establishing trust in order to reach out to this group. There is a need for further research on how professional helpers and services support or hinder recovery for persons with co-occurring conditions.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures followed were in accordance with the ethical standards of the Norwegian National Committee for Research Ethics in the Social Sciences and the Humanities and with the Helsinki Declaration of 1975, as revised in 2000.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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Article 3


Brekke, E., Lien, L., Nysveen, K. & Biong, S. (2018). Dilemmas in recovery-oriented practice to support people with co-occurring mental health and substance use disorders: a qualitative study of staff experiences in Norway. *International Journal of Mental Health Systems*, 12 (1), 30. <https://doi.org/10.1186/s13033-018-0211-5>

RESEARCH

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Dilemmas in recovery-oriented practice to support people with co-occurring mental health and substance use disorders: a qualitative study of staff experiences in Norway

Eva Brekke^{1,2*} , Lars Lien^{1,3}, Kari Nysveen¹ and Stian Biong²

Abstract

Background: Recovery-oriented practice is recommended in services for people with co-occurring mental health and substance use disorders. Understanding practitioners' perceptions of recovery-oriented services may be a key component of implementing recovery principles in day-to-day practice. This study explores and describes staff experiences with dilemmas in recovery-oriented practice to support people with co-occurring disorders.

Methods: Three focus group interviews were carried out over the course of 2 years with practitioners in a Norwegian community mental health and addictions team that was committed to developing recovery-oriented services. The thematic analysis was applied to yield descriptions of staff experiences with dilemmas in recovery-oriented practice.

Results: Three dilemmas were described: (1) balancing mastery and helplessness, (2) balancing directiveness and a non-judgmental attitude, and (3) balancing total abstinence and the acceptance of substance use.

Conclusions: Innovative approaches to practice development that address the inherent dilemmas in recovery-oriented practice to support people with co-occurring disorders are called for.

Keywords: Recovery-orientation, Co-occurring disorders, Mental health service provision, Staff perspective, Qualitative methods

Background

Recovery-orientation is increasingly recommended in practice guidelines for community mental health and addiction services across countries [1]. An understanding of recovery as a personal and social process that surpasses symptom reduction is increasingly accepted in the fields of mental health and substance use [2–4]. The individual is considered the central actor and decision maker in his or her recovery, each person's unique

experiences are considered important, structural factors are recognised, and everyday life is acknowledged as a central arena for change [5]. While recovery may occur regardless of professional help [6], relationships with professional helpers often play an important role in the recovery process of persons with co-occurring mental health and substance use disorders (co-occurring disorders) [7], but may constitute both barriers and facilitators [8]. Underpinning the recovery movement is the intention to make services available and beneficial from the perspective of service users and to promote citizenship and civil rights.

Recovery-oriented practices have been defined in different ways across countries and services. One such definition is that they “*identify and incorporate a person's*

*Correspondence: eva.brekke@sykehuset-innlandet.no

¹ Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust, Post box 104, 2381 Brumunddal, Norway

Full list of author information is available at the end of the article



own goals, interests, and strengths in the effort to support the person's own efforts to manage his or her condition while pursuing a meaningful life in the community" [9]. A qualitative analysis of recovery-oriented practice guidelines from several countries conceptualised recovery-oriented practice into four domains: promoting citizenship, organisational commitment, supporting personally defined recovery, and working relationship [10]. Norwegian health authorities recommend that *"the person's own resources should be supported throughout treatment in a way that leads to an improved quality of life"* [11].

Concern has been raised regarding the potential misuse of 'recovery' in the transition from a concept developed by people with lived experience into a concept defined by staff, researchers, and service developers [12, 13]. Previous research suggests that staff perceptions of recovery-oriented practice may differ from those of service users, that recovery-oriented practice may be combined with seemingly incompatible practices, such as formal and informal coercion [14, 15], and that it may pose dilemmas to practitioners [16]. While recovery has been suggested as an organising principle for integrating mental health and addiction services [17], different definitions of recovery in mental health services and substance use services may pose challenges for practitioners addressing both issues [18, 19]. Also, staff may experience competing priorities between recovery principles and structural demands, such as financial resources and time [20].

In spite of an increasing knowledge base for the recommendation of recovery-oriented practice, a gap seems to exist between recommendations and actual practice, a main challenge being the lack of a shared understanding of what recovery-oriented practice means, based on multi-stakeholder views [20]. Exploring and describing challenges, paradoxes and dilemmas faced by practitioners in recovery-oriented services within different contexts may be a key component in the process of implementing recovery principles in day-to-day practice [10].

The aim of this study is to explore and describe staff experiences of dilemmas in recovery-oriented community practice to support people with co-occurring disorders in a Norwegian context. 'Dilemma' is understood as a situation in which a difficult choice has to be made between two or more alternatives, especially ones that are equally undesirable.

Methods

Context

This study is part of a larger project to investigate recovery-orientation in services in a Norwegian local authority area, containing agricultural areas, forested areas, and two community centres (< 6500 inhabitants). The project, which has an exploratory and descriptive purpose, has

included individual interviews with residents with co-occurring disorders exploring what recovery means [21] and how professional helpers may contribute to recovery [7]. Interviews with family members have been conducted and results will be sought published. Results from these studies have been communicated to practitioners and leaders in the services, who were committed to developing recovery oriented services. Researches have otherwise not directed the local practice development.

Norwegian primary health care is run by local authorities, whereas hospital trusts are responsible for secondary and tertiary care. Municipal and specialised services share responsibility for providing services to people with co-occurring disorders. Since 2012, national guidelines have recommended recovery-oriented practice in Norwegian health and social services for people with co-occurring disorders [11]. Recovery-orientation was defined by services as recruiting peer support workers as part of staff at different system levels, and explicitly basing interventions on what was important for the person seeking help rather than their psychiatric diagnosis. As a tool for this, feedback informed treatment (FIT) was implemented in the services, which is a method for systematically getting feedback from the client on how the alliance and progress of treatment is experienced, and adjust interventions according to this [22].

Drawing on literature on collaborative research [23] and user involvement in research [24], a group of six people from the local community advised the authors throughout the process. Aiming to include different groups affected by the study [25], these were two people with lived experience of co-occurring disorders, one family member of a person with co-occurring disorders, one practitioner, the leader of the local peer support centre, and one experienced practitioner, who is the third author of this article. The group has had an advisory function throughout the process from planning the study through developing the interview guide, deciding the recruitment strategy and understanding the results in a local context.

Data collection

Based on their specific experiences with recovery-oriented practice to support people with co-occurring disorders, which were considered relevant in answering the study aim [26], all members of the local mental health and addiction team were invited to participate in the study. The leader of the services communicated the invitation, which all team members accepted. Participants were community support workers (2), mental health workers (2), peer support workers (2), specialist nurses (2), social workers (1), and psychologists (1).

Three focus group interviews [27] were conducted over 2 years. Six to eight team members were present at each

interview. The first interview lasted 90 min, and the second and third lasted 60 min. All interviews were led by the first and third authors. In order to facilitate participation, the interviews were carried out at the time of the weekly team meeting, in a meeting room at the team's office building. In the first interview, participants were asked to describe their current practice in the field of co-occurring disorders (see Additional file 1). In the second and third interviews, participants were asked to describe their experiences with recovery-oriented practice with this group of citizens (see Additional file 2).

Between the first and second interview, seven 1-h meetings with team members were arranged over the course of 6 months, aiming to encourage reflection on their own practice in relation to recovery principles. The third and first author participated in all of these meetings and the fourth author participated in one of the meetings.

Reflexive comments

The first and third authors, a clinical psychologist and a specialist nurse, knew some of the participants as collaborative partners from former jobs. The second and fourth authors, who are both professors with background from mental health and substance use treatment as psychiatrist and nurse, respectively, did not know the team members from before. All authors support a humanistic, person-centred approach to mental health and substance use treatment, guiding a common interest in recovery-orientation. Within this, the authors have adopted an intentionally non-judgmental and non-directive attitude in exploring recovery-oriented practice in this particular context, which has also been communicated to participants.

Data analysis

Interviews were tape recorded and transcribed verbatim by the first author. Before the second and third interviews, transcripts from the previous interviews were read through in order to prepare and plan the interview situation. A full analysis was only carried out after all three interviews had been transcribed. Here, thematic analysis [28] was used. An explicit aim of the analysis was to provide a detailed and nuanced account of *dilemmas* in the participants' descriptions. Within this aim, the analysis was inductive. An attempt was made to bracket the researcher's pre-understanding during analysis, although complete bracketing is acknowledged to be impossible [29]. Themes were identified on a semantic level, based on the surface meaning of participants' descriptions, with analysis moving from descriptions to interpretation. Firstly, transcripts were read several times while notes were taken, to enable familiarisation with the data. Secondly, the data set was read through systematically,

giving equal attention to each data item, and content was coded by tagging and naming selections of text using the computer software QSR NVivo 10. When all data had been coded and collated, codes were sorted into potential themes. All collated extracts for each potential theme were then read through, and themes were adjusted based on the criteria of internal homogeneity and external heterogeneity. Following this process, the entire data set was read through, considering the validity of the candidate themes in relation to the interviews, including coding of additional data that had been missed during the first coding process. A detailed analysis was carried out for each theme; here, data extracts were organised into coherent accounts with accompanying narratives, and the essence of each theme was identified. This led to the creation of an analytic narrative, which constitutes "Results" section of this paper.

Ethics

The study was approved by the Norwegian Centre for Research Data (Case No. 42244). Informed consent was a requirement for participation. The fact that team members were recruited by their leader may raise the question of whether participation was indeed voluntary, even though informed consent was a prerequisite for participation. The leader was not present during interviews and all information has been anonymised in order to ensure the confidentiality of participants.

Results

Three dilemmas were described by practitioners regarding recovery-oriented practice with people who have co-occurring disorders: (1) balancing mastery and helplessness, (2) balancing directiveness and a non-judgmental attitude, and (3) balancing total abstinence and the acceptance of substance use.

Balancing mastery and helplessness

In their daily practice with people with co-occurring disorders, team members described a challenge in determining how much help they should offer and how much responsibility they should put on the service user. They described that intervening with too much practical help might lead to disempowerment of the person and dependence on services, while not intervening might leave people in a deadlock situation which also hinders change.

"Well, it's about cooperating, playing as a team, advising them. There's a fine line here in that we're not supposed to take over their tasks, but at the same time you have to stand behind them a bit and be a motivator and push them. But you also have to try

and give them the feeling that they can master things by themselves. That you don't do everything for them. It's not good to make people helpless." (Interview 1)

The team described that some service users had life challenges which made it unreasonable to expect them to assume responsibility for making changes, for instance discrimination in the housing market, a lack of social network, poverty, unfair treatment from health and social services, lack of everyday coping skills, cognitive challenges, and a bad reputation in the local community. Practicing living skills, such as taking out the garbage, and making arrangements to secure the housing and economy, such as a standing order for paying the rent, were described as interventions to meet these challenges. The team described acting like *an extended arm* into the system to ensure equal access, and acting like *a buffer* in the face of unfair treatment.

"Another thing I've seen about people with substance use and mental health problems is that they're often not respected when they come to an office on their own. They're not listened to. (...) So we often come along as an extended arm." (Interview 1)

Sometimes, team members helped service users more than usual in order to enhance their motivation for change, even if the outcome was uncertain.

"Now and then you start out on one of those journeys that are kind of chaos projects. I'm in one of those now, where I kind of do lots of things that I feel I shouldn't be doing. But I'll continue as far as I have decided, to see if it can stabilise things enough for the person to either go back to how things were, and be left alone, or maybe be motivated to take a different path. Because there are some things you just have to do, and you think that it's worth it, but... I don't know how it will end, you know, and whether the person will be defined as outside the services, a dropout, who won't get any help... I don't know." (Interview 3)

Scarce resources made it necessary to prioritise between tasks, and avoid doing tasks that were not within their responsibility. Working towards agency and internal motivation for change was seen as more effective than helping out with practical things.

"If you want a change, you need to do something different. Holding down a job, that's not easy, it's based on your own efforts. You can't come in here every one or 2 weeks and expect me to make a change in you. Here you are, just like that. It needs to come from within. (...) So it's like, how do you work with change? How do you make people understand

change, and become active?" (Interview 3)

Another dilemma concerned how much effort to invest when people did not attend. The team described that reaching out may enable trust and strengthen the alliance, but also means less time spent with those who comply. Making people responsible for attending was considered as potentially empowering. The team described a change from more outreach in the first interview to less outreach at the time of the last interview.

"I think that I spend 70–80 percent of my time in the field and 20–30 percent in the office. If it is a burden to them to attend an appointment, of course I'll meet them out of the office." (Interview 1)

"If it's hard to get in touch with a service user and they're not interested, then I say, 'OK, well then you can come back when you're a bit more interested'. And I don't run after them like I used to do. Before, people did a lot to try to get hold of them, but I actually don't do that anymore. (...) And when I don't run after them, they have to kind of take some of the responsibility themselves, they have to contact us if they want help." (Interview 3)

Participants suggested that a solution to this dilemma may be to define and limit one's areas of responsibility. One example of this was to state that they worked primarily with addressing substance use, and that those who were not interested in this should rather be followed up by other services. Another solution may be to offer extensive practical help in chaotic or crisis situations, while gradually transferring more responsibility to the service user. The team also had a policy where it was easy to re-establish contact without waiting time.

Balancing directiveness and a non-judgmental attitude

A central aspect of recovery-oriented practice is that treatment goals should be based on what is important for the person seeking help. Practitioners described two possible pitfalls in connection with this principle in their day-to-day practice. On the one hand, judging the way people live their lives was described as paternalistic and ethically problematic. On the other hand, an "anything goes" approach might well lead to indifference.

Team members reported that adopting a non-judgmental attitude was an essential principle in their day-to-day practice.

"We shouldn't judge, we should listen to the person who's actually living that life. And we're all different, so we need to respect each individual, based on how he experiences his life and when he thinks his life is all right." (Interview 2)

However, when service users were content with living conditions that team members saw as unsatisfactory or undignified, respecting the other's view was described as difficult.

"In this FIT stuff, the service user's supposed to say how he feels. But then the question is: How he feels, in relation to what? What's your reference frame for feeling OK? For someone who's always been on drugs, and lives in a crappy little bedsitter and has practically nothing, eats once a day, but he says he feels OK! But in my world, he's not OK. (...) Should we be working to keep it like this, or what?" (Interview 2)

The team suggested that people with co-occurring disorders may have internalised a belief that they deserve little, due to past experiences with oppression and scarcity. Hence, directly accepting the service user's point of view may reinforce hopelessness and low expectations.

"The starting point is that we ask everyone: 'What's important to you?' At the same time, we can kind of dare to have slightly higher goals. Maybe particularly us, who work with substance abuse, we can dare to say: 'You know what, we believe you can achieve a lot.' Or, you know, we strongly believe they can get better, even in areas where they maybe don't believe it themselves." (Interview 2)

Team members described that one way to manage this dilemma was to introduce one's own ideas in ways that make people feel that they have figured them out themselves.

"You need to keep planting little seeds, which gradually give the person knowledge and ideas, so that people may start changing the way they think and maybe sort things out. Even though we're the ones who've figured it out for them, the process actually makes them feel that they're the ones who've sorted it out. But we plant some seeds, and when they start to blossom, that's when it gets really interesting." (Interview 2)

Balancing total abstinence and the acceptance of substance use

A third dilemma described by practitioners concerned relating to substance use in a recovery-oriented way.

Team members described that a professional, non-moralistic attitude towards substance use, including support and hopefulness in the face of relapse, enabled trust and honesty in the relationship with service users.

"It's important to establish a relationship when we're out there, so that the service users who may

not be too optimistic don't feel that we're moralisers, that we kind of tell them: 'Oh dear, you've been taking drugs, haven't you.' You must be there for them and try your best." (Interview 1)

However, accepting substance use was seen as a sign of giving up, denying people the opportunity to change. On the one hand, team members acknowledged the potential of change regardless of substance use. On the other hand, they feared that support without addressing substance use may enable the latter.

"I think we've been too good at tidying up in the consequences of substance use. (...) Because if we keep tidying up when a crisis comes, it'll be quite nice to just carry on taking drugs." (Interview 3)

In addition to being a dilemma, finding a balance between abstinence and the acceptance of substance use also concerned disagreement within the team. For example, some team members regarded opioid maintenance treatment as substance use, while others saw it as a support to improve quality of life. The team seemed to have moved from seeing it as their main task to assist people regardless of their substance use, to focusing mainly on addressing substance use with the goal of total abstinence.

"We need to ask what people are motivated for, which is not necessarily a change in substance use, and then focus on that. Because we work with change, and it doesn't need to be about substance use." (Interview 1)

"I think we agree that abstinence is the goal. I mean, that's when people are free to live their life to the full? But to get there, you may need to believe that kind of life is worth living." (Interview 3)

After extensive discussions, the team had decided to adopt a 12-step approach at the time of the third interview. This involved an attitude that everyone can and should obtain total abstinence, and that addiction was the root of other problems. Within this approach, telling people to stop using alcohol or drugs and go to AA or NA meetings was seen as recovery-oriented practice.

"For example a woman I'm working with who has severe alcohol problems... I've spent a lot of time telling her that she's got to stop drinking completely. And I've recommended her to go to AA meetings. And then I've talked to her between those meetings, about how she felt about them. That's a specific example of how I do recovery-oriented practice." (Interview 3)

Team members stressed that no one was rejected if they did not want total abstinence, but substance use was generally to be addressed first, and was seen as primary to mental health problems. Working towards total abstinence was experienced as difficult and ambitious, but also directing and inspiring.

“We help everyone regardless of what they want, or we try to help them as best we can. But I think agreeing on what could be a good recovery process, I mean total abstinence, I think that helps us as much as it helps the people with the problems. So that we don’t get burned out, and (...) can even spread hope that it’s possible to get into a recovery process and have a better life, even if the problem is drugs.” (Interview 3)

However, concern was raised that this approach would prevent individualised support and exclude people for whom abstinence was unrealistic, but who would still benefit from other services.

“I feel we’re a local authority, we’re not a narrow niche, so I think we should include everyone. We need to face the facts, we have some substance users who may never stop, and we have a responsibility towards them.” (Interview 3)

One way of addressing this dilemma was to balance the focus on total abstinence with other issues and work with social services to ensure basic needs.

“When we get into chaotic situations, where everything’s a mess and so on, it’s important to sit down with the service user and put it down on paper, make priorities, and just clear away all that noise before you can focus properly and move on. If you don’t, those other things steal so much time and effort, so you have no chance (to work on the substance use problem).” (Interview 3)

The team described that supporting people after they manage to stop taking alcohol or drugs was a priority, since this is a time when many people deal with issues such as loneliness, stressful life events, and housing or economic problems.

“Then you’re off drugs, and you have no friends, your housing is bad, you have practically no activity, you start feeling a lot of emotions, everything you’ve been through. And we need to address that, and it demands a lot of us. It’s not like we tell people that once you quit drugs, everything will be fine. That’s when an even bigger job starts. It’s hard work for us, but it’s hardest for the person who takes the step and makes a change.” (Interview 3)

Discussion

Practitioners in a community mental health and addictions team experienced dilemmas related to recovery-oriented practice to support people with co-occurring disorders. These were balancing mastery and helplessness, balancing directiveness and a non-judgemental attitude, and balancing total abstinence and the acceptance of substance use.

Practitioners in the same team held different opinions on what recovery-oriented practice meant, and this was particularly apparent in addressing substance use. While recovery within mental health has increasingly been defined as possible regardless of symptom reduction, recovery in substance use has typically focused on abstinence [19]. While the concept of recovery from mental health problems is traditionally associated with a biomedical psychiatric approach [30], the concept of recovery as total abstinence from addictive stimuli is rooted in certain service user movements. The debate on abstinence versus harm reduction has generated large controversy in the substance use field during the past decade at least [31], with service users, policy makers, and practitioners on both sides of the debate, which extends to legalisation as well as medications in substance use treatment. While service users may disagree with the way practitioners define recovery in addiction [32], disagreement does not necessarily mirror the discourse of the recovery movement in mental health. The dilemma of abstinence versus accepting substance use described in this study seems partly related to this debate, and some team members communicated strong opinions on the fundamentality of abstinence. Further, it seems to relate to the complexity of addiction and to what may be a paradox rather than a dilemma: that harm reduction and abstinence may both be necessary approaches when addressing substance use in a recovery-oriented way.

While studies on first-person experiences of recovery in mental health have stressed the right to live well “within or despite symptoms” [30], first-person perspectives on substance use problems tend to stress at least some sort of control over substance use in order to enable recovery [3, 33]. This also appears in first-person experiences of co-occurring disorders [21, 34–36]. Importantly, there seems to be considerable individual variation in how substance use relates to recovery among people with co-occurring disorders [37], as well as in reasons for quitting substance use [38], and a categorical total abstinence approach seems to be at odds with recovery principles of supporting each individual’s goals and interests. Further, as is reflected in team members’ descriptions in the present study, demanding total abstinence in community services may indirectly exclude citizens from services. To people with co-occurring disorders, who already face the

problem of falling between two stools in the health and social care system, this may mean a further alienation from fair access to services.

A central aspect of recovery-oriented practice is to empower people by supporting their own efforts in the recovery process. This implies sharing both power and responsibility. Life challenges, including structural factors, made the principle of empowerment problematic to practitioners in this study. Their descriptions of discrimination and unequal access to welfare goods resonate with critical voices that argue that focusing on empowerment without recognising structural factors may be destructive [12]. Balancing empowerment with fighting against, and compensating for, structural injustice seems highly important in recovery-oriented practice with this group of citizens. Interestingly, the team described moving towards sharing more responsibility for life changes by the time of the last interview. For example, they spent less time reaching out to those who did not attend services. This is not in accordance with guidelines, which recommend outreach services to people with co-occurring disorders. The terms noncompliance, nonadherence and dropout have been suggested as outmoded within a recovery-oriented system [39]. Also, patients who compliantly attend community services do not necessarily experience these services as helpful [40]. The issue of prioritising those who attend services may be seen as an example of competing priorities between recovery principles and structural demands, and illustrates that recovery-orientation depends on structural issues as well as training of staff [20].

Shared decision making about treatment goals was described as problematic because clients may have too low aspirations for change, hence needing directiveness. This is in line with the argument that shared decision making in the field of mental health is made difficult because practitioners, often incorrectly, do not think that patients know their own best [41]. This may be a universal phenomenon, indicating that such attitudes will need to be understood and addressed in order to achieve genuine shared decision making in the mental health and addictions field. When service users are perceived as unable to make decisions about their own life, directiveness will be a likely response from practitioners. Previous studies suggest that the usefulness and necessity of directiveness may be perceived differently by practitioners and service users. Coercion and paternalism have been seen as incompatible with recovery-oriented practice in qualitative studies with a service user perspective [8, 34]. Yet studies of practitioners' accounts show that recovery-oriented practice and directiveness are not always seen as opposed to each other [14] and that authoritative behaviour by community mental health professionals may negatively affect therapeutic

interactions, even when the professionals adopt a person-centred, recovery-oriented approach to practice [15]. An exploratory study of different levels of directiveness used by social workers in home health care found that disagreement between clients and social workers increased the risk of paternalistic action [42]. This resonates with descriptions in the present study that differing opinions of what a good life means may make it difficult to base treatment plans on the service user's goals.

Limitations and strengths

This article provides insights into practitioners' experiences with dilemmas that may arise in recovery-oriented practice in the field of co-occurring disorders, a phenomenon which to our knowledge has not been explored in the research literature before. The methods used in this study do not allow for an immediate generalisation of the results, but the insights may have relevance to other contexts, and may direct future research. The results are based on participants' descriptions of dilemmas in recovery-oriented practice as they appeared in group interviews. Other methods, such as participant observation or individual interviews, would have provided different descriptions. A case study approach would have enabled an exploration of the process of developing recovery-oriented practice in this particular context. However, the fact that interviews were carried out over 2 years enables insight into the changes over time. The service user perspective is not included directly in the data. Results are discussed with reference to studies of first-person experiences in order to counterbalance this limitation.

Conclusion

Practitioners in a municipal mental health and addictions team presented several dilemmas related to recovery-oriented practice to support people with co-occurring disorders. Team members held different opinions on what recovery-oriented practice meant, particularly regarding how to address substance use. There is a need for further definition of recovery-oriented practice from different stakeholders' perspectives. Innovative approaches to practice development and research that address the inherent dilemmas in recovery-oriented practice aimed at people with co-occurring disorders are needed.

Additional files

Additional file 1. Interview schedule, first interview.

Additional file 2. Interview schedule, second and third interviews.

Authors' contributions

All authors contributed actively in the research project, analysis and preparation of the manuscript. All authors read and approved the final manuscript.

Author details

¹ Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust, Post box 104, 2381 Brumunddal, Norway. ² Faculty of Health and Social Sciences, University of Southeast Norway, Post box 235, 3603 Kongsberg, Norway. ³ Faculty of Social and Health Sciences, Inland Norway University of Applied Sciences, Post box 400, 2418 Elverum, Norway.

Acknowledgements

We would like to thank all participants for generously sharing their time and experiences. We also thank the participants of the advisory group, who have provided valuable advice and reflection throughout the process.

Competing interests

The authors declare that they have no competing interests.

Availability of data and materials

The datasets generated and analysed during the current study are not publicly available due to considerations of confidentiality. Anonymised data (Norwegian only) are available from the corresponding author on reasonable request.

Consent for publication

Not applicable.

Ethics approval and consent to participate

The study was approved by the Norwegian Centre for Research Data (Case No. 42244). Informed consent was obtained from all individual participants included in the study.

Funding

The research is funded by Innlandet Hospital trust, Grant Number 150305.

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Received: 12 March 2018 Accepted: 2 June 2018

Published online: 07 June 2018

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APPENDIX

APPENDIX I: Guiding questions

APPENDIX II: Interview Schedule, Study 1

APPENDIX III: Interview Schedule, Interview 1, Study 2

APPENDIX IV: Interview Schedule, Interview 2, Study 2

APPENDIX I

APPENDIX I: Guiding questions for entering helping relationships

APPENDIX: GUIDING QUESTIONS FOR ENTERING HELPING RELATIONSHIPS

1. Can I be in some way which will be perceived by the other person as trustworthy, as dependable or consistent in some deep sense?
2. Can I be expressive enough as a person that what I am will be communicated unambiguously?
3. Can I let myself experience positive attitudes toward this other person – attitudes of warmth, caring, liking, interest, respect?
4. Can I be strong enough as a person to be separate from the other?
5. Am I secure enough within myself to permit him his separateness?
6. Can I let myself enter fully into the world of his feelings and personal meanings and see these as he does?
7. Can I be acceptant of each facet of this other person which he presents to me? Can I receive him as he is?
8. Can I act with sufficient sensitivity in the relationship that my behavior will not be perceived as a threat?
9. Can I free him from the threat of external evaluation?
10. Can I meet this other individual as a person who is in process of becoming, or will I be bound by his past and my past?

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APPENDIX II

APPENDIX II: Interview schedule, Study 1

INTERVIEW SCHEDULE

(Translated from Norwegian)

INTRODUCTION

Thank you for participating in the study. My name is Eva Brekke and I am a psychologist and researcher. I work on a study about what recovery means when you have substance use and mental health problems. The study also concerns how services may support recovery.

You are the expert here, since you have lived experience with these issues. I would like to hear about your experiences with recovery, and what leads to recovery, and how the services may support recovery. It is of course also OK to talk about things that did not help, or times when you did not experience recovery.

No answers are right or wrong here. I am interested in *your* experience. I will ask a couple of questions, and I would very much like you to describe your personal experience in detail.

Do you have any questions before we begin?

Before we start, I have a few questions:

How old are you?

Which substances have you mainly used?

Which mental health problems have you experienced?

How did it feel to get this invitation to participate, did you make any reflections already then?

OPEN QUESTIONS, MAIN THEMES

1. What are your experiences with recovery?
2. Based on your experience with being in contact with services, what has been helpful to you?
3. What do you think that professional helpers can do to support recovery?

ELABORATING QUESTIONS THAT ARE USED DURING THE INTERVIEW

- How did that feel?
- What are your thoughts about that?
- How was that like?
- How did that feel like to you?
- What did you think about that?
- Can you please tell me more about that?
- Do you have any examples of that?
- Can you please elaborate that?
- Please tell me more about that.

ENDING

I have asked you a whole lot of questions about recovery in substance use and mental health problems.

1. If you should highlight something that is particularly important in a study like this one – what would that be?
2. Was there anything that you think was missing, or anything that we should have talked about more?
3. Were there issues that we talked about that you think are less important?
4. Is it anything that you wanted to say, that you have not had the chance to say?
5. How do you think the interview was?

You have given valuable information that I will use in the research project. If necessary, is it OK that I contact you again? How may I contact you?

Thanks a lot!

APPENDIX III

APPENDIX III: Interview schedule, Study 2, first interview

INTERVIEW SCHEDULE, FIRST INTERVIEW

(Translated from Norwegian)

1: Thank you for accepting our request to interview you. We have reserved one hour and a half, and there will be no breaks. Before we begin, I ask you to sign a consent form which is on the table in front of you. Participation is voluntary and you are free to withdraw your consent at any time. I will tape record the interview. The recording will be saved in a safe place and will be deleted when the project is over. The researchers are committed to confidentiality. It will not be possible to identify you in the published reports.

2: Thank you for participating in this interview. Your experiences may give valuable knowledge about what may lead to recovery in co-occurring disorders.

Today, I would like to know more about how you work, as of today, to support people with co-occurring disorders. I would like to know concretely how you work, as well as your thoughts and experiences surrounding this issue.

We are interested in different opinions. Consensus is not a goal, rather the opposite! It is natural that you may hold different opinions, and I would like to hear those. There are no correct or wrong answers, and each one of you have valuable experience.

Sometimes people change their opinion during the interview, or think of new things, and that is also OK.

We would like to hear about what works well, and things that do not work so well, or where you may lack a good solution. It is your experience as practitioners that I would like to learn more about.

I will lead the interview and pose questions. I have some open questions and some detailed. It is my job to stick to the theme, so I might interrupt you at times. I will also summarise in order to check if I have understood what you said.

(Co-researcher) will observe and take notes, and she will help me to stick with the issue.

Are there any questions before we begin? Is it OK?

3: I would like to start with everyone saying their first name, profession, and how long you have been in the team. Very short.

4: How do you work, as of today, to support people with co-occurring disorders?

Can you please describe a course of intervention with a service user.

Can you please describe a normal day where you work to support people with co-occurring disorders?

5: When you think of recovery – what may that mean?

What may lead to recovery?

What may hinder recovery, as you see it?

Follow-up questions:

- Tell me more about that!
- I would really like to hear more about that.
- How do you work with that?
- What do you do to achieve that?
- Which experiences do you have with that?
- In which ways has that been useful?
- How does that feel like to you?
- What do the rest of you think about this?

7: Ending the interview

Is there anything that has not been said, that you would like to say?

Thank you for participating in this interview. You have contributed with valuable knowledge. If any of you should have questions afterwards, please contact me. My phone number is on the information sheet.

Thank you!

APPENDIX IV

APPENDIX IV: Interview schedule, Study 2, second and third interviews

INTERVIEW SCHEDULE, SECOND AND THIRD INTERVIEW

(Translated from Norwegian)

1: Thank you for accepting our request to interview you. We have reserved one hour, and there will be no breaks. Before we begin, I ask you to sign a consent form which is on the table in front of you. Participation is voluntary and you are free to withdraw your consent at any time. I will tape record the interview. The recording will be saved in a safe place and will be deleted when the project is over. The researchers are committed to confidentiality. It will not be possible to identify you in the published reports.

2: Thank you for participating in this interview. Your experiences may give valuable knowledge about what may lead to recovery in co-occurring disorders.

Today, I would like to know more about how you work, as of today, to support people with co-occurring disorders. I would like to know how you work, as well as your thoughts and experiences surrounding this.

We are interested in different opinions. Consensus is not a goal, rather the opposite! It is natural that you may hold different opinions, and I would like to hear those. There are no correct or wrong answers, and each one of you have valuable experience.

Sometimes people change their opinion during the interview, or think of new things, and that is also OK.

We would like to hear about what works well, and things that do not work so well, or where you may lack a good solution. It is your experience as practitioners that I would like to learn more about.

I will lead the interview and pose questions. I have some open questions and some detailed. It is my job to stick to the theme, so I might interrupt you at times. I will also summarise in order to check if I have understood what you said.

(Co-researcher) will observe and take notes, and she will help me to stick with the issue.

Are there any questions before we begin? Is it OK?

3: I would like to start with everyone saying their first name, profession, and how long you have been in the team.

4: What does recovery-oriented practice mean in this team? How do you work in a recovery-oriented way to support people with co-occurring disorders?

Can you please describe a course of intervention with a service user.

Can you please describe a normal day where you work to support people with co-occurring disorders?

Follow-up questions:

- Tell me more about that!
- I would really like to hear more about that.
- How do you work with that?
- What do you do to achieve that?
- Which experiences do you have with that?
- In which ways has that been useful?
- How does that feel like to you?
- What do the rest of you think about this?

7: Ending the interview

Is there anything that has not been said, that you would like to say?

Thank you for participating in this interview. You have contributed with valuable knowledge. If any of you should have questions afterwards, please contact me. My phone number is on the information sheet.

Thank you!

Doctoral dissertation no. 40

2019

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substance use disorders: A qualitative study
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Dissertation for the degree of PhD

Eva Brekke

ISBN: 978-82-7860-384-0 (print)

ISBN: 978-82-7860-385-7 (online)

usn.no

